Building an implementation strategy for community-based rehabilitation for mental health in Colombia

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ABSTRACT

Introduction: Scientific evidence indicates that the community-based rehabilitation (CBR) model is recommended for recovery from mental disorders. However, this approach encounters barriers and often lacks implementation strategies.

Aim: The aim of this study is to create a strategy for the implementation of CBR for mental health in Colombia through the identification of barriers and facilitators, together with the expected outcomes, from the perspective of mental health decision-makers in Colombia.

Methods: This study adopts a qualitative descriptive approach, using focus group data collection methods and thematic analysis to code and analyze the data.

Results: A total of 208 individuals participated in the study, including mental health decision-makers and health care professionals. Intersectoral collaboration, contextualization, financial resources, and community commitment and autonomy were identified as barriers and facilitators. The element that was considered a priority for successful implementation was the contextualization of strategies.

Conclusions: CBR needs to be strengthened through implementation science if these strategies are to be successfully developed and implemented in various contexts.

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Keywords: community health services; implementation science; intersectoral collaboration; mental health; psychiatric rehabilitation; treatment outcome

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What is known about the topic?

- In the approach to mental health, communities should become the cornerstone of recovery strategies.
- The resulting community development strengthens social networks and learning, thereby facilitating recovery.
- Despite being widely supported by scientific evidence, community-based rehabilitation (CBR) faces implementation challenges.

What does this paper add?

- To achieve CBR, organizational change is necessary, requiring the enhancement of the evidence base concerning quality, appropriate quality assessment, and the provision of information for decision-making.
- To address these challenges, it is imperative to take into account various factors, including health care organizations, public policy leaders, other sectors, as well as individuals with mental disorders, their families, and their environments.
- A methodology is presented for collaboratively developing a strategy with decision-makers that contributes to the implementation of CBR for mental health within a Latin American context.

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INTRODUCTION

Mental health has emerged as a priority topic on global public health agendas and in the development of plans and policies that involve multisectoral participation.[1,2] Efforts to build socially and culturally appropriate, efficient, and effective approaches in terms of resource investment and mental health outcomes are directed at strengthening communities

based on their strengths, the consolidation of networks within society, and support for mutual aid processes in mental health.[3] These processes increasingly promote mental health and disease prevention through approaches that involve individuals and communities in more active roles.[4]

Considering that factors influencing individual and community well-being involve dynamic aspects of both individual and community existence, various movements, approaches, and theoretical and practical frameworks have been proposed.[5,6] Notable strategies include strengthening national policies, programs, and legislation for mental health, integrating neuropsychiatric disorder treatment into primary care, merging psychiatric hospitals with general hospitals, community education to reduce mental health stigma, expanding research into mental health services, and focusing on human rights to enhance the quality of health care services.[3] The above entails designing recovery strategies with the community as the central axis of recuperation, complemented by involvement from decision-makers, within a framework of mental health governance.[3,4] The aim is to integrate other aspects and spheres that are necessarily linked to mental health approaches, closely related to well-being and personal development, as well as the development of communities, regions, and countries.[7]

The approaches that have gained the most traction in recent years are those that frame their clinical and collective actions within the context of human rights for individuals with mental health conditions. This has led to a gradual move toward community models, which enable this purpose.[3] One such model is community-based rehabilitation (CBR), which encompasses both a theoretical and a pragmatic approach. Unlike the asylum model, CBR embraces a more comprehensive vision of mental health and aims to empower individuals through connection with others. The model underscores the importance of aligning recovery objectives with hope, healing, empowerment, and fostering connections.[8,9] In this way, CBR emphasizes human rights within the context of mental health, with a specific focus on clinical practice guidelines.[8] To transition from a reactive approach to a more participatory one that is centered on group and community decision-making, treatments must be accompanied by education on civil rights, opportunities for engagement in shared interests, and interaction with individuals who have lived similar experiences.[8-11]

The community development that results from CBR strengthens social networks and learning, fostering greater awareness of social concerns and leading the community to take responsibility for mechanisms of change.[9] Perhaps due to the above, the concept of CBR could be perceived as a quick solution for numerous economic and social concerns.[12] However, the strategies must be implemented correctly to achieve the expected change: recovery. This entails defining the components, mechanisms, actors, and outcomes.[7]

Although progress has been made in different regions of the world in planning and developing CBR strategies in mental health, there is still limited evidence on its application and functioning from the perspective of implementation science.[10,11] The considerable diversity within CBR has posed a challenge in establishing uniform developmental frameworks and determining the key elements to assess the success of interventions.[12] Implementation science bridges the gap between research and the discussions in policy and academia, as well as the needs and real possibilities of communities.[7] Implementation results have been defined as the effects resulting from planned and intentional actions within a methodological framework aimed at producing specific changes in services, therapeutic approaches, or processes.[13-15] Different models have been suggested for this purpose, such as that proposed by Damschroder et al.,[16] which identifies the elements required to successfully implement a CBR strategy. These elements include acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, penetration, and sustainability.

The conceptualization and measurement of implementation outcomes will enhance understanding of implementation processes, enable comparative effectiveness studies of implementation strategies, and improve efficiency in implementation research.[17] Thus, implementation science often involves multiple stakeholders, including patients, providers, supervisors, agency leaders, and payers.[13]

Colombia is divided into 32 departments. There is low implementation of mental health services, with 70% of the country's departments having less than 5 implemented services out of the 11 services established under the National Mental Health Law.[18] The least implemented services are community services, especially CBR. Likewise, the departments with the least implementation of mental health services are those with the greatest multidimensional poverty.[18]

Furthermore, while methodologies to measure outcomes have been developed, mental health CBR approaches proposed by implementation science are still in their early stages.[7]

Thus, it is necessary to evaluate key concepts required for the implementation of CBR. This will ensure that intervention results are aligned with set objectives and meet the needs of the intervention recipients. The aim of this study is to formulate a strategy for implementing CBR in mental health in Colombia. This will be achieved by identifying barriers, facilitators, and anticipated outcomes, focusing on the perspectives of mental health decision-makers in Colombia.

METHODS

Study design

This is a qualitative descriptive study that uses focus group data and thematic analysis. Epistemically, the study is grounded in the implementation science approach[13-17,19] and contextual constructivism.[20] Hence, to achieve the stated objective, knowledge must be reciprocal and there must be ample opportunities for dialogue.[21]

Participants and procedure

The study started with the planning of an educational strategy named "The Urgency of Saying 'Us'." This strategy aimed to incorporate implementation science into the development of community mental health interventions.[22] The strategy was put forward by the Ministry of Health and Social Protection of Colombia in 2022–2023, with the support of the US Agency for International Development (USAID). The strategy aims to strengthen social inclusion and CBR in mental health as part of Colombia's public policy.

The educational strategy is aimed at mental health team leaders, departmental mental health referents, academic leaders, as well as local and national mental health decision-makers. These were the study participants. Mental health referents are those professionals at department or district level who are in charge of leading public policy on mental health.[18] The following inclusion criteria were considered: participating in the educational strategy and signing the informed consent form. There were no exclusion criteria.

Out of the participants, 182 were women (86%) and 26 were men (12.3%). The breakdown of professions was as follows: 29% were psychologists, 15% were social workers and professionals in family development, 9.4% were teachers, 8.4% were doctors and nurses, and 8% identified themselves as community leaders. Further, 44% identified themselves as representatives of health secretariats, government entities, or academic administrative bodies.

The study involved conducting focus groups[23] with participants from different departments and regions across the country to gather diverse perspectives on each component of the implementation.[16] The participants were divided into 16 groups, with each group consisting of 13 individuals. In each group, an effort was made to include various professions, ensuring that each group had a regional decision-maker to represent all of Colombia, along with a leader from community organizations. Each group was led by a tutor, who had training in community psychology or social work, had worked as a support group facilitator, and had experience in implementing CBR programs at the national level.

In each group, implementation variables[16] were discussed, along with barriers and facilitators regarding contexts, health care systems, and evidence-based practices.[19] A semi-structured interview guide was used to clarify aspects that influence the implementation of CBR in Colombia. The guide was divided into three sections: (1) implementation outcomes (focusing on barriers, facilitators, adoption, ownership, acceptability, feasibility, reliability, cost-effectiveness, penetration, sustainability, participation, and, within the latter, participation with an intercultural approach); (2) measurement of implementation outcomes, barriers and facilitators; and (3) strategies for achieving better implementation of CBR in mental health. The guide was tailored to the context of each participant and their role in the health care system.

The interviews were transcribed and thematic analysis[24] was conducted through line-by-line inductive coding using NVivo v. 1.7.1. An initial codebook was developed based on the interview guide and an analysis of interviews for each group. Subsequently, coding was conducted and three themes were identified: (1) barriers and facilitators, with eight categories; (2) strategies to overcome barriers, with ten categories; and (3) implementation outcomes, with nine categories.

To ensure transparency and reliability of the data, the analysis was shared with the group. The verbatim quotations from participants were methodically

categorized, ultimately culminating in the themes. The analysis was concluded once saturation was reached.

RESULTS

The results are presented in the three categories that emerged from the focus groups: (1) CBR barriers and facilitators; (2) strategies to overcome implementation barriers to CBR in mental health; and (3) proposed implementation outcomes for CBR. The latter category includes key comments from the participants about implementation outcomes that could be expected when carrying out CBR. Table 1 provides an overview of the barriers and facilitators resulting from the analysis.

Table 2 describes the strategies to address the barriers noted by the participants. In each category, the focus is on strengthening capacity among health personnel, administrative personnel, and the community, in addition to intersectorality and interventions related to culture.

Table 3 presents the identified outcomes, along with corresponding implementation strategies and the measurement methods applicable in each territory. The categories relating to implementation outcomes are presented in line with the framework of Damschroder et al.[12] An additional category emerges as an implementation outcome apart from Damschroder's eight elements, namely, participation.

DISCUSSION

Implementation science is a fundamental tool in ensuring that evidence-based practices become a reality. This is because it combines stakeholders and research evidence to inform decision-making, generating sustained improvement in the quality of health services,[19,24,25] and specifically mental health.[7] Based on these concepts, the current study aims to identify, from the perspective of decision-makers in mental health at a national level, the barriers, facilitators, and implementation outcomes of CBR in mental health. The study plans to contribute to guidelines for implementing CBR in Colombia. This aim is feasible since the participants were mostly decision-makers at the local level in terms of the national mental health policy.

These variables are based on the JBI evidence implementation framework, which considers culture, organizational capabilities, and communication and collaboration among interested parties.[15,26] These aspects were highlighted by the participants of the present study as the basis of strategies to achieve CBR. Similarly, the participants' feedback confirmed the results of a study on the national implementation of mental health programs in Colombia, which mentions that CBR implementation strategies must strengthen the capacity of professionals, administrative staff, and communities.[18] Therefore, a methodology that combines the voices of different stakeholders is proposed in this study.

By integrating the outcomes proposed by Damschroder et al.[16] with the implementation steps proposed by Munn et al.,[27] these implementation frameworks could reinforce what was proposed by the participants, in addition to developing a national implementation model for CBR in mental health. To achieve mental health CBR implementation in Colombia, it is necessary to consider the training and education of health professionals, equipping them with the skills, knowledge, and resources to carry out these practices.[10,11] This reaffirms the need for implementation frameworks to achieve this goal.[27] The category of "participation as an outcome" did not differentiate between process and outcome, which conforms with the theoretical basis of CBR.[28] In mental health, community platforms not only indicate recovery in terms of the health system,[4] but also create scenarios where people improve their mental health.[9,18]

With regard to the identification of area of practice change, the participants pointed out that there were barriers related to methods that failed to effectively stimulate the functioning of the group, as well as deficiencies in community training and leader training to understand the importance of CBR approaches. In this sense, fostering autonomy is directly linked to this component.[25,29] Implementation is much more likely to be successful when the questions answered are relevant to key stakeholder groups.[30]

Barriers to evidence adoption can occur at the system, personal, and intervention level.[31] Thus, in the present study, solutions have been proposed as action pathways, in line with Porrit et al.[19] These include understanding the skills and strengths of the work teams, identifying change agents, being knowledgeable about the contexts and being prepared for change, constant evaluation with scientific evidence as a guide, managing knowledge of applied practices, re-evaluation, and strategies for sustainability. These actions summarize the adoption of this

Table 1: Barriers and facilitators of CBR in Colombia

Categories	Barriers	Facilitators	Strategies
Structural determinants of health	Lack of own employment [CAR_BYF_6] There is no self-support [PAC_BYF_3] Lack of access to recreation and sports for the caregiver and the person with disabilities. [AND_BYF_4] Difficulties with mobility: limited financial resources, long distances, geographic barriers, responsibilities. [AND_BYF_5] Dependence on the health care system for CBR processes. [ORI_BYF_8]	No identified.	Build capacity in CBR in the territories. [CAR_-BARFAC_6] Improve access to technology and connectivity. [PAC_BYF_3] Create opportunities for employment for individuals with disabilities in businesses and government entities. [AND_BYF_4] Strengthen the skills of individuals and communities to generate employment. [AND_BYF_5] Promote support from different sectors to improve quality of life. [ORI_BYF_8]
Accessibility and stigma	Lack of awareness in the population about the existence of these strategies and groups. [CAR_BYF_10] Lack of awareness regarding the offerings of the community regarding CBR and underestimation of the impact of community-based work. [CAR_BYF_12] Limited availability of support groups in communities. Very difficult access in rural areas. [PAC_BYF_14] Negative beliefs about support groups [AND_BYF_15] Although it is a belief, not all individuals with mental disorders or illnesses seek help, either due to prejudice or stigma. [PAC_-BYF_17]	Inviting people to participate in the groups. [AND_BYF_16]	Raise awareness within the community about the existence of support groups. [AND_BYF_15]
Health care system	Difficulties in accessing mental health appointments and a shortage of professionals. [PAC_BYF_20] Difficulty accessing health care services due to the geographical dispersion of communities. [CAR_BYF_22] "Individuals who do not receive adequate care experience relapses and deteriorations that lead to emergencies and readmissions." [CAR_BYF_24]	Facilitating timely mental health assessment and diagnosis is crucial. [CAR_BYF_22] Recognizing the importance of incorporating psychotherapeutic support. [AND_BYF_27].	Ensure the presence of an adequate number of properly trained professionals in primary and secondary mental health care to provide timely attention and prevent vulnerable populations from having to travel long distances for care. [PAC_BYF_20] Identify uninsured individuals, enroll them in health insurance programs, and connect them with community support strategies and support groups. [PAC_BYF_25] Provide individual support sessions with professional assistance, followed by group sessions. [AND_BYF_27] Implement community-based rehabilitation (CBR) strategies linked to primary health care according to current guidelines. [AND_BYF_29]
Intersectorality and political will	Lack of political will for the implementation of CBR and support groups. [PAC_BYF_31] Difficulties in coordinating with community leaders. [CAR_BYF_33] The collaboration between health insurance companies, health care providers, and health institutions is fragmented and results in setbacks in the timely care of individuals with mental illnesses or special health conditions. [AMA_BYF_35] Lack of multisectoral and intersectorial collaboration. [CAR_BYF_39]	Activate the inter-institutionality to favor the access of the population to the different services or offers that the territory has and thus favor their quality of life. [AND_BYF_31]	Establish interinstitutional networks for the focus on mental health issues and for the optimization of actions. [PAC_BYF_31] Improve coordination among the government, businesses, health care sector, education sector, labor sector, sports sector, etc., to enhance the continuity of support groups, mutual aid groups, and CBR. [CAR_BYF_33] Create spaces for collaborative engagement among academic institutions, researchers, other professionals, government officials, and community members. [AMA_BYF_35] Work in a coordinated manner between health offices, health care providers and health insurance companies to optimize mental health care. [CAR_BYF_39]

Table 1: (*Continued*)

Categories	Barriers	Facilitators	Strategies
Support and care networks	Lack of family support networks for individuals who are or need to be part of support and mutual aid groups. [AND_BYF_40] "The family is apathetic towards the processes". [PAC_BYF_44]	No identified	Create true connections and networks between participants and supporting entities. [AND_BYF_40] Involve families and individuals as well as entities that can assist in the maintenance of the plans. [PAC_BYF_42] Create closer-knit groups for all communities, "nodes" that foster greater trust and similarities (train leaders in each neighborhood, motivate, and organize them). [AND_BYF_45] Establish clear goals in the implementation processes of support groups and overall CBR processes. [AND_BYF_48]
Methodology, content, and development of meetings	The methodology and didactic content are not clear or up-to-date. [CAR_BYF_51] The sessions are not regular. [PAC_BYF_54] Effective communication among group members is not achieved. [PAC_BYF_57] CBR is only implemented during the timeframe of the Collective Interventions Plan, but constantly. [AND_BYF_58] Interpersonal relationships are established between leaders and the community, but the individuals participating in the meetings change over time. [AND_BYF_61] Caregivers of people with disabilities often face restrictions due to focusing their attention on fulfilling their caregiving role for the person with disabilities. [AND_BYF_62] There is little recognition and validation of issues related to psychosocial well-being, which leads to a lack of interest in participating in support groups. [PAC_BYF_66]	Provide mhGAP training for health care personnel in the territories. [ORI_BYF_55]	Systematize experiences that generate trust and evidence. [AND_BYF_52] Maintain ongoing monitoring and communication with peer groups. [CAR_BYF_53] Access the current information and guidelines on CBR. [PAC_BYF_56] Identify the best intervention techniques with each group and favor support groups and/or mutual aid based on community needs. [CAR_BYF_60] Characterization of the institutional offer by entities in order to have clarity of the social, legal and other services that contribute to the quality of life of the population. [PAC_BYF_59] Disclose the strategies and groups that are created. [AND_BYF_61] Generate workshops that encourage emotional expression that involves families and groups. [CAR_BYF_63] Design didactic content based on playfulness and with clear language, and adapted to the culture of the participants. [CAR_BYF_65] Use cooperative methodologies. [PAC_BYF_66]
Facilitators and community training	Multiplicity of roles that the professional in charge of support groups must fulfill. [AND_BYF_71] Lack of training among professionals in primary mental health care. [PAC_BYF_72] Lack of expertise on the part of the facilitator in seeking individuals with suitable profiles to join support groups. [CAB_BYF_73]. Professionals lacking contextual understanding of the territory. [PAC_BYF_75] Facilitators' knowledge about the specific characteristics of support and mutual aid groups and their participants with special needs. [AND_BYF_76] Lack of interest and lack of humanization in health care personnel. [PAC_BYF_78]	Strengthening information, education, and communication regarding mental health. [PAC_BYF_72] Strengthening capacity development and self-esteem. [AND_BYF_76]	Generate spaces for continuous and quality training for professionals in mental health, CBR strategies and implementation of these. [AND_BYF_71] Establish compulsory CBR training for facilitators in all territories. [PAC_BYF_72] Prioritize training in mhGAP in health institutions and in the community with the support of territorial entities. [PAC_BYF_75] Provide mental health education in educational institutions, at work and in other spaces in the territories where there is also talk of human dignity, rights, citizen participation mechanisms, quality of life, coexistence, stigma, healthy lifestyles. [AND_BYF_76] Encourage the training of leaders with an emphasis on associationism, cooperativism, political advocacy and social mobilization. [AMA_BYF_77] Develop CBR capacities in the territories (interdisciplinary and primary care teams). [ORI_BYF_79]

Table 1: (*Continued*)

Categories	Barriers	Facilitators	Strategies
Community engagement and autonomy	Lack of interest from participants and the community to attend the meetings and establish support groups. [ORI_BYF_80] Lack of continuity in sessions and processes from the participants. [CAR_BYF_81] Lack of commitment in focusing on mental health issues, in forming support groups in the community, and in the process of appropriating them. [PAC_BYF_83] Constant turnover in the hiring of professionals in the territory, which hinders progress with support groups. [PAC_BYF_84] The programs are not consistent, which prevents comprehensive care from being provided. [AND_BYF_85] Lack of support groups in the area that provide ongoing support and assistance. [CAR_BYF_89]	Identifying goals by individuals as protagonists of their own process. [AND_BYF_85] The support group creates or strengthens mutual support groups. [AND_BYF_85]	Establish a greater number of support groups in neighborhoods and educational institutions. [ORI_BYF_80] General population's awareness of the existence of CBR groups. [CAR_BYF_82] Generate behavioral changes in the community regarding CBR groups. [AND_BYF_85] Promote self-awareness among the population benefiting from CBR strategies. [AMA_BYF_87] Engage actively in meetings. [CAR_BYF_81] Prioritize community participation. [CAR_BYF_86] The community should identify key areas of issues and needs to develop action plans. [AMA_BYF_88] Create or strengthen associations of individuals with mental disorders, exposure to violence, etc., and/or their families. [ORI_BYF_90] Empower artistic, listening, reading, and crop cultivation skills, among others. [PAC_BYF_84] Receive assistance from professionals in the formation of groups and subsequently promote their autonomy. [CAR_BYF_89]

mhGAP: Mental Health Global Action Programme. CBR: Community-Based Rehabilitation. The codes refer to the regions of Colombia: Caribbean (CAR), Insular (INS), Pacific (PAC), Andean (AND), Orinoquia (ORI), and Amazonian (AMA), as well as the proposed themes: Barriers and Facilitators (BYF), Strategies to Overcome Barriers (EST), and Outcomes (OUT).

recovery strategy used by health care systems and individuals within their respective contexts.[15]

Before implementing changes to practice, the first step is to consider the main stakeholders involved in the change.[27] These teams will seek to ensure that the autonomy of the recovery groups is able to solve the needs of the participants.[30] As other studies have already highlighted,[32,33] community initiatives flourish to the extent that resources are available and commitment is evident. The implementation of new mental health strategies involves, from the outset, human rights and the dignity of individuals living with mental health problems. This requires increased political and social commitment, as well as the strengthening of community and family-based resources.[4,11,34,35] Indeed, the United Nations Convention on the Rights of Persons with Disabilities promotes the reintegration and participation of individuals in the community, enabling them to fulfill roles and enjoy equal conditions.[8,36] These factors have an important impact on the success of interventions.[26]

The second step in implementing evidence is the identification of the practice area for change.[27] It should be noted that political will and the development of processes guided by current regulations are proposed as a viable and necessary framework of action in CBR in mental health.[25,37] The participants in the study emphasized the need for processes of collective mobilization that allow for multifocal actions. In this regard, it is essential to establish intersectoral links from the outset.[38]

The third step is to conduct a context analysis.[19] When initiating the planning and structuring of CBR, strong support from the health sector in the initial organizational and management component has a positive impact on community preparedness.[39] At this point, it is important to ensure that strategies are culturally appropriate to facilitate community ownership through community participation and empowerment.[4,32,34] The participants pointed out that the processes must be constantly evaluated and monitored. This agrees with the fourth step: the review of the practices that are being implemented.[26] In this regard, it is essential to integrate community perspectives with those of the government. This will allow for a more informed and realistic debate, where complementary points of view regarding actual political participation are discussed.[40]

The health needs and assets of the community require a detailed, participatory understanding of the context, actors, objectives, and resources.[11,41] This

Table 2: Strategies to overcome implementation barriers to CBR in mental health in Colombia

Categories	Strategies that enhance facilitators and reduce barriers
Addressing social determinants of health	• Building capacity in CBR at the local level. [PAC_EST_91] • Improving access to technologies and connectivity. [PAC_EST_92] • Creating opportunities for employment for individuals with companies and government entities. [CAR_EST_93] • Strengthening the skills of individuals and communities to generate employment. [AND_EST_95] • Promoting support from various sectors to enhance quality of life. [PAC_EST_97]
Accessibility and stigma reduction	• Raising awareness within the community about the existence of support groups. [CAR_EST_98]
Contextualization and inclusive approach	• Identifying the community's needs in collaboration with community leaders, who will provide support and monitor the proposed strategies. [AMA_EST_99] • Adapting action strategies according to cultural characteristics and needs, with a differential approach. [PAC_EST_101] • Inclusion and training of professionals proficient in the languages of the indigenous population, if present in the area. [CAR_EST_104] • Identifying personal and collective objectives within the groups and agreeing on topics that promote their achievement. [PAC_EST_107] • Ensuring that facilitators have the skills to adapt to the context. [PAC_EST_111] • Building trust relationships with formal and informal leaders. [AND_EST_114]
Improving resource allocation	• Allocating greater resources for the development of CBR strategies. [AMA_EST_116] • Increasing the financial commitment of entities that support CBR. [AND_EST_117] • Managing spaces with good lighting, ventilation, and appropriate accessibility according to the needs of the participants. [PAC_EST_119]
Preparing the health care system	• Ensuring the presence of an adequate number of properly trained healthcare professionals at the first and second levels of care in mental health to provide timely attention and prevent displacement of vulnerable populations. [AMA_EST_121] • Identifying uninsured individuals, enrolling them, and connecting them with community support strategies and groups. [AND_EST_124] • Providing individual professional support sessions followed by group sessions. [AND_EST_125] • Implementing CBR strategies linked with primary healthcare in accordance with current guidelines. [AND_EST_126]
Intersectoriality and political will	• Establishing interinstitutional networks to focus on mental health issues and optimize actions. [ORI_EST_127] • Improving coordination between the government, businesses, the healthcare sector, the education sector, labor, sports, etc., to enhance the continuity of support groups, mutual aid, and CBR. [AND_EST_128] • Creating spaces for joint collaboration between academic actors, researchers, other professionals, government officials, and community members. [AND_EST_129] • Working in coordination from health offices and administrations to optimize mental health care. [AND_EST_130] • Adhering to current regulations developed in action plans for the country and territories in mental health and harmonizing CBR actions with existing policies. [CAR_EST_131] • Establishing alliances with educational institutions, social institutions, among others, in the implementation of CBR. [CAR_EST_132] • Formulating realistic action plans proposing short, medium, and long-term actions. [CAR_EST_134] • Establishing alliances with Non-Governmental Organizations and governmental entities. Formalizing commitments and setting them as plans with objectives, responsible parties, activities, and timelines. Both political and private empowerment. [AND_EST_135]
Support and care networks	• Foster genuine connections and networks among participants and supporting entities. [ORI_EST_137]. Involve families, individuals, and entities that can assist in maintaining the plans. [AND_EST_138] • Create closer-knit groups for all communities, "hubs" that allow for greater trust and similarities (train leaders in each neighborhood, motivate and organize). [AND_EST_139] • Set clear goals in the implementation processes of support groups and in CBR processes in general. [AND_EST_140] • Establish long-term programs. Provide greater continuity to programs by promoting political will. [PAC_EST_141] • Initiate a face-to-face one-on-one approach with the family, and initially, explain the process, consistency, work dynamics, and benefits of support groups. [CAR_EST_142]

Table 2: (*Continued*)

Categories	Strategies that enhance facilitators and reduce barriers
Methodology, content, and development of meetings	• Systematize experiences that build trust and provide evidence. [AND_EST_143] • Maintain ongoing communication and follow-up with peer groups. [CAR_EST_144] • Access current information and guidelines on CBR. [PAC_EST_145] • Identify the best intervention techniques for each group and promote support or mutual aid groups based on community needs. [AND_EST_145] • Link individual needs with community interventions in support groups, which could start by creating a census in the area of people and their needs in order to educate families about home management strategies. At the community level, provide support and follow-up. [CAR_EST_146] • Characterize the institutional offering by entities to have a clear understanding of the social, legal, and other services that contribute to the quality of life of the population. [AND_EST_147] • Promote the dissemination of created strategies and groups. [CAR_EST_148] • Organize workshops that promote emotional expression involving families and groups. • Design didactic content based on playfulness, using clear language adapted to the participants' culture. [PAC_EST_149] • Utilize methodologies that include cooperatives within the framework of social inclusion. [PAC_EST_150] • Agree on the number of sessions and their methodology with the participants as the group progresses, and motivate the community through assertive and empathetic communication to establish working and emotional bonds. [CAR_EST_151] • Document the methodological steps of all implemented strategies for later analysis and evaluation of successes, mistakes, and outcomes of the experiences. [AND_EST_153]
Facilitator and community training	• Create spaces for continuous and high-quality training for mental health professionals, CBR strategies, and their implementation. [PAC_EST_154] • Establish the mandatory requirement of CBR training for facilitators in all territories. [ORI_EST_155] • Prioritize mhGAP training in healthcare institutions and in the community with the support of territorial entities. [PAC_EST_156] • Integrate psychoeducation into community training processes. [PAC_EST_157] • Provide mental health education in educational institutions, workplaces, and other spaces in the territories, addressing human dignity, rights, mechanisms of citizen participation, quality of life, coexistence, stigma, and healthy lifestyles. [CAR_EST_158] • Encourage the training of leaders with an emphasis on associationism, cooperativism, political advocacy, and social mobilization. [PAC_EST_159] • Build capacities in CBR within the territories (interdisciplinary teams and primary care). [CAR_EST_173]
Community commitment and autonomy	• Establish a greater number of support groups in neighborhoods and educational institutions. [PAC_EST_174] • Increase general population awareness of the existence of CBR groups. [PAC_EST_175] • Foster behavioral changes in the community regarding CBR groups. [PAC_EST_176] • Promote self-recognition among the population benefiting from CBR strategies. [PAC_EST_177] • Actively participate in meetings. [CAR_EST_178] • Strengthen individual and group autonomy. [AMA_EST_179] • Prioritize community participation. [PAC_EST_180] • The community should identify main areas of issues and needs to outline action plans. [PAC_EST_182] • Create or strengthen associations of individuals with mental disorders, exposure to violence, etc., and/or their families. [AND_EST_183] • Enhance artistic, listening, reading, and crop cultivation skills, among others. [PAC_EST_184] • Receive assistance from professionals in forming the groups and then promote their autonomy. [CAR_EST_185]

should be seen as an educational process that is professionally facilitated. It should also become part of routine clinical practice and should be standards-based, generate results that can be used to improve outcomes, and involve all stakeholders.[28,42] To this end, in mental health recovery it is essential to have adequate, timely, comprehensive, integrated, and responsive services in community settings.[35,43]

Different results have been reported in the field of implementation science regarding the development of community programs and models.[44,45] The description of these results is framed in such a way that it accounts for the complex processes that take place. These processes are heterogeneous; however, they share common elements that provide valuable information.[25]

Implementation theories, models, and frameworks propose different ways to address both the facilitators and the barriers that must be evaluated to increase the chances of success.[15-17,19] However, it is not a

Table 3: Proposed implementation outcomes for CBR in Colombia

Outcome	Promotion strategy	Measure
Adoption	• Community coordination with relevant entities based on the needs and socio-cultural context of the group. [PAC_OUT_190] • Implementation of a comprehensive mental health program and its official adoption, in order to allocate resources that ensure the program's sustainability. [AND_OUT_191] • Implementation of the CBR strategy in mental health, targeting different population groups, with a priority on women who are victims of gender-based violence. [CAR_OUT_193]	• Evaluation of knowledge, attitudes, and practices before and after the implementation of the CBR strategy. [AND_OUT_192] • Interviews regarding the benefits obtained. [AND_OUT_192]
Appropriateness	• This process is based on a family-community characterization that allows obtaining real information in order to achieve "making everyone part of CBR." [AND_OUT_194]	• Evaluation of the impact of the set objectives (measurement of knowledge, stigma, disability at different points in time). [AND_OUT_195]
Acceptability	• Providing practical tools that promote rehabilitation within the group, regardless of their characteristics, contexts, and approaches. [CAR_OUT_197]	• Collecting a list of positive and negative comments during the meetings (written by the participants). [PAC_OUT_198] • Adherence and continuity of care. [AND_OUT_199]
Feasibility	• Promoting educational and supportive environments that foster the successful development of group activities, individuals, and their families. [PAC_OUT_200]	• Implementation, evaluation, and adjustment of policies, plans, models, guidelines, protocols, and other roadmaps in mental health. [AND_OUT_201]
Fidelity	• Implementing and activating care pathways with competent entities. [ORI_OUT_203]	• Continuously reviewing and updating the implemented care pathways in territories based on the capacity to respond to needs. [AND_OUT_204]
Implementation cost	• Balance of implementation in the community rehabilitation processes. [AND_OUT_205] • This will be done considering the needs of each population and balancing the investment in implementation to optimize costs. [AND_OUT_206]	• Action plans that include cost data and evaluations over time. [AND_OUT_207]
Penetration	• Give it a new meaning mental health policy in competent entities, generating commitment and responsibility for the proper development and implementation of CBR in different communities. [PAC_OUT_207]	• Mapping of actions in the territory (georeferencing) that allows the identification of areas with CBR development. [PAC_OUT_206]
Sustainability	• Disseminate and promote CBR through various media channels; raise awareness among territorial entities through training workshops that emphasize legislation and strategies for its proper implementation. [CAR_OUT_209]	• Planning, execution, monitoring, and evaluation of interventions, according to the set objectives, context, regulations, and Sustainable Development Goals. [AND_OUT_210]
Participation	• Promote actions to raise awareness about the importance of mental health, support networks, and stigma. [PAC_OUT_211] • Facilitate joint actions among individuals, their families, organizations, communities, government and non-governmental entities in the fields of health, education, employment, social services, and others. [AND_OUT_213] • Create spaces that allow for the recognition of the needs of individuals with any type of disability, including mental disabilities, and emphasize the importance of support from families and the community in facilitating their processes. [PAC_OUT_215] • Raise awareness and sensitize families and communities about the inclusion of individuals with special needs, including mental health needs. [PAC_OUT_220]	• Evaluation of impact through the degree of adherence. [AND_OUT_212] • Development of measurement tools; facilitate short-term follow-up moments that allow for the systematization of the established and worked processes. [AND_OUT_214] • It is essential to establish an intercultural dialogue with ethnic communities to understand their needs, perceptions, and expectations in mental health. [PAC_OUT_216] • This dialogue should involve community leaders, traditional authorities, healers, and other members of the community. [PAC_OUT_217]

step-by-step guide, nor a structure that should be applied systematically. Rather, it is a set of guidelines to evaluate aspects related to barriers, facilitators, and their integration.[13] This coincides with other studies, which reaffirm the importance of these implementation frameworks to facilitate the organizational and structural change of mental health services, even in low-resource contexts.[46-48]

This was also indicated by the participants as mechanisms of change to achieve CBR outcomes in mental health. This supporting other findings[49-51] in which the increase in the acceptability and effectiveness of a strategy was greater if it had constant support from stakeholders. Although there is a progressive strengthening of community-based mental health care, this has not yet been fully consolidated as a CBR model that can be sustained over time. Therefore, this remains a challenge, especially for Latin American countries.[33] This study identified that the main barriers are related to difficulties with contextualizing the intervention, particularly the failure to listen to the voice of communities.[4] Thus, their perceptions and needs are not heard, triggering a series of actions that do not coincide with the real objectives of the implementation.[42]

In terms of limitations, the lack of greater regional participation and the broader community is recognized. While this study may be regarded as a milestone in the implementation of CBR in mental health, it is crucial to focus on the voices of the communities to facilitate implementation.[52] This can be seen as the next step in the research process. To achieve this, participatory action research must be considered in the development of implementation strategies involving health care professionals and individuals with mental disorders. Similarly, it would be possible to delve deeper into differentiated social determinants by territory, as these factors significantly influence the implementation of health services.[7]

CONCLUSIONS

This study emphasized the underlying connections between health empowerment, strengthening the knowledge and skills of health professionals, allocating greater resources for health, and progress in community processes. The implementation variables should be evaluated before, during, and after the implementation process. The process of evaluating barriers and facilitators that was carried out in this study focused on the elements that CBR participants experienced in their individual contexts. Implementation processes should tailor evidence-based practices to achieve the desired changes in specific contexts. To effectively implement change, there is a need for strategies that are based on sound evidence and theory, rather than introducing change ad hoc.

Ethical considerations

This study complies with the research ethics guidelines for human subjects as outlined in Resolution No. 008430 of 1993 by the Ministry of Health and the Helsinki Declaration of 2000. This is a minimal-risk research study and was approved through resolution CBE02_2022 by the Bioethics Committee of the University of Manizales, Caldas, Colombia.

Consent for publication

The publication of the data provided in this manuscript is authorized.

Availability of data and materials

Data are available upon request from the corresponding author.

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Author contributions

FAH: Conceptualization, planning leadership, formal analysis, research, validation, data presentation, writing, and editing. RRA: Conceptualization, data curation, formal analysis, research, methodology, software, validation, data presentation, writing, and editing. AGA: formal analysis, research, validation, data presentation, writing, and editing.

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REFERENCES

1. Bernardi L. Mental health and political representation: a roadmap. Front Polit Sci 2021;2:587588.
2. Greene MC, Likindikoki S, Rees S, Bonz A, Kaysen D, Misinzo L, *et al*. Evaluation of an integrated intervention to reduce psychological distress and intimate partner violence in

refugees: results from the Nguvu cluster randomized feasibility trial. PLoS One 2021;16(6):e0252982.
3. World Health Organization. Comprehensive mental health action plan 2013-2030 [internet]. WHO; 2021. https://www.who.int/publications/i/item/9789240031029
4. Pan American Health Organization. [Peer support mental health services: promoting people-centred and rights-based approaches [internet]. PAHO; 2022. Available from: https://iris.paho.org/handle/10665.2/56403. Spanish.
5. Thornicroft G, Tansella M. The balanced care model for global mental health. Psychol Med 2013;43(4):849–63.
6. Deacon BJ. The biomedical model of mental disorder: a critical analysis of its validity, utility, and effects on psychotherapy research. Clin Psychol Rev 2013;33(7):846–61.
7. Triece P, Massazza A, Fuhr DC. Effectiveness and implementation outcomes for peer-delivered mental health interventions in low- and middle-income countries: a mixed-methods systematic review. Soc Psychiatry Psychiatr Epidemiol 2022;57(9):1731–47.
8. World Health Organization. WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities [internet]. WHO; 2012. Available from: https://apps.who.int/iris/handle/10665/70927
9. Agudelo-Hernández F, Rojas-Andrade R. Design and validation of a scale of core components of community interventions in mental health. Int J Health Plan Mgmt 2023:1–12.
10. Docrat S, Besada D, Cleary S, Lund C. The impact of social, national and community-based health insurance on health care utilization for mental, neurological and substance-use disorders in low- and middle-income countries: a systematic review. Health Econ Rev 2020;10(1):11.
11. Ravaghi H, Guisset AL, Elfeky S, Nasir N, Khani S, Ahmadnezhad E, *et al*. A scoping review of community health needs and assets assessment: concepts, rationale, tools and uses. BMC Health Serv Res 2023;23(1):44.
12. Russell K, Rosenbaum S, Varela S, Stanton R, Barnett F. Fostering community engagement, participation and empowerment for mental health of adults living in rural communities: a systematic review. Rural Remote Health 2023;23:7438.
13. Means AR, Kemp CG, Gwayi-Chore MC, Gimbel S, Soi C, Sherr K, *et al*. Evaluating and optimizing the consolidated framework for implementation research (CFIR) for use in low- and middle-income countries: a systematic review. Implement Sci 2020;15(1):17.
14. Lewis CC, Fischer S, Weiner BJ, Stanick C, Kim M, Martinez RG. Outcomes for implementation science: an enhanced systematic review of instruments using evidence-based rating criteria. Implement Sci 2015;10:155.
15. Lockwood CS. Making implementation work. JBI Evid Implement 2023;21(3):195–6.
16. Damschroder LJ, Reardon CM, Opra Widerquist MA, Lowery J. Conceptualizing outcomes for use with the Consolidated Framework for Implementation Research (CFIR): the CFIR outcomes addendum. Implement Sci 2022;17(1):7.
17. Waltz TJ, Powell BJ, Fernández ME, Abadie B, Damschroder LJ. Choosing implementation strategies to address contextual barriers: diversity in recommendations and future directions. Implement Sci 2019;14(1):42.
18. Agudelo-Hernández F, Rojas-Andrade R. Mental health services in Colombia: a national implementation study. Int J Soc Determinants Health 2023;53(4):424–33.
19. Porritt K, McArthur A, Lockwood C, Munn Z. JBI's approach to evidence implementation: a 7-phase process model to support and guide getting evidence into practice. JBI Evid Implement 2023;21(1):3–13.
20. Jaramillo Marín J. [Reflexivity on the teaching and learning processes of research in social sciences]. Rev Colomb Humanidad (76):2010:103–24; Spanish.
21. Hamui-Sutton A, Varela-Ruiz M. [The focus group technique]. Invest Educ Méd 2013;2(5):55–60; Spanish.
22. University of Manizales. [Community-based Rehabilitation Diploma] [internet]. 2023 [cited 2023 Oct 14]. Available from: https://m.youtube.com/watch?v=8mgE56KM86s. Spanish.
23. Escobar JF, Bonilla-Jimenez I. [Focus groups: a conceptual and methodological guide]. Cuadern Hispanoamerican Psicol. 9(1):51-67. Spanish.
24. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006;3(2):77–101.
25. Ghasemi E, Majdzadeh R, Rajabi F, Vedadhir A, Negarandeh R, Jamshidi E, *et al*. Applying intersectionality in designing and implementing health interventions: a scoping review. BMC Public Health 2021;21(1):1407.
26. Lockwood C, Porritt K, McArthur A, Munn Z. An introduction to evidence implementation [internet]. In: Porritt, K., McArthur, A., Lockwood, C., Munn, Z., editors. JBI Manual for Evidence Implementation [internet]. JBI; 2020. Available from: https://implementationmanual.jbi.global.
27. Munn Z, McArthur A, Porritt K, Lizarondo L, Moola S, Lockwood C. Evidence implementation projects using an evidence-based audit and feedback approach: the JBI implementation framework [internet]. In: Porritt, K., McArthur, A., Lockwood, C., Munn, Z., editors. JBI Manual for Evidence Implementation. JBI; 2020. Available from: https://implementationmanual.jbi.global.
28. Zimmerman MA, Rappaport J. Citizen participation, perceived control, and psychological empowerment. Am J Community Psychol 1988;16(5):725–50.
29. Fernández A, Serra L. Grup de Dones de Radio Nikosia. [Community life for all: mental health, participation and autonomy. SESPAS Report 2020]. Gacet Sanitar 2020;34 (Suppl 1):34–8; Spanish.
30. Pearson A, Jordan Z, Munn Z. Translational science and evidence-based healthcare: a clarification and reconceptualization of how knowledge is generated and used in healthcare. Nurs Res Pract 2012;2012:792519.

31. Geerligs L, Rankin NM, Shepherd HL, Butow P. Hospital-based interventions: a systematic review of staff-reported barriers and facilitators to implementation processes. Implement Sci 2018;13:36.
32. Bruckner TA, Singh P, Snowden LR, Yoon J, Chakravarthy B. Rapid growth of mental health services at community health centers. Adm Policy Ment Health 2019;46(5):670–7.
33. Asher L, Birhane R, Weiss HA, Medhin G, Selamu M, Patel V, *et al*. Community-based rehabilitation intervention for people with schizophrenia in Ethiopia (RISE): results of a 12-month cluster-randomised controlled trial. Lancet Glob Health 2022;10(4):e530–42.
34. Carrà G, Bartoli F, Capogrosso CA, Cioni RM, Moretti F, Piacenti S, *et al*. Innovations in community-based mental health care: an overview of meta-analyses. Int Rev Psychiatry 2022;34(7–8):770–82.
35. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, *et al*. The Lancet Commission on global mental health and sustainable development. Lancet 2018;392(10157):1553–1598.
36. United Nations. Convention on the Rights of Persons with Disabilities [internet]. UN; 2008. Available from: https://www.un.org/esa/socdev/enable/documents/tccconvs.pdf.
37. Mathias K, Rawat M, Thompson A, Gaitonde R, Jain S. Exploring community mental health systems: a participatory health needs and assets assessment in the Yamuna Valley, North India. Int J Health Policy Manag 2022;11(1):90–9.
38. Pedrosa AL, Bitencourt L, Fróes ACF, Cazumbá MLB, Campos RGB, de Brito SBCS, *et al*. Emotional, behavioral, and psychological impact of the COVID-19 pandemic. Front Psychol 2020;11:566212.
39. Tillott S, Walsh K, Moxham L. Encouraging engagement at work to improve retention. Nurs Manag (Harrow) 2013;19(10):27–31.
40. Bjørlykhaug KI, Karlsson B, Hesook SK, Kleppe LC. Social support and recovery from mental health problems: a scoping review. Nordic Soc Work Res 2021:1–32.
41. Duncan A, Stergiopoulos V, Dainty KN, Wodchis WP, Kirst M. Community mental health funding, stakeholder engagement and outcomes: a realist synthesis. BMJ Open 2023;13(2):e063994.
42. Thornicroft G, Sunkel C, Alikhon Aliev A, Baker S, Brohan E, El Chammay R, *et al*. The Lancet Commission on ending stigma and discrimination in mental health. Lancet 2022;400(10361):1438–80.
43. Grandisson M, Hébert M, Thibeault R. A systematic review on how to conduct evaluations in community-based rehabilitation. Disabil Rehabil 2014;36(4):265–75.
44. Hall T, Kakuma R, Palmer L, Minas H, Martins J, Armstrong G. Service user and family participation in mental health policy making in Timor-Leste: a qualitative study with multiple stakeholders. BMC Psychiatry 2020;20(1):117.
45. Mueller-Stierlin AS, Meixner F, Kohlmann A, Schumacher M, Hänsel A, Pouwels M, *et al*. Effectiveness and cost-effectiveness of a community-based mental health care programme (GBV) for people with severe mental illness in Germany: study protocol for a randomised controlled trial. Trials 2020;21(1):598.
46. Fixsen DL, Van Dyke MK, Blase KA. Repeated measures of implementation variables. Front Health Serv 2023;3:1085859.
47. Frawley T, Meehan A, De Brún A. Impact of organisational change for leaders in mental health. J Health Organ Manag 2018;32(8):980–1001.
48. Babatunde GB, van Rensburg AJ, Bhana A, Petersen I. Identifying multilevel and multisectoral strategies to develop a Theory of Change for improving child and adolescent mental health services in a case-study district in South Africa. Child Adolesc Psychiatry Ment Health 2022;16(1):45.
49. Low LF, Baker JR, Harrison F, Jeon YH, Haertsch M, Camp C, *et al*. The Lifestyle Engagement Activity Program (LEAP): implementing social and recreational activity into case-managed home care. J Am Med Dir Assoc 2015;16(12):1069–76.
50. Matsuoka T, Kato Y, Shibata K, Nakamura K, Nishimura Y, Narumoto J. Importance of long-term involvement for older people living in severe squalor: a case report. Asian J Psychiatr 2020;52:102146.
51. Jablonski RA, Winstead V, Geldmacher DS. Description of process and content of online dementia coaching for family caregivers of persons with dementia. Healthcare (Basel) 2019;7(1):13.
52. Khalid AF, Grimshaw JM. Preparing for audit and feedback: practical considerations. JBI Evid Implement 2022;20:111–2.

