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A Multilevel Governance Framework for Community-Based Mental Health Promotion: Findings from a Qualitative Study

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Abstract

Mental health interventions in rural areas often face systemic and governance barriers that limit their implementation. This study analysed how governance dimensions at the municipal, state, and federal levels influence the perceived feasibility of implementing the Primary Care and Psychiatry Model (MAP-PSI), an early intervention strategy targeting adolescent depression in rural Mexico. A descriptive–interpretative qualitative design was employed, using semi-structured interviews and hybrid (deductive–inductive) content analysis. Participants were purposively selected institutional stakeholders involved in MAP-PSI implementation, including local health managers, state and federal decision-makers, and community-based actors. The coding process was collaboratively developed and validated through consensus and critical reflection among researchers. Five interrelated governance dimensions were identified: local leadership, intersectoral coordination, resource mobilisation, community participation, and institutional adaptability. These dimensions converge in a multilevel governance framework that illustrates how governance capacities across levels can enable or constrain community-based mental health interventions. The findings provide an empirically grounded framework to inform the design, adaptation, and future evaluation of community-based mental health strategies in underserved rural contexts.

Keywords: governance; community-based mental health; youth mental health; multilevel governance; qualitative study

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1. Introduction

Depression in young people represents a growing public health concern due to its high prevalence, associated functional impairment, and strong link to suicidal behaviour, especially in socially and economically vulnerable populations [1,2]. Young people exposed to academic stress, adverse life events, discrimination, limited educational opportunities, and structural poverty have an increased risk of depressive symptoms, with long-term consequences for health, education, and social participation [3,4]. In Mexico, mental health services remain highly centralised and concentrated in urban areas, leaving young people in rural and Indigenous communities with limited access to timely and culturally appropriate care.

To mitigate unmet mental health needs and persistent health inequities in these underserved contexts, community-based mental health interventions have emerged as a promising strategy to expand access to care [5]. Interventions that integrate mental health promotion, psychoeducation, psychological therapy, and tele-psychiatric care have demonstrated the potential to improve mental health literacy [6,7] and reduce depressive symptoms when adapted to the local cultural context [8]. Despite its potential impact on improving mental health care and wellbeing, community-based mental health interventions specifically tailored to youth and adolescents are scarce and seldom studied [9]. Moreover, these types of programmes are even rarer in mental health systems of lower- and upper-middle-income countries.

To tackle this gap, the Primary Care and Psychiatry Model (MAP-PSI) was developed within the primary health care (PHC) paradigm as an integrated, community-based intervention. Its main goal is to identify and address depression in young people from rural and Indigenous settings in Mexico [10]. MAP-PSI combines mental health promotion and psychoeducation with stepped psychological and psychiatric care delivered through tele-psychiatry, linking community, primary care, and specialised services to reduce gaps in access and continuity of care [11].

The feasibility and sustainability of implementing community-based mental health models such as MAP-PSI depend not only on their technical design, but on governance conditions at the local level [12–16]. Governance processes—including leadership, accountability, participation, coordination, and capacity for resource mobilisation—shape whether interventions are adopted, adapted and sustained within real-world health systems [12,17–19].

Local and municipal decision-makers play a central role in enabling these processes, as they are responsible for intersectoral coordination, institutional alignment, and the allocation of resources required to operationalise community-based services [13,20].

Despite recognition of the importance of governance for health system implementation, limited empirical evidence exists on how governance processes shape the feasibility of community-based mental health interventions across different levels of government [12,21,22], particularly in rural and Indigenous contexts. Understanding how local, state, and national actors perceive their roles and responsibilities is essential for informing implementation strategies and scaling efforts.

The aim of this study was to examine how governance processes shape the feasibility of implementing community-based mental health initiatives in rural and Indigenous settings in Mexico. Drawing on a pilot implementation of the MAP-PSI, we explored how key stakeholders at municipal, state, and national levels conceptualise governance and how dimensions such as leadership, intersectoral coordination, resource mobilisation, community participation, and system adaptability influence implementation conditions [12,17,23,24]. Based on these findings, we propose a multilevel, context-sensitive governance framework to inform the design alignment and potential scaling of community-based mental health interventions in settings with limited access to specialised care.

2. Materials and Methods

2.1. Study Design

We conducted a descriptive–interpretative qualitative case study to obtain a comprehensive and systemic understanding of stakeholders' perspectives on the governance processes during the implementation of MAP-PSI's intervention for adolescent depression. This approach facilitated in-depth examination of participants' experiences, institutional roles, and views on the feasibility of community-based mental health intervention.

2.2. Setting and Sociocultural Context

The study took place in Ciudad Fernández, in the middle region of the state of San Luis Potosi, Mexico. San Luis Potosí has 2.8 million inhabitants—23% of them speak an Indigenous language (Náhuatl, Téenek, Xi'ui) and 17% are aged 15–24. The Indigenous population in the state experiences high levels of structural disadvantage, with 83.9% living in poverty and an illiteracy rate of 10.8% [25].

Ciudad Fernández comprises a municipal seat, with 13 ejidos (large, communally farmed tracts of land) and 19 ranches, with most of the population concentrated in the main town. The local youth population aged 15–24 years totals 8341 individuals, of which only 39% remain enrolled in formal education. Access to digital resources is limited, with 38% of households reporting internet access and 27% owning a computer, reflecting broader patterns of social marginalisation.

Although 80.5% of the population reports nominal affiliation with health services, effective access to care is constrained by geographic barriers, poverty, and limited local service capacity. Access to specialised mental health care is virtually non-existent in the municipality due to the absence of dedicated mental health services [25].

2.3. Sampling and Participants

We used purposive sampling to recruit ten key actors. Inclusion criteria were: (a) direct or indirect participation in the MAP-PSI project, (b) representation of different administrative levels (federal, state, municipal), and (c) diversity of professional roles (management, operational, technical, administrative). Participants were eligible regardless of gender, age, ethnicity, or other personal characteristics, as the focus of the study was on institutional roles and governance experience rather than demographic attributes. Initial participants were identified through a predefined list of professionals directly involved in the implementation of MAP-PSI, which was available to the research team as part of project coordination records. These individuals were approached by the principal investigator via institutional email invitations and, when necessary, followed up by telephone to explain the aims of the study and invite their participation. Snowball sampling was initiated at the end of each interview by asking participants to suggest additional key informants who met the inclusion criteria and were knowledgeable about governance processes related to MAP-PSI. Suggested participants were subsequently contacted by the research team using the same institutional communication channels (primarily email and telephone). This process continued iteratively until information power and thematic saturation were reached. All actors agreed to participate.

2.4. Interviews and Procedure

Between June and July 2024, we conducted semi-structured interviews, lasting approximately 60–90 min, using an interview guide developed from the existing literature on health governance and community-based mental health interventions. The guide was designed to facilitate knowledge-sharing dialogue grounded in principles of participation, symmetrical relationship, and horizontal interaction.

The interview guide covered broad thematic areas, including conceptualisations of governance, youth mental health priorities, main barriers, and potential strategies (see Table 1 for operational definitions). All interviews were audio-recorded and transcribed verbatim. Transcripts were subsequently mapped to ten a priori thematic categories derived from the interview guide. Written informed consent was obtained from all participants prior to data collection.

Table 1. Operational definitions of governance-related topics explored in interviews. Mexico, 2025.

Theme of Analysis	Operational Definition
Trajectory and Current Role	Brief professional history, training, and how the actor came to their current position or function in the system/locality.
Professional Training	Academic discipline or basic career of the actor, relevant to understand their perspective and contributions.
Health Governance	Conceptualisation of the term governance in health
Youth Mental Health Perspective (Priority)	Perception and assessment of the importance or urgency of addressing mental health problems in adolescents and young people in the local context.
Main Barriers	Identified barriers to timely and adequate care for mental disorders (e.g., lack of personnel, resources, stigma, infrastructure).
Strategies/Proposed Support	Suggested or implemented actions to improve mental health care; this includes proposals for training, technological integration, alliances, etc.
MAP-PSI Assessment	Opinion on the relevance, efficacy and replicability potential of the MAP-PSI model/intervention in the local or national context.
Participation in Projects	Level and type of involvement of the actor in mental health projects, especially in MAP-PSI (leadership, training, management, peripheral support, etc.).
Potential Contribution to MAP-PSI	How, from their role and experience, the actor can contribute in a concrete way to the effective implementation of the MAP-PSI model.
Challenges to Face	Main internal and external challenges that the actor anticipates to achieving an effective implementation of the model/intervention.

Source: Own elaboration. Note. Operational definitions used to develop the interview guide and guide deductive coding during qualitative content analysis. Additional inductive themes emerged from participants' narratives.

Reporting in this study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines. A completed 32-item COREQ checklist has been provided as Supplementary Material to enhance transparency and methodological rigour.

2.5. Data Analysis

We applied qualitative content analysis using a hybrid directed–summative approach [26]. Data analysis followed a thematic approach using deductive and inductive coding. Deductive coding based on the predefined categories from the interview guide included governance, main barriers and youth mental health perspective. Inductive coding allowed new themes to emerge from participants' narratives, such as stakeholders' capacity to mobilise resources and the system's adaptability and flexibility required to tailor interventions to local realities.

This process was carried out in six-steps:

1. Unitisation—Text segments were mapped to ten a priori thematic categories derived from the interview guide (Table 1).
2. Sampling—Conceptual selection of ten stakeholders across governance levels (local operational, municipal/regional managerial, state/federal, technical expert).
3. Coding—Conducted in three phases: application of theory-driven codes, development of inductive subcategories [27], and iterative refinement using ATLAS.ti (Scientific Software Development GmbH, Berlin, Germany. Version 24).
4. Data reduction—Comparative matrices and conceptual maps highlighted patterns and divergences.
5. Abductive inference—Contextual analysis of professional background, institutional role, and system level to identify tensions, enablers, and barriers.
6. Narrative synthesis—Thematic integration of findings with illustrative quotes and visualisations.

The final coding structure was refined through team discussions and resulted in the five overarching governance dimensions presented in the findings. Measures to ensure credibility and analytic rigor are detailed in Section 2.6.

2.6. Trustworthiness and Reflexivity

Trustworthiness was ensured following the criteria proposed by Lincoln and Guba [28]. Credibility was supported through investigator triangulation involving three independent coders, member checking with participants, and the use of broad descriptions with verbatim excerpts. Member checking was conducted through in-person dissemination meetings with participating local decision-makers, during which a structured summary of preliminary findings was discussed. Feedback informed reflexive clarification of key implementation barriers, such as political will, recognition of local mental health needs, and coordination with state health authorities, without modifying the coding structure. Reflexive notes were documented by the principal investigator and jointly reviewed by the research team throughout analysis. An audit trail, including the interview guide, coding matrices, and analytic memos, was maintained using ATLAS.ti (version 24).

2.7. Ethical Considerations

This study was conducted in accordance with the Declaration of Helsinki and received approval from the Institutional Research Ethics Committee of the National Institute of Psychiatry Ramón de la Fuente Muñiz (Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz—INPRFM; registration number CEI/C/034/2022 and date of approval 18 July 2022). Written informed consent was obtained from all participants prior to data collection and included permission for audio recording, qualitative analysis, and the publication of anonymised quotations for academic purposes.

3. Results

This section first describes the stakeholder profile, highlighting the diversity in roles and governance experience. We then present the thematic categories that emerged from the interviews, and the five interrelated themes shaping MAP-PSI feasibility in rural Mexico—local leadership, resource mobilisation, intersectoral coordination, community participation, and system adaptability. These themes, varying by institutional role and trajectory, informed the development of an integrated multilevel conceptual framework.

3.1. Participant Profiles

Most of the decision-makers (six out of ten) were men, see Table 2. Women frequently held equal or higher qualifications, suggesting a gendered imbalance in governance processes. Participants included municipal directors, state policy advisors, clinical managers, technical specialists and community coordinators.

Table 2. Characteristics of stakeholders participating in the qualitative study. Mexico, 2025.

Actor	Gender	Scope (Action)	Professional Background	Current Role and Trajectory	Experience (Years) *
Actor 1	Man	State	Medical Doctor, MSc in Medical Research	Community mental health, coordination, training	40
Actor 2	Man	State	Medical Doctor, MSc in Public Health	Programme management in rural contexts, training	7
Actor 3	Man	Municipal	Medical Doctor, Specialist in Obstetrics and Gynaecology	Coordination of multidisciplinary teams, rural mental health	42

Table 2. *Cont.*

Actor	Gender	Scope (Action)	Professional Background	Current Role and Trajectory	Experience (Years) *
Actor 4	Woman	Municipal	Medical Doctor, MSc in Public Health	Physician, former Municipal Health Director, public health management	7
Actor 5	Man	Municipal	Basic and Secondary Education Teacher	Community programme management, training	30
Actor 6	Woman	Municipal	Pharmaceutical Chemist Biologist	Social assistance, DIF system, comprehensive care	40
Actor 7	Man	Federal	Economics degree, MSc in Hospital Administration	Programming and budgeting, Ministry of Health	10
Actor 8	Woman	Federal	Psychiatrist, experience in applied mental health technologies	Tele-mental health, technological innovation	5
Actor 9	Man	Federal	Biomedical Engineer, Specialist in Health Technologies	Community mental health, training, evaluation	19
Actor 10	Woman	Federal	Social Psychologist, PhD in Social Psychology	Community project management, technological integration	5

Source: Own elaboration. Note: The table describes the gender, governance scope (municipal, state, federal), professional background, current role, and years of professional experience of stakeholders included through purposive sampling. Participants were selected to ensure variation across governance levels and professional trajectories relevant to community-based mental health governance and MAP-PSI implementation. * Experience (years) refers to the number of years of professional experience in the field related to the participant's current role.

State level (n = 2): Participants were medical professionals with postgraduate training in medical research or public health, with 7 to 40 years of experience in rural programme implementation, training, and intersectoral coordination.

Municipal level (n = 4): Backgrounds included medicine, education, pharmaceutical chemistry, and social services. Their roles included municipal health management, multidisciplinary coordination, and community-based programme delivery, with professional trajectories ranging from 7 to 40 years.

Federal level (n = 4): Expertise covered psychiatry, health technology, hospital administration, and social psychology. They contributed to national mental health governance through involvement in tele-mental health, policy planning, budgeting, and technological integration, with 5 to 19 years of relevant experience.

3.2. Conceptualisation of Governance and Implications for Community-Based Mental Health

Governance was defined as the capacity to align decisions, resources and institutions to deliver effective health actions. Actors emphasised governance as the capacity to translate formal decision-making into concrete action, highlighting the role of authority, regulatory mechanisms, and alignment across government levels. As expressed by this participant:

> *"Governance [. . .] is the ability to make decisions and ensure they are carried out, considering all the mechanisms involved so that decision-making is effectively implemented; this is a crucial component of any health system"* (municipal-level stakeholder).

This perspective was further linked to institutional feasibility and scalability:

> *"MAP-PSI is a model that can be replicated and, with adequate financing, easily expanded without generating substantial additional costs"* (municipal-level stakeholder).

At the same time, the actors identified structural barriers—fragmentation and bureaucratic rigidity—as major impediments to coordination and resource flow. This was reflected in persistent financing patterns and limited reallocation capacity, as noted by the participant:

> *"The system remains essentially the same; we continue with the same out-of-pocket expenditure and the same historical financing structures, despite repeated recommendations to move towards universal approaches"* (federal-level stakeholder).

These constraints were described as contributing to significant service gaps, especially for mental health, which remains under-prioritised in resource allocation:

> *"There is a very large gap in services to meet these care demands, and financial efforts are still concentrated elsewhere, rather than on strengthening mental health services, despite the magnitude of the need"* (federal-level stakeholder).

Within this context, MAP-PSI was perceived as an adaptive response that operates across institutional silos, albeit requiring substantial effort and political will:

> *"This project [MAP-PSI], within these restrictions, is creating connections between services to follow up care demands in a specific area, but it requires a great deal of effort and commitment from those involved"* (federal-level stakeholder).

On the other hand, the actors emphasised that implementation gaps are heavily influenced by systemic resource limitations:

> *"The lack of specialists and inadequate technological infrastructure remain the main challenges for providing mental health services to the most vulnerable communities"* (municipal-level stakeholder).

Despite these limitations, MAP-PSI was perceived as a viable and contextualised model, capable of reducing access gaps if properly adapted and supported:

> *"Models like MAP-PSI demonstrate that it is possible to reduce access gaps and empower the community, provided they are adapted to local realities and receive the necessary support"* (municipal-level stakeholder).

Participants articulated governance as a set of shared, interrelated capacities shaping the feasibility of community-based mental health interventions. These perspectives converged into five governance dimensions—leadership and decision-making, intersectoral coordination, resource mobilisation, community participation, and system adaptability—which structure the practical conditions for implementing MAP-PSI.

Table 3 summarises these dimensions and their implications, supported by illustrative quotations in the text.

Table 3. Governance conceptualisations and practical implications for community-based mental health, Mexico, 2025.

Governance Dimension	Shared Governance Conceptualisation by Stakeholders	Implications for MAP-PSI Implementation
Leadership and decision-making	Capacity to translate decisions into action through local leadership and decision-making authority	Municipal leadership is critical for prioritising youth mental health and mobilising partnerships and resources for MAP-PSI; however, bureaucratic constraints and weak intergovernmental alignment may restrict autonomy and delay coordinated implementation.
Intersectoral coordination	Collaboration across health, social, and administrative sectors	Intersectoral coordination facilitates institutional linkages, continuous training, and technological integration, strengthening primary care and enabling the sustainable implementation of MAP-PSI.

Table 3. *Cont.*

Governance Dimension	Shared Governance Conceptualisation by Stakeholders	Implications for MAP-PSI Implementation
Resource mobilisation	Coordination of financial, human, and technological resources in constrained contexts	Effective resource mobilisation supports the adaptation of intervention models to local realities by enabling flexible allocation of financial, human, and technological resources. In practice, this includes investing in tele-health infrastructure, training local personnel, and adjusting tools and processes to context-specific constraints, thereby enhancing the feasibility and sustainability of MAP-PSI.
Community participation	Commitment to equity, participation, and responsiveness to local needs	Community participation facilitates local ownership, cultural relevance, legitimacy, and acceptability of MAP-PSI by engaging community actors and frontline services, supports empowerment at the primary care level, and strengthens the uptake of community-based mental health actions.
System adaptability	Adaptive capacity of organisational and technological models.	System adaptability enables flexible adjustment of organisational and technological processes, supporting responsive and sustainable implementation of MAP-PSI across diverse local contexts.

Source: Own elaboration. Note: All actors converge on the idea that governance is essential for translating policies and resources into concrete and sustainable actions. Practical application depends on the capacity to coordinate actors, resources, and processes, along with the flexibility to adapt to local contexts and overcome systemic barriers.

3.3. Priority of Youth Mental Health

Youth mental health emerged as a top priority, especially in the post-COVID-19 era, which saw increases in depressive symptoms and suicide attempts. Stakeholders emphasised the urgency of early intervention to prevent long-term social and health consequences.

> *"Providing priority care to children, young people, and adults facing any type of difficulty is essential for us. We can provide medication, but what matters most is not what we give them, but the care and attention that we offer"* (municipal-level stakeholder).

Despite policy rhetoric, funding and programme continuity are often insufficient, creating a mismatch between stated needs and available resources (Table 4).

Table 4. Summary of empirical evidence from stakeholder interviews on governance and feasibility of MAP-PSI. Mexico, 2025.

Governance Dimension	Dominant Patterns Identified Across Stakeholders
Priority of youth mental health	High priority across all governance levels, particularly for early intervention and post-pandemic demand
Main barriers	Shortage of specialised personnel, limited infrastructure, stigma, and technological gaps
Proposed strategies	Strengthening primary care, training, intersectoral coordination, and technological integration
Perception of MAP-PSI	Broadly positive; perceived as adaptable, scalable, and gap-reducing
Expected contributions	Training, coordination, monitoring, and technological adaptation
Key challenges	Resource constraints, budget rigidity, administrative continuity, and resistance to change

Source: Own elaboration. Note: This table summarises the content analysis of key governance themes explored in interviews with stakeholders, including their perceptions of priority for youth mental health, barriers, proposed strategies, perception of the MAP-PSI intervention, and perceived potential for implementation at local level.

3.4. Main Barriers

Participants described a range of structural and cultural obstacles that undermine MAP-PSI's implementation (Table 4). They highlighted chronic shortages of specialised personnel—particularly psychiatrists and clinical psychologists—across rural clinics, which limit the programme's reach. Unreliable internet connectivity and frequent power outages further impede tele-health initiatives and data management.

> *"The main obstacle lies in the lack of recognition of emotional and mental health problems at the community level"* (municipal-level stakeholder).

> *"There is no adequate infrastructure within state health services to care for these patients. Even the private sector does not provide this type of care or mental health approach, largely because there is also a shortage of human resources to deliver such services..."* (municipal-level stakeholder).

Social stigma manifests both at the community level, where depressive symptoms are often minimised or denied by families, and within institutions, where rigid budgeting processes and fragmented funding streams make sustained programme financing precarious.

> *"The main objective we have as a tertiary-level institution is to develop care models and test what works and what does not, in order to improve mental health care, particularly in community settings"* (federal-level stakeholder).

3.5. Proposed Strategies and Supports

Stakeholders recommended a multifaceted approach to address the identified barriers (Table 4). They advocated for ongoing training programmes targeting first-level staff—nurses, social workers and community health volunteers—to strengthen local capacity. The adoption of mobile tele-health platforms was deemed essential for overcoming geographic limitations, while formal intersectoral agreements between health, education and social services departments could enhance coordination and resource allocation. Concurrently, community-led awareness campaigns were proposed to reduce stigma, encourage early detection and foster collective engagement in mental health interventions.

> *"It is extremely important that we start talking about this, which has already begun, but also that we take action and strengthen our capacity to address these needs, given their long-term impact"* (federal-level stakeholder).

3.6. Perceptions of the MAP-PSI Model

All actors praised MAP-PSI for its community focus and psychoeducational components, describing it as "highly replicable" and "effective at closing service gaps". They cautioned, however, that long-term sustainability depends on continuous adaptation to local realities and securing both human and financial resources (Table 4).

> *"I saw MAP-PSI as a project with strong future potential: a health application that integrates mental health promotion, screening, and follow-up for patients with depression..."* (municipal-level stakeholder).

3.7. Project Participation

Levels of engagement varied from core leadership to advisory roles. Several participants led capacity-building sessions and oversaw technology rollouts, while others monitored implementation and collected feedback from community groups. This diversity of involvement strengthened local ownership. Engagement in the project was also driven by a shared recognition of the urgency of early intervention and the operational challenges

faced in rural settings, which motivated actors to assume different roles according to their institutional capacities:

> *"Early intervention in young people is fundamental to prevent affective disorders from evolving into more serious social and health problems"* (municipal-level stakeholder).

3.8. Potential Contributions to MAP-PSI

Drawing on their professional expertise and institutional roles, stakeholders articulated multiple avenues to support MAP-PSI implementation (Table 4). Managers highlighted their ability to secure dedicated budgets, advocate for policy endorsement, and integrate the model into existing institutional frameworks. Technical specialists offered to develop and deliver tailored training curricula on tele-health platforms, screening tools and data management. Frontline community workers emphasised organising peer-support groups, awareness drives and local leadership forums to foster engagement. Evaluation experts underscored their capacity to design monitoring indicators, conduct follow-up assessments and feed insights back into programme refinement, ensuring MAP-PSI remains adaptive to evolving community needs.

> *"What this project [MAP-PSI] is doing, within these restrictions, is creating connections between services to follow up care demands in a specific area; it requires a great deal of effort and commitment from those involved"* (federal-level stakeholder).

3.9. Challenges to Address

Key challenges include sustaining financing, overcoming resistance to change, bridging digital divides and addressing administrative discontinuities (Table 4). Actors stressed that flexible governance, able to reallocate resources and streamline decision-making, is essential for overcoming these hurdles.

> *"The lack of specialists and deficient technological infrastructure remain the main challenges for delivering mental health services to the most vulnerable communities"* (municipal-level stakeholder).

3.10. Emerging Conceptual Framework of Multilevel Governance

To provide a clear roadmap, first we summarise the categories coded during thematic analysis of stakeholder interviews. Figure 1 illustrates the distribution of coding frequencies across these categories, highlighting the salience of barriers, proposed strategies, and youth mental health as a priority, alongside governance conceptualisations and perceptions of MAP-PSI.

Gr indicates the absolute number of coded references assigned to each category. Categories correspond to main themes explored in the stakeholder interviews related to governance, implementation barriers, proposed strategies, and priorities for youth mental health in the MAP-PSI model.

Potential Contribution to MAP-PSI 1: implementation actions for MAP-PSI.

Potential Contribution to MAP-PSI 2: training for local primary health care personnel.

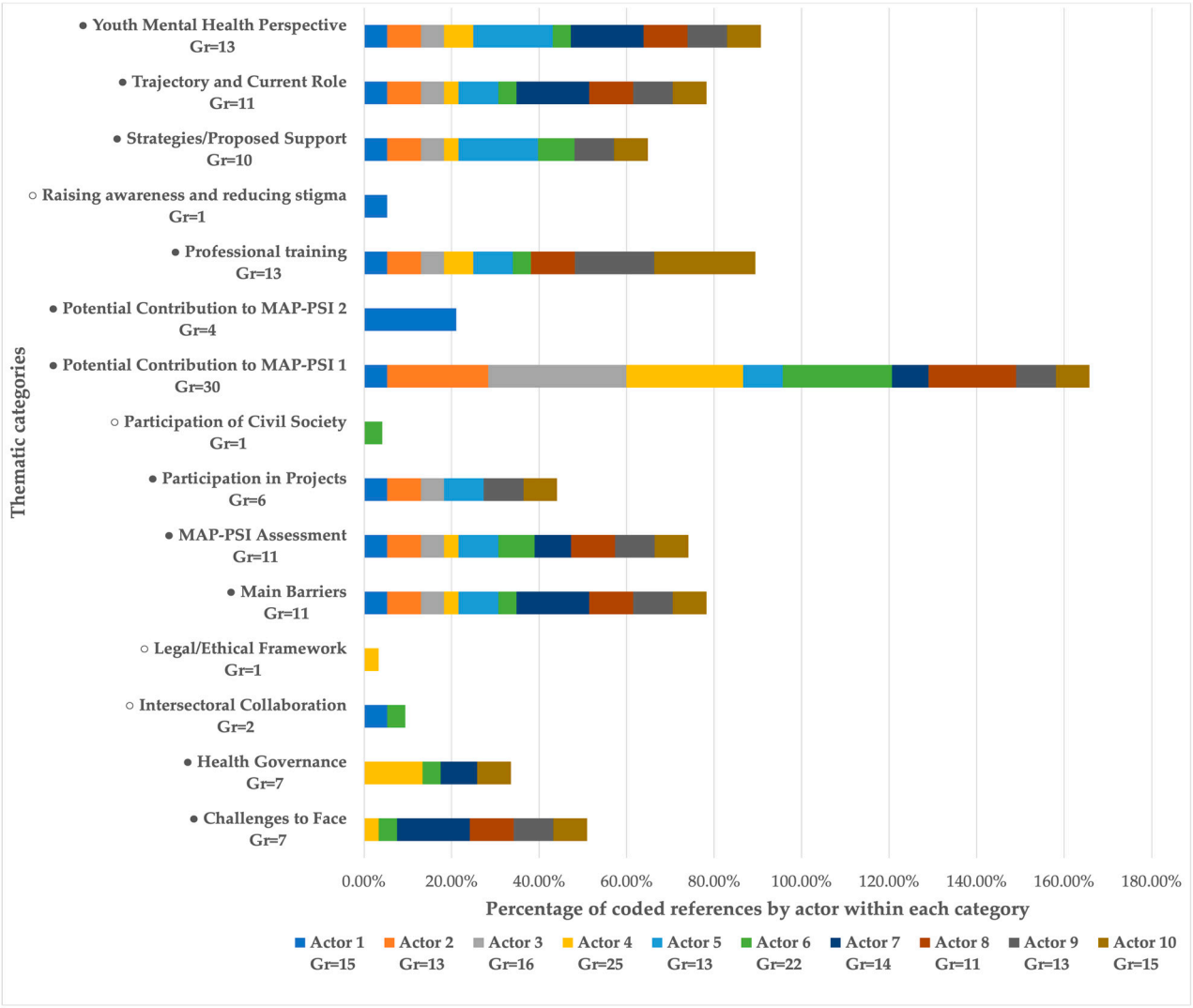

Figure 1. Distribution of coding frequencies across thematic categories derived from stakeholder interviews. Note: The figure presents the results of an Atlas.ti code-document cross-tabulation, showing the percentage contribution of each actor (Actors 1–10) to the total coded references within each thematic category. Bars represent the proportion of citations attributed to individual actors relative to the total references for that category.

Drawing on this coding process, we developed a multilevel conceptual framework that captures how governance shapes MAP-PSI's feasibility in youth mental health interventions (Figure 2). Five interrelated thematic categories of analysis emerged:

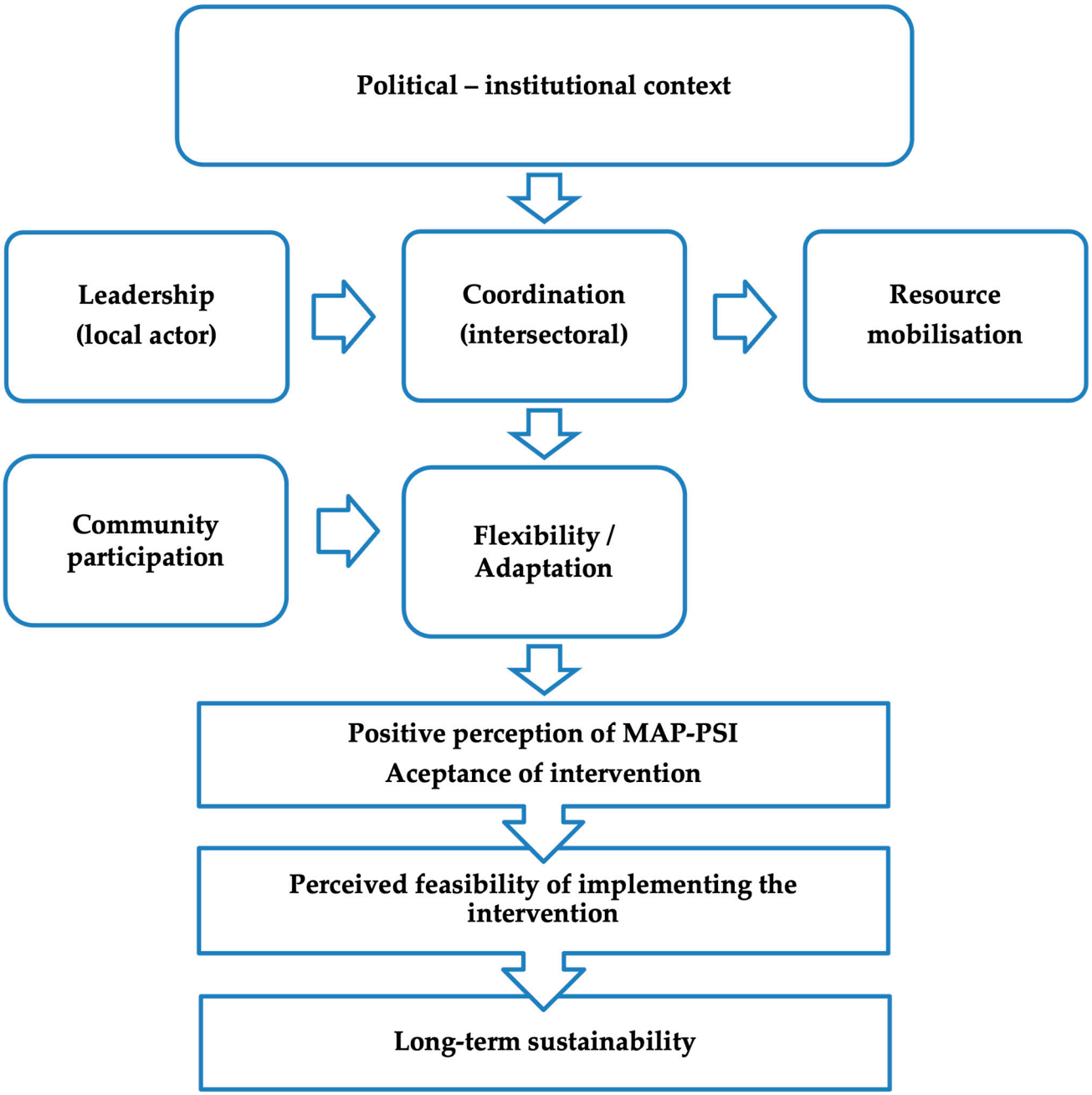

Figure 2. Emerging conceptual framework of multilevel governance for MAP-PSI implementation. Note: The figure illustrates an empirically derived conceptual framework based on stakeholders' narratives. Boxes (nodes) represent key governance dimensions identified through qualitative analysis, including the political–institutional context, local leadership, intersectoral coordination, resource mobilisation, community participation, and system adaptability. Arrows indicate perceived relationships of influence and enabling pathways among governance dimensions, shaping actors' perceptions of MAP-PSI, the perceived feasibility of implementation, and the long-term sustainability of the intervention in rural and underserved settings.

Five interrelated thematic categories of analysis emerged from the analysis:

1. Local leadership referring to actors' authority and capacity to mobilise resources and prioritise mental health within community agendas, including empowerment of the primary level and local autonomy.

2. Intersectoral coordination describes the formal and informal mechanisms, such as collaboration, alliances and partnerships, that bridge health, education and social services.
3. Resource mobilisation encompasses the securing and management of financial, technological and human resources, alongside challenges related to capacity building and budget rigidity.
4. Community participation captures the engagement of families, schools and local organisations through engagement, empowerment and bridges between institutions.
5. Finally, system adaptability highlights the flexibility needed to tailor interventions to local contexts and navigate systemic barriers, including bureaucracy, fragmentation, stigma, and technological integration.

These five categories are interdependent and are influenced by broader contextual factors, such as political alignment and institutional fragmentation that together determine MAP-PSI's acceptability, feasibility and sustainability across rural and underserved settings.

4. Discussion

4.1. Summary of Main Findings

This study examined how governance processes shape the feasibility of implementing the MAP-PSI intervention for youth mental health in rural Mexico. Based on stakeholder interviews, we derived a multilevel conceptual framework (Figure 2) showing that municipal, state and federal governance capacities jointly create an enabling or constraining environment for community-based mental health interventions. These findings are consistent with international evidence indicating that community mental health care should complement—rather than replace—hospital-based services [29]. They also expand system capacity [30] by consolidating integrated networks of primary care, community services, and psychiatrists; effective scale-up depends on integrated models that ensure access, continuity, and follow-up, particularly in underserved settings [29,30].

Our study reinforces that implementation is not solely driven by technical design [31], but by governance capacities that determine whether resources, roles, and accountability are aligned across levels of the system [29,30]. In this context, stakeholders consistently described feasibility as contingent on five interrelated governance dimensions: (1) mental health prioritisation and institutional commitment by local leadership and decision-making authorities; (2) intersectoral coordination to connect health, social and administrative actors and reduce fragmentation; (3) resource mobilisation to secure flexible financing, staffing and technological infrastructure; (4) community participation to build legitimacy, cultural relevance and local ownership; and (5) system adaptability to tailor delivery mechanisms—particularly tele-mental health components—to local constraints and evolving needs [31]. Together, these dimensions operationalise how governance functions in practice as a determinant of feasibility, shaping the adaptability, acceptability, and scalability of MAP-PSI in rural and Indigenous contexts.

4.2. Contribution to the Literature on Governance and Community-Based Mental Health Intervention

By applying governance theory to the Mexican rural context, our findings extend health-system-strengthening research [12,14,23] into the domain of community-based mental health interventions as a key strategy for primary health care. Whereas prior work has highlighted governance attributes such as leadership, transparency and accountability [15,17,24], empirical studies remain scarce on how these attributes play out at subnational and local levels [21]. Our framework also illustrates how broader governance models, such as TAPIC (Transparency, Accountability, Participation, Integrity and

Capacity), link governance principles to actors lived experiences [12] and answer calls for conceptualising governance as a multilevel process [13,26].

4.3. Multilevel Governance Framework: Theoretical and Practical Implications

Theoretically, our governance framework demonstrates that institutional design alone is insufficient for effective mental health interventions. It lacks impact without adaptive evaluation frameworks aligned with community priorities and system dynamics [32]; it also depends on the actors' ability to act, the quality of inter-institutional relationships and their capacity to adapt [15,19]. The interplay of leadership, coordination, resource mobilisation, participation and adaptability offers a holistic perspective that bridges structural and relational dimensions of health governance.

The model shows that the empowerment of local leadership must be accompanied by robust intersectoral coordination mechanisms and adequate resourcing [12]. Flexibility in budget allocation and bureaucratic processes is essential to overcome barriers such as budget rigidity and social stigma. Moreover, sustained community participation [33] serves as a lever for social acceptability and long-term ownership of interventions like MAP-PSI.

4.4. Policy and Practice Implications

Our results suggest four priorities for policymakers and programme managers. First, local leadership and intersectoral coordination should be embedded as core elements of mental health strategies, especially in local contexts [34]. Second, policy instruments must allow for flexibility for local adaptation to diverse realities [23]. Third, investments in community engagement are vital to reduce stigma and build ownership [17]. Fourth, alignment across national, state and municipal agendas is necessary to overcome fragmentation and secure sustained support for mental health promotion [24].

Likewise, the testimonies and experiences of key informants reveal the need for and feasibility of engaging in intersectoral governance with health, education, and social services departments to integrate mental health beyond formal health system channels. Through intersectoral involvement, the delivery of mental health services is complemented by better education, employment or overall wellbeing opportunities. This approach is a promising improvement strategy for MAP-PSI and other community-based mental health interventions aiming to adequately adapt services based on the primary health care approach [35].

4.5. Strengths and Limitations

This study's primary strength is the rigorous use of qualitative content analysis across municipal, state and federal governance tiers, with ATLAS.ti ensuring transparent coding and theme development. Grounding the emergent framework directly in stakeholders' own conceptualisations improves both its ecological validity and practical relevance for programme designers and policymakers. The purposive inclusion of diverse professionals provides a 360° view of governance dynamics in rural Mexican settings. In addition, methodological triangulation reinforced reliability and minimised researcher bias.

Nevertheless, some limitations should be noted. First, the sample was small (N = 10) and context-specific, reflecting a single subnational region; while information power and thematic saturation were achieved given the focused research aim and participant expertise, transferability to other settings may be limited. Second, findings rely on self-reported perspectives of institutional stakeholders, which may be influenced by recall or social desirability bias. Third, the study did not include triangulation with documentary sources (e.g., policy documents, budgets) or observational data, which could have provided additional validation of reported practices. Finally, the cross-sectional design captures perceptions at

a single point in time and cannot account for temporal changes such as political turnover or funding cycles that may affect implementation feasibility and sustainability.

Future research should refine this governance framework across diverse regions, incorporate service users and community perspectives, triangulate interview data with documentary sources, and adopt longitudinal designs to capture governance dynamics over time.

5. Conclusions

This qualitative study identified five governance characteristics—local leadership, intersectoral coordination, resource mobilisation, community participation, and adaptability—that shape stakeholders' perceptions of the feasibility and acceptability of implementing community-based mental health interventions such as MAP-PSI in rural settings. These findings offer an empirically grounded lens to inform the design, adaptation, and future evaluation of community-based mental health programmes.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/psychiatryint7030087/s1. Table S1: Interview Guide; Table S2: Consolidated Criteria for Reporting Qualitative Research (COREQ).

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Data Availability Statement: The data presented in this study are available on request from the corresponding author. The data are not publicly available due to ethical/privacy issues.

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