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REFORM OF MENTAL HEALTH SERVICES IN THE FEDERATION OF BOSNIA AND HERZEGOVINA

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Abstract

Pre-war psychiatric services in B&H were one of the best-organized in former Yugoslavia. The psychiatric care system was based on psychiatric hospitals and small neuropsychiatry wards within general hospitals, accompanied by psychiatric services in Community health center.

The war disaster brought demolition of numerous traditional psychiatric institutions. Moreover, psychiatric morbidity increased with massive psychological suffering of the whole civilian population. Already during the war, and even more so after the war, the reconstruction and reorganization of the mental health services was undertaken.

The basis of mental health care for the future is designed a system where majority of services are located in the community. The key role is assigned to primary health care (Family practitioners). Community based mental health centers (MHC) will be responsible for prevention and treatment of psychiatric disorders.

Chronic mental patients who are not able to live independently will be accommodated in designated homes and other forms of supporting living arrangement within the communities.

The principal change in mental health policy in B&H was a decision to transfer psychiatric services from traditional facilities into the community, much closer to patients.

Basic elements of the mental health policy in B&H are: decentralization and sectorisation of mental health services, intersectorial activity, comprehensiveness of services, equality in access and utilization of psychiatric service resources, nationwide accessibility of mental health services, continuity of services and care, together with the active participation of the community.

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This paper will discuss the primary health as the basic component of the comprehensive mental health care in greater detail, including tasks for family medicine teams as well as for each individual member.
Key words: *mental health, reconstruction of health care system.*

Introduction

Before the war (1992-95), the psychiatric services in Bosnia and Herzegovina were relatively well developed and represented one of the best organized such services in the republics of the former Yugoslavia.

There were a significant number of qualified professionals from various professions working above all in numerous in-patients psychiatric and other relevant institutions wherein the treatment of the mentally ill was effective and did not differ much from the treatment of such patients in some other European countries.

The basis of the whole system of psychiatric services was psychiatric hospitals and small neuropsychiatric wards of general hospitals accompanied by specialized psychiatric services in community health centers.

In general, Bosnia and Herzegovina psychiatric services system as a whole was until April 1992 organized based on the following principles:

a. In the majority of community health centers, there were psychiatric services staffed by neuropsychiatrists and nurses with psychologists and social workers as consultants. The psychiatric services in community health centers were in their work very closely related to primary health care services and dealt with treatment of psychotic and non-psychotic disorders. Activities aimed at prevention were given but a little attention, whereas the role of the community in promotion of mental health was almost completely neglected.
b. Within general hospitals on the territory of Bosnia and Herzegovina, there was a trend of establishing of small neuropsychiatric wards that treated acute psychotic and other mental disorders within a certain short time period.
c. On the territory of Bosnia and Herzegovina, there were at the same time big psychiatric hospitals (Sokolac, Jagomir, Domanovići) and a psychiatric colony (Jakeš near Modriča) that comprised a classic psychiatric hospital for chronic hospitalized psychiatric patients, a very developed occupational and work therapy, and accommodation for patients with hetero-families in

village households in surrounding villages (Garevac, Jakeš). Each psychiatric hospital had the average of about 300 severely disturbed chronic patients, while Jakeš near Modriča had between 800 and 1000 clients in treatment.

d. The treatment of alcoholism and drug addiction was organized through the Institute for the Treatment of Alcoholism and Other Addictions and the Center for the Treatment of Drug Abuse in the Psychiatric Hospital in Sarajevo. The primary and tertiary prevention of alcoholism was performed within 120 clubs of treated alcoholics.

e. More severely mentally retarded persons were treated in special institutions within the system of social welfare, whereas less severe cases of mental retardation were treated and rehabilitated within their families and educated in numerous specialized schools.

According to the data of the Republic Institute for Public Health, there were on December 31, 1991 in the neuropsychiatric services in Bosnia and Herzegovina 237 specialists neuropsychiatrists, 56 residents in specialistic study, 100 employees with two-year post-secondary school qualifications (senior nurses), 896 employees with secondary school qualifications (nurses) and 36 employees with lower educational background, whereas the total number of beds in all in-patient facilities was 2822 (1).

The war and destruction of psychiatric services in Bosnia and Herzegovina

During the first months of catastrophic events brought about by the war turmoil in Bosnia and Herzegovina, devastation and destruction was aimed at all spheres of life, including the closing and destruction of psychiatric hospitals and services. Psychiatric hospitals such as Jagomir and Domanovići were closed. Severely ill chronic mental patients were expelled from Jakeš. Many patients that had until then spent up to 20 or more years in hospitals were suddenly left on their own without any support. Some of them went missing and were never found, others were killed or wounded. Not a long ago, in the settlement Koprivna close to the Psychiatric Hospital Modriča, the exhumation of the mass grave of patients from Jakeš and Garevac killed in the spring of 1992 was performed. Found in the mass grave on the bank of the River Bosnia were remains of 33 bodies, out of which there were 16 female bodies. At another location, six more bodies were exhumed, while yet another mass grave with remains of 45 bodies of the patients from the same hospital was located. Such an inhuman treatment of such a handicapped group of people is unprecedented in the newer European history (2).

The precise data on the true quantitative consequences of the war catastrophe in Bosnia and Herzegovina do not exist and will probably never be known, by means of using the data of all three parties in the conflict, as well as the data of international organizations and institutions, and their mutual comparison, it is possible to get the numbers that are not far away from the truth.

Let us here, without having any pretensions to and at the same time being unable to describe all consequences of the war and its far-reaching implications, mention only some of the key ones that are mostly of a local character:

- Demographic losses in Bosnia and Herzegovina (in terms of the numbers of the slaughtered, killed, exiled that did not return, those that emigrated, that were not born and that died of consequences of war) in the period until the end of the year 2001 amount to 1.4 million persons (living in Bosnia and Herzegovina today are 3.1 million people, whereas there would have been around 4.5 million people if it had not been for the war);
- During the war in Bosnia and Herzegovina, approximately 236,500 persons were slaughtered or killed, out of which there are around 164,000 Bosniacs (about 126,000 civilians and around 38,000 soldiers), about 31,000 Croats (around 17,000 civilians and 14,000 soldiers), around 27,500 Serbs (about 6500 civilians and about 21,000 soldiers) and around 14,000 others (about 9000 civilians and 5000 soldiers);
- During the war in Bosnia and Herzegovina, approximately 225,000 persons were wounded;
- Approximately three-fourths of the total population of Bosnia and Herzegovina experienced immense suffering and humiliation and above one half of the population was forced to leave their homes;
- During the war in Bosnia and Herzegovina, the material goods worth about 35 billion dollars were destroyed or plundered.
- The losses in Bosnia and Herzegovina in terms of unrealized income until the end of the year 2001 amounted to about 125 billion dollars, and are estimated to amount to the additional 220 billion dollars until the year 2020;
- In Bosnia and Herzegovina and its neighboring countries, there is on the one hand a huge retrogression in the field of legislation, education, science, technology and many other areas, and on the other hand a true collapse in morale and internal security system.

Although it may be possible to establish how many people were killed or permanently physically debilitated, there is no simple way to

estimate the prevalence of psychological disorders that will deeply imbue the present and future generations and influence their future lives.

The intensity and frequency of the stated war atrocities are far from all normal human experiences, which makes perfectly understandable and fully justified the symbolic estimate of the WHO according to which there are over one million people suffering from war stress related mental disorders only on the territory of the Federation of Bosnia and Herzegovina. The biological defense mechanisms of persons that survived psychological traumas are severely impaired.

The catastrophic war events brought about turbulent and devastating disorders in the general population, and their severe repercussions have affected the whole health care system, including the system of psychiatric services (3).

The consequences of war can, if simplified, be divided into two focus areas that are mutually intertwined, and these are:

- War-induced traumatization of a significant portion of the population, and
- War-induced effect on the traditional system of psychiatric services through destruction of mental health institutions, great deterioration of the quality of mental health protection due to the lack of material resources, decline in the number of available health care professionals, as well as the destruction of social and family network, which limited the possibilities of discharging of patients and their treatment both in psychiatric institutions and outside of them (4).

Reconstruction and reorganization of the psychiatric services after the war catastrophe

During the war in Bosnia and Herzegovina and especially after it ended, the work on reconstruction and reorganization of mental health services began. The new system of organization of psychiatric services is based on the following principles:

- The future basis of mental health protection is conceptualized as a system wherein large part of the services is in the community, as close as possible to the place where the patient lives. The key aspect of the health care system as a whole is the primary health care, and the main role is given to family medicine physicians and mental health professionals working in the community.
- Large psychiatric institutions are either closed and/or devastated, or suffered a significant reduction in their capacities during the war. There will be no reconstruction and reopening of the old psychiatric institutions, nor construction of new ones.

- The most integral part of the psychiatric system is represented by community based mental health centers. Each of the centers will serve a certain geographic area inhabited by a certain number of people. The centers will be responsible for prevention and treatment of psychological disorders, as well as for promotion of mental health as a whole.
- Chronic mentally ill patients that do not have families and for any given reason can not live on their own within the community, will be accommodated in special houses and other forms of supportive living arrangements in communities where they come from.

Today in Bosnia and Herzegovina, we are trying to move the psychiatric activities from hospitals to communities, as close as possible to the places where people live. By doing that, we are working on transferring the interest that was earlier focused on the illness itself, towards the personality of the patient and his/her social dysfunction resulting from the mental disorder.

In order to be able to realize this, we are organizing ourselves so that we can replace individual activities with collective ones, using the cross-disciplinary approach by means of which we can enable mobilization of values and potentials of the patient himself/herself and his/her family.

At the same time, we are investing our efforts in intensive education of the general population about mental health problems with a special emphasis on alleviating and eliminating of stigmas and prejudice existing in our society against mentally ill persons.

We are trying to assign great importance to activities and cooperation with non-professionals as well as users of mental health services whose organization into associations we encourage and support.

Our efforts are also aimed at establishing the real value of biological and psychological therapies since we are aware that they alone cannot resolve the complex problems following from mental illness.

All our activities are directed towards maintaining, that is achieving the best possible quality of life of our patients. Therein we are especially taking care of all the legal and administrative conditions that are to serve as a guarantee of human rights of the patients.

In order for any of the above stated goals and intentions to be realized, we are attempting to enable a broad cooperation of mental health services with other sectors, especially social services, educational institutions and other important institutions in the community.

Helped by the international community, mental health services are going through a very slow but steady process of recovery, and so on

a new basis. The network of community based mental health centers is physically established within the deadlines defined in 1996 in the contract signed by the Government of Bosnia and Herzegovina and the World Bank.

However, it should be pointed out that we are still rather far away from the realization of the original plans for the reconstruction of mental health services and establishment of the full function of mental health centers network on the territory of the Federation of Bosnia and Herzegovina (5).

Mental health policy in the Federation of Bosnia and Herzegovina

Perhaps the most important change in mental health policy in the 20th century was the decision to move mental health services from in-patient psychiatric institutions to the community.

Until 1960s a general consensus was reached that milieu of big psychiatric hospitals did not enable satisfactory treatment and rehabilitation of patients with mental disorders, whereas their life in such institutions was not worthy of human beings.

It is for this reason that the number of psychiatric hospitals in Europe with over 1000 beds was significantly reduced between 1972 and 1983, for example in Denmark and Ireland from 4 to 2, in Sweden from 10 to 4, in Spain from 14 to 0, in Italy from 55 to 20 and in England from 65 to 23. Ever since, the trend of shifting the care of people suffering from psychological disorders from psychiatric hospitals have gradually but constantly moved the care of such patients as close as possible to the places where they live, so that the last few decades showed a clear commitment to this choice in many western countries (6).

The term "deinstitutionalization" was used to define this trend. Saraceno believes that, instead of deinstitutionalization, the term "dehospitalization" should have been used so as to avoid many traps and controversies following the concept of deinstitutionalization.

The term deinstitutionalization in his opinion primarily means the process of ending the rule and utilization of institutional psychiatric logic manifested through various forms of institutionalization, like institutionalization of diagnostics, of social invalidity, of forced hospital admission and treatment by new or old ready-made methods used regardless of the needs of patient and the nature of his/her illness. If only discharge from hospitals and prevention, i.e. prohibition of admission to psychiatric hospitals is set as the main and only "objective" of deinstitutionalization, the psychiatry will not change but will go on "in the old way" with the only change being its becoming a unique decentralized institution without walls. It is therefore logical to

look at dehospitalization as a fragment and a beginning of an infinite process that will serve to both patients and psychiatrists as a guarantee of constant critical reexamination of treatment and research in mental health domain. The process of deinstitutionalization continues nowadays in a more rapid way, although it is no longer going on within the walls of hospitals, whereas the dehospitalization process has in many countries ended or is in the final phase (7).

There are numerous and diverse examples of dehospitalization and continued deinstitutionalization in European countries. Establishing of community based mental health services in different countries and even different regions of the same country is done in different ways depending on the existing circumstances.

One of such models of organization of psychiatric services is the Italian model. It is based on the specific legislation representing the legal basis and "framework" of the organization of psychiatric care and its full reform.

Following the recommendations of the WHO, the basis of our mental health policy is contained in decentralization-sectorization of psychiatric services, intersectoral cooperation, comprehensiveness of services, equality in exercising rights, availability of all forms of mental health services in community, continuity of provision of services and active participation of the community.

In the end, it needs to be stressed that we have all the necessary conditions in order to realize, within the given deadline and on the whole territory of Bosnia and Herzegovina, the overall health care policy of the WHO stated in the 6th objective pertaining to the promotion of mental health and reading:

Until the year 2020 the psychosocial wellbeing of peoples shall be improved by means of developing better comprehensive services available to all persons with mental health problems regardless of very unfavorable demographic, social and medical indicators in Bosnia and Herzegovina (8).

The basic elements of the mental health policy in the Federation of Bosnia and Herzegovina

Decentralization-sectorization of mental health services

The basic concept in planning of mental health services in Bosnia and Herzegovina today is establishing of regional or sectoral responsibility. Therefore it is necessary to determine the sphere of responsibility for services in mental health domain, as well as to design services for a given population in order to enable people to be appropriately treated at places close to their place of living, which best

meets the needs of the patient, his/her family and the community. Establishing of sectors (or spheres of responsibility) is the basis of the new organization of mental health services in our circumstances at present.

Given the political and administrative organization of the Federation of Bosnia and Herzegovina, it is not simple to establish a new territorial organization of psychiatric services. The area of the sector is defined, as a geographic area including social structures that satisfy physical, psychological and social needs of the majority of people in the community. We should herein stress that people in a sector live together in a form of social organization and cohesion. Members of a community share to different extent the political, economic, social and cultural characteristics, i.e. interests and aspirations, including those pertaining to health. The community is, therefore, represented by a group of individuals mutually related by common experience, philosophy, moral, social beliefs, opinions and prejudice. The community is defined in terms of space but its exact boundaries are often impossible to determine since they are most frequently set due to political or administrative reasons. The area of the community is defined as a sector, i.e. a geographic area containing social structures that satisfy physical, psychological and social needs of the majority of community members. Each community has necessary resources of critical importance, like human (professionals and experts, laypersons, volunteers, ill and people with disabilities and their families), physical (buildings, equipment, services, economic resources, private property, business and industrial resources, etc.) and structural resources (municipal and other government services, local club organizations, business and industrial organizations, religious communities, etc.) (9).

Intersectoral action

The practical policy of mental health services must be integrated in the general health care policy of the Federation of Bosnia and Herzegovina that is its 10 cantons/counties. Therefore it is necessary at the level of the Ministry of Health and the Government of the Federation of Bosnia and Herzegovina to revise the programs of a number of various sectors in order to ensure a more purposeful and different promotion of mental health. In such different system of the organization of mental health services a special role and importance belongs to the sector of social welfare and social aspect in general.

This is all the more so since it is in the present circumstances almost impossible to realize and work on the promotion of mental health, prevention of mental disorders and psychosocial rehabilitation of chronic mental patients without adequate social care and professional

services of social work that certainly bring a new dimension into medical treatment of the patient enriching it with a more human, different and specific approach.

Although the presence of social work in the area of health care, i.e. in various types of medical institutions in the world, has been there for almost nine decades, getting its confirmation in the everyday practice of social workers, (unlike the developed countries of Europe and the world) the social work practice has in our country not yet been given the due position and appropriate professional dignity. It therefore appears that the new approach to organization and reform of mental health services in the Federation of Bosnia and Herzegovina represents a realistic possibility for the social work profession to get a due place in our system, with the main goal being the patient's wellbeing through treatment, more rapid recovery and social and professional rehabilitation. This is all the more the case since the everyday reality imbued with dreadful consequences of the war (affecting not only the mental health of the population), absolute poverty and social distress, imposes a need for a special kind of help to the patient. The fact proved in practice that there are, in the area of mental health, an increasing number of patients that, in addition to psychological difficulties, suffer from threatening social circumstances, undoubtedly speaks for itself about the close connection between the medical condition of the patient and numerous unfavorable social aspects and problems surrounding him/her. This all implies the need to include all possible social elements in the treatment of such patients, from the family to a broader environment wherein the patient lives and spends his/her time.

Deeply present awareness of unfavorable economic and other resources of the society should in no way represent an obstacle in providing, at least in the beginning, a legislative basis with a view to giving the social sector and social work profession a necessary position of priority in the reform of mental health, following the example of the countries where this approach has already been established. The number of social workers in a mental health center should thus be proportional to the size of the population of the local community served by the center. Naturally, we are still far away from the established world standard of one social worker per 3,500 inhabitants. It is with this regard necessary to create possibilities for social workers within mental health services to do jobs of various degrees of complexity, from individual and group sociotherapy to management, organizational and leader jobs for example in mental health centers. Such approach implicitly includes additional efforts in permanent education and professional specialization of social workers in particular, but also of other professionals in multi-disciplinary teams, which at the same time imposes the need for necessary changes in socio-health care policy of

the society as a whole that itself represents a basic condition for the transformation of social work.

Comprehensiveness

The comprehensive mental health policy in the Federation of Bosnia and Herzegovina especially promotes the protection of mental health as a whole on the level of local communities in corresponding defined sectors without reduction of function of any psychiatric institution and/or service, and in-patient psychiatric institutions in particular. It is for this reason that there was after the war no, nor there will in future be any reconstruction and/or construction of big or small psychiatric hospitals. Protection of mental health as a whole will be carried on in the community with the help of teams of family medicine physicians and specialized multi-professional teams in mental health centers and psychiatric wards of general hospitals and in-patient wards of clinical institutions. Always encouraged therein is seeking of alternative solutions for hospitalization that will by no means represent breaking of connections with the family and community. All the services are a part of the comprehensive system of differentiated mental health services especially designed so that they can meet the needs of the general population, as well as special age and risk groups.

Equality

Inequality and stratification are the basic characteristics of a modern social life. The modern world is based on the productivity and competition and inequality is a powerful force that drives it by means of money thereby determining the way and quality of life and destiny of the individuals and groups. Income, prestige and education level are nowadays the three most frequent indicators of inequality and social position of people. An important force that is already generating inequality and will be its source even more in future is the power of information since it is obvious that those who can create information have control over those that use it.

However, we need to bear in mind that there are other equally important inequalities and distances in human society, measured by other indicators and markers, like, e. g. ethnic or racial status wherein the racial status is a social category indicating a common genetic history, and ethnic status a recognizable social category suggesting a common cultural history. There are numerous indicators showing that social inequality and socioeconomic stratification directly influence the frequency of mental disorders, sometimes even more than cultural and even genetic factors.

Added here should be sex as yet another important indicator of inequality in modern societies that, due to its biological nature has a great role both in the arena of social stratification and in development of mental disorders. Many empirical studies in the field of sociology and social psychiatry are attempting to explain why people from lower social classes develop mental disorders much more frequently than those from higher classes. Numerous analyses showed that persons suffering from severe mental disorders are also severely handicapped on the labor market and are consequently not able to maintain the class status that would be expected based on their personal history.

The factor of belonging to a certain social class, i.e. the consequent social deprivation represents an important risk for developing of mental disorders. Established today are many other corresponding mediators of developing of mental disorders, like so-called "biological causes" (exposure to toxins, infections, allergens and unsafe working environment with high risks of injury), and "non-biological causes" wherein the most frequent ones are social and psychological stressors, that is the identified stress-imbued living environments. Based on the few stated observations, it is clear that, although the material conditions of living are improving, inequality of people in modern society is on the increase accompanied by all the risks following from it.

If we take into consideration the above mentioned "normal" factors of inequality and add to them the indicators of inequality in the present posttraumatic society of Bosnia and Herzegovina resulting from the years of war cataclysm (1992-1995), it becomes clear that equality in distribution of resources and approach to health care and its services is extremely difficult to achieve, especially when it comes to people suffering from mental disorders that represent a very vulnerable segment of population in the community.

Bearing in mind the large number of persons suffering from war stress related mental disorders, large number of the disabled, high percentage of unemployment (up to 40%), increase in the number of suicide, homicide and other violent acts in the community, family violence, occurrence of prostitution and increase in abuse of alcohol and drugs, it is obvious that establishing of equality in using of all segments of mental health services in Bosnia and Herzegovina is very hard to achieve.

At the moment, the main means of establishing some sort of equality and realizing the planned mental health and other policies, especially social policy, is the appropriate legislation. With this respect, first steps were made by introduction of mental health, i.e. mental rehabilitation in the Law on Health Care in Federation of Bosnia and Herzegovina, and particularly by preparation of the Law on Protection

of Persons with Mental Disorders, which was adopted by the Parliament. All needs to be done in order to obtain appropriate legal provisions that need to symbolize the stated and the still unspoken social attitudes and intentions of the society of Bosnia and Herzegovina aimed at maintaining the integrity and dignity of every individual with mental and psychosocial difficulties.

Availability

The right to treatment makes sense only when the treatment is available, and it is up to legislation to ensure the obligation of the health care system to provide it.

In this sense, the legislation represents a declaration of policy and manifestation of principles, i.e. social ideals of a society, whereas the medical indicators are true signs of practical distribution of entire resources of the community, including therein the distribution of resources allocated to health care and mental health in particular.

Continuity

In order for individuals to function within the community it is necessary to have a number of inter-related offices and services, including those services ensuring the fundamental human rights. With a view to ensuring the continuity of mental health protection, we will use the medical model, rehabilitation model and the model of social support aiming at satisfying the majority of needs of persons with short-term and long-term mental disorders. What we need to be aware of herein is that the comprehensive model of community based mental health protection is not represented by the buildings themselves, but by the system enabling persons with mental health problems to move from one level to the other, i.e. from one service in the system to the other without any obstacles.

As we have stressed for a number of times, the whole "new" mental health policy would make no sense at all without a very active participation of the community.

Active participation of the community

In the area of mental health, there are no good results without participation of individuals and the community in defining the policy. Therefore, mechanisms whereby people would be able to express their opinions, wishes, messages and decisions have to be established.

All activities in the area of community based mental health, i.e. in the sector, must be the result of agreement reached between citizens

and mental health care providers. In other words, they have to be accepted by the total population of the sector, that is the community of its inhabitants.

Comprehensive programs of mental health promotion and the very mental health services within community-based programs cannot be provided either by health care, or by the community alone. The effective policy and programs can be developed based on agreements, taking into consideration the needs identified both by those responsible for policy and services, and community members in need of the services. What has to be taken into consideration therein are the prevailing attitudes of the community towards mental illness and persons debilitated by mental disorders, which will ensure that the policy and services meet the specific needs of various communities in the sectors, i.e. mental health centers of the Federation of Bosnia and Herzegovina, as well as the varying needs of specific groups in individual communities. Due to the political and state organization of the Federation of Bosnia and Herzegovina, its mental health policy is specific both in the content and in implementation. The entire general policy of mental health, as well as the health care policy as a whole at the level of the Federation of Bosnia and Herzegovina, is executed by the Federal Ministry of Health. In the Ministry of Health, there is a special advisor for the problems of mental health. In each of 10 cantons, the Federation should appoint a responsible person that will be in charge of the mental health problems and will be employed in the Ministry of Health of his/her canton (county). It is in this way that the needs, demands and resources of cantons (counties) and local communities are being fully respected. It is also only in this way that we can simultaneously take into account the other sectors important for mental health, like education, police system, prosecution and juridical system, social welfare, issues pertaining to ecological problems and working conditions, as well as to special groups like displaced persons, children and adolescents, elderly, women, persons abusing substances and others. The comprehensive system of community based mental health protection, as we have already stressed, can not function without relying heavily on the "third sector", that is non-governmental organizations, associations of volunteers, associations of former patients and their family members, associations of service users, self-help groups, etc. These organizations can give an important contribution in realization of the proclaimed mental health policy and the planned mental health program. In many instances, these organizations can point out at and, by that means, correct the shortcomings, mistakes and ineffectiveness in the comprehensive system of community based mental health protection. In order for this model and the promotion of mental health to be realized, it is necessary, on the basis of the established policy, to

state the general priorities based on the identified needs of the local community, taking into consideration the available resources. Naturally, given the extremely difficult situation in the domain of mental health, it is necessary to first state the priorities based on the identified needs and established resources, and then select those priorities that need to be resolved immediately (10, 11, 12, 13).

General mental health program in the Federation of Bosnia and Herzegovina

Based on the established policy, we have conceptualized the program as a plan describing the priority needs and serving as a basis for organization of a group of activities aimed at achieving certain general and specific goals. Problems related to mental health in the Federation of Bosnia and Herzegovina represent an important priority that might very rapidly become a great burden for the society that has recently emerged from war and is traumatized to the point that it represents a genuine posttraumatic society. There are various sources confirming that this is truly so. For example, according to the already stated data of the Bosnia and Herzegovina Institute for Public Health from the year 2001 showed that, the total number of citizens at that time was 3,690,426. The same source claims that there are still 601,900 refugees from Bosnia and Herzegovina around the world, whereas the total of 487,652 are displaced persons within the country that are, due to various reasons, unable to return to their homes. Over 300,000 citizens are persons with disabilities. There is statistically registered decline in natality whose rate is regressive (in 1981 it was 17.2 and in 2001 – 9.04). At the same time, the mortality rate is on the increase (in 1981 – 6.3, 2001 – 6.84). Other important parameters are given in detail in Table 1.

In the course of the year 2000 and 2001, the Bosnia and Herzegovina Institute for Public Health performed a research study on the whole territory of Bosnia and Herzegovina, i.e. in the both entities and in the Brčko District, in 15 municipalities and on the sample of 2211 families from Bosniac, Croatian, Serbian and other ethnic groups, and by that means estimated the existing situation in respecting of human rights to life and health of the citizens of Bosnia and Herzegovina, with a special emphasis on the rights of displaced persons and returnees.

Table 1. *Demographic, social and health indicators in B&H for the period 1981-2001.*

Social and Health indicators	*1981*	*1991*	*2001*
Population	4.124.256	4.395.643	3.690.426*
Refugees	-	-	607.900**
Displaced persons	-	-	487.562
Natural growth	10,9	7,7	2,19
Biological type of population	*Progressive*	*Stationary-regressive*	*Regressive*
Natality	17,2	14,9	9,04
Mortality	6,3	7,2	6,84
GNP per capita in US$	1.707	2.719	1.230
Social product per capita in US$	1.876$	3.151$	2.106$
Employed: unemployed ratio	5,83:1	3,17:1	1,36:1
Average monthly income in US$	190	299	179
Health care participation in% of GNP	4,6%	11,7%	4,47%
Hospital beds per 1000 citizens	4,1	4,53,7	
Physicians per 1000 citizens	1,1	1,6	4,5
Nurses per 1000 citizens	3,9	4,6	1,4
Immunization coverage	85%	98%	80%

* Preliminary data, the estimation based on the status of January-September, 2001

** Bulletin refugees from Bosnia and Herzegovina and displaced persons – Ministry of Human Rights and Refugees to the B&H Council of Ministers

The study showed the alarming data that 42% of pollees believed that exercising of the right to health care was not ensured; 33% stated that the right to education was not ensured; 34% said the right to work was not ensured; 11% claimed it was not possible to receive medical services in the closest health care institution regardless of the place of living in cases when life was threatened; 50% of pregnancies could not be controlled regularly and free of charge, nor could the deliveries be performed free of charge; 21% of children were not regularly vaccinated; 31% of pollees gave up the prescribed treatment because they were not able to buy the prescribed medication or get it free of charge.

In addition to all the above stated, there is a huge decline in the employment rate (39% of the total labor force is unemployed), as well as the decline in the amounts of monthly salaries of the employed (US $ 299 in 1991 as compared to US $ 179 in 2001). Payment allocations for health care from the national product are on the constant decline and in the year 2001 they amounted to 4.47% (14).

Due to a number of different reasons, the population of Bosnia and Herzegovina lives in a very insecure and dangerous environment, threatened by mines and other unexploded ordnances, residual chemical, biological and radioactive materials that can still, six years after the end of war, cause illnesses and severe injuries to people and especially children.

According to symbolic estimates of the WHO, there are at the moment on the territory of the Federation one million people suffering from war stress related psychological disorders. Some believe that the real number may be much bigger. The complete pre-war structure of the psychiatric services is, both physically and in terms of personnel, destroyed to a significant degree.

Due to all the above stated, the basic strategy in realization of the plan and program of the reconstruction of mental health services on the territory of the Federation of Bosnia and Herzegovina, is establishing of the new model of organization of the comprehensive mental health services, which will enable persons suffering from mental disorders to live and receive treatment in their homes or as close as possible to their homes within the local community, and so in the best and most effective way.

The basic strategy of promotion of mental health, prevention of mental disorders, treatment of acute psychological disorders, psychosocial rehabilitation and protection of chronic mental patients, can be set out in simple terms through the following principles:

1. Primary health care physicians provide comprehensive psychiatric care, specialized community based mental health centers, and psychiatric wards of general hospitals and clinical in-patient institutions providing the "acute" short-term hospitalization.
2. Primary mental health protection was providing by family medicine physicians (primary health care physicians) and their teams.
3. Specialized psychiatric teams of professionals provide care in the community professionals specialized in mental health problems within mental health centers providing services in the given sector.
4. Herein, great importance is given to building and utilizing of connections and establishing of absolute trust between teams of family medicine physicians and specialized teams in mental health centers and psychiatric institutions for acute hospitalization.
5. Psychiatric wards within general cantonal/county hospitals, wards of psychiatric hospitals in Sarajevo, Tuzla and Mostar, as well as the Cantonal Psychiatric Hospital Sarajevo (Jagomir) will provide hospitalization for acute patients, and for chronic patients (in case of any new deterioration of their condition). The treatment in these wards will be short and patients will go back home continuing to

receive treatment from the family medicine physician or in the mental health center.

6. Chronic mental patients, i.e. persons with severe defects of social, psychological or somatic dimension of their personality resulting from mental illness, will, as a rule, live on their own or with their families within the community. Those chronic mental patients that do not have families, nor economic or other necessary conditions to live on their own, will be accommodated in special, supervised houses located in the town where they live, that is in the community that they come from. These supportive living arrangements can be organized in various ways. We have decided to establish the following forms in future:

- Nursing homes intended for chronic patients with serious, severe and permanent dysfunction, with around-the-clock available supervision and care by nurses, and beds for permanent stay of such mental patients.
- Half way houses for patients recovering from acute psychotic episodes resulting in psychosocial breakdown of the personality of the patient. These houses are, as a rule, situated next to the hospitals and are run and supervised by nurses. Patients stay in them for a long time, but the period of their stay is still limited.
- Group homes for permanent accommodation of persons suffering from chronic psychiatric disorders. Patients live in such homes independently, although their autonomy is still limited.

The above stated strategy of the program of mental health protection on the territory of the Federation of Bosnia and Herzegovina has basic and specific tasks.

The basic tasks of the program are:

- Reduction of the incidence and prevalence of some mental disorders and suicide, especially those related to the war stress.
- Reduction in the level of dysfunction resulting from mental disorders by means of improvement of treatment and protection of persons with mental disorders.
- Improvement of psychosocial wellbeing of persons suffering from mental health problems by means of organizing of comprehensive and accessible mental health services based in the community.
- Respecting of fundamental human rights of persons debilitated by mental illness.
- In addition to the basic tasks, the program also has specific tasks the most important of which are the following:
- To detect mental disorders as early as possible and ensure appropriate care and treatment.

- To direct all attention towards promotion of mental health and fighting mental disorders, especially in socially and economically threatened and vulnerable groups.
- To organize and further develop the living and working environment in order to help people from all age groups to develop feeling of closeness and coherence, build and maintain social relationships and cope with stress situations and adverse life experiences.
- On the part of the services for care of persons with mental health problems, to provide care and all forms of high quality treatment, organizing the work of community-based and hospital-based services in a balanced way, and giving a special attention to interventions on persons going through crises, as well as to minority and vulnerable groups.
- To reduce and alleviate other adverse circumstances related to mental disorders (somatic illness, disturbed psychosocial functioning, low social status, family problems and concerns).
- To work on establishing a positive social climate.
- To change the negative attitudes towards mental illness and persons suffering from it.
- To improve the quality of living of people with mental disorders.
- To rehabilitate persons suffering from mental disorders so as to reach the level of their optimal social reintegration.
- To ensure basic and permanent education of professionals working in mental health services.
- To ensure systematic supervision and control of the work of personnel employed in mental health services.
- To establish the information and patient registering system.
- To stimulate research in the area of mental health with a special emphasis on research of the services.
- To provide monitoring and evaluation of the program in a systematic and periodical fashion.

Understanding the practical goals in the broadest sense as quantitatively defined indicators of activities that need to be performed or changed within the given deadline, we have, starting from 1994, changed and upgraded the goals of the program after every two years. Eventually, in the period 1996-1998, after signing of the contract between the World Bank and the Federal Ministry of Health, we directed the practical goals primarily towards the physical reconstruction of community health centers wherein the future community based services will function. In the period 1998-2000, all our efforts were directed towards the implementation of community based mental health services

program in accordance with the principles of comprehensive and equal organization of mental health services, as well as towards education of personnel of various professional profiles, and education of the whole community wherein the services are situated.

The most important goals in the present two-year, that is five-year period 2000-2002-2005, are the following:

Until the year 2002, to implement the program of reform of mental health through ensuring full functioning of all 38 mental health centers on the territory of the Federation of Bosnia and Herzegovina.

Until the year 2002, to perform a ten-day additional education and re-education of at least 50% of all professionals employed in mental health services in the Federation of Bosnia and Herzegovina.

Until the year 2005, to create the conditions for 80% of all mental health problems to be treated by teams of family medicine physicians (primary health care physicians) and specialized mental health services, i.e. community based mental health centers.

Table 2. *Indicators and standards for Program of Mental Health protection program in Federation of Bosnia and Herzegovina*

Area	Criteria	Indicator	Standard
Organization of services	Sectorization	Adoption of sectorizing principles	38 CMHC Psychiatric clinics Jagomir Hospital
	Location of psychiatric beds	Psychiatric beds in general hospital	At least 50%
Accessibility of mental health services	Available hospital beds	Bed/population	0,5/1000
	Distance from nearest mental health institution	Inhabitants that lives one hour drive from the nearest institution	<20%
Staff	Psychiatrists	Psychiatrist/population	1/10.000
	Social workers	Social workers/population	1/10.000
	Psychologists	Psychologists/population	0,3/10.000
	Psychiatric nurses	Nurses/population	4/10.000
	Occupation therapists	Occupation therapists/population	0,1/10.000
Budget	Budget for mental health	% of budget for health care dedicated for mental health	At least 10%
Human rights	UN Charter on Human Rights	Formal approval	Yes
	Compulsory treatment in psychiatric institutions	Compulsory admissions (in%)	<10%

In order to be able to monitor the real level of realization of the defined practical goals of the program, it was necessary to establish criteria, indicators and standards of the program, which we have done to a high extent, following the recommendations of the WHO, as can be seen in Table 2.

The program was from the very beginning monitored and evaluated in a fairly adequate way, primarily by international experts as representatives of the creditor (World Bank) and donors (SWEBiH, HealthNet International, etc.).

Naturally, we have to continue the monitoring and evaluation in an even more strict fashion in order to be able to compare the present "zero" state of the program with the expected results and states in accordance with our detailed program.

We have worked on these activities and will continue to work on them in the course of the realization of the program so that we can make timely and necessary, tolerable corrections as the program implementation develops. What needs to be kept in mind therein is that the main task of the impartial evaluation process is to perform the interventions in the course of the program implementation in accordance with the program tasks, i.e. goals. Moreover, the evaluation needs to clearly determine the influence of the intervention and its connection to the defined activities, as well as the kind of the influence (positive, negative or irrelevant). In the course of the evaluation process, reliable and precise notes need to be kept using certain indicators.

Specialized community based mental health services

Psychiatric services in the community are, together with primary health care teams, responsible for care of the mental health of the community as a whole, and of all patients with mental disorders including those that are "most severely affected".

Community psychiatry, that is public psychiatry today, covers all aspects of care, starting from the usual psychiatric, diagnostic and therapeutic interventions, to partial and full hospitalization, case management, interventions and help in crisis situations, and up to providing of supportive living arrangements. The main organizational structure and prototype of institution of community -based psychiatry are mental health centers (MHC).

MHCs are the integral part of the primary health care and they are from the functional aspect connected with other primary health care services (e.g. family medicine physicians), with secondary health care (wards for acute hospitalization, organization of supportive living arrangements for chronic mental patients, etc.), with centers for social work and other institutions relevant for primary, secondary and tertiary

prevention, that is treatment, rehabilitation and re-socialization of persons with psychological disorders.

MHCs very closely cooperate with the "third sector" of non-governmental organizations and certain service user and volunteer associations.

Community based mental health center is located at the level of primary health care and is responsible for a geographic sector inhabited by the population of 25,000 to 50,000 people. The size of the sector, as well as the number of citizens covered by individual MHCs varies from one center to the other, depending on specific differences in geographical and distribution of settlements and population. This, of course, also depends on various human and financial resources in individual areas.

The MHC is, from the organizational aspect, situated within the primary health care with strong functional connections with all primary health care services, and family medicine in particular. Functional connections are also established with in-patient psychiatric institutions, as well as social and other institutions and areas of work in the given sector.

The basic principle of work is the work in the home of the patient, in his/her family and the wider community.

The partial hospitalization within MHCs represents a day care wherein patients with special needs stay in the facility during the period varying from two to twelve hours, with provided specialized individual and group therapeutic programs and full responsibility of the personnel during the period of the treatment.

If MHCs are functioning optimally and in full cooperation with other institutions and authorities, they can organize a special care for certain risk groups in the general population (children, adolescents, addicts, elderly).

Optimally functioning MHCs, together with primary health care services, take over the responsibility of resolving all mental health problems on a certain territory up to the level of 80% of total needs.

Cooperation and mutual connections among MHCs at entity levels and at the level of Bosnia and Herzegovina as a whole, are necessary with a view to creating a common doctrine of community based mental health care, evaluating the development of the system, as well as introducing certain corrections after a period of their full functioning.

The monitoring and supervision are necessary and include expert and organizational supervision of the system as a whole and at the entity level by entity reference centers or expert groups.

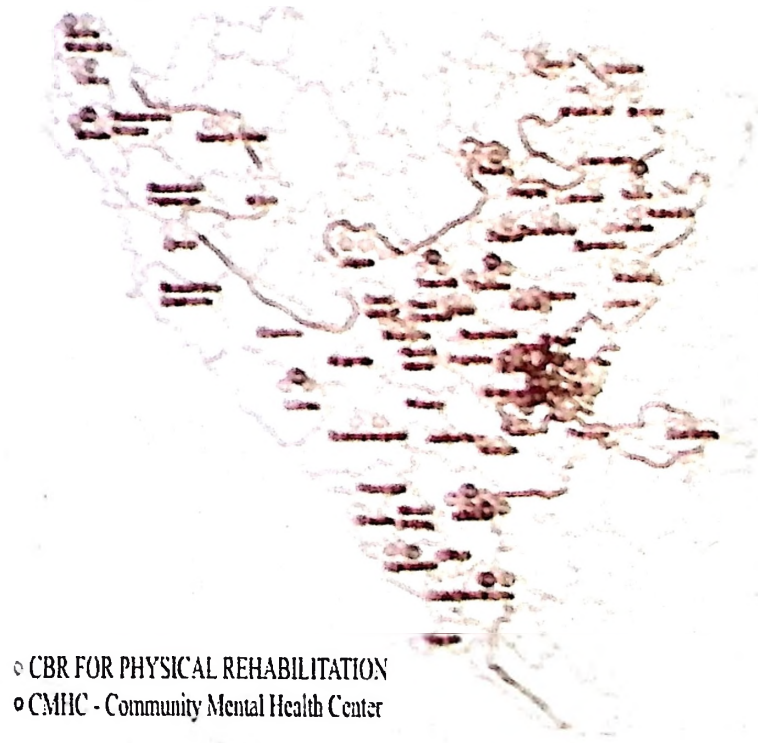
The basic principle of work in the MHC is teamwork performed through permanent and everyday functioning of multi-professional

psychiatric team comprising of the minimum of a psychiatrist, psychologist, social worker, four trained psychiatric nurses and an occupational therapist. In order for such a team to function well, it is necessary that its each individual member applies his/her knowledge and that mutual trust and high professional responsibility always exists. Owing to prejudice, but also to certain objective circumstances in our current situation, the team leader is always a specialist psychiatrist.

On the territory of the Federation of Bosnia and Herzegovina, we have to date established 38 mental health centers. The majority of centers are functioning. At the moment, two more centers that were not planned are being established, their organization being put together by local health care institutions that have understood the importance of such centers and the need for their establishment.

The geographic distribution of the centers can be seen on the enclosed map titled Figure 1.

Figure 1. *Bosnia and Herzegovina, Federation of Bosnia and Herzegovina*



Each mental health center has available 10 psychiatric beds intended for acute hospitalization and located in psychiatric wards of general hospitals and clinical institutions.

The concrete tasks of the specialized multi-professional team could in general be summarized in the following way:

- To provide comprehensive medical and psychological care for all persons suffering from serious mental illness related to severe functional damage and disabilities.
- To diagnose, treat and do the follow-up of patients coming to the MHC for help on they are own, or those referred by team of family medicine physicians or other primary health care practitioners.
- To participate as a team in education and consultation for employees in the primary health care.
- To act as consultants to primary health care providers, which requests a permanent interaction with family medicine physicians, nurses and other personnel, with a view to developing and maintaining mental health related skills in personnel employed in the primary health care.
- To establish the administrative framework for coordination of mental health protection in the MHC's sector of responsibility.
- The population for which a certain MHC is responsible should be in the "authentic" natural ambience and sector.
- The size of the sector's population needs on the one hand to be sufficient so that the MHC activities can be effective in their full range and provide the whole diversity of services, and on the other hand, it needs to be small enough to enable the smooth functioning of the center.
- The services need to be accessible to the population of the sector wherein the given MHC functions.
- 2% of the population in any given year and any given moment is seeking the services of mental health service providers due to mental health problems, and out of this number 80% is seeking the services from family medicine physicians and MHCs.
- To provide immediate care for patients referred by the family medicine physician (primary health care doctor) or coming directly to the center.
- To do the follow-up of patients discharged from psychiatric wards.
- To provide the supervision of personnel in primary health care institutions.
- To provide help to other organizations in the community like schools, prisons, etc.

- To cooperate with the center for social work.
- To cooperate both widely and concretely with non-governmental organizations, associations of former patients, volunteer groups, etc.

Based on the given list of tasks and jobs of the multi-professional psychiatric teams in mental health centers, we can clearly see the range of work that is very extensive but, if done systematically, can be performed fairly easily and without difficulties.

Naturally, in order for the team as a whole to be able to perform all these tasks, its individual members must be aware of their special responsibilities, starting from the team leader that is a specialist psychiatrist, via psychologist, social worker, psychiatric nurses and on to occupational therapist.

The project of reconstruction and reform of the psychiatric services in the Federation of Bosnia and Herzegovina was officially started in 1996, after signing of the contract with the World Bank whereby a long-term credit was given for the physical and psychosocial rehabilitation of the victims of war in Bosnia and Herzegovina. Out of this rather big credit, approximately 5 million dollars have been spent for the reconstruction of mental health services.

In the course of the first two years of the project, areas in community health centers allocated for mental health centers were physically reconstructed according to the unique project.

The premises were reconstructed and equipped. Adequate furniture was purchased and information system established. The necessary literature was also purchased.

The most difficult and most important part of the project of reform of mental health services had already began before the war ended in 1994/95, when the WHO organized one-year post-graduate course in the area of psychological trauma and its treatment. 150 psychiatrists, psychologists, social workers and nurses have successfully completed this important course. This was the beginning of the education process that is necessary for any change in the system, let alone such a radical undertaking as our reform of mental health services. Ever since, the intensive and continuous education has been conducted through seminars, consultation, study trips of our experts to other countries and visits of foreign experts serving as supervisors of the work of our mental health centers in the field.

For two years already we have been publishing the professional magazine "Mental Health in Community" with articles of both local and foreign experts. This has now become an integral element in the reform of mental health services.

In the area of education, there are at the moment several parallel and important on-going projects.

In the Travnik Canton, the Harvard Trauma Center from Boston is completing a very important three-year pilot project of education of primary health care physicians in the area of mental health. This intensive program has proved itself very useful in expanding the knowledge of family medicine physicians in particular. At the moment, the Harvard experts are conducting an identical program in New York, educating in the same way the primary health care physicians for providing help to people suffering from consequences of the catastrophic events.

The University of Sarajevo is, together with the University of Umeö from Sweden, completing a two-year post-graduate study in the domain of child and adolescent psychiatry. 30 students, psychiatrists and psychologists from all parts of Bosnia and Herzegovina are finishing this course.

A multi-disciplinary study attended by 30 psychiatrists, psychologists and social workers have just been completed at the University of Sarajevo. The main theme of this study was community psychiatry. The students attended the lectures of very competent experts and they spent one semester abroad working practically in Great Britain, Italy and Slovenia.

The further education of both professionals in mental health services and non-professionals, as well as the general population, will be continued permanently and intensively since it represents one of the most important segments and conditions of the reform in our country.

This summarized review of the reconstruction, i.e. reform of mental health services on the territory of the Federation of Bosnia and Herzegovina in the war and post-war period and in the country that is in addition going through the period of transition, shows how much energy, will and resources need to be invested in this huge undertaking that is from the temporal aspect unlimited and has numerous problems and obstacles yet to come.

Still, it appears that the most difficult period of reform is now behind us and that the further implementation of this program will go on more smoothly (15, 16).

Apstrakt

Psihijatrijska služba prije ratne katastrofe u Bosni i Hercegovini bila je relativno dobro razvijena i jedna od najbolje organiziranih u republikama bivše Jugoslavije. Osnovu cijelog sistema psihijatrijske zaštite činile su psihijatrijske bolnice i mala neuropsihijatrijska odjeljenja općih bolnica koje su pratile specijalističke psihijatrijske službe u Domovima zdravlja.

Prvih mjeseci katastrofičnih ratnih zbivanja u BiH, došlo je do pustošenja i razaranja u svim domenima života, uključujući i razaranje i

zatvaranje brojnih tradicionalnih psihijatrijskih institucija uz masovnu psihološku traumatizaciju cjelokupne populacije stanovništva.

Tokom rata, a naročito nakon njegovog završetka, započeta je rekonstrukcija i reorganizacija službe za mentalno zdravlje. Planirana osnova zaštite mentalnog zdravlja osmišljena je kao sistem u kojem se veliki dio službi nalazi u zajednici, što je bliže moguće mjestu življenja pacijenta. Ključni aspekt sistema sveukupne zdravstvene zaštite je primarna zdravstvena zaštita, a glavna uloga pripada ljekarima porodične medicine i profesionalcima mentalnog zdravlja koji rade u zajednici.

Velike psihijatrijske ustanove su bile zatvorene, često devastirane, ili su im kapaciteti bili tokom rata znatno smanjeni. Smišljeno, nije došlo do rekonstrukcije i ponovnog otvaranja starih psihijatrijskih ustanova, niti gradnje novih.

U poslijeratnom periodu integralni dio sistema zaštite mentalnog zdravlja predstavljaju Centri za mentalno zdravlje u zajednici. Svaki od ovih centara opslužju pripadajuću mu teritoriju u kojoj obitava određeni broj stanovnika. Centri su odgovorni za prevenciju i liječenje psihičkih poremećaja, kao i unapređenje cjelokupnog mentalnog zdravlja.

Hronični mentalno oboljeli pacijenti koji nemaju porodica i ne mogu, iz bilo kojih razloga, samostalno živjeti u zajednici, biće smješteni u posebne kuće i druge oblike zaštićenog stanovanja u zajednicama iz kojih potječu.

Ključne riječi: *mentalno zdravlje, rekonstrukcija zdravstva.*

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