



Mental Health, Public Policies and Primary Health Care in Colombia

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Abstract

In recent years it has become apparent emphasis promoted by the Pan American Health Organization-PAHO / WHO-mental health, trying to transcend disease and policy development in this line. This article discusses the progress made since the national level, in order to take responsibility of the State through the delivery of public policies for vulnerable groups or as life cycle, some with the intention of intersectoral, trying to make it possible to guarantee rights contribute directly or indirectly to mental health. Advances in policy, due to the weakness in the implementation of these at times, lack of assessment or other fragmentation and difficulty intersectoral linkages, unfortunately do not get the best results.

Key words: Mental health; Public policy; Primary health care; Health; Colombia

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INTRODUCTION

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policy development in this line. This article discusses the progress made since the national level, in order to take responsibility of the State through the delivery of public policies for vulnerable groups or as life cycle, some with the intention of intersectoral, trying to make it possible to guarantee rights contribute directly or indirectly to mental health. Advances in policy, due to the weakness in the implementation of these at times, lack of assessment or other fragmentation and difficulty intersectoral linkages, unfortunately do not get the best results.

MENTAL HEALTH, PUBLIC POLICIES AND PRIMARY HEALTH CARE IN COLOMBIA

The health system reform in Colombia is associated to constitutional elements and has a global nature since it implies deep modifications in sanitary legislation, intersector consequences, substantial change of relations between services providers and users of services and is facing the appearance of new stakeholders (Infante, De la Mata & López-Acuña, 2000). Thus, most of the first years are invested in adaptations and adjustments, which are essential for mental health due to the limitation of resources it implies, particularly due to the reduction of Benefit Plans in this area and the closing of some institutions that are not able to respond to the economic requirements of the model.

Subsequently, Law 790 from 2002, in article 5, orders the “(...) merge of the Ministry of Work and Social Security and the Ministry of Health” (Colombian Congress, 2002, p.2) comprising the Ministry of Social Protection, thus generating new frameworks for the health sector. Other modifications to the SGSS are set forth in Law 1122 from 2007 in terms of “(...) direction, universalization, financing, balance among system stakeholders, rationalization and improvement of health

service provision, strengthening the public health programs and the functions of inspection, surveillance and control and the organization and operation of networks for health service provision". (Colombian Congress, 2007)

During this period, an emphasis on mental health promoted by the Pan American Health Organization -PAHO/WHO- was evident, in an attempt to transcend the disease and create policies in this line. Progress has been observed in the national environment, seeking to assume the State responsibility through the promulgation of public policies for vulnerable groups or based on the life cycle, some were intended for inter-sectoriality, attempting to make it possible to guarantee rights that contribute directly or indirectly to mental health. It is necessary to point out that progress in the design of policies unfortunately does not obtain the best results sometimes due to weakness in their implementation, some other times due to lack of evaluation or fragmentation and difficulty for intersector linkage.

In 1998, the National Policy of Mental Health was promulgated under Resolution 02358, which is currently enforceable. This policy integrates conditioning factors of biological, environmental, behavioral, social, political, economic, cultural and health-level nature, measured by the structure of specific morbidity, mortality and disability per age group and gender, adjusted to prioritization criteria such as the magnitude, vulnerability and transcendence of the different phenomena that determine the health status of the population.

The objectives of this National Policy are: To promote mental health and prevent the appearance of mental disease; to control mental diseases; to foster the culture of mental health; to improve the access, coverage and quality of mental health care in all its phases. Specifically, it proposes to redirect and improve the quality of mental health service provision in the context of the General Social Security System for Health (SGSSS), encourage processes of basic and applied research on mental health and strengthen the network of institutions and service offer.

In order to develop these objectives, it proposes to work jointly in the component of surveillance in public health and epidemiological research on four fundamental aspects: psychosocial and behavioral factors that influence health and the development of the population; promotion of mental health and prevention of psychiatric diseases; control of psychiatric disorders, stimulating the related legislative initiatives and supporting training of human resource; and evaluation of mental health programs and services. Unfortunately, scarce dissemination and continuous changes caused by the adoption of the SGSSS did not make possible its full implementation.

From 2003 to 2004 the Ministry of Social Protection, supported by the National Council of Social Security for Health, by means of cooperation agreements with

the WHO, Harvard University and the FES-Social Foundation, developed the Third National Study of Mental Health, which also allowed to delimit an epidemiological panorama, establish relationships among mental health, socio-economic conditions, general health condition, social environment and degree of vulnerability. After this diagnosis, the aim is to redesign the National Policy of Mental Health from 1998, building the "Guidelines of Mental Health Policy for Colombia".

Such guidelines set as objective to suggest the contents for this redesign, recommendations for adequate incorporation of mental health into the SGSSS and design the methodology to establish costs of care for priority events in mental health. The target population identified by the document is made up firstly by people with mental disorders, followed by people with psychosocial problems and finally by the general population.

Such guidelines were intended to promote mental health, prevent negative impacts on psychosocial problems and reduce the negative impact of mental disorders. For this purpose, the guiding principles of continuity, functional integration, respect for differences, promotion and protection of human rights were followed, as well as the participation of patients, families and communities. The prioritized lines of action were: organization of mental health services, service provision, social inclusion, human resources, supervision of mental health events and services, research in priority mental health matters. Finally, the guidelines presented a series of strategies focused on the development of models to manage basic health services in mental health, applicable in every municipality of the country; integration of activities, procedures and basic interventions in the first and second level of complexity; strengthening of institutions that provide mental health services in the third and fourth level of complexity; strengthening of informal health services, and those offered by private non-profit institutions; and strengthening of links among mental health services from different levels.

In the same year, Regulation Letter number 0018 from 2004 was issued as a response to the indication of carrying out diagnosis and territorial plans of mental health, the Ministry published the Guide for Planning the Mental Health Component in the Territorial Plans of Health (Ministry of Social Protection, 2005), where different approaches were presented for mental health, development and planning concepts. Similarly, a review was made on primary health care (PHC) and the standards related to mental health, and finally, the methodological guide was presented from a pedagogical view of learning by doing. This instrument supported the making of local and municipal diagnoses in different places of the country (Ministry of Social Protection, 2004).

In 2006, the Colombian Association of Psychiatry -ACP- structured a proposal of the National Policy

of the Mental Health Field by means of an agreement with the Ministry of Social Protection. This proposal considers mental health -from its conceptual framework- as a transforming engine that boosts and contributes to the development, enforcement and guarantee of rights, contributes to solving the country's problems (armed conflict and its effects, disasters, extreme poverty, etc.), mitigates suffering derived from the vicissitudes of everyday life and specific situations (disability, deterioration of social conditions, etc.) and makes it possible to treat disorders. For this policy, mental health represents a collective and individual good of symbolic, emotional and rational nature, and thus, a social and individual desire that contributes to human development, generates global capital comprised by social, cultural, symbolic and economic capitals, and makes it possible to acknowledge, guarantee, enforce and restore rights. Thus, mental health is a dynamic and multidimensional / determined and determining construction. It is also an end, a means and a product: an end as an available *good*; a means for individual and collective development, the increment of capital and the enforcement of rights; and a product of its contribution to develop, increase and guarantee (Ministry of Social Protection and ACP, 2007).

It proposed the objective of fostering mental health and its transforming capacity combining actions that guaranteed compliance with rights from multiple places, impacted symbolic capital, fostered more equitable and including relationships, lessened suffering, restored emotional wellbeing and allowed Colombians to increase their global capital and enjoy a better life within the framework of development.

This proposal presented for discussion and agreements does not achieve its purpose despite its efforts to specify the problem and options to intervene in mental health, since the health standards refer only to specific matters related to it, mainly problems such as consumption of psychoactive substances, violence, depression, anxiety disorder, hyperactivity with attention deficit, suicide and suicide attempt, as well as, the comprehensiveness of the Mandatory Health Plan (POS in Spanish), care of psychiatric emergencies and procedures in service levels, defining actors, financing sources and competences in mental health in the SGSSS (Regulation Letter number 0018 from 2004, Law 1122 from 2006, Decree 3039 from 2007, Resolution 0425 from 2008, Agreement 008 from the Regulatory Health Commission –CRES-).

It is important to highlight that since 2001 developments have been achieved and the Inter-institutional Committee for Study and Prevention of Suicidal Behavior, The District Committee of Mental Health, the Committee of Good Treatment Networks and Disability Committees have strengthened participation and local spaces in the making and development of the Guidelines of the District Policy of Mental Health (2002).

Additionally, long ago the consumption of psychoactive substances became a phenomenon of great interest in the health sector. Thus, Annex No. 1 of Resolution 02358, adopting the aforementioned Policy of Mental Health, deals with the Strategy of Reducing the Risk of Psychoactive-Substance Consumption. In the same line, **technical, scientific and administrative standards for the operation of care, treatment and rehabilitation center (Resolutions 196 from 2002, 4750 from 2005, 1043 and 1315 from 2006)**, and in 2007 the Ministry of Social Protection -with the involvement of the National Commission of Drug Demand- introduces the National Policy to Reduce Psychoactive-Substance Consumption and its Impact, approved by the National Council of Narcotics. The National Plan of Drug Consumption Reduction is structured based on Resolution 014 from 2008 by such Council, which creates the technical inter-institutional commissions to design a comprehensive national anti-drug policy.

Forced displacement is another problem identified in the National Policy from 1998, considering its impact on mental health; however, different reasons, including some administrative reasons that establish the dependency of interventions in offices other than mental health offices, generate initiatives that cannot always be coordinated. In this sense, conceptual debates related to the multiple approaches and uses of the psychosocial term have originated (International Organization for Migration -IOM- and Javeriana University -PUJ- 2002), including the opposite stances considered and explained by Naranjo and others (2003): One is a psychotherapeutic stance associated to tragedy, trauma, victims and individual care, the other is a social-community stance associated to crisis, resilience, social stakeholders, care from social networks. Something similar can be indicated for mental health care in disaster situations.

Having said that, in 2006, by means of Law 1098, the Code of Childhood and Adolescence is introduced, identifying specific needs not only by life cycle, but aiming at the defense of the rights of this vulnerable group, and Law 1146 from 2007, issuing standards to prevent sexual violence and promote integral care of abused male and female children and adolescents and creating the Inter-institutional Advisory Committee of Care for Sexually-Abused Male and Female Children and Adolescents.

To this regard, the developments of the District Health Secretariat and its translation into the policy document and other supplements thereof account mainly for what occurs in the national sphere; at the beginning of the appropriation exercise during the design of the mental health policy guidelines for Bogotá from 2001 to 2004, the documents resulting from epidemiological, administrative, PHC and community psychiatry epistemes, together with discourses that praised the social movement for health as

the most suitable strategy to implement such policy, as well as, the systemic-constructive-constructionist postures (Urrego, 2002).

Subsequently, from 2004 to 2005, at the same time of a change in political tendencies of the district government, discourses of the Latin American Movement for Collective Health, the perspective of health as a right and equity in health were massively introduced, while keeping PHC as the milestone, and the approach of Social Determinants of Health was introduced (Urrego, 2010).

After 2005, the promotional approach of quality of life and health allowed mixing the perspective of human rights and a cross-sector orientation focused on meeting social needs based on universality, comprehensiveness and equity in sanitary action, deployed in different environments of the human flow. In this sense, the PHC Plan was rearranged for the Capital District (previously structured by programs, then by life cycle and intervention lines that responded to the main problems of public health), achieving the interrelation of actions to favor the development of values: autonomy, equity, democracy, environmental sustainability, acknowledgment of ethnic and cultural diversity and the construction of new social representations around mental health (Health Secretariat, 2011).

As far as the PHC Plan is concerned, an analysis of events occurred from 2002 to 2003 shows that it is carried out by Social State Companies -ESE- of first and second level in the twenty (20) city districts, by professionals who execute promotion and prevention actions in the community space, framed in skills for life, fostering resilience, community mental health and strengthening of family and social networks (Rúa, 2003).

In 2005, by means of Agreement 144, the Mental Health System is established in the Capital District comprised by: (...) *the set of public and private institutions and support social networks that include, among others, social State companies, Health Care Provider Institutions (IPS), non-profit organizations, representatives of the organized community and universities who perform control and supervision of diverse expressions of violence, stress and mental health, consumption of psychoactive substances, suicide, affective disorders and anxiety disorders, etc.; in order to determine public policies, plans, programs and projects intended for the prevention, health promotion, care, enabling, rehabilitation, education, mental health guidance in the Capital District (...)*

Together with progress in the conceptualization of mental health processes, the District Secretariat presents the summary document of the District Policy of Mental Health (2005), which is later reflected in the Bogotá Positiva Development Plan: Para Vivir Mejor (For a Better Living), 2008 - 2012 and the Plan de Salud Distrito Capital (Capital District Health Plan) 2008 –

2011 (Agreement 308 from 2008), “political attempt for transforming processes related to quality of life and health of Bogotá citizens” (SDS, sf), and it is today registered in the Public Health Directorate; guidelines that are essential for the Policy and relations with the remaining policies: adulthood, childhood, youth, old age, health for ethnic groups, gender, for LGTB people, food and nutrition safety, environment health, workers’ health, health for people in displacement situation, people with disabilities, etc. Special reference is made to the policy on sexuality, since after performing a closer analysis between the “sexuality without indifference” policy and the District Policy of Mental Health, the articulating milestone for enforcing rights and achieving equity conditions for all is found in the promotion of autonomous enforcement, understood as the enforcement of freedom in terms of the decisions made in the framework of their desires and needs.

From this postulate, the promotion of autonomy in individuals and collectives generates subsequent knowledge and actions that allow them to take care of themselves and the community, allow social participation and, progressively, the reduction of conditions of discrimination, risk, coercion and violence, among others. Similarly, these policies promote actions from community, sector and cross-sector levels that allow linking of all the relevant stakeholders who belong to both the District and the general society and assume an active role in benefiting the population.

Particularly, in the action lines of the District Policy of Mental Health and the “sexuality without indifference” policy, we can find common initiatives in education and training, social participation, linkage of social networks and promoters of quality of life, health and epidemiological surveillance; in such a way that it is possible to identify, prevent and address problems in comprehensive manner and evidence a positive impact on the population, specifically on population targets set by the policy given the epidemiological conditions.

Thus, it is essential to include mental health events in the strategies of dissemination and intervention led by the sexual and reproductive health programs and vice versa, jointly developing the process of identifying events associated to mental health such as situations of violence, family problems, decision-making on sexual life, or any violation of rights or attempt against people’s integrity.

For this reason, the following are relevant because they are linked to mental health: Agreement 091 from 2003 by the Council of Bogotá **that establishes the plan of fair opportunities for gender equity in the Capital District**, Agreement 152 from 2005 related to the District Council for Integral Care of Victims, Agreement 137 from 2004 **of the District System of Integral Care for People with Disabilities in the Capital District**, Decree 470 from 2007 adopting the Public Policy on Disability for the

Capital District and Decree 170 from 2007, setting forth dispositions related to the execution of the Integral Care Plan for Citizens Living in the Streets.

It is important to highlight that interest in community matters has been constant. Although Ardila (2009) made research about this concept and its application to the 2006-2007 period, he did not find any definitions or classifications in the reference documents that mentioned it; he states this might have caused the risk of turning it into a implied concept that may be interpreted from the logic of the health system, that is, management of wellbeing or disease by individuals. He also states that it might have become a focusing strategy and community matters in mental health are going to be associated with primary prevention and the first level of care, excluding the remaining levels from any intervention in this line. Subsequent facts are evidenced in documents derived from the policy, made it possible to guide community work, highlighting it as one of the fields of intervention.

It is thus worth mentioning here, in opposition to Ardila's findings, important aspects of structural development of the PHC strategy by the Public Health Secretariat since 2005, with community involvement. In this year, within a social context of unemployment, informal employment, poverty, health inequalities, low-response capacity of the system, access barriers, chronic, infectious diseases and deaths caused by avoidable reasons, in particular, in the maternal and child population, in addition to the lack of knowledge and lack of information and participation of the population, and due to the "International evidence suggesting that health systems organized based on strong PHC orientation reach better and more equitable health results, are more efficient and have lower care costs, and achieve greater user satisfaction compared to that of systems with weak PHC orientation, where reorientation of Health Systems with a PHC approach demands readjusting the health services towards promotion and prevention -an adjustment that has to be accomplished by assigning appropriate duties to each government level; integrating public health and personal care services; developing a focus on families and communities; and creating an institutional framework that encourages the improvement of service quality" (OPS, 2005)- the District Health Secretariat planned and started the development of public policy seeking to guarantee the right to health, supported on the promotional approach of quality of life and health and Primary Health Care (PHC). (SDS, 2005)

The adoption of this PHC strategy, based on the comprehensiveness of care and people's needs, understood as a way to organize health services at the different levels, articulating individual and collective actions that respond to the needs of the population, was in line with and emphasized social equity, the shared responsibility of the population, public and private sectors, solidarity

and social involvement and a wide concept of health. Additionally, it aimed at articulating the health sector efforts into other social sectors (education, integration secretariat, etc.), so that interventions developed with and for the community; it responded comprehensively to the population's problems and needs and managed to face the social determinants of inequality in health.

The developments achieved by the PHC on the impact of the social determinants of health in the local scenario allow being able to reach the creation of the PHC Complex, understood as set of processes, resources and requirements institutionally incorporated, so that they foster the linkage of all the social interventions developed with individuals and collectives. For this purpose, it would be located in each city district under the responsibility of Social State Companies of first level of care and it would operate through three entry doors, namely, everyday life spheres, Health at Home and health services, which would permanently coordinate with one another, the community and the user. The latter play a predominant role in the enforcement of autonomy and active participation to identify, resolve and follow collective needs (SDS, 2005).

Before this strategy became operational, difficulties were found -despite the increase in the health insurance of the population (Subsidized and Contributing Regimes)- given the separation of administration and service provision duties, with differential benefit plans and provided by different stakeholders in the health system, which generated conflict-of-interest situations, and its result not always favored the access to care, thus deteriorating the status of health and quality of life of the population. The geographic distribution of the health service offer responded to the preferences of providers more than to the population's needs of care, a situation that created barriers for the poorest to access services, despite its increase. In addition, most of the health service institutions were located at the north and center side of the city. During this time, the public hospital network was comprised by 22 Social State Companies (ESE), organized by levels of technological complexity; five were in the third level of care, seven in the second level of care and ten in the first level of care. The latter was made up by Immediate Medical Care Centers (CAMI), Primary Care Units (UPA) and Basic Care Units (UBA).

Additionally, there were some problems in the internal dynamics among those who insured and provided health services such as difficulty to authorize more complex or complementary services; request of a great number of administrative procedures and delays in service; lack of information that caused dropping the service request and stopping the controls established by health promotion and disease-prevention programs; lack of knowledge by professionals about the history of users, use of different concepts and treatments, causing distrust and abandonment of the service demand, and thus

deterioration of health; and, in general, lack of knowledge by the health staff about the role of the individual, the family and the community to identify and solve problems; in addition to the persistence of disinformation and negligence that contributed to inadequate practices to face the disease.

Facing this situation, the District Health Secretariat decides to implement the **Primary Health Care** strategy understood as a set of actions carried out to promote everyone's health and prevent and control disease by means of better distribution of resources and available means, based on the Renewed PHC, which understands values as social principles, goals or standards kept or accepted by an individual, class or society (OPS, 2005). These values are essential to fix and evaluate whether social plans meet the needs and expectation of the population. The District Policy of Health and its promotional approach on quality of life and health were to be constructed with the same values designed for the Renewed PHC: **Right to health, equity and solidarity**. (OPS, 2005)

The Secretariat adopted the principles internationally defined and related to sanitary service for the development and evaluation of this strategy: **Accessibility** or making the service easier when the population requires it. **Comprehensiveness** or articulating educational, communication, protection, promotion, disease-prevention, care and rehabilitation interventions. **Continuity** or monitoring of care processes throughout time, in networks of available sector and social services. **Verticality or link**, which is the continuation in time of the relation among people, care teams and health services. **Social participation**, by means of which the community, social organizations and other institutions contribute to the identification and intervention of the health situation, either in planning processes or the promotion and consolidation of health protecting factors.

Speaking of progress of its implementation, it originates with Health at Home, as a first phase, in vulnerable territories: population in stratum 1 and 2 and in precarious social and environmental conditions. 1,200 families associated with a family and community¹ health team, in charge of identifying -together with the population- their needs and problems, planning, executing and evaluating the interventions and monitoring the changes in the life and health conditions of the population and territory.

The second phase starts on 2006, through the creation of the "**Primary Health Care Complex**", understood as the set of processes, resources and requirements institutionally incorporated that foster the linkage of all the social interventions developed with individuals

and collectives to improve their health conditions. It is located in each of the districts of the city, under the responsibility of the Social State Companies (ESE) of first and second level of care, responsible for the first level, since they are the representatives of the health sector at the districts.

The PHC Complex is visible to the community and user by means of its entry doors, namely:

- a) Everyday life environments (school, gardens, community dining rooms. Community),
- b) Health at home (vulnerable territories),
- c) Health services (ESES I-II-III level and private IPS).

The entire set of interventions made in articulated manner by the institutions -that must address "the social" in a certain territory- was called "**Comprehensive Social Management**", which required the community participation.

The PHC interventions in the local sphere were based on the promotion of health and prevention of diseases (OPS, 2006), since their cost was low and good results were obtained, understanding that they granted power to communities and individuals to enforce greater control on health and they were essential to address the main social determinants of health.

The PHC development required articulating the individual and collective interventions and resources of the different stakeholders of the System and others from the social basis², which have made easier to comply with its principles: It improved accessibility since it helped the population to identify health problems, which are not treated on time due to lack of knowledge; reaching health services to households; increasing the service offer; extending service times; reducing administrative procedures (verification of rights, bills and admissions) and informing the population about their rights constantly. It improved Comprehensiveness, since response was given to the different problems that affect the health of the individual and their environment based on a specific need; it set unique, simple and clear mechanisms of reference among the different levels of health care and channeling and monitoring among fields, Health at Home, and health care points; it linked the needs found in the health sector to the social networks in order to integrate actions and resources for solving problems. It provided continuity as it constructed mechanisms that made the care flow possible, depending on the complexity or complementarity required until the problem could be solved successfully and it aimed at a longer association with the programs and interventions

¹ Teams comprised by physician, nurse, nursing assistant, health promoters, technical-environmental and nursing assistant, who depended on the ESE of first level of care.

² It includes the actions of the health sector and those from other sectors of the social basis: The District Secretariat of Social Integration, ICBF, Education Secretariat-SED, METROVIENDA, Caja de Vivienda Popular -CVP-, and other institutions and local stakeholders.

of the sector. It allowed Verticality or linking, since it fostered the close relation of the health staff and the population, which required mechanisms such as available medical history, either on line or in physical file, availability of queries for promotion and prevention programs, ongoing professionals to guarantee that citizens stayed active in the programs.

At district level the PHC development redirected the ruling role of the Secretariat by:

- Developing the Agreement with the Colombian Association of Integral Medicine Companies -ACEMI- seeking to improve the accessibility of health service for the insured population who inhabited vulnerable territories.
- Educating and training human talent of the Secretariat and the Social State Companies.
- Promoting comprehensiveness and complementarity among individual and collective services to guarantee equitable and efficient health care coverage, in particular for highly vulnerable groups.
- Coordinating and defining the intervention paths among the sectors of the social basis, as a result of the construction of the cross-sectoriality process.
- Promoting basic universal social protection that has generated the reduction of inequality in the access to necessary, efficient and quality services.
- Encouraging and strengthening social participation processes that make possible informed community decisions, organized social response and improvement of life conditions.

Speaking of participation, a right for all, it was supported and acknowledged as a principle of the PHC Strategy. It was set as a responsibility for the citizens and social organizations since it allows them to understand and reflect on social needs, take part in the decisions that affect them, promote the strengthening of the social organization, and finally, achieve a social movement to demand the right to health, reaching commitments with the communities and the State beyond particular interests, thus understanding that people's quality of life, or dignified living conditions, also depend on the how health is understood as a right and how stakeholders are involved. The generation of community organizations that sought to meet their needs of life-condition implied turning people into constructors and creators of change in their lives and the lives of others.

This active exercise of citizens could be developed by participating in health at the neighborhood, at the Zonal Planning Units (UPZ) in the district or the Capital District. It is necessary to mention that a way of making social involvement effective was to create or forming groups or organizations in charge of promoting the change-of-life conditions of close people or integrating the different spheres.

In order to consolidate institutional and community action in the PHC Complex, the following was identified and prioritized:

In the spheres: At the school sphere; the organization of **“managing groups”** mainly made up by students, teachers, directors of schools and psychologists, who would work in identifying the problems that were going to affect children and young people and in the proposals to solve them. At the community sphere: Health action and participation focus on the **“social groups or organizations”** interested in promoting the health of the neighborhoods it influences. At the institutional sphere, especially those providing health services: There are **“User Associations or Partnerships”** that work to improve service provision. In the territories of “Health at Home” the following was promoted: The creation of **“Management Cores”** made up by 20 or more people of the territory who were interested in working jointly to seek solutions to problems related to the environment, roads, community spaces, among others. For this purpose, informative sessions and community meetings were created, which led family and community health teams in each territory of Health at Home. At health institutions: There are traditional ways of participation such as the Committees of Community Participation in Health or **COPACOS, the User Associations and the Committees of Citizen Supervision.**

It is important to clarify that the COPACOS are spaces of agreement between the different social stakeholders and the State existing in each district. Its management is intended for linkage, strengthening and dynamization of community participation in relation to the promotion of health and health planning processes. In turn, the User Associations are groups of affiliates of Health Insurance Companies from the subsidized regime and the contributing regime and groups of non-affiliate poor population served by the ESE, who have the right to use the health services of public or private health service provider institutions, which associate in order to safeguard the service quality and defend health rights. The Supervision Committees are in charge of social control and monitoring the health investment of each district, and they are intended to contribute to the efficient making and execution of health projects. These committees are made up by citizens who freely express their will to do so.

At some UPZ of the Districts, there are intersector work tables, neighborhood improvement tables and community tables led by the community, where organization, participation and management are achieved. In these UPZ, they develop **“Community Analysis Units”** that seek to support the survey of health diagnosis, evidence hard-to-solve situations more strongly and involve the community and institutions in territorial planning.

While considering the district as a whole, the community or social organizations involved are highly skilled and knowledgeable about the strengths and

weaknesses of the district; there are many discussion, debate and agreement spaces fostered by the institutions, spaces that work around the local Mayor's Offices. For example, the **Local Council of Social Policy, the Local Planning Council, the Networks of Disability, Good Treatment, tables and committees** seek to solve social problems of the district comprehensively.

At District level, the proposal was to form -by means of an institutional call- **assemblies, meetings and forums of COPACOS User Associations, and managers from the school and Health at Home spheres**, in order to acquire political acknowledgment and position to be able to influence public policies and decisions that affect all citizens. From these spaces, the proposal is for problems of community interest to be defined with the shared involvement and commitment of the State and the community, since the latter is conceived as the guarantor of their rights.

As far as the public health sphere is concerned, the Collective Intervention Plan -PIC- shows substantial development; Figure 1 summarizes the actions considered in the policy and the location of mental health therein.

The following strengths of PIC interventions on mental health are identified: the creation of a District Committee of Mental Health, the operationalization of mental health committees in different ESEs of the city, the progressive increase of cases notified in events prioritized for public health in mental health, the dissemination of POS contents

and the PIC of mental health among different stakeholders in charge within Capital District, the positioning of Line 106 as effective network support for mental health in Capital District, and the development of action plans seeking to impact violence problems, suicidal behavior and psychoactive substance consumption in Capital District³

However, the following weaknesses of PIC interventions in mental health were also identified: Difficulties to articulate and establish coherence among different stakeholders, interventions and standards related to the topic, precarious work conditions for the responsible human talent with low labor stability, work overload of the human talent in charge, frequent work accidents and occupational diseases in the human resource in charge of PIC initiatives in mental health, which remained invisible, poor promotional activities for mental health, from a positive view, difficulties to achieve actual and efficient involvement of the communities in the different mental health processes of the Capital District, absence of applied research and systematization of experiences assigned to the ESEs, some social representations and imagery that prevailed in mental health at the Capital District made it difficult to work from the PIC, difficulties to obtain integral mental health care for cases detected in the PIC, deficit of every type of resources allocated effectively to the different PIC activities in mental health, and lack of evaluation based on performance indicators and impact on public health by the interventions performed.⁴

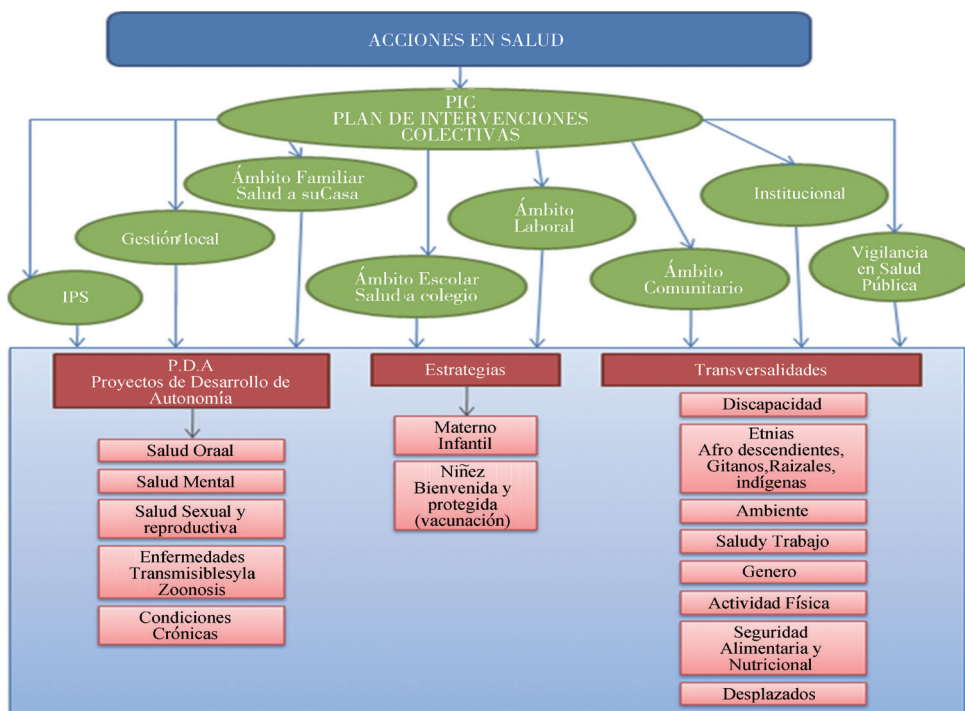


Figure 1
PIC Health Actions

Note. Source: Virtual Web Page of the District Health Secretariat

³ Evaluation of the Mandatory Health Plan of the Capital District performed in 2009.

⁴ Ibid.

Having said that, it is worth clarifying that in the framework of events occurred in the country since the implementation of Law 100 from 1993 and its subsequent modifications, which highly restricted the primary mental health care service, Bogotá had managed to keep throughout the years one of the most comprehensive welfare services in mental health in Colombia, protecting many of the achievements made, by means of strategies such as the design of integral mental health care packages through the network associated to the beneficiary population from the subsidized health regime and affiliate health regime. Particularly, some modifications to the standards that imply progress in provision for the rest of the country imply undermining the case of Bogotá; for example, children and adolescent care, services closed by transferring the payments to subsidized-EPS (Health Insurance Companies) since 2009, and Law 1438, in 2011 sets forth the unification of benefit plans, which implies that people served through the mental health packages in Bogotá must now start to be served not by the territorial institution, but by the subsidized-EPS under the POS of the contributing system we all know, which widely limits the psychiatry service. These packages focus on primary care and different situations and populations (Barrera, s.f.)

One of the last standards, which is to be used as a basis to update the district policy of mental health, is Law 1438 from 2011, the health Reform, which establishes the PHC strategy as the framework subject to set forth in its article 12: *To adopt the Primary Health Care Strategy comprised by three integrated and interdependent elements, namely, health services, intersector/cross-sector action for health and social, community and citizen participation.*

Primary Health Care is the intersector coordination strategy that allows comprehensive and integrated care, from public health, the promotion of health, the prevention of illness, the diagnosis, treatment, rehabilitation of the patient at all levels of complexity in order to guarantee a higher level of user wellbeing, without prejudice to the legal powers of each stakeholder of the General Social Security System for Health.

And in Article 65 it refers to integral mental health care as: *Health initiatives must include the guarantee of full enforcement of Colombians' right to mental health by means of integral mental health care to guarantee meeting the health needs and service as part of the Benefit Plan and the implementation, monitoring and evaluation of the national policy of mental health.*

In this line of thought, in 2008 the Ministry of Social Protection generated a Draft for Review of a Model for the Mental Health Component in the PHC Strategy for the SGSSS made by Posada (2008). This component (...) *makes it possible to carry out Mental Health promotion activities and activities to prevent mental problems and disorders, where users receive first aid in mental matters*

and, if necessary, the products or services designed for treating acute and episodic mental problems and disorders that require it, as well as managing chronic mental disorders in addition to the integration to more specialized services and other parts of the system whenever required. Currently, steps are being taken to implement this model through the following developments: The implementation of the National Mental Health Observatory, launched in October 2011, the training of human resource for mental health (general physicians), the making of Integral Mental Health Care Guides (Depression, alcoholism, Attention Deficit, Hyperactivity, Anxiety, Bulimia)

As it can be seen, in the last years (2009, 2010 and 2011), due to the scarcely clear weaknesses and needs generated in the SGSS, the regulation is extended nationwide and in the district in order to improve access, coverage and quality, with great interest in the unification of the benefit plan, emergency care and primary health care. In turn, changes are made to the regulation related to mental health, sometimes due to pressure by user associations and other times by interests of laboratories, which although apparently contribute to care, generate doubts and reflect inequalities in guaranteeing the right to mental health. (As shown in Agreements by the National Council of the Social Security System, CRES Agreements, Gambling Agreements, Official Communications, Concepts, Decrees, Laws, Bills, Resolutions, and Sentences related to Health). Some of them are presented below:

Agreement 029 from December 28, 2011 by means of which Agreement 028 from 2011 is substituted, and it is intended to define, clarify and update comprehensively the POS of Contributing and Subsidized Regimes; it must be applied to affiliates at health care insurance companies and health services providers. The POS is an instrument for effective enjoyment of the right to health and care in the provision of health technologies that each of these institutions will guarantee for affiliates through the provider networks nationwide and under the quality conditions established by the current regulation. In addition to defining concepts, it reiterates the general POS principles: comprehensiveness, territoriality, complementarity, demographic and epidemiological relevance, cost-effectiveness, financial efficiency and sustainability, participation, transparency, competence, shared responsibility, quality. It expresses implicitly in article 7 that the guarantee to access health services is responsible for the EPS through the provision of health technologies included in this agreement.

Speaking of the POS coverage, in terms of Health promotion and Prevention of disease, article 12 states that pursuant to the PHC strategy, the POS covers all the services of health promotion and prevention of disease, specific protection and early detection adopted by means of resolutions 412 and 3384 from 2000, 3442 and 0769

and 1973 from 2008 by the Ministry of Health and Social Protection.

Specifically for mental health, article 17 states that the POS must cover outpatient care with individual or group psychotherapy regardless of the stage of disease: 30 individual psychotherapy sessions in total through psychiatry or psychology during one calendar year and 30 group, family or couple therapies in total through psychiatry or psychology during one calendar year. And it must cover outpatient psychological and psychological care and hospitalization for women who are victims of physical, sexual or psychological violence whenever required and at physician's discretion (article 18). In the case of emergency mental health care, this service will be covered by the POS of the emergency and observation service during 24 hours, when the event jeopardizes the life or integrity of the person, their families or the community (article 22). In managing mental health disease, when hospitalization is required, the POS will cover up to 90 days, but partial hospitalization will be preferred. (Article 24). Although it is true that the provision of some services is clarified and extended, there have not been any mental health prevention and promotion initiatives so far; on the other hand, the service continues to be focused, with the risk of biasing resources, thus generating inequity. Currently, it is necessary to make an inventory of the infrastructure, human resources and actual network capacity to offer the requested Service, as well as having assessments that allow more objective monitoring and control of processes and having a baseline to implement these new standards.

Subsequent to Agreement 029, CRES Clarification No 20123210004271 appears on January 17, 2012, which ratifies the Mental Health POS contents for patients with mental disorders or diseases affiliated to the Contributing Regime and the Subsidized Regime, under 18 years old and older than 60 years old, in terms of medications, with charge to the UPC (Payment Unit for Training) of the corresponding regime, as follows: all the medications listed in Annex 1 of Agreement 029 from December 28, 2011, which substitutes Agreement 028 from 2011 (5 and 10 mg Olanzapine, 1, 2, 3 and 4 mg Risperidone and 25 and 37.5 and 50 mg vials, 25, 50 and 100 mg Sertraline); and the procedures, specifying the levels where it must be offered. Home Visit Care for general medicine (1st level), Home visit care for specialized medicine, psychology or Social work and inter-disciplinary team (2^o level). Additionally, First Time consultation for general medicine (1st level), first time consultation for specialized medicine, psychology, social work and inter-disciplinary team (2^o level); as well as control and monitoring consultation, inter-consultations, medical Board, internal hospital management and emergency consultation. Also, administering Personality test, Assessment of emotional and Behavioral alterations, determination of mental status,

Individual Psychotherapy, crisis intervention, couple and family psychotherapy, an Intervention in community Mental Health and mental health hospitalization of low, medium and high complexity, in addition to partial hospitalization and emergency observation room of low, medium and high complexity. It ratifies hospitalization up to 90 days, as well as individual psychotherapy through psychology or psychiatry and group, family and couple outpatient psychotherapy up to 30 sessions per year.

Additionally, there is an extension of coverage in the case of women of any age who is victims of violence and under 18-year olds who are victims of domestic violence, sexual abuse and eating disorders, use of psychoactive substances and in the situation of disability.

It specifies the medications and procedures for patients with mental disorders or disease affiliated to the subsidized regime from 18 to 59 year old that have not been incorporated to the POS, thus allowing the mediations of Agreement 029 in case of total or partial hospitalization and during the therapeutic phase included in the POS. The procedures performed in the outpatient sphere are kept pursuant to Agreement 008 from 2009 and are in charge of the Territorial Institutions under the provisions of Law 715 from 2001. It is not possible to disregard the costs of atypical anti-psychotic drugs, as well as the hospitalization costs, facing the informal work conditions of Bogotá, which in the end contribute to the stability of the insurance system of the Health System. A prior study that actually performs these inclusions is expected since currently there are frequent user complaints about the lack of psychotropic mediations, although they are not very expensive.

Agreement No 030 from December 28, 2011 by CRES, by means of which the UPA of the POS is established for the Contributing and Subsidized Regimes for year 2012, a UPC estimate was made for the Contributing Regime to be enforceable in 2012, based on the sustainability of SGSSS and the corresponding technical study, as follows: (before COP\$485,013.60) A weighted annual average amount of COP\$547,639.20, which corresponds to \$1,521.22 pesos a day. And adjustments were made on this value based on the age group, the final value for people under one year old was COP\$1,642.917, \$2,158,740.00 for people older than 75, and \$184,280.40 and \$175,629.60 for 5-14 and 15-18 year old, accordingly. On the other hand, adjustments were made based on the geographical area. Additionally, the EPS payment for general sick leave is established as 0.25% of the Basis for Calculation, and maternity or paternity leaves are charged to Fosyga. It acknowledges the EPS development of Promotion and Prevention activities in a year for an amount of COP\$20,160.00 for the Contributing Regime.

The UPC for the Subsidized Regime is COP\$352,229.20, that is, COP\$978.72 daily; similarly, adjustments are made based on the geographic area.

Consistent with the foregoing, the CRES recommends EPS companies that the increase of UPC value should be reflected in the modifications and rise of agreements with their corresponding health service networks. Although these economic determinations are not necessary for the system, the 18-to-60 year-old population group requiring care, both from the subsidized and contributing regime, does not evidence equity of resources and biases the access to health services.

In order to contribute to clarify the regulation in terms of the work at networks, the Health Secretariat adopts its resolution 1505 from December 19, 2011, by means of which the Territorial Networks of Public Hospitals are formed for the development of the health care model, considering that the health service in the territory must be provided by integrating networks that allow linking health service provider units, the proper use of the offer and establishing a reasonable cost of services; defining the network as the set of organizations or networks that provide services or make agreements to provide more efficient, equitable, integral and continuous individual and/or collective health services for a population defined based on their demand; whereas the implementation of PHC must guide the organization and operation of the network, propose to establish 8 territories in the District to form the networks, where the highlights by their events of interests are: the maternal-perinatal network, the mental health network, the functional rehabilitation network and the cancer network. It establishes the allocation of networks as follows: South Territorial Network 1: (The districts are Sumapaz, Usme and Tunjuelito, where services will be provided by the Usme, Nazareth, Tunjuelito and Tunal Hospitals). South Territorial Network 2 (Ciudad Bolívar district, where services will be provided by Meissen and Vista Hermosa Hospitals). South-West Territorial Network (The districts are Bosa, Kennedy, Puente Aranda and Fontibón, where services will be provided by the Fontibón, Bosa Del Sur, Pablo VI and Occidente de Kennedy Hospitals), North Territorial Network: (The districts are Usaquén, Chapinero, Barrios Unidos, Teusaquillo, Suba and Engativá, where the service will be provided by the Usaquén, Chapinero, Engativá, Suba and Simón Bolívar hospitals). Central-Eastern Territorial Network 1 (the districts are Santa fe, Candelaria, Mártires, Rafael Uribe and Antonio Nariño, where the service will be provided by the Santa Clara, Rafael Uribe and Centro Oriente Hospitals). And Central-Western Network 2 (the districts are San Cristóbal, where the service will be provided by Victoria, San Blas and San Cristóbal Hospitals).

CONCLUSION

Finally, viewed from the perspective of international standards, it is important to highlight four significant

aspects gathered by Urrego (2010). The World Health Report from 2001: Mental health, where experiences of implementation of mental health policies were collected, but especially 10 recommendations of initiative were given to the signing countries; five of them currently restate the need to develop work on PHC and work to involve, supervise and support the mental health of communities. The second aspect is that definitely particular historical and cultural conditions are going to determine the lines of action, development plans, programs and specific projects, depending on the population features and their health conditions, but it is necessary to consider that a Mental Health policy must be a Strategy State Policy, given the significance in productivity and development of the country. Thirdly, despite the historical negligence towards mental health, positive experiences are retrieved in Latin American countries such as Chile, Mexico, El Salvador and Peru and Colombia's participation in the World Mental Health 2000 survey stands out (SMM,2000) contributing elemental information about the prevalence and load of Colombian disorders, which allowed planners to compare the estimated cost for society of the alternatives of treating or not treating mental disorders and highlighted a better stance of Latin America compared to other countries in terms of mental health. Finally, it explains that the development of a systemic evaluation of performance indicators to control mental health, the thorough evaluation of the mental health service, community participation once again, the integration of services and the efficient use of resources are still pending considerations in the construction of this proposal of District Mental Health.

In the nation and the District sphere, despite progress in the health sector regulation, the existence of regulations for the protection of physical health would supposedly protect mental health as well, but they are not specifically for the mental health area. On the other hand, there is no proper monitoring and control of regulations, only the cases of user complaints are mentioned for an investigation to begin. On the other hand, the specific regulations do not contribute to guarantee the population's mental health; on the contrary, this is a time of transition, facing the proposal to construct a new health service model for public health in health care and mental health, which encourages the reduction of administrative costs. Work in networks is to be developed based on work by micro-territories, with a significant group in terms of quality of professionals, but without enough resources for the service. For total health service provision, 32 professionals are considered for serving 800 families made up by 4 people by family on average,

Additionally, from the perspective of the health professionals providing mental health services, although a progressive positioning of sanitary mental health care has been achieved in the different city districts and

mental health professionals are making constant efforts to provide the service in ethical, kind, efficient and quality manner, there are several differences in the availability of human resources and the organization of sanitary mental health care in the city of Bogotá, among others, which must be corrected through the involvement of the District Health Secretariat to be able to impact the health of city inhabitants positively and as best as possible.⁵

There is an uneven offer of mental health care packages throughout the different districts and social State companies in the city. Additionally, another of the most relevant aspects that carries difficulties to properly treat the mental health of the people of Bogotá, from the associated network, is the procurement of human resource in mental health (psychiatrists, psychologists, therapists and social workers⁶) by the Social State Companies operating the packages contracted with the SDS in amounts lower than those actually required pursuant to procurement guidelines, demanding professionals⁷ to serve patient volumes that exceed their contracted labor capacity, if minimum standards of quality and length of interventions are fulfilled, as well as cover several types of interventions simultaneously, and even several points of service at different city areas. In addition to the unjust wearing out of the human resource, this kind of practice undoubtedly threatens the quality of services provided and violates the rights of patients.

On the other hand, from the view of mental health care professionals providing services in the associated network, some of the mental health care services currently executed in Social State Companies such as community and hospital inter-consultations are not easily acknowledged for payment by the District Health Secretariat,⁸ which worsens the position of professionals at their work areas within an already dark scenario. This poor positioning of mental health services and professionals is even more evident in physical spaces, commonly insufficient, where the ESE organize the provision of contracted services; in addition to poor the resources frequently given for

such services. Professionals in charge of mental health care in the Capital District identified the urgent need of implementing strategies that allow linking the actions they develop through the different POS packages to actions carried out by means of PIC initiatives, as well as the generation of clear spaces of direct meeting between the different professional service providers at hospitals and those in charge of the corresponding processes at the District Health Secretariat, without intermediary administrative staff, who many times acts as representative and unnatural coordinator of the care staff and care services for patients.⁹

Pursuant to information of the District Secretariat of Public Health 2011 related to the offer of mental health care services in our network associated to the SDS in third level of care, there are 81 mental health packages offered, allocated as follows: 10 packages of integral mental health care and 11 complementary services of mental health.

Integral care for Victims of Domestic Violence, women abuse, child abuse and sexual Crimes provided by Psychology and Psychiatry (Simón Bolívar and Santa Clara Hospital), 2 in total.

- a) Intervention in Mental Health Crisis by Psychology and Psychiatry (Simón Bolívar, Kennedy, Santa Clara, and la Victoria Hospital), 4 in total.
- b) Medical care specialized in Mental Health (Simón Bolívar, Kennedy, Santa Clara, and la Victoria Hospital), 4 in total.
- c) Linking Intervention in Mental Health (Simón Bolívar, Kennedy, Santa Clara, and la Victoria Hospital), 4 in total.
- d) Integral Home Care for Chronically Ill Mental Patient (Santa Clara Hospital), 1 in total.
- e) Day Hospital for Children and Adolescents. 0 in total.
- f) Day Adult Hospital (Kennedy, Santa Clara, and la Victoria Hospital), 3 in total.
- g) Therapeutic intervention in consumption of psychoactive substances for adults (Santa Clara Hospital), 1 in total.
- h) Therapeutic intervention in consumption of psychoactive substances for female children, adolescents and young people. 0 in total.
- i) Mental Health Discharge for Adults (Simón Bolívar, Kennedy, Santa Clara, and la Victoria Hospital), 4 in total.

Complementary mental health services:

- a) Outpatient psychological service (Simón Bolívar and la Victoria Hospital), 2 in total.

⁵ Referentes Gestión Local de Salud Mental Secretaría Distrital de Salud. Matriz Descriptiva Integrada sobre Intervenciones de Salud Mental en las Empresas Sociales del Estado del Distrito Capital (Work Document). 2009, p.14. Urrego Z. Notes about field work for the proposal to adjust the guidelines of public policy in mental health, guideline of the action plan and other proposals (Work Document). 2009, p.30.

⁶ This situation is particularly evident in the case of psychiatry physicians.

⁷ Normally hired under a professional service provision agreement, which generates special conditions of vulnerability for professionals.

⁸ Mention is made of the absence of mental health professionals to treat psychosocial aspects of people who suffer chronic diseases and cancer, HIV or AIDS infection, growth and development, women and families with positive results in cytology or colposcopy, acute-respiratory-disease rooms, fertility regulation; in addition to the mental health component in projects such as disability, inter-consultation interventions at psychology and psychiatry areas performed in emergency services.

⁹ Referentes Gestión Local de Salud Mental Secretaría Distrital de Salud. Matriz Descriptiva Integrada sobre Intervenciones de Salud Mental en las Empresas Sociales del Estado del Distrito Capital (Work Document). 2009, p.14 Urrego Z. Notes about field work for the proposal to adjust the guidelines of public policy in mental health, guideline of the action plan and other proposals (Work Document). 2009, p.30.

- b) Outpatient psychiatric service (Simón Bolívar and Tunal Hospital), 2 in total.
- c) Inter-consultations of Psychiatric Hospitalization (El Tunal Hospital), 1 in total.
- d) Inter-consultation through Psychology (La Victoria Hospital), 1 in total.
- e) Inter-consultation through Psychiatry (La Victoria Hospital), 1 in total.
- f) Psychiatric Emergency Service (Santa Clara and la Victoria Hospital), 2 in total.
- g) Psychological Service in Special HIV Programs (El Tunal Hospital), 1 in total.
- h) Psychological and Psychiatric Support for Mourning Processes (El Tunal Hospital), 1 in total.
- i) Children Psychiatry (Kennedy Hospital), 1 in total
- j) Application of Neurophysiology Tests (Simón Bolívar Hospital), 1 in total.
- k) Psycho-homeopathy (Simón Bolívar Hospital), 1 in total.

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