Original Research Article

Mental Health Services in Colombia: A National Implementation Study

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Abstract

Laws in Latin American countries are based on scientific evidence that calls for mental health services to move to the community. These care modalities have implementation problems. The objective of this article is to describe the implementation of the services proposed in Law 1616 of 2013 of Colombia (Mental Health Law): emergencies, hospitalization, community-based rehabilitation, pre-hospital care, day hospital for children and adults, Drug Addiction Care Center, groups support and mutual aid, telemedicine, and home and outpatient care. We used a mixed study, with a cross-sectional descriptive quantitative component, where an instrument was used to determine the level of implementation of these services, consisting of a scale that established the availability and use of these services, in addition to the climate of implementation of the services and community mental health strategies, in addition to a qualitative determination of barriers and facilitators of implementation. We found a low availability of all services in departments such as Amazonas, Vaupés, Putumayo, and Meta and an implementation of services in Bogotá and Caldas. The least implemented services are the community ones, and those with the greatest presence at the territorial level are emergencies and hospitalization. We conclude that low- and middle-income countries have few community models and invest a large part of their technical and economic effort in emergencies and hospitalization. There are difficulties in the implementation of most of the services proposed by Colombian legislation related to mental health.

Keywords

research/service delivery, mental health systems/hospitals, mental health, implementation science

According to the World Health Organization, 13% of the people around the world have some mental problem, with 14% being young and 60% corresponding to anxiety and depression.[1] Affective problems are the main cause of illness and disability, especially in young people, where, in addition, suicide constitutes the second to third cause of death in this life course.[2] This situation worsened as a result of the dynamics of the pandemic, especially in young people.[3] One factor that could make this situation worse is that, although there are known and effective treatments for mental disorders, more than 75% of affected people in low- and middle-income countries do not receive any treatment,[4] despite being within the framework of laws that promote coverage, comprehensive care, and articulation with other sectors and with other public policies, which makes the problem a matter of rights.

In order to approach mental health problems, scientific evidence has insisted on a change in mental health references, as shown in Figure 1, where there has been a transition from hospital care to outpatient care and, subsequently, to an approach that considers the contexts and living conditions, thus forming what has been called community mental health. This epistemological opening allows the integration of scientific advances at the level of neurobiology and psychology, with the social sciences for the formation of community-based devices.

In Latin American countries, although this mental health approach has been recognized and described in laws, plans, policies, and strategies, it has not been possible to take the step to apply this evidence to specific social contexts.[5]

In Colombia, the last National Mental Health Services Survey (N-MHSS) mentions that the Self-Reporting Questionnaire scale that assesses mental health problems was positive for some mental disorder in 11.2% of men and 13.2% of women. In many cases, several symptoms

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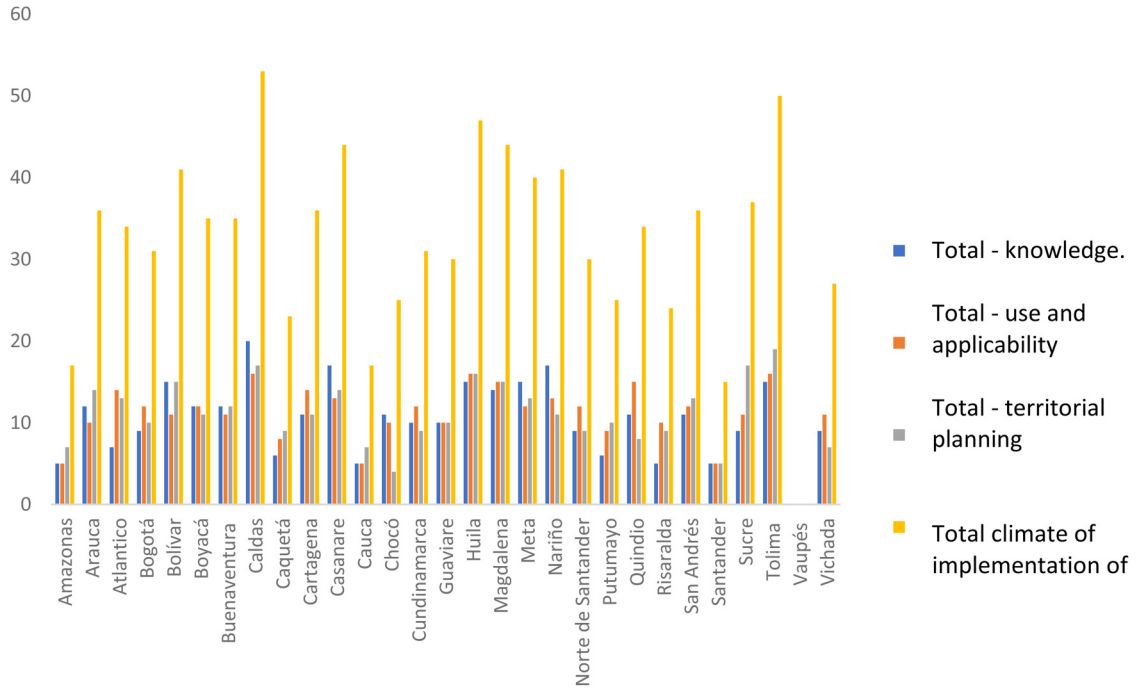

Figure 1. Implementation of group and community strategies in mental health. *Source:* The authors.

were present, especially depression, anxiety, and symptoms suggestive of psychosis. Regarding suicide, a proportion of total suicidal ideation was found to be 7.4% in women and 5.7% in men; for suicidal plan, the data was 2.5% in women and 1% in men. For attempted suicide, the prevalence was 2.9% in women and 2.1% in men; 48.5% of suicides occurred in individuals between the ages of 15 and 24.[6]

In a study in Colombia during the pandemic, it was found that[7] 30.1% of participants presented some risk in mental health, and the largest age group was 30 to 44 years old, which represented 43.4% of the total. On the other hand, 13.0% of participants showed some degree of risk related to the consumption of psychoactive substances, and 5.3% due to exposure to violence. It is worth noting the concurrent risks, represented by 7.33% of participants with 2 or more risk components, converging in the following proportions: 1.21% for mental health, substance use, and exposure to violence; 5.91% for mental health and substance use; and 0.21% of substance use and exposure to violence.

Beyond the figures, with scientific progress and human rights, the approach to mental health is becoming more and more relevant, which has been reflected in the public policies of Colombia. Since the establishment of the Law 1616 of 2013, which prioritizes mental health in Colombia and includes mental health care modalities and services[8] (see Table 1); the Statutory Law of Health (Law 1751 of 2015), which includes the social determinants to understand health and disease and mentions this as a right[9]; and the Policies of Mental Health and Prevention and Attention of the Consumption of Psychoactive Substances,[10,11] which emphasizes a focus on human rights, primary health care, gender, and social determinants.

This includes lines of action consisting of the promotion of skills for life, healthy environments, involvement of fathers and mothers in the lives of their sons and daughters; prevention, such as early detection in specific settings and reduction of stigma and self-stigma; comprehensive treatment, with access to the therapies and pharmacological management that will be required; social inclusion (community-based rehabilitation), with community strategies (mutual aid groups); and the intersectionality and knowledge management (research), with activation of routes for other needs such as those related to culture, sports, education, entrepreneurship, and social innovation.[10]

Besides the lack of strategies to address mental problems, a lack of knowledge about implementation variables at the level of care services accentuates these problems.[12] Despite theoretical and methodological advances, great problems have been described in the implementation of these strategies in Colombia.[13,14]

Before the publication of Resolution 4886 of 2018 (National Mental Health Policy), Rojas-Bernal and colleagues pointed out limitations to access the services constituted by all the actors of the health system, which are added to geographic, economic, and cultural barriers[15] that, apart from impacting living conditions, prevent individuals from starting and sustaining mental health recovery processes.

Theobald and colleagues call for action to increase the use of implementation research in global health, which means increasing the use of research to bridge the gap between research, policy, and practice to improve outcomes of health.[16]

Table 1. Mental Health Services in Colombia.

Ambulatory Care	Includes those establishments that are responsible for providing health services for people who do not require a hospital service. Both care in a doctor's office and a professional visit to the person's home are included.
Home Care	Independent and autonomous or dependent service for the management of people with acute or chronic health conditions, in a home environment with controlled criteria. Develops activities and procedures of the provision of health services, provided in the home or residence of the person with the support of professionals, technicians, or health assistants and the participation of the family or caregiver; that require an individualized care plan, seeking to keep the person in their environment, with the maximum possible comfort and relief of symptoms, guaranteeing their safety.
Pre-Hospital Care	It is the service provided to the community when emergencies, emergencies, or disasters occur at the site of the event and jointly with the actors of the General System of Social Security in Health (in this case, people with mental disorders).
Drug Addiction Care Center	It is any public, private, or mixed institution that provides health services in its treatment and rehabilitation phases, under the outpatient or residential modality, to people with addiction to psychoactive substances, through the application of a specific model or approach of care, based on evidence.
Patient and Family Support Groups	Interaction spaces convened and led by professionals (from health or social sciences, with prior training for this purpose), with the purpose of creating a welcoming and trusting environment, where identification, reactivation, or start-up is facilitated of the resources (emotional, family, social, and institutional, among others) that people have to deal with in conflicting or threatening situations with which they identify or share.
Adult Day Hospital	Modality of provision of health services in partial hospitalization, understood as intramural and institutional care for a period of less than 12 h, with the intervention of an interdisciplinary group integrating different therapeutic activities, with the aim of achieving the autonomy of the patient without separating the patient from the family environment.
Day hospital for children and adolescents.	It is a care device for the intensive institutional treatment, in a specific therapeutic environment, of severe mental disorders that appear at these moments of the life course and that have in common the fact that they cause a loss in their evolutionary possibilities and autonomous life, as well as serious difficulties in relational, social, and family life, and their academic or professional capacities are also seriously impaired.
Community-Based Rehabilitation	It is defined as the strategy that allows strengthening participatory processes in mental health, understanding the process as awareness and capacity development, which lead to greater empowerment and therefore participation. These actions allow individuals, families, and communities to consolidate their organizational processes and identify interests, difficulties, common projects, etc.
Mental Health Units	They are continuous care devices in a total hospitalization regimen for patients with severe mental disorders in the acute phase, who benefit from a short stay oriented toward continuity of care in the community.
Psychiatric Emergency	A psychiatric emergency or urgency is an acute or chronic condition that requires immediate psychiatric intervention: attempted suicide, substance abuse, psychosis, aggressive behavior, panic attacks (panic attacks), acute stress disorder, or post-traumatic stress disorder. For the care of these people, psychiatrists, nurses, psychologists, and professionals in social work are required.
Telemedicine	It contemplates several modalities: 1. Interactive Telemedicine: video call in real time between a health professional from a Health Service Provider Institution and a user; 2. Non-interactive telemedicine: asynchronous communication between a health professional from a Health Service Provider Institution and a user; 3. Teleexpertise: Two health professionals, one of whom attends the user in person and another who attends remotely; non-professional health personnel, that is, a technician, technologist, or assistant, who attends the user in person and a health professional distance health, - Health professionals who, in a medical meeting, carry out an interconsultation or advice requested by the treating physician, taking into account the clinical-pathological conditions of the person.

Source: the authors with information from Article 13 of Law 1616 of 2013.[8]

Currently, it is a challenge to understand the concepts and the functioning of the elements belonging to the health system, which has special interest for decision makers.[17] Based on the above, the objective of this study is to describe some aspects of the implementation, such as the implementation climate and availability, of the mental health services proposed in Law 1616 of 2013 in Colombia, emphasizing community strategies for mental

Table 2. Instrument to Determine Implementation Climate.

Category	Items
Knowledge orientations strategy groups	I know in detail each and every one of the components of the strategy that is applied in the territory.
	The national guidelines for the strategy express clearly, precisely, and unequivocally the essential components of the interventions.
	The strategy has understandable, attractive, and easy to understand guidelines.
	I have received sufficient training to monitor the implementation of the strategy.
	I have received technical assistance to support the implementation of the strategy in the territory.
Use and applicability	The strategy helps respond to public health needs.
	The strategy is easily accessible and always available for use.
	The strategy is applicable in the health services of the territory.
	The strategy is easy to use and implement in the health services of the territory.
	Health service users are satisfied with and welcome care based on the strategy.
Territorial planning	Territorial health information systems are aligned with the strategy.
	The annual planning of the territory includes the strategy.
	Local authorities favor the implementation of the strategy.
	The local government is committed to the implementation of the strategy.
	The annual budget of the territory takes into account the implementation and monitoring of the strategy.

Source: the authors, based on Rojas Andrade and Leiva and colleagues.[17]

health, which have been an indicator of good functioning of a mental health system.[18]

Methods

This is a mixed study, with a cross-sectional descriptive quantitative component and a qualitative component, which investigated barriers and implementation facilitators. The population established were the district or departmental mental health referents, with 19 responses (out of 35 possible), on dates between November 2021 and May 2022. Mental health referents are those professionals in charge of leading public policy processes in mental health, coexistence and, generally, in consumption of psychoactive substances, on a level of each department or district of the country; therefore, they have in-depth knowledge of the implementation of health services at the territorial level.

The presence and usefulness of the services proposed in Law 1616 of 2013 were inquired about and three response options were offered: *does not have this service, has this service but contributes little, has this service and contributes significantly*. In addition, questions were asked about the presence of an epidemiological analysis in mental health and the development of a mental health policy, both aspects at the territorial level. The data was summarized in frequency distribution tables. An integration of mixed methods was sought.[19] This study was approved by the bioethics committee of the University of Manizales.

Similarly, an instrument was designed in Google Forms with implementation climate questions, adapted from its original version[20] and applied to territorial health referents on the community strategies indicated in both the global public policy, as in Law 1616 of 2013, and in the National Mental Health Policy. This application was online, with scores ranging from 0 to 60. There was a list of statements for which participants described their level of agreement using a Likert scale of five options ranging from "Strongly agree" to "Strongly disagree."

The implementation climate is understood as the perception of the referents about the objectives and values of the services in accordance with the objectives that were proposed by Law 1616 of 2013. This instrument is divided into three domains: (a) knowledge of the guidelines to implement the community strategies, (b) use and applicability of community strategies at the territorial level, and (c) territorial planning of these strategies (see Table 2).

A SWOT analysis (Strength, Weakness, Opportunities, and Threat) of the territorial implementation of health services was carried out in the framework of a meeting of the Ministry of Health and Social Protection of Colombia in March 2022.

The mental health referents of the districts of Colombia that attended were divided into two subgroups at random. The first was made up of Santander, Córdoba, Vaupés, Bolívar, Chocó, Norte de Santander, Casanare, San Andrés, Bolívar, Cartagena, Arauca, and Amazonas; the second included Caldas, Risaralda, Huila, Bogotá, Cali, Valle, Nariño, Meta, Antioquia, Magdalena, and Vaupés. The focus group was led by the researchers, accompanied by a sociologist from the Ministry of Health and Social Protection.

Results

As can be seen in Table 3, the services that are least implemented on a national level correspond to community strategies, specifically support groups and mutual aid groups, with

Table 3. Use of Mental Health Strategies and Services in Colombia.

Department/ District	Ambulatory	Home Care	Pre-Hospital Care	Drug Addiction Care Center	Groups Support and Mutual Help	Day hospital for adults, children and adolescents.	CBR	Mental Health Unit	Emergency	Tele
Amazonas										
Arauca										
Atlántico										
Bogotá										
Caldas										
Boyacá										
B/ventura										
Caquetá										
Cartagena										
Casanare										
Cauca										
Guaviare										
Huila										
Magdalena										
Bolívar										
Chocó										
C/marca										
Meta										
Putumayo										
San Andrés										
Sucre										
N/Santander										
Quindío										
Santander										
Vichada										
Risaralda										
Vaupés										
Tolima										
Nariño										

CBR: Community Based Rehabilitation. The authors

Does not have the service

It has the service, but contributes little

It has this service and contributes significantly

only four departments where they are implemented (Bogotá, Caldas, Chocó, and Risaralda). As mentioned above, the services that are implemented the most are mental health units, emergency services, and outpatient services, in that order. In a significant proportion, there is evidence of services that contribute a small amount to the management of mental health, despite there being some experience at the territorial level.

At the territorial level, the departments with the greatest implementation of services and the greatest modalities are

Bogotá, Caldas, and Atlántico. At this point, the absence of diligence of departments such as Antioquia and Valle del Cauca is considered, where most of the services studied are implemented. The departments with the least implementation of mental health services, due to their absence or little use, were Amazonas, Meta, Buenaventura, Guaviare, Vaupés, and Casanare.

In the case of Amazonas, only 2 services have been implemented: community-based rehabilitation and telehealth. Meta only has proper functioning of telehealth services and Guaviare lacks adequate implementation of all the services proposed by Law 1616 of 2013, as does Buenaventura. The mental health unit is the most frequent mental health care service in Colombia; even territories such as Casanare have this as the only service stipulated in this law.

In this sense, 74.2% of the sample is using less than 50% of the services to which they would be entitled by law and 30% only use 1 or 2 services out of the 10 established by the law.

Regarding services, the one that is implemented the most is hospitalization, with 61.29% of the territories, followed by outpatient services, with 41.93%. The least implemented are groups, both support and mutual help (12.9%), followed by pre-hospital care (16.12%) and community-based rehabilitation in mental health (25.8%).

Regarding the sum of the climate instrument for the implementation of community strategies for mental health, it is found that Caldas, Huila, Tolima, and Magdalena present better scores (see Figure 1). No response from Vaupés was found in this specific component of the questionnaire. The lowest scores correspond to Amazonas and Cauca. Vaupés did not provide answers for this item.

The questions with a lower score refer to the receipt of technical assistance, low support to implement the strategies, and a scarce budget for their development. Group processes for mental health and low support from other sectors that make it possible to start and sustain these strategies are recognized as difficult to access.

If the domains of the instrument are analyzed, knowing that each one has a maximum score of 20, it is found that the lowest domain of this measure of implementation, at the national level, has to do with *Knowledge of community strategies*, with an average of 10.44, followed by *Territorial planning* with 10.86 and *Use and applicability* with 11.03.

Barriers in the Territories for Implementation of the Modalities

The barriers most identified by the territorial entities for the planning and implementation of each modality were systematized as follows:

- Little access to occupational therapists and physical therapists, which fragments the perspective on the rehabilitation of human capacities, considering mental health as differential actions focused and atomized at inter-sectoral and social levels
- Insufficient human resources
- Ignorance of strategies
- Little support from the government in the technical knowledge of the modalities
- Limitation of resources, dissemination of contributions, planning, integration of other institutions and organizations, monitoring, technical supervision, systematization, and analysis of information
- Few decentralized strategies of mental health policy, that is, specific, individualized actions have been developed, but as isolated experiences
- Lack of economic resources allocated for community strategies
- The existence of a global unification of the planning and actions that are developed
- Lack of follow-up and under-registration of people with mental problems and disorders
- Lack of qualification of human talent in health
- Lack of articulation of the institutions that provide health services and lack of continuity of services
- Lack of competence of human talent in health
- Limitation in accessibility to the mental health service
- Deficiency in the opportunity for mental health care
- Services concentrated in the urban area
- Deficiency in family and community support networks
- Lack of programs for social inclusion

At the level of each territory, other difficulties were emphasized. In the case of Amazonas, it is pointed out "intersectorality is not possible. Not having characterization in front of this population." For Arauca, it is noted that "The difficulties, the lack of priority (to address) them, lack of sectoral and inter-sectoral coordination, lack of fulfillment of roles and responsibilities in this area, lack of political commitment regarding the investment of resources financial."

It was found that the implementation of pre-hospital care in mental health presented a statistically significant correlation with the presence and use of services such as support groups, mutual aid groups, and outpatient care with day hospitals, both for adults and children.

In Atlántico, it is pointed out: "There were difficulties in the 2020 and 2021 periods of lack of connectivity, lack of human talent, and financial resources, as well as the articulation with Health Administrative Entities and providers, and various sectors to carry 100 percent of the scheduled activities." In the case of Boyacá, they note: "A repetitive difficulty is the lack of resources to advance the programs." In Caldas, it is pointed out: "High turnover of personnel of the Health Services Entities, there is no complementarity between the Collective Interventions Plan and the Benefits Plan, given that in the first levels there is no development of mental health activities, low resources allocated to both departmental and municipal mental health: the 26 municipalities of Caldas allocated between 15 and 20 million COP on average for mental health strategies, which is not enough to

cover public health events (gender violence, self-injurious behaviors, psychoactive substances consumption, and mental disorder)." Furthermore, "there is a lack of national guidelines for the development of the Comprehensive Mental Health Care Route, in Caldas the comprehensive care process for SPA consumption is in the process of being implemented, which was chosen as a priority." And they end by saying: "Community strategies require continuity and with the annuity of resources and contracting processes, they are reduced to less than 10 months and without continuity."

In Casanare, "barriers to access to mental health care services are mentioned; high rate of stigma in mental health in the population; high turnover of health professionals; ignorance of the social determinants by the municipalities." Cauca emphasizes the need for more specialists to strengthen primary health care strategies, while Guajira says that they must restart the processes because they do not give continuity to the people in the programs. Meta points out the lack of methodologies that help professionals execute strategies and points out that the focus on COVID-19 could have left aside the mental health problems in the region.

The instrument also added a question related to the facilitators, among which several territories converge in the political incidence of change agents and people with disabilities. This generates interaction with the district disability system, district care system, support interaction for caregivers, requesting resources for disability investment projects. Another enabler was noted as the consideration that the COVID-19 pandemic has made of mental health needs by intensifying surveillance of priority mental health events. This last point also increased the experience and knowledge of the professionals and entities in charge of the implementation of health services, the visibility of the needs in vulnerable areas and the participation of the users themselves in their health care processes.

Discussion

The objective of this research was to analyze the implementation of mental health services proposed by Law 1616 of 2013. For decades, this type of study has been pointed out as a necessity. In this regard, Proctor recognizes[21] that one of the most critical problems in research on mental health services is the gap between what is known about effective treatment and what is provided to people.

With the mentioned above, the search for specific strategies designed to put into practice an activity or program of known dimensions[22] is pointed out, which, in the case of this article, are strategies that are even stipulated in a national law.

An example of this is what is indicated in the results regarding the little technical assistance and the little support that the territorial referents could present to deploy these mental health care modalities, even when good applicability in these strategies is recognized. Therefore, implementation strategies must address the contingencies of various service systems or sectors (eg, specialized mental health, medical and non-specialized care) and practice settings, as well as the challenge of capacity building and staff support, in addition to the various properties of interventions that make them more or less accessible to implementation.[21]

This is how, although indicators have been developed related to coverage, with citizen participation in health and with differentiation in hospital and outpatient settings, it is still not very clear how to determine the continuity of care services between them (hospital to outpatient processes, outpatient processes to community processes, support in community processes); therefore, it is essential to carry out measurements of the implementation of health programs, plans, and strategies, based on the continuity of care[23]—that is, in a process that involves orderly care, an uninterrupted movement of people between the various elements of the service delivery system.[24]

In this regard, in *The Burden of Mental Disorders in the Region of the Americas*, it is mentioned that the countries that invest the most in mental health possibly allocate the largest amount of those resources to community support, which "respects social and human rights of patients, as opposed to segregationist approaches based in psychiatric hospitals that encourage isolation and possibly the violation of human rights."[25]

In other words, of the few available resources that may be available for mental health in low- and middle-income countries, the largest proportion of these are allocated to hospitalization and emergency services, which do not present continuity with other care services.

In the word segment of the questionnaire, where the second prioritized word IPS (Health Service Provider Institutions, by its acronym in Spanish), which refers to entities authorized to provide mental health services or procedures, in the context of prioritization denotes that it is the IPS that carry out the provision of mental health services. In third place, of prioritization, words are found, such as Hospital and Health, which denotes that the two words have the same importance for the referents. The foregoing reaffirms the quantitative data that indicates that the most implemented services are those related to hospitalization or institutions, subtracting weight from community services. In this regard, the Pan-American Health Organization mentions,[26] when referring to the barriers to achieving psychiatric deinstitutionalization: "Another barrier to deinstitutionalization is identified: the presence of treatment models, paradigms and practices. The lack of participation in the treatment of users of mental health services, low adherence and lack of effectiveness and preparation for reintegration into the community are conditions that oppose the model of mental health in the community. When paradigms stimulate autonomy in care and an appropriate implementation of services is observed, deinstitutionalization processes are facilitated."

All of the above shows that the greater investment in community-based services, the greater recovery in their own environments and fewer psychiatric hospitalizations, which ultimately will end up generating a positive impact,

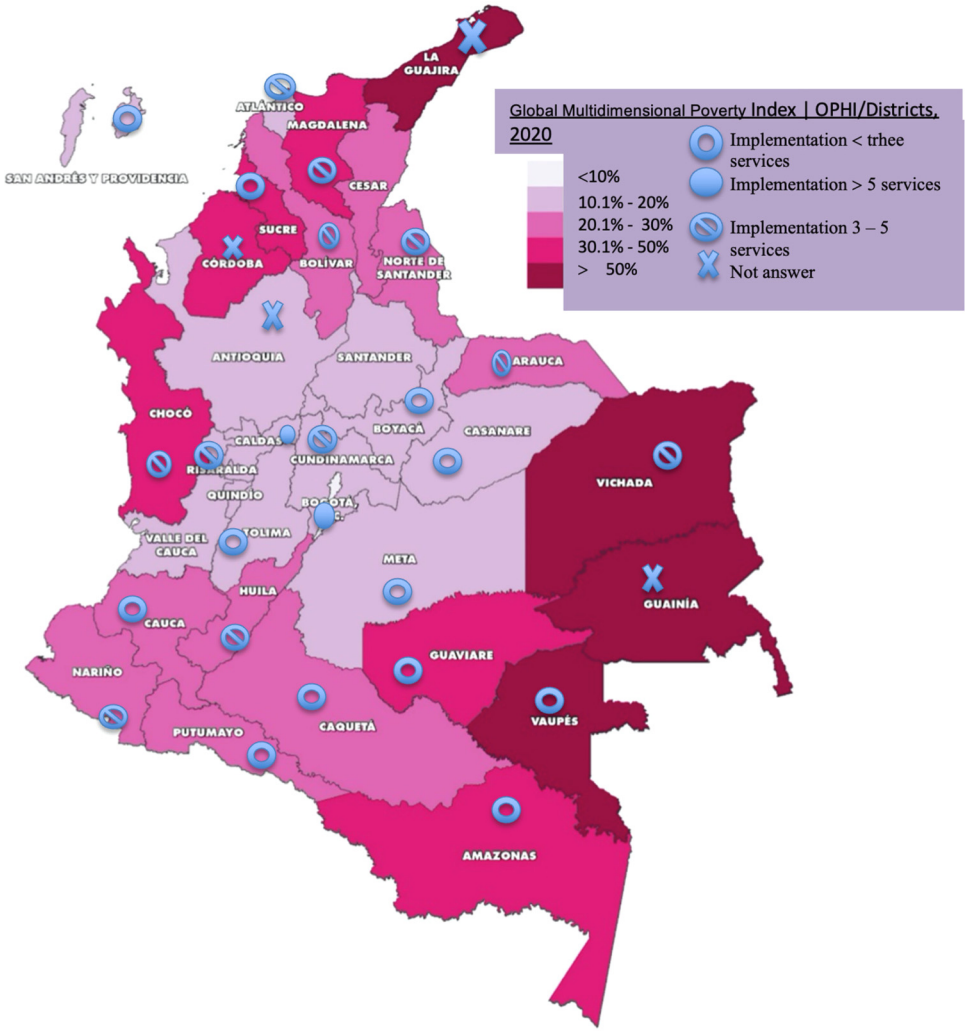

Figure 2. Territorial implementation of health services and multidimensional poverty in Colombia. Source: The authors with information from DANE.[32]

not only in individual and family capacities and functions, but also at social and economic levels in the health systems themselves.

The present study found at the national level an important reference of all the territories toward hospital services, with low availability and territorial use of community models or services of less intensity, represented in day hospitals, in community-based rehabilitation, and in group interventions. As well as the low implementation of most services in departments with important social problems such as migration, suicidal behavior in the indigenous population,[27] and access barriers, including Amazonas, Vaupés, Putumayo, Meta, and Casanare.

This distribution of low implementation coincides with most of the regions with the greatest inequality and multidimensional poverty in the country (see Figure 2). In this regard, one of the indicators of this last measure is health, with subcomponents established as: "Coverage: affiliates to the contributory regime and coverage of the subsidized regime (baseline 18,116,769 and 90.27%); and Access to health services when needed".[28] This validates the intersectionality approach with which it is necessary to address mental problems and disorders.[29]

Although the reforms of mental health services in the last 20 years have led to improved mental health care, these advances were clearly insufficient to respond to the enormous challenges that countries such as Colombia face in improving mental health services. This is due to insufficient funding, the absence of a solid consensus among all stakeholders, and the weakness of user and family associations, in addition to the lack of technical capacity of the coordination unit responsible for the development of services in the ministries of health, the resistance of professionals to change to new models of care, and the lack of human resources.[30]

Cubillos and colleagues carried out a thematic analysis using public records and semi-structured interviews on policies related to inclusion in psychosocial disability in Colombia,

Costa Rica, and Peru, finding that many programs do not include people with serious mental illness and pointing out some barriers in these recovery services, among these rigid labor markets, insufficient promotion, lack of community models, and lack of reimbursement for evidence-based psychiatric rehabilitation interventions,[31] which could be reaffirmed with the data presented in this study.

Similarly, it is noteworthy in this study that the adoption by itself of a public mental health policy at the territorial level does not imply substantial changes in the services it proposes: It needs to be implemented, which implies greater contact with the people who require the services and with the organizations that must implement these plans at the local level.[13,14]

This study could provide input to guide public policy actions to deal with this scenario and increase people's access to health services, which are considered by law. As limitations are the lack of information from some territories that could have been relevant for this analysis, such as Antioquia, Valle del Cauca, and La Guajira. In the same way, this analysis can be complemented with an analysis of barriers and facilitators identified by the professionals of the services or programs at the local level and by the same people with mental problems, which would imply addressing another fundamental variable of implementation, consisting of the acceptability of services or strategies.

A strength is of the present study is that it could be established as an input for the technical leaders of public policy at the level of Colombia and Latin American countries, since it allowed the territorial representatives of mental health to indicate which services should be strengthened, with their respective barriers and facilitators. This allows different stakeholders to address barriers and make use of facilitators in the planning phase of mental health services.

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Ethical Approval

This study was approved by the bioethics committee of the University of Manizales, which validated compliance with the principles and ethical standards of the Declaration of Helsinki of 1975 and its subsequent revisions and of the Resolution 8430 of 1993 of the Ministry of Health of Colombia.

Declaration of Conflicting Interests

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References

1. *World mental health report: transforming mental health for all*. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO. Disponible en https://www.who.int/publications/i/item/9789240049338
2. Patel V, Saxena S, Lund C, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018;392(10157):1553–1598. doi: 10.1016/S0140-6736(18)31612-X. Erratum in: *Lancet*. 2018;392(10157):1518. Epub 2018 Oct 9. PMID: 30314863.
3. Arora T, Grey I, Östlundh L, Lam KBH, Omar OM, Arnone D. The prevalence of psychological consequences of COVID-19: a systematic review and meta-analysis of observational studies. *J Health Psychol*. 2022;27(4):805–824. doi: 10.1177/13591053 20966639. Epub 2020 Oct 29. PMID: 33118376.
4. Rüsch N, Evans-Lacko SE, Henderson C, Flach C, Thornicroft G. Knowledge and attitudes as predictors of intentions to seek help for and disclose a mental illness. *Psychiatr Serv*. 2011;62(6):675–678. doi: 10.1176/ps.62.6.pss6206_0675. PMID: 21632739.
5. Bauer MS, Kirchner J. Implementation science: what is it and why should I care? *Psychiatry Res*. 2020;283(1):112376. doi: 10.1016/j.psychres.2019.04.025.
6. Gómez-Restrepo C, Aulí J, Tamayo Martínez N, Gil F, Garzón D, Casas G. Prevalencia y factores asociados a trastornos mentales en la población de niños colombianos, Encuesta Nacional de Salud mental (ENSM) 2015 [Prevalence and associated factors of mental disorders in Colombian child population, the 2015 National Mental Health Survey]. *Rev Colomb Psiquiatr*. 2016;45(Suppl 1):39–49. doi: 10.1016/j.rcp.2016.06.010. Epub 2016 Aug 21. PMID: 27993255.
7. Ministerio de Salud y Protección Social. 2022. *Situación de salud mental en Colombia en la pandemia por COVID-19*. Disponible en https://www.minsalud.gov.co/Paginas/Las-cifras-de-la-salud-mental-en-pandemia.aspx
8. Congreso de la República de Colombia. *Ley 1616 de 2013*. Bogotá. Disponible en https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/ley-1616-del-21-de-enero-2013.pdf
9. Congreso de la República de Colombia. *Ley Estatutaria 1751 de 2015*. Bogotá. Disponible en: https://www.minsalud.gov.co/Normatividad_Nuevo/Ley%201751%20de%202015.pdf
10. *Ministerio de Salud y Protección Social—Resolución 4886 de 2018*. Disponible en https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/politica-nacional-salud-mental.pdf.
11. Ministerio de Salud y Protección Social. Política Integral para la Prevención y Atención del Consumo de Sustancias Psicoactivas. Ministerio de Salud y Protección Social—Resolución 089 de 2019; Disponible en https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/politica-prevencion-atencion-spa.pdf
12. Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: conceptual distinctions, measurement

challenges, and research agenda. *Adm Policy Ment Health*. 2011;38(2):65–76. doi: 10.1007/s10488-010-0319-7. PMID: 20957426; PMCID: PMC3068522.
13. Agudelo-Hernández F, Rojas-Andrade R. Ciencias de la Implementación y Salud Mental: Un Diálogo Urgente. *Rev Colomb Psiquiatr*. 2021;64(4): 35–76. https://doi.org/10.1016/j.rcp.2021.08.001
14. Allotey P, Reidpath DD, Ghalib H, Pagnoni F, Skelly WC. Efficacious, effective, and embedded interventions: implementation research in infectious disease control. *BMC Public Health*. 2008;8(1):343. doi: 10.1186/1471-2458-8-343. PMID: 18826655; PMCID: PMC2567977.
15. Rojas-Bernal LA, Castaño-Pérez GA, Restrepo-Bernal DP. Salud mental en Colombia. Un análisis crítico. *Rev CES Med*. 2018;32(2):129–140.
16. Theobald S, Brandes N, Gyapong M, et al. Implementation research: new imperatives and opportunities in global health. *Lancet*. 2018;392(10160):2214–2228. doi: 10.1016/S0140-6736(18)32205-0. Epub 2018 Oct 9. PMID: 30314860.
17. Bonal R, López Vásquez N, Vargas P, Meoño T, Brañas Coelho R. Apoyo al automanejo de condiciones crónicas: Un desafío de los sistemas de salud de América Latina. *Rev Finlay*. 2017;7(4):268–277. http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S2221-24342017000400006&lng=es&tlng=es
18. Diez-Canseco F, Rojas-Vargas J, Toyama M, et al. Estudio cualitativo sobre la implementación del Programa de continuidad de cuidados y rehabilitación para personas con trastornos mentales graves en el Perú. *Rev Panam Salud Publica*. 2020;44:e134. https://doi.org/10.26633/RPSP.2020.134
19. Creswell W, Plano Clark V. *Designing and conducting mixed methods research*. SAGE Publications; 2021 https://us.sagepub.com/en-us/nam/designing-and-conducting-mixed-methods-research/book241842.
20. Leiva L, Rojas R, González L. Explorando la implementación del programa Habilidades para la Vida ¿Qué destacan los equipos ejecutores? En: Peña F, ed. *Apoyando el bienestar en las comunidades educativas*. Junta Nacional de Auxilio Escolar y Becas; 2021, pp.31–42.
21. Proctor EK, Landsverk J, Aarons G, Chambers D, Glisson C, Mittman B. Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges. *Adm Policy Ment Health*. 2009;36(1):24–34. doi: 10.1007/s10488-008-0197-4. Epub 2008 Dec 23. PMID: 19104929; PMCID: PMC3808121.
22. Fixsen DL, Naoom SF, Blase KA, Friedman RM, Wallace F. *Implementation research: a synthesis of the literature(No FMHI Publication #231)*. University of South Florida, Louis de la Parte Florida Mental Health InstituteNational Implementation Research Network; 2005.
23. Agudelo-Hernández F, Vélez-Botero H, Rojas-Andrade R. Traducción y adaptación de la Escala de Continuidad de Servicios de Salud Mental de Alberta en un contexto latinoamericano. *Rev Chil Neuropsiquiatr*. 2021;3. https://doi.org/10.5281/zenodo.6800084
24. Bachrach LL. Continuity of care for chronic mental patients: a conceptual analysis. *Am J Psychiatry*. 1981;138(11):1449–1456. doi: 10.1176/ajp.138.11.1449. PMID: 7294213.
25. Organización Panamericana de la Salud. *La carga de los trastornos mentales en la Región de las Américas, 2018*. OPS; 2018.
26. Desinstitucionalización de la atención psiquiátrica en América Latina y el Caribe. Washington, DC: Organización Panamericana de la Salud; 2020. Licencia: CC BY-NC-SA 3.0 IGO. Disponible en https://iris.paho.org/bitstream/handle/10665.2/53027/9789275323014_spa.pdf?sequence=1&isAllowed=y
27. Vargas-Espíndola A, Villamizar-Guerrero JC, Puerto-López JS, Rojas-Villamizar MR, Ramírez-Montes OS, Urrego-Mendoza ZC. Conducta suicida en pueblos indígenas: Una revisión del estado del arte. *Rev Fac Med*. 2017;65(1):129–135. http://dx.doi.org/10.15446/revfacmed.v65n1.54928
28. Gutiérrez López JA, Cortés Wilches N, Montaña Londoño CJ. La Pobreza Multidimensional y su relación con el espacio: Caso de estudio para Colombia. *Rev Visión Contab [Internet]*. 2020;(21):78–100. Disponible en: https://publicaciones.unaula.edu.co/index.php/VisionContable/article/view/733.
29. Holman D, Walker A. Understanding unequal ageing: towards a synthesis of intersectionality and life course analyses. *Eur J Ageing*. 2020;18(2):239–255. doi: 10.1007/s10433-020-00582-7. PMID: 33082738; PMCID: PMC7561228.
30. Caldas de Almeida JM. Mental health services development in Latin America and the Caribbean: achievements, barriers and facilitating factors. *Int Health*. 2013;5(1):15–18. doi: 10.1093/inthealth/ihs013. PMID: 24029840.
31. Cubillos L, Muñoz J, Caballero J, et al. Addressing severe mental illness rehabilitation in Colombia, Costa Rica, and Peru. *Psychiatr Serv*. 2020;71(4):378–384. doi: 10.1176/appi.ps.201900306. Epub 2020 Jan 3. PMID: 31896339.
32. DANE. *Encuesta de Calidad de Vida ECV 2019-2020*. 2021. https://www.dane.gov.co/files/investigaciones/condiciones_vida/pobreza/2020/presentacion-rueda-de-prensa-pobreza-multidimensional-20.pdf.

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