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"Razones para Vivir": Hybrid implementation study in Colombia for health governance and improving suicidal behavior

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ABSTRACT

Objectives. To describe the implementation of a strategy to promote reasons for living and to assess its impact on acute mental health symptoms, psychosocial disability, and perceptions of health services.
Methods. A quasi-experimental methodology that incorporates methods from a Type I hybrid implementation study. The Caldas Scale, Self-Reporting Questionnaire (SRQ-20), and the Zarit Caregiver Burden Scale were applied to people with a history of mental disorder and suicidal ideation, before and after the implementation of the "Razones para Vivir" strategy, to determine psychosocial disability associated with mental disorders and caregiver burden.
Results. The Razones para Vivir strategy has modified the relationship between the quality and perception of health services and psychosocial disability associated with mental disorders. Large effect sizes were found for the variables of occupational disability (r = 0.68), social disability (r = 0.55), therapeutic adherence (r = 0.71), and perception of services (r = 0.51), with a moderate effect size for acute mental health symptoms (r = 0.41).
Conclusions. The implementation of the strategy contributed to institutional involvement in promoting mental health, in addition to the improvement of acute mental health symptoms and some psychosocial disability variables. Mental health promotion strategies can be integrated with implementation frameworks to facilitate their development in specific sociopolitical contexts.

Keywords Suicide prevention; mental health services; hope; motivation; personal satisfaction; Implementation science; Colombia.

Suicide is a significant public health issue, resulting in substantial losses for affected families and societies (1). According to figures reported in 2019, suicide was the fourth leading cause of death worldwide in people between 15 and 29 years of age, with more than 77% of suicides recorded in low- and middle-income countries (1). Recent efforts have aimed to standardize the definitions of suicidal behavior (1, 2).

A suicide attempt refers to self-injurious behavior with at least some intent to die (3). In addition, active suicidal ideation involves the presence of thoughts about taking steps to end one's life, including: identifying a method, having a plan, and/or intending to act, as opposed to passive suicidal ideation in which there are thoughts about dying or wanting to be dead with some plan or intent (2, 3).

From a psychoanalytic perspective, depression, social isolation, and existential anguish amplify this state, making emotional support and access to networks essential to prevent progression into active ideation. Another theory suggests that psychological pain, when combined with hopelessness, contributes to the development of suicidal ideation; and when the pain overwhelms the connection with others, the reasons for living, and the meaning of life, this transition can lead from passive to active suicidal ideation (4). The Health Belief Model explains and predicts health behaviors based on individual beliefs. It

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highlights key factors influencing behavior: perceived susceptibility to a disease, perceived severity of its consequences, expected benefits of the action, perceived barriers, and motivating cues. Self-efficacy, or confidence in performing the behavior, is crucial in decision-making (5).

The concept of Reasons for Living has been defined in various ways throughout the literature. In a systematic review, it was proposed that Reasons for Living are a multidimensional and individual construct that constitutes a protective factor against suicidal behavior (6). Based on this, reasons for living are protective factors that discourage individuals from engaging in suicidal acts and help them affirm their existence despite external adversities (6, 7). Reasons for living offer individuals a sense of meaning and motivation, helping them endure hardships and resist suicidal thoughts. These include positive beliefs and expectations, such as resilience, moral values, family responsibility, and personal convictions, which help individuals cope with suffering and persevere despite challenges (7).

Reasons for living have been defined as the reasons one holds on to in order to stay alive and not commit suicide (8). They are also referred to as adaptive life-oriented beliefs or expectations, such as survival and coping skills, moral objections, responsibility to family, and beliefs that may mitigate the desire against suicide, acting as a protective factor against suicidal ideation and behavior (9). Others have defined this construct as protective factors that interact to prevent some people from thinking about suicide or engaging in suicidal behavior (10).

Deuter et al. (11) conclude that the ways to promote Reasons for Living are based on: Relationships of trust and support, social support, connectivity and interaction; Coping and adaptation; Physical and mental health care; Pain relief and adequate care for illness; Early intervention and treatment of emotional problems; Recognition of religious or spiritual values; Support in grief; and Recognition and relief of family conflict. Other ways of promoting the Reasons for Living are those protective factors that give meaning to life, such as family, spirituality, being a role model, and the fear of death (12). According to Sveticic and De Leo (13), the following are evidenced as protective factors against suicidal thoughts and behavior: religion, culture, social norms, and monitoring of depressive symptoms in society.

Other spaces conducive to promoting Reasons for Living have been identified as those where people at risk of suicide are encouraged to seek help; for example, telephone lines or psychological first aid (14). Likewise, psychoeducation is considered essential to cultivate expectations for the future, which implies promoting the creation of a solid life project and a positive self-concept. Some studies in Colombia have linked the promotion of Reasons for Living with psychosocial support to address individual and community needs, with access to health services that facilitate recovery and management of trauma, and that also strengthen family ties (7). Likewise, the development of awareness campaigns on mental health and suicide prevention is mentioned, highlighting the Reasons for Living and the method of seeking help in times of crisis (7).

Psychosocial disability emerges as a prominent risk factor in the problem of suicide. Mental disorders such as depression, schizophrenia, and bipolar disorder, commonly associated with this condition, significantly increase vulnerability to suicidal behavior (15). Social stigma, isolation, and barriers to accessing adequate health services exacerbate these risks (16). The lack of specialized services and the fragmentation of health systems make timely and effective care difficult.

Given this complex intersection, it is imperative to develop comprehensive preventive interventions that address both individual and contextual factors. These interventions should focus on mental health promotion, suicide prevention, and the provision of accessible, inclusive, and culturally sensitive services for people with psychosocial disabilities (16). Psychosocial disabilities stem from mental health conditions or psychological factors, limiting participation in society. They can affect social interaction, employment, education, and daily activities (15). These disabilities result from the interaction between mental health conditions and societal barriers to equality. They vary among individuals, can fluctuate, and require recognition to ensure appropriate support and social inclusion.

Implementation science offers a promising avenue to address this issue, serving as a bridge between research-generated evidence and the practical needs and capacities of communities (17). Implementation outcomes formulation aims to serve three important functions: to guide implementation success, to serve as proximal indicators of implementation processes, and to act as key intermediate outcomes in relation to effectiveness (18, 19). That is to say, for this specific case, implementation sciences, aimed at translating knowledge into effective practices, play a fundamental role in optimizing strategies such as the Reasons for Living approach, since it can be enhanced by applying the proposed implementation phases that guarantee its adoption, fidelity, and sustainability in clinical and community contexts, promoting its effectiveness and maximizing its impact on populations.

Suicidal behavior continues to increase worldwide, making it necessary to strengthen care environments with strategies that complement clinical management and validate the needs of people who seek them. To this end, "Razones para Vivir" (Reasons for Living) have been proposed as elements of mental health promotion and have been established as an element of clinical and psychosocial interventions. Few studies have addressed mental health promotion approaches in dealing with suicidal behavior, especially from mental health contexts. Therefore, the objectives of this study were to describe a practice implementation of the Razones para Vivir strategy and to determine its impact on acute mental health symptoms, psychosocial disability, and the perception of health services of people diagnosed with mental disorders in Caldas, Colombia. It is hypothesized that the implementation of the strategy improves these variables associated with recovery.

MATERIALS AND METHODS

It is a quasi-experimental methodology with a pre- and post-design that incorporates methods from a Type I hybrid implementation study to assess the intervention outcomes and implementation outcomes. This proposal is based on the Joanna Briggs Institute (JBI) Implementation Framework for Evidence Implementation (Evidence-Based Health Care model) (20). It is based on a specific implementation framework that accompanies an audit, feedback, and re-audit process, and a structured approach to identify and manage barriers to change. This implementation framework has been used to analyze implementation barriers and propose solutions in the Colombian context (16).

The combination of these approaches allows for the simultaneous assessment of the effects of the Razones para Vivir

strategy on protective factors against suicide and the implementation processes that influence its adoption in real-life settings. The quasi-experimental study allows for the measurement of the impact of the intervention on participants by comparing variables before and after implementation. The Type I hybrid approach therefore not only allows for the determination of effectiveness of the intervention in terms of impact on the protective factors of suicide, but also to generate evidence on its viability and sustainability in the Colombian health system, contributing to its possible scalability in other contexts.

Instruments and procedure

Colombia is administratively divided into departments, which are further subdivided into municipalities. The strategy was implemented in six semi-urban and rural municipalities in Caldas Department, Colombia. At the level of the health services of these municipalities, it was implemented in 45 people with a history of mental disorders and suicidal ideation reported in the mandatory notification system of Colombia. Participants were recruited through a collective intervention program aligned with Colombia's mental health policy.

The instruments were administered by researchers from the primary health care team. These questionnaires were applied before and after the implementation of the Razones para Vivir strategy, which is based on community-based rehabilitation. The strategy was carried out in semi-urban and rural areas.

The Self-Reporting Questionnaire (SRQ-20) is a mental health assessment tool widely used in Colombia to identify common psychiatric symptoms. It has two sections: the first, with 20 questions, evaluates symptoms of depression and anxiety, with a score of 11 or more indicating a positive result. The second section contains five questions focused on identifying psychosis and seizure symptoms. It is validated for use in Latin America, including Colombia (21).

The Zarit Caregiver Burden Scale aims to measure caregiver burden by assessing dimensions such as quality of life, self-care capacity, social support network, and skills to deal with behavioral and clinical problems of the patient being cared for. The scores range as follows: 22–46: no load; 47–55: light load; and 56–110: severe burden (22). The version validated in Colombia was used in this study.

The Caldas Scale evaluates psychosocial disability associated with mental disorders across five domains: treatment adherence, which examines understanding and continuity of treatment; personal and emotional disability, assessing self-care ability, meaningful activities, and emotional responsiveness; family functioning disability, considering family support; social disability, focusing on social interactions, support networks, and relationships; and occupational disability, which reviews job satisfaction, peer relations, and occupational performance. Based on the total scores in these areas, psychosocial risk is categorized into quartiles: low, moderate, high, and very high (23).

Perceptions of health services were obtained by constructing a set of eight questions specifically designed to generate the relevant indicators in the context of the study. Through Likert-type questions that indicated the degree of satisfaction from 0 to 4, this instrument investigated the proximity of people to their health provider, satisfaction with the provision of services, the perception of availability of health services, and the effectiveness of services in recovery processes.

Intervention

The intervention was through the Razones para Vivir strategy (24) (Table 1). This was carried out in accordance with what

TABLE 1. Components of the "Razones para Vivir" strategy

Purpose: A governance strategy that promotes each person's reasons for living by integrating functions at the macro (care systems and public policies), meso (environments and media), and micro (mental health care) levels. These reasons for living, rather than generic advice, emphasize individual motivations that can be mobilized from the environments and with the effective implementation of integrated public policies.

Level	Scope	Objective	Activities
Macro (Public policy)	Multi-level governance for public institutions to contribute and reaffirm Reasons for Living by fulfilling and integrating their functions.	To determine meeting points for mental health in all public policies, strategies, and regional programs.	Awareness and training for local and regional decision-makers in the implementation of public mental health strategies and in the construction of care and recovery routes. Application of life course, intersectionality, transculturality, gender, and human rights approaches. Mapping of actors for the formation of a community platform for mental health.
Meso (Environments)	Strengthening of environments and community organizations in skills for the first psychological response to the crisis and in mobilizing Reasons for Living from the environments.	To generate capacities in the environments to promote reasons for living in people close to them.	Training of leaders such as gatekeepers and teachers in schools, people who provide first psychological responses in the work environment, spiritual leaders, leaders of other community-based organizations. This training was complemented with information on care routes, psychoeducation, mental health rights, and risk communication and community participation strategies were carried out, which included the media. Communication pieces such as videos and audios were also generated for the media with the reasons for living of some people in the environments, emphasizing the more generic reasons; what was intended was that each person could generate or reinforce their own reasons for living.
Micro (Health services)	Support to primary health care groups and systems with a strategy to promote reasons for living in people who go to health services.	To generate capacities to strengthen the brief psychotherapeutic interventions proposed by the Mental Health Gap Action Programme (mhGAP) with elements of mental health promotion.	Two-session training aimed at health personnel at the first level of care trained in mhGAP. This training integrates basic concepts of communication, motivational interviewing, and the cognitive behavioral scheme.

Source: Prepared by the authors.

was established as an initiative of the Pan American Health Organization/World Health Organization (PAHO/WHO) in Colombia, in alliance with the Ministry of Health of Colombia and the Department of Caldas. Policymakers, psychologists, nurses, and social workers were trained on the strategy by staff from the department's health directorate.

Data analysis

The analysis was performed using R software version 4.4.0 and SPSS v.26. The assumption of normality for each of the quantitative variables was verified using the Kolmogorov–Smirnov test. To evaluate the effects of the intragroup intervention, the Wilcoxon test for two related samples was used, with a significance level set at $p < 0.05$ for significant differences between groups. The effect size was calculated using Wilcoxon, with the formula $r = Z / \sqrt{N}$, where Z was the standardized Z statistic and N was the total number of observations.

Ethical considerations

This work complies with the standards of Resolution No. 008430 of 1993 of the Ministry of Health and adhered to the guidelines for biomedical research established in the Declaration of Helsinki of the World Medical Association. It is a minimal risk research and was reviewed and endorsed by the Ethics Committee of the University of Manizales through act CB04-2024. This work has a Bioethics Committee for its execution. Absolute confidentiality of the names of the study participants, who gave their consent to participate, was guaranteed.

RESULTS

The median age was 49 years (range 17–79), 15.8% were displaced, 92.7% reported low socioeconomic income, 73.4% were women, 51.4% were single, 52% had 1–3 children, 48.6% had basic primary education, 40.1% were employed as housekeepers, 73.4% were on a subsidized regime, and 72.6% had 2–3-room housing. Regarding the scales, the descriptive statistics are listed in Table 2.

The strategy demonstrated large effect sizes for occupational disability (r = 0.68), social disability (r = 0.55), therapeutic adherence (r = 0.71), and perception of services (r = 0.51), while a moderate effect size was observed for acute mental health symptoms (r = 0.41). A smaller effect size was found for caregiver burden (Table 3).

The seven steps proposed for the implementation of the Razones para Vivir strategy in universal, selective, and specific prevention environments in Colombia, and its actions, are based, among others, on strategic planning, the empowerment of people, strategic leadership, and political, technical, and academic support (Figure 1).

For sustainability, it is essential to identify and plan resources and strategies that allow the development and expansion of the Razones para Vivir strategy, within the framework of a planning horizon. It is important to have the resources of the health system and the internal and external sources of financing of the sectors involved (24–29). An important form of sustainability is to include the strategy in comprehensive health planning. Some implementation indicators are proposed for monitoring and following up on the strategy at the national level in Colombia (Table 4).

DISCUSSION

Suicide is one of the most common causes of death worldwide, making strategies to address it a priority. The results obtained in this study suggest that the implementation of the Razones para Vivir strategy had a positive impact on the reduction of occupational, personal, and social disability in participants. However, no significant reduction was observed in the levels of perceived burden. The above could indicate that those variables related to modifications at the macro level (policymakers, leaders of public sectors and health services) and at the micro level (primary health care workers, people with lived experience, and community leaders, etc.), especially psychosocial disability and management of health services, could have a greater impact than those related to clinical aspects, such as acute symptoms or care overload. Although these variables

TABLE 2. Descriptive statistics of the scales

Item	Average	SD
Zarit	8.76	13.859
SRQ	8.94	5.652
Caldas scale overall	94.56	9.294
Occupational disability	12.17	1.463
Personal and emotional disability	11.97	1.652
Disability in family functioning	5.4	1.058
Social disability	3.91	0.744
Therapeutic adherence	5.62	0.931
Total perception	8.76	13.859

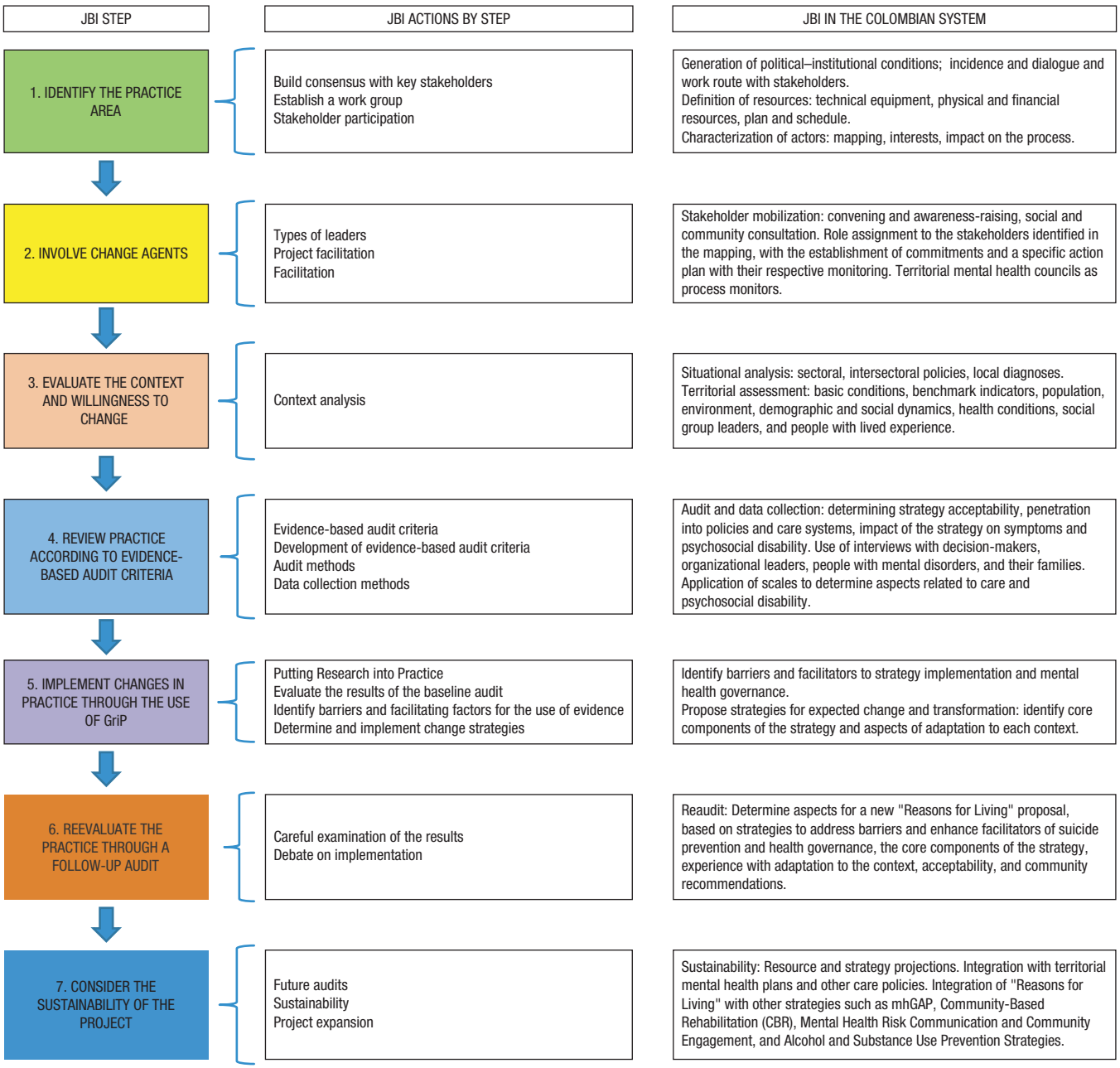
SD, standard deviation; SRQ, self-reporting questionnaire.
Source: Prepared by the authors.

TABLE 3. Effects by scale

Statistic/scale	Zarit	SRQ	Caldas total	Occupational disability	Personal and emotional disability	Disability in family functioning	Social disability	Therapeutic adherence	Perception
Z	–2.371	–2.771	–3.303	–4.590	–4.466	–2.719	–3.668	–4.742	–3.396
Sig.	0.018	0.006	0.001	<0.001	<0.001	0.007	<0.001	<0.001	0.001
r	0.35	0.41	0.49	0.68	0.66	0.40	0.55	0.71	0.51

Sig, asymptotic significance (bilateral); SRQ, self-reporting questionnaire; r, effect size.
Source: Prepared by the authors.

FIGURE 1. Steps and actions for the implementation of the "Razones para Vivir" strategy in Colombia



GriP, Getting Research into Practice; mhGAP, Mental Health Gap Action Programme.
Source: Prepared by the authors.

improved, the strategy did not produce a large effect size for them.

Regarding the strengthening of social networks, the strategy can facilitate the connection with other individuals who face similar challenges, which can generate a sense of belonging and social support. These social networks can provide valuable information about health services and help participants feel more connected and supported. The Razones para Vivir strategy, by promoting social connection and the development of interpersonal skills, can mitigate these effects and improve the perception of services. These findings are consistent with previous research that has demonstrated the effectiveness of interventions based on the identification and strengthening of protective factors in suicide prevention (30).

The lack of improvement in burden could be due to the complexity of this construct and the need for more specific and prolonged interventions. Likewise, its impact on reducing caregiver burden could be more limited because this is a complex phenomenon influenced by multiple factors, such as personal characteristics (disease severity, challenging behaviors), caregiver characteristics (age, health status, social resources), and environmental demands.

TABLE 4. Indicators for the implementation of the "Razones para Vivir" strategy

Indicator	Means of verification	Frequency
Percentage of health services that implement the Razones para Vivir strategy	Report from health service providers to the territorial entity	Quarterly
Percentage of local associations strengthened with the Razones para Vivir strategy	Report of the territorial entity	Quarterly
Percentage of Benefit Plan Administrator Entities (EAPB) that participate in the implementation of the Razones para Vivir strategy	Report of the territorial entity	Biannual
Percentage of health service providers participating in the implementation of the Razones para Vivir strategy	Report of the territorial entity	Biannual
Percentage of service providers from sectors other than health who participate in the implementation of the Razones para Vivir strategy	Report of the territorial entity	Biannual
Percentage of resources allocated to the implementation of the Razones para Vivir strategy	Report of the territorial entity	Biannual
Percentage of resources spent on implementing the Razones para Vivir strategy	Report of the territorial entity	Biannual

Source: Prepared by the authors.

The Reasons for Living strategy has the potential for transformational implementation, to improve not only psychiatric symptoms but also people's perception of health services, becoming a protective factor (31), toward avoiding thinking about suicide or participating in suicidal behaviors (10). In addition to the above, the strategy focuses primarily on personal well-being, fostering resilience, meaning in life, purpose, quality of life, and psychological well-being as essential elements in suicide prevention, complementing the treatment of the causes of suffering with a comprehensive approach, recognizing their strengths and internal resources and providing them with tools to cope with the disease. While this may have an indirect impact on caregiver burden by improving the patient's quality of life, it does not directly address the specific needs and concerns of the caregiver.

By empowering individuals, shifting their perspectives, and strengthening their social networks, this strategy can enhance quality of life and improve satisfaction with mental health services. The potential for change, the relevance of applying evidence within the local context, and the effectiveness of this evidence in scientific research are all crucial for contextualizing knowledge. That is, the transformational implementation of Razones para Vivir not only seeks to improve the clinical effectiveness of the strategy but also to generate a positive impact on the healthcare ecosystem, strengthening the integration of evidence-based practices in local systems. This requires identifying and overcoming contextual barriers, training health personnel in person-centered approaches, and cultural adaptation of the intervention to maximize its acceptance and adherence.

This proposal presents an implementation strategy within the Colombian sociopolitical system based on the JBI framework. Evidence suggests that people with mental disorders may resist accepting health recommendations based on classic concepts that are not focused on their own experiences or interests (32). Some messages may have a negative impact on help-seeking, which has justified the need to improve mental health communication (33). More sensitive messages that validate these aspects in people seeking help reaffirm human rights and contribute to recovery.

This methodological proposal contributes to the resolution of problems in the implementation of mental health strategies, which include, among others, access limitations associated with intersectoral action, system capacity, willingness of actors, adaptation and cultural integration of mental health strategies (17, 34); taking into account that the JBI implementation framework plays a key role in fundamental aspects such as the involvement of key actors, which creates opportunities for participatory decision-making (18).

According to health belief theory, people with health problems must assess the risk of their behavior and agree with treatment actions, otherwise it has been observed that there is very low adherence to recommendations (17, 18). Most people who come to clinics show a dynamic combination of characteristics between anxiety, anger, and sadness, in addition to previous traumatic experiences. When given the choice, most people living with mental disorders prefer psychosocial therapies to pharmacological options, citing trust in health professionals, validation of their dignity, and promotion of hope in their lives as reasons (17).

Furthermore, pharmacological and psychological interventions can often be used simultaneously so that they can reinforce their individual effects: both should contain key communicative elements to achieve the best effect. Psychotherapeutic interventions lead each person to address more directly their relationship with their own suffering and with the shaping of it through their parents and ancestors (35). Thus, for others, reasons for living consist of intertwined chains of signifiers (sounds, printed words, and images), which could help to deal with the symptom or, in their terms, with the need, the demand, and the desire (36). They awaken a "mechanical" solidarity based on similarity and an "organic" solidarity based on difference and specialization. In this way, Lacan (37) formalizes the relationship between the individual and the collective, where the individual is a subject and, as such, a function within a logical process. According to the present results, the need to strengthen primary care health services in addressing psychiatric symptoms is shown; promoting Reasons for Living from mental health care contexts, which implies including them in therapeutic interventions, especially in people at high risk of suicide, major depression, generalized anxiety disorder, among other psychopathologies. Another important point is to strengthen telephone helplines in case of crisis (14). Also, the creation of mutual aid groups, where social networks, social support, connection with others, support for others, social communication and community participation, and self-esteem are strengthened, could be a promising scenario to make more Reasons for Living evident (17).

Several models have been proposed for this purpose, including the framework developed by Fixsen et al. (19) and JBI (18, 20), which outline the key elements necessary to consider an evidence-based practice successful. In this case, these elements include anticipated outcomes such as adoptability (the likelihood that key decision-makers will decide to implement the strategy), implementability (the likelihood that the innovation will be implemented or delivered), and sustainability (the

likelihood that the strategy will be implemented or delivered in the long term) (32).

As limitations of this implementation proposal, it is recognized that it does not evaluate the public participation method. Likewise, it is considered necessary to determine other implementation variables, such as acceptability, costs, and sustainability, which could lead to future studies, where the voice of people with mental disorders helps guide the components of the strategy.

In this way, to ensure an effective and sustainable implementation of the Razones para Vivir strategy, it is essential to rely on robust conceptual frameworks that guide the integration process in health systems. In this sense, the Fixsen et al. (19) model and the JBI framework (20) provide a structured basis for evaluating and optimizing the adoption of evidence-based practices. The Fixsen et al. (19) model emphasizes the importance of key factors such as staff training, organizational support, and fidelity to the intervention, essential elements to maximize the impact of the strategy.

Further studies are required to understand the Razones para Vivir strategy's mechanisms and determine its applicability to other populations and contexts. Future research could focus on comparing the effectiveness of the Razones para Vivir strategy with other psychosocial interventions, as well as on identifying factors that may moderate or mediate the effectiveness of the strategy, such as individual characteristics of participants or characteristics of health services.

Conclusion

Promoting reasons for living can serve as an effective strategy to disrupt the suicidal process by harnessing individuals' personal motivations, thereby supporting the recovery of those with psychosocial disabilities. The implementation of Razones para Vivir contributed to institutional involvement in promoting mental health, in addition to the improvement of acute mental health symptoms and some psychosocial disability variables. Mental health promotion strategies can be integrated with implementation frameworks to facilitate their development in specific sociopolitical contexts.

Author contributions. All authors contributed to the study conception and design. FAH, LMSV, and LIPC prepared the material, collected the data, and analyzed the data. FAH drafted the manuscript. All authors reviewed the manuscript. All authors read and approved the final manuscript.

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"Razones para vivir": estudio de implementación híbrida en Colombia para la gobernanza en materia de salud y la prevención de conductas suicidas

RESUMEN

Objetivo. Describir la aplicación de una estrategia para promover las razones para vivir y evaluar su impacto en los síntomas agudos de salud mental, la discapacidad psicosocial y la percepción de los servicios de salud.

Método. Se usó una metodología cuasiexperimental que incorpora métodos de un estudio de implementación híbrida de tipo I. Se aplicaron la Escala de Caldas, el Cuestionario de autonotificación de 20 ítems (SRQ-20) y la Escala de carga del cuidador de Zarit a personas con antecedentes de trastorno mental y pensamientos suicidas, antes y después de la implementación de la estrategia "Razones para vivir", para determinar la discapacidad psicosocial asociada a los trastornos mentales y la carga del cuidador.

Resultados. La estrategia "Razones para vivir" ha modificado la relación entre la calidad y la percepción de los servicios de salud y la discapacidad psicosocial asociada a los trastornos mentales. Se observó una magnitud del efecto grande para las variables de discapacidad laboral (r = 0,68), discapacidad social (r = 0,55), adhesión al tratamiento (r = 0,71) y percepción sobre los servicios (r = 0,51), con una magnitud del efecto moderada por lo que respecta a los síntomas agudos de salud mental (r = 0,41).

Conclusiones. La aplicación de la estrategia contribuyó a la participación institucional en la promoción de la salud mental, y a la mejora de los síntomas agudos de salud mental y de algunas variables de discapacidad psicosocial. Las estrategias de promoción de la salud mental pueden integrarse en marcos de aplicación para facilitar su desarrollo en contextos sociopolíticos específicos.

Palabras clave Prevención del suicidio; servicios de salud mental; esperanza; motivación; satisfacción personal; ciencia de la implementación; Colombia.

Razones para Vivir: estudo de implementação híbrida na Colômbia para governança da saúde e melhora do comportamento suicida

RESUMO

Objetivos. Descrever a implementação de uma estratégia para promover razões para viver e avaliar o impacto sobre os sintomas agudos de saúde mental, a deficiência psicossocial e as percepções dos serviços de saúde.

Métodos. Utilizou-se uma metodologia quase experimental que incorpora métodos de um estudo de implementação híbrida de tipo I. A Escala de Caldas, o questionário *Self-Reporting Questionnaire* (SRQ-20) e a escala de sobrecarga do cuidador de Zarit foram aplicados a pessoas com história de transtorno mental e ideação suicida antes e depois da implementação da estratégia *Razones para Vivir* para determinar deficiências psicossociais associadas a transtornos mentais e à sobrecarga do cuidador.

Resultados. A estratégia *Razones para Vivir* modificou a relação entre a qualidade e a percepção dos serviços de saúde e as deficiências psicossociais associadas aos transtornos mentais. Foram encontrados tamanhos de efeito grandes para as variáveis incapacidade ocupacional (r = 0,68), incapacidade social (r = 0,55), adesão ao tratamento (r = 0,71) e percepção dos serviços (r = 0,51), com um tamanho de efeito moderado para os sintomas agudos de saúde mental (r = 0,41).

Conclusões. A implementação da estratégia contribuiu para o envolvimento institucional na promoção da saúde mental, além da melhora dos sintomas agudos de saúde mental e de algumas variáveis de deficiência psicossocial. As estratégias de promoção da saúde mental podem ser integradas a estruturas de implementação para facilitar seu desenvolvimento em contextos sociopolíticos específicos.

Palavras-chave Prevenção do suicídio; serviços de saúde mental; esperança; motivação; satisfação pessoal; ciência da implementação; Colômbia.