Breaking the Cycle: Rethinking Substance Use Care in Nepal

Aashish Dhakal[1], Shreejana Maharjan[2], Prerana Dahal[3]

[1,2,3] Annapurna Neurological Institute and Applied Sciences

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Introduction

Substance use disorder (SUD) represents a significant and growing public health concern in Nepal. The use of alcohol, tobacco and illicit substances affects individuals across age groups and different socioeconomic groups. Now of particular concern is the early onset of substance use among adolescents and young adults leading to long-term health, social and economic consequences. In spite of an increase in recognition of addiction as a chronic medical condition, response remains influenced by stigma, limited service capacity, and an over dependence on institutional care models.[1–5]

Stigma, Moralisation, and Delayed Care

Substance use in Nepal is commonly interpreted through moral and social frameworks rather than as a treatable health condition. Individuals with SUD are frequently labelled as irresponsible or bad moral character which further reinforces shame and social exclusion. Families often conceal substance use problems to avoid discrimination and social repercussions which results in delayed help-seeking. Even after entering treatment stigma persists within healthcare settings, workplaces and communities. Relapse which is a recognised component of recovery is often misinterpreted as personal failure, contributing to treatment discontinuation and poor outcomes.[1,3]

Institutionalisation, Forced Admission, and Systemic Limitations

The expansion of rehabilitation centres in Nepal has occurred largely in response to limited availability of hospital-based and community-based addiction services. In many cases, prolonged institutionalisation has become the default response rather than a clinically indicated intervention. Admissions are frequently initiated by families in situations where individuals lack insight, decline voluntary care, or show behavioural problems. In the absence of accessible crisis intervention and deaddiction facilities, families are left with forced admission as the only available option.[4,5]

Operational Challenges Within Rehabilitation Centres

A substantial proportion of rehabilitation centres are operated by individuals with lived experience of substance use. While peer experience can enhance empathy and engagement, its effectiveness depends on adequate clinical training, supervision and mental health support. In practice, because of a lack of professional oversight, the psychiatric symptoms are undermined particularly when recovery is framed primarily through motivational narratives such as “positive thinking.”[3,8]

Dual Diagnosis and Risk of Clinical Harm

A substantial proportion of individuals with SUD have co-occurring severe mental illnesses such as schizophrenia, bipolar disorder and major depressive disorder. Failure to recognise and adequately treat these conditions may result in worsening of psychiatric symptoms and increased risk of relapse. Psychotic features, mood instability and behavioural disorganisation are frequently misattributed to substance-related behaviour rather than underlying mental illness.[6,7]

Challenges in Societal Reintegration

Completion of institutional treatment does not guarantee successful reintegration into society. Individuals recovering from SUD frequently encounter persistent discrimination, limited employment opportunities and strained family relationships. Evidence suggests that only a minority of individuals are able to secure stable employment following treatment. This shows there are broader structural barriers rather than individual failure.[1,5]

Toward a Public Health–Oriented Response

A comprehensive national response to substance use should prioritise normalisation of addiction as a medical condition. This requires regulation and monitoring of rehabilitation centres, expansion of hospital-based and community-based services and integration of psychiatric care. Investment in harm reduction strategies, workforce training in addiction psychiatry and development of reintegration supports are essential components for a sustainable reform.[2,4,8]

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Address for correspondence:

Aashish Dhakal
Annapurna Neurological Institute and Applied Sciences, Kathmandu, Nepal
Email: ashishdhakku014@gmail.com

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Conclusion

Substance use in Nepal exists at the intersection of stigma, fragmented service delivery and limited reintegration mechanisms. Institutionalisation alone is insufficient to address the complex biopsychosocial dimensions of addiction. A shift toward voluntary evidence-based and community-oriented care is required to improve outcomes and uphold patient autonomy. Meaningful reform will depend on strengthening clinical services, enforcing ethical standards and fostering societal acceptance as a foundation for recovery.[1–4]

References

1. Shrestha P, Ojha SP, Danadhar PK. Stigma and help-seeking behavior among families of substance users in Kathmandu. J Nepal Health Res Counc. 2019;17:301–7. DOI:10.59284/jgpeman238

2. World Health Organization. Alcohol and drug use: key factsGeneva: World Health Organization; 2021.

3. Paudel S, Sharma R, Dhital R. Healthcare workers' perceptions toward people who use drugs in Nepal. Subst Abuse Treat Prev Policy. 2020;15:72. DOI:10.1007/978-981-97-6619-2_6

4. United Nations Office on Drugs and Crime. World drug report 2023. Vienna: UNODC; 2023.

5. Government of Nepal, Ministry of Home Affairs. National survey on drug use in Nepal 2020. Kathmandu; 2020.

6. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Epidemiology of co-occurring addictive and mental disorders. Biol Psychiatry. 2005;56:730–7. DOI:10.1037/h0080151

7. Hunt GE, Malhi GS, Cleary M, Lai HM, Sitharthan T. Prevalence of comorbid substance use in people with severe mental illness. J Clin Psychiatry. 2017;78:e135–43. DOI: 10.1016/j.jad.2020.01.141

8. Drake RE, O'Neal EL, Wallach MA. Psychosocial interventions for people with co-occurring severe mental and substance use disorders. Am J Psychiatry. 2016;173:317–28. DOI: 10.1080/10673220902724599