Addressing Severe Mental Illness Rehabilitation in Colombia, Costa Rica, and Peru

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Many Latin American countries face the challenge of caring for a growing number of people with severe mental illnesses while promoting deinstitutionalization and community-based care. This article presents an overview of current policies that aim to reform the mental health care system and advance the employment of people with disabilities in Colombia, Costa Rica, and Peru. The authors conducted a thematic analysis by using public records and semistructured interviews with stakeholders. The authors found evidence of supported employment programs for vulnerable populations, including people with disabilities, but found that the programs did not include people with severe mental illnesses. Five relevant themes were found to hamper progress in psychiatric vocational rehabilitation services: rigid labor markets, insufficient advocacy, public subsidies that create conflicting incentives, lack of deinstitutionalized models, and lack of reimbursement for evidence-based psychiatric rehabilitation interventions. Policy reforms in these countries have promoted the use of medical interventions to treat people with severe mental illnesses but not the use of evidence-based rehabilitation programs to facilitate community integration and functional recovery. Because these countries have other supported employment programs for people with nonpsychiatric disabilities, they are well positioned to pilot individual placement and support to accelerate full community integration among individuals with severe mental illnesses.

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Over the past 4 decades, many Latin American countries have experienced political and social transformations that have led to efforts to minimize fragmentation of health care services, end differential care to citizens on the basis of socioeconomic status, and realize the rights of vulnerable populations (1). As a result, many Latin American countries have increased public investments in the health and social protection of their communities. Increased use of general government revenue instead of payroll taxation and out-of-pocket spending has increased equity in financing, decreased impoverishment due to out-of-pocket health care spending (1), and supported new health policies that now cover millions of additional individuals (2). Subsidized universal coverage for vulnerable groups has improved access to diagnoses and pharmacotherapy for people with severe mental illnesses.

Although Latin American countries have improved health care access, the disability-adjusted life years related to mental illness have increased by more than 10% over the past 25 years. Between 1990 and 2017, mental illnesses moved from the 10th to the sixth leading cause of disability-adjusted life years (3). Rising rates of mental disorders have also had a significant impact on the economy (4). Additionally, the association between poverty and poor mental health is substantial (5). In Latin America, 82% of people with a disability live in poverty, and about 90% are unemployed or outside of the workforce (6). The Caracas Declaration (7)

HIGHLIGHTS

- Individual placement and support (IPS), an evidence-based intervention that aids the employment aspirations of people with severe psychiatric illnesses, helps service providers focus on supporting patients' strengths, functional capacities, and community integration.
- Colombia, Costa Rica, and Peru have implemented supported employment programs for some populations with disabilities but not for people with psychiatric disabilities.
- Current system capacity allows for pilot testing of IPS through the community-based mental health system in Peru and as an extension of existing supported employment services for individuals with disabilities in Colombia and Costa Rica.

and the Brasilia Consensus (8) represent nonbinding international commitments under which Latin American nations express the intent to pursue a person-centered, community-based approach to mental health care with an emphasis on primary care and psychosocial rehabilitation (9).

EVIDENCE FOR INDIVIDUAL PLACEMENT AND SUPPORT IN THE REHABILITATION OF PATIENTS WITH SERIOUS MENTAL ILLNESS

Individual placement and support (IPS) is a psychosocial intervention with a considerable body of evidence demonstrating improvements in health, employment, and income among people with severe psychiatric disorders (10). IPS increases employment, income earned in competitive jobs, self-esteem, and community integration among people with even the most severe mental disorders. It also decreases hospitalizations, dependence on public systems of care, and stigma in the community (11, 12). Most people with psychiatric illnesses want competitive employment, and IPS supports their aspirations to pursue this aspect of a full life. IPS also transforms the attitudes, goals, and roles of clinical teams. The intervention's focus on successful outcomes and patient's preferences shifts the role of clinicians from caretakers to professional consultants and partners and keeps service providers focused on the strengths, rather than the deficits, of the people they are serving. IPS has been proven cost effective and has saved on costs of care in cases in six European countries (13) and the United States (14). The intervention has been widely adopted in more than a dozen high-income countries to support, successfully, the recovery of individuals with severe mental illnesses. More recently, IPS has been researched for treatment in other populations, such as those with posttraumatic stress disorder (15), chronic pain (16, 17), and spinal cord injury (18).

This study aims to present and discuss the progress and challenges of implementing supported employment programs for individuals with severe mental illnesses in Colombia, Costa Rica, and Peru as one of the steps necessary for the rehabilitation of patients with severe mental illnesses. We conducted semistructured interviews with 12 key stakeholders in each country (N=36), including patients, family members, health system academics, human rights advocates, and policy makers. Additionally, we conducted a desk review of the regulatory framework of the health systems, extracted from pertinent laws, health policies, ministerial technical documents, gray literature, peer-reviewed articles, and publications from multilateral organizations. We also specifically searched for supported employment experiences that did not target individuals with serious mental illness (19, 20).

MENTAL HEALTH CARE SYSTEMS IN COLOMBIA, COSTA RICA, AND PERU

Mental health care in Colombia, Costa Rica, and Peru is predominantly hospital based with only discrete episodes of medication management and emergency services in the community (21). Table 1 summarizes the regulatory framework and the programs described in this section.

Colombia has a regulatory framework that advances a deinstitutionalized approach to mental health care and stipulates the need for community-based care and evidence-based interventions, such as assertive community treatment (ACT) teams and IPS supported employment (22, 23). Nevertheless, implementation is far from reaching the standards set by these regulations with regard to meeting the population's needs. A recent national mental health policy focused on coordinating networks of existing health care providers and promoting community-based recovery-oriented interventions (24).

In Costa Rica, mental health policy establishes standards for deinstitutionalization, community-based care, and the development of recovery-oriented programs (25). In principle, implementation efforts center on embedding mental health units in general hospitals and integrating behavioral health into primary care. However, progress has been slow because of insufficient funding, poor stakeholder coordination, resistance to change, and workforce shortages.

In Peru, a new mental health policy that stipulates funds earmarked by Congress, explicitly prioritizes community over institutional care and provides instructions for a recovery-oriented community-based model of care (26–29). As a result, Peru had developed 100 community mental health centers, 10 sheltered homes, and 20 short-stay inpatient units in general hospitals as of December 31, 2018, and the utilization of community mental health services had increased. Some of these centers offer additional evidence-based interventions, such as ACT teams, intensive case management, and acute crisis management.

In summary, these three mental health care systems are moving, to varying degrees, toward deinstitutionalizing patients and adopting variations of community-based care. However, they continue to invest heavily in non-recovery-oriented models of care for patients with severe mental illnesses, such as office-based management of psychiatric medication and inpatient care in psychiatric hospitals (30).

SUPPORTED EMPLOYMENT AND VOCATIONAL REHABILITATION

Mental illness can undermine household finances as well as personal dignity. Supported employment programs are central to transforming hospital-based systems into community-based, recovery-oriented systems (31).

In recent years, each country in this study has developed supported employment programs for individuals with a disability. Although these programs represent a significant step toward recovery-oriented interventions for people with disabilities, our findings suggest they have not reached individuals with severe mental illnesses. Below, we provide a brief review of the current employment services and vocational rehabilitation programs offered in these three countries.

TABLE 1. Laws for mental health and supported employment in Colombia, Costa Rica, and Peru

Mental health regulatory framework	Supported employment regulation/program
Colombia	
Mental Health Law (Law 1616 of 2013)	General Disability Rights Statutory Law (Law 1618 of 2013)
National Mental Health Plan 2014–2021	Incentives for hiring people with disabilities (Decree 392 of 2018)
National Mental Health Policy (Ministerial Resolution 4886 of 2018)	National Employment Service (Law 1636 of 2013; protection mechanism for unemployed citizens)
Schizophrenia Clinical Guideline (Ministerial Technical Document, 2014)	Productivity Alliance (Pacto de la Productividad; public-private partnership)
Costa Rica	
National Mental Health Policy 2012–2021 (Ministerial Technical Document, 2012)	General Disability Law and Equality of Opportunity Law (Law 9379 of 2016 and Law 7600 of 1996)
Technical Secretariat of Mental Health (Law 9213 of 2014)	Tax incentives for hiring people with disabilities (Law 7092 of 1998)
	Get-Employed and Inclusive Get-Employed Programs (Empleate and Empleate Inclusivo)
Peru	
Mental Health Law (Law 29889 of 2012)	General Disability Law and Operation Standards (Law 29973 of 2012 and Decree 002–2014)
Operation of the community mental health system (Presidential Decree 033–2015-SA)	Young and middle-aged adult employment programs (Programa Nacional de Empleo Juvenil and Programa Impulsa Peru)
Community Mental Health Centers standards (Resolution 574–2017)	

Colombia

In 2013, Colombia launched the National Employment Service, an agency that aims to both increase job opportunities for the general citizenry and provide temporary financial protection during periods of unemployment. Spearheaded by the Ministry of Labor, this agency seeks to systematically connect all public and private sector job opportunities with applicants throughout the country by using a combination of a national employment database, vocational rehabilitation, and local employment agencies (https://unidad.serviciodeempleo.gov.co/en). Also, the Colombian National Learning Services (SENA) offers a wide array of free and low-cost vocational and technical trainings (32). Government data indicate that between 2016 and 2018, nearly five million Colombians created profiles in the employment database, including approximately 17,000 individuals with disabilities. Over this period, although 1.5 million Colombians found employment, only 1,114 individuals with a disability of any kind, and only 30 individuals with a mental health disability, secured a job (33).

To support the work of individuals with any disability, a partnership between nongovernmental organizations, the national government, the private sector, and the Inter-American Development Bank launched the Productivity Alliance (34, 35). This alliance uses the infrastructure of the National Employment Service and leverages existing financial and tax incentives for companies hiring people with disabilities. It deploys a multistep supported employment model that includes basic academic training, vocational rehabilitation, support to navigate the national employment database and interact with employment agencies, coaching during the selection process, and assistance during the first 6 months after starting a job. Most beneficiaries are individuals with physical, hearing, and vision disabilities, followed by individuals with intellectual and developmental disabilities; those with severe mental illnesses are rare. Furthermore, we found no evidence of collaboration between these programs and the mental health care system for people with severe mental illnesses.

Vocational rehabilitation and supported employment programs targeting individuals with severe mental illnesses are scarce. A decade ago, a few mental health clinics partnered with the Ministry of Labor and SENA to offer vocational rehabilitation services to individuals with psychiatric disabilities who attended day hospital programs, but the plan was short lived. More recently, a small number of mental health care providers have offered isolated programs, including a vocational rehabilitation program developed by a methadone clinic in a semirural town where patients received training to work construction jobs. To date, no public reimbursement has been disbursed for these efforts.

Costa Rica

The Ministry of Labor and Social Security launched the Get-Employed program (https://www.facebook.com/EmpleateCR) to advance the employment of vulnerable young adults (36). Using a conditional cash-transfer model (37), this program offers supported employment services to the job candidate as well as to the hiring organization. It also provides financial assistance to fund a set of finite living expenses and vocational training for a technical degree. To

promote the employment of people with disabilities, Costa Rica has enacted several laws, including the mandate for companies to employ a minimum number of individuals with disabilities (5% of their workforce), a mandate for equal pay (38), and financial incentives for the employer.

Building on the structure and workflow of the Get-Employed program, in order to support the employment of individuals with any disability, the government launched the Inclusive Get-Employed program (39), an alliance with partner technical institutions that offers vocational rehabilitation followed by assistance in finding, selecting, and applying to job openings. It also supports the employer as well as the new employee during the contracting process and first months of employment. Over 30 companies are actively hiring people with disabilities. Although the program has had eight clients with severe mental illnesses, they were unable to join the workforce because of clinical instability.

The Ministry of Education supports over 30 vocational rehabilitation centers called Centers for Comprehensive Treatment of Adults with Disabilities (CAIPADs) across Costa Rica (40). These CAIPADs offer interdisciplinary lectures and workshops aimed at increasing the capacity of individuals with disabilities to find employment, but most beneficiaries of CAIPADs are individuals with physical disabilities. As in Colombia, Costa Rica's health sector has limited involvement in psychiatric rehabilitation. The National Psychiatric Hospital has offered informal and short-lived sheltered workshops in its hospital day services.

Peru

In Peru, the Ministry of Labor launched two nationwide supported employment programs to support teenagers and young adults (http://www.jovenesproductivos.gob.pe) as well as middle-aged adults (http://www.impulsaperu.gob.pe). These programs offer vocational rehabilitation, grant a technical degree, and provide employment services. Both programs are open to individuals with any disability. However, individuals with disabilities—particularly those with intellectual, developmental, or mental health disabilities—do not often register.

Two small-scale models have assisted individuals with severe mental illnesses in joining the workforce: patients' clubs and vocational rehabilitation programs. Patients' clubs are local rural networks of patients and families working with a mental health care professional or a community member to create regular structured daytime activities. A typical day includes education on self-care and housecleaning, followed by vocational training and recreational activities. These clubs are decreasing in number because of insufficient funding and loose coordination with the mental health system. Publicly funded rehabilitation centers offer more-formalized vocational training, such as in essential computer management, tailoring, and cooking. However, these programs do not provide a degree or employment specialists to connect patients to potential employers. Moreover, the limited capacity of these centers and the need to demonstrate at least 6 months of mental health stability create access barriers. The experiences and outcomes of these interventions are poorly documented.

FACTORS AFFECTING PSYCHIATRIC REHABILITATION

None of the three countries considered in this study deliver supported employment services at scale for individuals with severe mental illnesses. Using the qualitative interviews and the desk review, we identified five societal and health care factors contributing to the absence of this critical psychiatric rehabilitation service.

First, the labor markets in these countries are relatively rigid and have an oversupply of unskilled labor. For years, these middle-income countries have grappled with high levels of unemployment and underemployment (e.g., a higher-qualified individual employed at a low-paying job) in the informal economy. Given this situation, programs such as Get-Employed in Costa Rica or the National Employment Service in Colombia are a priority on the domestic agendas. However, given the rigidity of these labor markets, employers bear a real cost of hiring that can be up to 70% higher than the salary the employee receives (41). Thus, employers are prone to be risk averse and less inclined to hire people with disabilities, particularly those with severe mental illnesses. Regarding this point, one health system academic from Costa Rica stated,

> It has been challenging to incorporate [the patients] into society. They have this community organization, but they aren't paid enough money. When you ask me about dignity, I would say we are halfway there because they get a salary that is lower than the minimum wage just because they have a mental illness, but it is an intermediary effort because they haven't been able to incorporate them into the labor market.

Second, advocacy for individuals with severe mental illnesses is less visible than for individuals with other disabilities and has not been as successful in combating stigma. People with severe mental illnesses are perceived as lacking the necessary competence to perform a typically paying job. We could not identify any advocacy groups representing persons with severe mental illnesses who were interested in work that had successfully drawn focus to this issue on the public agenda. This lack of advocacy likely reflects the unique and persistent stigma associated with mental and behavioral disability. A government official from Peru, discussing the challenges of supported employment programs that may lead to increased stigma, said,

> There was a case where a young man assaulted his coworkers. We later found out that he had stopped his medication. Due to this, they had to let him go, and this hinders the project quite a bit; the employer feels, perhaps, fear or rejection against the person.

A government official in Colombia added,

> We continue to stigmatize mental health patients, [and employers might think], How am I going to keep [him or her] inside a company?

Third, these three countries use public subsidies to support the livelihood of individuals with low income and an inability to work because of a general or mental health disability. Patients and families fear that employment-seeking efforts can result in losing these subsidies. A medical provider in Peru stated,

> Family views [the patients] as a source of income, even though it is very little money. . . .This is where we find the family and economic problem. [Family members] say, "Doctor, don't take away his/her disability status, he/she is doing better, but we need that income."

A government official in Colombia shared,

> Programs tend to be highly based on assistance models, so when you reach the community, people are always thinking, Well, what are we getting in exchange for our participation?

However, this situation is not true for all patients or families. Many patients with severe mental illnesses perceive work as a source of financial stability as well as a source of dignity. They not only expect access to high-quality health care services but also aspire to attain stable employment and to improve their income, no different from expectations observed in patients with other chronic conditions. A medical provider in Costa Rica struggled with not being able to connect patients to employment opportunities:

> A patient was telling me, "I have three children, and I am depressed because I don't have a job. I come here, and I get pills, but why would I want pills if what I really need is money to buy food for my children and me?"

Likewise, a patient in Costa Rica shared,

> After discharge, all I wanted was to find employment. I wanted to feel motivated, I wanted to work.

Fourth, the health systems are still grappling with designing and implementing a reasonable model to deinstitutionalize and provide long-term clinical care for patients with severe mental illnesses. The use of evidence-based social supports (e.g., supported housing or employment) that are essential to improve patient outcomes is not mainstream in the health policy agendas of these three countries. As such, psychiatric rehabilitation is not a priority for their health systems. Additionally, existing rehabilitation programs for patients with disabilities mostly focus on patients with physical disabilities and not on those with mental health disabilities. Discussing the rehabilitation model, a medical provider in Costa Rica said,

> There is not an established network. All we do are informal efforts where, for example, if I think a person could benefit from a particular program or education advantage that is being offered by the education system, then I recommend the patient to the program, but the institutions are not obliged to accept my recommendation.

A government official from Peru commented,

> Over the last three years, regarding labor inclusion, we have not been able to develop a systemic response to labor opportunities and employment search. This is the case for our most advanced medical services for mental illnesses located at the community centers.

Fifth, evidence-based interventions providing social and clinical supports (e.g., case manager) are generally not reimbursed by the health care system. Except in Peru, which currently offers community-based clinical and some social support services, these services are usually not available. Employment agencies and employers in the private sector who are willing to hire people with severe mental illnesses expressed concerns about the lack of clinical stability and lack of additional support for this population. Existing programs do not have the resources to follow up with patients in rehabilitation programs, and their tasks are limited to helping patients find jobs. A government official in Costa Rica shared,

> Well, our capacity only focuses on helping people with disabilities find jobs. We do not have enough people working here to do more than that.

A health provider in Colombia said,

> We know about the importance of helping patients rehabilitate, but these services are not reimbursed by the health system.

In summary, supported employment programs for individuals with disabilities exist in these three Latin American countries, but they do not reach persons with severe mental illnesses. These employment programs operate in labor markets with an abundance of job seekers and with rigid hiring structures that may affect willingness to employ people with severe mental illnesses. The low level of intersectoral collaboration inhibits mental health providers from supporting the job-seeking efforts of their patients. Vocational rehabilitation for individuals with severe mental illnesses remains severely limited, existing only in same-day hospital programs, with little or no evidence of improved recovery, employment, or income.

DISCUSSION

Investing in Recovery-Oriented Models

Although these three middle-income Latin American countries have demonstrated a commitment to advance policies targeting recovery of individuals with disabilities, these efforts have not benefited individuals with severe mental illnesses. Furthermore, the health care systems of Colombia, Costa Rica, and Peru continue to invest in outdated vocational rehabilitation day programs that segregate people with severe mental illnesses despite well-established evidence that these programs are inferior to the standard of care, supported employment interventions (42).

Latin American countries could adopt current evidence-based practices by learning from the experiences of countries that started deinstitutionalization five decades earlier

(43, 44). Interventions such as day treatment programs, sheltered workshops, and incarceration of people with mental disorders have proved harmful in many high-income countries, whereas evidence-based interventions, including supported housing, ACT, and IPS supported employment, have provided clear benefits (45, 46).

Despite some barriers, Latin American countries have the financial resources, organizational capacity, and professional expertise to pursue innovative health solutions for people with severe mental illnesses. A model built around the delivery of evidence-based interventions can streamline the organization of services, with potential positive externalities on capacity building, staffing, and payment mechanisms.

Piloting IPS

Peru seems ripe to implement and study IPS in a community clinic because it has already made significant reforms to its mental health system and the community mental health care system is already adopting evidence-based recovery-oriented interventions for individuals with severe mental illnesses. In Costa Rica and Colombia, active community mental health services may take more time to develop. Nevertheless, these two countries have accrued experience using public-private partnerships to deliver supported employment services to people with physical and sensory disabilities. A collaboration with mental health care organizations providing ACT team services can increase the feasibility of an IPS pilot.

Three contextual realities may limit the adoption of IPS in Latin America and would need to be addressed. First, the incentives for employers to hire people with severe mental illnesses need to be large enough to offset the perceived risks. Addressing this issue necessarily includes educating employers on the realities of severe mental illnesses in order to combat stigma and emphasize that individuals with severe mental illnesses are fully capable of being productive employees. Second, IPS programs need reimbursement as an essential health service with earmarked public funds to ensure sustainability. Improved coordination between health and labor ministries would also benefit program sustainability and implementation. Third, the employment achieved through IPS programs would need to provide patients a consistent and adequate source of income in order to be accepted by populations receiving disability subsidies.

CONCLUSIONS

People with psychiatric disabilities in Latin America want and deserve the opportunity to work in regular competitive employment and to become fully integrated into their communities. Colombia, Costa Rica, and Peru have national policies and potential resources from both public funding and private employers to fulfill these rights; moreover, it is their constitutional duty to do so.

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