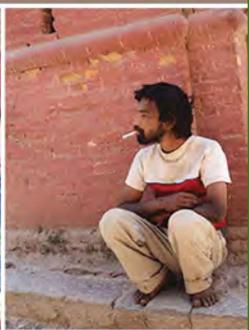




**CHHAHARI N-EPAL**  
for mental health



A year of working with  
mentally distressed people  
living on the streets of Lalitpur



# The **STREET** Project



**Evidence of exclusion and rights violations  
experienced by men and women with mental health problems**



To protect the identities, pseudonyms have been used in this report. Photographs have also been selected with care, to respect the dignity of the women and men who are living on the street or locked up at home.

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## **₪** acknowledgements

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This report is intended to facilitate the discussion on the conditions, needs and perception of mentally distressed men and women living on the streets. Based on the year long action oriented pilot phase of a the Street Project, it seeks to provide a detailed and varied account of individual experiences, along with Chhahari Nepal for Mental Health's efforts to provide support. The report provides evidences and insights of how poverty, social stigma, lack of legal provisions and awareness excludes mentally distressed men and women from receiving appropriate care and treatment.

In order to bring out this report, I am grateful to the Chhahari Team for their dedication and commitment shown during this period. Especially to Asmita Pariyar and Kamal Thapa for their tireless effort in providing support and care. I thank Surendra Panday, Anil Shrestha, Kedar Maharjan, Aruna Lama, Bidya Maharjan for their continued dedication. The support of the Barn Church and Gorebridge Church (Scotland) and NIM church (Lalitpur) has been invaluable. Alongwith the support provided by Dr. Gael Robertson, Ansu Tumbahangfe, Anita Subba, Rajendra Shrestha, Kalyan Mathema and Shiva Dhungana.

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**Dr. Chhatra Amatya**  
**Chairperson**



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This report provides evidence of the poverty and societal exclusion of the mentally distressed men and women who were contacted by The Street Project, an action research project implemented by CNMH in Lalitpur for one year from March 2011. Based on practical situations encountered during this year of activities, this report documents the individual experiences of mentally distressed men and women living on the streets and identifies a set of advocacy issues based on analysis of these experiences.

Mental health in Nepal continues to be a neglected issue. The Government provides no legal protection for mentally ill persons and does not ensure, either independently or in partnership with NGOs and the private sector, adequate countrywide social and health services able to respond to mental health needs. Consequently, mentally ill people have no safeguards against neglect and exploitation, and in some cases are barely regarded as human.

The Street Project is process orientated and works with men and women on the street, getting to know them and building trust, and where necessary providing food and clothing. If possible, contact is made with the family to negotiate options for treatment and longer term care, followed by referral to a mental health service provider if appropriate. Over the year CNMH met 54 mentally distressed people (35 men and 19 women) on the street, worked with 34 of these individuals and located families in 22 cases.

The stigma associated with mental health problems impacts across society, in families and the wider community. Societal norms are reflected in the attitudes and behaviours of mental health practitioners.

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Experiences reveal vulnerable men and women without protection in a range of situations. Issues that affect them include:

- » Poverty
- » Vulnerability, with no legal protection to safeguard their fundamental human rights
- » Stigma within the family and community, and even untouchability
- » Being locked up in the family home
- » Being deprived of the right to property ownership
- » Subjected to domestic violence
- » Victim of sexual abuse
- » Caught in the middle, between mental health and general health services
- » Falling through gaps in mental health services
- » Confused roles and legal responsibilities of Government, NGOs and private sector - an NGO is not securely positioned to offer protection
- » Inadequate health, social and legal services available to manage mental health problems of the elderly
- » Lack of practical skills and knowledge among existing mental health service providers in provision of holistic care
- » Lack of emergency psychiatric services that cover both medical and social needs
- » Bureaucratic processes lacking the flexibility to accommodate special needs
- » Discriminatory attitudes of mental and general health service providers
- » Lack of compassion among service providers and the public
- » Accidents contributing to mental health problems
- » Self-harming behaviour and violence towards others
- » Alcohol, solvent and drug abuse
- » A mentally ill person becoming a commodity, at the mercy of financial considerations
- » Media misuse of information and situations
- » The empty rhetoric of mental health and other charitable organisations, who often do not follow up talk with any kind of positive action.

The next steps for CNMH are to continue responding to the needs of mentally distressed men and women dislocated from their family and to advocate for a compassionate approach to mental health in Nepal.

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# Introduction

Chhahari Nepal for Mental Health (CNMH) is a secular non-government organisation, which was registered in 2009 with the Government of Nepal at the Social Welfare Council and at the District Administration Office in Lalitpur. The vision of CNMH is to establish a just and equitable society, where the mental health needs and wellbeing of all women, men and children are addressed. More specifically, our purpose is to facilitate appropriate treatment for mentally ill people living on the streets, to enable their reintegration and acceptance back into society and a dignified life. CNMH is committed to locally appropriate evidence based responses, utilising global blueprints as appropriate.

Prior to the establishment of CNMH from 2003 a group of dedicated professional men and women, who were concerned about the plight of mentally distressed people on the street, initiated activities under the auspices of the Saint Xavier's Social Services Centre. A rapid assessment of mentally distressed people on the streets of Lalitpur was undertaken and A Study of Institutions Working in Support of Mental Health and Exploration of Existing and Potential Networking and Coordination amongst them produced.

The name Chhahari was selected to capture the idea of providing shelter wherever a person maybe located. Thus our initial approach is to meet and support a mentally distressed person where they are living, on the street. Where possible we aim to find the person's family, discuss options for further support and longer term care and to refer the person to an appropriate mental health service. CNMH has no shelter or residential facility of its own. From the outset our working principle has been to respect the rights of the mentally distressed individual, including the right to self-determination. This is continually challenged by societal norms which are reflected in the practices of mental health practitioners.





**This report provides evidence of the poverty and societal exclusion of mentally distressed men and women contacted during the first year of The Street Project, an action research project implemented by CNMH in Lalitpur. Based on practical situations, this report documents the individual stories and experiences of mentally distressed men and women living on the streets, and a set of advocacy issues identified from analysis of these experiences.**

## **C**ontext

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Mental health continues to be a neglected issue in Nepal. Little empirical evidence exists about Nepal's overall mental health situation, but in recent years a greater awareness concerning mental health and mental illness can be observed in research and through newspaper articles and news items, Radio and TV. The Ministry of Health and Population has engaged with mental health issues as never before, but this still needs to be translated into practical action, including policy commitments and increased budget allocation. More NGOs are working on mental health, but the challenge remains for mental health to be integrated within all government responsibilities, incorporated into economic as well as social development, and in governance and human rights.

Currently the Government of Nepal provides no legal protection for mentally ill persons and does not ensure, either independently or in partnership with NGOs and the private sector, adequate countrywide social and health services able to respond to mental health needs.

Consequently, mentally ill people have no safeguards against neglect and exploitation, and in some cases are barely regarded as human. People with mental illness experience daily discrimination and violation of their fundamental rights. Bureaucratic procedures, for example to obtain citizenship, are prolonged, difficult and lacking in compassion, making it difficult for those suffering from any kind of mental illness to access the most fundamental rights of a citizen. Mental illness, whether acute or chronic, carries vulnerability. Being excluded from family, community and society, a reality for mentally ill people on the street, exacerbates this. Poverty further worsens the plight of a mentally ill person.





For this reason, CNMH has chosen not to use the term 'rescue', as this implies the existence of an environment of safety for a mentally ill person. In reality, there is no refuge in Nepal. Without statutory protection, accompanied by compassionate legal, social and health services, the mentally ill person, at particularly vulnerable times, is at risk. These risks are due to lack of clarity around the legal and moral responsibilities of the individual, the family and the community, including service providers in Government, NGO and private institutions. As a result, the

vulnerable mentally ill person can be caught amongst competing interests. Where does the legal authority lie, to ensure the rights of a mentally ill person are respected and protected? Access to treatment and rehabilitation provided by the Government, NGOs and emerging private sector remains discretionary and largely dependent on a mentally ill person's financial resources.

The cost of residential mental health treatment ranges between Rs. 6,000 and Rs. 18,000 per month. For full care (where an external carer is not required to be resident at the hospital), the Government Mental Hospital charge is Rs. 10,000 per month. Thus increasingly, care of a mentally ill person is becoming a commodity, at the mercy of financial considerations. Rural people are even more disadvantaged, as mental health services, which exist, are more available in urban areas, especially the Kathmandu Valley. In rural areas services are dismal.



# t he Street Project

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The **Street Project** was initiated in March 2011 in Lalitpur, and this report documents observations and findings from the first year of activities. The urban part of Lalitpur within the ring road was chosen as the project location because of its nearness to Nepal's only mental health hospital and to the CNMH office. The purpose of the project was to identify the issues faced by mentally distressed men and women who were living on the streets of Lalitpur, and working with them in their own context.



To achieve this, CNMH adopted an innovative, action learning, person centred approach. Such 'learning by doing' with compassion takes time and is emotionally demanding for staff who are prepared through a training that promotes reflective learning, with continued support throughout their working period. Emphasis is placed on building trusting relationships that enable staff to connect with people in difficult circumstances and to respond to the unique situation of each person. We consider this, investment of time essential to reaching men and women who have experienced profound and multiple exclusions.

Specific funding for the Street Project came from the Barn Church, Culloden in Scotland. Project staff were recruited from the Nepali Isiai Mandali (NIM) church network in Kathmandu. For funding of other activities and administrative and management costs, CNMH relies on individual donors in Nepal and Europe, including a number of churches in Scotland, in particular Gorebridge Church. The modest budget available does not stretch to contributing to the costs of a person's treatment and the role of CNMH has therefore been restricted to referral and facilitation.

## **p**rocess

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The project is process orientated, based on working with men and women where we find them, first getting to know them and building trust, and where necessary providing food and clothing. If possible, contact is made with the family to negotiate options for treatment and longer term care. This may be followed by referral to a mental health service provider. With no centre of its own, CNMH chooses to work with people where they are, while linking with existing mental health services to encourage and build their responsiveness to diverse mental health needs, especially those of poor and marginalised people. We endeavour to work with both government health services and NGOs that provide mental health services. Engaging with local community people, including shopkeepers, is also important, first in generating useful information about the mentally ill person in question and secondly as an opportunity to talk about mental health issues in general and spread awareness among the wider public. Regular contact is maintained with local police personnel.



In response to local interest CNMH organises community mental health awareness programmes. These may be in different forms, such as street drama or youth discussion programmes, and have been well supported. CNMH contributes to national advocacy on mental health and works with other like-minded organisations.

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# Experiences from the street



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## **E**xperiences from the street

Our experiences show that the men and women with mental health problems, who are found wandering on the street, usually do have families nearby who care about them. This challenged our assumption that these people were homeless, and we realised that in fact they are often simply disconnected from their families. In many cases families have given up trying to deal with their mentally ill relative, after a long struggle, as they do not know what to do or know where to turn for help. Rejection by mental health service providers who have been approached is also not uncommon. Families may be poor, but in general they do want to contribute towards treatment.

Over the year of activities, CNMH has met 54 mentally distressed people (35 men and 19 women) on the streets of Lalitpur. The discrepancy between the number of men and women met on the street is surprising, as our earlier rapid assessment indicated equal numbers of men and women. Thus there is a concern that we may be missing some women, if perhaps they are more inclined to hide in inaccessible places. The behaviour of our target group is often unpredictable, as they tend to roam from place to place at different times of the day or night, or may be forced to move on by authorities or local communities. Developing a relationship with the person is our priority but this can take time if s/he has been subjected to abuse or discrimination, and personal information may not be forthcoming immediately or even at all. The majority of our clients are Newari,<sup>1</sup> reflecting the predominant social group found in Lalitpur. However, we have made contact with individuals from most caste and ethnic groups, including Madeshis<sup>2</sup>. The age of our clients ranges from 20 to 65 years, with a greater number falling within the groups 20 to 30 years and 40 to 50 years.

Common issues we observed for men and women with mental health problems are:

- » Poverty
- » Vulnerability, with no legal protection to safeguard their fundamental human rights
- » Stigma within the family and community, and even untouchability
- » Being locked up in the family home
- » Being deprived of the right to property ownership
- » Subjected to domestic violence

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<sup>1</sup> Newar's are the local inhabitants of Kathmandu Valley.

<sup>2</sup> Madeshi's are the inhabitants from the Terai, the southern plains in Nepal.

- » Victim of sexual abuse
- » Caught in the middle, between mental health and general health services
- » Falling through gaps in mental health services
- » Confused roles and legal responsibilities of Government, NGOs and private sector - an NGO is not securely positioned to offer protection
- » Inadequate health, social and legal services available to manage mental health problems of the elderly
- » Lack of practical skills and knowledge among existing mental health service providers in provision of holistic care
- » Lack of emergency psychiatric services that cover both medical and social needs
- » Bureaucratic processes lacking the flexibility to accommodate special needs
- » Discriminatory attitudes of mental and general health service providers
- » Lack of compassion among service providers and the public
- » Accidents contributing to mental health problems
- » Self-harming behaviour and violence towards others
- » Alcohol, solvent and drug abuse
- » A mentally ill person becoming a commodity, at the mercy of financial considerations
- » Media misuse of information and situations
- » The empty rhetoric of mental health organisations, who often do not follow up talk with any kind of positive action.

## **St**ories from the street

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In this section we present a selection of CNMH staff experiences accumulated during the year. In total we have worked with 34 of the 54 people we met, and located the families of 22. The case of each person is unique in the combination of characteristics and events that have led to his/her situation. The time invested by CNMH staff varied according to the needs of the person and what was deemed appropriate within the resources available. We also present our analysis of the experiences, especially where common issues are identified. Learning from our experiences will guide the next phase of the Street Project and frame CNMH's advocacy work.



Evidence of the issues noted in the previous section is contained in the following individual stories in the following pages.

## Caught in the middle of a family property dispute

**Nur**, a 45 year-old man, was brought to CNMH's attention by his neighbour and old school friend. For about 22 years Nur had been locked up in one room of his family home. On the first home visit by CNMH staff, he was frightened, sitting in the corner of the darkened room amid his own excrement and urine. The bad odours made visits difficult. Although his mental health problems had previously been successfully treated at the mental hospital, his condition had relapsed after the death of his mother's and now Nur's mental and physical health appeared poor.

Building a rapport with Nur and his family took time. Gradually, as trust developed, options for his care were explored, and CNMH Staff worked with his two brothers to bath him and clean his room. Nur responded positively to the care and compassion, for example when a staff member massaged his back, he relaxed and smiled a deep smile of pleasure and trust.

Based on agreement with Nur and his family, he was escorted for an initial psychiatric assessment with a view to admission to a treatment



centre. As he was helped from his room it was apparent that he had difficulty walking, so an ambulance was arranged from a nearby church. On arrival at the clinic, the duty psychiatrist greeted Nur with an unwelcoming facial expression, possibly due to the lingering odour, despite his bathing. The CNMH staff, found themselves challenged, when asked "why have you brought him

here? We cannot help him". Consultation was quick and medication was prescribed, but residential treatment was refused due to his walking problem.

Nur was then taken to a general hospital, to investigate his leg problem. They diagnosed a fractured hip. How long he had suffered this fracture is anyone's guess. However, hospital admission was refused as his main problem was assessed as a psychiatric one! Nonetheless, the hospital staff responded compassionately to Nur and offered physiotherapy exercises to be carried out at home.

After Nur's return home, his mobility gradually improved as a result of the physiotherapy, which was supported by his brothers and CNMH staff. His mental health condition also picked up.

However, discussions about funding for Nur's treatment revealed differences of opinion between the two brothers, which mediation by CNMH staff has been unable to resolve. The family's resources are tied up in ancestral property, with the three brothers (including Nur) having an equal share. In Nepal, the property of a mentally ill person, (especially a man) can be transferred to the name of another. As the two brothers continue with their differences, Nur is caught in the middle with no one to protect his rights.

### **Stigmatised by family and community, locked up for long periods**

**Yam**, 45 years old, was once an agricultural worker. Now he wanders the streets or is locked up at home. Within his neighbourhood, he is taunted as a 'pagal manche' or mad person. Previously he received residential treatment for his mental illness but this appears to have been unsuccessful. He communicates only erratically with his family, and despite numerous attempts CNMH staff have not managed to meet them, due to their reluctance. We maintain regular contact with Yam and provide compassionate support in the form of food.

## Victim of domestic violence and sexually abused on the street

**Til**, is 40 years old and the local community informed us that for the past 17 years she has lived on the street, after her husband took a second wife and she was subjected to domestic violence. We have not been able to find any information about Til's family and her physical condition is poor. The local community on the one hand demonstrate a degree of support, while on the other hand they would prefer her to be taken away from their neighbourhood. The CNMH staff have developed a relationship with Til, offering her food and encouraging her to improve her personal hygiene. Discussions have been initiated with community people concerning Til's personal security, to look at ways of protecting her from being given alcohol and then sexually abused.



## Mental health problems exacerbated by head injury. Community hostile.

**Tandi** is 32 years old and at one time worked as a carpenter. For a long time he has experienced mental health problems, but following a head injury, when he was struck by a knife, his condition worsened. Tandi can say very little about his situation and is very nervous. He lives within a temple compound in poor conditions. The local community are hostile towards him but share information about his family situation. Although his family live nearby they have shown no interest in meeting with CNMH staff. We have developed a good rapport with Tandi and regularly meet him to offer food and encourage him to improve his personal hygiene.

## No citizenship to claim her property, sexually abused on the street



**Mangala** is 40 years old and has been mentally distressed since the death of her husband 12 years ago. Previously she was employed as a hospital cleaner, but now she wanders the streets not far from her home. She claims to have one ropani of land in her husband's name, but without citizenship, is unable to make the formal claim. The family situation is unclear. Her son (who is a drug user), daughter in law and daughter say they have tried to keep her at home but she refuses. However, Mangala reports that her daughter in law 'kicked her out'. Her personal hygiene is poor and her dress is dirty. She is regularly sexually abused by youths, who promise food or money in return for sex. Her vulnerable situation has been reported to the local police post, so they can 'keep an eye on her'.

There is no evidence that Mangala has received any mental health treatment. After discussion with CNMH staff the family agreed to welcome her back, and CNMH staff accompanied her home. However, after a few days she returned to the street. The family's economic situation is not good and so they are unable to pay for her treatment. Their expectation was for CNMH to pay treatment costs. The local community are hostile towards Mangala, blaming her for the situation in which she finds herself. CNMH staff continue to support Mangala wherever she is on the street, providing food and maintaining a good rapport.

## Untouchable, stigmatised and sexually abused

**Bhai**, is a 20 year old young man who wanders the streets in dirty, torn clothing. He is fearful of the people around him. Over time CNMH Staff have developed a relationship with Bhai, but he is reluctant to speak much and so far little is known about his family. The local community where he frequents are unable to provide information. CNMH Staff offer him food, but on one occasion when a glass of tea was ordered for him and the teashop owner realised who was about to drink it, the glass was snatched back and the tea poured into a plastic cup, as if Bhai was untouchable.<sup>3</sup> A further vulnerability arises as at times he is plied with alcohol and then sexually abused.

## The rhetoric of compassion: Actions belie words and media is (mis)used

**Geeta**, a young woman, was found at the gate of a social organisation in very poor physical and mental condition. Not knowing what to do, the organisation called a newspaper to publicise Geeta's situation. CNMH responded to the story, but when the CNMH staff arrived there the head of the organisation made it clear that he wanted her removed as soon as possible. Soon afterwards a representative of the Ministry of Women, Children and Social Welfare turned up with food, took photographs then quickly left .

As the day wore on, a CNMH staff member stayed with Geeta, keeping her calm and giving her water and fruit, while another attempted to locate a place where she could be taken to. There was increasing pressure from the neighbourhood to remove her, but even after several phone calls, no suitable place could be found. One call to a mental health organisation (promoting itself as a place of refuge), resulted in an immediate demand for a fee of Rs. 300 per day, although it was known that CNMH did not have the budget for this. When CNMH requested them to at least send their staff to help Geeta, the response was that no one was available. Another call to a treatment centre received a response from the duty doctor "I am too busy at the moment, call back on Wednesday" (which was 5 days later!).

<sup>3</sup> The concept of untouchability was previously applied to people of the lowest caste groups in Nepal. Those categorised as untouchable were not allowed to eat or drink using the same utensils as others. Legally it is now an illegal form of discrimination.

As the afternoon drew to a close and the situation was getting desperate, a young woman arrived on a scooter, claiming she ran a shelter and had come after reading Geeta's story in the newspaper. However, when she realised Geeta was mentally ill, her helpfulness suddenly changed and she entered into negotiation only reluctantly. With no alternative place available, it was agreed that Geeta be taken to the shelter. The social organisation contributed financial support for Geeta's care and CNMH committed to search for her family.

Suddenly, a television news crew arrived, having been called by the young woman from the shelter. In an aside, she commented that this would be good for fund raising. The filming focused entirely on the young woman with Geeta, side-lining the CNMH staff who had worked most of the day to help Geeta.

Many taxis were approached to take Geeta to the shelter, but they

all refused on the grounds that a mentally ill person may cause problems in the taxi. They said she would create a bad smell and later on other passengers would not want to use it. Eventually, a taxi driver agreed to take her and Geeta was escorted to the shelter by CNMH staff.

A few days later, when the CNMH staff visited the shelter they found that no psychiatric help had been arranged for Geeta. Her condition had become so poor, that she was unable to provide any information that would help them track down her family. On a subsequent visit, CNMH staff were informed that Geeta had gone missing and the shelter had reported this to the police. However, follow up at local police office found no documentation of Geeta's disappearance in the police records. Geeta still remains missing, and it is rumoured that she is dead.

## Alcohol misuse, family problems and subject to violence on the street

We met **Ek**, 32 years old, wandering the streets around his home in a filthy condition, at times being beaten up by local youths. Earlier, Ek had been a factory labourer, but following his mother's death he began to misuse alcohol. As a result his condition quickly deteriorated. Ek was responsive to the compassion we extended and cooperated with CNMH staff in improving his personal hygiene, including cutting his hair, beard and finger nails, bathing and washing his clothes. This helped him regain confidence. However, despite many meetings his family showed little interest in helping. Finally a cousin offered support, including financing Ek's treatment for six months at a rehabilitation centre. After this Ek improved enough to get married and resume work. Unfortunately after a few months he again began misusing alcohol, which caused a return of family problems. Recognising his deteriorating circumstances, Ek has requested further assistance from CNMH.

## Victim of domestic violence and poverty

**Nani** is 45 years old and estranged from her husband, due to domestic violence. Her daughter runs a small shop and tries to keep her mother at her home, but Nani prefers to be on the street. Given her limited facilities, Nani maintains herself well, earning a nominal amount washing dishes in a nearby restaurant and gardening in a few local homes. At times she displays violent behaviour towards strangers and initially greeted the CNMH staff with a bombardment of stones. Now she has got to know us she accepts the food we offer and she also receives food from her daughter. Initial discussion about treatment for Nani was viewed favourably, but so far the limited financial resources available have prevented treatment going ahead.

## Victim of childhood abuse misusing solvents and drugs

**Lalit** is a young man of 25 years, married with a son. He communicates well and has built up a relationship with CNMH staff. Sometimes he is on the street and at other times he goes home to his family. So far, we have had no contact with them. Lalit's early years were difficult as he lived on the street with his mother and many times he witnessed her being raped. This has left him with mood swings and he can be aggressive at times, while at other times is withdrawn and uncommunicative. Drug misuse and glue sniffing are part of Lalit's lifestyle. CNMH staff have observed him being beaten up by local drug users, and have sometimes been able to intervene and stop the attack. Lalit is in denial about his problems therefore resistant to the idea of treatment. CNMH staff respect his position, maintaining contact and sometimes offering food or a cigarette.

## Disowned by family, victim of domestic violence and sexual abuse

**Jan** is 35 years old and has lived in a community building (or rather a shell of a building) for many years, viewing the place as 'home'. She is well known in the community. Earlier Jan was a victim of domestic violence and received a considerable amount of inpatient mental health treatment. We have made no contact with her family on the advice of people who have experienced their indifference towards her. Living in such an open building means Jan is very vulnerable and she is regularly sexually abused. As the community building management committee were reluctant to make the building more secure, CNMH investigated a number of low cost options to improve it. Unfortunately, expert opinion was that the basic structure of the building was not strong enough to accommodate any improvement. Recently Jan left her 'home' and her current whereabouts are unknown.

## Freedom to choose: the myth of “rescue”

**Ravi** is a 33 year old man and a well-known figure on the streets. He was one of the first street people CNMH got to know. His general condition was poor, with long hair and dirty clothes. Building his trust took time, as he tends to be aggressive when approached. At one time he worked as a construction labourer but little is known about his family. Sometimes shopkeepers give him food, while at other times they chase him away. CNMH also sometimes offers Ravi food. Our relationship with him moved to another level after Ravi suddenly disappeared from his usual haunts. Investigation with local residents indicated that he had been taken away by “some people”, and it turned out he had been “rescued” by a Christian group. Follow up with this previously unknown group, who offered no mental health services, revealed he had been subject to two months of confinement and prayer. Now Ravi has returned to the street, as a result of his own self-determination, where he remains. CNMH staff continue to offer him compassionate support on his terms.

## Pass the parcel: the plight of the elderly

**Aama**, who is around 65 years old, was found by an expatriate woman amongst the garbage on the street. She was in poor physical and mental health. The woman who found her requested CNMH's assistance and committed to covering treatment costs.

Initially Aama was taken to a general hospital to deal with her poor physical condition and investigate a deep scar on her forehead. However, admission was refused because of her mental health problems. CNMH provided food and support until a place was found in a shelter for two nights, but they were unable to provide the constant care needed by Aama, so a move was necessary. Finding the next place was not easy. For three nights, the only room available was at an animal shelter. Eventually, after much negotiation, a place was found at an NGO treatment centre, based on a clear agreement between CNMH, the expatriate woman and the NGO running the treatment centre.

As the centre lacked the experience or staff needed to manage Aama's incontinence or provide food, a carer was contracted, funded by the expatriate woman. Still the treatment centre indicated their inability to continue providing accommodation and pressure on CNMH and the expatriate woman mounted for Aama to be moved on, although an alternative mental health care facility was not available and despite the earlier agreement. Eventually a place was found where Aama stayed for two months before being moved on again to a centre where she remained for many months. From this last place Aama wandered off and her whereabouts are unknown.

Concurrently with the moves from one shelter to another, CNMH staff searched for Aama's family, which took around 15 days of effort as they

were on the far side of Kathmandu. Aama had left the family following the death of her husband, taking her share of the property in cash. The family were reluctant to reconnect with Aama and their position did not change despite a long period of negotiation by the CNMH staff. However, the family and neighbours willingly offered assistance to obtain Aama's citizenship certificate, as the requirements of government offices, including the District Administration Office were beyond her capacity. However, assessing the situation after two months of effort, CNMH realised the process was on a bureaucratic road to nowhere and reluctantly decided to abandon efforts to obtain the citizenship certificate.

The **STREET** Project



## **ā** nalysis of experiences on the street

Our experiences from the Street Project, albeit limited, make a significant contribution to understanding the complexity of mental health issues within Nepal. In this report we have provided evidence and insight into the day to day realities of men and women living on the streets with mental distress, who experience exclusion and human rights violations.

The stigma associated with mental health problems, particularly if the sufferers are living on the street, impacts across society in families and the wider community. Societal norms are reflected in the attitudes and behaviours of mental health practitioners, evidenced in comments such as “why did you bring him here?” Mental health activists may turn a street person with mental illness into a commodity, generating pity (as opposed to exercising compassion) as a means of raising funds. Others claim “they give mental health a bad name”!

These women and men living on the street, disconnected from their families, have little chance of accessing the help they need and are vulnerable to abuse, due to a number of factors:

- » **Poverty:** acting as a barrier to accessing mental health services. Not only do consultations, medication and on-going therapy cost appreciable amounts of money, but recovery can be slow, requiring regular treatment over a long period, which further increases the cost.
- » **Lack of knowledge:** Families either do not know help is available or they do not know where to go to seek help.
- » **Nature of mental health services:** Mental health services provided by the Government and NGOs are discretionary (there is no obligation to provide the service) and generally not responsive to the diversity of mental health needs.
- » **Emergency service:** A compassionate emergency psychiatric service, with medical, social and legal provisions and a mandate to respond quickly in serious situations, is not available.

- » **Exclusion:** The nature of mental illness and the associated stigma tends to exclude a person from the rest of society and the rights enjoyed by others. In turn, due to the nature of their illness a mentally ill person can exclude themselves.
- » **Human rights:** There is no state protection to safeguard the basic human rights and legal position of men or women who are mentally ill. Particularly, at times of vulnerability when a person experiences an acute episode of mental illness.
- » **Sexual exploitation:** is the norm for women, but men are also subject to sexual abuse. Both are also often subject to physical and psychological violence (being beaten or taunted).
- » **Family support:** is often lacking, sometimes because of the stigma associated with mental illness, sometimes due to despair and not knowing what to do and sometimes because the mentally ill person appears to reject the family. The compassionate support of a caring family can make an enormous difference to the prospects of recovery from mental illness.
- » **Support for the family:** It is often forgotten that the family also needs support in the challenging task of nurturing a mentally ill person along the road to recovery, or at least enabling them to live a dignified life.



# ext steps for Chhahari and the Street Project

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Through the Street Project CNMH will continue to respond with compassion to the needs of mentally distressed men and women living on the streets, offering practical support as appropriate and within our capacity. Specific activities will include:

- » **Scaling up the street project:** Expanding geographical coverage, facilitating access to appropriate treatment, enhancing family support.
- » **Funding:** Making funding available to supplement families' contributions towards treatment where necessary. A mechanism will be developed to ensure equitable allocation of financial support, with priority for poor people and young adults.
- » **Negotiating:** alternative affordable treatment options, such as outpatient treatment in collaboration with Lalitpur Municipality and local clinics.
- » **Identifying:** men and women who are locked up in their family home due to mental illness and negotiating with their families to enable their participation in the Street Project support service.
- » **Livelihoods:** Initiating small scale activities to enhance livelihoods, building upon a person's existing interests and skills to develop their self-confidence and enable them to move towards supporting themselves.
- » **Voice:** Promoting the raising of 'voice' of men and women, including families, impacted by mental illness.
- » **Resource list:** Maintaining a list of mental health resources available within the Kathmandu Valley.

## dvocacy

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CNMH will continue to advocate, through appropriate forums and institutions, for a compassionate approach to mental health in Nepal, including:

- » **Holistic emergency service:** Collaborating further with the Mental Hospital to establish a compassionate and free emergency psychiatric service through which a person can receive a full range of general medical and psychiatric care, with specialist services, social and legal services available. This will enable, for example, a mentally ill woman who has been sexually abused and has a prolapsed uterus to receive immediate treatment for her physical problems at the same time as treatment for her mental illness.
- » **Drugs:** Advocating for reliable availability at appropriate outlets of the mental health drugs listed on the Government's essential drugs list.
- » **Legal protection:** Advocating for legal protection to safeguard the vulnerable person with a mental illness and protect them from exploitation.
- » **Public awareness:** Promoting awareness among local communities about mental health issues and options, to discourage the practice of locking mentally ill people away in the family home or throwing them out onto the street.
- » **Appropriate responses:** Promoting locally appropriate responses, based on evidence of what works and is available, while also utilising ideas from global research, as appropriate. Approaches used will work with local sensitivities and suggestions in the development of mental health services.



This report was compiled by:  
Ansu Tumbahangle,  
Anil Shrestha,  
Ashmita Pariyar  
and  
Dr. Gael Robertson

edited by:  
Cherry Bird

designed by:  
Stimulus Adverfizers

printing support by:  
Bhupendra Man Amatya

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If you would like to support us, please contact us at:

Chhahari Nepal for Mental Health (CNMH)

GPO: 8975, EPC: 983, Kathmandu, Nepal

Tel: +977 1-5188374

Email: [chhaharinepal@wlink.com.np](mailto:chhaharinepal@wlink.com.np)

Web: [www.cnmh.org.np](http://www.cnmh.org.np)

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