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Commentary

Coproduction in Community Mental Health Implementation: Resisting Reindividualization

Comment on "Routes of Well-Being, Spiritual Harmony and Recovery in Mental Health: The Community as a Policy-Maker"

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Abstract

Agudelo-Hernández and Giraldo-Álvarez show how coproduction can move communities from consultation to the authorship of mental health policy. I argue that this achievement is fragile at a stage coproduction rarely reaches: implementation. Implementation science includes substantial multilevel, contextual, participatory, and systems-oriented traditions, yet at particular operational points it can still carry a default grammar of individual core functions, provider-to-recipient delivery, and individual outcomes that quietly re-translates a relationally conceived policy into an individual intervention. I call this failure mode reindividualization during implementation and locate it in an underexamined question: who decides which functions are essential enough to preserve? Using the Riohacha pathway, I examine three points where reindividualization can occur or be resisted: the function, the agent, and the outcome. I then address the objection that this approach dissolves fidelity and argue that coproduction must extend to the intervention's theory of change itself.

Keywords: Implementation Science, Coproduction, Community Mental Health, Theory of Change, Indigenous Health, Colombia

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Agudelo-Hernández and Giraldo-Álvarez make an important contribution by showing that community participation can move beyond consultation into the authorship of mental health policy.[1] In Riohacha, Colombia, Indigenous peoples, children and adolescents, migrants, community leaders, and institutional actors jointly constructed a pathway for mental health, well-being, and recovery, later given normative force through a local administrative act.[1] At its center is an understanding of mental health as spiritual harmony: a collective good bound to community, territory, identity, autonomy, spirituality, worldview, and cultural practice.[1] This is not additional cultural content layered onto a conventional model. It is a different account of where well-being is located and how recovery happens, in relationships and collective life rather than exclusively within individuals.

Coproduction of this kind is most visible, and most celebrated, at the moment a policy is formed. My concern is what happens next, and in Colombia the stakes are concrete: community-based mental health services remain among the least implemented modalities nationally,[2] and work on community-based rehabilitation identifies contextualization, intersectoral collaboration, resources, and community autonomy as conditions of implementation.[3] The lead article itself flags unresolved issues of costing, intersectoral participation, and implementation planning.[1] The difficulty is not that implementation science is uniformly individualist. The field includes explicitly multilevel, contextual, participatory, and systems-oriented approaches. My concern is narrower: a default grammar can still operate at the points where a policy is translated into an intervention specification, a unit of delivery, a fidelity target, a reimbursable activity, or an outcome metric. At those operational points, implicit assumptions about what an intervention's essential functions are, who delivers them, and where success should register can re-translate a relationally conceived policy into an individual intervention, delivered through a provider-to-recipient relationship and evaluated through individual outcomes. I call this reindividualization during implementation. Two recent *IJHPM* commentaries have extended the debate toward Indigenous governance and epistemic redistribution,[4] and toward therapeutic hybridization and health-system preparedness for plural forms of care.[5] I take a complementary but distinct step: even where authority is redistributed and plural therapeutic systems are recognized, reindividualization can proceed if the theory of change is left untouched. Coproduction, I argue, must reach that theory of change at

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three points where it holds or fails: the function, the agent, and the outcome.

Where Reindividualization Begins: The Core Function

Implementation science distinguishes an intervention's core functions, its essential purposes and mechanisms of change, from the forms through which they are delivered.[6] The distinction is valuable because it frees fidelity from literal replication: forms can be adapted to context and to those they serve while the essential mechanism is preserved. Yet the distinction hides a question. What counts as core has itself been defined from some conception of how change happens. If an intervention assumes that change occurs primarily within the individual, then adapting its forms, including local metaphors, familiar practices, group settings, or community facilitators, can improve cultural fit while leaving that assumption intact. The intervention comes to look highly adapted while remaining individualist in its mechanism. Reindividualization requires no one to reject the community's meaning; it requires only that no one revisit who decided what was essential.

Group interventions make the stakes visible. A group can be a mere delivery format for individually targeted content, or the relationships within it, including trust, belonging, and collective strength, can themselves be the mechanism, as a realist review of community psychosocial groups found.[7] Whether the collective is packaging or mechanism is precisely the judgment the core-function distinction leaves to whoever defines the core.

The Riohacha pathway shows how concrete this becomes. Indigenous leaders proposed translating national Health Procedure codes into Traditional Actions for Mental Health, mapping practices such as the harmonization of soul, spirit, and thought, spiritual cleansing, and healing led by Mamos, Sagas, and Osus onto recognized procedures within the Health Benefit Plan.[1] This is a real achievement because it makes ancestral practice legible within the health system's financing architecture. The study does not show that this translation narrowed the relational character of these practices, and I do not mean to imply that it did. Rather, the example exposes a more general implementation risk: when recognition depends on procedural units designed for reimbursable care, relational practices could be recoded in ways that privilege an individual unit of care over the relationships through which the practice acquires meaning. A relational practice could therefore survive in name while its unit of change narrows in translation. The question is not whether spiritual harmony can be fitted into the system, but whether the system's definition of a recognizable and fundable action can itself be coproduced.

Who Implements Is Part of the Mechanism

The second point is the agent. Conventional models separate developers, implementers, and recipients; participatory implementation science shows how community processes can blur these positions.[8] This matters because the implementer is not always neutral with respect to the mechanism. When trust, reciprocity, shared experience, legitimacy, or territorial knowledge are part of what produces change, who facilitates is part of the intervention's active architecture rather than simply a delivery characteristic. The peer-support literature makes the point: lived experience and the distinctive position of the peer can themselves contribute to the mechanism rather than functioning merely as lower-cost labor.[9] Decolonial scholarship makes a parallel argument by emphasizing local leadership, relational accountability, and Indigenous authority as constitutive questions for implementation rather than peripheral matters of acceptability.[10,11]

In the Riohacha pathway this is explicit: the proposed intercultural team places Mamos, Sagas, and Osus alongside psychiatrists and psychologists.[1] Read through a conventional delivery model, traditional authorities risk being treated as auxiliaries who make an otherwise unchanged intervention more acceptable. Read through the community's account, they may be constitutive of the mechanism because the harmonization they perform is inseparable from their legitimacy, knowledge, and relationship to territory. Reindividualization here can take the form of substituting a community facilitator for a professional while assuming the mechanism is unchanged, or, conversely, adding traditional healers mainly to signal participation. The alternative is to treat facilitation itself as coproduced and ask what each actor contributes to the mechanism: technical knowledge, legitimacy, lived experience, territorial relationships, or collective practices that cannot simply be delivered from outside.[10,11]

At What Level Does Success Register?

The third point is evaluation. Implementation science usefully separates intervention outcomes from implementation outcomes such as acceptability, adoption, feasibility, fidelity, cost, penetration, and sustainability.[12] These remain indispensable because they tell us whether a policy can be taken up, delivered, and maintained. But they do not answer a prior question: what substantive change should count as success when mental health has been defined collectively? Here reindividualization takes a measurement form. A lower mean level of depression or distress is a genuine population improvement, yet it does not, by itself, evidence stronger reciprocity, social cohesion, belonging, collective efficacy, cultural continuity, or connection with territory. Treating the average of individual symptoms as a community outcome is not merely imprecise; it is an atomistic inference that reads a collective property from individual data as though the two occupied the same level.[13] The error is conceptual before it is statistical.

Individual responses can, of course, inform collective measures when the construct is explicitly relational and the theory justifies aggregation. What the levels problem forbids is assuming that aggregation happens on its own. Reviews of Indigenous well-being repeatedly find that conventional instruments omit domains communities themselves treat as central,[14] and recent Latin American evidence emphasizes territorial, spiritual, cultural, and collective dimensions of

well-being.[15] The Riohacha deliberation already names such domains, including protective environments, networks of support and care, and cultural continuity.[1] To let them define success is not to append culturally relevant indicators to a fixed evaluation. It is to measure change at the level where the community located it in the first place.

Does This Dissolve Fidelity?

A natural objection is that this dissolves what implementation science exists to protect. If communities may redefine core functions, what remains of fidelity, comparability, or the capacity to scale? The objection has force and deserves an answer rather than a slogan. First, fidelity properly attaches to functions, not forms; the argument does not abandon fidelity but insists that the function to which we stay faithful be coproduced rather than presumed. Second, what transfers across settings is not necessarily fixed content but a disciplined question. Two communities may answer differently about the locus and mechanism of change, yet both can be held to one standard: that the answer was deliberated, made explicit, and evaluated at the level it claims. A cost must be conceded: some redefinitions will be difficult to standardize, and a few may resist scaling entirely. But faithfully implementing the wrong theory of change is not the safer error. A group of individuals with fewer symptoms is still not, on that evidence alone, a community with better mental health.

A Diagnostic

These three points can be turned into a practical test. Before adapting an intervention for a community that understands mental health relationally, implementers and community members can ask three questions together. Function: What is the assumed locus and mechanism of change, and who decided it was essential? Agent: Is the implementer's identity part of the mechanism, or incidental to it? Outcome: At what level is success defined, and does the evidence represent that level rather than an aggregate of individuals? Where these answers were settled in advance by professionals, adaptation has not yet reached the theory of change, and reindividualization may already be underway.

Conclusion

Agudelo-Hernández and Giraldo-Álvarez show that communities can become authors of policy, not only its recipients.[1] The harder task is to keep them authors through implementation. The operational default described here can reindividualize what was coproduced at the points where core functions are defined, implementers are positioned, and success is measured. Resisting that process requires extending coproduction to the theory of change itself.

This argument is made from inside the tradition it questions: in the register of implementation science, by an external academic, drawing largely on its literature. That is a limitation worth stating, and it is also the point. The categories through which we implement are not neutral, and the most consequential adaptation may sometimes be to the categories themselves. A commentary cannot resolve this problem, but it can keep the question from disappearing. When a policy is conceived relationally and collectively, the field should ask not only whether a culturally adapted activity can be delivered, but whose theory of change survives the delivery.

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Ethical issues

Not applicable.

Conflicts of interest

No financial relationships or activities relevant to this Commentary are declared. The author has previously coauthored publications with Felipe Agudelo-Hernández and Ana Belén Giraldo-Álvarez, authors of the lead article, and reports this prior academic collaboration for transparency.

Disclaimer

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