Tajikistan

GENERAL INFORMATION

Tajikistan is a country with an approximate area of 143 thousand sq. km. (UNO, 2001). Its population is 6.297 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 35% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 99.7% for men and 99.3% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.3%. The per capita total expenditure on health is 43 international $, and the per capita government expenditure on health is 12 international $ (WHO, 2004).

The main language(s) used in the country is (are) Tajik. The largest ethnic group(s) is (are) Tajik, and the other ethnic group(s) are (is) Uzbek. The largest religious group(s) is (are) Sunni Muslim (five-sixths).

The life expectancy at birth is 61 years for males and 66.5 years for females (WHO, 2004). The healthy life expectancy at birth is 53 years for males and 56 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Tajikistan in internationally accessible literature. Bochkov et al (1971) conducted a clinico-genealogical investigation of the population of some small villages and found olygophrenia (0.4%), epilepsy (0.5%) and schizophrenia (0.7%) in the population. These indices did not differ significantly from those for other regions of the erstwhile USSR. There was an absence of genetic forms of olygophrenia. Services data (MoH, 2004) suggest lower figures for these conditions (0.3%, 0.4% and 0.6%, respectively) as expected because some patients may not come in contact with treatment services. Wasserman et al (1998) reported on the changing pattern of suicide across different countries that were a part of erstwhile USSR between 1984-90 prior to its break-up. Suicide rates varied greatly between different regions. It was 11.8 per 100 000 in Central Asia (Kazakhstan, Kirgizia, Turkmenistan, Uzbekistan and Tajikistan). Correspondence between the Ministry of Internal Affairs and Ministry of Health suggest that the suicide rate in Tajikistan has recently increased up to 19.9 per 100 000, perhaps due to the civil war and the resultant devastation, increase in unemployment, domestic violence, etc.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent. The 'National Program on Substance Abuse Prevention and Rehabilitation of Drug-dependants by 2010' was submitted for consideration to the legislative body in 2004.

National Mental Health Programme A national mental health programme is absent.
The national mental health programme has been drafted.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1999.
Therapy is based on outdated Russian books. Old and outdated modes of treatment are still used. Often there are no drugs to treat the patients (Veeken, 1997).

Mental Health Legislation The new law on mental health was discussed and recommended for approval by the Geneva Initiative on Psychiatry. A draft law in Russian is available.
Details about the year of enactment of 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.
The health care system is funded by the state in principle but depended largely on foreign aid. In 2004, the budget for mental health reached 2 416 278 USD, but it may be insufficient for covering even essential needs. Foreign financing stopped in 2003 due to completion of MSF-Holland activity in Tajikistan.
The country has disability benefits for persons with mental disorders. Disability benefits consist of pension funds and keeping right to the living property for institutionalized disabled.

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. About 50 primary health care facilities have access for mental health services.
Regular training of primary care professionals is not carried out in the field of mental health. A few NGOs are dealing with training in mental health. Their activity has to be coordinated with mental health state institutions.
There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	2.47
Psychiatric beds in mental hospitals per 10 000 population	2.47
Psychiatric beds in general hospitals per 10 000 population	
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	1.8
Number of neurosurgeons per 100 000 population	0.9
Number of psychiatric nurses per 100 000 population	3.6
Number of neurologists per 100 000 population	3.7
Number of psychologists per 100 000 population	0.1
Number of social workers per 100 000 population	

There are a few psychiatric institutes and they lack drugs, food, bedding, clothes, equipment and transport. Lack of heating is a problem during winter months. There is a lack of specialist staff. The salaries are extremely low. A psychiatrist is paid the equivalent of $3 a month.

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 There are children homes but the conditions are unsatisfactory.

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, levodopa.

Other Information There is almost no contact with international psychiatry. However, in August 1997, after an initial assessment of the mental health infrastructure by the Médecins Sans Frontières of Holland a three year project called 'Support for Inpatients of Mental Health Institutions and Dispensaries in the Republic of Tajikistan' has been undertaken with the aim of reducing the mortality rate in the two large psychiatric hospitals (Leninsky and Lakkon) and at the Child and Adolescent Centre. Since then, the programme has been extended to 14 psychoneurological dispensaries. The MSF has also rehabilitated two mental health institutions, one in the capital and the other in the north of the country. Besides improving the infrastructure it has provided training to personnel and has developed a community-based programme for treating individuals suffering from trauma.

Additional Sources of Information

Baibabayev, A., Cunningham, D., de Jong, K. (2000) Update on the state of mental health in Tajikistan. Mental Health Reforms, 5, 14-16.

Bochkov, N. P., Anfalova, T. V., Dement'eva, E. S., et al (1971) Medical genetic study of the population of the western Pamir. I. Sex ratio, hereditary neuropsychiatric diseases, and general anthropogenetic traits. Soviet Genetics, 7, 669-674.

Médecins Sans Frontières (2002) http://www.doctorswithoutborders.org

Veeken, H. (1997) Tajikistan: no pay, no care. British Medical Journal, 315, 1460-1461.

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

Thailand

GENERAL INFORMATION

Thailand is a country with an approximate area of 513 thousand sq. km. (UNO, 2001). Its population is 63.465 million, and the sex ratio (men per hundred women) is 96 (UNO, 2004). The proportion of population under the age of 15 years is 25% (UNO, 2004), and the proportion of population above the age of 60 years is 9% (WHO, 2004). The literacy rate is 94.9% for men and 90.5% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.7%. The per capita total expenditure on health is 254 international $, and the per capita government expenditure on health is 145 international $ (WHO, 2004).

The main language(s) used in the country is (are) Thai, Chinese and English. The largest ethnic group(s) is (are) Thai, and the other ethnic group(s) are (is) Chinese. The largest religious group(s) is (are) Buddhist (almost 95%).

The life expectancy at birth is 66 years for males and 72.7 years for females (WHO, 2004). The healthy life expectancy at birth is 58 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY

Bonyawongvirot et al (2004) conducted a two-stage survey (n=11 700) using the Alcohol Use Disorder Identification Test (AUDIT) and Mini International Neuropsychiatric Interview (MINI). The following disorders were common: alcohol use disorder (28.5%), major depression disorder (3.2%), generalized anxiety disorder (1.85%), psychotic disorders (1.76%), dsythymia disorders (1.18%), agoraphobia (0.89%), panic disorder (0.75%) and bipolar disorder (mnia: 0.65%). Thavichachart et al (2001) assessed 3000 adults selected through a multi-stage random sampling procedure using modified Composite International Diagnostic Interview (CIDI/DSM-IV). The life time prevalence of mental disorders was: schizophrenia (1.3%), manic episode (9.3%), major depressive episode (9.9%), dysthymia (1%), anxiety disorders (10.2%), mental retardation (1.8%), epilepsy (1.3%), suicidal idea (7.1%), drug and substances use disorders (11.2%) and alcohol use disorders (18.4%). Jitapunkal et al (2001) conducted a country wide survey of more than 4000 elders (over 60 years) using CMT (cut-off score < 15) and impairment as criteria to diagnose dementia. They found the overall prevalence of dementia to be 3.3% (1% in 60-64 years to 31.3% in the over 90 years age group). Senanarong et al (2001a) found that the prevalence of dementia (diagnosed according to Thai Mental State Examination score below 25th percentile and an impairment criterion) in a countrywide survey involving 3177 elderly people over 60 years to be in the 9.9%. In another study, Senanarong et al (2001b) found cognitive impairment in 52.7% of subjects in a community sample of 550 elderly subjects (age > 55 years) examined with the Thai Mental State Examination (cut off < 25). Cognitive impairment was associated with age, blood pressure, serum cholesterol, liver function parameters, haemoglobin, neutrophil counts and weight. Srisurapanont and Intaprasert (1999) mailed the Seasonal Pattern Assessment Questionnaire (SPAQ) to 520 randomly selected subjects and found the prevalence of summer SAD, sub-syndromal summer SAD and winter SAD to be 6.2%, 8.3% and 1%, respectively. Kongkanand (2000) assessed 1250 individuals in an urban area using pre-tested questionnaires and found that the rate of erectile dysfunction was associated with age, hypertension, diabetics or heart disease, smoking, alcohol and caffeine consumption. Eungprabhanth (1975) examined autopsy reports of 581 suicidal cases and found that the male:female ratio was 6:4 and the highest incidence was in the 20-39 years age group. Girls predominate among adolescents (0-19 years). Farmers showed the highest suicide rate, and poisoning (with parathion) was the commonest method of suicide. Wacharasindhu and Panyyayong (2002) assessed 1698 children (8-11 years old) in a two stage survey using Thai Youth Checklist (TYC) – Parent and Teacher form and the Child and Adolescent Psychiatric Assessment (CAPA). The overall prevalence rate of child psychiatric disorders was 37.6% with anxiety (10.8%), specific phobia (9.7%), depression (7.1%), conduct disorder (5.5%), ADHD (5.1%) and separation anxiety disorder (5%) being the common diagnoses. Cederblad et al (2001) evaluated 483 Thai children and youths, aged 7-18 years, using the Child Behavior Checklist (CBCL) and the Teacher's Report Form (TRF). Older children living in urban areas had higher problem scores than other groups. Boys showed more 'externalizing' and delinquent behaviour on both the CBCL and the TRF. Benjasuwantep et al (2002) assessed 353 school students (grades 1 to 6) using Connor's Rating Scale and behavioural observation in classroom. A DSM-IV diagnosis of ADHD was made in 6.5%. Mollica et al (1997) assessed 182 refugee adolescents aged 12-13 years based on a multistage probability sample of 1000 households using the Child Behavior Checklist (CBCL) and the Youth Self-Report (YSR). Nearly 54% had total problem scores in the clinical range by parent report on the CBCL and 26.4% by adolescent report on the YSR. The dose-effect relationship between cumulative trauma and symptoms was strong for total problems on CBCL and subscales for Anxious/Depressed and Attention Problems on both the YSR and CBCL. Mollica et al (1998) found that cumulative trauma continued to affect psychiatric symptom levels a decade after the original trauma events, especially for symptom categories of depression, PTSD and dissociative and culturally dependent symptoms. Savin et al (1996) found that PTSD endured in a sample of Khmer youths who had survived conflict as children. Sub-clinical forms of PTSD were found in those who reported their worst trauma during life in the camp, while the full PTSD syndrome was found in those who reported trauma related to the conflict. Extremely high rates of depressive disorder was also reported, which was interpreted as related to the impending repatriation back to Cambodia. In a sample of 486 primary students who did not have mental deficiency, Roongpraiwan et al (2002) found the prevalence of dyslexia and probable dyslexia to be 6.3% and 12.6%, respectively, with males affected 3.4 times more often than females. Nearly 90% of the affected students showed soft neurological signs and 8.7% had comorbid ADHD.

MENTAL HEALTH RESOURCES

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

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Administration and technical development is also a component of the policy. The mental health policy plans to promote mental health and prevent mental health problems, to expand and develop the service system of treatment and rehabilitation, to develop mental health knowledge and technology, to develop the management system for reformation of all aspects of mental health, to develop people's co-operation in order to achieve the goal of taking care of one's mental health by applying local wisdom to family assistance, community programmes, etc. and to develop modern psychosocial and other technical knowledge in order to apply them fruitfully to Thailand's mental health situation.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1998. On substance abuse there was an initial law from 1988 which dealt with Drugs Prevention and Suppression Policy. This was implemented under the strategy of state-civil alliance against drugs, which unites the power of civil and state agencies to continually and seriously fight against drug abuse under more systematic and cooperative administration. The more recent policy on Reformation of Addicts Treatment and Rehabilitation System guides all rural and urban centres to undertake programmes to look into the management issues of addicts. National institutes are urged to develop advanced technologies to tackle the treatment and rehabilitation of such addicts in cooperation with international agencies. It also specifies that the provincial health doctor would act as the chief of treatment and rehabilitation centres at provincial levels.

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

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. Details about the year of formulation are not available.
The National Drug Committee policy encourages general practitioners to use only drugs available from the National List of Essential Drugs. The Department of Mental Health has recently developed the practice guideline on the care of patients with mood disorders.

Mental Health Legislation There is no mental health legislation.
Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are budget allocations for mental health.
The country spends 2.5% of the total health budget on mental health.
The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family and social insurance.
Universal health care insurance is not available, but there are several types of limited coverage available. For Government officials, health coverage is extensive. Employees of private companies are usually covered by the company's health benefits. Such benefits are also available, to a more limited extent, to blue-collar workers or labourers whose companies are registered by the labour department. For citizens with low income, a special health insurance plan provided free of charge by the Government covers hospitalization for acute psychotic episodes for up to 15 days in Government hospitals. Drug use disorders in general are not covered by health benefit plans. Psychological assessment and therapy are not reimbursable.
The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.
Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 300 personnel were provided training. Training of trainers has been organized for mental health professionals. About 300 general practitioners were trained in the last two years on mental health. Mental health home visit project trains staff in caring for patients at home. A range of training manuals have been prepared.
There are no community care facilities for patients with mental disorders. It is planned to develop home health care centres and other community programmes. A total of 182 telephone counselling services, 470 counselling centres and 327 stress-relief clinics provide community services. A pilot project for vocational rehabilitation of mentally challenged and mentally ill persons is under way. A few halfway houses are available.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.4
Psychiatric beds in mental hospitals per 10 000 population	1.4
Psychiatric beds in general hospitals per 10 000 population	
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	0.6
Number of neurosurgeons per 100 000 population	0.4
Number of psychiatric nurses per 100 000 population	2.7
Number of neurologists per 100 000 population	0.2
Number of psychologists per 100 000 population	0.2
Number of social workers per 100 000 population	0.6

There are 17 occupational therapists. More than half of the beds are in Bangkok and the central region. Three-fifths of psychiatrists are located in Bangkok, even though three-fourths are in Government service. More than two-fifths of social workers are also placed in the central region. Psychologists and psychiatric nurses are distributed more evenly. Psychologists are active in the designing and implementation of training programmes and development of educational material.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and prevention. The NGO sector is quite active in opening mental health centres, funding campaigns, telephone counselling, child right and protection issues, etc.

Information Gathering System There is mental health reporting system in the country.
The country has data collection system or epidemiological study on mental health.
A database on mental health issues related to elderly is being built.

Programmes for Special Population The country has specific programmes for mental health for elderly and children.
The Government supports programmes for prevention of family mental health problems, for mental health education in institutions, for elderly, for physically challenged and underprivileged 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.

Other Information Quite a few projects are being implemented. The notable ones being the promotion of Buddhist monks' role in mental health, psychosocial care for the depressed, mental health prevention and support for the risk groups to suicide, mental health projects for the physically handicapped and underprivileged children, projects for prisoners and prison officers, model development of community participation in preventing substance abuse, programmes for the elderly and family, model programmes to look into the psychiatric mental health care in general hospitals, etc. The Department of Mental Health in the Ministry of Public Health has undertaken a quality inspection of agencies under its charge and has developed quality guidelines. Six of its hospitals have attained ISO 9002 quality certification. Many projects involving international collaboration are also under way. Studies on cost-effectiveness of services are being carried out.

Additional Sources of Information

Benjasuwantep, B., Ruangdaraganon, N., Visudhiphan, P. (2002) Prevalence and clinical characteristics of attention deficit hyperactivity disorder among primary school students in Bangkok. Journal of the Medical Association of Thailand, 85, 1232-1240.

Bunyawongwirot, P., Siriwanarungsun, P., Kongsuk, T., et al. (2004) Prevalence of mental disorders in Thailand: a national survey. Proceeding of the 17th National Epidemiology Seminar, Bangkok, Thailand, May 20th 2004.

Cederblad, M., Pruksachatkunakorn, P., Boripunkul, T., et al (2001) Behaviour problems and competence in Thai children and youths: Teachers', parents' and subjects' perspectives. Transcultural Psychiatry, 38, 64-79.

Department of Mental Health (2003) Mental Health in Thailand 2002-2003. Bangkok: Department of Mental Health, Ministry of Public Health.

Eungprabhanth, V. (1975) Suicide in Thailand. Forensic Science, 5, 43-51.

Jitapunkul, S., Kunanusont, C., Phoolcharoen, W., et al (2001) Prevalence estimation of dementia among Thai elderly: a national survey. Journal of the Medical Association of Thailand, 84, 461-467.

Kongkanand, A. (2000) Prevalence of erectile dysfunction in Thailand. Thai Erectile Dysfunction Epidemiological Study Group. International Journal of Andrology, 23, 77-80.

Ministry of Health. General Report on State of Mental Health and Associated Services in Thailand.

Ministry of Public Health, Narcotics Control Board. Strategies and Guidelines on Drugs Prevention and Treatment.

Mollica, R. F., Poole, C., Son, L., et al (1997) Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. Journal of the American Academy of Child & Adolescent Psychiatry, 36, 1098-1106.

Mollica, R. F., McInnes, K., Poole, C., et al (1998) Dose-effect relationships of trauma to symptoms of depression and post- traumatic stress disorder among Cambodian survivors of mass violence. British Journal of Psychiatry, 173, 482-488.

National List of Psychotherapeutic Drugs (Government document).

Roongpraiwan, R., Ruangdaraganon, N., Visudhiphan, P., et al (2002) Prevalence and clinical characteristics of dyslexia in primary school students. Journal of the Medical Association of Thailand, 85, 1097-1103.

Savin, D., Sack, W. H., Clarke, G. N., et al (1996) The Khmer adolescent project: III. A study of trauma from Thailand's Site II refugee camp. Journal of the American Academy of Child & Adolescent Psychiatry, 35, 384-391.

Senanarong, V., Jamjumrus, P., Harnphadungkit, K., et al (2001b) Risk factors for dementia and impaired cognitive status in Thai elderly. Journal of the Medical Association of Thailand, 84, 468-474.

Senanarong, V., Poungvarin, N., Sukhatunga, K., et al (2001a) Cognitive status in the community dwelling Thai elderly. Journal of the Medical Association of Thailand, 84, 408-416.

Siriwanarangsan, P., Liknapichitkul, D., Khandelwal, S. K. (2004) Thailand mental health country profile. International Review of Psychiatry, 16, 150-158.

Srisurapanont, M., Intaprasert, S. (1999) Seasonal variations in mood and behaviour: epidemiological findings in the north tropics. Journal of Affective Disorders, 54, 97-99.

Sukying, C. (2000) Pharmacotherapy of depression in Thailand: country report 1999. Singapore Medical Journal, 41, 53-54.

Tapanya, S. (2001) Psychology in medical settings in Thailand. Journal of Clinical Psychology in Medical Settings, 8, 69-72.

Thavichachart, N., Intoh, P., Thavichachart, T., et al (2001) Epidemiological survey of mental disorders and knowledge attitude practice upon mental health among people in Bangkok Metropolis. Journal of the Medical Association of Thailand, 84, 118-126.

Wacharasindhu, A., Panyyayong, B. (2002) Psychiatric disorders in Thai school-aged children: I Prevalence. Journal of the Medical Association of Thailand, 85, 125-136.

The former Yugoslav Republic of Macedonia

GENERAL INFORMATION

The former Yugoslav Republic of Macedonia is a country with an approximate area of 26 thousand sq. km. (UNO, 2001). Its population is 2.066 million, and the sex ratio (men per hundred women) is 100 (UNO, 2004). The proportion of population under the age of 15 years is 21% (UNO, 2004), and the proportion of population above the age of 60 years is 15% (WHO, 2004). The literacy rate is 97% for men and 91% for women (UNESCO/MoH, 2004).
The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.8%. The per capita total expenditure on health is 331 international $, and the per capita Government expenditure on health is 281 international $ (WHO, 2004).
The main language(s) used in the country is (are) Macedonian and Albanian. The largest ethnic group(s) is (are) Macedonian, and the other ethnic group(s) are (is) Albanian, Turkish, Roma, Vlachs and Serb. The largest religious group(s) is (are) Macedonian Orthodox Christian (three-fourths), and the other religious group(s) are (is) Muslim and Roman Catholic.
The life expectancy at birth is 69 years for males and 75.1 years for females (WHO, 2004). The healthy life expectancy at birth is 62 years for males and 65 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in The Former Yugoslav Republic of Macedonia in internationally accessible literature. Milcinski and Mrevlje (1990) compared the rate of suicide across different regions. The study showed that there was a wide variation in rates of suicide, with the northern region having very high rates (among the highest in Europe) and the southern and eastern regions including Macedonia having very low rates (among the lowest in Europe).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.
A mental health policy has been reviewed and it is in the process of being adopted by the Government. The document is constituted of three parts, namely National Policy, Strategy with Action Plan and Legislation on Mental Health.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1999. A substance abuse action plan is available, launched for the period 1999-2002, by the Inter-ministerial National Commission for Prevention of Illegal Drug Trafficking and Abuse.

National Mental Health Programme A national mental health programme is absent.
A National Master Mental Health Plan is already prepared by the National Task Force Team (assigned by the Minister of Health) in collaboration with WHO. It is expected to be adopted shortly by the Government.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present.
Details about the year of formulation are not available.
There is a list of essential drugs covered by the Health Insurance Fund as part of the health insurance scheme. Currently, this list is under revision to reflect prevailing needs.

Mental Health Legislation Currently, some of the legislative regulation is incorporated in the Law on Health Protection, and some under criminal law, but little relates to human rights of people with mental disorders and compulsory hospitalization. The mental health legislation is in a draft form. Compulsory hospitalization is under review with the aim to reflect international trends.
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 social insurance.
There are budget allocations for mental health services as part of the Law for Health Protection and Law for Health Insurance (Government budget and Health Insurance Fund).
The country has disability benefits for persons with mental disorders. Mental health patients according to the newly developed law are treated in the same way regarding employment as persons with somatic disabilities. There are examples from practice in cities of Gevgelia and Skopje where there are companies that facilitate the employment possibilities of mentally ill persons, an issue that previously was available only for persons with somatic disabilities.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Severe disorders are mainly treated at secondary and tertiary level.
Regular training of primary care professionals is carried out in the field of mental health. Regular training of primary care professionals is carried out in the field of mental health. A training programme for primary health care persons has been organized by the World Bank in 2000 and by the WHO since 2001.
There are community care facilities for patients with mental disorders. The country had a traditional hospital-based mental health services. New policy developments recognize the need for reform in this sector especially towards decentralization and community-

based services. Current developments of the community based mental health programme and services are due to the joint endeavour of the Ministry of Health and WHO, with support from the international community. A National Board for promotion and implementation of community-based services on mental health has been created.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	8.2
Psychiatric beds in mental hospitals per 10 000 population	6.2
Psychiatric beds in general hospitals per 10 000 population	2
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	7.5
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	24
Number of neurologists per 100 000 population	5
Number of psychologists per 100 000 population	2
Number of social workers per 100 000 population	1.5

There are 320 administrators. The country has traditional hospital-based mental health services, which are not efficient and largely depend on a centralized organization; they have not been able to meet these extensive needs. The services are unsatisfactory from the medical, psychological, human, outcome, efficiency or economic points of view. Over the last 20 years a 20% reduction in the number of beds in psychiatric hospitals has been achieved. Forty mental health professionals have been trained in a one-year post-graduate course entitled, 'Psychosocial and traumatic stress – understanding, prevention, treatment'.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and rehabilitation. The NGOs are also working in the field of legislation formulation and fight against stigma.

Information Gathering System There is mental health reporting system in the country. Information is collected as part of Annual National Statistics by the Republican Institute for Health Protection.
The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population The country has specific programmes for mental health for children.
The host families, local health and social services, the local communities and society in general are all involved in tackling the refugee and internally displaced persons problem. Some effort has been put into prevention of substance abuse, child abuse and domestic violence, mostly by NGOs, as well as in schools with the cooperation of NGOs and the Ministry of Education.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.
A list of drugs are covered by the health insurance, which is constantly changing the so-called positive list (with drugs covered by the national fund). Drugs like risperidone and sertraline are available in the positive list.

Other Information The four challenges facing the country are: elaboration of a national programme for mental health; adoption of mental health legislation; preparation of a national register of mental disorders, a database and epidemiological research.

Additional Sources of Information

Milcinski, L., Mrevlje, G. (1990) Epidemiology of suicide in Yugoslavia--methodological questions. Medicinski Pregled, 43, 453-456.
Ministry of Health.
Republic Institute for Statistic.
Republic Institute for Health Protection.
WHO, Country Office Skopje – Mental Health Programme.

Timor-Leste

GENERAL INFORMATION

Timor-Leste is a country with an approximate area of 15 thousand sq. km. (UNO, 2001). Its population is 0.82 million, and the sex ratio (men per hundred women) is 108 (UNO, 2004). The proportion of population under the age of 15 years is 34% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004).
The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 9.8%.
The main language(s) used in the country is (are) Tetum and Portuguese.
The life expectancy at birth is 54.8 years for males and 60.5 years for females (WHO, 2004). The healthy life expectancy at birth is 48 years for males and 52 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Timor-Leste in internationally accessible literature. Modvig et al (2000) carried out a national psychosocial needs assessment. An estimated 750 000 individuals from over 1000 households in 13 districts were interviewed. One respondent was selected from each household. Almost all (97%) respondents said they had experienced at least one traumatic event like direct exposure to combat situation, lack of shelter and ill health with no access to medical care. Death of parents, spouse and children and the stress of having to take over responsibility of the family was a common occurrence. Torture appears to have been widespread. Two-fifths of the respondents said that they had been tortured, but a larger number (57%) said they had experienced at least one of the six forms of torture included in the study instrument. One-third were diagnosed to have PTSD, based on a cut-off score of 2.5 or greater in the Harvard Trauma Questionnaire Symptoms Checklist.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.
The health policy suggests that mental health care would be provided by the public sector. The services would be centralized to facilitate uniform development across the country. The services would be free and sustainable. A mental health policy has been drafted in 2003. It has components of advocacy, promotion, prevention and treatment.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is absent.
The Ministry of Health has approved the National Project of Mental Health to increase the capacity of the Ministry to provide mental health care. The proposed components of the project are: policy development and service delivery; training and workforce development; community involvement and mental health promotion; effective project management.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2004.
Psychotropic drug procurement and distribution systems were set up.

Mental Health Legislation There is no mental health legislation. The courts usually follow Indonesian laws.
Details about the year of enactment of 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.
The Government has reached an agreement with the AusAID to fund a nation-wide mental health programme over the next 3 years.
The country does not have disability benefits for persons with mental disorders.

Mental Health Facilities Details about mental health facilities at the primary care level are not available.
Details about training facilities are not available. Psychosocial Recovery and Development in East Timor (PRADET) has trained local workers, mainly nurses, who established outreach clinics in and around Dili. Mobile outreach clinics extended the work to the most disrupted communities in the west of the country. Till now, 15 specialized mental health workers, 130 general health workers and 60 sub-divisional managers have been trained. Fifty more workers are being trained in 2004/5.
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

There are no dedicated hospital beds for people with mental illness. Some of the key trainees were lost to mental health services as they were moved to other posts in the health system.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Close links were established between the emerging Ministry of Health, key NGOs and other service providers.

Information Gathering System There is mental health reporting system in the country. Mental health service has its own data recording system. Data is given to MOH every month.
The country has data collection system or epidemiological study on mental health.

Programmes for Special Population The country has specific programmes for mental health for disaster affected population. The entire population can be considered post-conflict and therefore at a potential for increased mental distress.
Meetings, pamphlets and radio broadcasts were made to normalize stress, destigmatize mental illness, and encourage community support for families affected by mental illness. A consultation service to assist prison staff to manage incarcerated persons with identified mental health disorders was developed.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol.
Lithium was available but was discontinued because of non-availability of testing. Cogentin is used for side-effects of neuroleptics. Cost of psychotropic drugs and blood testing is prohibitive.

Other Information Since May 2000, AusAID has conducted the Program for Psychosocial Recovery and Development (PRADET), especially in the field of emergency psychiatry. There are a number of outreach centres attached with this programme. They provide services at health centers, homes and prisons.

Additional Sources of Information

Anonymous (2002) East Timor National Mental Health Project Design document. Executive summary.
Anonymous (2002) Ministers approve Timor becoming World Bank Member. www.un.org.
Modvig, J., Pagaduan-Lopez, J., Rodenburg, J., et al (2000) Torture and trauma in post-conflict East Timor. Lancet, 18, 356.
Povey, G., Mercer, M. A. (2002) East Timor in transition: health and health care. International Journal of Health Services, 32, 607-623.
Zwi, A. B., Silove, D. (2002) Hearing the voices: mental health services in East Timor. Lancet, 360, 45-46.

Togo

GENERAL INFORMATION

Togo is a country with an approximate area of 57 thousand sq. km. (UNO, 2001). Its population is 5.017 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 43% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 74.3% for men and 45.4% 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 2.8%. The per capita total expenditure on health is 45 international $, and the per capita government expenditure on health is 22 international $ (WHO, 2004).

The main language(s) used in the country is (are) French, Ewé, Mina, Kabyé and Cotocoli. The largest religious group(s) is (are) indigenous groups (half), and the other religious group(s) are (is) Christian and Muslim.

The life expectancy at birth is 50 years for males and 53.3 years for females (WHO, 2004). The healthy life expectancy at birth is 44 years for males and 46 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Togo in internationally accessible literature. Balogou et al (2001) used a WHO research protocol to study the prevalence of neurological disorders in two rural areas. The first survey was conducted in July-August 1989 on 19 241 inhabitants in one area. The second area was surveyed in January-February 1995 and involved 4182 subjects. The prevalence of epilepsy was 1.2% and 1.3% and that of psychomotor retardation was 0.3% and 0.8% in the two areas. The prevalence of neurological cretinism was 1.0%, while that of myxoedematous cretinism was 3.1% in the region that has a high prevalence of goiter (43% in females and 26.1% in males). Patients suffering from epilepsy commonly reported the occurrence of anxiety and depression, which led to significant interference with their quality of life (Nubukpo et al, 2004). Certain hereditary diseases (Huntington disease) that lead to dementia were reported to be relatively common in families living inshore (Grunitzky, 1995).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1994.
The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation.

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

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1994.

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

Mental Health Legislation There is a legislation on mental health. The mental health legislation as a whole will now be included in the new Health Code of Togo.
The latest legislation was enacted in 1999.

Mental Health Financing There are budget allocations for mental health.
The country spends 0.2% of the total health budget on mental health.
The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family and private insurances.
The country does not have disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Primary care is available only at the district level where the staff has been trained.
Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 70 personnel were provided training. Doctors and health workers have been trained in the last 2 years.
There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.4
Psychiatric beds in mental hospitals per 10 000 population	0.3
Psychiatric beds in general hospitals per 10 000 population	0.1
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.04
Number of neurosurgeons per 100 000 population	0.02
Number of psychiatric nurses per 100 000 population	0
Number of neurologists per 100 000 population	0.1
Number of psychologists per 100 000 population	0.2
Number of social workers per 100 000 population	0

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, 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 children. No specific programme exists.
Some services for children and adolescents exist.

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

Other Information

Additional Sources of Information

Balogou, A. A., Doh, A., Grunitzky, K. E. (2001) Neurological disorders and endemic goiter: comparative analysis of 2 provinces in Togo. Bulletin de la Société de Pathologie Exotique, 94, 406-410.

Dassa, K., Djassoa, G., Seck, B., et al. (2000) Perspectives for child and adolescent psychiatry in sub-Saharan Africa: a report from Togo. Neuropsychiatrie de l Enfance et de l Adolescence, 48, 284-288.

Grunitzky, E., et al (1995) Huntington disease in a large family in southern Togo. Annals Medicine Interne (Paris), 146, 581-583.

Nubukpo, P. et al. (2004) Psychosocial issues in people with epilepsy in Togo and Benin (West Africa). Part I. Anxiety and depression measured using Goldberg's scale. Part II. Quality of life measured using the QOLIE-31 scale. Epilepsy & Behavior, 5, 722-734.

Tonga

GENERAL INFORMATION

Tonga is a country with an approximate area of 0.75 thousand sq. km. (UNO, 2001). It consists of almost 150 islands, of which about a fifth are inhabited. Its population is 0.104 million, and the sex ratio (men per hundred women) is 103 (UNO, 2004). The proportion of population under the age of 15 years is 36% (UNO, 2004), and the proportion of population above the age of 60 years is 8% (WHO, 2004). The literacy rate is 98.8% for men and 98.9% for women (UNESCO/MoH, 2004).
The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.5%. The per capita total expenditure on health is 223 international $, and the per capita government expenditure on health is 138 international $ (WHO, 2004).
The main language(s) used in the country is (are) Tongan and English. The largest ethnic group(s) is (are) Polynesian. The largest religious group(s) is (are) Christian.
The life expectancy at birth is 70 years for males and 71.4 years for females (WHO, 2004). The healthy life expectancy at birth is 62 years for males and 62 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Tonga in internationally accessible literature. Murphy and Taumoepeau (1980) have reported that psychoses are genuinely infrequent in this relatively stable agricultural society.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent.

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

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2000.
The National Drug Policy has three principal objectives: to ensure the consistent availability within the country of medicinal drugs which are of acceptable quality, safety and efficacy; to provide equity of access to medicinal drugs; and to ensure that medicinal drugs are used rationally by prescribers, other health professionals and consumers.

Mental Health Legislation There is a Mental Health Act. It details the powers of the Minister and the mental health welfare officer. It also provides guidelines for compulsory admission, detention and release of mentally ill patients.
The latest legislation was enacted in 1992.

Mental Health Financing There are budget allocations for mental health.
The country spends 0.5% of the total health budget on mental health.
The primary source of mental health financing is tax based.
The country does not have disability benefits for persons with mental disorders. There is no state disability benefit.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level.
Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 14 personnel were provided training.
There are community care facilities for patients with mental disorders. Discharged patients are followed up through home visits if needed. Some social rehabilitation is provided by NGOs.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	2.6
Psychiatric beds in mental hospitals per 10 000 population	0
Psychiatric beds in general hospitals per 10 000 population	2
Psychiatric beds in other settings per 10 000 population	0.6
Number of psychiatrists per 100 000 population	1
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	1
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0
Number of social workers per 100 000 population	6

There are ten psychiatric assistants and one mental health welfare officer.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Special education is coordinated by the Red Cross.

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 indigenous population, elderly and children.

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

Other Information Efforts have been made to study mental disorders in the country from the transcultural perspective.

Additional Sources of Information

An Act to deal with mental health in Tonga and mattes related there to. No 18 (1992) (Government document).

Japan International Cooperation Agency Planning and Evaluation Department (2002) Country profile on Disability. Kingdom of Tonga. http://www.worldbank.org/DISABILITY//Resources/Regions/East-Asia-Pacific/JICA_Tonga.pdf.

Jilek, W. (1988) Mental health, Ethnopsychiatry and traditional medicine in the Kingdom of Tonga. Curare, 11, 161-176.

Ministry of Health (2000) Kingdom of Tonga National Drug Policy.

Ministry of Health (1998) Standard Drug List Revisited.

Murphy, H. B., Taumoepeau, B. M. (1980) Traditionalism and mental health in the South Pacific: a re-examination of an old hypothesis. Psychological Medicine, 10, 471-482.

Trinidad and Tobago

GENERAL INFORMATION

Trinidad and Tobago is a country with an approximate area of 5 thousand sq. km. (UNO, 2001). Its population is 1.307 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 22% (UNO, 2004), and the proportion of population above the age of 60 years is 10% (WHO, 2004). The literacy rate is 99% for men and 97.9% for women* (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 2.5%. The per capita total expenditure on health is 388 international $, and the per capita government expenditure on health is 168 international $ (WHO, 2004).

The main language(s) used in the country is (are) English. The largest ethnic group(s) is (are) African, and the other ethnic group(s) are (is) East Indian. 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 67.1 years for males and 72.8 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY

Neehall (1991) reviewed inpatient hospital data from a defined catchment area and suggested that the prevalence of mental disorders in the area was 0.5% with psychoses (38%), alcohol and drug use disorders (34%), affective disorders (15%) being the common diagnoses. Cembrowicz (1995) observed low rates of psychological disturbance as estimated by rates of recorded suicide, overdose and psychotropic drug use in Tobago. Singh et al (1991) conducted a questionnaire survey of 1603 secondary school students (14-18 years old). Prevalence of drug use was: alcohol (84%), tobacco (35%), marijuana (8%) and cocaine (2%). Those of Indian origin reported more frequent alcohol use, and those of African origin reported using marijuana more frequently. Alcohol use was associated with educational level, alcohol use by fathers and low religiosity. In a subsequent analysis, Singh and Mustapha (1994) found a significant association between substance abuse and the following factors: grades at school, religious involvement, pocket money, parental alcohol consumption, low self-esteem and low personal and parental educational expectations. Bhugra et al (1996) applied standardized diagnostic instruments to all new cases of psychosis presenting to various psychiatric services in two catchment areas. The incidence of broad schizophrenia and S+ schizophrenia was 2.2/1000 and 1.6/1000, respectively. These rates are similar to those from the WHO study in Honolulu and Aarhus and much lower than the rates for African-Caribbeans in London. The cases were followed up for one year and the poor outcome was observed in 19%. Hutchinson and Simeon (1997) noted a fourfold increase in male suicide rates, from 4.96/100 000 in 1978 to 20.8/100 000 in 1992 in an analysis based on national statistical data. Hutchison et al (1991) evaluated 270 patients who died at a general hospital over a 4.5 year period. Suicide was associated with gender (male), ethnicity (East Indian), age (half of the suicides occurred in the 11-34 years age group) and psychiatric morbidity (27.8%). Depression was the most common psychiatric illness diagnosed. Paraquat was used in 63.7% of the suicidal cases and other agrochemicals were used in another 20% of cases. Daisley and Simmons (1999) conducted a prospective autopsy study on deaths that occurred from poisoning (n=105). Suicide accounted for 94.29% of deaths, of which, 44.4% occurred in the 10-29 years age-group. The major poisons used were: paraquat (79%), organophosphate/carbamate insecticides (9%) and anti-psychotic drugs (5%). Ingestion of paraquat seems almost always fatal. Hutchison et al (1999) examined 48 cases of suicide in a defined region in a year; 81.3% were due to paraquat poisoning, yielding an incidence figure of 8.0 per 100 000. Among those who had ingested paraquat, half of the subjects were in the 25-34 years age group and nearly 90% were of East Indian origin. Neehall and Beharry (1994) suggested the rate of adolescent suicide for the catchment area of a general hospital to be 94/100 000 based on a sample of 102 adolescents seen over a 10 month period. Adolescent suicide was associated with gender (90% were girls), psychiatric morbidity (51%, mostly depression and adjustment disorders) and ethnicity (East Indians).

MENTAL HEALTH RESOURCES

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

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The formulation of the policy was supported by the WHO Regional Office for the Americas.

Substance Abuse Policy A substance abuse policy is absent. NGOs working in the field of substance abuse have developed guidelines related to activities in the field. A policy draft is nearing completion. There is a National Alcohol and Drug Abuse Prevention Programme.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 2000. There is a new Mental Health Plan, and under this plan there is a National Mental Health Committee and Regional Mental Health Committees.

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

Research shows that in outpatients psychiatrists generally prefer tricyclic anti-depressants and phenothiazines and only moderately use anti-cholinergics.

Mental Health Legislation A draft Mental Health Act has been prepared and is being revised to replace the old Act of 1975.
The Regional Health Authorities Act Number 5 of 1994 led to the establishment of health regions and provided support to a shift towards integration of specialist services with primary health care.
The latest legislation was enacted in 1975.

Mental Health Financing Details about disability benefits for mental health are not available.
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 carried out in the field of mental health. Doctors are being trained and 23 mental health officers have received training in community care.
There are community care facilities for patients with mental disorders. Five sectors with multidisciplinary mental health teams were created. Regional hospitals were used for admissions. Outpatient clinics were set up in each sector, and there are at present 75 outpatient clinics. There is a proposal for a 40% reduction in mental hospital beds and an increase in general psychiatry beds, child psychiatry and drug abuse management beds in the general care setting, beds in extended care setting (10 for elderly and 20 for rehabilitation) and units for supported living, day care and occupational therapy.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	10.29
Psychiatric beds in mental hospitals per 10 000 population	7.92
Psychiatric beds in general hospitals per 10 000 population	0.55
Psychiatric beds in other settings per 10 000 population	1.82
Number of psychiatrists per 100 000 population	1
Number of neurosurgeons per 100 000 population	0.31
Number of psychiatric nurses per 100 000 population	11.5
Number of neurologists per 100 000 population	0.5
Number of psychologists per 100 000 population	0.3
Number of social workers per 100 000 population	4

The others category is mainly comprised of nursing assistants. The island of Trinidad has one large mental hospital and a psychiatric unit at each of the two large general hospitals. The island of Tobago has a psychiatric unit but patients requiring long-term stay have to be referred to the mental hospital in Trinidad. Trinidad and Tobago have the highest number of trained mental health staff among the English speaking Caribbean countries, but distribution of staff is not adequate.

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 mental health reporting system in the country. Surveillance needs to be improved.
The country has data collection system or epidemiological study on mental health. Field studies are done for only data collection.

Programmes for Special Population The country has specific programmes for mental health for elderly. There is an Alzheimer's Disease Society.
The sub-specialities of forensic psychiatry, child psychiatry, geriatric psychiatry, alcohol and substance abuse need to be developed further.

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.
There is a wider range of psychotic drugs available at the present time, including three depot injections, fluphenozine dicanoate, pipothiozine-flucoclopenthixol.

Other Information A new mental health plan was approved in March 2000 and the implementation is to commence as part of a health sector reform with emphasis on promotion and primary care.
* According to the Ministry of Health (2004), the actual literacy rate is about 82%.

Additional Sources of Information

Bhugra, D., Hilwig, M., Hossein, B., et al (1996) First-contact incidence rates of schizophrenia in Trinidad and one-year follow-up. British Journal of Psychiatry, 169, 587-592.

Cembrowicz, S. (1995) Psychiatry on Tobago in 1989. Psychiatric Bulletin, 19, 421-426.

Daisley, H. Jr., Simmons, V. (1999) Forensic analysis of acute fatal poisonings in the southern districts of Trinidad. Veterinary & Human Toxicology, 41, 23-25.

Hutchinson, G., Daisley, H., Simmons, V., et al (1991) Suicide by poisoning. West India Medical Journal, 40, 69-73.

Hutchinson, G., Daisley, H., Simeon, D., et al (1999) High rates of paraquat-induced suicide in southern Trinidad. Suicide & Life-Threatening Behavior, 29, 186-191.

Hutchinson, G. A., Simeon, D. T. (1997) Suicide in Trinidad and Tobago: Associations with measures of social distress. International Journal of Social Psychiatry, 43, 269-275.

Moore, S., Jaime, L. K. M., Maharajh, H., et al (2002). The prescribing of psychotropic drugs in mental health services in Trinidad. Pan American Journal of Public Health, 12, 207-215.

Maharajh, H. D., Ali, A. (2004) The mental health policies of Trinidad and Tobago. International Psychiatry, 5, 13-16.

Neehall, J. (1991) An analysis of psychiatric inpatient admissions from a defined geographic catchment area over a one-year period. West Indian Medical Journal, 40, 16-21.

Neehall, J., Beharry, N. (1994) Demographic and clinical features of adolescent parasuicides. West Indian Medical Journal, 43, 123-126.

Singh, H., Maharaj, H.D., Shipp, M. (1991) Pattern of substance abuse among secondary school students in Trinidad and Tobago. Public Health, 105, 435-441.

Singh, H., Mustapha, N. (1994) Some factors associated with substance abuse among secondary school students in Trinidad and Tobago. Journal of Drug Education, 24, 83-93.

Tunisia

GENERAL INFORMATION

Tunisia is a country with an approximate area of 164 thousand sq. km. (UNO, 2001). Its population is 9.937 million, and the sex ratio (men per hundred women) is 101 (UNO, 2004). The proportion of population under the age of 15 years is 27% (UNO, 2004), and the proportion of population above the age of 60 years is 8% (WHO, 2004). The literacy rate is 83.1% for men and 63.1% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.4%. The per capita total expenditure on health is 463 international $, and the per capita government expenditure on health is 350 international $ (WHO, 2004).

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

The life expectancy at birth is 69.5 years for males and 73.9 years for females (WHO, 2004). The healthy life expectancy at birth is 61 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY

A community epidemiological study carried out on a representative sample of 5000 adults in one region reported a life time prevalence of about 9% for major depression and 0.6% for schizophrenia (Hachmi et al, 1995). Fakhfakh et al (2000) assessed the use of tobacco (smoking) in Tunisia since 1970 using different sources. Cigarette smoking increased from 1981 to 1993 but decreased slightly after that. The prevalence of current tobacco smoking was 30.4% (52% for males and 6% for females). In young people, the prevalence was 29.2% (50% for males and 3.9% for females). Young people who attended school smoked less than those who did not (18.1% versus 38.4%). Most started smoking between 14 years and 18 years. Gassab et al (2002) conducted a retrospective study of depression in a clinical sample (n=155) of bipolar (n=86) and recurrent depressive disorder (n=59) patients, diagnosed according to the DSM-IV criteria. The following factors were correlated with bipolarity: separation/divorce, family history of psychiatric disorders (especially bipolar disorders), early onset, number of affective episodes, sudden onset of depressive episodes and psychotic features, catatonic features, hypersomnia and psychomotor inhibition. Somatic comorbidity (diabetes, hypertension, rheumatic diseases) and dysthymic disorders were predictors of non-bipolar depression. The bipolar family history criterion had the highest positive predictive validity, while the psychotic characteristics criterion had the lowest positive predictive validity. Moalla et al (2001) found that organic (somatic illnesses, epilepsy) and environmental (parental quarrels, poor family support) factors were associated with onset of mental disorders in a sample of more than 1400 child psychiatry out-patients. Ayadi et al (2002) found divorce to be associated with mental disorders in children (personality disorders, functional disturbance and depressive disturbance). Karoui and Karoui (1993) compared children with pica with children without pica in a day care centre and found that pica was associated with gender (male), family history of pica (positive in 57% of the cases), socioeconomic status (low) and locality (urban). The onset was between 12 and 18 months in most cases. Children of divorced parents had worse short- and medium-term outcomes in comparison to children of parents who were staying together, but the long-term outcome was similar.

MENTAL HEALTH RESOURCES

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

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. There are committees and subcommittees looking into the training of personnel, preparation of manuals for physicians at the primary care level, visits of specialists to outpatient departments on a periodic basis, review of drug list, radio and television programmes and research. The main thrust of the policy are integration of mental health into primary care, training of non-psychiatric medical professionals in psychiatric care, creation of psychiatric services in general hospitals and sectorization of services.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1969. The substance abuse policy was revised in 1969 and 2000.

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

The goals of the programme are to promote and protect mental health and to prevent, detect and treat mental disorders.

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 national therapeutic drug policy/essential drugs list has been re-evaluated in 1993 and in 2000.

Mental Health Legislation Law No. 92-83 of 1992 on mental health and conditions of hospitalization of individuals with mental disorders was the first law in the field of mental health.

The latest legislation was enacted in 2003.

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

Details about expenditure on mental health are not available.

The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, private insurances and social insurance.
The country has disability benefits for persons with mental disorders. Mental health patients are provided financial, treatment and transportation 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. The general practitioners diagnose severe disorders and refer patients almost systematically to the second/third level care (a second level care is only available in a few regions) for treatment and monitoring.
Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 280 personnel were provided training. Though training has been provided to some primary care personnel, a system of follow-up has not been developed yet. A manual for training of physicians has been prepared.
There are community care facilities for patients with mental disorders. Some NGOs provide community based care for children under the aegis of the Social Affairs Ministry.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.13
Psychiatric beds in mental hospitals per 10 000 population	0.85
Psychiatric beds in general hospitals per 10 000 population	0.27
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	1.6
Number of neurosurgeons per 100 000 population	0.2
Number of psychiatric nurses per 100 000 population	0.2
Number of neurologists per 100 000 population	0.4
Number of psychologists per 100 000 population	0.6
Number of social workers per 100 000 population	

Two thirds of the specialists are based in the capital and along the coastline.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in promotion, prevention and rehabilitation. Some NGOs are involved in the care and training of the mentally retarded children.

Information Gathering System There is no mental health reporting system in the country. Preparations are going on for some indicators in the annual health reporting system.
The country has data collection system or epidemiological study on mental health. A data collection document is in effect, though inadequate; one study on depression and schizophrenia is on-going.

Programmes for Special Population The country has specific programmes for mental health for indigenous population, elderly and children. There are services for delinquents, abandoned children, prostitutes and patients affected by HIV.
There are some facilities for children and adolescents in the form of day care hospitals, consultancy clinics and medico-school centres. There is also a school health programme. There are homes for the elderly and mentally challenged individuals.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium.
Drugs like cloimipramine form a part of the essential drug list.

Other Information

Additional Sources of Information

Ayadi, H., Moalla, Y., Ahmed, S. B., et al (2002) Parental divorce and psychopathologic unrests at the child and the teenager. Tunisian comparative study. Neuropsychiatrie de l'Enfance et de l'Adolescence, 50, 121-127.

Fakhfakh, R., Romdhane, H. B., Hsairi, M., et al (2000) Trends in tobacco consumption in Tunisia. Eastern Mediterranean Health Journal, 6, 678-686.

Gassab, L., Mechri, A., Gaha, L., et al (2002) Bipolarity correlated factors in major depression: about 155 Tunisian inpatients. Encephale, 28, 283-289.

Karoui, A., Karoui, H. (1993) Pica in Tunesian children. Results of a survey performed in a polyclinic of the tunisian social security national administration. Pediatrie, 48, 565-569.

Moalla, Y., Ayedi, H., Laaribi, H., et al (2001) What etiologic factors at the tunisian children? Timely an epidemiologic investigation. Neuropsychiatrie de l'Enfance et de l'Adolescence, 49, 343-351.

Hachmi et al. (1995) Epidémiologie des troubles dépressifs et de la schizophrénie dans le gouvernorat de l'ARIANA. Mémoire de psychiatrie. Library of the Faculty of medicine of Tunis: Srairi LYES.

Republique Tunisienne Ministere de la sante (1998). Programme National de Sante Mentale.

Turkey

GENERAL INFORMATION

Turkey is a country with an approximate area of 775 thousand sq. km. (UNO, 2001). Its population is 72.32 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 8% (WHO, 2004). The literacy rate is 94.4% for men and 78.5% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5%. The per capita total expenditure on health is 294 international $, and the per capita government expenditure on health is 209 international $ (WHO, 2004).

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

The life expectancy at birth is 67.9 years for males and 72.2 years for females (WHO, 2004). The healthy life expectancy at birth is 61 years for males and 63 years for females (WHO, 2004).

EPIDEMIOLOGY

Prevalence estimates varied widely (from more than 40% lifetime prevalence of any mental disorder in the Netherlands and the USA to 12% in Turkey) in a study done by the International Consortium in Psychiatric Epidemiology (ICPE) that used the Composite International Diagnostic Interview (CIDI). Findings suggested that mental disorders were often chronic, typically had early ages of onset, were associated with socioeconomic measures of disadvantage (low income and education, unemployment, unmarried status) and that the lifetime prevalence had increased in recent cohorts (Anonymous, 2000). In a sample of 13 665 high school girls (13-18 years), Vicdan et al (1996) found that 19.7% smoked cigarettes, 14.9% used alcohol and 0.63% used other drugs. Elbi et al (2002) surveyed 1749 subjects using the Seasonal Pattern Assessment Questionnaire. The prevalence of winter seasonal affective disorder (SAD) and summer SAD were reported to be 4.8% and 8.4%, respectively. Danaci et al (2002) assessed 257 randomly selected mothers who had delivered within the past 6 months using the Edinburgh Postnatal Depression Scale. Depression was identified in 14% and it was associated with living in a shanty, being an immigrant, number of children, baby's health problems, psychiatric history in parents and poor relationship with husband and in-laws. Basoglu et al (2002) administered the Screening Instrument for Traumatic Stress in Earthquake Survivors to 1000 subjects living in camps. The prevalence of PTSD and major depression were 43% and 31%, respectively. Traumatic stress symptoms were associated with female gender, more intense fear during the earthquake, having been trapped under the rubble, death of a family member, past psychiatric illness, having participated in rescue work and lower education level. In a representative urban sample (n=994) assessed with the Dissociative Experiences Scale (DES), the Dissociative Disorders Interview Schedule (DDIS) and a confirmatory clinical interview in a three-stage study, the prevalence of dissociative disorders was 0.4% (Akyuz et al, 1999). Akkus et al (2002) evaluated 1982 men selected by a stratified random method and found an age-adjusted prevalence of erectile dysfunction to be 69.2% (mild 33.2%, moderate 27.5%, severe 8.5%). In a multivariate model, moderate/severe ED was significantly associated with age, low socioeconomic status, low physical activity and medical illnesses. Based on national records, Sayil (1997) reported that the rates of suicide and suicide attempts were 3.3/100 000 and 145/100 000 population, respectively. Eskin (1999) assessed large samples of Swedish and Turkish school students (n>600) and found that between 2.7% to 9.4% of Swedish students and 4.6% to 10.9% of Turkish students had made previous suicide attempts. In the Turkish group, suicide attempts were associated with previous psychiatric contact, low perceived family support, suicide attempts and psychiatric disorder in the family. Past suicide attempts and low perceived family support were the most powerful and consistent predictors of current suicidal risk. Goksu et al (2002) found that 78.7% of poisoning cases admitted to a hospital were due to suicide attempts. Most of the suicide attempts were by females. Mattila et al (1987) found that among 1188 children (aged less than 17 years) admitted with a diagnosis of poisoning deliberate self-poisoning was reported in 12.8%. Suicide attempts were associated with gender (girls) and age group (among adolescents 79% of poisonings were self-induced). Cuhadaroglu et al (1999) assessed 434 school students with the Symptom Check List 90-Rand and found that psychiatric problems were associated with gender (female), age group (15-16 years) and socioeconomic status (low). In large samples of students (>800 subjects), Fichter et al (1988) found significantly higher GHQ-28 scores in Greeks and Turks in their homeland as compared to Greeks in Munich. In a similar study (>800 subjects), Bengi-Arslan et al (1997) found that immigrant Turkish children (4-18 years) had higher scores on at least five Child Behaviour Checklist (CBCL) scales in comparison to Dutch and Turkish children in their homeland. However, the differences in scores and the patterns of problem behaviours were small in the two Turkish samples. Studies that assessed nocturnal enuresis in large samples (>1700 subjects) of children (4-12 years) through parental questionnaires (Gumus et al, 1999; Oge et al, 2001) found that the prevalence rate was in the range of 11.6% to 13.7%. Enuresis was associated with gender (male), age (younger), deep sleep, poor toilet habits, urinary tract infections, large family size, low parental socioeconomic class and family history of enuresis.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1983.
The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The goal then was the integration of mental health into primary health care (i.e. a horizontal approach) with promotion and prevention activities in addition to the improvement of curative services. For inter-sectoral and inter-disciplinary coordination there were efforts to get the involvement of different ministries, universities and non-governmental organizations, with the support of the World Health Organization.

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

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1987.
A new programme is being developed by a project supported by the World Bank after the earthquake in 1999.

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

Mental Health Legislation There is no existing legislation on mental health but a law on prevention of tobacco harm from 1996 does exist. The criminal law stipulates special conditions for the treatment of mentally ill offenders. Lack of an overall mental health law continues to be a concern for the mental health profession. The Psychiatric Association of Turkey has chosen to begin work on a draft law for the protection of the rights of psychiatric patients.
Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are no budget allocations for mental health.
Details about expenditure on mental health are not available.
The primary sources of mental health financing in descending order are social insurance, private insurances, tax based and out of pocket expenditure by the patient or family.
The country has disability benefits for persons with mental disorders. After being approved by a mental health board as a chronic mental health patient, the patient can benefit from the social security services.

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 in primary care is available in only some provinces.
Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 3000 personnel were provided training.
There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.3
Psychiatric beds in mental hospitals per 10 000 population	0.8
Psychiatric beds in general hospitals per 10 000 population	0.5
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	1
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	3
Number of neurologists per 100 000 population	1
Number of psychologists per 100 000 population	1
Number of social workers per 100 000 population	1

The number of child and adolescent psychiatrists per 100 000 is 0.3. Of the total beds available in the country about 2.5% are located in the private sector and 55 are under the charge of the Ministry of Social Security. Ethical rules for psychiatric practice were established in June 2002 by the Psychiatric Association of Turkey. Psychiatrists mainly work in the large cities and the western parts of the country. Almost two-thirds are located in Istanbul, Ankara and Izmir. Most psychologists work in private clinics. Within the government set-up, about two thirds of mental health staff are attached to general hospitals.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. The Association for Child and Adolescent Mental Health is functioning as the main organization in the subjects related to children and adolescents. There are some newly founded associations that focus on the rights and welfare of psychiatric patients and their relatives, most of which are currently led by professionals who wish to promote 'consumer-led' services.

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

Programmes for Special Population The country has specific programmes for mental health for disaster affected population and children. Services are limited.
Child and adolescent psychiatry has been a separate specialty since 1995. Committees on adolescence and ADHD within the Association for Child and Adolescent Mental Health are carrying on epidemiological research and interventional programmes. A child abuse and neglect team is functioning.

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.
Drugs like thioridazine and imipramine are a part of the essential drug list.

Other Information The mental health department was established within the General Directorate of Primary Health Care of the Ministry in 1983 with the primary tasks of improving the mental health services, development and dissemination of preventive mental health services, integration of mental health with primary care, community education and protection of the community from harmful behaviours. The means of achieving these aims were through determination of standards, training programmes, data collection, research, creation of counselling and guiding units, creation of psychiatric clinics in state hospitals, assigning proper tasks to personnel, developing rehabilitation facilities, carrying out public education through the help of media, educating the public on harmful behaviour and taking care of those who succumb to those behaviours.

Additional Sources of Information

Akkus, E., Kadioglu, A., Esen, A., et al (2002) Prevalence and correlates of erectile dysfunction in Turkey: a population-based study. European Urology, 41, 298-304.

Akyuz, G., Dogan, O., Sar, V., et al (1999) Frequency of dissociative identity disorder in the general population in Turkey. Comprehensive Psychiatry, 40, 151-159.

Anonymous (2000) Cross-national comparisons of the prevalences and correlates of mental disorders. WHO International Consortium in Psychiatric Epidemiology. Bulletin of the World Health Organization, 78, 413-426.

Basoglu, M., Salcioglu, E., Livanou, M. (2002) Traumatic stress responses in earthquake survivors in Turkey. Journal of Traumatic Stress, 15, 269-276.

Bengi-Arslan, L., Verhulst, F. C., van der Ende J., et al (1997) Understanding childhood (problem) behaviors from a cultural perspective: comparison of problem behaviors and competencies in Turkish immigrant, Turkish and Dutch children. Social Psychiatry & Psychiatric Epidemiology, 32, 477-484.

Coskun, B. (2004) Psychiatry in Turkey. International Psychiatry, 3, 13-15.

Cuhadaroglu, F., Yazici, K. M. (1999) Psychiatric symptoms among Turkish adolescents. Turkish Journal of Pediatrics, 41, 307-313.

Danaci, A. E., Dinc, G., Deveci, A., et al (2002) Postnatal depression in Turkey: epidemiological and cultural aspects. Social Psychiatry & Psychiatric Epidemiology, 37, 125-129.

Elbi, H., Noyan, A., Korukoglu, S., et al (2002) Seasonal affective disorder in eight groups in Turkey: a cross-national perspective. Journal of Affective Disorders, 70, 77-84.

Eskin, M. (1999) Gender and cultural differences in the 12-month prevalence of suicidal thoughts and attempts in Swedish and Turkish adolescents. Journal of Gender, Culture, & Health, 4, 187-200.

Fichter, M. M., Elton, M., Diallina, M., et al (1988) Mental illness in Greek and Turkish adolescents. European Archives of Psychiatry & Neurological Sciences, 237, 125-134.

Goksu, S., Yildirim, C., Kocoglu, H., et al (2002) Characteristics of acute adult poisoning in Gaziantep, Turkey. Journal of Toxicology – Clinical Toxicology, 40, 833-837.

Gumus, B., Vurgun, N., Lekili, M., et al (1999) Prevalence of nocturnal enuresis and accompanying factors in children aged 7-11 years in Turkey. Acta Paediatrica, 88, 1369-1372.

Hincal, F., Hincal, A. A., Sarikayalar, F., et al. (1987) Self poisoning in children: a ten year survey. Journal of Toxicology – Clinical Toxicology, 25, 109-120.

Mental Health Department. Goals and Long Range Planning Document.

Oge, O., Kocak, I., Gemalmaz, H. (2001) Enuresis: point prevalence and associated factors among Turkish children. Turkish Journal of Pediatrics, 43, 38-43.

Ozkan, S., Yucel, B., Turgay, M. et al (1995) The development of psychiatric medicine at Istanbul Facility of Medicine and evaluation of 889 psychiatric referrals. General Hospital Psychiatry, 17, 216-223.

Oral, R., Can, D., Kaplan, S., et al (2001) Child abuse in Turkey. An experience in overcoming denial and a description of 50 cases. Child Abuse and Neglect, 25, 279-290.

Sayil, I. (1997) Review of suicide studies in Turkey. Crisis: Journal of Crisis Intervention & Suicide, 18, 124-127.

Vicdan, K., Kukner, S., Dabakoglu, T., et al (1996) Demographic and epidemiologic features of female adolescents in Turkey. Journal of Adolescent Health, 18, 54-58.

Turkmenistan

GENERAL INFORMATION

Turkmenistan is a country with an approximate area of 488 thousand sq. km. (UNO, 2001). Its population is 4.94 million, and the sex ratio (men per hundred women) is 98 (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 99.3% for men and 98.3% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 4.1%. The per capita total expenditure on health is 245 international $, and the per capita government expenditure on health is 180 international $ (WHO, 2004).

The main language(s) used in the country is (are) Turkmen and Russian. The largest ethnic group(s) is (are) Turkmen, and the other ethnic group(s) are (is) Russian and Uzbek. The largest religious group(s) is (are) Muslim (nine-tenths).

The life expectancy at birth is 58.8 years for males and 66.9 years for females (WHO, 2004). The healthy life expectancy at birth is 52 years for males and 57 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Turkmenistan in internationally accessible literature. Suicide rates in the former USSR during 1984-1990 varied greatly between different regions. It was reported to be 11.8 in Central Asia (Kazakhstan, Kirgizia, Turkmenistan, Uzbekistan and Tajikistan) (Wasserman et al, 1998). Solov'eva et al (1997) compared emotional disturbances in patients suffering from gastrointestinal problems in cities in Russia and Turkmenistan. Psychological factors were common to all patients. Psychological factors were more prominent in children in Russia compared to children in Turkmenistan. Association of stress with peptic ulcers was stronger compared to other diseases. Similar association was noted for depression and chronic gastritis.

MENTAL HEALTH RESOURCES

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

The components of the policy are promotion, prevention, treatment and rehabilitation. The thrusts of the policy are on education, early detection and with timely assistance and treatment by family practitioners and specialists. In 1996, the president signed a decree 'Salt iodization and fortification of flour with iron', to prevent iodine deficiency diseases, that can lead to mental retardation of children and to improve mental capacity of adults. In 2001, the President adopted the 'National Plan on Fighting Illegal Trafficking of Narcotics and Medical Assistance to Substance users for 2001-2005'.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1996. In 2000, the Ministry of Health adopted the 'Improvement of Narcological Services' for prevention of substance abuse and treatment and rehabilitation of substance abusers.

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

In 1997, the Ministry of Health adopted a programme 'Improvement of Psychiatric Assistance' on prevention of inappropriate imprisonment of the mentally ill and facilitation of their referral and transfer to specialized treatment centres. A national programme entitled 'Free Electricity, Gas, Water, and Salt Until 2020' was launched in 2003. The quantity of iodized salt provided free of charge is 4000 units per person per month.

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

The Ministry of Health has adopted a law on the sale of psychiatric drugs.

Mental Health Legislation There is a Law of Turkmenistan on Psychiatric Assistance. It is based on internal laws on human rights of persons with mental disorders. It stipulates that mentally ill people have the right to Government and social support in the form of free medical treatment, allowances for medication and pension funds. In 2004, the law 'On narcotics, psychotropic substances and illegal drug trafficking' was adopted.

The latest legislation was enacted in 1993.

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

Details about expenditure on mental health are not available.

Details about sources of financing are not available.

The country has disability benefits for persons with mental disorders. Disabled people receive a pension.

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. At primary level, family practitioners work with psychiatrists in providing emergency services to persons with mental disorders and in deciding whether hospitalization is needed. Specialized treatment is provided by psychiatrists in inpatient and outpatient setting.

Regular training of primary care professionals is carried out in the field of mental health. There are courses on psychiatry and narcology for family practitioners.

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

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	3.5
Psychiatric beds in mental hospitals per 10 000 population	3.2
Psychiatric beds in general hospitals per 10 000 population	0.3
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	3
Number of neurosurgeons per 100 000 population	0.5
Number of psychiatric nurses per 100 000 population	
Number of neurologists per 100 000 population	4.2
Number of psychologists per 100 000 population	
Number of social workers per 100 000 population	

Continuing medical education of psychiatrists and narcologists is encouraged.

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

Information Gathering System There is mental health reporting system in the country.
The country has data collection system or epidemiological study on mental health.
Quarterly and annual reports are discussed in meetings of Ministerial Boards and medical industry. There are operational reports on psychiatry and narcology.

Programmes for Special Population There are no specific programmes.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, amitriptyline, diazepam, haloperidol, levodopa.
Other drugs like cyclodol and aminazine are included in the essential list of psychotropics.

Other Information

Additional Sources of Information

Polubinskaya, S. V. (2000) Development of Legislation and Psychiatric Care in the New Independent States. Mental Health Reforms, 5, 12-13.

Solov'eva, A. D., Sheptulin, A. A., Annamamedova, R., et al (1997) Emotional-personality condition of patients with some gastroenterological diseases. Klinicheskaia.Meditsina, 75, 27-28.

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

Tuvalu

GENERAL INFORMATION

Tuvalu is a country with an approximate area of 0.03 thousand sq. km. (UNO, 2001). The country consists of nine small islands. Its population is 0.01 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 7% (WHO, 2004). The literacy rate is 90% for men and 90% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.4%. The per capita total expenditure on health is 673 international $, and the per capita government expenditure on health is 359 international $ (WHO, 2004).

The main language(s) used in the country is (are) Tuvaluan and English. The largest ethnic group(s) is (are) Polynesian. The largest religious group(s) is (are) Christian (Church of Tuvalu).

The life expectancy at birth is 60 years for males and 61.4 years for females (WHO, 2004). The healthy life expectancy at birth is 53 years for males and 53 years for females (WHO, 2004).

EPIDEMIOLOGY

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

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1978.

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. The essential drug list and the national therapeutic drug policy have been officially endorsed by the Government in 2004.

Mental Health Legislation There is a Mental Treatment Law.
The latest legislation was enacted in 1978.

Mental Health Financing There are no budget allocations for mental health.
Details about expenditure on mental health are not available.
Details about sources of financing are not available.
The mental health service is free of charge for every citizen.
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.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	2
Psychiatric beds in mental hospitals per 10 000 population	0
Psychiatric beds in general hospitals per 10 000 population	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	0
Number of psychiatric nurses per 100 000 population	1000
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0
Number of social workers per 100 000 population	1000

Psychiatric patients are managed by medical officers.

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

Programmes for Special Population There are no special services available.

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

Other Information

Additional Sources of Information

Government of Tuvalu (2000) Tuvalu Essential Drug List.

Uganda

GENERAL INFORMATION

Uganda is a country with an approximate area of 241 thousand sq. km. (UNO, 2001). Its population is 26.699 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 50% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 78.8% for men and 59.2% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.9%. The per capita total expenditure on health is 57 international $, and the per capita government expenditure on health is 33 international $ (WHO, 2004).

The main language(s) used in the country is (are) English, Swahili, Luganda, Ateso and Luo. The largest ethnic group(s) is (are) Baganda, Basoga, Iteso, Langi and Acholi Banyankole/Bakiga, and the other ethnic group(s) are (is) Banyoro/Batoro, Yo'kwekyawa and Kwekubagiza. The largest religious group(s) is (are) Christian (two-thirds), and the other religious group(s) are (is) Muslim.

The life expectancy at birth is 47.9 years for males and 50.8 years for females (WHO, 2004). The healthy life expectancy at birth is 42 years for males and 44 years for females (WHO, 2004).

EPIDEMIOLOGY

Kasoro et al (2002) estimated the prevalence of psychiatric disorder in one district by interviewing members of randomly selected households and key informants and through focus group discussions. The estimated prevalence of mental disorders in adults was 30.7%. Orley and Wing (1979) conducted a survey in two small rural populations using standardized tools and methods of case identification and found that 20% suffered from a probable mental disorder and a further 5% from a definite disorder. Most suffered from depression, hypomania and anxiety. Cox (1979) examined 263 pregnant and 89 non-pregnant, non-puerperal women using a semi-structured psychiatric interview. A higher frequency of psychiatric morbidity was seen in pregnant women. Separated pregnant women were particularly at risk. Wilk and Bolton (2002) used ethnographic methods, free listing and key-informant interviews, among participants from two districts to examine the folk view of psychological consequences of the HIV epidemic in a severely affected community. Participants described two independent depression-like syndromes (Yo'kwekyawa and Okwekubaziga) resulting from the HIV epidemic. No syndromes similar to posttraumatic stress disorder were detected. Peltzer et al (1999) assessed the effects of trauma on the mental health of 323 refugees settled in Ugandan camps. One-third of adults and one-fifth of children had PTSD. Ex-soldiers had significant depression. While only a fifth of those seeking help from the formal health sector had psychiatric disorders, almost two-thirds of subjects visiting traditional healers had a psychiatric disorder (PTSD: 26% and depression: 39%). Drotar et al (1997) followed up 436 full-term infants (79 HIV-infected infants of HIV-infected mothers, 241 uninfected infants of HIV-infected mothers (seroreverters) and 116 uninfected infants of HIV-negative mothers) for 2 years. All evaluators were blinded to the HIV status of the child and family. Compared with controls, HIV-infected infants had more abnormalities in mental development at 6 and 18 months and an earlier onset of abnormalities. By 12 months, 26% of HIV-infected infants demonstrated cognitive abnormalities as compared with 6% in the other two groups. Information-processing abilities did not differ as a function of HIV infection. Home environments and infants' interactions with caretakers were similar across groups.

MENTAL HEALTH RESOURCES

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

Substance Abuse Policy A substance abuse policy is absent. There is no need for a separate substance abuse policy as mental health aspects of substance abuse are covered within the mental health policy

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1996.
Mental health is one of the 12 key services to be provided as a part of the minimum health package at all levels of care.
Intersectoral collaboration is emphasized, though it is happening only at the national level at present.

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1993.
The policy was reviewed in 1996 and 2001.

Mental Health Legislation The Mental Treatment Act is currently being reviewed. Enforcements of rights of patients is generally satisfactory in Government institutions. However, there is no specific body appointed to periodically review cases of involuntary admissions.
The latest legislation was enacted in 1964.

Mental Health Financing There are budget allocations for mental health.
The country spends 0.7% of the total health budget on mental health.
The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, private insurances and social insurance.

Funding for health is mainly from economic aid and does not favour mental health. People with mental illness might spend on an average $57 per year on mental health care, a large amount given that the per capita income is $89. Most families and consumers report a worsening of their economic situation and productivity as a result of their contribution to patient care. NGOs are increasingly getting involved in funding of primary health care.
The country does not have disability benefits for persons with mental disorders. Disability benefits are low and even lower for mental health.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Treatment for severe mental disorders are available only at the 10 regional referral centres and the National Mental Referral Hospital. Mental health is an integral part of primary health care policy.
Regular training of primary care professionals is carried out in the field of mental health. Though training facilities for the primary care workers are not present, there is a training manual which can be obtained for purpose of training staff. There has been an effort to instil basic knowledge about mental disorders and its treatment among medical students so that they are able to identify the disorders and manage them in primary care level. Community-based programmes which combine the services of traditional medical practitioners with modern medical services in providing sustainable rural health care have been supported. Such clinics are staffed by a trained nurse and a pharmaceutical technician and visited by doctors. Traditional herbalists may refer patients to mental health care staff at these clinics. These clinics also provide community health education, which emphasizes hygiene and the appropriate use of local medicinal resources. Traditional health practitioners care for the emotional and spiritual as well as the physical well-being of their patients.
There are community care facilities for patients with mental disorders. All community health departments at all health units provide some form of community based care but it is still in its infancy. Secondary mental health services can be found at 10 regional referral hospitals where services are run by a resident psychiatrist who are supervised through visits by a psychiatrist on a quarterly basis. There is a provision of a psychiatrist at this level once adequate numbers are trained and are available.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.44
Psychiatric beds in mental hospitals per 10 000 population	0.22
Psychiatric beds in general hospitals per 10 000 population	0.22
Psychiatric beds in other settings per 10 000 population	0.009
Number of psychiatrists per 100 000 population	1.6
Number of neurosurgeons per 100 000 population	0.009
Number of psychiatric nurses per 100 000 population	2
Number of neurologists per 100 000 population	0.1
Number of psychologists per 100 000 population	2
Number of social workers per 100 000 population	2

Out of the 55 other staff, 25 are psychiatric clinical officers. The bed strength in the Butabika National Mental Referral Hospital was reduced from 1000 to 450. With support of an ADB loan of USD 48 million, the Government has refurbished the Butabika National Mental Referral Hospital and constructed 6 Regional Mental Health Units with 35 beds each. There are 100 forensic beds, 50 beds for children and adolescents, 20 beds for psychologically traumatized patients and 10 beds for the treatment of drug abusers. Most health facilities try to segregate male and female patients. All qualified health workers are required to renew their registration – doctors every year and nurses every 3 years. All professionals are now prescribed minimum hours of exposure to continuing medical education for their reaccreditations, but the process is new and enforcement not particularly strict. There are few mental health professionals in the private sector, all of them are in the capital city. Trained specialists are found only in urban centres.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. There is some increase in NGO participation in capacity building and primary mental health care provision. Consumer support groups for mental health are also emerging. They are involved particularly with psychosocial care to war-afflicted populations. NGOs are also carrying out research in mental health.

Information Gathering System There is mental health reporting system in the country. They are mentioned broadly as 'mental illness' without the break-up into different disorders.
The country has data collection system or epidemiological study on mental health. Monthly and quarterly reports are received from referral hospitals and NGOs. Some key psychiatric and monitoring items have been developed (including diagnoses) to collect data. Routine health management information forms list just 2 items under mental health, mental illness and epilepsy. Guidelines for monitoring mental health have been developed but have to be disseminated.

Programmes for Special Population The country has specific programmes for mental health for refugees, disaster affected population and children. There are psychosocial support programmes in war affected areas.
Limited services are available for children, elderly and those in prisons. There is an initiative to set up a substance abuse and trauma centre at the national hospital.

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

Other Information Academic psychiatry was started in the late 1960s when the Makerere University Department of Psychiatry was founded. Psychiatry suffered during the Amin regime, but over the years, there has been a lot of improvement. However, problems remain; there is a lack of resources and the legislation needs to be upgraded. HIV and PTSD place an added burden on Ugandan psychiatry.

Additional Sources of Information

Boardman, J., Ovuga, E. (1997) Rebuilding psychiatry in Uganda. Psychiatric Bulletin, 21, 649-655.

Cox, J. L. (1979) Psychiatric morbidity and pregnancy: a controlled study of 263 semi-rural Ugandan women. British Journal of Psychiatry, 134, 401-405.

Drotar, D., Olness, K., Wiznitzer, M., et al (1997) Neurodevelopmental outcomes of Ugandan infants with human immunodeficiency virus type 1 infection. Pediatrics, 100, E5.

Kasoro, S., Sebudde, S., Kabagambe-Rugamba, G., et al (2002) Mental illness in one district of Uganda. International Journal of Social Psychiatry, 48, 29-37.

Njenga, F. (2002) Focus on psychiatry in East Africa. British Journal of Psychiatry, 181, 354-359.

Orley, J., Wing, J. K. (1979) Psychiatric disorders in two African villages. Archives of General Psychiatry, 36, 513-520.

Ovuga, E. B. L., Buga, J., Oboke, H., et al (2002) Promoting psychiatry in the medical school. Psychiatric Bulletin, 26, 194-195.

Peltzer, K. (1999) Trauma and mental health problems of Sudanese refugees in Uganda. Central African Journal of Medicine, 45, 110-114.

Tumwesigye, O. (1996). Bumetha Rukararwe: integrating modern and traditional health care in southwest Uganda. Journal of Alternative and Contemprory Medicine, 2, 3-6.

Wilk, C. M., Bolton, P., et al (2002) Local perceptions of the mental health effects of the Uganda acquired immunodeficiency syndrome epidemic. Journal of Nervous & Mental Disease, 190, 394-397.

Ukraine

GENERAL INFORMATION

Ukraine is a country with an approximate area of 604 thousand sq. km. (UNO, 2001). Its population is 48.151 million, and the sex ratio (men per hundred women) is 87 (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 21% (WHO, 2004). The literacy rate is 99.8% for men and 99.5% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 4.3%. The per capita total expenditure on health is 176 international $, and the per capita government expenditure on health is 120 international $ (WHO, 2004).

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

The life expectancy at birth is 61.7 years for males and 72.9 years for females (WHO, 2004). The healthy life expectancy at birth is 55 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY

Official statistics show that the prevalence of mental disorders reached 1 181 435 persons in 2003 or 2.47%. The incidence of mental disorders was 0.025% and 0.022% per year in urban and rural populations, respectively. The incidence of mental disorders among children was 0.049% and the prevalence 2.84%. About 0.53% were classified as having mental disability (Center of Medical Statistics of Ministry of Health, 2004). Buzanova (1981) did a comparative clinico-epidemiological study on a group of patients suffering from schizophrenia, living in urban and rural districts. The groups did not differ much with respect to age of onset and characteristics. In a clinical study done on a large number of patients (n=27 692), Dvirskii (1999) found that delirium tremens (DT) occurred in 8.1% of cases with alcohol dependence. Among patients with DT, 12.9% had more than one episode. Men were affected 5.3 times more than women. A number of studies have been done on different populations affected by the Chernobyl disaster. Most studies show that there is a significant increase in the prevalence of psychological problems and psychiatric disorders in the exposed population. Loganovsky and Loganovskaja (2000) examined the Chernobyl exclusion zone archives (1986-1997) and assessed 100 patients with acute radiation sickness and 100 exposed workers. They noted a significant increase in the incidence of schizophrenia in exclusion zone personnel in comparison to the general population (5.4 per 10 000 in the exclusion zone versus 1.1 per 10 000 in the rest of Ukraine) from the beginning of 1990. Those irradiated by moderate to high doses (more than 0.30 Sv or 30 rem) had significantly more left frontotemporal limbic and schizophreniform syndromes. Revonek (1991) showed that the rate of reactive psychosis was higher in inpatients affected by the disaster in comparison to the general group of inpatients. Napreenko and Loganovskii (1995) evaluated 476 subjects over a period of 8 years and found that mental disorders, especially psychoorganic (14.5%), neurotic (12.1%) and psychosomatic (58%) disorders were common. In a sample of 320 nonpsychotic patients, Panchenko et al (1996) found that five syndromes were common: astheno-neurotic (36.2%), astheno-depressive (28.8%), obsessive-phobic (17.8%), astheno-hypochondriac (10%) and hysteric-hypochondriac (7.2%). Revenok (1998) showed that personality and behavioural changes become predominant late in the course of organic brain affection. The rate of suicide has been reported to be in the range of 24.0-29.6 per 100 000 population over a 15 year period (1984 to 1998) and large regional variations have been noted (Mokhovikov & Donnets, 1996; Wassermann et al, 1998; Kryzhanovskaya & Pilyagina, 1999). In 2003, the rate of suicide was 26.1 per 100 000 (Center of Medical Statistics of Ministry of Health, 2004). Kryzhanovskaya and Pilyagina (1999) reported that the suicide rate had increased by 57% between 1988 and 1997. They also found that suicides were more prevalent in the industrially developed regions and that men committed suicide five times more often than women. Gadow et al (2000) conducted a study on ADHD in 10-12 year old urban children (n=600) in which parents, teachers and children were interviewed using standardized tools and DSM-IV criteria. They found the prevalence of ADHD to be 19.8% and that of inattentive, hyperactive-impulsive and combined subtypes to be 7.2%, 8.5% and 4.2%, respectively. Nyagu et al (1998) noted a significant increase in mental retardation, borderline and low range IQ, and emotional and behavioural disorders in children exposed to radiation prenatally (n=544) when compared to normal controls (n=759) in a study that involved examination of children and interviews with parents and teachers. However, these findings were not supported by Litcher et al's (2000) study, who examined the cognitive and neuropsychological functioning of children who had been less than 15 months of age or in utero at the time of the Chornobyl disaster (n=300).

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1988.
The components of the policy are prevention, treatment and rehabilitation.

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

National Mental Health Programme A national mental health programme is absent.
The project of national targets as a part of mental health programme has been prepared.

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

Mental Health Legislation There is a Law on Psychiatric Care. This was the first time in the history of the independent Ukrainian State that consideration was given by the supreme legislative body to a draft of a law by a non-governmental professional organization.
The latest legislation was enacted in 2000.

Mental Health Financing There are no budget allocations for mental health.
Details about expenditure on mental health are not available.
The primary sources of mental health financing in descending order are tax based and private insurances.
Though services are funded by the state, there are restrictions on the amount of free medication.
The country has disability benefits for persons with mental disorders.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. There are some local experimental programmes at Kiev.
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. There are experimental programmes only in some cities.
There are some polyclinics which take care of ambulant psychiatric patients, but no other psychiatric institution exists (Rupprecht et al, 2000).

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	9.6
Psychiatric beds in mental hospitals per 10 000 population	9.3
Psychiatric beds in general hospitals per 10 000 population	0.3
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	8.9
Number of neurosurgeons per 100 000 population	1.5
Number of psychiatric nurses per 100 000 population	34
Number of neurologists per 100 000 population	13
Number of psychologists per 100 000 population	0.06
Number of social workers per 100 000 population	0.4

Training of psychiatric nurses has been developed at Kiev. Training of social workers has been begun at the Kiev-Mogila Academy. There are 87 psychiatric hospitals in Ukraine. There is a trend to decrease the number of inpatient beds in hospitals. Almost one-sixth of psychiatric beds in Ukraine has been allocated for child and adolescent psychiatry.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. The positive experience of interactions between state psychiatric services, non-governmental professional organizations and organizations of relatives and users has been an important factor. As a result of these projects, the approach of multidisciplinary teamwork and case management have been introduced into practice of some facilities at Kiev, Zhitomir and Donetsk.

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

Programmes for Special Population The country has specific programmes for mental health for disaster affected population and children.
Each region has 1-3 child and 1-2 adolescent psychiatry departments. Special departments for drug dependent adolescents are also present. The Ministry of Social Security provides for boarding schools for mentally challenged children. A number of cities have also started municipal rehabilitation centres for disabled 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, levodopa.
In place of biperiden other anti-parkinsonian drugs are used.

Other Information The provision of psychiatric care, with its planning and financing on the national level, are implemented by the Department on Disease Treatment and Prevention of the Ministry of Public Health of Ukraine. Currently, the most important problem for this working group is to develop a 'Conception of Mental Health Care in Ukraine'. Throughout the country, there are similar working groups, consisting of the leading specialists in the field of mental health within each region. In addition, there is a problem-solving commission within the structure of the Ministry of Public Health. Its main goal is to plan the directions of further scientific studies in the field of psychiatry.

Additional Sources of Information

Buzanova, V. E. (1981) Schizophrenia among urban and rural patients. Comparative clinico-demographic characteristics (according to the results of an epidemiologic study). Zhurnal Nevropatologii i Psikhiatrii Imeni S-S-Korsakova, 81, 729-734.

Center of Medical Statistics of Ministry of Health. (2004) Indicators of mental health disorders prevalence and work of psychiatric institutions in Ukraine in 2004. Kiev: Center of Medical Statistics of Ministry of Health, 2004.

Dvirskii, A. A. (1999) The role of genetic factors in the manifestation of delirium tremens. Zhurnal Nevrologii i Psikhiatrii Imeni S.S. Korsakova, 99, 48-50.

Gadow, K. D., Nolan, E. E., Litcher, L., et al (2000) Comparison of attention-deficit/hyperactivity disorder symptom subtypes in Ukrainian schoolchildren. Journal of the American Academy of Child & Adolescent Psychiatry, 39, 1520-1527.

Kryzhanovskaya, L., Pilyagina, G. (1999) Suicidal behavior in the Ukraine, 1988-1998. Crisis: Journal of Crisis Intervention & Suicide, 20, 184-190.

Levinsky, M., Aksentyev, S. (1999) Child and adolescent psychiatry in Ukraine. In: H. Remschmidt, H. van Engeland (Eds). Child and Adolescent Psychiatry in Europe. Historical Development, Current Situation and Future Perspectives. Darmstadt, Steinkopff. pp381-393.

Litcher, L., Bromet, E. J., Carlson, G., et al (2000) School and neuropsychological performance of evacuated children in Kyiv 11 years after the Chornobyl disaster. Journal of Child Psychology & Psychiatry & Allied Disciplines, 41, 291-299.

Loganovsky, K. N., Loganovskaja, T. K. (2000) Schizophrenia spectrum disorders in persons exposed to ionizing radiation as a result of the Chernobyl accident. Schizophrenia Bulletin, 26, 751-773.

Mokhovikov, A., Donets, O. (1996) Suicide in the Ukraine: epidemiology, knowledge, and attitudes of the population. Crisis: Journal of Crisis Intervention & Suicide, 17, 128-134.

Napreenko, A. K., Loganovskii, K.N. (1995) The systematics of mental disorders related to the sequelae of the accident at the Chernobyl Atomic Electric Power Station. Likarska Sprava, 5-6, 25-29.

Nyagu, A. I., Loganovsky, K. N., Loganovskaja, T. K. (1998) Psychophysiologic aftereffects of prenatal irradiation. International Journal of Psychophysiology, 30, 303-311.

Panchenko, O. A., Tabachnikov, S. I., Kut'ko, I. I. (1996) Mental disorders in the participants in the cleanup of the aftermath of the accident at the Chernobyl Atomic Electric Power Station. Zhurnal Nevropatologii i Psikhiatrii Imeni S-S-Korsakova, 96, 34-37.

Polubinskaya, S. V. (2000). Reform in psychiatry in post-Soviet countries. Acta Psychiatrica Scandanavia 101 (suppl. 399), 106-108.

Revenok, A. A. (1991) The structural-dynamic characteristics of the reactive psychoses in persons subjected to ionizing radiation exposure as a result of the accident at the Chernobyl Atomic Electric Power Station. Vrachebnoe.Delo, 83-86.

Revenok, A. A. (1998) Psychopathic-like disorders in persons with an organic brain lesion as a result of exposure to ionizing radiation. Likarska Sprava, 21-24.

Rupprecht, R., Hegerl, U. (2000) The state of psychiatry in the Ukraine – psychiatric hospitals in Kiev and Shitomir. Nervenartz, 71, 420-422.

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

United Arab Emirates*

GENERAL INFORMATION

United Arab Emirates is a country with an approximate area of 84 thousand sq. km. (UNO, 2001). Its population is 3.051 million, and the sex ratio (men per hundred women) is 185 (UNO, 2004). The proportion of population under the age of 15 years is 25% (UNO, 2004), and the proportion of population above the age of 60 years is 2% (WHO, 2004). The literacy rate is 75.6% for men and 80.7% 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 3.5%. The per capita total expenditure on health is 921 international $, and the per capita government expenditure on health is 698 international $ (WHO, 2004).

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

The life expectancy at birth is 71.3 years for males and 75.1 years for females (WHO, 2004). The healthy life expectancy at birth is 64 years for males and 64 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in the United Arab Emirates 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. Details about the year of formulation are not available.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1991. It aims at the universal provision of mental health and substance abuse services by their incorporation in primary health care. The strategies for realizing this aim are through training of personnel in mental health at all primary care levels, strengthening existing centres and opening new ones, streamlining referral services and providing essential drugs, linking community and other sectoral services to it and developing manpower.

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

Mental Health Legislation There is a Federal Mental Health Act. It contains sections on definition of mental disorders, the role of authorities and police and on some details on detention and psychoses. The law needs to be reviewed. There is no specific mental health law on mentally abnormal offenders. The Sharia Islamic law addresses such issues. A national forensic psychiatric committee is being set up in collaboration with the ministries of health and justice. Attempted suicide is a crime.

The latest legislation was enacted in 1981.

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 Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. There are extensive primary care services which cater to all kinds of mental disorders.

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

There are community care facilities for patients with mental disorders. Facilities for rehabilitation are available through CBR approach. Community care services are not well developed and this is compensated by the primary care services.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.4
Psychiatric beds in mental hospitals per 10 000 population	
Psychiatric beds in general hospitals per 10 000 population	
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	2
Number of neurosurgeons per 100 000 population	
Number of psychiatric nurses per 100 000 population	11
Number of neurologists per 100 000 population	
Number of psychologists per 100 000 population	1
Number of social workers per 100 000 population	1.2

There are 7 occupational therapists. A psychiatric hospital opened in 1995 with facilities for general psychiatry, forensic psychiatry, addiction, emergency, child and adolescent psychiatry, consultation-liaison and community care. It has an attached day treatment centre. There are other psychiatric facilities in different cities. The private sector is well established. Most professionals work in the hospital in Abu Dhabi. In the other parts of the Emirate the number of personnel are limited and most have 1 or 2 psychiatrists only.

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.
The country has data collection system or epidemiological study on mental health.
A central psychiatric register has been established by the Ministry of Health for collection of data and research statistics regarding mental health, and data from all over the Emirate would be pooled into this information system.

Programmes for Special Population The country has specific programmes for mental health for elderly and children. There are services for the mentally retarded and delinquents.
There are also school health centres in some areas which deal with early detection and intervention of psychological problems in school-children. Residential centres for delinquents are also present in some areas.

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

Other Information Psychiatric services are based on the public health system which is organized on an emirate by emirate basis. A federal ministry has a coordinating role. Abu Dhabi has the most extensive services followed by Dubai. A special committee was established to advise on planning and development of psychiatric services nation-wide.
* The verification of this country profile is still being awaited from the Ministry of Health of the United Arab Emirates.

Additional Sources of Information

Kraya, N. (2002) Thirty years on: psychiatric services in the United Arab Emirates. Australasian Psychiatry. 10, 168-171.

Kronfol, N.M. (1999) Perspectives on the health care system of the United Arab Emirates. Eastern Mediterranean Health Journal. 5, 149-167.

United Kingdom

GENERAL INFORMATION

United Kingdom is a country with an approximate area of 243 thousand sq. km. (UNO, 2001). Its population is 59.428 million, and the sex ratio (men per hundred women) is 95 (UNO, 2004). The proportion of population under the age of 15 years is 18% (UNO, 2004), and the proportion of population above the age of 60 years is 21% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.8%. The per capita total expenditure on health is 1989 international $, and the per capita government expenditure on health is 1634 international $ (WHO, 2004).

The main language(s) used in the country is (are) English, Welsh, Scots Gaelic and South Asian languages. The largest ethnic group(s) is (are) English, and the other ethnic group(s) are (is) Scottish, Irish, Welsh and those from African Caribbean and South Asian backgrounds. The largest religious group(s) is (are) Anglican, and the other religious group(s) are (is) Roman Catholic and Muslim.

The life expectancy at birth is 75.8 years for males and 80.5 years for females (WHO, 2004). The healthy life expectancy at birth is 69 years for males and 72 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in the United Kingdom 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 1998.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The policy focuses on primary care and access to services, effective services for people with severe mental illness, services for carers and action to reduce suicide. National Service Frameworks for older people and children have also recently been published.

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 1999. Details can be obtained from the documents 'National Service Framework for Mental Health, 1999' and 'NHS Plan, 2000' for England. The NHS Plan has three major priorities: (1) All people in a crisis will have access to crisis resolution/home treatment teams – by 2005; (2) All people with a first episode psychosis will have access to intensive treatment for the first three years from early intervention teams – by 2006; and (3) All people with intensive needs will have access to assertive outreach teams – by 2004. There is also a major new initiative attempting to reduce the social isolation experienced by people with mental health problems, 'Social Exclusion and Mental Health', produced by the Office of the Deputy Prime Minister (2004). 'The Framework for Mental Health Services in Scotland' was published in 1997' and 'Our National health: A plan for Action, a Plan for Change, in 2000'. 'The Way Forward for Northern Ireland' was published in 1995.

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

Mental Health Legislation There is a Mental Health Act. There are proposals to reform it. Details can be obtained from the website: www.doh.gov.uk. The new proposal's focus is on managing risk and providing better health outcomes for patients in a way that strikes the right balance between public safety and the rights of individuals. One of the key changes proposed include extension of compulsory powers to the community – the 1983 Mental Health Act was exclusively concerned with detention in hospital, but services for people with mental disorder are increasingly being provided in the community. The new proposals would for the first time enable compulsory treatment to take place in the community. All patients would be formally assessed before compulsory treatment is imposed. One piece of legislation covers England and Wales, another Scotland (Mental health (Scotland) Act, 1984; The Mental Health (Public Safety and Appeals) (Scotland) Bill, 2001) and the third Northern Ireland (Mental Health Order, 1986). The Scottish legislation though historically different from the English legislation is similar in principle, however The Millan Committee (2001) has reviewed the Mental Health (Scotland) Act, 1984 and has suggested revisions.

The latest legislation was enacted in 1983.

Mental Health Financing There are budget allocations for mental health.

The country spends 10% of the total health budget on mental health.

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

About 85% of the expenses for health and social care for mentally ill is borne by the NHS and the remainder by the local authorities. Scotland and Northern Ireland have heavier investment in health care in comparison to England and Wales. NHS services are provided free at the point of delivery. Though some local authority services are chargeable, they are provided free to people with

severe mental illnesses. Social care is partly provided by the Social Services Department of local authorities. Most residential care is provided by the independent (voluntary and private sector). Employment services are provided by a range of agencies.
The country has disability benefits for persons with mental disorders. Disability Discrimination Act 1995 introduced laws aimed at ending the discrimination that many disabled people face. It gave disabled people new rights in access to goods, facilities and services as well as in employment and buying or renting property. The Disability Living Allowance is an extra costs benefit for the physically and mentally disabled, which is tax free, non-contributory and not income related. DLA is based primarily on the disabled person's self-reporting of their condition. The person has to demonstrate that their disability is of a long standing nature. Welfare benefits are provided primarily by the Benefits Agency, which is linked to the Department for Social Security.

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 Government has set out clear national standards in the National Service Framework for Mental Health (1999), in which it sets out ways to get easy access to more effective primary care with support from specialized care wherever necessary. There are seven national standards covering mental health promotion, primary care access and services, effective services for people with mental illness, caring about carers and the action necessary to achieve the suicide target in 'Our Healthier Nation'. The standards 2 and 3 allows any person with mental disorder to be effectively treated at the primary care level and get access to complete services around the clock.
Regular training of primary care professionals is carried out in the field of mental health. Training facilities for mental health workers, general practitioners, social workers, community workers are to be strengthened in future through the NHS Plan. 'The HSC 1999/154 Continuing Professional development: Quality in the New NHS' stresses the importance of continuous training. Different bodies like the Primary Care Groups, Workforce Action Team are supposed to address the issue of training. The training for general practitioners is regulated through the NHS regulations of 1997. New guidance on the GP Registrar Scheme came into effect in April 2000 and set out enhanced arrangements for the management and delivery of general practice vocational training. Training for psychosocial intervention is also available, as are training facilities for community health nurses.
There are community care facilities for patients with mental disorders. Health care is provided largely by the National Health Service (NHS) and social care by local authorities in England and Wales. The Scottish care system is globally similar, but has a different legal system. In Northern Ireland, the health and social services are unified. There are at present more than 800 community care teams, but subject to wide geographic variation. There are over 300 work or employment rehabilitation schemes and over 50 000 residential places available. The regional distribution is uneven, with the proportion of provision that is hospital based as opposed to community based varying from one-fifth to half. Community care has traditionally not been integrated adequately, although the NHS Plan requires all areas to implement new teams and ensure consistent access for all. 400 new teams will be appointed.
Attempts have been made to establish systems of key workers and care planning-led health and social services. The Care Programme Approach (CPA) was introduced in 1991 as one of the cornerstones of the Government's mental health policy; it provides a framework for the care of people with mental illness. In collaboration with local social services departments, Mental Health Service units are required to initiate explicit, individually tailored care programmes. These are for all inpatients about to be discharged from mental illness hospitals and for all new patients accepted by the specialist psychiatric services. The essential elements of the CPA are: systematic assessment of health and social care needs; a care plan agreed between the relevant professional staff and the patient; the allocation of a key professional worker and regular review of the patient's progress. The key worker has the responsibility for coordinating care, keeping in touch with the patient, ensuring that the care plan is delivered and calling for reviews of the plan when required.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	5.8
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	11
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	104
Number of neurologists per 100 000 population	1
Number of psychologists per 100 000 population	9
Number of social workers per 100 000 population	58

There are 15 040 occupational therapists, 594 psychotherapists, 856 psychiatric clinical assistants, 4 neurosurgeon clinical assistants, 39 neurologist clinical assistants. Not all of the above workers are attached to the mental health full time. Mental hospitals have mostly been phased out (about 110 mental hospitals were closed), so that the majority of acute beds are in general hospitals. The number of inpatient beds have declined by about 75% over the last 5 decades. Three high security hospitals (1500 beds), although these are reducing in size and a network of medium security units (1000 places), are present. A major problem facing the mental health services is in recruiting and retaining professionals.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, treatment and rehabilitation. User and carer movements have grown in a very significant way. Partnerships between user and carer agencies, voluntary organizations and professional groups often come together in influencing policy decisions.

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

Programmes for Special Population The country has specific programmes for mental health for minorities and elderly.
Separate services are available for children and adolescents, elderly and forensic patients. Programmes for homeless people who are mentally ill are available in the big cities. They provide assertive outreach, staffed hostels and ordinary move-on accommodation. Traditionally strong boundaries have existed between drug abuse and mental illness services. Some areas are now setting up specialist dual-diagnosis teams to tackle the problem of comorbidity.

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 listed are available through the NHS. Some patients require to pay a standard prescription charge for each item prescribed by general practitioners.

Other Information During the 1960s and 1970s new medical and psychosocial methods of care evolved and this led to the Government to change its policies and call for the closure of asylums in a gradual fashion. Community care has increased during the same period, though some areas are better placed than others. There is a wide anti-stigma movement which embraces families, patients and the general public, in addition to experts.

Additional Sources of Information

Becker T., Hullsmann, S., Knudsen, H. C. et al & the EPSILON Group (2002) Provision of services for people with schizophrenia in five European regions. Journal of Social Psychiatry and Psychiatric Epidemiology, 37, 465-474.

British Medical Association (2000) British National Formulary. Royal Pharmaceutical Society of Great Britain.

Department of Health (1998) Modernising Mental Health Services.

Department of Health (1999) National Service Framework for Mental Health – Modern Standards and Service Models.

Department of Health (1999) Reform of the Mental Health Act 1983 – Proposals for Consultation.

Johnson, S., Zinkler, M., Priebe, S. (2001) Mental health service provision in England. Acta Psychiatrica Scandinavica, 104 (suppl. 410), 47-55.

Loudon, J., Coia, D. (2002) The Scottish scene. Psychiatric Bulletin, 26, 84-86.

McClelland, R., Webb, M., Mock, G. (2000) Mental health in Ireland. International Journal of Law and Psychiatry, 23, 309-328.

McCulloch, A., Muijen, M., Harper, H. (2000) New developments in mental health policy in the United Kingdom. International Journal of Law and Psychiatry, 23, 261-276.

National Health Service (2000) The NHS Plan – A Plan for Investment, A Plan for Reform.

Pierre, S. A. (2000) Psychiatry and Citizenship – The Liverpool Black Mental Health Service User's Perspective.

Smith, M. (2003) Devolution and 'public psychiatry in Scotland. Psychiatric Bulletin, 27, 41-43.

United Republic of Tanzania

GENERAL INFORMATION

United Republic of Tanzania is a country with an approximate area of 945 thousand sq. km. (UNO, 2001). Its population is 37.671 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 45% (UNO, 2004), and the proportion of population above the age of 60 years is 4% (WHO, 2004). The literacy rate is 85.2% for men and 69.2% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 4.4%. The per capita total expenditure on health is 26 international $, and the per capita government expenditure on health is 12 international $ (WHO, 2004).

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

The life expectancy at birth is 45.5 years for males and 47.5 years for females (WHO, 2004). The healthy life expectancy at birth is 40 years for males and 41 years for females (WHO, 2004).

EPIDEMIOLOGY

Bondestam et al (1990) conducted a population survey on 10 776 randomly selected subjects in Zanzibar and found epilepsy in 4.9/1000 and psychotic disorder in 3.2/1000 of the population. Matuja et al (1995) reported on the prevalence of psychiatric disorders among 205 consecutive patients referred to a psychiatric unit over a 2 year period. Classification was done according to ICD-10. The ratio of males to females was found to be 1.6:1. A large number of cases were referrals from other departments of the same hospital and the remaining were from dispensaries and other hospitals. A fifth of the patients had consulted traditional healers prior to referral which was often delayed. The commonest presentations were psychosis (36.6%, of which three fourth were schizophrenia), neurosis (19.5%), seizures (16.6%), substance abuse (8.8%) and organic mental disorders (5.3%). Headache, sexual disorders and conduct disorders were also seen. Comorbid physical illness was present in 17%. Ndosi and Mtawali (2002) studied puerperal psychosis among 86 hospital inpatients using standardized questionnaires and ICD-10 criteria. The study was conducted prospectively over 2 years, and clinical progress was monitored. The mean age of patients was 23.6 years; the majority was primiparous women. Anaemia and infection were the major comorbid physical illnesses. The prevalence of puerperal psychosis was 3.2/1000 births. Organic psychosis was found in four-fifths of the mothers and schizophrenia in 8.1%. Most mothers received social support from their extended families. Ndosi and Kisesa (1997) examined the clinical notes of deceased patients in the same psychiatric unit over a 5 year period and found that functional psychoses (52.7%), organic psychoses (37.6%), epilepsy (6.2%) and puerperal psychosis (2.1%) were the main diagnosis among those who died. Two-thirds of patients were males, and the main cause of mortality in about half the patients was infectious diseases.

MENTAL HEALTH RESOURCES

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

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The mental health policy is integrated into the national health policy of 1990.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1995. A substance abuse policy is a part of the drug control legislation.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1980. The programme was developed with the help of WHO and the Danish Development Agency.

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 A draft of an updated mental health legislation was initiated in 2000. The final draft has been placed before the parliament for approval in 2005.

The latest legislation was enacted in 1958.

Mental Health Financing There are budget allocations for mental health.

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

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

A greater proportion of funding of mental health care is done by districts than was the case earlier. This makes the task of obtaining reliable figures on financing even more difficult.

The country has disability benefits for persons with mental disorders. Psychiatric patients are exempt from cost sharing charges for treatment.

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. Most mental patients in Tanzania are initially seen in primary care facilities, dispensaries and health centres or traditional healing practices. Primary mental health care is provided by mental health nurses and general health workers. Some regions provide follow-up psychiatric care to patients as a part of primary health care.

Regular training of primary care professionals is carried out in the field of mental health.
There are community care facilities for patients with mental disorders. Regional mental health coordinators run community-based care for the mentally ill. There are 119 districts with district mental health coordinators. Psychiatric rehabilitation villages in 6 regions accommodate a total of between 80-100 patients at any given time. They provide 'agriculture psychiatric rehabilitation', sheltered living conditions for homeless psychiatric patients, continued treatment and training facilities in interpersonal relationships and a sheltered working place. The villages are managed by mental health nurse, nursing assistants, artisans and agriculturists who are responsible for the farms. A psychiatrist and medical social worker makes weekly visits. Each patient stays for an average period of 6 months with a range of 3 months to 2 years. Besides these, there is a network of traditional healers. The decentralized programme reaches about 20% of the population. External evaluation of the programme was carried out in 2 regions and it was found to be cost effective as it helped to decrease bed occupancy rates.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.7
Psychiatric beds in mental hospitals per 10 000 population	0.36
Psychiatric beds in general hospitals per 10 000 population	0.04
Psychiatric beds in other settings per 10 000 population	0.3
Number of psychiatrists per 100 000 population	0.04
Number of neurosurgeons per 100 000 population	0.01
Number of psychiatric nurses per 100 000 population	2
Number of neurologists per 100 000 population	0.05
Number of psychologists per 100 000 population	0.005
Number of social workers per 100 000 population	0.2

In recent years, less than 50% of mental health nurses provide mental health care. There are 10 assistant medical officers in psychiatry. There are 3 centres at the tertiary care level. At this level, there is also a forensic psychiatric unit. In addition, there are 11 regions with psychiatric units with 30-50 general psychiatry beds, which provide care at the secondary level.

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. All regions send yearly statistics of mental patients attended at regional hospitals. Audit of inpatient records for the years 2001-2003 showed that the following disorders were common: neuropsychiatric disorders (47.2%), functional psychosis (34.5%), anxiety disorders, intellectual disability and alcohol and drug abuse.
The country has data collection system or epidemiological study on mental health. The data collection system was developed for primary care facilities. In 2004, a pilot epidemiological study on mental health was conducted in Dar es Salaam.

Programmes for Special Population The country has specific programmes for mental health for refugees, disaster affected population and indigenous population. There are no specialized services for substance dependence or children.
Family life education programmes in schools have a component of prevention of substance abuse. Similar programmes are being extended into colleges and community institutions with the help of grants from UNDCP and the Government of Finland.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: phenobarbital, amitriptyline, chlorpromazine, diazepam.
Availability of psychotropics are variable. More psychotropics are available in large urban centres. There are very few drugs available in the primary care level.

Other Information An inventory that covers mental health services in Tanzania mainland has been completed. It covers all 20 regions' reports.

Additional Sources of Information

Bondestam, S., Garssen, J., Abdulwakil, A. I. (1990) Prevalence and treatment of mental disorders and epilepsy in Zanzibar. Acta Psychiatrica Scandinavica, 81, 327-331.

Kilonzo, G. P., Simmons, N. (1998) Development of mental health services in Tanzania: a reappraisal for the future. Social Science & Medicine, 47, 419-428.

Matuja, W. P., Ndosi, N. K., Collins, M. (1995) Nature of referrals to the psychiatric unit at Muhimbili Medical Centre, Dar es Salaam. East African Medical Journal, 72, 761-765.

Ndosi, N. K., Kisesa, A. F. (1997) Causes of death among mental patients at Muhimbili Medical Centre, Dar es Salaam. East African Medical Journal, 74, 82-84.

Ndosi, N. K., Mtawali, M. L. (2002) The nature of puerperal psychosis at Muhimbili National Hospital: its physical co-morbidity, associated main obstetric and social factors. African Journal of Reproductive Health, 6, 41-49.

Njenga, F.(2002) Focus on psychiatry in East Africa. British Journal of Psychiatry, 181, 354-359.

United States of America

GENERAL INFORMATION

United States of America is a country with an approximate area of 9629 thousand sq. km. (UNO, 2001). Its population is 297.043 million, and the sex ratio (men per hundred women) is 97 (UNO, 2004). The proportion of population under the age of 15 years is 21% (UNO, 2004), and the proportion of population above the age of 60 years is 16% (WHO, 2004). The literacy rate is 97% for men and 97% 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 13.9%. The per capita total expenditure on health is 4887 international $, and the per capita government expenditure on health is 2168 international $ (WHO, 2004).

The main language(s) used in the country is (are) English and Spanish. The largest ethnic group(s) is (are) White (three-fourths of the population), and the other ethnic group(s) are (is) African-American and Hispanic-Latino (one-eighth, each). The largest religious group(s) is (are) Protestant (more than half of the population), and the other religious group(s) are (is) Roman Catholic (one fourth).

The life expectancy at birth is 74.6 years for males and 79.8 years for females (WHO, 2004). The healthy life expectancy at birth is 67 years for males and 71 years for females (WHO, 2004).

EPIDEMIOLOGY

There is substantial epidemiological data on mental illnesses in the United States of America 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.

In 2002, the President of the United States convened the New Freedom Commission on Mental Health which issued a report in July 2003 entitled 'Achieving the Promise: Transforming Mental Health Care in America'. The vision put forth is "…a future when everyone with mental illness will recover…, mental illnesses are detected early…, and everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community."

The goals articulated by this report are that Americans understand that: mental health is essential to overall health, mental health care is consumer and family driven, disparities in mental health services are eliminated, early mental health screening, assessment and referral to services are common practice, excellent mental health care is delivered and research is accelerated and technology is used to access mental health care and information. In 2004, the US Center for Mental Health Services began working closely with the States to implement the six goals of this report.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1988.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1946. It was changed by the legislation in 1992 and is carried out by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health (NIMH), National Institutes of Health (NIH).

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

Mental Health Legislation The Public Health Service Act (2000) defines the functions of the NIMH and CMHS. The Health Insurance Portability and Accountability Act (1996) covered issues like confidentiality/privacy/security (with particular reference to electronic records and claims processing). The Mental Health Parity Act (1996) that required parity between mental health and health care benefits has 'sunsetted' meaning that new legislation will be required to continue these benefits. The Children's Health Act (2000) authorized the SAMHSA to carry out children and adolescent focused mental health programmes. The forensic psychiatric system in the US is a combination of civil and criminal laws, which vary between states in definition and practices, though remaining fundamentally similar. The civil commitment laws help in maintaining the dignity of offenders with mental illness. The criminal laws, on the other hand, help in ascertaining incompetency to stand trial because of mental illness and insanity defense. The latest legislation was enacted in 2000.

Mental Health Financing There are budget allocations for mental health.

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

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

The United States does not have universal health insurance coverage (around one-sixth of the population is without any health insurance). In the 1980s, mental health care, on the federal level, began to be included in federal employees' insurance. Federal programmes, such as Medicaid and Social Security Disability Insurance were paid heavy attention to in the 1990s. The major focus was specifically on managed care, particularly to carve out plans where mental health benefits are separate from other medical benefits. However, public and private managed care plans are being developed independently. This multi-tiered system encourages dumping from one level to another (e.g. when private insurance benefits are exhausted, the consumer moves from the private to the public

sector). Such dumping has the effect of keeping private sector insurance costs artificially low, while encouraging the development of a large public safety net of mental health services.
The country has disability benefits for persons with mental disorders. Disability entitles one to Federal Supplemental Security Income (SSI) for poor persons and Social Security Disability Insurance (SSDI) for workers and family members. Eligibility for the former results in eligibility for Medicaid; for the latter, eligibility for Medicare.

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 are activities undertaken by the public speciality sector for children and adults.
Regular training of primary care professionals is not carried out in the field of mental health.
There are community care facilities for patients with mental disorders. Community care is organized by states, counties, localities, and private organizations, hence there are variations in the structure and quality of care. The 1950s saw the building of general hospital psychiatric units, outpatient clinics and halfway houses. The 1960s focussed on the philosophy of the least restrictive alternative. Comprehensive treatment became the primary focus of mental health services. Also, there was consolidation of services treatment for drug users, children and in impoverished areas. Case management and assertive community treatment are two relatively new forms of services. Evaluation of services began to be undertaken. Employment programs, travelling teams of professionals and pre-admission programs were developed. The message of the 1980s was that community services needed to be significantly improved for patients. The 1990s saw the U.S. focus shifting back to recidivism in the context of availability of community care. The other large foci of this decade concerned the homeless people who are mentally ill and the evolution of a recovery philosophy for consumer- and family-directed care. The latter focus has become even more pronounced in the first decade of the 21st century.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	7.7
Psychiatric beds in mental hospitals per 10 000 population	3.1
Psychiatric beds in general hospitals per 10 000 population	1.3
Psychiatric beds in other settings per 10 000 population	3.3
Number of psychiatrists per 100 000 population	13.7
Number of neurosurgeons per 100 000 population	1.6
Number of psychiatric nurses per 100 000 population	6.5
Number of neurologists per 100 000 population	4.5
Number of psychologists per 100 000 population	31.1
Number of social workers per 100 000 population	35.3

There are other mental health professionals like mental health counsellors, psychosocial rehabilitation specialists, school psychologists, marriage and family therapists and pastoral counsellors. Currently, mental health care is provided in several types of settings: by mental health and substance abuse providers (5.9% of all adults are served); by primary care physicians (5.0% of all adults are served); and by social service providers or self-help groups (3.8% of all adults are served) (Manderscheid, et al, 1993). There are at present 4300 mental health organizations in the country. State and county and private mental hospitals and residential treatment centres for emotionally disturbed children form over one-fifth of the total. Mental health service organizations employ about 680 thousand people, with over three-fourth being patient care staff and nearly half qualifying as mental health professionals (Mental Health, United States, 2002).

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

Information Gathering System There is mental health reporting system in the country. The National Health Interview Survey conducted by the National Centre for Health Statistics collects information on mental disorders in adults and children.
The country has data collection system or epidemiological study on mental health. The data collection system is currently funded by NIMH. The CMHS is responsible for statistical information on mental health populations and services through the National Reporting System.

Programmes for Special Population The country has specific programmes for mental health for minorities, refugees, disaster affected population, indigenous population, elderly and children. CMHS is involved in coordinating relevant services for refugees and disaster-affected populations. Other groups are targeted as part of the SAMHSA Block Grant Programs in mental health and substance abuse. There are special programmes for HIV patients.
SAMHSA CMHS is charged with improving the quality of and access to mental health services, especially for underserved populations and people at greatest risk – adults with serious mental illnesses and children and adolescents with serious emotional disturbances. There are geographic disparities in mental health services delivery; it is particularly difficult to deliver these services in rural areas due in part to shortages of mental health providers. Specific funds were allotted to support demonstration programmes on community support for adults with serious mental illness (including those who were homeless) and to programmes of clinical training

focusing on mental health for underserved populations, on HIV/AIDS, the Projects for Assistance in Transition from Homelessness (PATH) programme, the Protection and Advocacy Program, Employment Intervention Demonstration Program, and Comprehensive Community Mental Health Services for Children and Their Families Program. Currently, CMHS programmes are being transformed to address the recommendations of the President's New Freedom Commission on Mental Health.

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.
Data on commonest strength and cost of medicines are based on responses to the 2001 Medical Expenditure Panel Survey (MEPS), a nationally representative sample of households that participated in the National Health Interview Survey, conducted by the National Center for Health Statistics, U.S. Department of Health and Human Services (DHHS). The MEPS is conducted by the Agency for Healthcare Research and Quality, DHHS. This is the mean price reported by consumers in the MEPS sample. The FDA approves all prescription drugs for usage by Americans including psycho-pharmacological agents. Some national data are available on prescription medications through the National Health Interview Survey. Recently, the Food and Drug Administration (FDA) has begun investigating the negative side effects of anti-depressants administered to children and adolescents and has asked manufacturers of all anti-depressant drugs to include in their labelling a boxed warning and expanded warning statements that alert health care providers to an increased risk of suicidality in children and adolescents being treated with these agents and additional information about the results of paediatric studies (http://www.fda.gov/cder/drug/antidepressants/default.htm).

Other Information In 1999, the Surgeon General of the United States issued 'Mental Health: A Report of the Surgeon General' (U.S. Department of Health and Human Services [HHS], 1999), which engaged the American public in a discussion about the importance of mental health and the status of research on services. In 2002, the President of the United States stated strong support for mental health insurance parity. He also signed an Executive Order creating the New Freedom Commission on Mental Health and charged it with issuing a report describing barriers to care within the mental health system, providing examples of successful community-based care models and suggesting ways to fix the problems. Both CMHS and the States are now beginning to implement the recommendations in this report. This effort has been facilitated through the planning requirements of the Community Mental Health Services Block Grant administered by SAMHSA CMHS. Similar planning has been initiated in the private sector around particular mental health benefit plans. Thus, current efforts could be said to reflect planning for particular population segments, without comprehensive planning for all persons in a geographical area. More comprehensive geographically based planning approaches can be expected in the future with the implementation of the recommendations in the President's Report.

Additional Sources of Information

Area Resource File from the Bureau of Health Professions, US Department of Health and Human Services

Arons, B., Searle, T., Sweetman, A., et al (2004) Chapter 1. SAMHSA's Center for Mental Health Services: A Decade of Achievement, 1992-2002. SAMHSA's National Mental Health Information center. (http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA01-3938/Chapter01.asp).

Bloom, J. D., Williams, M. H., Bigelow, D. A.(2000). The forensic psychiatric system in the United States. International Journal of Law and Psychiatry, 23, 605-613.

Center for Mental Health Services (2001). Mental Health, United States, 2000. Eds: R.W. Manderscheid, M.J. Henderson. DHHS Pub No. (SMA) 01-3537. Washington, DC. (http:// www.samhsa.gov).

Department of Health and Human Services (1999) Mental Health: A report of the Surgeon General. DHSS. U.S. Public Health Service. Pittsburgh.

DHSS (2001). Mental Health: Culture, Race and Ethnicity. DHSS. Maryland. (http://www.surgeongeneral.gov/library).

Geller, J. (2000) The last half-century of psychiatric services as reflected in psychiatric services. Psychiatric Services, 51, 41-67.

Feldman, S. (2003) Reflections on the 40th Anniversary of the US Community Mental Health Centres Act. Australian and New Zealand Journal of Psychiatry, 37, 662-667.

Manderscheid, R. W., Henderson, M. J., Witkin, M. J. et al. (2000) The US Mental Health System of the 1990s. The challenges of managed care. International Journal of Law and Psychiatry, 23, 245-259.

Manderscheid, R. W., Rae, D. S., Narrow, W. E., et al (1993) Congruence of service utilization estimates from the epidemiologic catchment area project and other sources. Archives of General Psychiatry, 50, 108-114.

Uruguay

GENERAL INFORMATION

Uruguay is a country with an approximate area of 176 thousand sq. km. (UNO, 2001). Its population is 3.439 million, and the sex ratio (men per hundred women) is 94 (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 17% (WHO, 2004). The literacy rate is 97.3% for men and 98.1% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 10.9%. The per capita total expenditure on health is 971 international $, and the per capita government expenditure on health is 450 international $ (WHO, 2004).

The life expectancy at birth is 71 years for males and 79.3 years for females (WHO, 2004). The healthy life expectancy at birth is 63 years for males and 69 years for females (WHO, 2004).

EPIDEMIOLOGY

A nation-wide survey of randomly selected households from urban areas (n=2500 subjects in the age range of 15-65 years) showed that the lifetime, 1-year and 1-month prevalence of use of illicit substances (marijuana, cocaine, inhalants, hallucinogens, etc.) was 4.5%, 1.1%, and 0.7%, respectively. The 1-month prevalence rates for nicotine dependence and alcohol abuse, respectively, was 20% and 19.5%. Age and sex were significantly associated with drug use (Miguez & Magri, 1995). Miguez and Magri (1993) used descriptive anthropological methods to assess drug use among youngsters from high social class and found two clearly defined social-cultural patterns with regard to cannabis and cocaine use. Da Costa e Silva and Koifaman (1998) reported on smoking in Latin American countries including Uruguay. Kohn et al (2001) studied emotional and behavioural disorders among children and sought to establish an association between psychological problems in parents and psychiatric problems in children. Children (n=115) in the 5-15 age-groups from three communities (2 urban and 1 rural) were selected and the mothers were asked to answer the Child Psychiatric Morbidity Questionnaire (QMPI). Both the parents also answered questions from Psychiatric Epidemiology Research Interview Demoralization Scale, CAGE, the Social Support Network Inventory and also questions about their self-perceived mental health. 53% of the children had scores greater than 6 on the QMPI, which indicated the possible presence of behavioural or emotional problems. Fathers' self-perception of emotional problems and mothers' feeling of being demoralized were associated with a greater risk of behavioural or emotional problems in their children. Uruguay has the second highest rate of suicide in Latin America, after Cuba. In 1990, the figures were 10.4/100 000 (16.6/100 000 in men and 4.2/100 000 in women) (WHO, 2000).

MENTAL HEALTH RESOURCES

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

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. It was revised in 2003 through a consultative process that involved civil servants, mental health professionals and NGOs. There is no regular budget for its implementation and between 25 to 50% of its original content was put into practice.

Substance Abuse Policy A substance abuse policy is present. Details about the year of formulation are not available. There is no regular budget for its implementation and between 25 to 50% of its original content was put into practice.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1986. It was revised in 2003. There is no regular budget for its implementation and between 25 to 50% of its original content was put into practice. Its main components are strategy of services reform, promotion and prevention, integration of mental health services in primary care and development of specialized services

National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1971.

Mental Health Legislation The mental health law was revised in 2003. It has been implemented less than 10%. It focuses on promotion and prevention, human rights, housing, advocacy, but there is no reference to regulation of mental health services, involuntary treatment and admission and discharge procedures.

The latest legislation was enacted in 2002.

Mental Health Financing There are budget allocations for mental health.

The country spends 8% of the total health budget on mental health.

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

Approximately 4.0% of the budget on mental health is spent on general hospitals, 16.0% in psychiatric hospitals, 40.0% in ambulatory clinics and 40.0% in community care.

The country has disability benefits for persons with mental disorders. Chronic psychosis, mental retardation and dementia are the mental health conditions to be considered a disability for getting public disability benefits. The department in charge is B.P.S.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Less than 25 % of the population is covered by this kind of service. Mental health care in primary health care is provided by primary health care doctors, nurses and psychiatrists. A system of referral is in place.
Regular training of primary care professionals is not carried out in the field of mental health.
There are community care facilities for patients with mental disorders. About 34 multidisciplinary units work for community health. The community care system provides services for up to half of the treated population (preventive/promotion interventions, home interventions, family interventions for 25-50% of the intended population and residential facilities and employment programmes for less than 25%). Vocational training is not provided.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	5.4
Psychiatric beds in mental hospitals per 10 000 population	4.78
Psychiatric beds in general hospitals per 10 000 population	0.62
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	22.9
Number of neurosurgeons per 100 000 population	
Number of psychiatric nurses per 100 000 population	0.85
Number of neurologists per 100 000 population	
Number of psychologists per 100 000 population	15.1
Number of social workers per 100 000 population	62

There are many other psychologists working in different sectors. 30% of beds are occupied by long stay patients. More than four-fifths of professionals from various mental health disciplines work in the private sector.

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

Information Gathering System There is mental health reporting system in the country. ICD-10 is used for recording purposes. The country has data collection system or epidemiological study on mental health. Service data collection system is conducted for part of the mental health system (public sector) at the 'Dirección de Unidades Asistenciales Especializados' de ASSE. An epidemiological study has been carried out since 1998. Currently, the data for the year 2000 is being compiled.

Programmes for Special Population The country has specific programmes for mental health for minorities, disaster affected population, elderly and children.
There are programmes for women and victims of domestic violence. There is also a programme in the area of treatment and rehabilitation of drug abuse and dependence.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, sodium valproate, chlorpromazine, diazepam, haloperidol, lithium, biperiden, levodopa.
The national therapeutic drug policy was adopted in 2001 and revised in 2003. The essential drug list was created in 1971 and revised in 2003.

Other Information

Additional Sources of Information

da Costa e Silva V. L., Koifman, S. (1998) Smoking in Latin America: a major public health problem. Cadernos de Saude Publica., 14 (Suppl. 3), 99-108.

Kohn, R., Levav, I., Alterwain, P., et al (2001) Risk factors for behavioral and emotional problems in childhood: a community study in Uruguay. Pan American Journal of Public Health, 9, 211-218.

Miguez, H., Magri, R. (1995) National study of drug habits in Uruguay. Acta Psiquiatrica y Psicologica de America Latina, 41, 13-23.

Miguez, H. A., Magri, R. (1993) Patterns of drug abuse among youngsters of upper social class. Acta Psiquiatrica y Psicologica de America Latina, 39, 294-300.

WHO, Department of Mental Health (2000) Workshop on the Prevention of Suicide

Uzbekistan

GENERAL INFORMATION

Uzbekistan is a country with an approximate area of 447 thousand sq. km. (UNO, 2001). Its population is 26.479 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 33% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 99.6% for men and 98.9% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.6%. The per capita total expenditure on health is 91 international $, and the per capita government expenditure on health is 68 international $ (WHO, 2004).

The main language(s) used in the country is (are) Uzbek, Russian and Tajik. The largest ethnic group(s) is (are) Uzbek. The largest religious group(s) is (are) Muslim (nine-tenths).

The life expectancy at birth is 65.6 years for males and 70.8 years for females (WHO, 2004). The healthy life expectancy at birth is 58 years for males and 61 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Uzbekistan in internationally accessible literature. Suicide rates in the former USSR during 1984-1990 varied greatly between different regions. They were reported to be 11.8 per 100 000 inhabitants in Central Asia (Kazakhstan, Kirgizia, Turkmenistan, Uzbekistan and Tajikistan) (Wasserman et al, 1998). Danielov (1975) studied clinical and etiological characteristics of 214 children with mental retardation and found that siblings of a subgroup of these children had an increased rate of mental retardation. In a later study on 150 patients, Danielov and Utin (1988) found a high and approximately equal frequency of mild forms of mental retardation among parents and siblings of mentally retarded probands, which confirms a polygenic model of heredity. Both familial and psychological factors appeared to be involved in the formation of mental retardation.

MENTAL HEALTH RESOURCES

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

Normative acts by the Uzbekistan Ministry of Health have established a voluntary basis for treatment. Provision was made for social and legal assistance, protection by the courts, supervision by the prosecution service and legal aid to protect the legal rights and interests of psychiatric patients. With a view to regulating work with psychiatric patients, the Ministry of Health has issued a number of directives: No. 209 (1991) 'Measures to improve psychiatric care for persons below draft age and of draft age' provides for an increase in the number of psychiatrists working with children and adolescents; No. 303/169 (1994) 'Improving measures to prevent socially harmful activities by psychiatric patients' (with Ministry of Internal Affairs); No. 611 (1994) 'Situation of and prospects for the development of legal psychiatry in the Republic of Uzbekistan'; No. 681 (1993) 'Measures to further improve psychiatric care for the population of Uzbekistan', No. 786 (1996) that confirmed 54 regulations and instructions regulating the activity of psychiatric services; No. 458 (1997) 'Measures to ensure the implementation of decision No. 390 of the Cabinet of Ministers of 6 August 1997 (Measures to improve psychiatric care for the population)'; No. 06-9/125 (1998) 'State norms applicable to medical, pharmaceutical and teaching staff and to the kitchen staff of psychiatric hospitals, departments and wards and psychoneurological dispensaries, departments and practices'; No. 559 (1999) 'Improvement of suicide prevention services in the Republic'; and No. 589 (1999) 'Improvement of psychotherapeutic care for the population'. An annex has been included in the Criminal Code of the Republic of Uzbekistan which provides for heavier penalties for those who involve persons suffering from mental disorders in crimes. The mental health care situation is examined annually by the Ministry of Health. In 2003, the transition of psychiatric services to ICD-10 was completed.

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

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

A working group has been set up in the Ministry of Health to prepare a draft national programme for mental health. A 'Plan for the development of the state system of prevention, early detection and rehabilitation of children with mental disorders in order to constitute a healthy generation and reduce the level of mental disorders and disabilities among the Republic's children', is also being drafted as a part of national mental health programme.

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 Cabinet of Ministers has taken a number of decisions that affect mental health: Decree N° 153 (1997) 'Approval of the list of diseases of public health importance and determination of the benefits to which persons suffering from them are entitled'; Decision No. 390 (1997) 'Measures to improve psychiatric care for the population', which provides for a number of improvements to material and technical facilities, manpower availability, drug supply and social protection for patients, and rehabilitative and residential facilities (however, as the decision was not supported by the requisite funding); and Decree No. 532 (1997) 'Improvement of the system for financing preventive and curative services' that made provision for the free supply of drugs to mental health patients under outpatient treatment and dispensed them from payment for food when hospitalized. The

'Law on social protection for the disabled in Uzbekistan' deals with the occupational rehabilitation of disabled persons, including the mentally disabled, while the Tax Code (1997), introduces tax benefits for firms that employ disabled persons. The comprehensive mental health legislation 'On psychiatric care' was adopted in 2000. In 2000 itself, a supplement to the code of civil procedure entitled 'Compulsory hospitalization in psychiatric establishments' was added. The Mental Health Law provides for the protection of the rights and interests of persons suffering from mental disorders.
The latest legislation was enacted in 2000.

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 sources of mental health financing in descending order are tax based and out of pocket expenditure by the patient or family.
Funding for psychiatric services has been improving gradually and the shortages in food and drug procurement have been covered. Persons suffering from mental disorders are entitled to benefits such as free nursing care and treatment in psychiatric hospitals as well as free provision of special drugs for out-patients. Funding is also available for rehabilitation workshops for persons suffering from mental disorders. These measures have helped in the reduction of mortality among persons with mental disorders by a factor of 1.4 (from 3497 in 1998 to 2548 in 2003).
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. Efforts are being made to reinforce primary level psychiatric services. Psychiatrists hold mental health clinics at general purpose disease prevention and treatment centres for children and adults.
Details about training facilities are not available. On account of the shortage of psychiatrists, general practitioners have been authorized to practice as psychiatrists at the primary care level after completion of a three-month course in psychiatry in the Institute of Further Training for Physicians.
Details about community care facilities in mental health are not available.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	3.1
Psychiatric beds in mental hospitals per 10 000 population	3
Psychiatric beds in general hospitals per 10 000 population	0.1
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	3.3
Number of neurosurgeons per 100 000 population	0.9
Number of psychiatric nurses per 100 000 population	7.2
Number of neurologists per 100 000 population	5.9
Number of psychologists per 100 000 population	0.05
Number of social workers per 100 000 population	0.1

There has been a two-fold decline in beds in mental health institutions (from 6.2 per 100 000 population in 1991 to 3.1 in 2003), but an increase in general hospital mental health beds. In order to fill vacant district psychiatrist posts (children's, adolescents' and adults'), a Master's in psychiatry was introduced in higher medical education establishments (in addition to internships).
Standards for the diagnosis and treatment of mental disorders have been developed by specialists and implemented in psychiatric establishments.

Non-Governmental Organizations NGOs are involved with mental health in the country. An NGO named 'Sabr' has started two telephone help lines in Samarkand. Currently it has a staff of 15, including a psychologist, a sociologist, a jurist and a gynecologist. With the financial support from the United States Agency for International Development (USAID), the 'Hamdard' help centre has been operating in the capital of Djizak since 1999. The centre has established partnerships with state institutions, law-enforcement agencies, parliamentary committees and with the mass-media on issues of domestic violence prevention; it also runs training courses on legal aid and support for women, including solitary and elderly women. The centre also operates a telephone helpline which offers anonymous advice during crises in order to prevent suicidal behaviour. In 2002, the Association of Psychiatrists and Drug-abuse Specialists registered with the Uzbekistan Ministry of Justice.

Information Gathering System There is mental health reporting system in the country. The Ministry of Health's directives require the submission of reporting forms (Decree N° 10, 2004 – 'Mental and behavioural disorders' and form N° 38 Hlth – 'Report on the work of the Legal-psychiatric expert committee'). Reporting forms from psychiatric institutions are drawn up at the district level and submitted to the area's principal psychiatric administration (oblast or town). Reports from the areas are received and summarized by the Ministry of Health's Organization and Methods Department and submitted to the Ministry's Data Collection and Analysis Centre and to the Ministry of Macroeconomics. Since this year, reporting forms have been completed using two classifications – ICD 9 & 10.

The country has data collection system or epidemiological study on mental health. According to official figures, in 2003, only about 0.01% of those who were registered with hospitals and clinics had emotional disorders including depression. The attributed prevalence in the community (based on figures of those treated between 1991-2003) for schizophrenia was in the range of 0.226% to 0.336%, for mental retardation in the range of 0.441% to 0.518%, and for all mental disorders 1.245% to1.338%.

Programmes for Special Population The country has specific programmes for mental health for disaster affected population and children. The department responsible for dealing with emergencies has a plan setting out measures and clinical and diagnostic standards for outpatient and inpatient emergency psychiatric care for the population, including care during disasters.
When intrauterine foetal disorders are detected, screening centres provide postnatal monitoring for infants by specialized paediatricians and psychiatrists. Since 1998, an 'infant psychiatry service' has been in place. It operates from maternity hospitals, neonatal departments and paediatric departments. The service detects and treats children principally suffering from residual organic diseases of the central nervous system and convulsive syndromes of diverse etiology and 'transfer disorder' during the neonatal and postnatal period.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol.
Each year, the list of essential drugs, which includes new atypical anti-psychotics (such as Risperidone) is renewed.

Other Information

Additional Sources of Information

Danielov, M. B., Utin, A. V. (1988) Problem of the etiology of undifferentiated oligophrenia. Zhurnal Nevropatologii i Psikhiatrii Imeni S-S-Korsakova, 88, 78-81.

Danielov, M. B. (1975) Empirical risk of oligophrenia in siblings of proband-oligophrenics in populations with high levels of inbreeding. Genetika, 11, 121-127.

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

Vanuatu

GENERAL INFORMATION

Vanuatu is a country with an approximate area of 12 thousand sq. km. (UNO, 2001). The country is an archipelago of more than 80 islands. Its population is 0.217 million, and the sex ratio (men per hundred women) is 105 (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 5% (WHO, 2004). The literacy rate is 57% for men and 48% 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 3.8%. The per capita total expenditure on health is 107 international $, and the per capita government expenditure on health is 63 international $ (WHO, 2004).

The main language(s) used in the country is (are) Bislama, English and French. The largest ethnic group(s) is (are) Melanesian. The largest religious group(s) is (are) Presbyterian, and the other religious group(s) are (is) Roman Catholic and Anglican.

The life expectancy at birth is 66.4 years for males and 69.1 years for females (WHO, 2004). The healthy life expectancy at birth is 58 years for males and 59 years for females (WHO, 2004).

EPIDEMIOLOGY

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

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

Substance Abuse Policy A substance abuse policy is absent.

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

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

There is a sporadic shortage of essential drugs, but they are available in general.

Mental Health Legislation There is no mental health legislation.

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

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

Details about expenditure on mental health are not available.

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

Details about disability benefits for mental health are not available.

Mental Health Facilities Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Patients are sent to referral hospitals.

Regular training of primary care professionals is not carried out in the field of mental health. In remote areas, nurses, in the absence of doctors, are given special permission to prescribe medicines if given special training in the discipline. However, there is no nurse who is trained in mental health. Ten nurses have been oriented to mental health through a 3-day training programme in mental health arranged by the Ministry of Health in collaboration with WHO.

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

Psychiatric Beds and Professionals

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

There are no specific psychiatric nurses; general nurses handle patients. Only the referral hospital in the capital offers mental health services.

Non-Governmental Organizations NGOs are not involved with mental health in the country. The Vanuatu Women's Centre provides assistance to victims of domestic violence. It also provides telephone and face-to-face counselling and public education. The Centre for Vanuatu Society for the Disabled provides a day care centre for rehabilitation of disabled children including the mentally challenged ones. It is funded by UNICEF and the Christian Blind Mission of Germany. The Foundation for the People of South Pacific Vanuatu has started a mental health project on youth depression and associated violence with public education and peer support networks as the main components. The Wan Smol Theatre group runs a drop-in centre for youth and provides generic counselling services.

Information Gathering System There is mental health reporting system in the country. Mental disorders are usually reported in the health information.
The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population The country has specific programmes for mental health for disaster affected population. There is a Government disaster management department. All essential services are under it.

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 There is an extensive network of primary care, child and maternity clinics, which are all linked with a radiotelephone service.

Additional Sources of Information

Venezuela

GENERAL INFORMATION

Venezuela is a country with an approximate area of 912 thousand sq. km. (UNO, 2001). Its population is 26.17 million, and the sex ratio (men per hundred women) is 101 (UNO, 2004). The proportion of population under the age of 15 years is 32% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 93.5% for men and 92.7% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6%. The per capita total expenditure on health is 386 international $, and the per capita government expenditure on health is 240 international $ (WHO, 2004).

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

The life expectancy at birth is 71 years for males and 76.8 years for females (WHO, 2004). The healthy life expectancy at birth is 62 years for males and 67 years for females (WHO, 2004).

EPIDEMIOLOGY

Molina et al (2000) conducted autopsies on 611 brains. Out of them 39 showed features of dementia, in which features of vascular dementia were prominent in 33 cases, features of Alzheimer disease in 1 patient and unspecifiable features in 5 cases. Baptista and Uzcategui (1993) studied drug use among medical residents (n=191) using a self-administered questionnaire based on the Spanish version of the DIS. The questionnaire showed a high concordance with the clinical diagnoses and the frequencies of lifetime diagnoses were: tobacco dependence (20.9%), alcohol abuse (11%), alcohol dependence (0.5%), drug abuse (1%) and drug dependence (1%). Baptista et al (1994) also administered the Spanish version of the Diagnostic Interview Schedule (DIS-III-A) to undergraduate medical (n=1013) and pharmacy students (n=426). Substance use disorders were more common in single males. Seale et al (2002) used the Alcohol Use Disorders Identification Test (AUDIT) to interview a randomly selected community sample of indigenous people (n=105) and found that 98% of men and 53% of women had consumed alcohol at some point in their life with 94% of men and 26% of women reporting that they had used it in the last year. Almost 86.5% of men and 7.5% of women were identified as problem drinkers (cut-off score of 8 on AUDIT). Fuentes et al (1998) examined 148 subjects who had entered the emergency room due to lesions caused by aggression, accidents or intoxication and found that one in every four hospital admission for trauma was related to alcohol or drug abuse. A community study utilizing the Self-Rating Depression Scale by Zung (n=3218) found definite clinical depression among 36.8% of the sample (Eblen et al, 1990). Morillo et al (2002) used questionnaires to study erectile dysfunction in men above 40 years of age in Colombia, Ecuador and Venezuela (n=1946) and found that the age-adjusted prevalence of minimal, moderate and complete ED for all three countries was 53.4%, with 19.8% of all men reporting moderate to complete ED. Age was the variable most strongly linked to ED. Comorbid medical conditions like hypertension, prostrate hyperplasia and diabetes and the medications used to treat these conditions were associated with the prevalence of ED. Neehall and Beharry (1993) conducted a 10 month assessment of psychiatric referrals in a hospital. The study revealed that parasuicide was the commonest cause for referral (68%). The commonest disorders were adjustment problems (41%), depression (23%), alcohol dependence (5%) and schizophrenia (5%).

MENTAL HEALTH RESOURCES

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

The components of the policy are promotion, prevention, treatment and rehabilitation. It was revised in 1999. Funds for its implementation have not been earmarked; and between 25 to 50% of its original content has been put into practice.

Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1986. It was revised in 2002. It has a specific budget for its implementation, and is implemented to the extent of 25 to 50%.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1990. It was revised in 1999. There is no specific budget for its implementation, and it has been implemented to the extent of 10 to 25% by regional authorities. Its main components are strategy of services reform, promotion and prevention, integration of mental health services with primary care and development of specialized services.

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

Mental Health Legislation There is a new code under consideration by the legislature that includes promotion and prevention, human rights, regulation of mental health services, regulation of involuntary treatment, regulation of mental health services, admission and discharge procedures, advocacy and housing.

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

Mental Health Financing There are no budget allocations for mental health.
Details about expenditure on mental health are not available.
The primary sources of mental health financing in descending order are tax based, social insurance, out of pocket expenditure by the patient or family and private insurances.
The country has disability benefits for persons with mental disorders. All mental disorders that are associated with severe impairment are considered a disability for getting public disability benefits. Between 25 to 50% of the eligible persons actually receive the benefits. Disability assessment is performed by a multidisciplinary team organized by the Social Security Institute of Venezuela, Instituto Venezolano de los Seguros Sociales (IVSS), which is also responsible for granting disability benefits.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Less than 25 % of the population is covered by this kind of service. Mental health care is provided by primary health care physicians.
Regular training of primary care professionals is not carried out in the field of mental health.
There are no community care facilities for patients with mental disorders. However, there are some isolated community care facilities in Merida and Guarico states.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	2.5
Psychiatric beds in mental hospitals per 10 000 population	0.29
Psychiatric beds in general hospitals per 10 000 population	2.23
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	24
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	

Country-wide data for personnel is difficult to assess. About 46.5% of beds are occupied by long-stay patients.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. These organizations participate in mental health activities related to women, children, consumers and domestic violence. NGOs are responsible for 30% of all the mental health related activities in Venezuela. Their emphasis is on promotion/prevention and treatment of drug users and victims of domestic violence.

Information Gathering System There is mental health reporting system in the country. ICD-10 criteria are used for recording purposes.
The country has data collection system or epidemiological study on mental health. The epidemiology general department, Dirección General de Epidemiología, is in charge of the data collection system for mental disorders. A service data collection system is conducted for all the mental health system. There is special emphasis in the area of drug abuse.

Programmes for Special Population The country has specific programmes for mental health for disaster affected population and children. There is a National Institute of Child Psychiatry. Due to the disaster of 1999, the plan for psychosocial care and rehabilitation was implemented for victims of disaster.
Also, there are programmes for women and victims of domestic violence.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, diazepam, fluphenazine, haloperidol, lithium.
At present, the essential drug list is being revised to include SSRI's, newer anti-psychotics and other drugs.

Other Information

Additional Sources of Information

Baptista, T., Novoa, D., Hernandez, R., et al (1994) Substance use among Venezuelan medical and pharmacy students. Drug & Alcohol Dependence, 34, 121-127.

Baptista, T., Uzcategui, E. (1993) Substance use among resident doctors in Venezuela. Drug & Alcohol Dependence, 32, 127-132.

Eblen, A.,Vivas, V., Garcia, J. (1990) Prevalence of depression syndrome and its relationship with socioeconomic factors in a population of Valencia City, Carabobo State, Venezuela. Acta Cientifica Venezolana, 41, 250-254.

Fuentes, S. P. D., Medina-Orozco, E., Rojas, M. (1998) Drug consumption prevalence in adult patients attending the emergency room. Salud Publica de Mexico, 40, 234-240.

Levine, P. (1996) Developing a community mental health program in the Venezuelan Andes: implications for the international psychosocial rehabilitation. Psychiatric Rehabilitation Journal 19, 23-32.

Molina, O., Cardozo, D., Cardozo, J., et al (2000) Causes of dementia in Maracaibo, Venezuela: a re-evaluation. Revista de Neurologia, 30, 115-117.

Morillo, L.E., Diaz, J., Estevez, E., et al (2002) Prevalence of erectile dysfunction in Colombia, Ecuador, and Venezuela: a population-based study (DENSA). International Journal of Impotence Research, 14, 10-18.

Neehall, J., Beharry, N. (1993) The pattern of in-patient psychiatric referrals in a general hospital. West Indian Medical Journal, 42, 155-157.

Salud Publica de Mexico (2001) 43, 9-16.

Seale, J. P., Seale, J. D., Alvarado, M., et al (2002) Prevalence of problem drinking in a Venezuelan Native American population. Alcohol & Alcoholism, 37, 198-204.

Viet Nam

GENERAL INFORMATION

Viet Nam is a country with an approximate area of 332 thousand sq. km. (UNO, 2001). Its population is 82.481 million, and the sex ratio (men per hundred women) is 99 (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 7% (WHO, 2004). The literacy rate is 93.9% for men and 86.9% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.1%. The per capita total expenditure on health is 134 international $, and the per capita government expenditure on health is 38 international $ (WHO, 2004).

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

The life expectancy at birth is 67.1 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

McKelvey et al (1993) studied a cohort of 161 Vietnamese Amerasians in Vietnam awaiting settlement in the USA. Ninety-five members of the original cohort were reassessed in Philippines. The researchers used Felsman's 35-item Personal Information Form and the Hopkins Symptom Checklist-25 and found a significant relationship between number of risk factors identified in Viet Nam and symptoms, especially depression, in the Philippines. In a replication sample consisting of 147 Vietnamese Amerasians awaiting relocation, Webb et al (1997) found that the number of risk factors was linearly related to symptoms of both depression and anxiety. There was a decrease in depression and anxiety between the camps in Viet Nam and Philippines. However, these changes were not related to changes in refugee camp conditions or social support within the camp (McKelvey & Webb, 1997a). McKelvey and Webb (1996) found that the prevalence rate of DSM-III psychiatric disorders among Vietnamese Amerasians prior to migration from Viet Nam was lower than previously reported among Vietnamese refugees in the United States and Australia. McKelvey and Webb (1997b) also compared levels of psychological distress in a pre-migratory sample of Vietnamese Amerasians with those in a like-aged, non-migratory sample of Vietnamese living in Ho Chi Minh City, Viet Nam. Subjects were assessed using two measures developed and validated for Vietnamese clinical populations in the United States: the Hopkins Symptom Checklist-25 and the Vietnamese Depression Scale. Amerasians had significantly higher symptom levels on the depression scale of the Hopkins Symptom Checklist-25 but not on the other measures utilized. Amerasians' higher levels of depressive symptoms could reflect their traumatic lives in Viet Nam, but may also reflect acute situational factors or selection bias. Loughry and Flouri (2001) studied emotional and behavioural problems in two groups of children and young adults without parents aged 10-22 years – those who had been repatriated to Viet Nam from camps in Hong Kong and South-East Asia and those who had always remained in Viet Nam. The researchers interviewed 455 subjects of which 238 were refugees using the Achenbach Youth Self-Report, the Cowen Perceived Self-Efficacy scale, a Social Support scale as well as an Exposure to Trauma scale. Results showed that there was no significant difference between the two groups of children on the YSR total score. The former refugee children had significantly lower externalizing scores and failed marginally to report significantly higher internalizing scores than the local children. A significant interaction between the immigration status of the children and the children's subjective perception of their current standard of living explained the differences in the YSR. The study showed that the perceived self-efficacy, number of social supports and experience of social support did not differ between the two groups of children. The authors failed to find any difference in emotional or behavioural pattern among the two groups. There are a large number of studies on Vietnamese refugees settled in different developed countries and on Viet Nam War Veterans. Such studies have not been included in the present discussion. Studies on refugees settled in low-and middle-income countries have been included under the relevant section of those countries.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

In 2002, a 'Decision from the Prime Minister' provided for the 'Ratification of the Programme for some Non-Communicable Disease for 2002-2010', which includes mental disorders (epilepsy, depression). Schizophrenia had been included in the priority list of community health programmes earlier. It focuses on prevention and treatment, integration of services at the level of primary care, relevant health education and workforce development at this level and intersectoral collaboration.

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 1999. A mental health programme is one of the ten objectives listed in the National Health Programme.

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

Medications approved by the Ministry of Health for people with schizophrenia and epilepsy are routinely available and are free. Medications for other conditions may or may not be available and would not be free.

Mental Health Legislation There is no mental health legislation.
Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are budget allocations for mental health.
Details about expenditure on mental health are not available.
The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, tax based, social insurance and private insurances.
The Government limits financing to those patients suffering from schizophrenia and epilepsy. For other mental disorders, the patients' families are required to pay for treatment.
The country has disability benefits for persons with mental disorders. Benefits are given by Ministry of Social-Invalid-Labour.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Primary care is provided for maintenance and rehabilitation. Traditional medicines are routinely used for treatment.
Regular training of primary care professionals is not carried out in the field of mental health. All district hospitals and commune health stations have general practitioners. Mental health training for primary care providers has been provided in 7% of communities. A six-month training is provided to the district level physicians and a one-week training to the commune level physicians.
There are community care facilities for patients with mental disorders. Community based mental health care is integrated in the primary care system. Effective psychosocial rehabilitation is still to develop. Proper integration of different facilities is lacking. There is an experimental outpatient psychiatric rehabilitation project funded by the Ha Noi Health Services at one particular hospital. A 50-bed day care/night care psychiatric hospital has been opened. Apart from clinical (e.g. administration of medication on site) and rehabilitative functions (e.g. basic living skills) it has an important training and public education function. Besides this, up to 2-3 patients are allowed to stay overnight if they are in crisis. This helps in prevention/postponement of hospitalization. Three other day care clinics have been established. These clinics are run by district health physicians and nurses who have undergone mental health training under the supervision of psychiatrists. These facilities also cater to children. The health sub-committee of the commune people's committee are informed of the problems in health care follow-up and it plays an active role in convincing families to cooperate with treatment. General physicians either visit patients at their homes or receive these patients at the health centres. There is a monetary incentive for every patient that they attend to.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.63
Psychiatric beds in mental hospitals per 10 000 population	0.59
Psychiatric beds in general hospitals per 10 000 population	0.04
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.32
Number of neurosurgeons per 100 000 population	0.03
Number of psychiatric nurses per 100 000 population	0.3
Number of neurologists per 100 000 population	0.13
Number of psychologists per 100 000 population	0.06
Number of social workers per 100 000 population	0

Most of the personnel work in institutes or hospitals in bigger cities. Out of the 64 provinces and cities in the country, 47 have a psychiatric department in a general hospital and 29 have a psychiatric hospital. However, the level of services and access fall as one moves from province to district to community. Care for chronic patients, including for substance abuse problems is also provided by the Ministry of Labour, Employment and Social Affairs (MOLESA), which provides for about 2000 beds. There are 45 forensic psychiatry beds. Some beds are earmarked for women. There are 2 child and adolescent psychiatrists in the country.

Non-Governmental Organizations NGOs are not involved with mental health in the country. Social organizations like the youth union, the women's union and the union of farmers organize public information sessions twice a month to help families take care of their patients and help the medical staff protect the health of the people. Family associations or clubs exist in big cities.

Information Gathering System There is mental health reporting system in the country.
The country has data collection system or epidemiological study on mental health. Data collection is one of the activities of the national programme of mental health since 1999.

Programmes for Special Population The country has specific programmes for mental health for elderly. There are no special services available.

There is a 20-bedded inpatient child psychiatry unit. This centre also provides outpatient and day care facilities. Child mental health services in a few other cities consist of outpatient and day care centres. The Ministry of Education conducts a health promotion programme in schools where life skills education is provided to children and adolescents. Local women's and youth unions play a role in the psychosocial rehabilitation of adolescents with drug abuse and conduct disorders under the supervision of the district nurse. The Government Programme for drug abuse is under the Ministry of Labour, Invalids and Social Affairs (MOLISA). The MOLISA runs drug abuse treatment services that are not integrated with the general health system. The United Nations International Drug Control Programme (2001-2010) aims at control in supply and demand reduction. This programme is being undertaken with the Youth Union Drugs Project.

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

Other Information Psychiatry was identified as a separate speciality of medicine in 1970. The Russian classificatory system of mental disorders was replaced by ICD system only in 1980.

Additional Sources of Information

Lambert, T., McKenzie, D., Pennella, J. et al (1999) The influence of client's ethnicity on psychotropic medication management in community mental health services. Australian and New Zealand Journal of Psychiatry, 33, 882-88.

Loughry, M., Flouri, E. (2001) The behavioral and emotional problems of former unaccompanied refugee children 3-4 years after their return to Vietnam. Child Abuse & Neglect, 25, 249-263.

McKelvey, R., Sang, D., Tu, H. (1997) Is there a role for child psychiatry in Vietnam? Australian and New Zealand Journal of Psychiatry, 31, 114-119.

McKelvey, R. S., Webb, J. A., Mao, A. R. (1993) Premigratory risk factors in Vietnamese Amerasians. American Journal of Psychiatry, 150, 470-473.

McKelvey, R. S., Webb, J. A., Strobel, R. M. (1996) The prevalence of psychiatric disorders among Vietnamese Amerasians: a pilot study. American Journal of Orthopsychiatry, 66, 409-415.

McKelvey, R. S., Webb, J. A. (1997a) A prospective study of psychological distress related to refugee camp experience. Australian & New Zealand Journal of Psychiatry, 31, 549-554.

McKelvey, R. S., Webb, J. A. (1997b) Comparative levels of psychological distress in a pre-migratory refugee population. Australian & New Zealand Journal of Psychiatry, 31, 543-548.

Webb, J. A., McKelvey, R. S., Strobel, R. (1997) Replication and extension of a risk profile for Amerasian youth. Journal of Traumatic Stress, 10, 645-654.

Yemen

GENERAL INFORMATION

Yemen is a country with an approximate area of 528 thousand sq. km. (UNO, 2001). Its population is 20.732 million, and the sex ratio (men per hundred women) is 103 (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 69.5% for men and 28.5% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 4.5%. The per capita total expenditure on health is 69 international $, and the per capita government expenditure on health is 24 international $ (WHO, 2004).

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

The life expectancy at birth is 58.7 years for males and 62.2 years for females (WHO, 2004). The healthy life expectancy at birth is 48 years for males and 51 years for females (WHO, 2004).

EPIDEMIOLOGY

There is a paucity of epidemiological data on mental illnesses in Yemen in internationally accessible literature. Hassan et al (2002) assessed the effect of khat chewing on mood symptoms in 200 healthy volunteers in a hospital. They used the Hospital Anxiety and Depression Scale to assess symptoms in khat chewing and abstinent arms. More mood symptoms were reported by the group that continued to chew khat.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is present. The policy was initially formulated in 1986.
The components of the policy are promotion, prevention, treatment and rehabilitation.

Substance Abuse Policy A substance abuse policy is absent.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1983.
The goals of the programme are integration of mental health services into primary care, initiating a school health programme, increasing the number of psychiatric beds in hospitals and providing training facilities.

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 There is no mental health legislation. Islamic laws are used for people with mental illness.
Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing There are budget allocations for mental health.
Details about expenditure on mental health are not available.
The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family and tax based.
The country has disability benefits for persons with mental disorders. Monthly social benefits may be given to some 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. Primary care is available in some areas only.
Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 150 personnel were provided training. Medical officers and health workers from rural health facilities and district hospitals and general physicians were trained. Regular in-service training is being provided to nurses.
There are no community care facilities for patients with mental disorders. A community psychiatric care demonstration project has been set up with the help of WHO.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.85
Psychiatric beds in mental hospitals per 10 000 population	1.1
Psychiatric beds in general hospitals per 10 000 population	0.4
Psychiatric beds in other settings per 10 000 population	0.35
Number of psychiatrists per 100 000 population	0.5
Number of neurosurgeons per 100 000 population	0.06
Number of psychiatric nurses per 100 000 population	0.09
Number of neurologists per 100 000 population	0.08
Number of psychologists per 100 000 population	1.2
Number of social workers per 100 000 population	0.04

Some beds have been earmarked for women. The number of beds in prison psychiatric wards have been reduced by two-thirds and psychiatric patients are separated from other inmates in the prison.

Non-Governmental Organizations NGOs are involved with mental health in the country. They are mainly involved in treatment and rehabilitation. The International Committee of the Red Cross has helped in the provision of services and reform in prison psychiatric wards.

Information Gathering System There is mental health reporting system in the country. It is included in the 5 years plan of health reporting.
The country has no data collection system or epidemiological study on mental health.
Rehabilitation centres for mentally challenged individuals are available.

Programmes for Special Population The country has specific programmes for mental health for refugees. There is a mental hospital for women in Sanaa.

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.
Yemen follows the WHO Essential Drug List.

Other Information Mental health services were practically non-existent before 1966 and patients used to be kept in prisons. Since then, a lot of improvement has occurred. Hospitals have been built, training provided to different personnel at all levels of care and the administration has been educated about psychiatric illnesses. Different NGOs and WHO helped in building the infrastructure. However, there are some difficulties in the form of inadequate financial support or poor follow-up facilities that have slowed down the implementation of the mental health programme.

Additional Sources of Information

Hassan, N. A., Gunaid, A. A., El Khally, F. M., et al (2002) The effect of chewing Khat leaves on human mood. Saudi Medical Journal, 23, 850-853.

Zambia

GENERAL INFORMATION

Zambia is a country with an approximate area of 753 thousand sq. km. (UNO, 2001). Its population is 10.924 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 47% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 86.3% for men and 73.8% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.7%. The per capita total expenditure on health is 52 international $, and the per capita government expenditure on health is 27 international $ (WHO, 2004).

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

The life expectancy at birth is 39.1 years for males and 40.2 years for females (WHO, 2004). The healthy life expectancy at birth is 35 years for males and 35 years for females (WHO, 2004).

EPIDEMIOLOGY

Wapnick et al (1972) reviewed psychiatric diagnoses of a group of female patients admitted in a hospital over 2 consecutive years. The common diagnoses recorded were: depression (26% and 42%) and schizophrenia (14% and 21%). The diagnosis of acute transient psychoses was rare. Kwalambota (2002) assessed the mental health of pregnant women with HIV. 85% of women, who were diagnosed to have HIV during the index hospitalization, showed major depressive episodes and had significant suicidal thoughts, and about 60% showed signs of somatic illness. Those who knew their HIV status before becoming pregnant did not show severe depressive episodes during the index hospitalization but were anxious about the HIV status of their babies. Dhadphale and Shaikh (1983) described an outbreak of epidemic hysteria which was triggered off by a group of girls who were having educational and emotional problems prior to the epidemic. A change in the administrative policy of rigidly segregating the genders apparently prepared an emotionally charged background for the rapid spread of the illness. Rwegellera (1978) examined the records of all suicides and of all open verdicts in Lusaka (Zambia) over a 5-year period. The following suicide rates (per 100 000 of the population per annum) were found: 7.4 for all races (11.3 for males and 3.0 for females), 6.9 for Africans (11.2 for males and 2.2 for females), 12.8 for all Africans above the age of 14 years, and 20.9 for European (20.7 for males and 21.0 for females). In the African population, suicide was associated with gender (males committed suicide five times more often) and age. Hanging was the most common method of suicide by Africans. There was no definite seasonal variation and mental illness and physical diseases were important precipitating factors of suicide. Lin and Ebrahim (1991) studied behaviour patterns among 210 primary school children in the age group of 8-12 years using the Teacher's Rutter Scale and interviews of mothers. The frequency of behaviour disorder was 14.8%with a sex ratio of 1.9:1 (boy:girl). Behaviour disorder was largely associated with the type of school, socio-economic status, mother's occupation, play facilities at home and past history of hospitalization.

MENTAL HEALTH RESOURCES

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

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

National Mental Health Programme A national mental health programme is absent.
It is being formulated using the WHO's Public Mental Health Programme. Priorities for mental health services were outlined by the Ministry of Health in 1979.

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

Mental Health Legislation The Mental Disorders Act is old and there is a new draft bill.
The latest legislation was enacted in 1951.

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, private insurances and social insurance.
Funds for mental health have been through the basket funds under the Sector Wide Approach.
The country does not have disability benefits for persons with mental disorders. There is a National Disability Act and a National Disability Fund that is available for all persons with disability. However, patients hardly access them. patients who retire on medical grounds are given full benefits. However, it is difficult for the families to receive the benefits due to a shortage of funds.

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 hospitals have psychiatric outpatient facilities, and the psychotropic situation has improved in the recent past.
Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 100 personnel were provided training. Referral system is still a challenge. There is little communication between traditional and orthodox medicine. However, there is good communication between the Ministry of Health and the Mental Health Association, an NGO.
There are community care facilities for patients with mental disorders. Psychiatric units are present in 7 provincial general hospitals. They are managed by clinical officers. Community care is not well developed and is under threat due to the lack of funds. It was started as a pilot project in one particular district with the help of outside funds.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.5
Psychiatric beds in mental hospitals per 10 000 population	0.17
Psychiatric beds in general hospitals per 10 000 population	0.18
Psychiatric beds in other settings per 10 000 population	0.07
Number of psychiatrists per 100 000 population	0.02
Number of neurosurgeons per 100 000 population	0.03
Number of psychiatric nurses per 100 000 population	5
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0.04
Number of social workers per 100 000 population	0.04

There is a critical shortage of mental health providers. Clinical officers carry out most of the clinical work in psychiatry. They work independently and are registered by the Medical Council of Zambia. And for Zambia, with only one psychiatrist in Government practice, the clinical officers form the backbone of psychiatric practice. There are 154 secure beds for forensic patients. Considering the severe shortage of mental health professionals at all levels, plans are under way to reintroduce pre-service training for primary care professionals in mental health. Many nurses are being recruited for the British NHS.

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

Information Gathering System There is mental health reporting system in the country. The mental health reporting system requires to be reviewed to meet the challenges of the health reform programme. Although psychiatric facilities keep records of mental disorders, the ICD 10 criteria has been replaced by the country specific Health Information Management System (HMIS) which limits all types of mental illnesses under one category of 'mental disorders' causing concern among mental health professionals.
The country has data collection system or epidemiological study on mental health. Data are compiled at the main psychiatric hospital and psychiatric units in all provincial general hospitals.
All mental illness together form one rubric.

Programmes for Special Population There are no special programmes.
With the approval of the mental health policy, expectations are high for the development of programmes. Refugees had a trauma programme through UNHCR. The country successfully participated in the two-year WHO-UNDP global initiative on the primary prevention of substance abuse among the young. Currently, it is involved in the five-year Southern African Development Community Network on Drug Use Project.

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.
The newer anti-psychotics like pimozide are not available. Benzhexol (2mg) is used.

Other Information The overall state of mental health is not adequate from the human resources and services point of view. Health sector reforms in the early 1990s led to downgrading of mental health services. Zambia participated in the European Commission funded Concerted Action Report on Methods for Intervention in Mental Health in Sub-Saharan Africa coordinated by South Bank University of London from 1997-2000.

Additional Sources of Information

Dhadphale, M., Shaikh, S. P. (1983) Epidemic hysteria in a Zambian school: "the mysterious madness of Mwinilunga". British Journal of Psychiatry, 142, 85-88.

Gleisner J. (2002). What causes more destruction, AIDS or aid? Psychiatry in Zambia. Australasian Psychiatry, 10, 166-167.

Kwalombota, M. (2002) The effect of pregnancy in HIV-infected women. AIDS Care, 14, 431-433.

Lin, Y. Q., Ebrahim, G. J., et al (1991) Frequency of behaviour disorder and related factors in school children in Lusaka. Journal of Tropical Pediatrics, 37, 303-309.

Mayeya, J., Chazulwa, R., Mayeya, P.N., et al. (2004) Zambia mental health country profile. International Review of Psychiatry, 16, 63-72.

Rwegellera, G. G., Mambwe, C. C. (1977) Diagnostic classification of first-ever admissions to Chainama Hills Hospital, Lusaka, Zambia. British Journal of Psychiatry, 130, 573-580.

Wapnick, S., Castle, W., Nicholle, D., et al (1972) Cigarette smoking, alcohol and cancer of the oesophagus. South African Medical Journal, 46, 2023-2026.

Zimbabwe

GENERAL INFORMATION

Zimbabwe is a country with an approximate area of 391 thousand sq. km. (UNO, 2001). Its population is 12.932 million, and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 42% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 93.8% for men and 86.3% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.2%. The per capita total expenditure on health is 142 international $, and the per capita government expenditure on health is 64 international $ (WHO, 2004).

The main language(s) used in the country is (are) English, Ndebele and Shona. The largest religious group(s) is (are) Christian, and the other religious group(s) are (is) indigenous groups.

The life expectancy at birth is 37.7 years for males and 38 years for females (WHO, 2004). The healthy life expectancy at birth is 34 years for males and 33 years for females (WHO, 2004).

EPIDEMIOLOGY

Patel et al (1997, 1998) and Todd et al (1999) developed the Shona Symptom Questionnaire to measure prevalence of common mental disorders (CMD) among African populations. In an unmatched case-control study, they assessed a cohort of 199 cases with CMD recruited from primary health care facilities, traditional practitioners, general practitioners and 197 controls. CMD was significantly associated with female gender, older age, chronicity of illness, number of presenting complaints, beliefs in 'thinking too much' and witchcraft as a causal model, economic impoverishment, infertility, recent unemployment, an unhappy childhood for females, disability, and consultations with traditional medical practitioners and religious priests. The cohort was reassessed after 2 and 12 month. Of the 134 subjects interviewed at both follow-up points, 49% had recovered by 2 months and remained well at 12 months while 28% were persistent cases at both 2 and 12 months. Higher scores on the instrument, a psychological illness model, bereavement and disability predicted a poor outcome at both times. Poorer outcome at 2 month follow-up was associated with belief in witch-craft and an unhappy childhood. Caseness at follow-up was associated with disability and economic deprivation. Onset of new episodes of CMD was recorded in 16% at 2 and 12 months. Higher psychological morbidity scores at recruitment, death of a first-degree relative and disability predicted the onset of CMD at both follow-up points. While female gender and economic difficulties predicted onset at 2 months, belief in supernatural causation was strongly predictive of CMD at 12 months. Caseness at both follow-up points was associated with economic problems and disability. Patel et al (1999) reanalysed five epidemiological data sets from four low to middle income countries (India, Zimbabwe, Chile and Brazil). In all five studies, female gender, low education and poverty were strongly associated with common mental disorders. Broadhead and Abas (1998) found depression and anxiety in 30.8% of 172 randomly selected women in a township. Assessment with the Zimbabwean modification of the Bedford College Life Events and Difficulties Schedule revealed that events like humiliation, entrapment in an ongoing difficult situation and bereavement, which are known to be more depressogenic, were reported much more commonly in this sample compared to a sample in London. Reeler and Immerman (1994) examined the prevalence and factors associated with psychological disorders in Mozambican refugees in Zimbabwe using the SRQ-20. They found that 62% of refugees suffered from psychological disorders. They had multiple somatic complaints and a high suicidal risk. Acuda and Eide (1994) conducted a survey on 2783 secondary school students from randomly selected schools in rural and urban areas using a self-report questionnaire. Drug use was prevalent among the students. The main drugs involved, in descending order, were: alcohol, tobacco, inhalants (solvents), amphetamines and cannabis. Drug use increased with age and involved both sexes, the problem being more acute in the urban schools. Eide et al (1997 a, b) assessed 3061 secondary school children in Zimbabwe, selected by means of a two-stage sample design (first schools and then students registered with them were selected randomly). Standardized procedures were used by trained researchers to collect data. Sensation-seeking, addictive behaviour of significant others (social factors) and global and local cultural orientation (based on choice of media, language and music) explained 29.7% of the variance in dependent drug use. Social variables and global cultural orientation were significantly associated with increased use of cannabis and inhalants.

MENTAL HEALTH RESOURCES

Mental Health Policy A mental health policy is absent.

The mental health policy was developed over a three-year period and it will be officially launched in December 2004.

Substance Abuse Policy A substance abuse policy is absent. The initial formulation of the Zimbabwe National Drug Control Master Plan (substance abuse policy) was in 1999, and it is currently in the Parliament awaiting ratification.

National Mental Health Programme A national mental health programme is present. The programme was formulated in 1984. The national mental health programme was updated in 1996 and is known as National Health Strategic Plan 1997-2007.

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

The first essential drug list was published in 1985. The current list was published in the year 2000. The Zimbabwe National Drug Policy was published in 1995.

Mental Health Legislation There are two recent laws. The Mental Health Act 1996 and the Mental Health Regulation 1999. The latest legislation was enacted in 1996.

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 mentally ill are entitled to free health services.
The country has disability benefits for persons with mental disorders. Mental illness falls under the category that qualifies for tax credits.

Mental Health Facilities Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Primary health care workers have the capacity to handle patients with severe psychosis and refer only those that they feel require specialized services. Most of the rural and district hospitals do not have facilities for inpatient care and only 17 district, provincial and central hospitals have primary care teams.
Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 2000 personnel were provided training. There are training facilities for nurses, occupational therapists, rehabilitation workers and social workers. All student nurses are supposed to go through a period of training in mental health (4 weeks of theory and 8 weeks of practical experience). Training workshops for mental health are also organized from time to time at the district and provincial level. However, the programme has significant limitations. A system of supervision, referral and back referral has been established in some regions.
There are community care facilities for patients with mental disorders. There is a shortage of material and staff to sustain community care programme.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.2
Psychiatric beds in mental hospitals per 10 000 population	0.9
Psychiatric beds in general hospitals per 10 000 population	0.2
Psychiatric beds in other settings per 10 000 population	0.1
Number of psychiatrists per 100 000 population	0.1
Number of neurosurgeons per 100 000 population	0.07
Number of psychiatric nurses per 100 000 population	4.6
Number of neurologists per 100 000 population	0.009
Number of psychologists per 100 000 population	0.9
Number of social workers per 100 000 population	0.2

There are 221 physiotherapists and 243 rehabilitation technicians who help in mental health. There are 71 occupational therapists.

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

Information Gathering System There is mental health reporting system in the country. Although there is no mention of mental health in the secretaries' annual report, mental health is included in the National Health Profile Annual Report.
The country has data collection system or epidemiological study on mental health. Plans are under way to make the data collection form more user friendly.

Programmes for Special Population There are no special services for these populations. Mental health is integrated into other services and so all types of people benefit.

Therapeutic Drugs The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, biperiden, carbidopa, levodopa.
Benzhexol (5mg) is present. There is a shortage of drugs due to the lack of foreign currency.

Other Information In Zimbabwe, traditional healers have been allowed to form an association of their own through an Act of the Parliament.
The national training programme for registered nurses has been decentralized. In addition to the central hospitals, few rural district hospitals were selected for training, provided they had a separate ward for the care of psychiatric patients.

Additional Sources of Information

Acuda, S. W., Eide, A. H. (1994) Epidemiological study of drug use in urban and rural secondary schools in Zimbabwe. Central African Journal of Medicine, 40, 207-212.

Broadhead, J. C., Abas, M. A. (1998) Life events, difficulties and depression among women in an urban setting in Zimbabwe. Psychological Medicine, 28, 29-38.

Eide, A. H., Acuda, S. W. (1997b) Cultural orientation and use of cannabis and inhalants among secondary school children in Zimbabwe. Social Science & Medicine, 45, 1241-1249.

Eide, A. H., Acuda, S. W., Khan, N., et al (1997a) Combining cultural, social and personality trait variables as predictors for drug use among adolescents in Zimbabwe. Journal of Adolescence, 20, 511-524.

Fidelis, C., Manley, M. (1991). Psychiatry in Zimbabwe. Hospital and Community Psychiatry, 42, 943-947.

Patel, V., Araya, R., de Lima, M., et al (1999) Women, poverty and common mental disorders in four restructuring societies. Social Science & Medicine, 49, 1461-1471.

Patel, V., Todd, C., Winston, M., et al (1997) Common mental disorders in primary care in Harare, Zimbabwe: associations and risk factors. British Journal of Psychiatry, 171, 60-64.

Patel, V., Todd, C., Winston, M., et al (1998) Outcome of common mental disorders in Harare, Zimbabwe. British Journal of Psychiatry, 172, 53-57.

Reeler, A. P., Immerman, R. (1994) A preliminary investigation into psychological disorders among Mozambican refugees: prevalence and clinical features. Central African Journal of Medicine, 40, 309-315.

Todd, C., Patel, V., Simunyu, E., et al (1999) The onset of common mental disorders in primary care attenders in Harare, Zimbabwe. Psychological Medicine, 29, 97-104.

van der Hheide D. H., Gernaat, H. B. P. E. (2001) A psychiatric ward in an African district hospital. Tropical Doctor, 31, 135-138.