The mental health system can begin to address these challenges by improving access to mental healthcare, strengthening and expanding the mental health workforce, and prioritising long-term funding for mental health.

Mental health education and promotion activities must be maintained and further developed to reduce stigma and discrimination. The implementation of appropriate and comprehensive mental health legislation is necessary to protect the human rights and dignity of Timorese people with mental disorders.

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COUNTRY PROFILE

Mental healthcare in Serbia

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Serbia is located on the Balkan peninsula, which served for centuries as a vulnerable crossroads between the East and the West. At the beginning of the 1990s, some of the republics of the former Yugoslavia, including Serbia, were involved in disastrous civil conflicts. In 2006 Serbia became a sovereign republic. At the 2002 census, its population was 7 498 000.

The country has been exposed to many severe stressors, such as civil war in neighbouring countries, United Nations economic sanctions, which lasted for 3.5 years, and 11 weeks of NATO bombing in 1999. As a consequence, Serbia has experienced the destruction of infrastructure, large numbers of refugees and internally displaced people (currently there are half a million of them in Serbia), social instability, economic difficulties and deterioration of its healthcare system. In addition, a serious problem is the brain drain, since around 300 000 people, mostly young intellectuals, have left the country in recent years (Lecic Tosevski & Draganic Gajic, 2005).

After 2000, the country underwent economic liberalisation, and experienced relatively fast economic growth: gross domestic product per capita rose from US$1.160 in 2000 to US$6.782 in 2008, according to the International Monetary Fund (2008). The country is now passing through social transition and harmonisation with the European Union (EU). At present, the main problems are the high unemployment rate (18.8% in 2008 and currently rising due to the economic crisis) and the large trade deficit (US$11 billion). The major source of finance for public health is the national Health Insurance Fund, to which is allocated 6.1% of gross domestic product.

Mental disorders

The events outlined above caused a steady rise in mental and behavioural disorders. The prevalence of mental disorders increased by 13.5% between 1999 and 2002 and they now represent the second largest public health problem, after cardiovascular disease. The incidence rates of stress-related disorders, depression, psychosomatic illnesses, substance misuse and suicide are still high, as are rates of delinquency and violence among young people (Lecic Tosevski *et al*, 2007). Furthermore, the burnout syndrome is pronounced in many physicians, who have shared adversities with their patients and experienced secondary traumatisation (Lecic Tosevski *et al*, 2006). An international multicentre study carried out 7 years after major trauma has shown that the prevalence of chronic post-traumatic stress disorder (PTSD) is still very high (current, 18.8%; lifetime, 32.3%), as is that of major depressive episode (current, 26.2%; recurrent, 14.4%) (Priebe *et al*, 2009).

Mental health policy and legislation

In 2000, when the international community decided to take a proactive attitude rather than intervening only during crises, nine countries entered the Stability Pact for South-Eastern Europe (SEE): Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Former Yugoslav Republic of Macedonia, Moldova, Montenegro, Romania and Serbia. The mental health project 'Enhancing social cohesion through strengthening community mental health services' (Mental Health Project for SEE, http://www.seemhp.ba/index.php) brought together experts from the region with the aim of harmonising national mental health policies and legislation. The renewal of collaboration was also important for conflict resolution and reconciliation.

The National Committee for Mental Health was established in January 2003 by the Serbian Ministry of Health. As a coordinating body of the SEE Mental Health Project, the Committee prepared a national policy and action plan, and drafted a law on the protection of rights of persons

with mental disorders. Both documents were reviewed by distinguished international experts. The National Strategy for Development of Mental Healthcare was approved by the government in January 2007 (Ministry of Health of the Republic of Serbia, 2007). A national programme for substance misuse has also been prepared and approved.

Mental health services

The oldest psychiatric institution in the Balkans was established in Belgrade (capital of Serbia) in 1861 (the 'Home for Insane People'), with 25 beds. Nowadays, there are 46 in-patient psychiatric institutions in Serbia (specialist hospitals, psychiatric institutes and clinics, clinics for child and adolescent psychiatry, and psychiatric departments in general hospitals) and 71 out-patient services in municipal health centres. The entire mental health sector has 6247 beds, approximately half of which are in large psychiatric hospitals. Admissions in 2002 totalled 5833. The number of psychiatrists (neuropsychiatrists) in the country is 947, but some of them are involved in the treatment only of patients with neurological problems and do not deal with persons with a mental disturbance. A third of them work in the capital, Belgrade. About 5% of psychiatrists are engaged in child and adolescent psychiatry (Lecic Tosevski *et al*, 2005; Lecic Tosevski & Pejuskovic, 2005).

Healthcare in Serbia is free of charge and is provided through a wide network of public healthcare institutions, controlled by the Ministry of Health. The private provision of healthcare services, although limited, is on the rise, particularly in certain specialties, such as drug addiction.

Mental healthcare is well integrated with the primary healthcare system, at least in larger cities, which have mental health and developmental counselling units within municipal health centres. The first community mental healthcare centre was opened in 2005 in the southern part of Serbia. However, the widening of the network of community centres is rather difficult because of the economic crisis. There are other problems in mental healthcare, such as a lack of residential homes, as well as the poor condition of some of the large psychiatric hospitals. There are five of these in Serbia, and some patients have been hospitalised in them for many years, since they have no relatives, or the community would not accept them. Many patients with chronic mental disabilities are accommodated in social care homes, which are in need of deinstitutionalisation.

Non-governmental organisations are also involved with mental healthcare. Their role was invaluable during years of conflict since they supported local experts in preventive programmes for refugees and internally displaced persons, ex-detainees and torture victims. Non-governmental and paraprofessional groups have an increasing role within the mental health system, through various psychosocial programmes for deinstitutionalisation, destigmatisation, domestic violence, human rights and so on.

Until recently, prevention was not financed by the state and was carried out by enthusiastic professionals. Fortunately, the government has recently recognised its importance and is now supporting programmes for the prevention of suicide and violence among children and young people, as well as the prevention of substance misuse and alcoholism.

Training

The specialties of psychiatry and neurology were separated in 1993, and child psychiatry was established as a separate specialisation. The duration of training for adult and child psychiatry is 4 years. Both curricula are developed according to European standards and are accredited (Pejovic Milovancevic *et al*, 2009).

Postgraduate psychiatry training is well developed – there are subspecialties in psychoanalytical psychotherapy, forensic psychiatry, clinical pharmacology and so on. Psychotherapy has a long tradition and many psychotherapists were trained abroad, primarily in England and France, in various approaches – psychoanalytical, group analysis, systemic, cognitive–behavioural, and so on. Continuing medical education has become obligatory for all mental health professionals.

Research

Professionals from Serbia are publishing in leading psychiatric journals, books and textbooks. Serbia was included in two multicentre studies, supported by the EU, which have been carried out in the Balkans – STOP and CONNECT (Priebe *et al*, 2002, 2004). It is hoped that the results of these studies will represent an empirical basis for adequate programmes for people with PTSD.

The Belgrade Institute of Mental Health is a partner in the exciting EU project 'Copy number variations conferring risk of psychiatric disorders in children'. The aim of the project is to identify genetic variants that confer an enhanced risk of major mental disorders on children and adolescents

Professional associations

There are several psychiatric associations in Serbia, including the Serbian Psychiatric Association, the Serbian Association of Psychiatric Institutions, the Association for Child and Adolescent Psychiatry and Allied Professions of Serbia, and the Serbian Psychotherapeutic Association. These associations collaborate closely with international organisations such as the World Psychiatric Association, the European Psychiatric Association and the European Association of Psychiatry. Collaboration with the World Health Organization (WHO) is also flourishing and the Serbian Institute of Mental Health was recently nominated to be the WHO Collaborating Centre for Workforce Development.

Human rights issues

The human rights of all patients in Serbia are protected by the Healthcare Law. The Mental Health Act is expected to be approved shortly. In 2006, the government introduced the concept of 'carer of patient's rights' and now each hospital has a professional with such a duty, usually with a legal background. In addition to this, most institutions have ethical committees and are obliged to apply an ethical code in treatment and research.

Conclusion

The organisation of mental healthcare in Serbia has many advantages, as well as disadvantages. The main advantages are a balanced territorial coverage of psychiatric departments in general hospitals, well-educated professionals, as well as a relatively low proportion of institutionalised patients at the onset of the mental healthcare reform. Of special importance is a long tradition of psychosocial orientation, with day hospitals in clinics of all larger towns.

However, there is insufficient cooperation between primary, secondary and tertiary healthcare. This is exacerbated by a lack of catchment areas and patients' legal right to choose their own doctor (often by affinity or reputation of doctors), as well as lack of skills of general practitioners in mental healthcare. Stigma in relation to mental illness is prevalent among the public, which hinders early recognition and treatment. Furthermore, there is a lack of cooperation between the psychiatric and the social welfare institutions, a lack of community mental healthcare centres and other outpatient psychiatric services in the community (rehabilitation and professional orientation services), as well as insufficient information systems for registering and monitoring mental disorders.

The ongoing psychiatric reform certainly represents a challenge and opportunity for mental health professionals. The process of reform is not easy, especially in a country facing social transition, so it is expected that the implementation of the national strategy and action plan will take time.

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ORIGINAL PAPER

Alcohol dependence syndrome in women: an Indian perspective

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The estimated prevalence of alcohol misuse among Indian women is less than 5%. Misuse has been associated with the upper socio-economic classes, primitive tribal cultures and certain rural traditions. The problem of substance misuse in India has been underdiagnosed and underreported, but various health agencies and media reports suggest it is increasing.

The term 'abuse' has been used interchangeably in the literature for both dependence and harmful use; this is due to a lack of clarity in the diagnostic criteria used in most of the studies quoted in this article. However, the results of the current study are described only in terms of the ICD–10 criteria for dependence. In this paper we present findings which may contribute to our understanding of the prevalence of alcohol dependence in women in India.

Literature review

Indian studies that have looked at the prevalence of alcohol misuse in males (Mohan *et al*, 1978; Sethi & Trivedi, 1979; Agarwal, 2004) have reported rates ranging from 19% to