

The Swedish support to Bosnia Herzegovina: rebuilding mental health services after the war

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In the aftermath of the war in Bosnia Herzegovina, a task group of Swedish experts organised and supported training of community psychiatry and social work as part of the mental health reform. Among the basic principles of the programme were a close cooperation with the Ministry of Health, personal continuity, exchange of knowledge and long term engagement. With the support of the programme, community mental health centres were created and staffed with a team consisting of: a psychiatrist, four nurses, a psychologist and a social worker. They catered, on average, for 65,000 people of all ages and saw 25–30 patients a day. Of these patients, 75% had psychiatric problems. Among the trained personnel, a major attitude shift occurred in favour of community psychiatry. As a result of the training, informal networks between local professionals were established. An evaluation, four years after the project ended, found that the community mental health centres were the major providers of psychiatric services in the region.

Keywords: Bosnia Herzegovina, community psychiatry, post war, social work, training

Introduction: background

The Dayton agreement, signed in Paris on 14 December 1995, brought the war in former Yugoslavia to an end. One of the authors of this paper, (LJ), was then asked by Sida (Swedish International

Development Cooperation Agency) to explore the possibilities of improving the mental health situation in post war Bosnia Herzegovina (BiH) with Swedish support. It was assumed that more or less everyone living in BiH had suffered as a result of the war, and a large portion of the population had survived serious traumatic experiences (Beganovic et al., 1999). The demobilised soldiers were of special concern. They were considered a special risk group in terms of potential development of severe mental health problems, similar to Vietnam War veterans. Additionally, many of those demobilised had kept their weapons and were, therefore, a potential threat to the population.

A general psychiatrist (LJ), another psychiatrist with special experience of post-traumatic stress disorder (PTSD), and a representative of Sida were sent on a fact-finding mission. The members of this fact-finding group spoke with psychiatrists, administrators, politicians, demobilised soldiers, mothers who sons had been killed in the war, the military and members of the general public. It soon became clear that it would be a huge task to reach the more than 200,000 demobilised soldiers with any form of debriefing programme. It was also deemed impossible to reach all civilians who had been traumatised by the war.

While the former Yugoslavia had had a well-developed health service, as well as psychiatric services (the latter included specialised psychiatric hospitals, small neuropsychiatric wards within general hospitals and specialised psychiatric services at primary health care units), many of these hospitals had become severely damaged or eradicated during the war. This had resulted in patients left without support. The BiH health authorities, in collaboration with WHO, had already developed plans, to reform the traditional, mental hospital based system of the former Yugoslavia into a more community oriented system. In fact, the mental health reform proposed that a substantial number of community mental health centres (CMHCs, discussed below) should be opened. Additionally, the World Bank had, at that time, just started to fund repair and reconstruction of suitable locations for these CMHCs.

The fact-finding group's recommendation to Sida was to support the training of staff (to be recruited) to the new CMHCs. The training of nurses was considered to be of special interest as, traditionally, their training had not included any special focus on psychiatry and/or mental health care. The group also suggested that Sida should support training in child and adolescent psychiatry, because of a serious lack of specialists in this area. Social workers were another group important to train, as they would comprise a new type of professional at the CMHCs. Finally, the group members stressed the necessity of a long term engagement. This was of particular importance, as most of the international organisations active in the mental health field (primarily with a focus on PTSD) had begun closing down activities when the war ended.

Sida accepted the main points of the proposal and asked the Swedish East European

Committee (SEEC) to organise Swedish support for the reconstruction of the mental health services in BiH. SEEC was, at that time, an association of all major organisations in the Swedish health care community. SEEC appointed a task force called SweBiH, consisting of psychiatrists, nurses, social workers and psychologists. Several of them had personal connections to the former Yugoslavia from fieldwork during the war. Two of the authors of this paper (LJ and BL) were appointed to leading positions as head and co-ordinator of SweBiH, respectively. After that, they began to explore the needs of authorities and specialists in mental health in BiH and the potential for Swedish specialists, from various professional groups, to be engaged as trainers in the project.

This paper describes the process of rebuilding the mental health service in BiH after the war, from the perspective of Swedish support, including: the concept behind the programme; field activities, training, curricula, new subject matters; some outcome data; what happened after the project ended; and lessons learned.

The concept behind the programme

A complex context

The population of BiH is composed of three major population groups: Muslims, Croats (Roman Catholic) and Serbs (Orthodox Christians). After the war, BiH became a complex state consisting of two entities and one district: the Federation of Bosnia and Herzegovina (about 2.5 million, politically dominated by Muslims and Croats), the Republic of Srpska (about 1.5 million, politically dominated by Serbs) and the District of Brcko that has self government and officially belongs to both entities. The Federation of BiH is organised with

one Ministry of Health (MoH, for that entity) and 10 cantons with their own parliaments, governments and MoHs. The Republic of Srpska has one government and one Ministry of Health and Social Affairs. As a result of this construction, SweBiH had to work with a total of 12 MoHs. Cooperation between the two entities and the Brcko District was, at the end of the 1990s, extremely difficult in the aftermath of the war. The political situation was further complicated by the fact that the Republic of Srpska, because of its affiliation with neighbouring Serbia, was initially isolated from the Federation of BiH.

Developmental objectives

According to the Sida terms of reference, SweBiH had two major objectives: to train personnel to service the CMHCs and to train personnel for an updated form of social work to facilitate the mental health reform. The seven-year training involved a core group of 50 psychiatrists, 70 nurses, 30 psychologists and 20 social workers from the community mental health services. The national expert group for mental health, selected training topics with the group of Swedish experts, based on the expressed needs of the participants.

The CMHCs were still under development when the SweBiH project started. These centres were expected to care for about 25,000 – 50,000 people, within a defined geographic area, and were connected to primary health care centres. The basic staff is comprised of: one psychiatrist, four nurses, one social worker, and one psychologist (recruited from former psychiatric hospitals). At this stage, it then became an important part of the training to change attitudes in favour of community services.

SweBiH decided to respond to the needs that BiH authorities had expressed, with

support to the programme already planned by the central government in collaboration with WHO (Lagerkvist & Jacobsson, 2001). The planned programme was primarily to create a community based, psychosocial platform (van Ommeren et al., 2005; Silove, 2013).

At that time, it was also decided not to focus on PTSD for two major reasons. First, there had already been a number of programmes, run by different international organisations, focusing on PTSD. Secondly, PTSD had become such a wide concept that it had no specificity anymore. No doubt there existed a rather distinct form of PTSD, but most of the consequences of trauma are part of a wide range of issues that a population experiences in the aftermath of a war. These can include: poverty, loss of jobs, housing problems, families split up, grief and anger. Additionally, the SweBiH support was also seriously influenced by the ethnic conflicts between Muslims, Serbs and Croats (Kucukalic et al., 2005).

SweBiH attempted to establish contact with the political and administrative level at both federal and canton levels, and with the psychiatric community, during the first two years of the programme. During that period, the authors had multiple meetings with different groups of psychiatric personnel.

Cooperation with already existing institutions, as much as possible, formed an integral part of the programme. As a result, one important decision was not to establish a separate SweBiH office (as many other international organisations had done). This was in opposition to the wishes of Sida. Instead, SweBiH established a small working group of local experts, still active in the general health care system. One of the authors (NMB) became head of this unit. Regarding the need for vehicles, SweBiH

relied on cooperation with other organisations, such as WHO, during the first years and later on HealthNet International and governmental vans.

Field activities

General training of staff

The training of social and medical personnel was organised over a period of six years (1998 – 2003) and was comprised of community psychiatry and modernised social work, in line with developmental objectives. The training was conducted in weekend seminars and conferences, as well as short and long term curricula. The major sequence contained 50 seminars, at 14 separate localities all over the Federation, with a total of approximately 1500 participants.

In total, 38 Swedish experts were active as trainers in these seminars and, in principle, shared lecture time evenly with local experts. Most topics were specifically oriented towards one professional group at each seminar (i.e. doctors, nurses, social workers or psychologists). Nineteen of the seminars were organised in cooperation with HealthNet International (the Netherlands). Both participants and trainers were reimbursed for travel expenses, and had free accommodation. The local trainers also received a minor salary. The foreign experts continued their employment in Sweden during weekends, and received some extra days as project support from their employer. In terms of the SweBiH organised conferences, subject matter was broader compared to the weekend seminars and served as stimulation for complete teams. Some conferences were also open to politicians and decision makers. As in the seminars, local professionals and Swedish experts shared lecture time evenly. In total, 15 conferences were organised, with approximately 600 participants in total. However,

several participants attended more than one conference. Additionally, two of the conferences were organised in Sweden as study trips.

Short term curricula

SweBiH organised 16, short term curricula in addition to the weekend seminars and conferences. These curricula focused on one specific topic (examples discussed below) over a series of weekend meetings. This structure gave participants of different professions a more comprehensive training. Approximately 30 Swedish experts (psychiatrists, nurses, social workers, psychologists, child and adolescent psychiatrists) participated at separate seminars, sharing lecture time with local colleagues. The number of teaching sessions for each subject matter varied from 4–15 weekends, including supervision of centres for social work and CMHCs.

Some of the curricula were organised with homework to be completed between teaching sessions. Examples of subject matters included mother and child health, developmental psychology, methodology of psychotherapy, family therapy, child and adolescent psychiatry and treating psychoses within the community. The participants of the curricula should, in principle, consist of the same group at each session. More than 300 people participated in these short term curricula, led by about 30 different experts as teachers and supervisors.

One part of these curricula included supervision of operating CMHCs, medical issues and social work. Teamwork had been in use at referral level previously to this programme. The curricula, and in particular the supervision, facilitated the concept of simultaneous teamwork. One consequence of the project was the creation of a network of professionals across the BiH

that did not previously exist. Participants kept in contact and supported each other in discussing problems they faced within the new organisation.

Developing child and adolescent psychiatry

Child and adolescent psychiatry did not exist in the country as a recognised speciality before the war. However, these needs became apparent in the aftermath of the war. Therefore, SweBiH contacted the Child and Adolescent Department at Umea University (Sweden) to run a one-year clinical course. It was organised as a distance, long term curricula at half-time speed. All participants continued with their employment in BiH during training, but examinations were conducted by Umea University. Those who passed, received Swedish university diplomas, but were present in Sweden for only one short study visit to Umea during the course.

The evaluation criteria of the participants for these long term curricula were strict. A group of 30 psychiatrists, general practitioners and psychologists were chosen from approximately 60 applicants. They were expected to have had experience working with children in their current practice. Two Swedish teachers, a child psychiatrist and a psychologist, participated in all teaching sessions in order to foster continuity. They engaged both Swedish and local experts for specific topics. English was the language used, with an interpreter, and assisted by some participants translating major portions of the (Western) textbooks into Bosnian. Participants were not only expected to complete a large quantity of homework, but also to contribute a case presentation at each teaching session (Friday to Sunday). Most child and adolescent psychiatry participants also passed a high quality, written examination in Sarajevo to

get their diplomas. A few failed, but were given another chance to re-sit the exam. The impression of the primary teachers was that they had almost never had such an interested and skilled group of students. SweBiH then organised a following one-year curricula, on research methodology, for those who had received diplomas from the previous course. All participants, but one, attended the next course.

Training in research methodology

Almost all participants of this second, long term curricula carried through a master's project in child and adolescent psychiatry, or a similar topic, and were supervised by a local supervisor. SweBiH supported through assisting in consultancies, providing a budget and editing an Umea University report (in English) on all summaries of the master theses (Lagerkvist, 2008). Furthermore, SweBiH supported three doctoral studies and three other research projects, in addition to the 29 master theses. As a result, child and adolescent psychiatry became well introduced into BiH, but formal recognition of the field as a speciality was not yet finalised when SweBiH terminated the support.

A new school of social work

One specific task became the creation of a school of social work in Banja Luka, the main town of the Serbian entity. Participants from that part of the BiH had previously travelled to other towns in the former Yugoslavia for training and examinations. That became difficult after the war. Professors at the School of Social Work in Stockholm University took the lead in cooperating with local professors from the region to create a new school of social work. SweBiH supported the project from the beginning and planned for a first year curricula with 30 participants.

Around 70 applied and were all accepted. Stockholm University took over the project, and most participants completed their full training in the new school of social work (Hessle & Zavirsek, 2005).

Training of nurses

Joint teaching projects, aside from the SweBiH budget, developed based on personal contacts and study visits. Some examples include: cooperation between the departments of psychology in Gothenburg with Sarajevo and Banja Luka, between departments of psychiatry in Umea and Stockholm with Sarajevo, and Tuzla and Banja Luka and the school of social work in Stockholm with Banja Luka. The training of district nurses in BiH was arranged through nurses at the Karolinska Institute, Stockholm and included subject matters such as psychiatric teamwork and how to approach someone with psychiatric problems. Fifteen of the best from this group of nurses received special training to become trainers themselves. As a result, they were later able to organise courses without Swedish input.

Summary of activities

In summary, SweBiH contributed to the mental health reform with training of personnel, changing of attitudes to services in the community, and (as a side effect) supported teamwork and networking between medical and social professionals across the BiH. In addition to economic support, modern techniques of social work were introduced, as well as child and adolescent psychiatry, research methodology and the training of trainers. In total, probably more than 2000 individuals, from different professions, took part in some training. These ranged from single seminars up to four years for members of the group studying child

and adolescent psychiatry (Lagerkvist et al., 2003b).

Type of services

Individual and group therapy, counselling and medication were provided by all CMHCs. In addition, teamwork was provided by 32, home visits by 19, and occupational services, speech therapy and family therapy was provided by six of the CMHCs. Fifteen CMHCs cooperated with Centres for Social Work, users Associations or nongovernmental organisations, and seven cooperated with other CMHCs, or a psychiatric ward. Two CMHCs provided a telephone help-line and training in daily activities.

Some outcome data

Over the period of Swedish support, there was no formal evaluation of the whole project. However, regular reports to Sida were made each year over the progress of the project, in order to continue funding. Evaluations of most of the seminars and courses were carried out, and in general, the participants were highly satisfied with the arrangements and their experience. In 2002, during the fifth year of the project, SweBiH carried out an assessment of the CMHCs, in cooperation with the two Ministries of Health responsible for the Muslim-Croat and the Serbian entities. The mental health reform had developed rapidly and the CMHCs were an important part of the service delivery. The aim of the assessment was to explore the needs and satisfaction of users, current staffing structure, the actual working context, and to solicit the personnel's opinion on areas of potential improvement.

A questionnaire was sent to the manager of each operating CMHC. Data were collected for all operating CMHCs during an assessment period of two weeks, at the

beginning of March 2002. As well as this assessment period, trained interviewers were provided with a semi-structured guide and asked to contact both users and personnel of 13 carefully identified CMHCs. They represented both rural and urban areas, in all cantons, and were geographically evenly distributed.

Thirty-eight CMHCs were operating at this time and cared for an average of 60,000 inhabitants. Staffing consisted primarily of: one full time psychiatrist, three full time nurses, one full time psychologist and one part time social worker. These CMHCs were visited by 9755 patients during the two full week assessment period, or about 27 clients per day, per CMHC.

The main problems presented were psychiatric for 56% of the clients. Half of them had a non-chronic illness, such as depression. The other half was split equally between chronic disorders, such as schizophrenia and PTSD. Clients with non-psychiatric problems comprised 30% of the total. These were mostly children and adolescents with enuresis, behavioural problems, truancy and drug use. The rest of clients (14%) came for health check-ups, or for driving licences. These services were provided at CMHCs as the patients had nowhere else to go for these services.

Some results from the interviews

There were 64 professionals and 67 clients participating in the interviews. Social problems dominated the client's views on their situation. Lack of permanent housing, evictions, unemployment and poverty were frequently mentioned. The clients' biggest, single wish was for a job.

Professionals mentioned using a variety of methods within an individual approach of psychotherapy offered. Both professionals and clients expressed their surprise in the power of listening and talking.

Nurses and social workers carried out home visits. They went to see clients that needed medication, did not show up for control, or those with difficult access or fear of coming to a CMHC. Some of the nurses were also active at schools, or in the media, offering psycho-education on prevention of mental illness. Social workers offered counselling, including family issues, or preparation for a client's return from hospital. These new forms of service were not only tremendously appreciated by the clients, but also by the professionals.

Summary of the 2002 assessment

By 2002, the mental health reform was progressing satisfactorily, with more CMHCs operational, and staffed with trained personnel. By using modern techniques of psychiatric services, the professional teams were able to offer clients more comprehensive services. Additionally, most personnel had changed their attitudes to mental health and the current services, and were committed to implementing the mental health reform. As for the clients, most were very satisfied with the service provided.

Advantages of the CMHC concept reported included: accessibility and no need for referrals, teamwork, a holistic approach, continuity, reduced number of hospitalisations and a decrease of stigmatisation of clients.

Difficulties reported included: incomplete teams, lack of equipment and literature, large numbers of patients and a lack of legislation. One example of the latter problem was the uncertainty surrounding what nurses were allowed to do independently in this new form of organisation.

What happened after the project ended?

As a result of this project, during 2002 – 2012 the system of mental health services in BiH

underwent a fundamental change. The number of hospitalised patients was significantly reduced (due to an approximately 80% reduction of hospital beds), and consequently more people with mental illness live within the community. Optimally functioning CMHCs, together with primary health care services, now take responsibility for resolving all mental health issues within a certain territory, up to the level of 80% of the total needs. Psychiatric services have become significantly more economical and more effective. The new community based system of care can be said to have survived infancy, and there is now no way to return to institutionally based care.

Stability Pact Project for South Eastern Europe

In 1999, the Stability Pact Project for South Eastern Europe was formed with the intent to strengthen social cohesion and stability in the region, fostering peace, democracy, human rights and economic prosperity. Participating countries were the eight states of the region: Albania, Bosnia Herzegovina, Bulgaria, Croatia, Moldova, Romania, the Federation of Yugoslavia (Serbia and Montenegro), and Macedonia. Additionally, the Republic of Greece, Bulgaria, Sweden, the WHO and the Council of Europe supported the Stability Pact Project.

BiH became the leading nation on strategies to strengthen community mental health services, and as a result of the development of CMHCs that would soon cover the whole country. The developmental objective was to harmonise the mental health policy, legislation, information systems, programmes, and advocacy and public health campaigns of all countries within the region. BiH was responsible for organising the implementation of all components of the project that focussed on training of mental health professionals. The success of the Stability

Pact Project was a logical extension of previous reforms of the mental health system in BiH, implemented with support from SweBiH.

A new assessment of community mental health services in BiH (2008)

In early 2008, an agreement to implement the project's situation analysis and needs assessment of community mental health services in BiH was agreed with the Ministries of Health responsible for the Muslim-Croat and the Serbian entities, and the Swiss Agency for Development and Cooperation. The general aim was to review the current achievements during the period 2000–2008. The methodology was based on the experience of two previous studies conducted in 2000 (de Clercq et al., 2001) and 2002 (Lagerkvist, et al 2003a). The survey comprised professionals and clients in 50 CMHCs, of which 31 were in the Federation of BiH, 18 in the Republica Srpska (RS) and 1 from the independent District of Brcko. Results from this study are summarised in Box 1. Users gave a very positive opinion on the work of CMHCs. The clients were particularly satisfied with the support by team members to identify early signs of crisis and understanding mental illness, as well as with group therapy, which provided the potential contact with other clients, less hospitalisations and with an improved overall mental status of clients. Of the users, 59% indicated the team members' warm and human interaction as a special advantage of the CMHCs.

Professionals interviewed emphasised the unsatisfactory cooperation with psychiatric hospitals or clinics. The CMHC professionals had the best level of contact with local family medicine teams. Cooperation with the social sector varied from case to case, and communication occurred mostly

Box 1. Results of assessment in 2008

- Existing CMHCs are the main service providers of mental health care. Each centre covered approximately 66,000 inhabitants.
- Mental health policy documents exist in both geographic/political entities, however, professionals working at the CMHCs reported that 54% were not familiar with the mental health policy in their region.
- According to mental health policies in the regions, current CMHC financing mechanisms were not in line with the type of services that were expected.
- Fifty CMHCs employed 304 mental health professionals, with an average of six team members. The composition of team members varied considerably, and many teams were incomplete. There was no continuous education for the CMHC staff, instead this was implemented on an ad hoc basis by nongovernmental organisations and pharmaceutical companies.
- All directors passed mandatory training related to a specific information system for monitoring and evaluation. However, only 16% of the directors practiced the software for user registration.
- All CMHCs provided services for adults, 92% for the elderly, 90% for adolescents, 70% for children, 64% practiced home visits, 62% individual psychotherapy, 60% group psychotherapy, 40% family therapeutic interventions and 38% crisis intervention. CMHC teams estimated that they had most difficulties working with children.

by telephone. Only 18 CMHCs stated that they cooperated with various forms of patient or user organisations.

Lessons learned

Lessons learned from a BiH perspective

Reconstruction activities and reform of the mental health service had already started during the war. The decision by the health authorities not to reconstruct and reopen large hospitals was the key decision impacting mental health care. As a result, the project on community mental health (began in 1996) became therefore, of particular importance. It laid a foundation for future systems of services and mental health care. The two Ministries of Health responsible for the Muslim-Croat and the one responsible for the Serbian entity, worked in close cooperation with The World Bank and WHO, as well as the SweBiH working with HealthNet International

continued with a focus on the training of professionals. The transfer of knowledge within teamwork and the role of individual members within a team changed, in a positive way, the attitudes of the personnel's ability to deliver services within their communities.

Regardless of these positive aspects, as the training was open to professionals from opposing sides in the war, it was impossible to avoid unspoken ethnic intolerance. This further complicated the whole project and created a certain level of uncertainty.

The training programme, however, unexpectedly turned in a very good direction. This was probably due to a high level of professional curiosity and the desire for new knowledge exhibited by the local participants, combined with the extremely warm and friendly approach of the Swedish trainers. The results achieved during the seven years of active work and socialisation

resulted in trained teams within the mental health centres and established good mutual communication between people, regardless of their place of origin. In this way SweBiH was a better ambassador for reconciliation than many official services of the European Union responsible for that process.

Getting the CMHCs operating, with specially trained personnel, was the most important contribution of the SweBiH. Today, community based services covers all aspects of mental health care. Great importance is given to establishing a network between teams of family medicine and the specialised teams at CMHCs and psychiatric clinics for acute hospitalisation (Thornicroft & Tansella, 2004). The CMHCs also closely cooperate with the 'third sector', or nongovernmental organisations.

From the perspective of BiH, the numerous meetings and informal contacts between professionals from BiH and Sweden were of critical importance. This contact accelerated the implementation of mental health reform in BiH.

Lessons learned from the Swedish perspective

Over the seven years of the project, the total Swedish support amounted to 37.5 million Swedish crowns, or 4.5 million €, from 1997 to 2003. The Swedish support lasted longer than any other nongovernmental organisation activity in the field of mental health in BiH (Lagerkvist et al., 2003b).

There was a relatively small group of expatriate teachers engaged during the seven project years. The personal continuity among the teachers contributed to the friendships between local professionals and expatriates, and was important to the success of the project. The expatriate group was big enough to give input to several types of professionals. Swedish experts learned a lot during these years, especially about the

extreme situation that the war entailed, and how to reorganise services.

It soon became evident that the war had created a serious, deep conflict between the different ethnic groups in BiH. SweBiH tried to contribute to the reconciliation between these groups. For example, the activities in the Serbian part of BiH became quite limited during the first years of the project because of the difficult political situation. A shift occurred after 1999, enabling SweBiH to then organise a substantial number of seminars and courses in the two areas, with participants from both entities.

The professional community in BiH had been isolated from the international world for many years because of the war. The whole mission was organised to stimulate that professional community by introducing a number of experts or colleagues from outside BiH.

Initially Sida wanted SweBiH to create a full local organisation with office and cars. SweBiH, however, decided to collaborate as much as possible with already existing organisations, especially WHO and Health-Net International. Therefore, the Swedish support was based on the concept of local ownership (de Vries & Klazinga, 2006).

One of the authors (NMB) became the local project administrator during all these years, and used her office and administrative personnel for the needs of SweBiH. This form of organisation saved money for the core activities, got the local professionals more involved, and enabled collaboration with other actors and avoided competition and double work.

The evaluation done in 2008 highlights the strained financial situation in BiH after the war, and the difficulties in organising a sustainable progress in the restructuring of services. However, there was a remarkable development in the mental health care

services in BiH after the war. In this, the close collaboration with two leading psychiatrists in Sarajevo, professors Ismet Cerić and Slobodan Loga, was crucial. Both identified, and then supported, the local administrators during all these years, participated in the training and kept in contact with important people in the area.

Conclusions

In a post war society, a major part of the population has psychiatric needs. Training of personnel in community psychiatry as part of the mental health reform was successful, which also created informal networks between professionals. Basic principles included cooperation with MoH, personal continuity and the exchange of knowledge in a long term engagement. BiH is now in the group of 60% of all countries that have a mental health policy and belongs to the 75% of all countries that have passed a mental health law.

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