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Validation of an instrument to guide the implementation of strategies for mental health care in Colombia

Rodrigo Rojas-Andrade[1] *and Felipe Agudelo-Hernández*[2]

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ABSTRACT

Objectives. To validate the implementation drivers scale among first-level mental health care professionals in Colombia. The scale is designed as a tool to guide the implementation of strategies that effectively reduce gaps in mental health care.

Methods. The Active Implementation Framework was adopted, which is a widely used model for measuring implementation. The participants included 380 individuals (55.56% men) – 349 health personnel trained in the Mental Health Gap Action Programme (mhGAP) and 31 territorial personnel in charge of planning mental health strategies at the territorial level in Colombia. To assess the critical dimensions of mhGAP implementation, we developed a scale of 18 items based on the active implementation framework. We conducted content validity assessments and exploratory factor analysis to evaluate the scale. We used the Organizational Readiness for Knowledge Translation scale as a comparative standard.

Results. The implementation drivers scale identified four dimensions: system enablers for implementation, accessibility of the strategy, adaptability and acceptability, and strategy training and supervision. These dimensions had Cronbach alpha values of 0.914, 0.868, 0.927, and 0.725, respectively, indicating high internal consistency. In addition, all dimensions demonstrated adequate correlation with the Organizational Readiness for Knowledge Translation scale.

Conclusion. The implementation drivers scale effectively determines the adaptability and implementation of various components of mental health programs, particularly those focusing on community-based approaches and primary care settings. As such, this scale can contribute to the more effective implementation of strategies outlined by global and local political frameworks, thus improving mental health care.

Keywords Implementation science; mental health; primary health care; validation study; Colombia.

Mental health disorders are a major public health problem in Latin American countries (1). Globally, despite the high prevalence of mental disorders, between 76% and 85% of people with mental disorders do not receive the care they need (2). Some factors that influence this gap are stigma, the shortage of qualified providers of mental health care, and the limited funding that mental health services receive (3, 4).

In response to these gaps, it has been proposed to strengthen mental health services within primary health care (5). One of the most internationally disseminated community mental health initiatives is the World Health Organization (WHO) Mental Health Gap Action Programme (mhGAP). The objective of mhGAP is to strengthen the commitment of national authorities and the allocation of resources to expand the coverage of scientifically validated mental health interventions (6). When well implemented, mhGAP has been effective in multiple contexts, with greater impact than other interventions, especially institutionalization of people with mental health conditions (7).

Despite the potential benefits of community mental health programs, their evaluation can be challenging when it comes to ensuring that they are implemented faithfully in accordance with evidence-based practices (8). Fidelity is a critical factor in

[1] University Santiago de Chile, Santiago, Chile.

[2] University of Manizales, Manizales, Colombia. ✉ Felipe Agudelo-Hernández, afagudelo81703@umanizales.edu.co

the success of evidence-based interventions, as it ensures that the intervention is carried out as intended by the designers in the protocols, guidelines, or manuals (9). However, ensuring fidelity can be particularly difficult in low- and middle-income countries, where resources may be limited and providers of mental health care may have insufficient training in evidence-based practices (10, 11).

With regard to mhGAP, some measures related to planning, capacity-building, mental health care processes, and special events and populations have been proposed as implementation indicators (2). These indicators should be evaluated in health systems, in people with mental, neurological or substance use disorders, and in health care providers. However, most existing instruments enquire about symptoms in individuals or families, and there is no clear measure to investigate implementation skills in health systems and services (2).

In the case of Colombia, mhGAP is overseen by the Ministry of Health and Social Protection, which produces guidelines for implementation of the program through adaptation to the national context. Although the Ministry provides the guidelines, the health secretariats at the territorial level are responsible for managing and organizing training processes and must guarantee the availability of human resources to implement the program. Likewise, health management companies and service providers must include mhGAP in their service networks and facilitate the training of their staff (12). Despite these requirements, mhGAP and other outpatient processes for mental health care at the first level of care have faced implementation problems in Colombia (4, 13).

IMPLEMENTATION MEASURES

To ensure that primary health care programs are delivered faithfully and are effective in improving expected outcomes, the development and use of implementation measurement tools has been proposed (14). When using implementation measures, mental health providers can ensure that the intervention is being delivered as intended and can make adjustments to it as needed to improve outcomes (15, 16). Implementation measures can also help assess the effectiveness of mental health interventions by providing data on whether the intervention is achieving its intended results. They can help understand the obstacles to and facilitators of an intervention so action can be taken to correct or enhance its implementation (17, 18).

To measure implementation, one of the most widely used models is the active implementation framework (AIF) (19). The AIF recognizes that implementation is a complex and iterative process that requires continuous evaluation and adaptation to ensure success (20). The AIF incorporates five drivers that provide a framework for understanding the essential elements that must be in place to ensure that evidence-based practices are faithfully applied and sustained over time. The first driver is staff selection, that is, the process of identifying and selecting staff members who have the necessary skills, knowledge, and attitudes to successfully implement evidence-based practices. The second driver is training, that is, providing initial induction, ongoing training and support, and professional development and learning opportunities (21). The third driver is consultation or supervision, that is, providing ongoing support and guidance during the implementation process. The fourth driver is the adaptation of the intervention, that is, the process of modifying the intervention to fit the unique needs and contexts of the organization or population to which the service is provided (21). The fifth driver is organizational support, that is, the structures, policies, and practices that support the application of evidence-based practices (21). This last driver includes leadership support, resource allocation, and alignment of organizational goals and objectives with implementation of evidence-based practices.

Implementation drivers are evidence-based and have proven effective in promoting successful implementation and sustainability of programs in various fields, including community mental health services (22, 23). Researchers have used these drivers to guide implementation efforts and assess the effectiveness of implementation strategies in improving the quality and outcomes of mental health services (14).

RESEARCH OBJECTIVE

Despite the importance of implementation measures, they are usually designed and validated in specific settings in high-income countries, which restricts the generalization of the information provided (15). The objective of this research was to validate an implementation drivers scale using a sample of Colombian community mental health professionals. This validation evaluated the factorial structure of the scale, and the internal consistency and convergent validity of its dimensions compared with another instrument with similar characteristics.

METHODS

Participants

A total of 380 individuals trained in mhGAP participated in our study by completing an online survey that provided detailed instructions on the implementation drivers instruments and purpose of the study. Among these participants, 55.6% were men. The group comprised 349 health professionals trained in mhGAP and 31 territorial personnel who are in charge of planning mental health strategies in Colombia's 32 departments. The department of Antioquia was not included since the mhGAP components described by the health ministry and the Pan American Health Organization were not applied there. The 349 health professionals only responded to the survey we were validating; we did not ask their opinions on any aspects of it.

To assess concurrent validity, an additional 214 participants were recruited, including clinical and administrative staff and leaders of support or mutual aid groups. This group was selected based on the criteria of application of mhGAP after the initial training (first level care workers: general practitioners, social workers, nursing professionals, and psychologists). This group responded to both the survey we were validating and the Organizational Readiness for Knowledge Translation (OR4KT) scale, a Spanish-language instrument used to assess implementation in health centers (24).

Content validity

To assess the critical dimensions of mhGAP implementation, we developed 18 items based on the AIF. Each item was designed to capture the standards derived from the AIF. For

example, the item "I apply the ABC of the strategy correctly and completely" illustrates how complete and correct, although representing different aspects of implementation, must be simultaneously fulfilled for effective implementation. In this context, all items were evaluated by a panel of 18 mental health experts, including representatives from the Colombian College of Psychologists, the Colombian Association of Medical Schools, the Colombian Association of Humanities and Social Sciences Faculties, the Colombian Association of Public Health, the Ministry of Health and Social Protection of Colombia, and the Latin American chapter of the Global Implementation Society. This mixed panel ensured the input of specialized knowledge and different cultural perspectives, including experience in making judgments and evidence-based decisions, reputation in the community, willingness and motivation to participate, and fairness and inherent qualities such as self-confidence and adaptability (25).

These professionals were sent an email with the scale and a form, which used a four-point Likert scale that addressed the representativeness, relevance, adequacy, comprehension, ambiguity, and clarity of the items (26, 27). Interobserver agreement was determined using the Fleiss kappa index: 0.41–0.60 indicates moderate agreement; 0.61–0.80 indicates substantial agreement; and 0.81–1.00 indicates almost perfect agreement (28). The Fleiss kappa index revealed a high level of consensus among the experts (28), so the original items were retained with minor modifications in their wording. Through this process, a final instrument was formulated which comprised the 18 items, presented with a five-point Likert scale. Three items that asked about the budget allocation for the program, the willingness of the territorial administrative entity to implement it, and the willingness of the health insurer were discarded. These items were eliminated because they would limit the implementation of mhGAP to a single institution, thus excluding the formation of networks and partners that mhGAP requires for its implementation, both in a clinical and community setting.

Before applying the scale, a cultural evaluation was carried out (29). In this evaluation, the implementation drivers scale was given to 10 primary care professionals – five from medicine, three from nursing, and two from psychology. After completing the questionnaires, these professionals were asked to provide feedback on any questions that were unclear or difficult to understand, and to give their opinion on the overall acceptability of the instrument (see Table 1 for the original Spanish version of the scale).

Construct validity

Exploratory factor analysis was used to analyze the instrument's dimensional structure using the Kaiser–Meyer–Olkin test and Bartlett test of sphericity, as well as eigenvalues and communalities. Varimax rotation was applied, given that the dimensions are theoretically independent according to the AIF. In addition, for each identified dimension, internal consistency was calculated using both the Cronbach alpha and McDonald omega, thereby ensuring the reliability of each measured construct.

Concurrent validity

We established the concurrent validity of the scale by correlating the scores obtained in the dimensions with those of the OR4KT scale (24, 30). The OR4KT scale serves as a comparative standard for measuring the effectiveness of implementation strategies in health contexts. However, due to its length, it has limited feasibility for use in primary care settings, where time demands for care are high and resources are limited. The OR4KT scale was chosen because no similar instrument

TABLE 1. Implementation drivers scale in its original version, Colombia, 2023

Instrucción. Marque con una X la opción más adecuada según su experiencia en la aplicación del mhGAP: 0=Muy en desacuerdo; 1=En desacuerdo; 2=Ni de acuerdo ni en desacuerdo; 3=De acuerdo; 4=Muy de acuerdo.					
Ítem	0	1	2	3	4
Es de fácil acceso y está siempre disponible para su uso.					
Tiene un formato comprensible, atractivo y fácil de comprender.					
Expresa de manera clara, precisa e inequívoca los componentes o acciones inmodificables de las intervenciones.					
Conozco en detalle todas y cada uno de los pasos para realizar la estrategia en mi territorio					
Cumple mis expectativas y ayuda a responder a mis necesidades técnicas.					
Es aplicable a mi rol como referente o apoyo al referente					
Es fácil de usar e implementar					
He recibido la capacitación suficiente para aprender a aplicarla de manera correcta y completa					
He recibido supervisión y acompañamiento suficiente para aplicar de manera correcta y completa					
Los registros estadísticos y sistemas informáticos que utilizo están alineados con mhGAP					
La planificación anual de mi equipo considera la estrategia mhGAP					
El presupuesto anual de mi equipo se define tomando en cuenta mhGAP					
Otras autoridades locales de salud favorecen la implementación de la mhGAP					
Mis jefes directos están comprometidos con la implementación de la estrategia mhGAP					
Adecúo mhGAP a las características de mi contexto sin modificar los componentes esenciales					
Considero los componentes esenciales de mhGAP para adaptarlos a mi contexto					
Aplico los pasos o el ABC de mhGAP de manera correcta y completa					
Las personas usuarias están satisfechas y reciben bien la atención basada en mhGAP					

Source: Prepared by authors based on the results.

was found in Spanish and validated with primary health care personnel. This comparison validated the effectiveness of our instrument in similar contexts, while offering a more concise and manageable alternative scale.

Ethical considerations

All participants agreed to fill out the instrument by signing an informed consent form, which emphasized the confidentiality of identifying and workplace data. This research was approved by the bioethics committee of University of Manizales (CBE02-2022).

RESULTS

Table 2 describes the items of the implementation drivers scale.

With regard to construct validity of the instrument, the Kaiser–Meyer–Olkin value was 0.825, while the Bartlett sphericity test value was 5769.31 (153 degrees of freedom), which was statistically significant ($P<0.001$).

In the exploratory factorial analysis (orthogonal rotation varimax) with half the study sample, four factors explained 74.43% of the variance, with communalities that ranged between 0.514 ("I adapt the strategy to the characteristics of my context without modifying the essential components") and 0.954 ("I apply the ABC of the strategy correctly and completely"). All items showed factor loadings more than 0.4. Items loading on multiple factors were assigned to the factor with the highest loading to ensure that they did not load highly on others and to maintain theoretical consistency with their assigned factors.

The four domains were called: leadership and administrative support; innovation usability; implementation fidelity; and competency support. The internal consistency of the four factors was acceptable, with a Cronbach alpha of 0.914, 0.868, 0.927, and 0.725, respectively (Table 3). When comparing the remaining half of the study sample with OR4KT, significant correlations were found between all the components, both those of the implementation drivers scale and those of the OR4KT (Table 4).

DISCUSSION

The objective of this research was to describe the process of creating and validating the implementation drivers scale instrument in a sample of primary health care personnel. This instrument can be used to evaluate implementation of mental health programs in primary health care settings and community settings by leaders or implementaters, as an initial or follow-up evaluation. Important problems in implementation of evidence-based practices have been described, especially at the psychosocial level, where they may take up to 17 years to reach communities (23), especially in low- and middle-income countries (4).

Barriers related to mhGAP implementation processes are still evident; even though 100 countries have been using the strategy, implementation has been done mainly in training and not in the follow-up step (6, 7). In the case of Colombia, these problems have been described as difficulties in integrating mhGAP into health systems, which results in a lack of sustainability of the program and partial implementation (13). However, contextual factors have also significantly affected the development of this program (13).

These difficulties may be caused by lack of financial resources, lack of support from the institutional leadership, and resistance of some members of the implementing organizations (31). Likewise, adaptations of the components to the context should be a priority in the implementation process, since failure to make adaptations is also an important barrier (32).

In light of the above, an inquiry has been initiated to examine the constituents of the implementation process of mental health strategies. This inquiry includes an assessment of contextual factors, training protocols, implementation climate, and long-term sustainability (32). Thus, the domains proposed according

TABLE 2. Final version of the implementation drivers scale, Colombia, 2023

Item	Mean	Standard deviation	Asymmetry	Kurtosis
The statistical records and computer systems that I use are aligned with the strategy.	2.29	1.258	–0.056	–1.038
I adapt the strategy to the characteristics of my context without modifying the essential components.	2.69	1.088	–0.627	–0.281
My team's annual planning considers the strategy.	2.31	1.095	–0.015	–0.897
The annual budget of my team is prepared taking the strategy into account.	2.09	1.116	0.235	–0.615
Other local health authorities favor the implementation of the strategy.	2.21	1.243	0.153	–0.915
My direct managers are committed to the implementation of the strategy.	2.18	1.158	0.22	–0.735
The program is easily accessible and always available for use.	2.97	1.089	–0.707	–0.6
The program has an understandable, attractive, and easy-to-understand format.	3.20	0.933	–1.039	0.438
The program expresses clearly, precisely, and unequivocally the unchangeable components or actions of the interventions.	2.95	1.079	–0.7	–0.652
The program meets my expectations and helps meet my technical needs.	3.11	0.928	–0.989	0.587
The program is applicable to my job role.	3.15	0.958	–1.072	0.559
The program is easy to use and implement.	2.94	1.065	–0.809	–0.165
I look for a way to preserve the essential components, despite the adaptation to the context.	2.70	0.993	–0.455	0.052
I apply the steps (ABC) of the strategy correctly and completely.	2.90	0.916	–0.647	0.355
Health care users are satisfied with the care they receive based on the program.	2.80	0.948	–0.466	–0.005
I know in detail each and every one of the steps to carry out the strategy in my territory.	2.94	1.109	–0.847	0.004
I have received sufficient training on how to apply the strategy correctly and completely.	2.48	1.273	–0.36	–1.032
I have received sufficient supervision and support to apply the strategy correctly and completely.	2.31	1.288	–0.178	–1.109

Source: Prepared by authors based on the results.

TABLE 3. Rotation of factors of the implementation drivers scale

Item	Leadership and administrative support	Innovation usability	Implementation fidelity	Competences support	Communalities
1. The statistical records and computer systems that I use are aligned with the strategy.	0.716	NA	NA	NA	0.574
2. I adapt the strategy to the characteristics of my context without modifying the essential components.	0.798	NA	NA	NA	0.772
3. My team's annual planning considers the strategy.	0.893	NA	NA	NA	0.639
4. The annual budget of my team is prepared taking the strategy into account.	0.907	NA	NA	NA	0.628
5. Other local health authorities favor the implementation of the strategy.	0.893	NA	NA	NA	0.706
6. My direct managers are committed to the implementation of the strategy.	0.580	NA	NA	NA	0.578
7. The program is easily accessible and always available for use.	NA	0.700	NA	NA	0.597
8. The program has an understandable, attractive, and easy-to-understand format.	NA	0.869	NA	NA	0.865
9. The program expresses clearly, precisely, and unequivocally the unchangeable components or actions of the interventions.	NA	0.733	NA	NA	0.819
10. The program meets my expectations and helps meet my technical needs.	NA	0.831	NA	NA	0.690
11. The program is applicable to my job role.	NA	0.697	NA	NA	0.735
12. The program is easy to use and implement.	NA	0.684	NA	NA	0.826
13. I look for a way to preserve the essential components, despite the adaptation to the context.	NA	NA	0.965	NA	0.848
14. I apply the steps (ABC) of the strategy correctly and completely.	NA	NA	0.961	NA	0.818
15. Health care users are satisfied with the care they receive based on the program.	NA	NA	0.902	NA	0.514
16. I know in detail each and every one of the steps to carry out the strategy in my territory.	NA	NA	NA	0.534	0.934
17. I have received sufficient training on how to apply the strategy correctly and completely.	NA	NA	NA	0.841	0.954
18. I have received sufficient supervision and support to apply the strategy correctly and completely.	NA	NA	NA	0.742	0.898
Construct measures					
Cronbach alpha	0.914	0.868	0.927	0.725	NA
McDonald omega	0.904	0.863	0.714	0.808	NA
Number of items	6	6	3	3	NA
Explained variance	36.54%	18.10%	13.70%	6.09%	NA
Explained variance total			NA		74.43%
Cronbach alpha total			NA		0.892
Kaiser–Meyer–Olkin			NA		0.825

NA: not applicable.
Source: Prepared by authors based on the results.

to the factor analysis coincide with the implementation stages of AIF: exploration, installation, initial implementation, and full implementation (19, 20). Similarly, the items with lower values (items 6 and 16) are retained because they relate to the commitment of decision-makers and the fidelity of the program, which are fundamental components of its implementation (5–7).

At its core, the implementation process involves the application of various components that form the backbone of the strategies to strengthen health at the primary health care and community levels. As a crucial first step, the application of these components is viewed as a dependent variable in the implementation process (20). In this sense, the AIF, proposed to develop the implementation drivers scale, has been used in similar contexts, such as Peru (33) and Guatemala (34), and helped the implementation and research teams to consider aspects that they often missed – for example, choosing the right solutions for the local context, gathering information for data-driven decision-making and adaptations, and monitoring implementation results.

The concept of fidelity – the extent to which an intervention is executed according to the prescribed guidelines – was examined. This parameter is closely linked to the intended outcomes of the implementation process (31). There are other comparable instruments, including: the Therapy Procedures Observational Coding System – Strategies (TPOCS-S) and the ENhancing Assessment of Common Therapeutic factors (ENACT-18) (35),

TABLE 4. Correlations between the implementation drivers scale and OR4KT instrument

Dimension	Organizational climate	Contextual factors	Change content	Leadership	Organization support	Motivation	Total
Leadership and administrative support							
Pearson CC	0.556	0.531	0.486	0.562	0.585	0.603	0.655
P-value	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Innovation usability							
Pearson CC	0.446	0.455	0.404	0.542	0.531	0.622	0.593
P-value	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Implementation fidelity							
Pearson CC	0.497	0.480	0.459	0.555	0.536	0.625	0.621
P-value	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Competency support							
Pearson CC	0.553	0.541	0.497	0.614	0.611	0.687	0.691
P-value	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001

OR4KT, Organizational Readiness for Knowledge Translation; CC, correlation coefficient.
Note: P<0.05 (two-sided) was considered significant.
Source: Prepared by authors based on the results.

both of which have been used in community-based interventions. However, these instruments are designed to assess the performance of clinicians and may not be appropriate for people acting as facilitators in community-based interventions. Community action is a central component of mhGAP, and was considered with the participants in the present study. Thus the implementation drivers scale is a novel instrument, since it allows these implementation variables to be determined at the clinical, administrative, and community level, which is where people go in search of continuous care (3, 4).

In comparison with other assessment tools that measure implementation variables in health care (8, 24, 30), the implementation drivers scale has a high level of internal consistency, as indicated by Cronbach alphas of 0.72 or higher for all four dimensions. Preliminary evaluations indicate that removing the items "I adapt the strategy to the characteristics of my context without modifying the essential components", which comes under the leadership and administrative support dimension, and "I apply the ABC of the strategy correctly and completely", which comes under the implementation fidelity dimension, would raise the lower coefficient from 0.72 to more than 0.80. However, due to their important contribution to the accessibility-related domains in the factor analysis, it was decided to retain these two items.

Based on the evaluation of internal consistency and repeatability, the initial validation process demonstrates that the implementation drivers scale is a dependable instrument. The overall instrument has a Cronbach alpha of 0.892, a statistical indicator that strongly supports the instrument's reliability.

Three methods were used to assess the validity of the implementation drivers scale, taking into account both internal and external evidence. Internal validity was established to provide evidence of internal structure validity by evaluating the extent to which individual items aligned with the underlying construct of interest. The objective was to unify the arrangement of items by consolidating four factors.

Pearson correlations were used to examine the concurrent validity of the questionnaire of the implementation drivers scale by investigating the relationship between the dimensions evaluated by the scale and those evaluated by the OR4KT. Significant correlations were observed between similar dimensions in both instruments.

Realizing the benefits that evidence-based practices promise for people with mental disorders, such as improving quality of life and increasing capabilities, will also be dependent on local circumstances and an inclusive approach that acknowledges the intersection of various determinants of quality of life and well-being. Future studies could explore ways to examine the impact of these factors on implementation outcomes.

A limitation of this study is the lack of cognitive interviews during the item development process. Cognitive interviews could have provided a deeper insight into participants' perceptions and experiences related to the items. To address this limitation, incorporating such interviews in future versions of the scale may help identify item ambiguities. In addition, there was a potential desirability bias in the participants' responses. To mitigate this bias in future research, specific questions could be included in the questionnaire that directly address desirability bias and apply the instrument in different scenarios.

Experimental evaluations could be conducted to assess whether these instrument items can predict the implementation ability of the mhGAP strategy or effectively differentiate between different contexts. Developing concise, cost-effective, and valid instruments applicable in real-world settings is urgently needed to address the substantial implementation gaps faced by global public health.

Conclusions

The current study provides an instrument that can contribute to more effective implementation of strategies for mental health and that could be useful in developing plans, strategies, and policies. Despite its simplicity, the instrument can facilitate clinical care in primary health care and community settings for mental health which can result in favorable outcomes.

Author contributions. Both authors conceived the original study, planned the data collection, collected and analyzed the data, interpreted the results, wrote and revised the manuscript, and approved the final version.

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Validación de un instrumento para orientar la implementación de las estrategias de atención de salud mental en Colombia

RESUMEN

Objetivos. Validar la escala de impulsores de implementación en profesionales de la salud mental del nivel de atención primaria en Colombia. La escala está diseñada como una herramienta para orientar la implementación de estrategias que permitan reducir de manera efectiva las desigualdades existentes en la atención de salud mental.

Métodos. Se adoptó el marco de implementación activa, que es un modelo ampliamente utilizado para medir este tipo de implementaciones. Los participantes fueron 380 personas (55,56% hombres), de las cuales 349 eran profesionales de la salud capacitados mediante el Programa de acción mundial para superar las brechas en salud mental (mhGAP, por su sigla en inglés) y 31 formaban parte del personal territorial encargado de planificar estrategias de atención de salud mental a nivel territorial en Colombia. Para evaluar los dominios cruciales de la implementación del mhGAP, elaboramos una escala de 18 puntos basada en el marco de implementación activa. Para evaluar la escala se realizaron determinaciones de la validez de contenido y un análisis factorial exploratorio. Como patrón de referencia se utilizó la escala Predisposición Organizacional a la Transferencia del Conocimiento para el Cambio de Práctica Clínica.

Resultados. La escala de impulsores de la implementación determinó cuatro dominios: facilitadores del sistema para la implementación, accesibilidad de la estrategia, adaptabilidad y aceptabilidad, y capacitación en la estrategia y supervisión. Estos dominios presentaron valores de alfa de Cronbach de 0,914, 0,868, 0,927 y 0,725, respectivamente, lo que indica una coherencia interna elevada. Además, todos los dominios mostraron una correlación adecuada con la escala Predisposición Organizacional a la Transferencia del Conocimiento para el Cambio de Práctica Clínica.

Conclusión. La escala de impulsores de la implementación permite determinar de manera efectiva la adaptabilidad y la implementación de diversos componentes de los programas de salud mental, en particular de los que se centran en enfoques basados en la comunidad y en entornos de atención primaria. En este sentido, esta escala puede contribuir a una implementación más eficaz de las estrategias esbozadas en los marcos políticos locales y mundiales, con la consiguiente mejora de la atención de salud mental.

Palabras clave Ciencia de la implementación; salud mental; atención primaria de salud; estudio de validación; Colombia.

Validação de um instrumento para orientar a implementação de estratégias de atenção à saúde mental na Colômbia

RESUMO

Objetivos. Validar a escala de determinantes da implementação entre profissionais do primeiro nível de atenção à saúde mental na Colômbia. A escala foi concebida como uma ferramenta para orientar a implementação de estratégias que reduzam efetivamente as lacunas na atenção à saúde mental.

Métodos. Foi adotada a Estrutura de Implementação Ativa, um modelo amplamente utilizado para medir a implementação. O estudo incluiu 380 indivíduos (55,56% homens): 349 profissionais de saúde treinados no Programa de Ação para Reduzir as Lacunas em Saúde Mental (mhGAP, na sigla em inglês) e 31 profissionais dos territórios encarregados de planejar estratégias de saúde mental em nível territorial na Colômbia. Para avaliar as dimensões essenciais da implementação do mhGAP, criou-se uma escala de 18 itens com base na Estrutura de Implementação Ativa. Foram realizadas avaliações da validade do conteúdo e uma análise fatorial exploratória para avaliar a escala. A escala de prontidão organizacional para tradução de conhecimentos (OR4KT, na sigla em inglês) foi utilizada como padrão de comparação.

Resultados. A escala de determinantes da implementação identificou quatro dimensões: facilitadores sistêmicos de implementação; acessibilidade da estratégia; adaptabilidade e aceitabilidade; e capacitação e monitoramento da estratégia. Essas dimensões tiveram valores de alfa de Cronbach de 0,914, 0,868, 0,927 e 0,725, respectivamente, indicando alta consistência interna. Além disso, todas as dimensões demonstraram correlações adequadas com a escala OR4KT.

Conclusão. A escala de determinantes da implementação avalia efetivamente a adaptabilidade e a implementação de vários componentes dos programas de saúde mental, especialmente componentes que se concentram em abordagens baseadas na comunidade e ambientes de atenção primária. Dessa forma, essa escala pode contribuir para uma implementação mais efetiva de estratégias delineadas por estruturas políticas mundiais e locais, melhorando assim a atenção à saúde mental.

Palavras-chave Ciência da implementação; saúde mental; atenção primária à saúd; studo de validação; Colômbia.