Integrating Mental Health and Development: A Case Study of the BasicNeeds Model in Nepal

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Mental Health and Development

People who live in conditions of social disadvantage are at greater risk of developing mental illness [1]. Access to treatment in low- and middle-income countries (LMICs) is limited and can be expensive [2]. Stigma makes it difficult to secure already limited employment and education opportunities [3]. While a mental health treatment gap has been widely acknowledged, less attention has been paid to addressing the poverty gap, which often accompanies mental illness [4]. The recent World Health Organization (WHO) report on mental health and development concluded that people with mental health conditions met all the criteria for vulnerability and merit targeting by development strategies and plans [5].

BasicNeeds was founded in 2000 and developed its community-based integrated Mental Health and Development (MHD) model, inspired by development theory, which emphasizes user empowerment and community development, as well as strengthening health systems and influencing policy [6,7]. Figure 1 shows each component of the MHD model.

In practice, the five modules of the MHD model work in conjunction to address the treatment, capabilities, and opportunities gaps experienced by affected individuals. Evidence suggests that community-based models that integrate health care and social interventions can have a positive impact on clinical outcomes and social and economic functioning for affected individuals in low-resource settings [8,9]; and the BasicNeeds Model offers a feasible method of integrating mental health into existing community-based interventions [10].

BasicNeeds has witnessed exponential growth in response to requests for MHD programmes. In 2011, BasicNeeds operated MHD programmes in a total of 98 districts in 11 countries (Ghana, Uganda, Kenya, Tanzania, India, Sri Lanka, Nepal, Lao PDR, and Vietnam, with new programmes being initiated in China and the United Kingdom), working with 55 local partners, reaching 39,518 affected individuals. A major challenge has been sustaining existing programmes while adding new ones. After extensive consultations, BasicNeeds planned further scale up through a social franchise of the MHD model, i.e., a commercial franchising approach to replicate and share organizational models for greater social impact [11].

This paper will focus on a description of one particular MHD program in Nepal. The Nepal program was chosen because this allows highlighting operations in a fragile state where the government is unable to deliver even the most basic services, particularly in remote regions [12]. Nepal is also the first country where BasicNeeds has not set up a country office but operates through a direct partnership with an independent local nongovernmental organization, with expertise in community-based rehabilitation (CBR) and related training, called Livelihoods Education and Development Society (LEADS)—an operational prototype for future franchises.

MHD in Nepal—A Case Study

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The MHD model works in partnership with governments to provide the "great push" that is required to set up services where mental health and development has not been a priority.

The model is comprised of five key components: capacity building, community mental health, livelihoods, research, and management.

Involving affected individuals, their families, and communities in a program, as well as tapping into local resources, is essential to the success and sustainability of a program.

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| Mental Health & Development | Activities | Location | Institution/Human Resources/Roles |
|-----------------------------|------------|----------|----------------------------------|
| Identification & mobilisation of affected individuals | Field consultations (FC), home visits | VDC Centre OR Health Post | LEADS—staff and funds; engage all stakeholders involved; bring in patients/families to FC Health and Sub Health Posts (HP/SHP)—provide staff, maintain list of those identified Village Development Committees (VDCs)—provide FCHVs’ services. FCHVs bring in patients/families to FC |
| Community mobilization | Distribute posters, pamphlets, street theatre, interact with existing SHGs | VDC areas | LEADS—provide staff and funds; develop awareness material and organise activities Community—e.g. local village leaders—participate in community awareness activities Government—health staff, VDC members, FCHVs—provide space, staff and overall support |
| Training | Training workshops for general physicians & health staff, FCHVs and CBWs | District hospitals HPs & SHPs | LEADS—funds; organise training, translation of BasicNeeds’ training manuals Western Regional Hospital (government)—provide psychiatrist who leads the training |

### Community Mental Health

| Treatment services | MHC | Baglung district hospital (recently upgraded to Zonal hospital); Myagdi district hospital | Government District Hospitals—space & staff, services of District MH Focal person (senior health assistant) who overall coordinates services; Western Regional Hospital—Psychiatrist—diagnose and prescribe; VDC—provide FCHVs’ services, FCHVs direct affected persons from communities to MHC and follow-up clinics LEADS—provide staff, funds, medicines (as required) LEADS’ CBWs direct affected persons from communities to MHC and follow-up clinics Asian Pharmaceuticals (Pvt Co)—provide medicines to MHC |
| Follow-up clinic | District Hospital & 7 SHPs in Baglung and District hospital & 4 HP/SHP in Myagdi district | Government MH Focal person in district hospitals & trained government health staff in HP & SHPs in consultation (via mobile phone) with Psychiatrist at Western Regional Hospital—Assess clinical condition, adjust prescription, referral, maintain patients’ list LEADS—provide medicines, monitor |
| Home visits | Monitoring and support | Homes of affected persons | Government (VDC level) —FCHVs monitor use of medicines, support families, livelihood related activities (see below) LEADS—CBWs monitor use of medicines, support families, livelihood related activities (see below) |

### Livelihoods

| Assessment & Training | Assessment | Homes of affected persons | LEADS—discuss with affected individual/family on livelihoods activities; develop business plan with the affected individual/family |
| Skills Training | District head quarters | LEADS—funds & organise training Government/Private—resource persons from relevant trades—provide training |
| Funds and support | Individual support— in cash and kind | At user’s home or HP/SHP | LEADS—support execution of business plan, advice on livelihoods activity, distribute cash support HP/SHP—staff help distribute in kind support |
| | Group support— revolving fund | Village | LEADS—provide funds, incentivize existing (community) groups through training, matching grants Self Help Groups—included affected persons as members |

### Research & Management (Monitoring & Evaluation)

| Monitoring | Individual data collection (of all individuals in the programme) | MHC | LEADS—provide training in data collection, collect socio-economic data Government—District Hospitals, Health and Sub Health Posts—Provide space, staff, maintain clinical data |
| Evaluation | Baseline situational analysis study | Project catchment area | LEADS—coordinate data collection, Collect data BasicNeeds Research Team—design, train mentor and provide funds (http://www.basicleeds.org/HTML/Publications_Basicneeds_Baseline.htm) |
| | Prospective cohort intervention study | Project catchment area | **Evaluating clinical, functional and economic outcomes of MHD participants** LEADS—collect data BasicNeeds Research Team—design, research tools, training, data analysis, report writing University of Cape Town—design, analysis, report writing |
| Management support | Mentoring/monitoring/reporting | | BasicNeeds—train LEADS; provide operational guidance; mentoring; liaison with DFID LEADS—follow monitoring systems and send regular reports to BasicNeeds |
groups (SHGs), opening up opportunities to integrate into mainstream groups and ensuing opportunities. LEADS’ community-based workers (CBWs), coordinators, and female community health volunteers (FCHVs) made home visits to provide continuing support to the families and to also identify more affected individuals.

Impact, Barriers, and Opportunities

Figure 3 provides an overview of the characteristics of and benefits for persons affected by mental illness accessing the MHD program in the short span of the 8 months since its inception.

The most common diagnoses were common mental disorders, followed by psychosis and epilepsy [23]. Qualified psychiatrists made diagnosis using WHO ICD-10 criteria, and thereafter recorded follow-up assessments in individual clinical information sheets. Of the 311 patients registered with the program until March 2011, 269 have been reported to show improvement. Over time we saw an increasing number of identifications from home visits and some self-referrals.

Baseline data collected at MHC showed 142 had accessed pharmacological treatment earlier, the vast majority from private providers in Kathmandu (4 days travel) or Pokhara (2 days). Apart from the travel costs, these families also paid for the treatment. All of them now attend MHC at the district hospital (4 hours travel maximum) and follow-up clinics in their local health posts, do not pay for services or medicines, are registered as Out Patient Department (OPD) patients, and are therefore part of the district health management information system (HMIS).

Of the 311 persons who have so far accessed the program, 32/214 (15.2%) of those who were not in an income-generating occupation began earning an income, and 22/48 (46%) of persons who were not engaged in any form of productive work (e.g., household chores) began such work. While this is low proportion relative to the estimated epidemiological need, the capacity of the health facilities requires further strengthening to provide mental health services to a larger number of patients.

Between October 2010 and March 2011, 55 affected individuals, showing significant clinical improvement, were assessed by LEADS for eligibility for livelihoods interventions. A checklist was used followed by discussions with the individuals and their families. The indicators were: work before illness, interest to work, ability to work, traditional skills, family involvement, and market scope. Thirty-one individuals, with varying diagnoses (psychotic disorders-11, epilepsy-11, common mental disorders-9) were prioritized for support. In October 2011, LEADS carried out an evaluation of the outcomes of these 31 individuals. Data collected were: details of business plans, investment made, expenses incurred, income and savings details as well as their views about progress, problems, family support, financial situation, and future plans. Initial findings showed that all 31 were earning in a range of occupations including running a tea/grocery shop, chicken and goat rearing, tailoring, and embroidery. The six who earned prior to the program observed an increase in income ranging between 17% and 108%. Two individuals with epilepsy were doing skilled work (tailoring and making copper pots) and reported monthly earnings well above the stipulated minimum wage. Two persons diagnosed with depression, whose occupations were running a provision shop or tailoring, earned close to the minimum wage. The rest have incomes below the minimum wage. Ten have deposited savings with LEADS to be transferred into the account of a livelihoods co-operative that has been initiated.

The program has experienced a number of barriers in its implementation. Villages in both districts are remote, almost entirely inaccessible by road, and distances are still measured in number of days to walk. Despite the inhospitable terrain and associated difficulties, demand for services is growing and a key challenge is to keep pace with supply—i.e., availability of psychiatrists, trained health personnel, and medicines. At present, MHC held at the district hospitals every alternate month are the nearest point where/when the psychiatrist is available. LEADS is currently trying to bring together a reasonable number of persons from different villages to form SHGs that can be sustained over time for self-advocacy. Integrating affected persons into the innumerable existing village-level SHGs (which can also help address stigma) posed problems, as existing members resisted the idea of mentally ill people joining. Incentivizing the SHGs with revolving micro-credit funds and skills training has helped to integrate affected persons to some extent.

In Nepal, primary health care is offered through a decentralized system [24]. The MHD programme already works through this. Continued engagement with health facilities, support to affected persons and families for livelihoods, and repeated awareness activities over time will help integrate the model into the routine activities of the existing providers and communities, but funds for sustaining these activities will be required. Continued political instability in Nepal has delayed LEADS’ plans for engaging with the government more substantially.

Looking to the Future

In the two districts the plan is to expand access and sustain the program by building capacity in local resources by training more local doctors in mental health (both private and government); holding MHC in remote locations so persons living there have easier access to specialist attention; training and supporting all health posts to include mental health records in HMIS; widening the scope of training for health...
workers and FCHVs to support livelihoods interventions; establishing a livelihoods cooperative; training affected persons to evaluate services; and forming district-level advocacy groups of affected persons. LEADS will step up its engagement with the Primary Health Care Revitalization Division for policy changes, especially on psychotropic medicines allowed at the primary care level and budgetary allocations for mental health. Ultimately, lessons from the experiences in Baglung and Myagdi, and evidence from a cohort intervention study (underway), will be used for designing a scaled-up programme in six more districts in the Western Region.

BasicNeeds has implemented the MHD model in nine countries. Many of the older programmes have encountered and negotiated the kind of difficulties we are currently observing in Nepal, and lessons from those experiences may have relevance in Nepal. In Uganda, for example, advocacy groups now engage directly with district officials to lobby for improved treatment services. In Ghana, groups have come together as a registered national association, the Mental Health Society of Ghana (MEHSOG), for advocacy. In Lao PDR, mental health services are available through primary care in nine districts of Vientiane capital region. There are a number of lessons from BasicNeeds’ total experience in 10 years that can be relevant more widely in scaling up community-oriented mental health interventions in LMICs as well as developed countries.

Strategic engagement and effective working relationships with and involvement of government and other local/national stakeholders is critically important if a demonstration project has to influence mental health practice and policy for scale up. Involvement of affected persons and families is fundamental for maintaining relevance and effectiveness of interventions even if they are evidence based. Advocacy by affected persons is powerful and must be supported to become effective. Community involvement is important, as it supports affected persons and families in the process of recovery and can effectively support delivery of services. Involving affected persons, families, and communities requires detailed planning and has to be intrinsic to the intervention programme. Tapping into local or in-country resources, skills, and capabilities will help sustain service delivery. Designing simple yet rigorous records and data collection systems for complex community-based mental health programmes is feasible and crucial for monitoring quality and can substantially aid evaluations; such evaluations must be intrinsic to the intervention programme.

Above all, the MHD model is not in parallel or an alternative to government and other local efforts for effective mental health interventions. The model works to provide the “great push” required to set up mental health and development services in places where they are not on the agenda of government or civil society [25].

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References
1. Lund C, Breen A, Fisher A, Kakuma R, Corrigall J, et al. (2010) Poverty and common mental disorders in low and middle-income countries: a systematic review. Soc Sci Med 71: 517–529.
2. Knapp M, Funk M, Curran C, Prince M, Grigg M, et al. (2006) Economic barriers to better mental health practice and policy. Health Policy Plan 21: 157–170.
3. Sartorius N (2007) Stigma and mental health. Lancet 370(9590): 810–811.
4. Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, et al. (2011) Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. Lancet 378: 1502–1514.
5. Raja S, Boyce WF, Ramani S, Underhill C (2009) Success indicators for integrating mental health interventions with community-based rehabilitation projects. Int J Rehabil Res 31: 234–292.
6. Social Enterprise Coalition. Available: http://www.searo.who.int/LinkFiles/Mental_Health_Resources_WHO-AIMS_Report_MHS_Nep.pdf. Accessed 30 May 2012.
7. World Health Organization (2010) World development indicators and global development finance. Available: http://data.worldbank.org/datacatalog/mdgs. Accessed 30 May 2012.
8. World Health Organization (2006) WHO-AMIS report on mental health system in Nepal. Available: http://www.searo.who.int/LinkFiles/Mental_Health_Resources_WHO-AMIS_Report_MHS_Nep.pdf. Accessed 30 May 2012.
9. CMC Nepal (2004) UMN closer report. Internal report.
19. BasicNeeds and Livelihoods Education and Development Society (2010) Mental health and development programme baseline study report. http://www.basicneeds.org/download/PUB%20-%20LEADS%20Baseline%20Study%20Report%202010.pdf. Accessed 30 May 2012.
20. Jha A (2007) Nepalese psychiatrists’ struggle for evolution. The Psychiatrist 31: 348–350.
21. Prince MJ, Acosta D, Castro-Costa E, Jackson J, Shaji KS (2009) Packages of care for dementia in low- and middle-income countries. PLoS Med 6: e1000176. doi:10.1371/journal.pmed.1000176
22. Patel V, Simons G, Chowdhary N, Kaaya S, Acaya R (2009) Packages of care for depression in low- and middle-income countries. PLoS Med 6: e1000159. doi:10.1371/journal.pmed.1000159
23. Goldberg D, Huxley P (1992) Common mental disorders: a biosocial model. London: Tavistock and Routledge.
24. Bichmann W, Chaulagai CN (1999) Kaski District health services, Nepal. In: Khassay HM, Oakley P, eds. Community involvement in health development: a review of the concept and practice. No. 5. Geneva: World Health Organization, pp. 51–74.
25. World Federation for Mental Health (2011) Great push for mental health initiative. Available: http://www.wfmh.org/00GreatPush.htm. Accessed 30 May 2012.