MENTAL HEALTH LAW PROFILES

Mental health law profiles

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The Caracas Declaration, referred to in both of this issue's mental health law profiles on Bolivia and Colombia, and agreed by all national governments in the Latin American region in 1990, has set clear aspirations and extracted explicit signed commitments. Materialisation of these, however, has been distinctly patchy. On the evidence of the paper by Anne Aboaja and colleagues, Bolivia offers an alarming example of promises failing to materialise. This is particularly disappointing, because rights and service deficits remain largely unchanged despite a stable and popular government and a tripling of the size of the economy in the decade to 2014. Irrespective of future politics and economics, people with mental illness and their families have a right to expect early improvement and to hope that such wider social developments as have occurred in Bolivia will create a favourable climate in which to address mental health issues.

Both Bolivia and Colombia face major problems with substance misuse and domestic violence. In addition, Colombia faces the legacy of violent armed conflict that has repeatedly placed it at the top of relevant international tables. According to the report by Roberto Chaskel and colleagues, the suffering engendered by such violence, especially against women, seems to have spurred much research-informed progressive legislation tailored to the particular needs of the Colombian population. This is coupled with commitment to service provision in the area of mental health, particularly trauma-related mental health problems.

In their paper the Colombian authors lay emphasis on the importance of service provision (e.g. mandatory provision of 30 individual and 30 group sessions for all patients and unlimited sessions for victims of violence) and report less on the protection of liberty in relation to compulsory detention (e.g. they do not specify whether patients have a right of appeal and under what conditions). In part perhaps this reflects that 'institutionalisation is the rare exception' and lack of resources and services remains the paramount issue in that country. This, however, is cold comfort for the patient who is at risk or who has been detained in violation of fundamental human rights. Such rights are universal and their violation a contravention of the Caracas Declaration.

MENTAL HEALTH LAW PROFILE

Mental health law in Bolivia

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Bolivia's mental health plan is not currently embedded in mental health legislation or a legal framework, though in 2014 legislative change was proposed that would begin to provide protection and support for the hospital admission, treatment and care of people with mental disorders in Bolivia. Properly resourced, regulated and rights-based mental health practice is still required. Mental healthcare in the primary care setting should be prioritised, and safeguards are needed for the autonomy of all patients, including all those in vulnerable and cared-for groups, including those in prisons.

Bolivia is a lower-middle-income country in South America surrounded by four middle-income countries (Peru, Brazil, Paraguay, Argentina) and one high-income country (Chile) (World Bank, 2015). Despite the lack of large-scale psychiatric prevalence studies in Bolivia, there is some evidence to suggest that mental disorders are common. A cross-sectional study showed that nearly one in two women is a victim of violence perpetrated by an intimate partner and that this is associated with symptoms of depression (Meekers *et al*, 2013). According to a review published by Jaen-Varas *et al* (2014), alcohol addiction has a clear impact on psychiatric admissions, domestic violence and road traffic accidents in Bolivia. A study using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) tool examined the reasons for admission to psychiatric centres and showed that just over one-quarter of patients were admitted for psychotic illnesses, a similar proportion for substance misuse problems and a slightly lower proportion for affective or neurotic disorders (Caetano, 2008). There are, though, no data available on the prevalence of mental disorder in the general

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