**Jamaica**

**GENERAL INFORMATION**
Jamaica is a country with an approximate area of 11 thousand sq. km. (UNO, 2001). Its population is 2.676 million, and the sex ratio (men per hundred women) is 97 (UNO, 2004). The proportion of population under the age of 15 years is 30% (UNO, 2004), and the proportion of population above the age of 60 years is 10% (WHO, 2004). The literacy rate is 83.8% for men and 91.4% 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 6.8%. The per capita total expenditure on health is 253 international $, and the per capita government expenditure on health is 106 international $ (WHO, 2004).

The main language(s) used in the country is (are) English and Jamaican Creole. The largest ethnic group(s) is (are) African, and the other ethnic group(s) are (is) Afro-European. The largest religious group(s) is (are) Protestant.

The life expectancy at birth is 71.1 years for males and 74.6 years for females (WHO, 2004). The healthy life expectancy at birth is 64 years for males and 66 years for females (WHO, 2004).

**EPIDEMIOLOGY**
In a sample of 89 physically healthy subjects who were administered the Psychiatric Assessment Schedule, Hilton et al (1997) found that the prevalence of psychiatric disorder was 14% in men and 36% in women. Psychiatric disorders were associated with female gender, unemployment, difficulties with social adjustment and number of episodes of physical illness in the 6 months prior to the interview. Eldemire (1996) conducted a community based study in subjects over 60 years using the Mini Mental State Examination (MMSE) and identified 2.3% as severely impaired and 11.8% as having borderline impairment. Soyibo and Lee (1999) conducted a survey of more than 2400 high school children in 26 schools and found that drug use was common. The following drugs were used by the students: alcohol (50.2%), tobacco (16.6%), marijuana (10.2%), cocaine (2.2%), heroin (1.5%) and opium (1.2%). Illicit drug use was associated with gender (male), locality (urban) and parental occupation (professionals). Hickling and Rodgers-Johnson (1995) used the Present State Examination (PSE) to find the incidence of schizophrenia in the population by locating first contact patients (n=355). The incidence was found to be 1.2/10 000 population. The age adjusted (15-54 years) rate was 2.1/10 000 population. Hickling et al (2001) followed first contact patients with schizophrenia identified by the Present Status Examination (n=317) for one year. In this period, almost 38% were admitted to hospital for treatment, 83% were still being seen and only 43% were employed. The relapse rate was 13% and it was associated with hospital admission, being brought into care by the police or mental health officers, gainful employment and poor intramuscular medication compliance. Crijnen et al (1999) administered the parent version of the Child Behaviour Checklist for 13 697 children and adolescents aged 6 -17 years in 12 countries (including Jamaica). The researchers concluded that age and gender variations were cross-culturally consistent, although clinical cut-off points varied across all cultures. Medium effect sizes for cross-cultural variations were noted in total problem, externalizing and internalizing scores, but great cross-cultural consistency was seen in the decline of total and externalizing scores with age and increase in internalizing scores with age. Boys obtained higher total and externalizing scores but lower internalizing scores than girls. Lambert et al (1989) compared parent-reported behaviour problems of 360 Jamaican and 946 U.S. children aged 6 to 11 and found few differences in individual, total, internalizing (e.g. depression) and externalizing (e.g. fighting) problem scores as a function of nationality, gender or age. Thorburn et al (1992) used a modification of the International Classification of Impairments, Disabilities and Handicaps assessment to identify six types of disabilities (visual, hearing, speech, motor, cognitive and fits) in children (2-9 years) in a population-based survey. The estimated prevalence of all types of disabilities was 9.4% and for serious disability 2.5%. Cognitive disabilities were seen in 8.1%. Of the disabled children, 23% had two and 6% had three or four disabilities (Paul et al, 1992). Readett et al (1991) assessed 477 primary school children for nocturnal enuresis. If nocturnal enuresis was defined as 2 wet nights per week, it occurred in 62%, 48%, 42% and 40% of children at 2, 3, 4 and 5 years of age, respectively. If enuresis was defined as 1 wet night per month, it occurred in 68%, 58%, 53% and 52%, respectively. Though there was no significant differences between sexes, girls with family history of nocturnal enuresis were at significantly higher risk. Studies in two children’s homes in Jamaica showed that 33% and 66% of children had pica (Wong et al, 1988).

**MENTAL HEALTH RESOURCES**

**Mental Health Policy** A mental health policy is present. The policy was initially formulated in 1994. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Integration of mental health into primary health care is a component of the policy.

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

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

Jamaica has a Mental Health Act. Under the new Mental Health Bill, provisions have been made for the admissions of patients, whether voluntary or involuntary, and the designation of psychiatric facilities for the mentally ill. The provisions relate to the establishment of the Mental Health Appeal Tribunal, the consent of patients to treatment and the discharge of patients among others. Community care and role of urbanisation on mental health are also discussed. The latest legislation was enacted in 1997.

Mental Health Financing

There are budget allocations for mental health.
The country spends 5% of the total health budget on mental health.
The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family and private insurances.
Social security arrangements are limited. Destitute mentally ill people are issued food stamps under the Poor Law, but the registration process is cumbersome.
The country has disability benefits for persons with mental disorders. Relief for the poor and food stamps are provided to the indigent mentally ill and the National Fund subsidizes medication.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Primary care is traditionally performed by mental health officers and psychiatrists. These functions are now being handed over to medical practitioners (about 1200) and nurses in primary health care. They refer the more serious patients to psychiatrists, but within the community they are responsible to a substantial degree to modify drug dosages and carry out other therapies for which they are trained initially. They also liaise with the police and forensic experts and other community services linked to mental health. They also hold meetings and give lectures within their parishes to educate people about the role of mental health.

Regular training of primary care professionals is carried out in the field of mental health. Training in psychiatry is provided to all medical practitioners and nurses. The most experienced nurses were called mental health officers and given further training in psychopharmacology and psychotherapy. Besides these, there are psychiatric aides, paraprofessionals trained in basic mental health and supposed to help the mental health officers in the community and enrolled assistant nurses, nurses with shorter training periods with the function of helping the registered nurses in hospitals and clinics.

There are community care facilities for patients with mental disorders. Despite several changes in the Government over the past 30 years, continuity of public policy and fiscal support has allowed ongoing development of the island’s community mental health service. The National Community Mental Health Service relies on specially trained psychiatric nurse practitioners who provide crisis management, medication, supportive psychotherapy and make home visits and carry out treatment plans formulated by the psychiatrist.

More patients are treated within the community based services than in hospitals. This has led to a decrease in psychiatric hospital admissions by almost 50%. Many patients of schizophrenia receive depot neuroleptics at ‘Modecate Clinics’ run by general nurses with psychiatric training. However, there are few rehabilitation units and they are not well resourced. Also, there is little support for destitute mentally ill people in the community.

Psychiatric Beds and Professionals

| Total psychiatric beds per 10 000 population | 5 |
| Psychiatric beds in mental hospitals per 10 000 population | 4 |
| 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 | 1.6 |
| Number of neurosurgeons per 100 000 population | 0.2 |
| Number of psychiatric nurses per 100 000 population | 8 |
| Number of neurologists per 100 000 population | |
| Number of psychologists per 100 000 population | 0.7 |
| Number of social workers per 100 000 population | 0.4 |

There are 10 occupational therapists. The Bellevue Hospital (bed strength 900) offers the broad range of psychiatric services including (limited) rehabilitation services. Two general hospital psychiatric units provide just over 50 acute care beds. Psychotic patients are admitted to all general hospitals’ medical wards also. The University Hospital also has a small unit for alcohol and drug abuse patients. In the 1970s, as a step to educate the public, the Bellevue Hospital had started a novel programme where on one particular day the public were encouraged to come to the hospital and participate in cultural and sports activities with the patients. Weekly call-in programmes on the radio and sociodrama process was also started in 1978. These resulted in the publication of a large number of studies on mental health by the lay press and stigma was reduced. Many general nurses working in the mental health field have received 9 month training in psychiatric nursing. They deal with routine care of patients with psychotic illness and are the mainstay of mental health care. Some work almost independently of psychiatrists, and in rural areas may initiate treatment, including medication.
Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, treatment and rehabilitation. There are self-help groups providing help to schizophrenics and persons with attention-deficit disorder and also shelter for the homeless. The university hospital collaborates with the Alcoholic Anonymous.

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

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

Other Information

Additional Sources of Information
Bellevue Hospital Task Force Implementation Plan.
Integration of Mental Health Services into Primary Health Care. Health Centres in all Regions (Government document).
National Mental Health Policy (Government document).
The Mental Health Amendment Bill (Government document).
The New Mental Health Bill. Mental Health Report (Government document).
Japan

GENERAL INFORMATION
Japan is a country with an approximate area of 378 thousand sq. km. (UNO, 2001). The country has many mountainous islands. Its population is 127.799 million, and the sex ratio (men per hundred women) is 96 (UNO, 2004). The proportion of population under the age of 15 years is 14% (UNO, 2004), and the proportion of population above the age of 60 years is 24% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8%. The per capita total expenditure on health is 2131 international $, and the per capita government expenditure on health is 1660 international $ (WHO, 2004).

The main language(s) used in the country is (are) Japanese. The largest ethnic group(s) is (are) Japanese. The largest religious group(s) is (are) Shinto and Buddhist.

The life expectancy at birth is 78.4 years for males and 85.3 years for females (WHO, 2004). The healthy life expectancy at birth is 72 years for males and 78 years for females (WHO, 2004).

EPIDEMIOLOGY
There is substantial epidemiological data on mental illnesses in Japan 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 1950.

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

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1953.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1950.

In 1995, the Government announced the Plan for People with Disabilities – a 7-year Strategy for Normalization.

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

Mental Health Legislation The Mental Health Law was enacted in 1950 and is reviewed every 5 years. It was modified to the Mental Health and Welfare Law of 1995, wherein it provided the legal basis to perform adequate treatment (including voluntary treatment) and prevent abuse and supported the adoption of community care. The most recent amendment of 2000 emphasized that community-based programmes were eligible for public funds and exempted the family of a patient with mental disorder from responsibility for damages caused by the patient to self or others during the course of treatment.

The latest legislation was enacted in 2000.

Mental Health Financing There are budget allocations for mental health.

The country spends 5% of the total health budget on mental health.

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

All residents are insured by the national health care system. Semi-governmental insurance organizations typically cover up to 70% of the cost of services. The remaining 30% is borne by the consumer/family. However, some groups (children, elderly, disabled, those with specific chronic physical and mental illnesses) are exempted from this co-payment. Hospital reimbursement schemes are being changed to favour shorter inpatient stays. The National Government provides for half of the expenditure on community care and the remaining is shared by the prefectural Government, provider agencies and NGOs.

The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Only psychiatric emergency service networks are provided. Various treatments for mental disorders are available in mental hospitals and clinics.

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. In 1994, the law concerning the activities of community health centres was revised and called the Community Health Care Law. It led to the development of more adequate mental health care in the regional health care system. The Mental Health Welfare Law supports community-based services and deinstitutionalisation. However, the majority of beds (89%) are in the private sector, which makes the implementation of the policy somewhat more difficult. However, reform measures are beginning to promote the concepts of deinstitutionalization, disability benefits, differentiation of services, revisions in payment and quality assessment. A number of workshops and group homes have developed. There are about 1250 facilities offering psychiatric day care and night care of which a quarter are detached from psychiatric hospitals.
JAPAN

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 28.4
Psychiatric beds in mental hospitals per 10 000 population 20.6
Psychiatric beds in general hospitals per 10 000 population 7.8
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 9.4
Number of neurosurgeons per 100 000 population 5
Number of psychiatric nurses per 100 000 population 59
Number of neurologists per 100 000 population 2
Number of psychologists per 100 000 population 7
Number of social workers per 100 000 population 15.7

The Government has decided to reduce 72 000 beds (20% of the existing bed strength) within 10 years. The majority of psychiatric beds are in psychiatric hospitals in the private sector. Only about 0.2% of beds have been allocated to child mental health services. Japan has no specialized legal provision for mentally ill criminal offenders. Acquitted mentally ill offenders are treated in the same way as any other patient with psychiatric disorder according to the laws related to mental health. Convicted offenders with psychiatric illness are treated within the prison system. The discharge of a patient from a psychiatric hospital depends on the assessment of the treating doctor and hospital superintendent and this is reviewed by the Psychiatric Review Board. In 2003, the Diet (parliament) has passed a proposal for setting up forensic wards in public sector hospitals. Physicians, nurses, social workers and occupational therapists are licensed by the Ministry of Health, Labour and Welfare, and clinical psychologists are licensed by the Japanese Certification Board for Clinical Psychologists under the Ministry of Education, Culture, Sports, Science and Technology. Except for a mandatory 1-day course for extending qualification for an additional 5 years, no other systematic effort is made at refresher training of psychiatrists. There are about 300 child and adolescent psychiatrists in the country.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. NGOs help in community care delivery. Consumer (e.g. National Federation of Psychiatric Survivors and Users in Japan) and family (National federation of families with mentally ill in Japan) groups influence policies.

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

Programmes for Special Population The country has specific programmes for mental health for 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, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

The National Health Insurance designates the availability of drugs.

Other Information Prior to the second world war, Japan had two laws related to mental health, the Confinement and Protection for Lunatics Act (1900) and the Mental Hospital Act (1919). In 1950, the Mental Hygiene Law was passed, which allowed for compulsory institutionalized care for patients with psychiatric disorders. In 1958, a nationwide compulsory health insurance scheme was started and from 1961 onwards the Government restricted the construction of any public hospitals and encouraged private hospitals. Following the killing of two patients in one hospital, the Mental Hygiene Law was revised and was renamed as Mental Health Law (1987). Human rights issues of patients and community care and rehabilitation facilities were stressed upon. Voluntary admission was introduced. The Mental Health and Welfare Law (1995) added the social eligibility criteria for mental disabilities. Community care has not been well funded by the Government and private sectors were encouraged to provide psychiatric care throughout the past decades. Typically the major share of psychiatric care is provided by a mid-size private psychiatric hospital. The average length of inpatient stay is very long. Ambulatory services are provided by a third of the hospitals, and small scale vocational workshops are the most prevalent community care facilities in the country. The public health centres deliver a variety of services in spite of low intensity of service provision. The first patient satisfaction survey in Japanese psychiatric hospitals was conducted in 1997. A nation-wide outcome survey is now planned.
**Additional Sources of Information**


It also outlines service strategies, training strategies and management and promotion strategies. The national mental health programme aims to integrate mental health into public health and to promote mental health awareness. A draft for the mental health policy had been prepared in 1986, but is still to be implemented.

**Mental Health Legislation**

- National Therapeutic Drug Policy/essential list of drugs
- National Mental Health Programme
- Substance Abuse Policy
- Mental Health Policy
- Mental Health Legislation

**MENTAL HEALTH RESOURCES**

- **Mental Health Policy** A mental health policy is absent. A draft for the mental health policy had been prepared in 1986, but is still to be implemented.
- **Substance Abuse Policy** A substance abuse policy is present. The policy was initially formulated in 2000.
- **National Mental Health Programme** A national mental health programme is present. The programme was formulated in 1994. The national mental health programme aims to integrate mental health into public health and to promote mental health awareness. It also outlines service strategies, training strategies and management and promotion strategies.
- **National Therapeutic Drug Policy/essential List of Drugs** A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1988.
- **Mental Health Legislation** There is the Chapter 49/50/51 from the Law of Common Health regarding the compulsory admission to psychiatric hospitals. The latest legislation was enacted in 2003.
Mental Health Financing

There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary sources of mental health financing in descending order are tax based and out of pocket expenditure by the patient or family. The country has disability benefits for persons with mental disorders.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. There have been initiatives to train general physicians and nurses on aspects of mental health care. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 160 personnel were provided training. There are no community care facilities for patients with mental disorders. Psychiatrists now cover health centres in 5 regions. Psychological counselling centres have been established in the main schools.

Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Domain</th>
<th>Quantity per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>1.57</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>1.4</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.08</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0.07</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>1</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>0.2</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>2</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>0.3</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0.6</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>2</td>
</tr>
</tbody>
</table>

Prior to 1966, there was only one mental hospital in Bethlehem. After the 1967 war, patients on the East Bank did not have access to the services of the hospital and so a new 60-bed mental hospital was constructed and in 1987 the National Centre for Mental Health was opened. A day care centre and a rehabilitation centre are there. Recently, a 46 bedded centre for treatment of drug abuse was created. Although there are 3000 psychologists and 2000 social workers only a few work in the field of mental health. Many professionals seek vacancies with better salaries in neighbouring countries, while others move to private sectors. Among military psychiatrists, two have a diploma in forensic psychiatry and one in child psychiatry (they were trained in the UK). Clinical psychologists have to obtain a licence from the Ministry to practice.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in promotion and rehabilitation.

Information Gathering System

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

Programmes for Special Population

The country has specific programmes for mental health for elderly and children. Two geriatric homes with a capacity for 200 elderly individuals are under construction. As a part of the national mental health programme, initiative has been taken to start a school mental health programme.

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. Sinemet is available instead of carbidopa and levodopa (it combines 25 mg of the former and 250 mg of the latter). The cost per 100 tablets is 0.47 USD.

Other Information
Additional Sources of Information


Oweis, A. I. (2001) Relationships among the situational variables of perceived stress of the childbirth experience, perceived length and perceived difficulty of labor, selected personal variables, perceived nursing support and postpartum depression in primiparous Jordanian women living in Jordan. Widener University School of Nursing.


Kazakhstan

GENERAL INFORMATION
Kazakhstan is a country with an approximate area of 2,725 thousand sq. km. (UNO, 2001). Its population is 15,403 million, and the sex ratio (men per hundred women) is 92 (UNO, 2004). The proportion of population under the age of 15 years is 24% (UNO, 2004), and the proportion of population above the age of 60 years is 12% (WHO, 2004). The literacy rate is 99.7% for men and 99.2% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.1%. The per capita total expenditure on health is 204 international $, and the per capita government expenditure on health is 123 international $ (WHO, 2004).

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

The life expectancy at birth is 58.7 years for males and 68.9 years for females (WHO, 2004). The healthy life expectancy at birth is 53 years for males and 59 years for females (WHO, 2004).

EPIDEMIOLOGY
Seisembekov et al (1989) used a questionnaire to assess alcohol use among 1458 students and found that 35.3% used alcohol with 62% having started the use between 15-18 years of age. Alcohol use seemed to be increasing. In a tuberculosis dispensary, Khauadamova et al (1992) found the prevalence of alcohol dependence to be 11.2%. Among patients with active tuberculosis the prevalence was 1.6%. In another sample, Shefer and Nabokova (1989) found that 37.8% of tuberculosis patients were heavy alcohol drinkers and 17.2% suffered from alcohol dependence. Mustafetova and Pogosov (1999) compared cocnar dependence (n=172) and opium dependence (n=302) in a clinic-based study and found that those using cocnar were older (70 years compared to 40 years in opium use), continued use for longer (33 years compared to 5 years in the opium using group) and had lesser criminal activities. Wasserman et al (1998 a, b) reported that suicide rates varied greatly between different regions of the former USSR during 1984-1990. It was 11.8 per 100 000 in Central Asia (Kazakhstan, Kirgizia, Turkmenistan, Uzbekistan and Tajikistan). During 1984-1990, a decline in suicide rates (32% for males and 19% for females) took place in the former Soviet Union. Buckley (1997) conducted a descriptive analysis of suicide rates in post-Soviet Kazakhstan during the period 1990-94 and found a 27% increase in male suicide rates, while the suicide rates in females remained stable. They felt that men were more affected because their identity is grounded in the economic arena and the post-Soviet Kazakhstan is facing hardships in the form of unemployment, inflation and economic uncertainty. Stolarov et al (1990) examined changes in the rate of suicides in some cities of South Kazakhstan. They found that while positive changes were expected in light of measures aimed at the control of heavy drinking and alcohol dependence, the share of alcoholic intoxication as a cause for suicides remained at the former level. A similar relation between alcohol use and suicide was reported by Petrov et al (1991).

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 1997. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Providing social assistance and education is also a component of the mental health policy.

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.

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 The Law of Republic of Kazakhstan on Psychiatric Assistance and Guarantee of Rights of Patients is the most recent legislation on mental health. The law requires the state to establish special production units, shops or sections with easier working conditions for labour therapy, vocational training and employment for persons with mental illness along with mandatory quotas for employment of the mentally ill. 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 and social insurance. The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Regular training of primary care professionals is carried out in the field of mental health. Details about community care facilities in mental health are not available.
**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>6.5</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>5.9</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.2</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td></td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000</td>
<td>6</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000</td>
<td>1</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000</td>
<td>8</td>
</tr>
<tr>
<td>Number of neurologists per 100 000</td>
<td></td>
</tr>
<tr>
<td>Number of psychologists per 100 000</td>
<td>0.1</td>
</tr>
<tr>
<td>Number of social workers per 100 000</td>
<td></td>
</tr>
</tbody>
</table>

There are 855 psychiatrists and 526 narcologists. The psychiatric service in the Republic of Kazakhstan is provided through psychiatric hospitals, prophylactic centres and psychiatric departments in general hospitals. In the central regional hospitals, there are outpatient clinics, polyclinics, psychiatric emergency clinics. There are also day hospitals and workshops for treatment and social rehabilitation.

**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. The country has data collection system or epidemiological study on mental health. According to the National Statistics Agency data are being collected on mental disorders.

**Programmes for Special Population** Details about any special programmes in mental health are not available. There are 20 centres for preventative psychiatry, and 60 doctors work in this area.

**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.

**Other Information**

**Additional Sources of Information**

Kenya

GENERAL INFORMATION
Kenya is a country with an approximate area of 580 thousand sq. km. (UNO, 2001). Its population is 32.42 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 41% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 90% for men and 78.5% 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 7.8%. The per capita total expenditure on health is 114 international $, and the per capita government expenditure on health is 24 international $ (WHO, 2004).

The main language(s) used in the country is (are) English (official) and Swahili (national). The largest ethnic group(s) is (are) African (Kikuyu, Luo, Kalenjin and Kamba tribes are most populous), and the other ethnic group(s) are (is) Asian and European. The largest religious group(s) is (are) Christian (more than three-fourths), and the other religious group(s) are (is) Muslim, Hindu and indigenous groups.

The life expectancy at birth is 49.8 years for males and 51.9 years for females (WHO, 2004). The healthy life expectancy at birth is 44 years for males and 45 years for females (WHO, 2004).

EPIDEMIOLOGY
Ndetei and Muhangi (1979) studied 140 rural medical walk-in-clinic patients and found that 20% suffered from psychiatric illness, especially depression and anxiety. Sebit (1996) assessed 186 patients attending primary care facilities using the Self Rating Questionnaire (SRQ), the Clinical Interview Schedule/Revised (CIS-R) and the WHO Audit Instrument for Alcohol abuse. The diagnosis of a psychiatric disorder was made according to DSM-III-R criteria. The overall prevalence rate of psychiatric disorder was only 0.43% with an incidence of 0.43 per 1000 persons. In a cross-sectional survey involving 15 324 household heads who reported on a population of 68 487 people in a district. Some (1994) found that there was at least one person who regularly used drugs in 44.3% of the households. The prevalence of regular drug use was 6.4% for alcohol, 2.7% for cigarette smoking, 0.6% for marijuana and 0.2% for non-prescribed medicines. Significant social, financial, occupational/academic, legal, health and injury related complications were noted. Odek-Ogunde and Pande-Leak (1999) assessed 558 undergraduates with a questionnaire on drug use. The lifetime prevalence of commonly used substances was tobacco (54.7%), alcohol (84.2%), cannabis (19.7%) and inhalants (7.2%). The lifetime prevalence of hard drugs (heroin, cocaine, mandrax, amphetamines and LSD) was low (< 5%). Substance use was commoner in males. Rates for regular use (> 20 days/month) were high for tobacco (24.7%) and alcohol (11.5%). More than half of the subjects started using drugs at upper primary and secondary levels but nearly one fifth started substance use in lower primary school. Kuria (1996) interviewed 547 urban and 405 rural students with the WHO youth survey questionnaire. Alcohol was the most commonly abused drug (15% and 14% in urban and rural schools, respectively). Tobacco, cannabis and inhalants followed in that order. Male students abused drugs more often than female students. ‘Hard’ drugs were used more often in the rural schools. Ayaya et al (2001) found features of tobacco dependence in 37.6% of street children (n=191) who also frequently used other drugs. Saunders et al (1993) evaluated 188 subjects in 6 countries. After non-drinkers and known alcoholics had been excluded, 18% of subjects had a hazardous level of alcohol intake and 23% had experienced at least one alcohol-related problem in the previous year. Inter-country variations were noted. Omolo and Dhadphale (1987) found a high prevalence of Khat chewing among patients attending a primary health clinic (n=100). Dhadphale et al (1989) used a two-stage screening procedure to diagnose depression according to ICD-9 descriptions in a primary care sample of 881 patients. The prevalence of depressive disorders was 9.2%, with about a third having moderate to severe depression. Maj et al (1994) conducted a multi-country (including Kenya) WHO Neuropsychiatric AIDS Study. The mean global score on the Montgomery-Asberg Depression Rating Scale was significantly higher in symptomatic seropositive individuals than in matched seronegative controls in all centres. Sebit (1995) reported similar results in a study done in Kenya and Zaire (n=408). Maj (1996) also reported that in contexts where social rejection of HIV-seropositive subjects was harsh, symptomatic stages of HIV infection were associated with a greater prevalence of syndromal depression. Weisz et al (1993) interviewed parents of 11-15 year old children living in different societies – Embu in Kenya, Thai, African-American and Caucasian-American. Caucasian-Americans were rated particularly high on under-controlled problems (e.g. arguing, disobedient at home, cruel to others). Embu children were rated particularly high on over-controlled problems (e.g. fears, feels guilty, somatic concerns), largely because of the numerous somatic problems reported. Geissler et al (1998) identified geophagy in 73% of 285 school children. The prevalence decreased with age until age 15 and then stabilized for girls till age 18 but continued to decrease for boys.

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

In 1982, Kenya adopted mental health as the ninth essential element of its primary health care provision.

Substance Abuse Policy A substance abuse policy is absent.
National Mental Health Programme A national mental health programme is present. The programme was formulated in 1996. The main emphasis is on decentralization of mental health services, integration into general health care provision and establishment of community mental health services. Multidisciplinary and intersectoral collaboration are a central feature. The implementation of this programme has been slow due to inadequate resources, especially 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 1994.

Mental Health Legislation There is a Mental Health Act. The new act of 1989, provides for voluntary and involuntary treatment of people with mental illness and creates a regulatory board to oversee its implementation (The Act was implemented in May 1991). The latest legislation was enacted in 1989.

Mental Health Financing There are budget allocations for mental health. The country spends 0.01% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, private insurances and social insurance. The National Hospital Insurance Fund is a contributory fund for people in employment. It mainly covers bed charges. About 4.8% of Kenyans have health insurance, but the insurance does not cover mental illness. The Ministry of Health is working on a broader national social health insurance scheme. The country does not have disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Regular training of primary care professionals is not carried out in the field of mental health. Health care guidelines for primary health care workers are being developed. Only limited training facilities for training are available. However, a system of referral and back-referral exists and some outreach services have been established. More than 70 traditional health practitioners have been identified and are currently being trained in mental health to improve their intervention skills. There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

| Total psychiatric beds per 10 000 population | 0.4 |
| Psychiatrist beds in mental hospitals per 10 000 population | 0.3 |
| Psychiatrist beds in general hospitals per 10 000 population | 0.05 |
| Psychiatrist beds in other settings per 10 000 population | 0.02 |
| Number of psychiatrists per 100 000 population | 0.2 |
| Number of neurosurgeons per 100 000 population | 0.01 |
| Number of psychiatric nurses per 100 000 population | 2 |
| Number of neurologists per 100 000 population | 0.02 |
| Number of psychologists per 100 000 population | 0.01 |
| Number of social workers per 100 000 population | 0.2 |

One-third of the total psychiatrists work in the public sector. Mathari is the national referral and teaching hospital. Most of the patients admitted in this hospital are referred by the criminal justice system for assessment. As a result of the new legislation psychiatric wards were set up in general hospitals. The provincial units are 22-bed units. Seven out of 70 district units have also been set up. Nearly half of the psychiatrists are practicing in Nairobi. The provincial and district psychiatric units are under-staffed. Psychiatric nurses and medical officers are involved in mental health care.

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

Information Gathering System There is no mental health reporting system in the country. The country has no data collection system or epidemiological study on mental health. The national tally sheets contain only one section relating to mental disorders. A proposal for the inclusion of 8 categories has been submitted as a part of health sector reforms.

Programmes for Special Population Special clinics for children and adolescents are run.

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 Initially, Kenya had a system of psychiatric practice that was dependent on traditional practices. The first western style system developed in 1912 when a smallpox unit was transformed into a centre where ‘mad' people used to be locked up. Today, Mathare Hospital is the mental health referral and training centre. The Government is in the process of legislating to regulate the practice of traditional practitioners and incorporate it into the health sector.

Additional Sources of Information
Kiribati

**GENERAL INFORMATION**

Kiribati is a country with an approximate area of 0.73 thousand sq. km. (UNO, 2001). The country consists of more than 30 islands, two-thirds of which are inhabited. Its population is 0.077 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population above the age of 60 years is 7% (WHO, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8.6%. The per capita total expenditure on health is 143 international $, and the per capita government expenditure on health is 141 international $ (WHO, 2004).

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

The life expectancy at birth is 61.8 years for males and 66.7 years for females (WHO, 2004). The healthy life expectancy at birth is 52 years for males and 56 years for females (WHO, 2004).

**EPIDEMIOLOGY**

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

**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.

**Substance Abuse Policy**

A substance abuse policy is absent.

**National Mental Health Programme**

A national mental health programme is present. The programme was formulated in 1999.

**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**

There is no mental health legislation. Some issues related to mental health are covered in other legislations. 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. The country spends 1.6% of the total health budget on mental health. The primary source of mental health financing is tax based. The country does not have disability benefits for persons with mental disorders. There are no social benefits.

**Mental Health Facilities**

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 10 000 population</td>
<td>7.3</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
<td>7.3</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals per 10 000 population</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10 000 population</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists per 100 000 population</td>
<td>1</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</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>

**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. Details can be obtained from the Health Information and Statistics Centre of the Ministry of Health. The country has no data collection system or epidemiological study on mental health.

**Programmes for Special Population**

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

Other Information

Additional Sources of Information

Mental Health Annex 1 (Government document).
Kuwait

GENERAL INFORMATION
Kuwait is a country with an approximate area of 18 thousand sq. km. (UNO, 2001). Its population is 2.595 million, and the sex ratio (men per hundred women) is 151 (UNO, 2004). The proportion of population under the age of 15 years is 26% (UNO, 2004), and the proportion of population above the age of 60 years is 3% (WHO, 2004). The literacy rate is 84.7% for men and 81% for women (UNESCO/MoH, 2004).
The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.9%.
The per capita total expenditure on health is 612 international $, and the per capita government expenditure on health is 482 international $ (WHO, 2004).
The main language(s) used in the country is (are) Arabic. The largest ethnic group(s) is (are) Kuwaiti, and the other ethnic group(s) are (is) other Arab. The largest religious group(s) is (are) Muslim (five-sixths).
The life expectancy at birth is 75.4 years for males and 77.7 years for females (WHO, 2004). The healthy life expectancy at birth is 67 years for males and 67 years for females (WHO, 2004).

EPIDEMIOLOGY
There is substantial epidemiological data on mental illnesses in Kuwait 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 1957. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1983.

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

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

Mental Health Legislation There is no written legislation. However, efforts had been made to formalize a legislation, though it has not been successful. 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 social insurance, private insurances and out of pocket expenditure by the patient or family. The country has disability benefits for persons with mental disorders. Treatment is provided by the Government and social benefits by the Ministry of Social Affairs.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Primary care is provided by the family doctor. Facilities should be developed further. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 40 personnel were provided training. Primary care physicians and family physicians are attached to specialist mental health services for a 4 and 8 weeks period, respectively. There are community care facilities for patients with mental disorders. Community care is provided through district and general hospitals and family doctors. Community care facilities are not well developed. However, there are 2 day care centres which cater to more than 30 clients and one half-way house that caters to 30 clients.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 3.4
Psychiatric beds in mental hospitals per 10 000 population 3.4
Psychiatric beds in general hospitals per 10 000 population 0
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 3.1
Number of neurosurgeons per 100 000 population
Number of psychiatric nurses per 100 000 population 22.5
Number of neurologists per 100 000 population
Number of psychologists per 100 000 population 1.4
Number of social workers per 100 000 population 0.4
There are 19 occupational therapists. There is a plan to increase the beds strength in mental hospital from the current level of 3.4 per 10,000 to 4.58 per 10,000 population in 2005. Some beds have been earmarked for the management of drug abusers (260), geriatric and forensic patients. There is a specialized unit for treating PTSD patients. Although there are more than 1000 psychologists and social workers, only a few work in the field of mental health. Thirty-one of them are employed by the psychiatric hospital which serves as the main psychiatric set-up for Kuwait.

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. Only data from the psychiatric hospital is available.
The country has data collection system or epidemiological study on mental health.

Programmes for Special Population The country has specific programmes for mental health for 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, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

Other Information

Additional Sources of Information

**GENERAL INFORMATION**

Kyrgyzstan is a country with an approximate area of 199 thousand sq. km. (UNO, 2001). Its population is 5.208 million, and the sex ratio (men per hundred women) is 96 (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 9% (WHO, 2004). The literacy rate is 99% for men and 96% 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%. The per capita total expenditure on health is 108 international $, and the per capita government expenditure on health is 53 international $ (WHO, 2004).

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

The life expectancy at birth is 60.4 years for males and 68.9 years for females (WHO, 2004). The healthy life expectancy at birth is 52 years for males and 58 years for females (WHO, 2004).

**EPIDEMIOLOGY**

There is a paucity of epidemiological data on mental illnesses in Kyrgyzstan in internationally accessible literature. Some commentaries on childhood disabilities (Ul’ianova & Khokhnova, 1977) and alcohol dependence (Urakov & Ismailov, 1975) are available. Zharikov et al (1973) studied the association of age and sex on schizophrenia.

**MENTAL HEALTH RESOURCES**

**Mental Health Policy** A mental health policy is present. The policy was initially formulated in 2000. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Restructuring of the system is also a part of the mental health policy.

**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 present. The programme was formulated in 2000.

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

**Mental Health Legislation** The Law on Psychiatric Assistance and Human Rights. The latest legislation was enacted in 1999.

**Mental Health Financing** There are budget allocations for mental health. The country spends 7.9% 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 Facilities** Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 350 personnel were provided training. There are no community care facilities for patients with mental disorders.

**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>6.25</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>5.62</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.63</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>4.5</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>0.77</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>13.7</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>8</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0.4</td>
</tr>
<tr>
<td>Number of social workers</td>
<td></td>
</tr>
</tbody>
</table>

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in advocacy and rehabilitation. A non-governmental organization, ‘Awakening’, was established with the purpose of uniting families and friends.
of the mentally ill. The main goal of the organization is the improvement of the standard of living of mentally ill people and their social rehabilitation.

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

**Programmes for Special Population** A programme for medical care of children with donor support was started.

**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.

**Other Information**

**Additional Sources of Information**
Lao People's Democratic Republic

GENERAL INFORMATION
Lao People's Democratic Republic is a country with an approximate area of 237 thousand sq. km. (UNO, 2001). Its population is 5.787 million, and the sex ratio (men per hundred women) is 100 (UNO, 2004). The proportion of population under the age of 15 years is 41% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 77.4% for men and 55.5% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.1%.

The per capita total expenditure on health is 51 international $, and the per capita government expenditure on health is 29 international $ (WHO, 2004).

The main language(s) used in the country is (are) Lao. The largest ethnic group(s) is (are) Lao Loum, and the other ethnic group(s) are (is) Lao Theung and Lao Soung. The largest religious group(s) is (are) Buddhist (three-fifths), and the other religious group(s) are (is) indigenous groups.

The life expectancy at birth is 54.1 years for males and 56.2 years for females (WHO, 2004). The healthy life expectancy at birth is 47 years for males and 47 years for females (WHO, 2004).

EPIDEMIOLOGY
The Opium Survey was conducted across 11 provinces of northern Laos. The average prevalence rate of dependence was almost 3% in those above 15 years of age. Opium dependence was associated with age (age group 41-50 years and 61-70 years) and gender (male) (UNODC and LCDC, 2004). Choulamany (2000) showed that the use of Amphetamine-Type-Stimulants (ATS) had increased since the mid 1980s. Lifetime prevalence of drug use among school population ranged from 5.5% to 17.5% in different regions. ATS use was associated with gender (male), age (15-19 years), socioeconomic status (higher), presence of psychopathology related to methamphetamine use and deterioration in neurocognitive performance. Westermeyer (1976) noted that initially heroin use mostly occurred among indigenous Asian addicts, who had gradually switched from opium to heroin. Following the passage of an anti-opium law, a new group of indigenous addicts emerged: young, single, unemployed males in urban areas whose first narcotic drug was heroin. Gradually, American expatriates also started to use heroin. Westermeyer (1979) estimated opioid dependence rates in 10 communities (representing eight ethnic groups and three provinces). In six rural communities, data were obtained by a house-to-house survey and in four urban communities by opium den registration. Communities raising opium poppy as a cash crop had highest crude rates of dependence (7.0-9.8%). Those involved in opium commerce had intermediate rates (4.1-5.5%). Where neither opium production nor commerce was present the communities had the lowest rates of dependence (1.8-2.3%). Westermeyer (1977) showed that drug use was affected by availability in another study that compared opium use among two cultures in Laos, the Hmong (who have easy access to opium) and the Lao (who have a more difficult access). The Hmong's open availability appeared to favour the following: a greater proportion of female addicts; younger age of opiate usage and addiction; use of the more intoxicating route of administration; earlier onset of problems related to addiction; and shorter duration of addiction before seeking treatment. Westermeyer (1988) reported that much diversity occurred among the various ethnic groups with regard to male-female use of drugs and alcohol. Social changes were reflected in choice of substance made by younger and older people (e.g. cigarettes vs. pipes or cigars, heroin vs. opium, manufactured vs. village-produced alcohol). Westermeyer and Peng (1977) compared 51 heroin dependent patients with 51 matched opium dependent patients. Heroin dependent patients were more often from an urban background, had more frequent daily doses of drug, spent considerably more money for their drug, required higher initial methadone doses for detoxification and showed earlier worsening of condition leading to an earlier treatment contact. Westermeyer (1978a) compared a sample of drug dependent patients of Lao origin with expatriate Asian dependent patients living in Laos. Lao and expatriate addicts show marked similarity in their sociodemographic profiles and patterns of narcotic use. Some differences in their recent use of narcotic drugs appear related to the greater cash income of the expatriate Asians and their greater access to heroin. Treated prevalence figures in the year 2003 and 2004 suggest that neurosis (one-fourth of all cases), Schizophrenia (one-sixth), Epilepsy (one-sixth), Substance abuse (one-tenth) mainly ATS and depression (one-fifteenth) were common (Mental Health Unit, 2004). Westermeyer (1978b) found that subjects with psychosis had reduced longevity as compared to the general population and those with organic psychosis had a greater mortality than those with functional psychosis. Hempel et al (2000) found similarities between patients of Amok and those of sudden mass assault by a single individual. Both groups showed social isolation, loss, depression, anger, pathological narcissism and paranoia. According to a survey conducted by Handicap International and NCRM (1999) in 370 villages in 7 districts (n=400 000) the rate of handicap was 0.8%. Intellectual handicap was the 4th leading cause of disability (10% of all cases) and psychological problems were ranked 6th (7% of all cases), multiple handicaps represented 6% and epilepsy 4% of all disabilities.

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 2003. The Lao National Commission for Drug Control and Supervision (LCDC) launched national drug demand reduction strategies in January 2003, including the following components: prevention, treatment and rehabilitation of drug abuse/drug abusers. It emphasized the need for reliable data collection and drug information systems and the understanding of geographical distribution (e.g. urban versus rural areas), type of risk groups and main categories of substances abused.

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

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

Mental Health Legislation  The article 18 in the penal code mentions that persons suffering from mental disorders are not responsible for committing damages. The code of penal procedure dated on 23/11/1989 gives more details on the process. In most cases, conciliation is obtained either by village leaders or the police before the offences reach the tribunal. If there is a suspicion of mental disorder, the police will lead an investigation and refer the person to the hospital for diagnostic evaluation before sending a report to the tribunal. However, psychiatric evaluation is only available in the capital. Civil damages are to be paid by the family who is considered as responsible. If there is a need to look after the mentally disturbed, the head of the village might be requested to arrange this. Mental illness is not considered as a reason for divorce.

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

Mental Health Financing  There are no budget allocations for mental health. Details about expenditure on mental health are not available.

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

Nearly all medication have to be bought by the patient’s family.

The country has disability benefits for persons with mental disorders.

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

Regular training of primary care professionals is not carried out in the field of mental health. Two provincial hospitals provide limited mental health care on an outpatient basis because of the availability of two general practitioners who received on-the-job training at the mental health unit of the Mahosot hospital.

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

Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Description</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>0.07</td>
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<tr>
<td>Psychiatric beds in general hospitals</td>
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<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>0.07</td>
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<tr>
<td>Psychiatric beds in other settings</td>
<td>0</td>
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<tr>
<td>Number of psychiatrists</td>
<td>0.03</td>
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<tr>
<td>Number of neurosurgeons</td>
<td>0.07</td>
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<tr>
<td>Number of psychiatric nurses</td>
<td>0</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>0.02</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0</td>
</tr>
</tbody>
</table>

There are two full fledged psychiatric units, one in a general hospital setting and one in the military setting. The mental health unit at Mahosot hospital has 9 general nurses, 2 psychiatrists, 1 neurologist and 4 general practitioners. While the military hospital is staffed with 13 general nurses and 4 general practitioners. All psychiatrists and neurologists were trained in Europe.

Non-Governmental Organizations  NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. NGOs focus on the management of substance use issues. Monks have participated in TV and radio programmes on health promotion and prevention of drug abuse. In 2002, they sponsored youth gatherings in temples as part of a national campaign on drug abuse. Save the Children/UK and UNICEF provide some child mental health services. Handicap International provide free access to care for people suffering from epilepsy and mental handicap/retardation in some sites in collaboration with the mental health unit. However, these services are mainly accessible to those living in and around the Capital.
**Information Gathering System** There is mental health reporting system in the country. Reporting system on mental health is still in a preliminary stage of development and is mainly based on daily data register of out and inpatients seeking treatment at the mental health unit, Mahosot Hospital. This unit sends monthly data to the Department of Planning and Statistics of the Ministry of Health.

The country has no data collection system or epidemiological study on mental health. A mental health situation analysis (Didier & Choulamany, 2002) was carried out using in-depth interviews, with medical professionals and key informants including village leaders, teachers, monks or healers, focus groups and case reports. Lao folk diagnosis of mental problems covered 32 types. Spiritual causes were perceived as being predominant, followed by genetic and biological causes. Karma was referred as well as a cause. People suffering from mental health problems had had several ways of seeking help or services, e.g. modern medicines, moral support, traditional medicine, religious treatment and magical string and traditional souls calling ceremony. Major mental illnesses were also discussed.

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

Detoxification centres are available in the community where opium dependent patients are detoxified using tincture of opium, mainly in the northern parts of the country. The cost of a 15 day detoxification, including medication and food for the opium addict, was found to be around US$ 25 per addict. This does not include logistics costs for Government staff and villagers. (Kham Noan Hsam: Community Based Treatment and Rehabilitation as part of Drug Demand Reduction in on-going UNODC projects in the Northern Provinces of the Lao PDR, 2002). However, there is no rehabilitation programme.

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

The 4th revision was made in 2004.

**Other Information**

**Additional Sources of Information**

Choulamany, C., et al. (July 2003) ‘Evaluating the treatment of ATS abuse in the Mental Health Unit, Mahosot Hospital’.


Kham Noan Hsam: Community Based Treatment and Rehabilitation as part of Drug Demand Reduction in on-going UNODC Projects in the Northern Provinces of the Lao PDR, 2002.


Mental Health Unit (October 2004) ‘Statistics on new mental health cases seeking treatment at the Mental Health Unit, from 2000 – 2004’.

Service de Santé Mentale (Government document).


**Latvia**

**GENERAL INFORMATION**

Latvia is a country with an approximate area of 65 thousand sq. km. (UNO, 2001). Its population is 2.286 million, and the sex ratio (men per hundred women) is 85 (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 22% (WHO, 2004). The literacy rate is 99.8% for men and 99.7% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.4%. The per capita total expenditure on health is 509 international $, and the per capita government expenditure on health is 267 international $ (WHO, 2004).

The main language(s) used in the country is (are) Latvian. The largest ethnic group(s) is (are) Latvian, and the other ethnic group(s) are (is) Russian. The largest religious group(s) is (are) Evangelical Lutheran.

The life expectancy at birth is 64.6 years for males and 75.8 years for females (WHO, 2004). The healthy life expectancy at birth is 58 years for males and 68 years for females (WHO, 2004).

**EPIDEMIOLOGY**

Wasserman et al (1998 a) reported that suicide rates in the former USSR during 1984-1990 varied greatly between different regions, from 3.5 cases per 100,000 inhabitants in the Caucasus (Georgia, Azerbaijan and Armenia) to 28.0 in the Baltic region (Latvia, Lithuania and Estonia). This pattern was observed for both men and women, with suicide rates for men ranging from 4.9 in the Caucasian region to 45.9 in the Baltics, and suicide rates for women ranging from 2.1 in the Caucasus to 2.3 in the Baltics. During 1984-90, a decline in suicide rates of 32% for males and 19% for females took place in the former Soviet Union (Wasserman et al, 1998b). During 1968-84, the mean value of male suicide rates per 100,000 males and females in Latvia was 52.5 and 14.3, respectively. Suicide rates fell across all the Republics of the USSR during Perestroika. In Latvia, the male suicide rate reduced by 26.6% in the period 1986-90 compared to 1968-84. Female suicide rates were relatively stable and the male-female ratio reduced from 3.7 in 1968-84 to 3.1 in 1986-90 (Varnik et al, 1994). Rancans et al (2001a) found that there were rapid swings of suicide rates during 1980-98, driven by changes in male suicide rates which reached a maximum of 72 per 100,000 population in 1993. The sudden drop in gross domestic product, the rapid increase in first-time alcohol psychosis and the percentage of people unemployed did not correspond strictly with the dynamics of suicide rates. Rancans et al (2001b) found that the overall rate of suicide attempts in a city was 149 per 100,000. The male to female ratio for persons aged 15 years or more was 1:0.9. The highest figures were for females aged 15-24 and men aged 25-34. Females used poisonings in 75% of cases. Males used more violent methods (60%) like cutting, and suicide was associated with alcohol use in men. In a sample of 1412 Latvian liquidators drawn from the State Latvian Chernobyl Clean-up Workers Registry, Viel et al (1997) found greater psychosomatic distress in those exposed to work for longer periods of time in hazardous work areas.

**MENTAL HEALTH RESOURCES**

**Mental Health Policy** A mental health policy is present. The policy was initially formulated in 2004.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The work on the basic document for state mental health has started.

**Substance Abuse Policy** A substance abuse policy is present. The policy was initially formulated in 2004. Details about the drug policy can be obtained from the Latvia Drug Control and Drug Abuse Prevention Masterplan (1999-2003). The Alcohol use control programme (2004-2008) has been initiated.

**National Mental Health Programme** A national mental health programme is present. The programme was formulated in 2004. The adopted State Health Care Programme also includes the Psychiatric Aid Strategy and an underlying action plan (national mental health programme) with financial sources and evaluation activities.

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

**Mental Health Legislation** The most recent legislation on mental health is the Medical Law. In 1999, the new Latvian Criminal Law introduced the concept of diminished responsibility; however, the law was drafted without consultation with mental health professionals.

The latest legislation was enacted in 1997.

**Mental Health Financing** There are budget allocations for mental health. The country spends 6.3% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, social insurance, private insurances and out of pocket expenditure by the patient or family.
There are state budget allocations for mental health services through the State Compulsory Health Insurance Agency. The social security system is responsible for severely mentally ill and handicapped children and adolescents until the age of 18 years, covering expenses for medication, shelter and rehabilitation. The country has disability benefits for persons with mental disorders.

**Mental Health Facilities** Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. The psychiatrist at the local level promote networking and support services and support local primary health care specialists. Treatment of moderately severe and severe mental disorders is done by psychiatrists. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 160 personnel were provided training. There are training programmes for family doctors and general physicians. Training is provided through seminars, workshops and conferences as well as through general programmes and diplomas. Latvia has a community of well-trained mental health professionals who are committed to the welfare of people with mental illness. Since independence, many staff have received training in psychotherapy and other techniques which were not used before. There are community care facilities for patients with mental disorders. The state plans and coordinates activities, ensures psychiatric aid with the highly specialized services and ensures academic training. Regional services include inpatient facilities, day hospitals and ambulatory models. The local aid and support services are divided into treatment oriented aid and medical rehabilitation and support services. Rehabilitation is provided through employment centres and psychosocial rehabilitation houses.

**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>13.8</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>13.5</td>
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<td>Psychiatric beds in other settings</td>
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<td>Number of psychiatrists</td>
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<tr>
<td>Number of neurosurgeons</td>
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<td>Number of psychiatric nurses</td>
<td>40</td>
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<tr>
<td>Number of neurologists</td>
<td>10</td>
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<tr>
<td>Number of psychologists</td>
<td>2</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0.5</td>
</tr>
</tbody>
</table>

The system remains centred on large under-funded mental hospitals and nursing homes; large institutions consume most of the available mental health budget, while community care is under funded. The process of deinstitutionalization, however, has begun, and a 25% reduction in the number of beds in psychiatric hospitals has been achieved. Almost 160 beds are allotted to child and adolescent psychiatry. The trend in psychiatric institutions in Latvia is now towards the establishment of multidisciplinary teamwork – a process which is still in its infancy. Multidisciplinary teamwork is available in some hospitals. Generally, the multidisciplinary team in Latvia consists of: a nurse, nursing assistant, psychologist, psychiatrist, rehabilitation specialist and social worker. Occupational therapists help the patient develop and improve their functioning, while observing changes in the patient’s state, analysing the results of therapy, as well as assessing the level of current functioning and gradually increasing the complexity of exercises. Rehabilitation specialists help the patients to acquire skills such as drawing, painting, pottery and flower arranging. Additional training or refresher courses of mental health professionals is being organized with help from Denmark, Norway, Sweden, Germany and the Netherlands. The country has almost 30 child and adolescent psychiatrists.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in advocacy. NGOs are involved in running alternative mental health services. The Soros Foundation supports many projects. Self-help groups have also developed.

**Information Gathering System** There is mental health reporting system in the country. The country has data collection system or epidemiological study on mental health. There are accounting information systems, reports and registers from which data can be collected.

**Programmes for Special Population** The country has specific programmes for mental health for disaster affected population, indigenous population, elderly and children. A programme directed at suicide prevention that incorporates psychotherapeutic support groups and telephone hotlines has been organized in collaboration with the Soros Foundation. The World Bank is supporting a project on mental health promotion and prevention of mental disorders. Child and adolescent psychiatric services are restricted to cities. A few youth centres for handicapped adolescents have been started.
**Therapeutic Drugs** The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, carbidopa, levodopa.

Cyclodol is available instead of biperiden (commonest strength: 2 mg, cost for 100 tablets: 1.62 USD)

**Other Information** The Psychiatry Aid Strategy of Latvia has certain priorities: patients with serious mental disorders, mentally ill offenders, children and teenagers, young schizophrenics, patients with comorbidity and elderly. The policy project Improving of Citizens’ Mental Health Status is based on WHO World Health Report 2001.

**Additional Sources of Information**
Lebanon

GENERAL INFORMATION
Lebanon is a country with an approximate area of 10 thousand sq. km. (UNO, 2001). Its population is 3.708 million, and the sex ratio (men per hundred women) is 96 (UNO, 2004). The proportion of population under the age of 15 years is 28% (UNO, 2004), and the proportion of population above the age of 60 years is 9% (WHO, 2004). The literacy rate is 92.1% for men and 80.3% 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 12.2%. The per capita total expenditure on health is 673 international $, and the per capita government expenditure on health is 189 international $ (WHO, 2004).

The main language(s) used in the country is (are) Arabic. The largest ethnic group(s) is (are) Arab. The largest religious group(s) is (are) Muslim (two-thirds), and the other religious group(s) are (is) Christian (almost one third) and Druz.

The life expectancy at birth is 67.6 years for males and 72 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY
Weissman et al (1996, 1997) conducted a study in 10 countries including Lebanon to estimate the rates and patterns of major depression, bipolar disorder and panic disorder based on cross-national epidemiologic surveys (n=40 000). The lifetime rates for major depression ranged from 1.5% in Taiwan to 19% in Beirut. The annual rates ranged from 0.8% in Taiwan to 5.8% in New Zealand. The mean age at onset showed less variation, and the rates of major depression were higher for women than men at all sites. Major depression was also associated with increased risk for comorbidity with substance abuse and anxiety disorders at all sites. The lifetime rates of bipolar disorder were more consistent across countries (0.3% in Taiwan to 1.5% in New Zealand). The sex ratios were nearly equal and the age at first onset was on an average 6 years earlier than the onset of major depression. The lifetime prevalence rates for panic disorder ranged from 0.4% in Taiwan to 2.9% in Italy. The mean age at first onset was usually in early to middle adulthood, and females were affected more than males. Panic disorder was associated with an increased risk of agoraphobia and major depression in all countries.

Karam et al (2000) conducted a study on a stratified cluster sample of 1851 students from two major universities using the Diagnostic Interview Schedule (DIS) and DSM-III criteria. They found that the prevalence of alcohol, nicotine, tranquilizer and heroin use was 49.4%, 18.3%, 10.2% and 0.4%, respectively. Alcohol abuse was present in 2.1% and two major universities using the Diagnostic Interview Schedule (DIS) and DSM-III criteria. They found that the prevalence of alcohol, nicotine, tranquilizer and heroin use was 49.4%, 18.3%, 10.2% and 0.4%, respectively. Alcohol abuse was present in 2.1% and two major universities using the Diagnostic Interview Schedule (DIS) and DSM-III criteria. They found that the prevalence of alcohol, nicotine, tranquilizer and heroin use was 49.4%, 18.3%, 10.2% and 0.4%, respectively. Alcohol abuse was present in 2.1% and alcohol dependence in 2.4%. Abuse and dependence of other substances besides nicotine and alcohol ranged between 0.1 to 0.8%. Naja et al (2000) found that in a randomly selected community sample of 1000 people, the prevalence of benzodiazepine use during the past month was 9.6%, with half being dependent on the drug. Current use was associated with age greater than 45 years, female gender, cigarette smoking and recent life events. Karam et al (1998) interviewed randomly selected 658 subjects, aged 18-65 years, from four Lebanese communities with the Arabic version of the DIS (DSM-III-R criteria) and the War Events Questionnaire. The lifetime prevalence of major depression across the four communities varied from 16.3 to 41.9%. Level of exposure to war and a history of pre-war depression predicted the development of depression during war. Chaaya et al (2002) interviewed about 400 post-partum women at two points in time, 24 hours and 3-5 months after delivery. During the latter visit, subjects were screened using the Edinburgh Postnatal Depression Scale. The overall prevalence of postpartum depression was 21%, but it was significantly lower in urban (16%) compared to the rural (26%) area. Lack of social support and prenatal and lifetime depression, stressful life events, vaginal delivery, poor education, unemployment and chronic health problems were significantly related to postpartum depression. El Khoury et al (1999) used the DIS to interview a group of women (n=150) at two points in time of pregnancy, the first on the second post-delivery day and the second, one year later. The prevalence of major depression was 31.3% during lifetime, 10% during pregnancy and 10.9% during one year follow-up. Lifetime depression was associated with the number of children in the household. Depression during pregnancy was inversely related to economic and educational level. Weissman et al (1999) assessed over 40 000 subjects in 9 countries including Lebanon, using the DIS. The lifetime prevalence of suicide ideation ranged from 2.1% (Lebanon) to 18.5% (New Zealand) and for suicide attempts from 0.7% (Lebanon) to 5.9% (Puerto Rico). Women had a 2-3 fold higher rate of suicide attempts than men in most countries. Suicide ideation and attempts were associated with being divorced/separated. Chiementi et al (1989) used a questionnaire to interview mothers of more than 1000 three to nine year old children. Children who had experienced death of a family member, forced displacement of family or destruction of home or had witnessed death were about 1.7 times more likely to exhibit nervous, regressive, aggressive and depressive behaviour than those who had not experienced trauma. Macksoud and Aber (1996) interviewed 224 Lebanese children (10-16 years old) and found that PTSD varied according to the number and level of stressful exposure. Various types of war traumas were differentially related to PTSD, mental health symptoms and adaptational outcomes.
MENTAL HEALTH RESOURCES

Mental Health Policy  A mental health policy is absent.

Substance Abuse Policy  A substance abuse policy is absent.

National Mental Health Programme  A national mental health programme is present. The programme was formulated in 1987. Though the national mental health programme had been initiated in 1987, its progress has not been satisfactory due to the war.

National Therapeutic Drug Policy/Essential List of Drugs  A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1987.

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

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

Details about expenditure on mental health are not available.
The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family and social insurance.
Lebanon depends mainly on the private sector for the provision of health services. The Ministry of Health has contracts with the private sector and needy patients receive free treatment.
The country does not have disability benefits for persons with mental disorders. There is no disability funding for mental health.

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. In order to improve mental health services the Government is shifting from comprehensive care to areas of importance. The two areas of importance have been ambulatory mental health service within the primary care centres and a psychogeriatric care system within a comprehensive geriatric service with emphasis on a community-oriented programme.
Regular training of primary care professionals is not carried out in the field of mental health. A training programme was supposed to have started in 2001. General practitioners and general nurses receive 2-3 months training. Training is also under way on psychogeriatric issues.

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

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>7.5</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
<td>7.4</td>
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<tr>
<td>Psychiatric beds in general hospitals per 10 000 population</td>
<td>0.1</td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10 000 population</td>
<td>0.1</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>1</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td>5.3</td>
</tr>
<tr>
<td>Number of neurologists per 100 000 population</td>
<td>3</td>
</tr>
<tr>
<td>Number of psychologists per 100 000 population</td>
<td>0.6</td>
</tr>
<tr>
<td>Number of social workers per 100 000 population</td>
<td>1.5</td>
</tr>
</tbody>
</table>

The figures for personnel are approximations. The number of psychologists working in mental health is around 10% of the total number of psychologists. There is only one psychiatric hospital run by the nuns. This centre also runs schools, medical clinics and hospice centres. All psychiatrists have private clinics.

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

Programmes for Special Population  The country has specific programmes for mental health for children.
A comprehensive system of care has been developed for management of some child psychiatric disorders like attention-deficit/hyperactivity disorder.

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.
All drugs (including second and third generation anti-psychotics, anti-depressants, anti-convulsants and non-conventional medication) can be prescribed by primary care physicians and are available free of cost for poor patients through Ministry of Health.
Other Information

Additional Sources of Information


Lesotho

GENERAL INFORMATION
Lesotho is a country with an approximate area of 30 thousand sq. km. (UNO, 2001). Its population is 1.8 million, and the sex ratio (men per hundred women) is 87 (UNO, 2004). The proportion of population under the age of 15 years is 39% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 73.7% for men and 90.3% 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 5.5%. The per capita total expenditure on health is 101 international $, and the per capita government expenditure on health is 80 international $ (WHO, 2004).

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

The life expectancy at birth is 32.9 years for males and 38.2 years for females (WHO, 2004). The healthy life expectancy at birth is 30 years for males and 33 years for females (WHO, 2004).

EPIDEMIOLOGY
In a small community based study done in 2001, that involved all adults in a small lowland town, depression (10%) and anxiety (8%) were found to be common. The female to male ratio was 3:1. These rates were deemed similar to levels observed in the neighbouring country – South Africa (Makara, 2004). Hollifield et al (1990) interviewed adults in a village to determine the community prevalence of major depression, panic disorder and generalized anxiety disorder using the Diagnostic Interview Schedule. There was a significantly higher prevalence of all three diagnoses in Lesotho as compared with the United States. Women were at an increased risk for these disorders, although statistical significance was not demonstrated for depression. In an inpatient sample (year 2002), the point prevalence (n= 376) of mental disorders was as follows: 29% had cannabis related mental disorders, 20.2% had psychotic disorders, 17% had schizophrenia, 9% had organic mental disorders, 7.2% had bipolar mood disorders 6.4% had depression and 6.1% had alcohol related disorders. A similar audit of outpatients (year 2003) showed that about one-third of patients had epilepsy related diagnosis and 17% had depression. Depression was five times more common in women in comparison to men. Schizophrenia (14.6%) and alcohol and drug related mental disorders (9.3%) were also common (Makara, 2004). Hollifield et al (1994) conducted a study in the outpatient clinic of a general hospital to assess depression, generalized anxiety and panic disorder using a translated version of the Diagnostic Interview Schedule and DSM-III-R criteria. Out of the 126 randomly selected out-patients the researchers found that 23% had depression, 24% had panic disorder and 29% had GAD. Forty-six (36%) had either depression or panic disorder, with thirteen having concurrent illness. Patients with depression and/or panic disorder presented with a significantly higher number of physical symptoms and a higher percentage of symptoms that were pain or autonomic nervous system related than patients with no disorder ever. As part of a larger baseline survey of community health status, Siegfried et al (2001) randomly sampled households in 29 villages. Consenting adults (n=348) participated in a face-to-face interview about alcohol use, which included the CAGE. Blood was taken from participants for CDT determination. 53% of men (37/69) and 19% of women (53/279) reported drinking alcohol. 36% of men and 9% of women were found to have hazardous patterns of drinking as per predefined criteria. Hazardous drinkers were significantly more likely to be male and older. Using hazardous drinking as the standard, CAGE (score >=2) had a positive predictive value of 75% for men and 62% for women. CDT values also showed high specificity. Meursing and Morojele (1989) conducted a study to ascertain degree of alcohol consumption and attitudes and knowledge of alcohol use among 1133 high school students aged 11-22 years. They primarily used a questionnaire but additional information was obtained by means of classroom discussion and detailed interviews. About half of the students (54% of the boys and 42% of the girls) had drunk alcohol at some point in their lives. Drinking was found to be related to age, sex, drinking of friends, family income and drinking in the family.

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

The mental health policy is in the draft stage. It is likely to be adopted in 2005.

Substance Abuse Policy A substance abuse policy is absent. The substance abuse policy is also in the draft stage.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1964.

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

Mental Health Legislation There is the Mental Health Law No. 7. It is being updated.

The latest legislation was enacted in 1964.

Mental Health Financing There are budget allocations for mental health.

The country spends 7% 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. Psychosocial assessment is done and needy patients are being financially supported. However, this is in some areas only.
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 primary level care is provided through health centre/clinics where mental health services are integrated into the general health care and are carried out by general nurses with support and supervision from psychiatric nurses from local hospitals. Regular training of primary care professionals is carried out in the field of mental health. There is a continuous medical education programme for mental health workers at secondary care level (psychiatric nurses and medical officers). Community health workers are trained in four project areas and in future this will be extended to other areas.

There are community care facilities for patients with mental disorders. Community care is available through health posts where integrated services are carried out by community health workers. Support is also provided by mobile units comprising of psychiatric nurses and by resident social workers.

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>0.8</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10 000 population</td>
<td>0.3</td>
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<tr>
<td>Psychiatric beds in general hospitals per 10 000 population</td>
<td>0.5</td>
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<td>Psychiatric beds in other settings per 10 000 population</td>
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<tr>
<td>Number of psychiatrists per 100 000 population</td>
<td>0.05</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100 000 population</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100 000 population</td>
<td>0.2</td>
</tr>
<tr>
<td>Number of neurologists per 100 000 population</td>
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<td>Number of psychologists per 100 000 population</td>
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</tr>
<tr>
<td>Number of social workers per 100 000 population</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Moholoni Hospital is the national main referral hospital with 60 beds. Services are delivered by a multi-disciplinary team consisting of 1 psychiatrist, 2 psychologists, 3 social workers, 3 occupational therapists and 20 psychiatric nurses. Secondary level care is available though 9 Treatment and Observation Units attached to General Districts Hospital and is provided by psychiatric nurses. There is only one psychiatrist for the whole country but psychiatric nurses receive in-services training (workshops) once a year in order to effectively manage patients.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. The Christian Health of Lesotho (CHAL), the main partner in health service provision is also involved in all mental health care services including promotion, curative and rehabilitative services.

Information Gathering System There is mental health reporting system in the country. Mental health statistics are integrated in the Health Management Systems collected daily and reported monthly for compilation and analysis. Annual Statistics are published regularly together with other statistics generated by the Ministry of Health and Social Welfare.

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

Programmes for Special Population A proposal supported by the African Development Bank Project for specialized services for children, elderly and forensic patients has been developed. These services will be initiated in the year 2005. Two Drug and Alcohol Rehabilitation Centres based in the city of Maseru offer services for clients with problems related to substance abuse.

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

The therapeutic drug policy is in the draft stage. Anti-psychotics and anti-epileptics are given free to the indoor and outdoor patients. Carbamazepine, ethosuximide, fluphenazine, haloperidol, lithium and biperiden are available at the secondary level of care and sodium valproate is available at the tertiary level. All of the above mentioned drugs are in the drug list.

Other Information The Government of Lesotho adopted the strategy of primary health care in 1979. The country is divided into 18 Health Service Areas based on catchment areas of 18 hospitals that supervise 165 satellite health centres. The health centres in turn supervise Village Health Workers at community level. Almost half of the health facilities are owned by the Christian Health Association of Lesotho (CHAL). The complimentary services delivered by CHAL and the Government covers almost 80% of the population (i.e. almost 80% of the population lives within 2 hours walking distance form a static health facility). A resident Fly Doctors Service covers inaccessible mountain areas.

Additional Sources of Information


Liberia

GENERAL INFORMATION
Liberia is a country with an approximate area of 111 thousand sq. km. (UNO, 2001). Its population is 3.487 million, and the sex ratio (men per hundred women) is 100 (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 72.3% for men and 39.3% 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 4.3%.
The per capita total expenditure on health is 127 international $, and the per capita government expenditure on health is 97 international $ (WHO, 2004).
The main language(s) used in the country is (are) English. The largest ethnic group(s) is (are) African. The largest religious group(s) is (are) Christian (four-fifths), and the other religious group(s) are (is) Muslim (one-sixth).
The life expectancy at birth is 40.1 years for males and 43.7 years for females (WHO, 2004). The healthy life expectancy at birth is 34 years for males and 37 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Liberia in internationally accessible literature. Swiss et al (1998) assessed a random sample of 205 women and girls between the ages of 15 and 70 years (88% participation rate). And found that 49% of them reported experiencing at least 1 act of physical or sexual violence by a soldier or fighter. 15% had been raped, subjected to attempted rape, or sexually coerced. Women who were accused of belonging to a particular ethnic group or fighting faction or who were forced to cook for a soldier or fighter were at increased risk for physical and sexual violence. Young women (those younger than 25 years) were more likely than women 25 years or older to report experiencing attempted rape and sexual coercion.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is absent.
From September 2004, an emergency mental health strategy is being developed in collaboration between MOH and WHO.
Substance Abuse Policy A substance abuse policy is absent. An emergency substance abuse strategy has been integrated in an overall emergency mental health strategy being developed in collaboration between the Ministry of Health and WHO.
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 1970.
Mental Health Legislation The Public Health Act refers to mental health. There is no mental health legislation as such.
The latest legislation was enacted in 1970.
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.
There are no budget allocations for mental health within MOH. Funds were earlier allocated within the Regional University Hospital (JFK) to a psychiatric hospital, but the hospital was destroyed in 1990.
The country does not have disability benefits for persons with mental disorders.
Mental Health Facilities Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.
Regular training of primary care professionals is not carried out in the field of mental health.
There are no community care facilities for patients with mental disorders. A few facilities offer layman counselling and shelter, but these services do not cater to the needs of the severely mentally ill.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 0.08
Psychiatric beds in mental hospitals per 10 000 population 0.08
Psychiatric beds in general hospitals per 10 000 population 0
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 0.03
Number of neurosurgeons per 100 000 population 0
Number of psychiatric nurses per 100 000 population 0.03
Number of neurologists per 100 000 population 0
Number of psychologists per 100 000 population 0
Number of social workers per 100 000 population 0
There is only one psychiatrist and one psychiatric nurse in the country. No mental health services are currently available in the country as the psychiatric hospital was destroyed during the war. Under the emergency programme, a 25-bedded public hospital is reopening in Monrovia in Fall 2004 along with limited outpatient functions. These will constitute the only clinical mental health services in the country. Mental health is integrated in pre-graduate training of nurses and doctors, but due to the war and the lack of clinical services, the training is sporadic and mainly theoretical. Special training programmes for mental health are not present. The emergency programme plans restarting of in-service training and has restarted training of medical students.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy and prevention. One NGO is involved in reconstruction of emergency mental health services. A few other international NGOs are mainly involved in psychosocial and trauma work. A few local NGOs provide services for substance misuse.

Information Gathering System There is no mental health reporting system in the country. The country has no data collection system or epidemiological study on mental health. There is a strong need, but no current resources, for a national survey on needs and resources in mental health and substance abuse.

Programmes for Special Population There are no services for special population groups.

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

The listed therapeutic drugs are generally not available at the primary health care level. The list and prices are based on pharmacy prices in the capital. Prices vary significantly (minimum and maximum prices from survey 2004 is shown). Benzhexol (5 mg) is used as anti-parkinsonian drugs.

Other Information There is an urgent need for needs assessment as because of the civil war mental health problems have increased. Technical help is needed.

The years of war have had a significant effect on the deterioration of the health system in general with an expected shift also in the population in need of mental health care. Besides patients with classic mental health problems, there are now also serious war/conflict related mental health problems including substance abuse, while resources (funds and professional staff) for assistance are few or non-existent. There are no systematic or recent Needs and Resource Assessment of Mental Health and Substance abuse. In fall 2004, nearly all mental health services were closed due to lack of resources (funds and staff). Traditional and religious healing is common in the communities. The Ministry of Health has appointed a focal point for Mental Health in September 2004. Funding for the Mental Health emergency programme is urgently needed.

Additional Sources of Information
Libyan Arab Jamahiriya

GENERAL INFORMATION
Libyan Arab Jamahiriya is a country with an approximate area of 1760 thousand sq. km. (UNO, 2001). Its population is 5.659 million, and the sex ratio (men per hundred women) is 107 (UNO, 2004). The proportion of population under the age of 15 years is 30% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 91.8% for men and 70.7% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 2.9%. The per capita total expenditure on health is 239 international $, and the per capita government expenditure on health is 134 international $ (WHO, 2004).

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

The life expectancy at birth is 70.4 years for males and 75.5 years for females (WHO, 2004). The healthy life expectancy at birth is 62 years for males and 65 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Libyan Arab Jamahiriya in internationally accessible literature. Avasthi et al (1991) conducted a study on 1009 psychiatric in-patients. Using ICD-9 descriptions, they found schizophrenic psychosis in 39%, affective psychosis in 17%, neurotic disorders in 12%, organic psychosis in 8% and acute psychosis in 7%. Neurotic depression was the commonest type of neurotic disorder, and anti-social personality was the commonest among personality disorders. Pu et al (1986) did a sociodemographic study on 100 patients suffering from hysteria in one particular area. Verma (1990) conducted a cytogenetic analysis of cases of Down syndrome and found the prevalence to be 1 in 516 live births. 82% of the mothers of cases of Down syndrome were over 30 years of age as compared to 36% of the mothers of controls. Cytogenetically 96% of the cases were that of trisomy 21.

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

In Libya, the mental health policy is part of the general health policy.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1988. The national mental health programme was put forward with the objective of providing essential mental health care for all in all spheres of life, like work, family, community and national growth.

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 A ministerial resolution No. 654 in 1975 regulates the treatment of mentally ill in mental hospitals. It requires to be revised. There is a national committee looking into the aspect of a new legislation. The latest legislation was enacted in 1975.

Mental Health Financing There are no budget allocations for mental health. Details about expenditure on mental health are not available. Details about sources of financing are not available. The country has disability benefits for persons with mental disorders. A monthly stipend of 90 Libyan Dinars is provided to the mentally 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. Regular training of primary care professionals is carried out in the field of mental health. Psychiatric services are integrated in the primary care system. Training programmes for social workers, primary care physicians and clinical psychologists are components of the mental health programme. However, the facilities are poor and manuals for doctors and workers are not available. There are community care facilities for patients with mental disorders.
Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>1</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 per 100,000 population</td>
<td>0.18</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100,000 population</td>
<td>0.18</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100,000 population</td>
<td>0.5</td>
</tr>
<tr>
<td>Number of neurologists per 100,000 population</td>
<td>0.15</td>
</tr>
<tr>
<td>Number of psychologists per 100,000 population</td>
<td>5</td>
</tr>
<tr>
<td>Number of social workers per 100,000 population</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Most of psychologists are social psychologists. There are beds for the mentally retarded (500), elderly (130), drug abusers (50) and children, besides the beds mentioned. Patients with drug abuse are admitted only once. There is an acute shortage of occupational therapists.

Non-Governmental Organizations
Details about NGO facilities in mental health are not available.

Information Gathering System
Details about mental health reporting systems are not available. Details about data collection system or epidemiological study on mental health are not available. Hospital data collection is done.

Programmes for Special Population
The country has specific programmes for mental health for elderly and children. There are services for children and elderly and also forensic psychiatry services.

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

Other Information

Additional Sources of Information
GENERAL INFORMATION

Lithuania is a country with an approximate area of 65 thousand sq. km. (UNO, 2001). Its population is 3.422 million, and the sex ratio (men per hundred women) is 87 (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 20% (WHO, 2004). The literacy rate is 99.6% for men and 99.6% 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 6%. The per capita total expenditure on health is 478 international $, and the per capita government expenditure on health is 337 international $ (WHO, 2004).

The main language(s) used in the country is (are) Lithuanian. The largest ethnic group(s) is (are) Lithuanian, and the other ethnic group(s) are (is) Russian and Polish. The largest religious group(s) is (are) Roman Catholic (five-sixths).

The life expectancy at birth is 66.2 years for males and 77.6 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 68 years for females (WHO, 2004).

EPIDEMIOLOGY

Data from treatment services records show that about 4.6% of the total population sought treatment in mental health services (2.6% for mental disorders and 2% for drug use disorders). A pressing problem is the spread of drug use disorders. In 1994, there were only 26.1 clients per 100 000 and their number increased to 135.2 per 100 000 in 2003. Moreover, 11.5% of them were juveniles. In treatment samples, considerable increase was also noted of patients with affective disorders and Alzheimer disease, likely due to improved access to services and better recognition (Gaizauskiene et al, 2003; Davidioniene, 2004; State Mental Health Centre, 2004). Gailiene et al (1995) used national archive data to study suicide trends in Lithuania in 1924-39 and 1962-93. In pre-war independent Lithuania (1924-39), the suicide rate was 5-10 per 100 000 citizens. During the Soviet period, it gradually increased to 35.8 per 100 000 in 1984. During the period of perestroika, the suicide rate diminished (25.1 per 100 000 in 1986). In 1993, the rate had again increased to 42/100 000 because of economic hardships (Varnik et al, 1994) and has remained extremely high – 42.1 per 100 000 population in 2003. The rate was higher among the elderly (Davidioniene, 2004). Between 1968-84 the male suicide rate rose gradually from 33.0 to 61.3 and the female rate from 8.0 to 13.1; the average male and female suicide rates per 100 000 population for this period were 51.7 and 10.4, respectively. The mean male suicide rate dropped by 14.4% in 1986-90 compared to 1968-84, though the female suicide rate remained stable, and the male:female ratio was accordingly lower in 1986-90 (4.2) than in 1968-84 (5.0) (Varnik et al, 1994). Currently, very high suicide rates are seen among males (up to 77.2 per 100 000) and rural population (62.8 per 100 000) (Davidioniene, 2004). Kalediene (1999) also found that between 1970-95, age-standardized suicide rates had almost doubled in Lithuania. There was an increase in suicides in birth cohorts of males from 1910 to 1950, and in cohorts born after 1965. In females, an increase was observed in all successive birth years from 1905 to 1925 and after 1970. The period effect in males and the cohort effect in females were dominant. Suicide rates in the former USSR during 1984-90 varied greatly between different regions, from 3.5 cases per 100 000 inhabitants in the Caucasus (Georgia, Azerbaijan and Armenia) to 28.0 in the Baltic region (Latvia, Lithuania and Estonia). The same pattern was observed for both men and women, with suicide rates for men ranging from 4.9 in the Caucasian region to 45.9 in the Baltics, and suicide rates for women ranging from 2.1 in the Caucasus to 2.3 in the Baltics. During 1984-90, a decline in suicide rates of 32% for males and 19% for females took place in the former Soviet Union (Varnik & Wasserman, 1992; Wasserman et al, 1998 a, b). It was shown that the time of year, solar activity and geomagnetic activity were related to the monthly death distribution, especially regarding death from IHD and suicide. Age and gender differences were apparent in the relationship between death distribution and physical environmental factors (Stoupel et al, 2002). Ramanauskiene et al (2002) interviewed more than 5000 adolescents in three regions and found that prevalence of depressive symptoms varied from 47.9% and 58.8% and the suicidal ideas varied from 13.2% and 15.4%. Girls attempted suicide more often. Ribakoviene (2002), compared girls who attempted suicide and an age and locality matched control group of schoolgirls. Suicide attempters demonstrated significantly more internalized behaviour especially depression, somatic complaints, aggression and delinquency. Ribakoviene and Puras (2002) found that compared to healthy adolescent girls, girls with suicide attempts were more often from families that were broken, conflictual or financially strained. They also reported a greater frequency of abuse, conduct symptoms (truancy, arguments, delinquency) and poor academic performance. Puras (1987) estimated that severe mental retardation occurred in 0.3% of children aged 4-13 years. There were a higher number of males among the cases with undifferentiated forms.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1993. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1999. There are different policies on substance abuse, including the Goverment Commission on Drug Control (1995), the State Alcohol Control Programme (1999) and the National Drug Control and Drug Use Prevention Programme (1999).
LITHUANIA

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999. Details are available from the website: www.vpsc.lt. The National Programme for Prevention of Mental Disorders (1999) has the following main goals: to stabilize the morbidity of mental disorders, to reduce the rate of suicide, to develop an effective system of rehabilitation and reintegration into society of persons with mental disabilities, to develop a network of municipal mental health centres, to provide for adequate human resources, to develop a system of monitoring suicides and mental disorders and to develop intersectoral cooperation in the field of mental health. Lithuania has a national strategy for suicide prevention and a draft national programme for the same.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1995. Details can be obtained from the State Medicines Control Agency at the Ministry of Health of the country (www.vvkt.lt).

Mental Health Legislation The Law on Mental Health was passed in 1995. There is also a law on substance dependence – Law of the Control of Narcotic and Psychotropic Substances (1998). Under the Mental Health Act, each municipality has to establish a mental health centre for outpatient care. A psychiatrist, a child and adolescent psychiatrist, a psychologist and a social worker are included in the list of obligatory team members. Currently, there are 59 centres throughout the country, and it is estimated that there should be about 100 in the near future. An increasing number of municipal mental health centres are effectively cooperating with local social services, schools and other services. Consumer rights are assured in the Civil Code, the Patient’s Rights and Compensation Harm to Health Law and the Mental Health Care Law. The latest legislation was enacted in 1995.

Mental Health Financing There are budget allocations for mental health. The country spends 7% of the total health budget on mental health. The primary source of mental health financing is social insurance. The national health insurance system allocates a certain amount of money per inhabitant for primary mental health care. After active lobbying, the amount of money allocated per inhabitant for municipal mental health rose from the equivalent of $0.7 in 1997 to $2.8 in 1999. Of the insurance funds, 49%, 37% and 14% are directed towards inpatient services, psychotropic drugs and outpatient services, respectively. There exist three levels of prescription coverage to outpatients with specified diagnoses: 100%, 80% and 50%. The 100% coverage is applied to the treatment of schizophrenia and schizoaffective disorder (including new generation neuroleptic like amisulpride, clozapine, olanzapine, risperidone, and quetiapine). The 80% coverage is stipulated for the remaining psychotic disorders, moderate/severe depression (including anti-depressants of the new generation) and dementia. The 50% cover applies to organic psychoses. The insurance does not pay for the services of non-medical professionals (psychologists, speech therapists, social workers) and for day care. A recent proposal suggests the need for mixed funding (from health insurance and from budget) for mental health services. Drug abuse centres and mental health programmes of specific sectors (defence, interior affairs, education) are covered by the state budget and long term care institutions are financed through social welfare budget. A lot of progress has been made in the field of drug and alcohol abuse prevention – now officially recognized as integrated into Lithuanian public health provision, since it is attracting the maximum amount of funding given to prevention programmes. Private health insurance and accumulative funds systems are currently not in place. The country has disability benefits for persons with mental disorders. Severe mental illness leading to global disturbance of functioning is considered for disability benefits.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Severe mental disorders are treated at secondary and tertiary psychiatric care levels. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 287 personnel were provided training. General physicians have been trained. There are community care facilities for patients with mental disorders. Starting in 1998-1999, an increasing number of projects (supported by the Soros Foundation, state budget programmes and other sources) directed towards community-based services for mentally ill people have been developed. Currently, there are 64 mental health centres with multidisciplinary teams consisting of psychiatrists (adult, child and dependences), nurses, social workers and psychologists. Social service agency and various NGOs also provide care for the mentally ill in the community. Many new schools and day care centres have been opened for moderately or severely mentally retarded children and young adults who would have been institutionalized in the earlier system.

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>10</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>8.6</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>1.1</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0.3</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>15</td>
</tr>
</tbody>
</table>
The process of deinstitutionalization was started with persons affected by mental retardation due to active efforts of Viltis, a voluntary organization of parents of mentally challenged individuals. About 200 beds for alcohol and drug abusers, 130 beds for child and adolescent mental health care and 110 beds for forensic services are available. Most of mental health professionals are still working in mental hospitals. About 50 psychiatrists provide child and adolescent services.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and rehabilitation. Viltis is an organization formed by parents of children with mental handicaps. It has been able to bring about great changes in mental health care in Lithuania. It is now gradually beginning to function as a reform model for the surrounding countries.

Information Gathering System There is mental health reporting system in the country. Data are collected from mental health care institutions and state mental health centres and included in the annual report. The country has data collection system or epidemiological study on mental health. Only data from the state mental health centre on morbidity and sickness with mental disorders and suicides are available.

Programmes for Special Population The whole population of Lithuania is provided with mental health care. Emergency mental health care is provided for every person including tourists. Programmes dealing with prevention of suicide, juvenile delinquency, child abuse, violence and drug and alcohol abuse have been launched. Three large institutions under the Ministry of Social Welfare and a large network of special schools (more than 40 throughout Lithuania) cater to the needs of mentally challenged children.

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

A special list of medicines is compensated by the Sickness Funds.

Other Information The joint efforts of professionals, non-governmental organizations, politicians, mass media, and the general public has led to a new level of awareness about the burden of mental disorders on society and effective ways of their prevention.

Additional Sources of Information


Non-Governmental Organizations

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Other Information

The joint efforts of professionals, non-governmental organizations, politicians, mass media, and the general public has led to a new level of awareness about the burden of mental disorders on society and effective ways of their prevention.

Additional Sources of Information

**Luxembourg**

**GENERAL INFORMATION**

Luxembourg is a country with an approximate area of 3 thousand sq. km. (UNO, 2001). Its population is 0.459 million, and the sex ratio (men per hundred women) is 97 (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 18% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6%. The per capita total expenditure on health is 2905 international $, and the per capita government expenditure on health is 2611 international $ (WHO, 2004).

The main language(s) used in the country is (are) Luxembourgish, German and French. The largest ethnic group(s) is (are) Celtic. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 75.7 years for males and 81.7 years for females (WHO, 2004). The healthy life expectancy at birth is 69 years for males and 74 years for females (WHO, 2004).

**EPIDEMIOLOGY**

There is substantial epidemiological data on mental illnesses in Luxembourg 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.

**Substance Abuse Policy** A substance abuse policy is present. The policy was initially formulated in 1995. It consists of a drug substitution programme, syringe distribution, books and special locations for drug abusers.

**National Mental Health Programme** A national mental health programme is present. The programme was formulated in 1991. The document was prepared after consultation with WHO and a large representative panel of concerned professionals, institutions and NGOs.

**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 law on compulsory admission of persons with mental disorders is the latest legislation on mental health. The latest legislation was enacted in 2000.

**Mental Health Financing** There are budget allocations for mental health. The country spends 13.4% of the total health budget on mental health. The primary sources of mental health financing in descending order are social insurance, tax based, private insurances and out of pocket expenditure by the patient or family. The country has disability benefits for persons with mental disorders. Similar benefits as per physical illnesses are provided.

**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. During the 1990s, the evolution of services was constant. Different day-centres and sheltered living and work places offered all aspects of community mental health care. Gradually de-institutionalization has become more advanced.

**Psychiatric Beds and Professionals**

- Total psychiatric beds per 10 000 population: 10.5
- Psychiatric beds in mental hospitals per 10 000 population: 7.5
- Psychiatric beds in general hospitals per 10 000 population: 3
- Psychiatric beds in other settings per 10 000 population: 0
- Number of psychiatrists per 100 000 population: 12
- Number of neurosurgeons per 100 000 population: 0.9
- Number of psychiatric nurses per 100 000 population: 35
- Number of neurologists per 100 000 population: 4
- Number of psychologists per 100 000 population: 28
- Number of social workers per 100 000 population: 35
Over the last three decades, almost a three-fourth reduction in number of psychiatry beds has been achieved. In addition, a significant proportion of currently available beds are in the general hospital sector. Mental health services are easily accessible, e.g. in schools through governmental or non-governmental (financed by public authorities) agencies. During the last one and a half decade, staff working in community psychiatric care increased tenfold.

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

Information Gathering System There is mental health reporting system in the country. There is an annual report of the Ministry of Health.
The country has data collection system or epidemiological study on mental health. Data collection is done by the Ministry of Health and the ‘Union Des Caisses De Maladie’.

Programmes for Special Population The country has specific programmes for mental health for refugees, disaster affected population, indigenous population, elderly and children.
Support networks are available for young people as well as adults suffering from, or in danger of, developing mental health problems.

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.
All drugs are reimbursed either partly or wholly. Chlorpromazine is not available in the market since last year.

Other Information At the end of the 1980s, the authorities became conscious that there was an urgent need to modernize mental health care. The Ministry of Health appointed the Central Institute for Mental Health of Mannheim (Germany) to examine the situation in Luxembourg and make recommendations for organizational models of psychiatric care. The research work was done all over the country and was published in 1993 as Mental Health Care in Luxembourg, Current State and Recommendations for Future Development. The recommendations referred to results of international research and evaluation studies on psychiatric care, as well as to reliably reported experience in different European countries. Having full regard to the needs of psychiatric patients, this part of the study was submitted to a group of WHO experts, who gave an international dimension to the work. This helped the local decision-makers to propose optimal solutions, regardless of the pressure from local interest groups. These proposals were designed in collaboration with the national health authorities to serve as guidelines for the future development of psychiatric care in Luxembourg. This described the principles, guidelines, and priorities, as well as a timetable to implement the recommendations, depending on the available financial resources.

Additional Sources of Information
**GENERAL INFORMATION**

Madagascar is a country with an approximate area of 587 thousand sq. km. (UNO, 2001). Its population is 17.901 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 44% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 73.6% for men and 59.7% 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%. The per capita total expenditure on health is 20 international $, and the per capita government expenditure on health is 13 international $ (WHO, 2004).

The main language(s) used in the country is (are) Malagasy and French. The largest ethnic group(s) is (are) Merina and Betsileo, and the other ethnic group(s) are (is) Betsimisaraka, Bara, Tsimihety, Sakalava, etc. The largest religious group(s) is (are) indigenous groups, and the other religious group(s) are (is) Christian, Muslim and sects like Jesosy Mamony.

The life expectancy at birth is 54.4 years for males and 58.4 years for females (WHO, 2004). The healthy life expectancy at birth is 47 years for males and 50 years for females (WHO, 2004).

**EPIDEMIOLOGY**

There is a paucity of epidemiological data on mental illnesses in Madagascar in internationally accessible literature. A national survey carried out in 2003 showed that disabilities were diagnosed in 8% of the population. One-fifth of the disabled people had mental (intellectual) deficiencies and 2.3% had mental illness (psychic deficiencies) (MoH, 2004). Ratsifandrihamanana and Terrnova (1961) analysed 92 cases of delirium in a mental hospital and compared the symptoms with those seen in European patients.

**MENTAL HEALTH RESOURCES**

**Mental Health Policy** A mental health policy is present. The policy was initially formulated in 2000. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation.

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

**National Mental Health Programme** A national mental health programme is present. The programme was formulated in 2000.

**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 mental health law dates back to the 19th century. The latest legislation was enacted in 1838.

**Mental Health Financing** There are budget allocations for mental health. The country spends 0.82% 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 private insurances. The country has disability benefits for persons with mental disorders. Persons suffering from mental illness can avail 6-12 months of leave.

**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 integrated into districts. Regular training of primary care professionals is carried out in the field of mental health. Training models and tools are being worked out. There are no community care facilities for patients with mental disorders.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
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</thead>
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<tr>
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<td>Psychiatric beds in general hospitals per 10 000 population</td>
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<td>Number of psychologists per 100 000 population</td>
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<tr>
<td>Number of social workers per 100 000 population</td>
<td>0.02</td>
</tr>
</tbody>
</table>
Non-Governmental Organizations  NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, 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. A documentation centre is being planned.

Programmes for Special Population  The country has specific programmes for mental health for children. There are also programmes for workers in the enterprise having alcohol abuse problems and programmes on epilepsy.

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

Other Information

Additional Sources of Information
Ministry of Health (Coordination des Soins aux Personnes Handicapées [Center for the Treatment of Handicapped Persons]) 2004.
Malawi

GENERAL INFORMATION
Malawi is a country with an approximate area of 118 thousand sq. km. (UNO, 2001). Its population is 12.337 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 75.5% for men and 48.7% for women (UNESCO/MoH, 2004).
The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.8%.
The per capita total expenditure on health is 39 international $, and the per capita government expenditure on health is 14 international $ (WHO, 2004).
The main language(s) used in the country is (are) English and Chichewa. The largest ethnic group(s) is (are) Chewa, and the other ethnic group(s) are (is) Nyanja, Tumbuko and Yao. The largest religious group(s) is (are) Christian, and the other religious group(s) are (is) Muslim.
The life expectancy at birth is 39.8 years for males and 40.6 years for females (WHO, 2004). The healthy life expectancy at birth is 35 years for males and 35 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Malawi in internationally accessible literature. Carr et al (1994) compared characteristics of patients abusing marijuana with those of matched psychiatric patients and found that the abusers of marijuana (chamba) were more likely to be living in areas that grew chamba, less likely to be raised by natural parents and more likely to be educated. MacLachlan et al (1998) conducted focus groups to elicit responses from 44 male and 10 female psychiatric patients about their perceptions of marijuana (chamba) use in Malawi. Peltzer (1998) compared PTSD symptomatology among torture survivors from Malawi and refugees from Sudan in Uganda and found that among Africans somatic numbing was more common than psychic numbing as outlined in DSM-IV criteria. Simukonda and Rappsilber (1989) found high levels of anxiety among a group of male nursing students. They felt stressed about role differences between nurses and other male health workers.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 2002. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Provision of comprehensive and accessible mental health care services is the main goal of the policy. It hopes to do so through the inclusion of mental health in the National Health Plan and integration of mental health in primary health care. Human resource development is also a component of the policy.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 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 The Mental Treatment Act was amended in 1968. Currently, the Act is being reviewed. The latest legislation was enacted in 1959.

Mental Health Financing There are budget allocations for mental health. The country spends 2% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based and grants. The country does not have disability benefits for persons with mental disorders. Mental disorders are not considered a disability.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 1000 personnel were provided training. In medical undergraduate training, students are encouraged to consider how they may address mental health issues through the many and varied roles which doctors in resource poor countries must fulfil (administrator, trainer, primary health care doctor, and hospital physician). Training of general health workers in mental health issues is planned in 3 regions. There are community care facilities for patients with mental disorders. Currently, the district mental health care provides community mental health services throughout the country. These centres are staffed by psychiatric nurses. Plans are under way to provide for monitoring and supervisory visits to all districts.
MALAWI

Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 10,000 population</td>
<td>0.37</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals per 10,000 population</td>
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</tr>
<tr>
<td>Psychiatric beds in general hospitals per 10,000 population</td>
<td></td>
</tr>
<tr>
<td>Psychiatric beds in other settings per 10,000 population</td>
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</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>
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<tr>
<td>Number of psychiatric nurses per 100,000 population</td>
<td>2.5</td>
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<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 is one occupational therapist and 2 psychiatric clinical officers. Mental health services are now provided at central level, Zomba Mental Hospital, district hospitals and non-governmental hospitals and also at the health centre level, though the latter is not fully developed. Although, there are only few mental health professionals available in the country, general duty doctors are not deployed to the mental health services area. About 300 psychiatric nurses have been trained and posted in district health centres. Management guidelines and protocols are being developed.

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.

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

Programmes for Special Population

The country has specific programmes for mental health for minorities, refugees and disaster 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, fluphenazine, haloperidol, lithium. Procyclidine is available.

Other Information

Additional Sources of Information

Malaysia

GENERAL INFORMATION
Malaysia is a country with an approximate area of 330 thousand sq. km. (UNO, 2001). Its population is 24.876 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 7% (WHO, 2004). The literacy rate is 91.4% for men and 83.4% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.8%. The per capita total expenditure on health is 345 international $, and the per capita government expenditure on health is 185 international $ (WHO, 2004).

The main language(s) used in the country is (are) Malay, Chinese, Tamil and English. The largest ethnic group(s) is (are) Malay and other indigenous groups, and the other ethnic group(s) are (is) Chinese and Indian. The largest religious group(s) is (are) Muslim, and the other religious group(s) are (is) Buddhist and Hindu.

The life expectancy at birth is 69.6 years for males and 74.7 years for females (WHO, 2004). The healthy life expectancy at birth is 62 years for males and 65 years for females (WHO, 2004).

Epidemiology
The Ministry of Health (1996) conducted the National Health & Morbidity Survey on 30 114 respondents aged 16 years and above using General Health Questionnaire (GHQ-10). The adjusted prevalence of mental disorders was 10.7%. Prevalence of mental disorders was associated with gender (female), age (under 25 years and over 65 years), ethnicity (Indian), marital status (widowed, divorced), employment (unemployed, agricultural and production workers), income (low), physical illness (asthma, cancer and diabetes) and disability (physical, hearing and speech). The National Working Group (Ministry of Health, 2001) study on promotion of mental health conducted on a sample of 5651 adults and 2075 children using the General Health Questionnaire (GHQ-28) showed the prevalence of mental health problems to be 18.8%. Ramli et al (1991) carried out a 2-stage survey for psychiatric morbidity in a rural area, and found the point prevalence of all psychiatric disorders to be 9.7%. Neurotic disorders (6.15%), especially neurotic depression (3.31%) was common, particularly in women. Maniam (1994) used the 30-item version of the General Health Questionnaire (cut-off score of 6/7) to assess psychiatric morbidity in 206 patients attending an urban general practice. The corrected prevalence estimate of psychiatric morbidity was 29.9%. Though no significant difference was observed in sex or age distribution, Malays had higher scores than Chinese. Navaratnam and Foong (1989) did a trend analysis on data from the national drug abuse monitoring system and found that there was a significant increase in incidence and prevalence (from .084% to .75%) of drug dependence in Malaysia in the period 1970-86. Gan (1995) reported that 59.5% of 472 rural women interviewed by them chewed tobacco and women with less education were more likely to do so. In a sample of 1000 elderly men, Chen (1987) reported that nearly 20% smoked 15 or more cigarettes a day and 40% indicated that their families complained about their alcohol intake. Navaratnam et al (1979) surveyed a representative sample of 12-16 year olds in three different areas (n >16 000) and found that 10.5% (males 11.9% and females 8.6%) used drugs. Drug use was highest among 12-year old children (13.5%) and the common drugs used were sedatives (5.5%), tranquilizers (4.5%), stimulants (3.9%), heroin (3.6%), other opioids (3.9%), hallucinogens (3.1%) and cannabis (2.7%). About a quarter of the students had tried four or more drugs and had rapidly progressed to heroin use. Grace et al (2001) administered the Edinburgh Post-Natal Depression Scale (EPNDS) and the Bradford Somatisation Inventory (BSI) to 154 consecutive mothers who came for a post-natal check up at 6-weeks and found the rate of post natal depression to be 3.9%. The prevalence among Indians (8.5%), Malays (3.0%) and Chinese (0%) was significantly different. Maniam (1995) reported that the corrected suicide rate was between 8-13 per 100 000 population. Nadesan (1999) reviewed all autopsies in a hospital over 3 years and found that 48.8% of the suicides were committed by those of Indian origin, 38.1% by those of Chinese origin and 3.6% by Malays. The commonest age group was between 20-40 years, and poisoning and hanging were the usual methods of committing suicide. Maniam (1988) reviewed records of 95 cases of suicide and 134 cases of parasuicide in a district. Nearly four-fifths of those committing or attempting suicides were Indians. About 94% of suicides and 66% of parasuicides involved ingestion of agricultural poisons. Habil et al (1992) reviewed the records of 306 in-patients with suicide attempts. Suicidal behaviour was more common in young, females, social class IV and V (45%) and persons of Indian origin. Poisoning was the commonest method used. Adjustment disorder was diagnosed in 58.5% of the patients. Cheah et al (1997) conducted a two-phase study involving 589 children aged 10-12 years and found that the prevalence of emotional/behavioural deviance based on parent interview to be 40% in a rural school, 30.2% in an agricultural resettlement school and 32.3% in the urban school. On the teachers’ interview, the prevalence of deviance was 40% in the rural school, 10.8% in the agricultural resettlement school and 8.9% in the urban school. In the rural school, significantly higher prevalence of deviance was found among boys. However, Kasmini et al (1993) found a rate of only 6.1% for psychiatric morbidity in a sample of 507 rural children, aged 1-15 years, when they applied the WHO Research Questionnaire for Children (RQC) for initial screening and a semi structured interview at the second stage. Boo et al (1989) examined records of 34 495 live-births delivered in a maternity hospital and found the rate of Down syndrome to be 1044 per 1000 live-borns.
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. Accessibility and equity, continuity and integration, community participation, community care, quality of services and multi sectoral collaboration are the major components of the policy. The National Mental Health Framework was formulated in July 2002 as a blueprint for strategic planning and implementation for the delivery of mental health services and activities in hospital, primary health care and community based settings. The framework also sets standards and guidelines for the services.

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

National Mental Health Programme  A national mental health programme is present. The programme was formulated in 1998.

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  Mental Health laws are governed by the Mental Health Ordinance (1952) and the Laws of North Borneo. The new Mental Health Act (2001) provides the framework for care, treatment (including community treatment), control, protection and rehabilitation of people with mental disorders. The regulations for the Act were formulated in 2004 and awaiting approval. The regulations specify the specific standards for psychiatric facilities, personnel, rights of the patients, etc. The latest legislation was enacted in 1952.

Mental Health Financing  There are budget allocations for mental health. The country spends 1.5% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, private insurances and social insurance. The country does not have disability benefits for persons with mental disorders. Efforts have been made to categorize the severely mentally ill as a Disabled Person with the aim to improve the quality of life for the severely mentally ill and their integration into mainstream of society. A proposal paper was formulated and awaiting cabinet approval.

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 integrated into the primary health care system since 1998. In 2003, 733 (i.e. 85%) primary health care clinics were providing treatment for the mentally ill and 25 of these clinics were also providing psychosocial rehabilitation services. Defaulters tracing, family education and treatment in the home are also provided. Mental health has been incorporated in the Adolescent and Elderly Health Services provided in the primary health care. Guidelines and Standard Operating Procedures for implementation of mental health services in the primary health care level have been developed to facilitate the primary health care service providers to carry out their respective programmes and activities. The psychiatric clinics in the District Hospitals are run by medical officers supervised by visiting psychiatrists and also visiting psychiatrists providing services for more difficult cases and consultation. The visiting psychiatrists also provides on the job training as well as continuous medical education (CME) to the medical officers.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 1505 personnel were provided training. Training for the primary health care personnel are carried out regularly based on modular training, in-service and continuous medical training (CME) at national, state and local level. In-service training and continuous medical training (CME) are also been carried out by the psychiatric departments.

There are community care facilities for patients with mental disorders. There has been an emphasis for community based mental health care by the psychiatric departments since 1998. Home based services are being developed and provided at various levels by the psychiatric departments. These include home based care for the acutely ill in 6 districts and assertive follow-up in most districts with psychiatric departments. Families’ involvement has been a key feature for management of the mentally ill in Malaysia. In 2002, initiatives to formalize and develop the Family Support Group (FSG) started in Johor Baharu District and till the end of 2004, about 16 FSGs have been formed through the country with a total of 1084 carers. Training for the FSGs was carried out using a module developed in 2002.
### Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Category</th>
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</thead>
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<tr>
<td>Psychiatric beds in mental hospitals</td>
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<tr>
<td>Psychiatric beds in general hospitals</td>
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</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>0.6</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>0.06</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>0.5</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>0.05</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0.05</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0.2</td>
</tr>
</tbody>
</table>

There are 148 occupational therapists and 295 medical assistants. There are 4 mental institutions, 32 hospitals (27 under Ministry of Health, 3 University Hospitals and 1 Army Hospital) with psychiatric wards (each with 20 – 120 beds). Two of the 4 mental hospitals have over 1500 beds, each. Private nursing homes (nearly 70 at present) are currently licensed by the local authority. However, they will now have to seek legal permission under the 2001 mental health act. About one third of psychiatrists are in full or part-time private practice. Half of these private practitioners are in Kuala Lumpur, but most cities have private psychiatric practice. Most psychiatric units now have occupational therapists working with them. Recently, courses on child psychiatry have started.

### Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. At least 19 NGOs work in the area of mental health. NGOs provide community care facilities like day care centres besides public education and advocacy. The Government has recognized their influential role and a nominal amount of funding is available to some NGOs. They are also involved in planning and policy making. A National Council on Mental Health was formed in 1998 to ensure wide community participation on policy issues. The Befrienders operate a 24-hour telephone as well as face-to-face counselling service in many cities. Other NGOs care for abused children and women or provide marital counselling services.

### Information Gathering System

There is mental health reporting system in the country. The Ministry of Health has an Information Documentation System (IDS), where data on activities from the hospital and health care systems are collected and collated. Reporting on diseases (including mental disorders) are based on ICD-9. The country has data collection system or epidemiological study on mental health.

### Programmes for Special Population

The country has specific programmes for mental health for elderly and children. Training modules and manuals have been developed for training of psychiatrists, paediatricians, family medicine specialists and primary health care staff in child and adolescent mental health. Mental health promotion has been identified as a key strategy for improving the mental health status of the population through improving coping skills, lifestyle and increasing mental health literacy. Towards this end, the Ministry of Health launched the Healthy Life Style Campaign in 2000. The campaign targeted children, adolescents, working adults, parents and elderly. The activities were implemented through a national level training for trainers for all state facilitators, who conducted training for district facilitators, who were responsible for carrying out activities at the grass root level. Other mental health promotion activities include public forums, health talks and exhibitions. There are more than 30 governmental treatment and rehabilitation centres for drug abusers. Each can house over 300 patients for up to 18 months. A public education programme and a school education programme on drug abuse have been conducted over the past few years. Methadone is not routinely available and there is no needle exchange programme. But these centres provide training in work skills and aftercare for 5 years. A national anti-drug association PEMADAM (NGO) does valuable work in public education, prevention and aftercare. There are also a number of privately run treatment and rehabilitation centres for substance abuse. A few Alcoholics Anonymous and other counselling groups have also come up. Forensic psychiatry care is mainly provided through psychiatric hospitals. Two forensic psychiatrists work in the general hospital setting.

### 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**


Government document (1952) The Mental Disorders Ordinance.


Maldives

GENERAL INFORMATION
Maldives is a country with an approximate area of 0.3 thousand sq. km. (UNO, 2001). The country includes nearly 1200 coral islands. Its population is 0.328 million, and the sex ratio (men per hundred women) is 105 (UNO, 2004). The proportion of population under the age of 15 years is 42% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 97.3% for men and 97.2% 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 6.7%. The per capita total expenditure on health is 263 international $, and the per capita government expenditure on health is 220 international $ (WHO, 2004).
The main language(s) used in the country is (are) Dhivehi. The largest ethnic group(s) is (are) Sinhalese, and the other ethnic group(s) are (is) Dravidian, Arab and African. The largest religious group(s) is (are) Muslim.
The life expectancy at birth is 66.5 years for males and 65.6 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 57 years for females (WHO, 2004).

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

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is absent.
Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1977.
National Mental Health Programme A national mental health programme is absent.
National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present.
Details about the year of formulation are not available.
Mental Health Legislation There is no mental health legislation.
Details about the year of enactment of the mental health legislation are not available.
Mental Health Financing There are no budget allocations for mental health.
Details about expenditure on mental health are not available.
The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family and grants.
The Government has special budget allocations for provision of free medication to mental health patients and provides care and treatment for severe cases at the Home for People with Special Needs. The National Narcotics Control Bureau and the Rehabilitation Centre also have separate budgets allocated for their function.
The country has disability benefits for persons with mental disorders.
Mental Health Facilities Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.
Regular training of primary care professionals is carried out in the field of mental health. Training is integrated in the community health workers training programme. The Government plans to make comprehensive mental health services available at the central level. At the regional level, services are provided by visiting psychiatrists. At the atoll and island levels, trained community health workers and nurses provide basic psychiatric services. Home-based care of psychiatric cases will be given priority over institutional treatment. Emphasis will also be given to the prevention of mental illness and the promotion of mental health and well-being through awareness programmes.
There are no 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 0.36
Number of neurosurgeons per 100 000 population 0.36
Number of psychiatric nurses per 100 000 population 0
Number of neurologists per 100 000 population 0
Number of psychologists per 100 000 population 1.2
Number of social workers per 100 000 population 0
Most of the personnel work in the capital and in tertiary centres. The psychiatrists visits other islands whenever needed.
Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in treatment and rehabilitation. One NGO is involved in providing care and support to patients with severe mental illnesses and special needs. Two other NGOs are involved in providing counselling for drug users.

Information Gathering System

There is mental health reporting system in the country. A national registry that covers mental disorders is maintained at the Ministry of Gender, Family Development and Social Security. Similarly, a register is maintained at the National Narcotics Control Bureau. The country has no data collection system or epidemiological study on mental health. However, a prevalence study on mental disorders using the Self-Reporting Questionnaire (SRQ) developed by WHO is under way (in 2004).

Programmes for Special Population

There are no programmes for any special population.

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

Mali

GENERAL INFORMATION
Mali is a country with an approximate area of 1240 thousand sq. km. (UNO, 2001). Its population is 13.408 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 49% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 26.7% for men and 11.9% 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 4.3%. The per capita total expenditure on health is 30 international $, and the per capita government expenditure on health is 12 international $(WHO, 2004).

The main language(s) used in the country is (are) French. The largest ethnic group(s) is (are) Dogon, and the other ethnic group(s) are (is) Voltaic and Touareg. The largest religious group(s) is (are) Muslim.

The life expectancy at birth is 43.9 years for males and 45.7 years for females (WHO, 2004). The healthy life expectancy at birth is 38 years for males and 38 years for females (WHO, 2004).

EPIDEMIOLOGY
Carta et al (1997, 1999) conducted a two-level community study to estimate the prevalence of mental disorders with the help of the Questionnaire pour le Dépistage en Santé Mentale (QDSM), a 23-item screening questionnaire derived from the Self-Reporting Questionnaire (SRQ). In the first phase of the study, 466 randomly selected subjects from the major tribes were evaluated by means of the QDSM. In the second phase, all subjects who were ‘positive’ at the screening, as well as a sample who were ‘negative’ were examined by means of a semistructured interview. The estimated prevalence of psychiatric cases was 6.4%. A significant risk was associated with age and education. The common somatic diseases associated with psychiatric disorders were genitourinary tract disorders, tuberculosis and cardiac disorders. True et al (2001) assessed 42 mother-infant (10-12.5 months) pairs from a rural setting. The distribution of the Strange Situation classifications was 67% secure, 0% avoidant, 8% resistant and 25% disorganized. Infant attachment security was significantly related to the quality of observed mother-infant communication. Mothers of disorganized infants had significantly higher ratings of frightened or frightening behaviours.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 1983. The components of the policy are treatment and rehabilitation. Decentralization is a component of the policy.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1983.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1983.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1985.

Mental Health Legislation The 1938 decree of Gouverneur Général de l’AOF concerning the mentally alienated and the French legislation of 1838 were replaced by the new legislation. The latest legislation was enacted in 1990.

Mental Health Financing There are budget allocations for mental health. The country spends 0.02% of the total health budget on mental health. The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, tax based, social insurance and private insurances. The country does not have disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 48 personnel were provided training. There are community care facilities for patients with mental disorders.
Psychiatric Beds and Professionals

- Total psychiatric beds per 10,000 population: 0.2
- Psychiatric beds in mental hospitals per 10,000 population: 0
- Psychiatric beds in general hospitals per 10,000 population: 0.1
- Psychiatric beds in other settings per 10,000 population: 0.05
- Number of psychiatrists per 100,000 population: 0.06
- Number of neurosurgeons per 100,000 population: 0.01
- Number of psychiatric nurses per 100,000 population: 0.15
- Number of neurologists per 100,000 population: 0.02
- Number of psychologists per 100,000 population: 0.02
- Number of social workers per 100,000 population: 0.01

The number of personnel are insufficient.

Non-Governmental Organizations

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

Information Gathering System

There is mental health reporting system in the country. Mental disorders are classified under ‘other disorders’.

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

Programmes for Special Population

There are no programmes for special population.

Therapeutic Drugs

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

Trihexyphenidyl is used. Availability of drugs is inadequate.

Other Information

Additional Sources of Information

Malta

GENERAL INFORMATION
Malta is a country with an approximate area of 0.32 thousand sq. km. (UNO, 2001). The country consists of five islands. Its population is 0.396 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 18% (WHO, 2004). The literacy rate is 91.8% for men and 93.4% for women (UNESCO/MoH, 2004).
The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8.8%. The per capita total expenditure on health is 813 international $, and the per capita government expenditure on health is 557 international $ (WHO, 2004).
The main language(s) used in the country is (are) Maltese and English. The largest religious group(s) is (are) Roman Catholic.
The life expectancy at birth is 76.1 years for males and 81.2 years for females (WHO, 2004). The healthy life expectancy at birth is 70 years for males and 73 years for females (WHO, 2004).

EPIDEMIOLOGY
Baron et al (2001) interviewed carers at 13 residential homes using a semistructured questionnaire (n=309) about children and adolescents below the age of 16 years. They found behavioural problems in 20.7% and developmental delay (global or specific) in 23.3% of the subjects. Maslowski (1987, 1988) compared the cultural factors and symptomatology of schizophrenia among patients from Poland (n=120), Malta (n=80) and Libya (n=97). Differences were observed in symptomatology and prognosis. Savona-Ventura et al (2001) reported that domestic abuse was common in Mediterranean communities and that abused women were more likely to smoke cigarettes during pregnancy than their counterparts.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is present. The policy was initially formulated in 1994. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The policy strives to create healthy environments in family, school, workplace and community and also aims to offer a range of appropriate services to empower people to cope better with mental health issues, thus maximizing their productive and social life.

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

National Mental Health Programme A national mental health programme is present. Details about the year of formulation of the programme are not available. The national mental health programme is entitled ‘National Community Mental Health Strategy’.

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 The Mental Health Act was enacted in 1981 and amended in 1983. Currently, it is under review. A draft of the new Mental Health Act was prepared by the Mental Health Commission in 1999. The latest legislation was enacted in 1981.

Mental Health Financing There are budget allocations for mental health. The country spends 10% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family and social insurance. Residents receive comprehensive care, funded from general taxation. Those determined by means-testing to have a ‘low income’ and those suffering from chronic conditions (e.g. schizophrenia) are entitled to free drug treatment on an outpatient basis. The country has disability benefits for persons with mental disorders. Persons suffering from severe mental subnormality or those with certain neurological disorders like epilepsy are entitled to means-related disability benefit, and those suffering from chronic schizophrenia, drug abuse or resident in a therapeutic community are entitled to a means-related social assistance benefit.

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 approach is to move out of an institutional system to a community set-up. Many patients are either followed up on an out-patient basis in the state system or by a psychiatrist or general physician in private. 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. Community services are in the form of day centres, sheltered homes, long stay hostels, respite centres and independent living.
Psychiatric Beds and Professionals

- Total psychiatric beds per 10,000 population: 18.9
- Psychiatric beds in mental hospitals per 10,000 population: 18.86
- Psychiatric beds in general hospitals per 10,000 population: 0.04
- Psychiatric beds in other settings per 10,000 population: 0
- Number of psychiatrists per 100,000 population: 4
- Number of neurosurgeons per 100,000 population: 0.8
- Number of psychiatric nurses per 100,000 population: 102
- Number of neurologists per 100,000 population: 1
- Number of psychologists per 100,000 population: 2.6
- Number of social workers per 100,000 population: 3.1

There are 12 occupational therapists. There is a specialist registration system. The main psychiatric hospital still adheres to old custodial care approach with old management facilities and ineffective human resources management. There are hardly any specialized care units. The main psychiatric hospital focuses on personalized, holistic healing both of which are implemented in a multi-disciplinary ‘team’ approach. New infrastructures have been introduced into hospitals in order to enhance accountability for resource utilization and performance. Beds have been earmarked for elderly, children and adolescents, those with learning disabilities and forensic patients. Malta has a relatively high numbers of psychiatric beds per 1000 population in comparison to other European countries. However, acute inpatient options are limited. Formal training in psychiatry leading on to full qualification as a psychiatrist is partially provided in Malta and hence doctors must finalize their formal training abroad. Specialists are registered. There is a lack of trained personnel and a multi-disciplinary approach is lacking. Over the past three years, a large portion of resources have been utilized to train staff and management in modern psychiatric care.

Non-Governmental Organizations

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

Information Gathering System

There is no mental health reporting system in the country.

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

Programmes for Special Population

There are no programmes for special populations.

Provision for substance misuse falls under the Ministry of Family and Social Solidarity. Most of the substance misuse services are provided by a Government-funded autonomous agency, the National Agency against Drug and Alcohol Abuse (Sedqa). The services principally employ a multi-disciplinary approach and provide a range of treatment modalities, including outpatient and inpatient detoxification, community-based one-to-one as well as group psychosocial interventions, family therapy facilities and longer-term residential rehabilitation facilities. Other community-based provision includes prevention programmes and a parental skills programme. Acute provision for substance misuse, however, falls under the Department of Psychiatry within the main psychiatric hospital. A non-governmental organization, Caritas, works alongside the National Agency; its main roles are prevention and community-based rehabilitation. The Department of Psychiatry also provides for psychiatric care within the criminal justice system.

Therapeutic Drugs

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

The essential list of drugs is updated regularly. All drugs are dispensed free. The Division of Health uses a locally-produced National Formulary which includes all drugs available under the Maltese NHS and this was derived from the WHO list. Prior approval of the Minister or Director General is required before introducing a new drug. On an outpatient basis, drugs are dispensed free of charge or on a means-test, or if a client is suffering from an illness scheduled under the Social Security Act.

Other Information

Additional Sources of Information


Marshall Islands

**GENERAL INFORMATION**
Marshall Islands is a country with an approximate area of 0.18 thousand sq. km. (UNO, 2001). The country consists of two archipelagic island chains of about 30 atolls and more than 1000 islands. Its population is 0.057 million, and the sex ratio (men per hundred women) is 105 (UNO, 2004). The proportion of population under the age of 15 years is 42% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 100% for men and 88% 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 9.8%. The per capita total expenditure on health is 343 international $, and the per capita government expenditure on health is 222 international $ (WHO, 2004).

The main language(s) used in the country is (are) Marshallese and English. The largest ethnic group(s) is (are) Micronesian. The largest religious group(s) is (are) Christian.

The life expectancy at birth is 61.1 years for males and 64.6 years for females (WHO, 2004). The healthy life expectancy at birth is 54 years for males and 56 years for females (WHO, 2004).

**EPIDEMIOLOGY**
There is a paucity of epidemiological data on mental illnesses in Marshall Islands in internationally accessible literature. Dodd (1980) found that depression and alcohol abuse were common conditions encountered in a medical facility.

**MENTAL HEALTH RESOURCES**

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

**Substance Abuse Policy** Details about the substance abuse policy are not available.

**National Mental Health Programme** A national mental health programme is present. The programme was formulated in 1982.

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

**Mental Health Legislation** There are National Mental Health Planning Council By-Laws. The latest legislation was enacted in 1997.

**Mental Health Financing** There are budget allocations for mental health. The country spends 0.4% of the total health budget on mental health. The primary 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. The Ministry of Health and Environment offers mental health programmes under the auspices of Bureau of Primary Health Care, but all medical supplies and drugs are for curative health care. Regular training of primary care professionals is carried out in the field of mental health. There have been some workshops and training programmes, namely The Crisis Prevention and Intervention Training, Partners in Mental Health Performance Outcome Workshop, etc.

There are community care facilities for patients with mental disorders. Usually a community-based system of care is provided. Outreach prevention and treatment programmes are provided to communities around the country.

**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>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>
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<tr>
<td>Psychiatric beds in other settings</td>
<td>0</td>
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<tr>
<td>Number of psychiatrists</td>
<td>0</td>
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<tr>
<td>Number of neurosurgeons</td>
<td>0</td>
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<td>Number of psychiatric nurses</td>
<td>0</td>
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<tr>
<td>Number of neurologists</td>
<td>0</td>
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<tr>
<td>Number of psychologists</td>
<td>1</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>3</td>
</tr>
</tbody>
</table>

Only one medical doctor works with the mental health programme. A psychiatrist is going to be recruited.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in promotion, prevention, treatment and rehabilitation.
**Information Gathering System** There is mental health reporting system in the country. Monthly reports are sent to the office of the Director; annual reports are sent to the office of the Assistant Secretary of the Primary Health Care and the Planning and Statistics Office. The country has data collection system or epidemiological study on mental health. The Ministry of Health and Environment has collected data from 1992-2000.

**Programmes for Special Population** The country has specific programmes for mental health for minorities, elderly and children. Mental health programme and community outreach prevention and treatment programmes provide the services.

**Therapeutic Drugs** The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, amitriptyline, diazepam, fluphenazine, haloperidol, lithium, carbidopa, levodopa. Benztrpine 2mg is usually used for akathisia/dystonia.

**Other Information** The purposes of the National Mental Health Planning Council are: (1) to serve as advocate for chronically mentally ill persons; (2) to monitor, review and evaluate not less than once a year, the allocation and adequacy of mental health services with the republic; and (3) to carry out other activities that might be related to the purpose of the council.

**Additional Sources of Information**
Government document (1997) By-laws of the RMI Mental Health Planning Council (a Standing Committee of the RMI Health Advisory Board).
Mauritania

GENERAL INFORMATION
Mauritania is a country with an approximate area of 1026 thousand sq. km. (UNO, 2001). Its population is 2.98 million, and the sex ratio (men per hundred women) is 98 (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 51.5% for men and 31.3% for women (UNESCO/MoH, 2004).
The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.6%. The per capita total expenditure on health is 45 international $, and the per capita government expenditure on health is 33 international $ (WHO, 2004).
The main language(s) used in the country is (are) Arabic, Fula, Soninke, Wolof and French. The largest ethnic group(s) is (are) Maur, and the other ethnic group(s) are (is) African. The largest religious group(s) is (are) Muslim.
The life expectancy at birth is 49.8 years for males and 54.5 years for females (WHO, 2004). The healthy life expectancy at birth is 43 years for males and 46 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Mauritania in internationally accessible literature. According to the National General Survey on Mental Health, 16% of subjects had depressive disorders, 20% had anxiety disorders and 2% had psychoactive substance use disorders (MOH, 2004).

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is absent.
Substance Abuse Policy A substance abuse policy is absent. A decree was issued in November 1990 for the creation of the National Commission against Drugs and Psychotropic Substances.
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 absent.
Mental Health Legislation The country does not have any mental health legislation. A draft legislation is in preparation.
Details about the year of enactment of the mental health legislation are not available.
Mental Health Financing There are budget allocations for mental health.
The country spends 1% of the total health budget on mental health.
The primary sources of mental health financing in descending order are tax based and out of pocket expenditure by the patient or family.
The country has disability benefits for persons with mental disorders.
Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level.
Regular training of primary care professionals is not carried out in the field of mental health. Some training of primary care professionals is carried out in the field of mental health through workshops, seminars etc.
There are community care facilities for patients with mental disorders. Special units for mental health treatment have been developed in the community.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 0.2
Psychiatric beds in mental hospitals per 10 000 population 0.2
Psychiatric beds in general hospitals per 10 000 population 0
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 0.08
Number of neurosurgeons per 100 000 population 0
Number of psychiatric nurses per 100 000 population 0
Number of neurologists per 100 000 population 0.6
Number of psychologists per 100 000 population 0.1
Number of social workers per 100 000 population 0.1
Training of specialists in mental health is not adequate.

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

There is mental health reporting system in the country. Only hospital data collection is done.
The country has no data collection system or epidemiological study on mental health. A general survey on mental health was conducted. Data are not available as yet.

Programmes for Special Population

There are no special services.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, sodium valproate, amitriptyline, chlorpromazine, diazepam, haloperidol.
Trihexiphenidyl (5mg) is present.

Other Information

Additional Sources of Information
Mauritius

GENERAL INFORMATION
Mauritius is a country with an approximate area of 2 thousand sq. km. (UNO, 2001). Its population is 1.233 million, and the sex ratio (men per hundred women) is 99 (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 9% (WHO, 2004). The literacy rate is 88.2% for men and 80.5% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.4%. The per capita total expenditure on health is 323 international $, and the per capita government expenditure on health is 192 international $ (WHO, 2004).

The main language(s) used in the country is (are) English, French and Creole Patois. The largest ethnic group(s) is (are) Indo-Mauritian, and the other ethnic group(s) are (is) Creole. The largest religious group(s) is (are) Hindu (more than half), and the other religious group(s) are (is) Christian and Muslim.

The life expectancy at birth is 68.4 years for males and 75.5 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 65 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Mauritius in internationally accessible literature. Reynolds et al (2000) used the Schizotypal Personality Questionnaire in a sample of 1201 subjects and found that the three-factor model (cognitive-perceptual deficits, interpersonal deficits and disorganization) underlies individual differences across widely varying groups. Venables (1996, 1997) found that women’s exposure to influenza in pregnancy was associated with an elevation of positive schizotypy scores and electrodermal hyperresponsivity (associated with schizophrenia), whereas exposure to low environmental temperatures was associated with an elevation of anhedonia scores and electrodermal hyporesponsiveness in their offspring.

MENTAL HEALTH RESOURCES
Mental Health Policy
A mental health policy is present. The policy was initially formulated in 1983. The components of the policy are promotion, prevention, treatment and rehabilitation.

Substance Abuse Policy
A substance abuse policy is present. The policy was initially formulated in 1996. A Substance Abuse Strategic Plan was formulated in 2004.

National Mental Health Programme
A national mental health programme is present. The programme was formulated in 2000. A Mental Health Decentralization and Integration of Mental Health in Primary Health Plan was prepared 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 1972.

Mental Health Legislation
There is a Mental Health Care Act (act no 24). It repealed the older Lunacy Act. The Act is detailed and has provisions for procedure of admission and discharge of patients, rights of patients, living conditions of the hospitals, legal issues pertaining to courts and ability to stand for trial. There are also provisions for actual treatment issues like person responsible for care, plan of treatment, follow-up, etc. A new Mental Health Care Act is under preparation to cover developments related to community psychiatric services/care.

The latest legislation was enacted in 1998.

Mental Health Financing
There are budget allocations for mental health. The country spends 0.3% 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.

The country has disability benefits for persons with mental disorders. Two types of benefits are present: (1) basic invalidity pension for those who have 60% of mental handicap; (2) basic invalidity pension and carer’s allowance for those who are non-ambulant, have severe disability and who need constant carer’s assistance.

Mental Health Facilities
Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Primary care is provided as an outpatient service and as follow-up after treatment at the main psychiatric hospital.

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. Six centres provide community care facilities.
Psychiatric Beds and Professionals

- Total psychiatric beds per 10 000 population: 9.5
- Psychiatric beds in mental hospitals per 10 000 population: 8
- Psychiatric beds in general hospitals per 10 000 population: 1
- Psychiatric beds in other settings per 10 000 population: 0.5
- Number of psychiatrists per 100 000 population: 1
- Number of neurosurgeons per 100 000 population: 0.5
- Number of psychiatric nurses per 100 000 population: 5
- Number of neurologists per 100 000 population: 0.1
- Number of psychologists per 100 000 population: 1
- Number of social workers per 100 000 population: 1

There are 5 occupational therapists and 4 assistants.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in rehabilitation.

Information Gathering System

There is mental health reporting system in the country. Details about services, morbidity, cause of death are published in the Annual Health Statistics. Some information is available about neurotic disorders and alcohol dependence as per ICD 9 criteria.

The country has data collection system or epidemiological study on mental health. Details are given in the Annual Health Statistics. Hospital and community clinic attendance and discharge are reported under the broad group of ‘mental disorders’. An epidemiological survey was carried out in 1997-1998 under the aegis of Ministry of Health/Mauritius Institute of Health and Mauritius Psychiatric Association in collaboration with INS CCOMS Paris, under the title ‘Recherche Epidemio-Logique Multicentrique: La Santé Mentale en Population Generale. Image et Réalite’.

The Republic of Mauritius publishes two separate Annual Health Statistics from its two islands of Mauritius and Rodrigues.

Programmes for Special Population

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

Therapeutic Drugs

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

Other anti-cholinergics (benzhexol, orphenadrine and procyclidine) and newer anti-psychotics (olanzapine, risperidone) and anti-depressants (paroxetine) are also available. All the drugs are strictly controlled and dispensed against prescriptions. The prices are Government controlled. Other drugs are available from private pharmacies.

Other Information

Additional Sources of Information

Mexico is a country with an approximate area of 1958 thousand sq. km. (UNO, 2001). Its population is 104.931 million, and the sex ratio (men per hundred women) is 96 (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 92.6% for men and 88.7% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.1%. The per capita total expenditure on health is $544 international $, and the per capita government expenditure on health is 241 international $ (WHO, 2004).

The main language(s) used in the country is (are) Spanish. The largest ethnic group(s) is (are) Mestizo (three-fourths), and the other ethnic group(s) are (is) Native American. The largest religious group(s) is (are) Roman Catholic (nine-tenths).

The life expectancy at birth is 71.7 years for males and 76.9 years for females (WHO, 2004). The healthy life expectancy at birth is 63 years for males and 68 years for females (WHO, 2004).

**Epidemiology**

Caraveo-Anduaga et al (1997, 1999) assessed 1932 adults using a modified version of the Composite International Diagnostic Interview (CIDI). The prevalence of any disorder according to ICD-10 was 28.7% (commonest disorders were alcohol use disorders and depressive disorders). Comorbidity was present in 33% of cases (commonest comorbid conditions were anxiety disorders). The lifetime and 12-month prevalence of depression was 7.9% and 4.5%, respectively. The 1-year incidence of depression was 1.3%.

Lifetime prevalence of dysthymia was 4.4%, with a female-male ratio of 2:1. Based on the same study, Caraveo-Anduaga and Colmenares (2000) reported that the lifetime prevalence of various phobic disorders ranged from 2.1% to 2.8%. Most phobic disorders were more frequent in women. De Snyder and Díaz-Perez (1999) assessed 945 rural adults using the Fresno version of the Composite International Diagnostic Interview and ICD 10. The lifetime prevalence of depression, dysthymia and nervous, respectively were 6.2% (women 9.1% and men 2.9%), 3.4% (women 5.2% and men 1.4%) and 15.4% (women 20.8% and men 9.5%).

Caraveo-Anduaga and Bermudez (2002) assessed 1734 adults with a modified version of CIDI (DSM-III-R criteria) as a part of the International Consortium of Psychiatric Epidemiology (ICPE) study. Psychiatric disorders were more common among women while substance use disorders were more common in men. Depressive disorders (major depression and dysthymia) were two times more frequent in women (10% and 1.8%) than in men (5.5% and 0.9%); while mania was more frequent in men (2.1%) than in women (0.9%). Agoraphobia, social and simple phobias also predominated in women (5.1%, 2.9% and 3.4% women vs. 2.9%, 1.6% and 2.3% men). Alcohol use disorders were 8.6 times more common than any other substance use disorder, with lifetime prevalence estimates of 18.6% for alcohol abuse and 7.5% for alcohol dependence. Vega et al (2002) reported the results of the ICPE study on substance use. Using CIDI, the lifetime prevalence rates of use of alcohol (>11 times), marijuana (>4 times) and other drugs were 43.2%, 1.7% and 1.7%, respectively. Tapia-Conyer et al (1990) reported that alcohol dependence was present in 6% (12% of men and <1% of women) and tobacco dependence in 17% of adults. A number of surveys (including national surveys) on drug use among school students and adolescents have been conducted on large samples (500 to 60 000 subjects). Between 22.5%-58.3% reported use of substances in the past month. Drug use by school children/adolescents was found to be associated with gender (male), age (older), socioeconomic status (low) and drug use by peers and family members (e.g. Berenzen et al, 1996; Rojas, 1998).

Moreno et al (1999) found depression in 35% of 246 elderly subjects (above 65 years) who were assessed with the General Health Questionnaire. Depression was associated with gender (female), marital status (widowed/divorced), socio-economic status (low), education (poor) and unemployment. Pando-Moreno et al (2001) found sleep disorders (as per DSM-IV) in 33.3% of elders living in the community. Borges et al (1996) analysed death certificates and census data, and found that the rate of suicide increased between 1970 (1.1 per 100 000) and 1994 (2.9 per 100 000), particularly among males and in young (below 19 years) and old (above 65 years) people. The highest suicide rate was in elderly males. Hijar et al (1996) reviewed the mortality database and found that suicides accounted for a greater proportion of deaths in 1993 in comparison to 1979. The main methods of committing suicide were hanging, use of firearms and explosives and poisoning. Mondragon et al (1998) reported that use of different methodologies and samples yielded variable rates of suicide attempts and suicidal ideation (highest rates were 10% and 40.7%, respectively).

Borges et al (2000) assessed 1094 adult patients in a general hospital. The lifetime prevalence of suicide attempts was 6.1%. Suicide attempts were associated with gender (female), marital status, age, depressed mood, hopelessness, alcohol use and psychopathology. Gonzalez-Forteza et al (2001) assessed 996 adolescents and found that the rate of sexual abuse, depression and suicide attempts in girls was 7%, 15% and 11%, respectively, and among boys 2%, 14% and 4%, respectively. Sexual abuse and depression were associated with suicide attempts. In a study on 4157 adolescents, Swanson et al (1992) reported that 39.4% had depression (Center for Epidemiologic Studies’ Depression Scale score >16) and 11.6% reported current suicidal ideation. Caraveo et al (1995) validated the Reporting Questionnaire for Children (RQC) during the National Mental Health Survey – 1988. Studies in children (sample size >1000) using the parent administered RQC showed that between 13.4% and 20.7% of children had mental disorders (Caraveo et al., 1995; Rico et al., 1998). Rate of mental disorders in children was associated with gender (male), age (above 7 years), birth order (>3) and family type (single parent family) (Rico et al., 1998).
MEXICO

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1983. The components of the policy are promotion, prevention, treatment and rehabilitation. It was revised in 2001 by a process that involved politicians, mental health professionals, NGOs, public servants and consumers. Between 25 to 50% of its original content was put into practice. A psychiatric reform will be launched following the model of Miguel Hidalgo. The National Council of Mental Health was established in 2004. The model contemplates the creation of structures based on the respect of the rights of the users and on provision of integrated medical/psychiatric care with quality and warmth. The model emphasizes community care in the form of preventive services (offered through health centres, health centres with mental health modules, mental health community centres and mental health integrated centres), short-term hospitalization (in psychiatric units in general hospitals, acute wards of psychiatric hospitals and new hospital structures (villas) being created) and social reintegration (half way houses, community housing, independent flats, residences for the elderly, sheltered workshops, mixed cooperatives, social clubs, etc.). Presently, this model is being implemented in 3 federal entities: Tamaulipas, Hidalgo and State of Mexico.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 2000. It has a specific budget for its implementation and 25 to 50% of its content has been implemented. The law on substance abuse currently in use was formulated in 1983. The National Council of Addictions was established in 1984 and upgraded to the level of Commission in 2000. It has the function of setting the policies and strategies on addiction, as well as setting up the National Programme against Addiction.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2001. The reform programme of the health sector 2001-2006 includes the establishment and implementation of the national mental health programme. The 2000-01 programme included the New Model of Care in Mental Health, which proposed broader options including health centres, community centres, half-way houses, community residences, etc. It also took into account the patient’s rights and focused on their social reinsertion. The programme implementation for the years 2001-2006 includes the prevention and control of depression, schizophrenia, epilepsy, dementia and attention deficit disorder. It has been implemented to the extent of 10 to 25% by local, regional and national authorities. Its main components are strategy of services reform, promotion and prevention, integration of mental health services in primary care and development of specialized services. The various provinces/regions have different mental health programmes currently in place.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1970.

Mental Health Legislation The most recent legislation in the area was a chapter about mental health in the general health legislation. It was revised in 2000. Regular funds are available for its implementation and it has been implemented to the extent of 75% to 90%. Promotion, prevention, users’ rights, involuntary treatment, mental health services regulation, human rights and advocacy are some of its components. However, it lacks regulations on housing for mentally ill people. Under its provisions, about 50% of total admissions for treatment are involuntary. The latest legislation was enacted in 1983.

Mental Health Financing There are budget allocations for mental health. The country spends 1% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, social insurance and private insurances. The amount spent on mental health is assigned exclusively to the mental health services and the seven units depending on it. The psychiatric units of the decentralized institutions have their own budgets. In addition, there are two systems of social security (IMSS and ISSSTE) and Ministry of Health supports those who do not have social security. The country has disability benefits for persons with mental disorders. Disability benefits are included in the New Law of the Mexican Institute of Social Security (IMSS) and the Law of the Institute of State Workers Security and Social Services (ISSSTE). Benefits are available for severe disorders, but the process of documenting the disability is complicated and often difficult to obtain. Further, disability benefits are available only for those covered by social security (less than 10% of the population).

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. Human resources are limited and cannot fulfil the demands of mental health. Less than 25% of the population is covered by this kind of service and they are usually provided by primary health care doctors. Treatment for severe disorders is limited at the primary care level. A system of referral is in place. Regular training of primary care professionals is carried out in the field of mental health. There is a major movement towards decentralization that is likely to lead to educational programmes for the health staff, close contact with the communities and the inclusion of mental health programmes and activities at primary health care services. There are community care facilities for patients with mental disorders. The community based care system is mainly provided through outpatient clinics and includes prevention and promotion interventions, residential facilities and vocational training.
Psychiatric Beds and Professionals

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>0.667</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>0.51</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.051</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td></td>
</tr>
<tr>
<td>Number of psychiatrists per 100,000 population</td>
<td>2.7</td>
</tr>
<tr>
<td>Number of neurosurgeons per 100,000 population</td>
<td>1.5</td>
</tr>
<tr>
<td>Number of psychiatric nurses per 100,000 population</td>
<td>0.1</td>
</tr>
<tr>
<td>Number of neurologists per 100,000 population</td>
<td>1.2</td>
</tr>
<tr>
<td>Number of psychologists per 100,000 population</td>
<td>0.2</td>
</tr>
<tr>
<td>Number of social workers per 100,000 population</td>
<td>0.2</td>
</tr>
</tbody>
</table>

There are 2920 other mental health workers. There are 45,629 psychologists working under the Department of Health and related Ministries. Most public specialist mental health services are in big cities. There are few private psychiatric hospitals but recently services for drug abuse patients have increased. 28% of these beds are occupied by long stay patients. Only about 33% of psychiatrists work in public institutions.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Joint collaboration, as well as counselling in the implementation of the New Model of Mental Health Care is done with the NGOs. They participate in psychosocial and pharmacological interventions related to women, children, drug addiction, domestic violence and consumers. It is estimated that they are responsible for 25% of the promotion, prevention and advocacy activities that are carried out in Mexico.

Information Gathering System

There is mental health reporting system in the country. Mental disorders of discharged hospital patients are reported in the annual statistics of the Health Ministry. ICD 10 is used for recording purposes. The country has data collection system or epidemiological study on mental health. The ‘Dirección General de Estatística e Informática’ is in charge of the data collection system for mental disorders. Data collection is done only for part of the health system (public institutions).

Programmes for Special Population

The country has specific programmes for mental health for refugees, disaster affected population, indigenous population, elderly and children. There are facilities for victims of domestic violence. Also, there are programmes for women, children in vulnerable situation and domestic violence. They have the participation of national organizations.

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 2000. All the drugs are in the essential list and hence should be available always, but that is not so, especially in the rural areas. Some prices are subsided in some regions.

Other Information

There are two essential developments in mental health services. First, the establishment in 1997 of the Mental Health Services, formerly the Mental Health Coordination, as a decentralized institution, in order to set up, organize, supervise and evaluate the development of activities related to health care services, as well as improving psychiatric and mental health services in the country. Second, the setting up and implementation of the New Model of Mental Health Care, which is the beginning of the restructuring of the mental health care systems in Mexico.
Additional Sources of Information


Ley General de Salud. Titulo Decimosegundo, Control sanitario de productos y servicios y de su importacion y exportacion chp.6

Ley General de Salud. Titulo Primero, Disposiciones generales.

Ley General de Salud. Titulo Tercero, Prestacion de los servicios de salud.

Ley General de Salud. Titulo Decimoprimer, Programa contra las adicciones.


Secretaria de Salud (2000). Chapter 4 Sistemas de Informacion. Sistema de vigilancia epidemiologica de las adicciones, terminologia y clasificacion, Direccion General de Epidemiologia, Secretaria de Salud, Mexico.


Micronesia, Federated States of

GENERAL INFORMATION
Micronesia, Federated States of is a country with an approximate area of 0.7 thousand sq. km. (UNO, 2001). The country consists of four major island groups with more than 600 islands. Its population is 0.111 million, and the sex ratio (men per hundred women) is 102 (UNO, 2004). The proportion of population under the age of 15 years is 38% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 91% for men and 88% for women (UNESCO/MoH, 2004). The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.8%. The per capita total expenditure on health is 319 international $, and the per capita government expenditure on health is 230 international $ (WHO, 2004).

The main language(s) used in the country is (are) English and Micronesian languages (e.g. Chuukese, Pohnpeian, Yapese, Kosraean). The largest ethnic group(s) is (are) Micronesian (Chuukese/Mortlockese, Yapese, Outer Island Yapese, Pohnpeian and Kosraean), and the other ethnic group(s) are (is) Chinese, Caucasian and Filipino. The largest religious group(s) is (are) Roman Catholic (more than half of the population), and the other religious group(s) are (is) Protestant (about two-fifths).

The life expectancy at birth is 64.9 years for males and 68.1 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 58 years for females (WHO, 2004).

EPIDEMIOLOGY
Waldo (1999) studied schizophrenia in one island of Micronesia and found 22 patients giving a prevalence rate of 6.8/1000 and a male to female ratio of 6.3:1. Although the profile was similar to that found in western societies, the majority of the patients were episodically mute, especially when untreated or inadequately treated. Rubinstein (1983) reported that suicide rates had increased substantially in Micronesia among the post-war cohort, especially among the young adults. The authors inferred that gradual dissolution of social cohesiveness due to break-up of village and communal lineage-houses was the reason for such an increase. Allan and Hunter (1985) commented on regional variations in rates of occurrence of disorders, manifestation of symptoms, demographic characteristics and referral patterns and their relationship to social and cultural factors.

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 and treatment.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1989.

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

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

Mental Health Legislation Details about existing mental health legislation are not available. However, there is a tobacco law. All four states of Micronesia have passed the law making it illegal to sell tobacco to minors. This was formulated in 1994. 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 7.3% of the total health budget on mental health. The primary sources of mental health financing in descending order are grants, social insurance, out of pocket expenditure by the patient or family and tax based. A small amount ($14 000.00) is allotted to purchase medication for the mental health patients each year. The country has disability benefits for persons with mental disorders. Mentally ill children of a state/federation employee are provided with a small benefit of $50 if the parent dies.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 21 personnel were provided training. The Hawaii State Hospital is the primary site for teaching clinical psychiatry to the Pacific Basin Medical Officer Training Program. Transcultural issues are discussed. There are community care facilities for patients with mental disorders. CMHS supports the activities on mental health issues.
Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population 0.7
Psychiatric beds in mental hospitals per 10 000 population 0
Psychiatric beds in general hospitals per 10 000 population 0.7
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 0
Number of neurosurgeons per 100 000 population 0
Number of psychiatric nurses per 100 000 population 0
Number of neurologists per 100 000 population 0
Number of psychologists per 100 000 population 0
Number of social workers per 100 000 population 4

There is 1 occupational therapist, 4 hospital administrators, 5 medical assistants, 12 medical officers and 4 other kind of staff. The Government is considering the deployment of social workers as counsellors.

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. Quarterly and annual reports are made. The country has data collection system or epidemiological study on mental health. There is a mental health information system. This uses EPI and epidemiological surveillance system called MHIS.

Programmes for Special Population The country has specific programmes for mental health for minorities, disaster affected population, indigenous population, elderly and children. The whole population is composed of minorities and indigenous people (as per SAMHSA definitions).

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

Other Information Outreach service is hindered by the distances between the islands. The field trip ship runs about once every three months. Small planes can fly only to one island (once a week) with an airfield. Motor boats are used to extend the services.

Additional Sources of Information
Monaco

GENERAL INFORMATION
Monaco is a country with an approximate area of 0.002 thousand sq. km. (UNO, 2001). Its population is 0.032 million, and the sex ratio (men per hundred women) is 94 (UNO, 2004). The proportion of population under the age of 15 years is 13% (UNO, 2004), and the proportion of population above the age of 60 years is 20% (WHO, 2004).
The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.6%. The per capita total expenditure on health is 2016 international $, and the per capita government expenditure on health is 1131 international $ (WHO, 2004).
The main language(s) used in the country is (are) French. The largest ethnic group(s) is (are) French. The largest religious group(s) is (are) Monegasque Christian, and the other religious group(s) are (is) Roman Catholic.
The life expectancy at birth is 77.8 years for males and 84.5 years for females (WHO, 2004). The healthy life expectancy at birth is 71 years for males and 75 years for females (WHO, 2004).

EPIDEMIOLOGY
There is substantial epidemiological data on mental illnesses in Monaco 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. Details about the year of formulation are not available.

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

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

Mental Health Legislation The Law No 1039 of 1981 concerning the placement and protection of the mentally ill. The latest legislation was enacted in 1981.

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 social insurance. The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Details about training facilities are not available. There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals
Total psychiatric beds per 10 000 population 17.27
Psychiatric beds in mental hospitals per 10 000 population 0
Psychiatric beds in general hospitals per 10 000 population 17.27
Psychiatric beds in other settings per 10 000 population 0
Number of psychiatrists per 100 000 population 28.5
Number of psychiatric nurses per 100 000 population 0
Number of neurologists per 100 000 population 6
Number of psychologists per 100 000 population 33
Number of social workers per 100 000 population 81

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

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

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, lithium, biperiden, carbidopa, levodopa.
Phenytoin and Haloperidol are only for hospitals.
Other Information

Additional Sources of Information
Mongolia

GENERAL INFORMATION
Mongolia is a country with an approximate area of 1567 thousand sq. km. (UNO, 2001). Its population is 2.63 million, and the sex ratio (men per hundred women) is 100 (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 6% (WHO, 2004). The literacy rate is 98% for men and 97.5% 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 6.4%. The per capita total expenditure on health is 122 international $, and the per capita government expenditure on health is 88 international $ (WHO, 2004).

The main language(s) used in the country is (are) Mongolian. The largest ethnic group(s) is (are) Mongolian (Khalkh Mongol, four-fifths of the population), and the other ethnic group(s) are (is) Kazakh, Tuvin, Uzbek, Russian and Chinese. The largest religious group(s) is (are) Buddhist.

The life expectancy at birth is 60.1 years for males and 65.9 years for females (WHO, 2004). The healthy life expectancy at birth is 53 years for males and 58 years for females (WHO, 2004).

EPIEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Mongolia in internationally accessible literature. Dorjjadamba (1970) reported that historical cultural background, geographical environment and custom of ethnic groups were closely related to mental health including the rate, type and presentation of mental disorders. According to the results of epidemiological survey conducted in 1976-1984, the prevalence of major mental disorder ranged from 1.0% to 2.4% in different regions (Tsetsegdary, 2004). A study conducted in 2002-2003 showed a three-fold increase in rate of suicide over a decade (1992-2002), with figures for 2002 being 36 cases per 100 000 people. The prevalence of schizophrenia was 0.1% (Tsetsegdary, 2004).

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is absent. But the State Policy on Public Health adopted by the Parliament in 2001 included some statements on mental health.

Substance Abuse Policy A substance abuse policy is absent. The State Policy on Public Health adopted by the Parliament in 2001 also included some statements on substance abuse policy. There are laws on fighting against harm related to alcohol (1994 & 2000), tobacco (1993/under revision) and a Law on Control of Tracking in Narcotic Drugs and Psychotropic Substances (2002). There is also the National Programme on Prevention of Narcotics and Drug Abuse (2000) and Alcohol Prevention and Control (2003).

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2002. The programme emphasized mental health promotion, community mental health care, accessibility to care and intersectoral collaboration.

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

Mental Health Legislation The Law of Mongolia on Mental Health emphasized mental health promotion, community mental health care, accessibility to care, rights of mentally ill persons and their legal representatives, forced hospitalization, provision of security and social welfare assistance for mentally ill persons and intersectoral collaboration.

The latest legislation was enacted in 2000.

Mental Health Financing There are budget allocations for mental health. The country spends 5% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based and social insurance. Nearly 90% of total budget allocated from the State for the treatment, rehabilitation and social care of people with mental disorders is spent to cover hospital expenditures and for providing inpatient and outpatient mental health care. Three-fourths of the population is covered by health insurance. The country has disability benefits for persons with mental disorders. Disability benefits are provided according to the Law on Social Welfare adopted in 1998.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 350 personnel were provided training. WHO has assisted in the training of trainers, and translated training materials are available. Every province was covered. Almost 45% of general physicians and 3% of primary health workers have been trained. An evaluation of this programme has been carried out in 1999. Training on management of mental health issues during disasters was provided to family doctors, social welfare workers, Red Cross personnel, police and local administrators in provinces affected by dzud (winter natural disaster). There are community care facilities for patients with mental disorders. In the community drugs are provided free of cost, psychosocial rehabilitation welfare service towards children with mental retardation is also present. There are seven day care centres and
about 12 residential (tent based) programmes that carry out occupational rehabilitation. There is a plan to start a sheltered workshop in the community.

**Psychiatric Beds and Professionals**

<table>
<thead>
<tr>
<th>Type of Bed</th>
<th>Per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds</td>
<td>2.4</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>1.7</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</td>
<td>3.3</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>0.4</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>4.4</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>7</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>6</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>3</td>
</tr>
</tbody>
</table>

Psychologists and social workers are trained by state pedagogical institutes and work in social welfare organizations. There are 21 general hospital psychiatric units with 5 to 15 beds, each. Some beds in the psychiatry hospitals are earmarked for children. Forensic psychiatric services are available at the State Psychiatric hospital at Ulaanbaatar. About 50 beds for voluntary and 160 beds for involuntary (Under the Ministry of Justice) treatment of alcohol misuse are available. Designated psychiatrists have 4-6 months of on the job training in psychiatry in their internship. Postgraduate psychiatric education includes residential training (1-2 years), Master’s degree course (2 years), Refresher training course (2-3 month), PhD (3 years) and Scientific degree – Dr. Sc. Med. The Health Law of 1998 includes provisions related to the licensing of medical practitioners and the accreditation of health institutions.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and rehabilitation. The WHO initiated the formation of the Mongolian Mental Health Association (with psychiatrists, volunteers and representatives from other NGOs as members), which is active in promoting mental health public education and community care and rehabilitation. American, Belgian and Dutch NGOs and the Asian Development Bank have helped with equipment, funds and training of primary health care staff.

**Information Gathering System** There is mental health reporting system in the country. Details are available from the Health Statistics office of Directorate Medical Service under the Ministry of Health, and Statistics Unit of Mental Health and Narcology Center.

The country has data collection system or epidemiological study on mental health. It was established with the support of WHO. A mental health database has been established with the help of WHO.

**Programmes for Special Population** The country has specific programmes for mental health for minorities, disaster affected population, elderly and children. There are Government programmes on elderly and adolescent health and on disaster management. The Ministry of Health and the Ministry of Education, Culture and Science are introducing the concept of life skills education at the secondary school level. Teachers, school doctors and social workers are being trained to implement a school mental health programme. Telephone counselling services for adolescents have been set up in two provinces and three districts of Ulaanbaatar with the aid of WHO. A school for the intellectually disabled has been set up at the State Psychiatric Hospital with the help of the ADRA (the Adventist Development Relief Agency). UNICEF is providing psychosocial support to children in areas affected by dzud (winter natural disaster) in 4 provinces. A network of sobering stations function under the charge of the Ministry of the Interior (Police).

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

The fourth revision was made in 2000. Information on availability of drugs is from the Mongolian Government drug supply company ‘Mongol Em Impex’and Drug Information Center of the Directorate Medical Service, Ministry of Health.

**Other Information** Ensuring adequate health services throughout a sparsely populated (1.5 inhabitants per sq. km.) terrain with extremes in climate is a challenging task to the health system, particularly because one-fifth of the populace leads a nomadic life.

**Additional Sources of Information**


Morocco

GENERAL INFORMATION

Morocco is a country with an approximate area of 447 thousand sq. km. (UNO, 2001). Its population is 31.064 million, and the sex ratio (men per hundred women) is 100 (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 63.3% for men and 38.3% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.1%. The per capita total expenditure on health is 199 international $, and the per capita government expenditure on health is 78 international $ (WHO, 2004).

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

The life expectancy at birth is 68.8 years for males and 72.8 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 61 years for females (WHO, 2004).

EPIDEMIOLOGY

A WHO assisted study on prevalence of mental disorders has been conducted on representative samples (n=6000) from many regions of the country using the Mini International Neuropsychiatry Interview (MINI), and the results are being compiled. Data is regularly collected from public psychiatric institutions. In 2002, among outpatients (n=1 504 508), 34% had schizophrenia, 25.1% had mood disorders, 16.7% had neuroses and 1.8% had alcohol and drug use disorders. Among inpatients (n=15 398) 65.2% had schizophrenia, 11.9% had mood disorders, 2.5% had neuroses and 5.1% had alcohol and drug use disorders (Ministry of Health, 2004). Kadri et al (2002) used DSM-IV criteria to assess sexual dysfunction in a representative sample of the population of women aged 20 and older in one city (n=728).

The 6-month prevalence was 26.6% with dysfunctions of sexual arousal as the commonest disorder. Age, financial dependency, number of children and sexual harassment were positively associated with presence of sexual disorder. Ghazal et al (2001) evaluated a randomly selected and representative sample of students attending six secondary schools (n=1887) and a second group composed of students of the French secondary school (n=157). Subjects completed a sociodemographic questionnaire and the Bulimic Investigatory Test of Edinburgh (BITE). In the first group, 15.3% of subjects took at least one substance, 12.7% were dependent on tobacco and 5.7% consumed alcohol occasionally. Almost a sixth of students reported a familial history of disturbed eating behaviour. The overall prevalence of bulimia in this group was 0.8% (1.2% in female and 0.1% in male subjects). The mean age of bulimic subjects was 18.6 years. In the group from the French school, the prevalence of bulimia was 1.9% in the whole sample (3.4% among girls and no case among boys). Bulimic subjects did not differ from the non bulimic subjects with regard to sociodemographic characteristics. Kadri et al (2000) assessed 100 adult males for two consecutive years over a 6-week period during Ramadan with clinical interviews, visual analog scales and the Hamilton Anxiety Scale. Smokers were significantly more irritable than non-smokers before the beginning of Ramadan. An increase in irritability was noted in both groups during Ramadan, but irritability increased more in smokers than in non-smokers. Taoudi Benchekroun et al (1999) reported that during Ramadan the sleep chronotype as evaluated by the Horne and Ostberg scale changed significantly with an increase of the evening type and a decrease in the morning type. Daytime sleepiness as evaluated by the Epworth Sleepiness Scale was significantly increased.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1972. The components of the policy are promotion, prevention, treatment and rehabilitation. Decentralization is also a component of the policy. Since 1972, the mental health policy has been reviewed several times with the help of the ‘Moroccan Society of Psychiatry’. The legislation on mental health, which was formulated in 1959 by ‘Dahir’, is the highest legislation form in the country.

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

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1973. The mental health programme has been revised in 1992 and 1995. The programme was formulated according to the ‘Dahir’. The programme has been reviewed several times.

National Therapeutic Drug Policy/essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1972.

The list is revised each year. The last review was in 2000. New as well as old drugs (neuroleptics, anti-depressants, mood-regulators) are on the list.

Mental Health Legislation The Dahir 1-58-295 relating to the prevention of mental illnesses and protection of the patients is the latest mental health legislation. Though it is old, its articles are well formulated and were examined by WHO experts in 1998. Reviews may be done in the future. The main aim is to guarantee the medical characteristics of mental institutions by entrusting them with the prime mission of treating the sick while protecting their rights and their property during their period of illness. The Law created the Central Service for Mental Health and Degenerative Diseases and the Mental Health Committee, organized mental institutions and other psychiatric set-ups and specified different manners of patient admission and discharge among its many other laws, as well as the modalities of protection of the sick and of its material owns.

The latest legislation was enacted in 1959.
**Mental Health Financing** There are budget allocations for mental health. Details about expenditure on mental health are not available. The primary sources of mental health financing in descending order are tax based, social insurance, out of pocket expenditure by the patient or family and private insurances. Each state has its own budget line specified for equipment and investment work in hospitals at regional levels. The country has disability benefits for persons with mental disorders. Those who become handicapped or lose their autonomy benefit from the system in the form of paid sick leave plus disability card if the disability is definite. Common diseases are supported like other illnesses.

**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. Outpatient clinics are integrated to some extent into the primary health care system. Two hundred health centres spread over the country offer mental health services within primary health care. Regular training of primary care professionals is carried out in the field of mental health. Training on primary mental health care is integrated in basic academic courses of general physicians, in faculties of medicine and in the institutes of health works (Instituts de Formation en Carrières de Santé: IFCS). There are community care facilities for patients with mental disorders. The community programme includes the family which plays an important role in the therapeutic programme.

**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>0.783</td>
</tr>
<tr>
<td>Psychiatric beds in mental hospitals</td>
<td>0.52</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>0.17</td>
</tr>
<tr>
<td>Psychiatric beds in other settings</td>
<td>0.1</td>
</tr>
<tr>
<td>Number of psychiatrists</td>
<td>0.4</td>
</tr>
<tr>
<td>Number of neurosurgeons</td>
<td>0.12</td>
</tr>
<tr>
<td>Number of psychiatric nurses</td>
<td>2.2</td>
</tr>
<tr>
<td>Number of neurologists</td>
<td>0.3</td>
</tr>
<tr>
<td>Number of psychologists</td>
<td>0.03</td>
</tr>
<tr>
<td>Number of social workers</td>
<td>0.007</td>
</tr>
</tbody>
</table>

The condition is unsatisfactory, especially in public sector; e.g. occupational therapy is provided by psychiatrists, nurses and social workers.

**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. The country has data collection system or epidemiological study on mental health. Several specific studies were conducted by the main psychiatric university centers like Ibn Rochd (Casablanca) and Ar-Razi (Rabat-Salé). An exhaustive list of studies and results is available from the Ministry of Health.

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

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

Other drugs are available in the primary health centres.

**Other Information** There has been a psychiatric tradition in Morocco since the Middle ages – ‘The Moristanes’ (health care places for the mentally ill) were psychiatric hospital precursors of public sector. Then, two Psychiatric University Centres came up in Salé in the 1960s and in Casblanca in the 1970s. Recently, two university centers were created in Marrakesh and in Fès. According to mental health policy of the Ministry of Health, several mental health services are being created each year in the general hospitals. The goal is to have sectorized coverage of mental needs of the population in the entire country.

**Additional Sources of Information**

Des organismes chargés de la prevention et du traitement des maladies mentales et de la protection des malades mentaux (Government document).


Mozambique

GENERAL INFORMATION
Mozambique is a country with an approximate area of 802 thousand sq. km. (UNO, 2001). Its population is 19.183 million, and the sex ratio (men per hundred women) is 93 (UNO, 2004). The proportion of population under the age of 15 years is 44% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 62.3% for men and 31.4% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.9%. The per capita total expenditure on health is 47 international $, and the per capita government expenditure on health is 32 international $ (WHO, 2004).

The main language(s) used in the country is (are) Portuguese (official), Emakua, Xichangana and Elomwé. The largest ethnic group(s) is (are) African. The largest religious group(s) is (are) Roman Catholic, and the other religious group(s) are (is) Muslim and indigenous groups.

The life expectancy at birth is 41.2 years for males and 43.9 years for females (WHO, 2004). The healthy life expectancy at birth is 36 years for males and 38 years for females (WHO, 2004).

EPIDEMIOLOGY
There is a paucity of epidemiological data on mental illnesses in Mozambique in internationally accessible literature. In 2003, the Ministry of Health conducted a mental health community study in an urban and a rural district. The prevalence of psychoses, mental retardation and epilepsy in the urban area were 1.5%, 1.1% and 1.3%, while the prevalence of these disorders in the rural area were 5%, 1.8% and 3.9%, respectively. Rural-urban differences were highly significant (MoH, 2002-2003). Granja et al (2002) conducted a retrospective hospital-based study on deaths from injuries among pregnant/postpartum women (n=27) and found that suicide was the cause in one-third of cases.

MENTAL HEALTH RESOURCES
Mental Health Policy A mental health policy is absent. The final draft is now ready and is awaiting approval.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1997. The policy is to be reviewed every two years.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1990. The draft National Mental Health Strategic Plan is likely to be approved in 2004.

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 Specific legislation on mental health is not available. However, Law No 1/99 (formulated in 1999) controls and regulates access of youngsters to the night clubs as well as projection of certain videos and also controls the sale of alcohol and tobacco.

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 source of mental health financing is tax based. The state budget as well as funds from different partners are allocated to the health sector as a whole and re-distributed through different programmes. The specific amount for mental health is determined according the national yearly plans and priorities, which often vary.

The country has disability benefits for persons with mental disorders. Disability benefits are provided for persons with chronic mental disorders, such as epilepsy and psychosis by the National Institute of Social Welfare. Patients with chronic mental illness are also given a discount on their medical prescription.

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. Few health centres have outpatient facilities.

Regular training of primary care professionals is not carried out in the field of mental health. Seminars are organized from time to time to train health workers in mental health.

There are community care facilities for patients with mental disorders. Few such centres exist.
Psychiatric Beds and Professionals

| Total psychiatric beds per 10 000 population | 0.23 |
| Psychiatric beds in mental hospitals per 10 000 population | 0.2 |
| Psychiatric beds in general hospitals per 10 000 population | 0.04 |
| Psychiatric beds in other settings per 10 000 population | 0.01 |
| Number of psychiatrists per 100 000 population | 0.04 |
| 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 | 0.01 |
| Number of psychologists per 100 000 population | 0.05 |
| Number of social workers per 100 000 population | 0.01 |

Each province has at least 2 mental health professionals. Since May 2004, three newly trained Mozambican psychiatrists have joined the workforce; the remaining 7 are foreigners. Twenty-seven psychiatric technicians are now working in the health system. It is expected that by September 2005 the number will increase to 58 (31 technicians are under training). There is one psychiatric hospital in the country located in Maputo City, the nation’s capital, with a bed capacity of 260. The second psychiatric hospital located in the northern province of Nampula was closed as it did not offer minimal conditions for service delivery, and a Mental Health Community Centre was opened in its place. Service delivery (outpatient and inpatient care) primarily occurs at the provincial hospital level. Admissions are also made in general medicine wards, where approximately 3 to 5 beds are allocated to mental health.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in promotion, prevention and rehabilitation. Some NGOs focus on rehabilitation of drug abusers.

Information Gathering System There is mental health reporting system in the country. New indicators for mental health reporting system in the country have been approved; they are introduced in the General Health Information System. The country has data collection system or epidemiological study on mental health. Data collecting systems are being tested, statistical information on patients are being collected.

Programmes for Special Population A school for mentally challenged children exists. Efforts are now being made to mainstream the education of such 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, biperiden, levodopa. The essential drug list is under revision. Inclusion of newer (more effective) drugs has been proposed. The final list and new policy might be approved in early 2005.

Other Information WHO has undertaken a project in Cuamba district to integrate mental health into general health care at the primary level. Special emphasis is given to psychosocial support in collaboration with traditional healers. WHO has also assisted the Ministry of Health in drafting a mental health policy and updating the mental health programme. This programme would also be used in building the capacity of mental health professionals to provide community-based care.

Additional Sources of Information

Essential Drug List. (Government document).
GENERAL INFORMATION
Myanmar is a country with an approximate area of 677 thousand sq. km. (UNO, 2001). Its population is 50.101 million, and the sex ratio (men per hundred women) is 98 (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 89.2% for men and 81.4% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 2.1%. The per capita total expenditure on health is 26 international $, and the per capita government expenditure on health is 5 international $ (WHO, 2004).

The main language(s) used in the country is (are) Burmese. The largest ethnic group(s) is (are) Kachin, and the other ethnic group(s) are (is) Kayah, Kayin, Chin, Mon, Bamar, Rakhine and Shan. The largest religious group(s) is (are) Buddhist (nine-tenths), and the other religious group(s) are (is) Christian, Muslim, Hindu and indigenous groups.

The life expectancy at birth is 56.2 years for males and 61.8 years for females (WHO, 2004). The healthy life expectancy at birth is 50 years for males and 54 years for females (WHO, 2004).

EPIDEMIOLOGY
A community survey done in an urban area (n=915) showed that 8.6% of the population had psychiatric morbidity (Tin Nyunt Pu et al, 1976). Another survey in a sub-urban area (459 households were covered) revealed psychiatric morbidity in 5.6% of residents, with the prevalence of psychoses being 0.05%, mental retardation 0.4% and epilepsy 0.4% (Thane Htay Pe et al, 1982). A recent survey in an urban area (861 households, n=5106) showed that 8.6% of the population had mental disorders, with the prevalence rate of psychoses being 0.6%, epilepsy 0.4%, mental retardation (moderate and severe) 0.5%, alcohol use disorders 2.3% (7% in males over 18 years of age) and dementia (moderate and severe) in about 2.5% of those over 65 years of age. A similar survey in a rural area (225 households, n=1000) showed that 7.7% of the population had mental disorders, with the prevalence rate of psychoses being 0.6%, epilepsy 0.2%, mental retardation (moderate and severe) 0.1%, alcohol use disorders 2.3% (7% in males over 18 years of age) and dementia (moderate and severe) in about 3.5% of those over 65 years of age (Win Aung Myint et al, 2004).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1990. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Community integration is also a component of the mental health policy.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1993. The Narcotic Drug and Psychotropic Substances Law aims to prevent the danger of narcotic drugs and psychotropic substances, to implement the provisions of the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, to carry out more effective measures for imparting knowledge and education on the danger of these substances and for medical treatment and rehabilitation of drug users, to impose more effective penalties for offenders and to cooperate with state parties and other international organizations in respect of the prevention of the danger of narcotic drugs and psychotropic substances.

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

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 There is a Lunacy Act from 1912. A mental health act had been proposed in 1994. The latest legislation was enacted in 1912.

Mental Health Financing There are budget allocations for mental health. The country spends 1.3% 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. Any Government employee who is mentally ill and has a poor prospect of recovery is recommended for invalidation.

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. Consultant psychiatrists are posted in different states and divisions and patients are referred to them. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 2000 personnel were provided training. Consultants train medical officers and primary care workers about mental health illnesses and means of treating them. There are community care facilities for patients with mental disorders.
**Psychiatric Beds and Professionals**

- Total psychiatric beds per 10,000 population: 0.55
- Psychiatric beds in mental hospitals per 10,000 population: 0.33
- Psychiatric beds in general hospitals per 10,000 population: 0.11
- Psychiatric beds in other settings per 10,000 population: 0.11
- 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: 0.6
- Number of neurologists per 100,000 population: 0.02
- Number of psychologists per 100,000 population: 0.01
- Number of social workers per 100,000 population: 0.3

There are two occupational therapists and medical assistants.

**Non-Governmental Organizations** NGOs are involved with mental health in the country. They are mainly involved in promotion, prevention and rehabilitation. In line with the National Health Policy, NGOs such as Myanmar Maternal and Child Welfare Association and Myanmar Red Cross Society also take a share of service provision. Their role is becoming more important as the needs of collaborative actions for health become more prominent.

**Information Gathering System** There is mental health reporting system in the country. Mental illnesses are included in health management information system.

The country has data collection system or epidemiological study on mental health. Necessary training and educational material was given to primary care workers for data collection.

**Programmes for Special Population** The country has specific programmes for mental health for minorities, disaster affected population, indigenous population, elderly and children. Child Guidance Clinics and Geriatric Care Clinics are conducted twice a week.

**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.

**Other Information**

**Additional Sources of Information**

- The State Law and Order Restoration Council (1993): Narcotic Drugs and Psychotropic Substances Law.