

database and insufficient development of entity and cantonal public health services represents big problem for research, particularly epidemiological studies.

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## COUNTRY PROFILE

# Peru: mental health in a complex country

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**P**erú is a land of mixed cultures, multiple ethnic heritages and severe economic inequities. Its history goes back thousands of years, from accounts of the first inhabitants of the continent to the impressive Inca Empire, the rich Viceroyalty of Peru and the modern republic, which boasts one of the highest economic growth rates in South America. Yet, in spite of such complex cultural development, or perhaps because of it, 21st-century Peruvians have substantial difficulties establishing a national identity and recognising each other as members of the same community.

Persons with mental illness represent with poignant clarity 'the other' which we seem to have so much trouble accepting as equals in terms of dignity and rights. When we look at mental health in terms of legislation, services and human rights, therefore, we are faced with exclusion and discrimination, unequal and inefficient use of resources, and lack of public interest.

## Mental health as a component of public health

Peruvian psychiatrists have traditionally had a bio-psychosocial approach to mental health and illness. Social psychiatry studies, under the leadership of Rotondo and Mariategui in the 1950s and early '60s, were fundamental in the conceptualisation of mental health as a cultural construct (Perales, 1989). Another interesting development is that of psychosomatic medicine, under the leadership of Seguin, which originated in the establishment of a psychiatric ward in a general hospital, long before the Declaration of Caracas so suggested, and which also is the precursor of the current interest in women's mental health and in the consequences of violence in the country.

As far back as the 1960s, pioneers such as Baltazar Caravedo and Javier Mariátegui saw mental illness as a major obstacle to the development of the country, and they pointed to the need to devote public effort and money to the promotion of mental health and the prevention and treatment of mental illness. Others have followed this path, especially after the results of a large epidemiological study by the National Institute of Mental Health were made public (Rondon, 2006).

## Mental health and disorders

Anxiety, depression and schizophrenia are considered to be the most relevant psychiatric disorders in Peru. The use of alcohol, the prevalence of interpersonal violence and the high tolerance of psychopathic attitudes have also been identified as important (Instituto Especializado de Salud Mental, 2002).

Perhaps more striking than the prevalence of disorders is the large number of people (14.5–41.0% of those surveyed), mostly women, who report feelings of unhappiness, pre-occupation and pessimism (Instituto Especializado de Salud Mental, 2004).

Interpersonal violence, in all its modalities, plays a significant role in the production of psychiatric morbidity. Gender-based violence is widely tolerated, with roots in the complex culture of the country (Rondon, 2003). According to a World Health Organization multi-country study on violence against women, adult women in the Andean region of Cusco are the most physically abused females in the world, with those in Lima faring just slightly better (García-Moreno *et al*, 2005).

In the 1980s, the country suffered much political violence, largely targeted against the civilian population. This led eventually to the establishment of the Truth and Reconciliation Commission at the turn of the century. It has recognised that exposure to political violence during the internal armed conflict in the 1980s has inflicted severe psychological

damage to the population involved, and has left sequelae of 'fear, as an everyday experience, both at the individual and the collective levels, the disintegration of familial and communal bonds, loss of the ability to protect and nurture children, a negative impact on social cohesion, and damage to the personal identity'. The plight of the victims is, therefore, a major mental health concern (Peruvian Truth and Reconciliation Commission, 2003).

## Policy and legislation

After a long story of failure to implement mental health plans and due to the intervention of the Pan American Health Organization (PAHO) and reiterated demands of non-governmental organisations and relatives of users of services, the Guidelines for Action in Mental Health were promulgated by the Ministry of Health in 2004. The guidelines adhere to certain principles: respect for the rights of 'persons' (not 'human rights', careful wording in keeping with restrictive abortion laws), equity, integrality, universality, solidarity, shared responsibility and dignity and autonomy. According to this document, the Peruvian policy on mental health includes:

- direction from the Ministry of Health's specialised office (the Dirección Ejecutiva, although it has no budget of its own for service delivery)
- integrated services for mental and physical health
- prevention and treatment integrated in a new efficient way of delivering services
- promotion of mental health, human development and citizenship
- multi-sectoral coordination for mental health
- creation of an information system
- human resources development
- planning, monitoring, evaluation and systematisation of all mental health actions
- participation of users and their relatives in mental health services.

Two years later, the National Committee of Health, a part of the National Health Council, produced and obtained approval for the National Plan for Mental Health, which set objectives and goals for the policy guidelines. The objectives of the plan were stated as positioning mental health as a fundamental right of all persons, strengthening the normative role of the Ministry of Health, ensuring universal access to mental health services via the re-engineering of existing services and promoting equity in mental healthcare, with special attention given to vulnerable populations. The plan set forth three general objectives, 12 specific objectives and 31 actions. It is not being implemented, however, because of constant changes within the Ministry of Health.

There is no mental health law and several issues such as involuntary hospitalisation and treatment and informed consent are not sufficiently covered by appropriate legislation, with consequent risks for both patients and providers.

## Service delivery

Mental health services are mostly provided in psychiatric hospitals: 75% of psychiatric beds are in the three large psychiatric hospitals in Lima, with other beds in psychiatric centres in Piura, Arequipa and Iquitos. General hospitals belonging to

the Ministry of Health in Lima have psychiatric out-patient services but do not have any beds, whereas general hospitals in five regions do have in-patient facilities, although there is concern over the quality of services provided. Several regions lack psychiatric services of any kind, and so patients have to travel long distances. Mental health episodes represent 1.15% of the annual total of all episodes of patient care.

In the social security sector (which is based on health insurance for people in formal employment and their dependants only) all national referral hospitals and several national hospitals have beds, and there are psychiatric out-patient services in all tertiary establishments.

There is no mental healthcare at the primary level. The Ministry of Health has organised itinerant teams to attend to the needs of those affected by political violence with the purpose of supporting people in the affected communities; this includes promotion, prevention, attention and rehabilitation in mental health, as well as education in mental health with members of the community, especially primary health workers (Kendall *et al*, 2006).

The provision of psychiatric medications is very unequal: atypical antipsychotics and novel antidepressants are available in Lima and other large cities for insured patients, but outside the big urban centres not even the substances listed in the World Health Organization's list of essential medications can be obtained.

## Staffing and training

There are 602 psychiatrists registered with the Peruvian College of Physicians, eight of whom are child and adolescent psychiatrists. Seventy per cent of them live in Lima. Psychologists and specialised nurses are also located mostly in Lima, as are the few psychiatric social workers.

Of the 31 medical schools in Peru, five offer specialisation in psychiatry: three in Lima, one in Arequipa and one in Trujillo. Nonetheless, all undergraduate medical students receive a course on psychological medicine (centred on the doctor-patient relationship) and one course in clinical psychiatry.

Specialisation in psychiatry takes 3 years. Junior doctors have a chance to spend some time abroad to complete their training. The curriculum does not follow the World Psychiatric Association's core curriculum. The only recognised sub-specialty is child and adolescent psychiatry, training for which lasts 2 years.

## Research

Between 2005 and 2008, there was a project funded by the Japanese International Cooperation Agency that involved physicians, other health personnel in secondary and primary care and members of the community in five Andean regions in the integral care of people affected by political violence.

After 2000 there was a strong impulse for epidemiological research in psychiatry and the Lima Metropolitana, Sierra, Selva and Fronteras studies were completed. There is some ongoing work using the data from these important studies, such as the cross-country comparison of gender-sensitive mental health indicators. There is also some interest in participating in multicentre drug studies, and some psychiatrists participate as patient recruiters in fourth-stage studies.

## Human rights issues

The unavailability and inaccessibility of mental healthcare is the most important human rights issue. For those who do receive services, the poor quality of care, the high cost of medication, the generally miserable condition of the hospitals and the lack of attention to safety conditions are prominent concerns. Mental Disability Rights International published in 2004 a very critical report on the conditions of mental hospitals, after which both the ombudsman and the Ministry of Health, with the participation of the Peruvian Psychiatric Association, looked into providers' awareness of human rights and the conditions of the service (Ministry of Health, 2005). The Peruvian Psychiatric Association provided workshops on human rights for psychiatrists and other mental health providers and drafted the Declaration of Cusco, which calls for special concern for patients' rights. However, only the establishment of a national health system and universal health insurance with clear, state-of-the-art and consensual practice guidelines will improve current conditions.

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### COUNTRY PROFILE

# Psychiatric services in Bahrain: past, present and future

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The Kingdom of Bahrain is an archipelago of 33 islands, located in the Arabian Gulf, covering 2400 km<sup>2</sup>. The main island, Manama, is the nation's capital. The total population stands at 742 562, 62.3% of whom are local Bahrainis and the remaining 37.7% expatriates (Central Statistics Organisation Directorate, 1991). Bahrain first entered the historical stage around 3000 BC, and for almost 2000 years was the centre of the old Dilmun civilisation (Bibby, 1969). Dilmun was perceived as a sacred land by the Sumerians and Babylonians; it was a burial ground for their dead, and Bahrain has over 100 000 burial mounds each containing 200–250 bodies. In the old Babylonian epic of Gilgamesh, which antedates Homer's Iliad, Dilmun is described as a paradise where the worthy enjoy eternal life (Clarke, 1981).

## Psychiatric services

Al-Haddad & Al-Offi (1996) provide a history of Bahraini psychiatric services. Before 1930, no institution cared for psychiatric patients in Bahrain. Left to look after an ailing relative, families often devised their own form of therapy. One of the most common remedies was conducting a *Zar* ceremony, which was thought to help rid a person of the

demons or *jinn* believed to be responsible for mental ailments. Other forms of treatment included reciting verses from the Holy Quran, as well as cautery applied on either the occipital or parietal regions of the head.

In 1930, Charles Belgrave, the English counsel to Bahrain's ruler, suggested the creation of a place for local 'lunatics' which would safely put them under the direct supervision of the Municipal Council. In 1932 a small house was rented in the capital to host 14 patients (12 male, 2 female). The residence was named the 'Mad House' and psychiatric patients were looked after by 'attendants' (who were essentially labourers rather than nursing staff). The Municipal Council continued supervision of the asylum until 1948, when responsibility was transferred to the Department of Health. A report by Dr Snow, chief of the Department of Health at the time, illustrates improvements to the asylum; the building was refurbished and newly painted with pleasant colours, and patients were encouraged to spend more time outside their cells.

In 1964 Dr Butler, an English internist, started to run regular daily psychiatric out-patient clinics, recruited trained psychiatric nurses from India and Lebanon, and introduced the first drug (chlorpromazine) for the treatment of mental illness.

The 1970s witnessed many changes, such as the establishment of a child and adolescent out-patient unit (1975),