

Saint Kitts and Nevis*

GENERAL INFORMATION

Saint Kitts and Nevis is a country with an approximate area of 0.36 thousand sq. km. (UNO, 2001). Its population is 0.046 million, and the sex ratio (men per hundred women) is 99 (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 10% (WHO, 2004). The literacy rate is 97% for men and 98% 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 4.8%. The per capita total expenditure on health is 576 international \$, and the per capita government expenditure on health is 382 international \$ (WHO, 2004).

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

The life expectancy at birth is 68.7 years for males and 72.2 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 63 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Saint Kitts and Nevis in internationally accessible literature.

MENTAL HEALTH RESOURCES

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

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

National Mental Health Programme Details about the national mental health programme are not available.

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 Details about the mental health legislation are not available.

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

Details about expenditure on mental health are not available.

Details about sources of financing are not available.

Details about disability benefits for mental health are not available.

Mental Health Facilities Details about mental health facilities at the primary care level are not available.

Details about training facilities are not available.

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

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population

Psychiatric beds in mental hospitals per 10 000 population

Psychiatric beds in general hospitals per 10 000 population

Psychiatric beds in other settings per 10 000 population

Number of psychiatrists per 100 000 population

Number of neurosurgeons per 100 000 population

Number of psychiatric nurses per 100 000 population

Number of neurologists per 100 000 population

Number of psychologists per 100 000 population

Number of social workers per 100 000 population

In the past, patients were kept in geriatric homes. Nowadays, the mentally ill patients receive treatment through a seven bedded psychiatric unit and a network of health centres scattered all over the islands.

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.

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

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

Other Information * The verification of this country profile is still being awaited from the Ministry of Health of Saint Kitts and Nevis.

Additional Sources of Information

Saint Lucia

GENERAL INFORMATION

Saint Lucia is a country with an approximate area of 0.62 thousand sq. km. (UNO, 2001). Its population is 0.15 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 8% (WHO, 2004). The literacy rate is 65% for men and 69% 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 4.5%. The per capita total expenditure on health is 272 international \$, and the per capita government expenditure on health is 176 international \$ (WHO, 2004).

The main language(s) used in the country is (are) English and Patois. The largest ethnic group(s) is (are) African. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 69.8 years for males and 74.4 years for females (WHO, 2004). The healthy life expectancy at birth is 61 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Saint Lucia in internationally accessible literature. Perks and Jameson (1999) assessed 60 students using the teacher-rated Revised Behaviour Problem Checklist (RBPC) and the self-rated Reynolds Child Depression Scale (RCDS) or the Reynolds Adolescent Depression Scale (RADS). Students whose parents were experiencing violent marital discord had significantly greater depression and behavioural problems. Exposed children exhibited more behavioural problems but less depressive symptomatology than adolescents.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

A mental health policy is presently being developed by the Ministry of Health.

Substance Abuse Policy A substance abuse policy is absent.

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

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

Mental Health Legislation The Mental Hospital Act is the latest legislation on mental health. The latest legislation was enacted in 1957.

Mental Health Financing There are budget allocations for mental health.

The country spends 4% 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. Benefits are given on a case by case basis.

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. Cases are referred to the mental health clinics.

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. Community mental health services are provided through four health centres. The Government of St Lucia has recently signed a tripartite agreement with the Pan American Health

Organization and the UK based AMKAM Foundation to strengthen community mental health services in on the western part of the island.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	10.7
Psychiatric beds in mental hospitals per 10 000 population	10.7
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	1.9
Number of neurosurgeons per 100 000 population	
Number of psychiatric nurses per 100 000 population	2.6
Number of neurologists per 100 000 population	
Number of psychologists per 100 000 population	0
Number of social workers per 100 000 population	0.7

Mental health services are provided at the Golden Hope Hospital (Mental Health Facility) in the north of the island and at St Jude Hospital (General Hospital) in the south of the island. The services at the Golden Hope Hospital comprise clinical services inclusive of referral and intervention, assessment, domiciliary treatment and outpatient services. The adjunctive services include psychotherapy and occupational therapy. A drug rehabilitation centre provides specialized services. There are two consultant psychiatrists at the mental health facility who are responsible for the clinical services. There is one psychiatric nurse, nine registered nurses, seven nursing assistants and two occupational therapists at the facility. A consultant psychiatrist provides psychiatric services in the south of the island.

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

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

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

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

Other Information

Additional Sources of Information

Jameson, M., Perks, S. M. (1999) The effects of witnessing domestic violence on behavioural problems and depressive symptomatology. A community sample of pupils from Saint Lucia. *West Indian Medical Journal*, 48, 208-11.

Perks, S. M., Jameson, M. (1999) The effects of witnessing domestic violence on behavioural problems and depressive symptomatology. A community sample of pupils from St Lucia. *West Indian Medical Journal*, 48, 208-211.

Saint Vincent and the Grenadines

GENERAL INFORMATION

Saint Vincent and the Grenadines is a country with an approximate area of 0.39 thousand sq. km. (UNO, 2001). Its population is 0.121 million, and the sex ratio (men per hundred women) is 101 (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 9% (WHO, 2004). The literacy rate is 96% for men and 96% 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 358 international \$, and the per capita government expenditure on health is 227 international \$ (WHO, 2004).

The main language(s) used in the country is (are) English and French. The largest ethnic group(s) is (are) African, and the other ethnic group(s) are (is) European, East Indian and Carib Indian. The largest religious group(s) is (are) Anglican, and the other religious group(s) are (is) Methodist and Roman Catholic.

The life expectancy at birth is 67.8 years for males and 71.9 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Saint Vincent and the Grenadines in internationally accessible literature.

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, prevention, treatment and rehabilitation.

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

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2000. The mental health programme is reviewed and updated every year.

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 an Act (No. 56), which is related to mental health.

The latest legislation was enacted in 1989.

Mental Health Financing There are budget allocations for mental health.

The country spends 4.6% 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. Patients suffering from severe mental illnesses receive public disability benefits.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. District medical officers are trained to handle mental health issues and are experienced in administering psychotropic medication.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 25 personnel were provided training.

There are community care facilities for patients with mental disorders. Community mental health services are available in all districts. Psychiatric nurses are involved in these activities.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	10.6
Psychiatric beds in mental hospitals per 10 000 population	9.7
Psychiatric beds in general hospitals per 10 000 population	0.9
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.9
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	14.2
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	1.8
Number of social workers per 100 000 population	2.7

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

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

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, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, carbidopa, levodopa. Currently, only 2 children are on treatment with ethosuximide, so the drug is dispensed from the central pharmacy.

Other Information

Additional Sources of Information

Samoa

GENERAL INFORMATION

Samoa is a country with an approximate area of 3 thousand sq. km. (UNO, 2001). Its population is 0.18 million, and the sex ratio (men per hundred women) is 109 (UNO, 2004). The proportion of population under the age of 15 years is 40% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 98.9% for men and 98.4% 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 5.8%. The per capita total expenditure on health is 199 international \$, and the per capita government expenditure on health is 164 international \$ (WHO, 2004).

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

The life expectancy at birth is 66.8 years for males and 69.7 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 60 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Samoa in internationally accessible literature. Booth (1999) reviewed data from thirteen Pacific Island nations and showed that the Pacific countries had very high reported suicide rates. Among youth, females committed more suicide than males in Western Samoa. Paraquat ingestion was the commonest mode of self-poisoning, especially among females, in Western Samoa. Societal stresses were the commonest causal factors. Cribb (1999) ascertained variations in Western Samoan women's responses to domestic violence in three different contexts, in rural and urban Western Samoa and in New Zealand. On interviewing family, religious and community leaders and 90 women, the researchers found that social relations, changes in women's economic independence and differences in levels of formal support for battered women were probable causes for differences in women's responses to abuse in the three areas.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent. There is a felt need for developing a substance abuse policy in view of the problems being faced by the country with respect to rising alcohol and other substance used disorders.

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

The need for a programme is felt acutely. It is hoped that in future, programmes would be developed incorporating treatment, prevention and promotion. It is proposed to establish a multi-sectoral, multi-disciplinary national committee on mental health as a sub-committee of the national non-communicable diseases committee. This body would have specific functions and would include suicide and alcohol and drug use related problems. The committee would include experts from the Government, non-governmental organizations, international organizations, donors, etc.

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

There is a drug policy approved in 2001 and awaiting an implementation plan.

Mental Health Legislation There is a mental health law. The law is based on New Zealand's mental health laws of the 1960s and needs to be updated. Mental impairment is not clearly identified in disability legislation. Substance Abuse laws and regulations are enforced mainly in relation to marijuana. The licensing of the sale of paraquat to farmers was introduced by the Ministry of Agriculture, Forestry, Fisheries and Meteorology.

The latest legislation was enacted in 1961.

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

Details about expenditure on mental health are not available.

The primary source of mental health financing is tax based.

The country does not have disability benefits for persons with mental disorders. There are no disability benefits for mental illness or disabilities.

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

Regular training of primary care professionals is not carried out in the field of mental health. However, family care givers are receiving training. Community nurses working in the field have received focused short term (3 weeks) training sessions in 1998/99. The Mental Health Unit staff provide outreach support to district health centres and the village sub-centres, working with the district nurses and doctors.

There are community care facilities for patients with mental disorders. Community mental health care is family focussed and is completely provided by nurses. The services were started during the late 80's and 90's, but they face some problems like lack of special-

ist psychiatrist back-up for the community staff, limited availability of medicines, uncertain policy regarding distribution of medicines by nurses, limited diagnosis, referral and follow-up for people with mental disorders, poor transportation facilities in the rural areas and absence of any alcohol and drug use related services.

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
Psychiatric beds in other settings per 10 000 population	0.2
Number of psychiatrists per 100 000 population	0
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0.5
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

Patients can be admitted in general medical wards, under joint supervision of staff from the mental unit and the hospital ward staff. Psychiatric nursing is a component of the graduate course on nursing in Samoa. Nurses have prescription privileges.

Non-Governmental Organizations NGOs are not involved with mental health in the country. NGOs are involved in counselling and suicide awareness groups. The Traditional Healers' Organization (THO) in association with NGOs and the church provide some mental health services. The Faataua le Ola (Suicide Prevention/Awareness Group and International Lifeline) a multisectoral organization was founded in 2001 with Government support. It has a few trained counsellors. It conducts lifeline counselling, face-to-face crisis counselling, counsellor training and public education.

Information Gathering System There is mental health reporting system in the country. There was an Annual Report by the Department of Health in 1997 and 1998.

The country has data collection system or epidemiological study on mental health. A report is prepared every month and sent to the health planning and information section.

A database on suicide has been maintained since 1970 through the individual effort of Galumalemana S. Percival. The Government, with the collaboration of Inclusion International, is completing a disability census.

Programmes for Special Population The country has specific programmes for mental health for indigenous population, elderly and children. There are programmes to look after dementias in elderly and mental retardation and developmental problems in children and also victims of abuse and suicide.

It is proposed that school mental health programmes should be developed. There are programmes for awareness of epilepsy. Related Government departments, Village Council of Chiefs, NGOs and Churches address issues of substance abuse. A youth suicide prevention campaign was launched by the National University of Samoa in 2001 with support of donor agencies.

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

The supply of drugs is not uniform.

Other Information Samoa is the first country in the Western Pacific Region that has shown interest in starting a mental health promotion programme. This programme would be linked to other prevention programmes for suicide and programmes aimed at reducing stigma and discrimination against mental illness.

Additional Sources of Information

Booth, H. (1999) Pacific Island suicide in comparative perspective. *Journal of Biosocial Science*, 31, 433-448.

Cribb, J. (1999) Being bashed: Western Samoan women's responses to domestic violence in Western Samoa and New Zealand. *Gender, Place & Culture*, 6, 49-65.

San Marino

GENERAL INFORMATION

San Marino is a country with an approximate area of 0.06 thousand sq. km. (UNO, 2001). Its population is 0.027 million, and the sex ratio (men per hundred women) is 96 (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 24% (WHO, 2004). The literacy rate is 97% for men and 95% 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 6.8%. The per capita total expenditure on health is 1711 international \$, and the per capita government expenditure on health is 1334 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Italian. The largest ethnic group(s) is (are) Sammarinese and Italian. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 77.2 years for males and 84 years for females (WHO, 2004). The healthy life expectancy at birth is 71 years for males and 76 years for females (WHO, 2004).

EPIDEMIOLOGY

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

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

The Republic of San Marino refers to the EU guidelines.

Substance Abuse Policy A substance abuse policy is absent. The Republic of San Marino refers to the EU guidelines.

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 absent. The Republic of San Marino refers to the EU guidelines.

Mental Health Legislation The current mental health legislation is being updated. A mixed commission, made up of judges and psychiatrists, is working to adapt the present legislation on mental health to new needs of both the citizens and the services. In particular, the aim is to reconcile the demands of individual freedom and liberty of choice with the need for intervention in the care of mental disorder. A further matter of great relevance here is to respect patients' privacy. Details about the year of enactment of the mental health legislation are not available.

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

Details about expenditure on mental health are not available.

The primary source of mental health financing is tax based.

The country has disability benefits for persons with mental disorders. There is a possibility to obtain both economic benefits and a job with the public administration.

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.

There are community care facilities for patients with mental disorders. The mental health service is the only agency dealing with mental health. It is a multidisciplinary service and is based on the teamwork of psychiatrists, psychologists, social workers and nurses. Health and social care services are offered both at centres and in the patients' homes, schools and places of work.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	3.8
Psychiatric beds in mental hospitals per 10 000 population	0
Psychiatric beds in general hospitals per 10 000 population	3.8
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	15
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0
Number of neurologists per 100 000 population	19
Number of psychologists per 100 000 population	96
Number of social workers per 100 000 population	54

In 1969, the Neuro-Psychiatric Service (SNP) was created and in 1977 became part of the social services. The SNP or neuropsychiatric service is made up of psychiatrists, psychologists, neurologists, social workers, nurses, technicians of electrophysiology and a secretary. In 1980, a section dealing with alcohol-related problems and drug abuse was created within the SNP. Since there is no psychiatric department in the hospital, psychiatric admissions go to the department of general medicine or, if necessary, to an Italian psychiatric clinic.

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. The system is conducted by the neuropsychiatric services.

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.

All the drugs are provided free of cost by the Government at the primary care level.

Other Information The three matters of both concern and progress in San Marino are considered to be: destigmatization and social prejudice towards mental illness, improving the relationship between the mental health service and other structures, better collaboration between the mental health service, schools and the political and judicial spheres.

Additional Sources of Information

Sao Tome and Principe

GENERAL INFORMATION

Sao Tome and Principe is a country with an approximate area of 1 thousand sq. km. (UNO, 2001). Its population is 0.164 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 6% (WHO, 2004). The literacy rate is 85% for men and 62% 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 2.3%. The per capita total expenditure on health is 22 international \$, and the per capita government expenditure on health is 15 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Portuguese. The largest ethnic group(s) is (are) Foro and Angolare, and the other ethnic group(s) are (is) Minuye and Capeverdins. The largest religious group(s) is (are) Roman Catholic.

The life expectancy at birth is 61.7 years for males and 63.6 years for females (WHO, 2004). The healthy life expectancy at birth is 54 years for males and 55 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Sao Tome and Principe in internationally accessible literature.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1993.

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 latest legislation was enacted in 1963.

Mental Health Financing There are budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary source of mental health financing is tax based.

The country has disability benefits for persons with mental disorders.

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.

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

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	2.2
Psychiatric beds in mental hospitals per 10 000 population	0
Psychiatric beds in general hospitals per 10 000 population	2.2
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	1
Number of psychiatric nurses per 100 000 population	0.3
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	3
Number of social workers per 100 000 population	0.001

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

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

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

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: phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam, haloperidol.

Other Information

Additional Sources of Information

Saudi Arabia

GENERAL INFORMATION

Saudi Arabia is a country with an approximate area of 2150 thousand sq. km. (UNO, 2001). Its population is 24.919 million, and the sex ratio (men per hundred women) is 116 (UNO, 2004). The proportion of population under the age of 15 years is 39% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 84.1% for men and 69.5% 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 4.6%. The per capita total expenditure on health is 591 international \$, and the per capita government expenditure on health is 441 international \$ (WHO, 2004).

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

The life expectancy at birth is 68.4 years for males and 73.9 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 63 years for females (WHO, 2004).

EPIDEMIOLOGY

Al-Khatami and Ogbeide (2002) evaluated 609 adults, selected randomly from a family and community clinic at an Armed Forces hospital, using the Rahim Anxiety-Depression Scale. The prevalence of minor mental morbidity was 18.2% (women: 22.2%, men: 13.7%). Rates were higher among the young (15-29 years: 23.2%), divorcees and widows (more than 40%) and among those suffering from bronchial asthma (28.3%). El Ruffaie et al (1999) estimated the prevalence of somatized mental disorder (SMD) and psychologized mental disorder (PMD) in a sample of primary health care patients using the 12-item General Health Questionnaire and the Clinical Interview Schedule. SMD and PMD constituted 48% and 42% of those identified with a psychiatric disorder, respectively. The estimated prevalence rate of SMD was 12% and it was associated with less education and less severe disorders. The most common ICD-10 psychiatric diagnoses among both the groups were mixed anxiety and depressive disorder, generalized anxiety disorder and mood and adjustment disorders. Recurrent depressive disorder and dysthymia were significantly more prevalent in the PMD group. El-Ruffaie et al (1988) used the Arabic version of the Hospital Anxiety and Depression Scale (HAD) in primary care patients and found the prevalence rate of depression and anxiety to be 26% (17% had depression and 16% had anxiety). The rate of depression was higher among females and that of anxiety among males. Al-Shammari and Al-Subaie (1999) assessed 7970 elderly (above 60 years) subjects who were selected from primary health care in five administrative regions by a stratified two-stage sampling procedure using the Geriatric Depression Scale (GDS) and clinical evaluation. Depressive symptoms were reported by 39%, with 8.4% having severe depression. Depression was associated with gender (female), education (low), unemployment, marital status (divorced or widowed), locality (rural), housing arrangements (poor), isolation, financial constraints, life events (loss), participation in recreational activities (limited), medical illness (especially faecal or urinary incontinence), medication, perception of poor health and dependence on others for daily activities. Elfawal (1999) reviewed hospital data on suicides and estimated its prevalence to be 1.1/100 000 population. It was associated with gender (male:female ratio was 4.5:1), age (30 to 39 years: 44.3%), ethnicity (all immigrants: 77%, Indians: 43%). The most common means of suicide were hanging (63%). Malik et al (1996) found that more than four fifths of drug overdose cases (n=57) were self-inflicted (parasuicide). Parasuicide was associated with age (more than 95% were below 40 years), ethnicity (Saudi: 89%) and gender (females: 78%). Psychiatric illnesses were diagnosed in 74.4% of cases, with depression (39.5%) and personality disorders (34.9%) being common. Abolfotouh (1997) assessed 305 schoolboys aged 8-12 years using the Rutter Children's Behaviour Questionnaire. The prevalence of behaviour disorders was 13.4% and it was associated with family size, crowding index, parents' education, birth order, parental death, social class and poor academic performance of index child. These factors jointly contributed to 12.8% of the variance in total behaviour score. However, mother's illiteracy was the only significant predictor of maladjusted children. Al-Subaie et al (1996) validated the Arabic version of the Eating Attitude Test (EAT-26) and assessed a representative stratified random sample of grade 7-12 urban female students (n=129). Twenty-five were identified by EAT-26 as having abnormal eating attitudes. One case was identified as having anorexia nervosa and no cases of bulimia were found. Milaat et al (2001) assessed children (below 15 years) selected through a multistage sampling of households (n=875) using the ten questions survey. The point prevalence of any disability was 3.7%. Three-fifths of cases had a single disability, one-fifth had two conditions and one-fifth had three or more conditions. Speech, motor and mental disabilities were the commonest disabilities identified.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1989.

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

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

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

The national mental health programme aims at integrating mental health into primary and community care, developing a model keeping in view the social, cultural and religious values of the country in perspective, using mental health principles in promoting social health, decreasing untoward impact of social and economic development on society like drug abuse, smoking, delinquency and crime.

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 A mental health act is awaiting approval. The General Directorate for Mental Health has developed a manual of procedures and regulations for mental health institutions in the country until the mental health act is approved.

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.

Development of psychiatric services is incorporated in the budget of general health services.

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. All anti-depressants and neuroleptics and some anti-epileptics are exempt from control and so all primary care physicians can prescribe most of the drugs.

Regular training of primary care professionals is carried out in the field of mental health. The General Directorate for Mental Health has a well designed training programme for the mental health component of primary health care. There are training manuals and workshops for psychiatrists on methods how to train primary care personnel. All medical staff of primary care services are required to attend training programmes on the recognition and management of common mental disorders. The immediate and post-training evaluations of the trainees show favourable changes in their attitude and knowledge and enhanced motivation to practice psychiatry at primary health care centres. A system of ongoing training is needed because the majority of primary care doctors are expatriates (predominantly from neighbouring Arab states).

There are community care facilities for patients with mental disorders. Rehabilitative services were planned following a Royal decree in 1988 but it mainly concentrated among private organizations and self help groups like the Patients' Friends Committee, etc.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.18
Psychiatric beds in mental hospitals per 10 000 population	0.8
Psychiatric beds in general hospitals per 10 000 population	0.04
Psychiatric beds in other settings per 10 000 population	0.34
Number of psychiatrists per 100 000 population	1.1
Number of neurosurgeons per 100 000 population	0.5
Number of psychiatric nurses per 100 000 population	6.4
Number of neurologists per 100 000 population	0.07
Number of psychologists per 100 000 population	0.97
Number of social workers per 100 000 population	2.4

There are 22 other mental health staff belonging to different categories. There are three Amal hospitals which take care of patients with problems with drug abuse. They collectively have 840 beds. Some beds have been earmarked for mentally retarded individuals and mentally ill offenders. About three fourths of the psychiatrists and a majority of nurses are expatriates. Traditional healers and religious healers play an important part in mental health care.

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. There are no epidemiological studies, but data are available for all services.

Programmes for Special Population The country has specific programmes for mental health for children. Child psychiatric services are mainly provided as out-patient care and emergency cases are admitted in paediatric hospitals or general hospitals. Six school units are operational in Riyadh.

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 Till 1983, mental health care was mainly provided by the Taif mental hospital, but since then smaller hospitals and outpatient clinics have been set up. The next phase would involve integration of mental health into primary care.

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Senegal

GENERAL INFORMATION

Senegal is a country with an approximate area of 197 thousand sq. km. (UNO, 2001). Its population is 10.339 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 43% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 49% for men and 29.7% 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 4.8%. The per capita total expenditure on health is 63 international \$, and the per capita government expenditure on health is 37 international \$ (WHO, 2004).

The main language(s) used in the country is (are) French, Wolof and Serer. The largest ethnic group(s) is (are) Wolof, and the other ethnic group(s) are (is) Fulani, Serer, Toucouleur, Diola and Manding. The largest religious group(s) is (are) Muslim (approximately 95%).

The life expectancy at birth is 54.3 years for males and 57.3 years for females (WHO, 2004). The healthy life expectancy at birth is 47 years for males and 49 years for females (WHO, 2004).

EPIDEMIOLOGY

In a study done in the primary care setting, Diop et al (1982) used a 10-item screening questionnaire to assess 545 children (5-15 years) and the 24-item Self-Reporting Questionnaire (SRQ) to assess 933 adults. Almost 17% of children had emotional/behavioural or neuro-psychiatric disorders and 16% of adults had psychiatric illnesses. Beiser et al (1976) developed an emic questionnaire to tap symptoms of psychiatric distress. In a sample of more than 400 subjects, they found that the idiom of expressing distress was not limited to the somatic, and they were able to discriminate between mentally ill and well people in the local frame of reference. Seck et al (1994) reported on findings from a UNESCO study on epidemiology of drug abuse in young people. Drug use was common among the youth and was associated with certain religious practices, curiosity, ignorance of harmful effects and lack of education. Gueye et al (1998) identified erectile dysfunction in 16% of diabetic outpatients (n=431). Complications of diabetes (especially neurological) and duration of diabetes were associated with the risk of erectile dysfunction. Thiam et al (1998) assessed 1025 psychiatric out-patients. Schizophrenia and hysteria were the commonest diagnoses made. The occurrence of hysteria was associated with disturbances in interpersonal relationships (49.6%) and difficulties of daily life. Big Charcot attacks were seen in 10% of the patients. Hysterical personality type was common in these patients (85.1%). Reitter et al (1996) reviewed the hospital records of 450 persons with suicide attempts. Such attempts were common among young (particularly in young women) and the commonest cause was family problems (all problems: 42%, marital problems: 15%).

MENTAL HEALTH RESOURCES

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

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

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1997. The Law number 97 – 18 of 1st December 1997 serves as the policy for substance abuse.

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

The draft of the National Mental Health Plan is ready and it will be put up for approval in January 2005.

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

Mental Health Legislation The most recent laws in mental health are law 75-80 of 9th July 1975, Decree 75-1092 of 23 October 1975 and Decree 75-1023 of 23 October 1975. The Law number 97 – 18 of 1st December 1997 also has mental health implications.

The latest legislation was enacted in 1975.

Mental Health Financing There are budget allocations for mental health.

The country spends 9% of the total health budget on mental health.

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

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

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. The programme for primary mental health care was developed in 1975 with the assistance of WHO. 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. Out of the 200 personnel trained over the last two years, 100 were nurses and the remaining physicians. There are community care facilities for patients with mental disorders. Community care is provided by private clinics and traditional healers.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.3
Psychiatric beds in mental hospitals per 10 000 population	0.15
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	0.16
Number of neurosurgeons per 100 000 population	0.06
Number of psychiatric nurses per 100 000 population	0.06
Number of neurologists per 100 000 population	0.1
Number of psychologists per 100 000 population	0.04
Number of social workers per 100 000 population	0.035

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.

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, sodium valproate, amitriptyline, chlorpromazine, diazepam, haloperidol, lithium.

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Serbia and Montenegro

GENERAL INFORMATION

Serbia and Montenegro is a country with an approximate area of 102 thousand sq. km. (UNO, 2001). Its population is 10.519 million*, and the sex ratio (men per hundred women) is 99 (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 country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8.2%. The per capita total expenditure on health is 616 international \$, and the per capita government expenditure on health is 488 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Serbian. The largest ethnic group(s) is (are) Serb. The largest religious group(s) is (are) Orthodox Christian.

The life expectancy at birth is 69.7 years for males and 74.9 years for females (WHO, 2004). The healthy life expectancy at birth is 63 years for males and 65 years for females (WHO, 2004).

EPIDEMIOLOGY

Eric et al (1988) did an assessment of mental health among fresh medical students (n=523) in one area and found that 16.1% had psychiatric disorders and that two years later the rate had increased to 17.5%. The incidence rate was 5.3% per year with neuroses being the most frequent diagnoses (3.5%). Based on a register of treated alcohol dependent patients, Saponja et al (1996) suggested that there was a decrease in incidence, prevalence and risk of morbidity in the population of the examined territory during 1991-1993. Plavljanic and Mijic (1997) found that the alcohol abuse was 3.7 times more frequent in participants of combat actions compared to those who did not have such assignment in an investigated base on retrospective analysis of medical documentation. Durmisevic et al (1999) studied 208 primary school pupils and 232 secondary school pupils to assess drug use pattern. Prevalence of smoking, use of alcohol and use of narcotics was found to be 0.9%, 5.8%, and 0.9% among primary school children, 28%, 28.8% and 10.6% among secondary school students and 42.9%, 41.1% and 13.5% in the last two years of secondary school. Milic (2000a) assessed a group of primary and secondary school students (one-fifth of students from concerned classes in 17 schools were selected) and found that one in 30 students used psychoactive substances, with males using them more frequently. Among males, almost 52.9% of those who used alcohol and tobacco also used other drugs. Roncevic et al (1989) reviewed data related to poisoning and intoxication in children aged 0-15 years from 11 hospitals (n=795). Almost 6.5% of children had ethanol intoxication. Ethanol intoxication was associated with gender (male) and age. Starcevic and Bogojevic (1997) examined 90 consecutive day clinic patients with panic disorder and agoraphobia (PDA) who were administered the SCID-III-R (modified for DSM-IV). The overall comorbidity rate for simple phobia (SP) was 65.6%. The most frequent subtypes of SP were situational phobia and dental phobia, followed by natural environment phobia, death related phobia and blood-injection-injury phobia. Mandic et al (1994) assessed the prevalence of psychogenic headache in 150 displaced persons. Nearly 70% suffered from headaches (female to male ratio 2.5:1). Among males the common causes were depression (43%) and conversion (8.3%), and among females depression (66%), anxiety (10.7%) and conversion (4.3%). Headache was correlated with the severity of trauma and employment status (before and after displacement). Milcinski and Mrevlje (1990) found very high suicide rates in northern parts of erstwhile Yugoslavia e.g. Vojvodina and very low rates in southern parts, e.g. Kosovo (2.4 per 100 000). Petrovich et al (2001) studied suicide rates (between 1987-99) in a Serbian region using death certificates. The average annual suicide rate (per 100 000) in the region during the period 1987/1989 (economic/political stability) was 14.8 among males and 6.8 among females, and in 1999 (economic/political crisis) it was 13.8 among males and 3.7 among females. This was despite a rise in the rates of suicide and homicide during the war (1991-1994) (Biro & Selakovic-Bursic, 1996). During this period the rate of suicides committed by fire arms increased (from 8.1% to 14.5%), while there was a decrease in cases of poisoning. Milic (2000b) reviewed data obtained from the Ministry of Internal Affairs of Serbia and medical records from the psychiatry center for the years 1991-1995. Three-fifths of those attempting suicide were unemployed. There was a significant difference in the age of suicide attempters (average: 41.23 years) and suicide completers (average: 59.50 years). The suicide rate in the age groups above 45 years was approximately 27.2 per 100 000 population. Unemployment was related to suicide among the 15-24 and 55-64 age groups. The rate of suicide in 2002 was 19.3 per 100 000 population (9 National Committee for Mental Health of Serbia and National Committee for Mental Health of Montenegro, 2003)

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

The new policy of health care system reforms is described in the following document: Ministry of Health of Republic of Serbia: Better Health for All in Third Millennium – Health Policy, Vision of System of Health Care in Serbia; Strategy and Action Plan of Reform of System of Health Care in Republic of Serbia – draft version, Belgrade, 10/2003. Mental Health Policy and Action Plan has been drafted by the National Committee for Mental Health of Serbia in October 2004.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1991. Montenegro has a plan and programme for prevention of substance abuse (multidisciplinary) which was implemented in 2001.

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 Mental health legislation includes provisions on protection of the rights of people with mental disorders. These are distributed between stipulations of the Health Care Law (articles 1, 7 and 10), Out-of-court Proceedings Law, Marriage and Family Relations Law and Execution of Criminal Sanctions Law. A new law on mental health and protection of rights of mentally disabled persons has been drafted by the National Committee for Mental Health in October 2004. The latest legislation was enacted in 1931.

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. Mental health care is financed from the obligatory insurance, like general health. Details about disability benefits for mental health are not available.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Mental health care is quite well integrated with the primary health care system, at least in larger cities that have mental health sections and developmental counseling units within municipal health centers (which represent the primary organizational form of the primary health care system). However, some parts of Serbia do not have such mental health care units within municipal health centres (mainly because of the lack of adequate personnel). The mental health sector is also quite well integrated with the somatic health care sector, through the municipal health care centers, general hospitals or medical centers that have psychiatric outpatient services or psychiatric departments.

Regular training of primary care professionals is carried out in the field of mental health. Continuous education of primary care physicians started in 2000, by the Institute of Mental Health (supported by the Committee for Human Rights, Norwegian Medical Association). So far, four courses have been organized, the last two in cooperation with the colleagues from Sarajevo. Programmes were conducted by the use of the same teaching modules and were followed by an evaluation.

There are community care facilities for patients with mental disorders. Some elements of community mental health services have existed in various forms for years: psychiatric departments within general hospitals, day hospitals, outpatient services within stationary psychiatric institutions, mental health sections within municipal health centers, social work centers with their facilities for psychotherapeutic work with some categories of beneficiaries (the young suffering from behavioural disorders; the young delinquents, etc.), cooperation with pre-school and school institutions and various non-governmental and humanitarian organizations, in the field of prevention and some forms of psychosocial counselling. Mental health care is also integrated with welfare services through the cooperation of centres for mental health care and psychiatric departments with regional centres for social work which exist in each municipality of Serbia. There is also a good cooperation with other welfare institutions, such as retirement homes and orphanages, and there are some joint projects in the fields of prevention and therapy.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	9.6
Psychiatric beds in mental hospitals per 10 000 population	4.5
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	12.8
Number of neurosurgeons per 100 000 population	
Number of psychiatric nurses per 100 000 population	19
Number of neurologists per 100 000 population	6
Number of psychologists per 100 000 population	1.2
Number of social workers per 100 000 population	0.5

Until 1993, doctors were educated about neuropsychiatry, but since then the specialities of psychiatry and neurology have divided and there are further courses for child psychiatry and neurology. Psychiatric day hospitals have capacity of 495 patients. Forensic services in Serbia have capacity of 700 beds. Prison hospitals are managed by the Ministry of Justice. About 5% of psychiatrists are engaged in the practice of child and adolescent psychiatry.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in rehabilitation. Non-governmental and paraprofessional groups have had an increasing role within the mental health system, most of all through various psychosocial programmes, but also through cooperation and common projects with the mental health, social and educational sectors. Child Advocacy International established a comprehensive child and adolescent mental health service (CAMHS) in Kosovo in the postwar situation, when psychiatric services in the region were in a state of disarray. Clinics were located in primary

health care facilities and home visits were made as necessary. It also provided a training base for future child and adolescent mental health specialists.

Information Gathering System There is mental health reporting system in the country. Non-affective and affective psychoses as well as epilepsy are reported.

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

Programmes for Special Population The country has specific programmes for mental health for refugees, elderly and children. During the years of crisis, many programmes for mental health care of refugees and internally displaced people were developed, as well as programmes for rehabilitation of torture victims. These programmes were conducted by the governmental organizations and NGOs and supported by many organizations (UNHCR, UNICEF). The Stress Clinic, the Psychotrauma Center and the Center for Abused Children were established within the Institute of Mental Health. The Trauma Center of International Aid Network (IAN) has been established in 1997 and the Center for Rehabilitation of Torture Victims within this centre in 2000. International cooperation has been achieved through various multicentric research on posttraumatic stress disorder (STOP, CONNECT, supported by the EU).

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

Social insurance fully covers the cost of most of the above therapeutic drugs.

Other Information * Its population excluding Kosovo is 7.498 million (National Politics Census, 2002). The population of Montenegro is 0.672 Million (National Politics Census, 2003).

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Seychelles

GENERAL INFORMATION

Seychelles is a country with an approximate area of 0.45 thousand sq. km. (UNO, 2001). The country is an archipelago consisting of more than 100 islands. Its population is 0.081 million, and the sex ratio (men per hundred women) is 97 (UNO, 2004). The proportion of population under the age of 15 years is 28% (UNO, 2004), and the proportion of population above the age of 60 years is 9% (WHO, 2004). The literacy rate is 91.4% for men and 92.3% 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 6%. The per capita total expenditure on health is 770 international \$, and the per capita government expenditure on health is 525 international \$ (WHO, 2004).

The main language(s) used in the country is (are) English, French and Seselwa. The largest ethnic group(s) is (are) Seychellois. The largest religious group(s) is (are) Roman Catholic (five-sixths).

The life expectancy at birth is 67 years for males and 77.2 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 65 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Seychelles in internationally accessible literature. Myers and Davidson (1998) conducted a large controlled longitudinal study on the neurotoxicity of methylmercury in a population consuming seafood. No adverse associations were found in the Seychelles, where exposure is mainly from fish consumption. The study did not support the hypothesis that consumption of such fish during pregnancy places the fetus at increased neuro-developmental risk.

MENTAL HEALTH RESOURCES

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

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The policy was revised in 1995.

Substance Abuse Policy A substance abuse policy is absent. A National Alcohol Policy was formulated in 2003.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1989. The national mental health programme for the period 2000-2004 has been drafted for approval.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2001.

The essential drug list is being drafted. The essential drugs are compiled in the National Drug Formulary (NDF). The present NDF (Third Edition, 2000) is being reviewed and updated.

Mental Health Legislation The existing law on mental health, the Mental Treatment Act, has been reviewed and submitted for enactment in 2001.

The latest legislation was enacted in 1906.

Mental Health Financing There are budget allocations for mental health.

The country spends 2.8% of the total health budget on mental health.

The primary sources of mental health financing in descending order are tax based and private insurances.

The health services are free of charge to every citizen.

The country has disability benefits for persons with mental disorders. There are provisions for invalidity benefit by the social security funding.

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. Follow-up maintenance treatment is available with the support of the community psychiatry nurse along with other specialists and primary health workers. Since the return of the Seychellois psychiatrist in October 2003, the patients in the community are also being reviewed every 3 months by the psychiatrist.

Regular training of primary care professionals is carried out in the field of mental health. Training is provided to health workers as an ongoing continuous programme. Primary care doctors also attend seminars on mental health twice a year.

There are community care facilities for patients with mental disorders. Community care is provided by the community psychiatry nurse with help from the primary health care workers and other specialists.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	7.7
Psychiatric beds in mental hospitals per 10 000 population	6
Psychiatric beds in general hospitals per 10 000 population	1.7
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	2
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	8
Number of neurologists per 100 000 population	1
Number of psychologists per 100 000 population	1
Number of social workers per 100 000 population	48

There are only 3 occupational therapists working in psychiatry though there is an established network of them. The social workers are employed by different ministries. One social worker is working in mental health. There is no medical school or university, so most of the doctors are expatriates. Since February 2004, an 18-month diploma course in mental health nursing was started. Twelve nurses are enrolled in the programme.

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

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

The country has data collection system or epidemiological study on mental health. Mental disorders are included in epidemiological morbidity data.

Programmes for Special Population The country has specific programmes for mental health for elderly and children. Support for the special population is available only when asked for and is not an outreach programme. There are also programmes for the mentally retarded.

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, carbidopa, levodopa.

Some drugs which are not there in the primary health care can be dispensed if prescribed by consultants.

Other Information**Additional Sources of Information**

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Sierra Leone

GENERAL INFORMATION

Sierra Leone is a country with an approximate area of 72 thousand sq. km. (UNO, 2001). Its population is 5.169 million, and the sex ratio (men per hundred women) is 97 (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 45% for men and 18% 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 26 international \$, and the per capita government expenditure on health is 16 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) Muslim, and the other religious group(s) are (is) indigenous groups and Christian.

The life expectancy at birth is 32.4 years for males and 35.7 years for females (WHO, 2004). The healthy life expectancy at birth is 27 years for males and 30 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Sierra Leone in internationally accessible literature. Lacoux et al (2002) reported on the experience of 40 upper limb amputees (11 bilateral) with regard to stump pain, phantom sensation and phantom pain. All the patients lost their limbs as a result of violent injuries and were assessed 10-48 months after the injury. All amputees reported stump pain in the month prior to the interview and ten of the 11 bilateral amputees had bilateral pain. Phantom sensation was common (92.5%), but phantom pain was only present in 32.5% of amputees. Problems in translation and explanation may have influenced the low incidence of phantom pain and high incidence of stump pain. In the bilateral amputees, phantom sensation, phantom pain and telescoping all showed bilateral concordance, whereas stump pain and neuromas did not show concordance. There is one study on the problems of refugees from Sierra Leone living in camps in Gambia, which has been included in studies from Gambia.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

A Mental Health Coordination Group has been formed with the participation of various stakeholders, e.g. inter-governmental organizations, NGOs and the Government. This group is chaired by the Ministry of Health and seconded by WHO. It is charged with the responsibility of developing a Mental Health and Substance Abuse Policy, a modern mental health legislation and national mental health programme including a plan of action for short and long term initiatives. It is also responsible for developing models for decentralized community-based services and human resource development for all levels of care.

Substance Abuse Policy A substance abuse policy is absent.

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

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is absent. Both, the national therapeutic drug policy and the essential drug list are in the process of being developed.

Mental Health Legislation The Sierra Leone Mental Health Act is present.

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

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

Details about expenditure on mental health are not available.

The primary source of mental health financing is tax based.

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

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

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

There are no community care facilities for patients with mental disorders. Some traditional healers and general practitioners provide mental health care in the community setting.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.47
Psychiatric beds in mental hospitals per 10 000 population	0.32
Psychiatric beds in general hospitals per 10 000 population	0.11
Psychiatric beds in other settings per 10 000 population	0.03
Number of psychiatrists per 100 000 population	0.02
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0.04
Number of neurologists per 100 000 population	0.02
Number of psychologists per 100 000 population	0
Number of social workers per 100 000 population	0.06

There are 200 psychiatric assistants.

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

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

Details about data collection system or epidemiological study on mental health are not available. The first Systematic Needs Assessment on Mental Health and Substance Abuse Survey in post-conflict Sierra Leone was undertaken in October 2002 with the support of WHO under the direction of the MOH. In the random sample, 2% of subjects had psychosis, 4% had severe depression, 4% had prominent substance abuse, 1% had mentally retardation and 1% had epilepsy. Almost 85% of the population never took alcohol (97% of secondary school students) and even fewer had experimented with/abused drugs.

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

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

Other Information**Additional Sources of Information**

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Singapore

GENERAL INFORMATION

Singapore is a country with an approximate area of 0.62 thousand sq. km. (UNO, 2001). Its population is 4.315 million, and the sex ratio (men per hundred women) is 101 (UNO, 2004). The proportion of population under the age of 15 years is 20% (UNO, 2004), and the proportion of population above the age of 60 years is 11% (WHO, 2004). The literacy rate is 96.6% for men and 88.6% 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 993 international \$, and the per capita government expenditure on health is 333 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Malay, Chinese (Mandarin), Tamil and English. The largest ethnic group(s) is (are) Chinese, and the other ethnic group(s) are (is) Malays and Indian. The largest religious group(s) is (are) Buddhist, and the other religious group(s) are (is) Christian, Muslim and Taoist.

The life expectancy at birth is 77.4 years for males and 81.7 years for females (WHO, 2004). The healthy life expectancy at birth is 69 years for males and 71 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in Singapore 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 1952.

The components of the policy are advocacy and treatment. This has been further supplemented with the National Disease Control Plan for Major Mental Disorders which was formulated in January 2001. This policy framework identifies key mental diseases for Singapore, prioritizes the areas for action and formulates national level strategic initiatives for improving mental health. It also sets in place medium to long term targets for control of major mental disorders such as depression, anxiety and schizophrenia.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1973.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1993. The national mental health programme present was significantly expanded in 2001 with the launch of the 'Mind Your Mind' (MYM) Programme. MYM, which is run by Institute of Mental Health and funded by the Health Promotion Board, aims to promote mental health among Singaporeans, create greater awareness about mental disorders in the general public, and destigmatize mental disorders. It also aims to improve the rate of early detection and treatment for depression, anxiety disorders and schizophrenia in Singapore. MYM started in 2001 with a focus on stress management, followed by destigmatization in 2002 and depression in 2003 and 2004.

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

The essential drug's list was reviewed in 2002.

Mental Health Legislation The Mental Disorders and Treatment Act was enacted in 1952 but the latest revision was in 1985. The latest legislation was enacted in 1952.

Mental Health Financing There are budget allocations for mental health.

The country spends 6.1% 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 National Savings Scheme helps individuals to put aside part of their incomes in their accounts to meet their personal and immediate family's hospitalization expenses, especially after retirement. For the poor there is an alternative fund set up by the Government (Medifund).

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. Mental health care is provided across the continuum of care, from primary to tertiary levels. Primary mental health care is provided by private general practitioners and at the polyclinics.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 400 personnel were provided training.

There are community care facilities for patients with mental disorders. Community-based mental health services are organized by the Institute of Mental Health and comprise Outpatient Services, Day Centres, a Community Psychiatric Nursing Service, an Assertive Community Treatment Programme, a Mobile Crisis Team and a Crisis Hotline Service.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	6.1
Psychiatric beds in mental hospitals per 10 000 population	5.9
Psychiatric beds in general hospitals per 10 000 population	0.2
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	2.3
Number of neurosurgeons per 100 000 population	0.5
Number of psychiatric nurses per 100 000 population	10.4
Number of neurologists per 100 000 population	1.1
Number of psychologists per 100 000 population	1
Number of social workers per 100 000 population	3

All personnel are only those working in the public health sector. Secondary and tertiary level specialist care is delivered mainly at the Institute of Mental Health. Most of the acute general hospitals also provide some specialist mental health care. Patients with severe, refractory psychoses requiring long-term inpatient stay are cared for at Woodbridge Hospital, which is part of the Institute of Mental Health.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation. Some day-care services are provided by NGOs. The Singapore Anglican Welfare Council (SAWC) has started an On-the-Job Training (OJT) programme and the Certificate in Office Skills (COS), both programmes approved by the Singapore Institute of Technical Education (ITE).

Information Gathering System There is mental health reporting system in the country. The country has data collection system or epidemiological study on mental health. Details can be obtained from the Quarterly Statistics Bulletin of the Ministry of Health.

Programmes for Special Population The country has specific programmes for mental health for elderly and children. There is a Child Guidance Clinic (CGC) run by the Institute of Mental Health. It is located in the community and provides psychiatric services to children and adolescents mainly in an outpatient setting. CGC has strong links with both mainstream schools and schools for the mentally challenged. CGC has set up a 'Children One-Stop Educational Service' (COPES), which is a comprehensive, non-categorical educational centre for children with learning disabilities. CGC also operates a 20-bed inpatient unit for children and adolescents with severe, acute psychiatric illnesses. Older persons, aged 65 years and above, with a variety of psychiatric and emotional problems have access to a dedicated care at the Department of Geriatric Psychiatry of the Institute of Mental Health. A multidisciplinary team at the department provides for the psychosocial as well as physical care needs of these persons. The Institute of Mental Health runs an Early Psychosis Intervention Programme (EPIP). EPIP improves the outcome of patients with early psychosis by emphasizing early detection and intervention as well as establishing strong links with available community resources to provide carers with optimal support. The Community Addictions Management Programme (CAMP) is a programme run by the Institute of Mental Health to provide an integrated, comprehensive range of medical services (that span from prevention to rehabilitation) in the community for persons with addictions. CAMP also educates the public on addiction-related issues, provides treatment that is specific and relevant to the needs of special groups, develops resources in the community to support the recovery process and provides training to professionals in the field. Patients requiring an intensive in-patient detoxification programme are admitted to a dedicated 24-bed ward in the hospital.

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

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Slovakia

GENERAL INFORMATION

Slovakia is a country with an approximate area of 49 thousand sq. km. (UNO, 2001). Its population is 5.407 million, and the sex ratio (men per hundred women) is 94 (UNO, 2004). The proportion of population under the age of 15 years is 17% (UNO, 2004), and the proportion of population above the age of 60 years is 16% (WHO, 2004). The literacy rate is 99.7% for men and 99.7% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.7%. The per capita total expenditure on health is 681 international \$, and the per capita government expenditure on health is 608 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Slovak. The largest ethnic group(s) is (are) Slovak, and the other ethnic group(s) are (is) Hungarian, Czech, Romani, Ukrainian, and German. The largest religious group(s) is (are) Roman Catholic (more than half), and the other religious group(s) are (is) Protestant.

The life expectancy at birth is 69.8 years for males and 78.3 years for females (WHO, 2004). The healthy life expectancy at birth is 63 years for males and 69 years for females (WHO, 2004).

EPIDEMIOLOGY

Heretik et al (2003) applied the Mini International Neuropsychiatric Interview (MINI) and the shortened form of Beck Depression Inventory (BDI) to an adult population selected through quota sampling from across Slovakia (n=1212). They found that the 6-month prevalence of major depression was 12.8%, and that of minor depression was 5.1%. Regional differences in the prevalence of depression was noted. Depression was associated with ethnicity (Hungarian), availability of mental health services, residence (urban), gender (female), occupation (unemployed, students, disabled), marital status (widowed), social support (living alone) and life events (family and health related). Baska et al (2000) assessed more than 2400 students in five universities for smoking and eating habits. The results showed that 19.6% of males and 12.3% of females were regular smokers (min 1 cig/day) and 16.1% of males and 15.1% of females were occasional smokers. Smoking was associated with urban locality and alcohol consumption in males. One sixth of males were overweight (BMI \geq 25) and 8.5 % of females were grossly underweight (BMI \leq 17.5). Geckova et al (2002) assessed 1370 boys and 1246 girls (mean age 15 years) and found that adolescents from lower socio-economic strata were likely to exhibit health risk behaviour, except that a higher frequency of alcohol consumption was noted among girls whose parents were more educated. Okruhlica et al (2001) administered a questionnaire to 215 patients with heroin dependence (three-quarters of whom were males) and a control group of 231 adolescent students (one-quarter of whom were males). Gender specific analyses did not support the hypothesis that sports would help in the prevention of drug use. Okruhlica (1997) reviewed hospital records and noted that there has been a sharp rise in drug use since 1990. New patients consisted mainly of unemployed young (15-24 years) males (>70%). Intravenous use increased from 34% in 1993 to 72% in 1995. Okruhlica et al (2002) followed up more than 350 patients of opioid dependence after 3 years of treatment. Nearly 30% of patients had been abstinent for at least 6 months, 6% had been abstinent less than 6 months, 10% were on substitution treatment and 25% were regular heroin users. Patients were more likely to remain abstinent if they were going to work or school at the time of intake. Horazd'ovsky (1993) investigated trends in suicide rate in Czechoslovakia in 1975-1990 using national statistical databases. Suicide rates had decreased in both Czech and Slovak Republics. The rate was 13.4 per 100 000 in 2003, with the male to female ratio being 6.2:1 (Statistical Office of the Slovak Republic, 2004). Makinen (2000) discussed changing suicide patterns in Eastern Europe and former republics that formed the USSR. They found that the trends in suicide and their causes varied between countries. A model consisting of general stress, democratization, alcohol consumption and social disorganization (with a period-dependent effect) predicted fairly accurately the changes in the suicide rates in 16 out of the 28 Eastern Bloc countries in 1984-1989 and 1989-1994, but it failed to do so for Slovakia. Boehnke and Bergs-Winkels (2002) surveyed 42 independent samples of seventh graders from East and West Germany, Poland, Russia, Bulgaria, Slovakia, Hungary, Czechia and Greece in the years 1992-1995. Data on deviant school behaviour, delinquent drift, nurturant parenting and subjective feelings of justice in public were obtained from 7282 13- to 14-year-olds. Analyses showed that delinquent drift was a valid predictor of deviant school behaviour only on the individual level. The extent to which adolescents engage in pro-delinquent peer activities depends more on the cultural context in which adolescents live than on their personal experience in the family and in public. However, nurturant parenting co-varied negatively with deviant school behaviour irrespective of level of analysis.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

There is no official mental health policy, but a Programme for Psychiatric Care exists which was formulated in 1997. It is based on the work of a large group of psychiatrists in the beginning of the 1990s: The Reform of Psychiatric Care. There are recommended numbers for all kinds of services. It was accepted by the Government but it lacked a time frame. The reform was based on the regional (or catchment area) principle, with units of 100 000 to 150 000 inhabitants, in which all the required services should function. The emphasis was placed on the balance of inpatient and outpatient care, including restructuring the profile of beds (closing beds in mental hospitals and opening new wards in general hospitals). The development of new outpatient services and forms of

care such as day centres, rehabilitation facilities, sheltered workshops and sheltered housing were also included. Non-regional facilities were to be used for special forms of treatment (addiction, children, forensic units, etc.).

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 absent.

The national mental health programme was approved by the Government on October 6th 2004 as a basic document. It has to be elaborated in details as the intersectoral programme until October 31, 2005.

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.

The essential drugs list is still to be approved.

Mental Health Legislation Completely new health care legislation (6 health care laws) was approved by the parliament on October 21, 2004. This forms the basis for the reform of health care. There is no single mental health law. It is included in laws concerning health, social care and others. The general health care laws have a special section which deals with psychiatry, mainly with involuntary admissions. The courts have to decide on individual cases.

The latest legislation was enacted in 2004.

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 social insurance and out of pocket expenditure by the patient or family.

Efforts to transform the health care system began with the change in the political system. The Governmental budget system was replaced by an insurance system requiring compulsory payments by both employees and employers. The Government paid insurance only for those without jobs. Primary care was virtually completely privatized, as general practitioners entered into contracts with insurance companies. Direct cash payments by patients remained rare, as salaries for most of the population were very low. Employers and Government failed to pay insurance companies, who in turn failed to pay providers (e.g. private doctors, hospitals and pharmacies). As a result, hospitals were unable to pay for drugs, power, or food; a hospital's debts sometimes reached as high as its annual budget.

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.

There are community care facilities for patients with mental disorders. Most patients admitted to the ward are referred by outpatient psychiatrists. If the patient does not need inpatient treatment, he/she can be admitted to the day centre (18 in number), but most patients in the day centre come through the inpatient department.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	9
Psychiatric beds in mental hospitals per 10 000 population	6
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	10
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	32
Number of neurologists per 100 000 population	9
Number of psychologists per 100 000 population	3
Number of social workers per 100 000 population	1

There are 60 other mental health personnel. Over the last decade, a 10% increase in the number of beds in general hospitals and a 10% reduction in the number of beds in psychiatry hospitals has occurred. However, a true transformation of the entire system has not been achieved. The restructuring of hospitals, including the closure of unnecessary ones, failed to occur. It had been accepted that standard psychiatric care should be according to region, made generally accessible and diversified so it can care for the whole spectrum of patients with mental disorders within all age-categories. Special centres for drug dependence treatment have been opened. Some self-help groups have also started. About 320 beds have been allocated to child and adolescent psychiatry. Most psychiatrists and clinical psychologists work on a private basis.

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

Information Gathering System There is mental health reporting system in the country. The annual health report is not published but a statistical report of general health with psychiatry in it is published.

The country has data collection system or epidemiological study on mental health. A statistical list compiling number and types of services, treatment, demographical data on suicide and drug users are prepared.

Programmes for Special Population No special care programmes exist but children have outpatient child psychiatry clinics and services for the elderly are available in outpatient and inpatient care facilities in a limited way.

Child and adolescent psychiatric services are available in cities, but facilities are particularly limited in east Slovakia. Some of these centres offer day care services. Complementary services outside the health system include counselling centres in each district (under Ministry of Education), special schools and residential facilities (about 4500 places) for mentally challenged children and short-term stay centres for children with conduct problems and abused or neglected children prior to foster placement.

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

The drugs are divided into 3 categories, and the first category is fully reimbursed by the insurance.

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Slovenia

GENERAL INFORMATION

Slovenia is a country with an approximate area of 20 thousand sq. km. (UNO, 2001). Its population is 1.982 million, and the sex ratio (men per hundred women) is 95 (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 20% (WHO, 2004). The literacy rate is 99.7% for men and 99.6% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8.4%. The per capita total expenditure on health is 1545 international \$, and the per capita government expenditure on health is 1157 international \$ (WHO, 2004).

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

The life expectancy at birth is 72.8 years for males and 80.5 years for females (WHO, 2004). The healthy life expectancy at birth is 67 years for males and 72 years for females (WHO, 2004).

EPIDEMIOLOGY

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

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent. The Drug Office at the Slovenian Government is presently working on the National Programme for Prevention of Drug Misuse and a new strategy plan is under development.

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

Though a national programme of mental health has not yet been adopted, it is the responsibility of the Council for Health, a Government advisory body which includes experts from the fields of both health and social security. However, national programmes have been suggested for preventing suicide and dependence on alcohol and drugs.

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

A Medicinal Product and Medical Device Act was adopted in 1999.

Mental Health Legislation The Mental Health Act is in under Government evaluation. The Involuntary Commitment Law, Section 7 of 1986 and the Act on Legal Proceedings of 1999 deal with mental health. The different legislation on substance abuse are:

Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act (1999), Production and Trade in Illicit Drugs Act (1999), and the Law on Precursors for Illicit Drugs Act (1999). The Ministry of Health, together with competent experts from the field, the Ministry of Labour, Family and Social affairs and the Ministry of Justice are drafting a new mental health legislation which will include: voluntary and involuntary admission to treatment, emergency admission, prolonged detention, early discharge, patient rights, advocacy and care planning.

The latest legislation was enacted in 1999.

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

Details about expenditure on mental health are not available.

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

Part of the problems in the development of community mental health programmes in the country is related to the fact that insurance agencies finance hospital beds rather than programmes. Rehabilitation services are funded partly by health care and partly by the social care system.

The country has disability benefits for persons with mental disorders. The essential socioeconomic provisions for people with mental disorders, include disability allowance, social support, free medications and no restrictions in the number of outpatient psychiatry consultation. Retirement benefits are present for chronically mentally ill patients.

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

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 50 personnel were provided training. Though courses, mostly on depression, have been provided, most such practitioners do not have adequate mental health training.

There are community care facilities for patients with mental disorders. There are some attempts by psychiatric institutions and NGOs, but no system for community mental health approach has been developed as yet. In Ljubljana (the capital), a rehabilitation service has been created within the framework of the psychiatric service, which is intended to provide better coordination with

outside collaborators and introduce rehabilitation principles in treatment. The psychiatric rehabilitation service should enable suitable referral of patients and coordination among the so far poorly linked non-governmental and social services as well as GP services. The University Psychiatric Hospital in Ljubljana also gives professional and material support to non-governmental organizations that provide outpatient community care for its patients. It serves as a national tertiary referral centre. User organizations and associations of interested experts have been founded. The largest are ŠENT, ALTRA; OZARA; PARADOKS which, together with the psychiatric profession, are involved in preventive, mainly anti-stigma programmes. Among the psychosocial services offered are housing facilities with support (about 1800 places), day centres, vocational rehabilitation development, sheltered employments and education facilities for patients and carers.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	8.46
Psychiatric beds in mental hospitals per 10 000 population	7.2
Psychiatric beds in general hospitals per 10 000 population	1.26
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	5.35
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	5.8
Number of neurologists per 100 000 population	0.8
Number of psychologists per 100 000 population	1.65
Number of social workers per 100 000 population	0.45

There are altogether six regional psychiatric hospitals including the university psychiatric hospital and the Psychiatric Clinic. All have wards for general psychiatry, psycho-geriatrics and the treatment of alcohol dependency. The Psychiatric Clinic also has wards for adolescent psychiatry, drug dependency and psychotherapy. There is also the Child Psychiatry Ward in the Paediatric Clinic. About 30 beds have been allocated for child and adolescent psychiatry. Deinstitutionalization has not taken place significantly in Slovenia. Also, there are no psychiatric hospitals in the southern region. There are 24 child and adolescent psychiatrists in the country. In addition, 35 clinical psychologists, 25 educational psychologists, 42 social workers and a number of other professionals are involved in provision of child and adolescent mental health services. Some psychiatrists have started working as private practitioners following the implementation of the national insurance scheme.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. From 1997-98, there was an attempt to strengthen the civil initiatives in the country, initially with the help of the Netherlands MATRA funds. And education programmes for patients, carers and professionals were created. These helped to increase awareness regarding mental disorders, treatment facilities, psychosocial rehabilitation facilities, which in turn helped in reducing stigma. The network of organizations and services outside psychiatry which could support preventive activities – mainly early recognition and treatment of mental disorders – is weak. A national organization of relatives of people with severe mental illness called Forum of carers was established in 1999 and many self-help groups are functioning.

Information Gathering System There is mental health reporting system in the country. Details can be obtained from the Health Statistics Yearbook of Slovenia 1999, Institute of Public Health.

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

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

Preventive education programmes for recognizing suicidal tendencies take place constantly. Therapeutic work is done with the suicide survivors, individually and in groups, and some preventive work has been done with GPs and teachers to recognize and react with depressed and suicidal individuals. The Institute for Health Protection organizes numerous preventive programmes against smoking, other addictions and infection with AIDS. Health programmes are also organized at schools and kindergarten. A part of mental health services for children and adolescents is provided within the framework of education and social care programme. Most schools in Slovenia have one or more school counsellors, who often collaborate with social workers at regional centres for social care. Centres for social care supervise and run dwellings for adolescents with dysfunctional families. Child guidance clinics are also available and are usually staffed by psychologists.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, amitriptyline, diazepam, fluphenazine, haloperidol, lithium, biperiden, levodopa. The anti-epileptics prescribed most often are carbamazepine, valproic acid and gabapentin. The anti-parkinsonians, used most often are biperiden, levodopa and decarboxylase inhibitor and entacapone. The most popular anxiolytics/hypnotics in terms of prescription support are bromazepam, alprazolam and zolpidem; and the most popular anti-depressants are citalopram, sertraline and fluoxetine.

Other Information

Additional Sources of Information

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Solomon Islands

GENERAL INFORMATION

Solomon Islands is a country with an approximate area of 29 thousand sq. km. (UNO, 2001). The country is an archipelago of about 1000 mountainous islands and low-lying coral atolls. Its population is 0.491 million, and the sex ratio (men per hundred women) is 106 (UNO, 2004). The proportion of population under the age of 15 years is 42% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 85% for men and 68% 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%. The per capita total expenditure on health is 133 international \$, and the per capita government expenditure on health is 124 international \$ (WHO, 2004).

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

The life expectancy at birth is 63.6 years for males and 67.4 years for females (WHO, 2004). The healthy life expectancy at birth is 55 years for males and 57 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Solomon Islands in internationally accessible literature. Dohan et al (1984) reviewed multiple data sources and found only two cases of schizophrenia in Pacific Islands including Solomon Islands during the historical epoch when the islanders were unfamiliar with gluten containing cereals (e.g. wheat), when the expected number based on population estimates was 130. Later, when the eating habits of this region approached patterns common in Europe, the prevalence of schizophrenia also reached European levels. From this, the researchers inferred a role for grain glutes in the onset of schizophrenia.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

An initial draft of mental health policy is ready. Further progress could not be made because of absence of consultants to guide and advise on the development of the policy. The policy on mental health is expected to be finalized by January 2006.

Substance Abuse Policy A substance abuse policy is absent. There is no substance abuse programme, although it is a part of the national mental health programme.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999. It is a six year plan. Part of it was incorporated in the Ministry of Health's National Health Policies and Development Plans 1999-2003. The draft plan for the next 10-years is ready for approval of the Ministry.

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.

The national drug policy was drafted in 1999 but has still not been ratified. However, it is being applied in functions related to the essential drug programme, dangerous drugs and psychotherapy, administration and reporting, poison registration and pharmaceutical personnel development and training.

Mental Health Legislation There is a Mental Treatment Act. This act consolidates the law relating to persons of unsound mind and makes further and better provision for the care of persons suffering from mental disorders and for custody of persons and the management and control of mental hospitals. There is now an attempt to include community and primary care facilities incorporated into the act. The Act was amended in 1995 by two consultants and attempts are being made to get it passed by the parliament. It is a part of the mental health programme.

The latest legislation was enacted in 1970.

Mental Health Financing There are budget allocations for mental health.

The country spends 1.4% 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 is no public disability benefit. The insurance system does not insure against mental illness.

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. There is a basic continuum of service from acute care at the outpatient clinics to outreach services, but the links are erratic.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 62 personnel were provided training. Some psychiatric health coordinators have been trained and the plan is to train all registered nurses and nursing aides throughout the country over a five year period. A one-month training programme funded by WHO trained 12 nurse coordinators (4 underwent a full psychiatric nursing training later) who are now functioning in 7 out of 9 provinces. Similarly, about 50 nurse aids were trained in courses funded by the Health Institute Strengthening Project from the Australian Government. In addi-

tion to their regular duties, the nurse coordinators carry out psychiatric tours of remote areas, where they educate the public and give mental health talks to nurses and doctors besides providing clinical care and referral. Nurse coordinators do not have prescribing privileges.

There are no community care facilities for patients with mental disorders. Nurses give injections to patients in rural areas. There are plans to start a day care centre.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.26
Psychiatric beds in mental hospitals per 10 000 population	0.26
Psychiatric beds in general hospitals per 10 000 population	0
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0.9
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 a lack of specialists because of difficulties in getting through the advertisement and recruitment process. The appointment of an overseas psychiatrist is expected this year. The psychiatric ward at the National Psychiatric Unit was closed in 2002 following a shortage of medicines and daily necessities. Patients with suicide attempts/overdose are admitted in medical wards. The nurses are in psychiatric nursing training in Papua New Guinea, and a doctor has been sent for overseas training as a psychiatrist.

Non-Governmental Organizations NGOs are not involved with mental health in the country. Churches offer counselling, and the Richmond Fellowship has expressed a willingness to help in mental health services.

Information Gathering System There is no mental health reporting system in the country. Currently, mental health is not included in the Monthly Clinic Report System (Health Information System) but it would be reported in future and is a programme under the mental health programme. There is an annual mental health report by the Mental Health Division Heads which use standard reporting systems.

The country has no data collection system or epidemiological study on mental health. A prevalence survey was tried unsuccessfully and would be retried again.

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, chlorpromazine, diazepam, fluphenazine, lithium. Only chlorpromazine is stocked to area health centres and to some rural health centres. Other drugs such as fluphenazine, haloperidol and benzhexol are supplied to the patients who have been discharged from the hospital. Supplies are ordered against patients names to ensure patients have enough supply stocked in the rural clinics. Other drugs like trifluoperazine, benzhexol and fluoxetine are also available for use in primary care.

Other Information Training programmes are being conducted for community leaders, relatives and carers, police and those in the legal profession. The World Mental Health Day is celebrated to generate awareness on mental health issues.

Additional Sources of Information

Dohan, F. C., Harper, E. H., Clark, M. H., et al (1984) Is schizophrenia rare if grain is rare? *Biological Psychiatry*, 19, 385-399.

Somalia

GENERAL INFORMATION

Somalia is a country with an approximate area of 638 thousand sq. km. (UNO, 2001). Its population is 10.312 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 48% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 25.1% for men and 13.4% 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 2.6%. The per capita total expenditure on health is 15 international \$, and the per capita government expenditure on health is 7 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Somali, Arabic, English and Italian. The largest ethnic group(s) is (are) Somali (five-sixths), and the other ethnic group(s) are (is) Bantu. The largest religious group(s) is (are) Muslim.

The life expectancy at birth is 43 years for males and 45.7 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 Somalia in internationally accessible literature. Elmi (1983) conducted an epidemiological research on khat chewing in a random sample of about 7500 people. He suggested that the prevalence of the khat chewing has continuously increased in all social groups and that the excessive use of khat may create considerable problems of social, health and economic nature.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

There is no unified health policy.

Substance Abuse Policy A substance abuse policy is absent.

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

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

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

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

Details about expenditure on mental health are not available.

The primary source of mental health financing is grants.

The financing of mental health services is almost entirely dependent on grants from WHO and NGOs.

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. Recently, a Mental Health Coordinator was appointed for North West Somalia to initiate integration of mental health care in primary health care and training of primary health care personnel.

Regular training of primary care professionals is not carried out in the field of mental health. The voluntary workers of GAVO have been trained about the principles of psychiatric interview, introduced to DSM-IV, given training about psychopharmacology, psychosocial rehabilitation and hospital management. The training had lasted for 2 years and is not on a regular basis.

There are no community care facilities for patients with mental disorders. Limited community care through NGOs and WHO are available in very limited areas of one region in northwest Somalia. A psychosocial centre was established in Berbera in 1990.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population 0.398

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 0.06

Number of neurosurgeons per 100 000 population

Number of psychiatric nurses per 100 000 population 0.03

Number of neurologists per 100 000 population

Number of psychologists per 100 000 population 0

Number of social workers per 100 000 population 0.19

There are only three centres for psychiatry, the mental hospital in Berbera and the general psychiatric wards in Hargesia and Mogadishu. Until the arrival of the NGO from Italy, the condition of the mental hospital was appalling. Patients were kept in chains, and supply of food was largely dependent on charity. UNDP is supporting the psychiatric ward in Hargesia in terms of structural

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facilities and supplies. There is no private psychiatric inpatient facility though there are a few private clinics in Mogadishu and Hargesia. There is no specialized drug abuse treatment centre and there is no mental health training facility in the country. Only limited data about one area of Somalia, Somaliland is available. Psychiatrists have private clinics.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. The whole mental health set-up of Somalia is based on the efforts of NGOs – GRT-UNA of Italy and General Assistance and Volunteer Association (GAVO), a local Somali NGO. They help in the provision of services to mental patients and street children and provide training for primary health care personnel.

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 No programmes for special population exist. UNDP and NGOs are supporting the Government's plans for reintegration of militia including those that are mentally ill into the mainstream through projects involving occupation.

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

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Mental Health in Somaliland. (Government document).

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South Africa

GENERAL INFORMATION

South Africa is a country with an approximate area of 1221 thousand sq. km. (UNO, 2001). Its population is 45.214 million, and the sex ratio (men per hundred women) is 95 (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 6% (WHO, 2004). The literacy rate is 86.7% for men and 85.3% 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 8.6%. The per capita total expenditure on health is 652 international \$, and the per capita government expenditure on health is 270 international \$ (WHO, 2004).

The main language(s) used in the country is (are) eleven, with English being important for commerce. The largest ethnic group(s) is (are) African, and the other ethnic group(s) are (is) European and Asian. The largest religious group(s) is (are) Christian, and the other religious group(s) are (is) Hindu and Muslim.

The life expectancy at birth is 48.8 years for males and 52.6 years for females (WHO, 2004). The healthy life expectancy at birth is 43 years for males and 45 years for females (WHO, 2004).

EPIDEMIOLOGY

Rumble et al (1996) conducted a two-stage survey in a rural community (n=481) using the Self-Reporting Questionnaire (SRQ) and the Present State Examination (PSE). The weighted prevalence of psychiatric morbidity was 27.1%. Depression and anxiety disorder were common. Bhagwanjee et al (1998) assessed 354 rural adults with SRQ-20 and standardized instruments following a two-stage procedure. The weighted prevalence for DSM-IV generalized anxiety and depressive disorders was 23.9% (generalized anxiety: 3.7%, major depression: 4.8%, dysthymia: 7.3% and major depression and dysthymia: 8.2%). Michalowsky et al (1989) evaluated 1239 respondents from 3 mining areas. According to GHQ, the number of cases varied from 14.1% to 23.8%, and between 23.2% and 31.2% of respondents drank alcohol at least once a day. Women had more psychosocial illnesses in comparison to men. Ben-Arie et al (1983) examined 139 non-institutionalized coloured elderly (above 65 years) persons using the PSE and the Mini Mental State Examination (MMSE). Dementia (8.6%, severe: 3.6%), other psychiatric disorders (24%, depression: 16.5%) and alcohol dependence (15% of men) were common. Parry et al (2002) reported the findings of the South African Community Epidemiology Network on Drug Use (SACENDU) project. Between 1997-99, alcohol was the most commonly used drug (51.1% – 77% in various regions) and use of alcohol was associated with trauma and comorbid psychiatric disorders. School surveys showed a harmful drinking pattern in 36% to 53.3% of male students. Use of cannabis and methaqualone was also common. There was a significant increase in cocaine and heroin use during the period. Flisher et al (2002) assessed 2930 students of grades 8 and 11. Lifetime prevalence rates of substance use were: 42.1% for tobacco, 43.8% for alcohol, 12.3% for cannabis and 3.6% for methaqualone, ecstasy or crack. London (2000) reported problem drinking and dangerous drinking according to CAGE and a shortened version of the Michigan Alcoholism Screening Test (MAST) in about two-thirds and 9.3%, respectively, of a sample of farm workers. In a rural general practice (n=858), 15.6% of the subjects had major depression (Strauss et al, 1995). Cooper et al (1999) found depression (as per DSM-IV) in 34.7% of 147 women who had delivered two months previously. Maternal depression was associated with poor support from partners and insensitive engagement with the infants. Allwood et al (2001) reported an incidence rate of 2-3 per 1000 births for puerperal psychosis (n=381) and that it was associated with primiparity and family or past history of psychiatric or medical illnesses. Flisher and Parry (1994) analysed the suicide mortality data from the national registry (1984-1986). Suicides accounted for 1.3% of deaths, with higher rates among the Whites, but suicide were very common among young Asian women. The most common method of committing suicide in Whites was firearms and in others hanging. Sukhai et al (2002) reviewed the National Injury Mortality Surveillance System register and police and hospital records (1996-2000) and found that suicides accounted for 5.6% of deaths. The majority of suicides were reported for black women in their thirties. In a sample of 7340 school children, Flisher et al (1993) found that during the previous 12 months, 19% of students had suicidal thoughts and 7.8% had attempted suicide. Mhlongo and Peltzer (1999) found parasuicidal behaviour in 10% of young patients (15-24 years) attending a regional hospital. Robertson and Juritz (1998) found that 17.6% to 21% of 10-13 year-old children according to parents' reports, and 9.5% to 10.5% of children according to teachers' reports met the criteria for behaviour disorders. Behaviour disorders were associated with gender (boys), age (older), IQ (below 100) and learning disability. Robertson et al (1999) administered the Xhosa Diagnostic Interview Schedule for Children Version 2.3 to children and adolescents aged 6-16 years (n=500) in an informal settlement area. Psychiatric disorder with impairment was found in 15.2% of the children and adolescents. Peltzer (1999) assessed 148 secondary school children using the Children's Posttraumatic Stress Disorder Inventory and the Reporting Questionnaire for Children and found that two-thirds of the children had experienced a traumatic situation and 8.4% met a diagnosis of PTSD. In a sample of 7516 Black primary school children, Cartwright et al (1981) found that 22.4% had a learning problem and 8.7% had a physical or mental handicap. Couper (2002) found a prevalence rate of 6% for various disabilities in a two-stage survey (n=2036) of children (<10 years). Perceptual or learning disabilities were common. Christianson et al (2002) assessed 6692 rural children (2-9 years old) following a two stage procedure and found a rate of 3.6% for intellectual disability (severe – 0.6% and mild – 2.9%). The male:female ratio was 3:2.

MENTAL HEALTH RESOURCES

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

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The White Paper for the Transformation of the Health System in South Africa (1997) sets out the policy direction for the development and transformation of mental health services.

Substance Abuse Policy A substance abuse policy is absent. The substance abuse policy is in the process of being finalized.

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

The mental health programme is different for each province. The present move is towards establishing community-based services, with the integration of mental health services into primary health care. Concerted efforts are also being made to assist with preventive and promotive aspects of mental health.

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 existing legislation, the Mental Health Act, is old. The Mental Health Care Act, was passed by Parliament in 2002. It will be promulgated in 2004. The main aims of the Act are to promote human rights of people with disabilities; improve mental health services through a primary health care approach and an emphasis on community care; protect the health and safety of the public in circumstances where a person with mental disabilities may be a danger to him/herself or others; set out the framework and statutory roles with respect to voluntary users, assisted users, involuntary users, state patients and mentally ill prisoners. Current legislation will allow the possibility of non-medical practitioners having the right to prescribe (CRTP) medication in South Africa.

The latest legislation was enacted in 2002.

Mental Health Financing There are budget allocations for mental health.

Details about expenditure on mental health are not available.

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

Quite recently, a study was commissioned to calculate the expenditure on mental health. The study provided highly disputed figures as it failed to calculate the cost of the integrated mental health care. A patient advocacy NGO, the Depression and Anxiety Support Group, found evidence of discrimination against mental illnesses in South African medical aids and state-funded health systems. Specifically, some aids refused to cover hospitalization for suicide attempts and substance use disorders.

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. Care is provided in some cases by a psychiatric nurse and in others by a primary health care worker. The current psychiatric practice is varied and a new patient can be initially seen by either a psychiatrist or a community nurse or a primary nurse depending on the place. The patient is then either treated at that place or is immediately referred to a secondary facility. The aim is to make the system more efficient so that there is a comprehensive mental care facility at the community level. However the integration of mental health into primary health care services is sub-optimal.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 450 personnel were provided training. Primary health care practitioners, e.g. nurses undergo integrated training that provides for knowledge and skills needed to handle psychosocial issues. This is supplemented by further training in additional or contemporary mental health issues like crisis intervention/trauma counselling, pharmacotherapy, management of substance abuse etc. Evaluation of components of these programmes have shown that the interventions have been successful.

There are community care facilities for patients with mental disorders. Other than giving medical care, community care is very limited.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	4.5
Psychiatric beds in mental hospitals per 10 000 population	4
Psychiatric beds in general hospitals per 10 000 population	0.38
Psychiatric beds in other settings per 10 000 population	0.12
Number of psychiatrists per 100 000 population	1.2
Number of neurosurgeons per 100 000 population	0.3
Number of psychiatric nurses per 100 000 population	7.5
Number of neurologists per 100 000 population	0.3
Number of psychologists per 100 000 population	4
Number of social workers per 100 000 population	20

The staff-patient ratios cited above may be an over-estimation due to the high rate of emigration of health personnel and the employment of mental health professionals in other sectors. There are 109 occupational therapists, 89 medical officers and 28 community health workers besides a number of trainee mental health professionals working in the mental health services. About a quarter of the beds are acute beds and three quarters medium-long stay beds. There are large differences between bed strengths in each province, with Mpumalanga, North-West Province and Northern Cape having few beds and Gauteng and Northern Province having many beds for mental health care. In some province downsizing has occurred, but it was not accompanied by the development of residential and ambulatory care in the community. The only province to report residential care facilities in the community was Gauteng, which reported a total of 305 places. Most mental health professionals are concentrated in the Cape Town and Gauteng (Johannesburg-Pretoria) region. The North-West Province has no psychiatrist, and Northern Cape and Mpumalanga have only one each. These regions have a low concentration of other mental health professionals also. About 56% of psychiatrists in South Africa work in private set-ups. They provide services to about 20% of the population, the majority of whom are funded by medical insurance. Only 4.7% of psychiatrists are practicing in the rural setting. Most psychiatrists are biologically oriented and the few who practice psychotherapy use cognitive-behavioural models in most situations. However, Jungian School of analytical psychotherapy is practised by some in Cape Town. Limited private practice is permitted to psychiatrists in the Government set-up. A substantial proportion of psychiatrists recruited to English-speaking countries are from South Africa. Not many black doctors have been attracted to psychiatry; as a result only 10.8% of South African psychiatrists are able to communicate fluently in one or more African languages.

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 14 support groups are functioning in South Africa. However, 10 areas have no support groups. They rendered assistance in advocacy, providing for basic needs of their members, life skills teaching, crisis intervention and counselling. Rural support groups provide advocacy, treatment and rehabilitation.

Information Gathering System There is no mental health reporting system in the country. The national indicators do not include information on the prevalence of mental disorders. At the district level, data on clinical consultations is collected.

The country has data collection system or epidemiological study on mental health. Data are collected from hospital and community services. A national epidemiological study is under way. The South African Demographic Health Survey conducted in 1998 and the First South African Youth Risk Behaviour Survey (2002) contributed important findings on mental health of populations.

Programmes for Special Population The country has specific programmes for mental health for children. Some of the programmes are run by NGOs and the Government has also started working in some areas. There are some programmes for victims of violence.

Child and adolescent, geriatric and neuropsychiatric services are available, but dedicated staff and facilities are available at only a few centres. Some community psychiatric nurses have been given special training in child and adolescent mental health issues. As a part of the National Crime Prevention strategy, the mental health directorate has taken responsibility for training general health workers in 'victim empowerment', setting up 'violence referral centres' in disadvantaged areas, setting up violence prevention programmes in schools and developing mother-infant bonding programmes for violence prevention in poor communities. As a part of the national initiative to prevent the spread of HIV among school children, teachers in every school are being trained to teach HIV/AIDS-related and substance abuse-related life skills at primary and secondary school levels. The need for pre-test and post-test counselling on HIV/AIDS will lead to the deployment of counsellors in every clinic in a five-year period. A Mental Health Information Centre has been started to provide psychoeducation.

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, biperiden, carbidopa, levodopa.

The acquisition costs of new psychotropics is considerably greater than those of their predecessors.

Other Information In 1978, the APA compiled a report criticizing the racial bias in psychiatric practice. Similar reports were filed by the Royal College of Psychiatrists in 1983. Isolation from international forums followed from 1987. Though currently racial bias is not present in treatment issues, a recent study (Lee et al, 1999) found that the better centres tended to be utilized more by the white community. This was due to the availability of better services in the white population dominated areas, and the conclusion was to extend some of these services to the poorer sections of the community without compromising the existing structure present in the more affluent white community. In response to the gross violation of human rights in the past, the post-apartheid Government established a Truth and Reconciliation (TRC) in a move to promote national unity and reconciliation. Mental health professionals provided advice regarding the manner in which testimony should be taken, and provided psychological support when necessary to those who testified. TRC members were trained in issues relevant to psychological support, and some of the TRC commissioners were mental health professionals.

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Spain

GENERAL INFORMATION

Spain is a country with an approximate area of 506 thousand sq. km. (UNO, 2001). Its population is 41.128 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 22% (WHO, 2004). The literacy rate is 98.5% for men and 96.8% 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 7.5%. The per capita total expenditure on health is 1607 international \$, and the per capita government expenditure on health is 1148 international \$ (WHO, 2004).

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

The life expectancy at birth is 76.1 years for males and 83 years for females (WHO, 2004). The healthy life expectancy at birth is 70 years for males and 75 years for females (WHO, 2004).

EPIDEMIOLOGY

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

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1985.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Although in a strict sense, there exists no official policy on mental health issues at a national level, a mental health plan does exist in each of the 17 Autonomous Communities, framed in the health plan of each Community. However, it can be considered that the last reference at a national level to mental health are the recommendations of the Commission for the Psychiatric Reform (1985), and the General Health Law (1986). Each Autonomous Community has published a plan on mental health, the first ones dates from the late 1980s and the last ones from the 2003s. They include all the components listed above. Social insertion is also a part of the mental health policy. Details about the components of the policy can be obtained from the different Plans on Mental Health documents.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1985. Details can be obtained from the document- 'Estrategia Nacional Sobre Drogas, 2000-2008.

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

There is no national mental health programme but there are mental health plans formulated by each Autonomous Community. Although being very similar in their theoretical formulation they are not as similar in their practical application, there are marked differences with regards to funding of resources for psychiatric care among them. There are also no psychiatric care programmes at a national level making that the responses of each one of the Autonomous Community with regards to concrete problems on mental health differs.

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 The General Health Law has a chapter on mental health. The Commission for the Psychiatric Reform includes in its conclusion the need to substitute the old model of care giving, centred on psychiatric hospitals by an integral care of mental pathologies, outpatient and community based, recommending the replacement of psychiatric hospitals by hospitalization units for severe cases in general hospitals, the creation of outpatient mental health units, of intermediate and rehabilitation mechanisms. The Civil and Penal code have incorporated modifications to protect the rights of psychiatric patients and improve conditions for penal sentences for offenders with mental illness. As a part of these reforms prison hospitals were closed and special units under the National health Care were started. The latest civil legislation was enacted in 2000.

The latest legislation was enacted in 1986.

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 private insurances.

Some Autonomous Communities have a budget line for mental health. In the financing model currently in force, the Autonomous Communities receive from the State a final budget for health care calculated according to capitative criteria, with small correction criteria. Hospitals are financed through a global budget, calculated according to the volume and complexity of the foreseen activities, although some experiences of financing per capita have started to be introduced, a model reserved until now only for primary health. The overall health budget is provided through the central administration, the local bodies and private spending. In all it amounts to 7.8% of the GNP. In the frame of the private health care sector, the care of severe psychiatric pathologies is covered by all insurance companies, although they do establish maximum limits to the length of psychiatric hospitalization. Psychotropic drugs

(including newer ones) are subsidized by the social security system. A relatively small proportion of the population has additional health insurance, allowing them more freedom of choice for their health care. The care of severe psychiatric illness is covered by all private insurance companies, although they lay down maximum limits to the length of psychiatric hospitalization.

The country has disability benefits for persons with mental disorders. Psychiatric illnesses are considered as a transitory working disability and also a definitive one. In both cases its recognition gives right to an economic compensation, for the first case only if previously working and in the second case with different amounts, depending on whether the patient did contribute before or not to the social security system.

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. Specialists in Family and Community Medicine receive short training (two months) in mental health facilities. Several NGOs, international organizations, such as WPA and WHO Collaborating Centres promote the training of primary care physicians in mental health.

There are community care facilities for patients with mental disorders. The community care is provided by mental health centres, which were initially developed as support units for the primary care and are integrated in the network of psychiatric facilities (there is an exception of Cataluña where the mental health centres are included in primary care level).

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	4.4
Psychiatric beds in mental hospitals per 10 000 population	3.7
Psychiatric beds in general hospitals per 10 000 population	0.6
Psychiatric beds in other settings per 10 000 population	0.1
Number of psychiatrists per 100 000 population	3.6
Number of neurosurgeons per 100 000 population	0.9
Number of psychiatric nurses per 100 000 population	4.2
Number of neurologists per 100 000 population	2.5
Number of psychologists per 100 000 population	1.9
Number of social workers per 100 000 population	

There are 3913 other mental health professionals belonging to different categories. Until the adoption of the Commission for Psychiatric Reform the psychiatric care was mainly in the hands of local authorities (Diputaciones Provinciales or Local Councils) and religious orders, owners of the old psychiatric hospitals and university hospitals with psychiatric departments. In the last years of the 1970s, the first psychiatric units in general hospitals were opened although sometimes with minimal facilities sometimes limited to liaison consultation with other specialities. Since the 1980s, there has been an increase in development of new organizational structure for mental health, integration of psychiatry in general health care system (e.g. psychiatry departments have been established in all public hospitals with more than 200 beds), creation of an extensive community network and better public awareness about mental health along with adoption of legislation to improvement of patients rights. However, there needs a lot to be done in the sphere of intermediate community care (Garcia et al, 1999). Details can be obtained from the document 'Sistema de Informacion en Salud Mental Indicadores' (1996). Most psychologists work in the private sphere.

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. Details can be obtained from the CMBD National Report 1999 and INSALUD CMBD Report 2002.

The country has no data collection system or epidemiological study on mental health. Some records are available from certain Autonomous Communities and other regions.

Programmes for Special Population The country has specific programmes for mental health for children. Besides facilities for children there are facilities for drug addiction and for eating disorders.

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.

Psychopharmacological drugs, including the new anti-psychotics, neuroleptics and anti-depressants, are financed by the social security system and are given for free to pensioners and many of them at subsidized rates for active population, who in the worst of cases have to contribute 40% of the cost.

Other Information Custodial care continued till 1977, but due to increasing costs, poor conditions of the mental hospitals and professional awareness about community care, Autonomous Communities were created and health care was transferred into the hands of decentralized units. With the publication of the report of the 'Commission of Psychiatric Reform' in 1985, a large number of beds were established in general hospitals and community care units were set up in the Autonomous Communities. Sheltered accommodation, rehabilitation centres and centres for social integration also started functioning. The limitations are: uneven course of reform with lot of variability between communities, inadequate integration with general health system, especially where knowledge about psychological management is concerned, lack of support for families and carers of patients, a strong tendency to maintain mental hospitals in some form and lack of a national mental health information system and a national assessment system. Two years ago a Mental Health National Report was published, including the data of different Autonomous Communities (24). The EPSILON Group found that Santander has very few acute hospital residential care and day care services for patients suffering from schizophrenia. There were no self-help groups and non professional services. However, community services were present.

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Sri Lanka

GENERAL INFORMATION

Sri Lanka is a country with an approximate area of 66 thousand sq. km. (UNO, 2001). Its population is 19.218 million, and the sex ratio (men per hundred women) is 107 (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 10% (WHO, 2004). The literacy rate is 94.7% for men and 89.6% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.6%. The per capita total expenditure on health is 122 international \$, and the per capita government expenditure on health is 60 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Sinhala. The largest ethnic group(s) is (are) Sinhalese, and the other ethnic group(s) are (is) Tamil. The largest religious group(s) is (are) Buddhist (seven-tenths), and the other religious group(s) are (is) Hindu, Christian and Muslim.

The life expectancy at birth is 67.2 years for males and 74.3 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY

Wijesinghe et al (1978) conducted a community survey of a semi-urban population (n=7653) with a two-stage screening method. The 6-month period prevalence for all psychiatric disorders was 4.6%, with psychoses accounting for 0.7% (males 0.6%, females 0.8%) and neuroses for 2.5% (males 1.0%, females 4.1%). They also found a rate of 0.5% for possession and trance states (Wijesinghe et al, 1976). De Silva and Gunatilake (2002) found that 8.7% of subjects in a sample of 380 subjects over the age of 65 years from a semi-urban community had cognitive impairment (scored less than 18 points) when assessed with the Sinhalese version of the Mini Mental State Examination (MMSE). Somasundaram and Sivayokan (1994) interviewed one member each from 101 randomly selected families from a primary health area with the Stress Impact Questionnaire. The vast majority of the respondents had suffered numerous traumas. Common diagnoses reported were PTSD (27%), anxiety disorder (26%), major depression (25%) and alcohol and drug misuse (15%). Functional disability was reported in 18%. Somasundaram (1996) assessed a refugee population within two months of being exposed to aerial bombing (n=15). Nearly 74% had experienced an immediate but transient stress reaction. Subsequently, PTSD, anxiety, depressive and somatic symptoms were common and 44% met the DSM-III diagnostic criteria for PTSD. Reppesgaard (1997) conducted a study among a Tamil population affected by trauma. Surprisingly, the results showed that subjects in non-war zones had a significantly higher frequency of serious PTSD, depression and somatoform disorder as per DSM-III-R than subjects in war zones. The number of moderately affected was significantly higher in war zones. The young and the middle-aged groups had higher scores on serious manifestations than the older group. La Vecchia et al (1994) analysed suicide mortality for 57 countries on the basis of the World Health Organization mortality database. Sri Lanka has the second highest male suicide rate (49.6/100 000 population) and the highest female suicide rate (19.0/100 000 population). Sri Lanka also had an unfavourable trend over time, unlike most other developing countries. Ganesvaran et al (1984) found that the suicide rate was 53.5 per 100 000 population in a town in the northern region. The rate of suicide was increasing among the 15-34 age group. The commonest method was self-poisoning by agrochemicals and insecticides of organophosphorus type. Similar findings were reported by Berger (1998) who compared the rate of suicide in Sri Lanka and USA. Somasundaram and Rajadurai (1995) reported a decline in suicide rate during the civil war 1980-89, notably among males and youth. An inverse relationship between suicide and homicide rates was shown. The use of agrochemicals for suicidal purposes declined during war, while alary seeds (?) became more popular. Eddleston et al (1998) reported that ingestion of yellow oleander seeds has recently become a popular method of deliberate self-harm in northern Sri Lanka. Four hundred and fifteen cases were admitted to a general hospital in Sri Lanka's north central province during 11 months. Nearly half of the ingesters were less than 21 years old. The mortality rate was more than 6%.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Steps have been taken to gather evidence for policy formulation, and a committee has been appointed to formulate draft policy and legislation.

Substance Abuse Policy A substance abuse policy is absent. A substance abuse policy has been developed but is still to be ratified by the parliament.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1966. The current mental health programme is based on the WHO recommendations given in the World Health Report 2001 and the National Strategic Mental Health Plan formulated in 2001 with the assistance of WHO. It emphasizes equity and accessibility of services. The long-term goals are described under 5 broad categories of patient care and follow-up, rehabilitation, prevention and promotion, management and research. The public health approach of delivering mental health care integrated into general health services, primary health care services and community care is envisaged. The main strategies are to improve material resources, human resources in the periphery and to downsize specialized mental health hospitals. Linkages to promote intra- and inter-sectoral

collaboration for improved care of people with mental health needs is envisaged. A referral system and continuity-of-care system is to be developed with a good information system for effective monitoring and evaluation.

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

The new mental health policy will consider the issue of inclusion of newer anti-psychotics in the essential drug list.

Mental Health Legislation The current legislation dates back to the Mental Disease Ordinance of 1873 (amended in 1956). Efforts to formulate a new Mental Health Act have started since the year 2000. The act will emphasize community mental health services and rights of people with mental disorders.

The latest legislation was enacted in 1956.

Mental Health Financing There are budget allocations for mental health.

The country spends 1.6% of the total health budget on mental health.

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

There are budget allocations for mental health, but mostly for the mental hospital. Individual general hospitals meet their own mental health care expenses. Drugs are provided free of charge to those receiving services from the Government sector.

The country does not have disability benefits for persons with mental disorders. Mental illness is considered a disability, but is not entitled for 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. Primary care workers in some regions carry out mental health work including dispensing of medication.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 1500 personnel were provided training.

There are no community care facilities for patients with mental disorders. Up to the year 2000, psychiatry services were available only at tertiary care level. Appointment of Medical Officers Mental Health to 30 base hospitals made mental health services available at secondary care level. Outreach, liaison, community mental health and school mental health services have been launched. With the assistance of the Nations for Mental Health Programme of WHO, attempts have been made to resettle long-stay patients from mental hospitals in the community. Recently, the Ministry of Health has initiated a programme to develop intermediate-stay units at a regional level. Ten such units provide rehabilitation services to patients with disability, discharged from the psychiatry units at tertiary care level. Day care services and community care services are also provided from these centres. Health camps are conducted by the Ministry of Health medical teams in the community to provide holistic treatments including medication, counselling etc. A few NGOs (e.g. Sahanaya) also provide residential facilities and conduct rehabilitation programmes in the community. A special effort is being given towards developing primary and community care incorporating policies and programmes that would facilitate the alleviation of the problem of high suicide rates. Though community facilities are not uniformly distributed, different kind of services are often available in different areas.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.8
Psychiatric beds in mental hospitals per 10 000 population	1.4
Psychiatric beds in general hospitals per 10 000 population	0.3
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.2
Number of neurosurgeons per 100 000 population	0.03
Number of psychiatric nurses per 100 000 population	1.8
Number of neurologists per 100 000 population	0.06
Number of psychologists per 100 000 population	0.02
Number of social workers per 100 000 population	0.07

Most of the non-medical mental health professionals do not have formal training in mental health. The mental health facilities are mainly located in the urban areas. Both the Government and the private sector are involved in providing services. Almost three-fourth of the beds are in Colombo. There is only one private hospital providing inpatient services. Most of the psychiatrists work in the public sector, but almost all of them have private clinics also. Most mental health professionals are stationed in urban areas. Sahanaya (NGO) with the support of the Ministry of Health has initiated a 3-year training programme for general physicians (post-graduate training in psychiatry takes 5 years). This has led to the placement of 40 medical officers in mental health at secondary care hospitals. Later, a one-year training programme was also initiated.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Many non-governmental organizations provide mental health care in certain areas. Sahanaya provides day care services to those in need and training to mental health professionals. BasicNeeds, which is a UK based NGO, implements a community mental health project in the southern part of Sri Lanka. Horticulture Therapy Project initiated and supported by BasicNeeds is helping many of the long term inpatients at specialized mental hospitals to recover from their illness and to find self-employment. Local NGOs like Navajeevana and Gides help BasicNeeds to provide care to the mentally ill. Voluntary Services Overseas, another UK based organization provides psychiatry nurses, occupational therapists and management volunteers for mental health programmes. NGOs are also involved in community-based interventions in the areas of suicide prevention, disasters, mental retardation, alcohol related problems and mental disorders in elderly population. NGOs work in close collaboration with the Ministry of Health.

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

Programmes for Special Population The country has specific programmes for mental health for children. Occasional focussed projects are held for the special population but for limited periods of time. The country has specific programmes for mental health for trauma victims. However, they are not adequate. The maternal and child health programme and school health programme have components of child and adolescent mental health. Two child psychiatrists provide specialized services in the capital. Homes for children with severe learning and behavioural disorders are available. There has also been a steady growth of counselling centres in the private and NGO sectors. Counselling on war-related issues is done by NGOs in the northern and eastern regions.

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, carbidopa, levodopa.

Other Information A WHO (SEARO) Expert Committee Meeting in 2000 helped in defining some of the critical issues related to the development of mental health care in Sri Lanka. WHO is involved in a project to encourage a process of deinstitutionalization of psychiatric patients and promotion of reintegration in the community.

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Sudan

GENERAL INFORMATION

Sudan is a country with an approximate area of 2506 thousand sq. km. (UNO, 2001). Its population is 34.333 million, and the sex ratio (men per hundred women) is 101 (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 6% (WHO, 2004). The literacy rate is 70.8% for men and 49.1% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.5%. The per capita total expenditure on health is 39 international \$, and the per capita government expenditure on health is 7 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Arabic and English. The largest ethnic group(s) is (are) Arab and African. The largest religious group(s) is (are) Muslim, and the other religious group(s) are (is) indigenous groups and Christian.

The life expectancy at birth is 54.9 years for males and 59.3 years for females (WHO, 2004). The healthy life expectancy at birth is 47 years for males and 50 years for females (WHO, 2004).

EPIDEMIOLOGY

Rahim and Cederblad (1989) evaluated a sample of 204 subjects aged 22-35 years using the Self-Rating Questionnaire, the Eysenck Personality Inventory and a Sudanese rating scale of anxiety and depression, a psychiatric interview and a medical examination. Results showed that 16.6% of the subjects had at least one disorder as per DSM-III. The most common were depression (8.4%) and generalized anxiety (3.4%). Alcohol abuse was rare (0.4%). There was no sex difference in the prevalence of mental disorders. Cederblad and Rahim (1989) re-interviewed 104 randomly chosen subjects in 1983 (from the original pool of 197 children examined in 1964-1965). The overall psychiatric impairment was 14% (males 18%; females 8%). In an earlier study they evaluated the psychological effect of urbanization on children aged 3-15 years living in a sub-urban community that transformed from a rural to urban economy between 1965 and 1980. Interviews done in 1965 and 1980 showed an increase in behaviour problems in boys aged 7-15, while there was an improvement in physical health and nutrition. Behaviour problems were associated with factors related to parents (blue-collar workers, maternal anxiety/depression, harsh corporal punishment) and children (dropping out of school, poor somatic health) (Rahim & Cederblad, 1986). Cederblad (1988) assessed behaviour disorders in children of different ages in Sweden, Sudan and Nigeria. The similarities of frequencies of behaviourally disturbed children were more striking than the differences. Rural children generally had less behaviour problems than urban ones. However, in another multi-country study, carried out in a primary care setting (n=925), that employed a two-stage screening process, Giel et al (1981) found the prevalence of mental disorders among children to range from 12% to 29%. Rahim and Cederblad (1986) and Cederblad et al (1986) evaluated the prevalence of enuresis in 8462 children aged 3-15 living in the suburban area. 88% wetted their beds at least several times per week. The prevalence of enuresis was higher in boys than in girls. Only 5% of the children above 7 years of age had secondary enuresis. An intensive study of 245 children selected through stratified sampling did not reveal any association between enuresis and somatic, developmental, behavioural, socio-economic or child rearing (including bladder-training) factors.

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.

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

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1998. The national mental health programme aims to integrate with general health facilities along with promotion of comprehensive mental health care, train mental health personnel and establish a national organizational body for systematic coordination of related activities and the promotion of mental health.

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 is the state law 'Gezira Mental Health Law' of 1998. The mental health legislation forms a chapter of the Public Health Act of 1973, which was revised in 1985. The Mental Health Act has been drafted and has gone to the parliament for approval. The latest legislation was enacted in 1998.

Mental Health Financing There are budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is tax based. The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Mental health has not been integrated with the primary care, and there is also a lack of personnel.

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. Training facilities are present for primary care physicians, police and prison officers. The Gezira Mental Health Programme was aimed at modifying community concepts, attitudes and practices concerning mental health, ensuring community involvement and participation and extending mental health services by training primary health care staff. The evaluation of the programme showed that it helped in raising public awareness and community participation. Members of the health team and teachers who received training reported a better understanding of mental health problems and an improvement in their handling of the mental problems. Sudan has the experience of using traditional healers for provision of mental health services. There are no community care facilities for patients with mental disorders. Community care is absent due to the lack of proper transportation, lack of social workers and poor health education.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.2
Psychiatric beds in mental hospitals per 10 000 population	0.18
Psychiatric beds in general hospitals per 10 000 population	0.02
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.09
Number of neurosurgeons per 100 000 population	0.007
Number of psychiatric nurses per 100 000 population	0.2
Number of neurologists per 100 000 population	0.014
Number of psychologists per 100 000 population	0.17
Number of social workers per 100 000 population	0.1

Many mental health professionals including most psychiatrists have left for other countries.

Non-Governmental Organizations NGOs are not involved with mental health in the country. Special attention has been given to migrants, elderly, refugees, displaced and homeless and children.

Information Gathering System There is no mental health reporting system in the country. Some mental health information particularly numbers related to admissions for major disorders are collected from a few hospitals in the general health data collection system, but the system has many limitations.

The country has no data collection system or epidemiological study on mental health. There are no funds or personnel to carry out epidemiological studies.

Programmes for Special Population These groups are supported by NGOs and UNICEF.

A school mental health programme is present.

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

Since mental health is not integrated in primary care level, most of the drugs are not available at primary care level. A list of essential neuropsychiatric drugs for all levels has been formulated.

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Suriname

GENERAL INFORMATION

Suriname is a country with an approximate area of 163 thousand sq. km. (UNO, 2001). Its population is 0.439 million, and the sex ratio (men per hundred women) is 98 (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 8% (WHO, 2004). The literacy rate is 90.2% for men and 82.3% 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 9.4%. The per capita total expenditure on health is 398 international \$, and the per capita government expenditure on health is 240 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Dutch and Surinamese. The largest ethnic group(s) is (are) East Indian and Creole, and the other ethnic group(s) are (is) Javanese and African. The largest religious group(s) is (are) Hindu, and the other religious group(s) are (is) Protestant, Roman Catholic and Muslim.

The life expectancy at birth is 64.4 years for males and 70.8 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 61 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Suriname in internationally accessible literature. Hanoeman et al (2002) studied the incidence of schizophrenia among the Surinamese population in order to compare the results with those among Surinamese immigrants in the Netherlands who show a high incidence. The researchers examined the medical records of the sole psychiatric hospital in Suriname and found that the mean annual incidence rate of first admissions for schizophrenia or schizophreniform disorder (DSM-III-R criteria) in 1992 and 1993 was not low (1.6/10 000). These findings constitute a challenge to the hypothesis that selection explains the increased incidence in the migrants. The possibility of an increased incidence of the disorder in Surinam (which might also explain the increased incidence among migrants) could not be ruled out. Mahy (1993) reported on suicidal behaviour in different Caribbean countries where records suggest that the rate of suicide particularly by the use of agrochemicals has been steadily increasing in the East Indian community. Perriens et al (1989) studied records at the University Hospital that manages 83% of all cases of paraquat poisoning occurring throughout the country. For 1985 and 1986 the corrected incidence rates of paraquat poisoning were 211 and 68 cases/million population/year, among the highest reported worldwide. Paraquat poisoning was associated with gender (male) and ethnicity (Hindustani) and availability of the chemical (e.g. volume of monthly import of paraquat). Suicide attempts accounted for 76% of the cases. The overall case fatality rate was 71% and it was associated with gender (male) and age. In 2001, 72 deaths by suicide were noted (Punwasi, 2003). Of the deceased subjects, four-fifths were Hindustani, three-fourths were male and two-thirds were under 45 years of age. Regional variation was marked with projected figures for the population per district ranging from 5.55 to 55.06 per 100 000 population. The analysis in 2000 showed a similar pattern.

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 treatment and rehabilitation.

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

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

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1984.

Mental Health Legislation There is a Mental Health Act. The latest legislation was enacted in 1912.

Mental Health Financing There are budget allocations for mental health.

The country spends 4.2% of the total health budget on mental health.

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

The country has disability benefits for persons with mental disorders. Benefits are present but limited.

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

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

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

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	5.2
Psychiatric beds in mental hospitals per 10 000 population	5.2
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	1.25
Number of neurosurgeons per 100 000 population	0.2
Number of psychiatric nurses per 100 000 population	15
Number of neurologists per 100 000 population	0.83
Number of psychologists per 100 000 population	0.2
Number of social workers per 100 000 population	0.62

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

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 facilities for special population groups.

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

Other Information**Additional Sources of Information**

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Swaziland

GENERAL INFORMATION

Swaziland is a country with an approximate area of 17 thousand sq. km. (UNO, 2001). Its population is 1.083 million, and the sex ratio (men per hundred women) is 92 (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 82% for men and 80% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.3%. The per capita total expenditure on health is 167 international \$, and the per capita government expenditure on health is 115 international \$ (WHO, 2004).

The main language(s) used in the country is (are) English and Swazi. The largest ethnic group(s) is (are) African. The largest religious group(s) is (are) Christian (more than half), and the other religious group(s) are (is) indigenous groups.

The life expectancy at birth is 36.9 years for males and 40.4 years for females (WHO, 2004). The healthy life expectancy at birth is 33 years for males and 35 years for females (WHO, 2004).

EPIDEMIOLOGY

Guinness (1992) conducted a survey of 2040 senior secondary school students in different types of school (rural, urban and elite) with open-ended questions and SRQ-24. Symptom prevalence was generally higher among the rural and semi-urban schools in comparison to the schools in the city. The SRQ-24 items screening for psychosis were associated with a range of spontaneous symptoms representing anxiety. Neurotic symptoms were expressed in the form of 'spiritual' problems and it was concluded that under stress these could cause transient reactive psychosis. In a study on school-going adolescents and young adults from a combined sample from clinics and the community, Guinness (1992) found that the common presentations of psychopathology were somatized anxiety (brain fog), depressive neurosis characterized by hypochondriasis, cognitive complaints, dissociative states, culturally determined paranoid ideation and brief reactive psychosis. There was a temporal relationship between transient psychosis and the school calendar. Anxiety or depression often predated the florid psychotic reaction which served as a form of help-seeking behaviour or defence in intolerable stress. In a hospital based study, Guinness (1992) compared patients with brief reactive psychosis with patients of schizophreniform disorder, schizophrenia and manic-depressive psychosis. Brief reactive psychosis was found to be a composite syndrome with 50% showing a preceding history of depression. Of those with prodromal anxiety, most were precipitated by a major life event and a few showed a recurrent pattern. Schizophrenia occurred months or years later in 10-20%. The schizophreniform group comprised of symptoms intermediate between the transient and major psychoses. The pattern of precipitants and the over-representation of education and paid employment in the acute syndromes, compared with the major psychoses, in a society which was largely first-generation educated, suggested a link with rapid social change. Stephens et al (1999) compared eating behaviours of university students from Australia and Swaziland using EAT 26. The results did not support the hypothesis that more Australian students than Swazi students would display eating disorder symptoms.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

A draft policy is available.

Substance Abuse Policy A substance abuse policy is absent.

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

The current focus of the mental health programme is on the development of standardized guidelines for diagnosis and management of common mental health disorders.

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

Mental Health Legislation There is a Mental Health Act.

The latest legislation was enacted in 1978.

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

Mental health services are free.

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. The great majority of severe mental disorders are transferred to the National Psychiatric Centre. Regular training of primary care professionals is not carried out in the field of mental health.

There are community care facilities for patients with mental disorders. Lack of transport and shortage of staff have adversely affected the functionality of community outreach services for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	2
Psychiatric beds in mental hospitals per 10 000 population	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	0.1
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	10
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0.1
Number of social workers per 100 000 population	0.1

Mental health services are mainly managed by nurses. There is only one hospital, the National Psychiatric Centre, fully dedicated to mental health. In addition, two general hospitals have functional psychiatric units and capacity to admit severe mental health patients. Beds have been earmarked for women patients.

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

Information Gathering System There is no mental health reporting system in the country. Mental health reporting is not well established but is presently being addressed.

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

Programmes for Special Population A special programme addresses the needs of epileptic patients.

Counselling services are offered, but they are hampered by the shortage of trained staff. Mental health talks are delivered at health facilities, schools and tinkhundla centres.

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

These drugs are not routinely available at the primary health care level.

Other Information

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Sweden

GENERAL INFORMATION

Sweden is a country with an approximate area of 450 thousand sq. km. (UNO, 2001). Its population is 8.886 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 17% (UNO, 2004), and the proportion of population above the age of 60 years is 23% (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 8.7%. The per capita total expenditure on health is 2270 international \$, and the per capita government expenditure on health is 1935 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Swedish. The largest ethnic group(s) is (are) European. The largest religious group(s) is (are) Evangelical Lutheran.

The life expectancy at birth is 78 years for males and 82.6 years for females (WHO, 2004). The healthy life expectancy at birth is 72 years for males and 75 years for females (WHO, 2004).

EPIDEMIOLOGY

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

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent.

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

Mental health care reforms directed towards individuals suffering from severe and long-standing mental illness was initiated in 1995. Sweden has a comprehensive national suicide prevention programme.

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

Mental Health Legislation The fundamental legislation for psychiatric health and sickness are the Health and Illness Act (HSL), the Compulsory Psychiatric Care Act (LPT) and the Forensic Psychiatric Care Act (LRV). Guidance is also provided by the 1991 UN Resolution, supported by Sweden, concerning the principles for the protection of the mentally ill. The latest legislations are the Law on Compulsory Care and the Law on Forensic Psychiatry Care. The Swedish National Board on Forensic Medicine is responsible for the assessment of offenders with mental illness. Treatment is carried out in special wards within the civil psychiatric hospitals in each county or in special forensic psychiatric hospitals. The latest legislation was enacted in 2000.

Mental Health Financing There are budget allocations for mental health.

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

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

The Municipal Financial Responsibility Act makes it incumbent upon the municipalities to pay for the care of patients who have to remain in hospitals because of lack of community services. As a part of the Mental Health Reform (1995), the counties themselves receive a state subsidy in order to ease the transition from life in an institution to living in the community. In addition, there were specified subsidies for provision of case managers, severely mentally ill drug abusers, family programmes and for supporting user associations. Community services now account for about 15% of the budget of psychiatric care organizations.

The country has disability benefits for persons with mental disorders. The objective of the Swedish Disability Act and Assistance Compensation Act is to provide comprehensive and equal benefits to patients with physical or mental illness. Under these laws the individual is allowed counselling, personal assistance, housing with special services, contact people and companions. The municipalities are obligated to conduct outreach care facilities including rehabilitation for the elderly and disabled. The Municipal Financial Responsibility Act makes it compulsory for the municipalities to pay for the treatment of patients, who after 3 consecutive months of inpatient care are deemed treated but still require hospital care as they are not able to lead independent lives within a community care system. Disability benefits are reaching between 10-30% of those who need them, but the proportion is likely to rise as case management becomes more frequent.

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. There are some local and regional training programmes.

There are community care facilities for patients with mental disorders. Community care is primarily carried out by social services. As a result of the 1995 reforms, approximately 4000 patients and 400 rehabilitation programmes were transferred from psychiatric care organizations to municipal social services. Furthermore, nearly 900 projects related to employment and rehabilitation were financed with state subsidies and about 300 educational projects directed towards the staff of the social services were launched. There are,

however, regional variations in services. Day care facilities are currently available for about 50% of those in need. Mobile teams are operational in more than 50% of the catchment areas.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	6
Psychiatric beds in mental hospitals per 10 000 population	
Psychiatric beds in general hospitals per 10 000 population	6
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	20
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	32
Number of neurologists per 100 000 population	4
Number of psychologists per 100 000 population	76
Number of social workers per 100 000 population	

In Sweden, there has been sectorization, where the psychiatric service unit of a particular catchment area was responsible for comprehensive psychiatric care of the whole population belonging to that area. However, a referral is not required for contacting specialized services. There has been a reduction of inpatient beds (by almost 85% over a 25 year period starting in 1962) and an increase in community based treatment. Most of the stand-alone mental hospitals have closed. Regional differences in resources for care, methods of care and use of care have been noted. There are, specially in the northern part of Sweden, long distances between the municipalities, and as it is sparsely populated it is hard to fund the adequate resources needed. Individual care plans are drafted in consultation with patients and their relatives. Other than psychiatrists, the number of other mental health professionals, seem to be adequate. Most are employed by the municipalities. Sub-specialization in forensic and geriatric psychiatry is possible.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation. NGOs play an important part in suicide prevention programmes. Increased user influence through well-informed and participating patients and relatives is an important development. Under the mental health reform movement of 1995, financial support was provided for user and carer organizations and these were able to launch about 170 projects.

Information Gathering System There is mental health reporting system in the country. Reports of county council for inpatient care is available.

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

As required by the mental health reform, approximately 85% of the municipalities have conducted surveys to identify people with mental disabilities living in their communities and the needs these persons have for social assistance.

Programmes for Special Population The country has specific programmes for mental health for elderly and children. There is a Swedish National Programme to develop suicide prevention with the objectives: to decrease the number of successful and unsuccessful suicide attempts; early detection and management of high risk cases; public education on management of suicide both by laymen and professional staff. There is also a National Council for Suicide Prevention.

Specialized sub-systems exist for child, adolescent and forensic (there are six regional forensic hospitals) patients. Mobile teams are providing outreach, health care, food and other services for the homeless.

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.

Carbidopa is available in combination with levodopa (200 mg).

Other Information In 1967, the responsibility of care was shifted from the state to the counties. The 1970s saw the creation and reorganization of community centres in catchment areas and promulgation of the National Board on Health and Welfare's policies concerning deinstitutionalization, development of out-patient care, intersectoral collaboration and involvement of families in services development. In 1992, a parliamentary commission reported that much more needed to be done and the Mental Health Care Reform of 1995 provided the required mandate to municipal social services for providing mental health care.

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Switzerland

GENERAL INFORMATION

Switzerland is a country with an approximate area of 41 thousand sq. km. (UNO, 2001). Its population is 7.163 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 16% (UNO, 2004), and the proportion of population above the age of 60 years is 22% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 11%. The per capita total expenditure on health is 3322 international \$, and the per capita government expenditure on health is 1897 international \$ (WHO, 2004).

The main language(s) used in the country is (are) German (with several dialects), French, Italian and Romansh. The largest religious group(s) is (are) Roman Catholic and Protestant.

The life expectancy at birth is 77.7 years for males and 83.3 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 Switzerland in internationally accessible literature. No attempt was made to include this information here.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1990.

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 absent.

Mental Health Legislation The law regarding 'deprivation of liberty for assistance purpose' (Art: 397 ZGB) is a federal law concerning mental health. Its implementation is accomplished in accordance to Cantonal laws. The latest legislation was enacted in 1981.

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

Details about expenditure on mental health are not available.

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

Mental health insurance does not cover the services of non-medical psychotherapists, unless they are employed and supervised by licensed physicians or psychiatrists.

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.

There are community care facilities for patients with mental disorders. Communities are free to organize care for the mentally ill.

In 1977, the canton Bern took the decision to decentralize the existing system and community oriented institutions and psychiatric departments in some general hospitals were started. Since then it has been observed that an increasing number of patients are managed on an outpatient care basis and there has been a free flow of patients between private and public sectors for further management as and when required (Saameli et al, 1990).

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	13.2
Psychiatric beds in mental hospitals per 10 000 population	13.2
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	23
Number of neurosurgeons per 100 000 population	0.8
Number of psychiatric nurses per 100 000 population	46
Number of neurologists per 100 000 population	3.4
Number of psychologists per 100 000 population	40.8
Number of social workers per 100 000 population	106

2616 non-medical psychotherapists are available; most of them (85%) have a psychology background. Among nurses, about half are in full-time employment and the other half in part-time employment. Among social workers, one-third are in full-time employ-

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ment and two-thirds in part-time employment. Instead of housing long-term patients, psychiatric centres now cater to patients requiring short-term admissions for different mental disorders. Two-thirds of Swiss psychiatrists are involved in private practice. Those in private practice are more psychoanalytically oriented whereas those in universities are more biologically oriented (Guimon et al, 2000). There has been a lack of junior research scientists in psychiatry (Buddeberg et al, 1994). Since 1980, non-medical psychotherapists have been permitted to practice independently. Currently, they provide almost half of psychotherapy services provided.

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

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

The country has no data collection system or epidemiological study on mental health. Data collection occurs at the cantonal level for insurance systems or as a part of health surveys, but these are not reported annually.

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

There is a lack of facilities for admission of adolescents and towards this end the first adolescent psychiatry department was opened in Basel in 1993 as an open ward where milieu therapy, psychotherapy and pharmacotherapy work hand-in-hand.

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.

Almost all kind of drugs are available at the primary health care level and practically all are available in clinics (Government and private). Prices are usually higher than in the neighbouring countries, but 90% of the costs are covered by the health insurance. The usual practice is to prescribe low therapeutic doses, there are however some exceptions.

Other Information

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Syrian Arab Republic

GENERAL INFORMATION

Syrian Arab Republic is a country with an approximate area of 185 thousand sq. km. (UNO, 2001). Its population is 18.223 million, and the sex ratio (men per hundred women) is 102 (UNO, 2004). The proportion of population under the age of 15 years is 37% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 91% for men and 74.2% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.4%. The per capita total expenditure on health is 427 international \$, and the per capita government expenditure on health is 188 international \$ (WHO, 2004).

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

The life expectancy at birth is 68.8 years for males and 73.6 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 63 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Syrian Arab Republic in internationally accessible literature. Maziak et al (2002) recruited a sample of 412 women from 8 randomly selected primary care centres in one area. A special questionnaire was prepared for the study purpose consisting of SRQ-20 non-psychotic items and questions about background information considered relevant to the mental health of women in the studied population. Direct individual interviews were also conducted. The prevalence of psychiatric distress was 55.6%. The following factors were found to predict women's mental health on logistic regression: physical abuse, education (illiteracy), polygamy, residence, age and age of marriage. Among those predictors, women's illiteracy, polygamy and physical abuse were the strongest determinants of mental distress leading to the worse outcomes.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 2001.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1993.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2001.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1990.

Mental Health Legislation The legislation concerns organizing the admission and discharge of patients in Government psychiatric hospitals.

The latest legislation was enacted in 1965.

Mental Health Financing There are 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.

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. About 110 nurses and general physicians have been trained in the last ten years.

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

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.8
Psychiatric beds in mental hospitals per 10 000 population	0.78
Psychiatric beds in general hospitals per 10 000 population	0.02
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.5
Number of neurosurgeons per 100 000 population	0.6
Number of psychiatric nurses per 100 000 population	0.5
Number of neurologists per 100 000 population	0.9
Number of psychologists per 100 000 population	0
Number of social workers per 100 000 population	0

Beds have been earmarked for female patients. Forensic beds are available.

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

Information Gathering System There is no mental health reporting system in the country. Only statistical admission data of psychiatric hospitals are reported.

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

Programmes for Special Population The country has specific programmes for mental health for refugees and elderly. Services for mentally challenged and delinquents are available.

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

Other Information

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