Psychiatry & Addiction: Navigating Challenges & Opportunities in Nepalese context

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Habit & Addiction

It is challenging from the definition of 'habit', 'hobby' and 'addiction' themselves being elusive and illusive. Habit is something we do automatically and regularly often without much thinking or active choice, just because it's what we are use to doing. Hobby is something we do for pleasure and interest. Addiction is a compulsive behaviour that is difficult to control.

Habit and addiction have common characteristics, like- both are repetitive over long period, with no intention to do but difficult to change. However, they have differences; addiction is relatively more difficult to control, has adverse impacts on daily life, is difficult to quit and has some issues as underlying cause. Habits are formed through neural pathways in brain that are strengthened through repetition and reinforcement over time. Scientific literature shows 66 days and our shastras 3 weeks time as reference period for a behaviour to turn into a habit or an attribute. Habit can be broken with focused effort and replacement with new routines. Habit serves a utility purpose if healthy. Addiction is unhealthy one which is associated with changes in brain's reward system beyond habitual behaviors. Addiction is usually linked to some underlying issue, like stress, when the person's ego might be shaken and disturbed with negative emotions and events; and substance use might be an escape or coping. It is also usually associated with psychiatric conditions, like anxiety, depression, trauma, low self-esteem and others.

Many people exhibit addictive behaviors not only of substance/s but also of the things like gambling, social media, video gaming, sex, rituals, food, selfie, internet, and technology and many more.[1] Understanding this difference between habit and addiction is the first step towards making lasting changes and living a balanced life.

Substance & Addiction:

Substance (psychoactive substance) is a chemical compound (natural or synthetic) that can alter brain function and result in changes in perception, mood, consciousness, cognition or behaviour when consumed, and has addictive potential, i.e. tendency to develop compulsive use, tolerance and withdrawal symptoms. There will be use of the things more than necessary, there will be no growth, rather harmful effect, and there will be loss of control. There are evidences of similar correlates in addictive behaviors as with substance use.[2]

A substance ranges from those stimulating CNS to those depressing and altering it. By route also, there are oral, inhalants, intravenous substances. Adding to the complexity, substances range from household objects / products, socially accepted and medically prescribed to illegal drugs.

As with the typology of the substances, their effects are also diverse and elusive. They have wide variety of effects, both health and non-health. In health effects; substance use disorder, substance induced psychiatric disorders and neurological comorbidities are often forgotten in the disguise of physical comorbidities. Only liver disease and other physical diseases are in the notice and attention and alcohol addiction resulting from chronic and heavy alcohol use remains undetected and untreated, posing a great challenge.[3,4]

A great question continues regarding the normal and abnormal substance use. The spectrum of substance use ranges from controlled normal and social use to problematic, pathological, disorder. Classification systems are struggling hard to delineate them. The ICD-10 incorporates- Acute Intoxication, Harmful Use, Dependence Syndrome, Withdrawal and Induced disorders.[5] The DSM- IV has Abuse instead of Harmful Use.[6] The DSM-5 clubs Abuse and Dependence together.[7] The ICD-11 has adopted an integrated approach with: expanded classes of substances, severity qualifiers and introduction of new categories, i.e. a. Single episode, b. Harmful patterns, c. Disorders due to addictive behaviors (Gambling disorder and Gaming disorder).[8]

Non-health effect- adding to the complexity:

For many people, addiction problem is a bad character, moral downhill, public nuisance or social problem. Along with health consequences, many aspects of life are adversely affected; e.g. Familial, Sexual, Social, Financial, Occupational, Legal complications and, Accidents (RTAs) and many others.[9] In many of addiction cases, crime is associated and legal perspective is other complicating factor. Substance issue is largely determined by politics rather than science and facts. Sadly, addiction field is full of adverse effects and harms caused by criminalization of substances, like: those arising out of the legal framework for drug control and the consequences of criminalization and disenfranchisement plus exclusion from housing, education, health and social impact of imprisonment.[10]

Complexity in the root of Addiction:

As with other psychiatric conditions, addiction is the result of complex interplay of bio-psycho-social factors, posing the challenges in many respects. David H. Knott has conceptualized 'Agent, Host and Environment' factors as etiological factors for addictive phenomena in an attempt to explain this complex issue. Agent factor includes: its availability (easy, cheap, advertisement), free sale; Environment factor: influence of family, friends and society, religious and cultural context, stress; and Host factor: genetic transmission, neurotransmitter (dopamine), mental illness and personality/ disorder etc. Psychological and psychodynamic theories add to its complexity in an attempt to explicate it.

Down to earth- Psychiatry and Addiction:

Psychiatry is a medical specialty concerned with study, diagnosis, treatment and prevention of mental, behavioral and personality disorders.[11] It is based on Bio-psycho-social model. Training for psychiatry includes: study of psychopathology, biochemistry, genetics, psychopharmacology, neurology, neuropathology, psychology, psychoanalysis, social science and community mental health, plus many theories and approaches advanced in the field. Psychiatrist is a medical doctor (M.D. or D.O.) specialized in mental health, including substance use disorders.[11]

Addiction Psychiatry or Addiction medicine is an additional specialization after general psychiatry as training in other areas which is unaccredited fellowships but certified, e.g. by Accreditation Council on Graduate Medical Education (ACGME) like: Child and Adolescent Psychiatry, Consultation-liaison Psychiatry, Sexual Medicine, Forensic Psychiatry. Psychiatrists may also pursue additional training in areas (unaccredited fellowships), e.g. Emergency Psychiatry, Public and Community Psychiatry. They may have training in 2 or more specialties simultaneously for complex, medical and psychiatric issues, e.g. Internal Medicine and Psychiatry, Triple Board of Pediatrics, Adult Psychiatry and Child & Adolescent Psychiatry. Some other may have additional training in psychoanalysis, CBT or psychiatric research.[11]

Addiction Psychiatry:

Addiction Psychiatry is a medical sub-specialty that focuses on the diagnosis, treatment and management of people with substance use disorders and related conditions.[12] It is largely being provided so far by general psychiatrists in Nepal. Fellowship program of 1 year has been started since 2024 in TUTH, Kathmandu.[13] Risk factors particular to our Nepalese context are Environmental ones, like- Cultural sanction: ambivalent attitude of society, frequent natural calamities, adversities and disasters, lack of awareness and stress management skills, low resources, priority and policy, and social transition leading to family structure change and lack of parental monitoring.

Magnitude-Psychiatry disorders:

Both the psychiatric and substance use disorders lack national data but appear high in their burden in Nepal.

Region	Overall Mental disorder		Substance use disorder	
	Prevalence	Burden	Prevalence	Burden
World[14]	13 (2019) 1 in 8	4.9	variable- Alcohol, Drugs	5.6%
India[15,16]	14.3 (2017)	4.7	variable- Alcohol, Drugs	
Nepal[17,18,19,20]	13.5 (2019)	5.53	7.3 (Substance), 3.4 (Alcohol)	

Substance use disorder is a remarkable problem in Asian context too; with high prevalence of Tobacco chewing (21%), smoking (18.6%), alcohol abuse (12.9%), along with other substances.[21]

Substance problem in Nepal:

Comprehensive national data is yet to come; only sporadic, regional and clinical setting based data are available from Nepal. Alcohol and tobacco are No. 1 substance[22] and in current day Nepal, traditional barrier to substance use is hastily breaking down.[4, 23] Nicotine and tobacco use is quite high; prevalence among females and second-hand smoking

have been reported remarkably high especially in rural Nepal.[24] An initial profile report of de-addiction ward of TUTH shows majority of the clients using multiple substances: alcohol in 79%, opiates- 37%, cannabis- 25%, benzodiazepines- 18%.[25]

Cannabis cultivation and use are formally illegal but rampant. Trend and voice for legalization without adequate preparation is rising in current Nepal.[26] Periodic surveys show the number of hard drug users is steadily increasing (e.g. 46000- 2008, 91,534- 2013, 130,424- 2020). Only 1/7th with drug use disorder receive treatment. High prevalence of internet addiction is being reported one after other; a report shows 74.7% of the school students (10-12 class) with internet addiction.[27]

Globalization came up with increasing appearance of industrial products, other new substances use cases, and technology/ digital addiction. Migration and abroad work have resulted in decreasing parental monitoring due to their absence. On top of alarming situation of alcohol and tobacco/ nicotine problem, change in pattern of substance use and increase in use of New psychoactive (NPS)/ other illegal substances have brought new challenges of recognition, legislation, and treatment. Increasing abuse of prescription drugs is other great challenge, especially to health-care providers. Though small country, there are some regional variations in pattern and nature of substance use with in Nepal, warranting local efforts and programs.

Substance problem in eastern Nepal:

Alcohol use disorder (dependence and abuse) is reported 4.1% and other substance 0.4% in a community survey in eastern Nepal.[28] An intensive study in Dharan city reports 25.8% with alcohol dependence.[29] Among health camp attendees, substance use disorder is reported among 5%.[30] A retrospective report shows 813/ 3687 psychiatry in-patients (22.1%) with substance use disorder[31] and other Psychiatry ward study (2020) shows: Alcohol in 31.18%: Use- 9.32%, ADS- 21.86%; Tobacco/Nicotine- 48.03%: Use- 21.86, NDS- 26.17%; Cannabis- 17.92%: Use- 11.47%, CDS- 6.45%; Opiote- 7.62 (019), Benzodiazepine- 6.43 (019) and other substance- 0.71% (019).[32] Substance use disorders are reported among 8- 8.3% of psychiatry OPD attendees.[33,34]

It is the most common (30%) cause for psychiatry emergencies in BPKIHS[35] and remarkable proportion of Consultation liaison clients (24%) had been found with substance related disorders.[36]

Prevention Levels & Measures- Our Situation:

Mental, Neurological and Substance problems are complicated with stigma; substance problems with more stigma, less priority and more challenges.

A. Primary

Various aspects of primary prevention are full of challenges. Awareness among various stakeholders (public, patients, service providers, policy makers) are grossly inadequate. A study reported that the attitude towards alcohol use is largely positive but the knowledge is inadequate here.[37] Culture is intricately related with substance use; culture conducive and religions condoning here, overall Nepalese societies being ambivalent. We lack materials and information related to addiction in curriculum of various levels for health education (for- students, teachers, parents). Literature, art, music predominately possess inappropriate materials, deficient in effective awareness raising scientific facts and information. Media and IEC coverage is meagre regarding addiction.

Our current circumstance and state (of lack of employment) is forcing the parents out of home country, thereby resulting lack of monitoring and care of growing children. We have frequent disaster and high stress state but lack of awareness and skills of stress management and coping. Healthy entertainment means and environment keeping growing children and adolescents engaged in sports and healthy activities are less and our traditional ways like festivals are disappearing. At local level, we have negligible intensive programs addressing mental health and addiction.

B. Secondary

We lack data, but scarce data available clearly indicate a huge treatment gap. It is grounded by lack of awareness for timely identification and help seeking, widespread stigma and discrimination, and inadequate service facilities. There are negligible effective and easily available treatment and deaddiction services; limited ones are city centred. Though gradually increasing, we have inadequate resources, including health manpower, e.g. Addiction/ Psychiatrists, Psychologists, Psychiatric nurses, Social worker, OTs, other health professionals with training for essential information,

skill and capacity. Current health system is struggling hard for effective referral mechanism for comprehensive management and essential drugs and mechanism for continuous supply and availability.

Sadly, we lack various components of Care models of substance problems. First, Demand reduction strategies that reduce the desire to use drugs and to prevent, reduce, delay initiation of drug use, e.g. legislative steps, institutes, hospitals, DTCs, N/GOs; second, Supply reduction strategies that disrupt the supply and availability of drugs and third, Harm reduction strategies that reduce the negative impact of drug use on individuals and communities, e.g. Needle syringe exchange, we need to enhance all of these constituents. To start with, we need to focus on outpatient 'Drug Treatment Clinics' and community-based treatment. Overarching the objective would be to develop our own context based Guidelines and Protocols.

C. Tertiary: Rehabilitation

We generally lack the approach of management/ treatment as the 'process rather than step'. Here again, for current state to build infrastructure and service facilities from the beginning, we will require generosity in resource allocation. All cadres of health care manpower will require training for essential information, skill and capacity building. It will have to be incorporated into health service delivery system, including referral system. One particular note of attention in our context is that rehabilitation centers here are opened and run by people (ex-users mainly) with no essential knowledge, skill, training and there is currently no monitoring mechanism posing risk to the stakeholders.

D. Care taker/ Family issues

Co-dependence is reported high, especially among female spouses, 63.60 ± 9.27 (67.11 ± 6.36) vs. males (53.07 ± 8.73) here in Nepal.[38] Issues complicating the prevention efforts, requiring serious consideration include: Culture, Availability of substances, Politics, Policy and laws, Stress and disaster prone context. We need to enhance protective and reduce risk factors: in all Agent, Host and Environment factors.

Challenges:

There are general Global challenges for addiction problems and we have our own context based other challenges as well. We need to contextualize many strategies for Nepal and our own region.

Challenges	Global/General	Nepalese context	Regional context
Scarcity of work force: all cadres		Huge, esp. for substance	more seats, revision of curriculum to adequately incorporate substance
Treatment gap	alcohol- 78.1% (India- 97.2%, SUD- 90%)	need data, more centres, institutes, public-private-in-stitute partner-ship model	training of Health professionals
Limited availability of de-addic-tion cente		tertary care centres lack service, scarce in-patient services, serious lack of fund	
Infrastruc-ture and funding	variable	negligible	
Guideline and protocols: Context based	Developed and developing nations	PAN- Nepal Context based Guideline and protocols	Regional
Comorbid medical illness	effective collaboration with other medical disciplines to ensure holistic management		
reduce stigma and increase awareness		liaise with general and health practitioners, educate and liaise with traditional healers, and develop efficient referral	
New addictive problems and changing pattern of substance use disorders	early age of onset of addiction involving adolescents, weekend binging patterns, use of multiple substances and increasing use of party drug, technology and digital addictions		need IEC activities, school mental health program, information on harmful effects of substance use in school curriculum
Political committ-ment, leadership priority	bring into their notice, understanding and priority by continuous efforts of those all related stakeholders, including MH professionals/ psychiatrists		
Addiction psychiatry fellowship	Not a priority and no mechanism of support, stipend for the candidate in Nepal		

Opportunities

Challenges create opportunities- various general and specific strategies and opportunities for particular challenges. We need to contextualize strategies for Nepal and particular region, e.g. eastern Nepal.

Opportunities	Global/General	Nepalese context	Regional context
Research, Data generation and Bank		Work for national level	regional and local levels
Teaching School, Colleges	vary in developed part	Policy making	Mental health School programs
Public awareness			
Academic - Fellowship, CME, Training, Conferences	increasing fora and opportunities for sharing	all health science program curriculum	
Health facility create job, camp based		all hospitals, health institutes, innovative areas	school, ward, districts
Reform Rehabilitation centre policy	multidisciplinary	policy reform	MH professionals run/ provided
focus of Nepal government to mental health		also need to focus on substance problem	regional and local levels
focus on development of PG psychiatry department in established medical colleges, increasing number of MD psychiatry seats		Curriculum revision and policy	regionwise efforts
Provisions for development and strengthening of in-patient services in the government sector, private sector, involvement of various NGOs to provide in-patient servic		sporadic efforts- Insurance policy revision	to be extended to regions
GO/ NGO/ INGO co-work and collaboration- multidisciplinary			
New technology and means of management, e.g. telepsychiatry			

The UNODC's global project to disseminate family skills training programs in different regions of the world (Project GLO-K01) for the prevention of drug use, HIV/AIDS, and crime among young people still holds useful for our context and needs to be implemented across the nation.[39] The recommendations made for our neighbour country India hold true also for us to improve addiction care, e.g. Expansion of OSTs involving NGOs and private setups, Incorporating common substance use disorders (alcohol and tobacco) along with common mental illnesses (anxiety and depression) to the public health model of NCDs, Expanding the focus of intervention beyond urban areas (inclusion of rural and remote areas), Strict legislative control on drunken driving, Provision of drug screening and breath analyzers at all medical colleges, Improvement of monitoring services (quality of care, legislative implementation, etc.)[18]

Take home message

This way, opportunities are everywhere and every way as the challenges in our society, country and people. The more challenges, the more are the opportunities!! Lets work from respective positions for better present and future and less addiction problem. Lets promote, prioritize mental health and substance free working station- the theme of the Year!

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