

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Nepal. This will enable Nepal to develop information-based mental health plans with clear base-line information and targets.

Nepal's mental health policy was formulated in 1996. In terms of financing, less than one percent of health care expenditures by the government are directed towards mental health. There is no human right review body to inspect mental health facilities and impose sanctions on those facilities that persistently violate patients' rights.

In terms of the network of mental health facilities, there are 18 outpatient mental health facilities, 3 day treatment facilities, and 17 community-based psychiatric inpatient units available in the country. The majority of the mental health service users are treated in outpatient facilities.

Two percent of the training for medical doctors is devoted to mental health, and the same percentage is provided for nurses. One NGO is running a community mental health service in 7 of the 75 districts in the country. In other districts, community mental health services are not available, as mental health services are not yet integrated into the general health service system.

The total number of human resources working in mental health facilities or private practice per 100,000 populations is 0.59. There are no active consumer associations fighting for mental health issues in the public arena.

The department of health receives data from hospitals and primary health care centres, and publishes an annual report. Some research work is also done in mental health especially in teaching hospitals that have a psychiatry department.

# WHO-AIMS

## WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM IN NEPAL



World Health  
Organization



Ministry of Health  
and Population  
Nepal

**WHO-AIMS REPORT ON**  
**MENTAL HEALTH SYSTEM**  
**IN NEPAL**

*A report of the assessment of the mental health system in Nepal using the  
World Health Organization - Assessment Instrument for  
Mental Health Systems (WHO-AIMS).*

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Please refer to WHO-AIMS (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

[http://www.who.int/mental\\_health/evidence/WHO-AIMS/en/index.html](http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html)

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The WHO-AIMS project is coordinated by Shekhar Saxena.

## Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Nepal. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Nepal to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Nepal's mental health policy was formulated in 1996. Key components of the policy include: (1) to ensure the availability and accessibility of minimum mental health services for all the population of Nepal; (2) to prepare human resources in the area of mental health; (3) to protect the fundamental human rights of the mentally ill; and (4) to improve awareness about mental health. In terms of mental health financing, less than one percent of health care expenditures by the government are directed towards mental health. There is no human right review body with the authority to inspect mental health facilities and impose sanctions on those facilities that persistently violate patients' rights.

Mental health services are not organized in terms of catchment/service areas. There are 18 outpatient mental health facilities available in the country, none of which are reserved for children and adolescents only. These facilities treat 297.9 users per 100,000 general population. There are 3 day treatment facilities available in the country, which treat 0.766 users per 100,000 population, and there are 17<sup>1</sup> community-based psychiatric inpatient units (i.e. general hospitals and teaching hospitals) available in the country, with a total of 1.00 bed per 100,000 population. Finally, there is one mental hospital with a total of 0.20 beds per 100,000 population. The majority of users are treated in outpatient facilities.

Both physician based primary health care centres (PHC) and non-physician based PHC clinics provide primary health care (negligible mental health services) services in the country. In terms of training for primary health care staff, two percent of the training for medical doctors is devoted to mental health, and the same percentage is provided for nurses. One NGO is running a community mental health service in 7 of the 75 districts of the country. In these 7 districts, primary health care workers have received mental health training and refresher trainings. In other districts, community mental health services are not available, as mental health service is not yet integrated in the general health service system.

The total number of human resources working in mental health facilities or private practice per 100,000 population is 0.59. The breakdown according to profession is as follows: 0.13 psychiatrists, 0.06 other medical doctors, 0.27 nurses, 0.02 psychologists,

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<sup>1</sup> Nepal has no community based psychiatric inpatient units as such. Different governmental and private medical college hospitals with psychiatric inpatient units, except the mental hospital inpatient unit, have been grouped under Community Based psychiatric inpatients units according to WHO-AIMS definitions.

and 0.10 other health or mental health workers. The majority of psychiatrists work under the Ministry of Health, Ministry of Education (Government teaching hospitals), Ministry of Homes (Police hospitals), Ministry of Defence (Army hospital) and private sector medical college teaching hospitals. Others work in private hospitals and nursing homes. The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 8.52 times greater than the density of psychiatrists in the entire country, while the figure for nurses is 6.56. There are no active consumer associations fighting for mental health issues in the public arena.

The department of health receives mental health data from the hospitals and primary health care centres and publishes an annual report. In mental health it receives data under the broad heading of “mental disorders”. In other words, all mental disorders are included in one large category. There are plans to refine this broad category into five sub-categories in the future. Some research work is also done in mental health, especially in teaching hospitals that have a psychiatry department.



# WHO-AIMS COUNTRY REPORT FOR NEPAL

## Introduction

Nepal is a country with an approximate geographical area of 147 thousand square kilometres and a population of 25.72 million people (UNO, 2004). The main language used in the country is Nepali. The main ethnic group is Indigenous Nepalese and the other groups are Indo-Nepalese and Tibeto-Nepalese. Religious groups include Hindu, Buddhist, Muslim and Christian. The country is a lower middle income group country based on World Bank 2004 criteria.

Forty percent of the population is under the age of 15 and 6% of the population are over the age of 60 (UNO, 2004). Fourteen percent of the population is rural. The life expectancy at birth for males is 59.9 and 60.2 for females (WHO, 2004). The healthy life expectancy at birth is 52 for males and 51 for females (WHO, 2004). The literacy rate for men is 61.6% and 26.4% for women (WHO, 2004).

The proportion of the health budget to GDP is 5.3 (WHO, 2001). There are 18.82 hospital beds per 100,000 population (DoH, 2004) and 4.9 general practitioners per 100,000 populations (WHO, 2001). In terms of primary care, there are 268 physician-based primary health care clinics in the country (e.g., district hospital, health centres and primary health centre) and 3,179 non-physician based primary health care clinics (WHO, 2001).

Data was collected in 2006 and is based on the year 2005.

## Domain 1: Policy and Legislative Framework

Nepal's mental health policy was formulated in 1996. Key components of the policy include: (1) to ensure the availability and accessibility of minimum mental health services for all the population of Nepal; (2) to prepare human resources in the area of mental health; (3) to protect the fundamental human rights of the mentally ill; and (4) to improve awareness about mental health.. There is an essential drug list for different levels of health institutions. Health institutions with specialists (e.g., Central level hospitals) have more essential drugs available than do primary health clinics, in which there are only limited drugs available from the essential medicines list. In psychotropics, these medicines include Antipsychotics, Anxiolytics, Mood Stabilizers and Antiepileptic drugs.

There is no emergency/disaster preparedness plan for mental health but there is such plan for general health. There is no separate mental health legislation as yet, but a final draft of mental health legislation has been prepared and now it is in the ministry of health for review and finalisation.



Less than 1% of all health expenditures are directed towards mental health (0.17%) Of all the expenditures spent on mental health, a considerable amount of them are directed towards the mental hospital, whose annual budget was 10 million Nepalese Rupees in 2005. However, there is no clear data on how much of the budget is spent on the mental health service because the expenditure is made from different sources (the Ministry of Health and Population, Ministry of Education, Ministry of Home, Ministry of Defence and private sector hospitals). In terms of affordability of mental health services, a negligible portion of the population has free access to essential psychotropic medicines; however, there is no specific data on how many people are receiving them for free. For those that have to pay for their medicines out of pocket, the cost of antipsychotic medication is approximately 9 Nepalese Rupees (NRs) per day, and the cost of antidepressant medication is 9 NRs per day. This corresponds to approximately 8% of the daily wage of a day labourer. There is no social insurance scheme in Nepal.

None of the mental health service staff and inpatient psychiatric unit staff have participated in any trainings, meetings, or other type of working session on human rights in the year of assessment.

## **Domain 2: Mental Health Services**

There are 18 outpatient mental health facilities available in the country, of which none are for children and adolescents only. These facilities treat 297.9 users per 100,000 general populations. Of all users treated in mental health outpatient facilities, 46% are female. The percentage of children and adolescent is not known. The users treated in outpatient facilities are primarily diagnosed with schizophrenia (21%) and neurotic disorders (56%).

The average number of contacts per user is unknown. All outpatient facilities provide follow-up care in the community; while none have mental health mobile teams. In terms of available treatments, a few (1-20 %) patients in outpatient facilities last year received one or more psychosocial interventions. All of the outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a near-by pharmacy all year long.

There are 3 day treatment facilities available in the country, of which none are for children and adolescents only. These facilities treat 0.766 users per 100,000 population. Forty four percent of users in day treatment facilities are female and the percentage of children or adolescents is not known.

There are 17 community-based psychiatric inpatient units available in the country for a total of 1.00 beds per 100,000 population. None of the beds in community-based psychiatric inpatient units are reserved for children and adolescents only. Forty-four percent of patients are female. The diagnoses of admissions to community-based psychiatric inpatient units were primarily from the following two diagnostic groups:

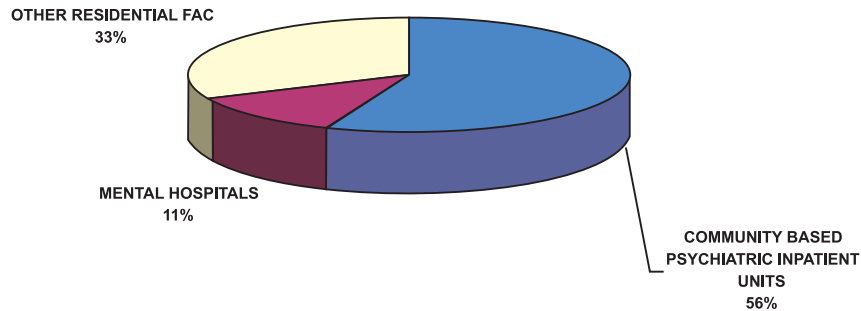
Neurotic, stress related and somatoform disorders (47%) and Mood [affective] disorders (26%). Few patients (1-20%) in community-based psychiatric inpatient units received one or more psychosocial interventions in the past year, while 100% percent of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility. There are no public community residential facilities for mental health patients in the country.

There is one mental hospital available in the country for a total of 0.20 beds per 100,000 population. This mental hospital is organizationally integrated with mental health outpatient facilities. There are no beds in mental hospitals reserved for children and adolescents only. These facilities treat 3.43 users per 100,000. Thirty-seven percent of patients are female. The patients admitted to mental hospitals belong primarily to the following two diagnostic groups: Schizophrenia, schizotypal and delusional disorders (34%) and Mood [affective] disorders (21%). On average, patients spend 18.85 days in mental hospitals. All of the patients spent less than one year in the mental hospital during the year of assessment. A few patients (1-20%) in mental hospitals received one or more psychosocial interventions in the past year. The mental hospital had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

There is no provision of separate forensic inpatient units. However medico-legal mental disorder patients, whenever necessary, are admitted in mental hospital inpatient units for evaluation, court report and for treatment. There are 145 beds in other residential facilities, such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc.

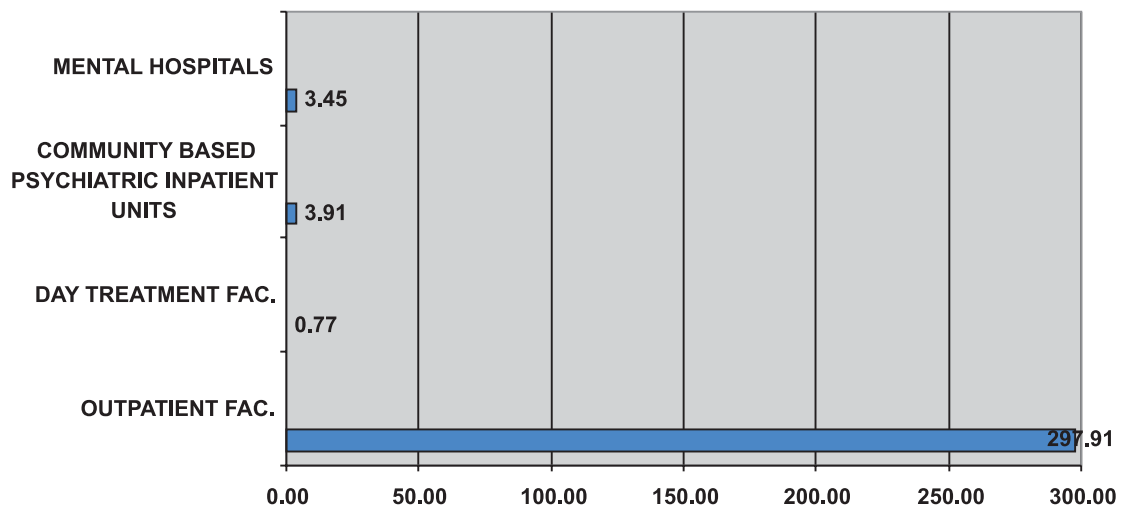
The data of involuntary admissions in community-based inpatient psychiatric units is not available; however, almost all the cases in the mental hospital were voluntary. Again, there is no data on how many patients were retained or secluded within the last year in community-based psychiatric inpatient units, but in comparison 6-10% of the patients in mental hospitals were retained or secluded. Eighty percent of the psychiatry beds in the country are located in or near the largest city. Such a distribution prevents access for rural users. Inequity of access to mental health services for other minority users is a moderate issue in the country.

**GRAPH 2.1 – BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES**



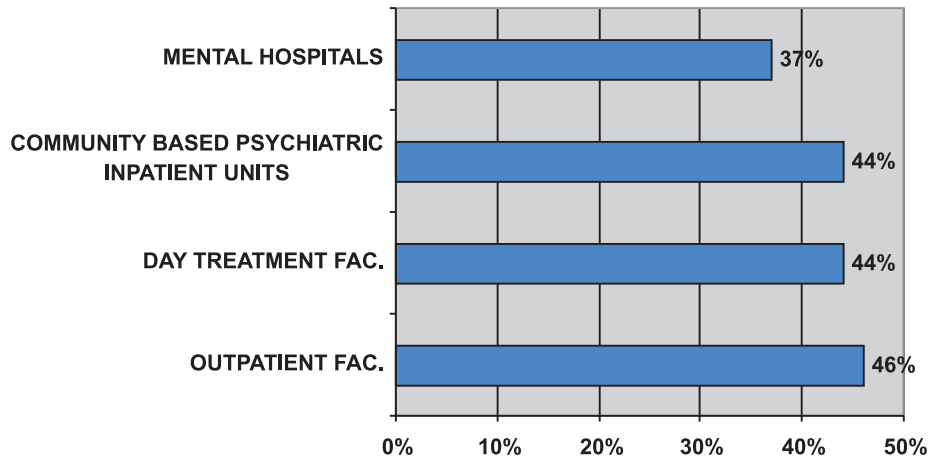
The majority of beds in the country are provided by community based psychiatric inpatient units, followed by residential units inside and outside the mental health system.

**GRAPH 2.2 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)**



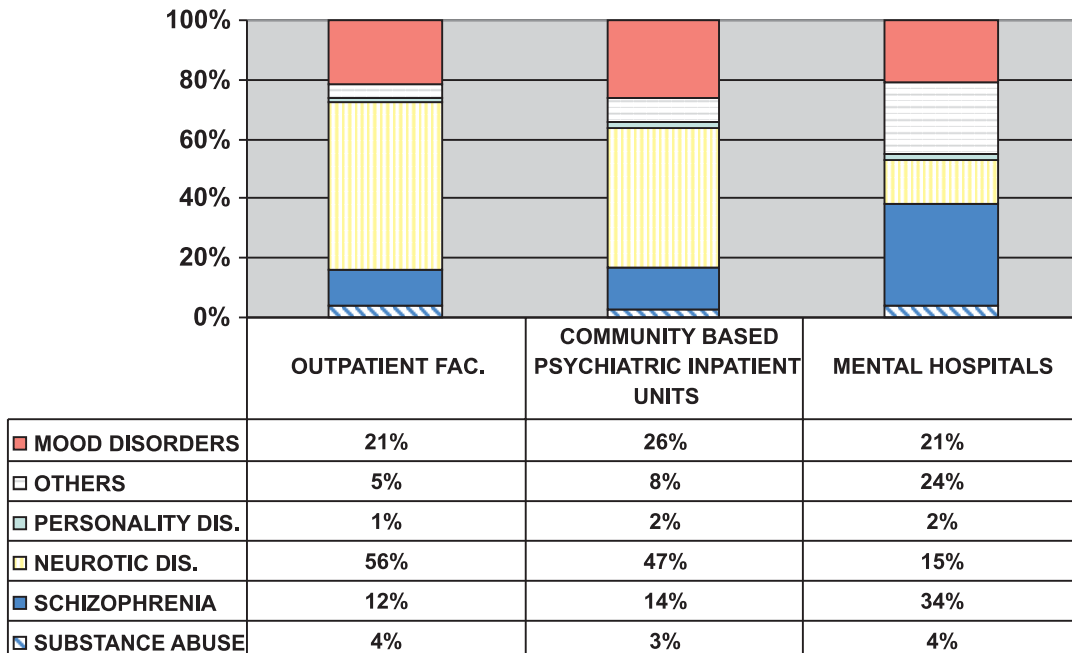
The majority of the users are treated in outpatient facilities, while the rate of users treated in day treatment facilities, mental hospital, outpatient and community based psychiatric inpatient units is considerably low. There is no community residential facility or forensic unit for treatment.

**GRAPH 2.3 – PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES**



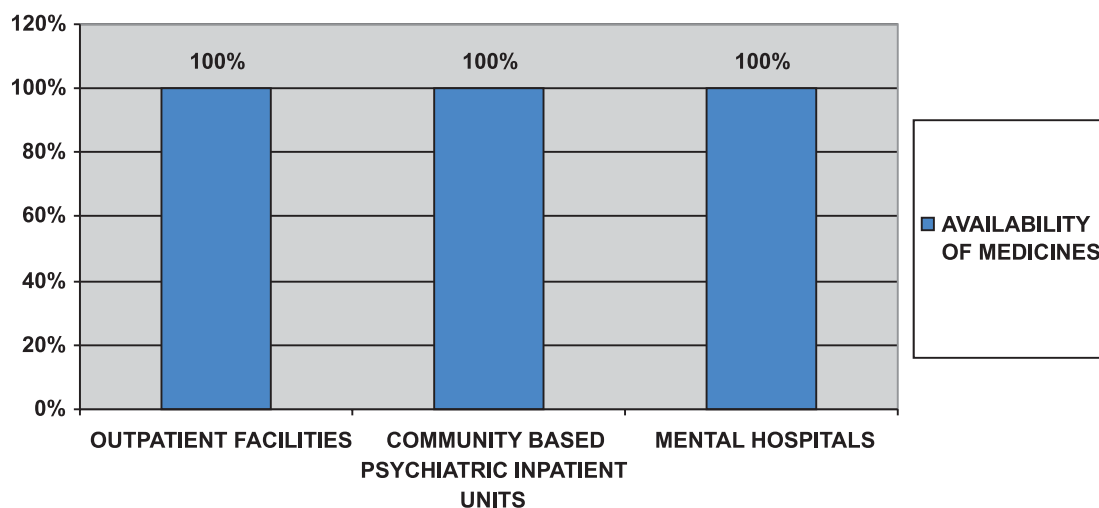
Female users make up over 35% of the population in all mental health facilities in the country. The proportion of female users is highest in out patient facilities, day treatment facilities and community based psychiatric inpatient facilities, and relatively lower in the mental hospital.

**GRAPH 2.4 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS**



The distribution of diagnoses varies across facilities: neurotic disorders and mood disorders are most common in community based inpatient units as well as in outpatient facilities, and schizophrenia, mood disorders and acute and transient psychosis and “other” diagnoses are most frequent in mental hospitals.

**GRAPH 2.5 – AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES**



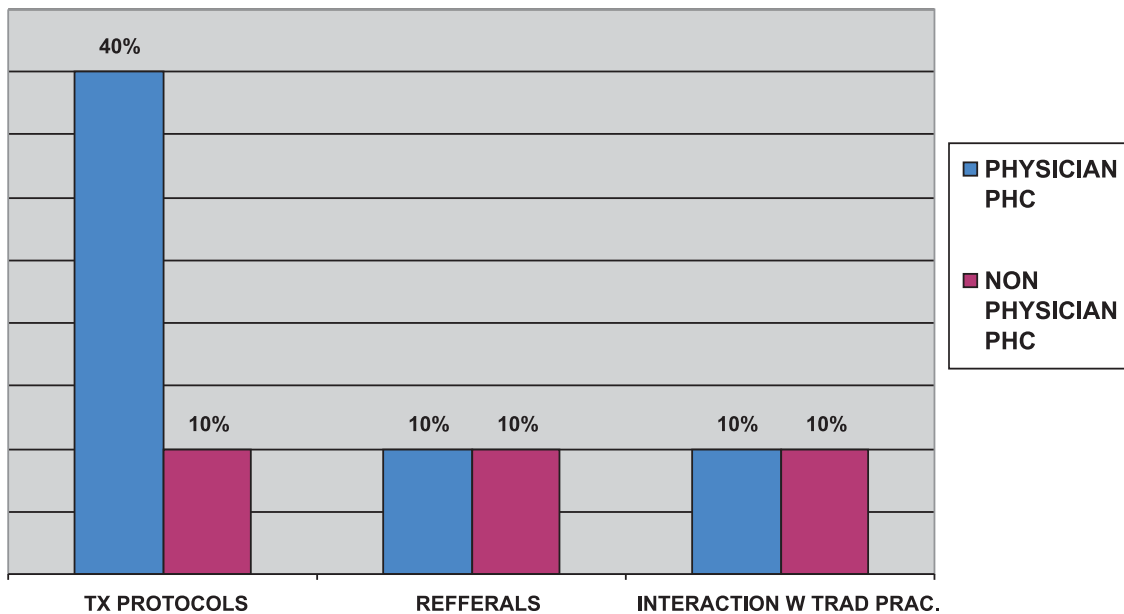
Psychotropic drugs are widely available in mental hospitals, inpatient units and outpatient mental health facilities.

### **Domain 3: Mental Health in Primary Health Care**

Two percent of the training for medical doctors is devoted to mental health, and the same percentage is provided for nurses. In terms of refresher training on mental health, none of the primary health care doctors have received such training.

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. In terms of physician-based primary health care clinics, some of the clinics (between 21-50%) have available assessment and treatment protocols for key mental health conditions. In comparison, only a few clinics (between 1-20%) in non-physician-based primary health care have these protocols. A few of the physician-based primary health care clinics (between 1-20%) make, on average, at least one referral to a mental health professional. A small number of these clinics make more than one referral per month. Some non-physician based primary health care clinics (between 1-20%) make a referral to a higher level of care (e.g., mental health professional or physician-based primary health clinic). In terms of professional interaction between primary health care staff and other care providers, some of the primary care doctors (between 1-20%) have interacted with a mental health professional at least once in the last year. Only a few from the physician-based PHC facilities (between 1-20%) have had interaction with a complimentary /alternative /traditional practitioner.

**GRAPH 3.1 – COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE**

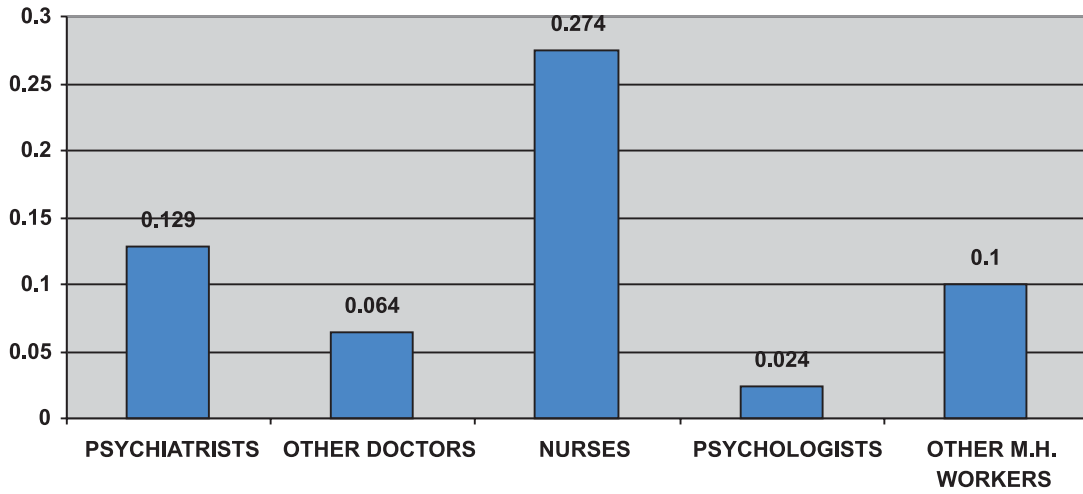


Primary health care nurses, non-doctor/non-nurse primary health care workers are allowed to prescribe but with restrictions. For example, they are not allowed to initiate prescription but are allowed to continue prescription. In addition to that, primary health care doctors are allowed to prescribe without restriction. As for availability of psychotropic medicines, a majority (51-80%) of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) in comparison to some (21-50%) of the non-physician-based clinics.

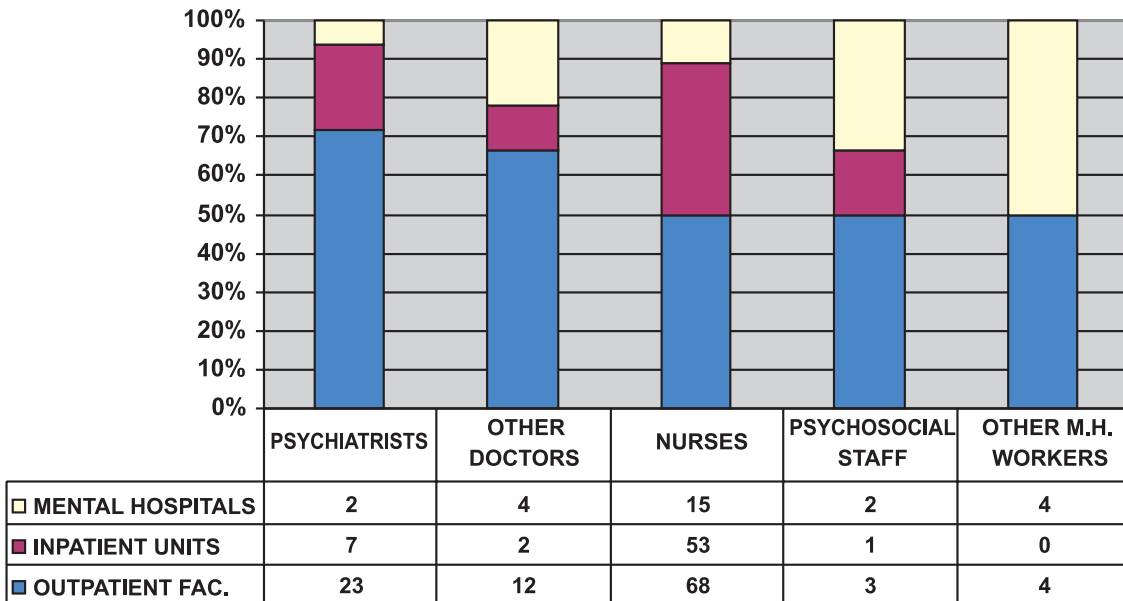
#### **Domain 4: Human Resources**

The total number of human resources working in mental health facilities, including the private sector, per 100,000 populations is 0.59. The breakdown according to profession is as follows: 32 psychiatrists (0.129 per 100,000 population), 16 other medical doctors (not specialized in psychiatry) (0.0645 per 100,000 population), 68 nurses (0.274 per 100,000 population), 6 psychologists (0.024 per 100,000 population), no social workers, no occupational therapists, and 25 (.101 per 100,000 population) other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors).

**GRAPH 4.1 – HUMAN RESOURCES IN MENTAL HEALTH**  
(rate per 100.000 population)

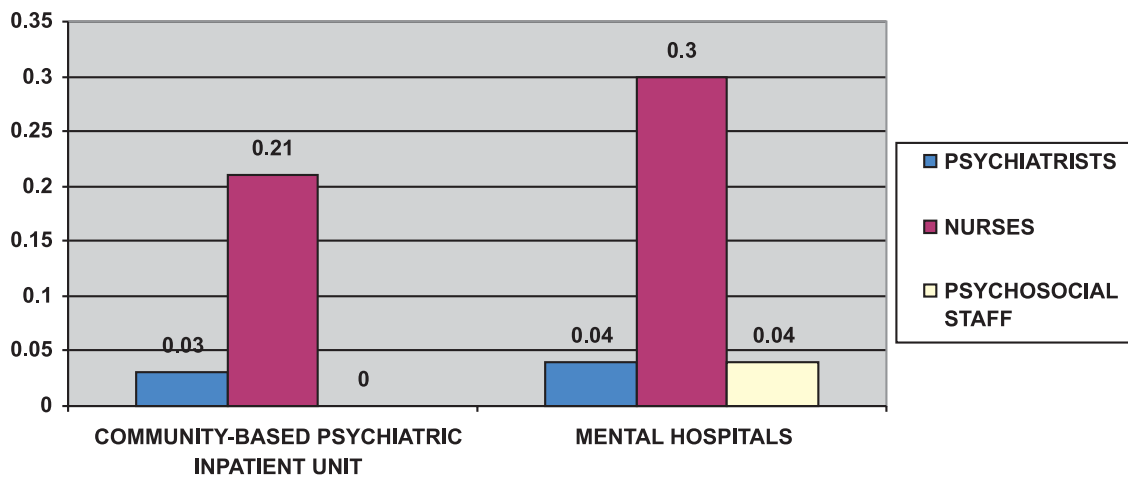


**GRAPH 4.2 – STAFF WORKING IN MENTAL HEALTH FACILITIES**  
(percentage in the graph, number in the table)



In terms of staffing in mental health facilities, there are 0.03 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.04 psychiatrists per bed in mental hospitals. As for nurses, there are 0.21 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.30 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, and other health or mental health workers), none of these professionals work in community-based psychiatric inpatient units. The rate of these professionals who work in mental hospitals is 0.12 per bed.

**GRAPH 4.3 – AVERAGE NUMBER OF STAFF PER BED**

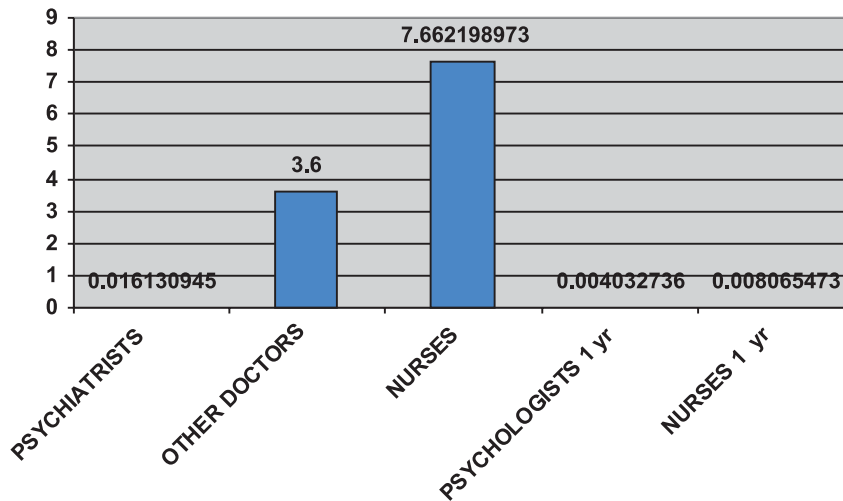


The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 8.52 times greater than the density of psychiatrists in the entire country. The density of nurses is 6.56 times greater in the largest city than in the entire country.

The number of professionals who graduated last year in academic and educational institutions per 100,000 is as follows: medical doctors (not specialized in psychiatry) 3.6, nurses (not specialized in psychiatry) 7.66, psychiatrists 0.016, psychologists with at least 1 year training in mental health care 0.004, nurses with at least 1 year training in mental health care 0.008, Some 21-50% of medical graduates immigrate to other countries within five years of the completion of their training.



**GRAPH 4.4 – PROFESSIONALS GRADUATED IN MENTAL HEALTH**  
(rate per 100.000 population)



There is no information on users/consumers that are members of consumer associations for health issues. However, there are 5 NGOs in the country that are involved in individual assistance activities such as counselling, housing, or support groups.

### **Domain 5: Public Education and Links with other Sectors**

There is no coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, and professional organizations have all promoted public education and awareness campaigns in the last five years. These campaigns have targeted the general population, as well as children and adolescents. In addition, there have been public education and awareness campaigns targeting professional groups, including teachers and healthcare providers.

There is no mental health legislation protecting the right of patients with mental disorders as yet. However, a draft of the mental health legislation has been prepared and at present it is in the Ministry of Health and Population for revision and finalisation.

Despite the lack of legislative and financial support for people with mental disorders, there are formal collaborations between the government department responsible for mental health and the departments/agencies responsible for Primary Health Care/ Community Health, Child and Adolescent Health and Substance Abuse.

In terms of support for child and adolescent health, less than 0.02% of primary and secondary schools have either a part-time or full-time mental health professional, and a

few (between 1%-20%) of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

The percentage of persons with mental retardation is about 3% (estimated figure). Few prisons (between 1-20%) have at least one prisoner per month in treatment contact with a mental health professional. As for training, some police officers (between 1-20%) and no judges or lawyers (0%) have participated in educational activities on mental health in the last five years. In terms of financial support for users, no mental health facilities (0%) have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders.

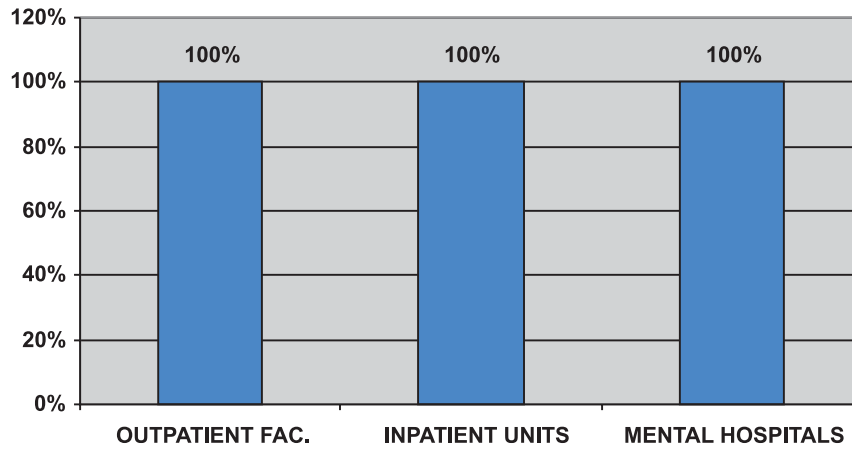
## Domain 6: Monitoring and Research

There is no formally defined minimum data set of items to be collected by mental health facilities. However, the government health department received some mental health data from the mental hospital, as well as from the community based psychiatric inpatient units, and mental health outpatient facilities. In terms of research, 3% of all health publications in the country were on mental health. This research focused on the following topics: Epidemiological studies in clinical samples, Non-epidemiological clinical/questionnaires assessments of mental disorders and Psychosocial interventions/psychotherapeutic interventions.

**Table 6.1 – Percentage of mental health facilities collecting and compiling data by type of information**

<b>TYPE OF INFORMATION COMPILED</b>	<b>MENTAL HOSPITALS</b>	<b>INPATIENT UNITS</b>	<b>OUTPATIENT FAC.</b>
N° of beds	1	17	NA
N° inpatient admissions/users treated in outpatient facilities	1	17	18
N° of days spent/user contacts in outpatient facilities.	1	17	0
N° of involuntary admissions	0	0	NA
N° of users restrained	0	0	NA
Diagnoses	1	17	18

**GRAPH 6.1 – PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT**



## **Strengths and Weaknesses of the Mental Health System in Nepal**

### **Strengths of the mental health system:**

The country has a national mental health policy and human resource development is taking place in the country. In addition, there is a good network within the general health service system where mental health can be integrated. There is a gradual increase in awareness of mental health in the general population and the number of people seeking treatment in the mental health institution is increasing. Psychotropic drugs are widely available. In the essential drug list psychotropic medicines are included up to the primary health centre. Some private medical colleges and NGOs are providing psychiatric services. There is a good family system, which takes responsibility for their sick family members at home. The community mental health system that is run by NGOs in 7 districts has been found to be useful and effective.

### **Weakness:**

Financial constraints exist and the majority of the people in the country are poor and therefore, cannot afford treatment. There is only one mental hospital in the country, which is not enough to address the huge need for inpatient care. Mental health services are not easily available in the rural areas and in remote places. There is a stigma around mental health. The infrastructure of mental health services is poor and the human resources are not sufficient. There is no mental health legislation as yet. There are no human rights issues addressed for mental health patients. The government has not allocated an adequate budget for mental health services. No consumer association exists in the country, which focuses on mental health services. Some connection with the health and education sector exists but there is no link with criminal justice and other sectors. The country's mental health information system is poor. There is no separate division for mental health under the Ministry of health.

### **Next Steps in Strengthening the Mental Health System**

To ensure the availability and accessibility of mental health services for all of the population of Nepal, and in particular for the most vulnerable and under-privileged groups of the population, mental health services has to be integrated into the general health services system of the country.

Mental health care facilities should be developed and have an active and dynamic interaction with the communities they serve. Mental health services have to be made available at the regional, district and peripheral levels. They have to be integrated into general health services at all levels including primary health care. Mental health resources have to be distributed in accordance with the mental health policy, and adequate supply of essential psychotropic drugs should be maintained. Research

exploring the development of a more efficient and effective mental health care structure has to be undertaken, and an evaluation of the impact of such structures and services has to be made.

Given that there are inadequate human resources in the area of mental health to address the need of mental health patients, mental health training for all health workers, preparation of personnel with a specialty in mental health, and training for groups are needed. There has to be adequate and appropriate mental health and behaviour science components in all health workers' curricula in the country. Mental health components have to be developed within the in-service training structures, especially at the National Training Centre and the Regional Training Centres. The manpower of specialists in mental health, i.e., psychiatrists, psychiatric nurses, clinical psychologists, psychiatric social workers, etc., has to be further developed.

Mental health legislation to insure the rights of people with mental disorders has to be developed and implemented. Finally, awareness raising activities on the formulated rights have to be done as well.