

Mental health in Colombia

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A hallmark of Colombia is population-wide exposure to violence. To understand the realities of mental health in Colombia requires attention to the historical context of 60 years of unrelenting armed conflict overlaid upon high rates of homicide, gang activity and prevalent gender-based and intra-familial violence. The number of patients affected by trauma is extremely large, and the population burden of alcohol misuse and illicit drug use is significant. These patterns have brought the subspecialties of trauma and addiction psychiatry to the forefront, and highlight the need for novel treatments that integrate psychotherapeutic and psychopharmacological modalities.

Colombia: sociodemographic profile

The Republic of Colombia occupies the north-west corner of the South American continent, bordered by Venezuela, Brazil, Peru and Ecuador. Colombia's remarkable ecological diversity includes three ranges of towering Andes mountains, the expansive Eastern Plains, the large Amazonian basin, and extended coastlines along the Caribbean Sea and the northern Pacific Ocean, separated by the isthmus of Panama. The three largest cities, Bogotá (the nation's capital), Medellín and Cali, are situated along the Eastern, Central and Western Andes ranges, respectively. Colombia's 45.8 million citizens (51.4% women, 75% urban, 80% Catholic religion, 93.6% literacy, 9.2% unemployed) are distributed among the nation's 32 'departments'. While Spanish is the predominant language and most citizens are of Spanish or Spanish and 'mixed race' origin, there are remnants of indigenous cultures (64 native American languages are spoken) and of Afro-Colombian populations.

In 2013, Colombia's gross domestic product (GDP) of \$526 billion put the country 29th in the world. In 2012, Colombia ranked 91 among 187 countries on the Human Development Index, with a designation of 'high human development'. Citizens are categorised into six socioeconomic 'strata'. However, Colombia is among the nations in the western hemisphere with the greatest socioeconomic disparities (Gini index of 55.9) and corresponding inequalities in access to essential services, including healthcare.

Epidemiology of mental disorders

The epidemiological profile of mental health derives from several nationally representative surveys. The most recent, the 2003 National Survey of Mental Health in Colombia (Posada-Villa *et al*, 2004), indicated that two in five Colombian citizens

(40.1% of respondents) met DSM-IV criteria for 'any mental disorder' at some point in their life. Past-year prevalence was 16.0% and past-month prevalence was 7.4%. Lifetime prevalence rates were 19.3% for anxiety disorder (women, 21.8%; men, 16.0%), 15.0% for affective disorder (women, 17.5%; men, 11.7%), and 10.6% for substance misuse disorder (women, 2.6%; men, 20.8%). Consistent with the gender disparities observed for lifetime prevalence rates, major depression was the most common psychiatric diagnosis for women and alcohol misuse was the most common problem for men. Survey results confirmed the early onset of mental disorders and, coupled with the chronicity of these diagnoses, findings suggest that many Colombians suffer from mental disorders lifelong. The 2003 profile revealed that only one in ten persons with a diagnosed mental disorder was receiving care, highlighting challenges for access and utilisation of mental health services.

Distinguishing features of mental health needs in Colombia

Armed insurgency

Colombia has experienced one of the most protracted internal armed conflicts in the world, dating from bipartisan political violence in the 1940s that led to the rise of leftist guerrillas in the 1950s. Both guerrilla and right-wing paramilitary forces, fuelled by income from drug trafficking, have carried out massacres and targeted assassinations that have triggered forced migration. Armed groups have engaged in kidnapping (39000 victims with extortion between 1970 and 2010), forced recruitment of youth and gender-based violence. Government figures estimate the casualty toll at 220000 conflict-associated deaths between 1958 and 2012, of which 81.5% were civilian (non-combatant) deaths.

The recent bilateral peace negotiations between the Colombian government and the largest guerrilla faction have shifted the nation into a 'partial post-conflict' phase and initiated the process of social reconciliation. The three main parties involved are victims of armed conflict, ex-combatants and the civilian population. Issues of relevance to mental health include: citizen security; demobilisation and reintegration of members of armed groups; and property restitution for internally displaced persons (IDPs). Even as the process evolves, clashes continue unabated between the Colombian military and armed outlaw groups (guerrilla, narco-paramilitary, criminal bands).

Following the passage of the Victims' Law in 2011, the Colombian government has created economic, legal, public health, medical, psychosocial

and mental health programmes for millions of persons officially designated as 'victims of armed conflict', an umbrella term that includes citizens affected by death, destruction, dispossession of lands, disappearance and displacement – all the casualties of the prolonged war.

Internal displacement

Among the categories of 'victims of armed conflict', Colombia has the largest population of conflict-affected IDPs in the world (Shultz *et al*, 2014a,b). Estimated at 5.7 million in 2013, Colombia's IDP population accounts for 19% of the worldwide total and 95% of IDPs in the entire western hemisphere. Nationally, one in eight Colombian residents are currently IDPs. Most displacement is 'rural to urban' and, once displaced, most Colombian IDPs are displaced for life. Throughout the trajectory of displacement – the phases of initial threat, forced expulsion, migration, early transition and long-term resettlement – IDPs face the stressors of physical and economic survival in unfamiliar places and vulnerable circumstances. These exposures elevate risks for common mental disorders (depression, anxiety, post-traumatic stress) as well as somatic complaints and substance misuse.

Conflict-related versus non-conflict-related violence

Studies have begun to examine the mental health impacts of violence in Colombia. Bell *et al* (2012) differentiated exposures to conflict-related and non-conflict-related violence, and found higher rates of anxiety disorders in the former and higher rates of substance misuse and aggression in the latter. However, it is not always possible to isolate the conflict and non-conflict effects; for example, conflict-displaced persons may relocate to urban settings where they are newly endangered by gang violence in the community, their children are bullied in school, employment opportunities are restricted to the 'informal sector' and partner abuse takes place within the household.

Family-based and gender-based violence

Most violence suffered by women and girls occurs in the home at the hands of male household members and intimate partners. Nationwide, one in five women living with a partner reports physical abuse and one in ten reports sexual abuse. As another variation of gender-based violence, in armed conflict zones, young girls have been forcibly recruited or kidnapped by armed groups and forced to work as fighters, informants, guides, messengers and conjugal partners to the group leaders, or sex slaves.

Substance misuse in the context of Colombia's role in international drug trafficking

From the supply side, Colombia is the primary cocaine source for drug markets worldwide. With recent crop diversification, the opium poppy is now cultivated and Colombia has rapidly become one of two primary source nations for heroin entering the USA.

From the demand side, the 2003 National Survey of Mental Health found that 10.6% of respondents met criteria for any substance use disorder (alcohol and drug use combined). Alcohol is the most common substance of misuse and drinking starts on average at age 14. The national lifetime prevalence rate of alcohol misuse, 6.7%, displays a pronounced gender disparity (one in ten men, one in 80 women). Survey data documented a significant association between substance misuse and the presence of depression and other psychiatric illnesses.

Psychiatric diagnosis, disability and suicide

An estimated 18% of persons with a psychiatric diagnosis qualify as having a disability. The lifetime prevalence of suicide attempt is 4.9% and the national suicide rate, 4.4 suicides/100 000 citizens in 2011, is one of the highest in the world – and rising in post-conflict populations.

Psychiatric training and services

Healthcare financing

Colombia's expenditures for healthcare, equivalent to 7.6% of the GDP, fund a two-tiered system that has attempted to achieve nearly universal coverage (Yepes Lujan, 2012). The contributory health insurance system for employers and their formally contracted employees covers healthcare provided by 22 'EPSs' (akin to health maintenance organisations) for 44% of the Colombian population. The remainder, including those who are poor or unemployed, receive 'subsidised' healthcare paid for by taxes and other deductions from workers' pay. There are gross disparities between the coverage and care provided within the two systems and Colombia's healthcare faces a grave crisis due to widespread corruption and regulatory failures (Yepes Lujan, 2012). A mechanism has been put in place to allow persons to sue for delivery of proper medical care but, in practice, this is crippling the system.

Mental health needs and care access

The number of psychiatric beds has decreased over the past decade, leading to overcrowding. About 75% of psychiatric beds are in public hospitals. In contrast, the military facilities are well equipped; however, many soldiers with post-traumatic stress disorder (PTSD) go untreated following their discharge and return to their rural communities.

Mental health workforce

About 900 psychiatrists (including 45 child psychiatrists) and 1500 psychologists are tasked with delivering mental healthcare in specialty medical centres, general hospitals and psychiatric facilities. Ninety per cent of psychiatrists are concentrated within Colombia's ten largest cities. Specialisation in psychiatry requires a 3-year residency programme (residents pay for their tuition and receive no compensation) based in 11 medical schools nationwide; currently about 100 resident physicians are in training. Psychiatric

training focuses on psychodynamic therapies and pharmacotherapy, with the recent addition of training in cognitive-behavioural and systemic therapies.

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International employment schemes for people with mental health problems

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It has been recognised that work is a positive factor for mental health since the days of Galen (2nd century CE). It was central to the theories and practice of William Tuke at the Retreat in York (founded 1796) and has continued in different forms as a therapy and/or a form of rehabilitation ever since. These forms can be usefully divided into four main categories: sheltered work, vocational training, transitional employment (or work experience) and supported employment. These broad categories have been adapted to different cultures and economic circumstances across the world. There are advantages and disadvantages to all forms, but the burgeoning research literature of the past 20 years does show that when it comes to finding people paid work in the open labour market, supported employment is markedly more successful than other methods.

The four main categories of employment schemes – sheltered work, vocational training, transitional employment (or work experience) and supported employment – have been adapted to different cultures and economic circumstances across the world, though if such schemes exist in low- and middle-income countries they tend not to appear in the literature. Paid employment is not always prioritised but increasingly this is what service users say they aspire to and in this article 'employment' is taken to mean work which is paid at the going rate for the job. Therefore, the extent to which these models lead to paid employment is considered a primary outcome. There are advantages and disadvantages to all forms – none is the complete answer for everyone who wants a job, but the burgeoning research literature of the past 20 years does show that when it comes to finding people paid work in the open labour market, supported employment is

markedly more successful than other methods. For the purposes of this brief article I have excluded discussion of volunteering – an important and valued activity in its own right but not necessarily a methodology for employment integration.

Sheltered work

Sheltered work – work in specially constructed protected environments – is slowly (and painfully) disappearing from modern mental health services across the world, along with other forms of institutional care. The reasons for this decline are manifold: the changing aspirations of mental health service users; poor-quality, repetitive work often with little or no pay; segregation from the workaday world; very low rates of transition to the open labour market; and cost. The end of sheltered workshops is painful because, as with other institutions, those who work in them (including the staff) become dependent on them. Thus, decisions are postponed until the work dries up and the costs become so huge that they are completely unsustainable.

Newer forms of sheltered work – social firms, social cooperatives – have minimised many of the disadvantages of the sheltered workshop. Beginning with the social integration (type B) cooperatives (Thomas, 2004) formed at the time of the reforms inspired by Franco Basaglia in Italy in the 1970s, large numbers of small and medium-sized enterprises whose main aim is to create employment for people with disabilities and those who are disadvantaged have sprung up across Europe, North America (where they are called 'affirmative enterprises') and elsewhere (Warner & Mandiberg, 2006). Ideally, these enterprises compete for business with other firms in the open market, pay workers the rate for the job, provide good working conditions and achieve high levels of worker participation. They are popular in places