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Integrated and Person-Centred Inpatient Mental Health Care in Colombia: A Qualitative Study of Patient and Caregiver Experiences

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Abstract

Background

Mental health care in Colombia continues to face challenges related to access, fragmentation, and continuity. The University Hospital Fundación Santa Fe de Bogotá developedZona Lavanda, an inpatient mental health unit designed to provide integrated and person-centred care through interdisciplinary coordination, supportive relationships, caregiver involvement, and a therapeutic environment. This study explored how patients and caregivers experienced this model.

Methods

We conducted a qualitative evaluation based on 13 semi-structured virtual interviews with patients and caregivers who had experienced care inZona Lavanda. Participants were 13–70 years old, and some caregivers provided continuous accompaniment during hospitalization. Interviews explored the physical environment, clinical care, communication, emotional support, caregiver experiences, administrative processes, and continuity after discharge. Interviews were transcribed and analyzed using thematic analysis following Braun and Clarke. The evaluation was conducted as part of institutional quality-improvement activities.

Results

Five themes were identified. Participants described integrated and relational care as a source of safety and trust, particularly when specialists communicated and a coordinating professional helped connect decisions. Communication, participation in decisions, and respectful treatment supported experiences of dignity and autonomy. Natural light, individual rooms, art, and music were perceived as part of what made the environment therapeutic, although participants also identified limitations related to space, noise, and mechanical restraint. Caregivers were recognized as active partners but reported fatigue, inadequate rest conditions, and limited support for their own needs. Participants also described a contrast between coordinated care inside the unit and greater fragmentation before admission and after discharge, including emergency delays, insurance barriers, difficulties obtaining follow-up care, and out-of-pocket costs. Some described access to this type of care as “almost a privilege” and wanted elements of the model to be adapted elsewhere.

Conclusions

Patients and caregivers experiencedZona Lavandaas a model in which interdisciplinary coordination, relational care, communication, caregiver involvement, and the physical environment worked together to support person-centred inpatient mental health care. However, integration inside the unit became more

fragile when access and continuity depended on administrative, financing, and outpatient arrangements. Strengthening caregiver support and continuity across the care pathway are important areas for future practice and research.

Background

Mental health has become a critical priority for health systems worldwide. Globally, mental health needs remain high, while health systems often have insufficient capacity to provide timely and appropriate care [1, 2]. This situation is especially concerning in Latin America, where a large share of people living with mental health conditions do not receive adequate treatment and continue to face important barriers to accessing care [3].

In Colombia, despite regulatory advances such as Law 1616 of 2013, its subsequent amendment through Law 2460 of 2025, and the National Mental Health Policy 2024–2033, important structural challenges remain [4, 5, 6]. Access, coordination, and continuity of mental health services continue to be important concerns. Recent evidence from Bogotá, for example, shows that people seeking mental health support, particularly young people, may experience long and complex pathways involving multiple formal and informal services, reflecting the difficulties of navigating available care [7]. These challenges are particularly relevant when people require specialized or hospital-based mental health care, where coordination across professionals, services, and different stages of the care pathway becomes essential.

In this context, the need to develop comprehensive and sensitive approaches to mental health care has grown more urgent. Person-centered and rights-based approaches emphasize dignity, autonomy, active participation in treatment decisions, involvement of support networks, and integration between mental health services and the broader health system [8, 9]. These dimensions are particularly important in inpatient mental health care. Evidence from psychiatric settings shows that relationships with health professionals, communication, autonomy, the care environment, and experiences of coercion can strongly shape how patients experience hospitalization and whether care is perceived as dignified and therapeutic [10, 11].

The physical environment is also increasingly recognized as an important component of inpatient mental health care. Features such as privacy, natural light, access to nature, appropriate levels of stimulation, and spaces that promote autonomy and social interaction can influence patients' experiences of safety, dignity, and well-being [12, 13]. However, these elements cannot be understood separately from the organization of care. Therapeutic environments operate alongside clinical coordination, relationships with health professionals, participation in decisions, family involvement, and continuity across different stages of care.

In response to these needs, the University Hospital Fundación Santa Fe de Bogotá (FSFB), located in Bogotá, Colombia, developed *Zona Lavanda*, an inpatient mental health area designed to integrate

specialized infrastructure with interdisciplinary and person-centered care. *Zona Lavanda* includes infrastructure designed to protect patient safety, with natural light, calming colors, individual rooms, common areas, continuous patient monitoring, and other safety features. It also provides interdisciplinary care in a therapeutic environment that aims to support the physical and emotional needs of patients and their families.

Based on this experience, we carried out a qualitative evaluation to understand how patients and caregivers experienced *Zona Lavanda* and the different components of this model of care. Through in-depth semi-structured interviews, we explored the physical environment, clinical coordination, communication and emotional support, participation in treatment decisions, the role of caregivers, and continuity of care. Beyond identifying strengths and areas for improvement within the program, this study examines which features of an integrated inpatient mental health model contribute to person-centered and dignified care, and how these experiences are shaped by the broader care pathway in which the model operates. By doing so, the study provides evidence from Colombia that may inform the development and adaptation of integrated inpatient mental health services in other settings, particularly across Latin America.

Methods

This evaluation used a qualitative approach focused on understanding how patients and caregivers experienced hospitalization in *Zona Lavanda* at the University Hospital Fundación Santa Fe de Bogotá (FSFB). The aim was to capture perceptions, meanings, judgments, and tensions around this model of care from the direct perspective of the people who experienced it, recognizing that their perspective is important for assessing the quality and relevance of the service [14]. *Zona Lavanda* is an inpatient mental health area within FSFB, a high-complexity university hospital in Bogotá, Colombia, which provides interdisciplinary care and seeks to integrate physical and mental health needs within a therapeutic hospital environment.

Approach and evaluation criteria

The evaluation was structured around the principles of person-centered care, dignified care, and the humanization of health services. From this perspective, we gave particular attention to aspects such as communication, clinical coordination, the physical and emotional environment, the relationship with the health team, participation in treatment decisions, and the role of caregivers. These elements are consistent with conceptual frameworks of person-centered care [8]. Although these areas were considered when developing the interview guide, the analysis was primarily inductive, allowing themes to be developed from the experiences described by participants rather than from a predefined analytical framework. In this way, the evaluation maintained some common areas of exploration across interviews while also allowing other issues and tensions to emerge from the participants' accounts [15, 16].

Participants and recruitment

Participants included patients who had received care through *Zona Lavanda* and caregivers who had directly accompanied patients during hospitalization. Eligible patients had a confirmed diagnosis of an eating disorder, acute confusional disorder, or affective disorder and had been hospitalized in *Zona Lavanda*. Participants were recruited through convenience sampling among patients and caregivers who met the eligibility criteria. The hospital contacted eligible individuals and invited them to participate voluntarily in the evaluation. The protocol anticipated approximately 12–15 interviews, with the aim of obtaining sufficiently rich and varied accounts from patients and caregivers with direct experience of hospitalization in Zona Lavanda. Data collection concluded after 13 interviews, which provided detailed accounts across different participant profiles, lengths of hospitalization, and caregiving experiences. Data collection was carried out during 2025.

A total of 13 participants were interviewed, including both patients and caregivers. Participants ranged in age from 13 to 70 years, and 10 of the 13 participants (77%) were women. Length of hospitalization ranged from approximately one week to more than three months, which allowed us to include experiences associated with different lengths and intensities of care. Some caregivers had accompanied patients continuously during long hospital stays and were therefore able to provide a detailed perspective on everyday caregiving, communication with the clinical team, and the experience of remaining in the hospital for extended periods. The purpose of the sample was not to achieve statistical representativeness, but to obtain detailed accounts from people who had direct experience with the *Zona Lavanda*.

Data collection

We carried out 13 in-depth semi-structured interviews, all conducted virtually via Microsoft Teams and in Spanish during 2025. Interviews lasted approximately one hour and were conducted by an external researcher with experience in qualitative health research, who was not part of FSFB or *Zona Lavanda* clinical team and had no role in the clinical care of participants. The interview guide was designed to explore, in an open way, different dimensions of the experience in *Zona Lavanda*, including the physical environment, the treatment received, communication with the clinical team, emotional support, participation in treatment decisions, the role of caregivers, and experiences related to admission and continuity of care. The semi-structured interview guide was developed specifically for this study and is provided in its English translation as Supplementary file 1. Moreover, participants were able to introduce other issues that they considered relevant and to describe specific situations that had shaped their experience.

All interviews were audio-recorded with informed consent and were then fully transcribed in Spanish by an independent transcriber contracted for this purpose under a confidentiality agreement. Identifying information was removed from the transcripts before the analysis. The quotations included in this

manuscript were translated from Spanish into English while seeking to preserve the original meaning of participants' accounts.

Data analysis

Data analysis followed a thematic approach based on the phases described by Braun and Clarke (2006), including familiarization with the data, generation of initial codes, identification and review of themes, definition and naming of themes, and production of the final analysis. The same external researcher who conducted the interviews led the analysis, beginning with repeated reading of the transcripts and the identification of initial codes related to experiences, perceptions, practices, and tensions around the model of care. NVivo was used to organize and code the qualitative material.

Codes were compared across interviews and gradually grouped into broader themes according to common patterns and relationships in the data. The themes were reviewed several times against the original transcripts and adjusted when necessary to better represent participants' experiences. Although the overall perception of *Zona Lavanda* was largely positive, the analysis also paid attention to experiences that differed from this general pattern and to areas where participants identified difficulties or opportunities for improvement. The final themes therefore included both positive aspects of the model and tensions related to issues such as the physical environment, caregiver needs, mechanical restraint, access to the unit, and continuity of care after discharge. Illustrative excerpts were selected to show the meaning and emotional depth of these experiences and to support the interpretation of each theme. The reporting of the evaluation was informed by the Consolidated Criteria for Reporting Qualitative Research (COREQ) [(17)].

Ethical considerations

All participants were informed about the purpose of the evaluation, the voluntary nature of their participation, the use of the information collected, and the conditions of confidentiality and anonymity. Informed consent was obtained before each interview. The evaluation was conducted as part of the institutional quality-improvement activities of Fundación Santa Fe de Bogotá, with the purpose of contributing to institutional learning and improvement of the model of care rather than testing a clinical intervention. The study was reviewed and approved by the Corporate Research Ethics Committee of Fundación Santa Fe de Bogotá and was conducted in accordance with the ethical principles of the Declaration of Helsinki, Resolution 8430 of 1993 of the Colombian Ministry of Health, and applicable institutional ethical requirements. In accordance with Article 11 of Resolution 8430 of 1993, the study was classified as minimal-risk research. For the participant under 18 years of age, assent was obtained from the participant and informed consent was obtained from the legal guardian, in accordance with the institutional requirements applicable to the evaluation. Audio recordings and transcripts were managed under confidentiality procedures, and identifying information was removed from the material used for analysis and publication. Large language models were used solely for grammatical and language

revision of the manuscript. No identifiable participant information was entered, and these tools were not used for data analysis or interpretation. All revisions were reviewed and approved by the authors.

Results

Across all 13 interviews, patients and caregivers described *Zona Lavanda* in very positive terms, but the reasons they gave were not limited to general satisfaction. Their accounts repeatedly connected the experience with the way professionals worked together, the possibility of being informed and involved in decisions, the emotional support received during hospitalization, and the characteristics of the physical environment. At the same time, the interviews also showed important tensions inside the unit and at the points before admission and after discharge. The eight dimensions identified in the original evaluation were reorganized into five broader themes that bring together these different parts of the experience.

1. Relational and coordinated care: integration as an experience of safety and trust

One of the strongest patterns in the interviews was the value given to coordinated care, particularly in cases where mental health needs were present together with physical conditions, chronic diseases, eating disorders, or other complex clinical situations. Participants mentioned psychiatry, psychology, nutrition, internal medicine, neurology, neurosurgery, gastroenterology, pediatrics, dermatology, hematology, ophthalmology, orthopedics, and other specialties. What they valued was not simply having several professionals available, but seeing that these professionals communicated with each other, knew what was happening in the case, and made decisions considering the patient as a whole. This was especially important for participants who had previously experienced care in which each specialty worked separately.

She received multidisciplinary care. The person who coordinated, or the professional who coordinated everything, was the pediatric gastroenterologist [...] there was a psychologist, there was a nutritionist, and because she also had problems with her platelets, we had a hematologist.

The psychiatrist was always in communication with the neurosurgeon and with the neurologist. We were always like a team, each working from their own side, with the same purpose.

The presence of a professional who coordinated the different areas was repeatedly mentioned as part of this experience of integration. Depending on the case, this role was assumed by a hospitalist physician or by one of the lead specialists. Participants described this person as someone who brought together the information from different teams, communicated instructions, followed changes in treatment, and helped avoid contradictory decisions. The coordinating role was therefore not perceived only as an administrative function, but as a practical way of giving coherence to complex care.

There was also a hospitalist physician there who served as a link [...] updating the medical record and communicating instructions between specialists.

The gastroenterologist coordinated everything, like all the information that the other professionals contributed.

Participants also mentioned coordination with the speed of care once they were inside *Zona Lavanda*. Laboratory tests, specialist evaluations, treatment adjustments, and follow-up were described as agile, and in some cases participants contrasted this with delays experienced at other points of the care pathway. The possibility of having different professionals available and communicating with each other reduced uncertainty for patients and families during complex hospitalizations.

It was very fast. Every day, for maybe the first twelve days, I would wake up at four in the morning to have tests taken [...]. The results were immediate, especially when my platelets started to go down.

This technical coordination was closely connected with a relational form of care. Participants did not describe *Zona Lavanda* only in terms of medical expertise. They repeatedly spoke about the availability of nurses, residents, hospitalist physicians, and specialists, and about small gestures that became important during long or difficult hospitalizations. Several participants used the idea of a family or a home to explain the relationship that developed with the clinical team.

The professionals, the nursing staff, were very caring, very attentive. It became like a family because in Zona Lavanda the stays are long. It becomes a home. For my daughter's diagnosis, [the care] was 24/7. We were there all day. She could never be left alone [...] it was like living with them all the time.

Everyday gestures were also part of this experience. Participants remembered conversations, hugs, food brought by residents, and activities such as painting or making bracelets. These actions were described as important because they occurred at moments of vulnerability and made the relationship with the clinical team feel less distant.

Look, I was in a very vulnerable moment; at that time I was pregnant. And I received a lot of support. In fact, I tell my husband that during a hospitalization [you] do not remember everything, but I keep telling him all the time: 'let's go and say hello!' Because I have a lot of affection for them because of that. I received so many hugs. I received so many small details. I remember that once some residents brought me some peanuts and a yogurt. You know? Something spectacular.

The hospitalist physician was not only clinical. The hospitalist physician brought, I don't know, things to paint, things to make bracelets. They become a support for the person who is there, who does not see them as just another doctor, but as someone to talk to, someone who can guide me, someone who can support me, who is not my family member, but someone else I can talk to.

For some participants, this emotional connection remained important after discharge. However, the continuity of this experience was not always the same during long hospitalizations. Some participants described difficulties during holiday periods, when key professionals were absent and replacement staff did not always give the same priority to certain diagnoses. This was one of the few moments in which participants described the internal coordination of the model as more fragile.

During the December holiday period, several professionals went on vacation, others stayed, and some of those who stayed said, ‘this case does not seem so important,’ and ‘go home’ [...] In the end, it was more expensive for [the insurer] to send me home than to finish the whole process. I think that, in that sense, perhaps there was a failure.

Taken together, these accounts show that integration was experienced not only as coordination between specialties, but also through continuity, availability, and relational support. When these elements worked together, participants described greater trust and safety during hospitalization; when continuity was interrupted, as happened during some staff changes, the limits of that integration became more visible.

2. Dignity and autonomy in inpatient care: communication, participation and the therapeutic environment

A second group of findings was related to how patients experienced communication, participation in decisions, and the physical environment. Participants generally felt that clinical information was explained clearly and that they had opportunities to ask questions and understand the procedures that were being proposed. Several accounts emphasized that decisions were discussed rather than simply imposed, which was particularly meaningful in situations where patients could otherwise feel that they had little control over what was happening during hospitalization.

They always kept me informed about what they were going to do, what they were going to give me, the procedure; they explained everything completely. For example, with the surgery, they explained absolutely everything, and they gave me the decision whether I wanted to have surgery or not. I made the decision, yes or no.

They kept asking me, and they also asked me if I understood everything, if we had questions for them. They explained it very well, so I think I never had any questions, but there was always space for them.

Participants also described the physical environment as part of this experience of dignity and control. Natural light, individual rooms, private bathrooms, cleanliness, views of trees and gardens, and the general design of the unit were repeatedly mentioned. These elements were not described only as aesthetic features. Participants connected them with calmness, privacy, rest, and the feeling that the space had been designed considering both physical safety and emotional needs.

What makes the difference, the plus, are the environments, the spaces, and also the area they face, because [there are] gardens. It is very close to Carrera Séptima, but what you see through the window, the first thing you see, is a very beautiful forest, you see many birds. I mean, the whole environment is very pleasant, very pleasant.

Here you do not share a room with any other patient, and I think that is great, unlike where I was before. There I had to share a room with another patient who, first, did not have, let’s say, the same psychological problem I had at that moment [...]

Art and music were another part of the environment that participants remembered in detail. Guitar, piano, saxophone, violin, songwriting, painting, and other activities gave a different rhythm to long days in hospital. Participants described these activities as something that made the stay easier and gave them moments that were not centered only on illness or clinical procedures.

They arrived with a guitar one afternoon, they brought instruments; I mean, there was also a different kind of support, and you do not have that everywhere.

And they create this sense of anticipation, like, 'oh, today is Tuesday! Today [they] are coming [...] with the guitar and the instruments,' and they composed songs and made up lyrics [...] That makes the time in the clinic much easier.

[It is important] not only in mental health [...] a day in the clinic is eternal, and the fact that, for 20 minutes or half an hour, someone comes and plays the piano [...] wow!

The cameras used for clinical monitoring were also mentioned as part of the sense of safety. In the accounts where cameras appeared, participants did not describe them as punitive surveillance, but as a way for the team to notice changes and respond without waiting for the patient or caregiver to call for help.

One of the pillars is that everything is being monitored through the cameras, so in that way there will always be attention to each of the things happening in each room. That is important because sometimes adjustments need to be made in the process; perhaps one medication can harm you and can cause more anxiety than another. In my case, that happened.

There is a camera and you feel safe and protected when you are there.

Across these accounts, dignity and autonomy were connected not only to formal participation in clinical decisions, but also to being informed, having privacy, feeling comfortable in the environment, and having activities that made hospitalization more bearable. Participants therefore described communication, participation, and the therapeutic environment as closely connected parts of the same experience of care.

3. The limits of person-centred care inside the unit: caregivers, space and restraint

The interviews also showed limits within a model that was otherwise described in very positive terms. One of the clearest tensions was related to caregivers. Caregivers were listened to, informed, and treated as people who had important knowledge about the patient, and several described direct and continuous communication with the clinical team. Residents were particularly valued because they were often available to connect families with the treating physicians. At the same time, the recognition of caregivers as part of the care process did not always mean that their own physical and emotional needs were adequately supported.

They looked for me to inform me about his condition and the next steps, so I never felt lost about my husband's progress.

I would call them, and they would get in touch with me. And if it was not in person, they would contact me by phone.

The residents are also another important point; they are a contact between the doctor and the family.

This difference became more visible during prolonged hospitalizations. Some caregivers remained in the unit continuously, particularly when the patient was a minor, and described sleeping on the floor, on chairs, or on uncomfortable furniture. Nonetheless, the problem was not only physical fatigue. Some caregivers also described the need for a place where they could step away from the patient for a moment, process what was happening, and return to the caregiving role.

The caregiver is key to the patient's improvement [...] but does not have this space where they can go out, breathe, cry, and come back.

There is no sofa bed, there is a chair [...] and that is where you have to sleep.

Being there 24 hours, sleeping in the clinic, waking up in the clinic, it is almost as if you are also hospitalized.

Some caregivers also wanted more structured guidance for families, beyond receiving information about the immediate clinical situation. They suggested that professionals such as social workers or family therapists could help families understand the condition, know what to expect, and learn how to respond during and after hospitalization.

They could integrate a social worker a little more into Zona Lavanda [...] or a family therapist who could welcome the family and explain the illness very well, and give many tips and recommendations throughout the treatment process [...] Not only [having] the psychiatrist, the psychologist, the nutritionist, the therapist, the physiotherapist, I don't know what else, but also giving the family a little more access to understand how I am going to deal with this illness.

Other limits were related to the physical space itself. Although participants valued the design, some considered the unit small for patients who could not leave the area or who needed more movement. Therapeutic and recreational activities sometimes took place in the corridor, and people using mobility devices also described limitations. Noise was another difficulty, especially when the needs of one patient were very different from those of another nearby patient.

I felt there were moments of agitation [in my husband], like frustration because of the space. Okay. Because [...] what I was telling you, it is a 20-meter corridor.

Everything has to be done inside that corridor [...] therapies and everything else were done in a corridor.

I was in a wheelchair and needed a little more space.

Each patient has their diagnosis and their situation. Maybe there is a patient who, because of their condition, needs silence [...] but on the other side [another patient] was screaming.

I do think it may be necessary to zone certain diagnoses. Or to have sound insulation, so that one patient's process does not affect another's.

Mechanical restraint was the most difficult tension described in relation to the humanized philosophy of the unit. Caregivers recognized that staff sometimes had to respond to crisis situations and protect the patient and the environment, but seeing a family member physically restrained was described as painful. Some questioned whether the available equipment was adequate or whether other strategies could be used in certain situations.

For someone accompanying the patient, it is very hard to see how they end up tying them down.

I felt they did not have the right equipment to keep him restrained without hurting him.

The way to control him was, well, to tie him down. But sometimes I also thought, like, let me take him there to the corridor, let him walk a little, get some air, because he is still a human being who is tied down all day. So I feel that this also went a little against recovery.

Taken together, these findings show that the limits of person-centred care were not related only to clinical interactions. They also appeared in the material conditions of hospitalization and in situations where the needs of caregivers, movement, sensory regulation, or crisis management were difficult to reconcile with the humanized approach described in other parts of the unit.

4. The boundaries of integration: access, continuity and financial barriers

A different picture emerged when participants described what happened before entering *Zona Lavanda* and after leaving it. Inside the unit, care was usually described as rapid and coordinated, but emergency services, insurance authorization, appointment systems, and outpatient follow-up created difficulties that were outside the immediate work of the clinical team but still shaped the complete experience. The emergency department was one of the most difficult points for some families, particularly when the person arrived during a mental health crisis.

When we arrived at the emergency department, it was not pleasant at all. It was the opposite. There were so many [people], of different ages, little babies crying all night. They were two distressing nights. But what distressed us the most was that the prepaid health plan we are enrolled in might not authorize admission to Zona Lavanda, because many prepaid health plans are not authorizing it.

Insurance conditions could determine whether a patient could reach the unit or continue with the same specialists. Some participants explained that their health plan did not include professionals from *Zona*

Lavanda. Others described waiting for psychiatric assessment in the emergency department. These experiences contrasted with the speed and coordination described once the patient was admitted.

Our prepaid health plan does not have those specialists from Zona Lavanda.

In the emergency department it was difficult, for example, for the doctor, the psychiatrist [...] to arrive; they would arrive the next day.

One caregiver also described difficulties accessing laboratory results and medical records for a minor through the hospital's digital platform. The problem required the family to collect information in person and added another administrative task to an already complex care process.

To see my own [tests], the ones I have at Santa Fe, it is very easy. But I have never been able to see my daughter's. It is difficult. I had problems with that because I could not create the user account [...] So I always had to collect them in person. That did seem difficult to me. I do not know why. I do not know if it was because she was a minor. But my own user account is easy; I can download everything very easily, but I was never able to create hers properly.

The contrast was even clearer after discharge. Several participants described difficulties obtaining follow-up appointments with the same specialists who had treated them during hospitalization. In these cases, the transition from inpatient to outpatient care interrupted relationships that had been built during the stay and made it difficult to maintain the same level of coordination.

At the end, [the patient] was referred to neuropsychology therapy with someone at Santa Fe, and it never happened. [...] I tried to contact them ten times. We never got the appointment.

Administrative rules around appointment classification also had financial consequences. Participants described situations in which a follow-up appointment that could not be scheduled within the expected period was later classified as a first consultation, with a higher cost. This was especially difficult for people requiring frequent follow-up.

When more than a month passes, they no longer take it [...] as a follow-up, but [...] as a first appointment [...] they charge you as if it were a first appointment, when you are actually a monthly patient, sometimes even weekly.

Some families maintained continuity by paying privately for several specialties. Nutrition, psychology, psychiatry, and pediatric gastroenterology were among the services mentioned. This allowed them to continue treatment, but it also meant that maintaining the interdisciplinary model after discharge depended partly on the family's ability to pay.

Yes, I have appointments throughout the week with nutrition and psychology, every two months with the pediatric gastroenterologist, and every month with the psychiatrist.

All the ones I have at Santa Fe I am paying for privately, nutrition and psychiatry.

These accounts marked a clear boundary around the integration experienced during hospitalization. The model was strongest when the patient was already inside *Zona Lavanda*, where professionals, information, and clinical decisions could be brought together. Before admission and after discharge, care became more dependent on insurance rules, emergency services, digital and administrative procedures, appointment availability, and out-of-pocket payments.

5. From an exceptional experience to an equity question

Participants often explained why they considered *Zona Lavanda* exceptional by comparing it with previous hospitalizations or experiences in other psychiatric services. These comparisons were usually based on specific memories of fragmented care, limited contact with specialists, isolation, impersonal treatment, or mistreatment. The contrast was not limited to infrastructure. Participants also compared the continuity of the clinical team, the way professionals communicated, and the degree to which they felt treated as a complete person.

When I entered the psychiatric area of [hospital Y], I deteriorated completely; I mean, I left in a complete depression [...] In contrast, when I entered Zona Lavanda in March, when I had surgery, I left practically like a new person, with a completely different perspective on everything.

When I was at [hospital Y], the psychiatrist saw me once a week and then left for two weeks, and I had no idea. I was there for about three months and, well, it was really hard. There was even mistreatment by the nurses.

Other participants described the contrast specifically in terms of fragmentation and connection between specialties. For them, the difference was not simply that one institution had more professionals, but that in *Zona Lavanda* they could see how those professionals communicated and built a common view of the case.

We were in another hospital and it was very difficult for us that each specialty was on its own; nobody gave us a complete view. In contrast, at Santa Fe, we did feel that there was a connection.

I had been hospitalized the previous year at [hospital Y] and [hospital Z]. Obviously, in [Zona Lavanda] the facilities, the treatment, the staff, everything is very different, much more personalized and more human. At [hospital Y] it is too inhuman.

These comparisons also help explain the strong expressions of gratitude that appeared throughout the interviews. Participants frequently said that they could not imagine how the same situation would have been managed elsewhere, or that they felt they had been in the best place available for their condition. At the same time, the same positive evaluation led them to ask why this experience was limited to one unit and whether its main elements could be used in other parts of the hospital or in other services.

Both the care, which was spectacular [...] and the environment. [...] I mean, the care and the environment seem to me like something that [...] should be replicated everywhere.

It should be generalized [...] not only when there are critical mental health problems, but for any type of intervention.

Participants mentioned general hospitalization, surgical units, and pediatric areas when talking about possible replication. Their comments were not limited to copying the physical design. They referred to the combination of environment, communication, integrated care, and emotional support as elements that they would like to see available more broadly. However, this desire for replication was accompanied by concern about the limited access to the model even within the same institution.

It is a little sad to know that [...] having this possibility is almost a privilege. Not everyone has it. Even within Santa Fe it is limited; many people managed to get into the emergency department and could not access the unit.

This produced an important tension in the accounts. The fact that participants described *Zona Lavanda* as exceptional was a recognition of the care they received, but it was also connected with an awareness that not everyone could access the same conditions. In this way, comparison and replicability moved the evaluation beyond satisfaction with a particular hospital unit and raised an equity question about why integrated, supportive, and dignified inpatient mental health care was experienced as something unusual or available only to some patients.

Discussion

This qualitative evaluation describes how patients and caregivers experienced inpatient mental health care in *Zona Lavanda*, a specialized unit located in a high-complexity university hospital in Bogotá, Colombia. The findings suggest that participants did not understand the quality of the model through one specific component, but through the combination of several elements. Coordination between professionals, close relationships with the clinical team, communication, participation in decisions, the physical environment, and the involvement of caregivers were all part of the same experience. At the same time, the study also identified tensions inside the unit and important problems before admission and after discharge. The study does not allow us to conclude that the model improves clinical outcomes, but it does provide evidence about the elements that patients and caregivers associated with an integrated, safe, and dignified hospital experience.

One of the main findings was the importance of relational care. Participants frequently talked about the availability of nurses, residents, physicians, and other professionals, and some described these relationships using the idea of a "family" or a "home." Previous qualitative research in inpatient mental health care has also shown that a psychiatric ward can be experienced as a safe environment and as a place where support is adapted to the individual needs of patients [(18)]. This is also consistent with the literature on dignity in psychiatric hospitalization. Plunkett and Kelly (2021) identified relationships with staff, the care environment, coercion, powerlessness, and involuntary treatment as important dimensions of how patients experience dignity during hospitalization. More recently, Hallett et al. (2025),

in a review of 111 studies from 25 countries, showed that adverse inpatient experiences are related to the interaction between the physical and social environment, institutional processes and transitions, and experiences related to autonomy and trauma.

Our findings show similar dimensions, but mainly from accounts of what participants valued in *Zona Lavanda*. Patients and caregivers talked about feeling accompanied, listened to, informed, and treated with respect during moments of high vulnerability. Communication was particularly important. Participants valued professionals who explained what was happening, gave time for questions, and included patients and families in decisions when possible. These elements are consistent with the framework proposed by Santana et al. (2018), which includes communication, respectful and compassionate care, shared decision-making, and coordination across providers as central components of person-centered care. In our study, these were not described as separate practices. They were part of what made participants feel that they continued to have a voice during hospitalization.

This is particularly important in inpatient mental health care because hospitalization can involve restrictions on autonomy and control over everyday life. Plunkett and Kelly (2021) show that powerlessness and coercion are central issues in patients' experiences of psychiatric hospitalization. In *Zona Lavanda*, participants often described the opposite experience when they talked about communication and decision-making: they appreciated being informed and consulted rather than simply receiving decisions already made by the clinical team. This does not mean that all decisions could be shared or that restrictions did not exist, but it shows how relatively simple communication practices can influence the way patients experience their own role in care.

Another important finding was the coordination between different professionals. Participants valued the availability of several medical and mental health specialties, particularly in cases where physical and mental health conditions occurred at the same time. However, what they valued most was not simply the number of professionals involved. They described communication between specialists, shared information, and treatment decisions that appeared to be connected rather than separate. This distinction is important because having several professionals involved does not necessarily mean that care is integrated.

The recent review by Isaacs and Duncan (2025) is useful for understanding this finding. They describe care coordination as a way of connecting different services and professionals through activities such as sharing information, developing coordinated treatment plans, identifying needs, making referrals, and monitoring care. Their review also shows potential benefits such as better access to services and collaboration between services, while identifying important implementation problems, including limited service availability, insurance restrictions, unclear processes, administrative complications, incompatible information systems, and insufficient resources. These findings are very close to several of the tensions identified in our evaluation.

Within *Zona Lavanda*, the professional who coordinated the different specialists was particularly important for patients and caregivers. Depending on the case, this function was performed by a

hospitalist physician or one of the main specialists. Participants described this person as someone who brought together information and helped them understand the overall care plan. The finding suggests that integration requires more than having different specialists available in the same institution. Someone, or some organizational mechanism, needs to connect their work. This may also explain why some participants noticed problems during vacation periods, when professionals who knew the case were replaced and the continuity of the process was sometimes affected.

The physical environment was another central part of the experience. Participants repeatedly talked about natural light, individual rooms, privacy, views of trees and gardens, colors, art, music, and spaces that felt different from other hospital environments they had experienced. The recent literature supports the relevance of these characteristics, although the evidence needs to be interpreted carefully. Rodríguez-Labajos et al. (2024), in a systematic review of 44 studies in adult inpatient mental health facilities, identified privacy and control over personal space, daylight, flexible communal spaces, home-like environments, and artwork among the main characteristics associated with a therapeutic environment. The authors also note that stronger evidence is still needed to understand the effects of design on clinical outcomes. Similarly, Bodryzlova et al. (2024) found that psychiatric hospital design can influence experiences related to stress, social interaction, autonomy, control, privacy, dignity, and levels of stimulation.

Our results therefore should not be interpreted as evidence that natural light, art, or individual rooms caused recovery or improved clinical outcomes. What the interviews show is that participants perceived these elements as important for calmness, privacy, safety, and well-being during hospitalization. This distinction matters because the contribution of the environment in *Zona Lavanda* appears to be experiential. Participants used physical characteristics of the unit to explain why the hospitalization felt more comfortable, private, and human than other hospital experiences.

At the same time, the findings also show that the physical environment had limits. Participants identified lack of space, activities taking place in corridors, noise, limited possibilities for movement, and situations in which the needs of different patients could affect each other. This combination of positive and negative experiences is consistent with Hallett et al. (2025), who describe the inpatient environment as part of a broader ecosystem that includes physical resources, other people, institutional processes, and individual experiences. In *Zona Lavanda*, having a well-designed environment did not eliminate all tensions. Different patients had different needs for silence, movement, privacy, or stimulation, and the existing space could not always respond equally well to all of them.

The role of caregivers also deserves particular attention. Caregivers generally described good communication with professionals and felt that their observations were considered in the clinical process. This is relevant when compared with the literature on family experiences in adult psychiatric hospitalization. Karpa et al. (2025), in a qualitative systematic review of 27 articles, identified persistent problems related to family exclusion, limited communication, uncoordinated care planning, and the feeling that family knowledge was not adequately recognized. The review also describes families' need

for information, emotional support, and greater participation in care. It should be noted that this review focused on adult psychiatric hospitalization, while our evaluation included a broader range of patients, including a minor. However, it provides a useful comparison for understanding the positive communication with caregivers reported in the *Zona Lavanda*.

At the same time, our findings show an important contradiction. Caregivers could be recognized as part of the care process while their own physical and emotional needs remained insufficiently addressed. Some described spending long periods in the hospital, sleeping on uncomfortable chairs or even on the floor, and having few opportunities to rest or leave the unit. Others wanted more guidance about the patient's condition and about how to provide support after hospitalization. For caregivers who stayed continuously with minors, this experience was particularly demanding. If caregivers are expected to participate actively in care, attention to their own conditions should also form part of a person-centered model. Better rest spaces, more structured information, and access to psychosocial support for families are therefore directly connected to the findings of this evaluation.

Mechanical restraint was less frequent in the interviews, but it produced some of the strongest negative accounts. Caregivers generally understood that staff were responding to a situation in which safety had to be protected, but they also described distress when seeing a family member restrained and questioned whether the equipment and strategies used could be improved. This issue is consistent with the broader literature on dignity and coercion in psychiatric hospitalization [(10)]. It is also supported by the recent systematic review by Whiting et al. (2025), which found wide international variation in the use of mechanical restraint and limited high-quality evidence about its outcomes and patient experience. The review also found that some ward-level strategies may reduce mechanical restraint, although the evidence is not uniform. For example, one large Spanish study included in the review reported reductions in restraint hours and episodes after a multicomponent intervention based on the Six Core Strategies. For *Zona Lavanda*, these findings support continuing to review the use, safety, and possible reduction of mechanical restraint as part of a model that aims to provide humanized care.

One of the most important findings of this study appeared when participants described what happened before entering and after leaving *Zona Lavanda*. The experience inside the unit was generally described as coordinated and responsive, but participants reported more difficulties in emergency care, insurance authorization, access to specialists after discharge, appointment systems, and the costs of maintaining outpatient care. Some families eventually paid privately for several services because they could not reproduce the same continuity through their insurance arrangements. This creates an important contrast between integration within the inpatient unit and fragmentation across the broader care pathway.

Evidence from Bogotá provides useful context for this finding. Shambo-Rodríguez et al. (2026) studied mental health help-seeking pathways among young people aged 10 to 19 and found that those who had actually used mental health services followed longer and more complex pathways than those describing hypothetical pathways. Actual service users reported an average of 14.7 services during their help-seeking journeys and also took longer to seek help after the onset of symptoms. The authors conclude

that the complexity of finding mental health support may contribute to delays and difficulties navigating available resources. Although their population and research question differ from ours, their findings show that complex pathways and navigation difficulties are also present in the broader mental health system in Bogotá.

The experience of the *Zona Lavanda* therefore raises an important question about where integration begins and where it ends. Inside the unit, participants described coordination between professionals, relatively rapid access to different specialties, communication, and continuity. Once they moved through emergency care, insurance authorization, or outpatient services, many of these connections became more difficult to maintain. This is also consistent with Isaacs and Duncan (2025), who identify health insurance, service availability, administrative processes, and technology as common barriers to care coordination. WHO guidance on hospital-based mental health services also emphasizes that hospital care should be connected with the broader health system and community services rather than operate separately from them [(9)].

This contrast is especially relevant for continuity after discharge. During hospitalization, some participants had several professionals working together and one professional helping to coordinate the overall process. After discharge, families sometimes had to reconstruct these connections themselves. Difficulties obtaining appointments or insurance coverage could therefore affect not only access to one consultation, but the possibility of maintaining the interdisciplinary approach that participants had valued during hospitalization. This finding suggests that strengthening the model may require thinking beyond what happens inside *Zona Lavanda* and paying more attention to the transition between inpatient and outpatient care.

The comparisons that participants made with other hospitals also help explain why they considered *Zona Lavanda* exceptional. They did not refer only to the physical space. They compared communication, continuity, emotional support, coordination between professionals, privacy, and the way patients were treated. In several cases, previous experiences had been described as fragmented, impersonal, or even involving mistreatment. These comparisons cannot be used to conclude that *Zona Lavanda* performs better than other institutions because this study was not designed as a comparative evaluation. However, they are useful for understanding which differences were meaningful from the perspective of participants.

The same accounts also introduced an equity question. Some participants described access to *Zona Lavanda* as "almost a privilege," recognizing that other people arriving at the same hospital could not necessarily receive the same care because of insurance conditions, administrative barriers, or limited capacity. This is important because the exceptional character of the model had two meanings in the interviews. On one hand, it reflected how positively participants experienced the care. On the other, it raised concern that a model described in terms of dignity, coordination, and human treatment was not equally accessible.

For this reason, replicability should not be understood only as reproducing the physical design of *Zona Lavanda*. Participants themselves referred to communication, interdisciplinary coordination, emotional support, caregiver involvement, and the general way care was provided when they discussed what should be extended to other settings. Some of these components may be adaptable to other hospital services without reproducing exactly the same infrastructure. However, the equity question cannot be addressed only at the institutional level. Expanding access also requires considering insurance arrangements, referral pathways, continuity after discharge, and the feasibility of adapting the model to public hospitals and settings with fewer resources.

Several limitations should be considered. The evaluation included 13 participants from a single high-complexity university hospital, so the findings represent experiences within a specific institutional context and cannot be assumed to represent inpatient mental health care in Colombia. Participants were recruited through convenience sampling among eligible patients and caregivers, and participation was voluntary; the sample may therefore overrepresent individuals willing to discuss their experiences. Interviews were conducted virtually, which facilitated participation but may also have affected how some experiences were discussed. The evaluation was carried out as part of an institutional quality-improvement process, although the interviews and analysis were conducted by an external researcher who was not part of the hospital or the *Zona Lavanda* clinical team. Finally, the study did not collect quantitative clinical outcomes. We therefore cannot determine whether the model reduced symptoms, readmissions, length of stay, or other clinical outcomes, and participants' perceptions of improvement should not be interpreted as evidence of clinical effectiveness.

Future research could combine qualitative findings with clinical and service indicators and could follow patients after discharge to examine continuity over time. It would also be useful to study how the different components of the model work in public hospitals and lower-resource settings. This would help distinguish which elements depend on the infrastructure and resources of a high-complexity hospital and which elements, such as communication practices, care coordination, caregiver involvement, and some aspects of the therapeutic environment, may be adapted more broadly.

Taken together, the findings suggest that integrated inpatient mental health care is not only a question of having different specialists in the same place. From the perspective of patients and caregivers in this evaluation, integration was experienced through coordination between professionals, sustained relationships, clear communication, participation in decisions, caregiver involvement, and an environment that supported privacy and safety. The main tensions appeared when this integrated experience reached the limits of the unit, where emergency care, insurance arrangements, outpatient follow-up, and financial barriers could interrupt the continuity experienced during hospitalization. *Zona Lavanda* therefore provides an important case for thinking not only about how to organize person-centered inpatient mental health care, but also about how this type of care can be connected with the broader mental health system and made accessible beyond a specific hospital unit.

Conclusions

Patients and caregivers described *Zona Lavanda* as an inpatient mental health model in which interdisciplinary coordination, communication, emotional support, caregiver involvement, and the physical environment were closely connected. Participants valued not only the availability of different specialists, but also the way professionals communicated with each other, the presence of a coordinating professional, the possibility of being informed and involved in decisions, and the continuous support received during hospitalization. Privacy, natural light, individual rooms, art, and other characteristics of the environment were also part of how participants explained their sense of safety, dignity, and well-being. Together, these elements shaped an experience that many participants considered different from previous hospitalizations in other mental health settings.

The findings also suggest that this positive experience had important limits. Caregivers were recognized as part of the care process but did not always have adequate conditions for rest or emotional support, while noise, limited space, and experiences related to mechanical restraint created tensions within the unit. More importantly, the coordination described during hospitalization was more difficult to maintain before admission and after discharge, when emergency care, insurance authorization, appointment systems, access to specialists, and out-of-pocket payments became important barriers. This contrast suggests that integrated care within a hospital unit can remain fragile when it is not connected with the broader care pathway.

Zona Lavanda therefore provides a useful example of how patients and caregivers experience integrated and person-centered inpatient mental health care in Colombia. Its value does not appear to depend on one intervention or one component, but on the combination of organizational coordination, relational care, patient participation, caregiver involvement, and a supportive environment. At the same time, participants' description of access to this type of care as "almost a privilege" raises an important equity question. Future efforts to strengthen or adapt this model should therefore consider not only what happens inside the unit, but also how these principles can be maintained across emergency, inpatient, and outpatient care and made available in different institutional and resource settings. In practice, this may include strengthening support and appropriate spaces for caregivers, preserving the coordinating role throughout hospitalization, continuing to review environmental conditions and restraint-related practices, and improving discharge planning and communication between inpatient and outpatient teams. Because some barriers identified by participants extend beyond the hospital, greater coordination with insurers and other actors in the health system may also be necessary to support continuity after discharge. Future research should examine whether the positive experiences described here are associated with clinical and service outcomes, including symptoms, readmissions, length of stay, and continuity of care. Longitudinal and mixed-methods evaluations, particularly in public hospitals and settings with fewer resources, could also help determine which components of the model can be sustained and adapted more broadly in Colombia and other Latin American contexts.

Abbreviations

- COREQ

Consolidated Criteria for Reporting Qualitative Research
- FSFB
Fundación Santa Fe de Bogotá
- WHO
World Health Organization

Declarations

Ethics approval and consent to participate

This study was reviewed and approved by the Corporate Research Ethics Committee of Fundación Santa Fe de Bogotá (CCEI-16849-2024). The study was conducted in accordance with the ethical principles of the Declaration of Helsinki, Resolution 8430 of 1993 of the Colombian Ministry of Health, and applicable institutional ethical requirements. In accordance with Article 11 of Resolution 8430 of 1993, the study was classified as minimal-risk research. All participants were informed about the purpose of the study, the voluntary nature of their participation, the use of the information collected, and the conditions of confidentiality and anonymity. Written informed consent was obtained from all adult participants prior to participation. For the participant under 18 years of age, assent was obtained from the participant and written informed consent was obtained from their legal guardian.

Consent for publication

Consent for publication of anonymized participant data and quotations was obtained as part of the informed consent process. For the participant under 18 years of age, consent for publication was obtained from the participant's legal guardian.

Competing Interests

The authors declare the following non-financial competing interests: SLG, MEL, AA, JCM, and FS have academic and/or professional affiliations with Fundación Santa Fe de Bogotá, the institution where Zona Lavanda was developed and where the evaluation was conducted. These affiliations are disclosed given the institutional nature of the evaluation.

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Author Contribution

SLG, MEL, AA, JCM, and FS contributed to the conceptualization and development of the study protocol. SLG conducted the participant interviews. All authors contributed to the analysis and interpretation of the findings, manuscript writing, drafting, and critical revision. All authors read and approved the final manuscript.

Data Availability

The datasets generated and/or analysed during the current study are not publicly available due to individual privacy concerns but are available from the corresponding author on reasonable request.

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