despite the obvious pressures, the integration of hospital and community work and of health and social services, and a significant per capita increase in public spending on health care, led during this period to worthwhile improvements in mental health services. These are things that may or may not have happened had peace prevailed.

That services have improved and the population as a whole has coped remarkably well does not mean, of course, that those individuals who are seriously affected do not require appropriate help and treatment. Daly (1999) examined the treatment needs of the community generally as well as specific victim groups such as the security forces, children, the bereaved and prisoners. This raises a further but as yet still anecdotal observation. After the much publicised cease-fires there was a substantial, albeit ragged, reduction in terrorist activity; however, many health care professionals would corroborate the remark by Curran & Miller (2001) that with this reduction in violence there has been some increase in the presentation of victims of the Troubles. One implication may be that once the curiously 'holding environment' of the Troubles is lifted we may observe a negative as well as a positive 'peace dividend'. Who knows if it may yet be too early to be fully clear about the impact of the past 30 years on the psychological welfare of the people of Northern Ireland?

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That services have improved and the population as a whole has coped remarkably well does not mean, of course, that those individuals who are seriously affected do not require appropriate help and treatment.

COUNTRY PROFILE

Development of mental health services in Pakistan

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Background

Pakistan is a country comprising four provinces: Punjab, Sind, Northwest Frontier Province and Baluchistan, in addition to the federally administered tribal areas and the federal capital territory of Islamabad. It is bordered by China, Afghanistan, Iran and India. It has a population of 152 million (excluding an estimated 3–4 million Afghan and Bangladeshi immigrants) and an area of 796 095 km^2.

The per capita gross national product (GNP) is $483 and the budget of the Ministry of Health is 5% of the national budget, or 0.7% of the GNP (1997 figures). The annual per capita expenditure on health by the Ministry of Health is $3.5, compared with the national expenditure of $31. The ratios of beds, doctors, dentists and nurses to 10 000 population work out at 6.9, 6.0, 0.25 and 4.1, respectively. The mental health budget is 0.4% of the overall health budget.

From a modest beginning in 1947, when there were only three mental hospitals, at Lahore, Hyderabad and Peshawar, and a psychiatric unit at the Military Hospital in Rawalpindi, psychiatric units were gradually established in all the medical colleges of the country, especially during the 1970s.

Training

At the undergraduate level, behavioural sciences have been incorporated in the curricula of all the medical schools in Pakistan. An indigenous behavioural sciences teaching module has been developed for medical students and a demonstration project of community-oriented medical education with an emphasis on behavioural sciences was established in 1998 in four of the public sector medical colleges in all the provinces of the country.

At the postgraduate level, fellowship (FCSP), MD and diploma courses are available. The College of Physicians and Surgeons Pakistan (CPSP) is the main certifying body for postgraduate training in psychiatry; a four-year training programme leads to a fellowship in psychiatry. This training is carried out at specified institutions under the supervision of certified trainers. The training involves exposure to adult, forensic, child and adolescent, geriatric and liaison psychiatry patients in a graded manner that is monitored by the CPSP through regular reports from the supervisors, trainees and its own inspectors. The trainee has to complete a research project and submit a dissertation during this training period, besides attending workshops (organised by

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the CPSP) on research methods, biostatistics and communication skills. The primary FCPSP examination focuses on basic sciences relevant to psychiatry, while part II forms the summative evaluation at the end of training.

In addition, universities also offer MD and diploma training courses of shorter duration. There are 320 psychiatrists based in major urban centres; of these, 70 are fellows of the CPSP, 50 are members or fellows of the Royal College, and the rest have qualifications from the American Board, European institutions or local universities.

There are two centres at Lahore and Karachi for the training of clinical psychologists; together they train about 30 every year. Currently about 200 clinical psychologists work in the country.

Psychiatric nursing is being offered as a separate subject at all the nursing institutions in the country and a curriculum for psychiatric nursing has been developed. A two-year postgraduate diploma for psychiatric nursing has been initiated in nurse training colleges in the country and so far 52 psychiatric nurses have qualified.

There is no provision for the training of psychiatric social workers at the university departments.

Epidemiology

Epidemiological studies carried out in Pakistan have shown that 10–66% of the general population suffers from mild to moderate psychiatric illnesses, in addition to the 0.1% suffering from severe mental illnesses (Mumford *et al*, 1996, 1997, 2000; Husain *et al*, 2000).

The prevalence of severe learning disability in children aged three to nine years has been estimated at 16–22/1000 and according to recent (2000) estimates 4 million people misuse substances in Pakistan. The most common substance of misuse is heroin (49.7%) and 71.5% of the abusers are below 35 years of age. There are about 232 facilities for drug detoxification in the country (Subcommittee on Mental Health and Substance Abuse, 2003).

Development of mental health services

The national programme of mental health was the first such programme to be developed, in 1986, at a multidisciplinary workshop; it was incorporated in the 7th–9th five-year national development plan. In the light of the above, it is evident that it will not be possible in the foreseeable future to realise the objective of the programme if reliance is placed exclusively on specialised workers. Instead, the aim is to incorporate mental health services within primary health care. This has been initiated in five districts of the country (each of the four provinces, plus Azad Kashmir). The government of Pakistan has now allocated a separate budget of more than Rs22 million for this purpose. This model was initially developed in two sub-districts of Rawalpindi, and is presently being replicated.

The majority of the policy and field-level administrators have been provided, including some from the armed forces. Mental heath training programmes, as part of the ongoing in-service training programmes of the district health development centres, are being initiated in the five target districts. These centres have been set up to build the capacity of primary care personnel to handle common health problems, by organising on-the-job training for them. More than 2000 primary care practitioners have so far been trained in mental health. Similarly, more than 40 000 lady health visitors (LHV), multipurpose health workers (MPHW) and lady health workers (LHW) have received training all over the country, in a decentralised manner, within the district health development centres, using indigenously developed training manuals.

In addition, so far more than 78 junior psychiatrists have been trained in community mental health to act as resource persons in the development of community mental health programmes in their areas, and to provide the training, referral and evaluation support to facilitate the integration of mental health within primary care. As well as psychiatrists from Pakistan, mental health professionals from Iran, Egypt, Tunisia, Afghanistan, Morocco, Yemen, Sudan, Palestine and Nepal (Mohit *et al*, 1999) have been trained in community mental health, to act as resource persons in their respective countries.

Another major development has been the incorporation of indicators for mental illnesses as part of the national health management information system.

Junior psychiatrists have been trained in community mental health to act as resource persons in the development of community mental health programmes in their areas, and to provide the training, referral and evaluation support to facilitate the integration of mental health within primary care.

Development of a school mental health programme

The school mental health programme works through a series of four phases: familiarisation, training, reinforcement and evaluation (Mubbashar, 1989; Rahman *et al*, 1998; Saeed *et al*, 1999).

During the year 2000, a mental health component was included in the teacher training programmes at national level. So far more than 150 education administrators from all provinces have been given orientation training.

Training of master trainers from all provinces (batches of 40 for four months each) started in January 2001. Textbook boards of all provinces are being approached for inclusion of mental health issues in the school curricula being prepared by them.

Activities with faith healers

Faith healers and religious leaders are the first port of call for the majority of people with a mental illness. One research project has shown that about 16% of the patients presenting to faith healers in a subdistrict of 0.5 million were given 'medical diagnoses' and referred to the nearest health facility. This marks a significant departure from past practices (Saeed *et al*, 2000).

Activities with non-governmental organisations

Non-governmental organisations (NGOs) are taking on an increasingly important role in developmental activities. The National Rural Support Programme (NRSP) is an organisation active in the fields of income generation, education, agriculture, forestry, tourism and health; it has direct access

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to about 20 000 village-level organisations. The NRSP and its sister organisations have agreed to include mental health among all their activities and about 20 000 community activists will be trained each year through this initiative; this highlights the role of mental health in national development activities.

Research and publications

Lack of indigenous research has been a major hindrance to the rational planning and allocation of resources; however, over the past few years a number of research papers have been published. Major areas of research activity include: mental health policy research, epidemiology (Minhas *et al*, 2001), health systems, economic evaluation of models of mental health care delivery (Chisholm *et al*, 2000), the development and validation of research instruments (Saeed *et al*, 2001), the evaluation of intersectoral linkages (Mubbashar *et al*, 2001) and clinical research.

Legislation

The government of Pakistan has repealed the Mental Health Act of 1912–26. The new mental health law, promulgated on 20 February 2001, embodies the modern concepts of mental illnesses, treatment, rehabilitation, and respect for civil and human rights. The first meeting of the Federal Mental Health Authority to develop an implementation mechanism for mental health ordinance 2001 was held on 29 December 2001. The ordinance provides for the prevention of mental illnesses, and the promotion of mental health through mental health literacy, the establishment of mental health services with stress on community-based services and integration with primary health care, the protection of the human rights of people with mental illnesses, and the reduction of stigma and discrimination.

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Lack of indigenous research has been a major hindrance to the rational planning and allocation of resources

COUNTRY PROFILE

Psychiatric country profile: Chile

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Chile has approximately 600 psychiatrists for its 15 million people. Although in the capital city, Santiago, the provision (per capita) is twice as high as in the rest of the territory, it is possible to see over the past decade a progressive increase in the number of these specialists in the other main cities. There are no more than 50 child psychiatrists and several cities have no local resource in this sub-speciality.

Training

Ten schools of medicine offer medical undergraduate education. The seven-year curriculum includes courses on medical psychology, psychopathology and general psychiatry.

Physicians may become specialists in psychiatry through a three-year postgraduate programme of studies, provided by seven universities. All these residence programmes

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