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A social model of mental health care in Nepal

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Designing a social model of mental health care – A case study

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Summary: Mental health issues are constituted one of the major causes of global burden with their incidence increasing with every passing year. Increased awareness and research on the global incidence highlights the necessity of providing biomedical treatments alongside social support. Despite this, limited empirical examples on such integrated models of care exist in the Global Mental Health literature. There is scarcity of information on what an effective social model of mental health and illness entails in practice and how context-specific psychosocial approaches can be developed in resource limited settings. There is a need to articulate and develop a deeper understanding of *how* involved in the design process of an effective social model that can be utilised alongside biomedical interventions. This research explores case study of a mental health NGO, CNMH, to articulate the design process of its social support model and highlights different steps involved in the design process.

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Abstract

Providing social support to mentally ill/distressed individuals has gained immense attention in the Global Mental Health (GMH) field. Still, less attention is given to designing an effective and practicable social model. Also, while social support is advised as an adjuvant to biomedical treatment, mental health literature still lacks ample empirical examples of such models from resource-stretched settings. This study, aims to explore what and how involved in devising and implementing an effective social model of care employable as an adjuvant service to biomedical treatment through a case study of mental health NGO, Chhahari Nepal for Mental health (CNMH). We adopted an in-depth exploratory case study approach to investigate and present a thick, contextualised description of the design process. Exhaustive data was collected through interviews (19), group discussions, direct observations, participant observations and archival records. Our findings revealed that instead of understanding clients independently of the external context, the organisation employed a thick social approach to understand and analyse the effects of multi-faceted factors, actors, environments and their interplay on the clients. This apprehension was achieved by Chhahari's participation in diverse research projects, which led it to harness and exchange knowledge. Enhancing knowledge further allowed the organisation to design a conceptual framework and individualised social support strategies that are delivered through diverse social actors who are weaved into (what we call) a *network of support* around clients. This study utilised a multidisciplinary methodological and theoretical perspective from the field of social work, public health and organisational studies which assisted in creating a hybrid interface between the divergent fields while the latter discipline helped articulate the relationality between the steps involved in design and implementation process.

Keywords

community mental health, psychosocial support, mental health care, social inclusion, design, development, transformation

Introduction

Mental health (MH) issues are increasingly identified as major causes of global burden (Patel et al., 2018) and addressing them is a global priority. Untreated MH problems account for 13% of the global disease burden, and this burden is subject to increase (WHO, 2011). Additionally, other key challenges dominating the MH field are: poor resource allocation (Chisholm et al., 2019), limited social inclusion of people with psychosocial disabilities (Puras and Gooding, 2019); sole dependency on medicalised treatments (White et al., 2017, Patel, 2014, Thieme et al., 2015); and allocating limited priority to social and psychosocial interventions (Burgess et al., 2020).

Although biomedical support has traditionally been the most prominent aspect of GMH, there has been an increasing focus on integrating psychosocial interventions alongside biomedical treatment (White et al., 2017, Kirmayer and Pedersen, 2014). More emphasis is now given to providing holistic support to the mentally distressed and people with psychosocial disabilities. While notable examples of holistic modes of care are contributed from high-income countries (HICs), however, only a few studies have been reported from low and middle income countries (LMICs) (Asher et al., 2017, Patel et al., 2016), despite the fact that the global burden for these countries is critically high (Vigo et al., 2016, Whiteford et al., 2015). The literature gravely lacks empirical illustrations of integrated models of care that employ biomedical solutions alongside social approaches from underdeveloped countries. Therefore, the first aim of this study is to fill the identified gap by providing an empirical illustration of a community-based MH NGO mobilising person-centred psychosocial support adjuvant to biomedical interventions in a resource-constrained setting. This aim assumes importance by presenting a

deeper understanding of the dynamics involved in establishing and deploying psychosocial support alongside medicalised treatments in community settings, which is highly valued (WHO, 1997, WHO, 2009) but is largely absent from the MH literature.

A further limitation of the MH literature is that it fails to inform what constitutes an effective social model (Tew et al., 2004) and how can efficient psychosocial interventions be designed (Mann et al., 2017, Webber and Fendt-Newlin, 2017). The accumulated research offers insights on topics ranging from the advocacy for utilising social support (Beresford, 2005), attributes of social models (Williams, 2017) and the outcomes/benefits of psychosocial support approaches (Asher et al., 2017). While these streams are essential, our objective in this paper is to present a less articulated discussion on the underlying dynamics of framing and designing contextualised psychosocial support interventions. Therefore, another objective of the study is to extrapolate the steps involved in the design process of a social model and psychosocial strategies and illustrate their effectiveness by presenting lived experiences of the vulnerable groups.

Literature review

The emergence of the GMH field

The debates on MH issues bear a long and distinguished history. The postcolonial era brought different ideologies about MH issues, and the transcultural psychiatry movement emerged as a prominent debate (White et al., 2017). The foundations of this movement resulted from the practitioners/researchers interested in exploring socio-cultural influences leading to the formation of an MH agenda called the Global Mental Health (GMH) (*ibid*). Thus, GMH emerged as a field of study focused on improving mental health and achieving equity for those suffering from such problems (Patel and Prince, 2010). Movements like MGMH and mhGAP were introduced to scale up support services by advocating the adoption of evidence-based westernised biomedical treatments (Patel, 2012, Patel et al., 2011).

In recent years, the dominant discourse in the MH field was driven by a biomedical paradigm that suggested mental illnesses arise within patients and require pharmacological interventions (Beresford, 2002, Lester and Tritter, 2005). Being a prevalent and compelling frame of reference (Beresford, 2005), the biomedical model also became a popular narrative in policy and practice while individuals primarily received drug-based treatments (Beresford et al., 2010). However, despite significant progress, the prevalence of mental illness has continued to rise (Tew, 2011, Mills, 2014), with one of the major contributing factors being the confinement of mental disorders to genetic anomalies/irregular brain function (Deacon, 2013) and the exclusive provision of medicalised treatments (White et al., 2017, Patel, 2014, Thieme et al., 2015).

Following these discoveries, the post-war discourses on social approaches (Beresford, 2005) and recent debates on the inclusion of socio-cultural elements gained traction (Kirmayer and Pedersen, 2014, White et al., 2016, White et al., 2017, Beresford, 2002). The critiques of biological determinants intensified, forcing for exclusion of psychiatric diagnostic tools but were quickly rejected for supporting a regressive interpretation of human health (Patel, 2014). The two narratives were eventually combined, and an integrated approach to mental health support was recommended as a viable solution (Kirmayer and Pedersen, 2014, WHO, 1997), that involves psychosocial support offered as an adjuvant to biomedical treatments to ensure that holistic care is provided to the distressed (Patel et al., 2016). However, despite the awareness, significant successful examples of integrated support models are contributed from HICs, while the evidence base remains far less robust for LMICs (Asher et al., 2017, Patel et

al., 2016). Consequent to the limited empirical examples from resource-stretched settings, it remains challenging to develop a deeper understanding of how mental health organisations can mobilise psychosocial support in parallel to the biomedical interventions in resource constraint settings.

Yet another limitation that persists in the GMH literature is the scarcity of information on what an effective social model of mental health and distress entails in practice (Tew et al., 2004), and how context-specific psychosocial approaches can be developed that are applicable in the real world (Mann et al., 2017, Webber and Fendt-Newlin, 2017). What is known, however, is that social models are imbued with values of holistic care, human dignity, unconditional acceptance, and equality (Beresford, 2005) and are based on psychosocial interventions, wherein social corresponds to the structural elements of the society which influence the prevalence of MH issues and opportunities to access appropriate support. The psychological component, on the other hand, involves examining the MH determinants by understanding and interpreting individual and group experiences through the accounts of lived experiences and coping mechanisms (Williams, 2017). Put simply, psychosocial interventions help tackle contextual issues of stigma, discrimination, inequality, and internalised oppression (Beresford et al., 2010, Bruce et al., 1991, Gomm, 1996) to relinquish socially constructed demarcation among *normal* and *distressed*. This is achieved by *building relationships* among the professionals and vulnerable to promote equality and respect, particularly in areas with grave inequality (Tew et al., 2004, Beresford et al., 2010). Psychosocial strategies, which are frequently recognised as *hands-on person-centred approaches* (Williams, 2017, Tew et al., 2004, Gask and Coventry, 2012), are designed to help vulnerable people develop coping mechanisms and change their beliefs about living a fulfilling, valued life (Anthony, 1993, Leamy et al., 2011, Bellack, 2006). For some individuals, social support can also lead to mental well-being/recovery if provided consistently and meaningfully (see Thieme et al., 2015, Simons and Baldwin, 2021, White et al., 2017, Asher et al., 2017, Barbui et al., 2020).

Moving beyond the basics of social model of care

There has been a significant effort to define, formulate, evaluate, and improve psychosocial interventions as part of humanitarian assistance (Strang and Alastair, 2001, Armstrong et al., 2004, Galappatti, 2003, England et al., 2015). Research, however, has proven that psychosocial interventions significantly vary based on the problem being addressed and the outcomes being targeted (Galappatti, 2003, Miller et al., 2021). For instance, support interventions designed for MH issues differ from those addressing health and nutritional issues (Miller et al., 2021). In addition to this, it is also imperative that MH support strategies are tailored according to individualised needs (Leamy et al., 2011, Tol et al., 2012). This therefore implies that there is a need to articulate and develop a deeper understanding of *how* involved in the design process of psychosocial practices if we are to develop a social model of care in the MH domain. Thus, our work is guided by the following research questions: How can community-based organisations mobilise psychosocial support adjuvant to biomedical interventions; what does a social model of care and distress look like in practice and how can psychosocial interventions be designed and implemented to construct an efficient social model of care?

Case Setting

Nepal is an ethnically diverse and multilingual country and home to 28.5 million people with having poor Human Development Index (142nd out of 189 countries) (UNDP, 2020). In the late 20th century, Nepal's health sector experienced significant advancement due to the admission of the World Health Organization (WHO) and the United Mission to Nepal (UMN) and the establishment of the first-ever MH NGOs consequent to the Maoist insurgency and large influx

of Bhutanese refugees (Chase et al., 2018b). Nonetheless, mental health and psychosocial support (MHPSS) has always been a part of humanitarian and emergency response in Nepal (Fassin and Rechtman, 2009) with NGOs playing a pivotal role in administering the support services (Upadhaya et al., 2014, Chase et al., 2018a).

Though the country's National Mental Health Policy has existed since 1997, its successful implementation is yet to be realised (Regmi et al., 2004, Rai et al., 2021, Gupta et al., 2021). The current healthcare system is a tiered referral system comprising primary and secondary levels. Community health units, health posts, urban health clinics and primary hospitals reside at the basic level, while secondary and tertiary-level hospitals are in charge of more complex cases (Rai et al., 2021). The Ministry of Health and Population (MoHP) is responsible for tailoring and monitoring overall health policies and regulations, however, the Department of Non-communicable Disease and Mental Health Section manages the MH programmes in the country. The psychiatry units of medical colleges, provincial government hospitals, private hospitals and NGOs are the primary source of MH services. Currently, an estimated 20 out of over 37,000 registered NGOs work on MHPSS, while there is only one specialised mental hospital located in Lagankhel, Lalitpur, with a capacity of 50 beds.

The Nepalese healthcare system is characterised by non-specialist treatment due to a shortage of appropriate human resources (Upadhaya et al., 2017) such as health assistants (HAs), certified medical assistants (CMAs) and certified nurses (CNs). Undergraduate hospital doctors are dispatched to remote locations, whereas MD doctors prefer residing in the cities despite their need in rural Nepal due to higher population density (Gupta et al., 2021). Also, primary MH services exist in big cities entailing 0.22 psychiatrists and 0.06 psychologists per 100,000 population (Luitel et al., 2015). Despite the high prevalence of disease, with roughly 30% of the population suffering from mental illness and distress (Hall et al., 2016), less than 1% of the annual health budget is allocated to MH sector (Regmi et al., 2004) with the majority of funding coming from foreign aid and local volunteers (Gupta et al., 2021). Another barrier to the delivery of MH support is the lack of a social welfare net (Rai et al., 2021), and most healthcare coverage still comes from out-of-pocket payments (Rajan et al., 2020).

Cultural perception and support seeking pathway

Like many countries, mental illness is subject to extreme stigma and negative cultural perceptions in Nepal (Adhikari et al., 2008, Gurung et al., 2022). As a result, individuals struggling with MH problems are largely rejected by their families and communities, leading to them becoming homeless and living on the streets (Regmi et al., 2004, Adhikari et al., 2008). Stigmatising terms like *paagal/baulaahaa* (mad/crazy), *taar khushkhele* (loose wire), *dimaag crack bhayeko* (one whose brain-mind has cracked) are used to classify victims while mental illness rarely being discussed (Gurung et al., 2022, Regmi et al., 2004).

Instead of recognising mental illness as a disease, it is vividly perceived as a spiritual dysfunction or weak mind and mainly attributed to being struck by a witch (*boksi laagyo*), spirit possession (*bhut laagyo*), and misdeeds committed in previous lives. There is a strong belief in traditional healing, and help is repeatedly sought from traditional healers (*lama-jhankri*) or faith healers (Kohrt and Harper, 2008, Rai et al., 2021). Therefore, a typical pathway of an individual's support-seeking journey generally initiates with spiritual/faith healers, followed by general practitioners, while psychiatrists reside at the end of this chain (Gupta et al., 2021, Pham et al., 2021). Acting as primary supporters, traditional healers utilise magico-religious diagnostics and play a pivotal role in supporting the vulnerable by crafting a symbolic spiritual narrative, providing individual psychological and social support by mobilising the victim's family and community, and facilitating spontaneous recovery (Pham et al., 2021). There is a predominant trend of recognising mental illness as somatic symptoms for avoiding the stigma

and loss of respect (*ijjat*), otherwise, loss of mind (*dimaag*) further leads to economic and social marginalisation. Therefore, several emotional and somatic idioms are utilised by the affected individuals and their family members, e.g. sadness (*dukkha lagyo*), fear (*darr lagyo*), tingling and numbing (*jhum jhum*) to inform the health professionals to make sense of their illness. Thus, health professionals also reframe mental distress as bodily issues (mainly nerve disease) (Kohrt and Harper, 2008) to avoid the associated stigma.

The family of the mentally distressed faces social exclusion and is frequently shunned by extended family members, neighbours and community members due to limited awareness and mental illness being recognised as a contagious disease (Kohrt and Harper, 2008). This situation is further worsened due to a lack of legislation on safeguarding the rights of the mentally vulnerable, which often results in distressed being deprived of their property rights (Regmi et al., 2004). Furthermore, due to inadequate infrastructure, human resources, and public awareness, a lack of steady psychosocial support for patients and caregivers remains a persistent problem. Despite the challenges, MH NGOs have always played a pivotal role in surmounting these issues and providing various support services through: capacity building by training para-professional counsellors; developing community-based service delivery models; employing culturally specific interventions; raising awareness; and devising methods to reduce MH-related stigma (Upadhaya et al., 2014).

Introduction to CNMH

CNMH (Nepali: shade or shelter) is an MH NGO with a mission *to create an equal society where everyone's MH needs, and well-being is addressed and catered for, irrespective of their location*¹. It was co-founded by Dr Gael Robertson and Mr. Mahesh, a local resident of Nepal, in 2009. Following the themes of social justice and equality, CNMH was established as a beacon of hope to construct *a more equal world*² for the mentally vulnerable homeless people whom public/private organisations largely neglected. Initially, the focal organisation received funding from the Churches of Scotland, while the organisation also earned some funds through research projects in which it participated. Over the past fourteen years, CNMH has consistently participated in several research studies and continues to do so.

The organisation started working formally as a registered NGO in 2011 with four aims which were: (a) establishing a responsive and learning organisation; (b) creating a socio-medical model for the management and treatment of mental illness emphasising holistic care; (c) supporting a client-focused mental health referral system and services that respect the rights and choices of the individual; and (d) creating public awareness and advocate/coordinate with other public/private institutions to develop more responsive systems (CNMH archives). A flexible logical framework was designed to achieve the targeted objectives. CNMH mainly runs three programs ie the research projects, The Street Project, the Welcome Centre gatherings and is consistently involved in raising public awareness and lobbying with the government.

CNMH has served approximately 136 clients since realisation, following a similar path, however, with a few exceptions. As a part of the Street Project, CNMH's staff members locate homeless mentally ill individuals³ on the streets of Lalitpur, provide them with food and clothes, and engage in informal communication with them. The staff also connects with the local community members to trace clients' family members. Another aspect of this intervention is weekly follow-up visits to clients' homes. On the other hand, homeless clients depend entirely on NGO staff support or voluntary assistance provided by the community members along the

¹ Mission statement taken from CNMH's website

² Connoted by Gael

³ called clients at CNMH

sidewalk where they reside. The Welcome Centre gatherings are held every Wednesday, where clients and carers spend the day performing various acts such as cooking, eating, and communicating with staff members, clients, and carers. Additionally, various accessories are provided during these gatherings, such as a stereo, guitar, sewing kits, jewellery crafting tools, sketchbooks, and board games, like Ludo, and Carom (table-top games), so they can enjoy performing different activities with others. CNMH also participates in events like youth awareness programs, Street drama, dance therapy, the Kathmandu Marathon, and the Kathmandu Chorale, and holds weekly training workshops with other NGOs (such as Elijah counselling and training centre) to raise public awareness, train caregivers and lobby with the government officials.

Methodology and Data collection

Our initial exploratory activities at CNMH demonstrated that the organisation was successfully providing social support while ensuring that clients received biomedical treatments from professional MH facilities. It thus represented an excellent theoretical fit with our inquiry and was chosen as an exemplar (Bryman, 2012, p. 70) to demonstrate one of the ways of offering social support to the mentally vulnerable. Due to limited information regarding social models, an exploratory case study approach was selected to investigate the attributes of CNMH's process model. This approach was chosen since it allows investigating complex social phenomena within real-life contexts and emphasises thick, holistic, and contextualised descriptions (Harre', 1979 cited in Eriksson and Kovalainen, 2008), even when the boundaries between the phenomenon and context are fuzzy (Yin, 1994, Yin, 2018). Moreover, this methodology also helped to articulate the “what” and “how” involved (Eriksson and Kovalainen, 2008, Yin, 2018) in the process of designing and implementing an effective social model and context-specific psychosocial interventions. Since the research sample was restricted to one organisation, diverse data collection techniques were utilised to gain detailed information to compensate for any information deficit and corroborate the information achieved (Yin, 2018, Yin, 1994, Eisenhardt, 1989). Being a constructive research, this case study utilises the understanding and interpretations of crucial actors and close observers to make sense of the implementation process (Guba and Lincoln, 1989).

The data was collected in two phases. The first phase involved fieldwork conducted by the first author in July 2019 where she spent around fifteen days at CNMH. This supported her in grasping an organisational overview and understanding organisational framework and its operations. Moreover, she also went on field visits to clients' homes and streets and attended the Welcome centre sessions as a participant observer to spend time with clients and carers. Open-ended/semi-structured interviews were conducted with clients and carers at all sites in the Nepali/Hindi language with the support of staff members. Qualitative interviews were selected as the data collection tool to gain insights from individuals based on their lived experiences and gather information about their identities, experiences and attitudes (Bauman et al., 2002, Blee and Taylor, 2002). Additionally, staff members and co-founders were interviewed in the English language. Notes were regularly taken throughout the field visits to observe and analyse in parallel (Van Maanen, 2011).

While the first visit to Chhahari was conducted as a pilot study, the next visit planned for 2020 was cancelled due to COVID-19. Thus, the data collection technique was switched to online semi-structured/structured interviews with Chhahari's founder, staff members and researchers/volunteers who had previously worked at CNMH. While many follow-up interviews with the same staff members were conducted, these discussions were critical for establishing and comparing insights about clients based on information gathered in 2019 to any transitions that occurred in them from 2019 to 2020. It also helped triangulate information and

see the evidence from multiple perspectives (Yin, 1994, Yin, 2018, Eisenhardt, 1989). Additionally, information was also gathered from organisational reports and archival records like video documentaries, which helped determine critical events in the organisations' history.

Interviews were conducted with a significant focus on the organisational culture and clients' journey during both phases of data collection. Written as well as verbal consent was taken from participants depending on their ability to speak/write. Clients and caregivers, for example, were requested to articulate their journey by narrating life history, healthcare experiences and any changes encountered after connecting with Chhahari. Further probing was also done to inquire how these individuals were able/unable to cope/recover or perform tasks in a better way. Though clients were unable to articulate the benefits clearly, carers, on the other hand, established many intriguing insights regarding the context and changes realised in clients and their behaviour after coming to Chhahari. Likewise, researchers/volunteers were also inquired regarding their experience with clients and caregivers and to reflect upon the effectiveness of the Chhahari's programs and clients' attitudes towards life. They were also asked to assume a counterfactual scenario i.e. to imagine the situation if Chhahari were missing from the support loop (see Durand and Vaara, 2009).

Additionally, staff members were also questioned about the organization's incubation stage, events/stakeholders deemed critical for establishing Chhahari's operations, and changes realised as a result of predicted and unforeseen events. Since the sample size was restricted to one organisation, substantial efforts were made to interview as many participants as possible. However, the collected data was declared sufficient once all the accessible participants were interviewed to the point of theoretical saturation (Eisenhardt, 1989) and it was evident that any additional case would add only minimal incremental value to the findings. Thus, 19 interviews/group discussions were conducted with eight clients, two caregivers, six staff members, and three researchers/volunteers. While staff members and volunteers/researchers agreed to use their original names, the names of the clients and caregivers were replaced by pseudonyms to protect their identities.

List of participants

Clients	Sur, Suku, Aka, Bij, San, Sau, Kriti, Gan
Caregivers	San mother (Nuch), Sur mother (Kai)
Staff members	Asmita and Hikmat (field workers), Bidya (operations manager), Surrender (finance manager), Gael and Mahesh (co-founders)
Volunteers/researchers	Dorrane (a trained clinical psychologist), Chiaki (occupational therapist), Pia, Leah

Data analysis

An abductive approach to phenomenon-based theorising (Fisher et al., 2021) was employed to understand the social model of care employed by the organisation. This approach involves identifying an under-theorised phenomenon to generate plausible theoretical explanations of the anomalies and allow the advancement of existing theories and perspectives related to it (Sætre and Van de Ven, 2021).

Data analysis was conducted in three phases. In phase one, a database was created based on the information gathered through archival data, verbatim transcribed interviews and field

notes. We began by constructing a detailed history of the organisation with a chronology of critical events (Webster and Mertova, 2007) and an account of organisational activities typically undertaken. This was done by analysing the information gathered from Chhahari's staff members. This narrative approach (Langley, 1999) further helped to consolidate and make sense of the rich, messy dataset while also allowing to develop insights on how Chhahari's process model and programs were tailored according to its mission.

In the second stage, the information gathered from the clients, caregivers and researchers/volunteers were analysed to map out the efficiency and impact of Chhahari's practices. Since most of the information received from the respondents was open-ended, critical text analysis was adopted to identify the recurring ideas. In order to understand the process, the gathered dataset was reviewed repeatedly, going back and forth to create first-order codes. These codes were debriefed among the researchers and finalised after mutual consent. After numerous iterations, 20 first-order codes emerged from the dataset, some of which are: a) knowledge creation, b) knowledge exchange, c) accessibility, d) outreach activities, e) in-house activities, f) association/friendship, g) inclusivity, h) support activities, i) awareness programs, and j) engagement techniques.

The last stage involved sorting and collating potentially relevant first-order codes into second-order themes (Braun and Clarke, 2006). This was done based on mutual observation and consensus among the authors (Nowell et al., 2017). Consequently, five second-order themes were created and presented to reflect the data in an orderly manner. These themes are: i) knowledge enhancement and exchange, ii) locating the mentally distressed, iii) creating safe space, iv) awareness at the micro and macro scale and v) indirect support techniques.

Findings

Persistent knowledge enhancement and exchange

Before registering as an MH NGO, CNMH was involved in collaborative research projects and baseline studies with local and international associations, e.g. Saint Xavier College, the University of Edinburgh, and INGO, UK. As a result, it allowed the NGO to understand the complex, multi-faceted grassroots realities that caused/co-existed with mental illnesses. Consequently, Gael and her partner established a philosophy and vision for the organization that was focused on providing social support without ignoring biomedical interventions (*see Table 1 excerpt 1*). The recurring learning and knowledge exchange with local and foreign organisations proved as a source of mutual growth for the involved stakeholders as it created a learning environment and provided a lens for comparing indigenous support interventions to overseas practices.

"It's about ... creating a learning environment... these projects helped in changing the mindset... so if we create an environment to engage people then we are beginning a process to open the mind. Being able to be involved in these smallish research projects, can actually be very beneficial. Because, ... it's helped us to become clearer about what we're doing, why we are doing"(Gael)

Working on collaborative research projects allowed CNMH to gain valuable information about the availability of public/private support services and create social ties with for example, Patan Mental Hospital, Patan Hospital, AshaDeep rehabilitation centre, non-profit NGOs, and professional counsellors.

Locating and reconnecting the mentally distressed

The Street Project was launched to help the mentally distressed on the streets of Lalitpur. Finding and familiarising with clients was a slow process which required several months. With time, it was discovered that very few clients were homeless, while most of them were disconnected from their families. This observation was drawn by the field workers based on the

information provided by neighbouring community members who observed clients regularly. (Table 1 *excerpt 2*). Realising the issue's complexity, CNMH shifted from only targeting the clients to locating and reconnecting their families through neighbours' support. Interacting with the former, it was found that clients were detached for two reasons: either the family was unable to comprehend the condition of clients or it was reluctant to accept excessive responsibilities. Therefore, a consistent confrontation by family members agitated the clients, and they preferred living on the streets (Table 1 *excerpt 3*).

Consequently, family members were also included in the support loop. They were educated and provided with social support. However, developing a rapport with them was a long and challenging task:

"They take time to open up and listen to us. For example, it took us many months to reach out and convince Sur's mother to think about his condition." (Asmita)

Staff members also involved the community members in the support provision process by requesting them to provide food and medication to clients if they see them around. This act proved significantly valuable for homeless clients (Table 1 *excerpt 4*). Another phase of this initiative is the weekly follow-up visits to clients' homes by NGO field workers. A primary objective of this is to establish a medication regimen with caregivers. Medications are usually stored in boxes marked with sun and moon sign to differentiate between morning and evening doses. It helps caregivers to administer the correct medication since many of them are illiterate and cannot do so on their own (Table 1 *excerpt 5*).

Field workers also help clients keep track of their appointments with practitioners during these visits. CNMH also networked with community ward leaders (the representatives elected by the community members who overlook the local issues) to support the clients if outreach workers are unable to visit them. This step proved significantly useful during the pandemic when social isolation restricted people from leaving their homes (CNMH archives). Another emergent impact of these visits was a behavioural shift in the neighbours' attitudes when they witnessed people visiting the mentally distressed and their families, whom they had shunned. This behavioural shift was narrated by Dorrane (Table 1 *excerpt 6*).

Constructing a safe space and a learning environment

Within a few months of commencing the Street Project, it was realised that sole reliance on meeting clients on the streets and families in their homes was insufficient as they were socially excluded. Consequently weekly gatherings named as the Welcome Centre gatherings were held at Chhahari which allowed them to meet other clients and caregivers experiencing similar issues in a close space. Spending time in an environment where they are not judged but instead accepted as *ordinary*⁴ people made them feel accepted. Leah shares her experience of spending time with Niki in the Welcome centre (Table 1 *excerpt 7*).

Following the inclusivity and acceptance felt during these gatherings, some clients and carers developed a connection with the place and wanted to visit Chhahari daily.

"Talking about CNMH, Niki expresses her wish to go there every day" (Leah)

Interactive team-building activities like playing games, music, watching movies, sketching, or eating while chattering with clients, carers and staff members, helped the clients and carers

⁴ This was my observation during the Welcome centre gatherings

relieve stress and develop acquaintance. Many clients identified these connections as friendships, which they cannot establish in communities.

"When clients were asked about their friendships in the community, they referred only to the friendships they had formed at CNMH" (Leah)

Another benefit that emerged from these social gatherings was the learning behaviour of clients and caregivers. Clients, for example, observed how staff members and caregivers performed everyday tasks like cooking, cleaning and sharing food. Watching this impacted the clients' behaviour significantly, and they also started performing chores like washing dishes or cleaning. Doranne shares her experience of observing a behavioural shift in Sur after he started attending the Welcome sessions (Table 1 **excerpt 8**). Additionally, caregivers felt relieved by the support they received during these social gatherings from staff members (Table 1 **vignette 9**). Caregivers also undergo a positive behavioural change when they get to observe and learn how to deal with clients (Table 1 **excerpt 10**).

Augmenting awareness in the horizontal and vertical direction

Chhahari began to sensitise and educate actors at the micro and macro levels after observing extreme stigma surrounding mental illness and a lack of awareness about social support interventions. For example, CNMH partnered with Kathmandu Marathons to raise awareness among commoners. However, later on, this initiative also became a source of funding for the organisation (Table 1 **excerpt 11**).

Formal and informal communication and knowledge exchange methods are further leveraged to raise awareness among the community members. Formal ways of education involve organising awareness and training sessions at Chhahari, while informal methods include presenting street dramas, organising youth awareness programs, and launching singing groups like Kathmandu Chorale in public spaces. "Mothers group" meetings are an example of formal awareness sessions held at Chhahari which help the attendees understand the dynamics of MH issues and learn about support services available in Lalitpur. Describing the experience, Bidya said (Table 1 **excerpt 12**). By organising such sessions, CNMH acts as a medium to connect the needy with the relevant support services (Table 1 **excerpt 13**).

Chhahari also approached state actors by catalysing the social networks created through the research studies to inform them about issues prevalent at the grassroots level and provide insight on the need for social support for the mentally ill. Political leaders like congress members were often invited to visit Chhahari to demonstrate the social dimensions of support provided during the Welcome Centre sessions (Table 1 **excerpt 14**). Furthermore, documentary evidence of Chhahari's programmes and operations was frequently shown, such as videos of Welcome Centre gatherings, Street Project support work, or short tutorials created for clients/caregivers demonstrating how to take the medication.

They live on the streets and they don't get attention from anyone. Our main purpose is to focus on their strengths. Building connection gives the client and family members to trust us and open up about themselves. (Video Documentary)

In addition to informing the powerful actors, these awareness mechanisms also aimed at advocating for a *rights-based approach* rather than a *needs-based approach* for the mentally vulnerable (CNMH archives).

Helping the family members to support the clients

At Chhahari, clients' needs are consistently monitored to tailor and/or revise the support interventions according to their evolving needs. However, it entails not only addressing their individualised needs but also resolving the needs of their loved ones. Clients are closely bonded with their family members, such as mothers, fathers, or siblings, therefore, seeing them in distress due to illness, financial instability or other factors deteriorates their mental health. Thus, in addition to providing social support, CNMH also assists clients' family members in resolving issues that are within the organisation's scope (Table 1 *excerpt 15*).

Furthermore, CNMH also offered full medical coverage to clients and partial financial assistance for medical coverage to carers in order to reduce carers' financial burden.

"We ensure to lessen the burden of caregivers by paying for 100% medical bills for clients and ... help caretakers out by providing them partial financial assistance for their medical coverage" (Surrender)

Discussion

This study aimed to examine the design process of a social model of care and psychosocial support strategies that can be mobilised alongside biomedical interventions. Our findings reveal that instead of understanding clients independently of the external context, the organisation employed a thick social approach to understand and analyse the effects of multi-faceted factors, actors, environment and their interplay with the clients (Chatterjee et al., 2022). This was achieved by Chhahari's participation in diverse collaborative research projects, which supported the organisation in harnessing knowledge on the socio-economic, structural and political dynamics and power relations affecting the MH sector at local and state levels.

In line with Mair and Seelos (2017) study, we theorise that having a comprehensive understanding of ground realities allowed Gael to define the problem space (identify and target clients' needs) and establish an organisational identity (i.e. core values, beliefs, sense of mission) for Chhahari. Thus based on this knowledge, a flexible logical framework and the first organisational program (the Street Project) was established subject to the resources and capabilities available to the organisation (*ibid*). Once employed, it led to finding more unmet needs of the clients. For example, reaching out to clients on the streets helped CNMH discover the underlying reasons for their displacement, which in most cases was the family's rejection/ignorance towards them. As a result, another intervention, i.e. finding and reconnecting clients' family members in the support process, was also added to the Street Project. This implies that CNMH's programs and support interventions were not developed systematically but were an organic process in which satisfying one need led to the discovery of other intertwined needs. This transformative learning (Jelinek, 1993) assisted the NGO in framing the problem and achieving a fit between the targeted needs, organisational identity, and available resources to create a vision on how can impact be created (Mair and Seelos, 2017). **Figure 1** (Annexure-A) illustrates the process model of the organisation. Our analysis shows that in order to provide holistic care, the organisation employs a person-centred approach to support mentally distressed people based on their individualised needs and experiences (Gask and Coventry, 2012, Hummelvoll et al., 2015). By studying the context and observing each individual over time helped the organisation to design and deliver individualised social support strategies while also constructing (what we call) a *network of support* around the clients by intertwining other actors, actions and resources across different locations. **Figure 2** (Annexure-B) depicts a *network of support model* where the client is positioned at the center while all the other actors influencing the client (directly or indirectly) are placed at the nodes.

Our analysis show that CNMH imparts dignity, respect and equality to mentally distressed by using positive discourse i.e, shifting their classification from *patients* to *clients*,

to contest the persisting beliefs and creating a respectable image (Tew et al., 2004, Beresford et al., 2010). The involvement of the social actors in the *support network* begins with Chhahari's involvement in joint research initiatives. Working with diverse care providers, national/international institutions for collaborative projects allows the NGO to form network ties which are mobilised and leveraged to connect clients with relevant care providers (Kidd et al., 2015) to help them receive appropriate medical care.

While NGO outreach workers utilise objects like food and water to mobilise a connection with clients on the streets and commence an individualised relationship-building process (Larsen et al., 2020), nearby community members are also triggered after witnessing visual enactment of support being provided (Barberá-Tomás et al., 2019). Consequently, they offer to support the clients when requested. By recognising family as a fundamental unit of Nepalese society, CNMH incorporates strengthening family relationships between the clients and their loved ones which is vividly useful for people with psychosocial disabilities (Mapanga et al., 2019). Chhahari also strives to manage well-being of family members since it acknowledges the extreme burden faced by them (Siddiqui and Khalid, 2019). Our analysis also reveals that CNMH utilises indirect means to comfort the clients e.g, by fulfilling various needs of family members. The weekly home visits help transform the client-employee bonds into more inter-personal relationships, which help re-construct their identities destroyed due to widely faced stigma (Mezzina et al., 2006, Tew et al., 2012). Confirming that clients consistently seek medical treatment aids in ensuring that clients are supported holistically (Patel et al., 2016). Furthermore, these home visits often prove instrumental in bringing about a positive behavioural change in neighbours who become more accepting of clients and their families as members of the community (Ware et al., 2007).

The weekly gatherings at Chhahari help establish a community inside its office with an enabling social environment where the attendees feel connected to the place and people around them (McMillan and Chavis, 1986, Mezzina et al., 2006). These gatherings aid in conceiving a communication structure among homophilous individuals (Rogers et al., 2014), which allows them overcome internalised stigma and rebuild positive individual and social identities (Tew et al., 2012). Staff members are seen as peers since no power asymmetries exist between them and the service users (WHO, 2021), allowing the latter to experience a subjective sense of belonging (Prince and Gerber, 2005) and develop an impactful *companionship* through informal social networking. The supportive environment and socialising strategies assist clients in gradually regaining control over their lives through self-actualization (Topor et al., 2011, Webber and Fendt-Newlin, 2017) also allowing them and carers in redefining their social identities as *friends, companions, and learners* (Larsen et al., 2020). Chhahari's awareness and engagement techniques educate community members about the various roles that can be played to create inclusive and open communities (Tew et al., 2012) while purposeful lobbying with macro-scale actors, aids in demonstrate the reality that behavioural shift requires socially sensitive support interventions alongwith biotechnological solutions (Pedersen, 2012, Kirmayer and Pedersen, 2014). While diverse social support models might comprise different interventions, this case study successfully depicts how an MH NGO in a resource-constrained setting designed and implemented a support model that integrates seamlessly with biomedical interventions. This model entails all the fundamental characteristics of psychosocial interventions, like equality, inclusivity, involvement of community-based people and family members in the care provision process and combating stigma and social exclusion. Therefore, this study successfully depicts the critical factors that require careful consideration and articulation when developing a social model of care and individualised psychosocial interventions.

Conclusion

An in-depth exploration of Chhahari's process model conducted in this study assisted in drawing out critical insights regarding the formulation and establishment of a conceptual framework for an effective social model of care. Results show that transformative learning played a critical role in developing Chhahari's impact creation logic by: fostering a deeper understanding of the problem domain, scrutinising organisation's identity relative to available resources and devising contextualised support strategies to create an impact. Building companionship among the staff members, clients and weaving other actors in a support network surfaced as Chhahari's technique for supporting and re-integrating mentally ill/distressed individuals in society. This study provides a methodological approach for mapping out the design and implementation process of social support interventions. Doing this allowed us to move beyond the widely available theoretical information and make sense of the pragmatic steps involved in the process. A multidisciplinary methodological and theoretical perspective from the field of social work, public health and organisational studies assisted in creating a hybrid interface between the divergent fields. The latter discipline helped articulate the concepts and relationality between the steps involved in the design and implementation process. In terms of limitations, the outcomes of this study are non-generalisable, given the relatively small sample size focused on a single context. Additionally, no evaluative metrics were appointed for evaluating the efficiency of support strategies; instead, participants' experiences were used to comprehend the effectiveness of the support strategies. Another limitation was the researcher's inability to re-visit the site and rely on the secondary information provided by other researchers/volunteers.

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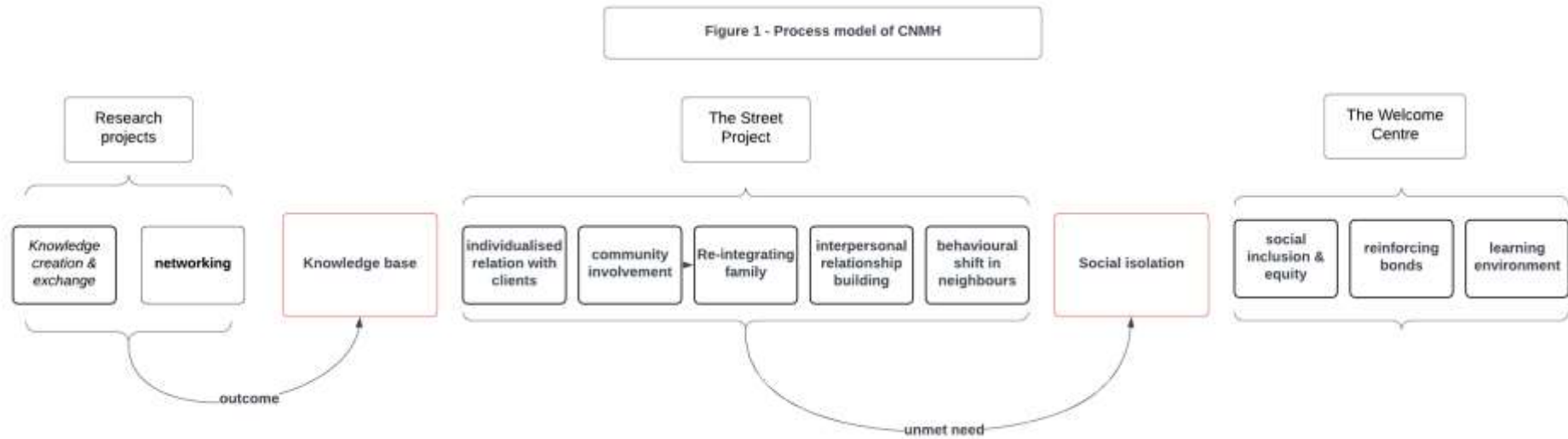
Table 1

Themes	Vignettes/excerpts
Persistent knowledge enhancement and exchange	1. <i>"The crux of struggle ... comes back to having a clear vision and a philosophical position, which in this case ... was either following the big discussion on utilising a medicalised approach or going for a social approach and my main aim was to look at person's needs in a holistic way... that also includes the medical part, because you can't just leave that, it's a part of the whole connectible. So, these [research] projects helped in gaining the sort of evidence which was well-utilised in terms of development of Chhahari"</i> (Gael).
Locating and reconnecting the mentally distressed	2. <i>"We started out really thinking that the people on the street were homeless and then quite quickly realised we are not actually working with people who are homeless. We're working with people disconnected from the family"</i> (Gael) 3. <i>" There were also some stories about how some [clients] who had been so aggressive at home ... because of mental illness ... [their family members] rejected them and did not understand them asking why you are not working ... [Clients] felt useless because they cannot work. They finally skipped going home to [avoid such questions] and [assertions that] you have an able body, but you can't work ... so [clients] would just ... go to the streets and ... they'd be in a terrible condition physically as well"</i> (Dorrane). 4. <i>"We have many clients who are still on the streets, ... and we locate them, sometimes we cannot find them ... but this is the nature so we ... communicate with, for example, certain clients live in certain ... community and [we] ... look at them in that community most of the time, then ... connect with the community members there... for example, we have one client in southern community and he just sleeps ... outside so and there's a shopkeeper who gives him food sometimes ... so we've connected with these shopkeepers to connect with them"</i> (Hikmat). 5. <i>One difficulty for me right now is that I have to remember if he has taken 5-6 different types of medicine every day. In this condition, I feel very much helped when Chhahari's staff regularly ... come to see me and my son and remind us".</i> (Clients' mother)

	6. <i>"So when Chhaharis' people do home visits, everybody [neighbours] is ... hanging out because they are thinking why are they coming and because ... [people] coming from around the world ... neighbours were always interested in that people are coming in, ... and that made them [clients and family] feel just important and happy because if Chhahari is coming to visit them, then they can't be too bad that's basically what the neighbours would think and then they would actually treat them better and the family better."</i>
Constructing a safe space and a learning environment	7. <i>"As we converse amongst the low chatter of other clients, staff members and caregivers who are present at the weekly welcome session she tells me more about herself. She tells me about her desire to learn English and her general enthusiasm for education. It is clear that Niki is comfortable and feels at home in the office."</i> 8. <i>"Sur, in the beginning, apparently, he didn't like washing his plate or cleaning up or making his own tea or anything. [Seeing others] he actually learnt eventually he was sweeping with the broom helping to clean up afterwards ..., but it wasn't verbal it was behavioural like through following other people's behaviour.... [so] if they are not rejected, and on the streets, they can be very learning" (Dorrane)</i> 9. <i>"Staff members recognise that a significant portion of the burden associated with mental illness shifts to a person's family or caregiver, so they work to incorporate and support the family and caregivers in the treatment process. This is achieved by offering social support to the caregivers at weekly welcome centre gatherings" (Leah)</i> 10. <i>"Their parents ... care as they come to Chhahari ... they change when they are educated on ... mental illness and how to treat them [clients], but it's not always like I said with formal training it's... through the staff behaviour towards the clients that [parents] ... see towards them on the Wednesdays" (Dorrane)</i>
Augmenting awareness in the horizontal and vertical direction	11. <i>"Runners participating in the marathon from Chhahari run while wearing shirts printed with Chhahari's name. So spectators also understand Chhahari's aim when they see the runners wearing these shirts. Moreover, these participants pay registration fees to run from Chhahari, and they also bring funds from their circle. Spectators also donate to Chhahari" (Surrender)</i>

	12. <i>"We had a meeting with the mothers' group ... [these women] didn't know that certain services exist. They had family members who were mentally ill, but they did not want to bring them out ... so they were really happy when they came to us and we talked about Patan Mental Hospital and ... many of them didn't even know about these services"</i> 13. <i>"So we are working as a medium to ... connect them to these services and supporting them towards getting these things so [who come to us] teach others from their experience, that is awareness and empowering them. We don't want to make our clients or make the people who come to us dependent on us ... because we are an NGO and we don't know how long we're going to be ... but the government hospital is something that is going to be there forever" (Bidya)</i> 14. <i>It was after the first round of the research ... that we had a meeting with the National Planning Commission which I ... think is quite significant. So ... I went to see one of the senior bureaucrats. So we discussed the findings [prevalent disparities and needs of mentally distressed]. He was very well prepared, and we put down all these questions. And the evidence that came through the research ... wouldn't have been possible and also that status... to say that you are with the University of Edinburgh, it is also quite powerful. (Gael)</i>
Helping the family members to support the clients	15. <i>"I remember Suku; she was really attached to her brother and very stressed when her brother got disabled due to an incident. He got pressure sores for sitting longer on the wheelchair. Chhahari provided financial assistance for his treatment" (Chiaki)</i>

Annexure-A



Annexure-B

