

Namibia

GENERAL INFORMATION

Namibia is a country with an approximate area of 824 thousand sq. km. (UNO, 2001). Its population is 2.011 million, and the sex ratio (men per hundred women) is 96 (UNO, 2004). The proportion of population under the age of 15 years is 43% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 83.8% for men and 82.8% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7%. The per capita total expenditure on health is 342 international \$, and the per capita government expenditure on health is 232 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Afrikaans, German and English. The largest ethnic group(s) is (are) African (Ovambo, Kavango, Herero, Damara, Nama, Afrikaners), and the other ethnic group(s) are (is) Asian (descent). The largest religious group(s) is (are) indigenous groups, and the other religious group(s) are (is) Christian.

The life expectancy at birth is 48.1 years for males and 50.5 years for females (WHO, 2004). The healthy life expectancy at birth is 43 years for males and 44 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Namibia in internationally accessible literature.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

The final draft of the mental health policy is ready and has been submitted for approval.

Substance Abuse Policy A substance abuse policy is absent. The final draft of the substance abuse policy is ready and has been submitted for approval.

National Mental Health Programme A national mental health programme is absent.

The mental health programme was drafted with assistance of WHO. It will be presented to the Primary Health Care Management Committee for final inputs and then it will be forwarded for approval.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1995.

Mental Health Legislation Mental health services are provided under the South African Mental Health Act no. 18 of 1973. This is in spite of the fact that the South African Mental Health Act has been updated in South Africa. Namibia is therefore using an outdated legislation. A new Bill is in the early stages of development. This is an essential element of reform that is needed as part of the implementation of the Mental Health Policy.

The latest legislation was enacted in 1973.

Mental Health Financing There are no budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary sources of mental health financing in descending order are tax based, grants, out of pocket expenditure by the patient or family and private insurances.

Namibia has no cost recovery mechanisms in place. As a result of this, incomes generated by health services through user fees, insurance recovery and donations are deposited in the general revenue of the Government. The Ministry of Health is currently exploring possibilities regarding retaining a portion of the collected fees. Mental health is under the primary health care programme and there is no special budget for mental health. The budget is allocated according to the annual mental health activities.

The country has disability benefits for persons with mental disorders. If a person is classified as chronically mentally ill then the application is forwarded to the social services for disability grant.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Treatment is generally available at the hospital level, but follow-up of discharged psychiatric patients is done in all health care facilities.

Regular training of primary care professionals is not carried out in the field of mental health. There is a proposal to train more mental health nurses and social workers. Community psychiatric nurses based in state hospitals also run satellite psychiatric clinics. However, such services are not available in the interior. Nurses cannot prescribe medication, for which they have to consult medical officers or psychiatrists. The psychiatric unit in the country's capital also plans to identify medical officers with interest in psychiatry and provide them with one-week intensive training followed by on-site basic psychiatry training. Traditional healers are also being encouraged to undertake training, and depot anti-psychotics are provided to them for managing psychotic disorders. The Namibia University has no medical school. The general nursing training includes a component of psychiatric nursing.

There are community care facilities for patients with mental disorders. Only follow-up of discharged psychiatric patients is done in the community.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.5
Psychiatric beds in mental hospitals per 10 000 population	1.5
Psychiatric beds in general hospitals per 10 000 population	0
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.2
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	6
Number of social workers per 100 000 population	6

The above mentioned psychologists and social workers work in the public sector. Two occupational therapists are working in Windhoek Mental Health Care Centre. A relatively broad range of mental health services are currently available only at tertiary care centres (Windhoek Mental Health Care Centre with 112 beds and Oshakati Psychiatric Unit with 80 beds). Emergency mental health services are also provided at the district hospitals as part of general wards (which do not have specialist mental health staff). All general hospitals are expected to have at least one or two rooms for severely psychotic patients. Follow-up and a limited range of psychotropic medications are available at some health care centres and clinics. Ninety-nine beds at the Windhoek Mental Health Care Centre are earmarked for forensic psychiatry services. At present, the referral system is not well established. The responsible doctors follow referral guidelines sent out to all regions for mentally ill patients for at least 72 hours. However, health professionals at these levels find it hard to adhere to these guidelines due to their limited training and experience in mental health areas. Even the specialized mental health centres lack the full complement of mental health professionals in terms of specialization and numbers. Recently, one registered nurse from Windhoek psychiatric centre completed her degree in psychiatric nursing with the financial support from Finland. A major portion of psychiatric care in primary and secondary care settings is provided by nurses and social workers, due to lack of trained psychiatrists. Private practitioners also provide mental health services (10 psychologists, 3 psychiatrists), but these services are limited to those who can afford them. Traditional healers also play a considerable role, however, the number of those mentally ill individuals seeking the services in this sector is unknown.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation. In the capital city, the German Evangelic Lutheran Church provides one accommodation facility for psychiatric patients who do not have a family to take care of them.

Information Gathering System There is mental health reporting system in the country. The Health Information System was revised in 2000, and new system was introduced in 2001. The analyses are based on the records of outpatients who attended clinics, health centres and hospital outpatient departments. Information on inpatients is also available. The facility based information contains data on all public health sectors and services including mission health care facilities. Mental illnesses are audited if they are among the first ten common disorders.

The country has data collection system or epidemiological study on mental health. Disorders are classified according to ICD 10 criteria.

Programmes for Special Population The country has specific programmes for mental health for children.

The Windhoek Mental Health Care Centre provides outpatient and inpatient services for children.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium, valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

A Namibian Essential Medicines List (NEMLIST) has been formulated. These drugs are frequently not made available because of a lack of review mechanisms and lack of staff skills.

Other Information

Additional Sources of Information

Feinstein, A. (2002). Psychiatry in post-apartheid Namibia: a troubled legacy. *Psychiatric Bulletin*, 26, 310-312.

Nauru

GENERAL INFORMATION

Nauru is a country with an approximate area of 0.02 thousand sq. km. (UNO, 2001). Its population is 0.01 million, and the sex ratio (men per hundred women) is 105 (UNO, 2004). The proportion of population under the age of 15 years is 42% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.5%. The per capita total expenditure on health is 1015 international \$, and the per capita government expenditure on health is 900 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Nauruan. The largest ethnic group(s) is (are) Nauruan Islander, and the other ethnic group(s) are (is) Chinese and European. The largest religious group(s) is (are) Protestant (more than half), and the other religious group(s) are (is) Roman Catholic, Confucian and Taoist.

The life expectancy at birth is 59.7 years for males and 66.5 years for females (WHO, 2004). The healthy life expectancy at birth is 53 years for males and 58 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Nauru in internationally accessible literature.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is absent.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1997.

Mental Health Legislation The Mentally Disordered Persons Ordinance is the latest legislation. The latest legislation was enacted in 1963.

Mental Health Financing There are no budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary source of mental health financing is tax based.

The country does not have disability benefits for persons with mental disorders. Mental illness is not considered a disability.

Mental Health Facilities Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.

Regular training of primary care professionals is not carried out in the field of mental health.

There are community care facilities for patients with mental disorders. Community services are very limited. Care facilities for children with mental disabilities have been set up with the cooperation of the Government and parents of these children. Mentally ill persons are easily absorbed into the community.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0
Psychiatric beds in mental hospitals per 10 000 population	0
Psychiatric beds in general hospitals per 10 000 population	0
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0
Number of social workers per 100 000 population	0

There are no mental health personnel in the country. There are no specified beds for psychiatry.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in treatment. The International Organization for Migration (IOM) has appointed a psychiatrist for asylum seekers living in camps in Nauru. The psychiatrist also provides assessment and management to referred Nauruan patients.

Information Gathering System There is no mental health reporting system in the country.

The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population There are no special services available.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, carbidopa, levodopa.

Other drugs like nortriptyline and midazolam are also available.

Other Information Suicide rates are on the increase in these islands and there is a need for mental health personnel.

Additional Sources of Information

Nepal

GENERAL INFORMATION

Nepal is a country with an approximate area of 147 thousand sq. km. (UNO, 2001). Its population is 25.724 million, and the sex ratio (men per hundred women) is 104 (UNO, 2004). The proportion of population under the age of 15 years is 40% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 61.6% for men and 26.4% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.2%. The per capita total expenditure on health is 63 international \$, and the per capita government expenditure on health is 19 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Nepali. The largest ethnic group(s) is (are) indigenous Nepalese, and the other ethnic group(s) are (is) Indo-Nepalese and Tibeto-Nepalese. The largest religious group(s) is (are) Hindu, and the other religious group(s) are (is) Buddhist, Muslim and Christian.

The life expectancy at birth is 59.9 years for males and 60.2 years for females (WHO, 2004). The healthy life expectancy at birth is 52 years for males and 51 years for females (WHO, 2004).

EPIDEMIOLOGY

Wright et al (1989) interviewed patients attending a primary care center for psychiatric illnesses using the Self-Reporting Questionnaire. Psychiatric morbidity was detected in one-quarter of all patients screened; more women were affected. Sharma (1975) examined 226 subjects with cannabis abuse and an equal number of matched (age, sex, education) normal controls. Compared with the controls, the cannabis users had a poor work record, poor social and family relationships, a lack of interest in sex and a general loss of initiative and efficiency. Regmi et al (2002) screened 100 women 2-3 months post-delivery and 40 control women using the Edinburgh Postpartum Depression Scale (EPDS). All those who screened positive for depression and 20% of the negatives also underwent a structured interview to assess depression by DSM-IV criteria. Predictive errors were minimized by using an EPDS score 13 to define depression. Using this threshold, there was no difference in depression prevalence between postpartum women (12%) and the control group (12.5%). Van Ommeren et al (2001) used standardized tools to interview 418 tortured Bhutanese refugees and 392 non-tortured Bhutanese refugees. Tortured refugees were more likely to report 12-month ICD-10 posttraumatic stress disorder, persistent somatoform pain disorder and dissociative (amnesia and conversion) disorders. In addition, tortured refugees were more likely to report lifetime posttraumatic stress disorder, persistent somatoform pain disorder, affective disorder, generalized anxiety disorder and dissociative (amnesia and conversion) disorders. Tortured women, compared with tortured men, were more likely to report lifetime generalized anxiety disorder, persistent somatoform pain disorder, affective disorder and dissociative (amnesia and conversion) disorders. Shrestha et al (1998) did a case-control study on a random sample of 526 tortured Bhutanese refugees and an equal number of non-tortured refugees matched for age and sex. The tortured refugees, as a group, suffered more DSM-III-R PTSD symptoms and had higher Hopkins Symptom Checklist-25 (HSCL-25) anxiety and depression scores and more musculoskeletal system- and respiratory system-related complaints than the non-tortured refugees. Buddhists were less likely to be depressed or anxious, and males were less likely to experience anxiety. Van Ommeren et al (2002) found that the number of PTSD symptoms, independent of depression and anxiety, predicted both number of reported somatic complaints and number of organ systems involving such complaints. Emmelkamp et al (2002) evaluated 315 Bhutanese refugees and found that the total number of coping strategies was correlated with anxiety and depression. Negative coping, in contrast to positive coping, was related to all symptom outcome measures. Received social support was more strongly related to symptoms than perceived social support. The findings from the first sample were replicated in the second sample of 57 Nepalese torture victims. In a case-control study that involved 68 cases and 66 controls in a Bhutanese refugee camp, Van Ommeren et al (2001) found that recent loss, early loss, childhood trauma and pulse-rate were predictors of case status during an epidemic of medically unexplained illness consisting of somatoform symptoms, acute anxiety and dissociation (which included visual and auditory hallucinatory experiences in 60% and 28% of cases, respectively). Karki et al (2001) found that 86.5% of patients (n=37) attending the emergency ward with severe organophosphorus poisoning (OPP) had consumed it with the intent of committing suicide.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1997.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The mental health policy is a part of the general health policy. Psychiatrists, psychologists, psychiatric nurses, lawyers and civil servants were involved in its development. The policy aims to provide minimum mental health care facilities for all by the end of the current National Five-Year Plan by integrating mental health services into the general health services of the country, develop human resource facilities in mental health, protect the fundamental rights of the mentally ill, improve awareness about mental illness and promote better mental health in the community.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1994.

National Mental Health Programme A national mental health programme is absent.

It is in accordance with the national mental health policy of the country.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1986.

Supply of 5 essential psychotropics has been ensured in the lowest level of the health delivery system of the country.

Mental Health Legislation Under the Civil Law there are some sections having legal provisions concerning insanity. A separate mental health legislation, that protects the basic human rights of the mentally ill, has been drafted and is now awaiting the approval of the parliament.

The latest legislation was enacted in 1964.

Mental Health Financing There are budget allocations for mental health.

The country spends 0.08% of the total health budget on mental health.

The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, tax based and grants.

The Government and NGOs like the World Health Organization, United Mission to Nepal etc. are important funders of mental health care services. Despite this, the family of the mentally ill has to spend around 25 000 Nepalese rupees per year (USD 320) as direct services costs.

The country has disability benefits for persons with mental disorders. Chronic mental illness has been classified as one of the mental disabilities and these patients have equal rights as other disabilities according to the Disability Act.

Mental Health Facilities Details about mental health facilities at the primary care level are not available. Mental health is not an integral part of primary health care, but treatment of severe mental health disorders are available in ten districts where community health programmes with the support of NGOs are going on.

Regular training of primary care professionals is not carried out in the field of mental health. Primary care physicians and health workers are trained in mental health. Subsequent refresher training and supervision by psychiatrists has been attempted in some regions. A system of referral has been established. Local faith healers have been involved in the referral network. Successful integration of mental health care in primary health care has already occurred in 7 out of 75 districts.

There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.08
Psychiatric beds in mental hospitals per 10 000 population	0.02
Psychiatric beds in general hospitals per 10 000 population	0.02
Psychiatric beds in other settings per 10 000 population	0.04
Number of psychiatrists per 100 000 population	0.12
Number of neurosurgeons per 100 000 population	0.04
Number of psychiatric nurses per 100 000 population	0.08
Number of neurologists per 100 000 population	0.08
Number of psychologists per 100 000 population	0.08
Number of social workers per 100 000 population	0.04

At least 40 beds (10 in the governmental and 30 in the private sector) are earmarked for drug dependence treatment. All mental health professionals are stationed in urban and semi-urban areas.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Apart from usual services, NGOs run mental health services for homeless psychotic patients and refugees and day care centres for drug users.

Information Gathering System There is mental health reporting system in the country. A morbidity form is available for outpatients and is filled by primary health centres.

The country has data collection system or epidemiological study on mental health.

Programmes for Special Population The country has specific programmes for mental health for refugees.

Orientation programmes have been organized for school teachers. Special clinics for children, psychosexual disorders, headache and drug abuse treatment are available at a few centres.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam.

The drugs listed above are in the essential drug list for health posts and sub-health posts. More psychotropic drugs are available in the district and primary health care level.

Other Information A national level Non-communicable Disease Prevention and Control Committee has been formed in the Ministry of Health. Eight non-communicable diseases (including mental disorder) have been prioritized. An overall national focal point for non-communicable diseases and a coordinator for each of the eight non-communicable diseases have been identified and a national Non-communicable Diseases Policy and strategies have been formulated. Activities for each of the eight non-communicable diseases are being planned.

Additional Sources of Information

DoHS (1998-99) Annual Report – National Health Policy.

Emmelkamp, J., Komproe, I. H., Van Ommeren, M., et al (2002) The relation between coping, social support and psychological and somatic symptoms among torture survivors in Nepal. *Psychological Medicine*, 32, 1465-1470.

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Netherlands*

GENERAL INFORMATION

Netherlands is a country with an approximate area of 42 thousand sq. km. (UNO, 2001). Its population is 16.227 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 18% (UNO, 2004), and the proportion of population above the age of 60 years is 18% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8.9%. The per capita total expenditure on health is 2612 international \$, and the per capita government expenditure on health is 1654 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Dutch. The largest ethnic group(s) is (are) Dutch. The largest religious group(s) is (are) Roman Catholic, and the other religious group(s) are (is) Protestant.

The life expectancy at birth is 76 years for males and 81.1 years for females (WHO, 2004). The healthy life expectancy at birth is 70 years for males and 73 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in Netherlands in internationally accessible literature. No attempt was made to include this information here.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1999.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The Government has developed a policy (National Mental Health Plan) to create a mental health care sector that has the following characteristics: the care provided is demand-driven, i.e. tailored to the care needs of the individual client and his or her specific social or cultural characteristics. It comes about through consultation with the client, is easily accessible and consists of both medical and psychiatric treatment and social assistance; the provision of care is organized effectively in accordance with a clear profile from 'light and general to heavy and specialized'; disorders that can be treated in the short term and by general means are dealt with in the locally organized first echelon of mental health care by the general practitioner, the health care psychologist and the social worker; disorders that are beyond the capacities of the first echelon are referred to the regionally organized specialist mental health care centres, which are preferably located in or near the general hospital. These regional centres offer a complete range of facilities (prevention, diagnosis, crisis care, outpatient and short-term inpatient treatment, resocialization and sheltered accommodation); super-specialist help is provided at the supra-regional or national level in the university hospitals and in a number of designated mental health care institutions. The Government had set up a broadly-based committee to advise on an active public mental health policy. This committee was to report at the end of the year 2001. Details can be obtained from the document 'Mental Health Care Policy Document'.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1995. In order to manage the drug problem in an effective way, there is a Netherlands National Drug Monitor which assesses the different situation both nationally and internationally and advises on policies. The drug policy distinguishes between drugs which present an unacceptable risk and those like cannabis which are less harmful. The policy is to limit the risks to individuals and socially integrate the patients. The policy is focussed more towards harm-reduction than towards total abstinence.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999. The Dutch Government issued an integral policy document on mental health care. It describes the ideal mental health care sector and how to reach (or to come close to) that ideal. Its principles include: demand-driven care, effectively and transparent organized care, deinstitutionalization, further development of the locally organized first echelon of mental health care, a logically configured professional structure, using methods that have been scientifically validated and coherent and integrated services for patients in which mental health care providers work closely with other care sectors, social sectors and local authorities.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. Details about the year of formulation are not available.

Mental Health Legislation The specialist mental health care sector, like the care for the handicapped and (in part) the nursing care sector, is managed on the basis of three related pieces of legislation: The Exceptional Medical Expenses Act (entitlements/accreditation), The Hospital Provision Act (planning and building), The Health Care Charges Act (charges). During the past few years, several acts have come into being to strengthen the position of clients in health care, such as: The Medical Treatment Contract Act, which stipulates that a care plan must be drawn up with the consent of the patient; The Client's Right of Complaint Act; The individual Health Care Professional Act, which regulates the duties and responsibilities of care providers; The Psychiatric Hospitals Act, which protects patients' rights in cases of committal and compulsory treatment. The Psychiatric Hospitals Act (1994) has recently been evaluated. Input from patients and family organizations has helped to identify a number of problem areas relating to the limited options for the compulsory treatment of patients who have no insight into their illness, as well as patients' need for more opportunities for autonomy by means of self-binding undertakings. Also, it has become evident that there is need for compulsory outpatient

treatment. Therefore, it is planned that The Psychiatric Hospitals Act will be changed in the coming years. Forensic psychiatry plays an important role in the care and treatment of prisoners with mental disorders. There are number of legislation related to forensic psychiatry, namely, the Penal Law (TBS), Psychiatric Hospital (Special Admissions) Act and certain articles of the Penitentiary Principles. Prisoners requiring treatment are treated at maximum security hospitals, forensic psychiatry hospitals and psychiatric hospitals for the mentally retarded delinquents. The level of care is high. Besides this, there are forensic psychiatry services in each district, psycho-medical teams, specific care departments, forensic observation and guidance departments, individual guidance departments, special care departments and addiction guidance departments.

The latest legislation was enacted in 1994.

Mental Health Financing There are budget allocations for mental health.

The country spends 7% of the total health budget on mental health.

The primary sources of mental health financing in descending order are social insurance, out of pocket expenditure by the patient or family and private insurances.

Since 1989, mental health care has been financed through the Exceptional Medical Expenses Act except for outpatient substance use care which is mainly paid for via the Welfare Act. Almost 73% of the mental health budget is spent on mental hospitals, 19% on ambulatory care, 6% on general hospitals and the remaining on sheltered living. About 75% is spent on mental health care of the adult and elderly, 15% on children and adolescents, 7% on substance use care and 5% on forensic care. After 1 year the patients in inpatient treatment, psychotherapy or sheltered care have to pay a part of their expenses besides the funding from the Exceptional Medical Expenses Act.

The country has disability benefits for persons with mental disorders. About 300 000 people are receiving benefits for mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. It is the Dutch policy to strengthen the primary care in the treatment of mental disorders. The majority of patients with mental disorders initially contact their primary carers which include the general practitioner, social worker or psychologist.

Regular training of primary care professionals is carried out in the field of mental health.

There are community care facilities for patients with mental disorders. Until the 1970s, the mental health care system had developed along private and religious lines. The Dutch Association for Community Mental Health Care was established in 1972 and the Government intention to develop community care was proclaimed in 1974. The first Regional Institute for Community Mental Health Care (RIAGG) was established in 1982. As a result of the moves towards care in the community and the changing wishes of patients, the mental health care sector, the other care sectors, social organizations and local authorities are increasingly becoming involved and reliant on one another in the areas of housing, jobs, education and participation. Former psychiatric patients can call on a wide range of social provisions: the regular care sector, social pensions, sheltered accommodation facilities, crisis centres, etc. Most of the alternatives to hospital are in the private non-profit sector. Large scale experiments have also been carried out for replacing inpatient care with day care and assertive home treatment.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	18.7
Psychiatric beds in mental hospitals per 10 000 population	15.4
Psychiatric beds in general hospitals per 10 000 population	1
Psychiatric beds in other settings per 10 000 population	2.3
Number of psychiatrists per 100 000 population	9
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	99
Number of neurologists per 100 000 population	3.7
Number of psychologists per 100 000 population	28
Number of social workers per 100 000 population	176

There are other professionals as occupational therapists (177), creative art therapists (856), psychomotor therapists (743), social pedagogical workers (2855), activity supporters (1546), spiritual workers (146), other medical doctors (607) and a large number of other personnel. In the Netherlands, the first effort to reduce traditional inpatient care was not deinstitutionalization but strengthening outpatient care. The substitution policy was successful to an extent that inpatient care was reduced and outpatient and other community-based care increased. Intensive community based care was increased almost 5 times more than hospital-based care was reduced. There are at present 3 times as many professionals involved in inpatient care as in community care.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and rehabilitation. In 1964, Pandora was founded with the purpose to normalize the image of psychiatric patients and help in rehabilitation. This was followed by the League of Clients in 1971, whose primary objectives were advocacy and empowerment. A post called the Independent Patient Confidential Counsellor was forged to look into the negative experiences of the patient during hospitalization. Client councils were initially formed in hospitals but later also developed among the RIAGGs. The National Foundation for Patient Council was formed in 1981. A number of self-help groups started to function since the 1980s and family groups since the 1990s.

Information Gathering System There is mental health reporting system in the country. The country has data collection system or epidemiological study on mental health.

Programmes for Special Population The country has specific programmes for mental health for minorities, refugees, disaster affected population, indigenous population, elderly and children. The facilities for child and adolescent care are divided into the clinics for child and adolescent psychiatry, the child protection agencies and the child care system. There are care circuits and programmes for children, elderly and adults with specific disorders. In these there are tailor made programmes for treatment of specific disorders including those related to forensic psychiatry. There are facilities for both sheltered care and short term care.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: unknown.

Other Information Mental health care in its present form dates back to the 1970s and 1980s when the regional Institutes for outpatient mental health care and facilities for sheltered care and part-time treatment were added. Other facilities like semi-residential care, inpatient care and care circuits are present. Dutch mental health care is facing three major challenges. In the first place, epidemiological research and the statistics on trends in the use of care services point towards a steep rise in demand, particularly for outpatient care. The mental health care sector must respond to this appropriately. In the second place, the nature of the demand for care is changing: many people with chronic psychiatric problems want to be given the opportunity to remain part of the community. This means the further transformation of residential care into outpatient care. A third matter of concern is that the mental health care sector has to establish a much more explicit presence in regard to a number of social problems. Examples include incapacity for work as a result of mental problems, the problems surrounding the 'neglected' and 'degenerate', as well as the mental health problems of prisons, abuse, loneliness and poor living conditions. Details can be obtained about the mental health care facilities from the 'Fact Sheet Mental Health care' published in August 2000. According to the EPSILON Group study, most of the care provided to patients suffering from schizophrenia is on site with some services at the patient's home or other places like police stations and hospital emergencies.

* The verification of this country profile is still being awaited from the Ministry of Health of the Netherlands.

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New Zealand

GENERAL INFORMATION

New Zealand is a country with an approximate area of 271 thousand sq. km. (UNO, 2001). The country consists of two main islands and a number of small outlying scattered islands. Its population is 3.905 million, and the sex ratio (men per hundred women) is 97 (UNO, 2004). The proportion of population under the age of 15 years is 22% (UNO, 2004), and the proportion of population above the age of 60 years is 16% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004). The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8.3%. The per capita total expenditure on health is 1724 international \$, and the per capita government expenditure on health is 1323 international \$ (WHO, 2004).

The main language(s) used in the country is (are) English and Maori. The largest ethnic group(s) is (are) European, and the other ethnic group(s) are (is) Maori. The largest religious group(s) is (are) Christian.

The life expectancy at birth is 76.6 years for males and 81.2 years for females (WHO, 2004). The healthy life expectancy at birth is 70 years for males and 72 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in New Zealand in internationally accessible literature. No attempt was made to include this information here.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1994.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Community based care, quality improvement, services for Maori, balancing personal rights with protection of the public, and developing a national drug and alcohol policy are the major issues addressed in the policy (the document 'Looking Forward' outlines the 10-year national mental health strategy). The strategy requires specialized mental health services to be delivered to the 3% of people who are the most severely affected by mental illness and mental health in primary care for the other 17%. A strategy to address Maori mental health issues, 'Te Puawaitanga; Maori Mental Health National Strategic Framework', was published in 2001.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1998. The National Drug Policy (1998) emphasizes the need for strong law enforcement (to control the supply of drugs), credible messages about drug-related harm (to reduce demand for drugs) and effective health services (to manage drug problems which do still occur).

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1997. The Mental Health Commission was established in 1996 to monitor the progress of implementation of the national strategy. In 1997, 'Moving Forward' was released. This document set a national mental health plan for more and better services. In 1998, the Mental Health Commission released the Blueprint for Mental Health Services in New Zealand. It provides a description of the mental health service and workforce developments required for the implementation of the National Mental Health Strategy. It emphasizes appropriate attention to mental health promotion, early intervention services and treatment for moderate and mild mental illness. In June 2000, the five-year mental health workforce plan was completed. Most of the milestones in the national mental health strategy have now been met. A successor strategy, with new milestones for 2006-2010 is being prepared. National mental health standards were developed in 1997 and subsequently revised in 2001. All mental health services must comply with these standards.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. Details about the year of formulation are not available.

An organization set up by the Government evaluates drugs considered to be essential for the health services and subsidizes them. Other drugs considered non-essential by the organization have to be paid for in full.

Mental Health Legislation There is a Mental Health (Compulsory Assessment and Treatment) Act of 1992, which was amended in 1999. The Criminal Procedure (Mentally Impaired Persons) Act 2003 regulates forensic issues in conjunction with Part 4 of the Mental Health Act. There is no capacity for diminished responsibility. The Mental Health Commission Act 1998 sets up a Commission to monitor and report on the implementation of the Government's mental health strategy. The latest legislation was enacted in 1992.

Mental Health Financing There are budget allocations for mental health.

The country spends 11% of the total health budget on mental health.

The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, private insurances and social insurance.

Hospital and community-based mental health services are publicly funded. Since 1999, District Health Boards have taken over the funding role from the erstwhile Health Funding Authority. They provide 70% of the mental health and drug abuse services directly and fund the other 30% of services provided by around 400 NGOs and independent general practitioner associations. Patients pay a proportion of the cost of their drugs and tests. Lower rates are levied for those on benefits. Public sector funding increased by 125%

between the years 1994 and 2003 to support the implementation of the national strategy. The Accident Compensation Corporation funded by employers and employees finances sexual abuse counselling. About 34% of people have private health insurance, but these provide limited mental health cover. Private expenditure on clinical psychological services is primarily out of pocket.

The country has disability benefits for persons with mental disorders. People are eligible for a range of Government funded benefits according to need.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. In 2001, a new Primary Health Care Strategy was developed and it led to the establishment of Primary Health Care Organizations (PHOs). The Strategy builds on a population health focus. As part of the implementation of the Strategy, work is under way to better integrate mental health into primary care. Even for those people who have moderate to severe mental illness, their needs are met in primary health care. Some specialist mental health and primary health shared care services operate jointly to manage people with severe mental illness in primary care.

Regular training of primary care professionals is carried out in the field of mental health. To support shared care services, additional training of primary care professionals in managing people with severe mental illness has been undertaken.

There are community care facilities for patients with mental disorders. A broad range of community services are available, for instance, residential care, community support, supported employment, consumer and family networks, education and some home based services. About 6-7% of people estimated to be using mental health services live in supported accommodation. Most of these are provided or funded by Community Housing Limited, with support services provided by DHBs or DHB contracted community providers. Currently, community-based services form around 68% of all mental health services. Increased community-based service delivery is a result of deinstitutionalization and the greater focus in recent years on the recovery based model of mental health as well as increased recognition of the human rights issues.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	3.8
Psychiatric beds in mental hospitals per 10 000 population	1
Psychiatric beds in general hospitals per 10 000 population	2.8
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	6.6
Number of neurosurgeons per 100 000 population	0.4
Number of psychiatric nurses per 100 000 population	74
Number of neurologists per 100 000 population	1.23
Number of psychologists per 100 000 population	28
Number of social workers per 100 000 population	

There are 1837 occupational therapists. Specialist mental health services are available for the 3% of people with severe mental illness. As a result of deinstitutionalization, stand-alone psychiatric hospitals have been replaced by mental health units in general hospitals. Inpatient beds have decreased by about one third in the last decade. In the same period, beds in services delivered by the community have more than doubled. There is only one private hospital. About 7% of available beds are earmarked for the elderly. Two-thirds of psychiatrists are based in Christchurch and Auckland. About 15% of psychiatrists and 30.5% of psychologists offering clinical, counselling and psychotherapy services are in private practice. The deployment of mental health professionals in the public mental health services has increased in the last decade (e.g. psychologists by more than 50%), but still a shortage is perceived. Psychologists and psychiatric nurses do not have medication prescribing privileges.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. NGOs also provide residential care facilities. Mental health services run by and for consumers operate throughout the country, and consumer representatives make an invaluable contribution in all policy and service development issues.

Information Gathering System There is mental health reporting system in the country. The centralized information system is known as the Mental Health Information National Collection (MHINC). Details are available from the website: www.nzhis.govt.nz. This provides ongoing information about people accessing mental health treatment and support services in inpatient and community settings, their diagnoses and the services they receive.

The country has no data collection system or epidemiological study on mental health. The development of systems to routinely collect information about client outcomes is in the early stages. A major epidemiology study, as part of the WHO World Mental Health Consortium, to examine the determinants of mental health and to provide information on the prevalence of mental disorders, disability and service utilization is also under way.

The Mental Health Information National Collection (MHINC) provides ongoing information about numbers of adults, children and young people accessing mental health services, their diagnoses and the services they receive. A major epidemiology study that

examines the determinants of mental health and provides information on the prevalence of mental disorders, disability and service utilization is under way.

Programmes for Special Population The country has specific programmes for mental health for minorities, refugees, disaster affected population, indigenous population, elderly and children. In addition, there are specific services for deaf subjects and those with alcohol and substance abuse, as well as forensic and maternal mental health services.

To improve the low mental health status of Maori, as compared with the rest of the population, Kaupapa Maori mental health services have been developed. These services are run by and for Maori, and operate according to Maori perspectives of health and well-being. Similarly, there are services by and for Pacific people living in New Zealand. Mainstream services must also ensure culturally responsive service delivery. The Ministry of Health's Public Health Directorate has developed a national mental health promotion strategy entitled 'Building on Strengths.' The Directorate is also leading a national campaign entitled 'Like Minds, Like Mine: Project to Counter Stigma and Discrimination associated with Mental Illness.' Broadly, the campaign comprises both national and regional components. The national work consists of mass media (including a television and radio advertising campaign), benchmark and tracking surveys on the general public's attitude towards mental illness and collecting information on attitudes, behaviours and policies that are, or could be, discriminatory. In collaboration with the Education sector, two programmes 'Health Promotion in Schools' and 'Mentally Healthy Schools' are available for school use. The Mental Health Directorate has responsibility for managing problem gambling through community services. DHB's have responsibility for developing 'Major Incident and Emergency Plans'.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

Though there is no WHO style national drug policy or essential drug list, there is a therapeutic policy and regulation that has all the elements of the WHO policy, and the current regulatory environment meets the WHO definitions. The Government funds pharmaceuticals in New Zealand via a separate agency (PHARMAC) that apply a cost utility approach to selection of medicines to fund. Inherent within the PHARMAC approach is consideration of maintaining a number of medicines in particular therapeutic groups.

Other Information The life expectancy for Maori, the country's indigenous population, is lower than the general population at 69.0 for Maori males and 73.2 for Maori females. The Government has established a broad based approach to social policy. A priority in this initiative is the low mental health status of Maori compared with the rest of New Zealand's population.

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Nicaragua

GENERAL INFORMATION

Nicaragua is a country with an approximate area of 130 thousand sq. km. (UNO, 2001). Its population is 5.596 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 41% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 76.8% for men and 76.6% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.8%. The per capita total expenditure on health is 158 international \$, and the per capita government expenditure on health is 77 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Spanish. The largest ethnic group(s) is (are) Mestizo (seven-tenths), and the other ethnic group(s) are (is) European and African. The largest religious group(s) is (are) Roman Catholic (five-sixths).

The life expectancy at birth is 67.9 years for males and 72.4 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 63 years for females (WHO, 2004).

EPIDEMIOLOGY

Penayo (1990) used SRQ-20 as a screening instrument to identify probable psychiatric cases (cut-off score of 9/10) in the general population (n=576) and primary health care (n=781). Confirmation of diagnosis was done through Present State Examination (PSE) assisted interview. Almost 23% of general population and 47% of the primary care subjects were identified as cases. Penayo et al (1992) estimated the prevalence of mental disorders in an area affected by armed conflict. Two-stage cluster sampling was used to select 219 families (n=584). Screening was done with SRQ and confirmation of diagnosis through the Present State Examination. The estimated prevalence rates were: neurosis (7.5%), depression (6.2%), reactive crisis (3.3%), alcoholism (5.8%), organic brain syndrome (3.9%), psychosis (0.5%) and other disorders (0.7%). The estimated overall prevalence of mental disorders in the study population was 27.9%. Disorders were more prevalent among men (30.8%) than women (26.3%). Caldera et al (2001) assessed a sample of 496 adult survivors of a hurricane in 4 primary care centres using the Harvard Trauma Questionnaire (HTQ). Prevalence of PTSD ranged from 9.0% in the worst afflicted area to 4.5% in a less damaged area. PTSD symptoms 6 months after the disaster (HTQ) were significantly associated with the death of a relative, destroyed house, female sex, previous mental health problems and illiteracy. Suicidal thoughts were reported by 8.5% of the sample and it was associated with a history of previous mental health problems and illiteracy. One year after the hurricane, half of those identified as PTSD cases at 6 months retained the diagnosis. Goenjian et al (2001) interviewed 158 adolescents from three differentially exposed cities using a Hurricane Exposure Questionnaire, the Child Posttraumatic Stress Disorder Reaction Index and the Depression Self-Rating Scale 6 months after a hurricane. Severe levels of posttraumatic stress and depressive reactions were found in the two more heavily affected cities and this was proportionate to the level of exposure. Level of impact (city), objective and subjective features and thoughts of revenge accounted for 68% of the variance in severity of posttraumatic stress reaction. Severity of posttraumatic stress reaction, death of a family member and sex accounted for 59% of the variance in severity of depression. Summerfield and Toser (1991) found that 62% of men and 91% of women ex-refugees still living in the war zone met criteria for caseness according to the General Health Questionnaire. Nearly 25% of men and 50% of women merited a diagnosis of posttraumatic stress disorder. Some distress reflected unresolved grief states. Caldera et al (1995) assessed 100 consecutive outpatients with the Structural Clinical Interview for DSM-III Disorders. One fourth of patients had a psychotic disorder where schizophrenia dominated. Among non-psychotic patients, major depression, anxiety and adjustment disorders were most frequent. Personality disorders were common (80%) among non-psychotic patients, with paranoid, obsessive-compulsive, passive-aggressive and masochistic personality disorders being the most frequent. Victims of spousal violence frequently experienced feelings of shame, isolation and entrapment and poor social support (Ellsberg et al, 1999, 2000). Suicide was the leading cause of death in the 15-34 year-old age group and the tenth leading cause of mortality overall in the year 2001. Suicidal behaviour is more common in men than women (2,5:1). The rate for 100 000 inhabitants has ascended of 2.80 in 1992 to 6.74 in 2002. Almost 29% of the parasuicidal behaviour is seen in the population younger than 20 years and more than 50% in those younger than 25 years. In this group women (more than 75%) are overrepresented. Herbicides are often used to attempt suicide (Ministry of Health, 2004).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1975.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. It was revised in 2001 by mental health professionals and public servants. Between 25 to 50 % of its original content was put into practice.

Substance Abuse Policy Details about the substance abuse policy are not available. It was revised in 2002. It has a specific budget for its implementation and has been implemented to the extent of 25 to 50%. Nicaragua also has laws on substance abuse, 'Ley 175 de 1994 – Creación Consejo Nacional Antidrogas', 'Ley 285 Ley antidrogas actualizada' and 'Ley 370 – Ley Creación Instituto contra el Alcoholismo y la Drogadicción'.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1979. It was revised in 2001. There are no specific funds for its implementation, but it has been implemented to the extent of 25 to 50% by local, regional and national authorities. Its main components are strategy of services reform, promotion and prevention, integration of mental health services in primary care and development of specialized services.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1999.

Mental Health Legislation The most recent legislation is from 2001 and was revised in 2002. There are no regular funds for its implementation but it has been implemented to the extent of 25 to 50%. It focuses on promotion and prevention and regulation of mental health services, but there is no reference to human rights of patients. Other laws related with mental health are the Handicap Law (Law 202), the Anti-Drug Law (Law 285), the Law on Creation of the Institute Against Alcoholism and the Drug Addiction and the Pharmacy Law.

The latest legislation was enacted in 2001.

Mental Health Financing There are budget allocations for mental health.

The country spends 1% of the total health budget on mental health.

The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, tax based, social insurance and private insurances.

The country has disability benefits for persons with mental disorders. Disability benefits are available only to those covered by social security. The health department has to assess a patient every 3 years.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Less than 25 % of the population is covered by this kind of service. Mental health care is provided by primary health care physicians.

Regular training of primary care professionals is not carried out in the field of mental health.

There are community care facilities for patients with mental disorders. The system of community care for the mentally ill includes preventive/promotion interventions, home interventions, family interventions, residential facilities, vocational training; employment programs; however, all of them are available for less than 25% of the population. Community care teams are often multidisciplinary (general clinicians, nurses, social workers), but they are understaffed.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.34
Psychiatric beds in mental hospitals per 10 000 population	0.32
Psychiatric beds in general hospitals per 10 000 population	
Psychiatric beds in other settings per 10 000 population	0.02
Number of psychiatrists per 100 000 population	0.64
Number of neurosurgeons per 100 000 population	0.01
Number of psychiatric nurses per 100 000 population	0.045
Number of neurologists per 100 000 population	0.4
Number of psychologists per 100 000 population	1.45
Number of social workers per 100 000 population	0.71

In addition, there are 10 general nurses, 74 assistants and a 1 pedagogue. Almost half of the psychiatrist work in the private set-up. No attempts have been made to close mental hospitals. However, only 10% of beds are occupied by long-stay patients. There are facilities to assess the quality of care at secondary and tertiary level. The ministerial resolution 31- 93 encourages attendance of psychiatric patients in general hospitals. About 15 general hospitals provide mental health care. There is significant geographic variation of mental health services with 96% of centres providing mental health care being along the Pacific Coast. More than 50% of mental health professionals are employed in public institutions.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. These organizations participate in mental health activities related to women, children, domestic violence and consumers.

Information Gathering System There is mental health reporting system in the country. They use ICD-10 codes. Besides psychiatric diagnoses, other mental health components reported are family violence, homicides, suicides, drug abuse and dependence. Epidemiological assessments of mental disorders are performed.

The country has data collection system or epidemiological study on mental health. The department in charge of service data collection system is the 'Dirección General de Sistemas de Información' of the Ministry of Health. Data is collected only in hospitals and some primary health care centers where mental health services are available. Cases registered in the system of registration of

the MINSA in 2002 showed that out of the 33 583 outpatients applying for mental health care (0.07% of all registrants) only 69% had diagnosable conditions. Sleep related disorders (22%), anxiety states (42%), psychoses (27%), and alcohol dependence (2.9%) were common (Ministry of Health, 2004)

Programmes for Special Population The country has specific programmes for mental health for disaster affected population, indigenous population and children.

Also, there are programmes for women, children in vulnerable situation, and victims of domestic violence.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, haloperidol, lithium, biperiden, carbidopa, levodopa.

The essential drug list was created in 1979 and revised in 2001. Availability of these medications is erratic. They are free of charge for chronic patients and at the primary care level.

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Niger

GENERAL INFORMATION

Niger is a country with an approximate area of 1267 thousand sq. km. (UNO, 2001). Its population is 12.415 million, and the sex ratio (men per hundred women) is 102 (UNO, 2004). The proportion of population under the age of 15 years is 50% (UNO, 2004), and the proportion of population above the age of 60 years is 3% (WHO, 2004). The literacy rate is 25.1% for men and 9.3% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.7%. The per capita total expenditure on health is 22 international \$, and the per capita government expenditure on health is 9 international \$ (WHO, 2004).

The main language(s) used in the country is (are) French, Kanuri, Arabe, Gourmantche, Toubou and Boudouma. The largest ethnic group(s) is (are) Hausa, and the other ethnic group(s) are (is) Djermana, Fula and Tuareg. The largest religious group(s) is (are) Muslim (four-fifths), and the other religious group(s) are (is) Roman Catholic.

The life expectancy at birth is 42.6 years for males and 42.7 years for females (WHO, 2004). The healthy life expectancy at birth is 36 years for males and 35 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Niger in internationally accessible literature.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1993.

The components of the policy are promotion, prevention and treatment.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1997.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2001. A new mental health programme was adopted in 2001. A national action plan in mental health is being formulated, in which activities in primary health care and mental health would be included and this would be adopted soon.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1995.

Mental Health Legislation The current legislation on mental health is the decree which created psychiatric services in western French Africa. A process to formulate new mental health legislation is under way. A draft of this legislation was expected before December 2001.

The latest legislation was enacted in 1928.

Mental Health Financing There are no budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, social insurance and private insurances.

The country does not have disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.

Regular training of primary care professionals is not carried out in the field of mental health.

There are community care facilities for patients with mental disorders. Traditional medicine is the only form of community treatment.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.2
Psychiatric beds in mental hospitals per 10 000 population	0
Psychiatric beds in general hospitals per 10 000 population	0.2
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.04
Number of neurosurgeons per 100 000 population	0.01
Number of psychiatric nurses per 100 000 population	0.04
Number of neurologists per 100 000 population	0.01
Number of psychologists per 100 000 population	0.03
Number of social workers per 100 000 population	0.05

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation.

Information Gathering System There is mental health reporting system in the country. Mental disorders are included in 'other disorders' category.

The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population There are no special mental health programmes for any specific population.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: phenobarbital, chlorpromazine, diazepam, haloperidol.

Other Information

Additional Sources of Information

Nigeria

GENERAL INFORMATION

Nigeria is a country with an approximate area of 924 thousand sq. km. (UNO, 2001). Its population is 127.117 million, and the sex ratio (men per hundred women) is 102 (UNO, 2004). The proportion of population under the age of 15 years is 44% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 74.4% for men and 59.4% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.4%. The per capita total expenditure on health is 31 international \$, and the per capita government expenditure on health is 7 international \$ (WHO, 2004).

The main language(s) used in the country is (are) English, Hausa, Yoruba, Igbo and Pidgin English. The largest ethnic group(s) is (are) Hausa and Fulani in the north, Yoruba in the southwest and Igbo in the southeast., and the other ethnic group(s) are (is) Efik/Ibibio, Tiv, Ijaw, Kanuri, Nupe, Edo and Idoma. The largest religious group(s) is (are) Muslim and Christian, and the other religious group(s) are (is) indigenous groups.

The life expectancy at birth is 48 years for males and 49.6 years for females (WHO, 2004). The healthy life expectancy at birth is 41 years for males and 42 years for females (WHO, 2004).

EPIDEMIOLOGY

Leighton et al (1963) conducted a cross-cultural study in which they found that subjects in Yorubaland, Nigeria had more mental symptoms especially those related to the organic domain but fewer cases of mental disorders in comparison to those in the Stirling County in North America. More men in the former setting and more women in the latter setting had mental disorders. Gureje et al (1992a) assessed 787 primary care patients using the Yoruba translation of the General Health Questionnaire (GHQ-12) and Composite International Diagnostic Interview (CIDI) in a two stage design. A weighted prevalence for specific DSM-III-R disorders was 27.8%. Abiodun (1993) assessed 272 primary care patients using a two-stage procedure with GHQ-12 and the Present State Examination Schedule (PSE). The prevalence of psychiatric disorder was 21.3%. Depressive neurosis (51.7%) and anxiety neurosis (36.3%) were common. Psychiatric morbidity was associated with age (older), gender (female) and marital status (widowed, separated or divorced). Gureje (2002) assessed 704 primary care patients with GHQ-28, a structured diagnostic interview and a disability assessment schedule, at 2 time points one year apart. About 10% met the ICD-10 criteria for any disorder and 25% met GHQ caseness criterion. Being a case on the GHQ at baseline (but not on ICD-10) was associated with disability at 12-month follow-up. Uwakwe (2000) assessed 164 rural community subjects aged above 60 years using the Self-Reporting Questionnaire and the Geriatric Mental State Schedule. Psychiatric diagnoses as per ICD-10 Research Criteria were recorded in 23.1% of the subjects, with depression constituting 79% of all diagnoses. Hendrie et al (2001) and Ogunniyi et al (2000) examined two elderly (65+ years) community-dwelling populations in USA (n=2147 African Americans) and Nigeria (n=2459) following a two stage procedure. The age-standardized annual incidence rates were significantly lower among the Nigerians (Dementia: 1.4%, Alzheimer's disease: 1.2%) compared to the African Americans (Dementia: 3.2%, Alzheimer's disease: 2.5%). The overall age-adjusted prevalence rates of dementia and Alzheimer's disease in Ibadan (2.3% and 1.4%, respectively) were also lower than the respective values (8.2% and 6.2%) obtained for African Americans. In Nigeria, dementia was associated with old age and female gender. The frequencies of the vascular risk factors were lower in Nigerians. In the same sample, Perkins et al (2002) found that dementia was associated with increased mortality at both sites (Ibadan RR = 2.83, Indianapolis RR = 2.05). Obot (1990) conducted a household survey (n=1271) and found that 22.6% of adults smoked regularly. Abiodun et al (1994) examined 1041 secondary school students using a 117-item WHO self-report substance-use questionnaire. Use of salicylates (56.2%), stimulants (21.6%), alcohol (12.0%) and cigarettes (4.4%) was common. Adelekan and Ndom (1997) evaluated more than 1800 secondary school students with the same instrument at two time points 5 years apart. On the whole, substance use was less frequent in the follow-up sample. However, there were significant increases in the current use of cocaine, organic solvents and hallucinogens. Mamman et al (2002) examined 300 women from rural/suburban areas and found that 64% of them used alcohol, with more than half reporting current use. Gureje et al (1992b) administered the GHQ-12, the Alcohol Use Disorders Identification Test (AUDIT) and the Composite International Diagnostic Interview (CIDI) to subjects in an urban primary care clinic. Alcohol abuse or dependence according to DSM-III-R was estimated to be present in 1.7%. The National Expert Committee on Non-Communicable Diseases (1997) reported that 8.9% of adults (n=16 019) smoked cigarettes. Smoking was associated with gender (male), age (25-34 years) and residence (urban). Also more urban males drank alcohol in comparison to rural males. The National HIV/AIDS and Reproductive Health Survey (2003) showed that 12% of adults (n=10 910) had consumed alcoholic beverages regularly in the past 4 weeks and 3% drank daily. Use of psychoactive drugs was reported by 1% of the population. Jablensky et al (1992) reported the findings of the Determinants of Outcome of Severe Mental Disorders (DOSMED) study. They found that schizophrenia had similar presentation and incidence rates across different countries, but a better outcome in developing countries. Aderibigbe et al (1993) examined 162 women during second trimester and 6-8 weeks postpartum using GHQ-28 and PAS. The rate of caseness was 30% at the prenatal assessment and 14% in the postnatal assessment. Marital and family problems were associated with morbidity. Ohaeri and Odejide (1994) evaluated 865 adults from primary care clinics using GHQ-28, the Self-Reporting Questionnaire (SRQ) and the Brief Disability Questionnaire. About 8.2% fulfilled criteria for probable somatoform disorders. Nwosu and Odesanmi (2001) reviewed autopsy records and reported that the rate of completed suicide was 0.4 per 100 000 population with a male to female ratio of 3.6 to 1. The majority of the

victims were in the third decade of life and the common methods of committing suicide were consumption of insecticides and use of firearms. Eferakeya (1984) reviewed records of attempted suicides. The incidence of suicide attempt was 7/100 000. The majority of attempters was below 30 years of age and used poisons (88%). Mental illnesses were reported in one-third of the sample. Abiodun (1992) examined 500 rural children aged between 5-15 years and found the prevalence of psychiatric morbidity to be 15%, with emotional and conduct disorders present in two-thirds of these subjects. Children from disrupted families were more likely to suffer from psychiatric morbidity. Adelekan et al (1999) administered the Rutter's A2 scale to parents of 846 primary school children. The criterion of caseness (cut-off of 13) was met by 18.6% (neurotic disorders: 7.3%, anti-social disorders: 8% and undifferentiated disorders: 3.3%) being common. Psychiatric morbidity was associated with gender (boys), physical and emotional problems during pregnancy in mothers, delayed developmental milestones, major illness during childhood, broken homes and attending rural schools. Gureje et al (1994) assessed 227 children (7-14 years) attending a primary care centre with the children's version of the Schedule for Affective Disorders and Schizophrenia. The weighted prevalence of any DSM-III-R disorders was 19.6% (depressive disorders: 6%, anxiety disorders: 4.7% and conduct disorders: 6.1%).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1991.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Training and research and management information system are also emphasized in the policy.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1990. National Drug Law Enforcement Agency Decree No. 48 was amended in 1990.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1989. It was adopted in 1991.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1991.

Psychotropics are available and relatively affordable. However, newer formulations are either unavailable or too expensive. For example, a month's supply of risperidone (2mg) would cost more than the minimum monthly wage in the public service.

Mental Health Legislation The existing legislation on mental health dates back to 1916, later adopted as the Lunacy Act CAP 112, Laws of the Federation of Nigeria, 1958. A revised Mental Health Bill is now before the National Assembly (Parliament) for inaction into law. In 2004, it had passed a public hearing stage and adoption by the Senate. It is now before the House of Representatives.

The latest legislation was enacted in 1958.

Mental Health Financing There are budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, tax based, grants, social insurance and private insurances.

The country does not have disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. However, relatively few centres have trained staff and equipment to implement primary health care. Regular training of primary care professionals is carried out in the field of mental health. Each state has a school of Health Technologists for training of primary care professionals including health care workers.

There are community care facilities for patients with mental disorders. Community care is available in a few states. Providers include private medical practitioners, NGOs, especially faith-based organizations, and traditional healers.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.4
Psychiatric beds in mental hospitals per 10 000 population	0.3
Psychiatric beds in general hospitals per 10 000 population	0.04
Psychiatric beds in other settings per 10 000 population	0.01
Number of psychiatrists per 100 000 population	0.09
Number of neurosurgeons per 100 000 population	0.009
Number of psychiatric nurses per 100 000 population	4
Number of neurologists per 100 000 population	0.02
Number of psychologists per 100 000 population	0.02
Number of social workers per 100 000 population	0.02

Many health professionals migrate to industrialized countries leading to a shortage of personnel. Most resources are located in urban centres and predominantly in the southern parts of the country. There is virtually no private practice in the country. Many psychiatrists who have trained in other countries have not returned.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation.

Information Gathering System There is mental health reporting system in the country. Mental health morbidity statistics are available in each mental health institution but not always aggregated comprehensively at the national level.

The country has data collection system or epidemiological study on mental health. A national survey of mental health and wellbeing conducted in 2003-2004 to provide information on the size and extent of mental health problems in the country is undergoing analysis.

Programmes for Special Population The country has specific programmes for mental health for refugees, disaster affected population, elderly and children. There is a National Emergency Relief Agency (NEMA) that caters for the needs of refugees and populations affected by disasters. Mental health workers are invited to render necessary assistance, whenever required. Specific programmes have been developed for substance use disorders.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, biperiden. Benzhexol (5mg) is available.

Other Information Many psychiatric researches have been directed to problems related to the scientific practice and acceptability of psychiatry as a distinct discipline of medicine. These research studies created a positive awareness which led to the establishment of more psychiatry units in the general hospital setting, several specialist psychiatric institutions in the community and psychiatric residency programmes in the country.

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Niue

GENERAL INFORMATION

Niue is a country with an approximate area of 0.26 thousand sq. km. (UNO, 2001). Its population is 0.002 million, and the proportion of population above the age of 60 years is 7% (WHO, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.7%. The per capita total expenditure on health is 1041 international \$, and the per capita government expenditure on health is 1010 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Niuean and English. The largest ethnic group(s) is (are) Niue.

The life expectancy at birth is 67.6 years for males and 73.3 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Niue in internationally accessible literature.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is absent.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1998.

Mental Health Legislation There is a Mental Health Act. New Zealand's mental health act is also used in the country. The latest legislation was enacted in 1969.

Mental Health Financing There are no budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary source of mental health financing is tax based.

The country has disability benefits for persons with mental disorders. There is a Government budget support for disability benefits.

Mental Health Facilities Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.

Regular training of primary care professionals is not carried out in the field of mental health.

There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0
Psychiatric beds in mental hospitals per 10 000 population	0
Psychiatric beds in general hospitals per 10 000 population	0
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0
Number of social workers per 100 000 population	0

Non-Governmental Organizations NGOs are not involved with mental health in the country.

Information Gathering System There is mental health reporting system in the country. Mental health reporting is available only as a statistical information.

The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population There are no special services available.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, carbidopa, levodopa.

The essential list of drugs is revised every 2 years. The most recent revision took place in 2004. It should also be noted that the drugs are dispensed from the hospital pharmacy and not through the primary health care.

Other Information

Additional Sources of Information

Norway

GENERAL INFORMATION

Norway is a country with an approximate area of 324 thousand sq. km. (UNO, 2001). Its population is 4.552 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 19% (UNO, 2004), and the proportion of population above the age of 60 years is 20% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8%. The per capita total expenditure on health is 2920 international \$, and the per capita government expenditure on health is 2497 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Norwegian. The largest religious group(s) is (are) Evangelical Lutheran, and the other religious group(s) are (is) Muslim, Roman Catholic and Orthodox Christian.

The life expectancy at birth is 76.4 years for males and 81.7 years for females (WHO, 2004). The healthy life expectancy at birth is 70 years for males and 74 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in Norway in internationally accessible literature. No attempt was made to include this information here.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1997.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Further information is given in the section on national mental health programme.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1991. The national mental health programme puts considerable emphasis on developing well coordinated treatment programmes targeted towards patients suffering from both drug-abuse and severe mental illness.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999. The national mental health programme was initiated by a White Paper of 1997 ('Stortingsmelding nr 25 (1996-97) ; Åpenhet og helhet – om psykiske lidelser og tjenestetilbudene') that analysed the then current situation regarding mental health services and the need for developing more user-friendly and decentralized mental health services. The national mental health programme/reform ('St prp nr 63 (1997-98) – Om opptrappingsplan for psykisk helse 1999 – 2006') was adopted by the Norwegian Parliament ('Stortinget') and later extended to apply to the period 1999 to 2008. The mental health programme aims at improving availability, accessibility, quality and organization of mental health services and treatment on all levels. It covers many different aspects and settings including primary health care, the specialized health services, the educational system, social services, occupation and employment, housing, etc. The Programme also focuses on deinstitutionalization, reorganization of specialized mental health services and primary mental health care around decentralized community mental health centers, strengthening of primary health and social care services to people with mental illness, participation of user-/patient organizations in mental health policy planning, educational campaigns to reduce stigma and discrimination towards people with ill mental health. Norway also has other national programmes dealing with mental health issues, such as a suicide prevention programme (started in 1994) and a major programme targeting traumatized individuals.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. Details about the year of formulation are not available.

Mental Health Legislation In July 1999, the Norwegian Parliament passed four new acts concerning different aspects of health: The Specialized Health Services Act, The Mental Health Act, The Patients' Rights Act, The Health Personnel Act. These new health acts with their additional provisions were put into practice in January 2001. The mental health act ('Ot prp nr 11[1998-99]: Om lov om etablering og gjennomføring av psykisk helsevern [psykiatriloven]') especially regulates the part of psychiatry that deals with coercion/mandatory treatment. However, the main principle is that psychiatry is to be regulated on the same grounds as other specialized medical disciplines in the Specialized Health Services Act. During the fall 2004/winter 2005 a major evaluation will be undertaken regarding the Mental Health Act and its provisions, based on the experiences Norway has had so far with the law. Also, the Directorate for Health and Social Affairs is currently working on a program where the main objective is reduction and quality assurance regarding use of coercive treatment in psychiatry/mental health services.

The latest legislation was enacted in 1998.

Mental Health Financing There are budget allocations for mental health.

The country spends 0.1% of the total health budget on mental health.

The primary sources of mental health financing in descending order are social insurance, tax based, out of pocket expenditure by the patient or family and private insurances.

The national mental health programme has required extensive economical grants and subsidies to the public health sector from the Government.

The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. The national mental health programme lays emphasis on the importance of the capability of primary health care services in dealing with persons with mental illnesses and problems and on close collaboration between different services and public entities.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 1600 personnel were provided training.

There are community care facilities for patients with mental disorders. Mental health facilities consist of decentralized community mental health centres and specialized psychiatric hospitals. Many psychiatrists and psychologists with private practices are financially supported from the state, and represent an important part of the overall pool of resources in the fight against mental ill health.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	12
Psychiatric beds in mental hospitals per 10 000 population	
Psychiatric beds in general hospitals per 10 000 population	
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	20
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	42
Number of neurologists per 100 000 population	4
Number of psychologists per 100 000 population	68
Number of social workers per 100 000 population	

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Official Norwegian health policy states that user participation is an essential factor if one is going to succeed in the overall improvement of mental health services. As a result, NGOs, including user/patient organizations, are strongly involved with mental health issues in the country.

Information Gathering System There is mental health reporting system in the country. MBDS (Minste Basis Data Sett) is a reporting system that is mandatory in all mental health service facilities. This system also includes a detailed reporting system for psychiatric patients undergoing mandatory/coercive treatment.

The country has data collection system or epidemiological study on mental health. The National Institute for Public Health (Folkehelseinstituttet) gathers epidemiological data, including mental health for the whole country.

Programmes for Special Population The country has specific programmes for mental health for minorities, refugees, disaster affected population, elderly and children. There are services for prisoners.

In addition, there are programmes/projects targeting other special groups/problems (diagnostic, ethnic etc), e.g. severe mental illness and violence, diagnosis and treatment regarding children, adolescents and adults suffering from ADHD, patients with severe mental illness and drug abuse, patients suffering from eating disorders, health and social services for refugees and health services for prisoners/inmates.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

Other Information Norway has traditionally emphasized the principle of equal rights and access to well-functioning health and social services for all citizens. This, however, is a challenge due to the country's geographical features and the low population density patterns in the country. A decentralized health service system creates its own problems that must be dealt with. For instance, it is a challenge to recruit qualified personnel to small local clinics in rural areas. Also it is essential to achieve and maintain a well functioning, collaborative and coherent service systems for the benefit of the user/patient.

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Oman

GENERAL INFORMATION

Oman is a country with an approximate area of 310 thousand sq. km. (UNO, 2001). Its population is 2.935 million, and the sex ratio (men per hundred women) is 134 (UNO, 2004). The proportion of population under the age of 15 years is 37% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 82% for men and 65.4% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3%. The per capita total expenditure on health is 343 international \$, and the per capita government expenditure on health is 277 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Arabic. The largest ethnic group(s) is (are) Arab, and the other ethnic group(s) are (is) Baluchi, South Asian and African. The largest religious group(s) is (are) Muslim.

The life expectancy at birth is 71 years for males and 76.3 years for females (WHO, 2004). The healthy life expectancy at birth is 63 years for males and 65 years for females (WHO, 2004).

EPIDEMIOLOGY

Chand et al (2001) conducted an 8-year retrospective analysis of hospital records of cases with dissociative disorder. These disorders were common, and female predominance was not marked. The most common presentations were dissociative convulsions, dissociative motor and dissociative trance disorders. Zaidan et al (2002) reviewed Accident and Emergency records over a 6-year period and found 123 cases of deliberate self-harm. Most patients with deliberate self-harm were women, students and unemployed. Analgesic (paracetamol) use was the preferred method followed by other non-pharmaceutical chemicals. Al Adawi et al (2002) used the Eating Attitude Test and the Bulimic Investigatory Test to assess eating disorders in Omani teenagers, non-Omani teenagers and Omani adults. On the Eating Attitude Test, 33% of Omani teenagers (29.4% females and 36.4% males) and 9% of non-Omani teenagers (7.5% of males and 10.6% females) showed anorexia-like behaviour. On the Bulimic Investigatory Test, 12.3% of Omani teenagers (13.7% females and 10.9% males) showed a propensity for binge eating or bulimia. Among the non-Omani teenagers, 18.4% showed bulimic tendencies with females outnumbering males. Only 2% of Omani adults showed any problems related to eating behaviours. Kenue et al (1995) assessed 492 children (<15 years of age) and found that 2% had disabilities related to chromosomal abnormality, genetic, perinatal and infectious factors. Down syndrome was present in 31% of children with chromosomal abnormalities.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1992.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1999. The Royal Decree 17/99, Law on Control of Narcotics and Psychotropics was formulated in 1999. The components of the policy are prevention, treatment, rehabilitation and advocacy.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1990. The national mental health programme was revised in 1992. It envisages to provide mental health care for all through the primary, secondary and tertiary level, taking into account measures for prevention, treatment, promotion and rehabilitation and keeping in view the culture, family and community. The aim was to involve the whole community along with religious teachers, incorporate programmes for the mentally retarded and substance abusers and train professionals. A review workshop is held every year to assess the progress of the national mental health programme.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1975.

Mental Health Legislation There is no specific mental health legislation. The provision of mental health care is an essential component of the National Health Policy as contained in the policy statement issued by the Ministry of Health in 1992. The Royal Decree 17/99, Law on Control of Narcotics and Psychotropics was formulated in 1999.

Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary sources of mental health financing in descending order are tax based, private insurances and out of pocket expenditure by the patient or family.

Psychiatric services are provided free of charge to most Omani patients.

The country has disability benefits for persons with mental disorders. Disability benefits are provided by the Ministry of Social Affairs to all Omani nationals who have physical or mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Primary care and referral services are available. Patients with severe psychiatric disorders are referred to secondary and tertiary levels and managed at primary level only after they are stabilized.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 250 personnel were provided training. Besides training during residency, there are some training facilities for nursing graduates and some for primary care doctors. The training programme for primary care doctors is held on a regular basis along with regional workshops. The Health Ministry has published a manual for primary health care professionals, which lays down the standard operating policy for primary management of psychiatric problems.

There are community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.49
Psychiatric beds in mental hospitals per 10 000 population	0.28
Psychiatric beds in general hospitals per 10 000 population	0.21
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	1.4
Number of neurosurgeons per 100 000 population	0.4
Number of psychiatric nurses per 100 000 population	5
Number of neurologists per 100 000 population	0.25
Number of psychologists per 100 000 population	0.25
Number of social workers per 100 000 population	0.5

There are 15 other mental health professionals. Besides the central psychiatric hospital near Muscat, there are psychiatrists at the nine regional hospitals, eight of which have four beds for psychiatry. There are also beds allotted to other major hospitals and universities. There is a 15-bed facility for the mentally retarded under the Ministry of Social Affairs with training schools for the handicapped. Some beds are earmarked for female patients.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and rehabilitation.

Information Gathering System There is mental health reporting system in the country.

The country has data collection system or epidemiological study on mental health.

Programmes for Special Population The country has specific programmes for mental health for minorities, elderly and children. There is a school mental health programme that involves participation of administrators, school teachers, school children. The programmes are mainly concentrated in rural areas and they are educated through lectures, debates, essay competitions, posters, etc. School health workers and teachers are given some training in order to pick up certain behavioural problems and learning disorders.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, chlorpromazine, diazepam, haloperidol.

Procyclidine and Maprotiline are available through the primary health care. Other psychotropics, except atypical anti-psychotics, are also available through primary centres if they are prescribed by secondary and tertiary centres.

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Pakistan

GENERAL INFORMATION

Pakistan is a country with an approximate area of 796 thousand sq. km. (UNO, 2001). Its population is 157.315 million, and the sex ratio (men per hundred women) is 105 (UNO, 2004). The proportion of population under the age of 15 years is 41% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 53.4% for men and 28.5% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.9%. The per capita total expenditure on health is 85 international \$, and the per capita government expenditure on health is 21 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Punjabi, Sindhi, Siraiki, Pashtu and Urdu. The largest ethnic group(s) is (are) Punjabi, and the other ethnic group(s) are (is) Sindhi, Siraiki, Pashtun and Muhajir. The largest religious group(s) is (are) Muslim. The life expectancy at birth is 61.1 years for males and 61.6 years for females (WHO, 2004). The healthy life expectancy at birth is 54 years for males and 52 years for females (WHO, 2004).

EPIDEMIOLOGY

Mumford et al (1996, 1997) used the Bradford Somatic Inventory to screen a general population sample in two rural areas. Further interviews were conducted using ICD-10 research diagnostic criteria. About 46% and 66% of women and 15% and 25% of men suffered from anxiety and depressive disorders. Emotional distress was associated with age, social disadvantage (in both genders), living in unitary households (in women) and lower education (in younger subjects). Ahmad et al (2001) used the Bradford Somatic Inventory (BSI) and Self-Reporting Questionnaire (SRQ) in another rural sample (n=664) and found that 72% of women and 44% of men were suffering from anxiety and depressive disorders. BSI and SRQ scores had negative correlations with socio-economic factors. In contrast, in an urban slum sample only 25% of women and 10% of men had depression and anxiety (Mumford et al, 2000). Emotional distress was associated with age (in both genders), less education (in younger women) and low financial status (in women) as in the previous study, but in the urban setting women living in joint households reported more distress than those living in unitary families. Husain et al (2000) conducted a two-phase survey of a rural general population sample, employing the Personal Health Questionnaire and the Self-Rating Questionnaire for screening (n=259) and the Psychiatric Assessment Schedule and Life Events and Difficulties Schedule for detailed assessment. The adjusted prevalence of depressive disorders was 44.4% (25.5% in males and 57.5% in females). Nearly all cases had lasted longer than 1 year. In comparison to non-cases, the affected individuals were less well educated, had more children and experienced more marked, independent chronic difficulties. Rabbani and Raja (2000) interviewed 260 mothers in an urban squatter settlement with the Aga Khan University Anxiety and Depression Scale (AKUADS) and found probable mental disorder in 28.8%. Psychiatric morbidity was associated with older age group, longer duration of marriage, interpersonal conflicts with husband or in-laws, husband's unemployment, lacking permanent source of income and lack of autonomy in making decisions. Khan and Reza (2000) conducted a 2-year analysis of reports related to suicide in a major newspaper in Pakistan (n= 306 suicides reported from 35 cities). Prevalence of suicide was associated with gender (male), age (under 30 years) and marital status (unmarried for men and married for women). More than half the subjects used organophosphate insecticides. Khalid (2001) analysed the pattern of suicide in a region based on newspaper reports (n=1230 news-items) and found a similar profile. Males adopted more violent methods (61.20%) while females more often ingested chemicals (35.20%). Khan and Reza (1998) reviewed records of 262 female and 185 male suicidal inpatients. Three quarters of the suicidal persons were under the age of 30 years. Compared to men, women were younger and more often married. Benzodiazepines were the commonest drugs used for self-poisoning among both genders, but women used organophosphorus insecticides more often than men. Javed et al (1992) used the Rutter Scale and found emotional and behavioural disorders in 9.3% of children. Yaqoob et al (1995) assessed a stratified sample (n=1303) of urban children from 2 to 24 months of age for serious mental retardation (DQ<50). The incidence per 1000 live births was 22 in the peri-urban slums, 9 in the urban slums, 7 in a village and 4 in an upper middle class group. Down syndrome was the most common cause of severe mental retardation (36%). Durkin et al (1998) conducted a two-stage survey of 2- to 9-year-old children obtained via cluster sampling (n=6365) using the Ten Questions screen for disabilities and structured medical and psychological assessments. Prevalence of mental retardation was 1.9% for serious retardation and 6.5% for mild retardation. Lack of maternal education, perinatal difficulties, neonatal infections, postnatal brain infections and injury and malnourishment were associated with mental retardation. Bashir et al (2002) identified mild mental retardation in 6.2% of children in a community sample of 6-10 year olds by a two stage method using the Ten Questions as a screening tool (n=649 families), psychometric tests (WISC-R and Griffiths) and clinical interviews. The distribution of mild mental retardation was uneven, the prevalence being 1.2% among children from the upper-middle class, 4.8% in the rural setting, 6.1% in urban slums and 10.5% in the poor peri-urban slums. Additional impairments were found in three-quarters of the children with mental retardation, of which speech impairment was the most common.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1997.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Intersectoral collaboration is also a component of the policy. The mental health policy envisages to train primary care providers, to establish resource centres at teaching hospitals and psychiatric and detoxification centres, to set up monitoring and evaluation systems and to prepare training and teaching modules. Special facilities would be established for mentally handicapped. Crisis intervention and counselling services for special groups of population would be started. Large mental hospitals would be reorganized and upgraded.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1997. It includes interventions for both reduction of supply and demand. The policy is being implemented by the Planning Commission of the Government of Pakistan.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1986. The national mental health programme is a part of the general health policy of the country and is aimed at incorporating mental health in primary care, removing stigma, caring for mental health and substance abuse across the country and maintaining principles of equity and justice in the provision of mental health and substance abuse services. It was fully implemented in 2001. It does not have a specific suicide reduction plan.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1997.

Mental Health Legislation In February 2001, a new mental health ordinance 2001 was enacted. The new ordinance puts emphasis on promotion of mental health and prevention of mental illness. It provides encouragement to community care and proposes the establishment of powerful federal mental health authority by the Government. It provides protection of the rights of the mentally ill and promotion of the mental health literacy. It also provides the guidelines for the development and establishment of new national standards for the care and the treatment of patients. Informed consent for treatment and investigations can be obtained from the patient or his/her relatives.

The latest legislation was enacted in 2001.

Mental Health Financing There are budget allocations for mental health.

The country spends 0.4% of the total health budget on mental health.

The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, tax based, social insurance and private insurances.

The country has disability benefits for persons with mental disorders. Disability benefit is paid to individuals who are not able to work due to mental illness.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. The programme has initially started in Punjab, the largest province, in 1985 and is being extended to others over the years. There are many residential and day-care facilities, especially for people with learning disabilities providing social, vocational and educational activities.

Regular training of primary care professionals is carried out in the field of mental health. Training programmes have started in the province of Punjab as a part of in-service training for primary care personnel. Till now, approximately 2000 primary care physicians and 42 000 primary care workers have been trained. Community activists from NGOs (e.g. National Rural Support Programme (NRSP) are also being trained. Though there are training programmes for physicians, nurses and psychologists, there are no such facilities for social workers. Mental health training has been included in the programme of the District Health Development Centres. The Institute of Psychiatry Rawalpindi Medical College was the first WHO collaborating Centre-EMR and is acting as a resource centre at national and regional level for training, services information system and research. Multiple training manuals for primary health care physicians, paramedics, community workers and teachers have been developed. In an additional training package on counselling skills for health professionals, a package for rehabilitation of mentally ill has been developed. People from Sudan, Egypt, Iran, Afghanistan, Yemen, Tunisia, Morocco, Palestine and Nepal have been trained in the Institute of Psychiatry. The National Steering Committee evaluates the quality of care delivery on a regular basis.

There are community care facilities for patients with mental disorders. The community mental health programme was planned in a phased manner. The first phase included collection of data pertaining to demographics, knowledge, attitudes and beliefs about mental health and sensitization of the community towards mental health. The second phase involved training of personnel in mental health. The third phase involved stimulation of community activities through advocacy campaigns using religious leaders and developing a workable referral system. In the final phase, qualitative changes were incorporated in the services and steps were taken to improve the knowledge of the population about mental health. The programmes have been initiated in all provinces but have not been generalized to the whole population. More than 78 junior psychiatrists have been trained in community mental health to act as resource persons in the development of programmes in their areas.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.24
Psychiatric beds in mental hospitals per 10 000 population	0.06
Psychiatric beds in general hospitals per 10 000 population	0.148
Psychiatric beds in other settings per 10 000 population	0.02
Number of psychiatrists per 100 000 population	0.2
Number of neurosurgeons per 100 000 population	0.2
Number of psychiatric nurses per 100 000 population	0.08
Number of neurologists per 100 000 population	0.14
Number of psychologists per 100 000 population	0.2
Number of social workers per 100 000 population	0.4

There are about 2000 other mental health personnel. There are four mental health hospitals in the country. All medical colleges have psychiatric units. Psychiatric units are also present in allied hospitals in both public and private sector. Some psychiatric care facilities are available at the tehsil level. Beds for the treatment of drug abusers are available at most hospital facilities (232 centres). Forensic beds are available at a few centres. There are two child psychiatrists in the country. Mental health professionals are concentrated in big urban centres. Most psychiatrists have private clinics.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Some of the NGOs like the Fountain House have done exemplary work in order to build the foundation of rehabilitation psychiatry in Pakistan. A concept of agrotherapy for the rural population has evolved. Recently, the organization the 'National Rural Support Programme' decided to include mental health among their activities.

Information Gathering System There is no mental health reporting system in the country. A mental health reporting system has been initiated in the National Health Management Information System.

The country has data collection system or epidemiological study on mental health. An information system for using in tertiary facilities has been developed at the WHO Collaborating Centre at Rawalpindi.

It has been agreed that the HMIS will collect information from primary care centres on depressive illness, substance abuse and epilepsy.

Programmes for Special Population The country has specific programmes for mental health for refugees and children. NGOs are involved in service provision and advocacy for the above groups. Afghan refugees are being provided services by international organizations. There are also facilities for women and victims of torture.

There are some facilities for children in the larger hospitals and regional hospitals, but the most parts of the country have no facilities for child and adolescent psychiatry. There are many residential and day care facilities for people with learning disabilities, especially in big cities. There is a school mental health programme and it aims to develop awareness of mental health among schoolchildren, schoolteachers and the community; to provide essential knowledge about mental health to teachers so that they are able to impart that to the students and are able to recognize and provide some counselling to the students for basic psychological problems. Its positive impact has been evaluated and published in international journals. Mental health issues have been incorporated in the teacher training programme at the national level. Text book boards have been approached for inclusion of mental health topics in school curricula.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, chlorpromazine, diazepam, haloperidol. Imipramine is supplied instead of amitriptyline. Procyclidine is supplied.

Other Information Active community research has been conducted regarding mental health in the last years which have been published. The innovative community mental health programme included the faith healers. Manpower development at national and international level has been carried out. Print as well as electronic media have been utilized to spread mental health education. Collaboration with schools and NGOs like the National Rural Support Programme has been established. Public educational material on sleep disturbance, anxiety disorder, phobias, drug dependence, depression and psychosis is available. Pakistan is actively involved in developing guidelines for economic analysis of community mental health care programme in low income countries.

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Palau

GENERAL INFORMATION

Palau is a country with an approximate area of 0.46 thousand sq. km. (UNO, 2001). The country consists of about 200 islands. Only eight of the islands are permanently inhabited. Its population is 0.02 million, and the sex ratio (men per hundred women) is 113 (UNO, 2004). The proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 93% for men and 90% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 9.2%. The per capita total expenditure on health is 886 international \$, and the per capita government expenditure on health is 816 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Palauan and English. The largest ethnic group(s) is (are) Palauan (two-thirds of the population), and the other ethnic group(s) are (is) Asian (Filipino and Chinese, one-fourth). The largest religious group(s) is (are) Roman Catholic (two-fifths), and the other religious group(s) are (is) Protestant (one-third) and Modekngai.

The life expectancy at birth is 66.4 years for males and 70.9 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 60 years for females (WHO, 2004).

EPIDEMIOLOGY

Jensen and Polloi (1988) conducted a study to assess the prevalence of dementia in people aged 90 years and above (0.2% of total population). They used an adaptation of the Wechsler Logical Memory Test and the Global Deterioration Scale to assess cognitive functions. The prevalence of dementia as determined by clinical assessment was high (25% mild and 42% moderate/severe). This prevalence was lower (44%) as determined by the Global Deterioration Scale. Major physical and mental illnesses were infrequent. But most subjects had at least one chronic illness, the most common being arthritis. Most chewed betel nut but few used alcohol or smoked. Hammond et al (1983) assessed 35 Palauan schizophrenic patients. They found that the sample showed an unusual 4:1 male predominance, a proclivity towards violence and substantial affective symptomatology. Male patients extensively abused alcohol and cannabis. In a field study, Kauders et al (1982) confirmed these findings. Myles-Worsley et al (1999) ascertained 160 strictly defined cases of schizophrenia in a population of 13 750 adults, which yielded a lifetime prevalence of 2% (2.8% in males and 1.2% in females). This greater than 2:1 male-to-female risk ratio for schizophrenia was accompanied by an earlier mean age of onset for males (23.3 years) than for females (27.5 years). The 160 cases belonged to 59 separate families. Eleven families had 5-14 cases representing nearly half of the total cases. When a family was defined to include third-degree relatives, only 11 cases were non-familial. The majority of the ascertained cases could be linked together into extended pedigrees with complex multi-lineal inheritance patterns.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The executive summary of the Mental Health Plan 2005 outlines programmes for adults, children and technical assistance needs.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1973.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is absent.

Mental Health Legislation There are different legislations in the field of mental health of which RPL 349 amends a previous legislation by adding provisions for non-judicial, involuntary 72-hour detention period for purposes of evaluation, diagnosis and treatment of mental illness and for other purposes.

The latest legislation was enacted in 1991.

Mental Health Financing There are no budget allocations for mental health.

The country spends 2% of the total health budget on mental health.

The primary source of mental health financing is grants.

The country has disability benefits for persons with mental disorders. There is a law now, RPPL 6-25, subsection 5-15 which is entitled 'Palau Severely Disabled Assistance Fund'. It makes small stipends available to persons with disability as set forth in the regulations. Mental illness, depending on severity, is included.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level.

Regular training of primary care professionals is not carried out in the field of mental health. The Behavioural Health Division provides some training, but a regular system has not evolved. Limited training is also carried out in the area of substance abuse.

There are community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	4.7
Psychiatric beds in mental hospitals per 10 000 population	0
Psychiatric beds in general hospitals per 10 000 population	4.7
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	5
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	10
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0
Number of social workers per 100 000 population	10

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy. The Palau Mental Health Council is involved in monitoring, reviewing and evaluating the allocation and adequacy of services in Palau, besides advocacy, which is its main activity.

Information Gathering System There is mental health reporting system in the country. There are monthly reports to the Ministry. The country has data collection system or epidemiological study on mental health. Data are compiled every month. Details about patients and service utilization are available from the Behavioural Health Division Report.

Programmes for Special Population Free medicines and counselling are provided to prisoners. A programme for substance abuse exists.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium.

A national therapeutic drug policy/essential list of drugs is being developed, and in the meantime a formulary is being utilized.

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Panama

GENERAL INFORMATION

Panama is a country with an approximate area of 76 thousand sq. km. (UNO, 2001). Its population is 3.178 million, and the sex ratio (men per hundred women) is 102 (UNO, 2004). The proportion of population under the age of 15 years is 31% (UNO, 2004), and the proportion of population above the age of 60 years is 8% (WHO, 2004). The literacy rate is 92.9% for men and 91.7% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7%. The per capita total expenditure on health is 458 international \$, and the per capita government expenditure on health is 316 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Spanish. The largest ethnic group(s) is (are) Mestizo (seven-tenths), and the other ethnic group(s) are (is) Amerindian. The largest religious group(s) is (are) Roman Catholic (five-sixths).

The life expectancy at birth is 72.8 years for males and 78.2 years for females (WHO, 2004). The healthy life expectancy at birth is 64 years for males and 68 years for females (WHO, 2004).

EPIDEMIOLOGY

In 1996, Panama conducted a National Youth Survey on Alcohol and Drug Use on students aged 12-18 years (n= 6477). More males, older students and students in higher grades had used licit and illicit drugs, but male-female differences were small. Public-private school differences and urban-rural trends varied depending on the drug (Gonzales et al, 1999). Delva et al (1999, 2000) estimated clustering of substance use by the Alternating Logistic Regression method. Modest clustering was observed at the school level for tobacco smoking, alcohol consumption, use of inhalants and other drug use. These findings suggested that chances of drug use among school-attending youths increased when another youth in the same school used drugs. They also found opportunities to use drugs and actual drug use to be greater at higher grade levels. Also, the probability of making a transition to use, given an opportunity, was more likely among upper-grade students. Males were more likely to have an opportunity to use marijuana, crack-cocaine and other forms of cocaine, but not more likely than females to make a transition into drug use once an opportunity had occurred to try each drug.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 2000.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The policy was formulated through a process that involved the participation of multiple stakeholder groups including health professionals, other governmental professionals and NGOs of patients and families. Between 50 to 75% of its original content has been implemented.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1996. It was revised in 2000. There is a specific budget for its implementation and it has been implemented to the extent of 75 to 90%.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1972. It was revised in 1996. There is a specific budget for its implementation, but it has been implemented only to the extent of 10 to 25% by local, regional and national authorities. Its main components are strategy of services reform, promotion and prevention, integration of mental health services in primary care and development of specialized services.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1993.

Mental Health Legislation The law establishing provisions about hospital and community mental health services and promotion of the rights of persons with mental disorders of 1997 was presented to the Legislative Assembly, but is yet to be approved. Details about any previous legislation are not known.

Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are no budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary sources of mental health financing in descending order are tax based, social insurance, out of pocket expenditure by the patient or family.

The country has disability benefits for persons with mental disorders. A psychiatrist works at the commission for handicapped persons of the Social Security to look after the disabilities of mentally ill patients.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. 50-75% of the population is covered by this kind of service. Mental health care is provided by primary health care doctors, nurses and psychiatrists. A referral system is in place.

Regular training of primary care professionals is not carried out in the field of mental health. Primary care nurses have been trained for management of mental disorders in a programme supported by PAHO/WHO. In an evaluation it was shown that the educational programme had a positive impact on their clinical practice at least in the short term.

There are community care facilities for patients with mental disorders. Some facilities for community care are being developed, e.g. day care centres and hospitals and health promotion centres. The community care system for the mentally ill includes outpatient clinics comprises preventive/promotion interventions, home interventions, family interventions (all the above are available for about half of the intended population), residential facilities, vocational training and employment programmes (these are available for less than 25% of the intended population). Multiple professional disciplines are involved but many teams are understaffed.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	2.55
Psychiatric beds in mental hospitals per 10 000 population	1.56
Psychiatric beds in general hospitals per 10 000 population	0.99
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	3.7
Number of neurosurgeons per 100 000 population	0.6
Number of psychiatric nurses per 100 000 population	5
Number of neurologists per 100 000 population	0.35
Number of psychologists per 100 000 population	2.6
Number of social workers per 100 000 population	0.07

The figures quoted are only for those working in the Government sector and with the Social Security. 70% of these beds are occupied by long stay patients.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. These organizations participate in mental health activities related to women, children and domestic violence.

Information Gathering System There is no mental health reporting system in the country.

The country has data collection system or epidemiological study on mental health. The 'Departamento de Análisis y Tendencias de Salud' is in charge of the data collection system for mental disorders. Service data collection system is conducted for part of the mental health system (emergencies, regional hospital discharges at national level). In 2001, considering mental health related outpatient consultations (specialized and general) the 3 most frequent psychiatric diagnosis, according to ICD-10 criteria, were anxiety disorders, affective disorders (mainly depression) and mental and behaviour disorders associated with drug use, including alcohol. Patient discharge from both psychiatric and general hospitals in 2000 points out as the most frequent diagnoses bipolar disorders, schizophrenia and drug use associated disorders.

Programmes for Special Population The country has specific programmes for mental health for indigenous population, elderly and children. There is a health section of indigenous people who are making efforts to facilitate inclusion of services for indigenous people.

In addition, there are programmes for women, abused children and victims of domestic violence. A national initiative named 'Know Depression and Face it' was launched in Collaboration with PAHO.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

The therapeutic drug policy was revised in 2001. The purchasing of general and psychiatric medicines is the responsibility of the Ministry of Health.

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Papua New Guinea

GENERAL INFORMATION

Papua New Guinea is a country with an approximate area of 463 thousand sq. km. (UNO, 2001). The country consists of the eastern half of the island of New Guinea, and many outlying islands. Its population is 5.836 million, and the sex ratio (men per hundred women) is 106 (UNO, 2004). The proportion of population under the age of 15 years is 41% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 70.6% for men and 56.8% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 4.4%. The per capita total expenditure on health is 144 international \$, and the per capita government expenditure on health is 128 international \$ (WHO, 2004).

The main language(s) used in the country is (are) English, Tok Pisin and Hiri Motu. The largest ethnic group(s) is (are) Papuan, and the other ethnic group(s) are (is) Melanesian, Micronesian and Polynesian. The largest religious group(s) is (are) Christian (more than half).

The life expectancy at birth is 58.4 years for males and 61.5 years for females (WHO, 2004). The healthy life expectancy at birth is 51 years for males and 52 years for females (WHO, 2004).

EPIDEMIOLOGY

Johnson (1990) administered questionnaires to a cross-section of university students and office workers (n=50). The results showed that both the student and clerical groups were moderately involved in substance abuse. The use of alcohol and cannabis was common. In another study on university students (n=90), Johnson (1998) found that alcohol, tobacco and other drugs were being used frequently. Johnson (1994) reviewed hospital data and noted a rise in alcohol, cannabis and diazepam related health problems, especially among males. Attah Johnson and Mostaghimi (1995) evaluated 132 consecutive adult dermatology outpatients using the Harding Self-Rating Questionnaire (cut-off point of 7) and clinical interview. The common psychiatric diagnoses for the women patients were: anxiety neurosis 16.9% and neurotic depression 56.9%, and for men anxiety neurosis 22.4% and neurotic depression 44.8%. Johnson (1997) found that schizophrenia (49%) was the commonest diagnosis among psychiatric inpatients. Pal (1997) interviewed 64 mentally ill offenders who had committed violent crimes and found schizophrenia in 42.2%, epilepsy in 10.9%, alcohol and cannabis abuse in 32.8% of the subjects and culture-bound syndromes like amok and spirit possession in a few cases. Canetto and Lester (1995) reported that suicide mortality was highest among young adult married females in Papua New Guinea and older single white adult males in the United States. They felt that these differences are due to cultural sanctions in relation to behaviour.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. Details about the year of formulation are not available.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1962. There is also a Mental Health and Social Change Program 2001-2010 which has the following priorities: review and update of the Public Health Act; increase staffing and training of psychiatric nurses; establish psychiatric units at all public hospitals; establish four regional referral and supervising units at level 2 hospitals; upgrade Laloki Mental Hospital; improve intersectoral collaboration in forensic psychiatry, domestic violence against women and the control and prevention of substance abuse; improve community knowledge and skills to support community mental health programmes; expand community mental health programmes and improve monitoring and reporting.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1950.

Mental Health Legislation There is a Public Health Act with certain sections on mental health.

The latest legislation was enacted in 1985.

Mental Health Financing There are budget allocations for mental health.

The country spends 0.7% of the total health budget on mental health.

The primary source of mental health financing is tax based.

The country does not have disability benefits for persons with mental disorders. Mentally ill patients are cared for by their relatives with no support from the Government.

Mental Health Facilities Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level.

Regular training of primary care professionals is carried out in the field of mental health. In seven provinces psychiatric services are provided by psychiatric nurses and in the remaining nine provinces by general physicians or general health workers. Formal training

conducted in 1999 and 2000 with the support of WHO has produced a minimum of one physician in each hospital (total 19) with sufficient skills to handle mental health problems. Outcome evaluation was not done. Training of primary care professionals such as Health Extension Officers is part of their curriculum. Formal training of mental health in primary health care for other workers in districts is also in place.

There are no community care facilities for patients with mental disorders. Community care is provided for known patients on medications prescribed by psychiatrist. Upon discharge of patients from the psychiatric hospital to another province, a member of the staff accompanies the patient to help reintegrate them into their local community and would spend time with the local health worker or psychiatric nurse in an educative role. Discharged patients are followed up at the local centre with advice from staff at the psychiatric hospital. There is a psychosocial rehabilitation centre for about 15 patients. It offers residential and day care facilities. It provides a variety of occupational therapy and social activities for former patients and support groups for families of mentally ill, and the centre carries out public education activities. Training for the staff was provided through the support of WHO. NGOs provide operational support.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.24
Psychiatric beds in mental hospitals per 10 000 population	0.17
Psychiatric beds in general hospitals per 10 000 population	0.07
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.09
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	1.2
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0
Number of social workers per 100 000 population	0.04

There is a lack of trained staff. Psychiatric facilities are limited. Since 1999, all hospitals including the 4 regional and 9 provincial hospitals have got psychiatric services. The only psychiatric hospital has 60 beds and some general hospitals have few (up to 10) mental health beds. The country has historically depended on overseas training, principally from Australia, for its professional staff. However, those people continue to work in mental health in the country after overseas training in small (about one-third). A one-year post-basic training course for nurses is now available in the country. A post-graduate training in psychiatry was started and 4 psychiatrists have graduated in 2002. All psychiatrists, except one, are in the capital city.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. The Center for Domestic Violence provides shelter for women victims and their children.

Information Gathering System There is no mental health reporting system in the country. National Department of Health's forms on reporting have no provision for mental health.

The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population There are services for prisoners and also for other forensic services.

Special programmes for armed forces/ Defence Force of Papua New Guinea are ongoing (2001). Rehabilitation programmes for chronic mental illness are in place. Programmes for school children are ongoing. The correctional institution has an infirmary for psychiatric care of mild mental illnesses in inmates. Those needing more intensive care are transferred to the psychiatric hospital. The Papua New Guinea Narcotics Bureau is engaged in a public awareness campaign, training of administrators and counselling.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, haloperidol.

All the drugs are available in primary health care.

Other Information Promoting materials such as posters, video, community awareness tapes are available; street awareness programmes, newspaper articles, radio talk shows are some of the arrays of success funded by the National Department of Health. The country has a radio telephone network, HEALTH NET, which was supplied by the Australian Agency for International Development. It is used to communicate between hospitals and clinics to obtain advice and emergency aid and to disseminate information. It had been underutilized for mental health services but has lately been used to provide training and supervision to the remote population.

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Paraguay

GENERAL INFORMATION

Paraguay is a country with an approximate area of 407 thousand sq. km. (UNO, 2001). Its population is 6.018 million, and the sex ratio (men per hundred women) is 102 (UNO, 2004). The proportion of population under the age of 15 years is 38% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 94% for men and 91.5% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8%. The per capita total expenditure on health is 332 international \$, and the per capita government expenditure on health is 127 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Guarani. The largest ethnic group(s) is (are) Mestizo (almost 95%). The largest religious group(s) is (are) Roman Catholic (nine-tenths).

The life expectancy at birth is 68.7 years for males and 74.7 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Paraguay in internationally accessible literature. Miguez et al (1992) administered questionnaires in Spanish and Guarani with acceptable reliability and validity to 2504 individuals selected through a stratified sampling technique. Use of legal substances such as alcohol, tobacco and psychotropic drugs was common. Among illicit substances, inhalants and marijuana use was frequent. Da Costa e Silva and Koifman (1998) analysed the results from prevalence surveys of smoking in 14 Latin American countries and observed that smoking prevalence among men varied from 24.1% (Paraguay) to 66.3% (Dominican Republic) and among women from 5.5% (Paraguay) to 26.6% (Uruguay). By applying point prevalence data to the stage model of the tobacco epidemic in developed countries they concluded that most of Latin American countries were in stage 2, i.e. with a clearly rising prevalence among men, a prevalence for women that is beginning to increase, and mortality attributable to smoking among men still not reflecting peak prevalence. However, Paraguay appeared to be still emerging from stage 1, i.e. with low prevalence rates among men, too. Pages et al (1981) conducted an ethnographic study on mental health issues of the Chiriguano, a tribe native to Paraguay that has migrated to Bolivia. It is described under the relevant section in Bolivia.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 2002.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. It was developed through consultations between mental health professionals, NGOs and consumers. It is in the very beginning of its implementation and there is no regular budget for it.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2002. It is to be implemented by national authorities, but this has not been done yet. There is no specific budget for its implementation. Its main components are strategy of services reform, promotion and prevention, mental health services at primary health care and specialized services.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2002.

Mental Health Legislation There are no regular funds for its implementation. There is a new code under consideration of the legislature that includes promotion and prevention, human rights, regulation of mental health services, regulation of involuntary treatment, regulation of mental health services, admission and discharge procedures, advocacy and housing. There is a law on substance abuse from 1989.

The latest legislation was enacted in 1980.

Mental Health Financing There are budget allocations for mental health.

The country spends 0.05% of the total health budget on mental health.

Details about sources of financing are not available.

Approximately seven-eighths of the budget is spent on the psychiatric hospital and one-eighth on other services.

The country has disability benefits for persons with mental disorders. According to the law, mental impairment is considered a disability for getting public disability benefits. However, for socio-economical reasons, less than 10% of the eligible persons actually receive the benefits. Psychosis, depression and drug dependence are considered for disability benefits. The evaluation procedure includes several interviews and psycho-diagnostic tests.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Less than 25 % of the population is covered by this kind of service. Mental health care is provided by Primary Health Care doctors and psychiatrists.

Regular training of primary care professionals is not carried out in the field of mental health. The first pilot project was conducted recently.

There are no community care facilities for patients with mental disorders. A pilot project on community care is under way in one health region (number 13).

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.731
Psychiatric beds in mental hospitals per 10 000 population	0.614
Psychiatric beds in general hospitals per 10 000 population	0.097
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	1.8
Number of neurosurgeons per 100 000 population	0.2
Number of psychiatric nurses per 100 000 population	0.08
Number of neurologists per 100 000 population	0.3
Number of psychologists per 100 000 population	
Number of social workers per 100 000 population	

About 6 general nurses per 100 000 population are working in the mental health area. On a regular basis, the psychiatric hospitals have approximately 450 inpatients in spite of having 340 beds. About half the beds are occupied by patients staying more than 6 months in hospital.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in promotion and prevention. These organizations participate in mental health activities related to women, children, consumers and domestic violence. Associations of consumers and their families are being organized. There is an organization for the rights of the mentally ill and others for substance users' treatment.

Information Gathering System There is no mental health reporting system in the country.

The country has data collection system or epidemiological study on mental health. The Technical Support for Mental Health is in charge of the data collection system for mental disorders.

Programmes for Special Population The country has specific programmes for mental health for minorities, indigenous population, elderly and children.

There are mental health programmes being run in association with the Ministry of Education, universities and NGOs. At international level, collaborative projects with Argentina (Rio Negro province), Brazil (Ministry of Health), Cuba, Italy (Modena) and PAHO/WHO are being conducted.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: haloperidol.

There is no essential drug list.

Other Information

Additional Sources of Information

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GENERAL INFORMATION

Peru is a country with an approximate area of 1285 thousand sq. km. (UNO, 2001). Its population is 27.567 million, and the sex ratio (men per hundred women) is 101 (UNO, 2004). The proportion of population under the age of 15 years is 33% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 91.3% for men and 80.3% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 4.7%. The per capita total expenditure on health is 231 international \$, and the per capita government expenditure on health is 127 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Spanish and Quéchuá. The largest ethnic group(s) is (are) Indian and Mestizo. The largest religious group(s) is (are) Roman Catholic (nine-tenths).

The life expectancy at birth is 67.5 years for males and 72 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY

In an urban community survey, the lifetime prevalence of selected psychiatric disorders according to DSM-III criteria, utilizing the Spanish version of the Diagnostic Interview Schedule (DIS) were: major depressive episode (9.7%), alcohol abuse and dependence (18.6%) and phobia (8.5%) (Hayashi et al, 1985). A later survey using the Spanish version (5.0) of the Mini International Diagnostic Interview (MINI) showed that 37.3% of the urban adult population met the ICD-10 criteria for at least one mental disorder during their lifetime. The most frequent were anxiety disorders (25.3 %) and depressive disorders (19.0%). The lifetime prevalence of depressive episode was 18.2%, generalized anxiety disorder was 9.9%, social phobia was 7.9% and PTSD was 6.0%. The one-year prevalence for alcohol abuse and dependence was 5.3 % (Estudio Epidemiológico Metropolitano en Salud Mental, 2002). Yamamoto et al (1993) studied the prevalence of alcohol use in 815 subjects from the community using a Spanish version of Diagnostic Interview Schedule and DSM-III criteria. The prevalence of alcohol abuse or dependence was higher among the men (34.8%) than among the women (2.5%), but the onset for women was earlier. Alcoholism was strongly associated with antisocial personality disorder and with drug abuse or dependence. The prevalence of alcoholism for the Peruvian men was higher than that for men in the USA, though the women had one of the lowest prevalences reported in literature. Montoya and Chilcoat (1996) estimated that the lifetime prevalence of cocaine or coca paste use was between 0.8%-3% in 5 countries (Bolivia, Colombia, Ecuador, Peru and Venezuela) in a population sample of more than 24 000 subjects. Coca paste or cocaine use was associated with age (middle-age), socioeconomic category (middle-class), gender (males), education (finished high school), income (high) and locality (urban). The most frequent age of first use was 15 to 24 years. Flores Agreda (1986) reported on the prevalence and incidence of drug use in Bolivia, Colombia and Peru. A survey in Peru showed that 37% of secondary school students used drugs and 27% used basic cocaine paste as their first drug. The abuse of basic cocaine paste was spread evenly across urban social classes. The increased drug use ran parallel to an increase in illegal cocaine cultivation in these countries. Gossop et al (1994) evaluated 68 drug users receiving treatment for cocaine problems at treatment centres in Bolivia and Peru. Levels of cocaine consumption were extremely high with a mean level of 16.4 grams. The majority of the users (87%) smoked cocaine in the form of pasta, pitillo or basuco. Severity-of-dependence scale scores were high. Vega-Dienstmaier et al (1999) assessed 321 women in the first postpartum year, 41 nulliparous women and 63 women who were more than 1 year postpartum. The prevalence of major depression in the first postpartum year (5.9%) was significantly lower than its prevalence in women who were more than 1 year postpartum. Depression was higher still in women who were more than 2 years postpartum. The risk factors associated with postpartum depression were obsessive-compulsive disorder, premenstrual dysphoric disorder, previous major depression, maternity blues, young age and lower education level. De Michelena (1993) examined 318 children and teenagers with Down syndrome in specialized educational institutions and a matched (date of birth, sex and maternal age) group of 1196 control individuals that was selected from the birth records of 2 general hospitals of the city. The means of paternal age in the 2 groups were compared, first globally and then by groups of maternal age (<21 years, 21-29 years, 30-34 years, 35-39 years and >39 years). The results obtained in this study gave no evidence that paternal age can be considered a risk factor for the conception of a child with Down syndrome.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1991.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. It was revised in 2001 by civil servants, mental health professionals and NGOs. There are regular funds for its implementation and between 25 to 50% of its original content have been put into practice. At present, some provisions are being developed within the national mental health policy, with the following objectives: to favour development and dissemination of the global health approach by promoting healthy styles and environments and taking care of mental health as a component which is inherent and necessary to the general state of complete health; to ensure access, coverage and quality of intersectoral health services and programmes by developing specific proposals for prevention, care and rehabilitation in accordance with the cultural reality and including equity among all; to improve quality of interventions by revising, evaluating and creating efficient patterns, which include the results of alternative practice and the psychosocial resources of the community; to improve the existing infrastructure in order to increase mental health coverage and contribute

to the quality of care; to improve the efficiency of mental health programmes and services by strengthening the process of planning, monitoring and evaluation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1996. It was revised in 2000. There are regular funds for its implementation and between 50 to 75% of its original content has been put into practice. The most recent substance abuse policies are 'Plan Nacional de Prevención y Control de Drogas (1994-2000)', 'Ley de lucha contra el narcotráfico (Decreto Legislativo 824 de 1996)', 'Programa Nacional de Prevención y Rehabilitación (1998-2002)' and 'Estrategia Nacional (de lucha) contra las drogas (2002-2007)'.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1991. It was revised in 2001. There are no regular funds for its implementation; it has been implemented to the extent of 25 to 50% by local and regional authorities. Its main components are integration of mental health services in primary care and development of specialized services.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2000.

Mental Health Legislation There is a law (law 27306), which modifies the protection law against domestic violence and this came into force in 2000. It was revised in 2001. This law does not address legal provisions for the protection of the basic human and civil rights of people with mental disorders. There is no comprehensive mental health legislation but the General Health Law, in its article 11, refers to mental health.

The latest legislation was enacted in 2001.

Mental Health Financing There are budget allocations for mental health.

The country spends 2% of the total health budget on mental health.

The primary source of mental health financing is tax based.

The Ministry of Health provides health care for those without any other type of coverage, 73.8% of general population; ESSALUD provides health care for workers with health insurance, covering 21.8% of the general population and the rest is covered by private health services (3.7 %), army health services (1.9 %) and others (3.8 %) (<http://corporativo.bibliomed.com.br>). Psychiatric hospitals receive 85% of the budget, outpatient care 10%, community care 2% and others 3%.

The country has disability benefits for persons with mental disorders. Public disability benefits are restricted only for those covered by social security (a minority of the population). Less than 10% of the population is entitled for getting benefits.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Less than 25 % of the population is covered by this kind of service. Mental health care is provided by primary health care physicians. After the initial consultation the patient is referred to a specialized centre.

Regular training of primary care professionals is not carried out in the field of mental health.

There are community care facilities for patients with mental disorders. It does not work as a system. It is intended to strengthen this intervention modality through psychosocial clubs.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.47
Psychiatric beds in mental hospitals per 10 000 population	
Psychiatric beds in general hospitals per 10 000 population	
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	2.06
Number of neurosurgeons per 100 000 population	
Number of psychiatric nurses per 100 000 population	6
Number of neurologists per 100 000 population	
Number of psychologists per 100 000 population	4
Number of social workers per 100 000 population	1

Most of the psychiatric beds and psychiatrists are in Lima. About 70% of the beds are in public institutions. 10% of these beds are occupied by long stay patients. Between 40 to 90% of professionals from various disciplines work in public institutions for mental health.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. These organizations participate in mental health activities related to women, children, domestic violence and consumers.

Information Gathering System There is mental health reporting system in the country. ICD-10 is used for recording purposes. Activities in promotion and prevention are also reported. The report is separated from the rest of health information. The data collection has limitations. The HIS-MIS system does not include most important mental health problems. The mental health programme collects activities information on a parallel system.

The country has data collection system or epidemiological study on mental health. The mental health area from the Ministry of Health is in charge of the data collection system for mental disorders. Service data collection system is conducted for all the mental health system. There is an epidemiological study in progress.

Programmes for Special Population The country has specific programmes for mental health for refugees, disaster affected population, elderly and children. Interventions are carried out in children and adolescent victims of armed violence. Also, there are special programmes for women and victims of domestic violence.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam, fluphenazine, lithium, biperiden.

Other Information

Additional Sources of Information

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Philippines

GENERAL INFORMATION

Philippines is a country with an approximate area of 300 thousand sq. km. (UNO, 2001). The country is an archipelago of over 7000 islands. Its population is 81.408 million, and the sex ratio (men per hundred women) is 101 (UNO, 2004). The proportion of population under the age of 15 years is 36% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 92.5% for men and 92.7% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.3%. The per capita total expenditure on health is 169 international \$, and the per capita government expenditure on health is 77 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Pilipino and English. The largest ethnic group(s) is (are) Christian Malay. The largest religious group(s) is (are) Roman Catholic (five-sixths).

The life expectancy at birth is 65.1 years for males and 71.7 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY

Parker and Balza (1977) examined the association between schizophrenia and winter birth in an equatorial region (n=3508). A 15% excess above expectation was found for patients born in the coldest 3-month period of the year (December-February). An excess of births in that period was found in both sexes and in each decade of birth examined. Guiao (1994) examined 200 women from an urban community and found a negative relationship between annual individual income, educational achievement and depression. Ramoso-Jalbuena (1994) conducted a survey on 500 urban women aged 40-50 years and found that climacteric symptoms affected 83% of the respondents, with 79% reporting psychological disorders. Fugita and Crittenden (1990) assessed 966 students from Korea, Philippines, Taiwan and US using the Zung Self-Reported Depressive Symptomatology (SDS) scale. Korean and Philippine students had higher scores than Caucasian Americans. Females had higher SDS scores in all but one group. Howard et al (1999) evaluated 351 tribal and non-tribal disaster victims 6 years after they were displaced following a volcanic eruption. The prevalence rates for PTSD and major depression were 27.6% and 14.0%, respectively. McKelvey and Webb (1997) assessed a group of 101 Vietnamese Amerasians at a transit center in Vietnam and subsequently at a refugee camp in the Philippines with the Hopkins Symptom Checklist-25 and a Camp Comparison Questionnaire. There was a significant decrease in anxiety and depression between the two centers; however, these changes were not related to changes in refugee camp conditions or social support within the camp. McKelvey et al (1993) assessed a cohort of 161 randomly selected Vietnamese youth in Vietnam awaiting placement in the US using the Felsman's 35-item Personal Information Form and the Hopkins Symptom Checklist-25 (HSCL-25). Ninety-five members of the original cohort were re-evaluated at a Philippine refugee center. Those with more pre-migratory risk factors had significantly more total and depressive symptoms in the latter stage. In another study, McKelvey and Webb (1995), found a history of physical and/or sexual abuse in 22% of male and 18% of female Amerasians (n=102). Abused males reported significantly higher levels of psychological distress than non-abused males, while abused and non-abused females did not differ in their levels of psychological distress. Giel et al (1981) assessed 925 children attending primary health care facilities in Sudan, Philippines, India and Columbia through a two stage survey. Rates of behavioural disorders varied between 12% and 29% in the four study areas. In a study on 961 school children, Maxwell (2001) showed that witnessing inter-parental violence was significantly associated with self-reported antisocial and delinquent activities. Williams et al (1986) examined the performance of 911 children with histories of perinatal risk events on a restandardized Philippine (Metro-Manila) version of the Denver Developmental Screening Test (DDST). This study established that the children performed significantly below Philippine norms. Mendez and Adair (1999) evaluated more than 2000 children and found that stunted growth between birth and 2 years was associated with deficits in cognitive ability at 8 and 11 years. Deficits in children's scores were smaller at age 11 years than at age 8 years, suggesting that adverse effects may decline over time.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1990.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The policy calls for community-based services and services that are integrated with the general health and primary care. It pays special attention to vulnerable groups (e.g. those affected by disasters, women, children, etc.) and overseas Filipino workers.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1972. It was amended in 2002.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1990. The primary objective of the programme is to fully integrate mental health in the nation's health system. Its strategies include: networking, nation-wide democratization of capabilities of mental health facilities, intensification and strengthening the training in psychiatry and mental health, focus on research, advocacy, social mobilization and peripheral development. Currently, efforts are being made to restructure the National Programme for Mental Health to the National Programme for Mental Health and Substance Abuse. The absence of a specific budget makes the implementation of the programme difficult when it is shifted to a lower priority.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1988.

Mental Health Legislation There is no mental health legislation. The laws that govern the provision of mental health services are contained in various parts of the Administrative and Penal Code promulgated in 1917. The Dangerous Drugs Act (2002) and Tobacco Regulation Act (2003) require that the Department of Health handles demand reduction efforts and accredits physicians to evaluate and manage substance misuse. A certification of mental health is necessary before issuance of a firearms licence, and a certification of being drug free is necessary before the issuance of a driver's licence. Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are budget allocations for mental health.

The country spends 0.02% of the total health budget on mental health.

The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family and social insurance.

The new social health insurance programme provides compulsory coverage to the employed sector and voluntary coverage to the self-employed and informal sectors. The indigent sector receives free coverage through financial counterparts in health and other sectors. However, mental health benefit is limited to acute inpatient care.

The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.

Regular training of primary care professionals is carried out in the field of mental health. Integration of mental health care in primary care has been achieved in a few demonstration projects. Training modules are available. Under the national mental health programme, trainers training was conducted for critical incident stress debriefing of disaster victims in the Department of Social Welfare and Development. These trainers have since trained other social workers in the field.

There are no community care facilities for patients with mental disorders. One regional hospital has been designated 'collaborating centre for comprehensive mental health'. It will serve as a model for development of comprehensive care including acute psychiatric units and outpatient clinics, home treatment and psychosocial rehabilitation. Family education programmes have been initiated in some areas.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.9
Psychiatric beds in mental hospitals per 10 000 population	0.56
Psychiatric beds in general hospitals per 10 000 population	0.3
Psychiatric beds in other settings per 10 000 population	0.03
Number of psychiatrists per 100 000 population	0.4
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0.4
Number of neurologists per 100 000 population	0.2
Number of psychologists per 100 000 population	0.9
Number of social workers per 100 000 population	16

There are 1199 occupational therapists. Three fourths of the beds available for psychiatric care are in the National Centre for Mental Health (NCMH) in the National Capital Region. Regional mental health units have 25-100 functional beds and are present in only 10 regions. These centres provide general psychiatric, consultation-liaison and forensic services. Ten general psychiatric units are also being developed with the aim of eventually phasing out the NMCH. The land on which the National Centre is located is urgently needed for other city programmes. Nearly three-fifths of the psychiatrists practice in the National Capital Region. Post-residency fellowships are available in child, social and consultation-liaison psychiatry. There are now 15 child psychiatrists. Most clinical psychologists work in the private sector. Emigration is a major issue, particularly in the field of nursing. A wave of physicians, both general practitioners and specialists have shifted to nursing in order to apply for vacancies in developed countries where there is an acute need for nurses. This combined with emigration of registered nurses, is causing concern about the future of health care delivery in the country.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. NGOs provide psychosocial rehabilitation services, organize family support groups and carry out public education efforts.

Information Gathering System There is no mental health reporting system in the country.

The country has no data collection system or epidemiological study on mental health.

No nation-wide study on the prevalence of psychiatric disorders has been done.

Programmes for Special Population The country has specific programmes for mental health for minorities, refugees, disaster affected population, indigenous population, elderly and children.

The National Programme for Mental Health in collaboration with the University of the Philippines Psychiatrists Foundation Inc. (UPPFI), an NGO, organized a Mental Health task Force in Disaster, which conceptualizes and implements the psychosocial intervention programme for victims of disasters. The country also has some child protection units. The Department of Health integrates mental health components in its annual advocacy and health promotion efforts especially in its healthy life style theme. Examples of such programmes include those on mental health of children and adolescents and stress in workplace. The Overseas Workers Welfare Assistance (OWWA) of the Department of Labour and Employment has developed a Pre-departure policy consisting of triage for mental disorders and a package on stress (especially cultural stress). It also offers services of physicians and social welfare officers to overseas workers at Consulates. There are policies specifying the need to ascertain a person's mental health before appointment to high positions in the Government or the assumption of specific responsibilities. The Department of Social Welfare and Development has adopted a psychosocial orientation in their training of childcare workers in their various institutions for street children, children victims of abuse and violence and for counsellors in women crisis centres.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

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Poland

GENERAL INFORMATION

Poland is a country with an approximate area of 313 thousand sq. km. (UNO, 2001). Its population is 38.551 million, and the sex ratio (men per hundred women) is 94 (UNO, 2004). The proportion of population under the age of 15 years is 17% (UNO, 2004), and the proportion of population above the age of 60 years is 17% (WHO, 2004). The literacy rate is 99.7% for men and 99.7% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.1%. The per capita total expenditure on health is 629 international \$, and the per capita government expenditure on health is 452 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Polish. The largest ethnic group(s) is (are) Polish. The largest religious group(s) is (are) Roman Catholic (almost 95%).

The life expectancy at birth is 70.6 years for males and 78.7 years for females (WHO, 2004). The healthy life expectancy at birth is 63 years for males and 68 years for females (WHO, 2004).

EPIDEMIOLOGY

The National Health Interview Survey based on an instrument derived from the General Health Questionnaire (GHQ-12) showed that almost 25% of women and about 18% of men had minor psychiatric morbidity (MPM). MPM was related to marital status (divorced/widowed), unemployment, disability and low education (Kiejna et al, 2001). In a small sample of primary health care patients, an assessment with the Munich-Composite International Diagnostic Interview (M-CIDI) (computer version) revealed that half of subjects had at least one and about a quarter two or more mental disorders. The most common diagnoses were neurotic, stress-related and somatoform disorders (32.9%), substance use disorders (26.5%) and mood disorders (16.5%) (Moscicka et al, 2001). In a two-phase population based study (Mini Mental State Examination followed by diagnostic examination with Cambridge Mental Disorders of the Elderly Examination) on a stratified random sample of 1000 persons, the prevalence of dementia was estimated at 5.7%. Age-specific prevalences in the age-groups 65-69, 70-74, 75-79, 80-84 were 1.9, 5.8, 8.6 and 16.5%, respectively. The rate of vascular dementia (2.7%) was higher than that of the Alzheimer's type (2.3%) (Gabrylewicz et al, 2002). In a study on a large sample of subjects (n=13 023), the point prevalence of dementia was noted to be 10% and the incidence (per year) of Alzheimer's Disease was recorded as 2.6% in those over 65 years of age (Wender et al, 1990). Chodorowski et al (2001) assessed 716 students with the Alcohol Use Disorders Identification Test (AUDIT) and showed that 8.2% were in stage B (comprised) and 10.2% in stage C (dangerous drinking) category. Another study on university students (n=1585) revealed a rate of drug dependence of 1.4% (Chodorowski et al, 2000). A study on 747 schoolgirls (14-16 years) that employed the Eating Attitude Test (EAT-26) revealed a prevalence of 2.3% for sub-clinical eating disorder (Włodarczyk-Bisaga & Dolan, 1996). Population based suicide statistics suggest that gender (male), age and place of residence are important risk factors of suicides in the elderly age group (Pecyna, 1993). Examination of forensic data on suicide in minors (below 18 years), revealed that the majority (87.5%) were in the age range of 16-18 years (Marek et al, 1976). Polewka et al (2002) reported that the average age of suicide completers was 43.6 years. Completed suicide was associated with male gender (four-fifths), employment (unemployed or pensioner) and mental/alcohol use disorders, while suicide attempts were associated with younger age group, female gender (three-fourths), marital status (divorced), residence (metropolitan), education (elementary/secondary), employment (unemployed or pensioner), mental disorders (depression, personality disorders) and suicide among friends or relatives. Data from regional centres of clinical toxicology showed that 43% of acute poisoning was due to suicide attempts. A mortality rate of 5.4% was observed when forensic data were taken into account (Kamenczak, 1990). A case control study of 323 inpatients with suicidal overdose and 219 patients with accidental overdose showed that the former group had a significantly greater number of people who were divorced/separated, had fewer children, had recently lost their jobs or had financial problems (Goszcz, 1999). Suicide attempts in the elderly was associated with gender (female), age (young old), occupation (retired), marital status (widowed), social isolation and physical disorders. Mental disorders (depression, organic brain disorders and alcohol use disorders) were common in both suicide attempters and suicide completers (Polewka et al, 2002). A comparison of subjects who made repeated suicide attempts and those who had made one attempt showed that the former had a greater proportion of subjects with mental disorders, divorce/separation, elementary education and unemployment/pensioner status (Polewka et al, 2001). Screening of large samples (n>500) of children and adolescents revealed probable depression in 32.8% of first-grade students, 31.7% of adolescents aged 13-14 years and 27.4% of those aged 16-17 years (Bomba, 1987; Bomba & Jaklewicz, 1990). In 490 Polish school districts, the prevalence of mental retardation, major mental retardation (I.Q. from 0 to 49) and Langdon-Down syndrome were 2%, 0.3% and 0.05%, respectively. Major mental retardation was associated with a family history of mental retardation and mental disorders and a history of birth asphyxia (Wald & Stomma, 1968).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1995. The components of the policy are promotion, prevention, treatment and rehabilitation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1999.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1995. The three greatest priorities of the national mental health programme are: deinstitutionalization and improvement of the quality of care; development of community-based psychiatry; mental health promotion. Large psychiatric hospitals are to be dismantled or transformed for some other purpose; communal coordinating teams would be created at the level of county areas, consisting of representatives of services providing health care to the mentally disordered. The team would serve also as an advisory body in matters of social policy concerning mental health issues and the needs of psychiatric care (including allotment of financial resources). A programme of postgraduate training for general practitioners is now under development. The monitoring of quality of care in psychiatric facilities is being promoted along with the co-operation of non-governmental organizations. The following activities for mental health promotion are being planned: develop in the community the knowledge and skills needed for an individual's growth and self-actualization, successful coping with stress and environmental demands and gaining better mental health; shape mental health-promoting behaviour and lifestyles; school education; implement programmes aimed at prevention of mental disorders in high-risk groups; organize various forms of service delivery in crisis situations; implement programmes of co-operation within the local communities on mental disorders, mental health promotion, and prevention of substance abuse. It is expected that the National Mental Health Programme will be included into Mental Health Act by the Parliament. Poland has a plan for national action with regard to the prevention of suicides.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2000.

The list of drugs are prepared on the basis of the Minister of Health Ordinance on the list of drugs which are supplied free of charge or at special low prices for persons suffering from specified diseases. The ordinance is published every year.

Mental Health Legislation The Mental Health Act regulates three major issues: (1) promotion of mental health and the prevention of mental disorders, shaping of appropriate social attitudes towards people with mental disorders and counteracting discrimination; (2) provision of comprehensive and accessible mental health care and assistance for people with mental disorders under the models of community care and social welfare; and (3) protection of the civil rights of people with mental disorders, in particular, definition of the guarantee of the rights of people admitted to and treated in hospitals without consent. The other relevant acts are: The Involuntary Commitment Law, Section 7 of 1986, the Act on Legal Proceedings (1999), the Act on Upbringing in Sobriety and Counteracting Alcoholism of 1998, the Act on Counteracting Drug Abuse of 1997, the Act on Social Assistance of 1990, with subsequent amendments; the Act on Vocational and Social Rehabilitation and Employment of the Disabled of 1997. The Penal Code (1998) has provisions for offenders with mental disorders and has laws to protect the fundamental rights of the victim and perpetrator.

The latest legislation was enacted in 1994.

Mental Health Financing There are no budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary sources of mental health financing in descending order are social insurance and tax based.

The Sickness Fund provides for the bulk of psychiatric services. In 1991, the State Fund for Rehabilitation of Disabled Persons was established. This resulted in organization of occupational therapy workshops.

The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 3500 personnel were provided training. There are training facilities for primary care doctors.

There are community care facilities for patients with mental disorders. The process of transformation of psychiatric care started in the middle 1970s, but was slow. The counselling system, which is the strong point of Polish psychiatric care, emerged some years before the dismantling of large psychiatric hospitals began. There are outpatient clinics (854 in 2002), day hospitals (221 for 16 160 patients in 2002), mobile community teams (22, mainly in cities), hostels (6 for 158 patients) and sheltered workshops (about 200). Co-ordination teams consisting of representatives of service providers will be created at the level of counties. Article 9 of the mental health act provides for two forms of community-based programmes – a specialist social help services and community self-help houses for persons who are unable to integrate themselves properly into the society due to their illnesses.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	7.8
Psychiatric beds in mental hospitals per 10 000 population	5.2
Psychiatric beds in general hospitals per 10 000 population	1.2
Psychiatric beds in other settings per 10 000 population	0.6
Number of psychiatrists per 100 000 population	6
Number of neurosurgeons per 100 000 population	
Number of psychiatric nurses per 100 000 population	18.4
Number of neurologists per 100 000 population	8
Number of psychologists per 100 000 population	3.4
Number of social workers per 100 000 population	0.6

The number of substance abuse therapists per 100 000 population is 3.0. Attempts at deinstitutionalization have resulted in a 20% reduction in the number of inpatient beds between 1970 and 1990. However, even now almost a quarter of beds are concentrated in 9 large mental hospitals, which account for 7620 beds. About 19% and 4% of beds are allocated to substance (alcohol and drug) abuse and child and adolescent services, respectively. The social welfare system provides for nursing homes (place for 40 000 clients) for chronically ill patients and for mentally challenged individuals. Currently, about 583 forensic psychiatry beds are available. Psychiatric services are also available in prisons. Such services are usually provided by psychologists in consultation with prison psychiatrists. Child and adolescent psychiatry and psychotherapy are recognized sub-specialities. About 200 psychiatrists and psychologists have forensic psychiatry as their special interest area.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, prevention and rehabilitation. A voluntary coalition for mental health was set up in 1993 as a national organization including many self-help and related associations and groups. Substantial part of the social support services is provided by NGOs, some of which are supported by the Government. More than 2005 Alcoholic Anonymous groups, 712 Alanon and 183 Alteen groups have been established.

Information Gathering System There is mental health reporting system in the country.

The country has data collection system or epidemiological study on mental health. There is a Statistical Yearbook on Mental Health Care and Neurological Care published every year.

Programmes for Special Population The country has specific programmes for mental health for elderly and children. There are separate facilities for children and elderly with mental disorders.

Child and adolescent psychiatry has been recognized as a sub-speciality since 1999. The main forms of psychiatric care and delivery of alcohol or drug abuse treatment are outpatient clinics and various forms of intermediate care – day hospitals, mobile community teams, crisis intervention centres, and rehabilitative facilities. Currently, psychiatric institutions in which detention is carried out have been divided into three groups based on their security arrangements. One psychiatric hospital in the country fulfils the criteria for maximum security. Courts decide on detention in psychiatric hospitals, and the National Psychiatric Board for Protective Measures selects the most suitable hospital.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

A number of other drugs like cloimipramine, fluoxetine, oxazepam, buspirone, etc. are available. The above mentioned drugs are only the example of fully reimbursed medications. The vast majority of other psychotropic drugs are also available but with patients co-payment, which varies substantially from one drug to the other.

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Portugal

GENERAL INFORMATION

Portugal is a country with an approximate area of 92 thousand sq. km. (UNO, 2001). Its population is 10.072 million, and the sex ratio (men per hundred women) is 93 (UNO, 2004). The proportion of population under the age of 15 years is 17% (UNO, 2004), and the proportion of population above the age of 60 years is 21% (WHO, 2004). The literacy rate is 93.7% for men and 88.5% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 9.2%. The per capita total expenditure on health is 1618 international \$, and the per capita government expenditure on health is 1116 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Portuguese.

The life expectancy at birth is 73.6 years for males and 80.5 years for females (WHO, 2004). The healthy life expectancy at birth is 67 years for males and 72 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in Portugal in internationally accessible literature. No attempt was made to include this information here.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1995.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Mental health and alcohol issues are coordinated by the same department at the Directorate General of Health within the Ministry of Health.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1999. The policy has a 5-year duration (1999-2004) (Council of Ministers Resolution 46/99 of 22 April). There is a specific structure within the Ministry of Health for this area. An alcohol policy is also present since 2000.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1996. A new national mental health plan is being prepared within the context of the National Health Plan 2004-2010. Several other programmes namely for the elderly, children and adolescents, depression, PTSD, alcohol use disorders and drug use disorders are also being prepared. There is a National Network, involving the Ministry of Defence and the Ministry of Health, for PTSD of ex-combatants and a National Network for Alcohol problems is being developed.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2000.

Mental Health Legislation There is the Mental Health Law 36/98. Other relevant national laws are: Law 35/99 (organization of services), Joint Ruling 407/98 (not specific for mental health) Order 348A/98 (social firms, not specific for mental health), Council of Ministers Resolution 166/2000 (Alcohol Action Plan), Law 281/2003 of (Continuity Care Network) and Joint Ruling 502/2004 (PTSD Network).

The latest legislation was enacted in 1998.

Mental Health Financing There are budget allocations for mental health.

The country spends 2.3% of the total health budget on mental health.

The primary sources of mental health financing in descending order are tax based, social insurance, private insurances and out of pocket expenditure by the patient or family.

The country has disability benefits for persons with mental disorders. Financial incentives were introduced for disabled employees in 1982. More recently, benefits were announced with the Dec.-Law 247/89.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. However, major psychiatric illnesses are generally treated in specialized psychiatric set-ups.

Regular training of primary care professionals is carried out in the field of mental health. During their training general practitioners are given theoretical and practical exercises in a mental health setting.

There are community care facilities for patients with mental disorders. Since 1989, community care (vocational training, employment support, day centres and residential support) has been progressively developed through cooperation of health services, social services and NGOs. Since 1998, there has been an integration of social support and continuous health care for people in situations of dependency (physical, mental, social), with mental and psychiatric disorders, for residential and occupational programmes, financed by social security. In 1998, the Ministry of Work and Solidarity defined the framework for recognition and granting of technical and financial support to integration within the context of social employment market as an active employment sponsored by the Institute for Employment and Vocational Training.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	7.5
Psychiatric beds in mental hospitals per 10 000 population	1.5
Psychiatric beds in general hospitals per 10 000 population	1
Psychiatric beds in other settings per 10 000 population	4.9
Number of psychiatrists per 100 000 population	4.7
Number of neurosurgeons per 100 000 population	1.5
Number of psychiatric nurses per 100 000 population	10.1
Number of neurologists per 100 000 population	3.2
Number of psychologists per 100 000 population	2
Number of social workers per 100 000 population	1.6

Over the last 15 years, a decrease of 40% in bed strength has been achieved.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. NGOs are active in suicide prevention programmes.

Information Gathering System There is mental health reporting system in the country. There is a national participation in European programmes, like 'European Community Health Indicators (ECHI-2)', in order to achieve national health indicators. The country has data collection system or epidemiological study on mental health. The 3rd National Health Survey contains some information about mental health and the 4th (in preparation) will deeper cover alcohol and mental health. There are three National Psychiatric Census (the latest in 2001). The Directorate General of Health within the Ministry of Health is preparing a national system for mental health information and the first National Morbidity Study.

Programmes for Special Population The country has specific programmes for mental health for disaster affected population, elderly and children. There are services for PTSD. There are separate clinics for child and adolescent psychiatry. For the elderly, there are outpatient clinics, inpatient services, home visit facilities and old people's home.

There are 3 child and adolescent psychiatry departments and 25 services and units (Rede de Referência em Psiquiatria e Saúde Mental, Direcção-Geral da Saúde, 2004). In the area of illicit drugs, the country has a nationwide network of 45 C.A.T. (care centres). In addition, there are three regional alcohol abuse treatment centres and 1 centre for psychiatric rehabilitation.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

Other Information In 2000, there was a 'Resolution of Assembly of Republic' No 76/2000 and a 'Resolution of Council of Ministries' No 166/2000 directed to fighting alcoholism. There was also a law- No 318/2000.

Although suicide rates have been declining in the last few years, there is a regional cluster of suicides in Alentejo and Algarve Regions.

Additional Sources of Information

Directorate General of Health (2004) National Health Plan 2004-2010.

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Ministry of Health – Directorate General of Health (2002) Health Gains in Portugal.

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GENERAL INFORMATION

Qatar is a country with an approximate area of 11 thousand sq. km. (UNO, 2001). Its population is 0.619 million, and the sex ratio (men per hundred women) is 172 (UNO, 2004). The proportion of population under the age of 15 years is 26% (UNO, 2004), and the proportion of population above the age of 60 years is 3% (WHO, 2004). The literacy rate is 94.9% for men and 82.3% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.1%. The per capita total expenditure on health is 782 international \$, and the per capita government expenditure on health is 574 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Arabic and English. The largest ethnic group(s) is (are) Arab, and the other ethnic group(s) are (is) Pakistani, Indian and Iranian. The largest religious group(s) is (are) Muslim (almost 95%).

The life expectancy at birth is 74.8 years for males and 73.8 years for females (WHO, 2004). The healthy life expectancy at birth is 67 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in Qatar in internationally accessible literature. No attempt was made to include this information here.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1980.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1986.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1990.

The national mental health programme stresses on legislation, family involvement, primary health care and counselling programmes.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1980.

Mental Health Legislation Details about the mental health legislation are not available.

Mental Health Financing There are budget allocations for mental health.

The country spends 1% of the total health budget on mental health.

The primary source of mental health financing is tax based.

The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Primary care is provided to a small number of centres. All psychiatric drugs are dispensed except for the controlled ones. Drug abuse patients are referred to the psychiatric clinics and only referrals from the catchment areas are seen. Generally, psychologists attend and handle referrals on-site.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 15 personnel were provided training. Training courses for physicians from primary health care and dermatology are held.

There are community care facilities for patients with mental disorders. A community nursing service was started in 1993 and domiciliary visits for assessments and home management of patients in liaison with their families have started. There are also day-care centres at certain hospitals which impart stress control, assertive training, job training, family education, increase self knowledge, rehabilitate institutionalized chronic patients and carry out family-oriented educational programmes.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.97
Psychiatric beds in mental hospitals per 10 000 population	0.97
Psychiatric beds in general hospitals per 10 000 population	0
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	3.4
Number of neurosurgeons per 100 000 population	0.8
Number of psychiatric nurses per 100 000 population	10
Number of neurologists per 100 000 population	1
Number of psychologists per 100 000 population	1.2
Number of social workers per 100 000 population	10

There are 3 other mental health professionals of different categories. Beds have been earmarked for women patients and for services related to rehabilitation, mental retardation, special education and psychogeriatrics.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in treatment.

Information Gathering System There is mental health reporting system in the country.

The country has data collection system or epidemiological study on mental health.

A computerized database information system covering all psychiatric clinical services includes modern diagnostic criteria and information on treatment and referral outcomes are possible, but only in the capital city.

Programmes for Special Population The country has specific programmes for mental health for elderly and children.

There are facilities for imparting mental health services to schools. There are also ambulatory child psychiatry facilities.

Psychogeriatric services consist of an inpatient service with follow-up protocol.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, carbidopa, levodopa.

Other Information Qatar's psychiatric service was established in 1971. Almost all hospital services are controlled by the Hamad Medical Corporation, which is a Government corporation.

Additional Sources of Information

El-Islam, M. F. (1995) Psychiatry in Qatar. *Psychiatric Bulletin*, 19, 779-781.

Republic of Korea

GENERAL INFORMATION

Republic of Korea is a country with an approximate area of 99 thousand sq. km. (UNO, 2001). Its population is 47.95 million, and the sex ratio (men per hundred women) is 101 (UNO, 2004). The proportion of population under the age of 15 years is 20% (UNO, 2004), and the proportion of population above the age of 60 years is 12% (WHO, 2004). The literacy rate is 99.1% for men and 96.4% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6%. The per capita total expenditure on health is 948 international \$, and the per capita government expenditure on health is 421 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Korean. The largest ethnic group(s) is (are) Korean. The largest religious group(s) is (are) Christian, and the other religious group(s) are (is) Buddhist.

The life expectancy at birth is 71.8 years for males and 79.4 years for females (WHO, 2004). The healthy life expectancy at birth is 65 years for males and 71 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in the Republic of Korea in internationally accessible literature. No attempt was made to include this information here.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1960.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The mental health policy of Korea is to decrease long-term hospitalization and to develop and extend the community-based mental health service system. In addition, the mental health policy emphasizes enhancing the priority of mental health, workforce development and developing a comprehensive service system.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1970. The substance abuse policy is not only diminishing supply but also diminishing demand of substance by developing prevention programmes on the substance use and abuse.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1995. The national mental health programme is developing a community mental health service delivery system including national mental hospitals, community mental health centres and community health centres.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2000.

Most mentally ill patients with medical insurance are able to afford most therapeutic drugs, while the poor people with medical aid have a limited availability to expensive new drugs.

Mental Health Legislation There is a mental health law. It was revised in 2000. The revision allows for legal support to the establishment of social rehabilitative facilities and their role in providing community mental health services. Disability benefits are covered under the Medical Protection Act and the Welfare Law for the Handicapped.

The latest legislation was enacted in 1999.

Mental Health Financing There are no budget allocations for mental health.

The country spends 3% of the total health budget on mental health.

The primary sources of mental health financing in descending order are social insurance, tax based and out of pocket expenditure by the patient or family.

There is a universal public insurance funded by premiums. There is no private health insurance. About 90% of the providers are in the private/non-government sector, whose services are covered through the public health insurance. The Government funds health care for the poor through tax-based funds. Medical insurance covers inpatient, outpatient and day care, while tax-based funds cover nursing home and rehabilitation services.

The country has disability benefits for persons with mental disorders. Since January 2000, mentally ill patients have been made eligible for similar support and rights as other disabled persons.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 7565 personnel were provided training. Community mental health nurses have also been trained.

There are community care facilities for patients with mental disorders. Since the formulation of the Mental Health Act in 1995, community care has started to develop. Currently, there are nearly 115 community health centres and 110 rehabilitation centres. Home help service and a visiting nursing programme for mentally ill have been developed by community mental health centres. Vocational

rehabilitation programmes including sheltered workshops and supported employment are also coming up with support from the Korea Employment Promotion Agency for the Disabled. Community care is being developed with a catchment area approach. The community health centres are mainly managed by public health centres and nearby university/psychiatric hospitals. Each centre has a part time psychiatrist who acts as the supervisor. The centre provides counselling, home-visit care, treatment, case management, education, rehabilitation and outreach activities. Rehabilitation services are also provided in the private/non-government sphere. Funds for community care are being increased and it is planned that community care capacity would be increased 10-fold over the next decade. At present there is a gap between the inpatient system and the community care system.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	13.8
Psychiatric beds in mental hospitals per 10 000 population	6.3
Psychiatric beds in general hospitals per 10 000 population	3.8
Psychiatric beds in other settings per 10 000 population	2.7
Number of psychiatrists per 100 000 population	3.5
Number of neurosurgeons per 100 000 population	3.1
Number of psychiatric nurses per 100 000 population	10.1
Number of neurologists per 100 000 population	1.4
Number of psychologists per 100 000 population	0.8
Number of social workers per 100 000 population	2.6

A special 1-year training programme for nurses, social workers and psychologists (certified by the Ministry of Health and Welfare) has been approved under the Mental Health Law to develop an appropriate workforce to implement the National Mental Health Programme.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and rehabilitation. The NGOs played a major advocacy role in the development of the mental health policy. NGOs and family associations work closely together in psychoeducation of families and users and in anti-stigma campaigns.

Information Gathering System There is mental health reporting system in the country.

The country has data collection system or epidemiological study on mental health. The Government is conducting a national epidemiological study to assess the prevalence of mental disorders.

Programmes for Special Population There are no special services.

A nation-wide anti-stigma campaign was launched in 2003 with multi-sectoral participation. A school mental programme has been set up and is run by school nurses trained in detection and counselling. Psychologists have been deployed in universities. Child and adolescent and geriatric care programmes are being developed by community mental health centres.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, haloperidol, lithium, biperiden, carbidopa, levodopa.

Other Information Since the enactment of the Mental Health Act, many private mental asylums have been changed into mental hospitals. Different psychosocial programmes have been developed for rehabilitation, open wards are slowly developing in mental hospitals and unrecognized 'houses of prayer' have been closed. Custodial care in mental hospitals is still present as is prolonged inappropriate stay of patients in mental hospitals, primarily due to lack of adequate staff to care for the patients in the community. Between 1970 and 1983, families began to be replaced by unauthorized facilities as primary care givers. As a result of increasing human rights problems, the Government began to take an active interest in their care of the mentally ill. This initially led to an increase in the number of mental hospitals and their beds. It was only after the formulation of the Mental Health Act of 1995, that community care and disability benefits began to develop. However, the length of inpatient stay is still very long and there is still a huge amount of stigma against mental disorders and patients. This is being addressed gradually through advocacy campaigns.

Additional Sources of Information

Regional Office for the Western Pacific (2001) Country report on mental health – Republic of Korea.

Suh, G.-H. (2004) Mental health care in South Korea. *International Psychiatry*, (in press).

Republic of Moldova

GENERAL INFORMATION

Republic of Moldova is a country with an approximate area of 34 thousand sq. km. (UNO, 2001). Its population is 4.263 million, and the sex ratio (men per hundred women) is 92 (UNO, 2004). The proportion of population under the age of 15 years is 20% (UNO, 2004), and the proportion of population above the age of 60 years is 14% (WHO, 2004). The literacy rate is 99.6% for men and 98.6% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.7%. The per capita total expenditure on health is 112 international \$, and the per capita government expenditure on health is 56 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Moldovan. The largest ethnic group(s) is (are) Moldavian and Romanian, and the other ethnic group(s) are (is) Ukrainian, Bulgarian, Gaguzian and Russian. The largest religious group(s) is (are) Eastern Orthodox Christian.

The life expectancy at birth is 64 years for males and 71.6 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Republic of Moldova in internationally accessible literature.

Wasserman et al (1998) found that the suicide rates in the former USSR during 1984-90 varied greatly between different regions. It was 18.1 per 100 000 in Moldova. In quantitative analyses Wasserman and Varnik (1998) showed that mortality data were reliable for Moldova.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 2000.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 2000.

National Mental Health Programme A national mental health programme is absent.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1997.

Mental Health Legislation In 1998, a programme to improve the psychiatric service was adopted, with emphasis on the rights and interests of persons suffering from mental disorders. This experience showed that it was necessary to pay more attention to the judicial rights of individuals receiving psychiatric help and to formulate appropriate criteria for compulsory admission. In 1998, the Law Concerning Psychiatric Assistance and Guarantees of the Citizen's Rights was adopted. Since January 1999, the project of developing humane mental health care in Moldova through professional training for psychiatric nurses and doctors in multidisciplinary teamwork have been in the process of implementation.

The latest legislation was enacted in 1998.

Mental Health Financing There are budget allocations for mental health.

The country spends 6.5% of the total health budget on mental health.

The primary source of mental health financing is tax based.

The budget is allocated by the National Company of Compulsory Medical Insurance. Both outpatient and inpatient treatment of mentally ill patients is free. Mental health services are financed from both Government and local authority budgets.

The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.

Regular training of primary care professionals is carried out in the field of mental health.

There are no community care facilities for patients with mental disorders. Since 1999, the project 'Developing humane mental health care in Moldova through professional training for psychiatric nurses and doctors in multidisciplinary teamwork' has been implemented with the support of the Geneva Initiative in Psychiatry. The number of places in day hospitals is also increasing.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	6.7
Psychiatric beds in mental hospitals per 10 000 population	5.9
Psychiatric beds in general hospitals per 10 000 population	0.8
Psychiatric beds in other settings per 10 000 population	0.1
Number of psychiatrists per 100 000 population	9
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	30.5
Number of neurologists per 100 000 population	9
Number of psychologists per 100 000 population	0.7
Number of social workers per 100 000 population	0.5

There are 3 psychiatric hospitals. Outpatient psychiatric care is provided by two psycho-neurological clinics and three departments within general clinics. The first stage of help is given in villages and districts in rural medical ambulatory sectors or in psychiatric clinics at district polyclinics. At the second stage, outpatient consultation is provided in towns by psychiatrists or psycho-neurologists; these provide high-quality help in a psycho-neurological dispensary polyclinic or a psychiatric hospital.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and prevention.

Information Gathering System There is mental health reporting system in the country. The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population There are no special services.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

Other Information**Additional Sources of Information**

Wasserman, D., Varnik, A. (1998) Reliability of statistics on violent death and suicide in the former USSR, 1970-1990. *Acta Psychiatrica Scandinavica*, Supplement 394, 34-41.

Wasserman, D., Varnik, A., Dankowicz, M. (1998) Regional differences in the distribution of suicide in the former Soviet Union during perestroika, 1984-1990. *Acta Psychiatrica Scandinavica*, Supplement 394, 5-12.

Romania

GENERAL INFORMATION

Romania is a country with an approximate area of 238 thousand sq. km. (UNO, 2001). Its population is 22.28 million, and the sex ratio (men per hundred women) is 95 (UNO, 2004). The proportion of population under the age of 15 years is 16% (UNO, 2004), and the proportion of population above the age of 60 years is 19% (WHO, 2004). The literacy rate is 99% for men and 97.3% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.5%. The per capita total expenditure on health is 460 international \$, and the per capita government expenditure on health is 365 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Romanian. The largest ethnic group(s) is (are) Romanian (nine-tenths), and the other ethnic group(s) are (is) Hungarian and Roma. The largest religious group(s) is (are) Orthodox Christian (seven-tenths), and the other religious group(s) are (is) Protestant, Roman Catholic and Unite Catholic.

The life expectancy at birth is 68 years for males and 75 years for females (WHO, 2004). The healthy life expectancy at birth is 61 years for males and 65 years for females (WHO, 2004).

EPIDEMIOLOGY

Greco et al (1990) found that the mortality index (1.97%) for patients with alcohol dependence (n=5580) was significantly higher than the index (0.36%) for other psychiatric patients (n=46 591). Berlescu et al (1995) reviewed hospital data on mental disorder occurring or aggravating during pregnancy or the postpartum period (n=642). Mental disorders in this period were associated with lower education level, labile biological and psychological structure, abortions and high post-natal complications. Ionescu and Popescu (1989) assessed a group of depressed students (n=111) and found that 70% had a concurrent personality disorder. Unstable, obsessive, hysteric, dysthymic and mixed personality disorders were more prevalent. Personality disorders were associated with earlier onset, severity, recurrence and non-reactivity of depression. Makinen (2000) found that patterns in suicide and their causes varied between countries of Eastern Europe and former republics that formed the USSR. A model consisting of general stress, democratization, alcohol consumption and social disorganization (with a period-dependent effect) predicted fairly accurately the changes in the suicide rates in 16 out of the 28 Eastern Bloc countries in 1984-1989 and 1989-1994, but it failed to do so for Romania. Voracek et al (2002) compared data for suicide by hanging in a county for 1990-98 and 1980-89 and found that there was no decrease in seasonality of suicide, nor was there a shift in location for suicide peak and trough months. Pluye et al (2001) assessed 508 children selected randomly from homes for children based on a clinical evaluation protocol. Using ICD-10 criteria, 54% of the children had a diagnosis of mental or behavioural disorder. Scripcaru et al (1991) found behavioural problems in 33% and post-school integration problems in 70% of the 1029 children cared for in orphanages. Kaler and Freeman (1994) assessed a representative group of Romanian orphans between the ages of 23 and 50 months. Deficits in cognitive and social functioning were present across all domains and were often severe. The deficits were unrelated to length of time in the orphanage, age at entrance, Apgar scores or birthweight. Indredavik et al (1991) studied 154 children in an institution for mentally retarded and found evidence of deprivation, anxiety and behavioural maladjustment suggesting physical, psychological, pedagogic and social neglect. Iftene et al (2000) reviewed records of 1467 adolescents (14-16 year olds) seen in 1995-2000 and 1985-90 and found a three-fold increase in number of offences. The increase in prevalence of delinquent acts was associated with locality (urban), gender (girls), age (reduction in age of onset) and unemployment in families. A change in offence profile was also noticed, with a greater degree of sexual offences, driving without license and forging money. Lupu et al (2002) interviewed 500 school-teenagers from 3 different districts with a structured questionnaire that included the 20 questions of the American Anonymous Gambling Association. They found that 6.8% of the teenagers were pathological gamblers, with a male to female ratio of 4.6:1. The majority (82.4%) preferred group gambling. Gambling was responsible for school absenteeism in 64.7% and modest results at school in 52.9% of subjects.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1998. There is a legal ban on smoking in public places.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999. The programme was developed mainly due to the efforts of the Romanian League for Mental Health and Romanian Psychiatric Association, but it is not yet promulgated. It is based on the analysis of the mental health assessment (morbidity and mortality figures) in Romania. It incorporates ideas on prevention and rehabilitation, health care system, community psychiatry, administration and legislation and coordination with other health care sectors. Within the national mental health programmes established and financed by the Ministry of Health and Family (according to Law no. 100/1998 concerning public health assistance) there is a 'National Programme of Mental Health and Prophylaxis and Psycho-Social Pathology'. Details about its implementation are not available. A national programme for the treatment of schizophrenia and depression is in place.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1994.

The new draft national drug policy was launched in 2000.

Mental Health Legislation Experts from WHO have made recommendations in the process of elaboration of the law. Currently, a commission is working to establish the implementation norms for this law. The law includes provisions for the use of the least restrictive alternative, confidentiality, informed consent and establishes detailed rules for involuntary hospitalization, with concern for protection of the civil rights of the patient. It prohibits discrimination in general and at workplace and in health insurance and disability benefits, in particular.

The latest legislation was enacted in 2002.

Mental Health Financing There are budget allocations for mental health.

The country spends 3% of the total health budget on mental health.

The primary sources of mental health financing in descending order are social insurance and out of pocket expenditure by the patient or family.

In 1998, the Health Insurance Scheme was introduced. It is based on a social health insurance fund, where the employers and the employees contribute 14% of gross salary incomes (7% each of them). The state provides funds for some activities, e.g. prevention. Through these systems, free health care services are guaranteed for all employees and their families, pensioners, self-employed, unemployed, children up to the age of 14 and pregnant women. Both state and private pharmacies are reimbursed for issuing approved free or subsidized drugs. For employees and their families, 50% of the price is reimbursed and for pensioners and unemployed 65%.

The country has disability benefits for persons with mental disorders. Persons with mental illness can take early retirement just like any other illness. Recently, the Labour and Social Protection Department has started providing some financial support to families/caregivers of the chronically ill with handicap (including those with dementia) who are treated at home.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.

Regular training of primary care professionals is not carried out in the field of mental health. A programme for training of general practitioners in depression and schizophrenia was elaborated by the Ministry of Health in 2001, but it has been implemented only partially.

There are no community care facilities for patients with mental disorders. Community-based care including sheltered homes is mainly provided by the NGOs, foundations and religious organizations. Some day care centres are available and a proportion (around 10%) of designated mental health laboratories provide ambulatory services. Geographical disparities in community services are marked (some counties do not have any outpatient facilities) and coordination between services is limited. In 2003 a programme to provide domiciliary care to elderly with mental disorders and dementia was started.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	7.6
Psychiatric beds in mental hospitals per 10 000 population	5.5
Psychiatric beds in general hospitals per 10 000 population	2
Psychiatric beds in other settings per 10 000 population	0.2
Number of psychiatrists per 100 000 population	4.1
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	8.9
Number of neurologists per 100 000 population	3
Number of psychologists per 100 000 population	4.5
Number of social workers per 100 000 population	

The territorial distribution of services is uneven. About 7% of the beds are located in day hospitals, 3.5% in secure units and about 1% are allocated for treatment of drug abuse. Some beds are also earmarked for geriatric and child and adolescent services. There are no private psychiatry hospitals. There are around 260 child and adolescent psychiatrists in the country, which forms more than one-fourth of the psychiatry workforce. Geriatric Psychiatry was recognized as a sub-speciality by the Ministry in 2001. Some psychiatrists work in private ambulatory clinics with authorization from the Ministry of Health. The Human Resources Department of the Ministry has begun the complex task of classification and categorization of medical staff employed in the mental health services. The Department in cooperation with the medical education authorities is trying to develop a training programme for psychiatrists. The profession of psychiatric nurse was officially recognized by the Ministry of Health in 2003. There are few trained social workers and occupational therapists. The practice of psychotherapy is not regulated.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. The Romanian League for Mental Health was the first organization involved in mental health promotion. It has developed a long term programme for changing perceptions about mental health and developed models of practice. Since 2000, large media campaigns on topics like domestic violence, child abuse, stigma and discrimination, depression and anxiety problems, child and adolescent mental health problems and alcohol abuse are being implemented by NGOs, with European Union assistance. A school for psychiatric nurses was initiated in 1993 by NGOs from Romania and Belgium. More than 250 nurses have already graduated from this school. In 2002, the first user organization was established, but the user/carer movement is not strong at present.

Information Gathering System There is mental health reporting system in the country. The health reporting system is based on ICD-10. The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population The country has specific programmes for mental health for minorities, refugees, disaster affected population, indigenous population, elderly and children. Mental health services are provided for the populations mentioned above, but they are insufficient.

At least 1-2 physicians specialized in child neuropsychiatry are posted in each region. The labour and social protection department and the education department also provide special schools and homes for mentally challenged and delinquent children and adolescents. However, many of these services are understaffed or staffed by under-qualified personnel and are handicapped by lack of complementary services. NGOs are also active in this sector and provide social assistance for street children and abandoned, neglected and abused children.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, carbidopa, levodopa.

Though a number of newer psychotropics have been included, they are not easily available at primary level.

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Russian Federation

GENERAL INFORMATION

Russian Federation is a country with an approximate area of 17075 thousand sq. km. (UNO, 2001). Its population is 142.397 million, and the sex ratio (men per hundred women) is 88 (UNO, 2004). The proportion of population under the age of 15 years is 15% (UNO, 2004), and the proportion of population above the age of 60 years is 18% (WHO, 2004). The literacy rate is 99.7% for men and 99.5% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.4%. The per capita total expenditure on health is 454 international \$, and the per capita government expenditure on health is 310 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Russian. The largest ethnic group(s) is (are) Russian. The largest religious group(s) is (are) Russian Orthodox (three-fourths), and the other religious group(s) are (is) Muslim.

The life expectancy at birth is 58.3 years for males and 71.8 years for females (WHO, 2004). The healthy life expectancy at birth is 53 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY

Bogdan (1998) found the prevalence of borderline minor psychiatric disorders in primary care samples to vary between 1.7% and 21%. Gavrilova and Kalyn (2002) identified psychiatric disorders (ICD-10 diagnoses) in 36.6% (6.1% psychotic disorders) of a sample of elderly subjects (n=1109). Bobak et al (1999) interviewed 1599 adults and found that 10% of men and 2% of women drank alcohol several times a week. Alcohol consumption was associated with smoking, unmarried status, unemployment and poor health among men. In women, higher education, widowed status, not smoking and poor health was associated with less alcohol consumption. Malyutina et al (2001) assessed about 3000 subjects in 1985/86 and 1994/95 and found that the proportion of men who drank at least once a week increased from 27% to 38% and among women from 0.6% to 6.5%. Lisenko and Richards (1994) found that alcohol dependence/alcoholic psychosis rates in Siberia and the Far East increased from 20/10 000 in 1965 to 250/10 000 in 1985. Gafarov and Gagulin (2000) found a reduction in smoking in a representative sample of urban adult males (about 700) who were assessed at two points in time in the 1990s. In a sample of 7093 students, Rozenfel'd and Kharisova (1990) found the following prevalence rates for use of various substances: alcohol (49.4%), tobacco (24.2%) and illicit drugs (9.8%). In a sample of 385 adolescents, Kemppainen et al (2002) reported that 29% of males and 7% of females smoked daily. Dershem (1996) administered the Centre for Epidemiological Studies – Depression scale (CES-D) to 263 rural subjects. Prevalence of depression was associated with age (elderly), gender (women), health (poor) and marital status (divorced/separated). Herrman et al (2002) reported the findings of the multi-country Longitudinal Investigation of Depression Outcomes (LIDO) study in which primary care subjects (n=18 489) were assessed using the Center for Epidemiologic Studies Depression Scale (cut-off 15/16). Nearly 37% (range 24-55% at different sites) met the criterion for caseness. As a part of the same study, Simon et al (2002) interviewed 968 depressed patients using the Composite International Diagnostic Interview and CES-D at baseline and 9 months. In this period only one third of patients had complete remission. Those with favourable outcome reported less work disability. Maksimova et al (1997) assessed 4000 people and found that the incidence of sleep disorders was about 30% in different regions of Russia. The rate varied from 5% in the 20-24 years age group to 40% in the elderly (above 60 years). Bogoyavlenskiy (2002) and Varnik et al (1998) reported that in the 1980s and 1990s the rate of suicide in Russia was among the highest in the world. Suicide rates were higher among men and had two peaks (at 50 and 70 years). In women, suicide rates increased after 70 years of age. Varnik and Wasserman (1992) reported that the overall rates of suicide in the former USSR increased from 17.1 per 10 000 inhabitants in 1965 to 29.6 in 1984. Rates were higher in the rural areas. The rate of suicide in the year 2002 was 38.6 per 100 000 population (Goscomstat of Russian Federation, 2004). Voitsekhovich and Red'ko (1996) found that the rate of suicide was associated with gender (male), age (over 60 years), marital status (divorced and widowed), isolation, occupation (temporary), illnesses (mental and alcohol use disorders) and disability. Analyses of trends in suicide rate have shown marked regional variation across the republics of the former USSR and the regions within the Russian Federation and an increase in the number of suicides in Russia over every decade of the 20th century with a sharp dip (almost by a third for men and a fifth for women) during the perestroika period in the late 1980s (Varnik & Wasserman 1992; Varnik et al, 1998; Bogoyavlenskiy, 2002). Varnik and Wasserman (1992) noted that the rate of suicide was low in regions with traditional lifestyles and strong family relationships (the Caucasus and Central Asia) and high in regions facing major sociopolitical changes (Baltic States and Russia). Burdeinyi et al (1991) evaluated 1179 rural children (7-14 years) and found mental deficiency in 5.7% of boys and 3.9% of girls in the highlands and 3.6% of boys and 2.1% of girls in lowlands. Neurotic disorders were common in all the subgroups (1.6% to 4.7%), and boys had a higher rate of overall psychiatric morbidity. Knyazev et al (2002) found that behavioural problems and school adjustment were associated in a study on 446 Russian adolescents (12-16 years).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1992.

The components of the policy are promotion, prevention, treatment and rehabilitation. The mental health policy is developed by the Ministry of Health in the form of statements/orders to be carried out by the governmental and non-governmental bodies.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1995. The substance abuse policy is developed by the Ministry of Health in the form of statements/orders to be carried out by the governmental and non-governmental bodies.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1995. The programme exists on sectoral level (in charge of the Ministry of Health). A national mental health programme for 1995-1997 was adopted by the Government and methodical recommendations on structural reorganization in psychiatric care were developed but the funds allotted to it were limited. At present a mid-term programme for 2005-2008 to introduce the above recommendations into practice is under preparation. Regional mental health programmes have been developed in several regions.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1993.

The order of the Ministry of Health is considerably renewed.

Mental Health Legislation The Law of Russian Federation on Psychiatric Assistance and Rights of Patients provides details about the rights of psychiatrists and patients regarding examination, ethics, types of services, patients' rights, social protection of the mentally ill, admission and discharge procedures and monitoring facilities. In 1999, many new additions and changes were made to the existing law and presented to the Government for further consideration and adoption in the Parliament. Forensic psychiatry is regulated by the following laws – Criminal Code, Criminal-legal Code, Civil-legal Code and two documents, 'The instruction for the forensic psychiatric assessment in the USSR' and 'The regulation concerning the outpatient forensic psychiatric expert commission. New laws have been proposed. The concept of limited responsibility has been introduced by the Criminal Code of 1997. From 2004, the Law of Psychiatric Care is the part of the Principles of Legislation of Health Protection of Citizens (of 22.07.1993 No. 5487-1 in version of 22.08.2004 No. 22).

The latest legislation was enacted in 1992.

Mental Health Financing There are no budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary source of mental health financing is tax based.

State psychiatric service on the whole is funded by the state, but is not covered by the obligatory state insurance. Regional (Municipal) financial support is an additional resource for psychiatric institutions. The programme of State Guaranties is the basis of free medication for disabled mentally ill, those admitted in hospitals, and for people suffering from schizophrenia and epilepsy. But the list of free medicines for outpatients is limited to inexpensive medicines.

The country has disability benefits for persons with mental disorders. Monetary assistance is allocated from the Ministry of Social Assistance's budget.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. The practice of recognition and treatment of depression in primary care is developing in several regions.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 720 personnel were provided training.

There are community care facilities for patients with mental disorders. A social rehabilitation system including workshops, rehabilitation units in industrial firms and residential homes (for about 125 000 persons) exists. Day care facilities are available for almost 15 000 persons. Home care is also provided in some cases. The University of Calgary and the Moscow Research Institute of Psychiatry have collaborated to develop two projects "Community Mental Health Rehabilitation" and "Russia Mental Health System Reform". The first project trained trainers for community care, developed curricula for community mental health care, led to some policy changes and initiated the process of creating a parent support organization. The second project helped in the development of support for consumer organizations, rehabilitation centres and vocational training centres and training of human resources. Russian Orthodox church also provides some services particularly in the drug abuse field. Some churches have opened in large psychiatric hospitals in St. Petersburg.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	11.5
Psychiatric beds in mental hospitals per 10 000 population	10.1
Psychiatric beds in general hospitals per 10 000 population	0.5
Psychiatric beds in other settings per 10 000 population	1
Number of psychiatrists per 100 000 population	13.3
Number of neurosurgeons per 100 000 population	1.7
Number of psychiatric nurses per 100 000 population	50
Number of neurologists per 100 000 population	1.58
Number of psychologists per 100 000 population	1.9
Number of social workers per 100 000 population	1.2

The system of Russian Ministry of Health consists of 278 mental hospitals, 164 psycho-neurological outpatient clinics (dispensaries) that include day-hospitals as separate wards in their structure (each dispensary provides sectorized coverage to a population of approximately 25 000 people); 2010 psychoneurological consulting rooms in rural areas; 1117 psychotherapeutic rooms, mostly in primary care facilities. There are also beds in 442 hostels, nursing homes and 'internats' under the authority of the Ministry of Social Protection. There is a 10-fold variation in the availability of beds in different regions (minimum – Altai, maximum – Kostroma). About 6% of beds have been allocated to child and adolescent mental health services. Three types of forensic units are available under the Ministry of Health, which differ according to the security level. Besides these, psychiatric hospitals managed by the Ministry of Justice also exist within the correctional system for treatment of inmates suffering from minor or temporary mental disorders. More than half of psychiatrists work in outpatient services. The territorial unevenness in professional manpower is almost 10-fold between Ingush republic and Moscow. The Code of Professional Ethics of the Russian Society of Psychiatrists, which is influenced by international conventions was adopted in 1994. Most mental health care psychologists work at specialized health facilities at companies or professional unions. Every 5 years a psychologist must undergo CME courses for 144 to 288 hours. Psychologists do not have prescription privileges. Salaries are very low, e.g. a physician gets the equivalent of \$50 to \$200 per month.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation. About 10 NGOs are dealing with mental health in the country. Social support is also provided by religious organizations (e.g. Russian Orthodox Church). The volume of care rendered by the organizations of care consumers themselves, acting mainly at regional levels, has increased (in approximately 20 regions).

Information Gathering System There is mental health reporting system in the country.

The country has data collection system or epidemiological study on mental health. The Ministry of Health has the Unit of Statistics in the Department of Development of Medical Care. The function of this Unit is to collect information, about morbidity in the country, including mental illness.

Programmes for Special Population The country has specific programmes for mental health for refugees, disaster affected population and elderly. Programmes on refugees and disaster victims are carried out by the Ministry of Emergency Situations (EMERCOM). Elderly population are looked after by the Ministry of Social Protection.

In large dispensaries there are specialized units of geriatric psychiatry, epilepsy, sexopathology and psychotherapeutic units. Each psychiatrist for children and adolescents administers psychiatric care over the catchment area with 15 000 children. As a rule, child psychoneurological units are situated in the local child primary-care system. Narcological dispensaries and hospitals (or, less often, narcological departments in psychiatric institutions), render care for alcohol and drug abusers. Psychiatric (as well as narcological) hospitals have close connections with the dispensaries. Various programmes for the examination, support and treatment of trauma affected persons have been implemented. Care for children with mental disorders is divided into three departments: Public Health (outpatient, inpatient and day care), Education (services for mentally challenged and delinquent children) and Social Protection (about 30 000 children with severe disability including mental retardation have been provided residential facilities, vocational training is also available). Psychologists are being increasingly used in school based care. Offenders suffering from mental illness are either subjected to compulsory outpatient care in dispensaries or inpatient care in either the dispensaries or specialized hospitals with high security.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

The Ministry of Health and Social Assistance approved the list of mentally ill who would receive free medication in 1993, the funds for which were to be allocated by local institutions.

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Rwanda

GENERAL INFORMATION

Rwanda is a country with an approximate area of 26 thousand sq. km. (UNO, 2001). Its population is 8.481 million, and the sex ratio (men per hundred women) is 91 (UNO, 2004). The proportion of population under the age of 15 years is 45% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 75.3% for men and 63.4% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.5%. The per capita total expenditure on health is 44 international \$, and the per capita government expenditure on health is 24 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Kinyarwanda, French, English and Swahili. The largest religious group(s) is (are) Roman Catholic, and the other religious group(s) are (is) Protestant and Muslim.

The life expectancy at birth is 41.9 years for males and 46.8 years for females (WHO, 2004). The healthy life expectancy at birth is 36 years for males and 40 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Rwanda in internationally accessible literature. Bolton et al (2002) estimated the prevalence of major depressive disorder among Rwandans 5 years after a civil war. They interviewed a random sample of 368 adults living in a rural community with the Hopkins Symptom Checklist and a locally developed functional impairment instrument. Using DSM-IV criteria they found that 15.5% met Criteria A, C, and E for current major depression. Depressive symptoms were strongly associated with functional impairment in most major roles for men and women. The authors conclude that a significant part of this population has seriously disabling depression. Keogh et al (1994) interviewed a group of 55 HIV infected women in 1988 and again in 1991 and found some differences in needs for services and noticed an increased acceptance by families of the status of the patient.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1995. The components of the policy are advocacy, promotion, prevention and treatment.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1995.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1995.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2000.

Mental Health Legislation The draft of the mental health legislation is being prepared with WHO's support. Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are budget allocations for mental health.

The country spends 1% of the total health budget on mental health.

The primary sources of mental health financing in descending order are private insurances, social insurance, out of pocket expenditure by the patient or family and tax based.

The country does not have disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. At the primary care level, the patients are diagnosed, referred and followed up.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 60 personnel were provided training.

There are community care facilities for patients with mental disorders. Motivating staff to work in the community and reinforcing pro-community behaviour continues to be somewhat difficult.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.2
Psychiatric beds in mental hospitals per 10 000 population	0.2
Psychiatric beds in general hospitals per 10 000 population	0
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.03
Number of neurosurgeons per 100 000 population	0.02
Number of psychiatric nurses per 100 000 population	0.8
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0.3
Number of social workers per 100 000 population	0

There are 200 other mental health personnel.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation.

Information Gathering System There is no mental health reporting system in the country.

The country has data collection system or epidemiological study on mental health. The district hospitals send quarterly reports to the central level.

Programmes for Special Population There are no special services available.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, sodium valproate, amitriptyline, chlorpromazine, diazepam, haloperidol, biperiden.

Other Information Rwanda's mental health delivery system is a tiered set-up. At the bottom are the community workers and health centres, followed by the district hospitals with capabilities to manage mental disorders. The third tier is formed by different speciality hospitals like the Ndera which is the main neuropsychiatric set-up.

Additional Sources of Information

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