The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) collected information on the mental health system in Bangladesh to improve the system and to provide a baseline for monitoring the change.

Bangladesh's mental health policy, strategy and plan were approved in 2006. In 2005, money spent for mental health services was less than 0.5% of the total national health expenditures. A national survey in 2003-2005 reported 16.05% of the adult population in the country suffering from mental disorders. No mental disorder is covered by social insurance, no human rights review body exists in the country to inspect mental health facilities, and no specific mental health authority in the country has been established.

There are 50 outpatient mental health facilities but no day treatment facilities. There are 31 community-based psychiatric inpatient units, 11 community residential facilities and one 500 bedded mental hospital in the country.

The density of psychiatric beds, psychiatrists and nurses in or around the largest city is 5 times greater than the density in the entire country. The total number of human resources working in mental health facilities or private practice per 100,000 population is 0.49.Only a small percentage of all health publications in the country are on mental health.

Next steps for improving the mental health system include strengthening community mental health facilities and the provision of mental health in primary care, as well as increasing mental health human resources.

WHO-AIMS

WHO-AIMS Report on Mental Health System in Bangladesh

World Health Organization

Ministry of Health & Family Welfare Bangladesh

WHO-AIMS Report on

Mental Health System

in BANGLADESH

A report of the assessment of the mental health system in Bangladesh using the World Health Organization – Assessment Instrument for Mental Health Systems (WHO-AIMS).

Dhaka, Bangladesh

2007

World Health Organization

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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Bangladesh. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Bangladesh to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Bangladesh's mental health policy, strategy and plan was approved in 2006 as a part of policy, strategy and action plan for surveillance and prevention of Non-Communicable Diseases (NCD) and community based activities in mental health is the main approach of the policy. A list of essential medicines is present in the country including antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs.

A disaster preparedness plan for mental health has been prepared and submitted to government for approval. A draft version of the mental health act in Bangladesh has been prepared and submitted to government for enactment. The amount of money spent for mental health services by the government health department in 2005 was Taka 10,62,54,224.00 which was less than 0.5% of health care expenditures by the government. Of all the expenditures spent on mental health, 67% are devoted to mental hospital.

According to National Mental Health Survey in 2003-2005 about 16.05% of the adult population in the country are suffering from mental disorders. A small portion of patients are reporting to government facilities and they receive some psychotropic medicines from the facilities. No mental disorder is covered in social insurance schemes. No human rights review body exists in the country to inspect mental health facilities.

There is no specific mental health authority in the country. There are 50 outpatient mental health facilities and no facility provides follow-up care in the community. There is no day treatment mental health facilities in the country. There are 31 community-based psychiatric inpatient units for a total of 0.58 bed per 100,000 population and on average patients spend 29 days in the facility per discharge. There are 11 community residential facilities in the country and 55% of the beds in these facilities are for children and adolescents and 81% of admitted patients are female and 73% of them are children.

There is one 500 bedded mental hospital in the country and on average patients spend 137 days in the hospital. There are 15 beds for mentally disordered people in forensic inpatient units and 3900 beds in other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc.

The density of psychiatric beds in or around Dhaka, the largest city, is 5 times greater than the density of beds in the entire country.

Four percent of the training for medical doctors is devoted to mental health, in comparison to 2% for nurses. Most of the primary health care clinics are physician based and they make few referrals to mental health professionals. No health staffs except doctors are allowed to prescribe psychotropic medications.

The total number of human resources working in mental health facilities or private practice per 100,000 population is 0.49. The breakdown according to profession is as follows: 0.072857143 psychiatrist, 0.182142857 other medical doctors (not specialized in psychiatry), 0.196428571 nurses, 0.007142857 psychologists, 0.002142857 social workers, 0.002142857 occupational therapists, 0.028571429 other health or mental health workers.

Fifty-four percent of psychiatrists work for both government and private sectors and 46% work for only private sectors. Regarding the workplace, 31 psychiatrists work in outpatient facilities, 56 in community-based psychiatric inpatient units and 4 in mental hospital. The density of psychiatrists and nurses in or around the largest city is 5 times greater than the density in the entire country.

There is no consumer association in the country but there is 1 family association with 40 members. There are about 10 NGOs in the country involved in individual assistance activities in mental health. There are no legislative and financial provisions to protect and provide support for mental health service users in respect of employment and protection of rights. The mental health service for prisoners is insufficient.

The government health department receives data from the lone mental hospital, 45% community based psychiatric inpatient units and 28% mental health outpatient facilities but the information are insufficient. Only a small percentage of all health publications in the country are on mental health.

WHO-AIMS COUNTRY REPORT FOR BANGLADESH

Introduction

Bangladesh is a country with an approximate geographical area of 147570 square kilometres and a population of 141.8 million people (WHO, 2005). The main languages used in the country are Bengali and English and the main ethnic groups are Bangalee and various tribal. Religious groups include Muslims, Hindus, Christians and Buddies. In addition, there is a small tribal religious population. The country is a lower middle income group country based on World Bank 2004 criteria.

Thirty-nine percent of the population is under the age of 15 and 6% of the population are over the age of 60. Seventy-four percent of the population is rural. The life expectancy at birth for males is 62.0 years and 63.0 years for females (WHO, 2005). The healthy life expectancy at birth is 55.3 years for males and 53.3 years for females. The literacy rate for men is 52.8% and the 44.5% for women.

The proportion of the health budget to GDP is 3.4. There are 37 hospital beds per 100,000 population and 250 general practitioners. Thirty-two percent of all hospital beds are in the private sector. In terms of primary care, there are 2122 physician-based primary health care clinics in the country (1822 in the public sector and 300 in the private) and 96 non-physician based primary health care clinics (96 in the public sector).

Data was collected in 2006 and is based on the year 2005.

Domain 1: Policy and Legislative Framework

Bangladesh's mental health policy was last revised in 2006. Mental health policy is incorporated in policy, strategy and action plan for surveillance and prevention of Non-Communicable Diseases (NCD). The policy includes the following components-organization of services, developing community mental health services, organization of services: developing a mental health component in primary health care, human resources, involvement of users and families, advocacy and promotion, human rights protection of users, equity of access to mental health services across different groups financing, quality improvement, monitoring system. Strategy and work plan for community based activities in mental health in Bangladesh was also approved in 2006.

In addition, a list of essential medicines is present which includes antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs.

The last revision of the mental health plans was in 2006. Mental health plan is incorporated in the policy, strategy and action plan for surveillance and prevention of non-communicable diseases (NCD). Mental health plan is also incorporated in the strategy and work plan for

community based activities in mental health in Bangladesh. This plan contains the relevant components of the mental health policy but also includes budget, a timeframe and specific goals. Some of the goals identified in the last mental health plan have been reached within the last calendar year.

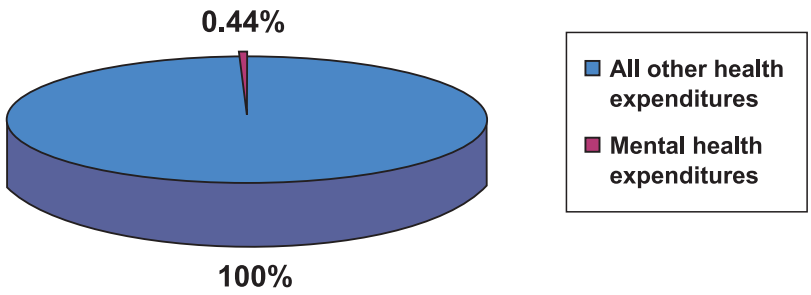
A disaster/emergency preparedness plan for mental health has been prepared and submitted to government for approval and necessary action.

Draft version of mental health act, Bangladesh has been prepared and submitted to proper authority in 2002 but still it is not approved and enacted.

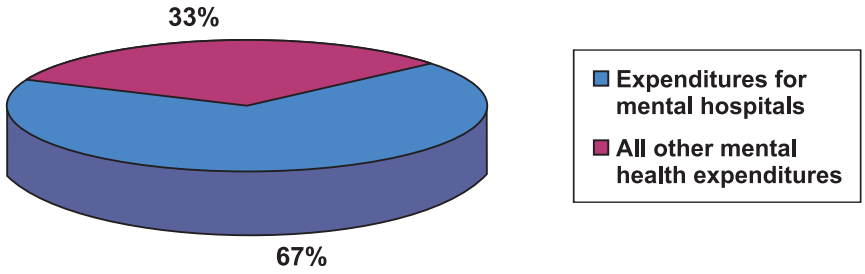
Financing of mental health services

Mental health expenditures from government health department are very insignificant and are less than 0.5%. Of all the expenditures spent on mental health, 67% are devoted to mental hospital. In terms of affordability of mental health services less than 0.11% of the population have free access to essential psychotropic medicines. For those that pay out of pocket, the cost of antipsychotic medication using the cheapest available antipsychotic drug in local currency is Taka 5.00 (US$ 0.07) per day and the cost of antidepressant medication using the cheapest antidepressant drug in local currency is Taka 3.00 (US$ 0.04) per day. No mental disorder is covered in social insurance schemes.

GRAPH 1.1 – HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



GRAPH 1.2 – MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



Human rights policies

No human rights review body exists in the country to oversee regular inspections in mental health facilities. In terms of training no (0%) staff of mental hospital, inpatient psychiatric unit and community residential facility has provision for training on human rights.

Domain 2: Mental Health Services

There is no specific mental health authority in the country and mental health services are not organized in terms of catchment/service areas.

Mental health outpatient facilities

There are 50 outpatient mental health facilities available in the country, of which 4% are for children and adolescents only. These facilities treat about 26 users per 100,000 general population. Of all users treated in mental health outpatient facilities, 44% are female and 7% are children or adolescents. The users treated in outpatient facilities are primarily diagnosed with schizophrenia (30%), mood disorders (20%) and neurotic disorders (20%).

The average number of contacts per user is four. No outpatient facility (0%) provides follow-up care in the community, while 2% have mental health mobile teams. In terms of available treatment, a few (1-20%) of patients in outpatients facilities last year received one or more psychosocial interventions. Fifty eight percent of mental health outpatient facilities have at last one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

Day treatment facilities

There is no day treatment mental health facilities available in the country.

Community-based psychiatric inpatient units

There are 31 community-based psychiatric inpatient units available in the country for a total of 0.58 bed per 100,000 population. Two percent of these beds in community-based inpatient units are reserved for children and adolescents only. Forty two percent of patients are female and 12% are children/adolescents. The rate of admissions in these facilities is 4 per 100,000 population. The diagnoses of admissions to community-based psychiatric inpatient were primarily from the following two diagnostic groups: schizophrenia (42%) and mood disorders (37%). On average patients spend 29 days in community-based psychiatric inpatient units per discharge. A few patients (1-20%) in community-based psychiatric inpatient units received one or more psychosocial interventions in the past year. While 100% of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community residential facilities

There are 11 community residential facilities available in the country for a total of 0.92 beds/places per 100,000 population. These facilities treat 0.85 patients per 100,000 population. Fifty-five percent of these beds in community residential facilities are reserved for children and adolescents. Eighty-one percent of patients are female and 73% are children. On average patients spend 350 days in community residential facilities.

Mental hospitals

There is 1 mental hospital available in the country for a total of 0.4 beds per 100,000 population and this facility (100%) is organizationally integrated with mental health outpatient facilities. There is no bed (0%) in mental hospital reserved for children and adolescents only. The number of beds has increased by 25% in the last five years. The patients admitted to the mental hospital belong primarily to the following two diagnostic groups: schizophrenia (70%) and mood disorders (30%). On average patients spend 137 days in mental hospital. Sixty-three percent of patients spend less than one year, 21% of patients spend 1-4 years, 11% of patients spend 5-10 years, and 5% of patients spend more than 10 years in mental hospital. A few patients (1-20%) in mental hospital received one or more psychosocial interventions in the past year. The mental hospital (100%) had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Forensic and other residential facilities

In addition to beds in mental health facilities, there are also 15 beds for persons with mental disorders in forensic inpatient units and 3900 beds in other residential facilities

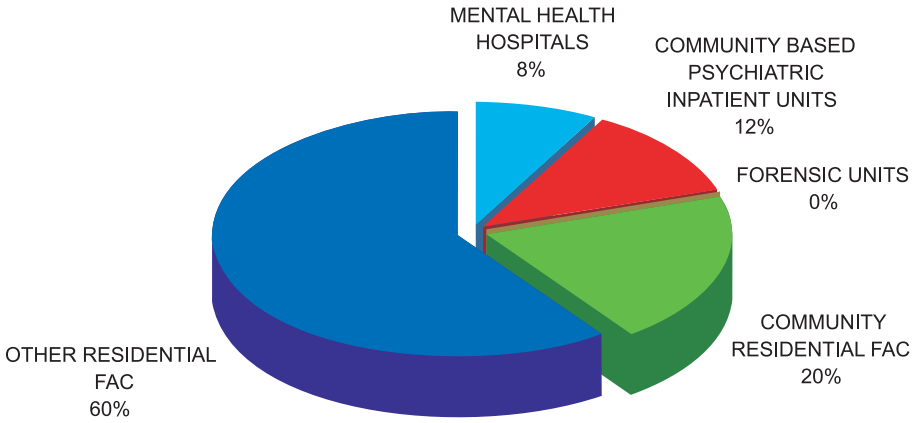
such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. In forensic inpatient units 100% of patients spend less than one year, 0% of patients spend 1-4 years, 0% of patients spend 5-10 years, and 0% of patients spend more than 10 years.

Human rights and equity

Eighty percent of all admissions to community-based inpatient psychiatric units and 100% of all admissions to the mental hospital are involuntary. The majority of the admitted patients in community-based inpatient psychiatric units are psychotic who are usually admitted without the consent of the patient but with consent of the attendant(s). Most of the neurotic patients also do not like to get admitted into psychiatry units because of social stigma and mental ward phobia. Almost all patients admitted in the mental hospital are psychotic and are admitted without the consent of the patient but with the consent of the attendant(s). Between 2 to 5% of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units and also in mental hospital. If the number of patients restrained or secluded is calculated in a figure it is likely to be higher in the mental hospital than in the community-based inpatient psychiatric units.

The density of psychiatric beds in or around the largest city is 5 times greater than the density of beds in the entire country. Such a distribution of beds prevents access for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

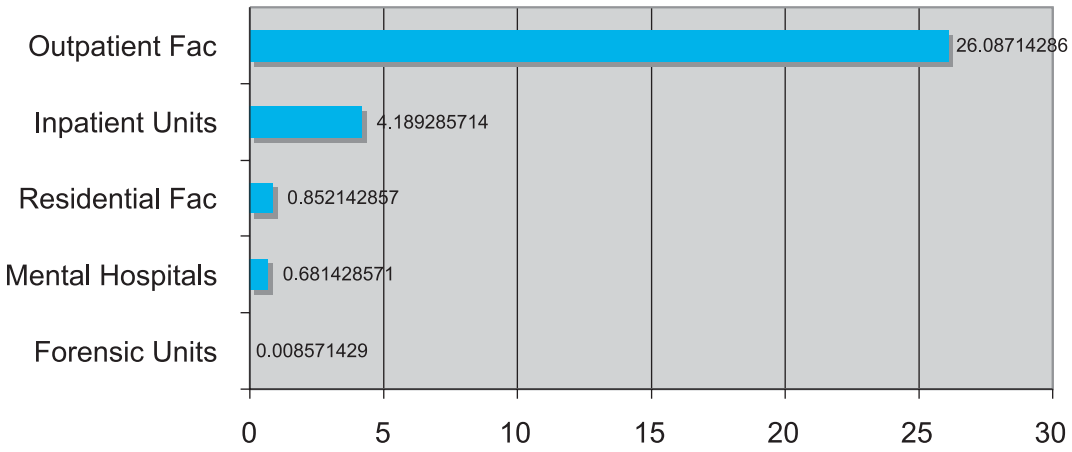
GRAPH 2.1 – BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



Summary for Graph 2.1

Mental health hospital and community based psychiatric inpatient units compose 20% of the available beds in the country, while sixty percent of beds in the country are provided by other residential facilities. The remaining 20% of available beds are provided by community residential facilities.

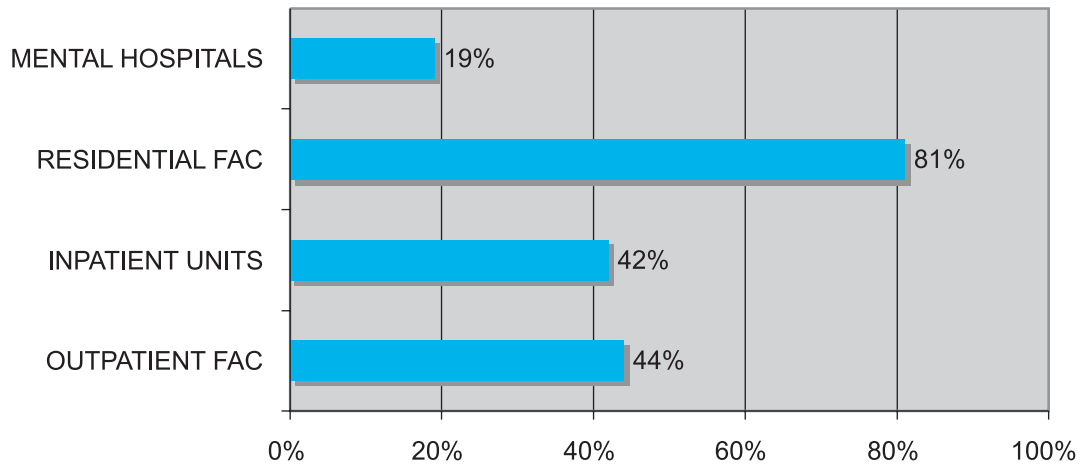
GRAPH 2.2 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES



Summary of Graph 2.2

The majority of the users are treated in outpatient facilities while the rate of users treated in inpatient units, mental hospital, residential facilities and day treatment facilities is lower.

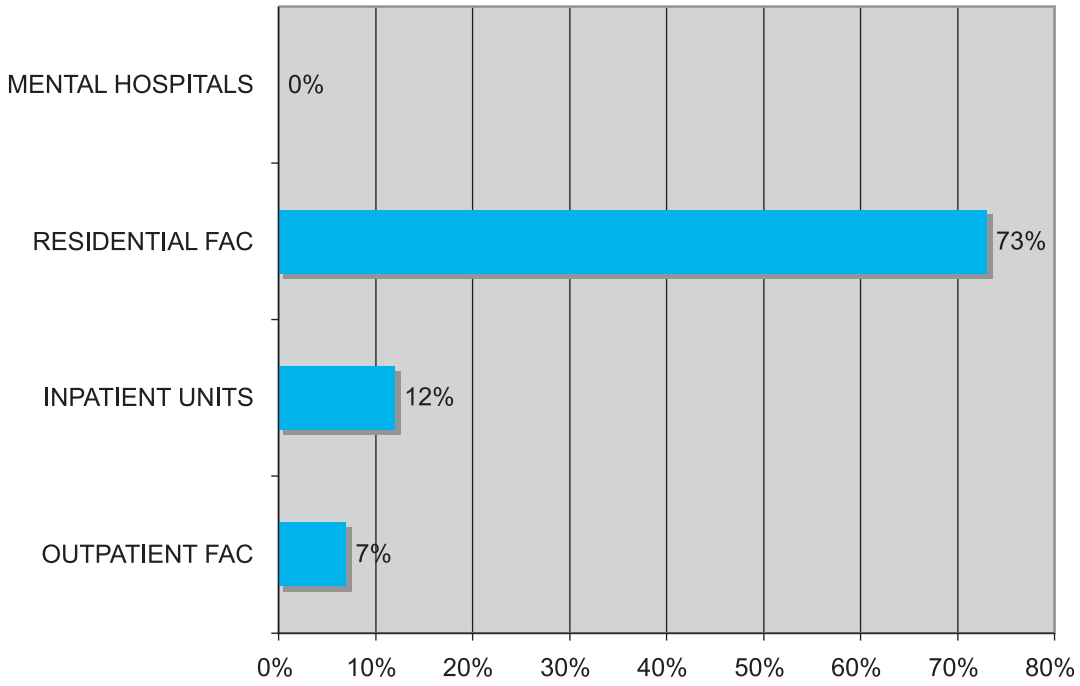
GRAPH 2.3 – PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



Summary for Graph 2.3

Female users make up less than 50% of the population in all mental health facilities in the country. The proportion of female users is highest in community residential facilities and lowest in mental hospital.

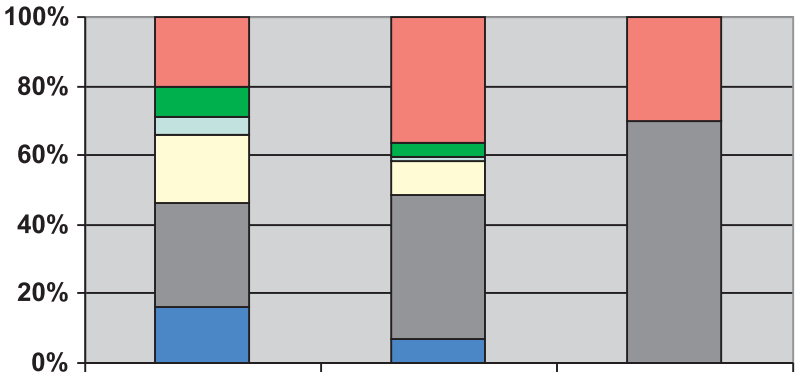
GRAPH 2.4 – PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES AMONG ALL USERS



Summary for Graph 2.4

The percentage of users that are children and/or adolescents varies substantially from facility to facility. The proportion of children users is highest in community residential facilities and lowest in outpatient facilities and zero in mental hospital.

GRAPH 2.5 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS

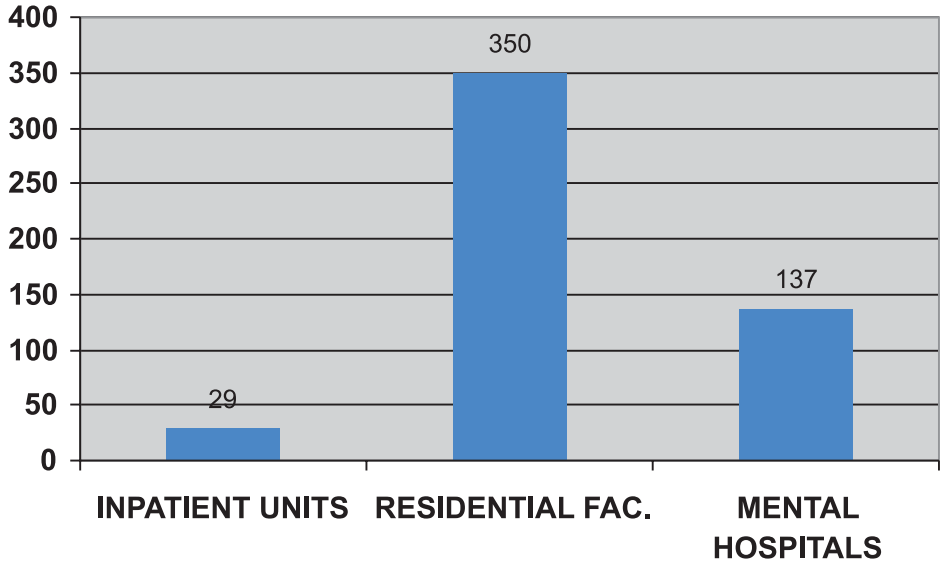


	OUTPATIENT FAC.	INPATIENT UNITS	MENTAL HOSPITALS
MOOD DISORDERS	20%	37%	30%
OTHERS	9%	4%	0%
PERSONALITY DIS.	5%	1%	0%
NEUROTIC DIS.	20%	10%	0%
SCHIZOPHRENIA	30%	42%	70%
SUBSTANCE ABUSE	16%	7%	0%

Summary for Graph 2.5

The distribution of diagnoses varies across facilities: in outpatients facilities neurotic disorders, mood disorder and schizophrenia are most prevalent, within in-inpatient units schizophrenia and mood disorders diagnoses are most common, and in the mental hospital schizophrenia and mood disorder diagnoses are most frequent.

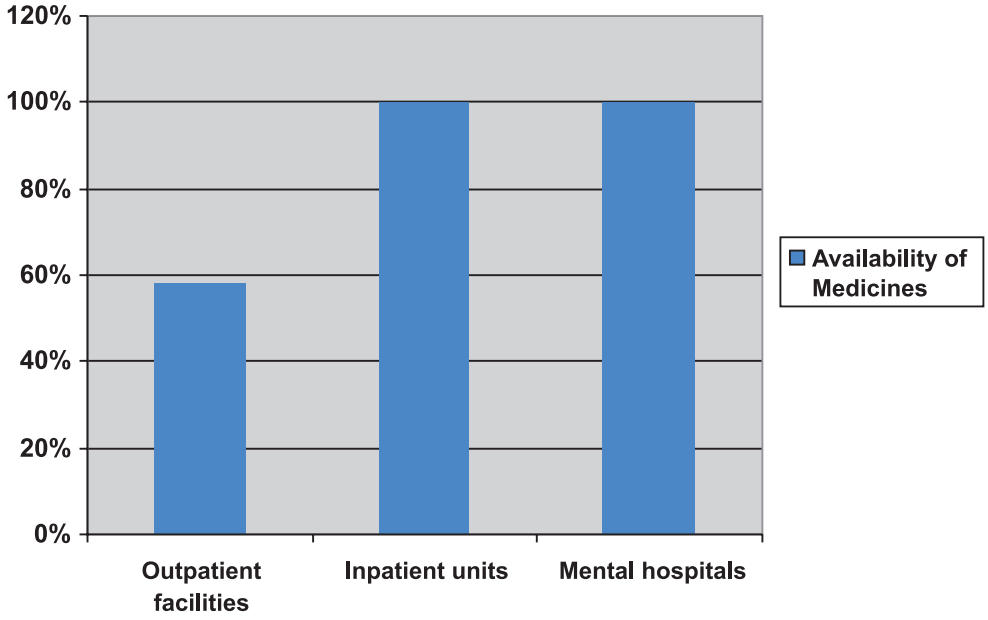
GRAPH 2.6 – LENGTH OF STAY IN INPATIENT FACILITIES
(days per year)



Summary of Graph 2.6

The longest length of stay for users is in community residential facilities, followed by the mental hospital and then community-based psychiatric inpatient units.

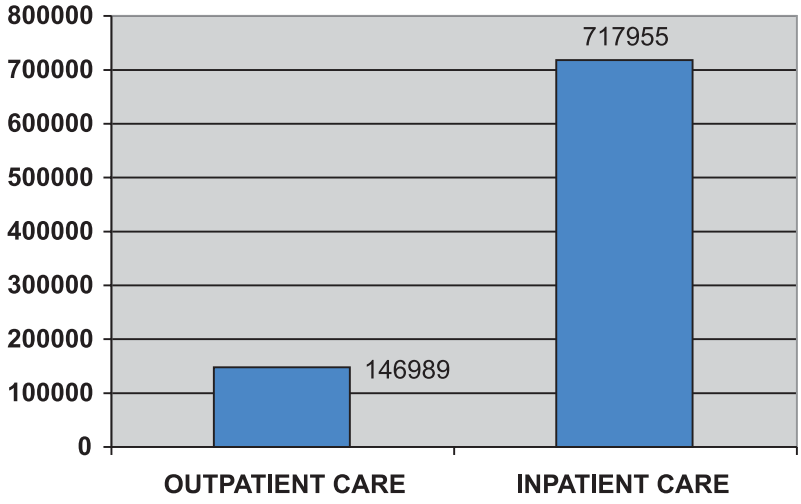
GRAPH 2.7 – AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



Summary for Graph 2.7

Psychotropic drugs are most widely available in the mental hospital and inpatient units followed by outpatient mental health facilities.

GRAPH 2.8 – INPATIENT CARE VERSUS OUTPATIENT CARE



Summary of Graph 2.8

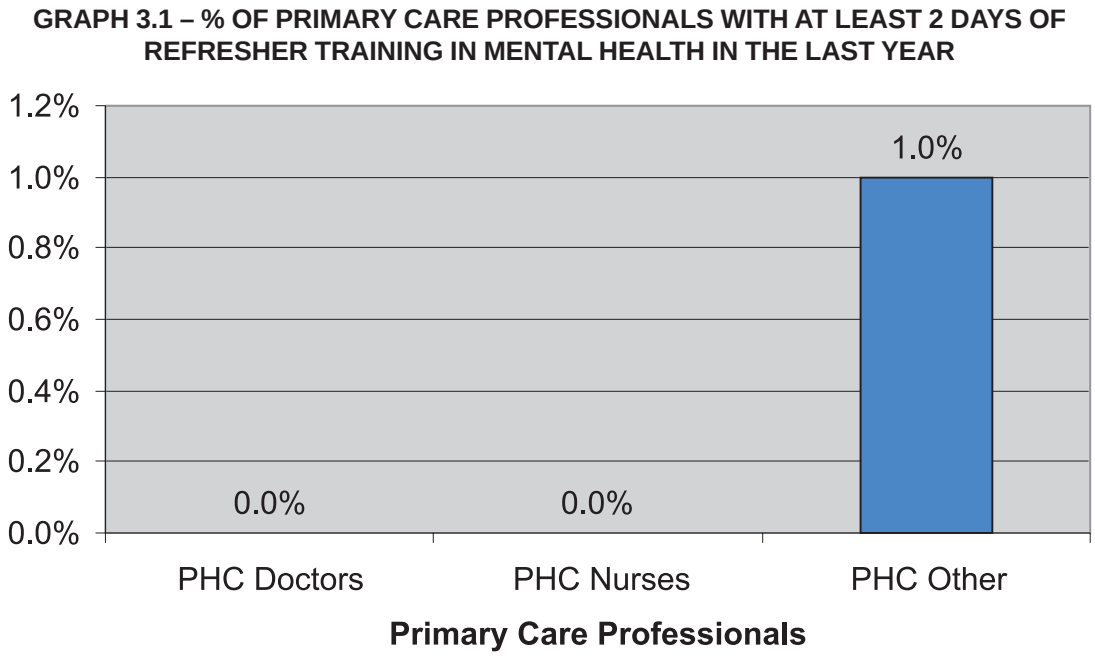
The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospital, residential facilities and general hospital units) is an indicator of extent of community care: in this country the ratio is 1:5.

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

Four percent of the training for medical doctors is devoted to mental health, in comparison to 2% for nurses and 0% for non-doctor/non-nurse primary health care workers. In terms of refresher training, very few (almost 0%) primary health care doctors have received at least two days of refresher training in mental health, 0% of nurses and 1% of non-doctor/non-nurse primary health care workers have received such training.

Graph 3.1: Percent of primary health care professionals with at least two days of refresher training in mental health in the last year

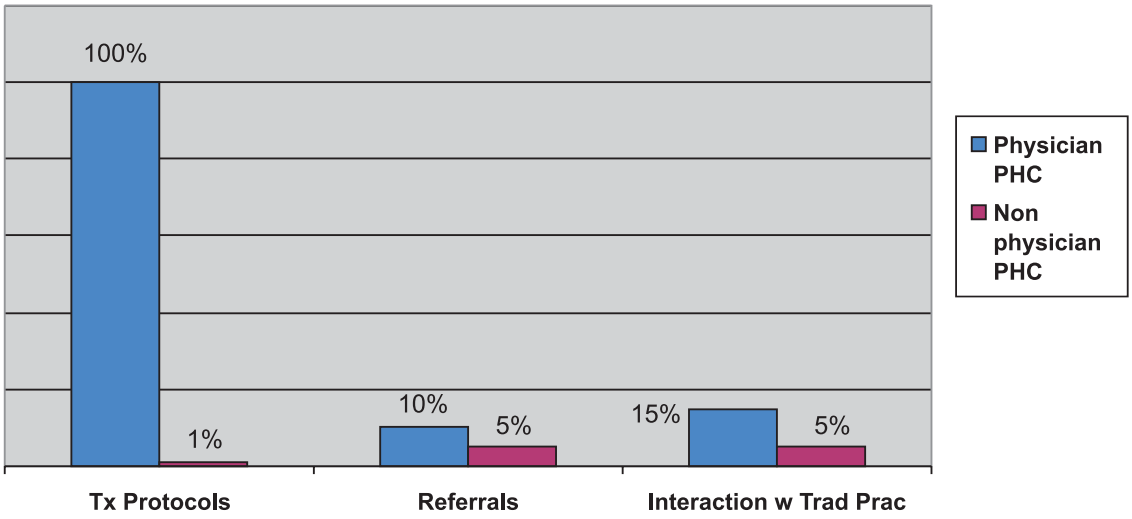


Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. In terms of physician-based primary health care clinics, all or almost all clinics (81-100%) have assessment and treatment protocols for key mental health conditions available, in comparison to only a few clinics (1-20%) in non-physician-based primary health care. A few (1-20%) of physician-based primary health care doctors make on average at least one referral per month to a mental health professional. Some of non-physician based primary health care clinics (1-20%) make a referral to a higher level of care. In terms of professional interaction between primary health care staff and other care providers, some (21-50%) of primary care doctors have interacted with a mental health professional at least once in the last year. Only a few (1-20%) of physician-based PHC facilities, a few (1-20%) of non-physician-based PHC clinics and a few (1-20%) of mental health facilities have had interaction with a complimentary/ alternative/traditional practitioner.

Graph 3.2: Comparison of physician-based primary health care with non-physician based primary health care

GRAPH 3.2 – COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE



Prescription in primary health care

Primary health care nurses and non-doctor/ non-nurse primary health care workers are not allowed to prescribe psychotropic medications in any circumstance. In contrast primary health care doctors are allowed to prescribe psychotropic medications without restrictions. As for availability of psychotropic medicines, all or almost all of physician-based primary health care clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) in comparison to no clinics (0%) in non-physician-based primary health care.

Domain 4: Human Resources

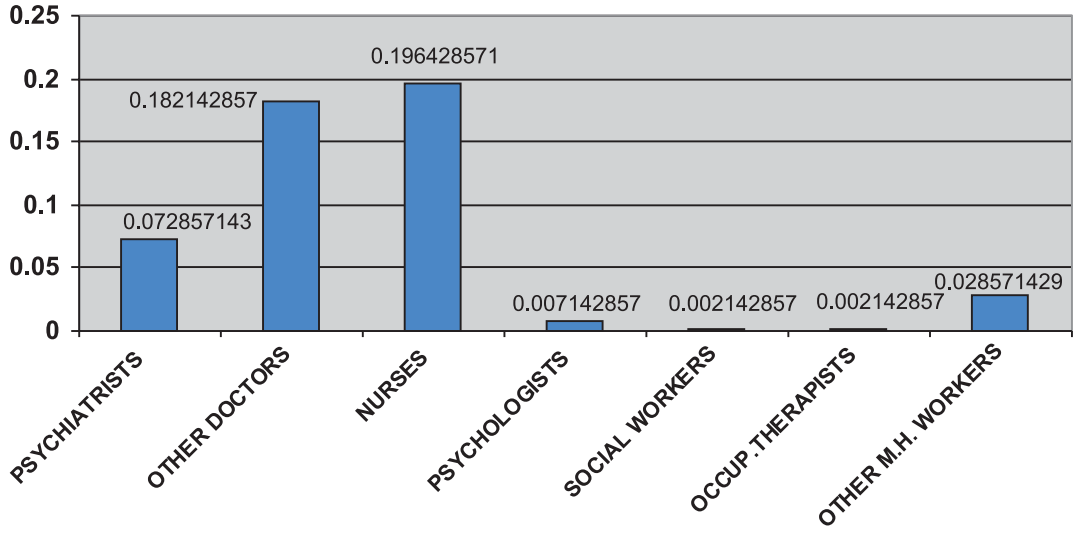
Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 population is 0.49. The breakdown according to profession is as follows: 0.072857143 psychiatrist, 0.182142857 other medical doctors (not specialized in psychiatry), 0.196428571 nurses, 0.007142857 psychologists, 0.002142857 social workers, 0.002142857 occupational therapists, 0.028571429 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors). Other medical doctors, not specialized in psychiatry did not include primary

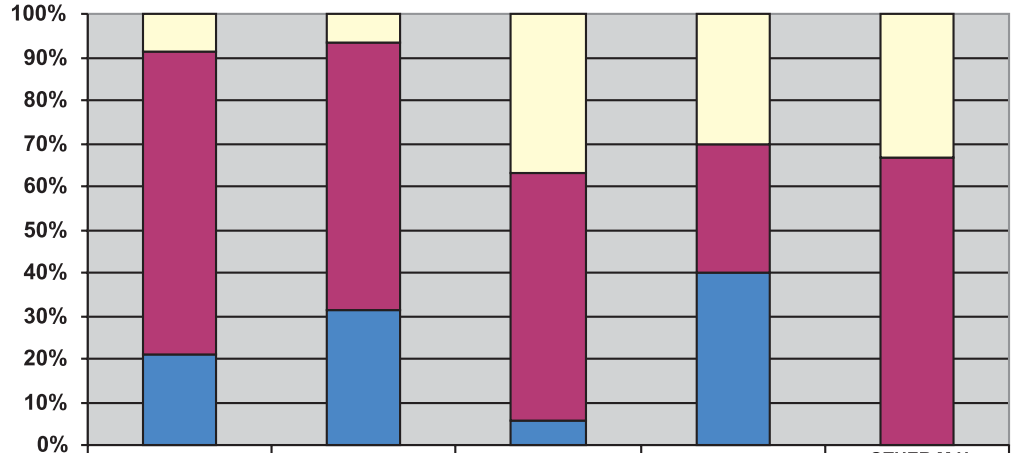
health care doctors trained on mental health. Other health or mental health workers also did not include health workers trained on mental health.

Majority of psychiatrists (54%) work for both government administered mental health facilities and for profit mental health facilities/private practice and 46% work for NGOs/for profit mental health facilities/private practice. Private practice is allowed for psychiatrists working in government service in Bangladesh. So all psychiatrists working in government sectors (54%) are doing private practice also. Sixty-two percent of psycho-social staffs (psychologists, social workers, nurses and occupational therapists) work for government administered mental health facilities, 26% work only for NGOs/for profit mental health facilities/private practice, while 12% work for both the sectors. Regarding the workplace, 10 psychiatrists work in outpatient facilities, 33 in community-based psychiatric inpatient units and 4 in mental hospital. Seventy medical doctors, not specialized in mental health, work in outpatient facilities, 140 in community-based psychiatric inpatient units and 15 in mental hospital. As for nurses, 21 work in outpatient facilities, 220 in community-based psychiatric inpatient units and 140 in mental hospital. Four psychosocial staffs (psychologists, social workers and occupational therapists) work in outpatient facilities, 3 in community-based psychiatric inpatient units and 3 in mental hospital. As regards to other health or mental health workers no one works in outpatient facilities, 20 work in community-based psychiatric inpatient units and 10 in mental hospital. In terms of staffing in mental health facilities, there is 0.04 psychiatrist per bed in community-based psychiatric inpatient units, in comparison to 0.01 psychiatrist per bed in mental hospital. As for nurses, there is 0.27 nurse per bed in community-based psychiatric inpatient units, in comparison to 0.28 per bed in mental hospital. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there is 0.02 per bed for community-based psychiatric inpatient units, and 0.03 per bed in mental hospital. The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 5 times greater than the density of psychiatrists in the entire country. The density of nurses is 5 times greater in the largest city than the entire country.

GRAPH 4.1 – HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)

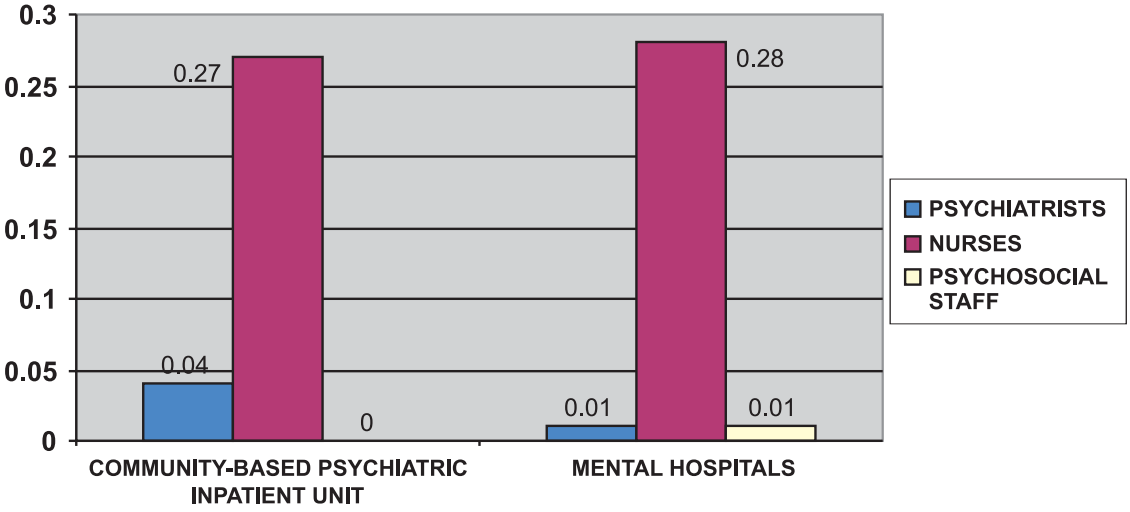


GRAPH 4.2 – STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



	PSYCHIATRISTS	OTHER DOCTORS	NURSES	PSYCHOSOCIAL \ STAFF	OTHER M.H. WORKERS
MENTAL HOSPITALS	4	15	140	3	10
INPATIENT UNITS	33	140	220	3	20
OUTPATIENT FAC.	10	70	21	4	0

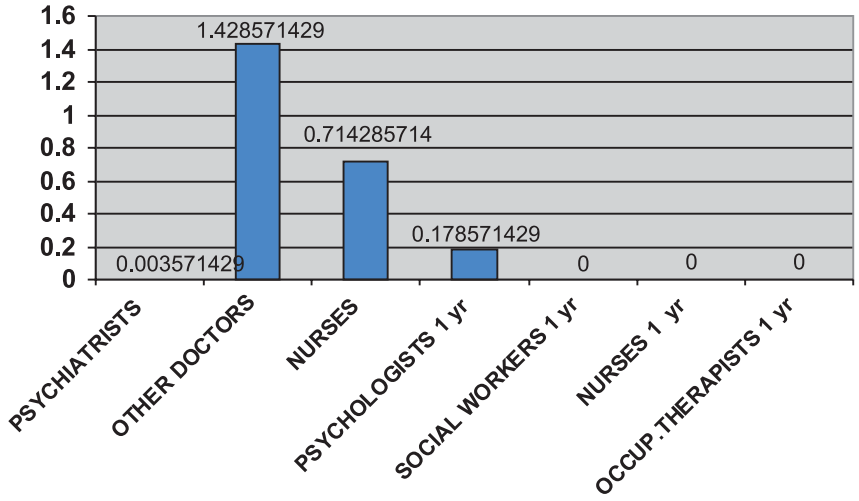
GRAPH 4.3 – AVERAGE NUMBER OF STAFF PER BED



Training professionals in mental health

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 0.0036 psychiatrists, 1.43 medical doctors (not specialized in psychiatry), 0.71 nurses (not specialized in psychiatry), 0.18 psychologists with at least 1 year training in mental health care, 0 nurses with at least 1 year training in mental health care, 0 social workers with at least 1 year training in mental health care and 0 occupational therapists with at least 1 year training in mental health care. Between 1 and 20% of psychiatrists emigrate to other countries within five years of the completion of their training.

GRAPH 4.4 – PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



Consumer and family associations

There is no consumer association. There is 1 family association which has 40 family members. The government does not provide economic support for the family association. The family association has not been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. There is no interaction between mental health facilities and consumer or family association. In addition to consumer and family associations, there are 10 NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups.

Domain 5: Public Education and Links with Other Sectors

Public education and awareness campaigns on mental health

There is a coordinating body (National Institute of Mental Health, Dhaka) to oversee public education and awareness campaigns on mental health and mental disorders. Ministry of Health & Family Welfare, NGOs, professional associations, private trusts and foundations and international agencies have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: general population, children, adolescents, women and trauma survivors.

Legislative and financial provisions for persons with mental disorders

There are no legislative and financial provisions to protect and provide support for users in respect of employment of disabled, protection from discrimination (dismissal, lower wages) solely on account of mental disorder, priority in state housing and in subsidized housing schemes for people with severe mental disorders, protection from discrimination in allocation of housing for people with severe mental disorders.

Links with other sectors

There are formal collaborations between the government department responsible for: mental health and the departments/agencies responsible for primary health care / community health, substance abuse, welfare and criminal justice. In terms of support for child and adolescent health, no primary and secondary school has either a part-time or full-time mental health professional and no primary and secondary school has school-based activities to promote mental health and prevent mental disorders. Regarding mental health activities in the criminal justice system, the percentage of prisoners with psychosis and mental retardation are unknown. A few prisons (between 1-20%) have at least one prisoner per month in treatment contact with a mental health professional. As for training, a few (between 1-20%) police officers and a few (between 1-20%) judges and lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, no mental health facility has access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, 5% of people who receive social welfare benefits do so for a mental disability.

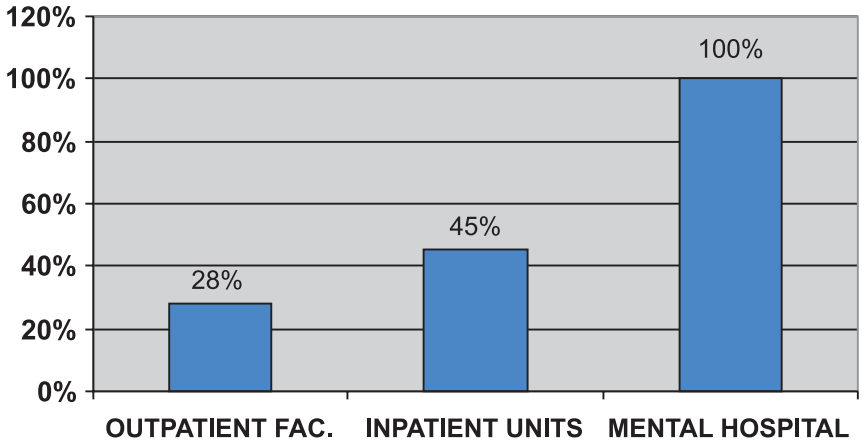
Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by some mental health facilities exists. This list includes number of beds, admissions, length of stay and patient diagnoses in mental hospital. The government health department received data from 100% mental hospital, 45% community based psychiatric inpatient units, and 28% mental health outpatient facilities. However, no report was published with comments on the data. In terms of research, 5% (according to pubmed) of all health publications in the country were on mental health. The research focused on the following topics: epidemiological studies in community samples, non-epidemiological clinical assessments of mental disorders, pharmacological and electroconvulsive interventions.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

TYPE OF INFORMATION COMPILED	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100%	UN	NA
N° inpatient admissions/users treated in outpatient facilities	100%	UN	UN
N° of days spent/user contacts in outpatient facilities.	100%	UN	UN
N° of involuntary admissions	0%	UN	NA
N° of users restrained	0%	UN	NA
Diagnoses	100%	UN	UN

GRAPH 6.1 – PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT



Strengths and Weaknesses of the Mental Health System in Bangladesh

Providing mental health services through trained primary health care physicians and health workers using existing government health network that is extended up to grass root level is the ongoing programme of the government.

There is one 500 bedded mental hospital in the country, where most of the patients remain admitted for long time leading to service provision for small number of people with bigger investment. The spectrum of community mental health facilities are increasing but the existing service is quite inadequate. The inpatient service is inadequate in comparison to outpatient care though the outpatient care is also insufficient. There are no mechanisms for supervision and protection of human rights of mental patients in the country. Mental health services are accessible to all people of the country irrespective of social class, religion, language and ethnicity. Special efforts are needed to make it more accessible to poor, tribal minority and the vulnerable. Less than 0.5% of government health budget is spent for mental health and about 67% of that is spent for mental hospital serving a small number of long stay patients. Training on mental health for primary health care physicians and primary care health workers are ongoing government programmes for more than two decades but the number of trained staff is still less than required number. Essential psychotropic medicines are satisfactorily available in Mental Hospital and the National Institute of Mental Health, but not widely available in general hospital psychiatry units. There is only one small family association in the country and no consumers' association exist. No good interaction exists between the family association and mental health service facilities. Mental health service is a formal activity of health ministry. Linkage with education, criminal, justice and other relevant sectors are informal which needs to be officially linked. Mental health care providers interact with primary care staffs during their training on mental health, out-reach programme,

awareness meeting with public, field survey and such other related activities. Initiatives have been taken to maintain continuous communication with four model upazillas (sub-districts) around capital city to develop community mental health services. A mental health policy and plan has been approved by government in 2006. A draft of the Mental Health Act is yet to be approved and enacted by government. The mental health information system is yet to start functioning formally, but its importance is intensely felt for development of evidence-based psychiatry in the country.

Progress is being made in overcoming the weakness of mental health service system but it should be accelerated keeping pace with the need of the time. Absence of separate mental health wing in the health ministry, inadequate awareness among people of relevant sectors, unsatisfactory co-ordination system, limitation of manpower, logistic and financial support are among the prime barriers to progress. The factors facilitating progress are an emergence of new leadership, increasing attention by relevant sectors including WHO, increasing number of qualified and trained manpower and recent development of policy and plan on mental health.

Next Steps in Strengthening the Mental Health System

Community based mental health facilities needs to be strengthened through broadening the existing training of primary health care physicians and primary health workers. Strengthening of existing outpatient and inpatient psychiatric facilities in the general hospitals and creation of such facilities in private medical college hospitals and big general hospitals existing at the divisional and greater district level may be considered important steps for development of community mental health services. Initiatives for development of qualified and trained manpower are also urgently needed. Awareness and promotional campaign on mental health involving relevant sectors are also needed.