

# Regional Collaboration in Reconstruction of Mental Health Services in Bosnia and Herzegovina

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**The war in the former Yugoslavia between 1991 and 1995 destroyed the mainly hospital-based mental health care system in Bosnia and Herzegovina. This report summarizes the situation before and after the war and describes efforts to rebuild and reform mental health services under politically and economically challenging conditions. As a result of these efforts, there are now 39 multidisciplinary community mental health centers that are linked to primary care and that aim to provide prevention, treatment, and rehabilitation of mental disorders. The reform process has been supported by international initiatives and is now continuing in collaboration with other countries in South**

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Bosnia and Herzegovina could be considered as the heart of former Yugoslavia, both geographically and culturally. It had a population of 4.36 million people (1991 census figure), 44 percent of whom declared themselves Bosniaks (Muslims), 31 percent Serbs, and 17 percent Croats; there were also significant numbers of Jews, Roma, Albanians, undetermined Yugoslavs, and others (1). However, the ethnic diversity did not equate with territorial or social division. For centuries, the different parts of the society had developed within a common historical, linguistic, and cultural space, giving rise to a specifically Bosnian paradigm of unity within diversity.

For four years, Bosnia and Herzegovina was torn by the most ruthless armed conflict in Europe since World War II. Its capital, Sarajevo, was the focus of a long-lasting siege. Its territory was divided into ethnic enclaves, and accounts of mass killing and rape shook the world's conscience. After the signing of the Dayton accords in November 1995, the country has been emerging from that torment and facing the challenge of reconstruction and reconciliation, working toward free elections and bringing accused war criminals to justice.

During the war the population de-

clined, and the present population is estimated to be 3.99 million, with a growth rate of .48 percent. More than 600,000 people are refugees, and there are an additional 500,000 internally displaced persons. The unemployment rate is around 50 percent. Information about the ethnic distribution varies substantially depending on the source, and reliable recent census data do not exist (1,2), because the last census was performed in 1991, before the massive sociodemographic changes due to war and war-related migrations in the Balkans took place.

## **Mental health care in the former Yugoslavia (1945 to 1992)**

Before the war mental health care in Bosnia and Herzegovina was in line with that in the rest of former Yugoslavia, based on asylum-type institutions and smaller psychiatric wards in general hospitals. The total number of beds was 2,822, or 64 beds per 100,000 population. Strengths of the system were a large number of qualified staff and generously funded social welfare services.

Community-based mental health services were largely absent or underutilized. In 1991, there were 237 psychiatrists (as in some other European countries, psychiatrists are also neurologists), 56 residents in psychiatry, 100 senior nurses, 896 other nurses, and 36 nurse aides in psychiatry (3).

In addition to the common features

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of mental health care in former Yugoslavia, Bosnia and Herzegovina had a unique setting for the treatment of patients with chronic disorders (located in Jakes). It consisted of a conventional hospital but with well-developed occupational and work therapy and accommodation for patients in households in surrounding villages.

With respect to legislation, the former Yugoslavia had a law about the protection of human rights of psychiatric patients, defining to some extent the procedure and indications for involuntary hospitalization and treatment. However, this was not consistently enforced in practice, and there were numerous examples of human rights abuse in mental health services. Also, there were some indications of political abuse of psychiatry, but no official reports on the topic.

### **The war and its consequences (1992 to 1995)**

The war brought large demographic and material losses (3) and turned a country that possessed industrial and agricultural resources to a point of being an impoverished land that depends on international aid. The fabric of communal life, which had been characterized by diversity and multi-ethnicity, also fell victim to the war. Since 1995 people in Bosnia and Herzegovina have been living in a post-conflict society in economic transition. The value system has changed substantially, requiring additional adaptation from individuals and the community as a whole, who have already had to cope with massive and prolonged traumatization that has produced a significant increase in the rate of PTSD (4).

The quality of mental health care deteriorated significantly as a result of the destruction of large institutions, a decrease in the number of qualified mental health professionals, and widespread damage to social networks, families, and other support systems (4).

### **Mental health reform in Bosnia and Herzegovina**

The reconstruction and reorganization of mental health services began even during the war and have continued since. Leading mental health

professionals and policy makers decided not to reconstruct or reopen the large psychiatric institutions that had been either closed or destroyed during the war and not to establish new similar institutions but, instead, to engage in an ambitious process of comprehensive reform. That decision laid grounds for the reform of mental health services.

The aim of the reform was to shift services from hospitals to the community—that is, as close as possible to the places where people live—and to deliver mental health promotion, prevention, treatment, and rehabilitation for patients with severe mental illnesses. This approach was very different from the previous model, which had focused exclusively on medical treatment of the affected individuals.

The central pillar of the new system of mental health care is community mental health centers, which are multidisciplinary and closely linked to primary care—for example, primary care physicians are often involved and no special referral is needed between primary care and the community mental health center (5,6). Staffing and catchment areas vary greatly. Most catchment areas have a population of between 35,000 and 70,000, and most teams have three to eight full-time staff members, typically with one psychiatrist and one psychologist, some social worker input, a number of nurses, and (rarely) other professionals, such as occupational therapists. Community mental health centers are connected with other services through an organizational network that also includes psychiatric wards in general hospitals and university hospitals. It is also intended that the centers will collaborate with a variety of statutory and voluntary organizations, both in health and in other sectors, including social welfare agencies and judicial services (5,6).

Community mental health centers work with different user groups—children, adolescents, adults, and the elderly—and provide care for a spectrum of mental health disorders, including substance abuse. They provide various interventions, ranging from individual treatment (psychotherapy and counseling), group work (in more than 80 percent of the

centers), crisis intervention, outreach service (in 50 percent of the centers), occupational and work therapy, activities for mental health promotion and prevention, and working with families and day services for patients with long-term illnesses (7). Community mental health centers offer special services for patients with PTSD, with health professionals trained through the Harvard trauma program.

The intended collaboration with other mental health services, such as psychiatric wards and other governmental and nongovernmental organizations, still needs to be developed. In practice, sharing of information about individual patients and coordination and continuity of care across different components of the mental health care system often fail. Main reasons for this failure may be the absence of a modern information technology system and appropriate forms of networking. Also, the staffing of the community mental health centers is not sufficient to take on the coordinating roles—for example, in the form of assertive case management.

The work of the community mental health centers has been complemented by efforts to promote public education on mental health and mental illness—in particular, an antistigma campaign—and on involving caregivers and the patients who use the services. Eight user associations are active in the country and are networked within a national organization.

The second cornerstone of the reform is mental health legislation that is in line with European standards. It defines the procedure of involuntary admission and treatment but also emphasizes care in the community as the leading principle in the organization of services.

A mental health task force has been set up in Bosnia and Herzegovina, and it has defined standards for mental health care that have been created according to suggestions of the World Health Organization and harmonized with European standards. Most of them have been implemented already (7).

The process of rebuilding and reforming mental health services would not have been possible without the help of the international community.

The network of community mental health centers was established as part of a contract between the government and the World Bank. Further development of services, particularly training and education of health professionals and evaluation of the reform, were facilitated by two international projects funded by the Swedish and Dutch governments, which provided support for almost ten years.

### **The future and the stability pact project**

Under the assumption that regional cooperation may present the most fundamental stabilizing factor in the region, a stability pact has been made, including a project called Enhancing Social Cohesion Through Strengthening Community Mental Health Services (8). South Eastern Europe is a diverse region in which some countries have a distinct tradition of and approach to mental health care. The project aims to improve the status of mental health care in the region through developing harmonized mental health policies and legislation, creating uniform information systems for monitoring and evaluation of service delivery, establishing advocacy and awareness programs, and implementing community-based mental health services. The project involves Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Moldova, Romania, Serbia and Montenegro, and the former Yugoslav Republic of Macedonia. The project has three objectives: to adjust and amend mental health policies and mental health legislation so that they are in line with international standards, in particular those of the European Community; to implement a harmonized model of community mental health services across the region; and to es-

tablish regionwide training curricula for mental health professionals.

This project provides an opportunity to learn from the experiences of other countries in South Eastern Europe that share some political and economic characteristics of post-conflict societies in transition.

### **Conclusions**

A country that has been devastated through a ruthless war of several years has regarded mental health care as a priority in the difficult process of rebuilding the society and has used the crisis as an opportunity for reform. Supported by international initiatives, a new care system has been established within less than ten years. By Western European standards, the system is poorly resourced, and it is likely to struggle to fulfill all envisaged roles in mental health promotion, prevention, treatment, and rehabilitation. Practical problems of service integration—all too familiar in most community mental health care systems—have already become obvious. Also, it is impossible to assess the precise effects of the reforms in the absence of outcome data (9). Although there currently are hardly any resources for systematic research, the lack of data has been acknowledged, and plans have been made to provide better data through the stability pact project in the future. The plans are particularly important given that there has been little tradition of mental health service research and routine data provision in the region.

Despite these and other shortcomings of the reforms in Bosnia and Herzegovina, the prioritization of mental health care, the sense of purpose and clear focus of the reforms, and the fact that achievements have led to wider projects for the compre-

hensive improvement of mental health care in South Eastern Europe, the reforms may be seen as a model for other regions and as encouraging for the future of mental health care, particularly in countries that are challenged by political and economic difficulties. ♦

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