

An analysis of Nepal's Draft Mental Health Acts 2006-2017: Competing values and power.

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Key messages:

1. Policy development involves competition between groups with different priorities and values. One stakeholder group focused on 'right to health', defending coercive practices. The other upholds the Convention on Rights of Person with Disabilities (CRPD) and prioritises 'equal legal rights'.
2. Psychiatrists are close to government, and dominate the drafting process, with no substantial involvement of service users or lawyers, who tended to resist passage of the drafts they see as contrary to rights-based principles.
3. The process is still at an agenda setting stage, and even events like emergencies and moments of collective action (like suicide response) have not seen sufficient momentum to overcome barriers in the national policy dynamics.

Reflexivity Statement:

The original data collection was done by one person as part of an MSc project, and as such it needed to be their own work and was limited by time and resources. They partnered with a mental health activist running a service user NGO to prepare, translate and collect the data. A local Nepali researcher helped to transcribe the interviews. The paper written was a collaboration between the primary author, the activist, and researchers from a range of disciplines in public health, including mental health, health promotion, and ethics. Three of the authors have over 20 years' experience of working in Nepal, and one author is Nepali. Authors come from a range of backgrounds in public health and have worked in many

regions of the world. We are aware of a lack of gender diversity in the authors, with the primary author being non-binary AFAB and four cis males. There were also far more males than females found to interview, and efforts were made to interview as many women as possible who were involved. In the participants, we think this reflects the paternalism of institutional structures and society in Nepal, which favours men being in positions of organisational power.

Ethical approval was obtained from both the London School of Hygiene and Tropical Medicine and the Nepal Health Research Council.

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Author contributions: JS conceptualised the project with some input from JP and JE, and JS carried out data collection and its analysis. A local civil society activist who is also service user (who wishes to remain anonymous) and PS assisted in gaining local ethical approval and translation of interview schedules. The civil society activist translated participant consent forms and helped engage participants. JE, PS, EvT and JP supported with analysis, interpretation and drafting of the manuscript. All authors contributed to, and approved, the final manuscript. JS, PS, JP and EvT revised the manuscript based on reviewer's comments.

The reasons for having all named authors are from HICs' (high-income countries):

There are no authors currently living in Nepal, as although a local NGO helped in the setting up of the study, and were invited to contribute to the manuscript, they have concerns around their own safety if their names are attributed to the research, due to the nature of the problem being investigated. This concern was also raised at the time, has been highlighted in the paper, and led to us having to report the results in a way that no individual or organisation could be identified. We are confident that with these precautions, no contributor can be identified.

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Conflicts of interest: The civil society activist mentioned above was also a participant in this study, as he met the criteria for inclusion. As a result of this, he did not have any input into the data analysis.

Abstract

This qualitative study maps the process of drafting and consulting on Nepal's Mental Health Act from 2006 to 2017. Fourteen people were interviewed, and interviews were analysed thematically. These themes were subsequently interpreted in the light of Shiffman and Smith's policy analysis framework, as the process was found to be at the agenda-setting stage. Two groups of actors were identified with different views on appropriate policy content and how the policy process should be conducted. The first group included psychiatrists who initiated and controlled the drafting process, and who did not consider people with psychosocial disabilities to be equal partners. The psychiatrists viewed forced detention and treatment as upholding people's Right to Health and lobbied the Ministry of Health and Population (MoHP) to pass the draft Act to Parliament. The second included civil society actors and lawyers who saw the Right to Equality before the Law as of utmost priority, opposed forced detention and treatment, and actively blocked the draft Act at the MoHP. There is no clear legal definition of mental health and illness in Nepal, legal and mental capacity are not differentiated, and people with mental and behavioural conditions are assumed to lack capacity. The analysis indicates that there were few favourable conditions to support the progression of this policy into law. It is unclear whether the drafters or blockers will prevail in the future, but we predict that professionals will continue to have more input into content than service users due to national policy dynamics.

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BACKGROUND

The United Nations adopted the Convention on the Rights of Persons with Disabilities (UN CRPD) in 2006 (UN, 2007). The stated aim is eliminating all forms of discrimination against people with disabilities, including psychosocial and intellectual disabilities, opening up a new opportunity to apply rights-based approaches to national law. Six years later the CRPD Committee found that many countries' laws were still not aligned with this standard (UN, 2013).

Despite this progressive normative guidance, globally people with psychosocial disabilities continue to have their rights violated often without protection against coercive practices (Freeman *et al.*, 2015). Legislation in this area is often absent, along with judicial procedures to appeal, for example, unlawful detention (Drew *et al.*, 2011). The 2017 World Health Organization (WHO) Mental Health Atlas indicated that just 57% of member states had stand-alone mental health legislation, and only 40% had updated their mental health laws recently (WHO, 2018).

Nepal ratified both the CRPD and its Optional Protocol in 2010 (UN, 2018). This important step became a consideration in a longer-term process in which various health policy actors have been writing and consulting on drafts of a Mental Health Act. The process thus far has been heavily contested around who can legitimately draft legislation, which laws and international frameworks apply, and content. In this paper we explore the dynamics between health policy actors over the course of 11

years, and seek to understand the factors that influenced the process of legislation development.

Nepal Mental Health Policy Context

The primary responsibility for drafting new health policies in Nepal rests with the Minister of Health and Population (MoHP). In theory, healthcare priorities are identified via research and consultations involving stakeholders including professionals, civil society and the public. Policy proposals are then made and assessed for feasibility, impact and concordance with current legislation. New policies are considered by Parliament which approves or rejects the proposals after debate, lobbying and voting. Wide stakeholder involvement has been a mark of Nepal's functioning since the Civil War which ended in 2006. In practice, the process is heavily influenced by lobbying and pressure from stakeholders, as this paper highlights.

No formal literature was found that specifically focused on Nepal's draft Mental Health Acts, although it is mentioned in other regional health policy research. These concurred that no progress had been made in passing legislation, and suggestions for action included establishing a mental health focal unit in the MoHP, NGOs (Non-Governmental Organizations) acting as a catalyst for change, and ringfencing a mental health budget (Luitel *et al.*, 2015; Upadhaya, 2013).

Three qualitative studies examined general mental health policy-making in Nepal. One explored experiences of service users and caregivers in two districts (Gurung *et al.*, 2017). Henceforth, we use 'service users' to refer to people with mental health

conditions. The paper reported that, at national level, service user involvement in policy-making was limited to those affiliated with country-wide organizations. Generally, service users reported feeling ignored and that their involvement was largely tokenistic. The second study reported that some participants thought involvement of people with mental health problems was irrelevant, whilst others considered it desirable (Upadhaya *et al.*, 2017). The third study concluded that service user involvement in policy development was not meaningful in developing mental health policy - in Nepal, Ethiopia and Nigeria (Lempp *et al.*, 2017). These findings align with a review of service user engagement in health planning in Nepal and Bangladesh, with the power-base lying with doctors and researchers, and the assumption that service users had little to add (Simkhada *et al.*, 2020).

Nepal's only stand-alone Mental Health Policy was published in 1996. It noted 'the fate of the majority of mentally ill in Nepal is pathetic', due to a lack of mental health services. One of its four aims was to develop mental health legislation to 'protect the fundamental rights' of people with mental illnesses' (National Planning Commission and Ministry of Health, 1996). Nepal's Non-Communicable Disease (NCD) Plan 2014-20 estimates national prevalence of mental conditions at 18%, though it is unclear how they reached this figure as no surveys exist (Government of Nepal, World Health Organization Country Office for Nepal, 2014). It is estimated that 0.7% of the health budget is spent on mental health, with services focused on one mental hospital in Kathmandu, and just 0.18 psychiatrists per 100,000 people (WHO, 2011). Globally, this problem of low spending on mental health and inequitable distribution across service levels is common (Saxena *et al.*, 2007). We found three draft Mental Health Acts produced since 2006, and none implemented. The 2006 and 2014 drafts

are in the public domain and the third (2016) was given to the interviewer by its author, with permission to use it for this study. The legal position of people with mental conditions is unclear. Nepal's Constitution 2015 gives equal rights to all and protections for people with disabilities, and therefore in principle is aligned to the CRPD. The Disabilities Act 2017 also accords people with mental conditions equal legal rights (Government of Nepal, 2017). This stands in contrast to the National Code 1963, which has many discriminatory clauses; for example, forced abduction of people with mental conditions with a guardian's consent, and does not permit them to make a contract, or be a witness in court. Whilst these examples are considered discriminatory both under CRPD and the 2015 Constitution, they tend to be more aligned to historical attitudes and practices and therefore often influence behaviour more than newer laws. The Nepal Medical Council's Code of Ethics 2017 allows families to make treatment decisions, known as substitute decision-making (Nepal Medical Council, 2017). Whilst the Constitution 2015 states that other laws that contradict it shall be void, the National Code has not been updated to reflect the Constitution.

AIMS AND OBJECTIVES

Mental health policy and legislation development has been slow, with a large gap between legislation development and implementation. There are various factors that might underlie this inefficient and very contested process. This study therefore aims to understand the dynamics between actors involved in developing Nepal's draft Mental Health Acts from 2006 to 2017 and how this influenced their progress.

METHODS

The analysis of data took place in two stages starting with a thematic analysis of participants' accounts, whereby transcripts were coded thematically by hand. We then conducted a policy analysis using the Shiffman and Smith framework (Shiffman & Smith 2007) to compare these themes to established theory (Table 1). This was chosen it became evident during thematic analysis that this process was still at the agenda-setting stage.

Firstly, key informant interviews were conducted in 2017 with 14 participants (12 agreed to audio-recording) using semi-structured topic guides (supplementary material 1) to elicit their perception of mental ill health and their involvement in the policy process. Two separate guides were used to reflect the different roles that service providers and civil society played in the process. These were pre-tested to ensure questions were worded neutrally and ordered appropriately (van Teijlingen & Huntley, 2005). We used purposive sampling to contact lead authors of the Mental Health Act drafts, then used snowball sampling to identify additional participants (Green & Thorogood, 2009).

Participants included the lead author of every draft; the senior psychiatrist/head of the mental hospital at the time. Other participants were selected because they had been consulted on, or lobbied for or against the drafts. They included lawyers (who supported civil society and disability advocates), MoHP staff (coordinating the process), mental health professionals (counsellors, community-based service managers) and a range of civil society activists, including people with lived experience. No MoHP lawyers involved in the drafting process could be traced.

Secondly, we identified the Shiffman and Smith framework as outlined in Table 1 as an appropriate policy analysis framework (Shiffman & Smith, 2007). Originally designed to assess agenda setting for global maternal health, it is equally applicable to mental health since maternal health and mental health are both complex problems affecting people whose voices are often ignored. The framework comprises four broad areas with eleven separate issues that can affect the agenda-setting process. These factors are: a) Actor power (policy community cohesion, leadership, strong guiding institutions, links with civil society); b) Ideas (the way the policy community both internally and externally frames the issue); c) Political context (presence of policy windows, a global governance structure); and d) Issue characteristics (measurable indicators, issue causes severe harm if not addressed).

Ethical Considerations

Ethical approval was obtained from both the primary author's institute and the Nepal Health Research Council, with clauses for protection of vulnerable people in the protocol. Two civil society participants involved in consultations disclosed that they had been threatened with violence due to cases they planned to take to Court. In order to ensure their safety, we decided to report the range of roles of participants, not names, specific roles or numbers interviewed by role. We have not identified any organizations by name except the MoHP and have ensured that views and quotes cannot be attributed to individuals.

RESULTS

The thematic analysis resulted in five policy-process themes, and three factors related to the specific context of mental health in Nepal that impacted on the process.

Respondents tended to have one of two world views, which aligned with previously documented positions established in mental health policy discourse (Freeman *et al.*, 2015). These positions are broadly defined as professionals' ability to act in patients' best interests versus a person's autonomy. We have labelled these 'the right to health' and 'the right to equality before the law', to reflect the CRPD. This was evidenced throughout the interviews, with the groups being quite polarised, and few actors being able to see the other group's point of view. Only community-based staff (Network 2 below) expressed a more nuanced position as they tried to balance human rights principles with their dependency on psychiatrists.

The two groups consisted of:

Group A "Right to Health": this included psychiatrists, MoHP staff, counsellors, and some civil society workers who delivered services. They considered provision of treatment more important than individual rights, did not view people with mental conditions as equal partners in the policy process and were mostly happy with the process thus far. For example, one psychiatrist said *'It is for his [the service user's] benefit we are doing [forced detention]. I don't see that as against any kind of human right'*.

Group B: “Right to Equality Before the Law”: this included all lawyers, service users, rights-based civil society activists and some treatment-based civil society workers. They considered equal rights for people affected as key and were unhappy with the drafting process thus far. For example, they tended to reject current cultural expectations that family members and psychiatrists should act in the best interests of service users.

Policy Process themes

1. Purpose of the Act and reasons for initiating the development process

The initiation of the first draft was said to be ‘*pushed*’ by WHO, which stimulated the process and offered seed funding. This was seen as a ‘*lack of local ownership*’ by several participants (across all groups). In terms of nationally-led drivers, Group A members envisioned a new law as a mechanism to leverage more resources towards mental health, with psychiatrists wanting it to also protect them against claims of abuse. A participant reported the impetus for the 2016 document was that the MoHP were drafting a Public Health Act, so they thought the Mental Health Act could go in as a chapter. Although some emphasised that any future Act’s purpose would be to protect human rights, their understanding was defined mainly by seeking to provide care, which was expressed in quite paternalistic ways.

Group B regarded a future Act as a mechanism to overturn all laws that discriminate against people with psychosocial disabilities. Their concern was much broader than psychiatric care, e.g. employment rights and support close to home. They were less concerned about public finances, seeing it as the Government’s responsibility to deliver on their Constitutional and CRPD commitments. One lawyer reported ‘*If the Government do not fulfil their promises in the Act, we will file a case in Supreme*

Court against them'. Two participants, a civil society activist and a lawyer, considered the Act unnecessary as protection provisions could be added to the Disabilities Act. They saw the current drafts as a way for psychiatrists to cement their power and keep resources at hospital level.

2. Drafting process controlled by psychiatrists

All participants agreed that psychiatrists, namely the incumbent head of the mental hospital, initiated each draft. No drafters interviewed suggested that the MoHP had initiated the process. The psychiatrists interviewed reported involving lawyers in 2014 and 2016 *'to get the wording right'*, so they could push the Act through Parliament. A consultation process was funded by WHO in 2006 to have multi-disciplinary input to the draft, but many reported having no input in reality. No drafters mentioned involving service users; when asked what they thought of this, one said *'there is no need- we have written it for them'*; another *'I suppose it is ok to take one or two opinions; they can have their say if they are well'*.

3. Lack of participatory consultation and blocking the draft

Consultations on the 2006 and 2014 drafts occurred only after the drafts were finalised, and participants reported no meaningful change being made afterwards. Many remembered a 2014 meeting attended by a wide range of actors, including psychiatrists, disability lawyers and civil society. Reports highlighted that there was not a level playing field between participants, and psychiatrists and civil society seemed unable to engage in productive communication. The psychiatrists presented the draft Act, then views were taken from the floor. One lawyer who attended felt this was not a consultation: *'If you call us last minute and ask for signature, this is not*

meaningful participation of beneficiaries'. One service user reported being too frightened to speak out against psychiatrists, and two activists reported psychiatrists dismissing service users' opinions; one said, *'When X speaks, I see people rolling their eyes, laughing and making rude gestures, like they are crazy!'* A psychiatrist acknowledged the communication issue, stating, *'The key problem is to close the mistrust between NGOs and psychiatrists.'*

Despite not being involved in drafting, service users and lawyers all expressed a strong desire for equal inclusion. Many collaborated to produce a desk report, highlighting how the drafts went against international human rights frameworks, which they circulated to Members of Parliament. Two civil society activists and a lawyer reported lobbying the MoHP repeatedly to block the Act for the same reason. One even asked the Prime Minister's wife to block it, saying *'then it was finished'*.

4. Sources of content and disagreement on priorities

There were substantial disagreements on content between participants. Drafters said they referred to legislation from India and Sri Lanka, but used no human rights protocols. All in Group A thought substitute decision-making was acceptable, with one saying *'this is the Nepali way'*, but only two from Group B agreed. Substitute decision-making is defined (in CRPD) as decisions taken on behalf of people with disabilities (based on 'best interest'). In contrast 'supported decision-making' is supporting people to reach their own decision. The remainder of Group B (civil society activists and lawyers) reported that psychiatrists are *'paternalistic'*, and people should make their own decisions, with support if necessary, and with guardians having no say. However, two from each group thought forced detention

and treatment was reasonable for a short time if the person is a ‘*severe risk*’ to their own or someone else’s life.

Discussion on consent and capacity were remarkably lacking, with only two participants from Group B mentioning them spontaneously. A lawyer explained there was a societal assumption that people with mental conditions have no capacity to decide anything for themselves, unlike those with physical illness, and that doctors make best interest decisions for patients. They reported consent is only applied for surgery, and explained there are no legal guidelines or training to assess capacity in Nepal. No-one differentiated between mental and legal capacity. Legal capacity refers to every person’s inherent right to make decisions and is a focus of CRPD, whereas mental capacity assumes that people have more or less right to make decisions based on an assessment of their mental state. These terms are often confused but distinct in legal terms and considered important in international rights circles. Whilst valued by Group B, the lack of inclusion of these issues implies that those drafting the legislation (Group A) did not consider these as important.

5. Networks and Focusing Events

No leader was identified whom all participants could get behind. Both groups reported there was a National Mental Health Network, but one participant said the network barely met as they never resolved who should be in charge. All reported they had lobbied the MoHP for a mental health focal unit which has now materialised. They credited this to the Minister for Health in 2016-17 who took mental health seriously. A committee including service users was formed to review mental

health legislation, but participants who attended reported only one meeting had occurred, and they felt MoHP staff were disinterested.

Two lawyers and some civil society activists from Group B identified a significant event in 2008 in which lawyers brought a case to the Supreme Court to overturn the National Code's ruling permitting people to lock up relatives with mental conditions in prison, and won. They reported the Government was ordered to release such people who had been detained without charge, provide treatment, and conduct a scoping exercise on the burden of mental conditions in Nepal (Balaram, Sharma & Shrestha, 2008). They reported that despite over 20 people being released, some remained in detention, with one lawyer reporting that those released have not been helped (we take this to mean through state-funded health or social services). They attributed this to people with mental conditions being unimportant to policy-makers: *'If the new law [benefits] politicians, it is easily applied! But for poor, vulnerable people, that doesn't come in force in reality'*.

Contextual Factors

6. Stigma

All participants reported that mental and behavioural conditions are stigmatised, and many felt this explained the lack of public or Government interest. Interestingly, none reflected on how their own stigmatising views might affect their contribution to the policy process. Many described stigma in others, along with psychosocial disabilities being *'hidden disabilities'* as having a negative effect on progress.

7. *Lack of national prevalence data makes health planning difficult*

Lack of prevalence data was cited by both psychiatrist and civil society participants as a reason for a lack of action. Two psychiatrists reported that national figures were extrapolated from small studies in high-risk populations, so they felt these were of limited use as a lever for policy change.

8. *Laws are vague, lack clear definitions around mental health, and largely ignored*

There was no legal definition related to mental health, nor guidelines to assess someone's mental capacity to fulfil an obligation, as identified by several participants, mainly civil society participants and lawyers. All reported society's assumption being that once someone has a label of 'madness', it was assumed to apply in all circumstances and forever. One lawyer explained:

Sometimes the family will tell others. It is hard to hide anything in Nepal! In court, they just look at you. If you look crazy, you know, unwashed, talking to yourself, the judge will let you off or send you to psychiatrist. If you look normal, they don't know.

Societal norms, which are largely in line with the National Code, influence daily practice. Mostly, Group A had poor knowledge of the law, seeing it as irrelevant. One psychiatrist responded to a question on the legality of forced detention with: '*it is our practice*'; another who worked in a treatment-based organization said '*not really, but if we get relative's consent it is similar to legal*'. Group B were much more informed of the law; they saw international human rights as the 'top' law, then the Constitution, with the National Code last. Therefore, they considered forced detention and treatment illegal as it is not permitted in the CRPD or Constitution.

Analysis using the Shiffman and Smith (2007) framework

We analysed our results (i.e. themes) against the Shiffman and Smith framework, comprising: actor power; ideas; political context and issue characteristics.

Actor Power: Networks present no united front to policy-makers and civil society is divided

Shiffman and Smith described the importance of 'policy community cohesion', but our analysis suggests that there were three 'loose' policy networks (Fig.1) whose activity on the policy was often opposed to each other. Network 1 (health workers, mainly psychiatrists) led the drafting of the Act, whilst Network 3 (rights-based civil society groups and lawyers) actively blocked it. Network 3 contained the most participants, followed by Network 1. Network 2 was the smallest, made up of people working in community-based treatment organizations, which functioned to communicate ideas between Networks 1 and 3, but was not actively pushing for policy change. Network 1 and the members of Network 2 who supported the position of psychiatrists comprised Group A participants ('right to health'); Network 3 and other members of Network 2 were mostly aligned to Group B ('equality before the law'). Although all Networks reported lobbying the MoHP, researchers were unable to assign the Ministry to any network and their human rights position (Group A or B) remains unclear.

(Figure 1 about here)

Networks 1 and 3 were the most active in this policy process. Network 1 generally aligned to Group A ('Right to Health') above, and had presented the draft Mental

Health Acts to the MoHP, Network 3, who aligned to Group B ('Equality before the Law'), worked to block the Act. Network 2, as service-based NGOs, sat in the middle; they relied on psychiatrists' support for their programmes whilst also supporting service user autonomy. There were three main areas of disagreement between actors: who had legitimacy to draft it, what the process should be, and the purpose of the Act.

Bourdieu outlined a theory for how power operates in society through different forms of capital, including economic, social, cultural and symbolic. His work emphasizes structural constraints, and how these lead to unequal access to resources in society. (Bourdieu, 1986). Here, we look at the different forms of capital in Networks 1 and 3. Psychiatrists sat within Network 1: they assumed that they had the right and knowledge to draft the Acts with tokenistic involvement from others. Network 2 did not challenge their legitimacy in public. In Bourdieu's typology psychiatrists hold a level of professional and symbolic capital that has been insufficiently challenged. Their ability to provide clinical care has been conflated with their right to draft legal documents, despite them having the poorest knowledge of the law and international human rights frameworks. In contrast, civil society activists (Network 3), believed lawyers should lead the drafting, given this was a piece of legislation, with full participation of service users and psychiatrists as equal stakeholders. They had knowledge capital through familiarity with national laws and international conventions. Service users had cultural capital in the form of lived experience, and Network 3 had strong social capital through working together on this topic. They disagreed with the content of the drafts, seeing it as contrary to the CRPD and Constitution; they wanted any future Act to secure the positive rights of service users

far more broadly in society and to address structural discrimination. They felt the drafts represented what they called a '*medical model*' of mental health and illness with little attention given to wider social determinants (Brisenden, 1986).

Actors within Network 3 appeared to have worked together effectively in attempting to block this policy progressing within MoHP, demonstrating a dimension of power, namely agenda-blocking or non-decision-making (Lukes, 2004). This was done by lobbying MoHP, MPs and the Prime Minister's wife. We are unable to conclude if their actions were causal, despite them assuming this was so. Network 1 presented drafts to MoHP, not realizing others were blocking it. No leaders or strong guiding institutions that everyone could get behind existed, nor was there policy community cohesion. Although a mental health focal unit existed, poor leadership within the MoHP meant it lacked legitimacy to lead the process.

Ideas and values: Internal versus external frames

Shiffman and Smith (2007) suggested that if actors can agree on the problem, its causes and solutions, i.e., share an internal frame, it is easier to present a case (an external frame) to policy-makers in a way that will attract support. In this case, the most active networks (1 & 3) had different internal frames, with similar external frames; but Network 3's internal and external frames were more consistent and thus convincing.

The key *value* for Network 1 was that service users need to be looked after, and it *internally framed* the problem as their right to health, seeing forced treatment as an acceptable means to that end. They *externally framed* this as 'supporting rights of

people with mental illness'. However, some admitted additional motives of wanting to attract more resources to mental health and avoid being sued, of which all others in this study were aware; and therefore, their argument to policy-makers was unconvincing.

Network 3's *value* appeared to be that every human being is inherently equal, and forced treatment or detention equates to torture. Their *internal frame* was that people with psychosocial disabilities have equal legal rights. They also recognised mental health services as lacking resources, but saw the Act as a way to nullify existing discriminatory laws. They were better versed in the law than Network 1, so could present a much better *external frame* to policy-makers, arguing that previous drafts went against both the CRPD and Constitution.

Political context: Policy window not recognised and little governance

A window of opportunity can occur or be created when the three streams of problem, policy and politics are brought together (Kingdon 1984). At this point, actors need to be ready with a solution (Cairney & Jones, 2016). The Supreme Court judgment of 2008 could have been such a window given it highlighted human rights abuses and lack of treatment. It appears it was not recognized as the action was brought by lawyers who were not linked to the disability movement and so no clear policy alternative was presented.

In terms of mental health governance, participants agreed that there was 'no rule of law', and 'no governance or oversight', hence Constitutional and CRPD norms had not yet been translated into action. Equally, what is considered to be 'good

psychiatric practice' in other contexts that assess capacity, such as the UK, has not been employed in Nepal (WHO, 2005). The de facto practice is based on societal norms, reflected in the National Code, wherein people with abnormal behaviour are assigned a status in which they are deemed to have no mental capacity. The concept of legal capacity is conflated with mental capacity in Nepal, despite the Constitution stressing equal legal rights.

Issue Characteristics: The problem has not been defined or measured, and there is no simple solution

Shiffman and Smith's framework suggested a problem is more likely to be taken seriously if it has measurable indicators, causes severe harm and a simple, cheap, feasible solution exists. Firstly, there was no national prevalence data for mental health conditions, which limits traction with policy makers. Secondly, there needs to be engagement in defining and understanding the issues around mental and legal capacity. Finally, those enacting the law would need the skills to make defensible decisions.

Suicide represents a major harm if not addressed (Table 1), and as the most serious harm caused by mental distress, it allows actors to highlight the need for legislation. A community-based study examined causes of death in fertile women in eight districts, reporting suicide at 16% as the leading cause of death (Suvedi *et al.*, 2009) and the WHO estimated suicide rates in Nepal via modelling in 2012 as the second highest cause of death in 15-29-year olds. However, even these dramatic statistics have not been sufficient to bring about policy change (Maharatta *et al.*, 2017).

Whilst actors agreed mental health is under-resourced, networks have not yet been able to move past their ideological differences to agree a common goal around legislation. Our findings concur with Gurung et al.'s that supportive conditions have not been created whereby Networks 1 (health workers) and 3 (civil society activists) can work together (Gurung *et al.*, 2017).

(Table 1 about here)

DISCUSSION

This paper examines the interaction of actors involved in national mental health policy-making in Nepal. It looks at how alliances across actors have operated in the development of the Mental Health Act drafts. It draws attention to underlying views of actors (especially around human rights) and how these influenced their activity around the policy. Whilst these opposing views have been discussed in previous literature, we also saw this phenomenon in our study (Freeman *et al.*, 2015).

We found the Shiffman and Smith framework helped in interpreting the dynamics of mental health policy reform. It worked particularly well in highlighting the importance of internal and external framing. The civil society participants had both strong and consistent internal and external frames which were clearly articulated to their advocacy targets. Whilst health professionals had inherent power, which enabled them to lead on policy reform, their motives were not trusted by others who judged them as seeking to maintain their power and attract more resources to outdated structures, thus undermining their credibility. Their assertion that they were defending a 'right to health' (external frame) was seen by others as a thin veneer, to

help maintain the status quo of established psychiatric services. The framework also worked well to elucidate factors that explain a lack progress beyond agenda setting, highlighting some potential areas for future action by stakeholders.

Several studies highlighted similar themes in policy making dynamics, both in Nepal and other LMICs. They reported service user participation was an ‘alien concept’ where there was no consideration of participation, and professionals were assumed to be the only group with the expertise to develop policy (Lempp *et al.*, 2017).

Studies of national policy processes outside of mental health in Nepal showed some successes, particularly in maternal and newborn health (Smith & Neupane 2011), stimulated by global commitments via the Millennium Development Goals, strong leadership with coordinated networks and local solutions.

Observations from collecting data

Through data collection, it became apparent that lawyers working on post-war reparations had only recently started dialogue with lawyers focused on disability and mental health, thus mental health was largely ignored within broader human rights legislation in Nepal. Both groups of lawyers sat within Network 3 and had a common commitment to international human rights protocols. The lawyers we interviewed had professional legitimacy and were working within a human rights framework, wanting users to have equality of input into legislation. We would encourage the development of links between civil society and human rights lawyers to find common ground within mental health advocacy, as together these groups could facilitate a more level playing field and human rights-informed legislation reform.

Another striking observation was the stigma around mental health within the policy community, which was not well acknowledged. This manifested in those with power, such as psychiatrists, laughing and shouting at service users in meetings, and not understanding the value of their input into the policy process. Equally, service users were frightened to speak up in public, which could be a manifestation of internalised, or 'self-stigma'. In this study, service users wanted equality of input, but conditions have not yet been created whereby this is possible. These findings are consistent with other studies across health in Nepal and other LMICs whereby professionals, in this case psychiatrists, are deemed to be the legitimate producers of policy, with no perceived need for the involvement of service users (Gurung *et al.*, 2017; Lempp *et al.*, 2017; Simkhada *et al.*, 2020). Stigma creates barriers to participation so until this is addressed, it will be very difficult for service users to have any meaningful involvement in the policy process. Researchers are exploring stigma in Nepal, which could provide insights in how to move forward (Gurung *et al.*, 2022).

Limitations of the study

Several biases are recognised. First, social desirability bias may have been at play as the interviewer (first author, JS) is an allopathic medical doctor, whom participants were pushing to 'take sides' around the argument. This expectation was resisted and JS tried to stay neutral throughout. Secondly, to ensure that the position of the interviewer did not dictate the direction of the interviews, topic guides were developed in advance with service users and other stakeholders. No lawyers from the MoHP were available to be interviewed so their views are not represented. We therefore ensured that we interviewed lawyers from different fields, but we cannot claim to have the perspective of government lawyers.

Moreover, themes were coded by one author (JS), without the benefit of independent analysis. However, the authors include medical ethicists, Nepali public health professionals, and sociologists, so the results were not limited to one person's perspective. Finally, no elements can be assumed to be causal, and it was not possible to assess which elements had more influence than others.

CONCLUSION

The polarisation in this study reflects the international debate on mental health legislation. For most professionals, governments, and arguably the general public, forced treatment is considered occasionally necessary to maintain someone's right to health and protect the public. Much of the disability movement and the CRPD Committee reject this (in line with Network 3). Like Nepali psychiatrists, countries look to WHO for guidance in drafting legislation, which is increasingly aligned to the CRPD. This is exemplified both by the QualityRights programme and the new guidance on mental health legislation (WHO 2019; WHO-OHCHR 2023), both of which advocate for much more participatory approaches in future drafting.

This research offers some practical approaches to move the agenda forward which those engaging in policy reform in similar low-income settings may like to consider. This case only meets one of Shiffman and Smith's criteria; severity of the problem being recognised due to the issue of suicide. However, whilst a powerful issue with substantial political traction, its impact on policy reform has been limited, perhaps as it is a relatively rare event, even if widely reported. No other conditions for policy change are met; it is therefore essential that the currently divergent groups find

common ground to create a more favourable environment for agenda-setting, like cross-stakeholder cohesion, clear leadership, agreeing common aims and indicators, and proposing feasible solutions. This will only be achieved if the symbolic and professional capital of psychiatrists can be contained.

It remains the case that in many countries, the medical profession has disproportionate power and their world view tends to dominate in policy processes. Reinforcing the strength of civil society could provide a counterbalance to this, as they often have legal knowledge and strong social network capital, as evidenced in this case. Service user organisations specifically have a unique and increasingly recognized role but for their participation to be meaningful, power dynamics must be considered. We found that some actors, like those in Network 2 working in communities, could 'speak the language' of the two polarised sides in this debate. They are therefore well placed to bridge the ideological divide and move policy processes forward.

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FACTOR	FINDINGS IN NEPAL	POTENTIAL FOR CHANGE
<i>ACTOR POWER</i>	<i>Strength of individuals & orgs involved in the problem</i>	
Policy Community Cohesion	Substantial differences between psychiatrists & service users, and between NGOs.	Reaching common agreement on desired change.
Strong leaders providing direction	None identified.	Strong leaders may naturally emerge but may not come from traditional power-holders. Provide clearer role for lawyers in drafting Act.
Strong guiding institutions	None that all actors can get behind. Those that exist work in silos, e.g. mental hospital, civil society.	Clearer leadership from mental health focal unit in MoHP. Civil society finding values in common & working together for change.
Strong link with civil society	Civil society strong, but service users not taken seriously due to stigma.	Allies and advocates working with service users to create a more level playing field and enabling the latter's' meaningful participation.
<i>IDEAS</i>	<i>Way in which actors understand & communicate the problem: how is the issue framed?</i>	
Internal frame (agreement of problem & solution within policy community)	Stakeholders divided between Right to Health (includes forced detention) & Right to Human Rights (CRPD compliant).	Conflicts of interest where professionals benefit from legal ambiguity need to be addressed. Examine public & professional attitudes towards rights, arriving at consensus that is nationally & internationally aligned.
External frame (clear communication of ideas outside network)	Equal Rights group more convincing and aligned with their internal frame.	Finding common ground for what constitutes good mental health & services across stakeholders.
<i>POLITICAL CONTEXTS</i>	<i>Political landscape in which actors operate</i>	

Policy Window (moments of opportunity to push agenda)	Potential window of Supreme Court case 2008 but not recognised so unused.	Be better prepared to capitalise on policy windows that present in emergencies (e.g. Building Back Better) and link with human rights issues more broadly.
Global Governance Structure (international norms aligned & active)	Lack of consensus on capacity assessment & coercion vs CRPD.	Engage with global governance structures & with debate and developments around capacity assessment & CRPD.
<i>CHARACTERISTICS OF ISSUE ITSELF</i>	<i>Features of the problem</i>	
Measurable indicators available	Only one perinatal mental health study.	Strengthen measurement of treatment gap & better align to globally recognised measures (WHO Mental Health Atlas, Countdown GMH).
Problem causes severe harm if not addressed	Problem is stigmatised & invisible but suicide emerging as potential traction point for advocacy.	Use the topic of suicide to raise awareness & strengthen political will around mental health.
Problem has simple, cheap solution	Solutions perceived as complex and costly.	Identify acceptable & universally agreed solutions, particularly when policy windows present.

Table 1 SHIFFMAN AND SMITH FRAMEWORK

*Table 1: Adapted from Shiffman J, Smith S. (2007) Generation of political priority for
global health initiatives: a framework and case study of maternal mortality.
Lancet, 370, 1370-79.*