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What innovative practices and processes are used to deliver psychosocial care in India? A qualitative case study of three non-profit community mental health organisations

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ABSTRACT

The global mental health field seeks to close the “treatment gap” for mental illness in low-and middle-income countries by scaling evidence-based interventions. The evidence base has often bypassed psychosocial interventions by local organizations who do not fit a biomedical approach to evidence building. In India, non-profit mental health organizations are addressing care gaps through novel approaches that emphasize social recovery and inclusion.

This study seeks to better understand the nature and dynamic of this innovation by examining what was working well in the practices and processes of three such community mental health care organizations. A comparative case approach was chosen for its strength as an exploratory means for inductive theory building. Three case organizations in Kerala, West Bengal and Uttarakhand states were selected based on their diverse socio-cultural and health systems settings. Qualitative data was collected in 2018–20, to examine their practices and processes using mixed methods and data sources including interviews, focus groups, participant observation and document analysis.

Common strategies observed across the three organizations, included engaging community, prioritising beneficiaries, co-opting resources, devolving care, reorganising communication and recovery and integration. These strategies were further categorized into three domains: constructing a sustainable resource base, managing knowledge and redefining meanings. In contrast with conventional problem-solving approaches, these cases used an approach that built on assets and strengths using inclusive governance which enabled coordination of the community health system.

This study argues that these organizations incorporate reflexive practice and two-way flows of knowledge to enable them to address complex social determinants of mental health. This has implications for how psychosocial care in CMH is conceptualized. We argue that the ways the organizations respond to the complexities of mental health difficulties contributes to reframing mental health as a social development issue, centering inclusion of people with psychosocial disabilities. Our findings argue against a polarization between biomedical and psychosocial CMH models and illustrate ways of integrating both approaches and their centrality to effective mental health care.

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1. Introduction

Addressing mental health and associated social determinants are global priorities (Burgess et al., 2020; Patel et al., 2018). Key challenges include the high burden of disease from mental health problems (Patel et al., 2018); poor resource allocation (Chisholm et al., 2019); the social inclusion of people with psycho-social disabilities (Puras and Gooding, 2019); limited priority given to social and psychosocial interventions (Burgess et al., 2020) and the question of whose voice counts as 'evidence' (Rose and Kalathil, 2019).

The field of global mental health (GMH) seeks to close the "treatment gap" for mental illness in low-and middle-income countries (LAMICs) by looking at scaling evidence-based interventions and beyond (Saraceno, 2019). By scaling we refer to deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects to benefit more people and to foster sustainable policy and programme development (Patel et al., 2013). Scaling strategies in GMH are premised on three foundations. First, the idea of innovation – a new approach that improves access to care (Patel and Saxena, 2014) second, that the effectiveness of this social innovation can be revealed through successful piloting (Simmons et al., 2007); and finally, taking the innovation to 'scale' to reach a greater number of beneficiaries (Becker and Kleinman, 2012).

Scaling processes depend upon an 'evidence base' to identify appropriate interventions for scaling. In global health, debates around 'evidence' have focussed on hierarchies of evidence, within which randomized control trials are regarded as the defacto 'gold standard' for determining effectiveness (Orr and Jain, 2015). This has crucial implications for what types of innovations are scaled, with those approaches seen as having 'strong' evidence bases such as RCTs, more likely to receive resource to scale and thus promoted as 'innovative'. Interventions that fit into existing disciplinary frames of evaluation and measurement that require a degree of standardization are favoured (Behague et al., 2009). Within policymaking and clinical circles, the voices of people with lived experience of mental health difficulties tend to carry less weight than conventional RCTs (Rose and Kalathil, 2019).

Organic grassroots interventions, however, often lack resources for or interest in, undertaking formal evidence-building (Bayetti et al., 2016; Stewart et al., 2016). Untangling what shapes the effectiveness of organic and socially complex interventions through an RCT, however, requires an isolation of 'active' ingredients to identify factors that are crucial to success (Behague et al., 2009). This is challenging in the case of local programmes whose success might be due to interrelated factors such as organizational culture, local knowledge, the role of the founder, and tacit organizational processes. Failure in replicating these initial successes might be due to the inability of traditional RCT approaches to measure or indeed understand these often intangible and interrelated factors (Bemme, 2019). While recognition of the need to promote innovation in GMH (e.g. Mental Health Innovation Network, https://www.mhinnovation.net/) has grown, the 'micro-practices' that constitute innovative responses to local needs are often overlooked. A narrow definition of what is considered 'valid' evidence within global mental health research and practice, has contributed to a lack of understanding and recognition of these 'micro-practices'.

Our motivation behind this paper is to demonstrate how a theoretically informed investigation of innovative mental health care organizations can provide insight into the value of these novel approaches. By contributing to our understanding of the nature and dynamics behind the efficacy of their innovative practices and organizational structures, we can better inform efforts to leverage scarce resource and scale efforts to improve community mental health.

India has long-standing policies towards community mental health care and a tradition of civil society organizations developing localized approaches, with its policymakers aware of the interdependence of mental health and social development, as well as the need for greater community participation to drive these imperatives forward (Balagopal and Kapanee, 2019b; National Mental Health Policy, 2014; Ranade et al., 2022; Thara and Patel, 2010). Indian state community mental health (CMH hereafter) care however, overwhelmingly emphasizes pharmacological approaches (Jain and Jadhav, 2009; Lang, 2019; Mathias et al., 2015; Shidhaye et al., 2019) with scant attention to social inequalities and lacking effective integration with state social welfare initiatives (Bayetti, 2020; Das and Rao, 2012; Davar, 2016; Jain and Jadhav, 2009; Sarin and Jain, 2013).

Anecdotal evidence suggests that while many Indian NGOs have developed novel approaches to mental health care which prioritize recovery and social inclusion, this presents a logical challenge to existing institutional state models of care (Murthy, 2017; Thara and Patel, 2010; World Health Organization, 2009). These civil society responses in the mental health sector have foregrounded the role of psychosocial care and addressing the social and structural determinants of mental health. This is underpinned by an analysis of inequalities in access to mental health care and support and how different groups experience poor mental health based on their intersectional social positions – caste, gender, socio-economic status, and disability for example (Davar, 2008; Jain and Jadhav, 2009; Mathias et al., 2015, 2019). These approaches espoused by the NGO sector have emerged through links between on the ground practice and emerging paradigms that situate mental health in relation to human rights and social inclusion (Balagopal and Kapanee, 2019b; Puras and Gooding, 2019; Ranade et al., 2022; World Health Organisation, 2021).

This focus on the 'social' has been driven by a disability rights discourse, particularly the emergence of the UN Convention on the Rights of Persons with Disabilities (CRPD) (Puras and Gooding, 2019; Burgess et al., 2020). Also ratified by India, this convention reaffirms that all people with a disability should enjoy human rights and fundamental freedoms, giving equal recognition to physical and mental disabilities. A core principle of the CRPD is that all people have the right to full and effective participation in society. Article 19 recognizes "the right to live independently and being fully included in the community" (United nations, n.d.). An implication for mental health is that it shifts the focus from how to make treatment more accessible towards how to improve social inclusion for people with a psycho-social disability. Such a shift potentially changes the nature of what service providers offer by drawing greater attention to aspects of care that might support social inclusion, such as employment, housing, and reducing discrimination (TCI Global, 2022).

Linked to social inclusion are recovery paradigms which challenge dominant biomedical approaches. Recovery and social inclusion are distinct yet inter-related concepts within community mental health care. As Jacob et al. (2015) note, in community settings, leading a meaningful life is dependent upon being a full participant in normal social, vocational, and cultural activities. Current state-led approaches in India, are structured upon the biomedical approach, and narrowly define the causes and appropriate treatment of mental health problems (Bayetti et al., 2016) Thus most resources are directed towards symptom remission with limited attention to issues of social inclusion and recovery (Bayetti and Jain, 2017). This focus on short-term objectives constrains available resources for long-term care planning, which is central to the idea of mental health recovery (Bayetti et al., 2016).[4]

[4] In using the term mental health recovery, we make reference to "a process, an outlook, a vision, a conceptual framework" which despite lacking a single definition, is understood to rely on "guiding principles, which emphasize hope and a strong belief that it is possible for people with mental illness can regain a meaningful life, despite persistent symptoms" (Jacob et al., 2015). This definition of mental health recovery stands in contrast to the notion of clinical recovery, involving "predefined and invariant 'getting back to normal' definition of recovery through symptom remission and restoration of functioning" (Leamy et al., 2011) which predominantly exist within India's state mental health care (Bayetti et al., 2019, 2016)

Although many mental health NGOs have emerged since the 2000s, several of these organizations simply mirror standard institutionalized forms of care in their approaches to treatment, recovery and inclusion. Nascent work on these new approaches often uncritically attributes the label 'innovation' without first evaluating what is truly innovative about these interventions in terms of organizational structures, processes and practices. Another genre of work is the model for developing case studies of community mental health programmes that draws on a range of data (Cohen et al., 2007, 2011) and has resulted in several case studies from different parts of the world (see e.g. Cohen et al., 2011; Ryan et al., 2020). With the exception of some notable case studies (e.g. see Balagopal and Kapanee, 2019a; Cohen et al., 2007, 2011; Thara and Patel, 2010), studies of innovation in Indian CMHs are few. It is this lack of detailed empirical work that we address with the following research question: What are the practices and processes of these organizations that constitute a psychosocial approach to community mental health care?

We do this through a comparative analysis of what was working well in CMH care service delivery in three Indian NGOs: 1) Mental Health Action Trust based in the southern state of Kerala, 2) Iswar Sankalpa in West Bengal state and 3) Burans in the northern state of Uttarakhand.

2. Methods

To identify and understand novel practices emerging within community mental health NGOs, we employed a comparative case study approach for: its strength as an exploratory research approach to inductive theory building (Eisenhardt and Graebner, 2007; Locke, 2007) especially where the boundaries between contexts and phenomenon are complex and difficult to distinguish; and for its ability to synthesise heterogeneous sources of primary and secondary data (Hollweck and Yin, 2015; Yin, 2009).

2.1. Case setting

Based on their knowledge of the sector, the authors identified exemplar organizations that stood out on several crucial dimensions, particularly: their approaches to relations with people with psychosocial disabilities, effective use of resources, and engagement with the community (Balagopal and Kapanee, 2019a; Bhattacharya et al., 2021; Chatterjee and Roy, 2017; Mathias et al., 2020, 2021; World Health Organisation, 2021). Employing an outlier approach to select organizations that are very different and often antithetical to conventional state and NGO approaches, we sought to identify and understand the unique organizational practices and processes (Starbuck, 1993) that have contributed to their relative success in inclusive delivery and positive recovery outcomes, with a focus on 'what worked well', while acknowledging that each organisation had shortcomings and multiple opportunities for improvement. To provide a diverse geographical, social, and cultural representation of India (North, East and South), and balance against practical concerns of logistics and access, we chose three organizations: Burans (Dehradun), Iswar Sankalpa (Kolkata) and the Mental Health Action Trust (Calicut), which we further detail below.

2.1.1. Burans[5]

Burans is based in Uttarakhand state, a region with below average health indices and poor provision for primary healthcare and mental health (Schneider et al., 2019). Non-profit healthcare provider Emmanuel Hospital Association, under the leadership of public health physician Dr. Kaaren Mathias, founded Burans in 2014 as an initiative to promote mental health in Uttarakhand through collaborative alliances with local non-profit community health and development organizations. While its mission is to work with local disadvantaged communities, its strategy is to leverage local knowledge by working with local partners to strengthen their resources and capabilities (Mathias et al., 2018)for community mental health and wellbeing rather than direct intervention. Burans' interventions in CMH include: the formation of psycho-social support groups; implementing resilience programmes among young people; and capacity building for mental health services and social inclusion within the existing public health care system, supported by robust documentation and research.

2.1.2. Iswar Sankalpa[6]

As one of the most densely populated cities in India, Kolkata has a homeless population of over 70,000. Iswar Sankalpa (IS hereafter) was founded by Dr K L Narayanan and Sarbani Das Roy after encountering a visibly distressed and severely dehydrated homeless person with mental health issues on the sidewalk in front of Mother Teresa's shelter. This was the impetus for Narayanan, Sarbani Das Roy and a few friends to develop an initiative to care for the homeless in Kolkata. When the lack of funding precluded a more conventional institutional approach, necessity led them to develop a care delivery approach within the homeless person's perceived personal space (e.g. the section of sidewalk where they reside). This approach mobilises volunteers from the community to act as individual caregivers; operating day-care and longer-term shelter facilities for the most vulnerable individuals; and providing support for recovery and reintegration into the community through employment opportunities. While its primary focus is on homeless individuals, IS also operates mental health services within Urban Health Centres for the Urban Mental Health Programme to provide accessible, equitable and affordable mental health care for disadvantaged communities. IS's culture has a strong commitment to organizational knowledge sharing through activities such as weekly meetings to share updates and discuss emerging issues.

2.1.3. Mental Health Action Trust[7]

The Mental Health Action Trust (hereafter MHAT) is based Calicut, Kerala, a region with a high rate of literacy and level of development (an Human Development Index (HDI) of 0.77). Disappointed by the quality of existing CMH provision, psychiatrist Dr Manoj Kumar developed a novel approach to delivering high quality MH provision to marginalised individuals by leveraging an existing network of palliative care centres[8] (McDermott et al., 2008; World Health Organisation, 2014) and resourcing its operations through in-kind community donations, pro-bono services by state employees, and drug donations by pharmaceutical companies. A key innovation of MHAT is its ability to overcome the lack of qualified and experienced clinical psychiatrists within the CMH system, through a devolved organizational structure which includes community health workers, community volunteers, and MHAT clinicians (i.e. psychologists and social workers). MHAT is led by a Psychiatrist and operates weekly clinics across 54 villages, which is 5–6 times the reach and capacity of a typical psychiatrist and nurse team. This flat organizational structure features frequent care team meetings that allow for a more agile identification of and response to emerging clinical and broader organizational issues.

[5] See Mathias et al., 2018 for a detailed description of the Burans model of community mental health care.

[6] For a detailed description of Iswar Sankalpa, please see Chatterjee et al., (2017) and WHO, 2021.

[7] Further description of MHAT's mission and approach to CMH is detailed in Balagopal and Kapanee (2019); Pallikkuth et al. (2021).

[8] Catalysed by a palliative care movement in the 1980s and supported by the substantial inward remittances of expat Kerala residents, the northern districts of Kerala developed a strong network of community run palliative care centres (McDermott et al., 2008; WHO, 2014).

2.1.4. Data collection

Our dataset was collected[9] and compiled through two phases. The initial phase commenced in February 2018 with three of the authors (SJ, WK and VS) visiting each site for several days to negotiate organizational access, introduce the study and its purpose, and to conduct initial individual and group interviews, gather relevant internal organizational documents and begin ethnographic observations. We then refined our research design to focus on several emerging themes and attendant questions. For the second phase (March–April 2018), one of the authors (VS) returned to each of the host organizations for a week-long site visit for direct interviews and group discussions, gather secondary documents such as organizational histories, organizational structure charts and strategy documents, and conduct brief organizational ethnographies by ‘following around’ and observing (Martin and Bateson, 1993) clinical and para-professional staff as they engaged in routine care delivery activities including: clinical consultations, home visits, group meetings, internal organizational meetings and staff training sessions.

We used these ethnographies to confirm the veracity of interview and discussion data from respondents through triangulation (Jick, 1979) and to gain insight into the meaning and function of these practices and activities (Fernandez and Herzfeld, 1998) within their respective organizations (Hammersley, 1992; van Maanen, 1979). Apart from internal organizational meetings which were recorded, most ethnographic observations were recorded contemporaneously through end-of-day reflective handwritten notes to preserve client confidentiality. This dataset was subsequently ordered and transcribed by one of the authors (VS), fluent in both English and Hindi, within NVivo v11.

2.2. Data analysis

This dataset was analysed through four stages. We began by constructing a detailed history of each of the three organizations with a chronology of critical events (Webster and Mertova, 2007); and a daily account of organizational practices and activities over a typical week. Following (Langley, 1999), this narrative approach allowed us to consolidate and begin to make sense of this heterogeneous and messy dataset, thus affording insight into how these organizations’ missions and purposes were expressed through their respective processes and structures.

In the second stage, we analysed each organization for novel organizational practices in their delivery of community mental health by coding for practices that were materially different that those typically employed in state and mainstream NGO approaches. Employing counterfactual reasoning (Durand and Vaara, 2009) we asked ‘how is X normally done (in state organizations)?’ and coded for the type of novelty observed (see beige boxes in Fig. 1a–c). After some iteration, these codes were refined into five distinct groupings which are: a) purpose and ethos, b) care activities, c) coordinating mechanisms, d) outreach activities and e) state engagement and illustrated as (see dotted-line boxes in Fig. 1a–c).

For the third stage, we iterated between these observed practices to identify second order constructs or ‘strategies’, which we define as recognizable patterns of action in pursuit of an identifiable organizational objective. We also noted that these strategies, with minor differences, were broadly common across all three organizations; and that the relation between practices and strategies was a complex web of interdependencies in which most practices were linked to multiple strategies and vice versa. After several iterations, we identified and defined a set of six strategies that were common across all three organizations, which are: i) prioritising beneficiaries, ii) engaging community, iii) recovery and reintegration, iv) co-opting resource, v) devolving care and vi) reorganising communication.

Finally, we developed second order themes of ‘constructing a sustainable resource base’, ‘broadening and redefining meanings’ and ‘managing knowledge’, which we saw as outcomes of the six common strategies. These second order ‘themes’, which are further elucidated in the Discussion section and illustrated in Fig. 2, are distinct from the six ‘strategies’ because they are emergent outcomes rather than intentional organizational goals.

3. Practices of psychosocial care

Our first order analysis of these organizations revealed that: a) each organization has a unique repertoire of emergent practices; b) the individual elements of this repertoire are interdependent and serve broader objectives or strategies; and c) between the three organizations, their strategies have strong similarities.

3.1. Unique and interdependent practices

Despite their unique histories, their respective organizational structures and practices are shaped by choices made in response to critical events including the loss of key staff, donors, government policy changes and other unforeseen contingencies. IS’s approach to working with homeless individuals in situ within the community was developed after efforts to raise funds to build a homeless shelter were unsuccessful. Although their practices emerged from the desire to pursue their respective organizational missions, they creatively used the resources at hand and engaged with opportunities as they presented themselves, rather than a linear process of implementation.

These organizations also have deeply interdependent practices. In MHAT, a single psychiatrist can supervise multiple and simultaneous clinics operated by a team of psychologists, social workers, community health workers and community volunteers. This approach delivers high quality care to many clients with far less resource than conventional biomedically oriented state or mainstream NGO approaches by leveraging technology to deliver a form of tele-psychiatric care. A change in one of these practices, such as a return to a conventional one psychiatrist per clinic model, would not only increase costs, but also might endanger the quality of care by disrupting the flat structure. This flat structure enables communication and knowledge exchange between care team members by providing them the legitimacy to autonomously engage with the local community.

These organizational trajectories illustrate how novel practices can emerge from the accumulation of responses to contingencies rather than the planned design.

3.2. Common strategies

Despite these differences in micro-level practice (beige boxes in Fig. 1a–c), there is strong convergence at the macro-strategic level (dotted-line boxes and orange circles in Fig. 1a–c). These findings demonstrate the difficulty in directly attributing individual practices to specific strategies – rather, each strategy is the dependent outcome of multiple interrelated practices (dark grey arrows in Fig. 1a–c). These are defined and summarized as common strategies in Table 1.

3.2.1. Prioritising beneficiaries

Despite sharing a mission of prioritising marginalised segments of the local community who are overlooked by the state mental health care system, each organization respectively arrived at this point via different influences and events. Burans and MHAT focus on serving socio-economically disadvantaged members of the community, the former emphasizes evidence-based interventions at community level with linkages to existing bio-medical care options. The latter focuses on providing high quality care that is often superior to private alternatives. IS’s primary goal is to provide care with dignity to homeless individuals

[9] Ethical approval was sought from ethics committees at the Emmanuel Hospital Association, New Delhi and the University of Edinburgh. Informed consent was sought from all participants in the study.

with psycho-social disabilities.

3.2.2. *Engaging with the community*

These organizations engage with the community through several common elements: i) advocacy and local action, ii) use of public spaces, and iii) involvement of families and peers. Community groups are organized to promote local action on CMH issues and to provide peer counselling support. A multiplicity of local community spaces – including clients' homes, temples, as well as available space in public buildings such as urban health centres and police stations – are creatively employed to deliver clinical care. They engage families and peers in the caregiving process. IS for example, recruits concerned neighbours to take on caregiving responsibilities such as giving medicine and providing hygiene care to local homeless individuals with psychosocial disabilities (referred to as PPSD hereafter). This empowers individuals with lived experience by granting a level of legitimacy that is equal to formal knowledge. These ongoing processes provide feedback on community concerns and priorities, as well as raising awareness of and reducing stigma around mental health issues.

3.2.3. *Recovery and reintegration*

These organizations share a strategy of broadening good care outcomes. Rather than focusing on the short-term treatment of symptoms as defined by conventional state and mainstream NGO approaches, they have independently arrived at a redefinition of what a good care outcome is. By expanding their respective operational emphases to support clients on a full recovery journey, their process of client engagement begins with the diagnosis and treatment of acute symptoms, and extends to reintegration back into society, which is necessarily a lengthy and non-linear process. Recovery is premised on social inclusion

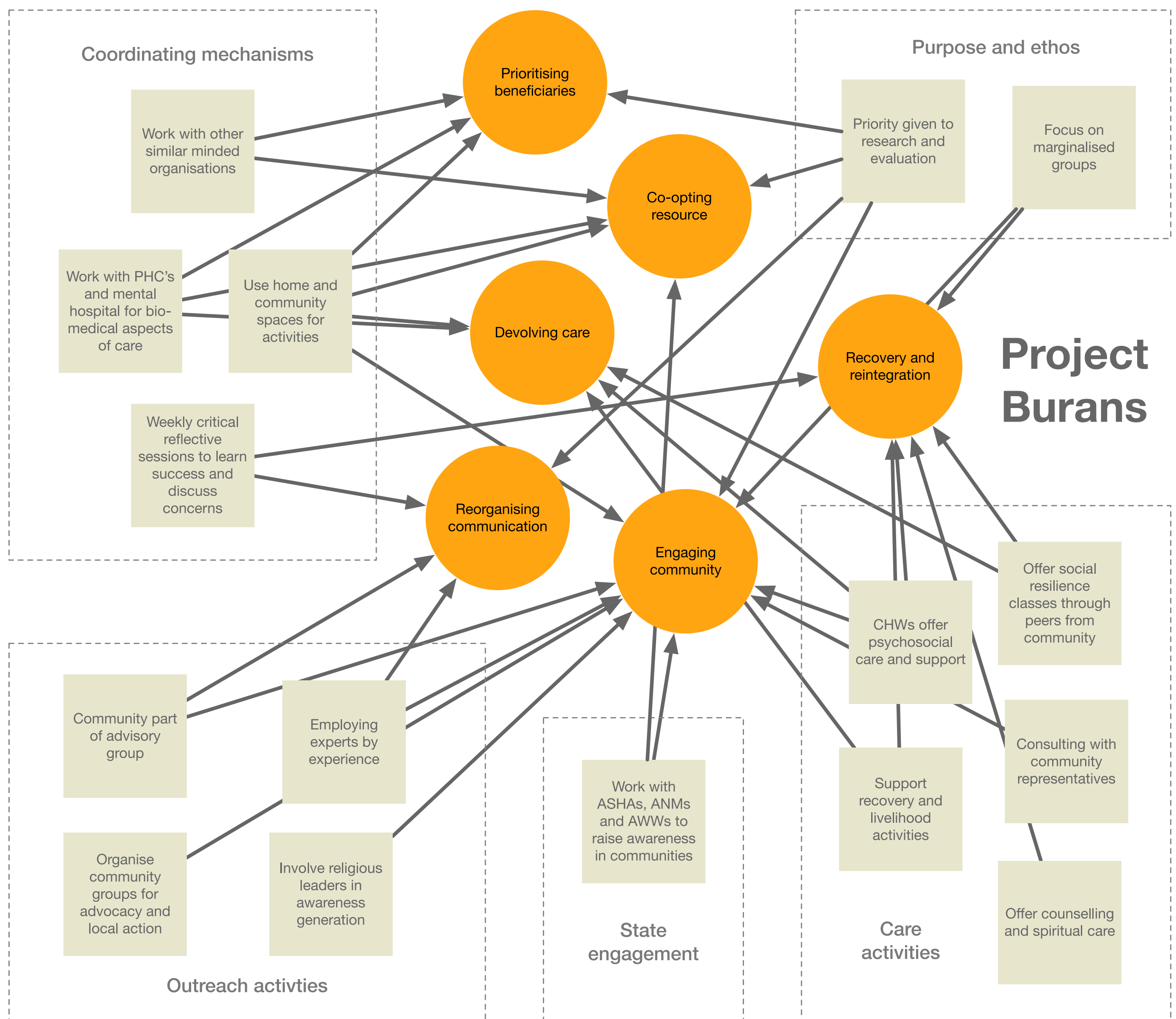

Fig. 1a. Burans observed practices.[10]

[10] Abbreviations in Fig. 1a: ASHA (Accredited Social Health Activist). ANM (Auxilliary Nurse and Midwife), AWW (Anganwadi Workers), CHW (Community Health Workers), PHC (Public Health Clinics).

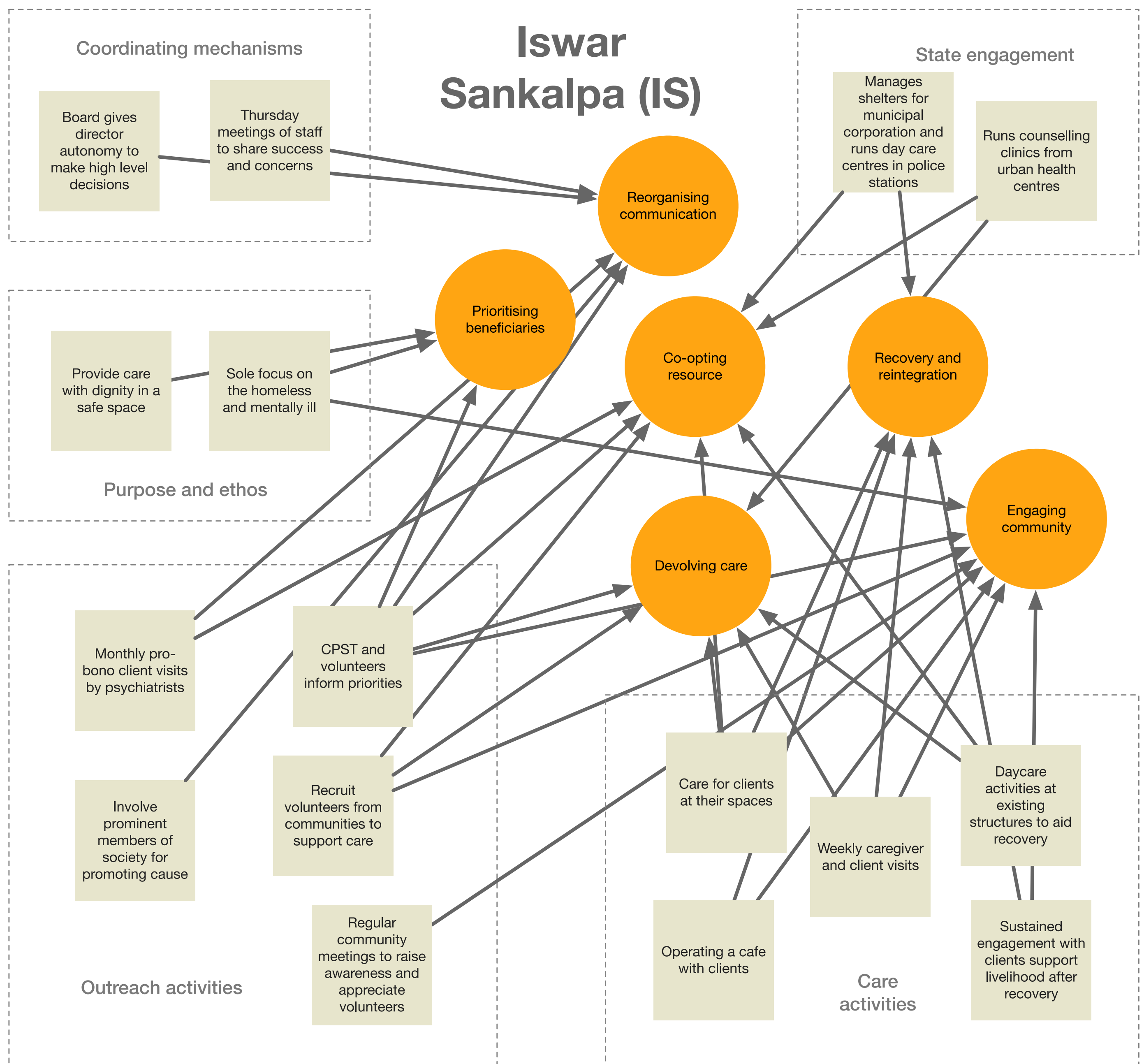

Fig. 1b. Iswar Sankalpa (IS) observed practices.

and involves: i) providing pastoral support and ii) developing employment opportunities for clients. These organizations have developed support activities including supporting devotional practices across different religious groups in Burans and creating day care facilities at IS to allow carers to continue full-time employment. Their activities extend developing clients' employability skills and paid employment opportunities for their clients through activities such as in-house social enterprises and microfinance loans to enable self-employment.

3.2.4. *Co-opting existing resources*

Given the lesser priority that CMH receives relative to other public health issues, government organizations and NGOs often struggle with funding issues. A particularly salient finding was how these organizations developed creative approaches for resourcing operations. While much of their CMH provision is funded through government subsidies and grants, these organizations have developed configurations of cash and in-kind resources from non-government sources including: i) rent-free venues, ii) pro-bono expertise and drugs, and iii) community donations. MHAT operates their rotating bi-weekly clinics from village hospices and public health centres. Burans and IS employ a variety of government and community spaces during off-hours to run their activities. Crucial to Burans is their reliance on coordination and cooperation with government health care workers and the staff of other NGOs to promote and support many of their outreach activities. Psychiatrists provide pro-bono visits on behalf of IS while MHAT is partially supported by donations of drugs from pharmaceutical companies. They benefit from monetary and non-monetary donations from the local community and grants from foundations.

3.2.5. *Organizational communication*

We also observed how inter- and intra-organizational communications differed from conventional approaches. Another common

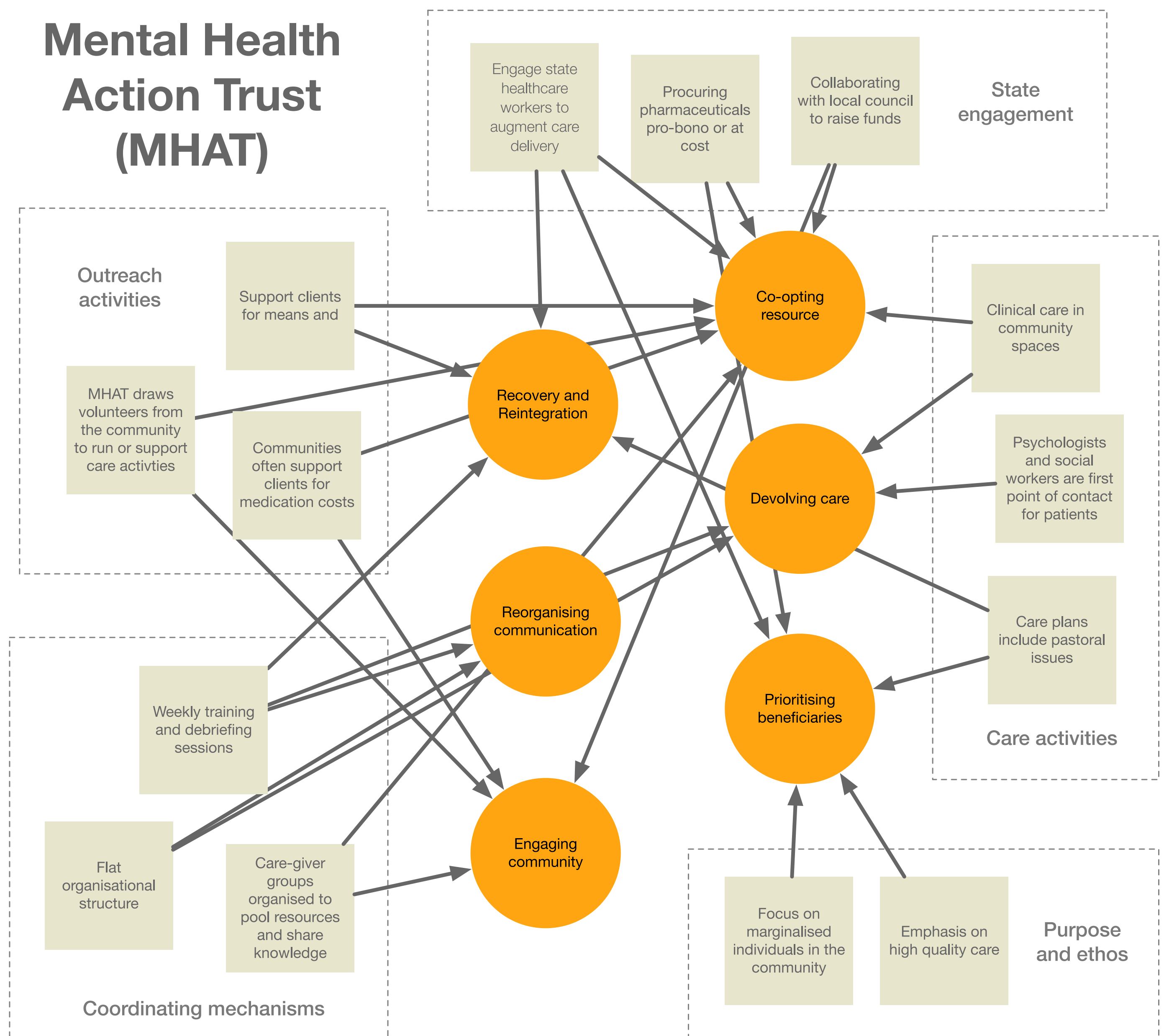

Fig. 1c. Mental Health Action Trust (MHAT) observed practices.

characteristic was the frequency of formal and informal sessions to coordinate issues ranging from treatment and medication of specific clients to broader operational and strategic concerns. Frequent meetings with volunteers and other external stakeholders in which personal and public issues were openly discussed were observed. In contrast with conventional Indian CMH settings, the degree to which communication occurred in all directions was exceptional. Rather than a typical top-down approach, opinions and ideas emerged bottom-up as well as horizontally across areas of responsibility and expertise. Several interviewees noted how this approach to organizational communication fostered greater collegiality and collaboration in their respective approaches to care delivery.

3.2.6. *Decentralizing and devolving care*

This multi-directional flow of information supported decentralised and devolved processes of care through decentralizing the role of the clinic and broadening the membership of the care team. Rather than confining the 'clinic' to formal institutional settings such as hospitals or public health care centres, the 'clinic' is effectively decentralised through delivering CMH via various public and private spaces. In addition to cost savings by co-opting existing state and community resources, this approach also reduces the perceived distance between the clinical professionals and the clients and their families. The care team hierarchy is flattened through inclusion of para-clinical staff and trained volunteers. Social workers and para-clinical staff are responsible for many issues that in conventional contexts are normally managed directly by a clinical psychiatrist. The reach and engagement of the care process is improved through trained volunteers, many of whom are former clients themselves or friends and relations of former clients and thus draw upon their lived experience in deliberations about the care process.

4. Conceptualizing psychosocial care

If common strategies are delivered through three unique configurations of practice, what are the implications for our understanding of

Fig. 2. Drivers and enablers of social inclusion in CMH.

innovation? We illustrate in Fig. 2 how the six common strategies (see orange circles) can be further abstracted into the three dimensions (see red circles) of: 1) broadening and redefining meanings, 2) managing and sharing knowledge, and 3) sustainable resourcing, whose relationship we now elucidate.

4.1. How are meanings broadened and redefined?

The biomedical based understanding of mental health that dominates state institutions in India tends to operate within a 'problem-service' paradigm, viewing people as 'problems' that require urgent response (Addlakha, 2008). In resource-scarce contexts such as CMH, this epistemological stance creates a tendency to focus on clinical recovery, or rapidly and successfully fixing symptoms to allow individuals to resume 'normal functioning' (Bayetti et al., 2019). This tendency is further exacerbated by a lack of alternatives to care within the training regime of most Indian psychiatric and other mental health professionals. Led by primarily by clinical professionals, this approach to care is characterized by short and discrete interventions whose outcomes are largely defined by the experts themselves (Bayetti, 2020), which is a paradigm that rarely includes individuals' perspectives of their own illness nor their hopes and aspirations. In overlooking the social determinants of mental illness, it removes "people from their context within communities and fails to recognise the wholeness of the human condition" effectively excluding PPSD "from opportunity and a broader sense of belonging" by "narrowing the responsibility of problem solving to PPSD and their associated specialised services" (HCCT, 2013).

By contrast, these three cases demonstrate an 'asset-based' approach to mental health that builds an "sense of value within individuals, a connectedness and a purpose" (HCCT, 2013), with the latter recognised as necessary precondition to a journey of recovery. These organizations deliver a more holistic form of care through focusing on the long-term recovery and integration of individuals back into the community, and expanding the temporal scope of intervention by redefining recovery and indeed well-being. Instead of an exclusive focus on clients, this approach aligns with a "social approach" to recovery by promoting the

Table 1
Observed practices and common strategies.

	Definition	Project Burans	Iswar Sankalpa (IS)	Mental Health Action Trust (MHAT)
3.1 Prioritising beneficiaries	Allocating resources to support organizational mission by prioritising beneficiaries and type of response	•Focus on access to care for marginalised groups and community psycho-social resilience •Evidence-based approaches are developed through research and evaluation activities	•Focus on homeless individuals with psycho-social disabilities by providing care with dignity	•Focus on providing high quality CMH to marginalised individuals in the local community
3.2 Engaging community	Engaging with families, and stakeholders to inform community concerns and priorities	•Organise community groups for advocacy and local action on CMH issues •Involve religious leaders to raise awareness •Peer model for adolescent social resilience workshop delivery	•Care for clients in urban health centres, home and other community spaces through weekly visits. • Recruit community volunteers to support care	•Clinical care delivered in palliative clinics and tribal homes •Care activities run by volunteers (e.g. former clients, relations of clients, other community members, etc.) • Informal groups created to provide mutual support between client families
3.3 Recovery and reintegration	Shifting from a short-term focus on acute symptoms to a long-term view that includes recovery and reintegration into society	• Support for recovery and livelihood activities for recovered PPSDs (e.g. small scale farming, raising livestock, etc.) • Social workers lead assessment, initiate treatment and support recovery, and also manage linkage with the gov't health care system for bio-medical aspects of treatment • Support for spiritual-based counselling and care.	• Sustained engagement for clients to support livelihood and reintegration with family after recovery • Operate shelters and day care centres • Social enterprise activities (e.g. café and tea stand) staffed by recovered clients • Equipment for self-employed (e.g. rickshaws donated to former clients)	• Client supporting in search for employment after recovery (e.g. provision of connections, references and micro-financing)
3.4 Co-opting resource	Drawing on existing and often unused state and community resources to support a sustainable model of care delivery	•Use home, temples, churches and other community spaces for activities • Collaborate with other mental and public health NGOs • Engage and cooperate with community health care workers in delivering initiatives	• Hold activities in alternative facilities (e.g. local police station, community health centres) • Monthly pro-bono client visits by psychiatrists • Recruit prominent community members of the society to promoting cause	• Use of government health facilities and healthcare workers to augment and support the services • Medication costs subsidised by cash and pro-bono from community groups and pharmaceutical companies • Close collaboration with local councils to raise funds from central government
3.5 Devolving care	Devolving authority and responsibility to a broader care team and a decentralised model of care	• Employing people with lived experience of mental health difficulties as part of the care team. • Community workers are trained to offer psychosocial care, support and referral to public health facilities.	• Responsibility for directing care rests with social workers who are the primary contacts of the clients and the caregivers.	• Psychologists and social workers are initial and ongoing points of contact for patients • Para-clinical staff run consultations at village clinics
3.6 Reorganising communication	Changing the dynamic of communications between internal and external stakeholders	• Consulting with community representatives, by including them on consultation forums and regular advisory groups, by interacting them on regular and informal basis. •Weekly critical reflective sessions held to share successes and discuss concerns	• Weekly staff meetings to share success and concerns • Social workers meet volunteers on weekly basis to follow up on cases	• Weekly training and debriefing sessions • Care-giver groups organised to pool resource and share knowledge

importance of relational and inclusive citizenship (Vandekinderen et al., 2012).

While this redefinition of CMH may appear diametrically opposed to the dominant biomedical approach, our observations of practice in this study suggest otherwise. Rather than *negating* the biomedical view, these organizations *broaden* and *complement* the conventional understanding of CMH by enacting changes in who provides care and where that care happens.

These organizations expand the 'care team' beyond mental health professionals to include groups already providing informal care, including families, neighbours, former clients, and other parts of the state healthcare system. Their respective roles are extended and redefined by capacitating them in ways that go far beyond existing models of task shifting and task sharing. As has been observed (Mapanga et al., 2019; Nunley, 1998) families play a central but informal role in the provision of community care provision in India, there is also clear evidence that communities can play a positive role in supporting PPSDs.[11] This is why many state CMH programmes will only accept someone as a client if they are accompanied by a family member or other responsible person (Nunley, 1998).

As the care team expands, so do the places where care is delivered. IS engages neighbours to provide care in community spaces where homeless people are part of the social landscape, while MHAT supports families and community volunteers as carers, and Burans employs workers from local communities to engage PPSD and provide care and support. These shifts are predicated on an understanding that family, neighbours, and other community members are best placed to deliver care in local places that are accessible and inclusive.

4.2. *How should knowledge be shared?*

An implication of changing how CMH is delivered is that it

[11] It should be noted that both 'family' and 'communities' can also exploit and inflict human rights abuses on PPSD.

challenges conventional GMH practices such as task shifting or sharing (Kottai and Ranganathan, 2020), which are inadequate for capturing how knowledge is shared and responsibilities are entrusted beyond conventional institutional and organizational boundaries to include family and community members. Redefining the 'who' and the 'where' of the caregiving process has implications for how social workers, nurses, psychologists, doctors, and community health workers as care providers must work together. The formally codified and explicit knowledge of clinicians must be reconciled with the more informal and tacit knowledge of other carers such as family, friends and community volunteers in a non-hierarchical way. This rethinking and renegotiation of hierarchy and power relations was identified in the relatively flat organization structures of Burans, IS and MHAT, which increased the participation and relevance of care for PPSD and carers and lay health workers in decision making processes. It is broadly accepted that more inclusive governance structures improves the effectiveness of responses to gaps in CMH treatment and care (Abimbola, 2020; Shidhaye et al., 2019).

While the inclusive governance of community health systems can enable the coordination of action at the level of community health system and drive greater engagement by involving community members in service design, it requires principled engagement through building of trust and sharing of information (Schneider et al., 2019). Ultimately, what these three organizations demonstrate is how the involvement of **people** (communities), **providers** (in this case NGOs), and working with policymakers (Abimbola, 2020) can realise the possibilities of inclusive health governance. Through collaborative governance processes such as: engaging key community stakeholders in the co-creation and co-production of services; downplaying power differentials to encourage new stakeholders join conversations about problems and solutions; supporting a culture which rewards trust, risk taking to empower individuals to develop their capabilities; and developing learning loops within organizations to learn from success and failure.

4.3. *How can this be resourced?*

As a field, CMH has long struggled with resourcing due to perceptions of legitimacy, urgency, and importance. This study reveals three distinctive yet broadly similar ways in which CMH initiatives can be supported by alternative means. Whether this is the free use of community buildings, pro-bono professional services, in-kind donations from client families, the time of community volunteers or cross-subsidization from fee-paying activities, IS built upon pre-existing care routines already provided to people on the street by local shopkeepers and family members. MHAT used an existing network of community palliative care centres and volunteers. Operating in a context of scarce resource Burans empowered local volunteers to directly provide psychosocial care and support within family and community spaces.

This flexible and heterogeneous resourcing approach is arguably more effective and sustainable because it co-opts community and state resources that are often underutilized or unused. This contrasts with the conventional model of funding via public grants and large private donations, which can subject the organization to pressures to from large private and public stakeholders and thus mission creep. This approach necessitates deep engagement with the local community and their places and processes of care. This in turn engenders a sense of ownership and greater accountability for resource allocation and outcomes. It challenges our assumptions about whether the responsibility for basic care should rest with the central government or the local community.

5. Towards a more inclusive approach to CMH

In examining the processes and practices of psychosocial care in community mental health, our study draws attention to two aspects of psychosocial innovation in CMH. First, it is premised on developing capacity to respond to the complex social, psychological, and biological nature of mental health difficulties leading to a conceptualization of mental health as a socio-development issue. Second, it is about expanding the social inclusion and community reintegration of people with PPSD.

State and private mental health providers in India tend towards a narrower view of mental health – as an acute medical issue viewed through the prism of clinical recovery. This biomedical view limits its consideration of how MH issues affect the ability of clients to engage with and function within the community. Psychosocial care, however, is not innovative for novel practice alone. Rather it can be understood as context dependent networks of practices that: enable the construction of a stable resource base; broaden and redefine mental well-being; and enable the conditions for knowledge across boundaries. Although the practices are often unique, the strategic outcomes of psychosocial CMH delivery are broadly similar.

Whilst the study highlights the importance of psychosocial approaches, it also argues against a polarization of positions between biomedical and psychosocial models of CMH. These NGOs illustrate diverse ways of integrating both approaches, and indeed the crucial role these approaches play in the delivery of effective mental health care, although their strategic outcomes are broadly similar and have different starting points.

5.1. *Contributions*

Our contributions are several. First, we provide a practical methodological approach for the comparative mapping of practices in the case studies of organizations that are otherwise difficult to comparatively understand. This enables us to go beyond description to investigate the complex relations and inter-dependencies of the diverse activities undertaken by these organizations.

Second, we demonstrate the value of applying an interdisciplinary lens to investigate empirical phenomena in global mental health. Study authors brought multidisciplinary methodological and theoretical perspectives from diverse fields including social work, public health, and organizational studies. We build on implementation research frameworks widely used in public and global health, which focus on the contexts and implementation strategies used to deliver health care. Organization studies is proposed as an example of implementation research in one of the seminal texts on implementation research (Peters et al., 2013) as it examines how the practices, processes, and structures of organizations are constructed by individuals, and how organizations in turn, shape human relations and construct institutions that influence people (Clegg and Bailey, 2007). This broad field of study encompasses a spectrum of approaches ranging from critical research to more functionalist approaches (Suddaby and Foster, 2017) Using a critical approach to both implementation research and organizational studies, our study provides methods and concepts to make sense of diverse implementation strategies which includes organizational structures and processes in these three mental health care providers.

Finally, while the expansion of the scope of care in India very much depends on state health systems, NGOs play a crucial role in undertaking experimentation that drives social innovation and broadening access to marginalised individuals and communities. The study therefore highlights the importance of encouraging collaboration between local health systems and civil society for mutual learning in CMH.

5.2. *Future research*

The study has several limitations. As we were necessarily limited in the time we could spend at each organization, this constrained our ability to develop more nuanced understandings of the culture and practices of each organization. Our limited resource constrained our ability to gather longitudinal data. These case studies are a snapshot in time and do not tell us as much about the process by which they developed, and how their respective contexts influenced this process.

Additionally, these findings are not necessarily generalizable to all settings, and need to be understood in context when considering broader applicability.

Given these limitations, we suggest a couple of directions for future research. There is a need for finer-grained ethnographic and longitudinal studies of community mental health practices and organizations. Using such approaches is an essential step in better understanding the long-term impact of these programmes. Indeed, they can provide a more detailed understanding of the complexities at the core of specific care practices (such as recovery approaches) and how the latter impact programme participants. Such approaches should complement the traditional monitoring of programme participants' outcomes but would also help challenges the orthodoxies of traditional programme evaluation practices by allowing for different forms of evidence of what is consider "success" and by allowing for a broader understanding of what leads to this success. In terms of organizational strategy, it would also be useful to see how the services delivered and the delivery mechanisms respond and change over time – for example is there an evolution of services from addressing specific needs and gaps in provision towards a more expansive approach to supporting the development of families and communities? While these case studies show how the organizations think about mental health in multiple ways, and link different forms of marginality in their practice, it would be important to investigate how these psychosocial initiatives address intersectionality. Although we know that characteristics such as gender, ethnicity, caste, and other social factors play a role in treatment and recovery, we still lack a nuanced understanding of how they interact to produce emergent outcomes. Future research can provide insight into how biomedical and psychosocial approaches to CMH can be synthesized for better individual and collective outcomes.

Ethical approval

Ethics approval was obtained from the Emmanuel Hospital Association, New Delhi ethics committee and from the University of Edinburgh.

CRediT authorship contribution statement

Varadharajan Srinivasan: Methodology, Formal analysis, Investigation, Data curation, Writing – original draft, Project administration. **Sumeet Jain:** Conceptualization, Methodology, Formal analysis, Resources, Writing – review & editing, Funding acquisition, Project administration. **Winston Kwon:** Conceptualization, Methodology, Formal analysis, Resources, Writing – review & editing, Visualization, Funding acquisition. **Clement Bayetti:** Conceptualization, Methodology, Resources, Writing – review & editing. **Anish V. Cherian:** Conceptualization, Methodology, Resources, Writing – review & editing. **Kaaren Mathias:** Conceptualization, Methodology, Writing – review & editing, Funding acquisition, Project administration.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: K. Mathias and V. Srinivasan work/worked as implementors at Burans, one of the organizations studied in the paper.

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