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Commentary

Whose Knowledge, Whose Plan? Developing Mental Health Policy With Communities, Not for Them

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

Kaaren Mathias[1*], **Anna Matheson**[2]

Abstract

This commentary builds on the recent paper by Agudelo-Hernández and Giraldo-Álvarez describing co-design with Indigenous communities in Colombia. This repositioning of community as policy-makers highlights three shifts needed for equitable health policy: from extracting knowledge to co-producing it; from participation as a method to sustaining participation within relational infrastructure; and from locating communities as intervention targets to recognising them as agents of their well-being. We outline how place-based knowledge, strong relationships, and decision-making processes matter as much as the products of collaboration. This points to the need for skills in developing non-hierarchical and collaborative relationships, expanding opportunities for communities to exercise agency and to challenge hierarchies. Scaling these approaches requires parallel shifts in financing, institutional power, and knowledge systems. The opportunity offered here is to ensure that community knowledge shapes decisions and actions, not simply informs them. This can lead to more effective, legitimate, culturally grounded, and equitable mental health policy.

Keywords: Community Participation, Co-Design, Community Health System, Community Policy-Makers, Mental Health

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Introduction

Providing healthcare that is high-quality, accessible and equitable is increasingly difficult everywhere. In response, health systems are moving away from one-size-fits-all models, which too often fail to engage with local needs, assets and contexts. Yet decentralisation is not, on its own, a solution. It delivers on its promise only when underpinned by authentically participatory processes – ones that engage local actors and local innovation so that services are genuinely shaped by, and accountable to, the communities they serve.[1] Nowhere is this shift from the amorphous and national to the specific and local more visible than in global mental health, where the value of communities is embedded in the central concept of "task-shifting." Moving responsibilities such as psychosocial therapy and counselling from professionals to community-based lay counsellors and health workers has expanded access to care, addressed social health determinants and often made care more culturally safe and relevant.[2,3]

The recent paper by Agudelo-Hernández and Giraldo-Álvarez, published in this journal, reframes the community as policy-maker.[4] Communities are understood here as people bound together by the localities in which they live, with all the shared conditions, relationships and histories that place entails.[5] Through a participatory codesign study with Indigenous representatives in Riohacha, Colombia, the authors link community context with well-being, spiritual harmony and recovery in mental health. Rather than treating this concept as background or barrier, they place it at the centre, as the starting point from which mental healthcare was codesigned together with government policy-makers.

Our commentary reflects on this contribution of Agudelo-Hernández and Giraldo-Álvarez in light of broader debates about participation, community assets, agency, and the relationship between place and health. We build on our own experiences working and living in communities Asia, Latin America and Aotearoa New Zealand where we have supported community development and codesign as well as building on our scholarship in this area.[2,5-7] We argue that their work illustrates three interrelated shifts that are necessary, though not yet sufficient, for more equitable mental health policy: from extracting knowledge to co-producing it; from participation as a method to sustaining it as relational infrastructure; and from positioning communities as targets of intervention to recognising them as agents of their own well-being.[6,8]

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Participation as Both Intervention and Outcome

Research and practice in Global Mental Health and wider health systems recognises the value of participation by people with lived experience of mental health (and their communities) in the design, delivery, evaluation, and governance of their care. This approach offers a paradigm change from long-standing colonial and biomedical knowledge practices where programmes are designed and enacted by people from a distance and position of power ("the centre") on behalf of people with less power ("the periphery").[1] Agudelo-Hernández and Giraldo-Álvarez propose that authentic participation and co-design function simultaneously as intervention and outcome, process and product. This is an important claim. It points toward a more expansive understanding of what mental health programmes seek to achieve: not only the reduction of symptoms or disorders, but the development of communities' capacity to name their own needs, mobilise their own assets, and influence the decisions that shape their lives.[3,5,8]

Participation in health systems by communities increases the relevance, acceptability and utilisation of care.[9] Yet participation is not simply a methodological choice. As Agudelo-Hernández and Giraldo-Álvarez demonstrate, the process of participation is itself transformative. By positioning community members as knowledge holders with legitimate expertise about their own contexts, needs, and resources, co-design processes build capability, generate trust, and produce locally grounded frameworks that are more likely to be implemented and sustained.[10] In Riohacha, their co-developed mental health plan was not delivered to the community but constructed with it, incorporating indigenous concepts of spiritual harmony and traditional healing practices alongside Western clinical approaches. The plan was subsequently signed by the district mayor, giving it administrative force and legitimacy.

This paper adds to a growing evidence base about the value of participatory action research and practices to community health systems, mental health promotion and healthcare.[3,10,11] This growing body of work reveals that the processes and products of participation are complex and entangled with notions of power and hierarchy, which are recognised as causative. For this reason, documenting these processes with care and transparency, including their limitations, is a necessary contribution.

Developing Relational Infrastructure

By engaging early with different actors including community leaders, indigenous representatives, government decision-makers and young people, Agudelo-Hernández and Giraldo-Álvarez show a commitment to trusted relationships as foundational to shared decision-making. Their iterative and relational engagement reflects what we might call the development of relational infrastructure: the social fabric of trust, mutual recognition, and accountable dialogue that makes genuine co-production possible, and links to the relational lens as a key component of the community health systems described by Schneider et al.[10]

Relational infrastructure is rarely documented in accounts of participatory research, yet it may be among the most important determinants of whether participation translates into meaningful change.[7] Relational infrastructure facilitates collective agency, the capacity of communities to influence their own circumstances, align resources, coordinate action, and adapt in response to changing conditions.[7] Yet we know that agency is not evenly distributed. Systemic inequalities shape who has the capacity to act, whose actions are recognised and supported, and whose voices are heard when decisions are made. For communities marked by poverty, discrimination, and marginalisation, the exercise of agency is not simply a matter of individual or collective will.[3,5]

The conditions that underpin infrastructure that can support agency, such as prior relationships, shared language and conceptual frameworks, organisational legitimacy, and sufficient time, are often invisible in published accounts, which tend to focus on methods and findings rather than the relational substance that precedes and sustains them.[6] The present paper offers some insight into this process through its description of the steps taken to build partnerships and bring key actors into the process. But even here there is an opportunity to trace the inception of this collaboration more fully in another paper. Understanding the whakapapa, (a Māori concept referencing lineage or genealogy), of participatory relationships is not only of methodological interest, it is a form of accountability to the communities involved which can provide insight into future outcomes.[12]

The integration of an intercultural leader and a Wayuú social worker into each focus group underlines the importance of territorial authority for indigenous people in this region, and that local action must be culturally grounded. Relationships built across cultural difference require attentiveness to the protocols and practices through which trust is established in specific communities, as well as to the dynamics of power. The paper's acknowledgment that no indigenous reviewers or authors were involved in the manuscript represents an honest and important limitation, recognising reporting standards for health research involving indigenous peoples.[12] It points toward the relational and epistemic work that remains to be done if community and indigenous capability and authority are genuine goals of participatory processes.[1,12]

Participatory codesign can miss its goals if is merely a tick box exercise. Missing out nuanced processes around community engagement and need can undermine the entire purpose. But, historically there has been limited evidence demonstrating what these processes look like for them to lead to successful outcomes.[9,13] However, this is changing with a growing evidence base that can guide and strengthen reflexive coproduction of programmes, plans and policies.[1,3,10,13]

Health in Local Place

The geography of mental health outcomes is not neutral. Where people live is among the most powerful determinants of mental well-being. The district of Riohacha, as described by Agudelo-Hernández and Giraldo-Álvarez, is a territory characterised by intersecting vulnerabilities: multidimensional poverty, child malnutrition, migration flows, and a large and

diverse indigenous population. These conditions are not incidental to the mental health challenges faced by Riohacha's communities; they are part of them. Experiences of precarity, displacement, discrimination, and daily pursuit of basic needs generate what the paper describes as a state of reciprocal determinism between adverse living conditions and mental ill-health.

And yet place is never only a source of disadvantage. Places also concentrate assets – including through their physical terrain of soil, rainfall, sunlight hours as well as social assets of social relationships, shared histories, cultural knowledge, and the daily practices through which communities sustain and restore well-being.[6,10] Agudelo-Hernández and Giraldo-Álvarez describe informal resources for mental health already existing in communities such as the existing support and care networks which can then lead to supportive family, school and work environments and strengthened recovery processes. They also describe healing practices already operating in communities such as interventions for spiritual cleansing, attention on a hill or sacred site or traditional therapy focused on harmonization of the soul, spirit and thoughts. Informal mental healthcare in many low-income communities includes engaged civil society organisations, neighbours, faith groups, and traditional healers, as well as family members providing support to one another.[6]

The concept of spiritual harmony, rooted in the land and worldview of indigenous communities in Riohacha, is not separable from the specific place in which it has meaning; the hills and sacred sites that appear in the table of traditional healing practices, the community relationships through which harmonisation of soul, spirit, and thought is achieved. Place is where both vulnerability and resilience are constituted.

A place-sensitive approach to mental health policy begins, therefore, not with a template to be applied but with a genuine inquiry into the specific conditions, assets, histories, and meanings of a particular territory. This is precisely what Agudelo-Hernández and Giraldo-Álvarez attempt, and it is what distinguishes their approach from top-down, context-free approaches. Their methodology began with documentary analysis of the territory, mapping community actors, which models a form of place-attentiveness that has broader relevance for global mental health policy. The challenge, as always, is whether the insights generated through place-sensitive inquiry can be institutionalised without being abstracted from the conditions that gave them meaning.[2]

Why Processes and Relationships Matter as Much as Products

Codesign and participatory approaches can support innovative and new partnerships. They offer a way to engage with community knowledge systems.[1,10] This is illustrated in a collaboration between community mental health workers and traditional healers in Ghana which improved access to care by addressing shortages in resources, countering stigma, and connecting people with housing, livelihoods, and local support networks.[14] When we only look at a product, we miss how it was achieved, whether it was a success or failure. Relationships and processes provide the memory, continuity and the agency to continue to adapt "products" to future conditions.

Agudelo-Hernández and Giraldo-Álvarez offer a textured, honestly documented account of developing mental health policy with, rather than for, a community. They pay attention to relational infrastructure, to the specific geography and history of Riohacha, and to the distribution of agency across community members and institutions. This models a place-sensitive, participatory approach relevant beyond Colombia. Yet their work illustrates that participation, relational infrastructure, and community agency are necessary but not sufficient conditions for equitable mental health policy.

To scale and systematise these approaches requires parallel shifts in financing, institutional power, and the systems of knowledge and that we use. Participatory approaches open opportunities for collaboration such as embedding social accountability (where citizens engage with public institutions for accountability in the provision of public goods) into the governance, design, delivery, and evaluation of health systems. This can increase transparency and accountability through bottom-up approaches and act as a bridge and conversation between the engaged community and the health system.

At a structural level, global mental health financing could be used to make co-design integral to health systems. Funders could require meaningful community participation in programme design and governance, supported by long-term, flexible contracts. This would allow programmes to evolve iteratively around community priorities and create space for innovation, adaptation and learning from failure. A New Zealand community-led prevention initiative, Healthy Families NZ, shows that flexible, long-term funding for a way of working, rather than for predetermined programmes, can enable both genuine co-design with communities and ongoing learning. But there is also a caution for global health financing, in that mandated co-design or participatory processes in funding agreements must be matched by changes in how funders hold recipients accountable including recognising community-defined outcomes, relational processes and learning as legitimate evidence of performance.[15]

Without scaling, co-designed local initiatives risk remaining isolated examples or performative. Whether developing mental health policy and plans for Riohacha, Rawalpindi or Rotterdam, realising the promise of this and similar studies requires sustained investment in the relationships, capabilities, and structures that allow community knowledge to shape decisions, not simply inform them.

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Ethical issues

Not applicable.

Conflicts of interest

Authors declare that they have no conflicts of interest.

Authors' contributions

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