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Bridging the Gap: Reimagining Colombia's Mental Health Policy for Suicide Prevention in Armenia, Colombia

Reduciendo la Brecha: Reimaginando la Política de Salud Mental de Colombia para la Prevención del Suicidio en Armenia, Colombia

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Abstract

Introduction: This study analyzes the implementation of the Mental Health Public Policy in Armenia, Quindío, Colombia, with emphasis on the approach to suicide. Method: The research uses a qualitative methodology based on grounded theory, including content analysis and semi-structured interviews with nine key actors in the mental health system. Results: The results reveal significant challenges in three main areas: integration of the medical model with community approaches, intersectoriality, and epidemiological surveillance systems. A historical disconnection between public health policies and community social psychology was identified, which has hindered the effective adaptation of the General System of Social Security in Health (SGSS, from Spanish initials) to mental health needs. The lack of articulation between public and private institutions, together with the absence of an efficient network system, hinders the implementation of comprehensive strategies for suicide prevention. In addition, the importance of considering specific contextual factors of the region in the formulation and implementation of policies became evident. Conclusions: It is urgent to propitiate a dialogue between public health policies and community social psychology to develop more effective strategies in addressing suicide. The adoption of community-based approaches, the improvement of intersectoriality through the Actor-Network Theory, and the implementation of community-based epidemiological surveillance systems are recommended.

Keywords: VSocial policy, mental health, suicide.

Resumen

Introducción: Este estudio analiza la implementación de la Política Pública de Salud Mental en Armenia, Quindío, Colombia, con énfasis en el abordaje del suicidio. Método: La investigación utiliza una metodología cualitativa basada en la teoría fundamentada, incluyendo análisis de contenido y entrevistas semiestructuradas con nueve actores clave del sistema de salud mental. Resultados: Los resultados revelan desafíos significativos en tres áreas principales: la integración del modelo médico con enfoques comunitarios, la intersectorialidad, y los sistemas de vigilancia epidemiológica. Se identificó una desconexión histórica entre las políticas públicas de salud y la psicología social comunitaria, lo que ha obstaculizado la adaptación efectiva del Sistema General de Seguridad Social en Salud a las necesidades de salud mental. La falta de articulación entre instituciones públicas y privadas, junto con la ausencia de un sistema de redes eficiente, dificulta la implementación de estrategias integrales para la prevención del suicidio. Además, se evidenció la importancia de considerar factores contextuales específicos de la región en la formulación e implementación de políticas. Conclusiones: Es urgente propiciar un diálogo entre las políticas públicas de salud y la psicología social comunitaria para desarrollar estrategias más efectivas en el abordaje del suicidio. Se recomienda la adopción de enfoques comunitarios, la mejora en la intersectorialidad mediante la Teoría del Actor-Red, y la implementación de sistemas de vigilancia epidemiológica basados en la comunidad.

Palabras clave: Política social, salud mental, suicidio.

INTRODUCTION

Colombia is currently on the verge of a new health reform, which implies the need to make changes in the traditional health care delivery system, as well as to improve coverage and access to quality services. In this context, the General Social Security Health System (SGSS) in Colombia faces problems related to inequality in human and monetary resources, low coverage, hospital crises, corruption and conflicts of interest.

In this context, the SGSS faces a number of significant and persistent challenges. These include marked inequality in the distribution of human and financial resources, resulting in regional disparities in the quality and availability of services (Oliveira *et al.*, 2017; Yu *et al.*, 2019; Yan *et al.*, 2023); insufficient coverage that leaves vulnerable sectors of the population without adequate access to healthcare (Afzal *et al.*, 2021; Patel *et al.*, 2015); recurrent hospital crises that strain the system's responsiveness; corruption cases that undermine public trust and divert crucial resources (Naicker & Naicker, 2023; Roncarolo *et al.*, 2017; de Medeiros-Costa, 2022); and conflicts of interest that hinder the implementation of effective, patient-centered policies (Bredenkamp *et al.*, 2015).

Delgado (2013) provides a detailed description of the SGSS, characterizing it as a competency-based system built under a market vision. This structure integrates in a complex manner public, mixed and private sectors in the provision of health services. The system, designed to be decentralized, includes a Mandatory Health Plan (POS) that seeks to guarantee access through various institutions and entities, including health service provider institutions (IPS), health promoting entities (EPS) and labor risk administrators (ARL). However, the interaction between these actors and the effective implementation of the POS have proven to be constant challenges. It is crucial to recognize that the problems inherent to the SGSS have had a considerable and multifaceted impact on the development of the mental health component in Colombia. The complexity of the system has hindered the effective integration of mental health services, resulting in significant gaps in the care and prevention of mental disorders, including suicide.

Suicide represents a complex public health challenge in Colombia, with profound implications for individuals, families and communities. The statistics are alarming: in 2021, 2,689 deaths by suicide were registered (National Institute of Legal Medicine, 2021), evidencing a steady and worrying increase in the last decade. These numbers not only represent lives lost, but also an indicator of widespread psychological suffering that requires an urgent and effective response. The increase in suicide rates in Colombia reflects a global trend, exacerbated by the COVID-19 pandemic (Caballero-Domínguez *et al.*, 2022; Gonzalez-Diaz *et al.*, 2020). This health crisis has amplified pre-existing risk factors, such as social isolation, anxiety, depression and economic hardship, creating an environment conducive to mental health deterioration. In addition, the pandemic has exposed deficiencies in mental health systems, revealing significant gaps in the accessibility and quality of prevention and care services (Figueroa & Aguilera, 2020; Muller *et al.*, 2020).

Now, the evolution of the regulatory framework for mental health in the country has been gradual but significant, reflecting a growing recognition of the importance of mental health in the overall wellbeing of the population. Resolution 2358 of 1998 (Ministry of Health, 1998) marked an important milestone in establishing the basis for a more inclusive and comprehensive approach to mental health. This resolution incorporated crucial community elements such as the psychosocial perspective, recognizing the importance of the social context in mental health; the epidemiological observatory, to monitor trends and patterns in the mental health of the population; and intersectoriality criteria, promoting collaboration among different sectors to address the social determinants of mental health.

Subsequently, the Law 1616 of 2013 (Administrative Department of the Civil Service, 2013), represented a significant advance in the prioritization of mental health in the Colombian public agenda. This law, named by Mendoza (Mendoza, 2021) as the "law of hope", elevated mental health to a priority status, promoting the inclusion of fundamental rights and duties in this area. The law seeks to guarantee the full exercise of the right to mental health for the entire Colombian population, with emphasis on children and adolescents. Although this law

faces challenges in its practical application, it has made significant progress in the inclusion of community services and in strengthening primary care, especially in relation to conditions such as epilepsy and suicide prevention.

The evolution of the regulatory framework continued with the Resolution 4886 of 2018 (Ministry of Health and Social Protection, 2018) that adopted the National Mental Health Policy. This policy establishes comprehensive guidelines for the full exercise of the right to mental health, emphasizing health promotion and prevention of mental disorders. The policy seeks a comprehensive approach that recognizes the complexity of the factors that influence mental health, from social determinants to biological and psychological aspects. However, as Walt & Gilson rightly point out (Walt & Gilson, 1994), there is a worrying tendency in Latin America, and Colombia is no exception, to focus excessively on the content of public policies. This narrow focus often results in the neglect of crucial elements such as the actors involved in implementation, the real and diverse needs of communities, and the context and culture in which these policies are to be implemented. This tendency can lead to policies that are well-intentioned but ineffective in practice.

In this complex and dynamic framework, this article focuses on analyzing three critical elements that we consider fundamental to effectively address suicide as a public health problem in Colombia: the problems of the current medical model, the challenges of intersectoriality, and the limitations of the epidemiological observatory. These elements, identified as crucial in previous studies (World Health Organization, 2018), have persisted throughout various legislative reforms, from Law 100 of 1993 to Resolution 4886 of 2018, suggesting the need for in-depth analysis and innovative solution proposals. To inform this analysis, we draw on the research of Lopez (2022), which examines Mental Health Public Policy using Walt & Gilson's model (Walt & Gilson, 1994). This approach allows us to consider not only the content of policies, but also the actors involved, the implementation context, and the processes of policy formulation and execution. The study focuses on the municipality of Armenia, Quindío, providing a concrete case study that illuminates the realities and challenges of mental health policy implementation at the local level.

This article seeks to contribute to a deeper and more nuanced understanding of the Mental Health Public Policy in Colombia. Through detailed analysis of its implementation in Armenia, we aim to provide valuable and practical information for informed decision making and the development of effective strategies against suicide. Our approach recognizes the dynamic and multi-causal nature of suicide, highlighting the need for holistic and adaptive strategies. This study aims to develop technical considerations that complement and improve the current medical model, strengthen intersectoriality, and optimize epidemiological surveillance in the context of mental health and suicide prevention. To enrich our analysis and proposals, we examined international experiences in countries such as England, Spain, Chile and Brazil (Lampert, 2018; Rosa-Dávila & Mercado-Sierra, 2020; Tavares, 2019), seeking to identify innovative and effective strategies that can be adapted to the Colombian context.

The ultimate goal of this research is to propose practical and evidence-based solutions that help to overcome the traditional perspective in Colombia, strengthening the SGSS in the processes of formulation, implementation and intervention of suicide through the Mental Health Public Policy. We aspire to contribute to a paradigm shift that prioritizes community, preventive and individual-centered approaches, recognizing the complexity of suicide and the need for multifaceted and coordinated responses.

METHOD

Research design

The present study adopted a qualitative research perspective, employing the grounded theory strategy (Strauss *et al.*, 2016). This approach allowed an in-depth exploration of the elements of the Mental Health Public Policy, specifically Resolution 4886, in relation to addressing suicide. The qualitative approach was selected for its ability to make visible aspects that are not well specified or underlying in public policies, facilitating a more holistic understanding of the phenomenon.

Participants

The study sample consisted of nine key actors, each representing diverse community contexts relevant to the implementation and impact of mental health policy. The participants included: a patient with a suicide attempt, a patient's family member, a physician from a mental hospital, a health department official, a public-school teacher, a leader from commune 8, which is home to some 36 neighborhoods in the municipality of Armenia, a clinic advisor, a SENA instructor, and a public university teacher (Table 1). This diversity of perspectives allowed for a multidimensional understanding of the problem and the policy in question.

Table 1

Characteristics of the participants

Pseudonym	Gender	Occupation	Experience
Alicia	Female	Salesperson	Patient treated in the psychiatric emergency department after suicide attempts.
Esmeralda	Female	Housewife	Patient companion in mental health care.
Roberto	Male	Physician	Mental hospital physician
Lucia	Female	Psychologist	Official of the Ministry of Health
Pedro	Male	Teacher	Teacher at CASD School
Andrés	Male	Community leader	Community leader of Commune 8
Miguel	Male	Clinic Advisor	Employee of the IPS Clínica Central
Sofia	Female	SENA Instructor	She participates in prevention programs on mental health activities.
Leónidas	Male	Quindío University Teacher	Administrative of the Academic Vice President's Office, programs and activities in mental health.

Note. Prepared by the authors

The participants were selected by means of an intentional sampling based on specific criteria that would guarantee the representativeness and relevance of the perspectives collected. The inclusion criteria were: (1) residence in Armenia, Quindío, for at least the last five years, to ensure a contextualized knowledge of the local reality; (2) direct link with any of the sectors involved in the implementation of the public mental health policy (health, education, public administration, community); (3) minimum experience of two years in their respective role or sector; and (4) voluntary willingness to participate in the study after being informed of its objectives and scope.

In the specific case of participants with direct experience with suicide (patient and family), additional criteria were established: (1) having been in contact with mental health services in the last three years; (2) being in a condition of psychological stability certified by a mental health professional; and (3) having passed at least six months since the suicide event to minimize possible effects of revictimization during the research process.

In addition, this study, due to its qualitative nature and focus on public policy, did not require the endorsement of an ethics committee. Nevertheless, it rigorously adhered to fundamental ethical principles in social research, including: (1) obtaining written informed consent from all participants; (2) guaranteeing confidentiality by coding identities; (3) explicit right to withdraw from the study at any time without negative consequences; and (4) application of specific protocols for handling sensitive information, particularly in cases related to experiences

of suicide attempts. In addition, all interviews were conducted by professionals trained in dealing with sensitive topics, with availability of referral to psychological support services in case any participant required it during or after the research process. These procedures ensured that the research was conducted with respect for the dignity, integrity and well-being of all participants.

Instruments

The semi-structured interview with scripts was used as the main data collection instrument. The scripts were developed considering the parameters of Guba and Lincoln (1981) to ensure quality and rigor in qualitative research. Prior to their application, the scripts were reviewed by a pair of experts to ensure their validity and relevance. The guiding questions used with the key actors are described in Table 2.

Table 2

Guiding questions

Sector	Questions				
Patient in mental health care	Describe in detail your experience in the mental health service from the beginning to the end of the process.	What kind of interventions were made during the process?	Where were emergencies related to suicide attempts attended?	Which persons or entities participated in the process?	What social problems do you recognize in Armenia?
Companion	Describe your experience in the accompaniment. Describe your participation	What kind of follow-ups did you receive during the process? Which persons or entities participated in the process?	What do you consider to be your mental health rights?	Have you ever heard about public mental health policy?	Do you know of any hotlines, emergency services related to mental health care?
Physician	What is the role of the Filandia mental hospital in the municipality of Armenia?	Have you ever been trained in the process of implementing the public mental health policy?	What actions, approaches or knowledge can be identified in the services offered by the hospital?	How is the intervention process of a person with a suicide attempt?	How is the psychosocial approach proposed by the public mental health policy recognized in the interventions?
Official: Health Department	Briefly describe your involvement in public mental health policy. Who are the actors and which sectors are involved?	What is the current status of the implementation process of the public mental health policy in the municipality of Armenia?	How will the actions and the community psychosocial model, present in the public mental health policy, be implemented?	What facilitators or limiters are identified by the public mental health policy in its implementation process?	How is the multilevel governance axis of the public mental health policy developed?

Teacher, community leader, and IPS employee	What are the problems that you are able to identify in the municipality that may be related to the phenomenon of suicide?	Do you recognize any historical event in the city that may be related to this phenomenon?	Do you know the public mental health policy? What do you know?	Describe the rights and duties in mental health	Describe your relationship with and knowledge of the Mental Health Public Policy.

Note. Prepared by the authors

Data collection and source evaluation

Se realizaron entrevistas individuales con cada uno de los nueve participantes. Posteriormente, se llevó a cabo una revisión exhaustiva de contenidos, incluyendo marcos legales y elementos de la Política Pública de Salud Mental de Armenia-Quindío. Para asegurar la calidad de las fuentes de información secundarias, se emplearon los procedimientos del Critical Appraisal Skills Programme (CASP). Este enfoque permitió evaluar críticamente la calidad y relevancia de las investigaciones utilizadas como referencia.

Data analysis

Data analysis was conducted using a multifaceted and rigorous approach, based on the principles of the grounded theory. This process involved several levels of constant comparison, adjustment and operation, with the objective of generating a deep and contextualized understanding of the Mental Health Public Policy in relation to suicide.

The first step in our analysis was the axial coding of the qualitative data. This process involved the fragmentation and coding of the participants' narratives, allowing for the identification of patterns and emerging themes. Simultaneously, a comprehensive content analysis of the legal frameworks and policy elements was conducted. This analysis carefully considered the actors involved, the proposed actions and the general context, all specifically oriented to the phenomenon of suicide.

To effectively manage and analyze the large amount of qualitative information collected, the Atlas.ti software was used. This specialized tool facilitated the systematization, management, categorization and analysis of the data, allowing a deeper and more structured exploration of the emerging themes.

The ultimate goal of our analysis was to generate a substantive theory that could serve as a reference point for the development of theoretical and methodological considerations around Mental Health Policy and suicide prevention. To ensure the robustness and credibility of our findings, we implemented several procedures to guarantee the quality of the qualitative data.

First, we continued data collection until we reached the point of theoretical saturation, thus ensuring that we had captured all relevant variability in our data. To facilitate the transferability of our findings, we provided a detailed description of the research context and participants. Confirmability was ensured by maintaining a meticulous record of the research and analysis process, allowing for a clear audit of our decisions and procedures.

Finally, to increase the validity of our findings, we conducted a theoretical, epistemological and content triangulation. This multiple triangulation process allowed us to examine our data from various perspectives, thus strengthening the credibility of our conclusions.

This rigorous and multifaceted methodological approach allowed us to conduct an in-depth and contextualized exploration of Public Mental Health Policy in relation to suicide. As a result, we have established a solid foundation for the development of recommendations and practical considerations, contributing significantly to the field of public mental health and suicide prevention.

RESULTS

The content analysis and participants' narratives revealed fundamental aspects in the implementation of the Mental Health Public Policy (Resolution 4886 of 2018) in Armenia, Quindío, with a particular focus on addressing suicide. The findings were structured around five main axes: historical and contextual analysis, characteristics of the implementation, disarticulation of theoretical and methodological elements, sociohistorical and cultural context, and narratives of the actors involved.

The study evidenced the critical importance of considering the historical links between health policy and social psychology knowledge. Crucial elements affecting policy implementation were identified, including the incorporation of the medical model, weaknesses in stewardship and governance capacity, limitations in intersectoral and interinstitutional articulation and cooperation, and deficiencies in the health information system that impact public health governance and stewardship.

Regarding the specific characteristics of implementation in Armenia, four critical aspects were observed. First, low supervision in the adoption and adaptation processes, which has resulted in excessive municipal freedom in the use of resources and in the formulation, evaluation and follow-up of the policy, leading to transitory actions and barriers in implementation. Second, a deficit of theoretical elements was evidenced, manifested in difficulties in integrating social psychology and public mental health policies, exacerbated by political traditionalism, corruption and low citizen participation. Third, methodological problems were detected, including the absence of guidelines, annexes and models to apply key elements such as intersectoriality, the inclusion of networks and the adaptation of the medical model to the community model in the Colombian health system. Finally, health personnel turnover emerged as a factor that negatively affects patient follow-up, the therapeutic relationship and opportunities for improvement in mental health of the population.

The analysis also revealed a significant disconnection among various documents and guidelines related to suicide assessment, intervention, promotion and prevention in Colombia. Gaps were identified among PAHO and WHO guidelines, MhGAP intervention guidelines, the intersectoral and community component in mental health, the clinical practice guide for the prevention, diagnosis and treatment of suicidal ideation and/or behavior, and the plan for the prevention and comprehensive care of suicidal behavior 2018-2021.

The results highlighted the importance of considering contextual factors specific to Armenia, Quindío, that influence the suicide phenomenon. These include the historical existence of the "suicide club of Armenia" since the 1930s, the persistent psychosocial effects of the 1991 earthquake that affected more than 200,000 people, and the high rates of unemployment and corruption in the municipality.

The narratives of the actors interviewed revealed difficulties in the follow-up of patients with suicide attempts, the need for greater inclusion of the family in the processes of care and prevention, the lack of effective intersectoral strategies to consolidate a system of networks between public and private services, and a disconnection between the actions of private institutions (IPS, EPS, ARL) and public institutions (SENA, public universities, health secretariat, hospitals and health centers).

These findings highlight significant challenges in the implementation of the Public Mental Health Policy in Armenia, particularly in relation to addressing suicide. The results reveal the need for a more integrated and contextualized approach that considers historical, social and cultural factors specific to the region, as well as better articulation between the different actors and institutions involved in mental health. Specific actors' narratives that reinforce these findings are presented in Table 3.

Table 3

Concepts of the National Public Policy on Mental Health according to the type of social actor

Social actor	Actions	Actors	Context
Patient with suicide attempt	· Primary medical care. · Crisis-oriented psychiatric care **Requirements:** · More therapies outside of psychiatry. · More and better therapies, not only occupational therapies. · More information · More and better involvement of families. · More and better involvement of health institutions such as EPS.	**Social actors:** · Family · Physician · Psychologist · Psychiatrist · Nurse **Institutional actors:** · Clínica Prado, Clínica Central, EPS	**Perception of the social context of Armenia:** · City with no employment opportunities · High crime rates · Dangerous city
Familia del paciente	· No family participation in the hospital setting. Little communication with the institution and health personnel. No follow-up after hospital discharge. **More family Requirements:** · Involvement · More information and education oriented to mental health. · Information for dealing with situations related to suicide attempts.	**Social actors:** · The community **Institutional actors:** · Government · EPS officials	**City without Perception of the social context of Armenia:** · Opportunities · People do not meet their basic needs · Dangerous city · City with drug addiction and prostitution
Mental Hospital Physician	· Intervention, diagnosis and treatment of patients with suicide attempts. **Programs related to mental health:** · Hospital day · Managers of hope · Methadone **Requirements:** · More time for accompaniment. · Strengthen psychosocial and community interventions. · The State should provide human resources such as health professionals. · Work where the focus of the problem is. · Budget for social workers to do community work.	**Social actors:** · Health personnel · The family network or support network. **Institutional actors:** · La Clínica El Prado. · Comfenalco, SENA, the Mental Hospital of Filandia, Sede San Juan Bosco. · EPS and the health system	**Perception of the social context of Armenia:** · City with a lot of corruption. · The pandemic generated many depressive behaviors.
Official of the Municipal Health Department	· Process of Implementation of Actions of the public mental health policy. · Field actions at the request of the population. · Support for users and family members with bipolar affective disorder. · “Sanamente” Program **Requirements:** · To solve the imbalance between supply and demand of mental health services in Armenia. · Improve some services from low competitiveness and primary care. · Intersectoriality should be implemented in a comprehensive way.	**Social actors:** · Community · Family or caregiver · Health personnel and teachers **Institutional actors:** · Ministry of Health and Social Protection. · The University. · SENA. · The IPS, such as the Mental Hospital of Filandia. · The EPS, El Prado clinic and the school.	**Perception of the social context of Armenia:** · 1999 Earthquake · The effects of the 2020 pandemic · Low employability. · Risk factors · Easy access to drugs.

School teacher	· Routes of care for mental health problems **Requirements:** · To promote this research in health entities and may solve part of the problem.	**Social actors:** · The family. · Guidance counselor, coordinator, university president, teachers, students. **Institutional actors:** · The Ministry of Health and Social Protection, the Ministry of Education. · The government.	**Perception of the social context of Armenia:** · Psychosocial causes · Very few job opportunities. · Problems at home or in the family. · Armenia Erthquake (1999) · The COVID 19 pandemic · Armenian culture
Leader of Commune 8	· No actions were carried out on the public mental health policy. **Requirements:** · New industries in Armenia · Training and sensitizing people	**Social actors:** · Students · Trainees' families · SENA instructor and administration · Political, religious, social leaders **Institutional actors:** · Nurseries · Indera · The social development secretary · The church, Community 8 action board	**Absence of industries in Armenia.** · Passive political leaders. · Unsafe city · Unemployment · The earthquake in Armenia (1999) · Corruption
IPS Administrative of the Central Clinic	· Parameters and behaviors applied to patients with health problems. · No activities related to the Mental Health Public Policy were carried out. **Requirements:** · Information should be public and easily accessible.	**Social actors:** · Medical staff. · Family · Patients, nursing and psychology staff. **Institutional actors:** · Medical staff. · Family and patients. · Nursing and psychology staff.	**Perception of the social context of Armenia** · City with high unemployment rates. · Problems with the family and at work. · Corruption · Earthquake (1999)
SENA Instructor	· Sena Intervention Program for mental health problems. · "Apprentices" program · "Sena Mentalmente Sano" program · Virtual groups to intervene in problems. · Training of instructors and administrative staff. · Financial support for students. **Requirements:** · Lack of cooperatives · Give the youth the field · Real politicians not politiqueros · Greater solidarity to generate employment.	**Social actors:** · Students · Families · SENA Instructor · Administrative staff · Workers · Doctor · Nurse · Psychologist · Social worker and pedagogues **Institutional actors:** · The Ministry of Labor, · Ministry of Health · Ministry of Commerce.	**Perception of the social context of Armenia:** · Unemployment · Aftermath of the earthquake (1999) · Families or individuals in a bad situation.

University lecturer	· Routes of care and actions related to Mental Health. · Health support with campaigns for students and the community · Psychological care for employees of this educational institution. **Requirements:** · Increased financial support · Increased presence of mental health in the university context.	**Actores sociales y actores institucionales.** · Administrative employees · Students · Doctor · Nurse · Psychologist, social worker and teacher. **Institucionales:** · University Welfare · ARL Positiva.	**Perception of the social context of Armenia:** · Corruption · Unemployment · Geological risk location · Problems generated by the 1999 Earthquake · Socioeconomic social problems

Readapted from López-Sanz (2022)

DISCUSSION

The analysis of the Mental Health Public Policy in Colombia, with a specific focus on the context of Armenia, Quindío, reveals significant challenges in its implementation and effectiveness, particularly in relation to the approach to suicide. This discussion focuses on four key areas that emerge from our findings: the historical evolution and divergences between public policy and social psychology, the challenges in integrating the medical and community model, the obstacles in intersectoriality and actor participation, and the importance of the local context and community surveillance systems.

The historical development of legal frameworks in mental health in Colombia, from Resolution 2417 of 1982 to Agreement 4886 of 2018, evidences a crucial lack of dialogue among psychology with scientific and technical criteria, the process of construction and implementation of social policies and the General System of Social Security in Health (Sistema General de Seguridad Social en Salud, SGSS). This disconnection contrasts sharply with the experience of European countries and the United States, where, as Alfaro (2013) points out, there has been a specialized dialogue since the 1960s.

The Colombian experience is particularly relevant for other Latin American countries such as Mexico, Peru and Ecuador, which are undergoing similar processes of transformation of their mental health systems (Minoletti et al., 2012). In these contexts, the lack of interaction between academia and politics has resulted in difficulties in adapting and articulating the necessary elements to develop mandatory technical-scientific and technical-administrative standards for all institutions related to mental health. This gap, also documented in African and Southeast Asian countries (Saxena et al., 2014), has hindered the overcoming of barriers related to the adaptation of the medical model to the community model, intersectoriality and the inclusion of an effective community surveillance system.

Regarding the integration of the medical and community model, international experiences from countries such as England, Spain, Chile and Brazil, described by Lampert (2018), Tavares (2019) and Rosa et al. (2020), demonstrate the importance of incorporating community strategies and actions in addressing phenomena such as suicide. These experiences underscore the need to direct mental health policies towards comprehensive human wellbeing, positioning mental health as a priority right and duty in public agendas.

In Colombia, a lack of congruence is evident between the community model needed to comply with the content of the policy and the traditional medical model of the SGSS. This discrepancy, also present in other middle-income countries such as South Africa, India and the Philippines (Patel et al., 2018), underscores the urgency of integrating theoretical, technical and methodological elements, such as the MhGAP guidelines (World Health Organization, 2017), which are currently disjointed from the actions of the Public Mental Health Policy. The Colombian case offers valuable lessons for countries seeking to reform their health systems towards more community-based models, particularly in

contexts where resources are limited and there are structural barriers to access specialized services.

The results of our study identified the critical need to generate a system of networks to articulate the actions and services that public and private entities have available to address suicide. Intersectoriality, essential to address public health problems such as suicide, presents technical difficulties from the origins of the policy. Otálvaro and López (2017) emphasize the importance of intersectorality in Colombia as a necessary process to reduce social inequalities and improve the coverage and scope of health services.

The implementation of Actor-Network Theory (ANT) is presented as a possible technical solution to address these challenges. This theory, by establishing socio-technical networks that include human, institutional and community participation, could help cohere public and private elements with governance, overcoming heterogeneity and challenging political traditionalisms in governance. This theoretical and methodological approach has shown promising results in contexts as diverse as Australia, Canada, and several Nordic countries, offering an adaptable framework for nations facing similar challenges in coordinating multiple sectors to address complex mental health problems.

Our analysis underscores the crucial importance of considering the local context for effective implementation of mental health policy. Factors specific to Armenia, such as the 1999 earthquake, the historical existence of the "suicide club," and the socioeconomic particularities of the region, including unemployment and corruption, must be integrated into the policy approach. This need for contextualization has global resonance, particularly in regions affected by natural disasters, conflicts or protracted economic crises, such as Puerto Rico after Hurricane Maria, post-conflict regions of Syria, or Greece during their economic crisis (WHO, 2020).

The inclusion of community-based epidemiological surveillance models, similar to those implemented in Spain and Brazil, appears as a promising strategy. These systems, which deploy services such as home-based care, residences and day centers, could significantly improve the collection of epidemiological information and surveillance of determinants through psychosocial teams, families and communities. The Armenia experience could inform the development of similar systems in other intermediate cities in Latin America and other regions where health resources are limited, but there is a strong community fabric that can be mobilized (Pan American Health Organization, 2021).

Finally, these findings reveal the urgent need for a more integrated and contextualized approach in the implementation of public mental health policies, not only in Colombia but also globally. The creation of international platforms for the exchange of experiences and good practices among countries with similar contexts could accelerate collective learning and the implementation of effective strategies to address complex problems such as suicide, thus contributing to the global goals of reducing suicide mortality established in the Sustainable Development Goals (UN, 2018b).

Limitations and future directions

It is important to recognize the limitations of this study, particularly in terms of the sample size and the scarcity of similar research in other municipalities in Colombia. Future studies should expand the sample and extend the analysis to other regions of the country to obtain a more complete understanding of the implementation of the Mental Health Public Policy at the national level.

CONCLUSIONS

This analysis reveals the urgent need to create spaces for the encounter between the knowledge of public health policies and community social psychology in Colombia. The integration of these fields is crucial for the development of technologies and knowledge that complement the adaptation of the SGSS with the contents of public mental health policy. This need for disciplinary integration is not exclusive to the Colombian context, but represents a global challenge documented in various international health systems, where the fragmentation among basic science, clinical practice and public policy continues to be an obstacle to effectively address complex phenomena such as suicide.

The technical considerations described, including the improvement of patient follow-up, the inclusion of the family in the care processes, and the implementation of community parameters, are fundamental to complement public mental health policy in the approach to suicide in Armenia, Quindío. These strategies coincide with the recommendations of the World Health Organization for suicide prevention and have shown positive results in various international contexts, such as community programs in Japan, Finland and Australia, which have achieved significant reductions in suicide rates through comprehensive approaches that connect the clinical and community levels.

Finally, this study contributes to the growing global literature on the importance of contextualizing mental health policies to local realities, avoiding the implementation of standardized models that do not respond to the specific needs of each population. The experience of Armenia, Quindío, illustrates how unique historical, cultural and socioeconomic factors shape both the expression of the suicide phenomenon and effective responses for its prevention, a principle applicable to diverse international contexts with their own particularities. Only through a comprehensive approach that combines scientific evidence, contextual sensitivity, community participation and intersectoral articulation, can the effectiveness of mental health policies at the local, national and international levels be significantly improved.

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JDL-S contributed to the study design, data preparation, data analysis, methodology approach, project management, supervision, validation, writing the original manuscript, and writing, revising and editing the final manuscript.

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