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**CASE STUDY:
BASICNEEDS: APPLYING COMMUNITY DEVELOPMENT PRINCIPLES TO
ADDRESS MENTAL HEALTH CHALLENGES**

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Abstract: As the burden of mental illness grows worldwide, access to treatment is not keeping pace. The need is particularly acute in low-resource communities that lack the infrastructure and trained workforce to provide comprehensive treatment. Using a community development approach, BasicNeeds' Model for Mental Health and Development leverages existing resources in new ways to increase access to and effectiveness of mental health services. By mobilizing and coordinating government agencies, community organizations, volunteers, and people with mental illness and their families, BasicNeeds programs drive local ownership and system change. The model, which has now used in 12 low-income countries in Africa and Asia, has demonstrated many positive impacts in access to treatment, mental health outcomes, quality of life, and engagement in income-generating work. It might also prove to be a cost-effective approach in U.S. communities for addressing disparities in access and lack of care coordination in mental health management.

BACKGROUND

Roughly 450 million people worldwide suffer from mental illness. Seventy-five percent live in the developing world, where extreme poverty exacerbates the issue.

Mental health problems represent a growing share of the global disease burden, yet access to effective treatment models is not keeping pace.ⁱ Communities often lack infrastructure to provide effective management, and the available treatment is often insufficient, expensive, poorly funded, and located far from the need. Social stigma also prevents people from accessing services.

In Kenya, for example, health care providers rarely have the training or resources to treat mental health conditions. Without other options, families often lock away or restrain mentally ill family members, who become a source of shame for the family. Despite the need, the nation's Ministry of Health spends only 0.01 percent of its annual budget on mental health care, leaving wide service gaps increasingly met by nongovernmental organizations (NGOs) and, more recently, local county governments.

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WHAT IS THE INNOVATION AND HOW DOES IT WORK?

The BasicNeeds Model for Mental Health and Development utilizes a community development approach to mental health. The model enables people with mental illness or epilepsy to live and work in their communities by combining health, socioeconomic, and community-oriented solutions with corresponding changes in policy, practice, and resource allocation. Developed and rigorously tested by BasicNeeds, a nonprofit organization founded by social entrepreneur Chris Underhill in 2000, the model has been implemented in low-resource settings in 12 countries in Africa and Asia.

This case study focuses on both BasicNeeds UK, the umbrella group that launches and serves all BasicNeeds country programs and partners, and BasicNeeds Kenya, a specific example of the model as locally implemented. BasicNeeds Kenya was founded in 2005 and serves both urban and rural populations.

FINDINGS

BasicNeeds acts as a catalyst to map existing assets and resources, fill gaps, and shift the program to local ownership. The model is designed to motivate and coordinate local efforts. Drawing on existing resources, BasicNeeds builds capacity and facilitates collaboration among partners. The resulting programs are locally owned and are organized into the following five primary modules.

When entering a new area, BasicNeeds conducts a site visit to identify people and organizations with an interest in mental health and engages this group to take up different pieces of the BasicNeeds model. Essential partners include people living with mental illness and the typical partners noted in Exhibit 1.

Exhibit 1. The BasicNeeds Model for Mental Health and Development

Module	Key Activities and Outcomes	Typical Partners
Capacity building	Identify and mobilize people living with mental illness and their families, create self-help groups, train mental health workers, implement anti-stigma campaigns.	Community organizations and associations, local government
Community mental health	Provide community-based, effective, affordable mental health treatment services, improve outreach and coordination, including home visits.	Community organizations, health workers, volunteers
Livelihoods	Create opportunities for people with mental illness to work, earn income, save money, and contribute to family and community life.	Community development organizations, micro-finance organizations, local government
Research	Generate evidence from the practice of mental health and community development that is used to improve the program and advocate for policy changes.	NGOs, academic institutions, local and national government
Collaboration	Bring together implementing partners and policy makers, develop productive relationships.	NGOs, community organizations, local and

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		national government
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BasicNeeds builds local capacity through training, rather than importing professionals from other countries. The training is provided to every level of provider, from physicians to community health workers. Programs also work with traditional healers and faith healers, when relevant.

BasicNeeds staff teams are lean; the idea is to use the smallest footprint possible to get the program running. BasicNeeds Kenya, for example, serves more than 4,000 beneficiaries yet has only four staff members, who work with community and government partners to implement the program activities and ensure local ownership (Exhibit 2). At the outset of each country program, BasicNeeds develops an exit strategy, typically based on a three- to four-year timeline, at which point the program should be self-sustaining. The BasicNeeds headquarters includes 10 staff members, most of whom are located in the United Kingdom. This team provides fundraising and quality assurance across the global network of country programs and partners, and direct management of some programs.

Exhibit 2. Partners in the BasicNeeds Kenya Country Program (2005-2015)

Module	Urban Partners	Rural Partners	Nomadic Partners
Capacity building	Kenya Association for the Welfare of People with Epilepsy, Kenya Kamili Organisation	Archdiocese of Nyeri Caritas, Meru Community-Based Organization	Social Welfare and Development (SOWED) Programme Kenya, Archdiocese of Nyeri Caritas
Community mental health	City County of Nairobi, Kenya Kamili Organisation, Users and Survivors of Psychiatry in Kenya, Schizophrenia Foundation of Kenya	County governments of Tharaka-Nithi, Nyeri, Nyandarua, and Laikipia	County governments of Kajiado and Laikipia
Livelihoods	Kenya Association for the Welfare of People with Epilepsy	Archdiocese of Nyeri Caritas	Archdiocese of Nyeri Caritas, Social Services department
Research	Africa Mental Health Foundation	Africa Mental Health Foundation, Ministry of Health–Tharaka-Nithi and Nyeri North	
Collaboration	Government offices, NGOs, faith-based organizations, community-based and user/caregiver organizations	Archdiocese of Nyeri Caritas	Archdiocese of Nyeri Caritas

BasicNeeds programs use a consistent set of principles that are applied in a customized way to each context. For example, BasicNeeds Kenya launched the model in Nairobi’s urban slum communities and then adapted it for rural farming communities. To do this, program staff drew on existing farmers’ cooperatives to establish self-help groups and focused on agriculture for

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livelihood opportunities. When moving into nomadic communities, BasicNeeds Kenya adapted the program to reach sparsely populated communities that move frequently and are strongly rooted in traditional healing practices. BasicNeeds relied heavily on a local church partner and changed the notion of scale, realizing they could only reach 80 people in nomadic tribes, instead of more than 1,000 as their urban and farming programs would.

The model applies a community development philosophy to address a health challenge.

Forming locally owned self-help groups is critical to the model. There are currently nearly 600 self-help groups across BasicNeeds programs globally, with almost 30,000 members, including people with mental disorders and their caregivers. These groups play multiple roles: some provide peer support and improve treatment adherence, others raise awareness in the community or advocate for policy changes, others are focused on livelihoods and income generation, through savings cooperatives and microloans. “Returning to work is a very important component for sustaining treatment. Once people gain confidence in their work and abilities, they want to stay well,” said Joyce Kingori, Kenya Country Program Manager.

BasicNeeds uses a systematic, data-driven approach to refine implementation and advocate for policy change.

Baseline situational assessments are conducted at each site before the program begins, and all programs provide data throughout implementation, using standardized metrics. Programs also conduct participatory data analysis to develop evidence-based findings directly from participants and their experiences in the program. A research center in Bangalore collects and analyzes data across all BasicNeeds programs, and the findings are shared with programs to improve their implementation models and assist with local advocacy efforts. (Findings of these research efforts are discussed below.)

The launch of BasicNeeds country programs is supported primarily by philanthropic funding, often with a diverse combination of donors, each interested in a particular aspect of the model, such as livelihoods or provision of medications. BasicNeeds channels donor funding to program partners implementing key activities of the program. For the Kenya program, typically about 40 percent of funding in a fully funded community mental health program goes to implementing partners; the remainder covers BasicNeeds’ expenses, including staff time, coordination of partners, logistical support, administration, and data collection. Over the course of the three- to four-year launch period, BasicNeeds identifies additional funding sources, including governments and in-kind support from community organizations, which begin to supplant donor funding for country programs. The program staff also train community partners to write funding proposals, increasing internal fundraising capacity.

BasicNeeds UK, as the headquarters, is primarily donor-funded but earns a small portion of revenue from consulting or training fees. The organization is currently testing a new social

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franchise model, which they hope will help to support the scale and sustainability of the country programs. Insurance reimbursement is also growing as a potential revenue source, as government insurance schemes in low- and middle-income countries increasingly include coverage for mental health treatment.

IMPLEMENTATION AND SCALE

The initial BasicNeeds model was developed by social entrepreneur Chris Underhill and piloted in India by disability activist D. M. Naidu. Underhill and Naidu consulted people with mental illness to understand their needs and the needs of their caregivers. In the process, they learned that people with mental illness prioritized their needs for company, income, shelter, and support for their families over medical support. However, the available treatment models focused entirely or primarily on medical treatment.

“The number of psychiatrists per population made it clear that model alone would never work,” Underhill said. “But a lot of the suffering that mentally ill people experience is not ameliorated by medicine. Having company, being integrated in a purposeful way with others makes a difference.” Seeing the success of women’s and farmers’ organizations in creating camaraderie and community, Underhill and Naidu worked to emulate these groups for mentally ill people in what became the BasicNeeds model.

Building credibility was a challenge initially. People often thought the idea of consulting with mentally ill people was a waste of time, and BasicNeeds staff had to convince others of the value at each stage of implementation. “The model evolved out of our experience with activism and community development,” said Underhill. “We brought medical intervention into a larger model that followed a community development framework.”

Start-up funding came from philanthropists. Bilateral funders, including the U.K. Department for International Development, then provided support to bring the model to scale. After rigorous testing and validation with academic partners, the model was implemented in India before being brought to Ghana. There, BasicNeeds demonstrated that the model could work even in those areas with the particularly difficult reputations—places where no one else wanted to work. Tanzania was next, followed by 12 other countries throughout Africa and Asia.

As noted, BasicNeeds has been adapted to many types of urban and rural communities. At the time the program was launched in Kenya, mental health treatment existed on a small scale, limited to the Ministry of Health in Nairobi and provincial hospitals, and occasionally district hospitals, depending on the availability of a trained psychiatric nurse. Private practitioners also offered services in Nairobi, but these were inaccessible for the majority of people living in poor

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rural and urban neighborhoods. By the end of the three-year launch period, BasicNeeds Kenya was working with 4,000 beneficiaries in multiple communities and has now expanded into South Sudan.

PREDICTING SUCCESS OR FAILURE IN NEW SETTINGS

A few important factors can predict the success or failure of the program in a new setting. The most critical is interest from the government. BasicNeeds has found that it is impossible to succeed if staff are unable to establish good relationships with the government, including local authorities. Also important is the presence of strong NGOs and community organizations, local leaders who can serve as project champions, and funders interested in that region.

The primary challenge to achieving broader scale has been a lack of donor funding. Often, misunderstanding about the impact of mental illness, its chronic nature, and the potential for treatment limits the appeal of this issue for funders.

BasicNeeds is now evaluating a move to a social franchising model, in which training, planning, and mentorship will be centralized functions provided by expert country programs and BasicNeeds headquarters. Franchisees, meanwhile, will independently implement the model, paying an annual fee to BasicNeeds, based on size of population served. The cost-effectiveness of this business model is being evaluated with the Kenya and Ghana country programs. BasicNeeds Kenya will begin with franchisees in populated regions within Kenya and then plans to develop franchise partners in South Sudan and Ethiopia. BasicNeeds Ghana will test the social franchise model in both Ghana and Nigeria. BasicNeeds is also establishing centers of excellence, including the BasicNeeds Kenya and BasicNeeds Ghana programs, which will serve as mentors and help incubate new programs.

EVIDENCE OF IMPACT

The BasicNeeds model affects multiple dimensions of mental health, including empowerment of consumers, access to treatment, reduction in symptoms, increase in income and community inclusion, reduction in hospitalization, and training of health care providers. Many of these impacts have been documented in the peer-reviewed literature. For example, a two-year study of participants in rural Kenyaⁱⁱ found statistically significant improvements from baseline in:

- Mental health (72% improvement in GHQ-12 scores);
- Functioning (16-point improvement on the Global Assessment of Functioning scale);
- Quality of life (17-point improvement on the World Health Organization's Quality of Life scale); and
- Engagement in productive work or income generation (increase from 45% to 64% of the study sample).

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BasicNeeds program data for 2014, collected across all country programs, demonstrates:

- 25 percent increase in access to treatment;
- 75 percent reduction of symptoms; and
- 26 percent increase in number of people able to work.

As an example of localized impact on the mental health ecosystem, the BasicNeeds Kenya program reports a significant increase in county-level funding allocated to mental health, changes in health care workers' attitudes toward mental health treatment, and changes to the existing curricula for nurses and doctors to include mental health care.

HOW CAN THE INNOVATION BE ADAPTED TO WORK IN THE UNITED STATES?

Mental illness is a significant health issue in the United States: among adults in 2011 and 2012, 18 percent reported experiencing mental illness and just over 4 percent reported serious mental illness.ⁱⁱⁱ However, less than half of people with serious mental illness receive adequate services.^{iv} Barriers to access include lack of providers (particularly in rural and minority communities), insufficient insurance coverage, stigma, and cultural and language barriers.^v Access gaps are particularly acute for minorities: white Americans access mental health services at twice the rate of African Americans and Latinos and three times as much as Asian Americans.^{vi}

With the passage of the Affordable Care Act (ACA), health plans that receive government funding are now required to cover “essential benefits,” defined by each state and often including mental health treatment. This change, together with the expected increase in people who now qualify for insurance without clauses denying treatment for preexisting conditions, will likely translate to increased demand for mental health services. However, as in many of the communities where BasicNeeds has already replicated, demand will likely outpace supply, particularly for minorities and rural areas. In this context, the BasicNeeds model may provide a cost-effective approach to leveraging existing resources and assets in a more coordinated and sustainable way to improve access to mental health treatment and community integration.

By starting with a community development perspective, BasicNeeds leverages underutilized resources in each community, including the consumers and their families, in order to improve care coordination and effectiveness. Patients and their families are empowered to participate both in shaping the program and in their own disease management. While self-help models, such as the Clubhouse Model, have proliferated in the U.S., these groups are rarely integrated into a comprehensive treatment model or have additional community development resources. The BasicNeeds model addresses these gaps.

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In addition, organizations that often operate separately, such as housing departments, workforce development training organizations, and mental health care providers, are brought together and coordinated by BasicNeeds around a common goal. The model also trains and empowers existing primary care providers and community health workers to address mental health, extending the potential reach of the model without adding large staffing costs.

Each of these attributes could translate to the U.S. There are unlikely to be scope of practice issues, as partners work within their own areas of expertise. Because the model works with and adapts to existing resources in each community, it can partner with and augment complementary models, such as Clubhouse organizations and health care provider systems, rather than compete.

Identifying sustainable revenue streams for the BasicNeeds model in the U.S. could be a challenge. However, under the ACA, Medicaid gained increased flexibility to cover home- and community-based services, as well as supportive housing. In addition, there are a number of states and counties with federal funding to implement innovative approaches to care. Together with health plans increasingly looking for cost-effective approaches for population health, these financing mechanisms could support a model like BasicNeeds.

Given the current landscape of mental health need and treatment in the U.S., implementation of the BasicNeeds model could result in improved coordination across community partners, government agencies, and funders; improved mental health outcomes; and increased self-management and community integration for affected individuals. Each of these would be expected to result in significant cost savings for health provider systems, counties, and states.

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APPENDIX: ADDITIONAL DETAIL ON THE BASICNEEDS MODEL AND PROGRAMS

Types of BasicNeeds Country Programs

The global BasicNeeds family of programs has two types of country programs. Independent programs have developed their own boards and have executive directors (Pakistan, Tanzania, Ghana, Uganda, Nepal, South Sudan, Vietnam, and South India). These programs have fully shifted to local ownership and are no longer directly managed by BasicNeeds UK. Other programs are managed and financially supported to varying degrees by BasicNeeds UK (Kenya, Sri Lanka, China, and Laos). BasicNeeds Kenya is moving toward becoming an independent program and has established an advisory board.

BasicNeeds is also identifying a few programs as centers of excellence (Ghana, Kenya, Nepal, and Vietnam) and plans to test a hub-and-spoke scaling strategy with these programs. These programs are encouraged to grow both within the country where they are based and also extend out to neighboring countries to establish “spoke” programs that will be mentored and incubated by the center of excellence programs.

Site Selection and Partner Engagement

Site selection for BasicNeeds programs is often opportunistic, following both the presence of strong partners and funding. Increasingly, the organization is also considering the benefits of having country programs near each other that can be supported by common staff, such as through the hub-and-spoke scaling strategy noted above.

The process of establishing a new program begins with a feasibility study, typically conducted in two weeks, during which needs and opportunities in the region, as well as potential partners, are identified. BasicNeeds partners with a respected leader or organization in the area to conduct the initial study. As part of this process, the study team meets people living with mental illness to better understand their experience of mental illness in that place and their needs, used to inform the program design. At the end of the feasibility study, the team analyzes the data and makes a decision about the potential for program implementation. Issues that may prevent BasicNeeds from going into a region include safety concerns and political insecurity, unresponsive government agencies, and gross logistical challenges (such as remote, unreachable areas).

If the feasibility study results are positive, final site selection is made jointly with all in-country stakeholders. The team then moves into fundraising. Once funds are available, a community needs assessment is conducted to set the baseline and determine details of the program implementation.

Because BasicNeeds goes into every new site with an exit strategy, program staff invests significant time and resources up-front to train and mentor partners with the expectation that they can and will carry the program independently in the future. BasicNeeds programs work with all relevant community stakeholders, including people with mental illness and their families, community-based organizations, community health workers, government agencies, churches, health care providers, and traditional healers.

Cycle of Engagement

BasicNeeds programs typically operate on a three- to four-year cycle of engagement, after which the programs are shifted to local ownership.

- Year 1 focuses on stakeholder engagement and launching activities, including formation of self-help groups and training care providers in mental health. In the first year, BasicNeeds staff typically work closely with government agencies to mobilize and train publicly funded health care

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workers in hard-to-reach clinics.

- Year 2 focuses on maturation of self-help groups, as symptoms of mental illness are reduced and participants stabilize. The program encourages a new focus on holistic care and livelihoods, versus the focus on medicine and clinical care that dominates Year 1.
- Year 3 focuses on mobilizing and training community groups to advocate to their governments for policies and services that better meet their needs. BasicNeeds also often provides training to community partners and NGOs in grant writing and fundraising, so that they can continue to raise money for the program after Year 3. By this point in the cycle, workers in all health clinics in the area should have received training and be able to address mental health effectively and refer when needed.
- Year 4 focuses on transition to sustained local ownership. BasicNeeds continues working with their partners, including the self-help groups, in the long term but in a more limited capacity after the first three or four years.

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Notes

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