BJPsych Open (2026)
12, e241, 1–9. doi: 10.1192/bjo.2026.12092

Development of a community intervention to increase help-seeking and adherence to depression care in India: mixed-methods study

Miriam Sequeira†, Yashi Gandhi†, Richard Velleman, Daisy Radha Singla, Kedar Mirchandani, Luanna Fernandes, Helen A. Weiss, Bijayalaxmi Biswal, Urvita Bhatia, Lalan Karapurkar, Lalan Madkaikar, Nikita Nalawade, Chunling Lu, Vikram Patel* and Abhijit Nadkarni*

Background

Access to depression care can be improved by overcoming a combination of supply-side barriers and demand-side factors.

Aims

To describe the systematic development of a community-based intervention to improve uptake of, and adherence to, a psychosocial treatment for depression delivered by trained primary healthcare staff in Goa, India.

Method

This mixed-methods study included five steps: Step 1, Synthesis of existing evidence by conducting relevant systematic reviews and a review of public health programmes in India; Step 2, In-depth interviews with community stakeholders ($n = 35$); Step 3, Consultation workshops with community stakeholders ($n = 19$) and primary healthcare staff ($n = 34$); Step 4, Triangulation of findings from the preceding steps; and Step 5, Content development for the intervention (e-course for training and the community intervention toolkit for delivery).

Results

Overall, 20 strategies to enhance help-seeking and 5 strategies to improve adherence were identified to constitute the intervention. The community-based intervention is organised into four domains (Learn, Inform, Engage and Follow-up), with self-care integrated throughout the intervention. This intervention is designed to be delivered by a community volunteer who is motivated to cater to the communities' needs. The community volunteer is trained to deliver the intervention via a blended approach, an e-course and in-person one-on-one learning support by a coach, who later acts as a facilitator during the intervention delivery phase.

Conclusions

The systematic method enabled the development of a comprehensive intervention with contextually appropriate delivery strategies. The effectiveness of the intervention is presently being tested as part of a Hybrid Type II Implementation-Effectiveness randomised controlled trial. If found effective, the intervention has the potential to be a low-cost and sustainable opportunity to improve demand and adherence to depression treatment while also providing essential social, emotional and logistical support during the recovery process.

Keywords

Depressive disorders; evidence-based mental health; low- and middle-income countries; primary care; qualitative research.

Copyright and usage

© The Author(s), 2026. Published by Cambridge University Press on behalf of Royal College of Psychiatrists. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (https://creativecommons.org/licenses/by/4.0/), which permits unrestricted re-use, distribution and reproduction, provided the original article is properly cited.

Depression is one of the leading causes of health burden and disability worldwide, yet access to appropriate care remains limited. A systematic review of 149 studies (2000–2021) from 84 countries found that service use for major depressive disorder (MDD) ranged from 33% (95% uncertainty interval 8–66) in high-income countries to 8% (95% uncertainty interval < 1–36) in low- and lower-middle-income countries (LMICs).[1] In India, an estimated 23 million adults need care for depression, but the treatment gap remains as high as 85%,[2] and there is substantial premature treatment discontinuation (21–59%) among those who access treatment.[3]

The lack of knowledge (e.g. little to no awareness about mental health problems and available services, fear of treatment side effects), negative attitudes (e.g. stigma, concerns about the effectiveness of services, cultural beliefs against certain treatments), the structure of existing psychological treatments, which require patients to return to the clinic for multiple sessions and poor structural organisation (e.g. cost of services, distance and transport barriers, lack of family or social support) are the main demand-side barriers contributing to this gap.[4] Although supply-side barriers (e.g. shortages of mental health professionals) are being addressed through task-sharing, demand-side barriers persist,[5] resulting in low rates of identification (and therefore help-seeking), limited entry into treatment and low rates of engagement with and completion of treatment.

Our project, 'Implementation of Facility- and Community-Based Interventions to Reduce the Treatment Gap for Depression' (IMPRESS), aims to address both supply- and demand-side barriers by (a) building the capacity of existing healthcare workers across 30 healthcare settings to deliver the Healthy Activity Program (HAP), an evidence-based counselling treatment for depression[6] and (b) empowering community volunteers (called *Sangathis*, meaning 'companion' in the local language) to deliver a community-based intervention that will improve help-seeking and adherence to HAP.[7]

Objectives

In this paper, we describe the systematic process used to collaborate in develop a contextually relevant community intervention to be tested in a Hybrid Type II Implementation-Effectiveness randomised controlled trial (RCT) to increase access to and adherence with HAP.[7] In other words, community volunteers informed the intervention strategies and reviewed content, while decisions regarding trial feasibility were made by the study team. We describe the intervention content and delivery strategies using the following

† Joint lead authors.
*Joint senior authors.

https://doi.org/10.1192/bjo.2026.12092 Published online by Cambridge University Press

domains:[8,9] (a) who is the delivery agent, i.e. the profile of a community volunteer; (b) what strategies can they use to increase help-seeking for and adherence to depression care; (c) where can the intervention be delivered; and (d) how can we train and support community volunteers to deliver this intervention.

Method

Setting

IMPRESS is being implemented in India's western coastal state of Goa, which has a population of 1.6 million[10] and one of India's highest depression prevalence rates at 3821 per 100 000.[11] Public mental healthcare is provided through one large tertiary care hospital and two district hospitals. The District Mental Health Programme (DMHP) provides limited mental health services in rural areas through primary and community health centres (PHCs and CHCs) once a month. Private mental healthcare is largely restricted to urban areas and is affordable only to more affluent populations.

Ethics

All procedures were approved by the Institutional Review Boards of Sangath (implementing organisation) (AN_2017_033), the London School of Hygiene & Tropical Medicine (16232) and the Directorate of Health Services, Goa. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013. Written informed consent (or a witnessed thumbprint for participants who were unable to read or write) was obtained after providing detailed information to all eligible participants.

Study design

Step 1: Synthesis of existing evidence

Systematic reviews: We conducted three systematic reviews to synthesise evidence on interventions to improve help-seeking for and adherence to psychosocial treatments. The first (yet to be published) updated an existing review of global trials of interventions to improve demand for and help-seeking for mental health problems[12] covering the period from 2016 to 2023. This review identified no studies from low-income countries and only three from middle-income countries (all in China).[12] Therefore, we conducted a second systematic review of interventions promoting help-seeking for mental health problems in LMICs, without restrictions on study design.[13] Our third systematic review synthesised evidence on interventions to improve patient adherence to psychosocial treatments for common mental disorders (CMDs).[14]

For each review, we used a structured data extraction spreadsheet to collect relevant details, including intervention content, delivery agent(s), duration and frequency, effectiveness and implementation-related outcomes (e.g. acceptability and feasibility).

Review of public health programmes in India: We identified and extracted relevant information about existing national and state-level community healthcare programmes that employed strategies to improve uptake of and adherence to treatment for any health condition. We searched relevant government websites (the Ministry of Health and Family Welfare, the National Health Systems Resource Centre and Goa's Directorate of Health Services) for reports on public health programmes delivered at the primary care level and extracted community intervention strategies or components used to increase help-seeking behaviours and treatment adherence. This step was undertaken entirely by the study team.

Step 2: In-depth interviews (IDIs) with community stakeholders

The aim of these IDIs was to develop an understanding about: (a) the perceptions and knowledge of mental health problems and the services available in Goa; (b) the formal and informal functioning of existing community-level work in which stakeholders were involved; (c) the strategies they used to raise awareness and engage with their communities; and (d) the facilitators and barriers to their current community work. We developed and iteratively revised the interview guides based on our experiences during the interviews.

We defined community stakeholders as individuals with experience of conducting community-level activities (e.g. awareness events on menstruation, organising sociocultural activities). We used a combination of purposive sampling (through existing networks) and snowball sampling to identify participants and achieve maximum variability in geographical location and community role.

Trained researchers conducted the interviews in English or one of the local languages (Konkani, Hindi or Marathi), based on the participant's preference. All interviews were audio-recorded and subsequently transcribed and translated into English for analysis ($n = 35$). Data collection ceased once data saturation had been reached. Two pairs of researchers, made up of various combinations of three researchers (independent researchers A.G. and B.Z. (see 'Acknowledgements' section) and co-author Y.G.), used NVivo 12 for macOS (QSR International Pty Ltd, Melbourne, Australia; https://lumivero.com/products/nvivo/) to independently code the data using a combination of inductive and deductive thematic analysis. Community volunteers were not involved in the analysis of data.

Step 3: Consultation workshops

We shared the findings from Steps 1 and 2 in two consultation workshops to collaboratively develop a 'pathway to care' map to achieve our long-term outcomes of increasing help-seeking behaviours and treatment adherence. Participants included 19 community stakeholders, some of whom had previously been interviewed as part of our study, while others were recruited through snowball sampling.

We also conducted workshops with PHC staff ($n = 13$), including medical officers, multi-purpose health workers (MPHWs), staff nurses and auxiliary nurse midwives (ANMs). We also held consultation meetings with homogeneous cadre groups ($n = 21$) to overcome barriers related to the power dynamics prevalent within the Indian public health system.

We shared all the strategies identified from Steps 1 and 2 with the workshop participants, who then discussed components of the interventions, their delivery processes, points of intersection between the two delivery agents (PHC staff and Sangathis), perceived challenges and mitigation strategies, and factors that could facilitate effective delivery of the programme. We added newly recommended intervention strategies to a triangulation sheet and rated all strategiesusing a predefined scale (described in Step 4).

We audio-recorded the workshops with participants' consent and took notes on participants' non-verbal cues. We used these data to develop a visual map outlining the pathways to change, together with the facilitators and barriers throughout the pathway. The outputs from all the workshops were synthesised into a final visual map.

Step 4: Triangulation of findings

We generated a consolidated list of strategies to improve help-seeking and adherence to treatment that emerged from Steps 1, 2 and 3. We then developed a decision-making scale (Supplementary Material S1: Scale to rate each help-seeking and adherence strategy on empirical evidence, contextual appropriateness and trial feasibility) to rate each strategy as high, moderate or low on (a) empirical evidence (from Step 1), (b) contextual appropriateness (themes

https://doi.org/10.1192/bjo.2026.12092 Published online by Cambridge University Press

emerging from Steps 2 and 3) and (c) trial feasibility (determined by the study team). While community stakeholders were the key decision-makers in Steps 2 and 3, the research team independently made decisions in Step 4.

Strategies with high ratings on all three criteria moved on to Step 5. Strategies with low to moderate ratings on any one criterion were either included in or excluded from Step 5, depending on the extent to which they were perceived to influence the study objectives.

Step 5: Content development

We organised the key strategies emerging from Steps 1 to 4 into relevant themes guided by the intervention goals. We then structured these strategies into an intervention manual based on the thematic areas that fitted well together. Subsequently, we used this manual to develop the training and delivery components of the intervention, namely: (a) the IMPRESS community intervention e-course (for training); and (b) the IMPRESS community intervention toolkit (for delivery) (see Fig. 1).

The IMPRESS community intervention e-course (training component): Informed by lessons from our previous implementation projects,[15,16] and the need to train more than 120 Sangathis, we chose a hybrid training model consisting of online prerecorded videos supplemented by weekly interactions with a 'coach' (programme staff known as Sangathi facilitators). Sangathi facilitators are non-specialist graduates from local communities who we trained to: (a) identify Sangathis through community networking; (b) conduct regular calls and meetings with Sangathis to collect and digitally document data (using REDCap 14.0 for Windows; Vanderbilt University, Nashville, Tennessee, USA; https://projectredcap.org/software/) relating to the various domains of the intervention; and (c) provide support and problem-solve as required.

We converted the intervention manual into scripts for the e-course, first in English and then translated them into Konkani, as recommended by participants in Step 3. After multiple rounds of review by the study team, we uploaded the final videos onto Graphy, an e-course hosting platform. The e-course is available on Google Play Store as the 'IMPRESS Sangathi e-course'. We placed assessment questions at regular intervals throughout the course to increase learner engagement.

The IMPRESS intervention toolkit (delivery component): This includes an illustrated manual, patient handouts, awareness banners and stickers to help Sangathis deliver the intervention. These materials were developed and reviewed in English by the study team, then translated into the local languages and reviewed by community representatives. We employed a local illustrator to produce contextually relevant illustrations for the toolkit.

Piloting

We piloted the e-course in two rounds with five community volunteers in each round. In the first round, we sought feedback on the videos for Module 1 of the e-course from community members. We used convenience sampling to recruit participants from the community. Their feedback informed revisions to the scripts and filming plan. Following revision of the videos, we conducted a second round of feedback.

Findings

The findings from the systematic reviews (Step 1) have been published separately[13,14] and the identified strategies are summarised in Supplementary Material S2 (Flowchart of strategies extracted from the empirical data sets – Step 1). The characteristics of the participants involved in the qualitative interviews (Step 2) are presented in Supplementary Material S3 (Sociodemographic details of participants – Step 2).

We synthesised the data from Steps 1 to 4, as described in the Methods, to answer the following key questions for researchers, practitioners and policy makers and guide intervention development and delivery.

A. Who is a suitable community volunteer to increase help-seeking for and adherence to depression care?

Based on the systematic reviews (Step 1), delivery agents for most programmes included community health workers, such as accredited social health activists (ASHAs), MPHWs, ANMs, *Anganwadi workers* (frontline workers who support maternal and child care) and village council members.

Findings from the qualitative interviews (Step 2) and consultation workshops (Step 3) with community stakeholders recommended that community volunteers should have the following characteristics:

(a) Be perceived as helpful within their community (e.g. they might help their neighbours apply for government welfare services).
(b) Be able to develop supportive relationships with people experiencing distress and their family members.
(c) Be intrinsically motivated to help people and their communities.
(d) Be members of existing community groups, such as self-help groups, farmers' associations, village councils and sports clubs, which conduct various community-level activities such as competitions, cultural events and public talks.
(e) Ideally, be motivated by non-monetary incentives (e.g. certificates of appreciation, recognition in newspapers).
(f) Have a fair understanding of depression or be trainable to share accurate information and debunk myths.
(g) Most importantly, be able to maintain confidentiality.

B. What community strategies can be used to increase help-seeking for and adherence to depression care?

Strategies to increase help-seeking: We identified 43 different help-seeking strategies from Steps 1 to 4 described above. Supplementary Material S4 (List of strategies extracted from the formative research work) lists these strategies, their descriptions and ratings against the criteria of empirical evidence, contextual appropriateness and trial feasibility. Of the 43 strategies, 20 met the criteria for inclusion in the community intervention (i.e. were rated high on all three factors). We excluded 21 strategies (see Supplementary Material S5 – Help-seeking and adherence strategies that were excluded) because they failed to meet 1 or more of the criteria, and 2 were excluded because they were more relevant to health facilities. These two strategies were: training primary healthcare staff to identify and address CMDs and providing mental health first aid.

Strategies to improve adherence: We extracted a total of 14 categories of adherence strategies from the steps described above. We use the term 'categories' here because, unlike the help-seeking strategies, some adherence strategies had multiple versions of the same strategy with minor differences. For example, 'prompts and cues' were delivered in different forms, such as telephone calls or text messages before a session. We excluded 4 of the 14 categories from the intervention because they scored low against our criteria. We excluded five adherence strategies because they were more relevant to delivery by the counsellor. These were: (a) collaboratively deciding the frequency and session dates, (b) creating contingency ('if-then') plans, including anticipating barriers to

https://doi.org/10.1192/bjo.2026.12092 Published online by Cambridge University Press

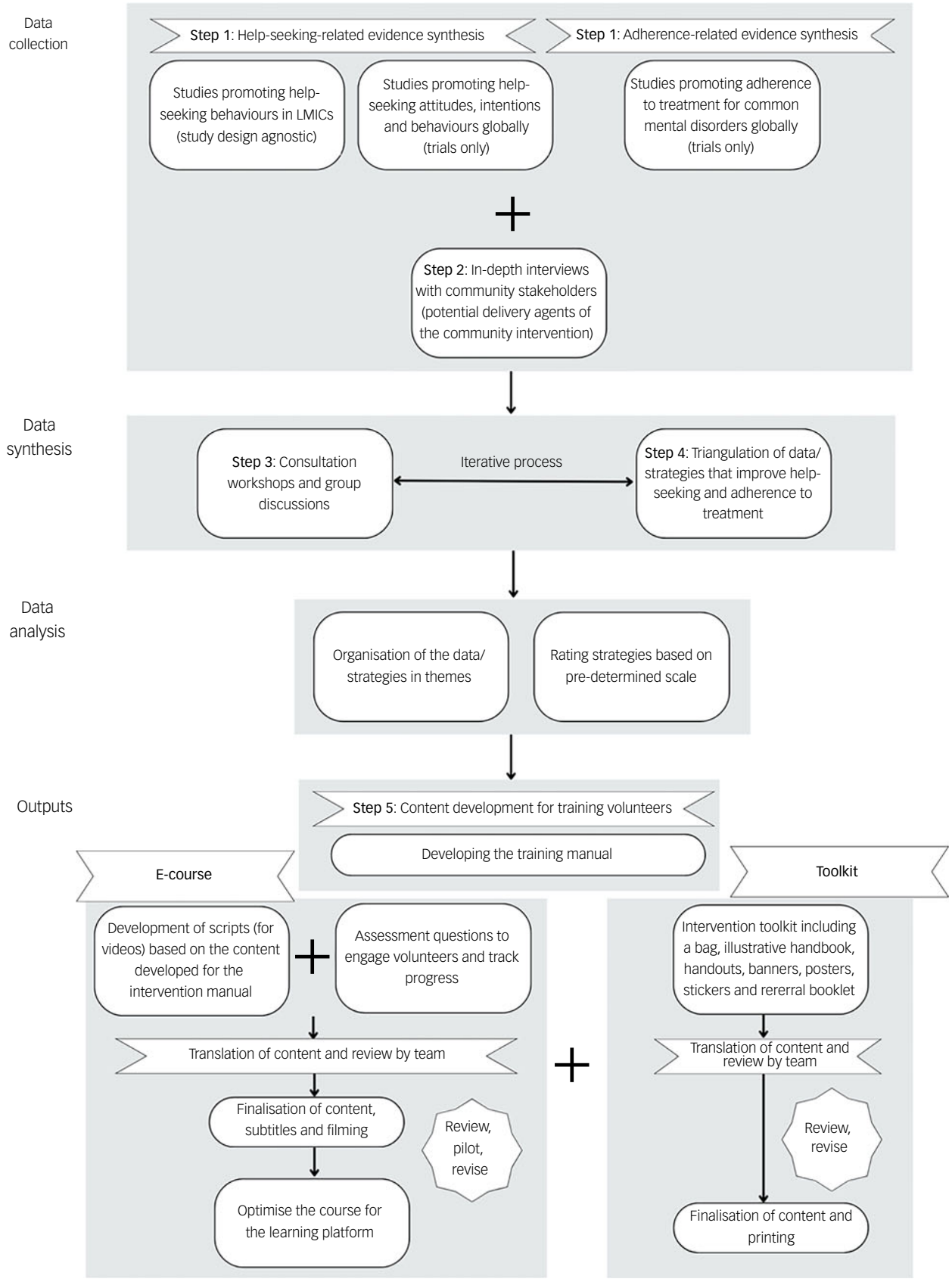


Fig. 1 Process followed to develop the IMPRESS community intervention. IMPRESS, Implementation of Facility- and Community-Based Interventions to Reduce the Treatment Gap for Depression; LMIC, low- and lower-middle-income country.

treatment compliance and generating potential solutions, (c) providing information about counselling and antidepressants, (d) linking daily habits of the patient to treatment compliance, and (e) helping patients manage side effects of medications and directing them to set treatment adherence goals. Table 1 lists all strategies eligible for inclusion in the intervention. Strategies

https://doi.org/10.1192/bjo.2026.12092 Published online by Cambridge University Press

Table 1 Help-seeking and adherence strategies included in the community intervention

Help-seeking strategies included	Adherence-related strategies included
Creating gatekeeper referral systems	Prompts and cues (e.g. reminder calls or mobile messages 1 day before a session)
Using community screening tools to identify the health problem	Providing psychoeducation about depression and counselling to the patient and their family
Using illustrative case vignettes to create awareness	Providing practical assistance with attending sessions or homework completion
Individual meetings with community leaders to create buy-in into the programme	Follow-up home visits between sessions and precounselling orientation to treatment
Providing extended support services (referrals to legal, social and economic welfare services)	Improving communication between the counsellor and patient (the community volunteer acting as a mediator)
Conducting public meetings to talk about the health problem	
Creating peer support groups in the community	
Screening videos of lived experiences in small groups	
Banners (instead of wall paintings) in the community to create awareness about symptoms and treatment options	
Increasing engagement between healthcare staff and community volunteer (e.g. orientation meeting between the two at the health facility before initiating the programme)	
Conducting community health camps and screening for the concerned health problem	
Creating community champions	
Distribution of IEC materials in-person	
Using folk media to encourage help-seeking	
Providing non-monetary incentives to community volunteers	
Setting up village committees to further the cause	
Including traditional healers in the referral pathway	
Training family members to identify the signs of depression	
Sport tournaments and other community-level competitions as platforms to create awareness	
Providing monetary incentives to community volunteers	

IEC, Information, Education, and Communication.

excluded from the intervention are listed in Supplementary Material S5 (Help-seeking and adherence strategies that were excluded), along with the rationale for their exclusion.

Considering community diversity (e.g. differences in language, religion and sociocultural practices due to occupation, migration or colonial influence), we found that a 'menu of options', where the Sangathis can choose intervention activities from a list, would be more acceptable than prescribing the same activities for all communities. All intervention strategies were categorised into four domains: Learn, Inform, Engage and Follow up, which are further expanded in Table 2. 'Learn' refers to the period when the Sangathi completes the e-course.

In addition to the 'menu of options', our findings recommend that community volunteers should first introduce themselves and their role as volunteers to community leaders, followed by creating a community advisory group to plan community activities from the 'menu of options' and then implementing the intervention. Many participants emphasised the need for a repository of information on services available for problems related to alcohol use, domestic violence and poverty, which are common in these communities. An inability to provide support with these services was identified as a potential barrier to the acceptability of the intervention.

The 'Inform' strategies, intended to influence help-seeking for depression among groups of people at a time were categorised into five types:

(a) Distributing educational materials (putting up banners, distributing flyers and stickers and sending multimedia content via messaging platforms);
(b) Public meetings (speaking about depression and counselling at village council meetings, organising events on World Mental Health Day or Women's Day and screening the lived experiences film at these events);
(c) Competitions (e.g. art, singing, sport, dancing, cooking, poster making);
(d) Street plays and local theatre;
(e) Health camps (liaising with their PHC to conduct general health screening camps, during which talks on depression and counselling services are delivered).

The 'Engage' strategies, used to interact with individuals and their families, include:

(a) Meeting people experiencing distress at their homes and encouraging them to seek help;
(b) Identifying signs of depression using the Patient Health Questionnaire-2 (PHQ-2) as a conversation aid and referring individuals to the health centre, where they would be screened by a trained screener using the PHQ-9 to address false positives;
(c) Sharing handouts about depression and counselling with individuals and their families;
(d) Sharing videos of people with depression talking about their counselling experiences.

The 'Follow up' strategies involve ways in which Sangathis can support adherence to treatment:

(a) Reminding patients about their sessions via telephone calls;
(b) Checking in after the session to ask whether they need assistance with the homework assigned;
(c) Offering practical assistance, such as transportation to the facility;
(d) Visiting people between sessions and motivating them to complete treatment;
(e) Mediating communication between counsellors and patients.

https://doi.org/10.1192/bjo.2026.12092 Published online by Cambridge University Press

Table 2 The IMPRESS community intervention framework

	← Self-care →			
	Orient Sangathis to potential support systems and developing individual self-care plans			
Intervention component	Learn	Inform	Engage	Follow up
Learning objectives as part of the e-course	Learn concepts of mental health, depression, counselling and orienting them to the depression care available at the health centre as part of the project	Learn different ways in which they can create mass awareness about depression and the programme in their community and to equip them with the skills required to conduct these events	Learn to identify people in distress using the PHQ-2, how to engage with them and encourage them to seek counselling for depression and interact with their families in a sensitive manner	Learn about ways in which the Sangathi can help the patient adhere to treatment
Stakeholder engaging with the component	Sangathi (community volunteer) + Sangathi facilitator (programme staff)	Sangathi + general population	Sangathi + person in distress and their family members	Sangathi + person receiving counselling and their family members
Mode of delivery	Self-paced online course and on-call/in-person coaching support from the facilitator	Community engagement activities e.g. video screenings, educational talks, street plays, folk theatre and distribution of leaflets	In-person interactions with the family at their home, handouts and videos of people with lived experience shared	Weekly reminder calls, text messages, help with between-session homework and in-person accompaniment to the session
Intended impact	Improved knowledge and skills among Sangathis to encourage people to seek help and adhere to counselling	Increased help-seeking for depression care at a group level	Increased help-seeking, social support and adherence to depression care at an individual level	Improved adherence to treatment (and consequentially improved clinical outcomes) at an individual level

IMPRESS, Implementation of Facility- and Community-Based Interventions to Reduce the Treatment Gap for Depression; PHQ-2, Patient Health Questionnaire-2.

Similar to the tailored approach for help-seeking strategies, Sangathis would personalise adherence strategies according to the needs of each patient.

In summary, Sangathis were conceptualised as individuals who would play the role of primary delivery agents for the community intervention. They would create awareness about the depression programme in their local villages through the 'menu of options' described above, encourage those at risk to seek support, engage with family members as required and coordinate continued care for people receiving HAP through reminders, follow-up visits and practical support (e.g. to reach health centres and/or for homework completion).

C. Where in the community can the intervention be delivered?

Both the empirical and contextual data revealed that the intervention should ideally be integrated within existing community structures and events, such as village council meetings, annual village competitions, village festivals and folk theatre. Street plays in public places were endorsed as acceptable and feasible. Community video screenings of people's lived experiences, although perceived as acceptable and innovative, were also perceived as having low feasibility because of the resources required. Social media dissemination was recommended instead; however, this was not feasible because of the potential risk of contamination between clusters.

Among the strategies to improve adherence, home visits, reminder calls and messages were endorsed only for families who are supportive of the person seeking counselling. For families opposing treatment adherence, psychoeducation for family members about the benefits of counselling, using brochures and testimonial videos of people with lived experience, was recommended. Being accompanied by a trusted community member for home visits and discussions was also advised.

D. How can we train and support community volunteers to ensure fidelity to the intervention?

Training (i.e. the 'Learn' component)

Considering the large number of volunteers who needed to be trained simultaneously, a self-paced online course with support from a 'coach' was recommended as more feasible than in-person training.

We developed an e-course aligned with the structure of the main intervention components described in Table 2. The e-course consists of 5 modules, with 41 videos in total, each lasting 3 and 5 min. The videos are in Konkani, the local language, and the total course can be completed in 3 h. Supplementary Material S6 (Blueprint of the IMPRESS community intervention manual and e-course) provides the outline and learning objectives of the e-course.

All the modules include potential challenges that Sangathis might face and suggest mitigation strategies. The e-course includes questions after each module to engage learners and pre- and post-training quizzes to measure the effect of training on knowledge, attitudes and beliefs about depression and counselling. Sangathis will be given 4 weeks to complete the e-course and will be supported by weekly calls/visits from a Sangathi facilitator.

Piloting of the videos developed for the e-course

We selected five community volunteers to review the videos in two rounds. Round one of the pilot informed us that each video should be limited to 5 min or less and that more skill-demonstration videos should be included instead of a lecture format. We received feedback to add quizzes between videos to sustain attention and retention. Round two indicated that the videos were appropriate in duration and comprehensibility but required multiple viewings to retain content. Participants recommended supplementing the e-course with coaching and a printed booklet and including subtitles in multiple local languages.

https://doi.org/10.1192/bjo.2026.12092 Published online by Cambridge University Press

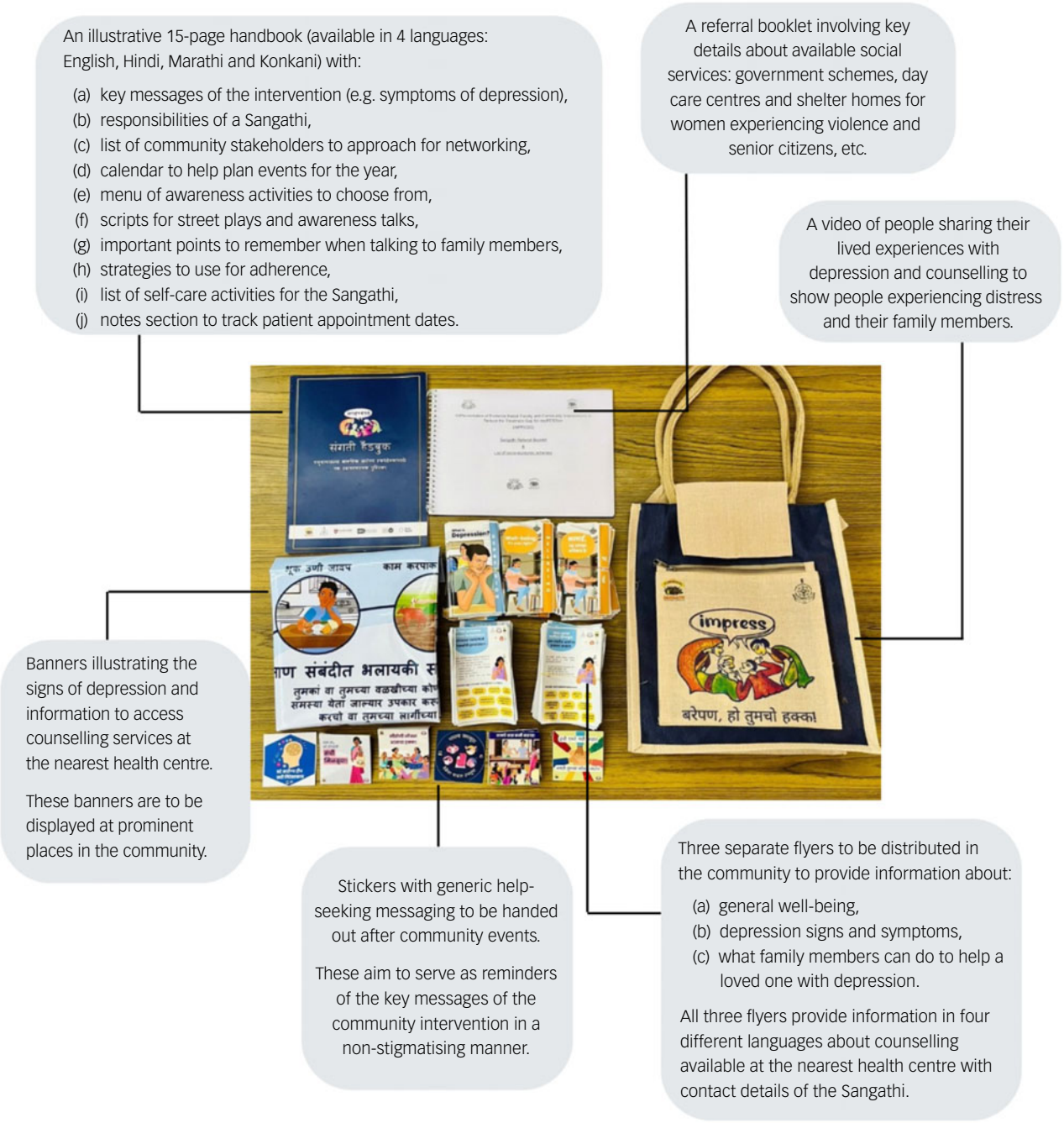


Fig. 2 Intervention delivery toolkit.

Intervention delivery toolkit

Once the Sangathis complete the e-course, they receive a certificate of completion and an intervention delivery toolkit (Fig. 2).

Discussion

Our paper describes the process of collaborating with community stakeholders to develop a community intervention to increase help-seeking for and adherence to depression care in India. We developed this intervention through a systematic process that began with extracting intervention components from global evidence via systematic reviews on help-seeking and adherence strategies. We supplemented this with contextual knowledge and experience from consultation workshops, a review of Indian health programmes and qualitative interviews with local stakeholders. Finally, through collaboration during the development process, we organised these components into an intervention delivery framework (see Supplementary Material S7 Intervention delivery and pathway to change map). In the resultant intervention, a community volunteer creates awareness about depression in their communities using contextually acceptable strategies, encourages people to be screened at the nearest public health facility and follows up with them to ensure that they engage with a six- to eight-module evidence-based counselling treatment delivered by a trained counsellor at the health facility. Sangathis do not provide counselling or directly address any of the clinical needs of the patients.

The effectiveness of this intervention is being tested through a cluster RCT comparing counselling for depression delivered by primary healthcare staff ('facility-only model') with the community intervention ('community model', consisting of the 'facility-only model' plus the Sangathi intervention described above).[7]

https://doi.org/10.1192/bjo.2026.12092 Published online by Cambridge University Press

We hypothesise that the community model will be superior to the facility-only model in: (a) increasing demand for depression treatment in primary care; (b) increasing uptake of treatment by patients with depression; (c) increasing treatment completion rates; (d) reducing symptoms of depression; and (e) being cost-effective. We expect this to occur through an increase in 'contact coverage' (the proportion of affected individuals who seek help) and 'effective coverage' (the proportion of individuals seeking care who ultimately derive the desired outcomes from the intervention).

We hypothesise that the community intervention can improve 'contact coverage' and 'effective coverage' through two mediation pathways. At the population level, we expect the community intervention to improve awareness of depression and its treatment, leading to increased help-seeking behaviour at health facilities ('contact coverage'). At the individual level, the community intervention is designed to increase perceived support (i.e. a person's belief that support is available when required; e.g. awareness of the presence of a Sangathi in their community) and actual support (e.g. Sangathis assisting them to complete homework or travel to the facility). This, in turn, will affect activation levels (i.e. the degree to which patients routinely engage in meaningful, goal-directed activities) and treatment completion rates, positively affecting the effective coverage outcome.

Finally, we will also examine implementation-related questions around motivation of delivery agents (primary healthcare staff and community volunteers/Sangathis), scalability and sustainability of the interventions.

Besides similar community interventions by Sangath,[17,18] we found two other interventions being tested in the Indian context[19,20] and two interventions being implemented in resource-constrained settings.[21,22] For all these interventions, we did not find descriptions of systematic intervention development processes that informed the content and delivery of the interventions, as described in this paper. However, we found some similarities with these interventions regarding the profile of volunteers in the Atmiyata study and some of the components in both the Atmiyata and SMART interventions (e.g. use of video testimonials to create awareness, door-to-door visits, addressing social determinants of mental health such as domestic violence and dependent drinking, and integrating these activities within existing community events). Some differences include the use of volunteers to deliver a low-intensity psychosocial intervention in addition to identifying CMDs in the population, the use of ASHAs and digital tools to identify people with CMDs and the use of volunteering as the active ingredient to treat depression and anxiety in young people.[23]

The strength of our intervention is that we followed a rigorous and systematic methodology of multi-stakeholder intervention development to triangulate global empirical evidence (Step 1) with contextual experiences (Steps 2–3), thereby increasing the potential for the intervention to be acceptable, feasible and effective.[24] Another strength of our intervention is the simultaneous focus on optimising both intervention content and delivery by identifying the most effective components to increase help-seeking for and adherence to depression care (content) and the most acceptable ways to train community volunteers to deliver this intervention (delivery). If found to be effective, this approach will inform policy and practice by providing direction to health system and social welfare decision-makers regarding entry points for financial and human resource investments, as well as providing avenues for partnership between civil societies, community partners and the primary healthcare system.

We acknowledge some limitations of our study. First, following such a rigorous intervention development methodology requires substantial resources, making it difficult to replicate. This is noteworthy because even contextually adapted interventions require further adaptation when implemented in similar but geographically different settings. However, to minimise the cost of redeveloping the e-course in other languages, we have retained the English scripts for all the intervention materials. Second, not all community volunteers may possess the requisite digital literacy or a smart phone. Additionally, although the e-course can be completed offline, it requires internet connectivity to download the videos to the phone and synchronise learner activity with the backend data dashboard. These challenges could be mitigated by using portable internet routers in the field to download the videos to volunteers' phones or by bringing volunteers to a location with internet access to download the e-course. Third, feedback from volunteers indicated that the videos required repeated viewing to retain the content. The need for a coach to bridge this gap is an additional burden in resource-constrained settings. Finally, this intervention does not train community volunteers to independently manage suicide risk in the community without referral to a trained mental health professional.

Our intervention builds on a strong evidence base for task-sharing to bridge the mental healthcare gap. It is designed to address demand-side barriers to depression care while supporting supply-side functions in resource-constrained settings. If shown to be effective, this community intervention could be adapted to increase help-seeking and adherence, thus improving the reach of psychosocial treatments in similar settings.

Miriam Sequeira, Addictions and Related Research Group, Sangath, India; **Yashi Gandhi**, Addictions and Related Research Group, Sangath, India; and Department of Population Health, London School of Hygiene & Tropical Medicine, London, UK; **Richard Velleman**, Addictions and Related Research Group, Sangath, India; and Department of Psychology, University of Bath, Bath, UK; **Daisy Radha Singla**, Campbell Family Mental Health Research Institute, Centre of Addiction and Mental Health, Toronto, Canada; **Kedar Mirchandani**, Addictions and Related Research Group, Sangath, India; **Luanna Fernandes**, Addictions and Related Research Group, Sangath, India; **Helen A. Weiss**, MRC International Statistics and Epidemiology Group, London School of Hygiene & Tropical Medicine, London, UK; **Bijayalaxmi Biswal**, Addictions and Related Research Group, Sangath, India; **Urvita Bhatia**, Addictions and Related Research Group, Sangath, India; and Department of Population Health, London School of Hygiene & Tropical Medicine, London, UK; **Lalan Karapurkar**, Addictions and Related Research Group, Sangath, India; **Lalan Madkaikar**, Addictions and Related Research Group, Sangath, India; **Nikita Nalawade**, Addictions and Related Research Group, Sangath, India; and Wolfson Institute of Population Health, Queen Mary University of London, London, UK; **Chunling Lu**, Department of Global Health and Social Medicine, Harvard Medical School, Harvard, Massachusetts, USA; **Vikram Patel**, Department of Global Health and Social Medicine, Harvard Medical School, Harvard, Massachusetts, USA; **Abhijit Nadkarni**, Addictions and Related Research Group, Sangath, India; and Department of Population Health, London School of Hygiene & Tropical Medicine, London, UK

Correspondence: Abhijit Nadkarni. Email: abhijit.nadkarni@lshtm.ac.uk

First received 19 Jul 2025 UTC, final revision 25 Jul 2026 UTC, accepted 28 Jul 2026 UTC

Supplementary material

The supplementary material is available online at https://doi.org/10.1192/bjo.2026.12092

Data availability

The data that support the findings of this study are available on request from the corresponding author (A.N.). The data are not publicly available because they contain information that could compromise the privacy of research participants.

Acknowledgements

We acknowledge the contributions of all the researchers who worked on the three systematic reviews, which have been published separately, and the support provided by Ankur Garg (A.G.) and Brian Zhou (B.Z.) in analysing the in-depth interviews conducted as part of Step 2.

Author contributions

M.S. conducted the formal analysis, investigation and supervision and wrote the original draft of the manuscript. Y.G. conducted the formal analysis, investigation and supervision, managed

https://doi.org/10.1192/bjo.2026.12092 Published online by Cambridge University Press

the project administration and wrote the original draft of the manuscript. R.V. contributed to the conceptualisation, acquired funding, developed the methodology and reviewed and edited the manuscript. D.R.S. contributed to the conceptualisation, acquired funding, developed the methodology and reviewed and edited the manuscript. K.M. conducted the investigation and reviewed and edited the manuscript. L.F. conducted the investigation and reviewed and edited the manuscript. H.A.W. acquired funding and reviewed and edited the manuscript. B.B. conducted the formal analysis and reviewed and edited the manuscript. U.B. supervised the study, managed the project administration and reviewed and edited the manuscript. L.K. conducted the investigation and reviewed and edited the manuscript. L.M. conducted the investigation and reviewed and edited the manuscript. N.N. conducted the investigation and reviewed and edited the manuscript. C.L. acquired funding and reviewed and edited the manuscript. V.P. contributed to the conceptualisation, acquired funding, developed the methodology and reviewed and edited the manuscript. A.N. contributed to the conceptualisation, acquired funding, developed the methodology and reviewed and edited the manuscript.

Funding

The IMPRESS study was funded by the National Institute of Mental Health (NIMH), USA (grant number R10MH115504).

Declaration of interest

None.

References

1 Moitra M, Santomauro D, Collins PY, Vos T, Whiteford H, Saxena S, et al. The global gap in treatment coverage for major depressive disorder in 84 countries from 2000–2019: a systematic review and Bayesian meta-regression analysis. *PLOS Med* 2022; **19**: e1003901.

2 Murthy RS. National mental health survey of India 2015–2016. *Indian J Psychiatry* 2017; **59**: 21–6.

3 Grover S, Dua D, Chakrabarti S, Avasthi A. Dropout rates and factors associated with dropout from treatment among elderly patients attending the outpatient services of a tertiary care hospital. *Indian J Psychiatry* 2018; **60**: 49–55.

4 Sarikhani Y, Bastani P, Rafiee M, Kavosi Z, Ravangard R. Key barriers to the provision and utilization of mental health services in low-and middle-income countries: a scope study. *Community Ment Health J* 2021; **57**: 836–52.

5 Subba P, Luitel NP, Kohrt BA, Jordans MJ. Improving detection of mental health problems in community settings in Nepal: development and pilot testing of the community informant detection tool. *Conflict Health* 2017; **11**: 1.

6 Patel V, Weobong B, Weiss HA, Anand A, Bhat B, Katti B, et al. The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: a randomised controlled trial. *Lancet* 2017; **389**: 176–85.

7 Nadkarni A, Gandhi Y, Fernandes L, Mirchandani K, Kamat S, Weiss HA, et al. Effectiveness and cost-effectiveness of a community intervention in enhancing access to care and improving clinical outcomes for depression: a protocol for a cluster randomised controlled trial in India. *Trials* 2024; **25**: 569.

8 Kohrt BA, Asher L, Bhardwaj A, Fazel M, Jordans MJ, Mutamba BB, et al. The role of communities in mental health care in low-and middle-income countries: a meta-review of components and competencies. *Int J Environ Res Publ Health* 2018; **15**: 1279.

9 Singla DR, Kohrt BA, Murray LK, Anand A, Chorpita BF, Patel V. Psychological treatments for the world: lessons from low-and middle-income countries. *Ann Rev Clin Psychol* 2017; **13**: 149–81.

10 International Institute for Population Sciences (IIPS). *National Family Health Survey (NFHS-5)*. IIPS, 2020.

11 Sagar R, Dandona R, Gururaj G, Dhaliwal RS, Singh A, Ferrari A, et al. The burden of mental disorders across the states of India: the Global Burden of Disease Study 1990–2017. *Lancet Psychiatry* 2020; **7**: 148–61.

12 Xu Z, Huang F, Koesters M, Staiger T, Becker T, Thornicroft G, et al. Effectiveness of interventions to promote help-seeking for mental health problems: systematic review and meta-analysis. *Psychol Med* 2018; **48**: 2658–67.

13 van den Broek M, Gandhi Y, Sureshkumar DS, Prina M, Bhatia U, Patel V, et al. Interventions to increase help-seeking for mental health care in low-and middle-income countries: a systematic review. *PLOS Global Public Health* 2023; **3**: e0002302.

14 Biswal B, Gandhi Y, Singla DR, Velleman R, Zhou B, Fernandes L, et al. Interventions for improving adherence to psychological treatments for common mental disorders: a systematic review. *Cambridge Prisms Global Ment Health* 2024; **11**: e83.

15 Tugnawat D, Singh A, Anand A, Bondre A, Chandke D, Dhurve P, et al. ESSENCE: an implementation research program to scale up depression care in rural communities. *Psychiatr Serv* 2024; **75**: 167–77.

16 Khan A, Shrivastava R, Tugnawat D, Singh A, Dimidjian S, Patel V, et al. Design and development of a digital program for training non-specialist health workers to deliver an evidence-based psychological treatment for depression in primary care in India. *J Technol Behav Sci* 2020; **5**: 402–15.

17 Shidhaye R, Murhar V, Gangale S, Aldridge L, Shastri R, Parikh R, et al. The effect of VISHRAM, a grass-roots community-based mental health programme, on the treatment gap for depression in rural communities in India: a population-based study. *Lancet Psychiatry* 2017; **4**: 128–35.

18 Chatterjee S, Naik S, John S, Dabholkar H, Balaji M, Koschorke M, et al. Effectiveness of a community-based intervention for people with schizophrenia and their caregivers in India (COPSI): a randomised controlled trial. *Lancet* 2014; **383**: 1385–94.

19 Shields-Zeeman L, Pathare S, Walters BH, Kapadia-Kundu N, Joag K. Promoting wellbeing and improving access to mental health care through community champions in rural India: the Atmiyata intervention approach. *Int J Ment Health Syst* 2017; **11**: 1.

20 Maulik PK, Tewari A, Devarapalli S, Kallakuri S, Patel A. The Systematic Medical Appraisal, Referral and Treatment (SMART) Mental Health Project: development and testing of electronic decision support system and formative research to understand perceptions about mental health in rural India. *PLOS ONE* 2016; **11**: e0164404.

21 Village HopeCore International. *How Our Community Health Volunteers are Empowering Communities to Address Mental Health*. Village HopeCore International, 2024 (https://www.villagehopecore.org/blog/how-our-community-health-volunteers-are-empowering-communities-to-address-mental-health [cited 19 May 2025]).

22 Yaresheemi S, Elangovan AR, Jangam K, Doraiswamy P, Sharma MK, Chandra PS. Outcome of capacity building in mental health for well-being volunteers. *Front Psychiatry* 2023; **14**: 1205344.

23 Ballard PJ, Daniel SS, Anderson G, Koehler AN, Caballero Quinones E, Strahley A, et al. An exploratory feasibility study of incorporating volunteering into treatment for adolescent depression and anxiety. *Front Psychol* 2022; **13**: 840881.

24 Mishu MP, Tindall L, Kerrigan P, Gega L. Cross-culturally adapted psychological interventions for the treatment of depression and/or anxiety among young people: a scoping review. *PLOS ONE* 2023; **18**: e0290653.

https://doi.org/10.1192/bjo.2026.12092 Published online by Cambridge University Press