

the conditions for involuntary placement and treatment do not include a therapeutic purpose. The law does not provide free legal representation for detained patients. The legal situation of people in social care homes remains largely unclear, as they are *de facto* detained but without the requirement for judicial reviews or other legal safeguards. A major concern for non-governmental organisations is that the new law has not been fully implemented.

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COUNTRY PROFILE

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The organisation of mental health services in post-war Bosnia and Herzegovina

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Bosnia and Herzegovina (BH) is located on the western part of the Balkan Peninsula. It has an area of 51 210 km² and a population of 3 972 000. According to the Dayton Agreement of November 1995, which ended the 1992–95 war, BH comprises two 'entities' – the Federation of Bosnia and Herzegovina (FBH) and the Republic of Srpska (RS) – and the District of Brcko. The administrative arrangements for the management and financing of mental health services reflect this. The FBH, with 2 325 018 residents, is a federation of 10 cantons, which have equal rights and responsibilities. The RS has 1 487 785 residents and, in contrast, a centralised administration. Brcko District has just under 80 000 residents.

Mental health policy and legislation

Healthcare systems in BH are regulated basically by the entities' different laws on healthcare and on health insurance. Each entity and Brcko District is responsible for the financing, management, organisation and provision of healthcare. The health administration is centralised in RS, through the Ministry of Health and Social Welfare, but in FBH is decentralised – each of the 10 cantonal administrations has responsibility for healthcare through its own ministries. The central Ministry of Health of the FBH, located in Sarajevo, coordinates cantonal health administrations at a federal level. The District of Brcko provides primary and secondary care to its citizens. The mental health policies and national programmes for mental health were created in 1999 and adopted in 2005. A law on the protection of persons with mental disorders was adopted in 2001 and 2002 in FBH (*Official Gazette of BH*, Nos 37/01 and 40/02), and in 2004

in RS (*Official Gazette of RS*, No. 46/04). These laws define the rights of people and regulates the procedure for voluntary or involuntary admission to a psychiatric hospital.

Mental health service delivery

There are no private mental health institutions. Psychiatric services are available for all citizens, paid from a special national fund for healthcare, financed by mandatory health insurance. The reform of mental health services began in 1995. The focus has been on care in the community, limiting the use of psychiatric hospital beds, establishing a network of community mental health centres (CMHCs), and developing other services in the community, a multidisciplinary approach and teamwork, as well as cooperation between sectors. Each CMHC is responsible for general mental health in a catchment area of 50 000–80 000 inhabitants; each has 10 psychiatric beds, intended for the acute admission of patients (these beds are in fact on neuropsychiatric wards of regional general hospitals). The CMHCs have many different functions, including the promotion of mental health, early detection of mental disorders, and the provision of multidisciplinary care (Ceric *et al*, 2001).

Psychiatric services are provided throughout BH through the network of 55 CMHCs and family medicine services at primary care level. Secondary and tertiary mental health services are provided in three psychiatric clinics, one department of a university clinical centre, two general psychiatry hospitals, two institutions for the treatment, rehabilitation and social care of patients who are chronically mentally ill, and neuropsychiatric wards in general hospitals in major cities. In the reform of the mental health services, mentioned above, new out-patient services were established, the existing

Table 1 Numbers of psychiatric beds and staff

| | Federation of Bosnia and Herzegovina | Republic of Srpska | Brcko District |
|---|--------------------------------------|--------------------|----------------|
| Total number of psychiatric beds per 10 000 residents | 3.6 | 3.93 | 3.5 |
| in psychiatry hospitals | 2.4 | 0.91 | |
| in general hospitals | 1 | 0.68 | 3.5 |
| in other institutions | 0.2 | 2.33 | |
| Numbers of professionals per 100 000 residents | | | |
| psychiatrists ^a | – | 2.3 | – |
| neuropsychiatrists ^a | 1.8 | 1.2 | 7.0 |
| nurses in psychiatry | 10 | 19.4 | 21.8 |
| psychologists | 0.5 | 0.86 | 1.8 |
| social workers | 0.03 | 0.66 | 1.8 |

^aIn Bosnia and Herzegovina until 1992 there was education in 'neuropsychiatry' only; during the war (1992–95), medical doctors from the Republic of Srpska were trained in Belgrade (Serbia), where they could gain a qualification in 'psychiatry'.

Source: World Health Organization (2005).

primary care services were adapted to mental healthcare and, in addition to the CMHCs, sheltered housing services for patients with a chronic mental illness were established.

The reform of mental health services had a direct impact on the development of users' initiatives in BH: there are now several user associations, which are provided with professional support and education from CMHCs and psychiatry clinics.

There are only two wards and two specialists for child and adolescent psychiatry within the psychiatry clinics. There are four institutions for the care of adults and children with special needs and chronic mental disorders, mainly financed from social welfare. Persons with drug addiction are treated in a specialist institute and two other centres for addiction; methadone is the predominant form of treatment.

There are no specific programmes for the mental healthcare of minorities and the elderly in BH. There are programmes for refugees and war victims of torture, through a network of non-governmental organisations developed during the war.

The provision of forensic psychiatry services is insufficient. Individuals with mental health problems who commit criminal acts are treated in one forensic ward of a general psychiatry department of a prison psychiatry hospital.

According to the Regional Office of the Mental Health Project for South Eastern Europe (2004), in 2002 in FBH there were 159 neuropsychiatrists, in RS 67 and in Brcko District 6. The number of psychiatric beds in FBH was 632, in RS 640 and in Brcko District 30. These data differ from those in Table 1, from the World Health Organization (2005) and based on data collected from 2001 to 2004.

Treatment of traumatised persons

At the beginning of the war (1992) knowledge about the psychological consequences of war and therapeutic approaches to post-traumatic stress disorder (PTSD) in BH was rather poor. The therapeutic approach was based on the experience of psychiatrists and their receptiveness to the ideas suggested by the foreign literature and the many foreign workers (Jensen & Ceric, 1994; Hasanovic *et al*, 2006). At the end of the war, various psychosocial

programmes were organised by the government and international non-governmental organisations (de Jong & Stickers, 2003; Nelson, 2003). The psychosocial approach to trauma aimed to reduce not only the risk of serious mental disorders but also stigma, through mass education about the psychological consequences of trauma. Working with traumatised people during the war, we perceived that religious people coped more successfully with difficulties than those who were not religious. In selected cases, spirituality and religion are therefore used in the process of healing, and so they found their place in educational programmes and psychotherapeutic treatment. In hospitals, adequate rooms for the spiritual and religious needs of patients were allocated (Pajevic *et al*, 2005).

Psychiatric training

There are five medical faculties, two in RS and three in FBH, with different education programmes, all lasting 6 years. At four medical faculties, the undergraduate courses include only two semesters of psychiatry, while at one medical faculty the undergraduate course has only a neuropsychiatry element. Medical schools are associated with psychiatric clinics. After graduation from the medical faculty and a 1-year internship, specialisation in neuropsychiatry/psychiatry is available, authorised by the entity's Ministry of Health.

Specialist training is different in the two entities. In FBH there is specialisation in neuropsychiatry, which takes 4 years, with 20 months of psychiatry, while in RS there is a programme of education in psychiatry only, which also lasts 4 years. There is no unified national programme of psychiatric education for residents.

Psychiatric sub-specialties and allied professions

The educational programme for the specialisation in neuropsychiatry/psychiatry does not include psychotherapy. Residents from neuropsychiatry/psychiatry are familiar with the theoretical basis of psychotherapy mainly from their undergraduate education. There are no institutions for education in psychotherapy in BH, and there is no regulation of psychotherapy licences. Education in psychotherapy is organised from psychiatry clinics and by psychologists' associations, in cooperation with psychotherapist educators from other European countries.

The only recognised sub-specialisations are in social psychiatry and alcoholism and drug addiction, each taking 1 year. There is undergraduate education in psychology, but no specialisation in clinical psychology. Furthermore, there is no specialist training for psychiatric nurses. Additional psychiatric education for nurses is provided through special education programmes organised at the psychiatric hospitals.

Main areas of research

Psychiatric research in BH is insufficiently developed. There is no professional psychiatry journal, nor a particular institute for research in psychiatry. Existing research projects are undertaken at the psychiatric hospitals and medical faculties. The main areas of research are currently related to the psychosocial consequences of war trauma. Lack of a uniform

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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Perú 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