DR. KAAREN MATHIAS (Orcid ID : 0000-0002-9607-9459)

Article type : Original Article

Strengthening community mental health competence – a realist informed case study from Dehradun, North India

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

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/hsc.12498](https://doi.org/10.1111/hsc.12498)

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 PPSD 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

India

Global mental health

Evaluation and Community-Based Research

Community Participation

Social Care

Mental Health Promotion

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.

Introduction

More than ten years after the Global Mental Health Movement was launched to profile the major disparities in mental health (Horton, 2007, Patel et al., 2011a) a call for greater focus on local priorities, strengthening community resources and developing endogenous solutions has gained traction (Kirmayer and 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 (Mathias, 2016, Campbell and Burgess, 2012). 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 socio-economic disadvantage (Burgess, 2015, Kirmayer, 2006).

Mental disorders contribute 11.8% of the Indian disease burden (Patel et al., 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 and Campbell, 2014, Burgess, 2015, Petersen et al., 2011, Petersen et al., 2012).

Research into community mental health in India has focused on increasing access to primary mental health care and developing community-based and culturally competent services (Jayaram et al., 2011, Padmavati, 2005, Jacob, 2001). 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 (LMIC) (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.

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 et al., 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).

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.

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

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

The case study – xx community mental health project

Xx is a partnership between xx 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 et al., 2001) xx 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], anganwadi (pre-school) workers [AWW], and auxiliary nurse midwives [ANM]. Xx 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'.

Data collection

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

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 Xx team members were held at approximately four monthly intervals and facilitated by a project volunteer (ZZ). Interview questions focussed 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 to 100 minutes long, conducted in Hindi, audio-recorded, translated and transcribed in English. Participant observation was carried out by the first author (YY) throughout the first 24 months of the project and recorded in a research diary. Document review used minutes of monthly team meetings.

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 coordinator and a monitoring officer visiting project sites and stakeholders.

Data analysis

Firstly, qualitative data were analysed thematically using an approach inspired by Braun and Clarke (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 and 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.

Table 2. Example of coding, intermediate 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 et al., 2013). Data analysis consisted of two phases. We checked plausibility by considering alternative explanations for the CMO patterns we observed (Marchal et al., 2010a).

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 Xx team members whether this ‘both-and’ response to mental distress was used widely and how it was practiced. Member checking was done by discussing findings with the community teams. YY and ZZ contributed perspectives as participant researchers (YY, a western origin woman who was born and raised in India, speaks Hindi and directs Xx. ZZ volunteers one day monthly as an advisor for Xx).

Ethical considerations

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

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 below.

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

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

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

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

Knowledge outcomes

Emergence of new knowledge about mental health and illness

Many community members understood mental illness 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 amongst stakeholders. Participants affirmed that new knowledge gained contributed to changes in attitudes as summarized 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

218

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

221

222 **Increased help-seeking with traditional and biomedical providers**

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

225

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

228 **Community member, 48-year-old man**

229

230 Over 700 ASHA workers in the district participated in mental health awareness workshops.

231 Participants and team members perceived a subsequent increased likelihood of referral of PPSD to
232 care:

233

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

237 **Xx team member, 43-year-old man**

238 Knowledge mechanisms

239 **Adding to existing explanatory frameworks**

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

244

245 **Knowledge sharing using opportunistic conversations with known others**

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

250

251 *'Community corner meetings seem to be the best way to build knowledge. We just go*
252 *somewhere and when we find four or more people sitting around outside then we call*
253 *them together. It's not pre-arranged and we just say we will be meeting to discuss*
254 *mental health and it lasts 15 – 30 minutes. There are lots of questions and*
255 *conversations. We lead around two or three of these each day.'*

256 **Community mental health promoter, 43-year-old woman**

257
258 Team members underlined the effectiveness of approaches presenting a small amount of
259 information, on several occasions and with the use of different formats and different contexts:

260
261 *'We break every key concept down into small steps and then share it in the community*
262 *in different ways. We follow it up with doing a role play with a community member, to*
263 *provide an example of reflective listening.'*

264 **Mental health nurse volunteer – Xx team, 66-year-old woman**

265 266 **Knowledge sharing using dialogue and horizontal (peer-to-peer) mechanisms**

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

270
271 *"The best is this type of gathering () Now we are all here and we have taken out time*
272 *from our other work - at least something must go into our heads...something good we*
273 *have learnt. This method is very fruitful as we can sit together and gain some*
274 *knowledge. Here we can share together things like I might say: "Didi (older sister) this*
275 *happened to me so what do you all think that I should do?"*

276 **PPSD support group member, 36-year-old woman**

277
278 The converse of this was also observed; a central challenge to the Project was the culturally
279 dominant approach of advice giving which often led to reduced participation and increased passivity.
280 PSD and younger community members expressed that they felt treated like children when given
281 advice. A young Xx team member describes Raju, a peer, working as a mental promoter:

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

286 **Xx team member, 22-year-old woman**

287
288 Safe social spaces – outcomes

289
290 **Increased social inclusion for PPSD and their families**

291 **Community members described that with increased knowledge, people held fewer discriminatory**
292 **attitudes. One group of women discussed that several decades ago marriage to someone in a**
293 **family affected by leprosy or 'pagalpan' (madness) was socially prohibited but that nowadays they**
294 **know that mental illness is not contagious and so marriage to someone with epilepsy or mental**
295 **illness occurs much more commonly.** Team members and community leaders described more
296 respectful interactions between family members including PPSD. Community and team members
297 reported increased intentional inclusion of PPSD and family in public gatherings e.g. weddings and
298 religious celebrations, and quantitative indicators from project staff substantiated this.

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

305 **Xx team member, 40-year-old man**

306 **Critical reflexive discussion about the nature of mental health emerges in the community**

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

311
312 *'How can we say whose mind is mentally healthy and whose is not? Everybody's mind is*
313 *different with different thoughts and sometimes they're feeling and doing okay and*
314 *sometimes they're not.'*

315 **Community member, 35-year-old man**

Safe social spaces - mechanisms

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 emphasized 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 neighborhood but after Xx (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 Xx 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's 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 five-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

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 sensitization, 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.'

Xx team member, 23-year-old woman

Community participants also described social inclusion of PPSP at Hindu, Muslim and Sikh places of worship, and felt this should guide their own attitudes. Sikh participants emphasized that social inclusion is a key construct of their faith tradition:

Of course, they (PPSP) 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.'

Xx team member, 22-year-old woman

Examples of inclusion notwithstanding, community members often said they didn't know how to interact with PPSP. 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

Partnerships for action outcomes

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 PPSP 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 PPSP 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.

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.'

Xx team member, 66-year-old man

Partnerships for action mechanisms

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.’

Xx team member, 24-year-old woman

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’s 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.”

Xx team member, 42-year-old man

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

Table 5. Context - mechanism – outcome statement summaries

Discussion

Findings are discussed under the following three domains of community mental health competence, 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-an conscientisation (Freire, 1970) enabled the integration of often unfamiliar medical knowledge with local frames of reference (Campbell and 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 uni-directional 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 (Summerfield, 2012, Kirmayer and Pedersen, 2014).

These findings suggest interactive dialogue about mental illness allows community members to absorb components of a biomedical model into existing explanatory models. Other studies in India (Shankar et al., 2006, Kermode et al., 2010) 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** (Shankar et al., 2006, Banerjee and Roy, 1998, Campbell and Cornish, 2012).

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 and receptive social environments in Kolkata, such dialogue was a critical step towards transformative communication** (Campbell and Cornish, 2012, Campbell and 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 and 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 et al., 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 and 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 et al., 2005, Raguram et al., 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 et al., 2010, Kermode et al., 2009b, 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 (Papa et al., 2000, Freire, 1970). 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 (Mathias et al., 2015, Koschorke et al., 2014, Mathias et al., 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 illness (Burgess and Campbell, 2014, Singh et al., 2016, Stansfeld et al., 2006). We found **collective** action usually starts by responding to immediate practical needs of people close to those affected by mental illness.

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 immunization day at the community health centre** (Bourdieu, 1986, Burgess and 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 et al., 2010, Campbell and Burgess, 2012). **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 XX Project increased receptivity and partnerships for action in the social environment.** The design and implementation XX 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.

Methodological considerations

A case study faces several methodological challenges, one of which is related to complexity and attribution. For example, interventions such as roleplays 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 (YY and ZZ) 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 (VV and WW) 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 and 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 YY and ZZ 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.

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 Right to Information 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.

References

- BANDURA, A. 1996. *Self efficacy in changing societies*, Cambridge, Cambridge University Press.
- BANERJEE, G. & ROY, S. 1998. Determinants of help-seeking behaviour of families of schizophrenic patients attending a teaching hospital in India: an indigenous explanatory model. *International Journal of Social Psychiatry*, 44, 199-214.
- BOURDIEU, P. 1986. Handbook of Theory and Research for the Sociology of Education In: RICHARDSON, J. (ed.) *Cultural theory: An anthology*. New York: Greenwood.
- BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, 3, 77-101.
- BURGESS, R. & CAMPBELL, C. 2014. Contextualising women's mental distress and coping strategies in the time of AIDS: A rural South African case study. *Transcultural psychiatry*, 51, 875-903.
- BURGESS, R. A. 2015. Supporting mental health in South African HIV-affected communities: primary health care professionals' understandings and responses. *Health Policy and Planning*, 30, 917-927.
- CAMPBELL, C. & BURGESS, R. 2012. The role of communities in advancing the goals of the Movement for Global Mental Health. *Transcultural Psychiatry*, 49, 379-95.
- CAMPBELL, C. & CORNISH, F. 2012. How Can Community Health Programmes Build Enabling Environments for Transformative Communication? Experiences from India and South Africa. *AIDS and Behavior*, 16, 847-857.
- CAMPBELL, C., CORNISH, F., GIBBS, A. & SCOTT, K. 2010. Heeding the push from below: How do social movements persuade the rich to listen to the poor? *Journal of health psychology*.
- CAMPBELL, C. & JOVCHELOVITCH, S. 2007. Health, Community and Development : toward a social psychology of participation. *Journal of Community and Applied Social Psychology*, 10, 255-70.
- DE SILVA, M. J. 2015. Impact evaluations of mental health programmes: the missing piece in global mental health. *Journal of Epidemiology and Community Health*, 69, 405-407.

618 DE SOUZA, D. E. 2013. Elaborating the Context-Mechanism-Outcome configuration (CMOc) in realist
619 evaluation: A critical realist perspective. *Evaluation*, 19, 141-154.

620 DREW, N., FUNK, M., TANG, S., LAMICHHANE, J., CHAVEZ, E., KATONTOKA, S., PATHARE, S., LEWIS,
621 O., GOSTIN, L. & SARACENO, B. 2011. Human rights violations of people with mental and
622 psychosocial disabilities: an unresolved global crisis. *Lancet*, 378, 1664-75.

623 EARL, S., CARDEN, F. & SMUTYLO, T. 2001. Outcome mapping. *Building learning and reflection into
624 development programs*. Ottawa: International Development Research Center.

625 FREIRE, P. 1970. *Pedagogy of the oppressed*, New York, Continuum.

626 GOVERNMENT OF INDIA. 2011. *Census 2011* [Online]. Available:
627 <http://www.census2011.co.in/census> [Accessed 29 September 2014].

628 HORTON, R. 2007. Launching a new movement for mental health. *Lancet*, 370, 806-806.

629 JACOB, K. 2001. Community care for people with mental disorders in developing countries Problems
630 and possible solutions. *The British Journal of Psychiatry*, 178, 296-298.

631 JAYARAM, G., GOUD, R. & SRINIVASAN, K. 2011. Overcoming cultural barriers to deliver
632 comprehensive rural community mental health care in Southern India. *Asian J Psychiatry*, 4,
633 261-5.

634 KERMODE, M., BOWEN, K., AROLE, S., JOAG, K. & JORM, A. 2009a. Community beliefs about
635 treatments and outcomes of mental disorders: a mental health literacy survey in a rural area
636 of Maharashtra, India. *Public Health*, 123, 476 - 483.

637 KERMODE, M., BOWEN, K., AROLE, S., JOAG, K. & JORM, F. 2010. Community beliefs about causes
638 and risks for mental disorders: a mental health literacy survey in a rural area of Maharashtra,
639 India. *Int J Soc Psychiatry*, 56, 606 - 622.

640 KERMODE, M., BOWEN, K., AROLE, S., PATHARE, S. & JORM, A. 2009b. Attitudes to people with
641 mental disorders: a mental health literacy survey in a rural area of Maharashtra, India. *Soc
642 Psychiatry Psychiatr Epidemiol*, 44, 1087 - 1096.

643 KIRMAYER, L. J. 2006. Beyond the 'new cross-cultural psychiatry': cultural biology, discursive
644 psychology and the ironies of globalization. *Transcultural Psychiatry*, 43, 126-144.

645 KIRMAYER, L. J. & PEDERSEN, D. 2014. Toward a new architecture for global mental health.
646 *Transcultural psychiatry*, 51, 759-776.

647 KOSCHORKE, M., PADMAVATI, R., KUMAR, S., COHEN, A., WEISS, H. A., CHATTERJEE, S., PEREIRA, J.,
648 NAIK, S., JOHN, S. & DABHOLKAR, H. 2014. Experiences of stigma and discrimination of
649 people with schizophrenia in India. *Social Science & Medicine*, 123, 149-159.

650 LINCOLN, Y. & GUBA, E. 1985. *Naturalistic enquiry*, Beverley Hills, Sage.

651 LODENSTEIN, E., DIELEMAN, M., GERRETSEN, B. & BROERSE, J. E. 2013. A realist synthesis of the
 652 effect of social accountability interventions on health service providers' and policymakers'
 653 responsiveness. *Systematic reviews*, 2, 1.

654 MARCHAL, B., DEDZO, M. & KEGELS, G. 2010a. A realist evaluation of the management of a well-
 655 performing regional hospital in Ghana. *BMC Health Services Research*, 10, 24-24.

656 MARCHAL, B., DEDZO, M. & KEGELS, G. 2010b. Turning around an ailing district hospital: a realist
 657 evaluation of strategic changes at Ho Municipal Hospital (Ghana). *BMC Public Health*, 10,
 658 787-787.

659 MATHIAS, K. 2016. *Shadows and light - examining community mental health competence in North*
 660 *India*. PhD, Umea.

661 MATHIAS, K., KERMODE, K., SAN SEBASTIAN, M., KORSCHORKE, M. & GOICOLEA, I. 2015. Under the
 662 banyan tree - exclusion and inclusion of people with mental distress in rural North India.
 663 *BMC Public Health* 15.

664 MATHIAS, K., KERMODE, M., SANSEBASTIAN, M., DAVAR, B. & GOICOLEA, I. 2017. An asymmetric
 665 burden - gendered experiences of caregivers of people with psycho-social disabilities in
 666 North India (forthcoming). *Transcultural Psychiatry (in press)*.

667 MINISTRY OF HEALTH AND FAMILY WELFARE 2015. National family health survey 4 : State fact sheet
 668 - Uttarakhand. New Delhi: Ministry of Health and Family welfare.

669 OFFICE OF THE REGISTRAR GENERAL & CENSUS COMMISSIONER 2013. Annual health survey - 2012-3
 670 Fact sheet. New Delhi: Ministry of Home Affairs, India.

671 PADMAVATI, R. 2005. Community mental health care in India. *Int Rev Psychiatry*, 17, 103-7.

672 PADMAVATI, R., THARA, R. & CORIN, E. 2005. A qualitative study of religious practices by chronic
 673 mentally ill and their caregivers in South India. *Int J Soc Psychiatry*, 51, 139-49.

674 PAPA, M. J., SINGHAL, A., LAW, S., PANT, S., SOOD, S., ROGERS, E. M. & SHEFNER - ROGERS, C. L.
 675 2000. Entertainment - education and social change: an analysis of parasocial interaction,
 676 social learning, collective efficacy, and paradoxical communication. *Journal of*
 677 *communication*, 50, 31-55.

678 PATEL, V., BOYCE, N., COLLINS, P. Y., SAXENA, S. & HORTON, R. 2011a. A renewed agenda for global
 679 mental health. *The Lancet*, 378, 1441-1442.

680 PATEL, V., CHATTERJI, S. & CHISHOLM, D. 2011b. Chronic diseases and injuries in India. *Lancet*, 377,
 681 :413-28.

682 PATTON, M. Q. 1999. Enhancing the quality and credibility of qualitative analysis. *Health services*
 683 *research*, 34, 1189.

- PETERSEN, I., BAILLEY, K., BHANA, A. & ET AL 2012. Understanding the benefits and challenges of community engagement in the development of mental health services for common mental disorders : lessons from a case study in a rural South African subdistrict site. *Transcultural Psychiatry*, 49, 418-437.
- PETERSEN, I., SSEBUNNYA, J., BHANA, A. & BAILLIE, K. 2011. Lessons from case studies of integrating mental health into primary health care in South Africa and Uganda. *Int J Ment Health Syst*, 5, 8.
- RAGURAM, R., VENKATESWARAN, A., RAMAKRISHNA, J. & WEISS, M. G. 2002. Traditional community resources for mental health: a report of temple healing from India. *BMJ*, 325, 38-40.
- SEN, A. 1999. *Development as freedom*, New York, Knopf.
- SHANKAR, B. R., SARAVANAN, B. & JACOB, K. 2006. Explanatory models of common mental disorders among traditional healers and their patients in rural south India. *International Journal of Social Psychiatry*, 52, 221-233.
- SINGH, L., SINGH, P. K. & AROKIASAMY, P. 2016. Social network and mental mealth among older adults in rural Uttar Pradesh, India: a cross-sectional study. *J Cross Cult Gerontol*.
- STANSFELD, S. A., MARMOT, M. & WILKINSON, R. 2006. Social support and social cohesion. *Social determinants of health*, 2, 148-71.
- SUMMERFIELD, D. 2012. Afterword: Against global mental health. *Transcultural Psychiatry*, 49, 519.
- UMEA UNIVERSITY 2014. Open Code 4.01. *In: ICT SERVICES AND SYSTEM DEVELOPMENT AND DIVISION OF EPIDEMIOLOGY AND GLOBAL HEALTH* (ed.). Umea: Department of Public Health and Clinical Medicine.
- WORLD HEALTH ORGANISATION 2011. Mental health atlas 2011. Geneva: WHO.
- YIN, R. 2009. *Case study research - design and methods 4th edition*, Sage Publications Inc.

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 1000 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

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

Table 2. Example of coding, intermediate and final themes

Original text (from Xx 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 Safe social spaces - Interactive dialogue in community	Knowledge - opportunistic approach Knowledge – interactive and inclusive	Knowledge – opportunistic meetings are perceived as effective

Knowledge –
Children
included

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
<p>Explanatory frameworks for mental health and illness are pluralistic and often dominated by magico-religious understandings</p> <p>Community members have limited knowledge about mental disorders to aid their recognition, management or prevention</p> <p>Minimal use of bio-medical mental health services and sparse services and resources for mental health</p> <p>Rural and older urban communities have stable membership</p>	Strategy to use clips of popular television series which promotes ' <i>dawa aur dua</i> '	Knowledge sharing using a process of addition to build on existing explanatory frameworks	New knowledge about mental health and illness Outcome 1 (OC-1)	Knowledge
	Conduct corner conversations in community	Knowledge sharing using opportunistic conversations with known others	Community members share new knowledge informally in their social networks (OC-2)	
	Training in participatory facilitation for community workers	Knowledge sharing using dialogue and peer-to-peer approaches		
	Training in mental health provided to Xx and ASHA, ANM and AWW workers	Knowledge sharing facilitated by repeated and small packets of information	Increased help-seeking with traditional and biomedical providers (OC-3)	
	Development of 5 brochures and 4 posters		Knowledge on mental health increasingly nuanced (OC-4)	

<p>Prevailing attitudes towards PPSD are harsh and socially excluding.</p> <p>There are pockets of inclusion such as within religious institutional structures</p>	<p>Support facilitation of PPSD and carer community support groups</p>	<p>Increased emotional sharing and social support by group members of support groups</p>	<p>Increased social inclusion for PPSD and their families (OC-5)</p>	<p>Safe social spaces</p>
	<p>Use of a pictorial flipcharts that narrate a story related to mental health to facilitate conversation at community level</p>	<p>Facilitation of 'conscientisation' (critical reflexive discussion) among community members about the nature of mental health</p>		
	<p>Role plays to build capacity of Xx team and PPSD family members to model respectful communication</p>	<p>Community members engage and practice respectful communication with PPSD</p>		
		<p>New knowledge of mental health (OC-1)</p>		
<p>Prevailing gender order of hegemonic masculinity which limits women's movement and social network building in public spaces</p> <p>Community naïve to rights-based frameworks</p>	<p>Xx supports facilitation of caregiver groups</p>	<p>Facilitation of opportunity to join new social networks through membership of PPSD and carer support groups</p>	<p>Women carers and PPSD provide mutual support to access care (OC-6)</p> <p>Community uses a rights based approach to advocate for access to care (OC-7)</p>	<p>Partnerships for action</p>
	<p>Training to community members and support group members in Right to Information act and UNCRPD</p>	<p>Engagement with rights based approaches by some members of community, PPSD and carer groups</p>		

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

Progress markers	Indicator	Months	Months
		0 - 9	0 – 22
Community leaders			

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
Government community workers			
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

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

Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:

Mathias, K;Mathias, J;Goicolea, I;Kermode, M

Title:

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

Date:

2018-01-01

Citation:

Mathias, K., Mathias, J., Goicolea, I. & Kermode, M. (2018). Strengthening community mental health competence-A realist informed case study from Dehradun, North India. HEALTH & SOCIAL CARE IN THE COMMUNITY, 26 (1), pp.E179-E190. <https://doi.org/10.1111/hsc.12498>.

Persistent Link:

<http://hdl.handle.net/11343/293441>