Cambodia

GENERAL INFORMATION
Cambodia is a country with an approximate area of 181 thousand sq. km. (UNO, 2001). Its population is 14.482 million, and the sex ratio (men per hundred women) is 95 (UNO, 2004). The proportion of population under the age of 15 years is 41% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 80.8% for men and 59.3% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 11.8%. The per capita total expenditure on health is 184 international $, and the per capita government expenditure on health is 27 international $ (WHO, 2004).

The main language(s) used in the country is (are) Khmer. The largest ethnic group(s) is (are) Khmer (nine-tenths). The largest religious group(s) is (are) Buddhism.

The life expectancy at birth is 51.9 years for males and 57.1 years for females (WHO, 2004). The healthy life expectancy at birth is 46 years for males and 50 years for females (WHO, 2004).

EPIDEMIOLOGY
De Jong et al (2001) conducted epidemiological surveys to establish the rate of PTSD in 4 post-conflict zones, Algeria, Cambodia, Ethiopia and Gaza, using the PTSD module of CIDI. The sample consisted of adults (aged >=16 years) who were randomly selected from community populations (Cambodia, n=610). PTSD was prevalent in 28.4% of the population surveyed in Cambodia compared to 37.4% in Algeria, 15.8% in Ethiopia and 17.8% in Gaza. The following risk factors were associated with PTSD in Cambodia: conflict-related trauma after age 12 years, psychiatric history and current illness, youth domestic stress, death or separation in the family and alcohol abuse in parents. A number of studies have addressed mental health issues of Cambodian refugees in camps in the Thai-Cambodian border. These are presented under the relevant section in Thailand. Some studies which have looked at issues related to substance use disorders were accessible.

MENTAL HEALTH RESOURCES

Mental Health Policy
A mental health policy is absent.
A draft was submitted to the Ministry of Health, but it has not been formally recognized yet. The development of the mental health policy is emerging as a national priority as a component of the national health policy.

Substance Abuse Policy
A substance abuse policy is present. Details about the year of formulation are not available.

National Mental Health Programme
A national mental health programme is absent.
A national mental health plan 2003-2020 has been prepared with inputs from WHO, mental health professionals, NGOs and other stakeholders. It focuses on promotion and prevention, access to care, integration of mental health care with primary and general health care, and development of mental health legislation and community care.

National Therapeutic Drug Policy/Essential List of Drugs
A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1997.
The National Sub-committee on Mental Health is trying to improve the distribution and availability of psychotropics. The basic essential drugs are available. Second generation drugs are freely available in private pharmacies but are expensive.

Mental Health Legislation
There is no mental health legislation. However, a draft is present which is to be finalized soon.
Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing
There are budget allocations for mental health.
Details about expenditure on mental health are not available.
The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, grants and tax based.
In the public sector, patients pay small consultation fees in public services, but prescribed medicines are provided free of charge. The country does not have disability benefits for persons with mental disorders. There is a Disability Action Council composed of personnel from the Government, non-governmental and international organizations and religious organizations. The Government provides support in kind, and the main funding is provided by international donors. The Council is dealing with themes like raising awareness, drafting legislation and community work. Pilot studies are being conducted in villages to ascertain the prevalence of disability, both physical and mental. Further studies would be conducted to ascertain service availability.

Mental Health Facilities
Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. It is available in some provincial and referral hospitals and is currently in the six most populous of the twenty-three provinces and municipalities.
Regular training of primary care professionals is carried out in the field of mental health. A two-year training in mental health for general practitioners (102) and nurses in one province was organized by the Harvard Trauma Programme in Cambodia. The Transcultural Psychosocial Organization also trained several general practitioners and nurses. The Cambodian Mental Health
Development Programme offers training for mental health care in primary care to general practitioners, military and police doctors. Besides this, the municipal health department of some areas also offer training. Training has been provided to staff, albeit to a small group (e.g. about 100 out of 3000 doctors), who have then gone on to train community leaders like teachers, monks, village elders in identification of mental health problems. Training of primary care officials has been carried out in the field of mental health since 1997. Several NGOs have included primary health care training in their project design. Outpatient services have been developed as an offshoot of such training programmes.

There are community care facilities for patients with mental disorders. Since there are no existing mental hospitals, it is felt that general hospital facilities for treatment of mental disorders needs to be developed. Some clinics are beginning to operate with the help of the newly trained professionals. Two community-based day care centres have been set up with the help of NGOs. An effort is being made to integrate grass root workers in the care of mentally ill under the broader framework of general health. Traditional healers are also being included in the rehabilitation process in rural settings.

### 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>0.16</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>0.009</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>0.22</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0.45</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Psychiatric services before 1975 included only one psychiatric hospital. Between 1979 and 1992, there were no mental health services as services and training programmes were available at some of the refugee camps in the Thai-Cambodian border. Currently, mental outpatient services are available in 12 out of 67 referral hospitals in the country. A 4-bedded ward is being developed for treatment of drug users. It may also be used for admission of acutely ill psychiatric patients. Training programmes in the country for psychiatrists and psychiatric nurses were established in 1994 with Norwegian (NORCOMH, NORAD, Norwegian Ministry of Foreign Affairs) financial assistance through the University of Oslo and IOM, the Association of Medical Doctors in Asia (Japan) and the Ministry of Health. 30% of the qualified psychiatrists are not involved in mental health work at a clinical level as they are in other health care positions and two-thirds are in the capital city. Psychiatrists are allowed part-time private practice. In one province, where there is no psychiatrist, a psychiatric nurse has been authorized to prescribe medication if needed on telephonic consultation with psychiatrists in Pnom Penh.

### Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Six NGOs are active in the mental health area. These NGOs are funded by donations from international NGOs and organizations. There is a proposal to organize all NGOs in a council to utilize their resources more effectively. The Transcultural Psychosocial Organization (TPO) and the Social Service du Combodge (SSC) train village level workers and social workers, develop self-help groups and aid in providing assistance and referral to mentally ill for treatment in 6 out of 21 provinces. In addition, the TPO supports mental health groups for land mine victims and amputees at the WARS (War Amputees rehabilitation Services) centre and has developed a manual entitled Community mental health in Cambodia for training workers. The SSC runs a day care centre with help from the Municipality Government. The Centre for Child Mental Health (CCMH) is a comprehensive child and adolescent assessment and treatment centre in Pnom Penh and it has an outreach project in another city.

### Information Gathering System

There is mental health reporting system in the country. Very few data are reported. The country has no data collection system or epidemiological study on mental health. There have been some form of epidemiological research but analysis is awaited.

### Programmes for Special Population

The country has specific programmes for mental health for children. There is a small clinic for children. A post-conflict family support programme has begun in Battambang under the aegis of the International Organization for Migration. Programmes of care and rehabilitation for landmine victims have included mental health.

### Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam, haloperidol. Carbamazepine, fluphenazine and lithium though available are not present in primary care.
Other Information Cambodia is in active transition from a post conflict situation to one of peace and development and that while the challenges are enormous; progress is being made under difficult circumstances. The Khmer Rouge shut the only mental hospital in 1975 and only a few traditional healers were allowed to practice and care for the mentally ill. After the Pol Pot regime was overthrown in 1979, the traditional healers gained more importance, though formal mental health care was not restored. It is only after 1990, when the international community started rebuilding the country that western methods of psychiatric care were introduced. The first western services were introduced in 1995. The Canadian Marcel Roy Foundation for Children of Cambodia started a child mental health clinic at a hospital in 1994. In the same year the International Organization for Migration along with the Norwegian council for Mental Health started the Cambodian Mental Health Training Programme to train 10 local doctors as psychiatrists. Psychiatry was included in the curricula of doctors and nurses in 1995. In 1996, the Harvard Training Programme in Cambodia started an outpatient department in the Siem Riep Provincial Hospital and in the following year provided psychiatric training to 48 doctors and medical assistants. An Office for Mental Health has been established within the Ministry of Health and budget has been provided for procuring essential psychotropic drugs, though no other financial support is currently available. The Ministry of Health feels that there is a huge scope for a close collaboration with WHO in developing programmes and policies in the field of mental health.

Additional Sources of Information

Cameroon

GENERAL INFORMATION
Cameroon is a country with an approximate area of 475 thousand sq. km. (UNO, 2001). Its population is 16.296 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 42% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 77% for men and 59.8% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.3%. The per capita total expenditure on health is 42 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 and English (official). The largest ethnic group(s) is (are) Cameroon Highlanders, and the other ethnic group(s) are (is) Equatorial Bantu, Kirdi, Fulani, Baka/pygmies, Northwest Bantu and other African groups. The largest religious group(s) is (are) indigenous groups and Christian, and the other religious group(s) are (is) Muslim.

The life expectancy at birth is 47.2 years for males and 49 years for females (WHO, 2004). The healthy life expectancy at birth is 41 years for males and 42 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Cameroon in internationally accessible literature. A rapid assessment study revealed that the use of cannabis, heroin and cocaine was common. Solvents were mainly used by street children (Wansi et al, 1996). Studies suggest that child sexual abuse may require public health attention (Mabassa et al, 1999; Menick, 2002).

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 1998. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Formation and legislation are also a component of the policy. The process of drafting began in 1992, but the mechanism for its implementation is still being worked out.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1992. The mechanism for its implementation is still being worked out.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999. It is included in the National Sectorial Strategy for Health.

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 Activities related to a mental health legislation have been issued in the draft form. Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are budget allocations for mental health. The country spends 0.1% 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 and private insurances. Mental health has been included as a public health priority since 1989 with a designation of a mental health national coordinator, but greater priority was given to family planning and hospital medicine. In 2003, the mental health sub-directorate was cancelled with a risk of rolling back of financing for mental health. For example, the 2000-2001 budget addressed mental health programme activities with particular regard to the development of community-based mental health and with a plan to implement it over the next three years, but these activities could not be implemented.

The country has disability benefits for persons with mental disorders. It is available only for public servants who have mental illness.

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. Mental health care in the primary health set-up is being developed as a part of the mental health action plan. Regular training of primary care professionals is carried out in the field of mental health. Training modules exist for training primary care personnel. Training of primary care workers commenced in 2004. There are no community care facilities for patients with mental disorders.
**Psychiatric Beds and Professionals**

Total psychiatric beds per 10 000 population 0.08  
Psychiatric beds in mental hospitals per 10 000 population 0.07  
Psychiatric beds in general hospitals per 10 000 population 0.0007  
Psychiatric beds in other settings per 10 000 population  
Number of psychiatrists per 100 000 population 0.03  
Number of neurosurgeons per 100 000 population 0.03  
Number of psychiatric nurses per 100 000 population 0.2  
Number of neurologists per 100 000 population 0.03  
Number of psychologists per 100 000 population 0  
Number of social workers per 100 000 population 0.1  

Psychologists get training in clinical psychology while working (but without structured clinical supervision). Some psychologists in the private sector carry out counselling.

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

**Information Gathering System** There is no mental health reporting system in the country. Data collection is poor because of insufficient staff.

The country has no data collection system or epidemiological study on mental health. Service reorganization (as prescribed in the existing sectorial strategy document) will allow for standardization of the epidemiological collection system.

An information gathering network is not yet developed due to a lack of trained and motivated staff and a lack of infrastructure.

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

**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, biperiden, carbidopa, levodopa.

**Other Information** Even if political and budget programmes are present, the plans in mental health are very slow to activate because of low priority, which leads to ineffective use of even existing human resources and capacities.

**Additional Sources of Information**

Canada

GENERAL INFORMATION
Canada is a country with an approximate area of 9971 thousand sq. km. (UNO, 2001). Its population is 31.743 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 18% (UNO, 2004), and the proportion of population above the age of 60 years is 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 9.5%. The per capita total expenditure on health is 2792 international $, and the per capita government expenditure on health is 1978 international $ (WHO, 2004).

The main language(s) used in the country is (are) English and French. The largest ethnic group(s) is (are) British and French (descent), and the other ethnic group(s) are (is) other European. The largest religious group(s) is (are) Roman Catholic, and the other religious group(s) are (is) Anglican and other Christian (United Church).

The life expectancy at birth is 77.2 years for males and 82.3 years for females (WHO, 2004). The healthy life expectancy at birth is 70 years for males and 74 years for females (WHO, 2004).

EPIDEMIOLOGY
There is substantial epidemiological data on mental illnesses in Canada 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.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Each of the provinces and territories in Canada have a mental health policy. The components of these policies can include support for advocacy, promotion, prevention, treatment and rehabilitation. The Federal Government is involved in health care at several broad levels: maintaining Canada's Health Act (the overarching legal framework that sets the minimum standards for health insurance in each province), financing (through taxation), health promotion, provision of services to federal inmates in custody and direct funding of services to aboriginal populations and military personnel. By virtue of having to meet the standards outlined in Canada's Health Act, Canada has thirteen interlocking health insurance plans and thirteen separate service delivery systems. Provided minimum standards are met, each province may adapt services and legislation to meet its own needs. Thus, there can be a significant variation in service access, programme coverage, funding, human resources and legislation across the country. Since the federal involvement in health and therefore mental health is restricted, there are few national policies or programmes relating to mental health treatment or service delivery.

One exception to this is the ‘Report on the Task Force on Mental Health’ (1991) published by the Correctional Services of Canada pertaining to federally incarcerated inmates. The Federal Government regularly releases National Action Plans, strategies and discussion documents relating to health and mental health. Often these are the result of national consensus-building exercises. While these are not policy statements per se, they are meant to stimulate thinking and guide provincial service developments. Perhaps the most important of these policy-type documents is the ‘Mental Health for Canadians: Striking a Balance’ (1988) which provided a set of guiding principles to assist Canadians engaged in developing and reviewing mental health related policies and programmes.

The Federal Government does not have jurisdiction over treatment/rehabilitation but is involved in policy coordination, knowledge development, strengthening communities, professional participation, mutual aid, human rights and citizenship and reducing inequalities. Since Canada's drug policy includes many issues related to federal law enforcement, the Federal Government provides leadership and undertakes national co-ordination on issues pertaining to alcohol and drugs by working collaboratively with Provincial Governments. Canada's Health Act limits the powers of the Federal Government in matters of health delivery and programming.

Provision is under the provinces or territories. In all provinces but one, the local ministries have divested authorities for direct service delivery to regional authorities and they carry out functions within the geographical areas. At the provincial level, mental health services are provided through a variety of means: primary care, general hospital care, community service, specialized treatment facilities, psychiatric hospitals, community providers, NGOs and consumer-run organizations. The extent to which all of these are organized under a single administration differ from one province to another. Implementation of evidence-based therapies and best practice models of service delivery are explicit aims of the mental health policies in most provinces.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1998.

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

Mental health programming occurs in the provincial level. Most provinces have an elected or appointed regional health board which has the responsibility for the planning and operation of all health, including mental health, services for a defined population.

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

Mental Health Legislation The latest legislation on mental health is Ontario's Brian's Law. Each of Canada's provinces can frame their own laws. While certain themes run throughout with respect to the key criteria for civil commitment (such as dangerousness to others) and underlying principles (such as promotion of the least restrictive alternative), provincial mental health acts may differ
widely on specific issues such as the extent to which they permit grave disability or need for treatment as criteria for involuntary confinement. The most recent legislation in mental health has been the Amendment to Ontario’s Mental Health Act (Brian’s Law). Across the country, people are debating about including Community Treatment Orders, a legal mechanism for ensuring compliance to treatment outside hospital settings, and three provinces have legislated involuntary community commitment. All people in Canada are entitled to the rights and freedoms enshrined in the Charter of Rights and Freedom. Besides this, there are common laws which are judgements passed by the judges in different trials and which become a precedent for future cases. In Canada, the Federal Government is responsible for enacting legislation governing criminal law. This is embodied in a set of statutes known as the Criminal Code of Canada. The provinces and territories are each responsible for delivery of health and enact their own laws related to services and care of mental health patients. The Criminal Code has undergone two recent amendments. Firstly, an offender with mental disorder can now be found guilty but nonetheless exempt from criminal responsibility. Secondly, well defined circumstances and procedures, including time lines, have been established to conduct psychiatric assessments of offenders. A revision to the mental disorder provisions of the Criminal Code are expected by the spring of 2005. The latest legislation was enacted in 2000.

**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, out of pocket expenditure by the patient or family, private insurances and social insurance.

There are no federal budgets for mental health, but each province has its own health and mental health budget. Virtually all necessary medical services have a tax based funding source. However, private services are paid for by patients themselves or through private insurances and form just less than one-third of the total health bill. The cornerstone of the Canadian health care system is a national health insurance programme called the Medicare. It is administered by the provinces and territories and regulated and partly financed through block transfer payments by the National Government. The Medicare pays basic medical and hospital bills. The direct and indirect costs related to mental health problems are estimated to be among the costliest of all conditions and represent nearly one-sixth of the national corporate net operating profits. Since 1970, more funds have been allotted to community care programmes, but this forms only about one-twentieth of the provincial mental health budget. Provincial health insurance plans fund general practitioners but do not usually cover services provided by other mental health professionals.

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. In a ‘shared care’ system, primary practitioners provide care while in collaboration with a psychiatrist. However, serious patients are often referred to the psychiatrist and primary practitioners take care of stabilized and less serious patients. About 50% of medical treatment for mental and emotional disorders are provided through the primary care system. Regular training of primary care professionals is carried out in the field of mental health. Though training is provided regularly, there are no official national figures for the number of persons trained per year.

There are community care facilities for patients with mental disorders. Canada uses a range of assertive community-based treatment strategies in combination with crisis intervention and residential treatment options. Case management is key to the success of community care. There are also community-based crisis response systems and these include phone lines, walk-in clinics, mobile crisis teams, free-standing crisis centres, hospital emergency departments with holding beds and inpatient psychiatric units. The other element in community care is supported housing. In some provinces, innovative arrangements between the Ministry of Health and Social Service Ministries have led to coordinated approaches, but in general, coordination between treatment and essential support services is sub-optimal. There are relatively few home care programmes existing in the country.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>19.34</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
<td>9.1</td>
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<tr>
<td>Psychiatric beds in general hospitals per 10 000 population</td>
<td>5.06</td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10 000 population</td>
<td>5.18</td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000 population</td>
<td>12</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 population</td>
<td>44</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td>44</td>
</tr>
<tr>
<td>Number of neurologists per 100 000 population</td>
<td>35</td>
</tr>
<tr>
<td>Number of psychologists per 100 000 population</td>
<td></td>
</tr>
<tr>
<td>Number of social workers per 100 000 population</td>
<td></td>
</tr>
</tbody>
</table>

The figures for professionals date back to 1991-93. The figures for social workers, occupational therapists and recreational therapists working for mental health are not known. Psychiatrists are mainly concentrated in the cities and vast remote areas lack psychiatrists. Non-medical professionals usually work within agencies or hospital settings on a salaried basis but may also offer services in...
a private practice. Secondary level care is provided by general hospital psychiatry units. They form an important part of the crisis response system, consultation and family education and general assessment and treatment. There is an increasing trend to have community-based tertiary care units having well-staffed specialized units. Between 1950 and 2000, almost 80% of beds for mentally ill patients were eliminated from psychiatric hospitals. Only three sub-specialities are recognized in psychiatry: child, geriatric and forensic. Members of other sub-speciality practices such as addiction or administration have sought credentialing from US organizations. About 10% of psychiatrists are child psychiatrists. International medical graduates have accounted for about a quarter of the supply of physicians in Canada, this portion doubling in the province of Newfoundland and the Saskatchewan. The current shortage of physicians and the fact that their average age is 49 years have spurred a renewed effort to streamline the entry of prospective immigrants through the Medical Council of Canada, provincial licensing colleges and medical schools. Psychiatrists are required to accumulate 400 Continuing Medical Education credits over a 5-year period to maintain speciality certification.

**Non-Governmental Organizations** NGOs are not involved with mental health in the country. Though there are no official NGOs in Canada, there are numerous self-help and advocacy groups. Some like Canadian Mental Health Association – National (CMHA) have been instrumental in altering views across Canada about consumer capacities and necessary elements of a system of care. provinces are now funding consumer survivor development initiatives. Twelve NGOs (Canadian Alliance on Mental Illness and Health), including the Canadian Psychiatric Association, have urged the Government to identify specific mental health goals, a policy framework embracing both mental illness and mental health promotion, adequate resources to sustain the plan and an annual public reporting mechanism.

**Information Gathering System** There is mental health reporting system in the country. Hospital morbidity data, mortality data, national surveys, etc. provide sources for annual reporting on mental health.

The country has a data collection system or epidemiological study on mental health. There are surveys on selected epidemiological data on mental health (such as stress and depression). Administrative databases describing hospital morbidity and mortality also exist. The ‘Population Mental Health in Canada’ provides a good summary of the population mental health indicators taken from the most recent National Population Health Survey. Health Survey Cycle 1.2 by Statistics Canada collected national statistics on five mental disorders – bi-polar disorder, panic disorder, social anxiety, agoraphobia and uni-polar depression – as well as information on alcohol and illicit drug dependence. This information is available on the Statistics Canada web site at: http://www.statcan.ca/english/health/atlas/health/cycle1

**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 the mentally disordered offenders and developmentally disabled patients.

Until recently, drug abuse management services were delivered separately from mental health services. Efforts are being made to integrate the two in some provinces. Forensic services have been developed along somewhat different lines in different provinces. Almost all seem to have small-medium secure regional forensic units; there are 3 maximum security forensic hospitals in Canada. Telehealth programmes appear to offer some relief to poorly resourced communities.

**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.

Costing and dosing has been taken from the Ontario Drug Benefit Formulary/Comparative Index (1998). These are recommended prices. At times people pay more, e.g. as dispensing fees, or at times they pay less as their insurances cover them. Elderly patients are eligible for special benefits.

**Other Information**

**Additional Sources of Information**

Arboleda-Flórez, J. El Sistema de Salud Mental en el Canadá.


Cape Verde

GENERAL INFORMATION
Cape Verde is a country with an approximate area of 4 thousand sq. km. (UNO, 2001). The country is an archipelago with mostly mountainous islands. Its population is 0.472 million, and the sex ratio (men per hundred women) is 92 (UNO, 2004). The proportion of population under the age of 15 years is 38% (UNO, 2004), and the proportion of population above the age of 60 years is 6%. (WHO, 2004). The literacy rate is 85.4% for men and 68% 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 4.5%. The per capita total expenditure on health is 165 international $, and the per capita government expenditure on health is 138 international $ (WHO, 2004).

The main language(s) used in the country is (are) Portuguese and Crioulo. The largest ethnic group(s) is (are) Creole, and the other ethnic group(s) are (is) African. The largest religious group(s) is (are) Roman Catholic, and the other religious group(s) are (is) indigenous groups.

The life expectancy at birth is 66.6 years for males and 72.9 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 63 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Cape Verde in internationally accessible literature. Neto and Barros (2000) assessed loneliness in students from Cape Verde and Portugal using standardized instruments. They found loneliness to be associated with neuroticism and dissatisfaction with life.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is absent. The national health policy covers some aspects of mental health.

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 present. The programme was formulated in 1986.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1979.

Mental Health Legislation Some old laws dating back to the pre-independence period, i.e. prior to 1975 do exist, but there is no legislation after that period except one on restriction on tobacco consumption of 1995. The latest legislation was enacted in 1975.

Mental Health Financing There are budget allocations for mental health. The primary source of mental health financing is tax based. The country has disability benefits for persons with mental disorders. Disability benefits for Government employees exist in the form that they are allowed to draw their salaries in spite of not working.

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. Patients are treated by admission to hospital. Rehabilitation is done with the help of family support. Regular training of primary care professionals is carried out in the field of mental health. There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 0.78
Psychiatric beds in mental hospitals per 10 000 population 0
Psychiatric beds in general hospitals per 10 000 population 0.78
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 0.9
Number of neurosurgeons per 100 000 population
Number of psychiatric nurses per 100 000 population
Number of neurologists per 100 000 population
Number of psychologists per 100 000 population 0.9
Number of social workers per 100 000 population 0.2

Occupational therapy is present at the Centre for Occupational Therapy. Only one occupational therapist is present.

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

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. The central hospitals have systems of registering admissions/discharges of inpatients. Hospital data from the central hospital is collected.

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

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, biperiden, carbidopa, levodopa.

Other Information

Additional Sources of Information
Central African Republic

GENERAL INFORMATION
Central African Republic is a country with an approximate area of 623 thousand sq. km. (UNO, 2001). Its population is 3.912 million, and the sex ratio (men per hundred women) is 95 (UNO, 2004). The proportion of population under the age of 15 years is 43% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 64.7% for men and 33.5% 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 4.5%. The per capita total expenditure on health is 58 international $, and the per capita government expenditure on health is 30 international $ (WHO, 2004).
The main language(s) used in the country is (are) French. The largest ethnic group(s) is (are) Baya and Banda, and the other ethnic group(s) are (is) Mandjia and Sara. The largest religious group(s) is (are) Roman Catholic, and the other religious group(s) are (is) Protestant, indigenous groups and Muslim.
The life expectancy at birth is 42.1 years for males and 43.7 years for females (WHO, 2004). The healthy life expectancy at birth is 37 years for males and 38 years for females (WHO, 2004).

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

MENTAL HEALTH RESOURCES
Mental Health Policy
A mental health policy is absent.
The national mental health policy formulation had to be stopped because of serious military-political events in the country. The situation analysis for this policy formulation is complete and funding is being sought to revive the activities.

Substance Abuse Policy
A substance abuse policy is absent.

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

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

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 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. Neuroleptics are very cheap. A campaign against drug abuse has been undertaken by the Ministry of Health.
Regular training of primary care professionals is not carried out in the field of mental health.
There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 0.07
Psychiatric beds in mental hospitals per 10 000 population 0
Psychiatric beds in general hospitals per 10 000 population 0.07
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 0.03
Number of neurosurgeons per 100 000 population 0
Number of psychiatric nurses per 100 000 population 0.03
Number of neurologists per 100 000 population 0.03
Number of psychologists per 100 000 population 0.08
Number of social workers per 100 000 population 0.03

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

Information Gathering System
There is no mental health reporting system in the country.
The country has data collection system or epidemiological study on mental health. An annual statistics report in psychiatry and mental health service does exist.
Programmes for Special Population  The country has specific programmes for mental health for refugees, indigenous population and children.

Therapeutic Drugs  The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, chlorpromazine, diazepam.
The essential drug list was revised in 2004.

Other Information

Additional Sources of Information
Chad

GENERAL INFORMATION
Chad is a country with an approximate area of 1284 thousand sq. km. (UNO, 2001). Its population is 8.854 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 47% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 54.5% for men and 37.5% 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 2.6%. The per capita total expenditure on health is 17 international $, and the per capita government expenditure on health is 13 international $ (WHO, 2004).
The main language(s) used in the country is (are) French and Arabic. The largest ethnic group(s) is (are) Toubou forming the majority in north, Arab in the Sahelian zone and Sara in the Soudanian zone. The largest religious group(s) is (are) Muslim (half).
The life expectancy at birth is 46.1 years for males and 49.3 years for females (WHO, 2004). The healthy life expectancy at birth is 40 years for males and 42 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Chad in internationally accessible literature. Katz and Katz (2002) found that social strain accounted for a significant proportion of variance in depressive symptoms and somatic complaints of intellectually disabled people.

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 1996.
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.
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 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, social insurance and private insurances.
The country has disability benefits for persons with mental disorders. Benefits are available only for public servants who get their full salary for the initial 6 months and then half the salary.
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. Very few psychotropics are included in the essential drug list and treatment is difficult.
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. Only traditional treatment is available at the community level.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 0.02
Psychiatric beds in mental hospitals per 10 000 population 0.01
Psychiatric beds in general hospitals per 10 000 population 0.01
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 0.01
Number of neurosurgeons per 100 000 population 0.01
Number of psychiatric nurses per 100 000 population 0.01
Number of neurologists per 100 000 population 0
Number of psychologists per 100 000 population 0.01
Number of social workers per 100 000 population 0
These resources are not widely used.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation.
Information Gathering System There is mental health reporting system in the country. Mental disorders are grouped as 'other disorders'. The country has data collection system or epidemiological study on mental health.

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, chlorpromazine, diazepam, haloperidol, levodopa.

Other Information

Additional Sources of Information
Chile

GENERAL INFORMATION
Chile is a country with an approximate area of 757 thousand sq. km. (UNO, 2001). Its population is 15.997 million, and the sex ratio (men per hundred women) is 98 (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 11% (WHO, 2004). The literacy rate is 95.8% for men and 95.6% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7%. The per capita total expenditure on health is 792 international $, and the per capita government expenditure on health is 348 international $ (WHO, 2004).

The main language(s) used in the country is (are) Spanish. The largest ethnic group(s) is (are) Mestizo (two-thirds), and the other ethnic group(s) are (is) European and Native American. The largest religious group(s) is (are) Roman Catholic (70%), and the other religious group(s) are (is) Evangelical and Protestant Christian.

The life expectancy at birth is 73.4 years for males and 80 years for females (WHO, 2004). The healthy life expectancy at birth is 65 years for males and 70 years for females (WHO, 2004).

EPIDEMIOLOGY
Araya et al (2001) interviewed 3870 adults from households selected by a probabilistic sampling design using the Clinical Interview Schedule-Revised (CIS-R). Almost 13% of the respondents met ICD-10 criteria for psychiatric illness. Female gender, low socioeconomic status, unemployment, low education, marital separation and single parenthood were associated with increased prevalence of mental disorders. In another study using a probabilistic design, Vincente et al (2002) assessed 2978 individuals from 4 regions of Chile using CIDI. The life time and 6-month prevalence of DSM-III-R defined psychiatric disorder was 36% and 23%, respectively. The most common lifetime diagnoses were agoraphobia (11%), major depressive disorder (9%), dysthymia (8%) and alcohol dependence (6%). The Third National Study of the Consumption of Drugs, conducted on a nationally representative sample of 31,665 individuals in the age group of 12 to 64 years, showed that 17.5% of individuals reported the life time use of one of the three illicit drugs (marijuana: 16.8%, coca paste: 2.3% and cocaine hydrochloride: 4.0%). The one-year and one-month prevalence of use of any of the three drugs were 5.3% and 2.2%, respectively. Lifetime use of anxiolytics, alcohol and tobacco was reported to be 28.4%, 84.4% and 71.9%, respectively. Use of drugs was associated with male sex (except anxiolytics) and the youth (19-25 years) (Fuententhalba et al, 2000). Florenzano et al (1993) reported the use of alcohol and tobacco by more than 50% and marijuana by more than 10% of the youth. Frequent use of tobacco (smoking), alcohol and marijuana was reported by 32%, 15.5% and 5% of the sample. Substance abuse, except cigarette smoking was more prevalent among males, those older than 15 years and in youth coming from dysfunctional families. Araneda et al (1996) reported the prevalence of problem drinking to be 9% in male and 3% female university students. Fuententhalba Herrera et al (1995) who used the locally validated Michigan Alcoholism Screening Test (MAST) reported the prevalence for abnormal drinking to be 40.3% in the major care givers of families living in extreme poverty (46.2% in males and 3.3% in females). In a community sample, Busto et al (1996) reported that the 1-year prevalence of benzodiazepine dependence (DSM-III-R) was 3.3%. Wolf et al (2002) assessed three groups of women with young children (n=1256) from Chile and Costa Rica using Center for Epidemiological Studies – Depression scale and found prominent depressive symptoms in 35-50% of the mothers. Durkin (1993) compared survey data from households affected by earthquakes in USA (n=288) and Chile (n=116) and an unexposed reference population in USA. Prevalence rates of major depression in the Chile sample were the same as in the exposed USA sample, and 2.7 times the background US rate. While the exposed US posttraumatic stress disorder (PTSD) rate was only slightly higher than the US background rate, the Chile PTSD rate was 7 times the US rates. Jardesic and Araya (1995) found the prevalence of postpartum depression as assessed by the Edinburgh Postnatal Depression Scale to be 36.7% in 542 women attending primary health care clinics. Women from lower socioeconomic status and those not currently married were more likely to be depressed. In a WHO study on psychiatric comorbidity in primary health care patients with chronic medical illnesses, Fullerton et al (2000) used GHQ and CIDI and found that two-thirds of the Chilean group had a coexisting psychiatric diagnosis compared to 31% of the global study group. The most frequent diagnoses in the Chilean sample were somatization disorders (25%), harmful alcohol use (14%), depression (35%) and hypochondriasis (6%). Mendez et al (1997) reviewed death certificates of deceased in a region and found that suicide rates had increased in the early nineties, particularly in males that led to the male:female ratio of 4.8:1. They did not find an age effect but noted a seasonal pattern with increase in suicide rates both in summer and winter months. Bralio et al (1987) used the Achenbach’s Child Behavior Checklist that was standardized in Chile for assessing a representative sample of primary school going children (n=517) and reported a prevalence of approximately 15% for behavioural and emotional problems. Toledo et al (1997) found that 24.2% of first-grade children had a syndromic psychiatric diagnosis and 17.2% had significant disability. ADHD and enuresis were the commonest diagnosis and 10% had a family history of psychiatric illness.

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. There is a National Plan on Mental Health and Psychiatry (2000). The policy addresses primary and specialist care, bed reduction and community based secondary serv-
Between 20 to 25% of the programme has been implemented by local, regional and national authorities.

**Substance Abuse Policy** A substance abuse policy is present. The policy was initially formulated in 1993. It was formulated by the Ministry of Interior with the participation of different sectors (Justice, Health, Education, Labour, Police, etc.). It was revised in 2003. It has a specific budget for its implementation, and between 20 to 25% of its content has already been implemented.

**National Mental Health Programme** A national mental health programme is present. The programme was formulated in 1999. The National Mental Health and Psychiatry Programme has only been implemented for those covered by the public health insurance programme (FONASA), i.e. almost two-thirds of the Chilean population (those on lower income). The priorities of the programme are: depression, alcohol and drug abuse and dependence, victims of domestic violence, schizophrenia, dementia and ADHD. Between 20 to 25% of the programme has been implemented by local, regional and national authorities.

**National Therapeutic Drug Policy/Essential List of Drugs** A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1990. The policy is meant both for primary and specialized level. It allows for psychotropic medications for specialized treatment.

**Mental Health Legislation** The most recent legislation in the area was in the form of a chapter about mental health in the general health legislation. Less than 20% has been implemented because funds for its implementation were inadequate. Its components include rights of users of mental health services (it conforms to international human rights laws), regulation of involuntary treatment, regulation of mental health services and admission and discharge procedures. A legislation on domestic violence and alcohol and drug abuse also exists. The latest legislation was enacted in 2001.

**Mental Health Financing** There are budget allocations for mental health. The country spends 2.33% of the total health budget on mental health. The primary sources of mental health financing in descending order are social insurance, tax based, out of pocket expenditure by the patient or family and private insurances.

Mental health services receive funding from the public social health insurance system (FONASA), which covers two-thirds of the population. Until 1990, most of this funding for mental health went to mental hospitals, but over the last one and a half decade about one-third has been spent on implementation of community programmes and incorporation of mental health in primary care. Currently, approximately 12.0% of the amount spent on mental health is spent on general hospitals; 36.0% in psychiatric hospitals; 33.0% in ambulatory clinics and 19.0% in community care. The National Council for Drug Control (CONACE) under the Ministry of the Interior has allocated funds to the health sector for the management of drug abuse. Private insurance (ISAPRES) covers almost one-fifth of the population. Private health insurance pays for only a very limited number of psychiatry and psychology sessions. Those covered under FONASA can get services from private sector if they make higher co-payment (out of pocket). The country has disability benefits for persons with mental disorders. Mental health is considered a disability for getting public and private disability benefits for those covered by insurance (the working population). There are also social security benefits for people with no working insurance and low family income. Between 70 and 80% of all the eligible persons actually receive the benefits. Schizophrenia, major depression, mental retardation, Alzheimer and organic psychosis are considered eligible for state/public and private 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. Treatment of severe mental disorders is available at specialized centres in all regions, mainly on an ambulatory basis. Primary care is available for depression, victims of domestic violence and alcohol abuse in most areas of the country. Overall, about 35% of the population receives treatment for mental health disorders through primary care. Nurses, social workers, psychologists and primary care physicians are responsible for treating mental disorders in primary health care. Psychiatrists meet primary care teams once a month to see and discuss the most difficult cases in about 25% of primary care facilities. All urban primary health care clinics (and approximately 90% overall) have incorporated psychologists to their health teams. The programme for treatment of depression has led to the treatment of over 100 000 people in the last 4 years (three-fifths of the people in need of treatment). Only 7% of these were referred for specialized treatment.

Regular training of primary care professionals is not carried out in the field of mental health. Training in family medicine has included some mental health components. The Psychiatric Society conducts periodic courses for general practitioners. There are community care facilities for patients with mental disorders. Each of the 28 health districts have at least one mental health and psychiatric community team of psychiatrist, psychologist and at least one other mental health professional. A community care network has been developed with different programmes (protected homes [more than 700 places], day care units [more than 1300], admittance service, outpatient care, psychosocial rehabilitation programmes, social clubs, protected workshops, etc.) which are at different levels of development within the country, but which are far from meeting the people's needs. Ten districts still don't have...
inpatient psychiatric beds and a few do not have day care facilities, sheltered homes and psychosocial facilities. Almost 50% of clients receive preventive interventions, home interventions, family interventions, have access to residential facilities, vocational training and employment programmes. Nurses, psychologists, occupational therapists, social workers and psychiatrists are responsible for taking care of patients with severe mental disorders in the community.

**Psychiatric Beds and Professionals**

- Total psychiatric beds per 10 000 population: 1.27
- Psychiatric beds in mental hospitals per 10 000 population: 1.04
- Psychiatric beds in general hospitals per 10 000 population: 0.24
- Psychiatric beds in other settings per 10 000 population: 0.13
- Number of psychiatrists per 100 000 population: 4
- Number of neurosurgeons per 100 000 population: 0.4
- Number of psychiatric nurses per 100 000 population: 1.1
- Number of neurologists per 100 000 population: 0.8
- Number of psychologists per 100 000 population: 15.7
- Number of social workers per 100 000 population: 1.5

There are 16.4 general nurses per 100 000 population with partial time for mental health. Among the 8021 social workers only a small number work in mental health. There are 200 occupational therapists. There are at present more than 800 acute and 800 long stay beds in the public sector and 240 long stay beds in private nursing homes. Just over one-third of admitted individuals are long-stay patients. Beds have also been specified for child, forensic (20 high security and 80 medium security) and drug abuse management services. Admissions to long stay wards was stopped in 2000. The private sector provides for some beds for acute care, child and adolescent and drug abuse services. Residential facilities are also available for patients with drug abuse. The Ministry of Health provides technical support for these small private hospitals and programmes and also for a few services in the non-health setting. About one-third of psychiatrists and half of clinical psychologists work in the private sector, which makes community-based human resource scarce. There are just over 50 child psychiatrists and only about half of the health districts have one. Clinical psychologists have to become accredited by the National Commission for the Accreditation of Clinical Psychologists. An ‘addiction rehabilitation technician’ certificate was recently created by the Ministry of Health, requiring two years of training.

**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 two main types of mental health NGOs: those formed by professionals, which act as service providers (e.g. therapeutic communities for alcohol and drug abuse, psychosocial rehabilitation programmes, treatment for survivors of torture), and those formed by consumers and families (e.g. self-help groups for alcohol and drug abuse, relatives and friends of people with mental disabilities). They are active in sensitizing the community, defending the rights of patients, advocacy and provision of services particularly rehabilitative services.

**Information Gathering System**

There is mental health reporting system in the country. ICD-10 is used for recording purposes. The country has data collection system or epidemiological study on mental health. Data collection is conducted both on inpatient and outpatient care. Mental health components include, besides diagnosis, length of stay, primary health care mental health consultations, drug intoxication and death rates caused by suicide. The Departamento de Estatistica e Informacion en Salud (Health Statistics Department) is in charge of data collection performed on part of the mental health system for the population covered by the public health system.

The National Plan for Mental Health and Psychiatry Information System covers the activities of primary and specialist care and evaluation and research of outcomes of specific programmes with specific funding. Further information will be obtained through general household surveys.

**Programmes for Special Population**

The country has specific programmes for mental health for elderly and children. There is a programme called PRAIS which is involved in compensation and total health care programme for victims of political violence. There are also programmes for victims of domestic violence and depression. Specific programmes, namely depression in primary care (oriented particularly towards women), treatment of drug addiction, forensic psychiatry, provision of atypical anti-psychotics to treatment-resistant patients and sheltered homes, have been assigned specific funding. Combined work with the Ministry of Education has led to project on training teachers on the prevention of alcohol and drug abuse and mental health programmes for grade 1 and 2 children. Intellectually disabled children are now integrated into regular school classes. Special services are also available for victims of human rights violation during the military dictatorship. The Ministry of Justice and the Women’s National Service have established a few centres for children and women who have suffered physical violence.
Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam, haloperidol. Fluphenazine is available in some places.

Other Information Development is under way for a national forensic psychiatry system with medium complexity units (2 working, 1 in the stage of designing) and one unit of high complexity (under construction) as well as ambulatory care and sheltered homes. In 2001, the following new programmes started: primary health care programme on depression, implementation of 20 new day hospitals and development of new treatment and rehabilitation plans for people with drug dependence or abuse problems. Though the efficient social health insurance system covers a significant proportion of the population for mental as well as other health interventions and public sector services are open to all, there are large waiting lists and long waiting times. A study on consumer satisfaction with care in psychiatric outpatient department has begun. The Mental Health Unit in the Ministry of Health has also recently developed several guidelines with the collaboration of health professionals, consumers and families. It is introducing an accreditation system for mental health facilities using PAHO/WHO standards. A National Commission for the Protection of People with Mental Illness and Civil Rights has been formed to go into complaints of clients.

Additional Sources of Information
Diario Oficial de la Republica de Chile (1995) Sanciona el trafico ilicito de estupefacientes y sustancias sicotropicas, 11.
Division of Health Program (1993) Politicas y plan nacional de salud mental.
Executive Secretary (1993) Political and National Plan of the Prevention and Control of Drugs. Republic of Chile.
China

GENERAL INFORMATION

China is a country with an approximate area of 9597 thousand sq. km. (UNO, 2001). Its population is 1.313 billion, and the sex ratio (men per hundred women) is 105 (UNO, 2004). The proportion of population under the age of 15 years is 22% (UNO, 2004), and the proportion of population above the age of 60 years is 10% (WHO, 2004). The literacy rate is 92.1% for men and 77.9% 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 5.5%. The per capita total expenditure on health is 224 international $, and the per capita government expenditure on health is 83 international $ (WHO, 2004).

The main language(s) used in the country is (are) Mandarin. The largest ethnic group(s) is (are) Han, and the other ethnic group(s) are (is) Zhuang and Man.

The life expectancy at birth is 69.6 years for males and 72.7 years for females (WHO, 2004). The healthy life expectancy at birth is 63 years for males and 65 years for females (WHO, 2004).

EPIDEMIOLOGY

Zhang et al (1998) used the Chinese Scale of Mental Disability and Intellectual Impairment and found the point prevalence and lifetime prevalence of all disorders (except neurosis) to be 1.12% and 1.35%, respectively. An increase in the prevalence of all mental disorders, particularly alcohol use disorders, Alzheimer’s disease and affective disorders was noted. A number of studies (e.g. Wang et al, 2000) have examined the prevalence of dementia in different regions in large samples (>1000) using a two-stage procedure in which the initial screening was done with the MMSE and diagnosis was confirmed by clinical interviews. The prevalence rates were in the range of 1.0% to 4.2%. Dementia was more common in women and the prevalence rate increased with age. Zhang et al (2001) assessed 5913 subjects over the age of 55 years from urban and rural communities, selected through a stratified multiple stage cluster sampling method, using a three-phase strategy in which the final evaluation was done by neurologists or psychiatrists using the DSM-IV, NINCDS-ADRDA and NINCDS-AIREN criteria. The age-standardized prevalence was 4.2% for dementia (all causes), 2.0% for Alzheimer’s disease and 1.5% for vascular dementia. The rate of Alzheimer disease (AD) doubled every 5 years with age, though that of vascular dementia (VD) increased little with age. Liu et al (2003) analysed 17 studies published in Chinese from 1990-1999, and found the prevalence rates for the population aged 60 years and over were 1.26% for AD and 0.74% for VD. The prevalence of AD was 2.10% in women and 0.76% in men, while the prevalence of VD was 0.71 and 0.69%, respectively. The prevalence of AD increased with age, but there was no association between VD and gender. Yan et al (2002) reported that the annual incidence rate of senile dementia was 0.9% in those above 60 years of age. The rate increased in almost each 5-year age groups to reach 5.1% in the 90 years (and above) age group. Niu et al (2000) assessed 991 current smokers from 488 randomly selected nuclear families by using the Fagerstrom Test of Nicotine Dependence (FTND) questionnaire and the Revised Tolerance Questionnaire (RTQ). The prevalence of nicotine dependence as defined by FTND (cut off - 7/8) and RTQ (cut off - 27/28) were 12.7% and 11.1%, respectively. Wei et al (1999) assessed 23 513 adults and found that the point prevalence of alcohol dependence (DSM-III-R) was 3.4% (males 6.6%, females 0.1%). Jiang et al (1995) assessed 6567 subjects with a screening questionnaire and the Present State Examination. The 1-year prevalence rate of benzodiazepine dependence rate was reported to be 1.63%. Chen et al (1999) conducted a meta-analysis on 10 cross-sectional studies (n=13 565) of depression in elderly subjects. The pooled prevalence of depression was 3.9% (rural 5.1%, urban 2.6%). Chen et al (2004) interviewed 1736 urban subjects aged 65 and over using the GMS -AGECAT. Age-standardized prevalence was 2.2%. Yan et al (2002) reported that the annual incidence rate of senile depression was 1.3% in those above 60 years of age. Zhang et al (1999) assessed women at an antenatal clinic (n=1052) with the Edinburgh Postpartum Depression Scale 7 days after delivery and found a rate of 15% for postpartum depression. Shen et al (1998) used the GHQ-12 and the Present State Examination in an urban elderly sample. The prevalence of neurosis was 2.1% (3.5% in women and 4.0% in men). The prevalence declined with age. Neuroasthenia, depressive and anxiety neurosis were common. Wang et al (2000) assessed 181 and 157 randomly selected subjects from two earthquake affected villages. Counter-intuitively, subjects from the village that faced greater damage (but received more support) had lower rates of PTSD. The incidence of DSM-IV PTSD within 9 months was 19.8% and 30.3% for the two villages. Zhang et al (1992) studied 509 college freshmen. Bulimia, as per Chinese and DSM-III-R criteria, was diagnosed in 1.1% of subjects. Review of data from different sources (e.g. National Disease Surveillance Point system, Chinese Public Health Annuals) have given varying rates of suicide (4.8 to 19.6 per 100 000), but there is unanimity that the rates are greater in women, in rural areas and in the elderly (e.g. Ji et al, 2001). Jenkins (2002) collated mortality data from the Ministry of Health for the period 1995-99 with an estimated rate of unreported deaths. The annual suicide rate was estimated at 23/100 000, accounting for 3.6% of all deaths. The rate in women was 25% higher than in men, primarily due to large number of suicides in young rural women. Rural suicide rates were three times higher than urban rates across both sexes, for all age-groups and over time. Phillips et al (2002) interviewed close associates of people who died due to suicide (n=519) or other injuries (n=536). After adjustment for different socio-demographic variables, the predictors for suicide were: depression score, previous suicide attempt, acute stress at time of death, low quality of life, high chronic stress, severe interpersonal conflict in the 2 days before death and a blood relative or friend with previous suicidal behaviour. Suicide risk increased substantially with exposure to multiple risk factors from 30% for those with 2 or 3 risks to 96% for those with 6 or more risks. Hesketh et al (2002) administered a self-administered questionnaire to 1576 middle school students and found that the frequency of severe depressive symptoms, suicidal ideation and suicide attempts was 33%, 16% and 9%, respectively. A number
of large (sample size >1000) community studies have been conducted on behavioural problems in school age children and adolescents using a variety of reliable tools (e.g. Liu et al, 2001). The prevalence rate of behavioral problems had been reported to be in the range of 7% to 23%. Boys have more behavioral problems, particularly externalizing problems and girls have more internalizing problems. Leung et al (1996) conducted a two-stage study on 3069 schoolboys and found the prevalence rates for hyperkinetic disorder (ICD-10), ADDH (DSM-III) and ADHD (DSM-III-R) respectively, were 0.8%, 6.1% and 8.9%. Liu et al (2000) assessed 3344 children in the 6-16 years age group and found the overall prevalence of nocturnal enuresis was 4.3%, with a significantly higher prevalence in boys. Zou et al (1994) assessed 85170 children (<14 years) using the WHO description of mental retardation and standard psychological tests. The prevalence of mental retardation was 1.2%, with the proportion of mild, moderate, severe and profound MR being 60.6%, 22.7%, 9.6%, and 7.1%, respectively.

**MENTAL HEALTH RESOURCES**

**Mental Health Policy** A mental health policy is present. The policy was initially formulated in 1987.

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

In September 2004, the Proposal on Further Strengthening Mental Health Work had been agreed by the Ministries of Health, Education, Security, Civil Affairs, Justice, Finance and the China Disabled Person's Federation, and it was transmitted in the name of the General Office of the State Council to all departments of and to all institutions directly under the State Council (including the People's Congress, the National Committee of the Chinese People's Political Consultative Conference, the Supreme Court and the military) and to provincial Governments. In the proposals, principles, aims, organization and leadership, intervention for key populations, treatment and rehabilitation for mental disorders, mental health team building, research and surveillance and legal rights protection are indicated; especially the community-based mental health service model is stressed.

**Substance Abuse Policy** A substance abuse policy is present. The policy was initially formulated in 1987.

**National Mental Health Programme** A national mental health programme is present. The programme was formulated in 1992.

The Ministries of Health, Civil Affairs, Security and the China Disabled Person's Federation jointly enacted the National Mental Health Project of China (2002-10) in April 2002. The three main areas of focus are: integrated care and multisectoral links, equity, community care, training of mental health professionals, increasing research, development of a mental health legislation. Specific targets have been set. A national disaster mental health response plan 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 1995.

**Mental Health Legislation** There is no existing mental health legislation. At the national level, although there is no existing mental health law, the Criminal Law (1980), the Criminal Procedure Law (1980), the Civil Law (1987), the Civil Procedure Law (1982), the Law on the Protection of Disabled Persons (1990), the Law on Maternal and Infant Health Care (1994), and the Marriage Law (2001) deal with some mental health issues. The national mental health law is in the process of being drafted since 1986; the 15th draft was finished and is being reviewed by relevant departments. The Ministry of Health is hoping it will be enacted before 2007. Provincial laws are also in different stages of development. The Shanghai Mental Health Regulations came into effect in 2002. It requires that all medium-size general hospitals and community medical centres should set up outpatient mental health services.

**Mental Health Financing** There are budget allocations for mental health.

The country spends 2.35% of the total health budget on mental health.

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

Insurance coverage of mental health issues is variable. Some like those covering Government employees are generous (so unemployment is doubly hard on ill people); others like those for people in the country side (funded from pooled resources of the community) are very basic. Less than 15% of the population are entitled to comprehensive health insurance that covers psychiatric disorders. Economic Reforms have partially diminished many insurance systems and pushed up health care costs. Inpatient care is expensive (a one month fee, approximately $100, is equivalent of average wage of 4 months in urban areas and 8 months in rural areas). For long-stay patients, two-thirds of the expenses are borne by the persons/family and the remaining by the state.

The country has disability benefits for persons with mental disorders. The law for disabled persons was formulated in 1990 and offers some benefits in getting jobs and public welfare. Other benefits are covered under the National Health Care Insurance. The family, work units and community organizations are also supposed to help the disabled.

**Mental Health Facilities** Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. In some bigger cities like Beijing or Shanghai treatment at primary care level is available.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 600 personnel were provided training. In 1999, a programme for training physicians from general hospitals in mental health was initiated by the WHO/Beijing Collaborating Centre for Research and Training in Mental Health. About 600 physicians were trained. Since then, short training
Programmes have been conducted by WHO consultants for doctors, nurses and other participants from hospitals, schools, media etc. on mental disorders, communication skills, psychosocial management of stress and trauma. WHO and the German Academic Exchange Service (DAAD) are collaborating with Chinese academic institutions and conduct short training programmes for doctors, paediatricians and health care workers in psychosocial management of children and adolescents. Trainers training courses have also been set up. There are community care facilities for patients with mental disorders. The community-based care for mentally ill individuals has developed under the initiative of the China Disabled Federation since 1991. Until now, 243 counties are covered under the cooperation with local health bureau, security department, civil administrative bureau, etc. The plan relies on collective industrial therapy in the community, guardianship networks (doctors, local officials, family members and possibly volunteers) and less restrictive treatments in hospitals. The national government has allocated some money for this project; however, most of the funding is supposed to be generated locally. Some provinces like Shanghai have relatively more community facilities like nursing homes, counseling centres and hotlines. A few locations have community-based suicide prevention programmes.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Category</th>
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</thead>
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<tr>
<td>Total psychiatric beds</td>
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<tr>
<td>Psychiatric beds in mental hospitals</td>
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<td>Number of psychiatric nurses per 100,000</td>
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<td>Number of neurologists per 100,000</td>
<td>0.79—0.95</td>
</tr>
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<td>Number of psychologists per 100,000</td>
<td></td>
</tr>
<tr>
<td>Number of social workers per 100,000 population</td>
<td>0</td>
</tr>
</tbody>
</table>

Three Ministries, Health, Civil Affairs (i.e. Welfare) and Security (i.e. police) provide inpatient services. Some mental health units also exist under the Ministry of Industry and Mining and the People's Liberation Army. The Ministry of Health provides services to mentally ill patients who are not mentally ill offenders, drug abusers or people without work ability, money and carers; the Ministry of Civil Affairs to the patients without work ability, money and carers but not mentally ill offenders or drug abusers; the Ministry of Security to mentally ill offenders and drug abusers. Through a meeting system, the three main Ministries and the China Disabled Person's Federation coordinate; however, formal horizontal linkages are not very strong. Setting-up of private hospitals has been permitted since 1985. There are a few (around 150) child psychiatry beds. About 150 qualified child psychiatrists are practicing in cities. Two national examination systems exist, one for psychological counsellors, another for psychotherapists. There is a national training programme for physicians from general hospitals. There is no formal system of psychiatric social workers and occupational therapists. Some mental health staff is leaving the sector because financial crisis at psychiatric hospitals (due to low occupancy rates) results in much lower incomes than for staff in other medical disciplines.

**Non-Governmental Organizations** A few NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and rehabilitation. The most important one is the China Disabled Person's Federation, a semi-NGO. NGOs have been consulted in the process of developing the national mental health programme and the mental health legislation. Telephone hotlines are being set up in many cities by NGOs.

**Information Gathering System** There is no mental health reporting system in the country. In the annual report of the Ministry of Health, there is a mention of the number of mental hospitals, beds and psychiatrists. The country has data collection system or epidemiological study on mental health. There were epidemiological studies for mental disorders in the country, and systematic studies were carried out by the WHO Collaborating Centre since 1982. Many local areas have done or planned to do their own epidemiological surveys.

**Programmes for Special Population** The country has specific programmes for mental health for disaster affected population, elderly and children. A five-year project on mental health promotion for children and adolescents has been launched by the Ministry of Health. To facilitate this, national workshops on mental health knowledge have been held for school teachers, school physicians and paediatricians. A PsychoSunlight Project has been designed for college students to promote their ability to cope with college life and prepare to go into society. Two large projects have targeted the elderly; these will help in the development of treatment guidelines for dementia, and screening scales for differentiation between normal aging and early dementia. An emergency psychosocial response plan for disaster affected population is being drafted. A set of four mental health education books were compiled for adolescents, women, working staff and the elderly. On the World Mental Health Day 2004, 3000 sets of these books were presented to the Chinese Central Youth League, the All-China Women's Federation, the All-China Federation of Trade Unions and the Chinese National Committee on Ageing, respectively. Many cities conducted different activities to promote mental health for the public on this day. Telephone hotlines are being set up in many cities and some are focussed on specific population groups (e.g. women or
adolescents) and issues (e.g. AIDS). The research group from the Institute of Mental Health, Beijing, carried out the post-earthquake and post-flood studies.

**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.

Artane 6-8 mg is used to treat side-effects of anti-psychotics.

**Other Information** Among all the cities of China, Shanghai has the most developed psychiatric set-up. It includes community follow-up programmes, guardianship networks, work therapy stations, mental health services in factories, day hospitals, night hospitals and family support groups. Services at each of the three levels-municipal, district and grass-root level are available. Non-psychiatric medical and paramedical staff helps in care-giving. Services for special population like for children, elderly and AIDS patients are also available. Different hotline services can be accessed. Further details can be obtained from Zhang et al (1994, 1997).

**Additional Sources of Information**


**GENERAL INFORMATION**

Colombia is a country with an approximate area of 1139 thousand sq. km. (UNO, 2001). Its population is 44.914 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 31% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 92.1% for men and 92.2% 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 5.5%. The per capita total expenditure on health is 356 international $, and the per capita government expenditure on health is 234 international $ (WHO, 2004).

The main language(s) used in the country is (are) Spanish. The largest ethnic group(s) is (are) Mestizo (half), and the other ethnic group(s) are (is) European (one-fourth) and native American. The largest religious group(s) is (are) Roman Catholic (95%).

The life expectancy at birth is 67.5 years for males and 76.3 years for females (WHO, 2004). The healthy life expectancy at birth is 58 years for males and 66 years for females (WHO, 2004).

**EPIDEMIOLOGY**

National surveys on mental health were conducted in 1993 and 2003. In the former study, SRQ (criteria DSM-III) and Zung Scale were applied to a random sample of 25135 adults. The lifetime prevalence for depression was 25.1%, anxiety disorders 9.6%, and alcohol abuse 7.8%. The latter study utilized the World Mental Health Survey methodology and applied CIDI 2000 (criteria DSM-IV) to 4596 adults and 1586 adolescents in a random sample of 5526 urban homes. The lifetime prevalence of mood disorders was 12.9%, anxiety disorders 24.0%, alcohol use disorders 9.2% and drug use disorders 1.7% (Ministry of Health, 2004). Torres de Galvis and Murrelle (1990) evaluated 2800 adults (12-64 years) from four cities and found the use of alcohol (56%), tobacco (29.7%), tranquilizers (6%), marijuana (1.1%), basuco (6%) and cocaine (3%) to be common. Approximately 8.1% of the subjects were dependent on alcohol and 7.3% were at risk of becoming dependent on alcohol. Drug use was associated with male gender (except tranquilizers), medium age groups and unmarried status. Differences in suicide rates between users and non-users were statistically significant in the population aged 15 to 54. Montoya and Chilcoat (1996) reported the integrated findings of a survey carried out in Bolivia, Colombia, Ecuador, Peru and Venezuela to estimate cocaine and coca use prevalence (n=24108). The lifetime prevalence of cocaine or coca paste use was between 0.8 and 3.0% and it was associated with age (middle-age), class (middle), gender (male), education (high school), income (high) and residence (urban). In a cross-sectional study involving 512 schools, the prevalence of substance use was 59.4% in public schools and 40% in private schools. Alcohol, marijuana, cocaine were the commonly used drugs and family history of mental disorders and personal conflicts were associated with substance use (Bergonzoli et al, 1989). Brook et al (1999) interviewed more than 2800 adolescents and their mothers and found that factors like violence, drug availability, and machismo, family drug use, a distant parent-child relationship and unconventional behaviour are risk factors for adolescent illegal drug use. Jablensky et al (1992) reported the results of the WHO multi-country Determinants of Outcome of Severe Mental Disorders (DOS) that was carried out in a group of patients making their first treatment contact because of symptoms of a possibly schizophrenic illness. Better outcome was reported in patients living in developing countries. Significant differences were found between centres in the incidence of schizophrenia using a broad definition, although the rates ranged only from 1.5 to 4.2 per 100 000 population aged 15-54. In contrast, the incidence of schizophrenia using a narrow definition (category S+ of the CATEGO programme derived from the PSE-9 interview) was not significantly different between centres. Lima et al (1993) assessed 113 adult victims of a major Latin American disaster 1 and 5 years after the catastrophe with the Self-Reporting Questionnaire. The prevalence of emotional distress decreased from 65% in 1986 to 31% in 1990. A study conducted in three countries, Columbia, Ecuador and Venezuela (n=1946), showed that 53.4% of subjects had erectile dysfunction with 19.8% of all men reporting moderate to complete ED. Increasing age, hypertension, benign prostatic hyperplasia and diabetes mellitus were associated with the disorder (Morillo et al, 2002). In a general population sample of 1879 Spanish-speaking university students (mean age=24.0), the prevalence of self-reported stuttering was found to be 2% (Ardila et al, 1994). Giel et al (1981) assessed 925 children attending primary care centres in Columbia, India, Philippines and Sudan using a 2-stage design and found that the rate of psychiatric disorders varied between 12-29%. Pineda et al (1999) used multiple standardized rating scales, clinical interviews and neurological tests on large samples of preschool and school going children and reported the prevalence of ADHD to be more than 16.1%. But, the prevalence of subtypes differed in the two studies. Gender (male), age (school going) and economic status (lower) were significantly related to prevalence. Pinzon-Perez and Perez (2001) found that 21% of school students (n=1692) expressed suicidal ideation, 19% suicidal plans and 16% reported at least one attempt in the 30 days preceding the study.

**MENTAL HEALTH RESOURCES**

**Mental Health Policy** A mental health policy is present. The policy was initially formulated in 1979.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The policy was reviewed in 1998, but it was not implemented. The policy is being reviewed again to make it consonant with the health system and the priorities emerging from the National Study of Mental Health, 2003.
Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1979. The policy was reformulated by the National Board of Economic and Social Policy in 2002 (CONPES 3078 of 2002). Currently, the ‘Policy for the Reduction of the Demand for Consumption of Psychoactive Substances’ is in final phase of consensus-building and implementation, under the leadership of the Ministry of the Social Protection.

National Mental Health Programme A national mental health programme is absent.
Under the guidelines defined by the Ministry of the Social Protection, each department is formulating plans of action in mental health that should be implemented within a period of 2 years.

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 There is no comprehensive national mental health legislation, however, Law 715-2001 includes mental health functions in the regional-local levels, but it has not been enacted. The Ministerial Resolution No.2417 of 1992 allows for a charter of rights for mental health patients. Resolution 2358 of 1998 and Law 30 of 1986 relate to drug statutes. Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are budget allocations for mental health. The country spends 0.08% 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 country has disability benefits for persons with mental disorders. There is no mention to the proportion of the population entitled to get these benefits.

Mental Health Facilities Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Despite some pilot projects, mental health services are not provided under the Primary Health Care scheme. 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. Mental health care is provided with different approaches according to users’ affiliation with social security.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population
Psychiatric beds in mental hospitals per 10 000 population 0.45
Psychiatric beds in general hospitals per 10 000 population
Psychiatric beds in other settings per 10 000 population
Number of psychiatrists per 100 000 population 2
Number of neurosurgeons per 100 000 population
Number of psychiatric nurses per 100 000 population
Number of neurologists per 100 000 population
Number of psychologists per 100 000 population
Number of social workers per 100 000 population
20% of psychiatric beds are dedicated to long-stay patients. There are facilities in prison for offenders with mental disorders.

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

Information Gathering System There is mental health reporting system in the country. ICD-10 and DSM-IV criteria are used. Information on ambulatory morbidity, admission and hospital discharge of mental disorders are recorded in the Individual Registries of Delivery of Services, however, this information is still not available with the opportunity, coverage and quality desired, which is in the process of standardization and implementation of the registry. The country has data collection system or epidemiological study on mental health. The ‘Asociación de Hospitales Mentales’ (Psychiatric Hospitals Association) conducts specific surveys on mental health from time to time. There are ‘Mental Health Groups’ in charge of the data collection system for mental disorders both at regional and national levels. There are, in addition, records of data on injuries due to external cause such as accidents, homicides, domestic violence and other type of assaults, in routine registries of Forensic Medicine and through Observatories of Violence that operate in some departments.
Programmes for Special Population The country has specific programmes for mental health for minorities, refugees, disaster affected population, indigenous population, elderly and children. Also, there are programmes for women and victims of domestic violence. Although specific programmes for indigenous populations are not present, they are provided comprehensive care through the Compulsory Plan of Health. Programmes for persons with mental disorders who are ‘not criminally responsible’ and psychological immaturity care have more than 250 places available.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, haloperidol, lithium, biperiden, carbidopa, levodopa. The national therapeutic drug policy was revised in 2002 and the essential drug list was revised in 2002. Medicines are supplied as part of the benefits from compulsory health plan (POS) within the social security system.

Other Information Methods for assessing quality of care at primary, secondary and tertiary levels are available.

Comoros

GENERAL INFORMATION
Comoros is a country with an approximate area of 2 thousand sq. km. (UNO, 2001). The country is an archipelago with four main islands. Its population is 0.79 million, and the sex ratio (men per hundred women) is 101 (UNO, 2004). The proportion of population under the age of 15 years is 42% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 63.5% for men and 49.1% 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 3.1%. The per capita total expenditure on health is 29 international $, and the per capita government expenditure on health is 17 international $ (WHO, 2004).

The main language(s) used in the country is (are) French, Arabic and Swahili. The largest ethnic group(s) is (are) Arab, and the other ethnic group(s) are (is) African, Malay-Indonesian and Creole. The largest religious group(s) is (are) Sunni Muslim (five-sixths), and the other religious group(s) are (is) Roman Catholic.

The life expectancy at birth is 61.6 years for males and 64.9 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 mental illnesses in Comoros in internationally accessible literature.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent.

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

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

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.

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. Patients are hospitalized in general hospitals. Regular training of primary care professionals is not carried out in the field of mental health.

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

Information Gathering System There is no mental health reporting system in the country. The reporting system has not worked for the last four years.

The country has no data collection system or epidemiological study on mental health. A survey had been done in 1998, but it has not been circulated.
Programmes for Special Population There are no special services for any population group.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: phenobarbital, chlorpromazine, diazepam. If the drugs are not available in the PNAC they have to be bought from private pharmacies. Haloperidol may be ordered outside the PNAC by doctors. The essential list of drugs is presently being revised.

Other Information

Additional Sources of Information
Congo

GENERAL INFORMATION
Congo is a country with an approximate area of 342 thousand sq. km. (UNO, 2001). Its population is 3.818 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 47% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 88.9% for men and 77.1% 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 2.1%. The per capita total expenditure on health is 22 international $, and the per capita government expenditure on health is 14 international $ (WHO, 2004).
The main language(s) used in the country is (are) French. The largest ethnic group(s) is (are) Kongo in the south and Sangha and M’Bochi in the north and in the center. The largest religious group(s) is (are) Christian, and the other religious group(s) are (is) indigenous groups.
The life expectancy at birth is 51.6 years for males and 54.5 years for females (WHO, 2004). The healthy life expectancy at birth is 45 years for males and 47 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Congo in internationally accessible literature. Salignon and Legros (2002) have reported on the physical and psychological impact of war on the population. Ibara et al (2002) found neuropsychiatric presentations in 49.7% of 175 hospitalized elderly HIV patients, and Hornabrook (1975) has reported on the occurrence of endemic cretinism in the region.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 1999.
The components of the policy are advocacy, promotion and rehabilitation.

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

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

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 Till Independence, the French legislation was being used. Since Independence no legislation is in effect.
Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are no budget allocations for mental health.
Details about expenditure on mental health are not available.
The primary source of mental health financing is out of pocket expenditure by the patient or family.
The country does not have disability benefits for persons with mental disorders. Mental disorders are treated as any other disorder.

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 are no facilities for therapy.
Regular training of primary care professionals is not carried out in the field of mental health.
There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 0.06
Psychiatric beds in mental hospitals per 10 000 population 0
Psychiatric beds in general hospitals per 10 000 population 0.06
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 0.03
Number of neurosurgeons per 100 000 population 0
Number of psychiatric nurses per 100 000 population 0.1
Number of neurologists per 100 000 population 0.03
Number of psychologists per 100 000 population 0.26
Number of social workers per 100 000 population
There are 3000 social workers, but the specific number working in mental health is not available.

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

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

Programmes for Special Population There are no specific programmes 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, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol.

Other Information

Additional Sources of Information
Cook Islands

**GENERAL INFORMATION**
Cook Islands is a country with an approximate area of 0.23 thousand sq. km. (UNO, 2001). The country consists of two main islands and many low-lying coral atolls. Its population is 0.018 million, and the sex ratio (men per hundred women) is 107 (UNO, 2004). The proportion of population under the age of 15 years is 36% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 4.7%. The per capita total expenditure on health is 598 international $, and the per capita government expenditure on health is 404 international $ (WHO, 2004).

The main language(s) used in the country is (are) English and Maori. The largest ethnic group(s) is (are) Maori. The life expectancy at birth is 69.2 years for males and 74.2 years for females (WHO, 2004). The healthy life expectancy at birth is 61 years for males and 63 years for females (WHO, 2004).

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

**MENTAL HEALTH RESOURCES**

**Mental Health Policy**
A mental health policy is absent.

**Substance Abuse Policy**
A substance abuse policy is absent.

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

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

**Mental Health Legislation**
The mental health legislation is a part of the Crimes Act. The latest legislation was enacted in 1969.

**Mental Health Financing**
There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is tax based. The country has disability benefits for persons with mental disorders. A monthly monetary benefit is made on recommendation of a physician to the social welfare department.

**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. Medications are provided by doctors and nurses. 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 the responsibility of public health nurses. A community-based programme has been started by an NGO with the agreement with the Ministry of Health.

**Psychiatric Beds and Professionals**

<table>
<thead>
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<th>Description</th>
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<td>Psychiatric beds in mental hospitals per 10 000 population</td>
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<td>Psychiatric beds in other settings per 10 000 population</td>
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<td>0</td>
</tr>
<tr>
<td>Number of social workers per 100 000 population</td>
<td>0</td>
</tr>
</tbody>
</table>

General physicians deal with psychiatry.

**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. The country has no data collection system or epidemiological study on mental health. Information on known patients are collected.

**Programmes for Special Population**
There are no special services available.
**Therapeutic Drugs** The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, carbidopa, levodopa.

**Other Information**

**Additional Sources of Information**
Costa Rica

GENERAL INFORMATION
Costa Rica is a country with an approximate area of 51 thousand sq. km. (UNO, 2001). Its population is 4.25 million, and the sex ratio (men per hundred women) is 103 (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 95.7% for men and 95.9% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.2%. The per capita total expenditure on health is 562 international $, and the per capita government expenditure on health is 385 international $ (WHO, 2004).

The main language(s) used in the country is (are) Spanish. The largest ethnic group(s) is (are) European (descent). The largest religious group(s) is (are) Roman Catholic (three-fourths), and the other religious group(s) are (is) Evangelical Christian.

The life expectancy at birth is 74.8 years for males and 79.5 years for females (WHO, 2004). The healthy life expectancy at birth is 65 years for males and 69 years for females (WHO, 2004).

EPIDEMIOLOGY
Miguelz (1984) found the prevalence of alcohol use disorder to be 14% in a sample of 469 subjects selected from a shanty town. Drug use was reported by 8% of the respondents. Escamilla et al (2001) recruited 110 subjects from two high-risk (for bipolar illness) Costa Rican pedigrees and 205 unrelated Costa Rican bipolar subjects and assessed them using structured interviews. Substance use disorders (primarily alcohol dependence) occurred in 17% of the bipolar patients from the population sample and 35% of the bipolar patients from the pedigree sample. Comorbid substance use disorder was strongly associated with gender but did not significantly alter the prevalence of psychosis or age of onset of mania in bipolar subjects. In comorbid subjects, alcohol dependence tended to predate the first manic episode. Sandi Esquivel and Avila (1990) did a case-control study in which they showed that patients with alcohol use disorder had greater likelihood of having noteworthy problems in family/social relations, work/finances and psychological status. A number of studies on substance use are available. Sandi et al (2002) used the Latin-American version of Drug Use Screening Inventory (DUSI) to interview randomly selected 304 students from rural schools. Results showed a high prevalence of past-year alcohol use for both males and females (56.6% and 47.4%, respectively), and a lower prevalence of past-year tobacco use (44.0% and 7.7%). In terms of illicit drugs, males preferred cocaine and marijuana whereas females preferred amphetamines. Costa Rica was one of the many countries involved in the Global Youth Tobacco Survey conducted by WHO and CDC, Atlanta, which showed that between 10-33% of adolescents used tobacco (Warren et al, 2000). The annual incidence of schizophrenia was reported to be 0.48/1000 population; however, the estimate was based on data on first time hospital admissions for schizophrenia (Handal & Dodds, 1997). De Lisi et al (2001) studied families of patients with schizophrenia in Costa Rica and the USA. Within multiplex families (both in the USA and Costa Rica), age of onset was found to have a familial component. There was significantly lower prevalence of affective symptoms (depression and mania) and drug abuse among the Costa Rican multiplex families by comparison with those from the USA. The families with only one ill member from Costa Rica had significantly more alcohol abuse than the multiply affected families. Maternal depression was assessed using the Center for Epidemiological Studies – Depression scale in three samples of women (total n=1256) in Chile and Costa Rica (Wolf et al, 2002). Lifetime prevalence of major depressive episodes was assessed in two Costa Rican samples by the Diagnostic Interview Schedule. Between 35% and 50% of all mothers had experienced at least one episode of major depression or were experiencing severe dysphoric mood at the time of the evaluation. In addition, one-third of the Costa Rican mothers had experienced dysphoric mood following delivery of a child. Lester (1995) reported that suicide rates are lower in Costa Rica than in the United States. Firearms are used less often and hanging more often as a method for suicide in Costa Rica. Suicide rates do not increase with age in Costa Rica, unlike the United States. A study on Tourette’s disorder in a sample (n=85, aged 5-29 years) showed that the gender ratio (male: female) was 4.6:1 and that the mean age of onset was 6.1 years. However, many subjects denied any impairment or distress due to the disorder even when objectively impairment was evident (Mathews et al, 2001).

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 and about 50% of its contents have been implemented. Currently, it is included within the National Policy of Health 2002-2006 and in the National Plan of Development. It emphasizes mental health care at the primary level, child and adolescent mental health and prevention of drug use disorders.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1986. It was revised in 2001. It has specific budget for its implementation and has been implemented to the extent of 25-50%.

National Mental Health Programme A national mental health programme is absent. It exists within an intersectoral national plan of mental health, 2004-2010. There is no specific budget for its implementation. Its main components are strategy of services reform, promotion and prevention and specialized services.
National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1982.

Mental Health Legislation The mental health legislation focuses on promotion and prevention, human rights, regulation of mental health services, but it has no reference to regulation of involuntary treatment. Regular funds have not been allocated for its implementation and implementation is to the extent of 25 to 50%. The latest legislation was enacted in 1995.

Mental Health Financing There are no budget allocations for mental health. The country spends 8% of the total health budget on mental health. The primary sources of mental health financing in descending order are social insurance and private insurances. Approximately 10% of mental health funding is spent on general hospitals and 90% on psychiatric hospitals. The country has disability benefits for persons with mental disorders. More than 90% of the eligible persons actually receive the benefits. Disability assessment is performed by a psychiatrist if it is for a short term period; if it is for a long term period, an expert committee is required. Any ICD-10 mental disorder that is associated with severe disability may avail public disability benefits. The department in charge is the ‘Caja Costarricense del Seguro Social (CCSS)’ (Social Security Department of Costa Rica).

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. Although general health care through primary health care is available for most of the population, less than 25% of the population has mental health care provision in primary health care. The general staff structure is composed of primary health care doctors, auxiliary nurses and health care workers. General doctors are the main providers. Treatment for severe mental disorders is available at primary health care, mainly in the form of provision of anti-psychotic medications to patients discharged from psychiatric hospitals. A referral system is in place. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 500 personnel were provided training. A regular programme to train primary care professionals (general clinicians, auxiliary nurses and health care workers) in mental health started in 2001. The duration of the training is 2 days once a year. There are community care facilities for patients with mental disorders. The community care based system for the mentally ill covers about 25% of the intended population and includes preventive/promotion interventions, home interventions, family interventions, residential facilities, vocational training and employment programmes.

Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>2.6</td>
</tr>
<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>
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<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>2</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 population</td>
<td>0.8</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td>2</td>
</tr>
<tr>
<td>Number of neurologists per 100 000 population</td>
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</tr>
<tr>
<td>Number of psychologists per 100 000 population</td>
<td>2</td>
</tr>
<tr>
<td>Number of social workers per 100 000 population</td>
<td>0.5</td>
</tr>
</tbody>
</table>

There are 2 psychiatric hospitals in the country, the larger one has 811 beds. These hospitals are managed by the Social Security Department (the Ministry of Health does not take care of the psychiatric hospitals). 60% of these beds are occupied by long stay patients.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. These organizations participate in mental health activities related to women, children, consumers and domestic violence. Two-fifths of non-treatment related mental health activities (except psychiatric care), 5% of psychiatric care and 95% of care for drug abusers is provided by NGOs through 60 authorized programmes.

Information Gathering System There is mental health reporting system in the country. It is under the Social Security Department of Costa Rica. The mental health components reported are morbidity in emergencies and hospital admissions. It also conducts diagnostic evaluations on samples of outpatient consultations. The country has data collection system or epidemiological study on mental health. The Department of Information and Health Services Statistics of the Social Security System is in charge of data collection.
**Programmes for Special Population** The country has specific programmes for mental health for elderly and children. AIDS patients receive psychiatric care from CCSS. The children's hospital provides services for children, whereas the geriatric hospital has a psychiatrist on its staff. Also there are programmes for women, abused children and victims of domestic violence.

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

The national therapeutic drugs policy was revised in 1989 and the essential drug list was revised in 2001. The information on medication is from the Social Security Department of Costa Rica.

**Other Information**

**Additional Sources of Information**
Côte d’Ivoire

GENERAL INFORMATION
Côte d’Ivoire is a country with an approximate area of 322 thousand sq. km. (UNO, 2001). Its population is 16.897 million, and the sex ratio (men per hundred women) is 104 (UNO, 2004). The proportion of population under the age of 15 years is 41% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 59.5% for men and 37.2% 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 6.2%. The per capita total expenditure on health is 127 international $, and the per capita government expenditure on health is 20 international $ (WHO, 2004).

The main language(s) used in the country is (are) French, Akan and Mandés. The largest ethnic group(s) is (are) Akan, and the other ethnic group(s) are (is) Voltaiques, Northern Mandes, Krous and Southern Mandes. The largest religious group(s) is (are) indigenous groups and Muslim, and the other religious group(s) are (is) Christian.

The life expectancy at birth is 43.1 years for males and 48 years for females (WHO, 2004). The healthy life expectancy at birth is 38 years for males and 41 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Côte d’Ivoire in internationally accessible literature.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 1962.
The components of the policy are treatment and rehabilitation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1984.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999.

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

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

Mental Health Financing There are budget allocations for mental health.
The country spends 0.1% of the total health budget on mental health.
The primary 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 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.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 0.15
Psychiatric beds in mental hospitals per 10 000 population 0.13
Psychiatric beds in general hospitals per 10 000 population 0.02
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 0.2
Number of neurosurgeons per 100 000 population 0.02
Number of psychiatric nurses per 100 000 population 0.2
Number of neurologists per 100 000 population 0.07
Number of psychologists per 100 000 population 0.07
Number of social workers per 100 000 population 0.03

There are 3 occupational therapists.

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

Information Gathering System There is mental health reporting system in the country. It exists as the Annual Report of Mental Health Activities.
The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population There are no special services available.
CÔTE D’IVOIRE

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.

Other Information

Additional Sources of Information
Croatia

GENERAL INFORMATION

Croatia is a country with an approximate area of 57 thousand sq. km. (UNO, 2001). Its population is 4.416 million, and the sex ratio (men per hundred women) is 93 (UNO, 2004). The proportion of population under the age of 15 years is 17% (UNO, 2004), and the proportion of population above the age of 60 years is 22% (WHO, 2004). The literacy rate is 99.3% for men and 97.1% 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 9%. The per capita total expenditure on health is 726 international $, and the per capita government expenditure on health is 593 international $(WHO, 2004).

The main language(s) used in the country is (are) Croatian. The largest ethnic group(s) is (are) Croatian (nine-tenths), and the other ethnic group(s) are (is) Serb. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 71 years for males and 78.6 years for females (WHO, 2004). The healthy life expectancy at birth is 64 years for males and 69 years for females (WHO, 2004).

EPIDEMIOLOGY

Kozaric-Kovacic et al (2001) used the CAGE and Watson's Posttraumatic Stress Disorder (PTSD) Questionnaire to interview more than 350 displaced men and women. They found that PTSD (50.3% men, 36.5% women), alcohol dependence (60.5% men, 8.1% women) and comorbid alcohol dependence and PTSD (69.6% men, 11.7% women) were common. Comorbidity of alcohol dependence and PTSD in women was influenced by pre-war alcohol-related problems. Sakoman (2000) reviewed data from various registers and found that the number of patients with dependence on illicit drug (mostly heroin) increased from 1.0 per thousand population in 1991 to 2.7 in 1999. Kozumplik et al (2001) interviewed 582 school students and found that 23% had used drugs or alcohol (15.5% cigarettes, 3.3% alcohol and 2.6% drugs) and 17.9% used them periodically or continuously. Males and those with family or academic problems used drugs more often. Folnegovic et al (1990) found that the hospital based annual incidence rates (proxy variable for population rates) for schizophrenia ranged from 0.21 to 0.22 per 1000 population (0.26-0.29 per 1000 population aged over 15). Folnegovic et al (1992) found variable prevalence rates with a constant incidence rate of schizophrenia across various population groups in Croatia. Lemkau et al (1980) noted regional variation in the rate of psychoses in a representative community sample. Psychoses were more common in older age groups. Mollica et al (1999) interviewed 534 adults from a refugee camp using culturally validated measures for depression and posttraumatic stress disorder (PTSD) including the Hopkins Symptom Checklist 25, the Harvard Trauma Questionnaire and the Medical Outcomes Study Short-Form 20. Approximately 39.2% and 26.3% had a DSM-IV diagnosis of depression and PTSD, respectively. A total of 25.5% reported having a disability. Comorbidity (20.6%), older age, cumulative trauma and chronic medical illness were also associated with disability. In a follow-up study conducted after 3 years, Mollica et al (2001) found that almost 45% of the ill group continued to have these disorders and disability and another 16% developed depression or PTSD. Bosnar et al (2002) found that the suicide rate had increased from 16.2 to 19.1 per 100 000 population in the period between 1986-90 (pre-war period) and 1991-95 (war and post-war period). An increase in rate was noted particularly among those below 40 years and men. A fourfold increase in the use of firearms was also noted. Grubisic-Ilic et al (2002) examined 5349 suicides committed in the period 1993-1998. The suicide rate was significantly lower in the areas directly affected by war than in other areas. In war affected areas the number of suicides declined (more significantly in men). Suicide risk was higher in middle- and old-aged people in both areas. Firearms or explosive devices were used significantly more often in the areas directly affected by war, whereas hanging was significantly more frequent in other areas. Catipovic (2001) found that nearly 23.4% of suicides were committed by psychiatric patients (alcohol use disorders: 28.4%, depression: 25.4%, schizophrenia: 13.6%, personality disorders: 13.6% and neurosis: 11.9%). Males, single patients and those with physical comorbidity were significantly more likely and those with children less likely to commit suicide in the post-war period. Medical records of almost one third of the patients showed previous suicide attempts. Rudan et al (2002) found that the prevalence of learning disability (defined as the inability to attend the public school system which is mandatory in Croatia) ranged from 0.43% to 2.47% in isolate populations and that the prevalence was related to inbreeding. Hecimovic et al (2002) reported a rate of 3.5% for Fragile-X syndrome in a population of mentally retarded children attending a special school in Croatia (n=114) who were examined by molecular screening methods. In a study done on children injured during the war (n=322) using a structured interview in a clinical setting, Kocijan-Hercigonja (1996) found that PTSD correlated significantly with the degree of disability, social circumstances (displacement) and family situation (one or both parents killed).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

A draft of the mental health policy and of the action plan was prepared in 2003. The Health Care Act of 2003 established the Croatian Mental Health Institute that has the responsibility of formalizing mental health policy and plans. The intention of health system is to rely on well-developed primary health care.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1996. The Commission for Narcotics is a permanent Government body, comprising representatives of health, education and social welfare authorities. A strategy on prevention of drug abuse has been accepted by the Croatian Parliament.

National Mental Health Programme A national mental health programme is absent.
A national mental health programme is in development. Several programmes that contain mental health elements are ongoing. An action plan for the implementation of a prevention programme on alcohol abuse was prepared by the Ministry of Health according to WHO guidelines in 2003.

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

**Mental Health Legislation** The Protection of the Rights of People with Mental Disorders Act has been approved by the Croatian Parliament in 1997 and revised in 1999. It defines the rights of people with mental disorders to protection and care, and to equality in health services. The law requires the use of the least restrictive alternative. Compulsory hospitalization is subject to court supervision. The law specifically prohibits discrimination of mental health patients concerning housing and employment. The Social Welfare Act includes provisions on vocational rehabilitation, employment consultation, and supported housing. Other relevant legislations are the Family Act (which protects the rights of family members without the means to support themselves) and the Family Violence Protection Act. National legislation restricts access to alcohol, nicotine and drugs. 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 sources of mental health financing in descending order are social insurance and tax based. According to legal regulations in force since 2002, health insurance may be basic, supplementary and private. The basic health insurance is compulsory. The basic insurance is provided by CHII, while the additional may be provided by either CHII or other insurance companies. Within private insurance the CHII beneficiaries may insure themselves for other rights not included in the basic health insurance. All mental services for persons suffering from chronic mental disorders remain fully covered by obligatory insurance. The share of the private spending is estimated to be about 20%. All major classes of psychoactive drugs are covered by the obligatory health insurance. When co-payment exists, holders of supplementary health insurance are exempted from it. Chronic mentally ill patients are exempted from co-payment. Overall spending on psychoactive drugs was for a prolonged period among the top three therapeutic classes by spending. In 2002, it was the first therapeutic class by spending, because of inclusion of several novel drugs on the essential list.

The country has disability benefits for persons with mental disorders. Mental illness has the same status as other disabilities, i.e. compensations policy is regulated in a by-law regulating the issue of disabilities.

**Mental Health Facilities** Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. The most numerous health care institutions owned by the state or counties, including the City of Zagreb, in Croatia are primary health care centres – amounting to 123. At present, mental health services are not uniformly provided at primary health care level. However, the new legislation defines creation of mental health units in primary health care centres.

Regular training of primary care professionals is carried out in the field of mental health. Training programmes to enable professionals to deal with trauma victims have also been held on a regular basis.

There are community care facilities for patients with mental disorders. A certain number of chronic patients is settled in institutions of social welfare system. Though these institutions are not formally dedicated for chronically ill mental patients, some institutions’ capacities are almost entirely used for chronically mentally ill. In addition, some capacities of retirement homes are also used to treat mentally ill patients.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>10.06</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
<td>8.02</td>
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<td>Psychiatric beds in general hospitals per 10 000 population</td>
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<td>Psychiatric beds in other settings per 10 000 population</td>
<td>1.06</td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000 population</td>
<td>8.7</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 population</td>
<td>1.13</td>
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<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td>3.76</td>
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<td></td>
</tr>
<tr>
<td>Number of social workers per 100 000 population</td>
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</tbody>
</table>

The number of psychiatrists has increased in the past decade by more than 50%. Social workers and clinical psychologists are present in all major psychiatric wards and hospitals. In Croatia, a considerable decrease (one quarter) in the total number of hospital beds took place between 1990 and 1996. However, large mental hospitals still represent the major share in overall inpatient capacities (four-fifths). Capacities for acute psychiatric care are present in 17 out of 23 general hospitals. About 50 beds are available for children and adolescents, but adolescents are also admitted to beds meant for adults. Specialization in child and adolescent psychiatry has been recognized by the Ministry since 1994. In paediatric clinics, mental health consultations are generally performed by psychologists.
Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and prevention. The Ministry of Health, is regularly co-operating with and sponsoring activities of various NGOs dealing with mental health programmes, including those of service providers and consumers. However, the number of NGOs is small, especially those of users.

Information Gathering System There is mental health reporting system in the country. Health morbidity and mortality data (including mental health) are regularly collected and analysed by the Croatian Institute of Public Health. The same institution maintains the Register of Psychoses that is operational since 1956. Mental health mortality accounts for 0.93% of total deaths in 2002. SDR from suicide and self-inflicted injuries in all ages was 17.38 per 100,000 and from selected alcohol related causes was reported 95.9 per 100,000. Among mental disorders, the most common disorders diagnosed in primary health care were neurotic/ stress and somatoform disorders, schizophrenia, alcohol related disorders, dementia, psychoactive substances abuse and mental retardation. There is a rise in incidence of alcohol and illegal drug use. Alcohol psychosis incidence per 100,000 is 23.41 in 2001.

Programmes for Special Population The country has specific programmes for mental health for refugees, disaster affected population, elderly and children. Information about services for minorities and indigenous people are not known.

The country has specific programmes for substance dependencies and victims of war traumas. Child and adolescent mental health services are available in most cities, with two centres having day-treatment programmes. The social welfare system provides foster homes for abandoned and abused children and retirement homes for elderly.

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, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

The drug list is revised every year by the Croatian Health Insurance Institute.

Other Information Recent changes in health legislation will contribute to mental health awareness, to the development of community-based services in mental health and to enhancing cooperation between different sectors.

Additional Sources of Information
Cuba

GENERAL INFORMATION
Cuba is a country with an approximate area of 111 thousand sq. km. (UNO, 2001). Its population is 11.328 million, and the sex ratio (men per hundred women) is 100 (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 14% (WHO, 2004). The literacy rate is 97% for men and 96.8% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.2%. The per capita total expenditure on health is 229 international $, and the per capita government expenditure on health is 198 international $ (WHO, 2004).

The main language(s) used in the country is (are) Spanish. The largest ethnic group(s) is (are) European (Spanish descent) and African (descent), and the other ethnic group(s) are (is) Asian and racially-mixed. The largest religious group(s) is (are) Roman Catholic (five-sixths), and the other religious group(s) are (is) Protestant, other Christian and traditional African (e.g. Yoruba).

The life expectancy at birth is 75 years for males and 79.3 years for females (WHO, 2004). The healthy life expectancy at birth is 67 years for males and 70 years for females (WHO, 2004).

EPIDEMIOLOGY
Libre et al (1999) interviewed a representative sample of almost 1140 people aged over 60 years from two regions using a two stage sampling technique. DSM-III-R and NINCDS-ADRDA criteria were used for the diagnosis of dementia. The authors found dementia in 8.2% of subjects, with rates of Alzheimer’s disease and vascular type dementia being 5.1% and 1.9% respectively. Dementia was associated with older age, female sex and absence of spouse (due to widowhood or being single). De la Rosa et al (1998) used data from a natural survey of Cuban adult population to assess patterns of alcohol use. While 45.2% of the respondents reported themselves as drinkers, the overall prevalence of alcohol dependence in the population above 15 years was 8.8%. Higher prevalence rates were reported in the eastern areas and for men and older age groups. Smoking is significantly associated with heavy drinking. Data from the State Registry of Health suggest that in 1981 the rate of suicide for all ages was 21.7 per 100 000 population, which decreased in the year 2002 to 14.1 per 100 000. The rate of suicide was associated with age (elderly), gender (men), locality (rural). Regional variation was noted (MOH, 2004). Masso and Leon (1998) reported a retrospective case control study on suicide attempts in patients over 15 years of age. Suicide attempts were commoner in females, the age group between 15-25 years, housewife or unemployed category and in families that were incomplete/dysfunctional and less common in those who had stable partners. Reynaldo et al (2002) used psychometric tests and semi-structured interviews to assess the prevalence of psychiatric disorders in 150 patients with spinocerebellar disease type 2. They found that 88% manifested symptoms related to mental disorders which included – disorders involving adaptation, sleep, mood and sexual disorders. Mental retardation and dementia were also diagnosed.

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. It was revised in 2002 through a process that involved mental health professionals, civil servants and consumers. There are regular funds for its implementation. Between 85 to 90% of its original content has been put into practice.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 2000. It has a specific budget for its implementation that follows the principles of decentralization of resources, and it has been implemented to the extent of 50 to 75%. A specific law on substance abuse is currently not in place, but the issues are discussed in various laws and statutes on general health.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1997. It was revised in 2001. There is to specific budget for its implementation, and it has been implemented to the extent of 85 to 90% by local, regional and national authorities. Its main components are strategy of services reform, promotion and prevention, integration of mental health services, health services in primary care and development of specialized services and community care.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1960. Due to US sanctions and its pre-eminence in the pharmaceutical industry, nearly half of the new drugs on the market are not available in Cuba.

Mental Health Legislation The funds for the implementation are decentralized (provided by each province by its local Government). It has been implemented to the extent of over 90%. It focuses on human rights, regulation of mental health services, regulation of involuntary treatment, but it does not makes reference to advocacy, housing and regulation of mental health services. The latest legislation was enacted in 1997.
Mental Health Financing
There are no budget allocations for mental health.
The country spends 5% of the total health budget on mental health.
The primary source of mental health financing is tax based.
Cuban constitution makes health care a right of every citizen and the responsibility of the Government. The national health care provides free preventive, curative and rehabilitation services. Medication and medical aids are charged for, but the prices are low and subsidized. Services are financed 80% by the Ministry of Health and 20% by Social Security from the Ministry of Labor. In the Cuban system, no other form of financing applies.
The country has disability benefits for persons with mental disorders. More than 90% of the eligible persons actually receive the benefits. It is not the type of mental disorder, but the associated impairment that is considered when a person is evaluated for disability benefits. The family doctor or the psychiatrist is in charge of evaluation for less than 6 months periods. Above that, a national expert within the Ministry of Labor and Social Security and Ministry of Health (health and mental health experts) makes the decision.

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. Cuba has developed a system that prioritizes primary and preventive care. More than 75% of the population is covered by this kind of service. Mental health care is provided by primary health care physicians and psychiatrists. A system of referral is in place.
Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 120 personnel were provided training. The country has one doctor for just over 200 persons, the world’s highest doctor-patient ratio. This makes the integration of mental health in primary care a little easier. Each year between 4 and 5% of primary care personnel from a wide range of disciplines receive training.
There are community care facilities for patients with mental disorders. The community care system for the mentally ill provides coverage for more than 75% of the treated population. Emphasis is made on preventive/promotion interventions, home interventions, family interventions and residential facilities. Vocational training and employment programmes are included. Each of the 14 regions have a 20-30 bedded psychiatric unit, attached to the general hospital. These centres are responsible for comprehensive mental health care including social rehabilitation. There are sheltered rehabilitation centres which are located near the place of employment of the patients. These are managed by a male nurse, an occupational therapist and a work instructor. There are different sheltered rehabilitation centres based on the occupational profile, sex and community location of the patient.

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>7.36</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>5.72</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>1.54</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>1</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>10</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>2.3</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>2.7</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>1.0</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>9</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>12</td>
</tr>
</tbody>
</table>

There are 1328 occupational therapists, logopedists and psychometrics. About 100 psychiatric beds are available in a private psychiatric hospital. Almost 15% of mental health beds are occupied by long stay patients. Specified beds for care of forensic psychiatry patients, patients with drug abuse exist. There are 200 child psychiatrists.

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

Information Gathering System
There is mental health reporting system in the country. ICD-10 system is used. The mental health components reported are morbidity, admission and discharge, suicide attempts and suicide, among others.
The country has data collection system or epidemiological study on mental health. The Department of Health System Statistics and the Health Tendencies Analysis Units is in charge of the data collection.

Programmes for Special Population
The country has specific programmes for mental health for disaster affected population, elderly and children. There are no ethnic minorities, indigenous people or refugees for whom special mental health facilities should be present.
Also, there are programmes for women, victims of domestic violence, suicide, substance use problems, and social rehabilitation and reintegration of patients.
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, fluphenazine, haloperidol, lithium. The national therapeutic drug policy was revised in 2001, and the essential drug list was released in 2001. Medicines are free for patients with chronic illnesses and for those entitled to public invalidity benefits. Others pay subsidized prices.

Other Information Mental health is integrated in one programme and several sub-programmes, all administered by the National Commission of Mental Health and the groups of psychiatry, child psychiatry and psychology and are present at the provincial level with a town hall person responsible. Psychiatry is being reoriented towards primary health care. The country provides health tourism service through primary care in the form of physicians at hotels and international clinics, secondary care in clinics and hospitals offering specialized medical care, and a large number of medicines and medical aids. Among these clinics there are some that specialize in the management of drug and alcohol misuse and degenerative and neurological conditions. The health tourism industry also offers centres to improve the quality of life. These include thermal centres etc. where tourists can receive procedures that aid in stress control, sleep problems etc. The majority of health tourists are from Spanish-speaking countries, but the number from North America is increasing.

Additional Sources of Information
**Cyprus**

**GENERAL INFORMATION**
Cyprus is a country with an approximate area of 9 thousand sq. km. (UNO, 2001). Its population is 0.807 million, and the sex ratio (men per hundred women) is 100 (UNO, 2004). The proportion of population under the age of 15 years is 21% (UNO, 2004), and the proportion of population above the age of 60 years is 16% (WHO, 2004). The literacy rate is 98.6% for men and 95.1% 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 8.1%. The per capita total expenditure on health is 941 international $, and the per capita government expenditure on health is 449 international $ (WHO, 2004).
The main language(s) used in the country is (are) Greek, Turkish and English. The largest ethnic group(s) is (are) Greek, and the other ethnic group(s) are (is) Turkish. The largest religious group(s) is (are) Greek Orthodox Christian (four-fifths), and the other religious group(s) are (is) Sunni Muslim.
The life expectancy at birth is 75.5 years for males and 79.1 years for females (WHO, 2004). The healthy life expectancy at birth is 67 years for males and 68 years for females (WHO, 2004).

**EPIDEMIOLOGY**
There is substantial epidemiological data on mental illnesses in Cyprus 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 1985.
The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The mental health policy is concerned with updating legislation according to European standards, integrating mental health with community care and improving the living conditions of patients in the mental hospital in Nicosia.

**Substance Abuse Policy**
A substance abuse policy is present. The policy was initially formulated in 1978.

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

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

**Mental Health Legislation**
Cyprus has a Mental Health Act. The new law covers treatment, admission and care of the mentally ill. Human rights issues are also covered. Under this law, the mental hospital can admit voluntary patients, too. A new legislation envisaging a national anti-drug committee is under discussion in the parliament. The latest legislation was enacted in 1997.

**Mental Health Financing**
There are budget allocations for mental health. The country spends 7% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, social insurance and grants. 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. There is an ongoing cooperation of the community psychiatrists with general practitioners, and there are regular workshops with the participation of WHO experts. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 60 personnel were provided training. Mental health services offer a three month training course for doctors trained as general practitioners. There are community care facilities for patients with mental disorders. Community psychiatric nurses are present in all regions. In addition to regular services, they make home visits and provide crisis intervention. Nicosia has an Information and Counselling centre for drug abusers. Day care centres are available in 3 regions. These are run in cooperation with NGOs. A group home for 4 half-way patients and 3 hostels for ex-patients are available.
Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population 5.2
Psychiatric beds in mental hospitals per 10 000 population 4.5
Psychiatric beds in general hospitals per 10 000 population 0.6
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 5
Number of neurosurgeons per 100 000 population 1.3
Number of psychiatric nurses per 100 000 population 45
Number of neurologists per 100 000 population 2.6
Number of psychologists per 100 000 population 19.3
Number of social workers per 100 000 population 25

Besides the mental hospital at Nicosia there are other psychiatric units and specialized units like the child psychiatry centres, detoxification centres, psychiatric units for geriatrics, mentally retarded, community centres, etc. Ongoing training has increased. Personnel are being trained locally and abroad in psychotherapy and other interventions. Workshops on research methodology are held.

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 no data collection system or epidemiological study on mental health. WHO support is being sought to develop a system.

Programmes for Special Population The country has specific programmes for mental health for minorities, refugees, 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, biperiden, carbidopa, levodopa.

Other Information The National Five-Year Plan proposes to divide the country into five administrative sectors with each having their own mental health centre with most facilities for rehabilitation. Non-governmental organizations, church, other health services, local authorities and other interested bodies will help. Consultants from UNHCR have proposed that a bi-communal mental health services programme for the Greeks and Turks would help persons from both communities to share resources and professional expertise.

Additional Sources of Information
Czech Republic

GENERAL INFORMATION
Czech Republic is a country with an approximate area of 79 thousand sq. km. (UNO, 2001). Its population is 10.226 million, and the sex ratio (men per hundred women) is 95 (UNO, 2004). The proportion of population under the age of 15 years is 15% (UNO, 2004), and the proportion of population above the age of 60 years is 19% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).
The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.4%. The per capita total expenditure on health is 1129 international $, and the per capita government expenditure on health is 1031 international $ (WHO, 2004).
The main language(s) used in the country is (are) Czech. The largest ethnic group(s) is (are) Czech (four-fifths), and the other ethnic group(s) are (is) Slovak. The largest religious group(s) is (are) those without religious affiliation, and the other religious group(s) are (is) Roman Catholic.
The life expectancy at birth is 72.4 years for males and 79 years for females (WHO, 2004). The healthy life expectancy at birth is 66 years for males and 71 years for females (WHO, 2004).

EPIDEMIOLOGY
Dragomirecka et al (2002) assessed 1534 subjects aged 18 to 79 years using the Composite International Diagnostic Interview (CIDI). At least one mental disorder was detected in almost 27% of respondents (30% of women). The most frequently reported mental disorders were: neurotic disorders (18%), alcohol and tobacco use disorders (13%) and affective disorders (13%). Baudis et al (2002) reported findings on comorbidity from the same study. Lifetime comorbidity was found in 10.5% of respondents (8.6% men and 12.2% women) and 1-year comorbidity was found in 5.2% of the sample (5.0% men and 5.6% women). A significant association existed for the following sets of disorders: alcohol and tobacco use disorders, tobacco use disorders and affective disorders (mainly depression) and between affective disorders and neurotic disorders. Alcohol use disorders were correlated with all other groups of mental disorders in women. Psychiatric comorbidity was significantly associated with age and number of years of education. Koukolik (1996) reported a prevalence rate of 7.5% for Alzheimer’s disease based on 2197 autopsies on patients aged 65 years and above. Beckova et al (1999) investigated drug use in over 950 university students. The most frequently used drug was marijuana (26.6%). Data from 142 treatment centres across the country showed that the commonest drugs being used were methamphetamine, heroin, marijuana and toluene. One-third of users were in the 15-19-year age group. Regional differences in prevalence and drug preferences and a trend towards an increase in intravenous drug use was also noted (Polaneczy et al, 1996). The current figure for drug misuse in the 15-39 years age range is 10.37/1000 (Polaneczy et al, 2004). Sejda et al (1998) also reported that there was a gradual decrease in the average age of use and problematic use, especially in women. Consequently, the most affected age group was 15-19 years old and the male to female ratio stood at 2:1. Kubicka et al (1995) found an increase in alcohol use among 608 women interviewed twice in 1987 and 1992. Rate of heavy drinking increased from 7.2% to 14.0% and self-employed and independent women showed a greater increase in alcohol use. Topinkova and Neuwirth (1997) interviewed 1162 long-term residential elderly patients and found the prevalence of depression to be 47.7% (nearly 70% of the depressed individuals were more than 75 years old). Poor cognitive ability and physical disability was associated with depression. Jablensky et al (1992) discussed the results of the WHO Collaborative Study on the Determinants of Outcome of Severe Mental Disorders (DOS) in which Prague was one of the centers. The study showed that schizophrenia has similar incidence in different cultures but the outcomes were better in developing countries. In a six-country study in Europe, Wiersma et al (2000) assessed patients with schizophrenia at 1, 2 and 15 years intervals after the initial contact using the WHO Disability Assessment Schedule. Almost 83% of subjects had disability and 24% suffered from severe disability. A deteriorating course was more frequent than late improvement. Severity of disability at the first three assessments of the illness contributed significantly to the explanation of its variance at 15 years. In a study conducted on 981 adolescents, using standardized tools, bulimia nervosa (DSM-IV) was reported in 5.7% women with another 15% being at risk. None of the males met the criteria for eating disorders (Krč & Drabkova, 1996). Horazdovsky (1993) found a decline in the rate of suicides during 1975-1990 in a study based on statistical registers. Kvasnicova et al (1992) examined the records of 23 510 children from special schools and social care institutes and identified 510 with mental retardation (prevalence 2.2%). The prevalence of mental retardation was much higher in Gypsy children. Out of the 106 children in whom genetic analysis was done, 31.1% showed an evidence of chromosomal abnormality and a non-genetic etiology was found in 19.8%. The mean incidence of Down syndrome was 7.91 per 10 000 liveborn infants during 1961-1997 (Sipek et al, 1999). Gebhart et al (1990) screened 5080 children for minimal brain disorder in three districts by interviewing mothers. They found that 14.8% had minimal brain disorder and this was reflected in their poor academic performance.

MENTAL HEALTH RESOURCES
Mental Health Policy
A mental health policy is present. The policy was initially formulated in 1953.
The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The last amendment was in 2001. The policy in the field of mental health is formulated by the Psychiatric Society of the Czech Medical Association. This policy in the form of a programme document is presented to the Ministry of Health. The goals were published in 1997 and are known as Psychiatric Care in the Czech Republic – Programme Document and Mental Health Care Policy. This programme defines the status
CZECH REPUBLIC

of psychiatry in the health care system and underlines requirements and conditions of modern trends in treatment, rehabilitation and social reintegration of mentally ill people.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1989. The policy is a part of a law amended in 1989 (Act No. 37/1989).

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1953.

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

The national therapeutic drug policy/essential drug list was formed through the Act No. 48/1997 on Public Health Insurance, which defines 521 groups of pharmaceutical products.

Mental Health Legislation There is no specific law on mental health. The legislative regulation in the field of mental health is covered by the Law on Health Care for the Population (Act No.20/66 Coll.). This act, adopted in 1966, has been changed and amended by a series of health care reform legislation, most recently in 1999. More details can be obtained from the document: Health Care Systems in Transition – Czech Republic. European Observatory on Health Care Systems (WHO, 2000). There is another civil law bill on Involuntary Hospitalisation and Withdrawal of Legal Disposition, but it is yet to be passed.

The latest legislation was enacted in 1966.

Mental Health Financing There are budget allocations for mental health. The country spends 3% of the total health budget on mental health.

The primary sources of mental health financing in descending order are social insurance, tax based, out of pocket expenditure by the patient or family 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 available at the primary level. In principle, the primary health care is available for severe mental health disorders, but practically the preferred and common option is to use the services of ambulatory specialists.

Regular training of primary care professionals is carried out in the field of mental health. There are various options of training and education. Mental health care is a part of the training of general practitioners and nurses in primary care.

There are community care facilities for patients with mental disorders. There has been a substantial improvement in the quality of treatment provided in hospitals and also improvement in the living conditions of patients. Despite this positive changes, the current situation in rehabilitation and social reintegration of mentally ill patients is not satisfactory. The current status is partly due to limited financial resources. The costs of treatment are covered by health insurance fund, but for other interventions like social rehabilitation, coverage does not exist. The majority of work in this field is done by various non-governmental organizations and in few places by establishments supported by the churches, but they are unable to meet the demands. However, a number of very promising initiatives in day care (35 centres), sheltered housing, sheltered work and reintegration to the community have been started.

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>11.4</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>9.8</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>1.5</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0.2</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>12.1</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>1.7</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>33</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>12.7</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>4.9</td>
</tr>
<tr>
<td>Number of social workers</td>
<td></td>
</tr>
</tbody>
</table>

The total number of beds in residential facilities has decreased markedly within the last one and a half decade (by approximately one-fourth).

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Sheltered housing is also provided by NGOs.

Information Gathering System There is mental health reporting system in the country. Mental health is reported as a part of the report of the health sector.
The country has data collection system or epidemiological study on mental health. The Institute for Health Information and Statistics is responsible for data collection in the health care sector. The information on psychiatric care are systematically collected and regularly published since 1963.

Programmes for Special Population The country has specific programmes for mental health for minorities, refugees, disaster affected population, elderly and children. There are also programmes for patients with eating disorders.

Development of the community mental health care led to the establishment of the Network of Crisis Services.

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

Other Information Socio-political changes in 1989 have started a process of rapid transformation of the whole society. The system of health care underwent a fundamental reform which affected the organizational structure of services as well as the system of funding and management. The major elements of the transformed health care system are 1) compulsory health insurance and establishment of health insurance funds; 2) decentralization, diversity and autonomy of service providers; and 3) the supervising and regulating role of the Government in negotiations between health insurance funds and health care providers on coverage and reimbursement issues. In the recent years, there were positive shifts in the attitudes of the public towards mentally ill persons and this continuing process will contribute to destigmatization and easier reintegration of patients to the community.

Additional Sources of Information


Democratic People's Republic of Korea*

GENERAL INFORMATION
Democratic People’s Republic of Korea is a country with an approximate area of 121 thousand sq. km. (UNO, 2001). Its population is 22.776 million, and the sex ratio (men per hundred women) is 100 (UNO, 2004). The proportion of population under the age of 15 years is 25% (UNO, 2004), and the proportion of population above the age of 60 years is 11% (WHO, 2004). The literacy rate is 99% for men and 99% 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 2.5%. The per capita total expenditure on health is 44 international $, and the per capita government expenditure on health is 32 international $ (WHO, 2004).

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

The life expectancy at birth is 64.4 years for males and 67.1 years for females (WHO, 2004). The healthy life expectancy at birth is 58 years for males and 60 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Democratic People’s Republic of Korea in internationally accessible literature. In a multi-country study, involving Bahrain, Burma, DPR Korea, Egypt, Indonesia, Jordan, Sri Lanka, Thailand and Tunisia, Lamb (1996) assessed the quality of life of the non-institutionalized elderly population. Results showed that there were six profiles or types of disablement: functionally and emotionally healthy, functionally healthy with some depressive symptoms, some strength problems, severely depressed, mobility problems and functionally frail. The very depressed were more likely to be female, younger and single. Functional and emotional limitations were correlated with lower quality of life. Depressed profiles were associated with negative self-assessments of health, lower morale scores and low instrumental social support in terms of available kin. Country-specific patterns of elderly disablement indicate a possible disability transition such that as countries become more developed there may be an increase in the prevalence of disabled elderly. Mackinnon et al (1998) showed that the Center for Epidemiological Studies Depression (CES-D) scale could be used in the North Korean population.

MENTAL HEALTH RESOURCES

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

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

Substance Abuse Policy A substance abuse policy is present. Details about the year of formulation are not available.

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

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 There is a law on Regulation on Prevention of Mental Diseases. 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 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.

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.
**Psychiatric Beds and Professionals**

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

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

**Information Gathering System** There is a mental health reporting system in the country. There are annual mental health related tasks; periodic reports of these are prepared by the Ministry.

The country has a 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, elderly and children.

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

**Other Information**

* The verification of this country profile is still being awaited from the Ministry of Health of the Democratic People’s Republic of Korea.

**Additional Sources of Information**


Democratic Republic of the Congo

GENERAL INFORMATION
Democratic Republic of the Congo is a country with an approximate area of 2345 thousand sq. km. (UNO, 2001). Its population is 54.417 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 47% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 88.9% for men and 77.1% 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 3.5%.
The per capita total expenditure on health is 12 international $, and the per capita government expenditure on health is 5 international $ (WHO, 2004).
The main language(s) used in the country is (are) French. The largest ethnic group(s) is (are) Bantu (the four largest tribes), and the other ethnic group(s) are (is) Mangbetu-Azande and about 350 tribes. The largest religious group(s) is (are) Roman Catholic, and the other religious group(s) are (is) Protestant, Kimbanguist, Muslim, Syncretic and indigenous groups.
The life expectancy at birth is 41 years for males and 46.1 years for females (WHO, 2004). The healthy life expectancy at birth is 35 years for males and 39 years for females (WHO, 2004).

EPIDEMIOLOGY
Chabwine and Mugabwa (2001) reported that mental disorders were common, especially in the urban population and during the active decades of life. Tashala et al (1999) used clinical tests, laboratory tests and epidemiological data to find the cause of a paralysis epidemic in a school population. Results showed that conversion of the somatic type were responsible for most of the cases with environmental factors playing an important role in the spread of the illness. Sebit (1995) estimated the prevalence and course of psychiatric and neuropsychological problems in patients with HIV-I. They found that symptomatic seropositive individuals were more depressed than matched seronegative controls. In another study done on a clinical sample of older (than 55 years) AIDS patients, Ibara et al (2002) found that neuropsychiatric disorders were present in a large proportion (49.7%). Lalive and Zivojinovic (1987) reported that nearly three-quarters of asylum seekers in Zaire had psychological dysfunction. Stanbury et al (1973) reported on issues related to endemic cretinism in the region.

MENTAL HEALTH RESOURCES
Mental Health Policy
A mental health policy is present. The policy was initially formulated in 1999.
The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Formation is also a component of the policy.

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

National Mental Health Programme
A national mental health programme is present. The programme was formulated in 1999.

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
A draft for a mental health legislation exists at the level 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 source of mental health financing is out of pocket expenditure by the patient or family.
The cost of psychiatric treatment is considered to be high by the average earning capacity.
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. Mental health is being included in the primary health care and process charts are being defined for mental disorders.
Regular training of primary care professionals is carried out in the field of mental health. The Government also partially supports some charitable organizations like the Soins de Santé Mentale (SOSAME) that provide mental health services.
There are no community care facilities for patients with mental disorders. There is one mental health care centre.
Psychiatric Beds and Professionals

- Total psychiatric beds per 10,000 population: 0.17
- Psychiatric beds in mental hospitals per 10,000 population: 0.15
- Psychiatric beds in general hospitals per 10,000 population: 0.009
- Psychiatric beds in other settings per 10,000 population: 0.009
- Number of psychiatrists per 100,000 population: 0.04
- Number of neurosurgeons per 100,000 population: 0.004
- Number of psychiatric nurses per 100,000 population: 0.03
- Number of neurologists per 100,000 population: 0.04
- Number of psychologists per 100,000 population: 0.01
- Number of social workers per 100,000 population: 0.4

One occupational therapist is present.

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

Information Gathering System
There is no mental health reporting system in the country. Only epilepsy is reported. 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, elderly and children. There is a project for street children and also one for affected population.

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, levodopa. The essential list of drugs was revised in 2001. The drugs mentioned are dispensed by the private sector and not by the Government.

Other Information

Additional Sources of Information


**GENERAL INFORMATION**
Denmark is a country with an approximate area of 43 thousand sq. km. (UNO, 2001). The country consists of more than 400 islands, of which about a quarter are inhabited. Its population is 5.375 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 19% (UNO, 2004), and the proportion of population above the age of 60 years is 20% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004). The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8.4%. The per capita total expenditure on health is 2503 international $, and the per capita government expenditure on health is 2063 international $ (WHO, 2004).

The main language(s) used in the country is (are) Danish. The largest ethnic group(s) is (are) Scandinavian, and the other ethnic group(s) are (is) Inuit, Faeroese and German. The largest religious group(s) is (are) Lutheran Christian.

The life expectancy at birth is 74.8 years for males and 79.5 years for females (WHO, 2004). The healthy life expectancy at birth is 69 years for males and 71 years for females (WHO, 2004).

**EPIDEMIOLOGY**
There is substantial epidemiological data on mental illnesses in Denmark 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 1991.
The components of the policy are prevention, treatment and rehabilitation. Since 1991, the policy has been implemented through three consecutive 3-year-period agreements between the Government and the counties dealing with priorities and agreements of financing. The Government makes an annual report concerning psychiatric facts and status.

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

**National Mental Health Programme**
A national mental health programme is present. The programme was formulated in 1997. Denmark has a comprehensive national suicide prevention programme.

**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 is a departmental order concerning imprisonment and other coercion in psychiatry. The other relevant departmental orders (laws) concern procedures for compulsory commitment and involuntary hospitalization; procedure for complaints regarding treatment in psychiatric departments; guidance about possible revision of the fundamental law of psychiatry; and the procedure for appointment and conduct of patients’ advocates. The Danish Mental Health Act was introduced in 1989 and primarily regulates involuntary civil commitment, detainment and use of coercive measures in psychiatric hospitals and departments in Denmark, but also contains regulations relating to all hospitalized psychiatric patients. Certain sections of the Danish Penal Code pertain to issues related to forensic psychiatry. They established the type and extent of special provision orders for offenders with mental disorders. The latest legislation was enacted in 2002.

**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 tax based.
The country has disability benefits for persons with mental disorders. A mental health diagnosis makes it possible to have 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. Patients are treated by specialists in general practice or by psychiatrists. 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. There is a decentralized system across the country.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>7.1</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
<td>7.5</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals per 10 000 population</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10 000 population</td>
<td>59</td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000 population</td>
<td>16</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 population</td>
<td>2</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td>3</td>
</tr>
<tr>
<td>Number of neurologists per 100 000 population</td>
<td>3</td>
</tr>
</tbody>
</table>
There are 450 occupational therapists and 3000 nursing aides.

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

Information Gathering System There is mental health reporting system in the country. There are Government yearly reports about psychiatric services.

The country has data collection system or epidemiological study on mental health. Details can be obtained from the Danish National Board of Health and the Psychiatric Demography Centre in Aarhus.

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

Treatment for forensic patients is provided in general inpatient or outpatient psychiatric facilities or in some cases in high security units. The Danish Medico-Legal Council provides consultative medical advice regarding legal cases to criminal cases as well as cases related to involuntary admission or detention.

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 During the last 10 years, there has been an increasing focus in Denmark on issues concerning mental illness and its care. This includes a growing political awareness of the problem, as well as an increasing political will and commitment in regard to the need for improving mental health services. It has led to the development of three consecutive 3-year period national agreements between the Government and the counties, who are responsible for the health care system, including mental health care. The first one was in 1997 and the third goes from 2003 – 2006. These agreements represent a nationwide strategy for development and improvement of care and treatment offered to patients suffering from mental disorders. These agreements also contain arrangements for the payment of accepted improvements. The planned improvements include education of doctors, nurses and other professional workers, new and modern hospital facilities (including single rooms for psychiatric patients), extension of community-based psychiatry, improvement in the treatment of children with mental illness, etc. Intersectoral co-operation is essential at all levels in the system.

There is a significant degree of co-operation between the counties’ social services and health service departments. Usually, the health department is the responsible authority for mental health care, however, in some counties, the social service department is responsible for the management and organization of the mental health care system. This arrangement demonstrates the focus of the last ten years on decentralization and the social psychiatric services. In respect of the individual patient, the major goal is interdisciplinary teamwork (between psychiatrist, psychologist, physiotherapist, occupational therapist, social worker, etc). The Ministry of Health and the Ministry of Social Affairs regularly sponsor activities concerning mental health. The Ministry of Health cooperates with the National Board of Health regarding mental health issues, as it does for other national health questions. Various consultative groups have been established concerning mental health, e.g. an advisory body with expert members within the framework of the National Board of Health. Statistical reviews and reports about mental illness are prepared continuously, e.g. dealing with objectives and treatment for different kinds of psychiatric problems and quality of care. National objectives in the next few years include: establishing databases of patients to permit quality assurance of psychiatric treatment; improving the conditions for those patients with chronic mental disorders; continuing education of mental health staff; improving the capacity of departments of child and adolescent psychiatry; and improving the quality of hospital accommodation for acute psychiatric patients. A recent study by the EPSILON Group on type of mental health services in Copenhagen for patients suffering from schizophrenia shows that there is comprehensive system of mental health services with the exception of outpatient and community emergency care.

Additional Sources of Information


Djibouti

**GENERAL INFORMATION**

Djibouti is a country with an approximate area of 23 thousand sq. km. (UNO, 2001). Its population is 0.712 million, and the sex ratio (men per hundred women) is 99 (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 75.6% for men and 54.4% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7%. The per capita total expenditure on health is 90 international $, and the per capita government expenditure on health is 53 international $ (WHO, 2004).

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

The life expectancy at birth is 48.6 years for males and 50.7 years for females (WHO, 2004). The healthy life expectancy at birth is 42 years for males and 43 years for females (WHO, 2004).

**EPIDEMIOLOGY**

There is a paucity of epidemiological data on mental illnesses in Djibouti in internationally accessible literature. Mion and Oberti (1998) found that the prevalence of Khat use among 100 army recruits was 84% with a mean consumption of 400 grams per chew. Khat abuse is believed to be common and associated also with other mental disorders (Mohamed, 2004).

**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.

A national mental health programme is being formulated. This is expected to lead to the development of primary mental health care services, treatment facilities and human resources.

**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** An old French legislation forms the basis of legal action. New legislation needs to be formulated. Details about the year of enactment of the mental health legislation are not available.

**Mental Health Financing** There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is grants. The country does not have disability benefits for persons with mental disorders.

**Mental Health Facilities** Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Mental Health will be included with primary care in the new National Mental Health Programme. 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. Ambulatory care is available following hospitalization and for those for whom hospitalization is not deemed necessary.

**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>0.7</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.7</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>0</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>0.16</td>
</tr>
<tr>
<td>Number of neurologists per 100,000 population</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychologists per 100,000 population</td>
<td>0</td>
</tr>
<tr>
<td>Number of social workers per 100,000 population</td>
<td>0</td>
</tr>
</tbody>
</table>

There are 4 nursing attendants. A Chinese psychiatrist is providing services temporarily. Psychiatric assistance is concentrated to the psychiatry department of Peltier Hospital. Besides that, psychiatric services are non-existent.

**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. Data of 1999 is available. The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population No specialized services exist. International organizations like the UNHCR provide help for refugees.

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. These drugs are available only at the general hospital and not at primary care level. None of the anti-parkinsonian drugs are available.

Other Information Magico-religious treatment is present to a great extent. General knowledge about mental disorders is very limited.

Additional Sources of Information
Dominica

GENERAL INFORMATION
Dominica is a country with an approximate area of 0.75 thousand sq. km. (UNO, 2001). Its population is 0.071 million, and the sex ratio (men per hundred women) is 103 (UNO, 2004). The proportion of population under the age of 15 years is 33% (UNO, 2004), and the proportion of population above the age of 60 years is 10% (WHO, 2004). The literacy rate is 76% for men and 82% 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%. The per capita total expenditure on health is 312 international $, and the per capita government expenditure on health is 222 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) Carib Amerindian. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 71 years for males and 75.8 years for females (WHO, 2004). The healthy life expectancy at birth is 62 years for males and 66 years for females (WHO, 2004).

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

MENTAL HEALTH RESOURCES
Mental Health Policy
Details about the mental health policy are not available.

The protocol of the policy is not available. Lack of mental health personnel and stigma are constraints towards the development of the policy.

Substance Abuse Policy
A substance abuse policy is present. Details about the year of formulation are not available. Lack of human resources and infrastructure hamper the development and implementation of the substance abuse policy.

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

Staff development, mental health promotion and prevention along with evidence based practice are some of the components of the programme.

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

Mental Health Legislation
There is a Mental Health Act.

The latest legislation was enacted in 1987.

Mental Health Financing
There are budget allocations for mental health.

The country spends 2.9% 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 is covered as other illnesses. The coverage is limited.

Mental Health Facilities
Mental health is a part of primary health care system. Actual treatment of severe mental disorders available at the primary level. There is a need to develop primary and community care.

Regular training of primary care professionals is not carried out in the field of mental health. Psychiatrists and other mental health professionals function as an integral part of the primary health team.

Details about community care facilities in mental health are not available.

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

The old mental hospital was destroyed in the hurricane of 1979 and was not rebuilt. A new inpatient psychiatric facility was created in the general hospital. There is a lack of multi-disciplinary approaches towards care.
Non-Governmental Organizations NGOs are not involved with mental health in the country. Efforts are under way to include NGOs in mental health.

Information Gathering System There is mental health reporting system in the country. Details about data collection system or epidemiological study on mental health are not available.

Programmes for Special Population Details about any special mental health programmes are not available.

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

Other Information WHO could play a role in training and research development.

Additional Sources of Information
Dominican Republic

GENERAL INFORMATION
Dominican Republic is a country with an approximate area of 49 thousand sq. km. (UNO, 2001). Its population is 8.873 million, and the sex ratio (men per hundred women) is 103 (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 7% (WHO, 2004). The literacy rate is 84.3% for men and 84.4% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.1%. The per capita total expenditure on health is 353 international $, and the per capita government expenditure on health is 127 international $ (WHO, 2004).

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

The life expectancy at birth is 64.9 years for males and 71.5 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY
Garcia et al (1996) asked mothers of 199 students to respond to the Wender Utah Rating Scale and found the prevalence of ADHD to be 6% with a male to female ratio of 3:1. The commonest age-group was 5-11 years. Sattler et al (2002) found that social support and personal resources were inversely associated with psychological distress after being affected by a hurricane in a sample of 697 college students from Dominican Republic, Puerto Rico, US Virgin Islands and USA. Da Costa e Silva and Koifman (1998) conducted a study measuring the prevalence of smoking across 14 Latin American countries. The prevalence in men varied from 24.1% (Paraguay) to 66.3% (Dominican Republic) and that in women, from 5.5% (Paraguay) to 26.6% (Uruguay). A wide variance in mortality patterns was also noted across the countries. Application of the point prevalence data to the stage model of the tobacco epidemic in developed countries suggested that the Latin American countries are in stage 2, i.e. with a clearly rising prevalence among men, a prevalence for women that is beginning to increase and mortality attributable to smoking among men still not reflecting peak prevalence.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

The policy exists in the form of norms for action in mental health released by the Secretary of Health.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1998. It was revised in 2000. There is a regular budget for its implementation and it has been implemented to the extent of 50 to 75%. 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 1977. It was revised in 2001. There is a specific budget for its implementation and it has been implemented to the extent of 25 to 50% by local, regional and national authorities. Its main components are strategy of services reform, promotion and prevention, integration of mental health services at primary health care and development of specialized services.

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

Mental Health Legislation A proposal of law on Mental Health has been placed before the Senate and is pending its approval. Regular funds for its implementation have been proposed. It focuses on promotion and prevention, human rights, regulation of mental health services, but there is no reference to regulation of involuntary treatment. The latest legislation was enacted in 2001.

Mental Health Financing There are no 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 out of pocket expenditure by the patient or family, tax based, social insurance and private insurances.

The country does not have a separate budget line for mental health except for central expenses of the General Directorate of Mental Health. Approximately 40.0% of funds in mental health is spent on general hospitals, 40.0% in psychiatric hospitals, 10.0% in ambulatory clinics and 10.0% in community care.

The country has disability benefits for persons with mental disorders. Disabilities associated to mental health problems were included as conditions considered for getting state/public benefits in November 2002. Procedures are still to be worked out.

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. 25-50% of the population is covered by this kind of service. Mental health care in primary health care is provided by general doctors. Cases are identified and referred. Medication is supervised once they have been prescribed by specialists. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 260 personnel were provided training. About 60 general physicians and 200 community workers have been trained.
There are community care facilities for patients with mental disorders. The community care system for the mentally ill includes preventive/promotion interventions family interventions, residential facilities, and vocational training. Current services cover about 25 to 50% of the treated population. Home interventions are available for 50 to 75%. Community center coordinators, psychologists, counsellors, physicians and health workers are provided training in mental health. A day hospital is functioning.

**Psychiatric Beds and Professionals**

| Total psychiatric beds per 10 000 population | 0.37 |
| Psychiatric beds in mental hospitals per 10 000 population | 0.3 |
| Psychiatric beds in general hospitals per 10 000 population | 0.07 |
| Psychiatric beds in other settings per 10 000 population | 0 |
| Number of psychiatrists per 100 000 population | 2 |
| Number of neurosurgeons per 100 000 population | 0.12 |
| Number of psychiatric nurses per 100 000 population | 0.4 |
| Number of neurologists per 100 000 population | 0.18 |
| Number of psychologists per 100 000 population | 2.2 |
| Number of social workers per 100 000 population | |

There are 25 assistants in psychiatry. The country has approximately 6000 psychologists, but all of them do not work in the mental health area. During the last 3 years, mental health units have started activities in 10 general hospitals. About 50% of beds are occupied by long stay patients. The SESPAS has 123 psychiatrists distributed in the eight sanitary regions, 60% of them in the National District (region 0), 15% in region II (Santiago) and the rest for the other six regions. At least two-thirds of mental health professionals from each discipline work in the public institutions.

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

**Information Gathering System** There is mental health reporting system in the country. Both ICD-10 and DSM-IV criteria are used in the reporting system. The mental health components reported are morbidity, treatment and discharge. Suicides are notified through the institute of forensic pathology. Violence and abuse against women are also notified. The country has data collection system or epidemiological study on mental health. The ‘Estadística de Salud General’ (General Health Statistics) is in charge of the data collection system for mental disorders. Service data collection system is conducted for part of the mental health system (Psychiatric Hospital). Data from the only psychiatric hospital in the country indicate that affective disorders (particularly depression) are the main condition for seeking help in outpatient, inpatient and emergency mental health care. Other leading conditions are schizophrenia, drug abuse and dependence, mental retardation and epilepsy (Análisis de la Situación de la Salud Mental en la República Dominicana, Secretaría de Estado de Salud Pública y Asistencia Social, 2002).

**Programmes for Special Population** The country has specific programmes for mental health for disaster affected population, elderly and children. The country does not have any indigenous people or refugees. After the last hurricane, a mental health programme for victims of disaster was initiated, based on the experience of countries like Nicaragua and Honduras. There are some programmes with little coverage of the elderly population. There are institutions for children in the area of rights and duties of children, healthy child raising and prevention of child sexual abuse. Also, there are programmes for women and victims of domestic violence.

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

The essential drug list was revised in 1997. Diazepam is assigned to the first level, which means that it can be managed by that level without the due authorization of a specialist. All the medicines included in the listing are free.

**Other Information** Since 1997, a decentralization process has started, due to which the number of beds in mental hospitals have reduced by 50% and 15 general hospitals are receiving inpatients with acute disorders and also long term patients. Three psychology schools have started functioning with more than 100 students.

**Additional Sources of Information**