Community Problematization of Suicide: Recommendations for Local, Regional, and National Plans and Strategies

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ENG Abstract: The framing of suicide as a public health issue and its exclusive treatment by healthcare institutions is conditioned by a predominantly biomedical and psychologistic perspective, and therefore, one that tends to individualization. While this is helpful for targeted care in the prevention, intervention, or postvention of suicidal behavior, it presents a significant limitation when designing plans and strategies that address cultural factors and socioeconomic context. Therefore, this limitation can become a barrier to effectively implementing and measuring selective and universal actions in populations particularly affected by suicide. Contrary to the goal of improving interventions, this approach leads then to stigmatization and medicalized interpretations of suicidal behavior that neglect the social fabric –an element explicitly recommended by the World Health Organization (WHO). In this regard, the present article proposes a theoretical and literature-based review of the elements that define a community approach to suicide prevention, intervention, and postvention, in line with WHO standards and those of the field of Social Work. The main goal of this work is to highlight a research line that not only addresses suicide from a community-based approach but also considers alternative frameworks for the development of public policies at various administrative and territorial levels.
Keywords: Community, Policy-making, Mental Health, Public Health, Suicide.

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Resumen: La consideración del suicidio como un problema de salud pública y su exclusiva atención integral por instituciones sanitarias viene a estar condicionado por un enfoque predominantemente biomédico y psicologicista, por ende, individualizante. Esto, si bien útil en la atención indicada de las conductas suicidas, ya sea en su prevención, intervención o postvención, representa un importante límite en el diseño de planes y estrategias que aborden aspectos culturales y del contexto socioeconómico. De hecho, este límite puede tornarse en una barrera de cara a concretar y medir la eficacia de actuaciones selectivas y universales en poblaciones especialmente afectadas por el suicidio. Esto, contra toda intención de mejora, redunda en estigmatizaciones y lecturas que medicalizan la atención a la conducta suicida sin tener en cuenta al tejido social, aspecto que recomienda la Organización Mundial de la Salud (OMS). A este respecto, el presente texto propone una revisión bibliográfica y teórica de los aspectos que definen una aproximación comunitaria a la prevención, intervención y postvención del suicidio según estándares tanto de la OMS como del Trabajo Social. Este trabajo tiene así como principal objetivo visibilizar una línea de investigación que no sólo problematiza el suicidio desde una óptica basada en la comunidad, sino que aborda otros enfoques de conformación de las políticas públicas adscritas a diferentes niveles administrativos y territoriales.
Palabras clave: Comunidad, Elaboración de políticas públicas, Salud mental, Salud pública, Suicidio.

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1. Introduction

Since 1969, the World Health Organization (WHO) has identified suicide as a global public health emergency (WHO, 1969, 2014, 2021a), emphasizing the shared responsibility of states and other actors in adopting effective preventive measures (WHO, 2012, 2018, 2021b). Currently, it is estimated that the number of annual suicide deaths has declined over the past decade, dropping from 800,000 to 700,000 worldwide, especially in high-income countries (WHO, 2021a). Nonetheless, suicide remains a major challenge for healthcare systems and social services across both the Global North and South, with profound consequences for social life, families, and communities.

Beyond the North-South disparities –particularly regarding the development of welfare-state models, which vary widely and are currently undergoing post-crisis reconfigurations in Europe (Giarelli & Saks, 2024; del Pino & Rubio, 2024)–, the key issue in addressing suicidal behaviors lies in the predominantly healthcare-centered approach. This has resulted in the hegemonic framing of suicide as a public health problem (WHO, 2012), often aligning with its classification as a mental health issue (APA, 2010).

It is essential to understand that the public health approach is rooted in a collective vision of protecting, promoting, and restoring health (WHO, 2014; Ministerio de Sanidad, 2022). In this context, the historical contribution of Social Work to a community-based understanding of health and its social determinants is crucial (Ruth et al., 2012; Brea Iglesias et al., 2024). However, the current design and implementation of public policies are largely limited to epidemiological surveillance criteria, particularly within institutionalized systems (García-Haro et al., 2020; Oaten et al., 2024). This restricts governmental action to a single dimension of suicide control and management, treating it as a disease, despite its complex phenomenology. As a result, most governmental actions are technicalized, distancing from the standards of (co)governance and citizen participation that are presupposed in the general foundations of public health, as well as in the specificities of a European salutogenic model based on community-based/community-driven approaches (Gostin, 2010; Flear, 2015).

This approach also tends to emphasize prevention understood as early detection and emergency intervention, typically through hospital-based crisis services. Consequently, aspects related to other actions, such as awareness and stigma reduction campaigns, which are key to understanding suicide as a problem *of* and *within* the community, are devalued and isolated (WHO, 2019; Blanco, 2020). The dominance of biomedical and emergency-based models also contributes to a weak engagement with postvention –understood as the beginning of active, participatory prevention (WHO & IASP, 2008; Andriessen, 2009; Jordan, 2017).

Accordingly, this article examines the various proposals from the WHO for community-based interventions and public policy design aimed at addressing suicide. To this end, the study is based on a narrative literature review, focusing on technical and programmatic documents issued by the WHO, along with reports from governmental bodies and other specialized entities both in Spain and internationally. The literature search was conducted using academic databases and complemented with gray literature sources that incorporate public policies, local experiences, and contributions not typically disseminated through conventional scientific channels. The primary descriptors used included terms such as "suicide", "suicide prevention", "community model", "community-based", and "community intervention". From this review, the main strategic guidelines were identified, particularly those related to local and regional initiatives developed in Spain. This documentary base is further completed by a theoretical reflection that explores the potential, tensions, and limitations of community-based approaches in a comprehensive response to suicide behaviors.

2. Suicide Prevention, Intervention, and Postvention from a Community-Based Approach

2.1. Relevant Background on the Social and Community Problematization of Suicide

According to the WHO (2014), suicide is a complex, multidimensional phenomenon associated with biological, psychological, environmental, genetic-familial, and (socio)cultural factors. However, earlier sociological works, such as those by Émile Durkheim (1897/2015), already recognized suicide as shaped by both social and extra-social factors. Among these, the social factors are quite significant, as they conceptualize suicide as a societal issue, positioning it fundamentally as a social phenomenon.

Later framings of suicide as a public health issue are closely linked to the emergence of Social Medicine and the early development of Social Work in the early 20th century, particularly in its health-oriented branch (Brea et al., 2024). Yet contemporary approaches that define suicide as a public health emergency often overlap with its framing as a mental health problem, privileging a psychopathological view. Consequently, suicide is frequently understood as self-destructive behavior tied to serious mental disorders such as depression, schizophrenia, or alcoholism (APA, 2010; WHO, 2014). However, this view of suicide as a self-destructive behavior –frequently linked to a diagnostic label–, has received several criticisms given that such categorization and labeling arises from a historically recent process of psychiatricization of suicidal behaviors (Marsh, 2010). This stands in contrast to perspectives that, historically in the West, have framed suicide more as a moral problem than as the result of an illness, despite ongoing scientific debate (Andrés, 2021; Castillo Patton, 2024). Crucially, what matters in the medicalization of suicide is that, until well into the mid-20th century, multiple approaches coexisted regarding how to respond to the phenomenon, all of which acknowledged its roots in profound personal suffering –as emphasized by Edwin Shneidman's Suicidology (1995).

Before the consolidation of this clinically driven interpretation –tightly bound to Dynamic Psychology–, two main models of care for suicidal behavior coexisted in the early 20th century. The first was based on reinforcement and institutionalization within psychiatric facilities following a suicidal crisis, thus deepening

psychologistic and biological interpretations of suicide as a behavior linked to individual psychopathology. The second model viewed the community –particularly the neighborhood and family–, as a collective subject of intervention, primarily focused on prevention and the control of suicidogenic conditions.

One illustrative example of the latter approach comes from the North American context of the Chicago School of Sociology, where the sociologist and criminologist Ruth Shonle Cavan observed that suicide could not only be explained, but also addressed, through psychosocial variables and factors. In her work, Cavan (1928) argues –similarly to Durkheim and other contemporary sociologists and social workers–, that suicide results from profound social disorganization, ruptured life expectations, and a loss of trust in peers. Drawing from testimonials and biographical documents, Cavan noted that suicide often reflects the accumulation of crises across an individual's life course. These crises lead to a progressive collapse in coping capacities and emotional regulation –an idea that anticipates current models in Suicidology and Contextual Psychology (Joiner, 2005; O'Connor & Kirtley, 2018). Furthermore, Cavan's diagnostic and analytical methods share principles with early Social Work pioneers such as Ida Maud Cannon, who focused on the social origins of distress and evaluated suffering using both objective and subjective criteria. In fact, Cannon (1913) identified numerous cases of suicide in the United States as being rooted primarily in context. Specifically, problems related to social integration and institutional violence, as well as other causes linked to neurasthenia or the so-called "mental fragility" of particularly vulnerable individuals. Thus, her work also contains early traces of the current biopsychosocial understanding of suicide.

In Spain, early examples of this approach to community elements can be found in the first third of the 20th century, when suicide was considered a matter of public interest. Following the establishment of an official statistical register in 1906 –the Suicide Statistics (Orgaz & Amezaga, 2018)–, various sociological studies highlighted key areas for intervention, while also raising questions about why suicide occurred and why it should not be criminalized (Bernaldo de Quirós, 1904). Beyond moral judgments associated with the secularization of the Spanish working class, statisticians and statemen such as Carlos Salicrú Puigvert (1924) emphasized that suicide is fundamentally a social issue and a matter of mental hygiene. As Royal Confessor, Salicrú advocated for a "social, emotional, and religious therapy" for suicide, including measures such as "health insurance", "fair working hours", and "affordable housing" (Salicrú, 1924, pp. 126-127), a perspective remarkably aligned with the foundations of Cannon's Social Work or even Mary Richmond's case-based approach (Richmond, 1922).

These perspectives stand in stark contrast to the subsequent development of an intervention model that individualizes suicide and its etiology through psychiatric diagnosis and institutionalization as the primary therapeutic strategy, whether in general or specialized hospital units. This contributed to the stigmatization and invisibility of the phenomenon throughout much of the latter half of the 20th century, framing suicide as a marginal, immoral, and, ultimately, a criminal behavior despite its progressive legal decriminalization (Pérez, 2012; Castillo Patton, 2024).

2.2. Recommendations for a Community-Based Approach to Suicide Care

Currently, suicide is understood as a set of dynamic and discontinuous behaviors, not all of which originate strictly from biological or psychopathological causes (García-Haro et al., 2023; Al-Halabí & Fonseca-Pedrero, 2024). However, a hegemonic view frames suicide primarily as a medical and psychological issue, fundamentally subject to clinical practice (Velasco & Pujal i Llombart, 2010; Marsh, 2010). As a result, most suicide prevention plans, strategies, and programs have become excessively centered on interventions and protocols within the healthcare system, notably hospital facilities. This observation does not imply that the clinical dimension is worthless in practical terms, particularly in cases where pharmacological therapeutic interventions are strongly recommended and evidence-based (WHO, 2014; Oficina C, 2024). However, when examining contexts such as Spain, where the majority of public proposals and policies remain concentrated in hospital-centered frameworks and epidemiological surveillance within the healthcare circuit (García-Haro et al., 2020; Castillo Patton, 2023), one can observe clear contradictions with WHO standards and recommendations (2012, 2019, 2021b).

In this regard, although Spain has developed a number of initiatives that integrate certain elements of a community-based approach to suicide care –such as the Interinstitutional Commission for Addressing Suicidal Behaviors (NAPRESUI) in Navarra (Gobierno de Navarra, 2014) or the preventive and care network in Barcelona (Ayuntamiento de Barcelona, 2023)–, there remains a lack of broader recognition of the need to incorporate public-community collaboration in suicide prevention at local, regional, and national levels. This contrasts with substantial empirical evidence showing that community-based approaches strengthen protective factors in suicide prevention (Zadravec et al., 2017; Hanlon et al., 2022; Linskens et al., 2023). Nevertheless, although the report *Active Suicide Prevention* by the Office of Science and Technology of the Spanish Congress of Deputies (Oficina C, 2024) emphasizes that, in community interventions, "the work of social service professionals (typically in education, social work, and psychology) becomes highly relevant, as they provide psychological support to hundreds of thousands of people in Spain" (p. 17); there is little in-depth attention to the contributions of the Social Sciences –particularly Social Work– in suicide prevention, intervention, and postvention (Joe & Niedermeier, 2008; Ruth et al., 2012; Prades-Caballero et al., 2024).

For this reason, it is pertinent to outline below the measures and tools proposed by the WHO (2019, 2021b) to guide the development of community-based actions. These not only enhance the effectiveness of suicide prevention efforts but also reinforce mandates related to governance, citizen participation, and, consequently, democratic quality and accountability.

3. The World Health Organization's Community-Based Model

3.1. Levels of Care and Collaboration Strategies in Suicide Care

The complexity that defines suicide and the various behaviors it comprises recognizes, primarily, three dimensions in which action can be taken: prevention, intervention, and postvention (WHO, 2014, 2014). First, prevention refers to those measures aimed at avoiding, as much as possible, the proliferation of suicidal behaviors, from ideation to attempts and, above all, death. Intervention, secondly, focuses on measures directed at managing suicidal behaviors once they occur, predominantly in contexts of psychological, psychiatric crises and/or emergency situations. Finally, postvention refers to actions taken after suicide, predominantly in cases resulting in death; and it focuses on care for family members and close ones, that is, "survivors" or those affected by the loss (WHO & IASP, 2008).

Likewise, across each of these dimensions, different organizations and authors (WHO, 2018; Pirkis et al., 2023) identify three levels of healthcare at which planned, structured, and coordinated care of suicidal behaviors can be carried out: universal level, selective level, and indicated level. These levels identify specific measures for each field of intervention. The universal level is directed at the general population, while the selective level focuses on vulnerable groups. The indicated level, however, addresses individuals at risk or already affected by suicidal behaviors. Despite these categorizations, the most predominant approaches show that these levels are clearly compartmentalized and disconnected from each other. This lack of integration hinders the comprehensive care of suicidal behaviors, as recommended by international organizations (WHO, 2018; Pirkis et al., 2023), as proposed in Figure 1.

Figure 1. Comprehensive Model for Suicide Prevention
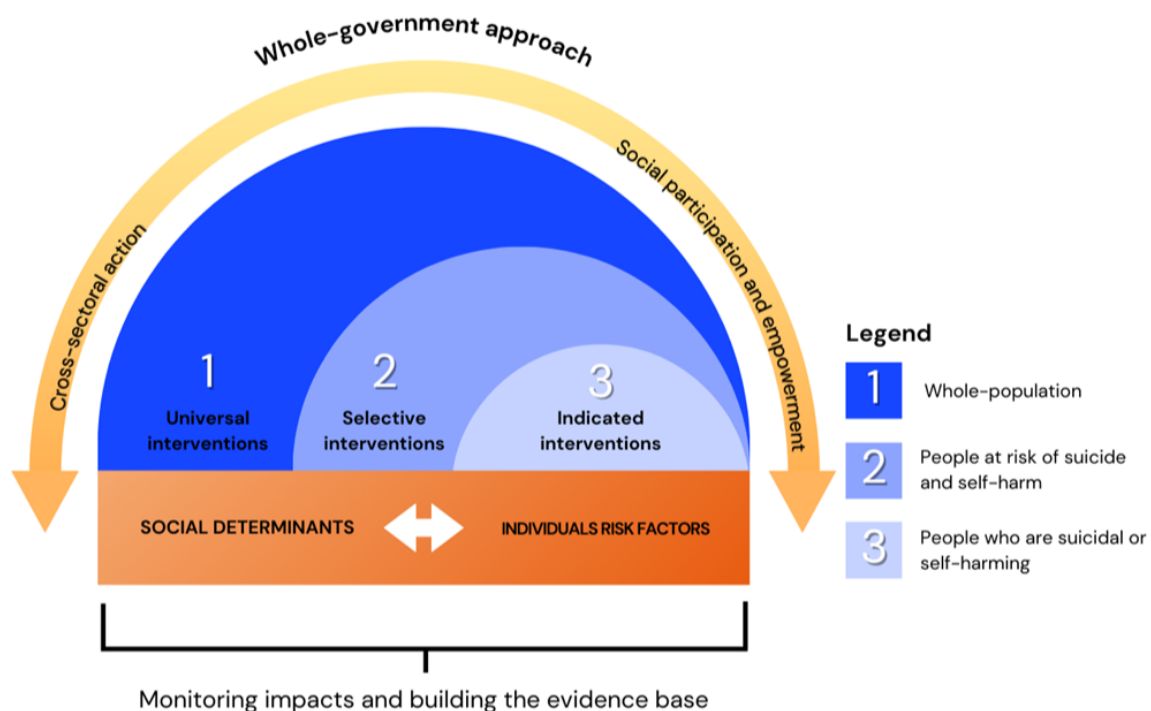
Source: Adapted from Oficina C (2024, p. 14). Readaptation of the model by Pirkis et al. (2023).

According to this comprehensive model for addressing suicidal behaviors, it is essential to recognize the interrelationship between the social determinants of health and individual risk factors. In this regard, the measures have a dual purpose. On the one hand, they seek to implement intersectional actions that address diverse situations and case-specific circumstances. On the other hand, they aim to ensure social and community participation in their development. These measures should ideally be framed within a national suicide prevention plan or strategy that establishes understandable objectives and measurable indicators.

The model proposed by Pirkis et al. (2023) thus envisions a basic planning framework for the prevention, intervention, and postvention of suicide across the different levels of healthcare. Although it is based on the strategic recommendations of the WHO, this model is also recommended for Spain by the committee of experts convened by the Office of Science and Technology of the Spanish Congress of Deputies (Oficina C, 2024). In alignment with these recommendations, the WHO (2012, 2019, 2021b) emphasizes that any public policy focused on the prevention, intervention, and/or postvention of suicide must be structured through a broad network of stakeholders. Among these stakeholders are survivor associations; media outlets; content creators; public officials; primary care and educational professionals; emergency services –especially police and firefighters, as first-responders; penitentiary institutions; businesses and labor unions; and local leaders,

whether from religious communities, neighborhood associations, or other types of organizations[1]. In this way, as illustrated in Figure 2, the WHO has been developing since the early 21st century a model of collaboration and cooperation that places the community at the core and foundation of any suicide prevention project. While scientific evidence and panels of experts and healthcare professionals are indispensable, this model stresses that these groups represent only one part of the various sectors and social groups that must be incorporated into public policy.

Figure 2. Framework for the development of a suicide prevention plan according to the WHO
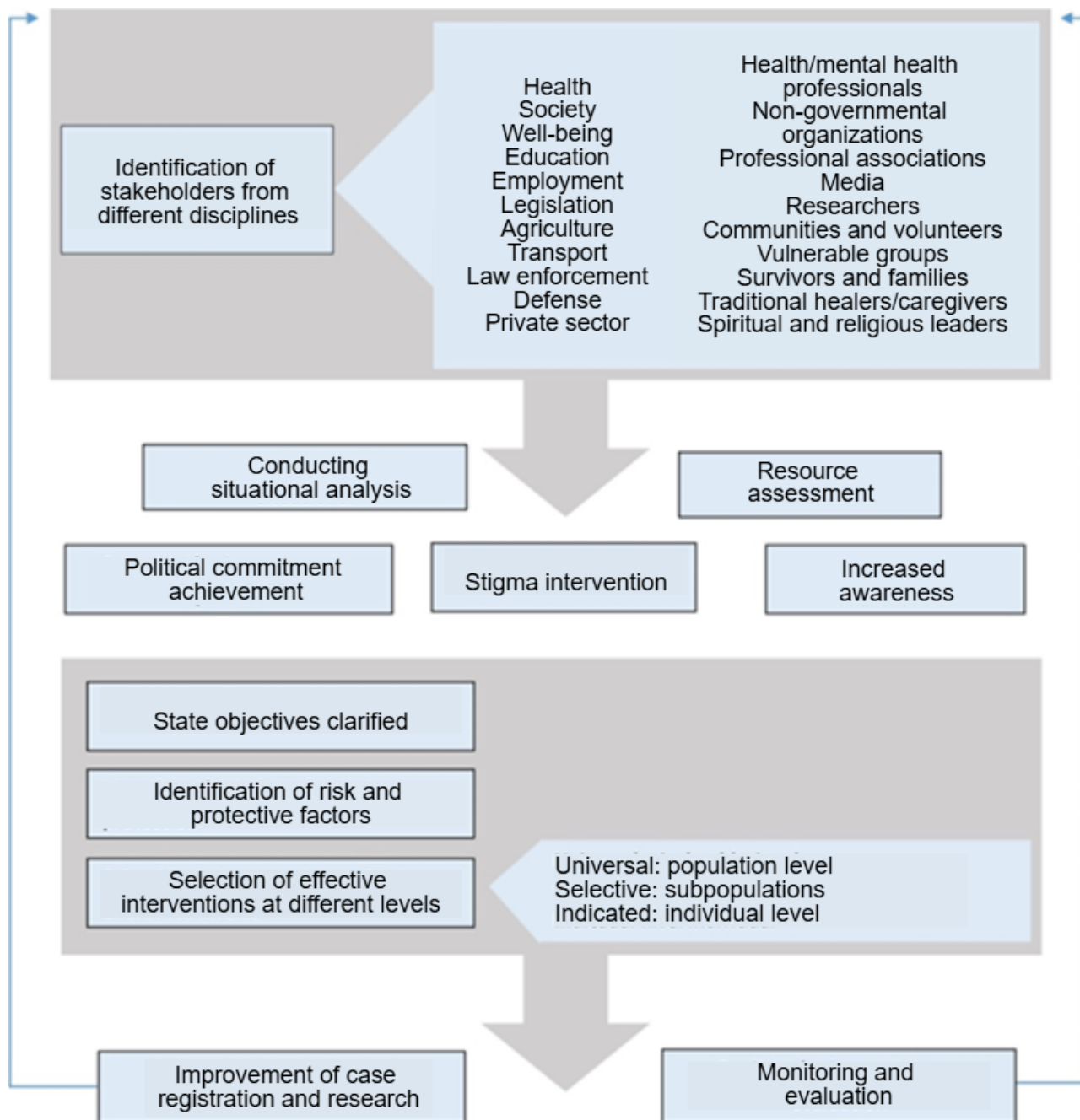
Source: Own elaboration based on WHO (2012, p. 22).

According to this framework, the WHO emphasizes the importance of recognizing diverse voices in both the diagnosis and the development of proposals to address suicidal behaviors from the most comprehensive perspective possible. Key aspects include challenging stigma, fostering collective awareness, and promoting long-term commitment as general objectives that contribute to secondary goals across the three levels of care. Furthermore, WHO complements these guidelines with technical recommendations. Along with the
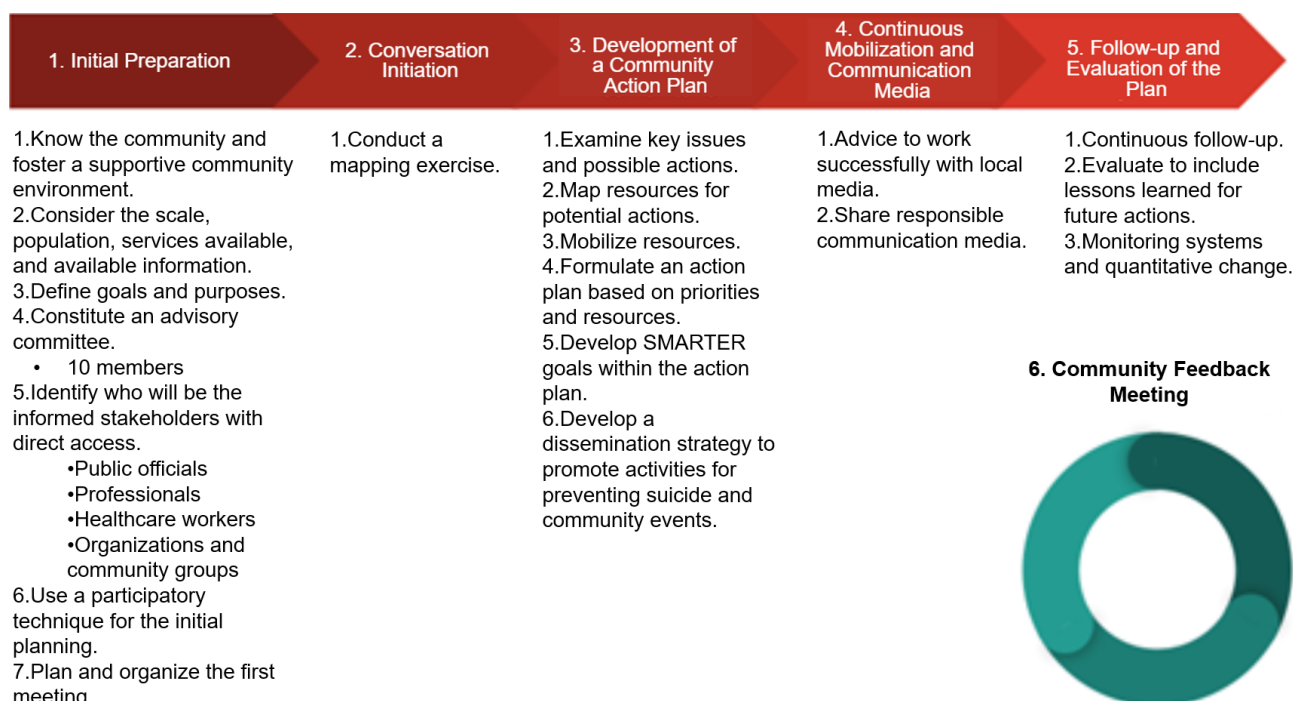
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[1] In this regard, from the year 2000 to the present, the WHO has offered through its framework document collection *Preventing Suicide: a resource series* (https://www.who.int/publications/i/item/preventing-suicide-a-resource-series) a set of recommendations for each of the aforementioned scenarios.

essential improvement of case registries and evaluation of measures, it is proposed that objectives for improving suicide care should meet SMART criteria: Specific, Measurable, Achievable, Relevant, Time-bound (WHO, 2012).

This criterion is not only connected to other key questions present in a standard evaluation matrix for assessing the quality of public policy design in suicide prevention (Castillo Patton, 2022), but it also reinforces general evaluation mechanisms for community-based measures and plans. This is evident in subsequent instruments and recommendations from the WHO (2019), which further emphasizes the need to promote initiatives that reduce highly hierarchical processes dominated by technical criteria and profiles. Instead, it proposes recognizing the reliability and feasibility of bottom-up processes.

All of this is reflected in the guide *Preventing suicide: A resource for community engagement* (WHO, 2019; PAHO & WHO, 2021), which thoroughly addresses how to develop strategies that contribute to building initiatives aimed at creating a community plan to address suicide at a local or regional level. Furthermore, the WHO asserts that these initiatives should be part of the technical and legitimizing foundation of a national prevention plan, in which "(...) Ultimately, policy, evidence, and local interests influence public policy and decision-making" (PAHO & WHO, 2021, p. 12). Therefore, this guide significantly complements the standard design for developing public policy from a public health perspective, as suggested in the framework document *Public health action for the prevention of suicide: A framework* (WHO, 2012). In this regard, it is relevant to consider how the WHO recommends structuring community plans in different phases. Additionally, it emphasizes the importance of evaluating every process and practice from a collaborative approach involving different actors, preferably community-based, and not necessarily linked to the healthcare field, although the latter remains an essential support (Figure 3).

Figure 3. Framework for the Development of a Suicide Prevention Plan According to the WHO

1. Initial Preparation	2. Conversation Initiation	3. Development of a Community Action Plan	4. Continuous Mobilization and Communication Media	5. Follow-up and Evaluation of the Plan
1.Know the community and foster a supportive community environment. 2.Consider the scale, population, services available, and available information. 3.Define goals and purposes. 4.Constitute an advisory committee. • 10 members 5.Identify who will be the informed stakeholders with direct access. •Public officials •Professionals •Healthcare workers •Organizations and community groups 6.Use a participatory technique for the initial planning. 7.Plan and organize the first meeting.	1.Conduct a mapping exercise.	1.Examine key issues and possible actions. 2.Map resources for potential actions. 3.Mobilize resources. 4.Formulate an action plan based on priorities and resources. 5.Develop SMARTER goals within the action plan. 6.Develop a dissemination strategy to promote activities for preventing suicide and community events.	1.Advice to work successfully with local media. 2.Share responsible communication media.	1.Continuous follow-up. 2.Evaluate to include lessons learned for future actions. 3.Monitoring systems and quantitative change.

6. Community Feedback Meeting

Source: Own elaboration based on PAHO and WHO (2021).

The development framework for designing and monitoring a community-based plan for the prevention, intervention, and postvention of suicide identifies five key phases. These phases define the main guidelines to consolidate a project and a work team that emerge and are territory and socially-oriented. Thus, according to this tool, it is essential for the community and its representatives to come together in a common space to identify the specific aspects that characterize suicide in a given locality or region. It is also necessary to understand why this phenomenon constitutes a problem in terms of threat and/or risk to the individual and collective well-being of that community[2].

Additionally, the WHO emphasizes the importance of including public officials, healthcare professionals –especially those in Primary Care–, representatives of religious organizations, and other associative settings, such as parent-teacher associations or sports federations, among others, in this deliberative process. This

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[2] Here, it becomes evident that the WHO mobilizes its broad definition of "health," understood as a social construct in which "(...) Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946/2014, p. 1). This definition aligns with the framing of "mental health" as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community" (WHO, 2013, p. 7).

approach, based on the recommendation to establish a steering committee of experts from various fields, promotes a comprehensive representation and participation of the community. Therefore, this particular "toolbox" proposed by the WHO is especially valuable both for the formation and evaluation of measures that institutionalize public-community collaboration in addressing suicidal behaviors, taking into account both general and specific aspects.

3.2. Practical Examples and Opportunities for Public-Community Collaboration

The set of measures and processes promoted by the WHO offers multiple opportunities for communities to express various sensitivities and social realities concerning suicide. These initiatives may complement –or, in some cases, contrast with– traditional healthcare approaches[3]. This perspective thus brings a practical dimension to the problematization of how suicide can be collectively addressed, with applications both in the design of plans and the subsequent institutionalization of their monitoring. It fosters cooperation among various public, private, and Third Sector stakeholders.

Among the noteworthy practical experiences in this direction –with particular relevance to the discipline and profession of Social Work– is a case of community gathering outlined in the WHO's framework document (2019), presented as a paradigmatic example in which a community makes visible that it has a problem with suicide, especially among young people. The case refers to a plan implemented in Kenya, where the NGO Befrienders Kenya facilitated a collective conversation about youth suicide in a context marked by strong stigma, deep-rooted taboos, and low-quality hospital records and official statistics. In this initial meeting, 240 participants took part, including representatives of the youth community, teachers, nurses, merchants, and religious leaders, among others. During the discussion, persistent issues related to mental health and alcohol abuse within the community were addressed, in addition to the impact of suicide on survivors. According to Befrienders Kenya's report (2016), the very act of speaking about the issue allowed key needs to be identified: such as training for healthcare professionals and community gatekeepers, as well as strengthening measures to mitigate and/or control depression. What is particularly relevant about this gathering is that it also fostered a public debate about the problem of suicide and its social consequences, issues that cannot be addressed solely through purely institutional frameworks or top-down approaches[4].

In this regard, and drawing from other examples in the United States, the United Kingdom, and Australia, there are a variety of initiatives that place a greater emphasis on and give more prominence to community-based measures, with the community understood as the central actor in the process. In the U.S. case –especially considering the precedents leading to the current national suicide prevention strategy (HHS, 2024)–, the National Action Alliance for Suicide Prevention (Action Alliance, 2017) stands out. This alliance has developed initiatives and best-practice documents that complement WHO framework materials, although with a stronger focus on public-private rather than public-community collaboration. Nonetheless, the design of its interventions –particularly those targeting vulnerable populations such as ethnic minorities, LGBTQ+ youth, and war veterans–, includes relevant recommendations as they directly engage with public policy plans and objectives, fostering direct connection and coordination between various government bodies, professional sectors, and civil society. A similar approach can be seen in suicide prevention programs in rural areas of the United States, which adopt a community-based perspective that positions the community as the primary interlocutor for any intervention. These programs especially aim to establish and strengthen prevention networks involving local associations and educational institutions (RHRC & NORC Walsh Center for Rural Health Analysis, 2022; SPRC-OUHSC, 2024).

Likewise, and in order to complement with other practical cases and local initiatives, the Spanish context offers several experiences that align with this model of community-based problematization and monitoring in suicide care, despite the lack of a consolidated European framework supporting this approach[5]. One of the most notable examples –particularly in terms of consolidation– is the Interinstitutional Commission for Addressing Suicidal Behavior in Navarra (NAPRESUI), formalized in July 2014 within the framework of the

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3. One of the persistent gaps in the debate on suicide prevention from the community-based model lies in the limited empirical systematization of its effectiveness. While it is not the focus of this work, it is worth noting that some recent reviews highlight significant effects. Hanlon et al. (2022) show that interventions (co)created with local actors, when they promote sustained community agency, help to mitigate suicidal ideation and social isolation. Linskens et al. (2023), point out that multistrategic programs based on reducing access to lethal means, organizational policies, community screening, and educational or awareness interventions have a greater impact than those focused on individual care. However, the empirical literature on these programs reveals ongoing tensions in the prevailing evaluative frameworks, where the technical-administrative logic tends to obscure the social processes involved and their forms of collective appropriation.

4. It should be noted that in Kenya, suicide is classified as a minor offense under Section 226 of the Kenyan Penal Code, with prison sentences of up to two years for those who attempt to take their own lives. This, in the context of the aforementioned experience, represents an adverse element despite recent efforts to develop a public policy for suicide prevention in Kenya, as outlined in its National Strategy for 2021–2026 (Ministry of Health, 2021). However, this also illustrates how public-community collaboration can play a key role in driving changes in contexts where, for example, a country's own legislation and justice system constitute barriers to the effective prevention of suicide.

5. The European Union provides a common framework aimed at improving and protecting health, though predominantly from a security-oriented perspective, particularly through an epidemiological lens (Flear, 2015). In this regard, while there have been initiatives such as EUREGENAS (European Regions Enforcing Actions Against Suicide) between 2010 and 2014, or projects linked to independent efforts like the European Alliance Against Depression (EAAD), there are currently no concrete proposals supporting a European-level community-based approach to suicide prevention. In any case, the EUREGENAS initiative stands as the most notable example of collaboration between administrations and research centers, with direct engagement of survivor groups and educational institutions, as well as a strong commitment to the development of digital technologies grounded in ethical principles and social responsibility.

approval of the *Protocol for the Care of Suicidal Behavior in Navarra* (Gobierno de Navarra, 2014). What makes NAPRESUI unique is that it stands as the first and leading collaboration model between institutions and citizens at the regional level, with notable permanence over time. Also, its relevance comes that the main healthcare competencies in Spain are constitutionally delegated in the different Statutes of Autonomy of the Spanish regions ("Comunidades Autónomas"). In the case of Navarra, this is formalized through the approval of the Organic Law of Reintegration and Improvement of the Foral Regime of Navarra (LORAFNA) of August 10, 1982.

The statutes governing NAPRESUI's activity specify that its functions focus on "developing protocols and proposing to the respective institutions the actions to be carried out in the prevention of and response to suicidal behavior" (Gobierno de Navarra, 2014, p. 111), as well as monitoring and evaluating the actions implemented. Initially, NAPRESUI was composed by ten representatives, including the regional survivors' association Besarkada/Abrazo, the Navarra Association of Journalists, and the local representative of the Hope Helpline ("Teléfono de la Esperanza"), along with representatives from various departments of the Regional Government and other administrations. Currently, after expansions approved in 2021 and 2023, NAPRESUI includes 19 regular members, including representatives from the Federation of Municipalities and Councils of Navarra, activists, members of patients' associations, Primary Care professionals, and various police forces. This expansion has not only increased visibility for the different stakeholders who can (and should) be involved in suicide care, but has also fostered an approach that embraces and respects diverse voices from the community. However, since the commission operates within the institutional framework under the coordination of the Navarra Department of Health, reports detailing the decision-making process and the monitoring and evaluation of implemented measures are difficult to access. Combined with the absence of official representation from the field of Social Work, this reveals areas for improvement in NAPRESUI's composition and operation as a more open and transparent space, one that should not avoid external accountability. Despite this, the Navarra model remains one of the most established and experienced in the Spanish context, possibly representing the closest regional-level example of a community-based approach. However, its foundation is based on interinstitutional and interdepartmental collaboration, as it defines itself.

At the local level, other ongoing initiatives exist in Spain, such as the Barcelona Mental Health Board. This experience, intertwined with the 2020 Mental Health Emergency Plan, the Barcelona Suicide Prevention Strategy, the successive Mental Health Plans of Barcelona (2016-2022, 2023-2030), and the "Barcelona Cuida" program, involves a total of 40 representatives with the right to participate in the space. However, a smaller steering committee of 13 representatives specifically focuses on suicide care (Ayuntamiento de Barcelona, 2023). Nevertheless, the objectives and community-based approach remain somewhat blurred due to the complexity of this Board. Despite that, this initiative is promising, as it incorporates perspectives on vulnerability and the need to involve the community in suicide prevention. This is an important outstanding issue in the development of public policies in Spain, particularly regarding the implementation of a shared code of good/best practices along with a culture of evaluation and accountability.

4. Final Reflections

Currently, the prevention, intervention, and postvention of suicide in Spain are predominantly governed from a biomedical approach that prioritizes hospital-centered frameworks and those within the healthcare system (García-Haro et al., 2023). This is evident in the set of strategies, plans, and programs that make up the asymmetric and fragmented field of public policy development and design for addressing suicide in the country (Navarro, 2020; Castillo Patton, 2022). Although the current *Mental Health Strategy of the National Health System (2022-2026)* and the *Suicide Prevention Action Plan (2025-2027)* make progress in laying the foundation for better and more extensive coordination of objectives and measures at the regional level, references to a community-based approach remain scarce. This approach is generally addressed in a residual manner under frameworks that promote only slight openness to the participation of vulnerable groups and the general public. This demand, highlighted in various technical reports, remains partial and insufficient if the goal is to adopt the WHO's recommendations or adapt other community-based experiences and initiatives, without resorting to guardianships or co-directions that would distort the meaning and objectives of such an approach.

Throughout this analysis, efforts have been made to highlight, on the one hand, the theoretical and practical background that legitimizes a community-based and/or public-community collaboration approach for addressing suicidal behavior. On the other hand, the discussion of the framework documents has exposed the key elements that define what this approach consists of and its adoption as, ultimately, a management and (co)governance model that promotes a democratization of suicide prevention measures as well as the improvement of public policy development processes and subsequent monitoring. This vision, widely disseminated by various United Nations divisions and projects focused on developing more participatory and sustainable initiatives, also aligns with the Sustainable Development Goals (SDGs) of the 2030 Agenda, ranging from 3.4.2, which establishes the need for a reduction in suicide deaths within the health and well-being targets, to goals 16.6 and 16.7. These SDGs advocate for, respectively, effective and transparent institutions and greater citizen participation to promote goals for peace, justice, and stronger institutions. Additionally, under the promotion of this community-based approach, Goal 17 should be highlighted, as it calls for building partnerships to achieve common goals. In this case, both the reduction of suicide and a greater citizen involvement and engagement in public affairs.

The community-based model proposed by the WHO is presented then as a necessary comprehensive strategy to address this crisis as a social issue with a community impact. Therefore, suicide prevention must

go beyond traditional medical approaches and be adopted as a collective challenge in which the community and its actors, such as survivor associations, media, and community leaders, who play key roles in creating environments of support, solidarity, and collective awareness. This model of public-community collaboration emphasizes the importance not only of identifying risk factors but also of integrating the community into diagnostic processes and in the construction of solutions, allowing public policies to align with and adapt to local realities and the specific needs of the involved communities.

One of the most relevant aspects of this approach is its insistence on integrating the phases of suicide prevention, intervention, and postvention. While emergency care and support for survivors are essential in addressing suicidal behavior, prevention must be understood as a long-term commitment involving education, awareness, and stigma reduction. Within this framework, the literature has demonstrated that the implementation of preventive measures must be proactive, and therefore, citizen participation and community empowerment must coexist to ensure the effectiveness of policies. In this sense, the creation of national regulatory frameworks addressing these recommendations is imperative, but their success will depend on the ability of governments to forge partnerships between systems, resources, and social and healthcare institutions, fostering a culture of collaboration and accountability at all levels of public intervention. Here, models like Navarra's region protocol, as well as experiences in the U.S. and other countries with different cultures and legal frameworks, highlight the importance of interinstitutional cooperation while also underscore the need to incorporate different voices that ensure that public policies are continuously evaluated and adapted to changing needs and citizens' demands.

In this context, the lack of integration among the various levels of universal, selective, and indicated healthcare remains one of the most significant challenges in responding to suicidal behavior. The fragmentation of services and the lack of coordination among public, private, and Third Sector actors hinder the creation of an integrated support system. Thus, the WHO's proposal for an intersectional and collaborative approach stands as a model that must be urgently adapted and adopted, both at the national and community levels, to ensure that all individuals –regardless of their socioeconomic or geographical context–, have access to adequate care in relation to the suicide issue.

Finally, within the community approach and recommendations, there is no doubt about the key role that Social Work professionals can play as accompaniers and/or (co-)managers in these processes, given the capacity and appropriate prior knowledge to contribute to a collective and orderly conversation around a problem of interstitial nature, between social and health factors. This means, then, between what concerns the community and what concerns institutions. Consequently, in this respect, Social Work not only contributes to diagnosing and mapping social issues, but also plays a role in: promoting citizen participation n the identification their own needs and decisions; empowering communities to develop their own capacities; creating safe spaces for dialogue and community support; and establishing partnerships with professionals, leaders, and organizations to develop more effective prevention strategies. Thus, Social Work, acting as a bridge between the social and healthcare sectors, becomes a catalyst for a community-based model in addressing suicidal behavior, ensuring that all voices are heard and that public policies can adapt to collective sentiments.

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