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Strengthening Community Mental Health Systems: Evidence from Interventions for Families Left Behind by Migrant Workers

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Abstract

This study aimed to strengthen community mental health systems, increase mental health service access and promote community resilience. A mixed-methods cross-sectional evaluation was conducted in seven municipalities of Salyan and Kailali districts. Quantitative data were collected from 91 participants, representing a subsample of baseline respondents, using structured questionnaires. Qualitative data were gathered through 20 key informant interviews (KIIs) with health workers, local government representatives, and project staff, and four focus group discussions (FGDs) with beneficiaries. Data were analyzed using descriptive statistics for the quantitative component and thematic analysis for the qualitative component. Findings revealed reduced stigma, increased community awareness, and stronger coordination between local authorities and service providers. The project significantly contributed to mental health system strengthening, building Mental health and psychosocial services (MHPS) service, and community development by integrating mental health into primary health care system, empowering local stakeholders, and fostering social inclusion. These findings underscore the potential for scaling up similar community-based mental health interventions to enhance wellbeing and resilience in low-resource settings.

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Introduction

Mental health is a growing global health concern, contributing a significant proportion to the burden of disease measured by disability-adjusted life-years (DALYs). In 2019, mental disorders accounted for 5.5% of all DALYs in Nepal, comparable to global trends, with low- and middle-income countries (LMICs) like Nepal being disproportionately affected by mental health challenges(Dhungana et al., 2023). Depression and anxiety remain among the leading causes of DALYs worldwide(Dhungana et al., 2023; Global, regional, and national burden, 2022), and the share of mental health-related disease burden has increased considerably in recent decades.

Nepal's mental health system continues to face notable challenges, including low government priority, a critical shortage of mental health professionals, and limited availability of hospital-based and community care services(Mental health services in Nepal, 2025.; Improving access to mental health services, 2025.) . The country's handful of psychiatric beds and specialists are concentrated in major cities, making access difficult for rural, marginalized, and vulnerable populations. Individuals suffering from mental health problems face widespread stigma, dis crimination, and misunderstanding, which frequently prevents them and their families from seeking or receiving appropriate care(Tamang, 2023; Moktan, 2024) .

Migrant workers and their left behind families are the most vulnerable group for mental health conditions Nepalese youths migrate for employment opportunity to Gulf countries, Malasiya and other countries. They encounter significant psychological distress due to difficult work conditions, high job insecurity, separation from support of social and family networks, and exploitative environments(Sharma et al., 2023; Chapagain, 2024) High rates of depression, anxiety, and psychological distress are consistently reported among Nepalese migrants, with social isolation and lack of adequate support compounded these issues(Sharma et al., 2023; Chapagain, 2024). Persons with disabilities and their families similarly confront barriers stemming from stigma, poor access to services, and social isolation in daily life.

Few community level initiatives of Nepal have sought to address these challenges by integrating mental health services into the primary health care (PHC) system which will capacitate service provider in timely detection and primary management of mental health conditions at the community level s (Improving access to mental health services, 2025) . Community-based interventions include enhancing social connections by involving migrant family members, establishing peer support networks, organizing group activities, and providing psychosocial counseling services. This is further strengthened through active participation of local government and civil society group including mental health self-help group. It has shown effectiveness in improving mental health outcomes, reducing distress and depression, and enhancing social inclusion in resource-constrained environments(Giebel et al., 2022; Bolton et al., 2023).

Despite these advances, the evidence-based comprehensive, community-driven mental health interventions—especially those targeting migrant workers - remains limited for Nepal as like other many Asian countries. The PARBARDAN project, implemented by Centre for Mental Health and Counselling (CMC- Nepal), addresses this gap by strengthening local mental health systems, reforming delivery models, and fostering community resilience and inclusion for some of the country's most vulnerable groups.

Objectives

This article aims to present the outcome of the community level intervention of the project which seeks to assess the effectiveness of community-based interventions in reducing psychological

distress, stigma, and social isolation among migrant workers and their families and examine the integration of mental health services into primary healthcare settings.

Literature Review

Mental health disorders represent a substantial and growing public health concern worldwide, contributing significantly to the global burden of disease, particularly in low- and middle-income countries (LMICs) like Nepal (Vos et al., 2020). Despite this burden, mental health services in Nepal are severely underdeveloped and concentrated predominantly in urban centers, leaving rural and marginalized populations with minimal access (Vos et al., 2020). Since the adoption of its National Mental Health Policy in 1997, Nepal has aimed to integrate mental health into primary healthcare; however, systemic challenges including inadequate human resources, insufficient training, and inconsistent supply of psychotropic medications have restricted effective implementation (National Mental Health Survey Report, 2020).

Nepal's mental health workforce is critically limited, with approximately 0.22 psychiatrists and 0.06 psychologists per 100,000 population (Vos et al., 2020). This shortage is exacerbated by a lack of mental health training among primary healthcare workers and limited supervision, which poses challenges for scaling up mental health services in decentralized settings (Jordans et al., 2013; Luitel et al., 2015). Recent improvements include the development of community mental health programs by NGOs and government collaboration to boost service delivery and training, yet the treatment gap remains large (Jordans et al., 2013). The Nepal Health Research Council's National Mental Health Survey (2020) estimated that approximately 10% of adults experience mental health disorders, a prevalence comparable to global estimates, underscoring the urgent need to expand access to care (National Mental Health Survey Report, 2020).

Migrant workers in Nepal are particularly vulnerable to mental health problems due to occupational hazards, exploitation, language barriers, prolonged family separation, and social isolation while working abroad. Studies reveal high prevalence rates of depression, anxiety, and psychological distress among this population and their families, aggravated by limited psychosocial support services and persistent stigma (Sharma et al., 2023; Thapa & Hauff, 2005). This group faces heightened risk factors driven by socio-economic determinants such as low income, limited education, and uncertain legal status, which negatively affect mental health outcomes (Jordans et al., 2013).

Community-based mental health interventions have emerged as effective strategies to bridge the vast treatment gaps in LMICs, including Nepal. These approaches prioritize task-sharing, whereby non-specialist health workers are trained to deliver mental health care, supported by peer and community volunteers (Patel et al., 2017). Evidence from Nepal highlights the success of integrating mental health services within primary healthcare and community platforms, which has improved accessibility and reduced stigma (Luitel et al., 2015; WHO, 2021). In particular, peer support groups and psychosocial counseling have demonstrated positive psychosocial and clinical outcomes by enhancing social inclusion and fostering community resilience (Jordans et al., 2013).

The intersection of mental health with disability inclusion and livelihood promotion is gaining recognition as essential in holistic programming. Evidence suggests that empowerment through economic activities and social inclusion significantly improves psychosocial well-being among persons with disabilities and socially marginalized groups (Adhikari et al., 2024). Such multidimensional interventions resonate with Sustainable Development Goals aiming to reduce inequalities and enhance well-being worldwide, by addressing social determinants of mental health comprehensively.

Although Nepal has made strides in policy development and initial program implementation, major challenges remain. Service coverage is uneven, stigma persists in rural areas, human resources are insufficient, and therapeutic medicines often face supply chain issues (National Mental Health Survey Report, 2020; Jordans et al., 2013). Furthermore, formal mental health legislation has yet to be enacted, and governance structures for coordination remain weak(Jordans et al., 2013).

Despite these challenges, increasing collaboration between government institutions, NGOs, and international partners fosters hope for sustainable mental health system strengthening in Nepal. There is a critical need for rigorous evaluations that assess the impact of integrated, community-based mental health and psychosocial interventions targeting vulnerable populations such as migrant workers and persons with disabilities.

This study aims to address these existing research gaps by evaluating the PARBARDHAN project, which endeavors to integrate mental health service reform, capacity building, policy advocacy, community empowerment, and livelihood support to improve mental health outcomes and community resilience among Nepal's migrant worker families and marginalized populations.

Methodology

Study Design

This study employed a mixed-methods, cross-sectional design, combining quantitative and qualitative approaches to assess the impact of the PARBARDHAN project on mental health service strengthening and promotion of psychosocial well-being among migrant workers, their families, and other vulnerable groups within targeted communities. The PARBARDHAN project aimed to strengthen local mental health systems, integrate mental health services into primary care, build capacity of community health workers and self-help groups, provide psychosocial counseling, and promote social inclusion and livelihood opportunities. The baseline study, conducted prior to the intervention, collected data on mental health status, service access, psychosocial well-being, stigma, and social inclusion among participants. The baseline findings provided a reference point for evaluating changes in mental health outcomes, service utilization, and community engagement resulting from the project interventions.

Study Setting and Participants

The evaluation was conducted across seven municipalities in the Salyan and Kailali districts of Nepal, where the project was implemented. The quantitative sample comprised 91 participants, representing approximately 25% of the original baseline cohort from each municipality and selected randomly. Participants included families of migrant workers, persons with mental health conditions or disabilities, their family members, and adolescents directly engaged with project interventions.

For the qualitative component, 13 Focus Group Discussions (FGDs) and 26 Key Informant Interviews (KIIs) were conducted. FGD participants selected purposively, comprising female community health volunteers, school students, and self-help group members, while KIIs involved health professionals, local government officials, civil society representatives, and other key stakeholders.

Data Collection Tools and Procedures

Quantitative data were collected using standardized and validated psychometric instruments to assess mental health outcomes and well-being. The General Health Questionnaire (GHQ-12), a 12-item scale, measured psychological distress, with a cutoff score of ≥2 indicating distress. Anxiety and depression symptoms were assessed using the Hopkins Symptom Checklist (HSCL-25), a 25-item instrument with scores ≥1.75 reflecting significant distress. Participants' overall satisfaction with life

was measured using a 6-item Likert Life Satisfaction Scale, while the Happiness Scale captured subjective well-being. The GHQ-12 and HSCL-25 had previously been validated in the Nepalese population, and the other scales were adapted from the baseline study with translation into the Nepalese language to ensure cultural relevance and comprehension. Trained Psychosocial Workers (PSWs) served as research assistants, conducting surveys in accessible community locations such as health facilities, municipal offices, and schools. Local peer support volunteers assisted in mobilizing participants, ensuring adequate participation and engagement. Data collection procedures followed standardized administration guidelines, with careful attention to participant privacy and ethical considerations.

FGDs and KIIs were conducted using semi-structured guides tailored to explore effectiveness of project intervention in mental health service strengthening and community development. Interviews were audio recorded with consent and notes were taken simultaneously to capture key points, non-verbal cues, and contextual information that might not be evident from the audio recordings alone. These notes also served as a backup in case of technical issues with the recordings and helped guide follow-up questions during the discussions, ensuring that important topics were fully explored.

Data Management and Analysis

Survey data were entered into SPSS version 21.0 for analysis. Descriptive statistics summarized participant characteristics, prevalence of mental health outcomes, and service utilization. Inferential statistics were used to examine trends and changes compared to baseline data.

Audio recordings were first transcribed in Nepali and then translated into English. Thematic analysis was conducted using an inductive approach, allowing themes to emerge directly from the data rather than being imposed a priori. Initially, two independent researchers read the transcripts multiple times to familiarize themselves with the content. They then generated initial codes capturing key concepts and patterns. These codes were systematically grouped into broader categories, which were further refined into main themes and sub-themes through iterative discussion and comparison between researchers. Discrepancies in coding were resolved through consensus, ensuring reliability and enhancing the validity of the identified themes. The process emphasized capturing both recurring and divergent perspectives from participants to provide a comprehensive understanding of the project's impact.

Ethical Considerations

The study protocol was reviewed and approved by the National Health Research Council (NHRC) of Nepal. Written informed consent was obtained from all participants or their legal guardians where applicable. Confidentiality was strictly maintained by anonymizing data and securely storing all records within the CMC-Nepal data management system to prevent unauthorized access.

Results

Mental Health System Strengthening

Expansion of Mental Health and Psychosocial Services

The project significantly enhanced the availability and accessibility of mental health and psychosocial support services (MHPSS). The number of health facilities providing mental health services increased from 4 at baseline to 19 at midterm. These services are now offered through primary healthcare centers and health posts of municipality, reducing the need for referrals to distant hospitals and cost of the treatment. Community-based counselling sites and regular outreach services have further improved accessibility. "In the past, we had to travel to Dang or Nepalgunj for about 4 to 6 hours for treatment, but now services are accessible here in few minute walk. Regular meetings and coordination have made it convenient to receive services." (FGD participant)

Capacity Building and Human Resource Development

Training sessions and mentorship activities strengthened the capacity of stakeholders. A total of 31 female SHG members and OPD staff were trained on advocacy, promotion of mental health care, and rights of persons with disabilities. Volunteers at the ward level played a critical role in early identification, referral, and community mobilization.

Improved Referral and Medicine Supply Mechanisms

Coordination among local governments, district health offices, and CMC Nepal improved medicine supply and referral pathways. Shortages of medicines were addressed using project funds.

"First, we demand medicines at the district level, then province, and if more needed, we purchase from our budget. Sometimes, we also request CMC Nepal to provide timely service." (KII participant-health facility in-charge)

Mental Health Service Reform

Integration of Mental Health into Primary Care

Mental health services are now integrated into routine primary healthcare services. Beneficiaries reported increased access to counselling, medication, and psychosocial support closer to their homes. Mental health trained heath workers are available for treatment in project supported health facilities.

Policy and Budgetary Support

Several municipalities drafted mental health policies or psychosocial strategies, with some adaptation of the National Mental Health and Psychosocial Strategy 2079. Budget allocations for mental health have increased, averaging 16% of total health budgets (ranging from 5% to 27%).

"We have developed a mental health policy, but we are facing challenges in getting it approved due to the municipal assembly not convening. Once ratified, implementation will be easier." (KII participant-Municipality administration chief)

Reduction in Stigma and Discrimination

Community perceptions toward mental illness have shifted positively. Stigma and social exclusion is reduced because of regular awareness activities and mobilization of SHG members resulting more families seeking treatment without fear of judgment.

"Earlier, people with mental health problems were isolated. Now, they are treated like everyone else, and families encourage them to seek treatment." (FGD participant)

Community Development and Well-being

Improvement in Psychological Well-being

Quantitative findings show a significant reduction in mental health symptoms:

- Anxiety decreased from 37.2% to 20.9%**,**
- Depression decreased from 26.2% to 13.2%**,**
- Psychological distress remained around 20.9%**.**

Participants also reported increasing happiness and life satisfaction scores compared to baseline. The project has demonstrated significant progress towards outcomes as evidenced by the findings of mid-term evaluation where happiness and life satisfaction were assessed using standard and culturally adapted tool. Results showed that 16.5% rated in extremely happy, 26.4% rated very happy, 1.15 rated somewhat happy, 52.7% were neither unhappy nor happy, and 3.3% rated somehow not happy. In the life satisfaction scale, 8.8% rated extremely satisfied, 35.4% rated satisfied, 33.85 rated slightly satisfied, 5.9 were neutral, 8.8% rated slightly dissatisfied, 4.4% rated dissatisfied and 2.9% rated extremely dissatisfied. Likewise, the extent to which migrant workers with mental health problems and persons with disabilities feel respected by their families and others was assessed. Results

showed that among 8 participants of aged between 15-24, 12.5% felt not respected at all, 37.5% sometimes, and 50% most of the time. Similarly, among 83 participants over age 25, 8.4% felt not respected at all, 33.8% sometimes, and 57.8% most of the time. Anxiety and stress symptoms of 91 beneficiaries reduced significantly from than baseline of 37.2% to mid-term 20.9% and depression 26.2% to 13.2% in midterm evaluation. Among the female migrant workers and their families, distress reduced from 20% to 17.6%, anxiety from 20% to 14.7%, and depression 20% to 0% in the mid-term. A similar trend was observed person with a disability. There is also improved well-being, as showed 25% of male migrant workers rated very happy, 33% satisfied and another 33% rated as very much satisfied with their lives. Among female migrant workers, 25% rated very happy, 22% rated happiest and 43% rated satisfaction, and 10% rated very satisfied with their lives. Families of female migrant workers including persons with disabilities rated 33.3% being very happy and all rated satisfaction with their lives. In the age group 15-24, 4.7% of females feel valued most of the time, 3.5 % rated they sometimes feel valued and accepted and 2.1% never felt that they were valued and accepted by others. Of female participants above 25 years 52.3% rated feeling valued and accepted, 30.2% rated feeling valued and respected whereas 9.3% felt never valued and respected. This result showed examples of inclusion of beneficiaries with mental health conditions in family and community which needs to be advocated continuously to mainstream it.

Enhanced Livelihood and Economic Stability

The project promoted self-employment opportunities, enabling 39 individuals **(**33 female, 6 male) to engage in small businesses. Persons with disabilities (PwDs) were issued disability identity cards and started receiving incentives, which improved family treatment and support.

Suicide Prevention

Qualitative results showed that the reduction trend of suicide incident as reported by the participants, mainly in 20–40 age group, attributing it to timely psychosocial and mental health support service, increase awareness on availability of hotline (1166) service, psychosocial support, and community awareness activities."Compared to before, there has been a decrease in suicide incidents. People are now aware, seek counselling, and receive medications when needed." (KII participant)

Social Cohesion and Peer Support

The establishment of 9 Self-Help Groups **(**SHGs**)** and 7 peer support groups fostered community engagement, mutual support, and increase psychosocial resilience. These groups facilitated sharing of experiences, support in solving the problem-, and advocacy for mental health rights. "In our peer support group, joys and sorrows are shared. When someone faces problems, the group supports him/her emotionally and financially." (FGD participant)

Discussion

This midterm evaluation of the PARBARDHAN project reveals considerable progress in strengthening mental health systems and fostering community development in Nepal's Salyan and Kailali districts. The expansion of mental health services from 4 to 19 primary healthcare facilities demonstrates successful integration consistent with global recommendations for task-shifting in mental health care to improve access in low-resource settings (Adhikari et al., 2024; Luitel et al., 2015). At baseline, mental health service coverage was limited, and many community members reported low access to counseling and treatment, highlighting the importance of the current expansion. The establishment of community counseling sites and outreach services reduced geographical barriers, a critical factor given Nepal's dispersed rural population, addressing a key limitation identified in the baseline assessment (National Mental Health Survey Report, 2020).

Capacity-building efforts targeting Self-Help Group members, service providers, and volunteers addressed workforce shortages and promoted sustainable community engagement. Such human resource development is essential for mental health system resilience and aligns with National Mental Health Strategy goals (Luitel et al., 2015; Adhikari et al., 2024). Strengthened referral and medicine supply mechanisms achieved through coordination between local governments and implementing agencies mitigated longstanding issues of medicine supply and fragmented care pathways, supporting treatment continuity (Improving access to mental health services, 2025.; Adhikari et al., 2024).

Community engagement, peer support groups, and stigma reduction campaigns contributed to positive social outcomes. At baseline, stigma and discrimination limited help-seeking behaviors; current qualitative findings indicate meaningful shifts in attitudes, consistent with evidence from low- and middle-income settings (National Mental Health Survey Report, 2020; Luitel et al., 2015). The project's linkage of mental health interventions with livelihood support and disability incentives further addresses social determinants of health, contributing to observed improvements in life satisfaction, happiness, and reductions in anxiety and depression (Improving access to mental health services, 2025).

Importantly, reduced stigma and discrimination toward mental illness indicate meaningful shifts in social attitudes, promoting help-seeking behaviors and inclusion. Community engagement and peer support groups likely contributed to this effect, consistent with global findings on community-based stigma reduction strategies in low- and middle-income countries (Luitel et al., 2015; Adhikari et al., 2024).

Significant reductions in anxiety and depression prevalence alongside improved happiness and life satisfaction scores emphasize the project's positive psychosocial impact. The linkage of mental health interventions with livelihood support and disability incentives strengthens these outcomes by addressing social determinants of health, in line with best practices recommended by the World Health Organization (Improving access to mental health services, 2025.). The project's reported decline in suicide cases further underscores the efficacy of integrated psychosocial support and community awareness initiatives. Stakeholder recommendations for continued collaboration, expanded awareness programs, reliable medication supply, and increased local employment generation align with evidence-based strategies to promote mental health system strengthening and socio-economic resilience (Improving access to mental health services, 2025.; Adhikari et al., 2024). Despite successes, persisting challenges merit attention, including medicine supply irregularities, limited reach in remote areas, high staff turnover, and stigma persistence in rural communities. These systemic barriers are well-recognized in Nepal's mental health landscape and require sustained multi-sectoral efforts to overcome (Luitel et al., 2015; Adhikari et al., 2024)

Conclusion

This study demonstrates positive changes in strengthening the mental health system and fostering community development in resource-limited settings of Nepal. The integration of mental health services into primary care, expansion of service availability from 4 to 19 facilities, targeted capacity building for health workers, and improved referral and medicine supply mechanisms have enhanced access to mental health and psychosocial support for migrant workers, persons with disabilities, and their families. Midterm evaluation data indicate measurable improvements in service utilization, community engagement, and psychosocial outcomes compared with baseline assessments, supporting these observed changes. Positive shifts in community attitudes and reductions in stigma, combined with improvements in life satisfaction, happiness, and reductions in anxiety and depression symptoms, highlight the project's contribution to social inclusion and resilience. These outcomes were

strengthened by community-based interventions, peer support groups, and the linkage of mental health support with livelihood and disability incentives.

Strengths of this study include the mixed-methods approach, use of standardized and validated psychometric instruments, and engagement of diverse community stakeholders, allowing for comprehensive assessment of project impacts. Limitations include a relatively small quantitative sample, lack of complete inferential statistical analysis, and limited generalizability beyond the targeted districts. Sustaining and expanding mental health integration within primary health care, particularly in remote areas, remains essential. Ongoing capacity building for health workers and community volunteers, consistent medicine supply, strengthened policy support, and increased budget allocation are critical for long-term sustainability. Community awareness and engagement initiatives should continue to further reduce stigma and foster inclusive mental health practices.

Disclosure Statements

No potential conflict of interest was reported by the author(s). Author(s) read and reviewed the final version and agreed consent for publication. All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

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