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BasicNeeds: Scaling Up Mental Health and Development

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Responding to the Global Mental Health Challenge

Mental health problems are increasingly recognised as a significant and growing contributor to the global burden of disease (Murray et al. 2012). The majority of people with mental health problems live in low- and middle-income countries (LMICs) and receive little or no evidence-based treatment, a situation often described as the 'treatment gap' (Lopez et al. 2006). This means that citizens of LMICs bear a disproportionate share of the burden of global mental illness (Whiteford et al 2013).

Moreover, the close links between mental health and development (MHD) are critically underemphasised. Conditions of deprivation or social exclusion increase the risk of mental illness (Lund et al. 2010) and reduce access to treatment and its affordability (Knapp et al. 2006). At the same time, mental illness exacerbates inequalities in wealth and income (Kessler 2008). Where social supports are inadequate, households are vulnerable to the income shocks created by mental ill health (Lund et al. 2011). Mental disorders reduce the ability of affected individuals and their carers to engage in productive activity

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as well as wage earning. This effect is especially large where stigma and social exclusion reduce the ability of affected individuals to engage in formal and informal labour markets (Sartorius 2007). The risk of stigma also reduces demand for treatment (Saxena et al. 2007).

In response to this situation, *BasicNeeds* was set up in 2000 as an international not-for-profit mental health organisation. The organisation delivers the MHD model in developing countries and has, to date, reached 631,441 beneficiaries through field operations in 12 countries in Africa, South Asia and South East Asia. Field programmes are operated either directly by *BasicNeeds* or through franchisee, that is, independent organisations licensed by *BasicNeeds* through a Social Franchise agreement to operate the *BasicNeeds* model (BasicNeeds 2014d, 2014e). *BasicNeeds* was founded by Chris Underhill who previously founded 'Thrive' and 'Action on Disability and Development'. Both organisations worked with vulnerable people affected by physical or mental disabilities. Lessons learned were applied designing the *BasicNeeds* model.

The *BasicNeeds* model of MHD, described in detail further in this chapter, comprises five modules: capacity building, community mental health, livelihoods, research, and collaboration (Raja et al. 2012). Taking a whole life approach, the *BasicNeeds* model addresses the health, social and economic needs of people with mental illness and their families. The model emphasises the importance of supporting the development of local institutions and community capabilities, participatory methods in all aspects of programme development, and grounding programmes in research on effectiveness (*BasicNeeds* 2008)

Operating in challenging contexts where as many as 85% of mentally ill people in LMICs are unable to access treatment or work opportunities (WHO 2004a), the *BasicNeeds* model has gained global attention for its innovative interlinking of mental health care, poverty alleviation and good practice (WISH 2013; Skoll Foundation 2013; Ashoka 2012; World Economic Forum 2014).

Working with colleagues in India, Chris conceived of the *BasicNeeds* model by listening to persons with mental disorders in rural and urban areas through a series of community meetings held in 2000–2001. Once the model was fully designed, *BasicNeeds*' first field programmes were implemented in India (BasicNeeds 2004). From 2002 onwards, MHD programmes were rapidly expanded to other countries in Asia and Africa. *BasicNeeds* works with communities and supports the health systems of LMIC to address the many challenges of Global Mental Health (GMH) in an integrated and holistic way (Lund et al. 2013).

The *BasicNeeds* model for MHD has emerged over more than 14 years. Within the framework of the MHD model, the finer details of implementation

could differ from location to location depending on the needs of communities and the capacities of local systems. Because it is inclusive, it also depends on the conditions with which individuals present. In some regions, care is focused heavily on individuals with epilepsy, for example, while in others epilepsy is rarely treated.

This chapter introduces the *BasicNeeds* MHD model and describes its operations using examples from field programmes to demonstrate how each component of the MHD model aligns to the needs of the problem context. In the subsection on the 'Research' module, the authors elaborate on the method used to monitor *BasicNeeds*' impact on an annual basis. In addition, the chapter draws from papers and a recent independent review in India to illustrate key outcomes, discussing also some of the limitations. Finally, cognizant of the GMH community's consistent advocacy for scaling up, the chapter explains *BasicNeeds* experience and strategies in making the MHD model scalable.

Initial Engagement

Running a successful national MHD programme depends on identifying a region with a significant opportunity for improvement, understanding the local context and priorities and creating a partnership which builds on the assets of the communities involved. None of this can be achieved without performing a careful feasibility study in advance of implementing the MHD model.

The initial feasibility study involves reviewing the legislation and policy affecting mental health care provision, as well as the programmes and resources currently in place. In addition, estimates of baseline prevalence of illnesses must be made, although this can be difficult. These points establish the possibility and nature of improvement. For example, an initial feasibility study of Ghana's mental health services by *BasicNeeds* (2001) determined that existing services were limited and were hampered by lack of facilities and local practices, which marginalise people with mental illness from service provision. It identified that there were no existing plans to extend mental health services, either by the government or by non-governmental organisations, to the north of the country and the substantial logistical challenge created by poor transport links between the north and south. These made it difficult for individuals in northern Ghana to come to treatment centres in the south of the country (*BasicNeeds* 2001). This analysis informed the priorities of the programme in Ghana, leading to a focus on community-based self-help groups across a broad geography including northern Ghana (*BasicNeeds* 2014a). Feasibility

studies help to identify different national or local priorities which determine how to adapt the MHD model for a particular setting.

Capacity Building

The first module 'capacity building' is broader than simply building the capacities of existing institutions to provide services. It involves engaging with affected individuals themselves, their caregivers and families, and others such as community leaders, traditional healers, local traders, health personnel, local officials, and so on. It crucially involves mobilising, sensitising and training stakeholders who will be involved in the implementation of the MHD model in one way or another. Executing this module involves the concept of *animation*, a core concept for *BasicNeeds* in building communities where MHD is practiced. This builds on a tradition in development work of enabling 'a higher degree of self-realisation, self-expression, and awareness of belonging to a community which they can influence' (Simpson 1989). Rather than imposing a solution on a community, *animators* aim to challenge and support a community to develop an analysis of its own problems, which will lead it, after reflection, to act (Underhill 1996). Thus, 'the animator has a special responsibility to stimulate people to think critically, to identify problems and to find new solutions' (Hope et al. 1984). Animation is an important component in which affected persons, often with low literacy, are involved in large numbers, and organised to create self-help groups. This allows communities to build ownership of their care.

Animation typically begins with field consultations, in which individuals with mental illnesses and their carers have an opportunity to discuss the problems they face as well as potential solutions. They begin by describing the people, organisations and experiences that shape their lives.

After they have an opportunity to discuss their world, participants move on to their needs and concerns. Lastly, they move on to the future and ask, 'what next?' From here, the group decides what they themselves can commit to resolving and where they require external help.

Gunasiri (a 33-year-old man affected by bipolar affective disorder) was one of the first participants of *BasicNeeds* programme in Sri Lanka. A volunteer who recorded Gunasiri's story writes:

> I first saw Gunasiri at the field consultation that was organized by *BasicNeeds* in the village of Rathmalwela. Not only Gunasiri, but his mother and father also

attended that day. These three individuals who had come there in search of solutions to many problems of the mind, played key and poignant roles that day. In particular, Gunasiri had faced rare and unfortunate circumstances, not often faced by a man during his lifetime. At the close of the proceedings that day, Gunasiri was amongst the group of villagers that volunteered to form the committee representing the village, the Volunteer's Committee. They were invited to help BasicNeeds and its partner organisation, Navajeevana, in their work with people with mental disorders, getting their needs addressed, their problems solved and their expectations achieved.

This community-based approach is a powerful tool in the contexts where *BasicNeeds* works. In addition to empowering local communities and the individuals within them, it helps to overcome the shortage of trained psychiatrists and other mental health workers and the logistical challenges of travelling to remote specialist centres. *BasicNeeds* explicitly encourages the creation of self-help groups. These groups can provide peer support to help manage mental illness as well as to share information or raise awareness within communities. These groups can also form part of broader networks, which campaign for change on a regional and national level. This can involve collaboration with campaign groups for women's or disability rights (Underhill et al. 2014):

Saidi Hamisi said he decided to join the Tuleane self-help group so as to join forces with people, lend a hand in farm production and raise awareness about mental disorders in Lisekese ward. … They have shown the community that they are capable of improving their lives. People are pleasantly surprised as they see this self-help group producing enough from their farming. The group sells their produce to neighbouring people. They are seen to be 'normal', like other people. Laiza said that when they wait for the harvest, she engages in other small businesses like selling vegetables, fruits and other necessities.—Laiza Jofrey's story, BasicNeeds Tanzania (2007)

In many localities, one of the main challenges is to sensitise the community to the nature of mental illness. This improves the ability of the community to later be involved in treatment and supporting livelihoods, but it also makes it easier for people with illnesses to seek help. Approaches taken include street theatre, personal counselling, sensitization workshops, consultations and media campaigns. *BasicNeeds* has found it helpful to focus these attempts on particular groups such as teachers, the police and judiciary, health professionals or schoolchildren.

Community Mental Health

> It is a long distance to go by bus and there's no money. If he is told to go alone, he wants me to go with him. We don't have money for two persons. One has to earn something to be able to pay!—Care giver from India, 2004

A key issue for building capacity for mental health services in LMIC relates to the lack of available human resources (WHO 2011). Trained professionals are often available only in major cities and they struggle to meet the demand placed on them. Individuals are hesitant to travel to the cities where treatment is available because of the associated transport costs and loss of productive working time. This reduces the extent to which individuals will seek diagnosis, because they have an accurate expectation of the lack of availability of services and the excessive cost of treatment (Saxena et al. 2007).

In *BasicNeeds*' experience, the key to improving availability is to provide services geographically closer to the individuals requiring treatment, as also advocated by the WHO (2008). One approach to this is to form a partnership with local health centres and community organisations. These organisations take the lead role in identifying and treating individuals with mental illness. Mental health professionals visit community health posts, clinics, community centres or health centres to provide additional training and support. An alternative is the use of mental health camps (Raja et al. 2012). A team of mental and general health professionals set up temporary facilities for a single day in order to provide treatment. This allows professionals to treat large numbers of people in a relatively short amount of time and to serve the areas most in need. This approach certainly has limitations, as professionals are able to spend very little time with each person. However, camps are backed up by home visits by trained community workers who provide the vital link between the family and the treatment facility (Raja et al. 2014). The community workers in most cases are already attached to primary care facilities treating communicable diseases, maternal and child-care, and so on, and *BasicNeeds* trains them to also address mental health.

The philosophy of *BasicNeeds* is to treat all individuals who present at the camps but the organisation appreciates the importance of outreach to identify individuals who could benefit and encourage them to attend. This work is often performed by community workers and volunteers (who are trained by *BasicNeeds*) and local mental health professionals. Follow-up support is provided primarily through the community workers. This is vital to make sure prescriptions are being followed, particularly where affected individuals are unable to read prescription instructions. However, ongoing supervision is

important to ensure that local workers maintain standards, particularly where turnover is high (Raja et al. 2014):

> Eunice got to know of the mental health clinic through the community mental health volunteers in the area. 'George Ratemo comes from this village and knows that I suffer from a mental disorder so he informed us—my mother and I—that a clinic was starting in the neighbourhood in the beginning of May 2006. He even sent someone to keep reminding us of the date.—Extract from the life story of Eunice Wangeci Wambui Kihara, 25 years old female, diagnosed with Panic disorder, Kenya Programme. (BasicNeeds 2007)

Livelihoods

Mental health interventions, which neglect the context of poverty, risk ineffective delivery. This is partly because mental illness and the stigma surrounding it can be a causal factor behind a family's poverty. Many people with mental illness are unable to maintain paid employment, and illnesses can get in the way of other productive work (Razzano et al. 2005). In addition, the stigma of mental illness can reduce individuals' prospects indirectly by making it harder to acquire education. For example, Fatuma Mohamed, who participated in *BasicNeeds*' Tanzania programme commented: 'I wish to go to school like my fellow pupils, but I'm afraid of being called awful names' (*BasicNeeds* 2006a). Depending on location, this stigma can take multiple forms. In India, a fear that mental illness will harm marriage prospects can lead to it being hidden, and this is felt more strongly by women than by men (Thara et al. 2003). Thornicroft et al. (2009) found degrees of anticipated and experienced discrimination are consistently high among people with schizophrenia through a study across 27 countries (see chapter 13 by White, Ramachandran and Kumar in this volume for further details about mental health related stigma and discrimination).

Equally, having an occupation can help in sustaining recovery from mental illness (Bush 2009). Where individuals are able to engage in wage earning or other productive work, it can offer a renewed sense of purpose and feeling of meeting the responsibilities one has towards one's family. Participants of *BasicNeeds*' programmes have reported feeling satisfied that they no longer feel like a burden on their families, and are proud to be able to contribute. Regaining a sense of purpose can be part of managing mental illness. Nguyen Thi Mui, a 43-year-old woman from Vietnam, diagnosed with schizophrenia, told *BasicNeeds*:

> I have learnt how to make a broom and now I can sell it at the local market. It is very wonderful. Every day, I can earn 10,000 to 15,000 VND ($0.47–$0.72) so that I can buy some food for myself. My parents are very happy because I can overcome my illness.

BasicNeeds provides, alongside its community-oriented mental health treatment, interventions designed to enable affected individuals to engage in paid employment or other productive work. This first involves an assessment of the opportunities available to the individual, which includes the skills of the individual, the skills shortages locally and locally available institutions that can provide support. In addition to this assessment, *BasicNeeds* and its partner organisations visit affected individuals to offer support, mentoring and information about opportunities such as micro-finance initiatives. While some independent micro-finance organisations have been hesitant to offer loans to individuals with mental illness due to stigma, *BasicNeeds* has offered a subsidy in the form of a loan guarantee in some regions. This support can be accompanied by communities organising self-help groups as part of the animation process or communities supporting the affected individuals by identifying valuable activities they could work towards:

> Before he became ill, Venkatesh worked for thirty years in the weaving industry. He gave it up and concentrated on overcoming his illness with the support of his family. Following treatment and ongoing assistance from one of *BasicNeeds*' partners in India, Grameena Abyudaya Seva Samsthe (GASS), Venkatesh decided to set up a small business—supplying snacks to travelers using the bus shelter in his village. Trade has been good and he turns over about R.300 [$7.50] a day, a modest sum but comparable to the incomes of many people in the area. Most importantly, Venkatesh describes himself as having a completely new beginning. He is confident and contented, enjoying the relative freedom of the work he does now. Notably, the local panchayat (local elected body) has been instrumental in allowing Venkatesh to use the bus shelter, which is a favourable location for his business. (*BasicNeeds* 2006b)

Research

Global research on mental health is growing. However, local relevance of international epidemiological studies is limited. Furthermore, individuals with mental disorders, especially those who are poor, are marginalised due to stigma, their needs and valuable insights often overlooked by researchers and policy makers (Patel and Kleinman 2003). Of the small amount of

internationally accessible mental health research conducted in LMIC, very little is practice based and people living with mental disorders remain largely unheard (Sharan et al. 2006).

BasicNeeds regards an evidence-based approach to improving practice and policy as highly important. The research module helps to embed a research 'culture' into the operations of the MHD model. The module facilitates evidence generation from field operations and also brings forth views of those affected by mental illness. The research module has two components.

Quality Assurance and Impact Assessment System

A standardised semi-automated quality assurance-impact assessment (QA-IA) system operates across *BasicNeeds*' programmes to monitor progress, reach and quality of implementation and to assess impact. Detailed protocols and standardised tools guide data collection. Both quantitative and qualitative data are collected.

Quantitative data comprises data of *individual beneficiaries* collected at baseline (i.e., at the time of their joining the *BasicNeeds* programme) and follow-up (collected annually from a sample of the total beneficiaries), and data of field *implementation*, that is, data on every activity carried out recorded regularly and systematically together with costs. Qualitative data comprises *Life Stories* and *Participatory Data Analysis* reports. The *Life Stories* are akin to semi-structured in-depth narrative interviews. Life stories of purposively selected beneficiaries are collected at baseline and updated annually to record narrations of their experience and perceptions. *Participatory data analysis* is an inclusive research process where participants evaluate the services they receive and also the change they experience. In a typical session, affected persons and their carers analyse their own data and discuss and summarise them under predetermined themes, often based on the MHD model, and suggest very practical recommendations. Through this method, they evaluate the intervention activities of the MHD model (Raja et al. 2012).

The quantitative analysis includes quarterly statistics assessing the progress of individuals: an analysis of implementation costs and results and an assessment of the scale of the programme. These are collected at a country level and are drawn annually into the organisation-wide impact report alongside qualitative analysis.

Providing econometric analysis to establish the impact of the MHD programmes is challenging given the scale and complexity of the operational context. Collecting and collating routine good quality data from every user from

programmes across several countries is a huge task. Standardised high-quality training to field personnel and systematic quality checks at various stages minimises errors. Furthermore measuring cost per beneficiary is complicated by beneficiaries often accessing different interventions multiple times with varied frequencies. Detailed cost analysis is therefore done by activity factoring in also personnel time. This provides the basis for total cost per beneficiary calculations during a given period in a particular programme site.

A mix of qualitative and quantitative evidence combined with anecdotal narrations from different stakeholders provides a comprehensive picture of the actions and impact of the MHD model. Additionally, to mitigate the limitations of methodological rigour posed by the QA-IA system, an in-depth evaluation (mostly external) of the model is undertaken from time to time in different programme sites.

Evaluation of the MHD model

The outcomes of the *BasicNeeds* MHD model have been evaluated in Kenya (Lund et al. 2013) and the model has been case studied in Nepal (Raja et al. 2012) Additionally, all *BasicNeeds* MHD programmes are evaluated by external experts for performance and impact against the programme targets and deliverables as required by programme funders. We present findings from Kenya, Nepal and India.

Kenya

In Kenya, a cohort of *BasicNeeds* participants (n = 203) was assessed for general health, mental wellbeing, quality-of-life and economic activity before treatment and at 1- and 2-year follow-up. The study was carried out in a rural area, in the Meru South and Nyeri North districts of Kenya, and participants were enrolled from May–July 2009.

Participants selected were adults diagnosed with a severe mental or neurological disorder. They were selected from 529 individuals attending community engagement meetings and identifying themselves as having a mental health problem, of whom 408 attended psychiatric clinics, 317 were diagnosed with mental health problems. Individuals with substance abuse or moderate to severe intellectual disability were excluded from the study, leaving 203 participants. This selection was representative of the participants who receive support from *BasicNeeds* and is therefore an accurate reflection of the population being treated.

The study found significant improvements and large effect sizes in all assessments among the cohort, for example, almost tripling monthly median family income. A key limitation of the study was the inability to measure performance against a control group for ethical and practical reasons (Lund et al. 2013).

Nepal

The case study of the MHD model in Nepal analyses the treatment of 311 patients who registered between August 2010 and March 2011. Of those individuals who received treatment, 269 reported improvements during follow-up assessments by qualified psychiatrists, who recorded in individual clinical information sheets. There was also evidence of improved economic activity, with 15% of those not earning any income beginning to over the period, and 46% of those not engaged in any productive work beginning to do so (Raja et al. 2012).

Perhaps most markedly, 55 individuals showed signs of clinical improvement in the short time to March 2011. Of these, 31 were given some form of livelihoods support, which appears to have increased their earning power. Detailed business planning information was gathered, demonstrating that all 31 individuals became successfully employed, and the 6 who had previously been employed saw their earnings rise between 17% and 108% (ibid.). However, since this was a case study, the analysis does not feature a control group, does not define clear inclusion and exclusion criteria and makes no attempt to test for statistical significance.

India

The MHD programme in India, funded by Department for International Development (DFID), is implemented collaboratively by *BasicNeeds* with its partner Nav Bharat Jagriti Kendra (NBJK) in the states of Bihar and Jharkhand. This programme was recently evaluated by an independent evaluator (*BasicNeeds* 2014b).

Of those who accessed services through the programme, 53% reported a reduction in symptoms of mental illness, as recorded by the psychiatrists in individual clinical information sheets. In total, 41% of those who had access to treatment reported an improvement in social integration. This included acceptance by family members, community members and even selection as community representatives. There were reports of improvements in the mari-

tal prospects of women with mental illness, and that this further improved the marital prospects of their sisters (*BasicNeeds* 2014b). The overall cost per person supported was £59.61 over the course of the four-year intervention (an average of £14.90 per year) (ibid.).

The evaluation identified certain limitations to date. In Bihar, where the project was completed in 2014, there were reports that lack of access to medication was reversing the positive effect of symptom reduction. The evaluation also identified a need for continued support of advocacy groups as they learn to become independent in working with the government to improve the quality of care provision. It appears that men were over-represented in this project with only 41% of those seeking treatment being women.

A qualitative study evaluating peer support in the Ghana MHD programme indicated that membership in self-help groups appeared to be associated with more consistent treatment and better outcomes for those with mental disorders (Cohen et al. 2012).

Collaboration

Collaboration is a critical part of implementing the MHD model. Where collaboration is with an implementation partner, agreements are typically underpinned by a Memorandum of Understanding (MoU) which explicitly sets out shared values and principles, the relationship of the parties, planned activities to be carried out, the role of each organisation, the annual budget and a mechanism for dispute resolution. The MoU is supported by regular partner meetings, financial reporting and monitoring arrangements. *BasicNeeds* also typically perform regular skills assessments of partner organisations and provider additional technical training in key areas.

Effectively delivering mental health care depends on taking full advantage of existing resources and institutions. The treatment partnerships that *BasicNeeds* has forged have been mostly with state providers, for example, Ghana Health Services. The advantages of partnering with the state are many: the most obvious of which is the commitment to provide mental health services where no commitment existed before, an elementary but essential contribution to sustainability and replication. In almost all the countries that *BasicNeeds* works, medical staff from the state provide the front-line service in the clinics that are established. These staff are not particularly familiar with psychological treatments and indeed the numbers of clinical psychologists in government service are very few in number.

Where there is sufficient capacity, *BasicNeeds* has been able to offer a larger range of services through its partners. To give the best example, *BasicNeeds* has just finished a four-year programme in Thua Thien Hue province Vietnam, where district doctors were taught to administer rational emotive behaviour therapy to persons diagnosed with general anxiety disorder. This treatment was offered as treatment choice to patients and about half opted for the weekly sessions (*BasicNeeds* 2014c).

BasicNeeds is concerned to offer a service to a large volume of people and one-on-one therapy over a number of weekly sessions can slow down this goal. However, where the state provider has sufficient staff who can be trained in psychological therapies, the objective of reaching a large number of people is not impaired and the power of offering a choice of therapeutic approach is in of itself empowering. The *BasicNeeds* model in this context is flexible and can deliver effective treatment choices to patients.

BasicNeeds often acts to support and inform existing services as opposed to providing services directly. This trend is at work in the move towards franchising the MHD model to local partner organisations responsible for delivery (*BasicNeeds* 2013). For example, in *BasicNeeds*' programme in Nepal, a local organisation, Livelihoods Education and Development Society (LEADS), led most of the delivery. It relied on *BasicNeeds* primarily for training, support and liaison with other organisations such as pharmaceutical suppliers (Raja et al. 2012). Similarly, in Bihar and Jharkhand in India, *BasicNeeds* has been acting in a supporting role through its local partner NBJK (*BasicNeeds* 2014b).

Collaboration is not, however, limited to franchising and working through partners. It also includes fundraising, managing and building other sorts of partnerships, including relationships with governments as well as direct collaboration with community groups and existing self-help groups.

Over the years, *BasicNeeds* has developed a number of strategies for collaboration to help scale up and sustainability. At first, relatively standard design international programmes were developed in many low-income settings collaborating with a number of local organisations. The innovation was in seeing mentally ill people as being the central contributors to the development processes of their own countries. In many cases, more than one programme was developed in a given country thus giving good coverage and providing in-country opportunities for replication. With increasing experience in implementation, building capacities of local independent organisations was seen as the way forward. India was the first programme to establish its own board and register as an independent organisation. A few years later, Ghana and Uganda became independent organisations and more latterly, Tanzania also

has just registered in the same fashion with Kenya intending to do the same thing in 2015. With independent programmes, *BasicNeeds* acts in a more supporting capacity (*BasicNeeds* 2013) to maintain quality, with in-country Boards taking ownership for effective implementation. Registering in their own countries also increased funding opportunities for the newly independent organisations.

Key Drivers and Challenges

There are a number of key drivers that have helped *BasicNeeds* sustain the impact of its programmes. First is the use of the MHD operational model that is wide in scope and inclusive of affected persons, carers and family, community, government and other key stakeholders. Secondly, offering clinical services and opportunities for work/income generation, which are facilitated through government and other local facilities and resources, helps build infrastructure and skills locally as well as generate positive attitudes for continuing service provision. Organising and building capacities of affected persons to self-advocate ensure sustained demand and pressure for effective provision of services (WISH 2013).

Equally there are many challenges. In each programme site, the everyday delivery of the model involves the execution of a planned set of interventions that translate into myriad activities carried out jointly by several agencies. This comes with innumerable problems, a spectrum of logistics, pooling resources, planning and coordination all operating under one umbrella—but made up of multi-disciplinary approaches, mindsets and conflicting priorities. This can result in compromises in order 'to get things moving'. A first casualty here could be quality of the services provided since in many locations services are introduced for the first time with the start of the model implementation. Furthermore, often there is no policy or legislative backing that binds this collaborative work. In fact, creating that backing is a compelling part of the rationale for collaboration and scale up.

Other more specific challenges relate to keeping pace with demand and the acute needs of affected individuals and families while working through government and other existing local resources—an approach important for long-term sustainability. Persistent and skilled negotiations are required in working with psychiatric and health personnel as a majority of them are not familiar with the concept of a community-based approach. The non-availability of psychotropic medicines in the health systems to meet the increased demand

generated from the community is a serious challenge in all countries of operation and often requires creative local solutions. Again, sufficient and consistent allocation of funds and other required resources from government are far from forthcoming, and successes here can often be small and piecemeal.

Scaling Up: Experience and Strategies

BasicNeeds has transitioned from being a delivery-oriented organisation to being a support-, research- and advocacy-oriented organisation, which enables partner organisations to build on its experience to create local programmes. This transition has been driven both by the global funding environment and by the perception that local collaboration and resourcing will have more long-term value (WHO 2004b).

Early *BasicNeeds* projects in India involved heavy commitment of on-the-ground resources relative to the size of the population served. At this time, *BasicNeeds* employed individuals who were primarily engaged in direct work assessing the needs of communities and developing appropriate interventions. It soon became clear that there were substantial capacity shortfalls in existing provision of mental health services. This led, in 2002, to the launch of a major project involving a partnership of *BasicNeeds*, *BasicNeeds* India Trust (a local organisation supported by *BasicNeeds*, which has now assumed independent control of *BasicNeeds* in India) and NBJK along with 25 other local partners (featured in the evaluation section). NBJK is a well-established non-governmental organisation that works in the states of Bihar and Jharkhand operating numerous field programmes that focus on vulnerable groups such as low-income families, women, children and adults with disabilities and mental health problems. This pattern of expanding reach by partnering local organisations with substantially greater operational scale would later be repeated in other programmes.

Several innovations in delivery enabled *BasicNeeds* programmes to scale effectively across socio-economic and geo-political contexts. Developing a codified model that outlines the major areas to be addressed in each intervention was one of these. Developing a standardised training package that is applicable for training in the MHD model in different countries and locations was another. In addition, scaling is supported by the standardised QA-IA system described earlier. The initial driver for this was a managerial one—it was valuable to get a picture of the resource distribution across *BasicNeeds* as well as to know who is being served and with what impact. This has been a crucial

factor in allowing *BasicNeeds* to deliver programmes effectively across a much larger number of geographies than would otherwise have been possible.

Having collected the information, however, additional uses became evident. *BasicNeeds* is more able to partner academic institutions to carry out primary research into implementation of community-based development and mental health models. The evidence base also makes it easier for *BasicNeeds* to engage with policy makers in countries where programmes are in place to influence policies around MHD. Lastly, donor communities are increasingly interested in a robust evidence base backing claims of effectiveness.

Many of the other barriers to scaling have been overcome by emphasising partnership. Specifically, it became clear that the financial stability and sustainability of *BasicNeeds* was an important factor in its ability to continue to provide services across a wide range of geographies. By partnering local organisations to deliver the intervention, and by ultimately serving as an experienced knowledge partner, rather than simply as a delivery vehicle, *BasicNeeds* has been able to scale up more effectively, more quickly, and more robustly to serve more people than it could otherwise.

Developing the ability to engage in partnerships effectively depended on developing a standardised approach to due diligence for potential partners. This involves measuring their governance, financial, legal, HR and operation status. This allows *BasicNeeds* to ensure that partners have the capabilities necessary to become an independent partner, which will deliver the MHD model effectively. Local leadership is also a decisive criterion in identifying potential partners.

BasicNeeds places a heavy emphasis on partnership and collaboration with *communities, local organisations and especially also government* because this has helped faster scaling and effective adaptation to the local context far more quickly than a centralised delivery model could. There are a number of reasons why this is the case. First, local communities are essential to the economic inclusion of individuals with mental illnesses. Being engaged in productive work can give individuals a renewed sense of purpose and social engagement which can be effective in treating some mental illnesses and can improve wellbeing (Patel and Kleinman 2003). Often, the opportunities that enable individuals to engage in productive work depend on community engagement in two ways. They require communities to overcome prejudices and assumptions about mental illness, which marginalise or exclude individuals. They also can involve the proactive support of the community to create the opportunity.

Secondly, partner organisations allow *BasicNeeds* to leverage its experience and understanding across a much wider range of resources that can be garnered through a collaborative approach. For example, even when under-funded and

staffed, existing national care delivery systems' budgets dramatically exceed the size of most development grants. Ignoring the ability to partner with government (often through its local arms) is missing a major opportunity. As seen earlier in the chapter, *BasicNeeds* programmes now routinely steer integration of mental health into primary care through task shifting involving specialists as well as non-specialists in changed roles in treatment provision (Raja and Wood 2008).

Thirdly, partner organisations allow *BasicNeeds* to learn from their experience of the local context. In no region has *BasicNeeds* simply transplanted their programmes from another region. Every environment has its own local context, which must be considered. For example, geographic conditions influence the importance of transportation in securing treatment. Access to microcredit influences the priority of using this tool for improving livelihoods.

Fourthly, existing organisations or individuals such as traditional and faith healers provide a large share of some mental health services (Abbo 2011). The nature of these services as well as the proportion of all mental health care provided by traditional and faith healers varies substantially depending on the region examined as well as the cultures present, levels of poverty or ethnic background (Sorsdahl et al. 2009). In some cases, a lack of understanding of mental illness by traditional and faith healers results in practices which can be counterproductive, for example, the use of toxic chemicals in treatment (Sorsdahl et al. 2010). Human rights abuses such as physical restraint and beatings can also occur. The United Nations special rapporteur on torture, Juan Mendez (2014), documented cases of physical torture, shackling, denial of food and water to mentally ill persons including children in psychiatric hospitals and spiritual healing centres of Ghana.

Conclusion

Jeffery Sachs, Special Advisor to the United Nations Secretary-General on the Millennium Development Goals, in his preface to the handbook on the *BasicNeeds*' model stated:

> Through its model *BasicNeeds* has proved that by working with people with mental disorders and their families in a holistic and participative way, their mental health can be improved and their levels of poverty reduced.

We can understand something of the nature of the changes created by *BasicNeeds* at the level of individuals by examining a typical story of a beneficiary from one of the oldest programmes operated by *BasicNeeds*:

A young woman, named Huzeima, in Ghana was training to become a teacher when she became affected by an illness with caused her eyes to redden and prevented her from speaking as her tongue swelled. She also collapsed, overcome by fatigue. She was cared for by a traditional healer for six months, after which time she had recovered. Over time, however, she became forgetful and unable to associate with people.

Huzeima was put in contact with BasicNeeds after attending a hospital where the nurse informed her of a consultation meeting at the hospital. After attending the meeting, Huzeima was diagnosed with psychosis at a BasicNeeds facilitated outreach meeting. As a result, she began to take medication.

In addition, *BasicNeeds* put Huzeima in contact with a local self-help group, which provided Huzeima with a small loan she used to trade in grain. This provided her with a small income after repaying the loan, which stabilized her livelihood. The group was also able to arrange for her to be employed in a non-professional teaching role at a local school. Huzeima works there today, in addition to her work as Secretary of the Nanumba North District Association of mentally ill people and carers in Ghana.

We can see, therefore, that there are multiple smaller interventions which are facilitated by the presence of *BasicNeeds* and which developed as part of an ecosystem in which *BasicNeeds* took part alongside other governmental and non-governmental organisations. Huzeima benefited from access to medication, from a low-cost loan and from facilitated access to employment opportunities. In each of these cases, she benefited from a service, which would otherwise have been unlikely to be available.

The *BasicNeeds* model, when it was conceptualised in 2000, was an innovation because it brought development theory and practice to community-based mental health interventions. By implementing the MHD model in several LMICs in the last 14 years, *BasicNeeds* has gained valuable experience and knowledge bringing a wide range of alternative solutions to the current discourses of the GMH community, that is, essential alternatives to approaches limited to bridging the treatment gap.

Firstly, it is possible, and beneficial, to develop a generalised mental health delivery model which can serve as a template for local interventions in a variety of geo-political-economic contexts. It is important that the model includes enough flexibility to be adjusted to local contexts, but it can be useful for local contexts to have a framework within which to deliver their interventions.

Secondly, it is effective for organisations with an international spread to serve a quality assurance, policy, research, knowledge sharing and coaching role while local partners deliver the interventions making use of existing connections and relationships.

Thirdly, marrying development with mental health interventions is an effective strategy. Securing economic outcomes for individuals is a vital step in improving mental health. Projects which neglect livelihoods in delivering mental health outcomes are both failing to address a major risk factor and are neglecting to take advantage of the benefits which community involvement in livelihoods can bring (BasicNeeds; Livelihoods Education and Development Society 2010).

The *BasicNeeds* story is presented here as a case study of how mental health care can be combined with development and of how such an approach can be scaled up. Both are important for meeting the mental health challenge especially in LMIC where low resources, policy neglect and poverty of the affected families sustain the magnitude and complexity of the problem posed by mental disorders (UNDP 2012).

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