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Mental health law in Colombia

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Mental health law in Colombia has evolved over the past 50 years, in concert with worldwide recognition and prioritisation of mental healthcare. Laws and policies have become increasingly sophisticated to accommodate the ongoing transformations throughout Colombia's healthcare system and improvements in mental health screening, treatment and supportive care. Mental health law and policy development have been informed by epidemiological data on patterns of mental disorders in Colombia. Colombia is distinguished by the fact that its mental health laws and policies have been formulated during a 60-year period of continuous armed conflict. The mental health of Colombian citizens has been affected by population-wide exposure to violence and, accordingly, the mental health laws that have been enacted reflect this feature of the Colombian experience.

Historical perspective

In Colombia, the latter half of the 20th century was marked by a growing awareness of the importance

of mental health and the need for mental health services based on public education and advocacy from the Colombian Psychiatric Association, the Colombian Psychological Association, a variety of non-governmental organisations and information dissemination via a broad spectrum of media channels.

During the 1960s, the Colombian Ministry of Health established a small section of mental health that, for decades, was staffed by one or two individuals. Only since 2004 has the Ministry expanded mental health to division status, focusing on diagnosis and design of services. However, the Ministry has encountered barriers to the provision and implementation of mental health services due to competing priorities.

During the 1990s, developments in Colombia coincided with hemispheric shifts in healthcare delivery. The 1990 Declaration of Caracas paved the way for adoption of the primary healthcare model promoted by the World Health Organization (WHO). In 1991, the WHO released its 25 Principles for the Protection of Persons with Mental Illness (United Nations General Assembly, 1991). In the same year, Colombia redrafted the

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national Constitution and mental health issues were subsumed under provisions for persons with disabilities. Law 100 reconfigured the social security system to provide national healthcare coverage in a manner more favourable to mental healthcare delivery. Moreover, a 1992 resolution specified the rights of persons with mental illness and these were amplified in the national health policy of 1995. Despite the progressive language, the legislation was not matched by sufficient funding and much of the public health infrastructure collapsed.

A national mental health policy promulgated in 1998 expanded the purview beyond the traditional focus on mental illness. Operating within the context of social security reform, the policy encompassed prevention, screening and mental health services. Additionally, it focused on improved access, coverage and quality of services, while strengthening the network of service providers. Once again, meagre funding for this initiative curtailed its diffusion.

Colombia's 2003 national mental health survey was conducted as a collaboration between the Colombian Ministry of Health, the WHO and Harvard University (Posada *et al*, 2004; Ministerio de la Protección Social, 2005). The survey provided an epidemiological profile (including prevalence estimates for common mental disorders) and explored the interconnections among mental health indicators, socioeconomic status, physical health, social environment and measures of vulnerability. National survey results were cited when transforming the national mental health policy into guidance for action. The resulting document asserted that national mental health policy should focus on decreasing the burden of mental health conditions in the population and the concomitant consequences for social development (Ministerio de la Protección Social, 2009). The strategy document recommended strengthening the capacities of the state and the provider institutions to deal with the challenges of mental health service delivery within the structure of the national health system. As an offshoot, in 2004, the Ministry of Health developed a planning guide for use by local health departments for integrating mental health into their operations. The Colombian Psychiatric Association drafted a proposal for restructuring the mental health system and conducting systematic research in 2006.

Mental healthcare services

Synergisms between the judicial and health systems have greatly accelerated the process for mental health intervention in recent years. From a patients' rights perspective, the Obligatory Plan of Health, released in 2011, specifies that the national health system must provide each patient with 30 individual or group psychotherapy sessions, regardless of the patient's stage of illness, and unlimited sessions for victims of armed conflict.

Electroconvulsive therapy (ECT) is an accepted treatment modality but may be prescribed only

if psychopharmacological and psychotherapeutic treatments are ineffective.

Regarding in-patient care, in academic settings the average length of stay is 12 days, while in state institutions the average stay is 30 days. Institutionalisation is the rare exception; most patients with chronic and persistent mental illness live with their families and are cared for within the community. Admissions to mental health facilities require the signed consent of the patient, a family member, a guardian or a designated employee of the judicial system, depending upon the situation (compulsory, judicial or emergency admission).

Female victims of physical, sexual or emotional abuse have the right to access psychological or psychiatric services and to be hospitalised when necessary in accordance with medical criteria. Psychiatric emergency services must be available and include a minimum 24-hour mandatory observation period for persons who are deemed to pose a risk of harm to self or others. In this case, the patient has the right to be hospitalised for a maximum of 90 days.

Mental health and addictions are considered in tandem. Definitions of common mental disorders include addictions. Institutions are equipped to treat persons with addictions and dual diagnoses. The Ministry of Health released a national policy for decreasing drug demand and drug misuse in 2007, in response to observed patterns of increasing illicit drug use. In 2011, the National Observatory on Mental Health was created at Universidad CES to conduct systematic surveillance of national patterns of mental disorders and substance use. In 2014, the Ministries of Health and Justice combined forces to launch the Colombian National Drug Observatory. Data generated from research conducted by these observatories are intended to provide informational support for mental health and drug policy decisions.

The intersection of mental health law and population exposure to violence: Law 1448 (Victims and Land Restitution)

Mental health law in Colombia is related to the context of population-wide exposure to trauma and loss stemming from 60 years of armed insurgency, high rates of homicide (Pan American Health Organization, 2012), pervasive gender-based violence (Pan American Health Organization & Centers for Disease Control and Prevention, 2013) and community violence associated with drug trafficking, gang activities and criminal bands ('BACRIM') (Médecins Sans Frontières, 2006, 2010; Pan American Health Organization, 2012; Pan American Health Organization & Centers for Disease Control and Prevention, 2013; Shultz *et al*, 2014a,b).

The landmark Law 1448, 'The Law of the Victims and Land Restitution', was enacted in 2011 to provide comprehensive support for 'victims of armed conflict' (Ministry of Justice and Law, 2012). Victims who are eligible for services include those who have been affected by combat,

terrorist acts, improvised explosive devices, landmines, massacres, homicides, kidnapping, forced disappearance, assaults, gender-based violence, torture and internal displacement (Acción Social, 2011). Globally, Colombia consistently ranks first or second in numbers of internally displaced persons (Shultz *et al.*, 2014a,b). Moreover, Colombia has the highest tally of victims of kidnapping (Centro Nacional de Memoria Histórica & Cifras y Conceptos, 2013).

Law 1448 is not mental health legislation *per se* but includes provisions for psychotherapies and both ambulatory and in-patient treatment. Health promotion and prevention programmes must dedicate 10% of their budgets to mental health. The Law creates a protocol for comprehensive healthcare based on a psychosocial approach that assesses the needs of the victim in relation to the victimising event and the consequences for the victim population. The Ministry of Health serves as the administrative home, but service delivery occurs at the municipal level. A special victims administrative unit, operationalised under the name PAPSIVI (Programa de Atención Psicosocial y Salud Integral a las Víctimas del Conflicto Armado), oversees the coordination of medical, mental health, social and legal services. The psychosocial care 'pathway' includes active outreach to victims, creation of a psychosocial profile, development of a care plan, provision of care, referrals for specialty medical and psychological/psychiatric care as needed, and ongoing client surveillance. Multidisciplinary mobile outreach teams are used to deliver the PAPSIVI services to the households of victims.

Mental health is a right in Colombia

Law 1616, enacted 21 January 2013, establishes mental health as a fundamental right. The Colombian state is charged with ensuring the promotion of mental health and the prevention of mental illness; and providing for the diagnosis, treatment and rehabilitation of mental disorders. Law 1616 and Resolution 5521, enacted 29 December 2013, specify the state's responsibilities to promote mental health and prevent the occurrence of mental disorders through interventions that mitigate risk factors for psychopathology. Emphasis is placed on the early detection of psychological risk and protective factors, and actions that positively influence mental health.

Concluding comments

Colombia's mental health laws and policies have become increasingly comprehensive over recent decades. As happens worldwide, in practice, the finely crafted language of the laws does not guarantee that the intended outcomes are rapidly and equitably realised. However, to address the pervasive population-wide exposure to trauma, loss and violence, Colombian mental health laws have been generating far-reaching and innovative programmes. Grounded on science and evidence-based clinical practice, and scrupulously

evaluated, the results of Colombia's approach of converting mental health policy into practice (such as PAPSIVI) will be well documented.

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