Section II

WHO Member States
Afghanistan

GENERAL INFORMATION
Afghanistan is a country with an approximate area of 652 thousand sq. km. (UNO, 2001). Its population is 24.926 million, and the sex ratio (men per hundred women) is 107 (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 5% (WHO, 2004). The literacy rate is 47% for men and 15% 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 34 international $, and the per capita government expenditure on health is 18 international $ (WHO, 2004).

The main language(s) used in the country is (are) Pashtu, Dari Persian and Turkic. The largest ethnic group(s) is (are) Pashtun (nearly half), and the other ethnic group(s) are (is) Tajik, Hazara and Uzbek. The largest religious group(s) is (are) Sunni Muslim (five sixths). The life expectancy at birth is 41.9 years for males and 43.4 years for females (WHO, 2004). The healthy life expectancy at birth is 35 years for males and 36 years for females (WHO, 2004).

EPIDEMIOLOGY
Some studies on refugees are available. Mukhamadiev (2003) studied the prevalence of depression in 908 Tadjik refugee women in Afghanistan and found a high prevalence of endogenous depression (28.6%). A 1.5 year follow-up showed good prognosis in subjects who had subsyndromal depression, but not in those with endogenous depression. Rasekh et al (1999) found that symptoms that met the diagnostic criteria for anxiety, depression and PTSD were common in 160 Afghan women (including 80 women currently living in Kabul and 80 Afghan women who had recently migrated to Pakistan) during the Taliban regime. Mghir et al (1995) used the Structured Clinical Interview for DSM-III-R to detect mental illness among 38 children and young adults and identified depression and PTSD in more than one-third of the subjects.

MENTAL HEALTH RESOURCES

Mental Health Policy
A mental health policy is present. The policy was initially formulated in 1986.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The new Afghan Government has identified mental health as one of five health priorities. Since 1986, there has been no new Government policy regarding mental health and the old mental health policy is still followed. The policy outlines prevention, treatment and rehabilitative facilities for mentally ill patients.

Substance Abuse Policy
A substance abuse policy is present. The policy was initially formulated in 1988. A new policy on Drug Demand Reduction was formulated in 2002.

National Mental Health Programme
A national mental health programme is present. The programme was formulated in 1988.

The national mental health programme has the following objectives: provision of mental health care to all, integration of mental health with primary care and community care, services for special population, especially the war-affected. It also outlines services, training, administrative strategies and approaches for promotion of mental health and provision of services for the war-affected. It advocates the development of a nucleus of trained mental health professionals to act as ‘master trainers’ for primary health care physicians and health workers in their respective provinces in order to ensure at least a minimum provision of mental health services.

National Therapeutic Drug Policy/Essential List of Drugs
A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1996.

Mental Health Legislation
There is a mental health legislation.

The latest legislation was enacted in 1997.

Mental Health Financing
There are budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary source of mental health financing is out of pocket expenditure by the patient or family.

The country has disability benefits for persons with mental disorders. Disability support services are provided for persons with physical, psychiatric, intellectual, sensory or age-related disabilities (or a combination of these) which are likely to continue for a minimum of six months and reduces independent functioning to the extent that ongoing support is required.

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. Community level workers from the local population (villages) have been involved in providing integrated health care for the last 8 years.

Regular training of primary care professionals is not carried out in the field of mental health. Two mental health manuals were prepared in Dari for primary health care doctors and other staff in 1998. WHO has organized mental health training for primary health care physicians. NGOs are running training courses for primary health care doctors, nurses and midwives, village health volunteers and traditional birth attendants.
There are community care facilities for patients with mental disorders. Mental Health is included in Basic Package for Health Services (BPHS) which covers health service delivery up to district level. New treatment guidelines for common mental health disorder are being formulated (draft is ready). Four Community Mental Health Centers have been established in the capital, but further expansion is required. There are 2 general psychiatric rehabilitation centres with 160 beds.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Category</th>
<th>Per 10,000 Population</th>
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<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>0.055</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>0.031</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.024</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>0.036</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>0.034</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>0.07</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>0.07</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0.09</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0</td>
</tr>
</tbody>
</table>

Currently, there are no social workers, and there are only very few trained psychiatrists. Most doctors working as psychiatrists have either had in-service training or have attended short courses abroad. A three month diploma course was held in 1996 to train some doctors in psychiatry. Postgraduate training in psychiatry is not present. Psychologists get their training from Kabul University. Much of qualified manpower and technical expertise has left the country.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in treatment. The Afghan Government collaborates with non-governmental organizations to rapidly expand basic (mental) health services to underserved populations.

**Information Gathering System** There is no mental health reporting system in the country. Each hospital maintains registry books on their inpatient and outpatient information. Quarterly reports are submitted by the mental hospital to the Ministry of Public Health. 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 disaster affected population. There is a regular programme for traumatized children (trauma and grief programme) which is supported by UNICEF.

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

The cost of medicines keeps fluctuating as the local currency is unstable due to the war. Over-the-counter sales of psychotropics occur.

**Other Information** There is a shortage of staff due to the war and more international support is needed. A new Mental Health Unit under Primary Care Directorate was established in 2003 (it is not functional as yet). Since mental health is a component of the Basic Package for Health Services, guidelines and treatment protocol for common mental disorders in primary health care have been developed. Treatment guidelines for substance use have also been almost finalized. A strategy for integration of mental health services into primary care was finalized in 2004.

**Additional Sources of Information**


Albania

GENERAL INFORMATION
Albania is a country with an approximate area of 29 thousand sq. km. (UNO, 2001). Its population is 3.193 million, and the sex ratio (men per hundred women) is 104 (UNO, 2004). The proportion of population under the age of 15 years is 27% (UNO, 2004), and the proportion of population above the age of 60 years is 10% (WHO, 2004). The literacy rate is 99.2% for men and 98.3% 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 3.7%. The per capita total expenditure on health is 150 international $, and the per capita government expenditure on health is 97 international $ (WHO, 2004).

The main language(s) used in the country is (are) Albanian and Greek. The largest ethnic group(s) is (are) Albanian (98.6%), and the other ethnic group(s) are (is) Greek (1.17%). The largest religious group(s) is (are) Muslim (almost 70%), and the other religious group(s) are (is) Orthodox Christian and Roman Catholic.

The life expectancy at birth is 67.3 years for males and 74.1 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 63 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Albania in internationally accessible literature. Bilanakis et al (2001) conducted a community survey using Langner and CES-D scales to identify psychiatric morbidity among 217 randomly selected subjects. The results showed that about 26.2% had some psychiatric morbidity and 18.2% had depressive features.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 2003.

The focus is given to the following priorities: fighting segregation and social exclusion in the respect of human rights; establishing a Mental Health Department within the Ministry of Health; ensuring the de-institutionalization process; establishing a non-admission policy (partial and gradual) for long term purposes; innovative and flexible use of resources; defining and instituting a separate mental health budget; integrating the mental health services with primary care; providing continuous training and extension of experiences; reviewing the legal frame; involving as many actors on both national and international level as possible; including of the Mental Health Policy into the National Health Strategy.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is present. Details about the year of formulation of the programme are not available.

The national mental health programme in Albania has been actively supported and furthered by the WHO Country Office. WHO supported the establishment by the Minister of Health of the National Steering Committee for Mental Health (NSC) and provided numerous inputs regarding mental health policy and planning. The Policy for Mental Health Services Development in Albania was finalized by the NSC and approved by the Minister of Health in March 2003, and the strategy for its implementation was drafted in September 2004 (awaiting approval). Albanian Mental Health Reform supported by the WHO Country Office in Albania has received the assistance of a wide net of Collaborative Centers and other partners (Birmingham Northern Trust, University of Central England, UK Health Department, Verona University, Asturias Mental Health Services) and also other organizations (UNOPS, Geneva Initiative on Psychiatry).

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 essential drug list is updated periodically.

Mental Health Legislation During the year 2003-2004 there were efforts, by governmental, intergovernmental and non-governmental partners to review and improve the whole legislative frame with regard to mental health. Laws on social care are also being reconsidered to provide comprehensive answers to the complex needs of the mentally ill.

The latest legislation was enacted in 1996.

Mental Health Financing There are budget allocations for mental health.

The country spends 6% of the total health budget on mental health.

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

Autonomous budget is allocated only to two psychiatric hospitals; the rest of the mental health services of the country (in- and outpatient units) receive undiscriminated budget within larger health care institutions.

The country has disability benefits for persons with mental disorders. Disability benefits are called invalidity benefits and are based on certain criteria.

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. Parallel to the elaboration and promotion of the Mental Health Policy, WHO has supported the Ministry of Health in implementing demonstration good practice mental health services in 4 areas and has promoted the implementation of similar services in 2 other areas by UNOPS/PASARP. The community centres provide multidisciplinary care, day care, rehabilitation and outreach services, including assertive outreach in a few cases. They vary in functions, roles and service provision types, depending on the specific conditions of each district. The services provided by the public system through community mental health centres include consultation and treatment, home visits, psychosocial interventions and in few cases assertive outreach. The services provided by the non-governmental non-profit sector are mainly in the form of day centres with focus on rehabilitation. In general, the community services cover urban populations, with exception of two Community Mental Health Centers that do reach rural populations as well, through linkages with respective primary care workers. The catchment areas of the Community Mental Health Centers tend to be around 100,000 inhabitants, which is in line with the proposed catchment area of the drafted Strategy for the Implementation of the Mental Health Policy.

### Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Category</th>
<th>Per 10,000 Population</th>
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</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>2.5</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.5</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists per 100,000 population</td>
<td>2.2</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100,000population</td>
<td>4.2</td>
</tr>
<tr>
<td>Number of neurologists per 100,000 population</td>
<td>1</td>
</tr>
<tr>
<td>Number of psychologists per 100,000 population</td>
<td>0.2</td>
</tr>
<tr>
<td>Number of social workers per 100,000 population</td>
<td>0.4</td>
</tr>
</tbody>
</table>

There are 96 neuropsychiatrists and psychiatrists, with the latter forming 54% of the total. The resources for health care in Albania are low compared to other European countries. The uneven resource distribution leaves entire remote areas out of real health care coverage. The staff consists of only psychiatrists and nurses. There is no special training for nurses working in mental health. There are few outpatient units. The first psychologists to graduate out of the university were in 2000. The involvement of psychologists and social workers in the official mental health structures has started. A curriculum for a 4-year residency training in child and adolescent psychiatry has recently been approved.

**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 no mental health reporting system in the country. The Information gathering system in the country in general is composed of fragmented data blocks reported independently on a vertical line from field services to central institutions. The main institutions that collect data about health care are Ministry of Health and INSTAT. Hospital data are reported as well as primary care data, but they are not aggregated into a unique mental health database either at the Ministry of Health or at INSTAT. The country has no data collection system or epidemiological study on mental health. Albania was one of the countries selected for WHO’s Mental Health System and Service Monitoring exercise, which involved systematic assessment of over 300 indicators related to 10 key components of mental health systems.

**Programmes for Special Population** The country has specific programmes for mental health for refugees and children. Programmes for special populations are mainly provided by NGOs.

**Therapeutic Drugs** The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, sodium valproate, amitriptyline, chlorpromazine, fluphenazine, haloperidol, lithium. Other drugs are included in the essential drug list include clozapine, risperidone, clozapine and fluoxetine.

**Other Information**

**Additional Sources of Information**


Ministry of Health (2003) Policy for Mental Health Services Development in Albania (supported by WHO).


Algeria

GENERAL INFORMATION

Algeria is a country with an approximate area of 2382 thousand sq. km. (UNO, 2001). Its population is 32.339 million, and the sex ratio (men per hundred women) is 102 (UNO, 2004). The proportion of population under the age of 15 years is 32% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 78% for men and 59.6% 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 4.1%. The per capita total expenditure on health is 169 international $, and the per capita government expenditure on health is 127 international $ (WHO, 2004).

The main language(s) used in the country is (are) Arabic and French. The largest ethnic group(s) is (are) Arab. The largest religious group(s) is (are) Muslim.

The life expectancy at birth is 67.5 years for males and 71.2 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY

An epidemiological study done by the Ministry of Health (2004) showed that chronic mental disorders were diagnosed in 0.7% to 1.9% of subjects of different age groups and epilepsy in 0.2% to 0.8% of subjects in different age groups. Chronic mental disorders and epilepsy were more common in those below 40 years of age and in women. There was no rural-urban difference in prevalence of these conditions. The prevalence of posttraumatic stress disorder (PTSD) assessed using the PTSD module of the Composite International Diagnostic Interview Version 2.1 was found to be 37.4% in a community survey conducted on a sample of 653 subjects (de Jong et al, 2001). Conflict-related trauma after age 12 years, torture, poor quality of camp and daily hassles were associated with the occurrence of PTSD. Brunetti et al (1982) compared depression between French (n=125) and Algerian (n=45) women. The one-year prevalence of depressive syndrome (structurally similar in both cultures) for the two samples combined (n=170) was 15% for the mildly impaired and 3% for the more markedly impaired, but the severity of depression was greater in Algerian women. Touari et al (1993) reviewed 3984 clinical interviews of criminals over a period of 23 years. In case histories concerning 1007 criminals, who had committed or attempted homicide, psychosis was identified in 19.9%. Psychotic subjects were older, more likely to have a previous psychiatric history, less likely to come from very large families and less likely to have been raised by both parents. A prevalence survey on psychotrauma on 12 000 school children between the ages of 12 to 18 years conducted in 10 regions showed that 9.2% to 29.2% of children in different regions had mental health problems related to trauma (MoH, 2002).

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 promotion, prevention, treatment and rehabilitation. The components of the current mental health policy were defined more clearly in the 4 axes of the national mental health programme established since 10 October 2001.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1990. A National Bureau for Fighting against Substance Abuse has been set up since 2003.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2001. The national mental health programme prioritizes decentralization, primary health care, community approach, availability of psychotropics, adaptation of the mental health legislation, prevention of mental and neurological disorders, psychosocial rehabilitation of people with psychological problems related to violence, education of the public, formation of community and family associations, human resource development, and mental health research.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1997. A national list (nomenclature) exists, in which psychotropic drugs are included and are defined based on their medical use. Also, a ministerial circulation letter in 1997 defines the drugs to be distributed at no cost for mentally ill whose care is prioritized in the national mental health programme.

Mental Health Legislation The mental health law is included in the Law on Health Protection and Promotion of 1985. The Law no. 98.09 is the most recent legislation related to mental health. Presently, the mental health legislation is being revised. The latest legislation was enacted in 1998.

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. The mentally ill are assessed for disability and benefits are provided accordingly.
**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. There is availability of treatment in primary health care following the integration of mental health care within primary health care as a part of the national mental health programme. There is an organization of intermediary mental health centres in the structures of primary health care.

Regular training of primary care professionals is carried out in the field of mental health. Training in mental health is provided to doctors and nurses and to the psychologists who provide primary health care.

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

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Description</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>1.4</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>0.86</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.2</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0.36</td>
</tr>
<tr>
<td>Number of psychiatrists per 100,000</td>
<td>1.1</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100,000</td>
<td>0.32</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100,000</td>
<td>1.1</td>
</tr>
<tr>
<td>Number of neurologists per 100,000</td>
<td>0.42</td>
</tr>
<tr>
<td>Number of psychologists per 100,000</td>
<td>0.8</td>
</tr>
<tr>
<td>Number of social workers per 100,000</td>
<td>0</td>
</tr>
</tbody>
</table>

Some beds have been earmarked for mentally challenged individuals and for children.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in promotion. The APAMM (Association des parents et amis des malades mentaux – Association of parents and friends of the mentally ill) and the AAMMB (Association d’aide aux malades mentaux de Blida – Relief Association for the mentally ill of Blida) help in the care of the mentally ill. Other associations work in the area of research, such as the Algerian Society of Psychiatry, the Algerian Society for Research in Psychology, the Algerian Society of Psychiatric Epidemiology etc.

**Information Gathering System** There is mental health reporting system in the country. Presently, several epidemiology studies on different topics related to mental health, such as the psychological consequences of violence, are under development. Furthermore, the Algerian Society of Psychiatric Epidemiology works in the area of epidemiology.

The country has no data collection system or epidemiological study on mental health. There are no national level epidemiological studies, but psychiatric institutions have their own epidemiological data collected through local surveys.

A system exists on mental health data collection since 2002 on various activities such as: care of the victims of violence, mental health activities (till mental health intermediary centre level), hospitalization, distribution of drugs, establishments meant to provide intersectoral care to mentally ill persons with social problems.

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

An information service which deals with psychiatric emergencies has been operating since September 1997.

**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, carbidopa, levodopa.

**Other Information**

**Additional Sources of Information**


Andorra

GENERAL INFORMATION
Andorra is a country with an approximate area of 0.45 thousand sq. km. (UNO, 2001). Its population is 0.067 million, and the sex ratio (men per hundred women) is 108 (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 22% (WHO, 2004).
The country is a high 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 1821 international $, and the per capita government expenditure on health is 1292 international $ (WHO, 2004).
The main language(s) used in the country is (are) Catalán (official) and Spanish. The largest ethnic group(s) is (are) Spanish and Andorran, and the other ethnic group(s) are (is) Portuguese, French and others (70% of the population has a migratory background). The largest religious group(s) is (are) Roman Catholic.
The life expectancy at birth is 76.8 years for males and 83.7 years for females (WHO, 2004).

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

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent. A substance abuse policy is under the active consideration of the Parliament.

National Mental Health Programme A national mental health programme is absent. So far, Andorra does not have a national mental health plan. However, in 1996, a document from the Regional Office for Europe of WHO described the relevant needs, services and organizational strategies.

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

Mental Health Legislation There is a Law on Guarantee of Rights of People with Discapacity. 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 3.9% of the total health budget on mental health. The primary sources of mental health financing in descending order are social insurance, private insurances, out of pocket expenditure by the patient or family and tax based. The primary care and social services budget are not included in the total health budget. Most doctors in the country have an agreement with the Government such that the patient pays 25% of the cost of consultation and the rest is covered by the national insurance system. If hospitalization is required, the patient pays only 10%. 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. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 42 personnel were provided training.
There are community care facilities for patients with mental disorders. The Mental Health Services that have been developed since 1998 are based on the general principles of ‘community psychiatry’. The services, including child psychiatry and geriatric psychiatry, are available to everyone covered by the National Insurance System (the great majority of the population). These services are concentrated in the general hospital, which is located in an area of the main urban zone of the country and has good communications. The Mental Health Centre offers an outpatient unit with psychiatric and psychological services together with a day care centre where psycho-social rehabilitation programmes are offered to patients with chronic severe mental disorders. There is a Day-Hospital for less chronic or severe patients. Two apartments with support have been opened in 2004.
**Psychiatric Beds and Professionals**

- Total psychiatric beds per 10 000 population: 1.6
- Psychiatric beds in mental hospitals per 10 000 population: 0
- Psychiatric beds in general hospitals per 10 000 population: 1.6
- Psychiatric beds in other settings per 10 000 population: 0
- Number of psychiatrists per 100 000 population: 10
- Number of neurosurgeons per 100 000 population: 0
- Number of psychiatric nurses per 100 000 population: 9
- Number of neurologists per 100 000 population: 3
- Number of psychologists per 100 000 population: 30
- Number of social workers per 100 000 population: 26

There are two occupational therapists and one music therapist. The process of deinstitutionalization has not been necessary in Andorra, since there were no psychiatric institutions till the present time. Several Andorran patients are still resident in private psychiatric institutions, either in France or Spain, as this had been the method of management for chronic psychotic disorders in the past. The mental health team co-operates at different levels with other sectors of health care. It has regular meetings with the Association of General Practitioners, the Social Work Services and the Nursing Centres Network.

**Non-Governmental Organizations**

NGOs are involved with mental health in the country. They are mainly involved in advocacy and rehabilitation. An association of families of mental patients has been formed.

**Information Gathering System**

There is a mental health reporting system in the country. The country has a data collection system or epidemiological study on mental health. The information gathering system has been implemented only recently.

There have not been any specific epidemiological studies on mental health, but a National Inquiry on Health has been done.

**Programmes for Special Population**

The country has specific programmes for mental health for elderly and children. An Addictive Behavior Unit has opened and specific programmes also exist for eating disorders.

**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**

The three greatest matters of concern are: developing the structures and programmes which are still lacking, e.g. a long-stay centre for highly dependent chronic patients; promoting a sensitivity towards cultural and social factors which are liable to affect the mental health of the population among mental health professionals and health professionals in general; and developing a mental health legislation.

**Additional Sources of Information**
Angola

GENERAL INFORMATION
Angola is a country with an approximate area of 1247 thousand sq. km. (UNO, 2001). Its population is 14.078 million, and the sex ratio (men per hundred women) is 97 (UNO, 2004). The proportion of population under the age of 15 years is 48% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 57% for men and 29% 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 70 international $, and the per capita government expenditure on health is 44 international $ (WHO, 2004).

The main language(s) used in the country is (are) Portuguese, Bantu, Ovimbundu, Kimbundu and Kikongo. The largest ethnic group(s) is (are) Ovimbundu, and the other ethnic group(s) are (is) Mbutu, Bakongo, Fiote, Nganguela, Kuanhama and Tchokwe. The largest religious group(s) is (are) Christian (two-thirds of the population).

The life expectancy at birth is 37.9 years for males and 42 years for females (WHO, 2004). The healthy life expectancy at birth is 32 years for males and 35 years for females (WHO, 2004).

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

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 1989.

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

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 Details about 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 source of mental health financing is out of pocket expenditure by the patient or family. The country has 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. There is no facility in the primary level due to the lack of a mental health policy. 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. This inadequacy of community facility is due to lack of training of personnel.

Psychiatric Beds and Professionals

| Total psychiatric beds per 10 000 population | 0.13 |
| Psychiatric beds in mental hospitals per 10 000 population | 0.07 |
| Psychiatric beds in general hospitals per 10 000 population | 0.06 |
| Psychiatric beds in other settings per 10 000 population |  |
| Number of psychiatrists per 100 000 population | 0 |
| Number of neurosurgeons per 100 000 population | 0.032 |
| Number of psychiatric nurses per 100 000 population | 0 |
| Number of neurologists per 100 000 population | 0.032 |
| Number of psychologists per 100 000 population | 0 |
| Number of social workers per 100 000 population | 0 |

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy 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. Data from the psychiatric hospital in Luanda is collected.

Programmes for Special Population The country has specific programmes for mental health for disaster affected population and children. There are some NGOs who work for people displaced by war, street children and victims of 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, haloperidol, lithium. Prices keep on fluctuating depending on the availability of drugs.

Other Information

Additional Sources of Information

Antigua and Barbuda

GENERAL INFORMATION
Antigua and Barbuda is a country with an approximate area of 0.44 thousand sq. km. (UNO, 2001). Its population is 0.077 million, and the sex ratio (men per hundred women) is 92 (UNO, 2004). The proportion of population under the age of 15 years is 28% (UNO, 2004), and the proportion of population above the age of 60 years is 10% (WHO, 2004). The literacy rate is 90% for men and 88% 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 5.6%. The per capita total expenditure on health is 614 international $, and the per capita government expenditure on health is 374 international $ (WHO, 2004).

The main language(s) used in the country is (are) English. The largest ethnic group(s) is (are) African, and the other ethnic group(s) are (is) British, Portuguese, Lebanese and Syrian. The largest religious group(s) is (are) Anglican, and the other religious group(s) are (is) Roman Catholic.

The life expectancy at birth is 69 years for males and 73.9 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 Antigua and Barbuda 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 present. The programme was formulated in 1978.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2003.

Mental Health Legislation The latest legislation was enacted in 1951.

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 tax based and social insurance. 
The Medical Benefit Scheme for chronic mental illness is the source of financing for medication. 
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. Treatment is administered by the 6 mental health clinics in the country. 
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 care is also administered from the 6 clinics.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 17.9
Psychiatric beds in mental hospitals per 10 000 population 17
Psychiatric beds in general hospitals per 10 000 population 0.7
Psychiatric beds in other settings per 10 000 population 0.2
Number of psychiatrists per 100 000 population 2
Number of neurosurgeons per 100 000 population 0
Number of psychiatric nurses per 100 000 population 4.5
Number of neurologists per 100 000 population 0
Number of psychologists per 100 000 population 3
Number of social workers per 100 000 population

There are 5 social workers, but none work in mental health. Antigua and Barbuda provided long-term care services for Leeward Island for a long time in exchange for a nominal fee. There is an old style mental hospital with psychiatric care at the general hospital.

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 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 The country has specific programmes for mental health for children. The child and family guidance centre at the general hospital is run by an NGO (Collaborative Committee for the Promotion of Emotional Health in Children).

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. Benztropine is available.

Other Information

Additional Sources of Information
Argentina

GENERAL INFORMATION

Argentina is a country with an approximate area of 2780 thousand sq. km. (UNO, 2001). Its population is 38.871 million, and the sex ratio (men per hundred women) is 96 (UNO, 2004). The proportion of population under the age of 15 years is 27% (UNO, 2004), and the proportion of population above the age of 60 years is 14% (WHO, 2004). The literacy rate is 97% for men and 97% 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 9.5%. The per capita total expenditure on health is 1130 international $, and the per capita government expenditure on health is 604 international $ (WHO, 2004).

The main language(s) used in the country is (are) Spanish. The largest ethnic group(s) is (are) European. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 70.8 years for males and 78.1 years for females (WHO, 2004). The healthy life expectancy at birth is 62 years for males and 68 years for females (WHO, 2004).

EPIDEMIOLOGY

Di Marco (1982) carried out a representative general population survey (n=3411) in the Greater Buenos Aires area using the Present State Examination (PSE) and found a prevalence of mental disorders to be 26% (30.8% in females and 20.3% in males). About 13% of the population had neurotic disorders, especially of depressive type, 6% had affective psychosis, 4% schizophrenic psychosis and 1.3% paranoid states. The prevalence rate of psychiatric disorder was associated with gender and socioeconomic level. The National Study on Consumption of Addictive Substances showed that almost 91.4% of the adult population reported a lifetime use of alcohol and 66.2% reported using it in the last thirty days. Almost 6.6% of the subjects (11.9% men and 1.6% women), mostly young people from low socioeconomic background had consumed alcohol in large amounts in the previous month (>70 grams/day) and 4.3% (6.7% men and 1.7% women) were dependent on it. The prevalence of lifetime use of any illegal substance, was 10.09% (SEDRONAR, 1999). However, alcohol consumption represented the main cause for diagnosis of mental disorders (Ministry of Health, 2004a). In a household survey in a middle- and lower-class section of Greater Buenos Aires, Tarnopolisky et al (1975) reported that disorders related to alcohol use were present in one-sixth of adults. They were present almost exclusively among males and were more prevalent among those with lower levels of education, occupation and residential status and among migrants.

A survey of three Buenos Aires hospitals revealed that 5% of all the cases attended during a single week were related to the consumption of alcohol and drugs. Lack of formal education, unemployment and marital separation were associated with substance abuse by males (especially in the case of alcohol abuse among older men and the abuse of psychoactive and illegal drugs among the young), while women tended to take overdoses of psychoactive drugs in times of personal crisis (Miguez & Grimson, 1989). In a study conducted on more than 1200 school going adolescents of both sexes and 51 male adolescents in a drug treatment programme, Moss et al (1998) found that older age, deviant behaviour, deviant peer behaviour, school related problems and familial drug abuse were associated with drug abuse in study subjects. Alvarez (1996) showed a strong association between drug use and drug consumption by friends or sibs and consumption of tobacco or alcohol. Serfaty et al (1991) found severe depression in 4.5% of the sample of adolescents (n=553) who had applied for military service. Sadness in childhood, drug abuse by sibs, family conflict and suicidal ideations were associated with the occurrence of depression. Chemerinski et al (1998) assessed a consecutive series of 398 patients with probable Alzheimer’s Disease (AD) for the presence of generalized anxiety disorder (GAD) using a standardized neuropsychiatric evaluation. 5% of patients showed GAD during the 4 weeks preceding the psychiatric evaluation. Vasquez et al (2000) studied 149 hospital patients for delirium and found that 20.5% suffered from delirium with severity of illness, chronicity and fever being the main factors associated with it. Official mortality statistics showed that crude rate of suicides increased from 6.3 per 100 000 in 1997 to 8.4 per 100 000 in 2002. Suicides were more common in those in the age range of 15 to 24 years and to a smaller degree in the age range of 50 to 54 and 65 to 69 years (Ministry of Health, 2004b). Rizzi et al (1998) reviewed reports of autopsies of all violent deaths in women aged 12-44 years over a 5-year period (n=272) and found that suicide accounted for 17.6% of all violent deaths.

MENTAL HEALTH RESOURCES

Mental Health Policy

A mental health policy is present. The policy was initially formulated in 1957. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. It was revised in 2001 through a process that involved multiple stakeholders (politicians, mental health professionals, NGOs and public servants). Regular funds for its implementation were allocated.

Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1987. The substance abuse policies are established by the National Secretariat of Prevention and Action against Narcotraffic that reports to the President. It has a specific budget for its implementation and is supported by a legislation on substance abuse that was formulated in 1990.

National Mental Health Programme

A national mental health programme is present. The programme was formulated in 1998. Its main focus is on strategy for services reform, promotion and prevention, integration of mental health services with primary care and consolidation of specialized services. As Argentina is a federal country, different regional mental health programmes are currently in place in different provinces. Consultations for updating the national mental health programme have been initiated in 2004.
**National Therapeutic Drug Policy/Essential List of Drugs** A national therapeutic drug policy/essential list of drugs is absent.

**Mental Health Legislation** The most recent legislation in this area is one on mental health in primary care. It also covers promotion/prevention, users’ rights and advocacy and it conforms to International Human Rights Laws. However, it does not contain regulations on involuntary treatment, mental health services, admission and discharge procedures and housing/employment facilities for the patients. A specific budget has not been assigned to it. Data on percentage of involuntary admissions is not available. The National Law regarding admissions (Law 229/4) was passed in 1982. The latest legislation was enacted in 2001.

**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, social insurance, private insurances and out of pocket expenditure by the patient or family. At national level, the budget for a health area (e.g. mental health) depends on the ministerial office to which it belongs. Various regions make their own budget allocations for mental health; for example Buenos Aires assigns 2% of health budget to mental health. At the national level, approximately 10% of mental health expenses are allocated to public psychiatric hospitals. Data regarding other expenses such as public and private general hospitals, ambulatory clinics, community care, etc. are not available. 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. Facilities are not uniform across the country (less than 25% of the population is covered by mental health services through primary care. Usually patients reach the specialist system directly or through referral from other sources. 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. Facilities are not uniform across the country. A budget for community services is available in some provinces.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>6</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
<td>5.4</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals per 10 000 population</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10 000 population</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000 population</td>
<td>13.25</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 population</td>
<td>1.1</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td></td>
</tr>
<tr>
<td>Number of neurologists per 100 000 population</td>
<td>1.6</td>
</tr>
<tr>
<td>Number of psychologists per 100 000 population</td>
<td>106</td>
</tr>
<tr>
<td>Number of social workers per 100 000 population</td>
<td>11</td>
</tr>
</tbody>
</table>

The number of psychiatric nurses, occupational therapists is not known. There are 43 000 psychologists but the specific number working for mental health is not available. There are 225 facilities in Argentina with psychiatric beds. Psychiatric beds are almost equally divided between public and private psychiatric institutions. 80% of these beds are occupied by long stay patients (>1 year); 15.0% medium stay (3 months to 1 year) and 5.0% short stay (<3 months). There are no psychiatric beds in prison for offenders with mental disorders. Hospitals for forensic purposes and general hospitals receive patients sent by the judge. Private hospitals also assist forensic services if the patient can afford the expenses. Mental health professionals are concentrated in the urban centres.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. These organizations participate in mental health issues related to women, children, domestic violence and consumers. NGOs are often registered with the ministry.

**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. There are no general studies, only isolated ones like the one for Buenos Aires.

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

Some special programmes carried out in collaboration with national and international organizations. The Forensic Psychiatric System involves civil and penal areas, each with its own legislation. The Constitution of Argentina provides the ethical and juridical framework for the purpose and operation of prisons and other safety psychiatric institutes from the penitentiary services. Unimputability and the implementation of safety measures according to danger are ruled by the Penal Code from 1921 (last modified in 1997). In the civil area, the Civil Code (1997) in force at the national level looks into the issue of involuntary care. The objective of care of forensic patients is to avoid prolonged hospital stay and to integrate the patient into the community through a self-managed sys-
tem. While admitted, some forensic patients are allowed to attend day care centres for occupational therapy. After discharge from the hospital, supervision is maintained for 4 years. Though a number of programmes cover forensic psychiatry, a specific course leading to recognition as a forensic psychiatrist has not been organized.

**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, lithium.

**Other Information** Methods to assess quality of care at primary care level are unavailable, however, tools for quality assurance are available at secondary and tertiary levels.

**Additional Sources of Information**


Ministry of Health (2004a).


Armenia

GENERAL INFORMATION

Armenia is a country with an approximate area of 30 thousand sq. km. (UNO, 2001). Its population is 3.052 million, and the sex ratio (men per hundred women) is 94 (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 13% (WHO, 2004). The literacy rate is 99.7% for men and 99.2% 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 7.8%. The per capita total expenditure on health is 273 international $, and the per capita government expenditure on health is 112 international $ (WHO, 2004).

The main language(s) used in the country is (are) Armenian and Russian. The largest ethnic group(s) is (are) Armenian. The largest religious group(s) is (are) Armenian Apostolic Christian.

The life expectancy at birth is 67 years for males and 73 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 63 years for females (WHO, 2004).

EPIDEMIOLOGY

Recent data (2000-2002) obtained on a representative sample (n=395) by means of a specially elaborated unified questionnaire and properly adapted and standardized Symptom Checklist (SCL-90R), Beck Depression Inventory (BDI) and Hospital Anxiety and Depression Scale (HADS) suggested high levels of emotional disorders in comparison to that reported in Western Europe and Russia. Anxiety and depression were significantly higher in those areas reporting an inability to access medical aid due to financial reasons. Surprisingly, no substantial differences were seen in the level of anxiety and depression as well as on the majority of SCL-90R scores between respondents from disaster and non-disaster areas (Khachaturyan, 2002; Khachaturyan & Nersesyan, 2004). Armenian et al (2000) interviewed 1785 adult victims, identified through stratified population sampling 2 years after the 1988 earthquake, with the National Institute of Mental Health (NIMH) Disaster Interview Schedule/Disaster Supplement. A comparison of pure PTSD (without comorbidity, n=154 cases) and controls (without psychiatric diagnoses, n=583) showed that PTSD was positively associated with geographic location (level of destruction) and loss to the family, and negatively associated with level of education, being accompanied at the moment of the earthquake and making new friends after the earthquake. Armenian et al (2002) also reported a rate of 52% for depression. A comparison of cases of pure depression (no comorbidity) with controls revealed that depression was positively associated with female gender, geographic location (level of destruction) and loss to the family, and negatively associated with receiving disaster related assistance and social support after the earthquake and alcohol use. Goenjian et al (1994a) evaluated 179 adults 1 1/2 years after the 1988 earthquake with the Posttraumatic Stress Disorder (PTSD) Reaction Index. PTSD reaction index score was associated with nearness to the epicentre (higher exposure) and loss of family members. Although there was no difference in total mean score on the PTSD Reaction Index, the elderly had higher scores on arousal symptoms and lower scores on intrusive symptoms in comparison to young adults. In another study, Goenjian et al (1994b) assessed 202 adults exposed in 1988 to political violence in Azerbaijan and/or the earthquake in Armenia. High rates of severe posttraumatic stress reactions were found among the most highly exposed individuals, irrespective of the type of trauma. The same group of workers (Goenjian et al, 2000) evaluated 78 non-treatment-seeking subjects with self-report instruments approximately 1.5 and 4.5 years after the 1988 earthquake in Armenia and the 1988 pogroms against Armenians in Azerbaijan. No significant differences in PTSD severity, profile or course were seen between the two groups. Those exposed to severe trauma (earthquake or violence) had high initial and follow-up PTSD scores that did not remit over the 3-year interval, though the depressive symptoms subsided. Posttraumatic stress, anxiety and depressive reactions were highly correlated and each with the extent of loss of family members. Goenjian (1993) found high rates of psychiatric morbidity (post-traumatic stress disorder: 74%, major depressive disorder: 22%) in a sample of 582 school children. In a sample of 231 children, Pynoos et al (1993) found that the Children's Post-traumatic Stress Disorder Reaction Index (CPTSD-RI) score strongly correlated with a clinical diagnosis of PTSD and that there was a strong positive correlation between the epicentre and overall severity of post-traumatic stress reaction. Analyses controlling for exposure revealed that girls reported more persistent fears than boys. Goenjian et al (1995) evaluated 218 school-age children using the Child Posttraumatic Stress Disorder Reaction Index, the Depression Self-Rating Scale and the section on separation anxiety disorder from the Diagnostic Interview for Children and Adolescents. They found high rates of current PTSD, depressive disorder (and the co-occurrence of PTSD and depression) among victims residing in the two heavily impacted cities. Separation anxiety disorder was comparatively less frequent. Severity of post-traumatic stress and depressive reactions were highly correlated and each with the extent of loss of family members. Najarian (1996) found that two groups of children with high exposure to the earthquake (those remaining in the earthquake city and those relocated to another place) demonstrated significantly higher rates of PTSD, depression and behavioural difficulties in comparison to a control group. There were no differences between the relocated children and those who remained in the earthquake zone. An article comparing suicide patterns across different countries that were a part of the erstwhile USSR reports that during 1984-1990 the rate of suicide was 3.5 cases per 100 000 inhabitants in the Caucasus (Georgia, Azerbaijan and Armenia) (Wasserman et al, 1998).

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 and prevention.
ARMENIA

**Substance Abuse Policy** A substance abuse policy is present. The policy was initially formulated in 1992.

**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. Details about the year of formulation are not available.

**Mental Health Legislation** The law regulates the rights of mentally disturbed individuals (excluding any discrimination for psychiatric patients), provision of professional medical aid and social insurance, as well as issues of compulsory and non-compulsory treatment. The latest legislation was enacted in 2004.

**Mental Health Financing** There are budget allocations for mental health. The country spends 4.5% of the total health budget on mental health. The primary source of mental health financing is tax based. The treatment of psychiatric patients is financed by the state. However, in the situation of slender budgets for public health care, the funding of the psychiatric service is obviously inadequate. The country has disability benefits for persons with mental disorders. Chronically mentally ill patients receive monthly payments.

**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 of severe mental disorders is carried out by specialized centres and psychiatric dispensaries (specialized outpatient departments). Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 175 personnel were provided training. Treatment of patients is organized in close cooperation with the local primary care service. Regulations for continuous training of family doctors in the field of mental health are in the stage of development. Since 1999, mental health issues are considered in postgraduate training and respecialization (concerning experienced general practice physicians) programmes for family doctors. Special emphasis is placed on identification and management of neurotic and somatoform disorders, affective (especially mild and masked depressive) disorders, drug use disorders, behavioural syndromes connected with physiological disturbances and other physical factors, personality disorders and developmental disorders. Approximately 250 family doctors have been trained in the field of mental health since 1999. There are community care facilities for patients with mental disorders. Each community and locality has its mental health providers.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Category</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>4.8</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>4.78</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.02</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists per 100,000 population</td>
<td>4</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100,000 population</td>
<td>1.2</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100,000 population</td>
<td>0</td>
</tr>
<tr>
<td>Number of neurologists per 100,000 population</td>
<td>9.8</td>
</tr>
<tr>
<td>Number of psychologists per 100,000 population</td>
<td>0.4</td>
</tr>
<tr>
<td>Number of social workers per 100,000 population</td>
<td>0.08</td>
</tr>
</tbody>
</table>

Psychiatric provision in Armenia is carried out by two kinds of medical service: outpatient and inpatient. It is represented through the network of dispensaries, hospitals and health centres within the various communities. In recent years, the policy of reducing hospital beds has been implemented and new day hospitals have been opened; the development of night hostels is proposed. The psychiatric hospitals have been broken up into smaller units; whereas they formerly had 500-1000 beds, at present the greatest number of beds in any one is 400.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in advocacy and promotion. In 1999, with the assistance of the international organization Médecins Sans Frontières, it became possible to open a rehabilitation workshop at one of the biggest psychiatric hospitals.

**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 refugees, disaster affected population and children.

In 2000, the Association of Child Psychiatrists and Psychologists (ACPP) and the Geneva Initiative on Psychiatry (GIP) successfully implemented a project entitled ‘Public Education and Training of Professionals Working with Children in Primary Health Care
System of Armenia.’ One of the outcomes of this project was the creation of the Child and Adolescent Mental Health Care Project (CAMHCP). This programme attempts to respond to the mental health needs of children and adolescents in Armenia by a quick response to requests and referrals, involving parents and teachers in the early detection of behavioural problems in a multidisciplinary, supportive and therapeutic environment.

**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, levodopa.

**Other Information**

**Additional Sources of Information**


Australia

GENERAL INFORMATION
Australia is a country with an approximate area of 7741 thousand sq. km. (UNO, 2001). Its population is 19.913 million, and the sex ratio (men per hundred women) is 99 (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 17% (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 9.2%. The per capita total expenditure on health is 2532 international $, and the per capita government expenditure on health is 1718 international $ (WHO, 2004).

The main language(s) used in the country is (are) English. The largest ethnic group(s) is (are) Caucasian, and the other ethnic group(s) are (is) Asian and indigenous groups. The largest religious group(s) is (are) Anglican, and the other religious group(s) are (is) Roman Catholic.

The life expectancy at birth is 77.9 years for males and 83 years for females (WHO, 2004). The healthy life expectancy at birth is 71 years for males and 74 years for females (WHO, 2004).

EPIDEMIOLOGY
There is substantial epidemiological data on mental illnesses in Australia 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 1992. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The national mental health policy together with the Statement of Rights and Responsibilities and the three consecutive National Mental Health Plans is a foundation document of the National Mental Health Strategy, the umbrella for mental health reform in Australia. The aims of the policy are to: promote the mental health of the Australian community and, where possible, prevent the development of mental health problems; reduce the impact of mental disorders on individuals, families and the community; and assure the rights of people with mental disorders. The national mental health policy discusses twelve key policy areas including: consumer rights; promotion and prevention; service mix; mainstreaming of mental health services; mental health workforce; legislation; research and evaluation; and monitoring and accountability. The Policy is implemented through the National Mental Health Strategy and the 5-year National Mental Health Plans (1992-1997; 1998-2003; 2003-2008).

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1985. The National Drug Strategy 2004-2009 provides a framework for a coordinated, integrated approach to drug issues in the Australian community. It is a national policy framework that is complemented, supported and integrated with a range of national, state, territory, governmental and non-governmental strategies, plans and initiatives. It builds upon the experience and achievements of its policy predecessor, the National Drug Strategic Framework 1998-99 to 2003-04, and is overseen and guided by key advisory and decision making bodies. Its mission is to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1992. The programme progressed through the first and second National Mental Health Plans. Under the National Mental Health Strategy, the Australian Government and all State and Territory Governments are working to achieve reform of mental health care in Australia. The private sector is also engaged in reform activity. The current National Mental Health Plan 2003-2008 has four priority themes: mental health promotion and prevention of mental illness; increasing service responsiveness; strengthening quality; and fostering research, innovation and sustainability. The Plan aims to continue the reform processes previously begun and to engage with other sectors such as housing, education, welfare, justice and employment. Under the Plan there is also an increased focus on issues of recovery and rehabilitation and the need for a broad Government and community response.

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

Mental Health Legislation Mental health legislation in Australia is the responsibility of each of the eight State and Territory Governments. In 1996, under the National Mental Health Strategy, a Rights Analysis Instrument was developed by the Federal Attorney-General’s Department for assessing compliance of state and territory legislation with national and international standards. All jurisdictions have undertaken such assessment and suitable amendments to legislation have been incorporated based on assessment findings. The assessments looked for conformity with the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care and the National Mental Health Statement of Rights and Responsibilities. 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 9.6% of the total health budget on mental health.
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.

The figure 6.4% refers to the proportion of the total health budget spent on specialized mental health services (excluding alcohol and drug services). When all health services are taken into account, an estimated 9.6% of total recurrent health expenditure is spent on mental disorders. The Federal Government share is about one-third and the remaining is provided by the State and Territory Government with some contribution from the private sector. Between 1993 and 2002, federal spending grew by 128% and state and territory funding by about 40%. In this period, the state and territory spending on community care increased by 145%; NGOs increased their share of the mental health budget from 2% to 5%. In 2000, only 20% of mental health resources were accounted for by stand-alone psychiatric institutions, down from 49% in 1993. Financing arrangements differ across states and territories. State funded specialized mental health services are largely funded through block grants. Victoria funds specialized mental health services on the basis of unit costs – number of beds available and staff employed. Some other states use a case-mix system for their acute hospitals where providers are funded according to the number and type of patients treated (the classification system used for this is the Australian National Diagnosis Related Groups). In cases where the case-mix system is restricted to acute care, community care is funded on block grants. Under the Australian system all citizens are eligible to free medical care in the public sector and the national health insurance system covers some portion of the expenses incurred under the private sector. Private mental health care is also funded by private insurance (almost one-third of the population has private health insurance) and workers’ compensation insurance. 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. Primary care is now acknowledged as part of the mental health workforce. The majority of Divisions of General Practice have developed and implemented mental health projects that focus on partnership development. In 2001-2002, the ‘Better Outcomes in Mental Health Care’ initiative was launched to advance primary mental health care. It provides incentive payments for general practitioners to provide mental health care and in particular to deliver focused psychological strategies. It supports ongoing general practitioner education and access to allied health specialists to provide non-pharmacological treatments and multi-disciplinary care. Changes were also made to the Medicare Benefits Schedule to fund psychiatrists for case conferencing with general practitioners. 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. Detailed information can be obtained from the Government website and also other published literature.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>3.9</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>1.2</td>
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<tr>
<td>Psychiatric beds in general hospitals</td>
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<tr>
<td>Psychiatric beds in other settings</td>
<td>1</td>
</tr>
<tr>
<td>Number of psychiatrists per 100,000 population</td>
<td>14</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100,000 population</td>
<td>0.6</td>
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<tr>
<td>Number of psychiatric nurses per 100,000 population</td>
<td>53</td>
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<td>Number of neurologists per 100,000 population</td>
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</tr>
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<td>Number of psychologists per 100,000 population</td>
<td>5</td>
</tr>
<tr>
<td>Number of social workers per 100,000 population</td>
<td>5</td>
</tr>
</tbody>
</table>

All state and territories have transferred the management of public mental health services to the mainstream health system. Psychiatric beds in stand alone psychiatric hospitals have been reduced. In 2002, 83% of acute psychiatric beds were in general hospitals (up from 55% in 1993). The proportion of clinical staff providing ambulatory mental health care has grown from 24% in 1993 to 40% in 2002. Australia has supply side control on the number of medical practitioners by limiting the number of places in Australian medical schools, all of which are in public universities.

**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 often funded by the Government and provide support services like a wide range of accommodation, rehabilitation, recreational and social support and advocacy programmes.

**Information Gathering System** There is mental health reporting system in the country. The information collected through the annual National Mental Health Survey of mental health services is collated and analysed nationally and reported through the National Mental Health Report. There is a mental health information development strategy developed under the Second National Mental Health Plan. Priorities include the development of a mental health information infrastructure and implementation of nationally agreed clinical mental health outcome measures. Information development priorities are being updated under the National Mental Health Plan 2003-2008. The country has data collection system or epidemiological study on mental health. The data collection systems covers all public specialist mental health services. A national epidemiological study on the mental health of the Australian population was conducted in 1996. Populations included in the study were adults aged between 18 and 24 years, children and adolescents and people living with a psychotic illness. Results are available in a number of reports on the National Survey of Mental Health and Wellbeing.
Australia has a mental health reporting system. National information on mental health in Australia is published annually in the National Mental Health Report.

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

A Community Awareness Programme was launched in the mid 1990s aimed at destigmatizing mental illness. School, community and media based activities are also under way. ‘MindMatters’ resources containing material related to mental health promotion and prevention and early intervention have been provided to all secondary schools in Australia and 73% have participated in professional development. Similarly ‘Mindmatters Plus’ and ‘Families Matter’ have been launched to assist children with high support needs and families. A National Action Plan for Depression was released in November 2000. An innovative alliance, ‘Beyondblue: the national depression initiative’ was formed between a number of sectors to progress the activities of the Action Plan. Telepsychiatry is now considered an important component of mental health service delivery to rural and remote areas. Kids Help Line, a national telephone counselling service, has introduced internet and web-based counselling for children. Special programmes are being developed for specific population groups including Aboriginal people and Torres Strait Islanders. However, there is still a shortage of indigenous health workers and an ongoing need to improve the links between indigenous specific services and mainstream services. The report ‘Towards a National Approach to Forensic Mental Health’ was released in 2000 as a guide for discussion and planning of good practice. The forensic mental health services are the responsibility of the states and territories with the Federal Government advocating strategies and standards. Key issues include – availability of appropriately secure forensic hospitals; shifting care out from institutions to the community; on-site mental health liaison/assessment services in the courts; systematic mental health assessment of all new receptions into prisons; multidisciplinary services; easily accessible consultation/ liaison services to the general mental health programmes.

**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** Consumer rights and consumer and carer participation at all stages in the planning and delivery of mental health services is an impetus for the reform within the mental health system. Consumers and carers have been included in all national planning groups since the advent of the National Mental Health Strategy, and mental health leads the health industry in this area. A number of advisory groups have been established to increase consumer and carer input at the national, state and territory levels. The Mental Health Council of Australia (MHCA) includes consumers and carers as 25% of its membership. It was established as the peak national NGO to represent and promote the interests of the mental health sector. At the service delivery level, by 2002, 89% of organizations had established a specific, formal mechanism for consumer participation in local service issues as against 33% in 1994. The participation, however, is variable across jurisdictions and services. National Standards for Mental Health Services were developed in 1997 for use in assessing service quality and act as a guide to continuous quality improvement. All public mental health services in Australia, and many private services, are undergoing review against the National Standards as part of a quality assurance and accreditation cycle. National Practice Standards for the Mental Health Workforce were endorsed in 2002. These workforce standards target the professions of psychiatry, nursing, social work, psychology and occupational therapy and address the shared knowledge and skills required when working in a multi-disciplinary mental health environment. The National Practice Standards are designed to be used in conjunction with the National Standards for Mental Health Services. In a major mental health industry development initiative all public mental health services are participating in the routine collection of consumer outcome measures together with the bulk of the private sector.

**Additional Sources of Information**

- http://www.mentalhealth.gov.au
Austria

GENERAL INFORMATION
Austria is a country with an approximate area of 84 thousand sq. km. (UNO, 2001). Its population is 8.12 million, and the sex ratio (men per hundred women) is 96 (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 21% (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 2259 international $, and the per capita government expenditure on health is 1566 international $ (WHO, 2004).

The main language(s) used in the country is (are) German. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 76.4 years for males and 82.2 years for females (WHO, 2004). The healthy life expectancy at birth is 69 years for males and 74 years for females (WHO, 2004).

EPIDEMIOLOGY
There is substantial epidemiological data on mental illnesses in Austria 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 Federal Minister responsible for health matters reports every 3 years about activities of the Ministry of Health to the Parliament.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1997. Though at the federal level there is no fixed drug strategy, different provinces have adopted their own drug plans based on the traditional Austrian Drug policy (The Narcotic Substances Act, 1997) principles. Details can be obtained from the document ‘Report on the Drug Situation-2000’.

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

There are mental health plans at the level of all nine provinces, however, there are regional differences. For instance, some provinces already follow the principle of sectorization, others do not. Since 1997, there has been a National Hospital Plan, which involves a certain degree of obligation on individual provinces to fulfil its requirements until 2005. These include a few pages on psychiatry, with a subsection on community services (development period also until 2005). This plan is continuously adapted (latest version July 2003) and contains suggestions for the establishment of psychiatric units in general hospitals. Until now, nine of 23 planned psychiatric units in general hospitals have been created, with several others in advanced planning stage for 2005. The country has a plan for national action with regard to prevention of suicides.

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

Mental Health Legislation Though there is a legislation related to confinement of mentally ill persons in hospitals (1990/1997), there is no comprehensive mental health act or any obligation to provide adequate services. Under the scope of forensic psychiatric services, the penal reform in 1975 brought the treatment of mentally ill offenders under the jurisdiction of the Ministry of Justice.

The patients were to be committed to designated institutions for an indefinite period of time, but since the institution was still in the planning phase, actual treatment took place in hospitals. With the opening of the institution in 1985, a large number of male forensic patients were transferred out of psychiatric hospitals. The last reform came with the formulation of the inpatient civil commitment in 1991, which intended to improve the situation of mentally ill patients involuntarily admitted in psychiatric hospitals. It provided for patient’s lawyers at psychiatric hospitals. The Austrian Penal Code has legislation for assessment of offences committed by individuals with mental disorders and takes relevant measures for involuntary treatment. In 1991, the Psychology Act and Psychotherapy Act established the state certified professions of ‘clinical/health psychologists’ and ‘psychotherapists’. The Health Care and Nursing Act of 1997 redefined the nursing professions and especially psychiatric nursing, including aspects of community psychiatric nursing.

The latest legislation was enacted in 1997.

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, tax based, private insurances and out of pocket expenditure by the patient or family.

There are no special allocations for mental health as mental health is a part of the primary health care system. Psychiatric services are funded by a variety of sources (among others health insurance), which sometimes leads to difficulties in transition between in-, day- and outpatient as well as medical and social services. Clinical/health psychologists can be partly reimbursed by social security, and psychotherapists can be partly reimbursed by health insurance. The Austrian Hospital and Major Equipment Plan limits the rate of psychiatric beds (including day hospital places). The financing arrangements are such that it is more attractive to have day hospitals.
The country has disability benefits for persons with mental disorders. Different laws are present like the Federal Longterm Care Allowance Act, Provincial Longterm Care Allowance Act, Social Maintenance Act and Disabled Persons Employment Act. Patients with mental disorders can receive benefits based on the provisions made by these acts.

**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. General practitioners usually work in solo practices which are accessible also for patients with mental health problems. From there, patients may be referred to psychiatrists who also work in solo practices and in some cases (about 120 out of 540) have a contract with social security.

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. Responsibility for providing community care lies with the federal provinces. Since the mid 1970s – starting with the WHO/EURO project ‘Mental health services in pilot study areas’ – Austrian psychiatry has gradually moved away from large mental hospitals to community-based services. The number of community psychiatric services has been steadily increasing over the last 15 years. There are now at least 1000 tax funded services/projects (counselling services, residential facilities, day structure services, vocational rehabilitation services) run by more than 250 providers (usually charitable and private organizations). Nearly all are multi-professionally staffed and often non-psychiatric professionals dominate. It has been suggested that the reduction in suicide mortality might be related to the increase in community psychiatric services. Given the federal character of the country, this development has occurred at different speeds in different provinces. Some provinces have quite advanced community-based psychiatric services, while others still lag behind. In community-based services like day hospitals, crisis intervention services and hostels for psychiatric patients, multidisciplinary teamwork prevails. In some parts of the country, there are procedures for the systematic supervision of such teams.

**Psychiatric Beds and Professionals**

| Total psychiatric beds per 10 000 population | 6.5 |
| Psychiatric beds in mental hospitals per 10 000 population | 4.5 |
| Psychiatric beds in general hospitals per 10 000 population | 2 |
| Psychiatric beds in other settings per 10 000 population |  |
| Number of psychiatrists per 100 000 population | 11.8 |
| Number of neurosurgeons per 100 000 population | 1.7 |
| Number of psychiatric nurses per 100 000 population | 37.8 |
| Number of neurologists per 100 000 population | 8.2 |
| Number of psychologists per 100 000 population | 49 |
| Number of social workers per 100 000 population | 103.4 |

Psychotherapists can be clinical/health psychologists, psychiatrists and also others who have undergone training in psychotherapy. Since there is a large overlap between these professions, their numbers cannot be simply added. Over the last 3 decades, there has been a reduction of almost 60% in bed strength. These beds are distributed over more than 30 psychiatric and general hospitals and only three hospitals have more than 500 beds. This has gone hand in hand with diversification (e.g. Austria has many day hospitals) and specialization (e.g. child and adolescent psychiatry, geriatric psychiatry, substance abuse etc.). However, this process has not been even throughout the country. Almost three-fifths of psychiatrist work in private (mostly ambulatory) practice, but only a fraction of these (one-ninth) had contact with social security (i.e. they were accessible to those who could not afford to pay commercial fees). Almost 5% of neurosurgeons and 20% of neurologists have a contract with social security. There is a state certified profession of psychotherapy (psychologists, psychiatrists, but also person without any other professional background who have undergone training in psychotherapy; 5495 in the year 2002, i.e. 68 per 100 000 population). Most clinical and health psychologists (90% are trained in both disciplines and more than 40% are also trained as psychotherapists) and psychotherapists are in private practice. The majority of psychiatric nurses work in psychiatric or general hospitals.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. There are few initiatives to promote mental health in relation to positive or negative factors in society. However, the Austrian Society of Psychiatrists is carrying out a de-stigmatization project for schizophrenia. Some local anti-stigma initiatives exist (e.g. school projects in the provinces of Lower Austria and of Tyrol).

**Information Gathering System** There is no mental health reporting system in the country. Mental health details are mentioned only in hospital discharges and mortality figures. The country has data collection system or epidemiological study on mental health. The only service use data routinely available on a countrywide basis are data about ‘hospitalization, originating in the performance related hospital financing system based on the ‘Diagnosis Related Groups’ (DRG).

**Programmes for Special Population** The country has specific programmes for mental health for refugees, disaster affected population, elderly and children.
Patients who are fit to stand trial are detained in special institutions in the prison system. Those who are not fit to stand trials may be detained in these special institutions or in other psychiatric hospitals. There are also three small forensic outpatient clinics run by universities. Many of the discharged mentally ill offenders have to accept, as an additional condition for release, the services of a probational officer.

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

The drugs are dispensed through pharmacies.

**Other Information** The fragmentation of responsibilities at national and local level makes the cooperation between different providers of services and the intersectoral cooperation difficult. The federal structure has also restricted the establishment of common definition of services and quality assurance criteria outside hospitals.

**Additional Sources of Information**


GENERAL INFORMATION
Azerbaijan is a country with an approximate area of 87 thousand sq. km. (UNO, 2001). Its population is 8.447 million, and the sex ratio (men per hundred women) is 95 (UNO, 2004). The proportion of population under the age of 15 years is 28% (UNO, 2004), and the proportion of population above the age of 60 years is 9% (WHO, 2004). The literacy rate is 99% for men and 96% 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 1.6%. The per capita total expenditure on health is 48 international $, and the per capita government expenditure on health is 32 international $ (WHO, 2004).

The main language(s) used in the country is (are) Azerbaijani and Russian. The largest ethnic group(s) is (are) Azerbaijani (four-fifths), and the other ethnic group(s) are (is) Russian and Armenian. The largest religious group(s) is (are) Muslim (five-sixths), and the other religious group(s) are (is) Russian Orthodox and Armenian Apostolic.

The life expectancy at birth is 63 years for males and 68.6 years for females (WHO, 2004). The healthy life expectancy at birth is 56 years for males and 59 years for females (WHO, 2004).

EPIDEMIOLOGY
There are some articles comparing the prevalence of PTSD and other mental disorders and associated factors between two groups of populations – Armenians affected by the 1988 earthquake and Armenians affected by violence in Azerbaijan (Goenjian et al, 1994, 2000). These studies showed that after exposure to severe trauma (earthquake or violence) adults are at high risk of developing severe and chronic posttraumatic stress reactions that are persistent. Gulakmedove et al (2002) found that among 9500 children with psychoneurological illnesses, 2336 suffered from mental deficiency. An article comparing suicide patterns across different countries that were a part of the erstwhile USSR reports that during 1984-1990 the rate of suicide was 3.5 cases per 100 000 inhabitants in the Caucasus (Georgia, Azerbaijan and Armenia) (Wasserman et al, 1998).

MENTAL HEALTH RESOURCES
Mental Health Policy
A mental health policy is absent. With the help of international organizations (including the Geneva Initiative on Psychiatry and the International Consortium for Mental Health Services) a working group has been established to draft the documents on mental health policy and national mental health programme. The main priority is a programme of deinstitutionalization and the simultaneous development of community services.

Substance Abuse Policy
A substance abuse policy is present. The policy was initially formulated in 1996.

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 1999.

Mental Health Legislation
The law focuses on the protection of civil and human rights of mentally ill people and regulates the provision of mental health services. Several acts related to privileged services to refugees have been passed because of their large numbers. Order 145 simplifies the admission of refugees to psychiatric institutions. The latest legislation was enacted in 2001.

Mental Health Financing
There are budget allocations for mental health. The country spends 1.6% 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 grants. Hospital treatment is expensive by the average standards. The country has disability benefits for persons with mental disorders. Disability benefits do not correspond to minimum subsistence levels.

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. Primary health care is provided at regional level by psychiatrist but general physicians do not provide that service at the primary health care 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. Currently a community based programme is being developed with the help of NGOs.
**Psychiatric Beds and Professionals**

- Total psychiatric beds per 10 000 population: 7.1
- Psychiatric beds in mental hospitals per 10 000 population: 6.9
- Psychiatric beds in general hospitals per 10 000 population: 0.11
- Psychiatric beds in other settings per 10 000 population: 0.09
- Number of psychiatrists per 100 000 population: 5
- Number of neurosurgeons per 100 000 population: 0.4
- Number of psychiatric nurses per 100 000 population: 3.9
- Number of neurologists per 100 000 population: 5.2
- Number of psychologists per 100 000 population: 0.2
- Number of social workers per 100 000 population: 0.3

Psychologists and social workers are being trained. Most professionals charge fees for their services. Psychiatrists have to undergo refresher training for 4 months after every 5 years. The official involvement of clinical psychologists in the provision of mental health services has not been established.

**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. Annual data on the mentally ill is forwarded to the Central Statistics Department.

**Programmes for Special Population**

The country has specific programmes for mental health for refugees. In the state programme of health of refugees there is a section on mental health assistance. Some small projects on psychosocial rehabilitation of refugees, particularly children and invalids have been implemented. However, educational programmes for the refugees need to be established in order to help them to be aware of mental health problems and to reduce the stigma associated with mental health. This information would also benefit them when they return to their own country. Order No. 145 allows a simplified process of acceptance of refugees by psychiatric institutions, irrespective of their country of origin. Some special pharmacies that supply medicines free of charge to refugees have been established.

**Therapeutic Drugs**

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

**Other Information**

**Additional Sources of Information**


 Bahama

GENERAL INFORMATION
Bahamas is a country with an approximate area of 14 thousand sq. km. (UNO, 2001). The country is an archipelago of about 700 islands and 2 400 cays. Thirty islands are inhabited. Its population is 0.317 million, and the sex ratio (men per hundred women) is 97 (UNO, 2004). The proportion of population under the age of 15 years is 29% (UNO, 2004), and the proportion of population above the age of 60 years is 8% (WHO, 2004). The literacy rate is 94.5% for men and 96.3% 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 5.7%. The per capita total expenditure on health is $1220, and the per capita government expenditure on health is $695 (WHO, 2004).

The main language(s) used in the country is (are) English. The largest ethnic group(s) is (are) African (descent). The largest religious group(s) is (are) Anglican, and the other religious group(s) are (is) Baptist and Roman Catholic.

The life expectancy at birth is 69.4 years for males and 75.7 years for females (WHO, 2004). The healthy life expectancy at birth is 61 years for males and 66 years for females (WHO, 2004).

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

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.
The policy is being developed.

Substance Abuse Policy A substance abuse policy is absent. A policy is currently before the Cabinet.

National Mental Health Programme A national mental health programme is absent.
The programme 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 1997.

Mental Health Legislation The mental health legislation is under review.
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 11% 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 available at the primary level. Cases are only assessed and then referred to specialized centres.
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.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 11.96
Psychiatric beds in mental hospitals per 10 000 population 11.69
Psychiatric beds in general hospitals per 10 000 population 0.27
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 4.7
Number of neurosurgeons per 100 000 population 0.3
Number of psychiatric nurses per 100 000 population 21.6
Number of neurologists per 100 000 population 1
Number of psychologists per 100 000 population 3
Number of social workers per 100 000 population 3.7
Besides trained psychiatrist there are other trained doctors who deliver psychiatric care.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in prevention and treatment. The majority of the NGOs work in the field of substance abuse.

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. A data collection system is being developed.
Programmes for Special Population The country has specific programmes for mental health for disaster affected population, elderly and 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, carbidopa, levodopa.

Other Information More emphasis needs to be placed on developing psychiatry in a general hospital set-up.

Additional Sources of Information
Bahrain

GENERAL INFORMATION
Bahrain is a country with an approximate area of 0.71 thousand sq. km. (UNO, 2001). The country is an archipelago of low desert islands, of which the largest is Manama. Its population is 0.739 million, and the sex ratio (men per hundred women) is 135 (UNO, 2004). The proportion of population under the age of 15 years is 29% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 4.1%. The per capita total expenditure on health is 664 international $, and the per capita government expenditure on health is 458 international $ (WHO, 2004).

The main language(s) used in the country is (are) Arabic and English. The largest ethnic group(s) is (are) Arab. The largest religious group(s) is (are) Muslim.

The life expectancy at birth is 72.1 years for males and 74.5 years for females (WHO, 2004). The healthy life expectancy at birth is 64 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY
There is substantial epidemiological data on mental illnesses in Bahrain 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 1993. 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 1983.

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

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 The latest mental health legislation is Decree 3. The latest legislation was enacted in 1975.

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 and out of pocket expenditure by the patient or family. 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. Primary care is provided only after stabilization of the case. There are 23 primary care centres, each within 5 km of the catchment area, and have all psychiatric drugs. Any new drugs can be procured within a day. Regular training of primary care professionals is carried out in the field of mental health. The psychiatry department is involved in the training of family physicians. Child care workers have been trained on issues related to mental health and behavioural disorders. There are community care facilities for patients with mental disorders. There are regular home visits through outreach programmes of the hospital. The psychiatric community care was started in 1979 and forms an important aspect of mental health delivery system along with primary care. During community visits, family members are encouraged to participate in the treatment. Patients are given information on treatment, management and other educational items related to their illness. A day care centre that can provide services for 40 clients exists.

Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>3.3</td>
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<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
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<tr>
<td>Psychiatric beds in general hospitals per 10 000 population</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10 000 population</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000 population</td>
<td>5</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 population</td>
<td>0.3</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td>23</td>
</tr>
<tr>
<td>Number of neurologists per 100 000 population</td>
<td>1</td>
</tr>
<tr>
<td>Number of psychologists per 100 000 population</td>
<td>0.8</td>
</tr>
<tr>
<td>Number of social workers per 100 000 population</td>
<td>1.5</td>
</tr>
</tbody>
</table>
Psychiatric training is undertaken in the country with licensing from the Arab Board of Psychiatry. Beds have been earmarked for treatment of drug abusers and management of mentally challenged individuals.

**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. Data are available from the Bahrain Health Statistics, 1999. The country has data collection system or epidemiological study on mental health. Data collection is hospital-based.

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

**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, fluphenazine, haloperidol, lithium, biperiden.

All drugs available at the psychiatric hospital can be made available to health centres on request and according to needs of known patients.

**Other Information**

**Additional Sources of Information**

Bangladesh

GENERAL INFORMATION
Bangladesh is a country with an approximate area of 144 thousand sq. km. (UNO, 2001). Its population is 149.665 million, and the sex ratio (men per hundred women) is 105 (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 5% (WHO, 2004). The literacy rate is 50.3% for men and 31.4% for women (UNESCO/MoH, 2004).

The main language(s) used in the country is (are) Bangla. The largest ethnic group(s) is (are) Bangla (nine-tenths). The largest religious group(s) is (are) Muslim (four-fifths).

The life expectancy at birth is 62.6 years for males and 62.6 years for females (WHO, 2004). The healthy life expectancy at birth is 55 years for males and 53 years for females (WHO, 2004).

EPIDEMIOLOGY
In a study on 1288 primary school children screened with the Rutter B2 Scale, 13.4% had behaviour disorders (males 20.4%, females 9.9%). Emotional, conduct and undifferentiated disorders were detected in 3.2, 8.9 and 1.2% of cases. Psychiatric morbidity was greater in higher school grades (Rabbani & Hossain, 1999). A two-phase survey on over 10,000 children aged 2-9 revealed that the prevalence rates of severe and mild mental retardation were 0.6% and 1.4%, respectively. Mild mental retardation was strongly and significantly associated with low socioeconomic status (Islam et al, 1993). Further analyses showed that significant risk factors of serious mental retardation in rural and urban areas were maternal goiter and postnatal brain infections, and in rural areas consanguinity and landless agriculture. Risk factors for mild cognitive disabilities included maternal illiteracy, landlessness, maternal history of pregnancy loss and small for gestational age at birth. Durkin et al (1993, 2000) used a structured measure for assessment of 162 children affected by a flood, who had been evaluated earlier, and found that an additional 10% had aggressive behaviours and 34% had enuresis. A survey for physical and psychiatric disorders of the entire population (n=1181) of a village revealed a point-prevalence rate of 6.5% (3.6% of subjects had psychiatric disorders alone and 2.9% had both psychiatric and physical disorders). Depressive and anxiety states were common and psychiatric disorders occurred more frequently in women (Choudhury et al, 1981). A study that covered 4751 health facilities throughout Bangladesh evaluated deaths among women aged 10-50 years by examining medical records and interview. Among 28,998 deaths in women aged 10-50 years 11.4% were attributable to suicide. Regional variations were noted (Appleby, 2000). Neurotic disorders were reported to be common in general practice (Alam, 1978) and medical outpatients (31%) (Chowdhury et al, 1975). Schizophrenia, affective disorders and anxiety neurosis were common among adult psychiatric outpatients (77%) (Ahmed, 1978), and dissociative disorder (Hysteria) (21.65%) and epilepsy (19.59%) among child psychiatry outpatients (Rahim et al, 1997).

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 1990.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1984.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1983.

Mental Health Legislation There is the Lunacy Act. A national workshop on the draft of the Mental Health Act was held in 1999 to formulate the final version of the act and for its enactment. The latest legislation was enacted in 1912.

Mental Health Financing There are budget allocations for mental health. The country spends 0.5% 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 grants.

The country has disability benefits for persons with mental disorders. Lifetime pension is provided for mentally handicapped children after the death of the father or mother who was receiving some pension.

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. Efforts are being made to provide cheaper drugs at primary level.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 6000 personnel were provided training. Training on mental health for primary care physicians and health workers is being conducted by the Ministry of Health and Family Welfare. They are trained to develop diagnostic skills, to participate in activities to collect data, to develop biological, psychological and social orientation towards all health problems and to develop training abilities to further train other mental health staff. Medical administrators have also been trained on mental health issues.
There are community care facilities for patients with mental disorders. Periodic mental health extension services are being provided at the primary care level by the Institute of Mental Health Research, Dhaka. Public education and family counselling with the supervision of specialists are done. Though specific rehabilitation programmes are not available in an organized form, efforts are being made to implement day care facilities, sheltered workshops and rehabilitation programmes for chronic schizophrenics.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Professional Type</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric</td>
<td>0.065</td>
</tr>
<tr>
<td>beds in mental</td>
<td>0.03</td>
</tr>
<tr>
<td>hospitals</td>
<td>0.009</td>
</tr>
<tr>
<td>psychiatric beds</td>
<td>0.024</td>
</tr>
<tr>
<td>in general</td>
<td></td>
</tr>
<tr>
<td>hospitals</td>
<td>0.05</td>
</tr>
<tr>
<td>Number of</td>
<td></td>
</tr>
<tr>
<td>psychiatrists</td>
<td>0.01</td>
</tr>
<tr>
<td>Number of</td>
<td></td>
</tr>
<tr>
<td>neurosurgeons</td>
<td>0.06</td>
</tr>
<tr>
<td>Number of</td>
<td></td>
</tr>
<tr>
<td>psychiatric nurses</td>
<td>0.02</td>
</tr>
<tr>
<td>Number of</td>
<td></td>
</tr>
<tr>
<td>neurologists</td>
<td>0.02</td>
</tr>
<tr>
<td>Number of</td>
<td></td>
</tr>
<tr>
<td>psychologists</td>
<td>0.002</td>
</tr>
<tr>
<td>Number of</td>
<td></td>
</tr>
<tr>
<td>social workers</td>
<td>0.001</td>
</tr>
</tbody>
</table>

There is one occupational therapist and 4011 medical assistants. The number of mental health professionals is inadequate. Prior to 1957, there were no psychiatric services in Bangladesh. One mental hospital was established at Pabna in 1957, and in 1969 the first outdoor clinic started functioning in Dhaka Medical College. Since the 1970s, more institutes were opened. In 1981, the OTMH institute was opened with the help of WHO to cater to mental health exclusively; it was later renamed as the National Institute of Mental Health. Mental health care is provided at the primary level by primary care physicians and health workers, at the secondary level by the district hospital, though unfortunately, only one such hospital is equipped to provide the services, and at tertiary level by teaching hospitals.

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

**Information Gathering System** There is mental health reporting system in the country. There are some figures related to incidence and prevalence of mental disorders. The country has data collection system or epidemiological study on mental health. Only hospital based service data collection is present. A WHO supported country wide population-based survey on mental disorders has been undertaken recently.

**Programmes for Special Population** The country has specific programmes for mental health for elderly and children. The National Institute has special units for child and adolescent and elderly population. All other groups are cared for by the general adult psychiatry units.

**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, levodopa.

**Other Information**

**Additional Sources of Information**

Barbados

GENERAL INFORMATION
Barbados is a country with an approximate area of 0.43 thousand sq. km. (UNO, 2001). Its population is 0.271 million, and the sex ratio (men per hundred women) is 95 (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 13% (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 6.5%. The per capita total expenditure on health is 940 international $, and the per capita government expenditure on health is 623 international $ (WHO, 2004).
The main language(s) used in the country is (are) English. The largest ethnic group(s) is (are) African (descent), and the other ethnic group(s) are (is) Caucasian, East Indian and Chinese. The largest religious group(s) is (are) Christian, and the other religious group(s) are (is) Hindu, Muslim, Jew and Rastafarian.
The life expectancy at birth is 70.5 years for males and 77.9 years for females (WHO, 2004). The healthy life expectancy at birth is 63 years for males and 68 years for females (WHO, 2004).

EPIDEMIOLOGY
A 12-month study of all persons in the 18-54-year age group presenting with a psychosis for the first time was carried out on the population of Barbados. Information was collected using World Health Organization screening and measurement instruments. On an island of just over a quarter of a million, 40 out of the 53 patients that met the inclusion criteria were categorized as S+ (narrow) schizophrenia, giving an incidence rate of 2.8/10 000. The incidence rate for broad schizophrenia was calculated at 3.2/10 000, which is significantly lower than the comparable rate for London's African-Caribbeans of 6.6/10 000. The very high rate for broad schizophrenia among African-Caribbean people in the UK is probably due to environmental factors like migration and psychosocial stressors (Mahy et al, 1999). Mansoor and Edwards (1991) used the Michigan Alcohol Screening Test (MAST) and found that 18% were problem drinkers among 203 emergency admissions. Problem drinking was found in 31% of males and 5% of females. 70% of all problem drinkers had a first degree family relative who drank compared to 28% of non-drinkers. A high prevalence of alcoholism (48%) was found among smokers. Comorbid medical complications were high. House staff detected just over half of male (56%) and female (60%) alcoholics who were MAST-positive. Studies on attempted suicide/parasuicide are also available (Mahy, 1987a, b).

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 2004.
Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1995. A National Council on Substance Abuse (NCSA) Act sets the roles and functions of the NCSA. It was promulgated in March 1996.
National Mental Health Programme A national mental health programme is present. The programme was formulated in 2001. A National Mental Health Framework Plan is present. It was formulated with an active collaboration between the Ministry of Health and PAHO. A draft of a revised plan was ready in September 2004.
National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1989.
Mental Health Legislation The Mental Health Act is of 1980. The Mental Health Act- Laws of Barbados (Chapter 45) is the most recent legislation.
The latest legislation was enacted in 1985.
Mental Health Financing There are budget allocations for mental health.
The country spends 12% 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.
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. Primary care is provided through a mental health team providing services in each polyclinic.
Regular training of primary care professionals is not carried out in the field of mental health. A training programme for primary care personnel was carried out by PAHO in May 1999. Another training programme for core clinical mental health professionals was conducted by PAHO in February 2004.
There are community care facilities for patients with mental disorders. It is provided through mental health personnel and mental health officers working out of the psychiatric hospital. There are District Psychiatric Nursing Services across the country which provide the bulk of community care. They collectively make up to 6000 domiciliary visits per year.
Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Category</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>26</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>22</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.3</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>4</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>3</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>1</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>97</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>0.7</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>9</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>2</td>
</tr>
</tbody>
</table>

Two social workers are trained in psychiatry social work till the masters level. Barbados has one large mental hospital. The private set-ups have no fixed number of psychiatric beds. Mental health officers play an important role in psychiatric care. A training programme for core clinical mental health professionals was conducted by PAHO in February 2004.

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 data collection system or epidemiological study on mental health. The annual health reporting system and data collection system are being upgraded.

Programmes for Special Population

The country has specific programmes for mental health for elderly and children. The child guidance clinic is a weekly outpatient affair. The liaison service is in its infancy. There are also substance abuse related programmes. Services in forensic psychiatry are also present.

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, carbipoda, levodopa.

Other Information

Additional Sources of Information

Belarus

GENERAL INFORMATION
Belarus is a country with an approximate area of 208 thousand sq. km. (UNO, 2001). Its population is 9.851 million, and the sex ratio (men per hundred women) is 88 (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 99.8% for men and 99.6% 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 5.6%. The per capita total expenditure on health is 464 international $, and the per capita government expenditure on health is 402 international $ (WHO, 2004).

The main language(s) used in the country is (are) Belarusian and Russian. The largest ethnic group(s) is (are) Belarusian (five-sixths), and the other ethnic group(s) are (is) Russian. The largest religious group(s) is (are) Orthodox Christian (four-fifths) among those who rank themselves as religious (about half of the population).

The life expectancy at birth is 62.6 years for males and 74.3 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 65 years for females (WHO, 2004).

EPIDEMIOLOGY
Aleksandrovskii (1991) found a 38% rate of psychiatric morbidity in a sample of 300 persons living in a polluted area of Byelorussia after the Chernobyl nuclear disaster in 1986. Havenaar et al (1996) used the General Health Questionnaire (12-item version) and the Munich Diagnostic Checklist for DSM-III-R in a two-stage survey of a broad based population sample affected by the disaster (n=1617). Psychiatric disorders were present in 35.8% (affective: 16.5%, anxiety: 12.6%). Dysthymia, general anxiety disorder, adjustment disorders and ‘not otherwise specified syndromes’ made up almost two-thirds of the observed morbidity (22.9%). A higher prevalence of mental health problems was observed among people who have been evacuated and in mothers with children under 18 years of age. In a later study, Havenaar et al (1997) studied two population samples 6 1/2 years after the event (n=3044), one from the region close to the accident site and one from a region 500 miles away, with a variety of self-report questionnaires and a standardized psychiatric interview. The prevalence of psychological distress and DSM-III-R psychiatric disorders was exceptionally high in both regions. Scores on the self-report scales were consistently higher in the exposed region; however, a higher risk of DSM-III-R psychiatric disorders could be demonstrated only among women with children less than 18 years of age. Kolominosky et al (1999) compared children who had suffered prenatal radiation exposure (n=138) and a control group (n=122) at the age of 6-7 and 10-11 years. The exposed group manifested a relative increase in the prevalence of specific developmental speech-language disorders (18.1% vs. 8.2% at 6-7 years; 10.1% vs. 3.3% at 10-11 years) and emotional disorders (20.3% vs. 7.4% at 6-7 years; 18.1% vs. 7.4% at 10-11 years). The mean IQ of the exposed group was lower than that of the control group, and there were more cases of borderline IQ (IQ=70-79) (15.9% vs. 5.7% at 6-7 years; and 10.1% vs. 3.3% at 10-11 years). In utero thyroid exposure was not related to IQ, but educational level of parents was moderately associated with IQ. In an extension of this study (Igumnov & Drozdovitch, 2000) compared 250 children at the age of 6-7 and 10-12 years who had been exposed in utero with a control group of 250 children. No statistically significant distinctions in average IQ were found between the different subgroups of children in relation to the gestational age at the time of the Chernobyl accident. Exposed children had a higher relative risk of emotional disorders (OR=2.67, P<0.001) but not for mental retardation, hyperkinetic disorders and other mental and behavioural disorders. In both studies, there was a moderate correlation between high personal anxiety in parents and emotional disorders in children. In a study using multivariate analysis, Little (1993) suggested that there was no increase in the rate of congenital abnormalities like Trisomy 21 following the nuclear disaster. Similar conclusions were reached by Laziuk et al (2002) who analysed the annual and monthly prevalence of Down syndrome (n=2786) in Belarus for a 19-year period (1981 to 1999). Based on data obtained from national registers, Razvodovskaia (2002) showed a strong positive correlation between the incidence of alcoholic psychoses and alcohol use disorders and the level of alcoholic beverage consumption per capita in Belarus from 1970 to 1999. Wasserman et al (1998) reported that suicide rates were high (25.6 per 100 000) in the Slavic region (Russia, the Ukraine and Belarus) of the former USSR. Declines in suicide rates from 1984 to 1986-1988 occurred in all republics, with the largest decreases in Russia and Belarus, at 42% for men and 20% for women (Varnik et al, 1998). Suicide rates have risen in Belarus since 1990 and are higher in rural than in urban areas. The regional distribution of suicide rates suggests a north-south variation that may be a result of ethnic and cultural differences between the regions (Kondrichin & Lester, 1998).

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is absent.

Prevention of mental ill-health is a part of the National Policy, even though there is no national mental health programme for the country.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 2000. The following have been developed, adopted and implemented: Outline for state alcohol-control policy, (decree No. 23, 2000), Outline for state policy for controlling abuse of narcotics and psychotropic substances in the Republic of Belarus (decree No. 583, 1996), the state programme for comprehensive measures to combat abuse of and illegal trade in narcotics and psychotropic substances for the period 2001-2005 (decree No. 25, 2001), the state programme of national activities to prohibit and eliminate drunkenness and alcoholism

Belarus
The coordination of intersectoral activities at a state level is governed by the Interministerial Commission on Drug Abuse and Crime, under the Council of Security, and the Interministerial Commission on Control of Drugs and Psychotropic Substances, under the Council of Ministers.

**National Mental Health Programme** A national mental health programme is absent. There is no national mental health plan in Belarus. Mental health plans are included within the framework of the annually developed Health Ministry Plans. Currently, the Health Ministry is trying to establish the legislative basis for mental health programmes by amendments to the Law ‘On Health Care’ and is involved in the development of standards for psychiatric care. Some measures have been planned for a transition to the use of ICD-10.

**National Therapeutic Drug Policy/Essential List of Drugs** A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2003. The supply of medication for maintenance treatment sometimes gets interrupted due to shortages.


**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 and out of pocket expenditure by the patient or family. The Ministry of Health plans expenditure on a per capita expenditure basis using budgetary allocations. For this purpose, planning and funding of expenditure on health, including that on mental health services, is determined by the volume and type of medical care. The country has disability benefits for persons with mental disorders. Public disability benefits are given to mental health invalids. Mental health patients including working ones are treated free of charge at polyclinics.

**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. Specialized primary health care is rendered at the polyclinic by therapists and neuropathologists; at the psychiatric and narcologic clinics by psychiatrists and narcologists; at the hospital in cases of psychosis by psychiatrists and narcologists. The national system of psychiatric care has been developed based on the needs of society, as stipulated by the community as a whole and by the consumers of these services in particular. In the past, such care was mainly provided at large psychiatric institutions. At present, it is provided as near as possible to the patient’s home, aiming to shift the provision of care from the inpatient to the outpatient level. Establishing a network of outpatient clinics, psychotherapeutic facilities and socio-psychological care at each area polyclinic, integration of psychiatric care into GP practice, developing cooperation with social services and NGOs are also being planned. 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 no community care facilities for patients with mental disorders. Community care services have not fully developed. There are psychiatric wards in general hospitals and specialized psychiatric teams in polyclinics even in rural areas, but there are few day care centres or psychosocial programmes. Day-patient psychiatric care for adults is provided by day clinics located within and outside psychiatric institutions. In order to prevent suicide, telephone mental health helpline services have been set up and are still being set up throughout Belarus.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Category</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>8</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>7.5</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.5</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>10.1</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>1.5</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>25.6</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>15.4</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>1.14</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0</td>
</tr>
</tbody>
</table>
The current focus continues to be on an inpatient (in mental and general hospitals) rather than an outpatient care. Staffing norms are being developed, along with norms for ratios of psychiatrists, psychotherapists, drug-abuse specialists and psychologists which will make it possible to provide mental health care through multidisciplinary teams with intensive use of technology and minimum isolation of patients. Outpatient psychiatric care for adults is provided by psychiatrists, psychotherapists and psychologists at surgeries located in specialized mental-health institutions. Positions for psychotherapists and psychologists also exist in surgeries in municipal general hospitals. Psychiatric beds are organized on the basis of age (adults, children, adolescents and geriatric), by sex (male, female, mixed) and by category of disorder (treatment of depression, anxiety disorders, post-suicide, psychoses and somatic disorders). There are in-patient facilities for mandatory treatment of psychiatric patients who have committed offences contemplated by the Criminal Code. The number of psychiatric beds fell from 11 370 (11.1 per 10 000 population) to 7868 (8.0 per 10 000 population) between 1999 and 2004, i.e. by 30.8%. During the same period, the number of beds for drug-abuse patients fell from 4490 (4.4 per 10 000 population) to 1347 (1.4 per 10 thousand population), i.e. by more than two thirds. There are no specialized drug-abuse clinics in Belarus; beds for drug-abuse patients are provided in psychiatric hospitals. Psychiatric care is provided in part outside the Ministry of Health system, e.g. in Ministry of Labour and Social Protection establishments – at homes for chronic mental health patients without any family or social ties and in Ministry of internal affairs establishments – at penal establishments of the prison service. There is a move towards deinstitutionalization, replacing long-term hospitalization with various forms of outpatient treatment, medico-social and socio-legal care. In the 1990s itself, a reduction of nearly 12% in mental health beds and 30% in substance abuse beds was achieved. Treatment by psychotherapy is being introduced at outpatient clinics. Limited services are available in the private sphere, mostly for drug abuse and psychotherapy. However, no effective mechanisms presently exist for the quality control of private services and for ensuring the right balance between governmental services and developing private practices within the mental health field. Separate wards are available for the treatment of children and elderly. Demented patients are usually referred to institutions for chronic psychiatric patients that are under the jurisdiction of Ministry of Social Welfare. Multidisciplinary teams with the participation of doctors, nurses, psychologists, and social workers usually provide care in mental health facilities, but the number of psychologists and social workers is still insufficient. Preparations for the assignment of social workers to the staff of psychiatric institutions are under way.

**Non-Governmental Organizations** NGOs are not involved with mental health in the country. The current legislation authorizes the establishment of social organizations. Professional non-governmental organizations exist in Belarus (the Belarusian Psychiatric Association, the Belarusian Association of Psychotherapists) and issue their own publications. There are associations of users of psychiatric services and their relatives, although they are non-operational and their registration has lapsed. There are also a number of social organizations that deal with rehabilitation for drug users.

**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. Since 1998, the suicidal behaviour of the population of Minsk city has been studied as an indicator of mental health. It is also planned to collect information on suicides and parasuicides throughout the country.

**Programmes for Special Population** The country has specific programmes for mental health for disaster affected population and children. The disaster affected population are those affected by the Chernobyl accident. Outpatient paediatric psychiatric care is provided by child psychiatrists, psychotherapists and psychologists at clinics in children’s hospitals. Day-patient paediatric mental health care is provided at situated within and outside mental health institutions. Inpatient psychiatric care for children is provided in children’s mental health clinics, located in psychiatric hospitals and general children’s hospitals. Psychiatric care is also provided by Ministry of Education Establishments at preschool establishments and schools for children with psychiatric disorders.

**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, carbodopa, levodopa. The essential list of drugs (decree N° 43, 2003) which must be available at mental health hospitals is renewed every two years. In 2004, the Ministry of Health drew up a formulary of drugs whose use is authorized in Belarus. Supplies of drugs to treat mental and behavioural disorders are sufficient to meet demand.

**Other Information**

**Additional Sources of Information**


BELARUS


Belgium

GENERAL INFORMATION
Belgium is a country with an approximate area of 33 thousand sq. km. (UNO, 2001). Its population is 10.339 million, and the sex ratio (men per hundred women) is 96 (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 22% (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 2481 international $, and the per capita government expenditure on health is 1778 international $(WHO, 2004).

The main language(s) used in the country is (are) Dutch, French and German. The largest ethnic group(s) is (are) Fleming (half), and the other ethnic group(s) are (is) Walloon. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 75.2 years for males and 81.5 years for females (WHO, 2004). The healthy life expectancy at birth is 69 years for males and 73 years for females (WHO, 2004).

EPIDEMIOLOGY
There is substantial epidemiological data on mental illnesses in Belgium 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 1988. It was amended in 1990. Now, since both Federal Government and communities are in charge of different parts of mental health, there is a national and a community mental health policy.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1921. It has been amended several times and is now in the process of being renewed.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1990. Various adaptations have been made over time. Belgium has suicide prevention programmes but not at a national level.

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. There is no list of essential drugs since all officially registered drugs are available.

Mental Health Legislation There is a Royal decision of May 2000 changing the previous one of 1976 concerning the fixation of maximum number of beds in psychiatric services. The communities are in charge of all non-hospital mental health care such as sheltered housing, centres for mental health, etc. The Federal Government is in charge of hospitals, location of psychiatric care and quality of hospital care.

The latest legislation was enacted in 2000.

Mental Health Financing There are budget allocations for mental health. The country spends 6% of the total health budget on mental health. The primary sources of mental health financing in descending order are social insurance, private insurances, out of pocket expenditure by the patient or family and tax based. The country has disability benefits for persons with mental disorders. Different parameters like ability to work and measurement of handicap are assessed.

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 carried out in the field of mental health. There are community care facilities for patients with mental disorders. The forensic psychiatry services are limited to some experimental areas.

Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Description</th>
<th>Per 10 000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>22.1</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
<td>12.9</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals per 10 000 population</td>
<td>2.6</td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10 000 population</td>
<td>6.6</td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000 population</td>
<td>18</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 population</td>
<td>1.5</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td></td>
</tr>
<tr>
<td>Number of neurologists per 100 000 population</td>
<td>1</td>
</tr>
</tbody>
</table>
Number of psychologists per 100 000 population
Number of social workers per 100 000 population

Psychiatrists include adult psychiatrists, child psychiatrics and neuropsychiatrists; some of the latter exclusively work in the area of neurology. Hence, the figure for psychiatrists is an overestimate, while that for neurologists is an underestimate. Figures for psychiatric nurses, psychologists and social workers are not available because these professional titles are not recognized by the federal authority, therefore they are not registered.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in promotion, prevention 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. The document containing psychiatric information is known as the Minimal Psychiatric Dataset.

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

**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, diazepam, haloperidol, lithium, biperiden, carbidopa, levodopa. Drugs are partially or wholly reimbursed. Carbidopa and levodopa are always prescribed in association with others.

**Other Information**

**Additional Sources of Information**
GENERAL INFORMATION
Belize is a country with an approximate area of 23 thousand sq. km. (UNO, 2001). Its population is 0.261 million, and the sex ratio (men per hundred women) is 102 (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 6% (WHO, 2004). The literacy rate is 76.7% for men and 77.1% 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 5.2%. The per capita total expenditure on health is 278 international $, and the per capita government expenditure on health is 125 international $ (WHO, 2004).

The main language(s) used in the country is (are) English and Spanish. The largest ethnic group(s) is (are) Mestizo (almost half of the population) and Creole (one-fourth), and the other ethnic group(s) are (is) indigenous groups (Mopan, Yucatec and Ketch) and Garifuna. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 67.4 years for males and 72.4 years for females (WHO, 2004). The healthy life expectancy at birth is 58 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Belize in internationally accessible literature. McClusky (1999) conducted an ethnographic study on domestic violence against rural Belizean women of Mayan origin.

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. Details about the year of formulation are not available.

Mental Health Legislation The country has a mental health legislation dated 1965 and based on the British model, which is currently being reviewed and updated to ensure that it adheres to international human rights standards. Multiple stakeholder groups are involved in this process. The latest addition to the legislation was enacted in 1998 after the Mental Health Association extensively lobbied for the decriminalization of suicide, as well as ensuring that survivors of suicide attempts received professional help rather than face criminal charges.

The latest legislation was enacted in 1998.

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 tax based, out of pocket expenditure by the patient or family, private insurances.

The country has disability benefits for persons with mental disorders. If patients have worked they are entitled to social security 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. It is available mainly at secondary 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. For over ten years, Belize has followed a community-based approach to addressing mental health issues. Psychiatric nurse practitioners (PNP) who are trained in field work, function under the supervision of the psychiatrist to provide services to patients in their respective communities. Every district hospital has PNPs working out of the Mental Health Clinic. This helps in the integration of community psychiatric services with general health services. An acute psychiatric unit exists within a general hospital. No day hospital service is currently in place. Most patients have to travel only short distances to their clinics.
**Psychiatric Beds and Professionals**

- Total psychiatric beds per 10 000 population: 2.3
- Psychiatric beds in mental hospitals per 10 000 population: 2.1
- 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: 1.3
- Number of neurosurgeons per 100 000 population: 0.9
- Number of psychiatric nurses per 100 000 population: 0.5
- Number of neurologists per 100 000 population: 0.9
- Number of psychologists per 100 000 population: 0
- Number of social workers per 100 000 population: 4.3

The social workers were not trained as psychiatric social workers. There are no occupational therapist currently working in the programme. The country has one psychiatric institution; and in 2001, a General Hospital Psychiatric Unit was opened that can accommodate approximately four patients. It is anticipated that an additional psychiatric unit will be constructed at the referral hospital in Belize City. In addition, there are 3 private hospitals which admit psychiatric patients occasionally. The country has one psychiatric institution, the Rockview Hospital, one psychiatrist and two clinical psychologist (who are working in the private sector) working in country. Currently, there are 10 Psychiatric Nurse Practitioners working at district clinics and the outpatient clinic in Belize City, and 13 additional PNPs are being trained at the University of Belize. This is the second training of Psychiatric Nurse Practitioners as mental health is not included in the regular training of primary health care providers. The psychiatrist is based in the capital but visit district clinics every six weeks. They also visit the mental hospital and other health facilities. Psychiatric Nurse Practitioners can prescribe medication and admit patients to the hospital, though there is no legal provision for prescription by nurses. Time for Continuing Medical Education was limited.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation. The Mental Health Association helps in raising awareness about issues related to mental well-being and advocates on behalf of those with mental illness and their families. Dedicated work by psychiatric nurses led to the formation of Mental Health Consumer Associations in almost each district. Two of these groups are very active, and since their formation were instrumental in lobbying for the availability of new drugs.

**Information Gathering System** There is no mental health reporting system in the country. The Psychiatric Unit has recently developed key indicators which will be included in the update of the Belize Health Information System. The country has data collection system or epidemiological study on mental health. Data collection is currently done through psychiatric units in each of the six districts. An anthropological and epidemiological overview of the mental health situation in Belize was conducted in 1993 (Bonander et al, 2000). Preliminary results are available. The high use of drugs among young people was revealed in two studies: the National Secondary School Prevalence Survey conducted in 2002 and the Global Youth Tobacco Survey conducted in 2003.

**Programmes for Special Population** There is no specific programme, but patients belonging to any special group of population can go for consultation as outpatients, depending on their needs. The National Drug Advisory Council, which is a part of the Ministry of Health, has a well organized drug prevention programme.

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

A selected list of the newer psychotropic drugs were added to the National Drug Formulary recently.

**Other Information** Issues of stigma and discrimination continue to be a major problem and are often a hindrance for mental health consumers advocating for better services. With limited human resources for mental health, the Psychiatric Nurses have played an instrumental role in meeting the direct needs of the communities in which they serve. Beside their main duties, they have provided ongoing counselling for survivors of domestic violence, including rape and child abuse, HIV/AIDS Counselling etc.

**Additional Sources of Information**

- Cayetano, C. (April 2004). The need for the psychiatric services.  
- National Health Information Surveillance Unit, Ministry of Health Belmopan. 2003.
Benin

GENERAL INFORMATION
Benin is a country with an approximate area of 113 thousand sq. km. (UNO, 2001). Its population is 6.918 million, and the sex ratio (men per hundred women) is 97 (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 54.8% for men and 25.5% 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 4.4%. The per capita total expenditure on health is 39 international $, and the per capita government expenditure on health is 18 international $ (WHO, 2004). The main language(s) used in the country is (are) French. The largest ethnic group(s) is (are) African. The largest religious group(s) is (are) indigenous groups (four-fifths), and the other religious group(s) are (is) Christian. The life expectancy at birth is 50.1 years for males and 52.4 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 Benin in internationally accessible literature. Some studies on common conditions like depression and panic disorder in clinical samples are available (Bertschy, 1992; Bertschy et al, 1992).

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 1999.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1997.

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 Details about the mental health legislation are not available.

Mental Health Financing Details about disability benefits for mental health are not available.

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 and tax based.

Mental health care for the chronically sick persons with very low or no resources is financed from the state budget. Private insurance companies do not provide for the care of mentally ill people.

The country does not have disability benefits for persons with mental disorders. Treatment is provided free.

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. This will be possible only when decentralization is done.

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. It is available only where pilot projects are going on.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population 0.08

Psychiatric beds in mental hospitals per 10 000 population 0.03

Psychiatric beds in general hospitals per 10 000 population 0.05

Psychiatric beds in other settings per 10 000 population 0.05

Number of psychiatrists per 100 000 population 1.2

Number of neurosurgeons per 100 000 population 0.05

Number of psychiatric nurses per 100 000 population 0

Number of neurologists per 100 000 population 0.05

Number of psychologists per 100 000 population 0.05

Number of social workers per 100 000 population 0.02

Ten psychologists are in training. Four-fifths of the psychiatrists practice in the southern side of the country where the population mainly consists of the majority ethnic community, i.e. the Fon.

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

Information Gathering System Details about mental health reporting systems are not available.
The country has no data collection system or epidemiological study on mental health. Only thesis works related to epidemiological studies exist.

Programmes for Special Population The country has specific programmes for mental health for elderly and children. SMRR cares for children with psychiatric problems and the university for the elderly with psychiatric problems.

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, levodopa.

Other Information

Additional Sources of Information
## Bhutan

### GENERAL INFORMATION

Bhutan is a country with an approximate area of 47 thousand sq. km. (UNO, 2001). Its population is 2.325 million, and the sex ratio (men per hundred women) is 102 (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 56% for men and 28% 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 64 international $, and the per capita government expenditure on health is 58 international $ (WHO, 2004).

The main language(s) used in the country is (are) Chhokey, Ngalopkha (in the west), Sharchopkha (in the east) and Nepali (in the south). The largest ethnic group(s) is (are) Tibetan, Indo-Mongoloid and indigenous (three-fourths), and the other ethnic group(s) are (is) Nepalese. The largest religious group(s) is (are) Mahayana Buddhist (seven-tenths), and the other religious group(s) are (is) Hindu.

The life expectancy at birth is 60.2 years for males and 62.4 years for females (WHO, 2004). The healthy life expectancy at birth is 53 years for males and 53 years for females (WHO, 2004).

### EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Bhutan in internationally accessible literature. Some data are available on Bhutanese refugees living in Nepal. These are described under the relevant section in Nepal.

### 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 and treatment.

#### Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1988. The Narcotic Drugs and Psychotropic Substances Notification deals with definitions, offences and penalties and prohibition, control and regulation.

#### National Mental Health Programme

A national mental health programme is present. The programme was formulated in 1997. The primary objectives of the programme are to integrate mental health into primary care and to help in improvement of general health care, undertake public education and to reduce problems related to neuropsychiatric conditions and training of personnel.

#### National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1987.

#### Mental Health Legislation

There is no mental health legislation.

#### Mental Health Financing

There are budget allocations for mental health. The country spends 0.17% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, grants and social insurance. The country has disability benefits for persons with mental disorders. Mentally ill patients are exempted from paying labour tax. Some are given cash benefits.

#### 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. Some drugs like chlorpromazine and diazepam are available at the basic health unit. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 100 personnel were provided training. There are community care facilities for patients with mental disorders. Basic emergency and follow-up services are done by health workers in the community but more training is required.

### Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Category</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>0.3</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>0.16</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0</td>
</tr>
</tbody>
</table>

There is one occupational therapist. There is a shortage of trained mental health staff.
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. All mental illnesses are lumped under the heading of mental disorders; moreover, reporting may not be correct.

The country has data collection system or epidemiological study on mental health. JDWNR hospital in Thimpu has started maintaining patient treatment data since July 1999.

Programmes for Special Population The mental health programme, being in an early stage, is not able to provide special care.

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

Most of the listed drugs are available at the referral hospitals and district hospitals and some of the drugs in basic health units. Those marked out above are only those drugs available at basic health units.

Other Information

Additional Sources of Information

Health Services Administration (1997) Project HSD 05: Mental Health Programme.
Report on Community-Based Mental Health Programme (as part of National Mental Health Programme).
Bolivia

GENERAL INFORMATION
Bolivia is a country with an approximate area of 1099 thousand sq. km. (UNO, 2001). Its population is 8.973 million, and the sex ratio (men per hundred women) is 99 (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 7% (WHO, 2004). The literacy rate is 93.1% for men and 80.7% 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 5.3%. The per capita total expenditure on health is 125 international $, and the per capita government expenditure on health is 83 international $ (WHO, 2004).

The main language(s) used in the country is (are) Spanish, Quechua and Aymara. The largest ethnic group(s) is (are) Quechua, and the other ethnic group(s) are (is) Aymara. The largest religious group(s) is (are) Roman Catholic (almost 95%), and the other religious group(s) are (is) indigenous groups.

The life expectancy at birth is 61.8 years for males and 64.7 years for females (WHO, 2004). The healthy life expectancy at birth is 54 years for males and 55 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on Bolivia. But some studies suggest that articles in relation to drug use and abuse may be available in other languages. An interesting study that employed ethnographic methods suggested that migration changed the rates of mental pathology in a special ethnographic population group (Chiriguano) (Pages et al, 1981).

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 1985. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. It was revised in 2001 through a process that included consultations with stakeholder groups that included politicians, mental health professionals and civil servants. Between 10 to 25% of its original content was put into practice.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1977. It was revised in 2001, and a regular budget was set aside for its implementation. Currently, about 10-25% of the policy goals have been implemented. There is also a specific legislation for substance abuse from 1988.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1972. It was revised in 2001, and a regular budget was set aside for its implementation. Currently, about 10-25% of the programme has been implemented by 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 1992. The national programme of essential drugs has grown steadily from 1991 onwards.

Mental Health Legislation The mental health legislation was revised in 2001. There are regular funds for its implementation. It focuses on promotion and prevention, human rights, regulation of mental health services, etc., but there is no reference to regulation of involuntary treatment. The latest legislation was enacted in 1978.

Mental Health Financing There are budget allocations for mental health. The country spends 0.2% 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.

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 psychiatrists. A referral system is in place. 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 community care system for the mentally ill includes outpatient clinics, preventive/promotion interventions, home interventions, residential facilities and vocational training, however, these are available for less than 25% of the population. Primary health care doctors and nurses are responsible for taking care of patients with mental disorders in the community.
**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>0.791</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 pop.</td>
<td>0.51</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals per 10 000 pop.</td>
<td>0.04</td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10 000 pop.</td>
<td></td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000 pop.</td>
<td>0.9</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 pop.</td>
<td>0.8</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 pop.</td>
<td></td>
</tr>
<tr>
<td>Number of neurologists per 100 000 pop.</td>
<td>0.5</td>
</tr>
<tr>
<td>Number of psychologists per 100 000 pop.</td>
<td>5</td>
</tr>
<tr>
<td>Number of social workers per 100 000 pop.</td>
<td></td>
</tr>
</tbody>
</table>

About half of mental health professionals of various disciplines are employed in the public sector.

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

**Information Gathering System** There is mental health reporting system in the country. Both ICD-10 and DSM-IV are used for recording purposes. 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 elderly and 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, haloperidol, lithium, biperiden, carbidopa, levodopa.

The essential list of drugs was revised in 2003.

**Other Information**

**Additional Sources of Information**


Bosnia and Herzegovina

GENERAL INFORMATION

Bosnia and Herzegovina is a country with an approximate area of 51 thousand sq. km. (UNO, 2001). Its population is 4.186 million, and the sex ratio (men per hundred women) is 98 (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 15% (WHO, 2004). The literacy rate is 98.4% for men and 91.1% 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 7.5%. The per capita total expenditure on health is 268 international $, and the per capita government expenditure on health is 99 international $ (WHO, 2004).

The main languages used in the country are (are) Bosnian, Serbian and Croatian. The largest ethnic group(s) is (are) Bosniac, and the other ethnic group(s) are (is) Croat, Serb, Roma and Slovenian. The largest religious group(s) is (are) Muslim, and the other religious group(s) are (is) Catholic and Orthodox Christian.

The life expectancy at birth is 69.3 years for males and 76.4 years for females (WHO, 2004). The healthy life expectancy at birth is 62 years for males and 66 years for females (WHO, 2004).

EPIDEMIOLOGY

Community studies in war torn areas showed enormous increase of mental disorders (total: over 60%, neurotic disorder: over 40%, psychotic disorders: about 20%). Dahl et al (1998) assessed 209 displaced women in a war zone in 1994 using a 10-item Posttraumatic Symptom Scale (PTSS-10). The proportion of caseness (defined by a score of six or more symptoms) was highest (71%) among women who had survived the most severe trauma (concentration camps or other kinds of detention) in comparison to others (47%) with less severe trauma. Caseness was also associated with severity of trauma and marital support (absent husband) in a multivariate analysis. Goldstein et al (1997) found that the majority of children in their sample had faced multiple stresses (separations from family, bereavement, close contact with war and combat and extreme deprivation) and that the prevalence and severity of experiences were not significantly related to a child's gender, wealth or age, but were related to their region of residence. Almost 94% of the children met DSM-IV criteria for posttraumatic stress disorder. High levels of other symptoms were also found.

Children with greater symptoms had witnessed the death, injury or torture of a member of their nuclear family, were older and came from a large city. Allwood et al (2002) assessed 791 children aged 6 to 16 years during the 1994 siege in Sarajevo with the help of the Impact of Event Scale, PTSD Reaction Index, the Children's Depression Inventory, the Child Behavior Checklist, and the War Experience Questionnaire (completed by teachers). Nearly 41% had clinically significant PTSD symptoms. Children were adversely affected by exposure to both violent and non-violent war-traumas. An additive effect of trauma exposure on trauma reactions was also found. As part of a UNICEF-sponsored Psychosocial Programme in Bosnia, Smith et al (2001) collected data from a representative sample of 339 children aged 9-14 years, their mothers and their teachers in order to investigate risk and moderating factors in children's psychological reactions to war. Self-report data from children revealed high levels of post-traumatic stress symptoms and grief reactions, but normal levels of depression and anxiety. Mothers' self-reports also indicated high levels of post-traumatic stress reactions, but normal levels of depression and anxiety. Structural equation modelling showed that child distress was related to both their level of exposure and to maternal reactions. Among the children and adolescents there was an increase of neurotic and psychotic disorders in the very beginning of the first year of the war, and a decrease of the same diagnoses during the second year. Stein et al (1999) who examined 147 displaced children residing in refugee centres in Bosnia reported that symptoms of posttraumatic stress, anxiety and depression showed a greater decrease in boys relative to girls over time. A study on soldiers showed that alcohol abuse was 3.7 times more frequent in participants of combat actions compared to those who did not have such assignment (Plavljanc & Mijic, 1997). Loga et al (1999) reported that stress/reactive psychoses increased and alcoholic psychoses decreased in clinical samples during the war. Studies on Bosnian refugees in Croatia are detailed under the relevant section of Croatia.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1996. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Basic elements of the mental health policy are: decentralization and sectorization of mental health services; intersectoral activity; comprehensiveness of services; equality in access and utilization of psychiatric service resources; nationwide accessibility of mental health services; continuity of services and care, together with the active participation of the community.

Substance Abuse Policy A substance abuse policy is absent. A substance abuse policy is in the implementation phase. Government and Parliament of Federation of Bosnia and Herzegovina have approved the Action Plan for Prevention and Treatment of Addictions, while a similar Plan still needs to be approved by the Parliament of Republic of Srpska. The best achievements in prevention and treatment of addictions are in two Cantons – Sarajevo and Tuzla.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1996. The national plan needs are: postdoctoral study seminars on stress, PTSD, trauma psychology, treatment of war trauma; training programmes for staff including doctors, psychologists, psychiatric nurses, social workers, teachers and students of medicine and psychology; psychiatric and psychological services for individual and group counselling, psychotherapy for psychiatric patients, supervision of staff; mobile professional emergency teams for psychological trauma, with screening for PTSD, depression, suicidal states and...
other kinds of psychiatric emergencies; institutions for forensic psychiatry; telepsychiatry service for assessment of callers and their reported problems; national plan for mental health care.

**National Therapeutic Drug Policy/Essential List of Drugs** A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1996.

**Mental Health Legislation** The mental health legislation is in the form of a general law, ‘Law on protection of persons with mental health’. A similar law in the Republic of Srpska is awaiting the approval of the Parliament. The latest legislation was enacted in 2000.

**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 out of pocket expenditure by the patient or family. Local authorities also contribute a small proportion of financing of mental health care. The country has disability benefits for persons with mental disorders. The Complete Health Care Insurance takes care of any disability benefits.

**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. Primary care services are available for some cases. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 200 personnel were provided training. A network of community mental health centres is operational. An efficient and useful training of the staff in these centres has been carried out. Training programmes for family doctors and general practitioners are also available. There are community care facilities for patients with mental disorders. Community care services are partially developed and are in the process of development. After the war, 38 community mental health centres (with catchment areas of 25 000-50 000 inhabitants) were proposed in Bosnia and Herzegovina and 7 in Republic of Srpska with funding by World Bank. These were to be established within or appended to the existing health centres and serve a catchment area of 50 000 to 100 000 inhabitants. Their aims were to provide clinical services for the mentally ill people and psychosocial rehabilitation to those traumatised by war. They offer a variety of services. Most personnel have changed their attitudes to mental health and relevant service provision and devoted to implement mental health reforms. Studies show that mental health personnel would like to have more influence on decision making for future service and policy improvements and that service users are satisfied with the service provided.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Professional Type</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>3.6</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>2.4</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>1.0</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0.2</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>1.8</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>0.08</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>10.0</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>0.4</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0.5</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Even during the war (1992-1995), WHO and the Universities in Sarajevo and Tuzla conducted a one year post-graduate course on ‘Psychological Trauma and Healing’ for psychiatrists, psychologists and social workers. There is continuous education in the field of mental health since 1999. Sarajevo University in cooperation with Centro di Studi in Trieste, Italy and within the TEMPUS Project organized postgraduate study ‘Community Psychiatry’ for young psychiatrists, psychologists and social workers. Sarajevo University, in cooperation with Umea University, Sweden, is organizing a full postgraduate study in Child and Adolescent Psychiatry and Psychology.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Many NGOs and international organizations, e.g., UNICEF, Médecins sans Frontières, Save the Children and Oxfam, have mental health programmes in the country with a focus on crisis counselling but a long term perspective. They have established accessible counselling centres and trained local counsellors and supervisors. Others like SweBiH (Swedish-Bosnian Association for Psychological and Social assistance to Bosnia & Herzegovina, founded by Swedish East Europe Committee and financed by SIDA), and HNI Bosnia-Hercegovina have focused on training of personnel from different professions. Users are a key element in the operation of mental health services. Five associations of former psychiatric patients, have organized under the umbrella Alliance at the state level.
**BOSNIA AND HERZEGOVINA**

**Information Gathering System** There is mental health reporting system in the country. But the system is not fully functional. The lacks of the system now represent a danger to the implementation and the future of the system itself. The country has no data collection system or epidemiological study on mental health. There is a need for development at the national level of a data set on mental health.

**Programmes for Special Population** The country has specific programmes for mental health for refugees, disaster affected population and children. It is estimated that in the Srpska Republic, there are more than 500,000 refugees (from ex-Yugoslavia, Croatia, etc.) and about 20,000 internal displaced persons (from Kosovo and the Federal Republic of Yugoslavia). These refugees are living in collective shelters, in private accommodation, or with relatives and friends all over the country. The more vulnerable subjects have developed serious psychiatric disorders. In the country, there are only 5 centres for community-based rehabilitation. The main clinical problems which most urgently require attention are: enduring personality change, post-traumatic stress disorder and suicide. Special centres or special programmes within psychiatric clinics are urgently needed to treat existing problems of these kinds. The main goals of projects concerned with psycho-social support and rehabilitation of persons with PTSD are: education and training for nurses, doctors, psychologists, social workers, teachers, and students of medicine and psychology, as well as volunteers; detection of traumatised persons, as a consequence of stressful experiences; development of a programme for the treatment and evaluation of each high-risk group; psychological and psychiatric help, as well as psycho-social support and rehabilitation for psychologically traumatised persons with symptoms of PTSD or anxious-depressive and psychosomatic reactions; prevention of suicide. The reorganization of services for the mentally ill is aimed at both war victims and others; and this is organized at community mental health centres. Similarly, a public mental health approach was used to develop and implement a school-based postwar trauma/grief intervention programme for adolescents. This approach included the development of multilateral partnerships with various stakeholders, systematic assessment that yields a detailed understanding of the specific range and severity of trauma and loss experiences, current adversities and trauma reminders among the affected population, and a training programme aimed at developing the capacities of local service providers and an indigenous support infrastructure so that the intervention programme could be directed and sustained by people within the communities served.

**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** The country comprises of two separate entities – Bosnia and Herzegovina and Srpska Republic. The information is a combination of information available from both parts. The country comprises of two entities Federation of Bosnia and Herzegovina and Republic of Srpska, as well as District Brcko. The first neuropsychiatry unit was set up in Sarajevo University in 1947, and since then the psychiatric services have gradually expanded (Ceric et al, 1995).

**Additional Sources of Information**


Botswana

GENERAL INFORMATION
Botswana is a country with an approximate area of 582 thousand sq. km. (UNO, 2001). Its population is 1.795 million, and the sex ratio (men per hundred women) is 97 (UNO, 2004). The proportion of population under the age of 15 years is 39% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 76.1% for men and 81.5% 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 6.6%. The per capita total expenditure on health is 381 international $, and the per capita government expenditure on health is 252 international $ (WHO, 2004).

The main language(s) used in the country is (are) English and Setswana (official). The largest ethnic group(s) is (are) Setswana speaking tribes. The largest religious group(s) is (are) Christian.

The life expectancy at birth is 40.2 years for males and 40.6 years for females (WHO, 2004). The healthy life expectancy at birth is 36 years for males and 35 years for females (WHO, 2004).

EPIDEMIOLOGY
Ben-Tovim and Cushnie (1986) ascertained the one-year prevalence of schizophrenia among individuals aged 15 years or older living in six villages in a remote area of Botswana. All cases were diagnosed independently by two experienced psychiatrists, following ICD-9 rubrics. DSM-III criteria were also applied, separately. Accurate contemporary population estimates of the villages were available. The age-adjusted prevalence of schizophrenia was 5.3 per 1000 in terms of ICD-9, or 4.3 per 1000 by DSM-III, which has an upper age limit for onset of 45 years. Ben-Tovim (1983, 1985) encountered substantial psychiatric morbidity in primary level psychiatric care facilities in Botswana, but he found that acute psychoses and culture-bound syndromes were rare. Lobatse Mental Hospital reports indicate that acute psychotic conditions are a common cause of admissions. Almost 18% of admissions at the main national referral hospital were HIV positive (Sidandi et al, 2004). Ben-Tovim and Boyce (1988) compared patient profiles in psychiatric hospitals of Botswana and South Australia. The patients in Botswana in comparison to Australia had shorter duration of illness, were likely to suffer from psychotic illnesses rather than personality and neurotic illnesses and were more likely to suffer from violence against property or others rather than self. A few articles on sexual behaviour and HIV and wife abuse were also accessible (Herring, 2001; Mmidi & Delmonico, 2001; Maundeni, 2002).

MENTAL HEALTH RESOURCES

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

Substance Abuse Policy A substance abuse policy is present. Details about the year of formulation are not available. The plan to develop a substance abuse policy is in the advanced stage.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1992. Plans are under way to have the programme evaluated.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1992. Revision of the policy is under way.

Mental Health Legislation The mental disorders act is under revision and will be soon replaced by the Mental Health Act of Botswana. The latest legislation was enacted in 1971.

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 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. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 343 personnel were provided training. Facilities for training community mental health nurses is present. It is an 18 months post-basic course which teaches nurses to function effectively in the community, district and tertiary psychiatric hospitals. The training is comprehensive. There are community care facilities for patients with mental disorders. Community care is mainly provided by family welfare educators based in primary care facilities. A community mental health nurse can provide all aspects of mental health and psychiatric nursing as well as render promotional, preventive, therapeutic and rehabilitative mental health services. They also provide consultative services due to the lack of trained psychiatrists and also train other non-specialized colleagues in the field of mental health.
Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 1.1
Psychiatric beds in mental hospitals per 10 000 population 0.7
Psychiatric beds in general hospitals per 10 000 population 0.4
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 0.4
Number of neurosurgeons per 100 000 population 0.1
Number of psychiatric nurses per 100 000 population 9
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 3

One neurologist visits from South Africa. There are 821 family welfare educators, 9 occupational therapists and 6 occupational therapy assistants.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation. Research is also an activity of NGOs.

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 There are no services for special population groups.

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
Additional Sources of Information
Central Statistics Office, Government Printer, Gaborone
Brazil

GENERAL INFORMATION
Brazil is a country with an approximate area of 8547 thousand sq. km. (UNO, 2001). Its population is 180.655 million, and the sex ratio (men per hundred women) is 97 (UNO, 2004). The proportion of population under the age of 15 years is 28% (UNO, 2004), and the proportion of population above the age of 60 years is 8% (WHO, 2004). The literacy rate is 88% for men and 88.3% 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 7.6%. The per capita total expenditure on health is 573 international $, and the per capita government expenditure on health is 238 international $ (WHO, 2004).

The main language(s) used in the country is (are) Portuguese. The largest ethnic group(s) is (are) Portuguese (descent), and the other ethnic group(s) are (is) mixed Caucasian and African (descent). The largest religious group(s) is (are) Roman Catholic (almost 70%), and the other religious group(s) are (is) Protestant.

The life expectancy at birth is 65.7 years for males and 72.3 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY
Andrade et al (2002) conducted a community survey for mental disorders in adults (n=1464) using Composite International Diagnostic Interview (CIDI-1.1). The life time, 1-year and 1-month prevalence of ICD-10 mental disorders were 45.9%, 26.8% and 22.2%, respectively. The most prevalent disorders (lifetime, 12-month and 1-month, respectively) were: nicotine dependence (25%, 11.4%, 9.3%), any mood disorder (18.5%, 7.6%, 5%) with depressive episode the most common mood disorder (16.8%, 7.1%, 4.5%), any anxiety disorder (12.5%, 7.7%, 6%), somatoform disorder (6%, 4.2%, 3.2%) and alcohol abuse/dependence (5.5%, 4.5%, 4%). No gender differences were found in overall morbidity. However, if substance use disorders were excluded, women had a higher risk for non-psychotic disorders. Kohn et al (2004) examined 1464 subjects utilizing the CIDI 1.1 and the DSM-III-R criteria and found that the lifetime prevalence for major depression was 12.6 %, for alcohol use disorders 14.9%, for non-affective psychosis 2.1% and for bipolar disorder 1.3%. In a multi-site study, Almeido Filho et al (1997), employed a two-stage methodology to assess 6476 subjects. Age-adjusted prevalence of cases ranged from 19% to 34% with anxiety and alcohol use disorders being the commonest (18% and 8% respectively). A number of studies that used only a screening instrument for ascertaining caseness found rates between 22.7% and 37.5% (De Lima et al, 1999; Faria et al, 1999). Higher rates were found among women (24.5%-26.5%) in comparison to men (11.7%-17.9%) (De Jesus et al, 1993; De Lima et al, 1999). An inverse relationship was seen between level of income, schooling and prevalence of minor psychiatric disorders (De Lima et al, 1999). Faria et al (1999) found that pesticide poisoning was strongly associated with minor psychiatric disorders in a population of farm workers. Herrera et al (2002) interviewed 1656 individuals aged over 65 years and found that 7.7% suffered from dementia (55.1% Alzheimer's disease, 9.3% vascular type and 14.4% mixed type). Age, female gender and low educational level were significantly associated with a higher prevalence of dementia. The prevalence of Organic Brain Syndrome in the elderly varied from 5.9% to 29.8% and of depression from 19.7% to 35.1% in a community study done in three cities (Veras & Murphy 1994). Moreira et al (1996), assessed 1091 individuals selected through a population-based multistage random sampling using the CAGE questionnaire and found the rate of depression to be 39.3%. Chaieb and Castellarin (1998) compared age and sex matched alcoholics (identified by the use of CAGE questionnaire) and non-alcoholics. Alcohol dependence was associated with male gender, smoking (in self and family members) and low educational, employment and income status. De Carvalho (1986) identified drug abuse in 23.8% of college students with cannabis, amphetamines, tranquilizers and cocaine abuse being the most prevalent. Moreira et al (2001) found erectile dysfunction of some degree in 39.5% to 46.2% of respondents in three large population surveys. Age, marital status (never married), educational attainment (low), race/ethnicity (black), homo/bisexuality and a history of physical and mental illnesses were associated with an increased prevalence of erectile dysfunction. Silva et al (1999) reviewed data in files catalogued by the Legal Medical Institution and other indirect sources of information and found that suicide occurred more often among single men between 21 and 30 years of age. They also reported that the rate of suicide was not increasing and that the preferential method for committing suicide was hanging. Baus et al (2002) assessed 478 elementary and high school students during the 4th National Survey on Drug Abuse. Regular use (6 or more times per month) of alcohol, marijuana, solvent drugs and amphetamines was found in 24.2%, 4.9%, 2.5% and 2.3% of students, respectively. Age, gender, social status and living with both parents were significantly associated with drug abuse. Girls were more likely to consume weight loss drugs, stimulants and tranquilizers, and boys were more likely to use solvent drugs. Guardiola et al (2000) found ADHD in 18% of 484 first-graders while applying DSM-IV criteria and 3.5% using neuropsychological criteria.

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. There are regular funds for its implementation. 50-75% of its original content was put into practice.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 2000. It was revised in 2001, and has a specific budget for its implementation. A specific legislation for substance abuse exists since 1978.
National Mental Health Programme  A national mental health programme is present. The programme was formulated in 1991. It was revised in 2001. There is a specific budget for its implementation and 50% to 75% of it is already implemented. Its main components are strategy of services reform, integration of mental health services into primary care and development of specialized services. The various states in the country have different mental health programmes currently 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 1978.

Mental Health Legislation  There is a mental health legislation. Funding is available for its implementation. It focuses on human rights (conforms to International Human Rights laws), regulation of involuntary treatment, regulation of mental health services, admission and discharge procedures, housing, accommodation and employment facilities for patients. Brazil’s Psychiatric Reform Law shifted the emphasis from hospital-based care to community-based care. In Brazil, the national laws are hierarchically superior to state laws. Some subjects like penal laws are exclusively federal while others like laws that regulate penitentiary and health services can be either federal or state. The national laws that are relevant to the field of forensic psychiatry are the Federal Constitution, the Penal Execution Law, the Health Organic Law, the Penal Code and the Penal Procedural Code. Different states have their own laws in addition to the above. There is a provision for recognition of guilty but mentally ill. Under Brazilian law, notwithstanding competence, the defendant is submitted to trial. This is possible because the defendant has a passive role. The latest legislation was enacted in 2001.

Mental Health Financing  There are budget allocations for mental health. The country spends 2.5% 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. Approximately 2.0% is spent on general hospitals, 80.0% in psychiatric hospitals, 15.0% in ambulatory clinics and 3.0% in community care. There is a plan to audit psychiatric hospitals. The new laws permit remuneration for consultations performed by professionals like psychologists, nurses, social workers and for management at centres of psychosocial attention. The slow growth of mental health care in private general hospitals is hypothesized to be related to the low rates paid for psychiatric services by 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 not available at the primary level. This kind of service is available for less than 25% of the population. Mental health care is provided by primary health care doctors and nurses. A system of referral is in place. 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 community care system for the mentally ill includes outpatient clinics, preventive/promotion interventions, home interventions all of them available for less than 25% of the treated population, and residential facilities available to 50 to 75% of the treated population. Current services involve an active participation of multi-disciplinary teams. Over the last one and a half decade, hundreds of new services including day care centres have been created. However, services are heavily concentrated in the most developed regions and state capitals.

Psychiatric Beds and Professionals  

| Total psychiatric beds per 10 000 population | 2.56 |
| Psychiatric beds in mental hospitals per 10 000 population | 2.44 |
| Psychiatric beds in general hospitals per 10 000 population | 0.12 |
| Psychiatric beds in other settings per 10 000 population | 4.8 |
| Number of psychiatrists per 100 000 population | 4.8 |
| Number of neurosurgeons per 100 000 population | 31.8 |
| Number of psychiatric nurses per 100 000 population | 0.12 |
| Number of neurologists per 100 000 population | 0.12 |
| Number of psychologists per 100 000 population | 0.12 |
| Number of social workers per 100 000 population | 0.12 |

More data are being collected on human resources in mental health. There was a gradual closing down of hospital beds even before the new law (2001). In the last one and a half decades, the number of beds came down from 85,000 to about 43,000. 30% of these beds are occupied by long stay patients (>1 year). Of the over 6000 general hospitals in Brazil, less than 2% had psychiatric units. There has been a gradual growth of the private sector particularly for care of drug abuse patients. There is a provision of forensic psychiatric hospitals, but all states do not have them. A system of progressive discharge helps in acceptance and integration of forensic psychiatric patients in the community. Mental health professionals are concentrated in the south and south-east of the country. Brazil is the only country in South America where the profession of psychology is regulated. This is important as more
than 90% of the causes are conducted by private institutions. Almost two-thirds of psychologists are employed in private institutions. Continuing education is neither required nor regulated. Psychologists cannot prescribe medication, and few can directly admit patients to hospitals. Psychiatric nursing started to develop in Brazil since 1970, when community care began to be emphasized. Due to the creation of new services, the prospects of employment of nurses have risen.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, treatment and rehabilitation. They participate in 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. The mental health components are for inpatients, admission and discharge and for outpatient care consultations. The country has data collection system or epidemiological study on mental health. The Statistics Department from the Unified Health System (DATASUS) is in charge of the data collection system for mental disorders. Data collection is conducted in parts of the system: hospitals and outpatient clinics.

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

**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, haloperidol, lithium, biperiden. The National Therapeutic Drugs Policy was revised in 1999.

**Other Information**

**Additional Sources of Information**


Brunei Darussalam

GENERAL INFORMATION
Brunei Darussalam is a country with an approximate area of 6 thousand sq. km. (UNO, 2001). Its population is 0.366 million, and the sex ratio (men per hundred women) is 108 (UNO, 2004). The proportion of population under the age of 15 years is 30% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 96.3% for men and 91.4% 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 3.1%. The per capita total expenditure on health is 638 international $, and the per capita government expenditure on health is 507 international $ (WHO, 2004).
The main language(s) used in the country is (are) Malay, Chinese and English. The largest ethnic group(s) is (are) Malay (two-thirds), and the other ethnic group(s) are (is) Chinese and Iban. The largest religious group(s) is (are) Muslim.
The life expectancy at birth is 74.8 years for males and 77.4 years for females (WHO, 2004). The healthy life expectancy at birth is 65 years for males and 66 years for females (WHO, 2004).

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

MENTAL HEALTH RESOURCES
Mental Health Policy
A mental health policy is absent.
Though the country has no mental health policy, certain components of the policy like advocacy, prevention, etc. are undertaken from time to time on an ad-hoc basis.

Substance Abuse Policy
A substance abuse policy is present. Details about the year of formulation are not available. The substance abuse policy deals with misuse of illicit drugs and prohibition of alcohol.

National Mental Health Programme
A national mental health programme is absent.
Though at present the country lacks a national mental health programme, it has been identified as one of the six priority programmes under the National Committee of Health Promotion formed in March 2000.

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 Lunacy Act is under the process of revision.
The latest legislation was enacted in 1929.

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 mental illness allowance given from the Ministry of Youth, Culture and Sports.

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. Treatment is undertaken at the psychiatric units of two hospitals and 6 other outpatient psychiatric clinics under the care of psychiatrists.
Regular training of primary care professionals is not carried out in the field of mental health. Training of primary care personnel in mental health is done on an ad-hoc basis and is integrated into the CME for doctors, nurses and other health professionals.
There are community care facilities for patients with mental disorders. There are three day-care centres and one community care team.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 1.2
Psychiatric beds in mental hospitals per 10 000 population 0
Psychiatric beds in general hospitals per 10 000 population 1.2
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 1.9
Number of neurosurgeons per 100 000 population 0.6
Number of psychiatric nurses per 100 000 population 0.3
Number of neurologists per 100 000 population 0.9
Number of psychologists per 100 000 population 0.3
Number of social workers per 100 000 population 1
The 6 social workers and 1 clinical psychologist provide some services for the mental health units but are not specifically allocated to mental health. The geographic distribution of mental health facilities is uneven because of their limited number, e.g. inpatient facilities may be relatively inaccessible for the population residing in the rural interior areas to the west.

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

**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 facilities at present and support services are provided through mental health services coordinating with other programmes.

**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, haloperidol, lithium, carbidopa, levodopa.

**Other Information** The system of primary care clinics as such is well developed and a regular flying doctor service covers most populous areas.

**Additional Sources of Information**
Bulgaria

GENERAL INFORMATION

Bulgaria is a country with an approximate area of 111 thousand sq. km. (UNO, 2001). Its population is 7.829 million, and the sex ratio (men per hundred women) is 94 (UNO, 2004). The proportion of population under the age of 15 years is 14% (UNO, 2004), and the proportion of population above the age of 60 years is 22% (WHO, 2004). The literacy rate is 99.1% for men and 98.1% 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 4.8%. The per capita total expenditure on health is 303 international $, and the per capita government expenditure on health is 248 international $ (WHO, 2004).

The main language(s) used in the country is (are) Bulgarian and Turkish. The largest ethnic group(s) is (are) Bulgarian (five-sixths), and the other ethnic group(s) are (is) Turks. The largest religious group(s) is (are) Bulgarian Orthodox Christian (five-sixths), and the other religious group(s) are (is) Muslim.

The life expectancy at birth is 68.8 years for males and 75.6 years for females (WHO, 2004). The healthy life expectancy at birth is 63 years for males and 67 years for females (WHO, 2004).

EPIDEMIOLOGY

Dimitrova et al (1997) reviewed registers and reported that projected psychiatric morbidity had increased by 4% over the period 1989-93 to 2.4%. As a part of a WHO collaborative project, Saunders et al (1993) determined the prevalence of hazardous and harmful alcohol use among patients attending primary health care facilities in several countries including Bulgaria. After non-drinkers and known alcoholics had been excluded, 18% of subjects had a hazardous level of alcohol intake and 23% had experienced at least one alcohol-related problem in the previous year. Popova (1996) found that between 1961 and 1991 suicide rates had doubled to 17.2/100 000 population. Suicide was associated with mental illness, gender (male) and age (elderly). Akabaliev and Iliev (2002) conducted a study on all documented completed suicides (n=353) due to poisoning in a region of Bulgaria during the period of socioeconomic transition and crisis (1990-2000). Age, female gender, local and rural residence, pensioner status, intake of drugs, pesticide and corrosive intoxications and receipt of medical aid were significantly associated with lethal suicidal poisoning when compared to lethal accidental poisoning. Men predominated in the working age group and women in the pensioners’ age group. Men tended to use poisons and corrosives while women used drug overdoses as means of committing suicide. Iliev et al (2000) found that younger age and female gender were associated with deliberate self-poisoning in a retrospective study on a representative sample (n=311) from a regional toxicological centre. Almost half of the subjects had a psychiatric disorder with adjustment disorder (53.6%) and depressive and schizophrenic disorders (26.8%) being the leading diagnoses. Milev and Mikhov (1992) reviewed hospital data (n=9235) and found that female subjects were four times more likely to attempt suicide. More than half of the patients were below 24 years and were single. Iliev et al (2001) studied the whole caseload (n=571) of acute overdose with psycho-active substances in a regional toxicology center (catchment area served 8.8% of the population of the country) in a 10 year period between 1990 and 2000. Alcohol (62.8%) and opioid (15.3%) intoxications were common especially among severe intoxications. The lethality rate was 1.6%. Serious reading and writing disorders were detected in 14.8% of all pupils in a study done in the setting of a single school. These disorders were encountered in 29.3% of children with low marks and in only 1% of those with good marks (Bircheva, 1979).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 2004. It was adopted by the Council of Ministries along with an Action plan for the period 2005-2012. This policy incorporates all the relevant elements of the National Health Strategy ‘Better health for better future’ and develops the main principles of the mental health reform formulated since 2001. The main goals are: to substitute for centrally funded, hierarchically administered institutions a network of comprehensive community-based mental health services; and to integrate mental health services in the general health system. Suicide, drug and alcohol abuse and learning disabilities are subject to other policy documentation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 2001. The policy covers the areas of prevention, treatment and rehabilitation. A specific legislation on psychoactive substances and their precursors also exists. A National Drug Service was created at the Ministry of Health to implement the Act of Drugs and their Precursors.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2001. The mental health programme includes several demonstration projects related with the basic principles of the reform – a pilot community mental health center, mobile teams for crisis intervention, acute psychiatric wards and protected homes. An important part of the programme is the international epidemiological study on stress related disorders in Bulgaria (EPIBUL) in cooperation with WHO and Michigan University. A comprehensive national suicide prevention programme is present.

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. Pharmacotherapy is widely applied, and access to new drugs is unimpaired.
Mental Health Legislation
Bulgaria does not have a specific mental health act. There are some provisions in two chapters in the actual Public Health Act (enacted 1973) that postulate rules for involuntary treatment of mentally ill persons. During the last few years, partial changes have been made in Bulgaria (i.e. exclusion of sections on compulsory admission for alcohol and drug abusers without psychotic symptoms and compulsory work activity in the course of such treatment; a new option for outpatient and day care treatment under compulsion). In the new Health Act (2004), in a separate chapter for mental health, there are more detailed provisions for compulsory treatment, informed consent, definition of the mental health services and responsible institutions and patients’ rights. The Bulgarian Penal Code for offenders with mental illness was formulated in 1968. The Health Services Act (1999) made access to specialist care conditional on referral from primary care. The latest legislation was enacted in 1973.

Mental Health Financing
There are budget allocations for mental health. The country spends 2.5% of the total health budget on mental health.

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

The Bulgarian Ministry of Health funds 11 large governmental psychiatric hospitals. Some hospitals and dispensaries are financed by the Ministry of Finance and local municipalities. From the 1st of July 2000 with the introduction of the new health insurance system, inpatient services are financed through taxes (state budget) and outpatient services through the National Health Insurance Fund. According to the Health Insurance Law all citizens in the country have a compulsory health insurance. This makes outpatient health services accessible to about 90% of the population in the country. The funding for NGO projects is exclusively from external donors on a grant basis.

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. Severe mental disorders are treated by specialists.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 450 personnel were provided training. The programme for training of the GPs in mental health is in its preliminary stage. A module for mental health training was introduced within the post-graduate training for GPs a few years ago.

There are no community care facilities for patients with mental disorders. There are very few community care facilities such as day centres, sheltered houses, etc. for patients with mental disorders. Pilot projects for such services are run by NGOs, National Mental Health Programme, Stability Pact SEE Mental Health Project and some are planned for the future under the PHARE project (starting 2005). With the process of reform in psychiatry, the existing system of mental health services will be changed and community-based mental health care will be introduced. At present, Bulgarian psychiatrists do not practise the components of modern community-based psychiatry in a way that meets international standards. The implementation of these components would require the development of new training programmes based on experiences derived from these pilot services.

Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th></th>
<th>per 10 000 population</th>
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</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>8.3</td>
</tr>
<tr>
<td>Psychiatric beds in</td>
<td></td>
</tr>
<tr>
<td>mental hospitals</td>
<td>4.1</td>
</tr>
<tr>
<td>Psychiatric beds in</td>
<td></td>
</tr>
<tr>
<td>general hospitals</td>
<td>1.9</td>
</tr>
<tr>
<td>Psychiatric beds in</td>
<td></td>
</tr>
<tr>
<td>other settings</td>
<td>2.3</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>9</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>1.6</td>
</tr>
<tr>
<td>Number of psychiatric</td>
<td></td>
</tr>
<tr>
<td>nurses</td>
<td>15</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>15</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0.9</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0.3</td>
</tr>
</tbody>
</table>

The other specialists are working in private set-ups. Mental health needs are defined from a medical point of view. This implies that control of symptoms is the most important service and it underestimates the need for other types of intervention programmes – occupational, psychological, etc. Staffs, mainly composed of psychiatrists, dominate the treatment process and reflect a paternalistic treatment model. Some special residential facilities under the social welfare administration provide care for chronically mentally ill patients. The delivery of outpatient services is based on geographical responsibility. There is a lack of coordination between hospitals and outpatient services in terms of procedures for referral and follow-up. About 100, 80 and 20 beds are available for treatment of drug abusers, forensic cases, and children, respectively. Mental health needs are defined from a medical point of view. The introduction of National Health Insurance prompted several psychiatrists to leave their salaried positions within the Government system and establish private specialist services. Postgraduate training in child and adolescent psychiatry is available.
Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. The Geneva Initiative on Psychiatry is helping in the training of psychiatric nurses and future trainers. Open Society Foundation is also interested in promoting activities in mental health reform.

Information Gathering System There is mental health reporting system in the country. It is based on the national and regional centres for health information. 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, elderly and children. Most of the programmes are run by NGOs and have a limited scope of action. There are programmes for women victims of violence. There are well established psychiatric services for children, for alcohol and drug abusers and for forensic psychiatry. There are also psychiatrists who work predominantly with elderly mentally ill. WHO in collaboration with the Bulgarian Institute for Human Relations has been involved in a project to improve the mental health and well-being of the community through engaging adolescents in prevention and promotion related activities. Every city has a child psychiatric ambulatory unit; some of these units have a day-treatment centre.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, sodium valproate, amitriptyline, chlorpromazine, fluphenazine, haloperidol, biperiden, carbidopa, levodopa. Some medicines are reimbursed totally or partially by the health insurance system. Only the tablet form of fluphenazine is reimbursed. A combination of Carbidopa and Levodopa is reimbursed.

Other Information There are no procedures for the cost assessment of psychiatric disability or psychiatric care. The significance of stigmatization and discrimination because of mental illness is not widely recognized. This leads to a poor quality of life for mentally ill patients and their relatives, as well as to a poor quality of services offered. However, the process of recognition of the importance of patients’ participation in the decision-making process has started.

Additional Sources of Information


Bircheva, E. (1979) Reading and writing disorders in elementary school students with varying achievement. Problemi Na Khigienata, 4, 136-142.


Burkina Faso

GENERAL INFORMATION
Burkina Faso is a country with an approximate area of 274 thousand sq. km. (UNO, 2001). Its population is 13.393 million, and the sex ratio (men per hundred women) is 96 (UNO, 2004). The proportion of population under the age of 15 years is 49% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 18.5% for men and 8.1% 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%. The per capita total expenditure on health is 27 international $, and the per capita government expenditure on health is 16 international $ (WHO, 2004).

The main language(s) used in the country is (are) French. The largest ethnic group(s) is (are) Mossi, and the other ethnic group(s) are (is) Dioula, Peulh, Gourmantché, Bobo, Gourounsi, Samo. The largest religious group(s) is (are) Muslim, and the other religious group(s) are (is) indigenous groups.

The life expectancy at birth is 40.6 years for males and 42.6 years for females (WHO, 2004). The healthy life expectancy at birth is 35 years for males and 36 years for females (WHO, 2004).

EPIDEMIOLOGY
In a community study, Ouedraogo et al (1997) found enuresis in 12.9% in a sample of 1575 adolescents. Among them, 78.9% had primary enuresis. Ouedraogo et al (1998a) estimated the prevalence of disorders in child and adolescent population in a psychiatric hospital. The most current pathologies were epilepsy (31.5%), psychoses (25.7%) and adjustment disorders (21.5%). Ouedraogo and Ouango (1998) found paranoid schizophrenia to be the predominant subtype of schizophrenia among psychiatric patients. Ouedraogo et al (1998b) found that psychosocial support and parity play an important role in postpartum depression among patients admitted to maternity wards.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is absent.

Some features of mental health policy are defined in the Public Health Code.

Substance Abuse Policy A substance abuse policy is present. Details about the year of formulation are not available. Substance abuse issues are also discussed in the Public Health Code.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2002.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1996.

Mental Health Legislation The Public Health Code has references to mental health. 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. Details about sources of financing are not available. Details about disability benefits for mental health are not available.

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. Psychiatric units are present in national and regional hospitals and one in an isolation hospital. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 50 personnel were provided training.

There are community care facilities for patients with mental disorders. Traditional treatment by healers provide community care. Since 1983, the mental health system has been gradually decentralized.

Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Psychiatric Beds and Professionals</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>0.18</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
<td>0.06</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals per 10 000 population</td>
<td>0.12</td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10 000 population</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000 population</td>
<td>0.05</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 population</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td>0.4</td>
</tr>
<tr>
<td>Number of neurologists per 100 000 population</td>
<td>0.01</td>
</tr>
<tr>
<td>Number of psychologists per 100 000 population</td>
<td>0.03</td>
</tr>
<tr>
<td>Number of social workers per 100 000 population</td>
<td>0.02</td>
</tr>
</tbody>
</table>
Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, treatment and rehabilitation.

Information Gathering System There is mental health reporting system in the country. Data are only available at the hospital level; abstracts can be obtained from the Health Statistical Report 1996. The country has data collection system or epidemiological study on mental health. A National Health Information System consists of data related to epidemiological study and hospital data. They are included in the National Health Statistics Report 1996 and the Mental Health Activities Assessment 2000.

Programmes for Special Population The country has specific programmes for mental health for children. In 2001, new strategies were developed to look into the children with mental conditions.

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

Other Information

Additional Sources of Information
Burundi

GENERAL INFORMATION
Burundi is a country with an approximate area of 28 thousand sq. km. (UNO, 2001). Its population is 7.068 million, and the sex ratio (men per hundred women) is 96 (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 57.7% for men and 43.6% 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 3.6%. The per capita total expenditure on health is 19 international $, and the per capita government expenditure on health is 11 international $ (WHO, 2004).
The main language(s) used in the country is (are) French and Swahili. The largest ethnic group(s) is (are) Hutu, and the other ethnic group(s) are (is) Tutsi and Twa. 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 38.7 years for males and 43 years for females (WHO, 2004). The healthy life expectancy at birth is 33 years for males and 37 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Burundi in internationally accessible literature. A study showed that sexual abuse is not as uncommon as thought (Baribwira et al, 1994). Some data are available on Burundese refugees living in Tanzania. These are described under the relevant section in Tanzania.

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 present. The programme was formulated in 1998.
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 Details about 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 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 not available at the primary level. Personnel are not trained as yet, and the number of drugs are limited.
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 care is available only in four provinces and is undertaken by an NGO.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 0.1
Psychiatric beds in mental hospitals per 10 000 population 0.1
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 0.02
Number of neurosurgeons per 100 000 population 0.02
Number of psychiatric nurses per 100 000 population 0
Number of neurologists per 100 000 population 0.06
Number of psychologists per 100 000 population 0.2
Number of social workers per 100 000 population 1.5
There is a special workers school and the university produces psychologists.

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 no mental health reporting system in the country. The personnel are untrained and the questionnaires do not contain questions on mental disorders. The country has no data collection system or epidemiological study on mental health. The system is being built.

Programmes for Special Population There are no special programmes for any population group.

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, levodopa.
There is also an essential list of drugs which was initially made in 1980, and the last revision was done in 1994.

Other Information

Additional Sources of Information