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Identifying Challenges to the Equal Realization of Human Rights for Individuals with Psychosocial Disability in Nepal

Identifikasi Tantangan dalam Mewujudkan Kesetaraan Hak Asasi Manusia bagi Penyadang Disabilitas Psikososial di Nepal

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ABSTRACT: Nepal is currently facing a severe mental health crisis characterized by a significant prevalence of mental illness that remains largely unaddressed. The issue is exacerbated by pervasive social stigma, lack of awareness, and insufficient political commitment, pushing mental health to the bottom of the political agenda. In Nepal, mental health treatment predominantly focuses on biomedical interventions, mainly ignoring the human rights aspects, highlighting the crucial need for a paradigm shift in approach. The enactment of the Convention on the Rights of Persons with Disabilities (CRPD) on June 6, 2010, presents an opportunity for a transformative shift in Nepal's approach to mental health. This research investigates the barriers within Nepal's rights-based mental health framework, drawing insights from individuals with psychosocial disabilities, their families, policymakers, legal experts, and NGO representatives. It features four case studies that highlight the challenges these individuals face, and the roles played by their families and communities in providing care. The objective is to provide insights into the daily realities of community members in Nepal. In summary, the study highlights the importance of adopting a robust human rights-based approach to quality practice. Such an approach, which fosters trust in engaging individuals with psychosocial disabilities, their families, the community, and mental health service providers, is not merely a theoretical concept but a vital requirement for enhancing mental health practices in Nepal.

ABSTRAK: *Nepal tengah menghadapi krisis kesehatan mental yang parah, yang ditandai dengan tingginya prevalensi penyakit mental yang sebagian besar belum ditangani. Masalah ini diperburuk oleh stigma sosial yang meluas, kurangnya kesadaran, dan rendahnya komitmen politik, sehingga kesehatan mental tidak lagi menjadi agenda politik. Di Nepal, perawatan kesehatan mental yang sebagian besar berfokus pada intervensi biomedis dan mengabaikan aspek hak asasi manusia, menunjukkan pentingnya kebutuhan perubahan paradigma. Pemberlakukan Konvensi Hak-Hak Penyandang Disabilitas (CRPD) pada tanggal 6 Juni 2001, menghadirkan peluang untuk mengubah pendekatan Nepal terhadap kesehatan mental secara transformatif. Penelitian ini menganalisis hambatan dalam pendekatan kesehatan mental berbasis hak di Nepal, dengan dalam perspektif para penyandang disabilitas psikososial dan keluarganya, serta para pembuat kebijakan, pakar hukum, dan LSM. Penelitian ini menyajikan empat studi kasus yang menyoroti tantangan yang dihadapi oleh para penyandang disabilitas psikososial serta peran keluarga dan komunitas dalam memberikan perawatan. Tujuannya adalah untuk memberikan wawasan tentang realitas sehari-hari anggota komunitas di Nepal. Penelitian ini menyoroti pentingnya mengadopsi pendekatan berbasis hak asasi manusia yang kuat untuk praktik yang berkualitas. Pendekatan semacam itu, yang menumbuhkan kepercayaan dalam melibatkan individu dengan disabilitas psikososial, keluarga mereka, komunitas, dan penyedia layanan kesehatan mental, bukan sekadar konsep teoritis tetapi persyaratan penting untuk meningkatkan praktik kesehatan mental di Nepal.*

Keywords:
psychosocial disabilities; human rights approach; Nepal mental healthcare; CRPD implementation; mental health policy

Kata Kunci:
disabilitas psikososial; pendekatan hak asasi manusia; perawatan kesehatan mental Nepal; implementasi CRPD; kebijakan kesehatan mental

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1. Introduction

The prevalence of mental illnesses among Nepalese, such as depression, anxiety, and schizophrenia, is on the rise annually. Despite this trend, the Nepalese Government's efforts in addressing this issue have been underwhelming, with less than 1% of the health budget allocated to mental health.[1] The Nepal government ratified the CRPD and Optional Protocol on June 6, 2010, signifying a significant milestone. Following this development, the government anticipated actively enforcing policies to uphold human rights for individuals with disabilities. However, in practice, these rights remained merely theoretical and not effectively implemented or enforced, with little emphasis on the inclusion of individuals with psychosocial disabilities at the local level.

The Movement for Global Mental Health (MGMH) emerged to make mental health accessible to all, focusing on evidence-based service expansion to promote mental health for everyone.[2] Nevertheless, critics argue that the scientific evidence driving this objective fails to capture the everyday challenges faced by those living with mental health issues.[3]

This study aims to investigate case studies involving individuals with psychosocial disabilities, their caregivers, and various mental health stakeholders. Through in-depth interviews and observations, the study explores their perspectives on the rights of individuals with psychosocial disabilities. These diverse viewpoints influence the formulation of mental health policies and practices. The research highlights emerging relationships between stakeholders and individuals with psychosocial disabilities, underscoring the importance of effective communication and trust in these interactions.

The potential outcomes of this research promise to influence the Nepal government and stakeholders advocating for individuals with psychosocial disabilities. By fostering enhanced collaboration, the findings could pave the way for developing more inclusive and impactful mental health regulations and practices, instilling a sense of hope and encouragement among stakeholders.

While this study examines psychosocial disability from both biological and social standpoints, its main focus is not on deconstructing the concept of psychosocial disability. Instead, it explores how stakeholders define and interpret psychosocial disability and how these perceptions shape policies and services. This critical area of study warrants our undivided attention and active involvement.

The structure of this paper will follow the analytical framework of Michel Foucault, encompassing an overview and background, historical context, problem statement, current legal frameworks, research questions, research methodology, researcher's perspective, and assumptions. It will conclude with discussions and interpretations of the key findings.

This study seeks to analyze the lived experiences of people with psychosocial disabilities, their carers/family members, and individuals working in mental health in Nepal. The research is particularly relevant in the context of Nepal, where mental health issues are often stigmatized, and people with psychosocial disabilities face significant social and institutional barriers.

This research also explores various works on mental health analysis. A significant contribution comes from Michael Foucault, a critical historian, in his book, "Madness and Civilization: A History of Insanity in the Age of Reason."[4] Foucault's examination of the evolution of thought and the ongoing isolation of individuals with psychosocial disabilities in the contemporary era is particularly insightful. His work emphasizes the importance of understanding the historical perspective on mental health, as it provides a context for the current state of mental health treatment and enables us to appreciate the progress made.

China Mills' book, "Decolonizing Global Mental Health: The Psychiatrization of the Majority World," offers compelling narratives regarding how psychiatrists and organizations 'treat' individuals with mental health issues. Mills criticizes psychiatry for overprescribing medications and promoting the medical model while neglecting the social aspects of treatment. She discusses the human rights of individuals with mental health problems, stressing the moral imperative to address these violations in their treatment.

1 Nawaraj Upadhaya et al., "Current Situations and Future Directions for Mental Health System Governance in Nepal: Findings from a Qualitative Study," *International Journal of Mental Health Systems* 11, no. 1 (June 8, 2017), https://doi.org/10.1186/s13033-017-0145-3.

2 Vikram Patel et al., "The Movement for Global Mental Health," *The British Journal of Psychiatry* 198, no. 2 (February 1, 2011): 88–90, https://doi.org/10.1192/bjp.bp.109.074518.

3 China Mills, *Decolonizing Global Mental Health* (UK: Routledge, 2014).; Summerfield, 2008.

4 Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Vintage Books, 1961).

In "Dignity in Care: The Human Side of Medicine," Dr. Harvey Max Chochivon offers insights into a critical aspect of healthcare. He discusses how neglecting the human side of medicine can inadvertently cause further harm, undermining patients' sense of being understood. Comparing Dr. Harvey's insights with Foucault's analysis reveals how modern psychiatry, through its scientific and technological advancements, evolved into an institution that used scientific methods to isolate and repress individuals with psychosocial disabilities. Foucault describes a significant shift in the treatment of such individuals, referring to it as 'The Great Confinement' (1965). This term, coined by Foucault, denotes the widespread practice of confining people with psychosocial disabilities in asylums, marking a significant turning point in the history of mental health treatment. The role of societal rejection in shaping modern mental health treatment is crucial, as it significantly contributes to the current treatment approaches for mental illnesses.

This article seeks to examine how the barriers faced by people with psychosocial disabilities in Nepal impact their ability to achieve, access, and realize their human rights while also exploring practical solutions to address these challenges. Understanding and highlighting these barriers' immediate and significant effects is crucial for shedding light on the realities experienced by this vulnerable group and proposing actionable measures to promote inclusivity and equity. This focus is essential in advancing a comprehensive understanding of the human rights challenges faced by individuals with psychosocial disabilities and in fostering meaningful change to improve their lives.

2. Method

The qualitative approach was applied to collect data for this research. The researcher used a case study approach to collect data. In collaboration with a local NGO working in mental health, interviews were conducted with four people with psychosocial disabilities and four family members/carers of an individual with a psychosocial disability. These interviews were not just data collection but a platform for these individuals to share their lived experiences, providing invaluable insights into the subject, and making them the heart of this research.

Table 1. Respondent Profile for Case Studies

	Case 1: FEMALE SITA	**Case 2: MALE RAM**	**Case 3: FEMALE MAYA**	**Case 4: MALE SUNIL**
Main Carer/Family Member Mother	C1/M	C2/M		C4/M
Main Carer/Family Member Husband			C3/H	
Additional Family Members	C1/ Sister	C2/Brother		C4/Father

Source: Author (2022)

This chart represents the four people with psychosocial disability interviewed: Sita, Ram, Maya, and Sunil. Carers/ Members of their families who were interviewed are presented accordingly. Under ethical considerations, pseudonyms have been used.

Furthermore, 20 semi-structured interviews with stakeholders working in mental health were conducted to ensure full representation. Each meeting, conducted with utmost care and respect, lasted 45 minutes. The interviews were detailed, studied, and transcribed carefully, ensuring that no valuable information was overlooked in the research process.

Participants were selected based on their relevance to the objectives of the research study, their ability to adequately articulate their experiences of care and mental health in Nepal, and their accessibility and familiarity. This selection process, known as purposive sampling, was used to ensure that only those participants who were sufficiently well enough to participate were chosen. Background information on the participants' case studies was gathered via collaborative work with the local NGO's documents and case files to avoid repeating any questions that prove challenging for them to answer. Rather than ask about their mental health, the interview questions focus solely on their access to services.

Also, the study analyses the barriers embedded in Nepal's rights-based approach to mental health practice by interviewing altogether 12 critical stakeholders working in the mental health area:

- Four Government Policymakers making the laws affecting people with psychosocial disability and their family members

- Two lawyers/legal experts knowledgeable of human rights issues in Nepal and who are involved in advising the policymakers
- Two Mental Health Researchers who have been doing research on mental health in Nepal
- Two human rights advocates who have experience working with the rights-based approach.
- Two Psychiatrists and 2 NGO social workers as they are experts in the issue faced by
- People with psychosocial disability and their family members/carers.

The IRB review board from Mahidol University approved and consented to this research.

3. Findings and Discussion

3.1 Contextual background

This section provides a brief history of mental health in Nepal, a low-income country (LIC) landlocked between China and India. Nepal is no exception to this trend, where the severe stigma associated with mental illness banishes the topic from communities[5] and relegates it to the bottom of the political agenda.[6]

3.1.1 Mental Health Burden in Nepal

Mental health is a universally neglected issue, with mental illness globally accounting for 13.0% of disability-adjusted life years. The unmet need for mental healthcare, characterized as the "treatment gap," remains significantly high in most low and middle-income countries (LMICs).[7] Nepal has been identified as one of the LMICs with the lowest health spending, mental hospital beds, and staff per person. Due to the inadequacy of reliable national data, there is no precise estimate available on the prevalence of mental illness in Nepal.[8]

The devastating 2015 earthquake in Nepal further compounded the burden of mental illness, weakening the already fragmented mental health system and drawing political attention to its deficiencies. Nonetheless, the mental health system remains insufficient mainly, with less than 5% of the national budget allocated to the health sector and only approximately 0.17% of the total budget dedicated to mental health.[9]

3.1.2 Nepal political restructuring and mental healthcare governance

In September 2015, Nepal adopted a new Constitution,[10] establishing a federal government structure to replace the previous unitary system.[11] The Constitution envisions the "coexistence, collaboration, and coordination" of three governing tiers comprising federal, seven provincial, and 753 municipal governments.[12] The first provincial and municipal government elections were held in late 2017, marking a significant step in the federalization process.[13]

"Good governance is necessary for ensuring effective healthcare delivery and policy implementation."[14] Following Nepal's tumultuous political history, this new political structure promises scope for health sector reform and strengthening the mental health system through improved governance. The municipal and provincial governments have been granted greater autonomy, and power devolution to these tiers is intended to facilitate bottom-up participatory planning tailored to local needs and an opportunity for enhanced accountability and

5 Nagendra P Luitel et al., "Mental Health Care in Nepal: Current Situation and Challenges for Development of a District Mental Health Care Plan," Conflict and Health 9, no. 1 (February 6, 2015), https://doi.org/10.1186/s13031-014-0030-5.

6 Lokanath Mishra, "Focus Group Discussion in Qualitative Research," TechnoLearn: An International Journal of Educational Technology 6, no. 1 (2016): 1–5, https://doi.org/10.5958/2249-5223.2016.00001.2.

7 Julian Eaton et al., "Scale up of Services for Mental Health in Low-Income and Middle-Income Countries," The Lancet 378, no. 9802 (October 2011): 1592–1603, https://doi.org/10.1016/s0140-6736(11)60891-x.

8 Upadhaya et al., "Mental Health System Governance in Nepal."

9 James Mugisha et al., "Health Systems Context(S) for Integrating Mental Health into Primary Health Care in Six Emerald Countries: A Situation Analysis," International Journal of Mental Health Systems 11, no. 1 (January 5, 2017), https://doi.org/10.1186/s13033-016-0114-2.

10 Nepal Law Commission, "Constitution of Nepal," 2015.

11 The Asia Foundation, "Diagnostic Study of Local Government in Federal Nepal 2017," 2018, https://asiafoundation.org/wp-content/uploads/2018/07/Diagnostic-Study-of-Local-Governance-in-Federal-Nepal-07112018.pdf.

12 Rajshree Thapa et al., "Implementing Federalism in the Health System of Nepal: Opportunities and Challenges," International Journal of Health Policy and Management 8, no. 4 (December 22, 2018): 195–98, https://doi.org/10.15171/ijhpm.2018.121.

13 The Asia Foundation, 2018.

14 Upadhaya et al., "Mental Health System Governance in Nepal."

transparency. Such decentralization has been reported to improve health outcomes and enhance local resource usage.[15] However, it is essential to remember that the prospects of improved governance of the mental health sector are not guaranteed and are contingent on a host of complex factors. Caution should be taken not to view this political transition as a panacea.

A study[16] found that in the initial stages of federalization, less than six months after the first municipal election, municipal governments could not discharge their constitutional mandates due to the lack of legal, political, institutional, and fiscal frameworks. The lack of clarity and resources prevented them from exercising their autonomy in the spirit of the Constitution and forced them to rely heavily on the federal Government (Ibid).

3.1.3 Healthcare Implementation Challenges Literature

The challenges to expanding mental healthcare coverage in LMICs have been studied and documented, including the context of Nepal.[17] Common obstacles across LMICs include financial and human resource constraints, community stigma and lack of mental health awareness, scarcity of trained mental health personnel,[18] deficient information systems regarding the treatment coverage of mental disorders, and the absence of monitoring and evaluation mechanisms. A key solution to these challenges is the introduction of a dedicated service coordinator in Nepal's mental healthcare system. The low priority and political commitment to mental health have been identified as critical barriers to mental healthcare implementation.[19] Nepal must establish a national government mental health policy, strategy, program, or legislation to address these challenges.[20]

All these common challenges have been reported in Nepal, both before and since[21] the adoption of the new Constitution. Furthermore, poor governance, which lacks accountability and solid mental health leadership, has been identified as a critical challenge to the mental health system in Nepal.[22] Additional obstacles have arisen in Nepal, stemming from the political transition's confusion. Of particular concern in federalism is the need for a clear delineation of authority between jurisdictions in the different layers of government, highlighting the importance of a well-defined organizational structure.

3.1.4 Policies and Legal Frameworks Related to Mental Health and Psychosocial Wellbeing in Nepal

3.1.4.1National Mental Health Policy 2052 (1996)

In Policy 2052 (1996), Nepal introduced the National Mental Health Policy, a crucial component of the government's ninth five-year plan. This policy was designed with key objectives in mind: to ensure universal access to mental health services, to enact legal measures for the protection of the human rights of individuals with mental health issues, to enhance public awareness, and to combat stigma within the general population.

The policy was missing psychosocial aspects related to healthcare. Lack of financial and human resources management became a significant barrier to its implementation, making it less effective. In addition, proper data regarding mental health needs across the country for appropriate activity planning is lacking.

3.1.4.2Public Health Service Act 2075 (2018)

The Public Health Service Act 2075[23] is a comprehensive legislation ensuring Nepali citizens' right to free primary health and emergency services, as guaranteed by the Constitution of Nepal.[24] It establishes the right of all Nepali citizens to health services, making them regular, effective, efficient, and readily available. The Act also includes specific provisions related to mental health, further strengthening its comprehensive nature.

Under this Act, two chapters (2 and 8), sections (3, 8, 45 and 52, 53), few sub-sections and clauses are related to mental health. In the second chapter, under section 3 of ''Access to and certainty of health service,'' sub-section four mentions that every citizen shall have the right to obtain free essential health services, and clause (e) mentions services relating to mental disease. Similarly, under section 8, the duties of the service recipient are

15 Thapa et al., "Health System of Nepal."
16 The Asia Foundation, 2018.
17 Eaton et al., "Mental Health in Low-Income and Middle-Income Countries."; Hanlon et al., 2014.
18 Eaton et al., "Mental Health in Low-Income and Middle-Income Countries."; Hanlon et al., 2014.
19 Eaton et al., "Mental Health in Low-Income and Middle-Income Countries."; Hanlon et al., 2014.
20 Eaton et al., "Mental Health in Low-Income and Middle-Income Countries."
21 Upadhaya et al., "Mental Health System Governance in Nepal."
22 Upadhaya et al., "Mental Health System Governance in Nepal."
23 Nepal Law Commission 2018, "Public Health Service Act."
24 Nepal Law Commission, "Constitution of Nepal," 2015. http://www.lawcommission.gov.np/en/wp-content/upload/2021/01/constitution-of-Nepal.pdf.

noted, and the recipient shall not commit any act that constitutes physical, mental, or gender violence against a health worker under clause (e). There has been violence and vandalization targeted at the health workers. Section 45, Advertisement, dissemination and transmission affecting public health, under sub-section 2, strictly prohibits publicly advertising any materials and services that affect mental and physical health.

Under Chapter 8, sections 52 and 53 of the Public Health Service Act 2075,[25] mistreating a person with mental health problems is considered a severe offense. This includes physically restraining or inhumanely confining them. Those found guilty of such actions could face a fine of up to fifty thousand rupees or imprisonment for one year or more.

3.1.4.3National Health Policy 2076 (2019)

The National Health Policy, 2076 (2019) is designed to create an inclusive environment where all citizens can enjoy the right to health. It aims to strengthen social health protection and increase the outreach of health services, particularly to the most marginalized populations. While the Policy adopts a universal health care approach, it does not have any specific strategies or special provisions for persons with psychosocial disabilities. However, it reflects Nepal's international commitments, ensuring that no one is left behind in our pursuit of better health.

The Policy has a strategy to develop and expand mental health services integrated into overall health systems at the primary level. It aims to ensure people's access to mental health and psychosocial services through primary hospitals by building the capacity of related professionals. The document also contains two other policies (6.8 and 6.9) essential to the MHPSS sector, which aim to develop skilled human resources and create structures of health professional councils for regulation.

3.1.4.4National Mental Health Strategy and Action Plan 2077 (2020)

The National Mental Health Strategy and Action Plan 2020 for Nepal is a comprehensive roadmap that outlines the government's plans for the mental health sector at all three levels. Approved by the Ministry of Health and Population (MoHP) for five years from 2077/78 to 2081/82 (2020-2025), the strategy envisions providing free primary care-level mental health services nationwide. This comprehensive approach is designed to instill confidence and reassurance in all stakeholders.

3.2 Findings

Summerfield[26] strongly critiques the MGMH, arguing that its biomedical focus reflects broader development interventions that follow a free-market ideology and impose capitalism. This approach can directly contribute to the deterioration of mental health, as capitalism has been shown to increase social inequality. Summerfield,[27] Mills,[28] and others have strongly advocated for the inclusion of the broader social context in the design of mental healthcare systems, underlining the importance of considering social factors in mental health.

One response of the MGMH was to advocate for community-based services. However, research has found that these are often still separated from local realities and revolve around psychiatric drug treatment.[29] The parallel with other types of international intervention is unmistakable. The danger of the medicalization of everyday life is that it deflects attention from what millions of people worldwide might cite as the basis of their distress – for example, poverty and lack of rights.

3.2.1 Analysis and Findings from the Case Studies: People with Psychosocial Disability and Their Carers/Family Experiences

This section outlines four case studies of people with psychosocial disability and their carers, giving the reader a taste of the people whose journey, perspectives, and experiences reflect the paper. All clients have been diagnosed with various mental illnesses and are residents of Lalitpur, Nepal.

25 Nepal Law Commission 2018, "Public Health Service Act."
26 Summerfield, 2008, 993.
27 Summerfield, 2008.; Derek Summerfield, "Afterword: Against 'Global Mental Health,'" Transcultural Psychiatry 49, no. 3-4 (July 2012): 519–30, https://doi.org/10.1177/1363461512454701.
28 China Mills, "From 'Invisible Problem' to Global Priority: The Inclusion of Mental Health in the Sustainable Development Goals," Development and Change 49, no. 3 (March 6, 2018): 843–66, https://doi.org/10.1111/dech.12397.
29 Summerfield, "Global Mental Health."

3.2.1.1Case Study 1: SITA

The first case involves Sita, a female in her 30s. When experiencing low moods, she can become reclusive or violent and wanders the street. She has been taking medication for the last ten years. The first time when Sita started showing signs of her mental health condition, her family just used to tie her in the courtyard. Her mother (carer) stated that:

> *"We used to tie Sita's hand with a shawl and tie the shawl to the fence. Sita would sit there helplessly and would occasionally scream when people went near her. We were scared that she might attack everyone around her. Therefore, we did not have any other option than to tie her up."*

Her family shifted Sita to the rehabilitation center, where she experienced much abuse. She explains

> *"I loved the food there, but I hated the place. There was no bed nor a pillow to sleep on. I had to sleep on the floor, and I could not sleep. The room was cold during the day and night. There was just a tiny window that gave me a sense of relief. I screamed a lot because they used to tie me up with a chain. I used to cry a lot, and one day, they even shaved my beautiful hair without asking me. That place was a mess. "*

3.2.1.2Case Study 2: RAM

The second case involves Ram, a male in his thirties. He experiences auditory hallucinations and persecutory delusions. Ram depends on his elderly mother for food, medication, and hygiene.

When he first started showing mental health signs, his older brothers and mother took him to a mental hospital, where they found out that he was suffering from mental health-related issues. The doctors in the hospital studied him in "great detail" and advised that he had to be kept there for a few weeks. The family admitted him to the hospital, but on the eighth day, he ran away from there and returned home. Ram's mother states that:

> *"Ram sleeps the whole day. I visited eight different temples and fasted for his recovery, but "nothing happened." His condition became "even worse." "One day, Ram took all his medicines at once and almost died. I took my son to a hospital, where the doctors phoned the police, and the police arrested me, suspecting me of using medicines to poison my son. Only after "long hours of interrogation" was I finally allowed to return to the hospital to take care of my son. There was no support for me to look after my son from the government, and still, they arrested me. That was the worst day of my life."*

Ram's mother is his only carer. She cooks food for him every day. One time, when she got accidentally hit by a school bus, she had to be hospitalized for eight days. During this time, Ram had to survive on instant noodles and water. She is already 70 years old and has been the only person caring for her son since his mental condition deteriorated. She complained:

> *"I used to be invited by my relatives during every festival. But now they invite me no more. I could not go to their parties because I didn't want to leave my son in this condition. Now, I need somewhere to go. I need somewhere to turn to. All my relatives have abandoned me. Sometimes, I feel as if my entire life is one big punishment. I have no rest and no holiday."*

3.2.1.3Case Study 3: MAYA

The third case involves Maya, a 28-year-old female. She experiences hallucinations. Maya is unable to go to school and socialize considerably. Low self-esteem and feelings of anxiety cause a reluctance to engage socially. She says:

> *"I have no friends; I feel stupid because I cannot do anything like my brother, and I feel guilty because it has taken me so long to finish my studies. However, I should have a job by now. "I think that I am destroying my family."*

Corrigan and Watson[30] claim that stigma negatively affects self-esteem and self-efficacy in mentally ill people. A typical example illustrates Maya's internalization of the stigma attached to mental illness in Nepal. Maya has a passion for education. Unfortunately, this passion is a source of self-stigmatization, as she cannot perform on par with her peers. Based on her experience of exclusion at school and in society, Maya does not perceive herself as a valued community member. In a way, mental health care models can benefit from including

30 Patrick W Corrigan and Amy C Watson, "Understanding the Impact of Stigma on People with Mental Illness," World Psychiatry: Official Journal of the World Psychiatric Association (WPA) 1, no. 1 (February 1, 2002): 16–20, 35, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489832/.

social methods that work to negate the harmful effects of stigma at an individual level.[31]

3.2.1.4Case Study 4: SUNIL

My final case involves Sunil, a male in his 40s. He experiences auditory hallucinations. Without assistance, he rarely takes his medication. His mother explains:

> *"Sunil talked about getting a job and starting a new life. I once negotiated with a mineral water distributor and an LPG gas distributor to hire my son as their porter. After that, he started working and doing his job well. He was very excited about his new job and told me he would take me to a momo restaurant once he got his salary. However, after a few days, his employers stopped allowing him to work, and he became very disheartened. I tried a lot to find him a place to work, but the fact that he has a psychosocial disability is enough to scare even educated and socially conscious people. Not finding any work troubles him a lot. Whenever he meets any new person, he tells them he is looking for a job. I wish we could find a good job for him, but that is challenging. He loves playing the guitar, and we may find a band that needs a good guitarist. I appreciate how he has transformed from an angry and violent young man to a calm person."*

Even her neighbors "were not happy" to see Sunil around. They warned her that Sunil should be locked in the room; otherwise, he could get into serious trouble, and that was what happened. According to Sunil's Mother, one day, "a voice told him to snatch the bag of a teen girl who was roaming in the neighborhood." He did just that, but it had "dire consequences":

> *"The girl's entire family came to my home and dragged my son from one room to another, beating him with clubs, rods, and hands. He had a serious injury during this time. I begged the attackers to forgive my son, but they were relentless. I thought my son would be dead, but to my surprise, a large number of people from my neighborhood came to my home and stopped the attackers. It was my neighbors who told the attackers that the mental condition of my son was not stable, and they asked for forgiveness on our behalf. The attackers left the house, but one of them warned us that if my son ever came around any one of the female members of their family, then that day would be the last day of his life."*

3.2.2 Analysis & findings from interviews with stakeholders

'THIN VS THICK' Understanding of Rights-Based Approach:

Many of the mental health stakeholder interviews conveyed a mixed image of the mental healthcare system in Nepal. One group of practitioners thinks that reaching out to the community means delivering counseling and medical services to people with psychosocial disabilities. They see such activities as rights-based because they assist people to access services in their communities that were absent before their intervention. This demonstrates a typical example of the 'thin' approach, which leans heavily on the biomedical perspective.

> *"We go to this village monthly to only provide them with medication because they cannot always visit Kathmandu. Providing medication is the most important thing for people with psychosocial disability" (a Psychiatric Doctor from a private hospital)*

Another group of practitioners provides services to the people but also spends many days and months with the people with psychosocial disability and support them through different stages of their struggle towards recovery and to access their rights. This 'thick' approach takes longer, leading to sustained support for holistic recovery and rehabilitation in their communities.

> *"We have launched projects in many communities and worked with the local municipality in providing medical and social support for people with psychosocial disability. We have connected many to the government's system in achieving their social security allowance. Involve many in a livelihood program for a sustainable future, which is their right. However, this takes a long period to accomplish with huge challenges" (local NGO worker)*

Many practitioners adopted a model that strongly influenced biomedical perspectives, resulting in medical services and counseling only. There was fragmentation and an abrupt stop after this thin-based approach, which left people with psychosocial disability in limbo.

According to Kaplan,[32] thin societies prefer a human rights framework that offers broad protections for

31 Corrigan and Watson, "Stigma on People with Mental Illness," 16–20, 36.

32 Seth D Kaplan, "Human Rights in Thick and Thin Societies," In Human Rights in Thick and Thin Societies: Universality without Uniformity (UK: Cambridge University Press, 2018).

individual choice and gives the state a significant role in enforcing rules. Thick societies, in contrast, choose a human rights framework that ensures specific minimum standards are met and provides maximum flexibility for local adaptation. This is reflected in the findings obtained, which show a massive need for a thorough understanding of mental health services.

Additionally, the political instability in Nepal resulted in the non-prioritization of the mental healthcare system. According to Government officials, following the imminent finalization and ratification of a mental health policy, strategy, and action plan, a clear road map will be set for all tiers of government to follow and strengthen the mental healthcare system. However, this optimistic speechmaking bears little resemblance to reality, and the practical implementation of mental health is limited. Besides some general mental health provisions under the Public Health Service Act[33] and the Act developed for the Rights of Persons with Disabilities,[34] there is no mental health policy, strategy, or regulation, and there are confused views over whether such documents would be endorsed.

Nepal's new federal structure conceptually provides an excellent opportunity for strengthening the mental healthcare system through decentralized governance planning and coordination. Poor implementation of federalization and the mental healthcare system was sometimes portrayed as a transitional period that would be resolved with time. Granted, little time has passed since the adoption of the new Constitution in 2015. Still, there needs to be more evidence suggesting transformative change shortly before the critical gaps hindering the implementation of the mental healthcare system.

A government official working at the Disability Division in the Local Municipality mentioned:

"Governments at the local and provincial levels are not very aware of prioritizing mental health. They're focusing on other sectors, the other areas of the preventive and curative services, rather than mental health. So I think they still need awareness regarding the need; the advocacy is required."

An NGO mental health worker pointed out that society holding the government accountable is contingent upon people being aware of their rights in the first place:

"First of all, people need to know their rights; that is when people hold their government accountable. Not everyone is unaware of their health and rights. So mental health is still (I will say) far-fetched." (A staff from a local NGO)

Additionally, a psychiatrist acknowledged that the government could not hire qualified personnel produced in Nepal due to the non-prioritization of the mental healthcare system.

"The Government could not engage human resources appropriately even though there are experts, but the system does not absorb them, so again, all the psychiatrists went abroad to countries like Australia, the U.K., or the USA. Otherwise, those working here are working at private hospitals." (Psychiatric Doctor working at the government hospital)

The Nepal government can play a massive role in bringing these stakeholders together to develop a clear understanding of robust right-based mental health care services, planning, and a collaborative approach. Based on this research, three key challenges afflict mental healthcare service provision in Nepal:

1. Lack of awareness, coordination and collaboration
2. A chronic lack of political prioritization of mental health
3. Persistent resource usage shortages, both financial and human

3.3 Analysis

This research shows that social support at the family and community level is the most significant determinant of well-being for people with psychosocial disabilities. The findings demonstrate strong local contexts and understandings of psychosocial disability. Though there is a broad debate over the universal applicability of Global Mental Health (GMH), this research focuses on exploring local understandings of mental health. Nevertheless, the evidence explains that the influences of the West have influenced the interpretation of the concept, highlighting the inseparable relationship between the local and the global.

Realizing global health for all necessitates a deep understanding of the voices of the vulnerable. This paper draws extensively on the perspectives of disadvantaged and vulnerable people with psychosocial disabilities,

33 Nepal Law Commission 2018, "Public Health Service Act," http://lawcommission.gov.np/en/archives/category/documents/prevailing-law/statutes-acts/the-public-health-service-act-2075-2018/.

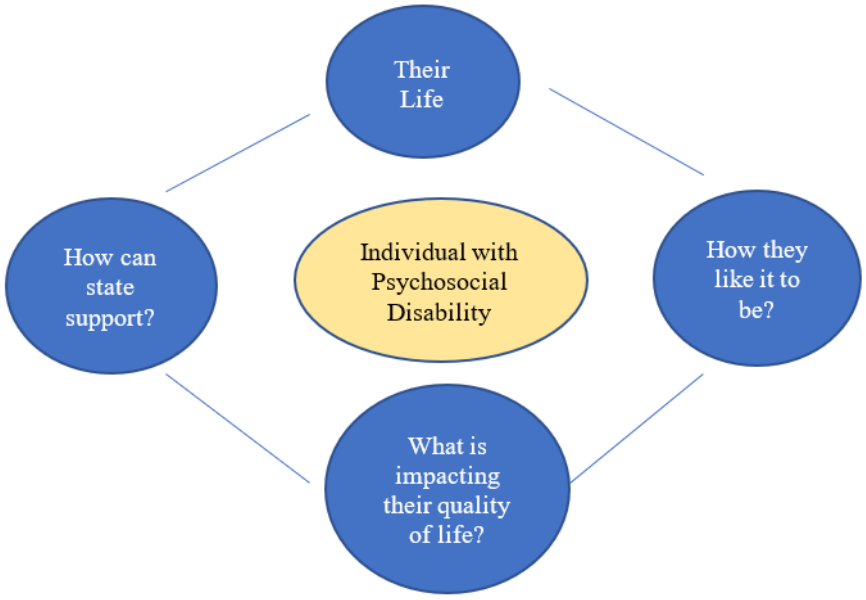
34 Nepal Law Commission, "The Act Relating to Rights of Persons with Disabilities," 2017, https://www.lawcommission.gov.np/en/wp-content/upload/2019/07/The-Act-Relating-to-Rights-of-Persons-with-Disabilities-2074-2017.pdf.

presenting their lived realities to bridge the gap in GMH discourse. It is crucial to approach GMH with a compassionate attitude that seeks to enhance the well-being of those with psychosocial disabilities. Given the significant links between poverty and mental health, these case studies provide a crucial example of the positive effects of social inclusion, a substantial theme in development discourse. As development policy primarily focuses on poverty alleviation, this presents an opportunity for GMH and development to amplify the voices of the vulnerable, whom GMH aims to support.

This research has found out that Nepal still depends highly on the medical approach, in which mental health services get excluded from the general public health system but rather exclusively through the nation's jails or institutions, which involuntarily keep people with psychosocial disability out of sight from their communities.[35] Nepal's government failed to recognize its commitment, under the CRPD and as part of the implementation process, to transform the nation's old-fashioned isolation-based system into a community-based one and build a principle of inclusion and humanity for all.

This study demonstrates discrepancies in the relationship between stakeholders working in the mental health sector and people with psychosocial disability and their families, a relationship that demonstrates dependency and domination as the main factors. A huge improvement is needed from these two groups to come together and develop common understanding and belief. As Adhikari and Denison mentioned, individuals fear to validate their existence without the freedom to reason or participate. Including people with psychosocial disability as the foremost central is the main way to go forward in combatting intensive stigma and discrimination. This is a way of viewing PWPD as resourceful and resilient in the face of inconvenience.

Figure 1 Recommended Framework for Inclusion and Human Rights for Individuals with Psychosocial Disability



Source: Author (2023)

On the one hand, governments must order inspections closely, regularly monitor state-run and private institutions, and take appropriate action against abusive services. Most mental health providers and services are concentrated in urban areas, mainly in Kathmandu, which causes difficulties in accessing services.[36] Inspectors should check compliance with an established code of practice and rules. There is a need to provide adequate mental health services that promote the rights to liberty and security of a person with a psychosocial disability.

Conversely, Nepal has the potential to set a new standard of inclusion by establishing a community-based mental health system with equal participation and data that incorporates the reality of people with psychosocial

35 Health Research and Social Development Forum (HERD), "Mental Health In Nepal," Backgrounder, Kathmandu, Nepal: HERD, 2017.

36 K.P. Adhikari and B. Denison, "Mental Health in Nepal: A community Survey of a Village in South Lalitpur" (1999)

disabilities. However, suppose the government continues to overlook this. It risks reverting to the old, isolating, institutionalizing medical model due to a lack of concurrent data and information to drive policies forward. Listening to the collective and individual voices of people with lived experiences of psychosocial disability in their contexts is then the next crucial step.

4. Conclusion

An individual has the power to free themselves and their dominators. However, when the dominators become established, freedom will be complicated. Therefore, in doing so, this research paper is trying to create a platform for the voices of those who have been historically silenced or do not feel free to believe they have a voice worth hearing. The voices of PWPD are not just critical; they are crucial to the development of mental health policy and practice, particularly in decision-making. However, there is always a space for working together by building a stronger relationship of confidence and trust. This research hopes to narrate a clear picture between the stories of the actual people living with disability and the stakeholder's lens on these issues, revealing several common themes but also some discrepancies between the two. Strong recommendation for the need for a holistic approach in working in the mental health field; this may help in the substantial development of standard generalized healthcare and, consequently, localized mental health care.

Based on the limitation, this study's sample size is small; research on a large sample, including PWPD and various stakeholders, should be conducted to document more evidence. The call for further research is a call to action for all stakeholders. Further research should include a larger sample and collection of distinctive stakeholders. These would consist of organizations operating in rural and urban settings and, most notably, the Nepal government. Given the limited help and dire situation of the mental health service providers, one can more clearly understand the concern put forward by the participants in this research.

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