

Strengthening community mental health competence—A realist informed case study from Dehradun, North India

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Abstract

Few accounts exist of programmes in low- and middle-income countries seeking to strengthen community knowledge and skills in mental health. This case study uses a realist lens to explore how a mental health project in a context with few mental health services, strengthened community mental health competence by increasing community knowledge, creating safer social spaces and engaging partnerships for action. We used predominantly qualitative methods to explore relationships between context, interventions, mechanisms and outcomes in the “natural setting” of a community-based mental health project in Dehradun district, Uttarakhand, North India. Qualitative data came from focus group discussions, participant observation and document reviews of community teams’ monthly reports on changes in behaviour, attitudes and relationships among stakeholder groups. Data analysis initially involved thematic analysis of three domains: knowledge, safe social spaces and partnerships for action. By exploring patterns within the identified themes for each domain, we were able to infer the mechanisms and contextual elements contributing to observed outcomes. Community knowledge was effectively increased by allowing communities to absorb new understanding into pre-existing social and cultural constructs. Non-hierarchical informal community conversations allowed “organic” integration of unfamiliar biomedical knowledge into local explanatory frameworks. People with psycho-social disability and caregivers found increased social support and inclusion by participating in groups. Building skills in respectful communication through role plays and reflexive discussion increased the receptivity of social environments to people with psycho-social disabilities participation, thereby creating safe social spaces. Facilitating social networks through groups increases women’s capacity for collective action to promote mental health. In summary, locally appropriate methods contribute most to learning, stigma reduction and help-seeking. The complex social change progress was patchy and often slow. This study demonstrates a participatory, iterative, reflexive project design which is generating evidence indicating substantial improvements in community mental health competence.

KEYWORDS

community participation, evaluation and community-based research, global mental health, India, mental health promotion, social care

1 | INTRODUCTION

More than 10 years after the Global Mental Health Movement was launched to profile the major disparities in mental health (Horton, 2007; Patel, Boyce, Collins, Saxena, & Horton, 2011a), a call for greater focus on local priorities, strengthening community resources and developing endogenous solutions has gained traction (Kirmayer & Pedersen, 2014; Summerfield, 2012). Community mental health competence (CMHC) means people collectively are able to participate in promotion, prevention, treatment for their mental health and advocate for the same (Campbell & Burgess, 2012; Mathias, 2016). Programmes developing CMHC often must address stigma and exclusion, low levels of mental health awareness, advocate for responsive mental health services and additionally engage with social determinants of mental ill-health such as gender inequality and socioeconomic disadvantage (Burgess, 2015; Kirmayer, 2006).

Mental disorders contribute 11.8% of the Indian disease burden (Patel, Chatterji, & Chisholm, 2011b) yet less than 1% of the national health budget is allocated to mental health service provision, and only 10% of people with psycho-social disabilities (PPSD) access biomedical mental health services (World Health Organisation, 2011). We use the term PPSD which is preferentially used by mental health service users (Drew et al., 2011). Studies set in South Africa describe supporting the development of informal networks among PPSD and self-help groups as effective strategies to strengthen community mental health and social inclusion underlining the importance of engaging with the social context of PPSD (Burgess, 2015; Burgess & Campbell, 2014; Petersen, Ssebunnya, Bhana, & Baillie, 2011; Petersen et al., 2012).

Research into community mental health in India has focused on increasing access to primary mental healthcare and developing community-based and culturally competent services (Jacob, 2001; Jayaram, Goud, & Srinivasan, 2011; Padmavati, 2005). Yet few studies have investigated efforts to build CMHC, and almost no studies provide detailed information on the context, assumptions and mechanisms underlying efforts strengthen community resources for mental health in low–middle-income countries (De Silva, 2015; De Souza, 2013).

This study’s aim was to use a realist lens to distil which features of communities, interventions and context influenced CMHC outcomes using a community mental health project in the district of Dehradun, North India as a case study.

2 | METHODS

Adapted from critical realism, realist evaluation facilitates appreciation of how complex programmes work, for whom they work and under what circumstances rather than simply asking “does it work?” (De Souza, 2013; Marchal, Dedzo, & Kegels, 2010b). This research focused on three outcomes of CMHC: strengthened community knowledge, the development of safe social spaces and presence of functioning partnerships for collective action by examining inter-relationships of context, intervention, mechanisms and outcomes in their natural setting as a case study (Yin, 2009).

What is known about this topic

- Cultural competence is essential to build knowledge on mental health in communities.
- Building social networks and participation in self-help groups increases social inclusion for people with mental distress.
- Engaging with the social context is essential to build community mental health.

What this paper adds

- Informal conversations on mental health allowed integration of new information with existing explanatory models and promoted social learning.
- Social support available in communities in this case study was prevalent and enhanced safe social spaces.
- New social networks formed through facilitated support groups in the community facilitated both social inclusion and collective action for mental health.

2.1 | Setting

The study was set in Dehradun, a district characterised by vibrant towns, and productive fields. Socio-demographic features are summarised in Table 1. Of note are the gender disparities evidenced by grossly unequal new-born sex ratios and literacy rates.

2.1.1 | The case study—Burans community mental health project

Burans is a partnership between Emmanuel Hospital Association and the Uttarakhand cluster of the Arukah (formerly CHGN) network

TABLE 1 Socio-demographic profile of the study district, with state-level and national comparison data

Indicator	National—India	Uttarakhand	Dehradun
Total population (million people)	1,200	10.1	1.7
% population rural	72.2	69.5	44.5
% population under 15 years	34.9	28.9	26.9
Sex ratio (female to 1,000 males)	940	963	902
Literacy (% literate female)	65.5	70.1	78.4
Literacy (% literate male)	82.1	87.4	89.4
Maternal mortality	178	292	178
Infant mortality	40	40	32

Sources: Government of India (2011), Office of the Registrar General & Census Commissioner (2013), Ministry of Health and Family Welfare (2015).

working in four communities of Dehradun district with a total population of 80,000 people. In each community, five community-based team members (employed staff) work with community volunteers (community mental health promoters) to build community knowledge, safe social spaces and partnerships for action. Over the first 24 months, 437 PPSD and their primary carers were registered in the programme.

Using an outcome mapping framework (Earl, Carden, & Smutylo, 2001), Burans collaborates with key stakeholder groups seeking to strategically influence attitudes, behaviour and relationships related to mental health. This study focuses on: PPSD, carers of PPSD, community leaders, and community-based government functionaries. "Leaders" included office bearers like the elected village council (*panchayati raj*) and also informal leaders. Government functionaries are accredited social health activists [ASHA], anganwaddi (pre-school) workers [AWW] and auxiliary nurse midwives [ANM]. Burans team set an "outcome challenge" for each stakeholder group which describes ideal behaviour, relationships and attitudes. For example, the outcome challenge for government community workers is:

ASHA, AWW and ANM have knowledge and skills to identify PPSD and refer appropriately. They facilitate access to care and work actively to increase community knowledge and social inclusion of PPSD and carers and promote mental well-being.

Strategy maps co-ordinate project activities and are reviewed in an iterative cycle: "think, plan, act, review."

2.2 | Data collection

Quantitative and qualitative data were gathered over 24 months from June 2014 to May 2016.

2.2.1 | Qualitative

Three sources of qualitative data were used: focus group discussions (FGDs), participant observation and document review. Of a total of 11 FGDs, five were with purposefully selected community members (PPSD, carers and community leaders) in months 8 and 24. Six FGDs with Burans team members were held at approximately four monthly intervals and facilitated by a project volunteer (JM). Interview questions

focused on the three domains of knowledge, safe social spaces and partnerships for action, challenges and enabling features of the project design and implementation. A particular focus was, why and under what circumstances outcomes were achieved. FGDs were 35–100 min long, conducted in Hindi, audio-recorded, translated and transcribed in English. Participant observation was carried out by the first author (KM) throughout the first 24 months of the project and recorded in a research diary. Document review used minutes of monthly team meetings.

2.2.2 | Quantitative

A monitoring matrix of outputs/outcomes related to changes in behaviour, attitudes or relationships of the four stakeholder groups was captured monthly by team from months 8 to 24. Outcomes were verified by the project director, field co-ordinator and a monitoring officer visiting project sites and stakeholders.

2.3 | Data analysis

First, qualitative data were analysed thematically using an approach inspired by Braun and Clarke (2006): transcripts were read repeatedly and coded with Open Code (Umea University, 2014) yielding around 60 codes. Codes were analysed thematically using the framework of knowledge, safe social spaces and partnerships for action (Campbell & Burgess, 2012). We tried to identify key outcomes and their associated enabling factors and barriers considering contexts and mechanisms. Table 2 provides an example of coding, intermediate themes and final themes.

The second phase of qualitative data analysis searched the themes identified during the first stage of analysis for patterns in the mechanisms or context of observed outcomes. Combining information from FGDs, participant observation and document review, we developed a "thick" description of the case, its CMO (Context, Mechanisms and Outcomes) and patterns to explain those outcomes (De Souza, 2013). Context is understood as anything that triggers or modifies a "mechanism" which is defined as elements of the reasoning used by actors connected to the intervention, i.e. project intervention strategies are not themselves mechanisms (Lodenstein, Dieleman, Gerretsen, & Broerse, 2013). Data analysis consisted of two phases. We checked plausibility by considering alternative explanations for the CMO patterns we observed (Marchal, Dedzo, & Kegels, 2010a).

TABLE 2 Example of coding, intermediate and final themes

Original text (from Burans community mental health promoter)	Codes	Themes emerging: domains of CMHC	Domain of CMHC—final theme
The other way we share knowledge is when we go to the community to do a follow-up visit with a client. As we talk to the PPSD and carer, a whole group from their household and neighbours will gather around. They ask questions and we explain lots of things to them. Even the children join in and ask questions and we don't chase them away.	Knowledge—Share information ad hoc meeting	Knowledge—opportunistic approach	Knowledge—opportunistic meetings are perceived as effective
	Safe social spaces—Interactive dialogue in community	Knowledge—interactive and inclusive	
	Knowledge—Children included		

Triangulation was carried out by comparing findings and seeking confirmation from diverse qualitative sources. For example, a FGD participant described using the state mental health services while continuing to cook mustard leaves traditionally used for people with mental distress, so we discussed with community and Burans team members whether this “both-and” response to mental distress was used widely and how it was practised. Member checking was done by discussing findings with the community teams. KM and JM contributed perspectives as participant researchers (KM, a western origin woman who was born and raised in India, speaks Hindi and directs Burans project. JM volunteers 1 day monthly as an advisor for Burans).

2.4 | Ethical considerations

Ethics approval was granted by Emmanuel Hospital Association's Institutional Ethics Committee in May 2014.

3 | RESULTS

We present the outcomes domains of community knowledge, safe social spaces and partnerships for action and the proposed mechanisms contributing to them, derived primarily from analysis of the qualitative data. The supporting verbatim quotes are from the “thick description” of the case study. Names in verbatim quotes are changed. A summary of the CMO and planned interventions grouped by domain of CMHC is provided in Table 3.

Cumulative tallies for output and outcome indicators measured by Burans community team members are shown in Table 4.

Information in this table indicates some of the changes in the attitudes, behaviour and relationships of two major Burans stakeholder groups. It shows a marked improvement for most indicators.

3.1 | Knowledge outcomes

3.1.1 | Emergence of new knowledge about mental health and illness

Many community members understood mental health problems as magico-religious in origin, describing practices such as holding smelly socks in the face of a person during an epileptic seizure. Basic knowledge about mental health illnesses substantially increased among stakeholders. Participants affirmed that new knowledge gained contributed to changes in attitudes as summarised below:

Previously we just saw these people who wander about the streets in torn clothes and rags () as influenced by ghosts or spirits, or we thought that they've just gone crazy and that there's nothing we can do to help them. We didn't understand much about mental health before but now you have given us a new understanding.

(Village council (FGD) member, 45-year-old man)

Community members described sharing new knowledge informally with their social networks leading to increased help-seeking, and to more empowering modes of care-giving.

3.1.2 | Increased help-seeking with traditional and biomedical providers

Community members described continuing to use traditional forms of treatment as well as now using biomedical mental health services:

Well of course anyone who is mentally unwell is given mustard leaves, cooked or raw but then we also take them to Selaqui mental hospital.

(Community member, 48-year-old man)

Over 700 ASHA workers in the district participated in mental health awareness workshops. Participants and team members perceived a subsequent increased likelihood of referral of PPSD to care:

After our ASHA training the five ASHA supervisors said that they are now referring all community members with severe mental disorders directly to Selaqui. So because of these relationships there are so many more people going to the outpatient care.

(Burans team member, 43-year-old man)

3.2 | Knowledge mechanisms

3.2.1 | Adding to existing explanatory frameworks

Community members and the project team considered an approach of “dua aur dawa” (prayers and medicines) as both effective and acceptable. A team member described how one traditional healer had moved from a position of wariness to referring clients for counselling and follow-up, while another traditional healer himself sought counselling from a Burans team member.

3.2.2 | Knowledge sharing using opportunistic conversations with known others

“Corner conversations” with small groups of community members who know each other well emerged as the optimal way to share knowledge in the community. Community team members found that larger scale awareness meetings provided fewer opportunities for dialogue and required more resources. A team member describes the organic nature of corner meetings:

Community corner meetings seem to be the best way to build knowledge. We just go somewhere and when we find four or more people sitting around outside then we call them together. It's not pre-arranged and we just say we will be meeting to discuss mental health

TABLE 3 Summary of context, interventions, mechanisms and outcomes grouped by domain of community mental health competence

Context	Project planned intervention	Mechanism	Outcome	CMHC domain
Explanatory frameworks for mental health and illness are pluralistic and often dominated by magico-religious understandings Community members have limited knowledge about mental disorders to aid their recognition, management or prevention Minimal use of biomedical mental health services and sparse services and resources for mental health Rural and older urban communities have stable membership	Strategy to use clips of popular television series which promotes “dawa aur dua” Conduct corner conversations in community Training in participatory facilitation for community workers Training in mental health provided to Burans and ASHA, ANM and AWW workers Development of 5 brochures and 4 posters	Knowledge sharing using a process of addition to build on existing explanatory frameworks Knowledge sharing using opportunistic conversations with known others Knowledge sharing using dialogue and peer-to-peer approaches Knowledge sharing facilitated by repeated and small packets of information	New knowledge about mental health and illness Outcome 1 (OC-1) Community members share new knowledge informally in their social networks (OC-2) Increased help-seeking with traditional and biomedical providers (OC-3) Knowledge on mental health increasingly nuanced (OC-4)	Knowledge
Prevailing attitudes towards PPSD are harsh and socially excluding. There are pockets of inclusion such as within religious institutional structures	Support facilitation of PPSD and carer community support groups Use of a pictorial flipcharts that narrate a story related to mental health to facilitate conversation at community level Role plays to build capacity of Burans team and PPSD family members to model respectful communication	Increased emotional sharing and social support by group members of support groups Facilitation of “conscientisation” (critical reflexive discussion) among community members about the nature of mental health Community members engage and practice respectful communication with PPSD New knowledge of mental health (OC-1)	Increased social inclusion for PPSD and their families (OC-5)	Safe social spaces
Prevailing gender order of hegemonic masculinity which limits women’s movement and social network building in public spaces Community naïve to rights-based frameworks	Burans supports facilitation of caregiver groups Training to community members and support group members in Right to Information act and UNCRPD	Facilitation of opportunity to join new social networks through membership of PPSD and carer support groups Engagement with rights-based approaches by some members of community, PPSD and carer groups	Women carers and PPSD provide mutual support to access care (OC-6) Community uses a rights-based approach to advocate for access to care (OC-7)	Partnerships for action

and it lasts 15–30 min. There are lots of questions and conversations. We lead around two or three of these each day.

(Community mental health promoter, 43-year-old woman)

Team members underlined the effectiveness of approaches presenting a small amount of information, on several occasions and with the use of different formats and different contexts:

We break every key concept down into small steps and then share it in the community in different ways. We follow it up with doing a role play with a community member, to provide an example of reflective listening.

(Mental health nurse volunteer—Burans team, 66-year-old woman)

3.2.3 | Knowledge sharing using dialogue and horizontal (peer-to-peer) mechanisms

Community members preferred learning was through conversation rather than written or didactic instruction. Younger team members were more open to non-hierarchical dialogue, and less likely to position themselves as experts.

The best is this type of gathering () Now we are all here and we have taken out time from our other work—at least something must go into our heads... something good we have learnt. This method is very fruitful as we can sit together and gain some knowledge. Here we can share together things like I might say: “Didi (older sister) this happened to me so what do you all think that I should do?”

(PPSD support group member, 36-year-old woman)

TABLE 4 Summary of several key outcome indicators measured with cumulative monthly tallies by community teams for two key stakeholders

Progress markers	Indicator	Months 0–9	Months 0–22
<i>Community leaders</i>			
Community leaders can describe in simple terms common and severe mental disorders	Number of leaders who can describe simply CMD and SMD	27	544
Community leaders taking actions to support increased participation (presence and actions) of PWMD in Community activities, e.g. community or social functions	Count number of actions taken by community leaders (mean per month)	0	4
Community people give space for participation by PWMD in collective functions, e.g. to speak publicly	Number of PWMD who have spoken at af public functions	7	49
Community leaders advocate to government for mental health services.	Number of advocacy actions	0	5
<i>Government community workers</i>			
AWW/ASHA can identify PWMD	Number of AWW/ASHA who can identify people with CMD/SMD	113	584
AWW/ASHAs refer PPSD to mental health services	Number of PPSD referred by ASHA/AWW (mean total per month)	10	14
AWW/ASHA takes action/speaks at community level to advocate for mental health	Number of occasions where AWW/ASHA speaks publicly on mental health (mean per month)	5	29
AWW/ASHA give a training to community on depression and anxiety	Number of trainings given by AWW/ASHA on MH (mean per month)	3	13

The converse of this was also observed; a central challenge to the Project was the culturally dominant approach of advice giving which often led to reduced participation and increased passivity. PPSD and younger community members expressed that they felt treated like children when given advice. A young Burans team member describes Raju, a peer, working as a mental promoter:

So I was watching Raju and he kept interrupting X (PPSD). He was trying to give advice and kept trying to put his words in the mouth of X. Additionally, he was asking all these closed questions so that he (PPSD) couldn't express his opinion.

(Burans team member, 22-year-old woman)

members including PPSD. Community and team members reported increased intentional inclusion of PPSD and family in public gatherings, e.g. weddings and religious celebrations, and quantitative indicators from project staff substantiated this.

There are several people who have a severe mental health problem who told me that they used to be chased away from community gatherings. Now several I have talked to have told me that they are now being invited to weddings and being involved in the community. One was telling how he was especially invited to the Eid feast (a shared festive meal at the end of the Muslim season of Ramadan) and many people were sharing food and gifts with him. Such was not the case before.

(Burans team member, 40-year-old man)

3.3 | Safe social spaces—Outcomes

3.3.1 | Increased social inclusion for PPSD and their families

Community members described that with increased knowledge, people held fewer discriminatory attitudes. One group of women discussed that several decades ago marriage to someone in a family affected by leprosy or “pagalpan” (madness) was socially prohibited but that nowadays they know that mental health problems is not contagious and so marriage to someone with epilepsy or mental health problems occurs much more commonly. Team members and community leaders described more respectful interactions between family

3.3.2 | Critical reflexive discussion about the nature of mental health emerges in the community

During FGDs, some community members moved beyond an understanding of mental health as the absence of mental health problems to engage in debates about who has the right to classify someone as mentally ill, and whether mental health status is best understood as a continuum or as a binary category as summarised below:

How can we say whose mind is mentally healthy and whose is not? Everybody's mind is different with different

thoughts and sometimes they're feeling and doing okay and sometimes they're not.

(Community member, 35-year-old man)

3.4 | Safe social spaces—Mechanisms

3.4.1 | Social and emotional support within PPSD and carer support groups

Female community members said membership of support groups increased opportunities for social engagement and emotional support. They emphasised that they needed to first trust whoever they shared troubles with. Women experienced increased trust and social interaction after participating in community groups:

Earlier we were not speaking with others in our neighbourhood but after Burans (facilitated meetings) we are speaking respectfully, understanding others feelings and not getting angry with others. () We used to be inside the home and not allowed to go outside, but now our parents trust us and we can go out and about.

(Support group member, 16-year-old girl)

Women in Burans support groups also explained how membership created opportunities for practical support, e.g. taking other women's children to school or helping each other with housework. Here is a woman's response to a fellow group member with post-partum illness:

Mamta has not been in her right mind and gets violent spells and beats her baby daughter. She herself doesn't know what is happening to her. So I have been caring for her young kids. She has a 5-month old daughter and in the early months I even gave her my own milk as my daughter was very young at the time. Her daughter stays with me most of the day.

(Support group member, 28-year-old woman)

3.4.2 | Modelling respectful communication and participatory inclusion

Team members described that through increased awareness and observing respectful interactions with PPSD community members were more inclusive:

The most important steps for reducing stigma in the community have been by increasing awareness and sensitisation, and I think because of our ways of talking nicely to PPSD and listening to what they say, and then others see that and follow.

(Burans team member, 23-year-old woman)

Community participants also described social inclusion of PPSD at Hindu, Muslim and Sikh places of worship, and felt this should guide their

own attitudes. Sikh participants emphasised that social inclusion is a key construct of their faith tradition:

Of course, they (PPSD) can come to the gurudwara. There is no discrimination in the gurudwara even if there is someone unwell then people will still eat together with them at the langar (community feast). This is the rule in the gurudwara.

(Community member, 19-year-old girl)

Team members thought Buran's participatory project implementation helped them in turn support participation and inclusion among community members:

I like it that we try to be really inclusive of everyone's ideas and we don't just listen to ideas and wash them away somehow. It's like if someone says that something is not going very well we try to think of a way we can do it better in the future.

(Burans team member, 22-year-old woman)

Examples of inclusion notwithstanding, community members often said they did not know how to interact with PPSD. Some felt that lack of skills and knowledge limited social inclusion:

Her medications are finished and I think she is OK now. But she doesn't talk to people much. She just sits there. And we try talking to her, but she only answers occasionally. She just sits outside and relaxes while we feel stressed about her and don't know what to say. It is hard to speak about matters of the heart with her.

(Community member, 44-year-old woman)

3.5 | Partnerships for action outcomes

3.5.1 | Community and team members take collective action for mental health

Community participants described that they could help each other to access mental health services after having the support of project staff in the first one or two visit to the State mental institute. A PPSD participant described picking up a neighbour and catching the bus together to the government mental hospital and that after that the neighbour could travel alone. Other PPSD described experiences of discrimination, which stimulated discussion about the need for attitude change. Group members felt that this was something they could collectively support by sharing their knowledge as suggested in the quote below.

We ourselves can take action by gathering people together and explaining about it (mental health). We can explain that we should not speak badly about others and

we have to change our thinking. If people change their attitudes, then slowly the world will become a more accepting place.

(Community member, 17-year-old girl)

Community members described using newly gained knowledge to identify PPSD among neighbours and relatives, and supporting them to access care, for example arranging to travel together to the hospital.

3.5.2 | Use of rights-based approach to advocate for access to care

Community leaders both acted and advocated for the needs of PPSD. One village leader provided his personal vehicle to take a PPSD to hospital and wrote a letter using the Right to Information (RTI) Act to investigate government service providers not supplying psychotropic medications:

Now in our community there have been PPSD who cannot get access to medicines. So the Pradhan (elected village head) wrote an RTI to find out why Doon hospital is not supplying these medicines for free. () That same leader is providing his personal vehicle to take patients to hospital who are not able to behave when they go on public transport.

(Burans team member, 66-year-old man)

3.6 | Partnerships for action mechanisms

3.6.1 | Building on existing social capital to increase community mental health

Community members described how they actively shared knowledge within their existing social networks to encourage people who they thought could benefit from care, to seek help as described below:

The shopkeeper at Sahaspur has referred something like 20 people (with mental distress) to us. It's amazing that people in the community are seeking us out and they're saying "I know so many people like this." With a little bit of conversation together, they have opened their minds and they're taking action in their own communities.

(Burans team member, 24-year-old woman)

3.6.2 | Support the development of receptive social environments

Strategies such as facilitating meetings between PPSD and health administrators to discuss health service deficiencies, and running community workshops in using the RTI act contributed to a social environment that was responsive to collaborative action. Here is an example of that subtle cultural change happening:

We met with the village council members and discussed how PPSD are so often treated badly and left out of public meetings and weddings. Only a few weeks later our PPSD clients were telling us that they have been invited to weddings and functions and asked to speak. I think those guys just hadn't thought about how these people are excluded before.

(Burans team member, 42-year-old man)

The key context-mechanism-outcome findings are summarised in Table 5.

4 | DISCUSSION

Findings are discussed under the following three domains of CMHC, knowledge, safe social spaces and partnerships for action.

Strengthening community knowledge horizontally and bi-directionally between peers emerged as the approach most acceptable to community members. Opportunistic corner conversations using Freire-inspired conscientisation (Freire, 1970) enabled the integration of often unfamiliar medical knowledge with local frames of reference (Campbell & Burgess, 2012). Conversations are a form of para-social interaction that can support learning, and lead to new thought patterns and behaviour (Papa et al., 2000). The standard culturally sanctioned approach to strengthening community health knowledge is unidirectional and vertical (expert to community) and was perceived as less effective and acceptable to community members because it risks framing community members as passive recipients, limits dialogue and ignores the ways that poor communities can advance their own interests (Kirmayer & Pedersen, 2014; Summerfield, 2012).

These findings suggest interactive dialogue about mental health problems allows community members to absorb components of a biomedical model into existing explanatory models. Other studies in India (Kermode, Bowen, Arole, Joag, & Jorm, 2010; Shankar, Saravanan, & Jacob, 2006) identify pluralist explanatory models for mental distress similar to these findings. The interaction between beliefs about illness and patterns of seeking help have complex psychological, behavioural and cultural dimensions, and suggest community members need to build on existing frameworks as has been evidenced in other health literacy campaigns in India, which have operated in dialogue with local patient perspectives (Banerjee & Roy, 1998; Campbell & Cornish, 2012; Shankar et al., 2006).

Meshing new understanding into existing local knowledge is not straightforward. Local traditional healers may provide empathy in a way that outsiders may not. Use of traditional therapies that at best are harmless, combined with potentially helpful biomedical approaches is not problematic; however, local approaches such as managing seizures with smelly socks is at variance with the health of someone with epilepsy. A constructive, knowledge sharing dialogue between programme implementers and community members seems a necessary pre-condition for effectively promoting mental health. For example, in one HIV-prevention programme to increase knowledge

TABLE 5 Context–mechanism–
outcome statement summaries

CMO statement	Outcome described in Table 3
Efforts to increase community knowledge in mental health typically operate in a context of social hierarchies and didactic teaching practices. Horizontal, informal and interactive conversations between community members increased learning and allowed integration of unfamiliar biomedical knowledge with local explanatory frameworks to increase help-seeking.	OC-1, OC-2, OC-3
In these stable communities, increasing knowledge by building on existing relationships (such as government health workers) and existing explanatory frameworks increased trust, dialogue and engagement in mental health	OC-2, OC-3, OC-4
Despite prevalent social exclusion PPSD and caregivers increased their knowledge, and social support by participating in groups opening up new relationships and increased social inclusion.	OC-4, OC-5
In a context of routine disrespect and exclusion for PPSD, building skills in reflective listening and respectful communication through role plays and reflexive discussion increased the receptivity of social environments to PPSD participation	OC-5, OC-6
In a setting of stark structural and gender inequalities facilitating new social networks and knowledge supported women's capacity to take collective action to promote mental health and inclusion of PPSD.	OC-6, OC-7

PPSD = people with psycho-social disabilities; CMO = Context, Mechanisms and Outcomes.

and receptive social environments in Kolkata, such dialogue was a critical step towards transformative communication (Campbell & Cornish, 2012; Campbell & Jovchelovitch, 2007).

This case study underlines that communicating nuanced mental health messages such as “not all PPSD need medications but for some they can be life-changing” is challenging. Like others who have worked with health literacy inside and beyond India, in this case study, we found that stories and role plays to share information, and participatory dialogue, facilitate the sharing of subtle messages, and provides opportunities for social learning (Kirmayer & Pedersen, 2014; Papa et al., 2000; Shankar et al., 2006). Additionally, in this case study, we observed that non-dualistic thinking allows community members to hold a “both-and” understanding and perhaps this is specific to community knowledge of mental health. For example, people are willing to seek care with a range of providers, even those who may seem incongruent with their explanatory framework, such as seeking help with an allopathic provider for a problem they might believe to be supernatural in origin. Another study on health literacy in India describes people simultaneously consulting priests and allopathic providers for a mental health issue (Kermode, Bowen, Arole, Joag, & Jorm, 2009a).

Providing community members with opportunities for critical reflection as a springboard to more politicised collective action to resist disempowering social relations was both an outcome and a mechanism for creating safe social spaces (Campbell & Burgess, 2012). Participants in this study demonstrated critical thinking leading to changes in attitude and action, for example in their questioning of whose right it is to declare if someone is mentally healthy. Community members also emphasised that religious institutions and festivals, such as Eid, were opportunities for greater inclusion and healing for PPSD,

which others have also recognised (Padmavati, Thara, & Corin, 2005; Raguram, Venkateswaran, Ramakrishna, & Weiss, 2002).

Participants in this study said their own lack of skills and knowledge were a barrier to increasing social inclusion. Increasing community knowledge and skills through formal and informal dialogue, role plays and facilitated support groups is a critical part of reducing stigma and discrimination (Kermode, Bowen, Arole, Pathare, & Jorm, 2009b; Kermode et al., 2010; Petersen et al., 2012). According to participants, changes in attitudes were strengthened by modelling of respectful interaction with PPSD by caregivers, project team members and by members of religious institutions such as gurudwara (Papa et al., 2000).

Social change, influenced by power dynamics and resistance, is patchy and non-linear. In a North Indian setting, the entwined hegemonies of caste, gender and class mediate the extent to which people can engage with and enact new attitudes of inclusion (Freire, 1970; Papa et al., 2000). Social exclusion of PPSD in India is well-described and contributes to reduced access to care, lower income, increased poverty and reduced social capital for PPSD (Koschorke et al., 2014; Mathias, Kermode, San Sebastian, Korschorke, & Goicolea, 2015; Mathias, Kermode, Sansebastian, Davar, & Goicolea, 2017). “Islands” of acceptance and social inclusion were described by participants, for example being able to now move freely in the community, going out and meeting with peers, being invited to attend weddings, and in being allowed to visit the gurudwara and eat with others, to demonstrate that change is possible. Participants identified project-facilitated community support groups for either caregivers or PPSD as useful to increase social inclusion. Such groups enable relationship building with others in the community and increase social capital. Through reflexive research and programme actions such changes can be identified and their scope and influence expanded.

The importance of social support for mental health is an important social determinant that enhances recovery from mental health problems (Burgess & Campbell, 2014; Singh, Singh, & Arokiasamy, 2016; Stansfeld, Marmot, & Wilkinson, 2006). We found collective action usually starts by responding to immediate practical needs of people close to those affected by mental health problems.

There was evidence of first steps in developing and using social capital (e.g. the community leader who wrote an RTI inquiry to advance community interests and the young women in community support groups who described increased peer relationships and friends outside the house). Increased awareness among ASHA and AWW may also have increased social inclusion and social capital of PPSD by ensuring they were identified and invited to participate in events such as the boisterous monthly immunisation day at the community health centre (Bourdieu, 1986; Burgess & Campbell, 2014).

Enacting new social behaviours requires of community members a sense of collective efficacy. For example, a shopkeeper who identified and referred 20 people with possible mental distress to the project team, thus enacting social responsibility and altruism. People need to believe that they can solve their mutually experienced problems through unified effort to increase the probability of effectively reaching group goals (Bandura, 1996). The importance of developing social efficacy is supported by Sen, who underlines that the poor and marginalised are often denied the “capability” to make effective political demands, such as the right to access health services (Sen, 1999). Along with strategies to empower excluded groups, it is important to develop receptive social environments so that more powerful groups listen (Campbell & Burgess, 2012; Campbell, Cornish, Gibbs, & Scott, 2010). By holding corner meetings with groups of community members to increase knowledge and awareness, as well as building awareness among decision-makers such as religious leaders, it seemed possible that Burans increased receptivity and partnerships for action in the social environment. The design and implementation Burans focused on outcomes (desired changes in behaviour, attitudes and relationships among stakeholders) rather than the delivery of activities. A range of participatory and interactive processes were used to facilitate iterative changes in the intervention, based on reflection and evidence of effectiveness. The outcome mapping approach (Earl et al., 2001) also seeks to influence attitudes and relationships of both powerful and disempowered groups.

4.1 | Methodological considerations

A case study faces several methodological challenges, one of which is related to complexity and attribution. For example, interventions such as role plays of respectful communication with PPSD seek to increase social inclusion; however, there are many other simultaneous influences on community attitudes such as government schemes or television series. Attribution becomes hard to unravel; contribution might be the most a programme can claim.

The involvement of researchers in project implementation (KM and JM) ensured in-depth understanding of implementation, strategies, outcomes and context but may have influenced participants to

provide socially desirable responses and risked subjective analysis. Two co-authors resident in high-income countries (IG and MK) gave cultural distance, possibly increasing attention and curiosity but risking misunderstanding cultural nuances (Patton, 1999). Reflexivity on positionality may have mitigated these limitations.

To address methodological rigour, we incorporated four strategies to promote the trustworthiness (Lincoln & Guba, 1985): credibility, transferability, dependability and confirmability. Triangulation using diverse data sources and analysis by authors with different ethnic backgrounds increased the study's credibility, while dependability and confirmability were increased through the familiarity of KM and JM with the study area, and by the authors working together to develop the thematic overview and by using inductive analysis. We maximise transferability by providing detailed contextual information.

This case study comes from rural and semi-urban areas of Dehradun district, Uttarakhand, India but the setting of multiple cultural understandings, limited mental health services, social exclusion of PPSD, unequal gender relations operates across South Asia. We believe that many of our findings are more widely relevant to many other settings.

5 | CONCLUSIONS

This case study describes the collaborative efforts of a mental health project working to strengthen mental health competence by identifying the outcomes achieved, and the mechanisms by which they were achieved in this context. The objectives to increase safe social spaces and collaborative partnerships for mental health are ambitious, demanding paradigm shifts in social attitudes and values.

This study suggests outcomes of increased CMHC will be patchy, slow and step-wise requiring project processes that are reflexive, participatory and deeply seated in the context. Programmes working with diverse players and contexts, i.e. in complex systems must have ways to recognise positive outcomes, to understand why they emerged and mechanisms to iteratively change design and process to maximise them.

To increase community knowledge in mental health, mechanisms that other programmes could aim to trigger include facilitation of non-hierarchical community conversations that allow new knowledge to be integrated into existing explanatory frameworks. Mechanisms to aim to trigger to increase safe social spaces include building mental health knowledge, increasing opportunity for participation for excluded groups and at macro levels by facilitating formation of social networks and helping create a receptive environment among diverse “boundary partners” in the community. Training to community members in how to advocate with national legislative frameworks such as the RTI act, increased collaborative actions for mental health, but a longer period of programme implementation is needed to observe significant collaborative initiatives.

While gestures of social support, social inclusion and advocacy for mental health services were taken by community members and groups, they were only just starting to interact with the structural

drivers of mental ill-health. Building CMHC is a long journey but this study provides evidence that communities that promote mental health and socially include PPSD can collectively conspire to forge a path towards better mental health for all.

ACKNOWLEDGEMENTS

We thank the participants in the Burans project for their time and particularly Jeet Bahadur as research assistant as well as team leaders: Pooja Bhatt, Kundan Goshal, Sanjeev Isachhar, Pooja Pillai, Samson Rana, Atul Singh, Arun Sherring, and the implementing partners of HOPE, OPEN and Sneha. Appreciation to all community workers and *grameen sanchalak* in the Burans team. We thank the Community Health and Development programme of the Emmanuel Hospital Association and the Uttarakhand CHGN cluster for support to this project. A small private donation assisted in conduct of this research.

AUTHORSHIP

KM, MK and IG conceived of the study objectives and design; KM and JM collected data; KM, JM, MK and IG worked together on analysis; KM wrote the first draft; and all authors contributed to subsequent drafts.

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How to cite this article: Mathias K, Mathias J, Goicolea I, Kermode M. Strengthening community mental health competence—A realist informed case study from Dehradun, North India. *Health Soc Care Community*. 2017;00:1–12. <https://doi.org/10.1111/hsc.12498>