

BasicNeeds: New Initiatives in Mental Health and Development

After thirty years working in the textile industry, Mr. Kumar found that he could work no more. Like many other people with a mental illness, he became disorientated and distressed. Living in the intense community environment of a village in India, his situation was misunderstood by many local people. He was vulnerable to abuse and neglect. Unable to perform the roles of husband and father and needing constant support from his family, Kumar struggled to find his feet again.

Where services fail to reach

BasicNeeds was established in 1999 as a response to the situation in which many people find themselves when affected by mental illness. According to the WHO, mental illness accounts for 12.3% of the global burden of disease and will rise to 15% by the year 2020. It is often said that mental health is the poor relation within the spectrum of health services. This is particularly apparent in many countries in Asia, where access to mental health services for a large proportion of the population is very low or non-existent. To use an expression common in many villages; 'The government doesn't reach this far'.

BasicNeeds is planning to extend its programs to Orissa, one of the poorest states of India, which offers a typical example of shortfalls in services. In Orissa, there are only nineteen psychiatrists for a total population of 36 million people. The internationally recommended number of psychiatrists for this population would be 367. Other professional services show similar levels of under-resourcing. In Laos, where BasicNeeds commences a community mental health program this year, there are two psychiatrists and a single mental health unit with fifteen beds for a total population of over six million people.

In many countries (arguably in all countries) awareness of mental health issues in general society remains low. Mental illness is largely misunderstood, leading to discrimination against families that have a

mentally ill member, who are largely ostracized from the community. In poor rural areas and urban shanties, food insecurity, poor physical health, migration, alcohol abuse and limited preventative health programs all have a direct impact on the vulnerability of large numbers of people to mental disorders.

The Model for Mental Health and Development

BasicNeeds promotes the Model for Mental Health and Development, which weaves together concepts of inclusion, treatment, human rights and development practice delivered in partnership with a large variety of organizations in Asia and Africa. The five elements of the Model are:

1. *Community mental health*: To improve access to appropriate treatment and follow-up services for mentally ill people in or near their own communities.
2. *Capacity-building*: To enable mentally ill people and families to be involved in the development process and for development organisations to include them.
3. *Sustainable livelihoods*: To support mentally ill people and their families to attain financial stability that can be sustained through illness.
4. *Research and policy*: To research the situation of poor mentally ill people for the evolution of mental health and development approaches and enabling them to advocate for their rights to government at all levels and other organisations.
5. *Management and administration*: To provide efficient administrative, financial and evaluative systems for all programs

One principle that underlies this approach is that the recovery of people from mental illness depends on diagnosis and treatment in the first instance, but also inclusion in social, family, community and economic life. So achieving access to medicines for large numbers of people living far from urban areas is a first priority. But this goes hand-in-hand with the need to raise awareness of mental illness both for the individuals and their families and then the wider community. This is followed by support for individuals to return to the livelihood that they had before they became ill, or to start work of another kind, depending on their circumstances.

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This brings us back to Mr. Kumar. Through the BasicNeeds program in Tamil Nadu State, he was able to access medicine and to stabilize his condition. Supported by field staff of one of our partner organizations, Kumar approached the local community council or panchayat for help. They permitted him to set up a snack business in the bus shelter in the village. Kumar now rises at 4.00am to prepare the snacks and sells them to passengers from 8.00am to noon. He makes a reasonable living by local standards, taking into account that many people are living well below the poverty line. Most importantly, he has a sense of pride and hope for the future. "I like working close to home and I have confidence once again", he says.

Partnerships and alliances

Our experience has been that, once stabilized, mentally ill people go on to give voice to their own needs and aspirations. Self-help groups, volunteer committees and caregivers associations are one means of people organizing themselves to have a voice within their communities. This raises a second principle of the work of mental health and development; resources for mental health are scarce and so creative approaches are required to make them reach as many people as possible.

Partnerships with existing community organizations to enable them to integrate mental health into their existing disability, preventative health or economic development programs, has been critical. The work of volunteers and the support of a range of funders and individual donors has been absolutely essential to us. The most recent evaluation of our work, in December 2007, reveals that 45,279 mentally ill people and 27,946 caregivers have participated in BasicNeeds' programs in seven countries since 2000. The proportion that have returned to wage-earning work is 22%, with a much higher number commencing some kind of productive activity such as home-based farming or contributing to the family and the household once again.

Some lessons

The experience of mental health and development offers many lessons on health service delivery, social inclusion and recovery. The following may be interesting in the context of Colombia:

- Poverty exacerbates mental illness and reduces options for recovery. The consequence of poverty is an economic burden on families leading to debt traps and increasing stress within the household.
- Mentally ill people aspire to do productive work and to better social integration. Many local organizations are willing but feel unequipped to work with mentally ill people. Training and capacity-building exercises equip them with skills to work meaningfully with such families.
- Partner organizations, community groups and their staff exhibit very high levels of commitment to mental health and development after a short period of experience in the field.
- Visible positive changes in people with mental illness help to generate awareness in the community with family motivation and improved follow-up. This approach is cost-effective and meets the needs of the wider community.
- Mental illness can be treated with simple, relatively inexpensive medication at the community level and without the need for institutional care.

The primary needs of both women and men with mental illnesses are access to diagnosis and treatment, a return to a viable livelihood and support to overcome stigma and social exclusion. The latter includes returning to 'normal' life with involvement in continuing education, personal and professional relationships, regaining property, assuming appropriate responsibilities and participation in social and religious functions.

Recent initiatives

BasicNeeds commenced a pilot program in Usaquén, Bogotá in early 2007 under the leadership of Andrea Padilla and with financial support from CBM. Our intention is to establish a long-term presence in Colombia and to consider programs in other countries in Latin America too.

In the field of training, BasicNeeds has built an extensive program for tsunami-affected communities in Sri Lanka, which is now extended to other disaster-affected countries through a 'training of trainers' program that includes a ten-day residential course and a twelve-month follow-up and monitoring process with 'on the job' support. A new program on integrating mental health into community-based rehabilitation has also commenced.

We have launched an e-journal on mental health and development issues and a campaign entitled 'One Psychiatrist Per Million People: Developing a Mental Health Program for the Poorest Countries in the World'. New mental health and development programs are planned for Indonesia and Australia, with other countries also under consideration through new partnerships.

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