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Review

Nurturing transformative participation: A participatory realist review of mental health interventions in low resource settings

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ABSTRACT

Purpose: The importance of involving people with lived experiences of mental health difficulties and the communities they inhabit, in interventions for them is now widely recognised. However, there is a lack of scrutiny around the theory and practice of how - and to what extent - participation occurs in global mental health interventions. The aim of this review was to examine existing literature and consult with community groups in low and middle income settings in order to understand how, for whom and under what conditions participatory approaches work to lead to positive outcomes for mental health.

Methods: Informed by a realist approach, we developed a new methodology combining a realist literature synthesis with the experiences of everyday citizens and service users from communities within low and middle income countries. Across a ten-step process we systematically reviewed literature and iteratively conducted focus group discussions, to inform the development of mid-range theories and a programme theory of participation that was reviewed and approved by community members in our LMIC sites.

Results: Participation in global mental health varies widely across contexts and programmes. We developed a programme theory based on seven principles, to understand how and under what circumstances participation can be meaningful, transformative and lead to improved mental health. The principles were: 1. Interventions and programmes should be built on strong relationships with communities in their localities; 2. Long term engagement in a locality means that services are more responsive; 3. A trusting, supportive and collaborative therapeutic relationship is critical when responding to mental health needs; 4. it is important to integrate existing beliefs, metaphors and traditions into understandings about mental health; 5. Groups and peer support can be important sources of social support leading to changes at individual and group levels; 6. Providing mental health support in spaces which are physically and emotionally safe helps marginalised groups to participate; and 7. Facilitating opportunities for participation and collective action strengthens mental health and social wellbeing.

Conclusions: Bringing together theory and practice, this realist review underscores the importance of meaningful participation in global mental health. Through this work we develop a programme theory, identifying seven key principles important to facilitating transformative participation.

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1. Introduction

Globally, mental health conditions are highly prevalent and are a leading cause of disability (GBD 2019 Mental Disorders Collaborators, 2022). While historically people with lived experience of mental health difficulties have had little involvement in decision making regarding service and research (Allan et al., 2018; World Health Organization, 2010), there is an increasing consensus within Global Mental Health (GMH) research and practice of the importance of involving people with lived experience of mental health (and their own communities) in the design, delivery, evaluation and governance of their care (United Nations General Assembly Human Rights Council, 2017; World Health Organisation, 2021). However, while participation is often championed, evidence suggests participation of those most affected remains limited in low and middle income contexts (Allan et al., 2018; Lempp et al., 2018). Furthermore, there remains limited articulation of what participation means in practice, from the perspectives of communities themselves, and how this interfaces with wider power dynamics in research and care.

The extent of participation at different stages within the implementation process varies hugely. Participatory theories recognise the spectrum of participation, often expressed through typologies (stages) or continuums (Heap et al., 2022). Minimum levels of participation - described as *consultation, information* (Goetz and Gaventa, 2001; Wilcox, 1994) or even *manipulative* (Arnstein, 1969; Pretty, 1995) are where people have little voice, and their inclusion is tokenistic. The highest level of participation,- described as *self-mobilising* (Pretty, 1995), *influence* (Goetz and Gaventa, 2001) or *citizen control* (Arnstein, 1969) is community-led, leading to tangible change as dictated by people who are the end-users of interventions. These continuums recognise that levels of participation may vary and shift over time. Furthermore, levels of participation, *who* participates and for *what* purpose are influenced by often differing motivations, resources and power dynamics. We previously developed a mind-map bringing together key debates around participation and the impact of participatory approaches (Supplementary File 1), recognising the diverse possible actors, motivations, and structural and interpersonal power dynamics (Heap et al., 2022). Crucially, wwe also recognise that relationships and power dynamics vary over time, including within the timeframes of projects and when service users are involved. This has important implications for ethics and the nature of participation and our efforts to ensure participation is meaningful for those involved.

As a group of authors we are interested in both the theory and application of participation within GMH. In this programme of work we have focused specifically on how participation is conceptualised and applied in low and middle income countries (LMIC) recognising that most mental health interventions include dimensions of locality requiring local participation (Bemme and D' souza, 2014). We examine the extent of participation with a particular interest in "transformative" participation as defined by White (1996), which calls attention to the ways in which participation seeks to address multiple vectors of social adversity as it relates to poor health outcomes, including acknowledgement of injustice, multiple forms of poverty, and how collective action is necessary within such spaces to improve mental health.

1.1. Aims and research questions

The aim of the review was to examine existing literature relating to participatory mental health interventions in LMICs and consult with community groups in different LMIC settings to understand how, for whom and under what conditions participatory approaches 'work'. Through this work we aimed to answer the following research questions:

1. Why and for whom has participation been used in mental health interventions in LMICs?
2. How and to what extent has participation been operationalised in research versus implementation?
3. What are the mechanisms of action of participation and how are they linked to local contexts?
4. Why, how and under what circumstances can community participation in mental health interventions lead to improved mental health?

2. Materials and methods

2.1. Realist review

To our knowledge this paper presents the first realist review of participatory approaches in the global mental health intervention landscape. Realist reviews are valuable for interrogating literature for the purpose of identifying the parameters for successful interventions in relation to concepts and approaches (Pawson et al., 2005). A realist methodology seeks to answer "what works for whom and under what circumstances?" through combining theoretical and empirical observation (Brown et al., 2018; De Weger et al., 2018; Klingberg et al., 2001; Pawson et al., 2005; Wong et al., 2013).

In reviewing and synthesising evidence, realist reviews focus on understanding the mechanisms through which an intervention does or does not work (Rycroft-Malone et al., 2012). They typically involve an initial programme theory, which is refined through the development of mid-range theories (Brown et al., 2018; Goodman et al., 2016; Saul et al., 2013) which are generated through 'Context' 'Mechanisms' and 'Outcome' (CMO) configurations. These are developed in response to research questions and extracted from the literature to explain how interventions work (mechanisms), the circumstances needed (context), for whom, and the results (outcome)and then collated to inform a revised programme theory or summary "principles" (De Weger et al., 2018).

2.2. Conceptual framework – The purpose of participation?

We are interested in the theory and application of participation within GMH. Our working definition of participation is *"the active involvement of people affected by interventions or targeted action (including research) in them"*. We recognise a range of actors representing a range of interests and motivations, the wider socio-economic context and structural and interpersonal power dynamics as well as their changing nature over time.

When examining levels of participation as part of this review, we apply the work of White in her article "depoliticising development" (White, 1996). Drawing on case studies from projects in LMICs, White argues that participation can take multiple forms and serve many different purposes and that while participation can challenge existing patterns of dominance, it can also be a means of entrenching and reproducing existing power structures. It is therefore vital to scrutinise *who* participates and the *level* of participation. In ranking interests in participation she outlines four typologies: nominal (which is primarily for legitimation or display), instrumental (which is efficient and functions as a means), representative (which gives communities both a voice and leverage) and transformational (empowerment). White et al. (2014) describes transformational participation as "the idea of participation as *empowerment* is that the practical experience of being involved in considering options, making decisions, and taking collective action to fight injustice is itself transformative. It leads on to greater consciousness of what makes and keeps people poor, and greater confidence in their ability to make a difference" (p.8-9). We draw on this model as it aligns with our conceptualisation of participation and it recognises the dynamic nature of participation, the variety of interests and its interplay with power. In examining participation, we conceptualise that it should be striving towards transformative – where communities affected are empowered, interventions are directed by those most affected and collective action is taken.

2.3. Overall approach

Our application of a realist approach, involved collaborative decision making and the active involvement of service users and communities. We opted to include a combination of academics, activists, and practitioners (see author positionality statement supplementary file 2) within our core team rather than include them as experts in later consultations, as is typically done with realist reviews. As part of the review process itself we included a series of focus group discussions (FGDs) and consultations in four LMIC settings: Zimbabwe, North India and an urban and rural site in Nepal. These groups included people with lived experience, which we define as personal experience of a psychosocial disability/mental health difficulties (details of the FGDs are in Table 3) as well as other interested citizens. The findings from the FGDs are reported as part of the review, and contributed to the final TOC and corresponding principles (steps 7–9). While typically realist reviews do not include lived experience consultations, the inclusion of people with lived experience of the phenomenon explored within a realist review has recently been recognised as valuable praxis, with examples of this approach being taken in recent years (Ashman et al., 2024; Jones et al., 2024; Walsh et al., 2022). Expanding the core team and including communities was consistent with our interests in applying a participatory praxis in our work, to ensure a disruption of traditional hierarchies and pathways through which non-academics shape knowledge production (see Freire, 1972).

Our 10-step process was broadly informed by Saul et al.'s stages of a rapid realist review (2013) - expanding significantly to include the groups in LMIC settings. Following reviewer response to our published protocol (see Heap et al., 2022), we labelled our work a realist review, as our process extended beyond typical timings of 'rapid' reviews. Fig. 1 outlines the 10-step process. We outline the 10 specific steps and related procedures in the following sections. we deviated from pour protocol in one area, by refining our TOC (step 9) prior to dissemination (step 10) this enabled community and lived experience input into our final TOC. Supplementary file 3 reports our completed checklist for realist reviews, in line with the RAMESES (Realist And Meta-narrative Evidence Syntheses: Evolving Standards) guidelines (Wong et al., 2013): see Nyssen and colleagues (2016). Our reporting structure in the manuscript follows Saul's 10 stages.

2.3.1. Step 1 and 2: Defining key concepts and developing research questions

To develop a deep understanding of our key theoretical concepts around participation we developed a mind-map based on a conceptual review of literature from the academic fields of development, health and human rights in January 2021 (supplementary file 1). The mindmap and group discussion in later monthly team meetings were used to develop our research questions. Based on this mind map, we established our initial programme theory which would anchor the remaining steps of the process (see protocol paper for mind map and initial programme theory).

2.3.2. Step 3 and 4: Search terms and identifying papers

Search terms and databases were discussed in team meetings and finalised in March 2021. Our inclusion and exclusion criteria were also informed by our conceptual review, to ensure that the notion of participation was clearly articulated early on. Table 1 summarises our inclusion and exclusion criteria for the search (full details are in our protocol). We included seven databases: Web of Science, Medline, PsychINFO, ASSIA, CINAHL Complete, EMBASE and JSTOR. Searches were conducted by all team members using Rayyan software. Screening was coordinated by CH, under the supervision of HMJ. 10% of papers were double screened by RAB, and conflicts were resolved during team meetings. Full text-screening involved the whole team, working in pairs.

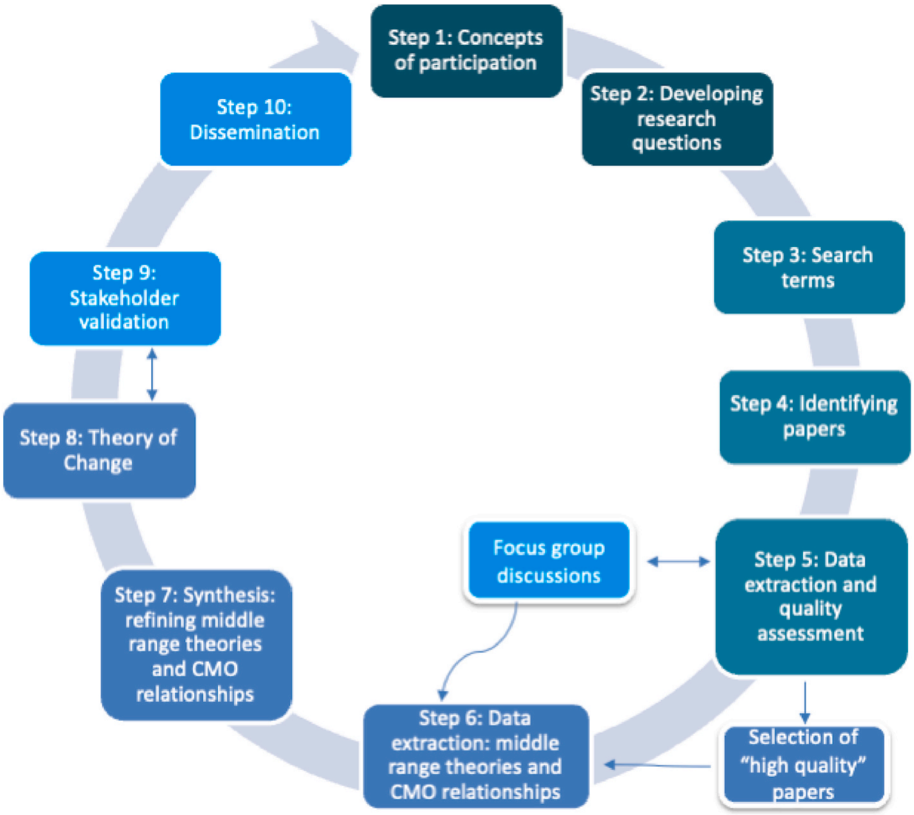


Fig. 1. 10-step methodology.

Table 1
Inclusion and exclusion criteria.

Inclusion Criteria	Exclusion Criteria
Located in low- and middle- income countries; Health and development projects/ interventions addressing mental health; Intervention, or research study about an intervention, which claims to be participatory OR clearly demonstrates the active involvement of the target population in concept, design, implementation, or evaluation; Any ‘level’ of intervention including individual, group, and systemic interventions such as national and international projects; Any method - qualitative, qualitative, or case study; Participants are people with mental health problems, their unpaid carers, or other people from the community such as local health workers or laypeople; On or after 2001, based on the World Health Report which presented community-based mental health services as critical	‘Participation’ does not include the active involvement of people from the target community (e.g. laypeople, local professionals, people with mental health problems, carers); Not about an intervention (‘intervention’ = support group, a specific mental health policy, training)

Table 2
Definitions and categories for data extraction.

Category	Definition/report
Study title and year of publication	As stated in the paper
Country	Country where the intervention occurred
Aims of study	As stated in the paper
Description of study methods	Brief description of methods used
Intended beneficiaries	The people who are suppose to benefit from the intervention
Participants	Those who take part in the study/intervention i. e. as research participants, deliver the intervention (may be overlap with beneficiaries)
Formal theory of participation	Theory of participation that is explicitly mentioned
Conceptual and pragmatic justification for participation	Conceptual: theories that are used to justify participation Pragmatic: Practical reasons for participation
How participation is used	‘What’ is participation used for i.e. at what stage in the process e.g. design, implementation, evaluation
Outcomes of the study	What was reported by the authors (measurements, descriptions)
Mention of power?	Yes or no
Definition of power	If power was mentioned what definition (if any) was given
Level of participation	As defined by White: Nominal, Instrumental, Representative, Transformative
Author stated mechanisms	Mechanisms of change due to participation (not the intervention)
Author stated outcomes	Outcomes stated due to participation (not the intervention)
Quality Assessment	Joanna Briggs Quality Assessment (Qualitative, RCT, Quasi Experimental) or Mixed Methods QuADS
Realist Quality Rating	Relevant and Rigorous (Low, medium or high)

Table 3
Focus group discussions details.

Country (site)	Demographic details	Total (N)
India (Uttarakhand): FGD1	4 women; all Muslim; age range 21–40 years old 2 carers, 2 PWLE[a]	4
India (Uttarakhand): FGD2	5 men; all Sikh; age range 18–30 years old 2 PWLE, 3 community members	5
India (Uttarakhand): FGD3	5 women; all Hindu; age range 21–40 years old 2 carers, 1 PWLE, 2 community members	5
Nepal (Surkhet district): FGD1	3 women, 2 men; 3 Chhetri (‘high’) caste, 2 Dalit caste; age range 21–62 years old 2 carers, 3 PWLE	5
Nepal (Surkhet district) FGD2	5 women, 2 men; all Dalit caste; age range 21–60 years old 2 carers, 5 PWLE	7
Nepal (Kathmandu, Lalitpur): FGD1	8 women, 4 men; age range 25–57 years old 6 carers, 6 PWLE	12
Nepal (Kathmandu, Lalitpur): FGD2	9 women, 4 men; age range 25–57 years old 7 carers, 6 PWLE	13
Zimbabwe (Shamva district): FGD1	10 women: age range 18 and over 4 carers, 2 PWLE, 3 health workers, 1 community leader	10
Zimbabwe (Shamva district): FGD2	8 men: age range 18 and over 3 Carer, 1 PWLE, 1 health worker, 2 community leader, 2 community members	9
Zimbabwe (Shamva district): FGD 3	3 women, 5 men: age range 18 and over 2 carers, 2 PWLE, 1 health worker, 1 community leader, 2 community members	8

Note: Exact ages are often not known, hence some ages were missing. All participants however were confirmed as over 18 years old.
Note.
[a] People with lived experience (of psychosocial disability/mental health problems).

2.3.3. Step 5: Data extraction and quality assessment

The first level of data extraction for all included papers was organised by a live excel sheet, with common categories including: study aims, methods, details on participatory processes and levels and use, as well as references to power (see Table 2 for full definitions).

We used two quality assessment approaches. First we applied Joanna Briggs Critical Appraisal tools to assess methodological rigour. Second we rated the papers according to realist principles of *relevant* (to the research question) and *rigorous* (methodological rigour of good enough quality to make a meaningful contribution to the review). We rated every study according to whether they were high, medium or low on these two assessments (Wong et al., 2013). Uncertainties as to the data extraction, relevance and rigour were discussed in team meetings and CH, RB and HMJ did final quality checks.

The findings were collated, synthesised and written up descriptively, focusing on the first two research questions: why and for whom has participation been used in mental health interventions in LMIC? How and to what extent has participation been operationalised in research versus implementation?

2.3.4. Focus group discussions

Concurrently with step 5, two rounds of FGDs across four sites were conducted between April and July 2021 (details of FGDs and participants are in Table 3). The first explored understandings and experiences of participation. The second round explored levels (as defined by White, 1996) and types of participation; case studies from the review were shared and the different forms of participation were discussed. FGDs were recorded and transcribed (Nepal) or detailed notes taken/reported (India, Zimbabwe). The transcripts were reviewed and organised thematically around five themes: meanings of participation; how participation is done in practice; the importance of participation; the impact of participation; barriers and facilitators to participation. The analysis was conducted by researchers at Chhahari Nepal for Mental Health (BM, SM, RM), organised into tables and shared with the wider group.

2.3.5. Step 6: Data extraction: middle range theories and CMO relationships

The second level of data extraction focused on a subset of “high quality” papers that would enable the production of middle range theories. High quality papers were considered rigorous, relevant and with enough detail to extract CMO configurations. Potential studies for this were identified by the research team. From the initial 62 papers, 24 were identified. RAB, HMJ and CH reviewed 24 papers. Initially two members of this sub-team reviewed each paper individually and recommended whether it should be considered for the final list, any differences of opinions were resolved through consensus. The criteria for "high quality" papers depended on having at least two of the following criteria: 1. Rigorous based on the quality assessments, 2. Relevant to the research questions with enough detail to extract CMOs on participation (i.e. include discussions of participation) and 3. Considered transformative or representative under White's participation framework. This process took place July–August 2021 resulting in 10 "highest quality" papers selected for the second round of data extraction.

In August 2021 KM facilitated an online workshop on realist reviews and CMO (context-mechanism-action) extraction with the research team. CMO configurations identify "enabling contexts" for "enabling mechanisms" which will trigger outcomes. The aim of CMO extraction was to identify CMO configurations explicitly related to participation triggering positive outcomes for mental health, rooted within each "highest quality" study. Following the workshop small teams (3–5 people) worked together to extract 2–5 CMO combinations from each paper.

2.3.6. *Step 7: Synthesis: Refining CMO relationships and middle-range theories*

The identified CMOs and FGD data were reviewed and combined to finalise seven principles – based on mid-range theories of participation explaining the *enabling contexts* needed for *enabling mechanisms* that trigger *positive outcomes* for mental health in LMICs. Each principle is supported by evidence from high quality research papers and FGDs.

The process of combining and refining the principles involved an initial review of the CMOs from each paper which were combined by a small group (led by KM and HMJ) which were shared with the wider team for further feedback and refinement. The wider team met online to discuss and review the principles, on the basis of the combined CMO list. This process took place between September and December 2021. The principles formed the basis of our revised theory of change.

2.3.7. *Steps 8 and 9: Theory of change and stakeholder validation*

Based on the seven principles we revised our programme theory developing a comprehensive *theory of change (TOC) for participation in mental health interventions.* RB led two workshops with the wider research team (in May and September 2022) where we discussed each principle in depth, organised and refined the TOC according to principles, contexts, mechanisms and outcomes. The TOC is rooted in research and aims to be practical and pays attention to the processes, application and theories of participation, taking into account power dynamics and the different interests of communities. It lays out the context needed for change/transformation in mental health, the mechanisms that should be triggered and the resulting medium and long-term outcomes of ideally transformative participation.

The TOC was translated into Nepali, Hindi and Shona and shared with people who had been involved in the FGDs, through 6 workshops in Nepal, India and Zimbabwe between February and June 2023. During the workshops. Participants reflected on the TOC overall and each principle, as well as the project and review overall. A report on the reflections was written up for each workshop and following all the workshops the TOC was finalised.

2.3.8. *Step 10: Dissemination*

We plan to share our final TOC, following publication, through a webinar inviting partners and third sector organisations. We will also disseminate the translated versions locally through our partner organisations in India, Nepal and Zimbabwe.

3. Results

We present the results in two parts. First we descriptively report the findings of the literature and the FGDs, steps 1–5, answering our first two questions: *1. Why and for whom has participation been used in mental health interventions in LMICs?; 2. How and to what extent has participation been operationalised in research vs implementation?* Secondly, we report on steps 6–9, extraction of mid-range theories from our "high quality papers" and FGDs and the revised programme theory, answering the subsequent questions of the review: *3. What are the mechanisms of action of participation and how are they linked to local contexts, 4. Why, how and under what circumstances in mental health interventions lead to improved mental health?*

3.1. *Section one: Why, for whom and how has participation been used in mental health in LMIC and to what extent has it been operationalised*

3.1.1. *Overview of papers reviewed*

The systematic search yielded a total of 1469 papers. Following screening, 97 papers went forward for full-text review. Of these, 62 were included in the data extraction for the first round of the review. Supplementary file 4 outlines these studies and summarises the data extracted. The studies covered at least 25 LMICs. Asia and Africa had the highest percentage of papers (36% and 41% respectively) followed by 11% each for the Middle East and South America. The Caribbean had one paper. Some papers crossed several countries and even continents. All included studies were academic articles except one Doctoral dissertation (Lasater, 2018) and two book chapters (Thomas, 2006; Hubbard and Pearson, 2004). The papers reported on mental health interventions, at different stages in the process including: formative research pre-intervention, feasibility and acceptability of interventions, the process of development, experiences of the intervention, evaluations and lessons learned.

Supplementary file 5 summarises the 24 papers finally included by the research team (described in section 2.3.4) to answer our second research question. The 10 papers that met the criterion for "highest quality" papers were used to answer questions three and four and development of the PT (these 10 papers are highlighted in supplementary file 5). The findings from the FGDs are summarised in supplementary file 6.

3.1.2. *Why has participation been used?*

Within the full sample of papers: 19 (31%) studies reported participation as part of informing the design of an intervention (i.e. formative and scoping research), 18 (29%) reported participation as a part of the development or adaptation of the intervention, 33 (53%) as part of the implementation and 23 (37%) the evaluation. Several studies (N = 25, 40%) reported on more than one stage of participation within the project (and were double counted). We acknowledge that multiple papers can report on a single study, meaning participation within various stages of a project are not reported in a single paper. Within our original sample we found linked studies for three projects: the PRIME study, a multi-country study for improving mental health care (Catalao et al., 2018; Makan et al., 2015; Mendenhall et al., 2014), the PREMIUM study aimed at addressing problematic alcohol use among men in India (Nadkarni et al., 2015; Singla et al., 2014) and the *Nae Disha* programme in Northern India targeting young people affected by mental illness (Kermode et al., 2007; Mathias et al., 2018). In our second stage we added a study (Asad et al., 2011) linked to another study in the initial sample (Hirani et al., 2010).

3.1.2.1. FGD findings. Participants of the FGDs described participation as being a "part" of things such as an organisation, groups and activities. Participation was understood primarily in the actual implementation of programmes or events with a focus on action across all the FGDs. For example going to meetings or taking part in events or campaigning. Several of the groups reported the benefits of participation such as increased access to services, resources and emotional support.

3.1.3. For whom has participation been used?

Table 4 shows a list of beneficiaries for the interventions reported on and study participants from the full sample. This distinction is relevant, as some studies did not include the intended recipient of the mental health intervention as participants in the research (N = 11). The beneficiaries of interventions were primarily women (N = 16 studies, 10 of which were related to pre or the postpartum period or early motherhood), adults seeking mental health support or identified with mental health problems (N = 15), and young people (N = 19). Men were primary beneficiaries in just three studies: two in relation to alcohol use and linked to the same overall project (Nadkarni et al., 2015; Singla et al., 2014) and one in relation to their pregnant partner (Iheanacho et al., 2015). Some interventions had multiple beneficiaries, notably the inclusion of families and caregivers (who were not the main target of any interventions in their own right). In the majority of studies the intended beneficiaries were part of the research in some way (N = 51, 82%) studies. The majority of studies included mixed groups of stakeholders and participants (N = 41, 69%). However, there were large variations in how many groups of participants were included, and often they were consulted at different stages in the project and research.

3.1.3.1. FGD findings. Group members identified inclusion and being open to a range of people (particularly groups often excluded from society) as important. A group in rural Nepal reported that many community groups exclude people with mental health problems. Groups in both Nepal and Zimbabwe stressed the importance of including carers when considering support for PWLE: as well as being able to support their family members, they should be able to support themselves. Group members described participation being limited due to individual and societal level barriers. Examples included barriers due to societal norms that limit women moving freely (India), and the stigma of mental health problems meaning people may not want to be a part of mental health projects, noting that this stigma could extend to carers (Nepal). In Zimbabwe groups noted that women and girls were more likely than men to attend mental health programmes.

Table 4

Intended beneficiaries and participants of research.

Intended beneficiaries of the intervention	Number of studies	Research participants in the study	Number of studies
Women primarily (pregnancy related or early motherhood)	16 (10)	Women	14 (7)
Adults with mental health problems and/or seeking treatment	15	Adults with mental health problems	13
Adult refugees and disaster survivors	4	Adult refugees and disaster survivors	4
Men	3	Men	3
Children and young people (including with mental health difficulties and disaster survivors)	19	Children and young people (including with mental health difficulties and disaster survivors)	11
Other groups: people with physical illness, general community, elderly	6	People with physical health problems or elderly	2
Parents/families/caregivers	9	Parents/families/caregivers	11
Care providers (including volunteers)	3	Health care providers	23
		Volunteers/peer counsellors and community workers	20
		Community members including civil society and faith based organisations	12
		Experts	7
		Policy makers/local government and donor organisations	5
		Educators/teachers	3
		Informal/traditional/religious healers	2

3.1.4. How has participation been operationalised?

3.1.4.1. Theories and conceptualisation of participation in full sample of studies. Very few studies used formal theories or conceptual frameworks to define their use of participation. Hart's eight-rung model of participation (1997) was used by Zeng and Silverstein and White's framework (1996) was mentioned by Mayston. Two studies used UN guidelines (Allan et al., 2018; Read et al., 2020), and two developed their own theory of change during the study (Makan et al., 2015; Malla et al., 2019). Four studies explicitly used 'participatory research' methods as their main approach (Hirani et al., 2010; Puffer et al., 2013; Vostanis et al., 2019; Zeng and Silverstein, 2011). Other theories used to consider participation included ethnopsychology and ethnophysiology (Lasater, 2018); social psychology (Kohrt et al., 2020); "self-empowerment" and "self-regulated learning" based on psychology theories (Khbbache et al., 2017); trauma theory (Hubbard and Pearson, 2004).

Four studies were pragmatic about participation. This involved listening to participants, making "active change" and ensuring contextual relevance (Nadkarni et al., 2015; Gureje et al., 2018), for sustainability and acceptability (e.g. Malla et al., 2019), and emphasising the importance of participation generally (Read et al., 2020).

Power was explicitly mentioned by 12 studies (Baradon and Bain, 2016; Caplan et al., 2018; Constantino et al., 2012; Hubbard and Pearson, 2004; Khabbache et al., 2017; Kohrt et al., 2020; Lasater, 2018; Makan et al., 2015; Puffer et al., 2013; Thomas, 2006; White et al., 2014; Zeng and Silverstein, 2011), and just three gave a definition(s) of power (Baradon and Bain, 2016; Constantino et al., 2012; Zeng and Silverstein, 2011). Several studies mentioned power in terms of imbalances; for example between HIC and LMICS (Caplan et al., 2018), between communities and researchers (Puffer et al., 2013) and service users and service providers (Kohrt et al., 2020). Read and colleagues (2020) highlighted the social context and often limited power of people with mental illness, while Hubbard and Pearson (2004) referred to "social power". Seven studies did make reference to 'empowerment' (Asher et al., 2018; Vostanis et al., 2019; Khabbache et al., 2017; Nadkarni et al., 2015; Gelkopf et al., 2008; Kermode et al., 2007; Sapkota et al., 2020) without a corresponding definition of power.

Social and cultural power was often implicit in study context descriptions, particularly linked to poverty and gender differences. In all studies that included women as beneficiaries, the lack of women's social, political, and economic power was mentioned. One study mentioned that the intervention was adapted to apply culturally acceptable ways of expressing views, opinions and feelings in regards to gender norms – this meant women would not directly challenge masculine authority (Gelkopf et al., 2008).

The majority of studies (N = 42, 68%) were linked to an intervention that had at least some elements of 'task-shifting', whereby local community members (including health workers) were trained to deliver an intervention. Families and caregivers tended to be research participants only when they were *also* a beneficiary of the proposed intervention (i.e. in this review, carers were not participants 'on behalf' of the people they care for).

3.1.4.2. What does participation look like in practice?. Levels of participation as described by White (1996) are: Nominal, Instrumental, Representative and Transformative (see Table 5 for explanations). Of the 62 studies, 34 were representative and three studies were transformative

(Thomas, 2006; Vostanis et al., 2019; Zeng and Silverstein, 2011; Vostanis et al., 2019). A further three studies were on the borderline for transformative approaches (Baradon and Bain, 2016; Hubbard and Pearson, 2004; Salerno et al., 2009). Only four studies were judged nominal (Becker, 2007; Desta et al., 2017; Fayyad et al., 2010; Scivoletto et al., 2011).

When examining the representative studies, a key aim of participation was ensuring sustainability of the mental health intervention. While it was rare for any study to be designed from initial concept stages by 'the community', most studies did consider local contexts with the intervention.

While transformative and borderline transformative studies were in the minority, there were elements of transformative participation in many of the included studies. Instead of 'leverage' (i.e. to influence a project and have a 'voice heard' in decisions) the participants were genuinely seeking empowerment or support. Many studies referred to mental health 'stigma' and desiring to address social and cultural barriers to inclusion, even studies where the intervention itself wasn't transformative. Therefore, this data cannot capture the full nuances of the "participatory-ness" present in the dataset. It can be considered a broad guide.

3.1.4.2. Use of participation in research methods. A range of research methods were used in the design and evaluation of projects. Focus group discussions (FGD) and interviews were commonly used to inform the design and evaluation of projects.

There were few randomised control trials, to assess the effectiveness of interventions, where participation was in the assessments. Mixed methods approaches were common; these typically included interviews and FGDs alongside standardised mental health questionnaires such as AUDIT (alcohol), SRQ-20 (mental health), or WHODAT (World Health Organisation disability measure). The majority of mixed-methods studies used qualitative interviews and FGDs in a content-based fashion (e.g. how can an intervention be improved, or what was good about an intervention). There were some qualitative evaluations that were experience focused (for example: Allan et al., 2018; Hubbard and Pearson, 2004; Thomas, 2006).

Rarely was participation used as an end in itself. Only in participatory action studies was participation used on principle or for empowerment (Kermode et al., 2007; Zeng and Silverstein, 2011). Elsewhere, participation tended to be used pragmatically or as a vehicle for a better, more sustainable intervention.

Table 5
Levels of participation.

Form	What 'participation' means to the implementing agency	What 'participation' means for those on the receiving end	What 'participation' is for
Nominal	Legitimation – to show they are doing something	Inclusion – to retain some access to potential benefits	Display
Instrumental	Efficiency – to limit funders' input, draw on community contributions and make projects more cost-effective	Cost – of time spent on project-related labour and other activities	As a means to achieving cost-effectiveness and local facilities
Representative	Sustainability – to avoid creating dependency	Leverage – to influence the shape the project takes and its management	To give people a voice in determining their own development
Transformative	Empowerment – to enable people to make their own decisions, work out what to do and take action	Empowerment – to be able to decide and act for themselves	Both as a means and an end, a continuing dynamic

Note: Reference: Cornwall, A., 2008; page 273. Table adapted by Cornwall (2008) from White (1996: pages 7–9).

3.1.4.3. Use of participation in implementation studies. In our sample of 24 shortlisted studies, we reflected on how participation was used in relation to the broader research cycle. Here we were informed by the principles of participatory action research cycles of planning, action and reflection (Braum, 2016). We paid attention to the importance of including key actors in the conceptualisation, design, implementation of the intervention, participation with the intervention through to the evaluation. We identified that in these studies, there was use of participation in all five stages and this breakdown is presented in Fig. 2.

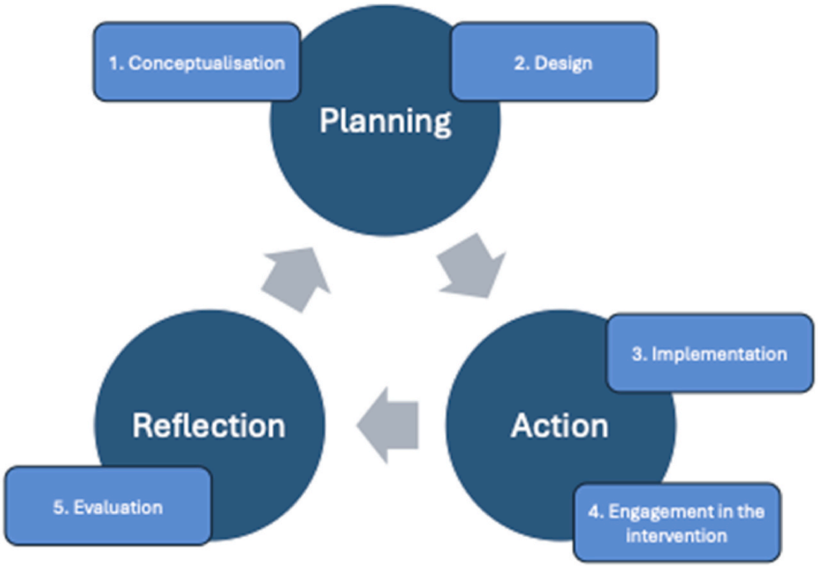
In the longlist of 24 studies, 13 studies reported participation at two or more stages in their programme of work. Of the studies labelled as transformative or with transformative aspects, four of the five studies had participation at two or more levels of their programme work, confirming that transformative participation will likely be linked to increased opportunities to take ownership and define the parameters of the work. There was only one study (Khbbache et al., 2017) where people engaged in a participatory intervention that they did not contribute to in terms of the design, implementation or evaluation. Six studies had participation in conceptualisation, and eight in evaluation. There were more occurrences of participatory involvement in the design (n = 10) and implementation (n = 13) stages suggesting that this remains a common way to have people be 'involved'.

3.1.4.4. FGD findings. The importance of *meaningful* participation was highlighted in groups in Nepal, who noted that when this did not happen it had negative effects and people felt under-valued or frustrated. They gave examples of being asked to participate in events for the "headcount" or one-way interactions with health care professionals (i.e. tokenistic participation). In contrast, they also gave examples where participating and working together as a group had led to collective action and positive change. For example, groups in India and Nepal spoke about working together to put pressure on institutions leading to increased access to services or practically providing support to people in the wider community. Meaningful, two-way participation valuing beneficiaries could be actively facilitated by organisations practically. Suggestions included having accessible spaces, being available to contact, providing opportunities and providing practical support. Furthermore the behaviour and attitudes of people within organisations was important, for example participants described that supporting and encouraging staff would facilitate participation.

3.2. Section 2: Developing a programme theory of Participation in mental health interventions

This section describes our final programme theory and its seven principles that emerged from steps 6–9. Based on the final ten "highest quality" papers and FGD data to develop refined-mid range theories by the core team, the principles and PT were shared through community consultations in India, Nepal and Zimbabwe in 2023. The group members reflected on each principle as well as the theory overall, and gave a final approval. As the process is organised within a realist approach, we will report our findings organised by our final seven principles. Our framework is summarised in Fig. 3 and the principles (with their corresponding enabling contexts, mechanisms and outcomes) are described in supplementary file 7.

The centre of the flower diagram (yellow) highlights the primary overall outcome of participatory services. The middle ring (pale blue) highlights the often-shared outcomes from key mechanisms (dark blue petals) and their related principles. Wording of principles in the diagram has been edited slightly to increase legibility but reported in full sentences below. Principles one and two relate to intervention development



1.Conceptualisation = involvement in generating ideas, identifying needs (i.e. scoping, formative research).
2.Design = involvement in building/construction of the intervention (content of the intervention)
3.Implementation = involvement in delivery of the intervention (i.e. peer led).
4.Engagement in the intervention = participant in a participatory intervention but not involved in the design, conceptualisation etc.
5.Evaluation = involvement/inclusion in evaluating impact/efficacy/reflections

Fig. 2. Participation in the research cycle.

and design; principles three, four and five relate to content of interventions and delivery of care, and principles six and seven relate to the development of bridges between treatment and care, and wider community impacts and changes.

3.2.1. *Principle 1: Interventions and programmes should be built on strong relationships with communities in their localities*

The active involvement of communities from the start of intervention development was noted as critical in our final sample of studies, and by communities. Active involvement was defined as opportunities for communities to define their resources and needs, as well as the responses. Papers suggested that this would trigger key mechanisms, including shared decision making and a more equal balance of power which gives a greater sense of ownership and responsibility (Salerno et al., 2009; Zeng and Silverstein, 2011), feelings of inclusion (Hubbard and Pearson, 2004; Mayston et al., 2016) and a greater sense of trust, value and self-efficacy (FGDs; Salerno et al., 2009). It will also trigger the increased offering of resources, time and collective action (Mayston et al., 2016; Salerno et al., 2009). Practical, relevant and responsive support in turn further strengthens relationships between communities and organisations. For example, the work of Zeng and Silverstein (2011) highlighted the value of staged activities and work with children that was geared at building up trust and the identification of needs that could be addressed collaboratively. FGDs in both India and Nepal argued for the need for relationships of trust and mutuality within projects, while in Zimbabwe participants noted that communal projects would evoke feelings of pride, ownership and a sense of belonging. Likely outcomes include: interventions are person-centred in theory and practice to respond to the priorities of service users (FGDs; Mayston et al., 2016; Salerno et al., 2009; Zeng and Silverstein, 2011) and investment in increased resources (staff, infrastructure, time) from both programmes and communities (Mayston et al., 2016; Salerno et al., 2009) to enable programmes to continue, which contributes to a greater sustainability of programmes. For example, Salerno et al. (2009) highlighted development of eight diverse mental health programmes being established in response to the wide range of issues raised by participants.

3.2.2. *Principle 2: Long term engagement in a locality means that services respond to the priorities of communities*

Time and long-term commitment to a project/programme by partners emerged as key for engaged participation. Enabling contexts for this include: services and staff that are committed to being there beyond the parameters of a project, local human resource investments (hiring and supporting of local and long-term staff), and implementation design which allows for flexibility but recognises the afterlife of an intervention. When projects adhere to this principle, mechanisms such as trust in the service (Hubbard and Pearson, 2004), are triggered, and services are more likely to be able to respond to priorities/adapt to the needs of the wider community (Hubbard and Pearson, 2004; Malla et al., 2019; Mayston et al., 2016; Salerno et al., 2009), with effective tracking and responses to changes in the project and people's experience within the project over time. For example, Hubbard and Pearson (2004) highlighted that outside staff made long term commitments to working closely with local staff and volunteers, and committed to supporting local takeover of tasks, making themselves available year-round. Malla and colleagues (2019) noted the importance of long-term engagement through appointment of local staff only, who were given ongoing training and support throughout and after the project. FGDs from all of our settings highlighted that trust in organisations and programmes is developed when they are able to serve and respond to community priorities, including those beyond the project.

Studies and community members highlighted that triggering these mechanisms would likely lead to both a greater uptake of services, and better management of mental wellbeing (Aggarwal et al., 2020; Asher et al., 2018; Asad et al., 2011; Hubbard and Pearson, 2004).

3.2.3. *Principle 3: A therapeutic relationship that is trusting, supportive and collaborative is critical when responding to mental health needs*

This principle highlights that the nature of relationships between practitioners and service users is a primary determinant of good outcomes, regardless of the modality of delivery. Collaborative, consistent trusting two-way relationships between service providers and communities was identified as triggering key mechanisms such as trust in

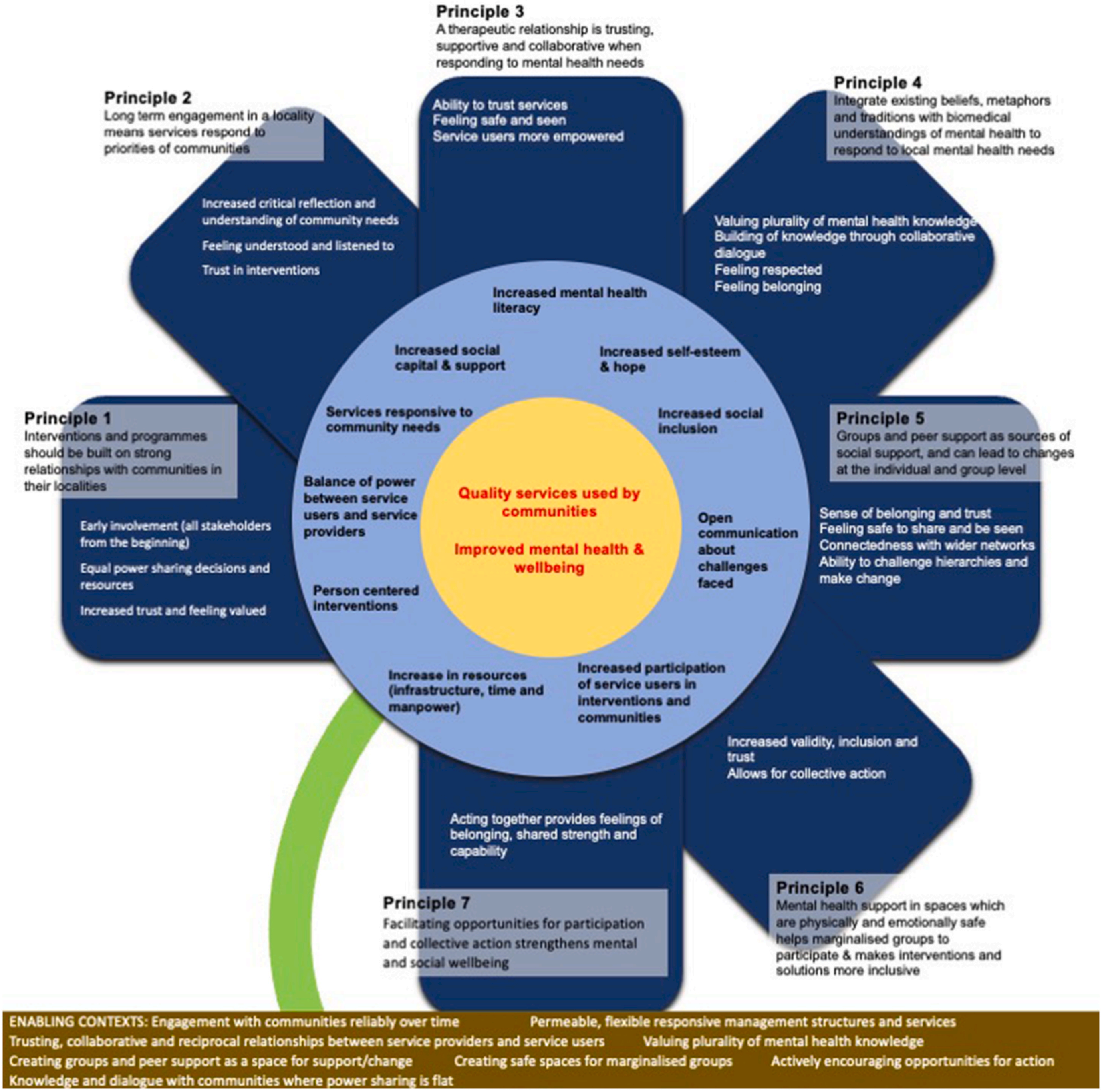


Fig. 3. The Blossom Model: nurturing transformative participation in low resource settings.

services and workers, which increased likelihood of accessing services (Aggarwal et al., 2020; Asher et al., 2018; Hubbard and Pearson, 2004). These therapeutic relationships should also lead to more sustained and improved support for service users (Asher et al., 2018; Hubbard and Pearson, 2004; FGDs), which can increase hope and self-esteem (Asher et al., 2018). For example, FGD participants in Nepal and India described that they appreciated being treated with respect by healthcare workers, which was in sharp contrast to how other services typically interacted with PWLE in their settings. They also highlighted that the needs of specific groups (such as women and carers) needed to be considered. We also identified key enabling contexts for such mechanisms to be triggered, such as organisations embedding a therapeutic relationship which includes two-way trust; This also requires a shift in power relations particularly in places with very strong hierarchies within society and health services.

3.2.4. Principle 4: It is important to integrate existing beliefs, metaphors and traditions into understandings about mental health in order to respond to local mental health needs

Integrating an understanding of mental health into existing context specific knowledge and practices triggered increased understanding of mental health (Malla et al., 2019) as well as sharing and discussions between people (Hubbard and Pearson, 2004). Some studies highlighted that it can also lead to a community acceptance of an intervention (Asad et al., 2011). Our focus group discussions highlighted how many communities highly value religious and cultural traditions which provide indigenous ways of understanding and responding to mental health. As such, necessary enabling contexts included: time and material resources; collaboration; gender-sensitivity; and working closely with communities ensure a deep understanding of existing traditions and metaphors and how to move forward. For example, Malla and colleagues' (2019) work in Kashmir started with GMH and WHO understandings of mental health, but were adapted using context specific understandings and metaphors. Assad and colleagues worked with women to design a community group-based intervention, as women felt that individual home-based interventions would reflect negatively on individual households, exposing them to further stress and social stigmatisation. FGDs in Zimbabwe and Nepal highlighted the inseparability of culture and religious structures in both settings, as well as specific cultural practices that are linked to tenets of well-being. For example,in Zimbabwe, the *Nhanga,* a women's safe space for dialogue and discussion dates back centuries (Gumbonzvanda et al., 2021) and *Guthis* in Nepal are participatory social groups among *Newars* in Kathmandu valley that aim to promote social harmony and cooperation.

3.2.5. *Principle 5: Groups can be important sources of social support and lead to changes at individual and group levels*

Participatory group interventions provide opportunities through the nature of their structure for collective and peer support. High quality studies and our focus group participants agreed on the value of self-help groups to provide opportunities for support, solidarity, belonging and social networking to trigger mechanisms such as the formation of friendships and sense of belonging, competence and trust (Asad et al., 2011; Mathias et al., 2018; FGDs). This in turn, increased social support (e.g. Aggarwal et al., 2020; FGDs) and shared responsibility, while group membership increased social capital (Hubbard and Pearson, 2004; Mathias et al., 2018) and lead to development of responses to specific social and economic needs such as literacy and food (Asad et al., 2011; Hubbard and Pearson, 2004; FGDs). As a result, some studies noted improved mental health (Aggarwal et al., 2020; Hubbard and Pearson, 2004), or reduced anxiety and depression (Mathias et al., 2018). More widely, this resulted in increased access to social resources (Asad et al., 2011; Hubbard and Pearson, 2004), opportunities for economic empowerment (such as saving groups developed in Zimbabwe) and power (Nepal FGD 4). Crucially, contextual resources are needed for this principle to be achieved successfully, such as supporting the formation of groups. Finally, both researchers and participants called for an awareness of hierarchies and power dynamics within communities and groups, as people may be unwilling to join groups where there is a lack of trust or fear about stigma associated with participation in a group.

3.2.6. *Principle 6: Providing mental health support in spaces which are physically, and emotionally safe helps marginalised groups to participate. This makes interventions and solutions more inclusive*

The value of safe spaces was clearly articulated within both the high-quality studies and focus group discussions. Emotionally and physically safe spaces were enabled through responsive policies and planning, and there needed to be a culture of support and openness to each other. Importantly, the early involvement of participants (in a project or intervention) can give the opportunity to describe what resources are needed, and to shape the questions as well as solutions. In such spaces it was highlighted that participatory process where community voices can collectively identify and prioritise problems and solutions can trigger self-efficacy and value for collective community action (Asad et al., 2011; Hubbard and Pearson, 2004; Salerno et al., 2009; Zeng and Silverstein, 2011).

Accommodating spaces provide people with a sense of validity and inclusion (Read et al., 2020), trigger trust in a project and can lead to collective group action (Zeng and Silverstein, 2011). Physical safety can allow women in particular to communicate more openly about topics which are important to them and shape interventions (Asad et al., 2011; Mathias et al., 2018; FGDs). Safe spaces provide a more enabling environment and more meaningful involvement (Asher et al., 2018; Asad et al., 2011; Read et al., 2020; Zeng and Silverstein, 2011; FGDs).

3.2.7. *Principle 7: Facilitating opportunities for participation and collective action strengthens mental health and social wellbeing*

Across the previous six principles, a series of mechanisms were identified, which also map across understandings of collective action. Though our high-quality studies did not articulate a clear definition for this concept, this can be approached from the position of empowerment of service users and groups intentionally working together to enable change (Hubbard and Pearson, 2004; Salerno et al., 2009; Zeng and Silverstein, 2011; FGDs). This principle synthesises how specific activities embodied within transformative and representative forms of participation help to contribute to better mental health outcomes. For example, dialogue within safe spaces should be meaningful in that organisations learn, develop and respond to community voices (Mayston et al., 2016). Dialogue should be engaging and interactive, continuing over time, to make it accessible and interesting (Asad et al., 2011; Hubbard and Pearson, 2004; FGDs). The FGDs emphasised the importance of two-way dialogue, and Hubbard and Pearson (2004)'s paper described the use of storytelling to facilitate active dialogue. This leads to increased engagement and attendance. Three of the studies highlighted that participatory interaction and learning approaches including in the design of interventions and programmes (Aggarwal et al., 2020; Malla et al., 2019; Salerno et al., 2009) triggered development of increased knowledge and skills for both communities, and those trying to help them. Active dialogue also triggers power-sharing. Dialogue, active participation and a more horizontal balance of power can in turn trigger collective action – for example Zeng and Silverstein (2011) describe how young people came together to plan events to help their community and contribute to post-disaster recovery. Assad and colleagues (2011) discuss how a mental health intervention led to the creation of literacy groups due to the participatory methods used and community demands.

The impact of dialogue, power sharing and working collectively can lead to an increase in skills for self-care and emotional management (Hubbard and Pearson, 2004; Salerno et al., 2009; Zeng and Silverstein, 2011), social change – including changes in norms, a reduction in violence and increased sense of "place" (Salerno et al., 2009; Zeng and Silverstein, 2011), maximising of resources (Asad et al., 2011; Hubbard and Pearson, 2004) and an increase in support and social support and networks (Aggarwal et al., 2020; Hubbard and Pearson, 2004; Mayston et al., 2016; FGDs).

4. Discussion

Our participatory realist review describes how participation is "done" in mental health interventions in LMICs and demonstrates the variety of interventions, contexts and methods of participatory approaches. Importantly this review provides a new road map to put transformative forms of participation into action within the mental health research and service landscape. The seven principles of the new Blossom model are the outcome of a co-production process of knowledge synthesis that has pulled out typically hidden features of participatory processes which can improve mental health in resource poor settings. The principles coalesced across our included studies identify a stepwise model to operationalise transformative participation, and also generate new theory around participation for mental health and refine interpretations of published literature.

Our seven principles sequentially move across the research and intervention process from development to delivery to translating impacts to wider social and community levels. Our work also highlights multiple mechanisms that relate to transfers of power which operate in more hidden ways. These mechanisms help clarify the symbolic and relational forms of power bound up in participation and highlight their importance across the lifecycle of intervention and research. Our final "highest quality" ten papers provide insight into many of these areas, although notably no single study utilised all seven of these principles, which reinforces the value of a framework that illuminates the need for all principles, in the hope of changing practice in our field. For example, none of the "high quality" papers explicitly discussed positionality either in relation to the authors or local staff - hence, the potential pressure on the latter in contributing to the 'research' and nuances of these power dynamics and their impacts on research and interventions were likely missed. By making these principles explicit within a new framework, we hopefully direct others to engage in such practices more consistently in future studies.

The experts by experience groups contributed to the development of these principles both through noting how participation had been done well as well as by identifying their experiences of "participation done badly". As such, the Blossom Model emerges as a vision of the ideal that can be used by practitioners and researchers to ensure that participation has been "done right" by widening our frameworks of participation (see supplementary file 1) from those that prioritise hierarchy and typologies (Arnstein, 1969; Eyben, 2003; Pretty, 1995) and theory (Campbell and Jovchelovitch, 2000; Wallerstein, 1993) to includes those that focus more on the pragmatics of "how" and the "for what purpose" (Bennetts et al., 2011; Crawford et al., 2002; World Health Organisation, 1978). Beyond this, the Blossom model provides a novel platform for evaluating practice expanding on frameworks such as Rifkin and Kangare (2002)'s Spidergram model which has been used extensively in development settings. Future research should explore the potential of this model's application as an evaluation tool.

Our review helps to illuminate what is needed to make participation in mental health interventions and research "transformative". Our second principle draws out how valuable it is for research and interventions to engage with the full complexity of people's realities, situating mental health within the context of structural, normative, and cultural domains of everyday existence (Burgess et al., 2024). In transformative approaches, these dimensions are held and acted upon in real time as the first step of action towards health and healing. Furthermore, transformative participation is also oriented to time, and to "start before the beginning" (Hāpuku et al., 2024) This requires committing to the foundational work needed to build trusting relationships and spaces that are safe for the full range of actors to participate before even starting on codesigning together (Burgess and Choudary, 2001; Pillai et al., 2023). In order to achieve the ideal vision suggested by our Blossom Model, participation needs to be valued and resourced appropriately, especially by including those whose voices have typically been kept quiet (Mulvale et al., 2024; Pillai et al., 2023). In principle 4 we highlight the necessity of including a plurality of knowledge, perceptions. However, to do this in practice, requires a commitment to paying people for their time and contributions in ways that acknowledge this expertise as equally valuable.

This work points to the need for transformation in the governance, commissioning, design and delivery of mental health care to seek and even require authentic participation by communities, including people with lived experience. Informal ways that this has been done have been well documented in some recent studies, for example, Siston et al. (2023) in a co-production project for mental health in Brazil, describe how their group of young people and academics engaged in mutual capacity-building, building interpersonal knowledge, and implementing practices to reduce overload and promote equitable participation. Formal approaches to ensure authentic participation could include a requirement for mental health care policy makers, service commissioners or providers reporting to communities and service users as well as funding bodies, on the ways communities have participated in codesign of their work. Formal accountability mechanisms for genuine participation have been developed, for example, in the "Code of Expectations for health entities' engagement with consumers and whānau" developed by the New Zealand Health and Quality Commission (Te Tāhū Hauora Health Quality and Safety Commission, 2023). Our new Blossom model could also be used as a framework to support reflexive discussion among groups of community members and technical experts co-designing work together, to reflect on the quality of the participatory processes.

Cutting across all seven principles is a need for working relationally, which requires openness, understanding and time (Burgess and Choudary, 2001; Siston et al., 2023). In this review we found many examples of participation "done well" and we could draw out learnings on how to do this from both the papers reviewed and discussions with communities. However for participation to be meaningful across places and implementation cycles requires a fundamental shift in how mental health is "reimagined" particularly in terms of how knowledge is generated, valued and how power is shared. In our work, we focused on participation within LIMC countries, given the current emphasis of the global mental health field on these settings. However, the ways in which power impacts on participation will differ across settings, particularly in high-resource settings. For example, resources needed to promote involvement will be different among some service users in HIC; or a legacy of patient and public involvement will help lay people feel more confident and trustworthy of participatory processes. Future work should explore the relevance of our model to mental health participation in high income settings. Overall, our works builds on other calls to re-think or "re-imagine" global health and mental health, (Burgess and Mathias, 2017; Farmer et al., 2013; Rasanathan and Rasanathan, 2020), by ensuring that individuals and communities most affected by global challenges remain at the heart of research and practice, such that they have the power to decide and direct efforts on their behalf. Our work gives a theoretical and practical framework to strive towards implementing such transformative approaches in mental health.

4.1. Strengths and Limitations

We present a new ten-step methodology which includes people with lived experience within the review, validating both the process and findings at multiple stages. We do recognise the varying levels of power within communities themselves, and hence the data collected from the FGDs may have been limited if certain groups felt less able to contribute. We sought to mitigate this through holding the FGDs in familiar places, organising them through partners who were trusted/known, and cognisant of challenges linked to power and participation keeping the groups small and being mindful of those invited to participate. The FGDs added insight and practical examples, helping to shape the principles and PT. Sharing the blossom model with the same communities, and the subsequent positive feedback gave us confidence as to its usefulness and practicality. The methodology, and meaningful participation of different communities in it, is a strength of this review.

We note three structural issues linked to global mental health research which are likely to have impacted our findings. Firstly, the papers we identified as 'high quality' were predominantly led by researchers in high-income countries, and the authors based in LMICs tended to be high powered professionals working within mental health practice, universities or health clinics. Global health research asymmetrically represents high-income residing researchers which means this study must work within the unjust structural epistemology of current published peer-reviewed literature, and creates limitations in the availability of our framework to include southern perspectives of participation. Secondly, the inherent complexity in using participatory methods is likely to have limited reporting of these methods, particularly for researchers based in some low and middle-income settings. This may be linked to state regulations around mental health research, rules that require State permission(s), the lack of safety or perceived risk in conducting transformative participatory research which can limit reporting on findings from such research (Pratt and de Vries, 2018). Thirdly, it is plausible and even likely, that there have been constraints on participatory research linked to codesigned approaches receiving low priority in research grants. Funders typically prefer fully designed studies at grant writing inception rather than the more nebulous spaces linked to participatory approaches where the research question is codesigned with the priorities of the communities that emerge as the project unfolds (Charani et al., 2022; Pratt and de Vries, 2018). This is a further cause of injustice in global (mental) health research and will have limited the literature available to use in this review. Exploring constraints on the use of participatory methods in global mental health research merits funding and formal research.

Implementing this participatory realist review methodology required time to synthesise literature review findings, present these accessibly to community participants and to engage in two-way conversations on the findings of other expert by experience groups as well as the synthesised literature. This means that our findings are limited to papers published up to March 2021. However, our teams' knowledge of the field provides us with confidence that studies published after our initial review confirm these findings (Beames et al., 2021; Burgess et al., 2022; Mathias et al., 2023; Pascoe, 2022).

5. Conclusion

Bringing together theory and practice, this realist review underscores the importance of participation that has the ability to transform communities for improved mental health in low resource settings. Our review provides insight into the how of participation across diverse contexts and at different phases in the project cycle. Through bringing together theory and practice we present a way forward for transformational participation through the development of our programme theory and its underpinning principles. The seven principles of our new Blossom model provide 'best practice' trail signs for how authentic participation can be done (the processes of participation) with the people who ultimately will be end-users of interventions and programmes.

CRediT authorship contribution statement

Rochelle A. Burgess: Writing – review & editing, Writing – original draft, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Hannah Maria Jennings:** Writing – review & editing, Writing – original draft, Visualization, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Kaaren Mathias:** Writing – review & editing, Methodology, Investigation, Formal analysis, Conceptualization. **Farirai Gumbonzvanda:** Investigation, Formal analysis. **Nyaradzayi Gumbonzvanda:** Supervision, Investigation, Formal analysis, Conceptualization. **Garima Gupta:** Investigation, Formal analysis. **Cheyann Heap:** Writing – review & editing, Project administration, Methodology, Formal analysis, Data curation. **Sumeet Jain:** Methodology, Formal analysis. **Pashupati Mahat:** Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Rakchhya Maharjan:** Investigation, Formal analysis. **Sujen Man Maharjan:** Investigation. **Pooja Pillai:** Investigation. **Martin Webber:** Writing – review & editing, Methodology, Investigation, Formal analysis. **Jerome Wright:** Writing – review & editing, Methodology, Investigation, Formal analysis. **Bidya Maharjan:** Writing – review & editing, Supervision, Methodology, Investigation, Formal analysis, Conceptualization.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmmh.2025.100416.

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