effect of the country's depleting oil reserves. The economy has not significantly diversified; if the prosperity dries up along with the oil wells, foreign workers are likely to leave. An exodus of Brunei's expatriates would be devastating for the mental health services, whose medical staff is composed entirely of foreigners. Psychiatry remains an unpopular choice of career with Brunei's small number of medical graduates, who are mostly trained in the UK, where they usually have a few weeks' exposure to psychiatry as undergraduates. A handful of Bruneian junior doctors are currently training as psychiatrists in nearby countries, but it is unlikely that a fully trained Bruniean psychiatrist will emerge for a number of years.

The mental health services face a number of tasks. The priorities are to raise the profile and understanding of psychiatry, as well as to undertake epidemiological research. There are plans to expand specialist services but these developments are already facing paralysing bureaucracy. Furthermore, there is a need for psychological treatments as well as better and newer drugs to be made available. The most ominous of unmet needs, however, is the establishment of drug treatment services. Finally, a new Mental Health Act is being drafted; it is hoped that it will afford greater protection to patients and will take account of the opinion of psychiatrists in the process of involuntary detention.

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COUNTRY PROFILE

Nepal: trying to reach out to the community

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Sandwiched between India and China, Nepal is a small landlocked lower-middle-income country in South Asia. Once a peaceful country, it is striving to overcome the legacy of a 10-year Maoist rebellion, a royal massacre and continuing political chaos. Nepal has been in dispute with neighbouring Bhutan over the repatriation of hundreds of thousands of refugees in several camps in Nepal. In addition, the country experiences frequent natural disasters (floods and landslides) and faces several environmental challenges, including deforestation and a population explosion in southern Nepal.

Slightly bigger than England in size, Nepal is 885 km long and 200 km wide, with an area of 147 181 km^2. It has a total population of nearly 28 million, and an annual population growth rate of 2.2%. Life expectancy at birth is 63 years. Almost 90% of the population still live in rural areas and 38% live below the poverty line. Nepal has an annual per capita income of less than US$300 (compared with US$800 in India and over US$1700 in China).

Health resources and statistics

Healthcare facilities in Nepal are generally poor (Box 1) and beyond the means of the majority. The provision of health services is constrained by low government spending, rugged terrain, lack of health education and poor public expectations. Most hospitals are located in urban areas; rural health facilities often lack adequate funding, trained staff and medicines and have poor infrastructure. In rural areas, patients sometimes have to be carried in a basket through the mountains for 3 or 4 days to reach the nearest primary care centre, which may in any case be devoid of trained medical personnel.

For administrative purposes, Nepal has been divided into five developmental regions, 14 zones and 75 districts. According to the institutional framework of the Department of Health Services, which is one of three departments under the Ministry of Health and Social Welfare, the sub-health posts (SHPs) are the first contact point for basic health services. Each level above the SHP is a referral point in a network from SHPs to health posts to primary care centres, and to district, zonal and regional hospitals, and finally to the specialist tertiary care centres in Kathmandu. Nepal currently has 10 tertiary care centres, 83 hospitals, 700 health posts and 3158 SHPs. There are a few private non-profit hospitals as well. Almost all the private sector hospitals, including those run by non-governmental organisations, and private, profit-oriented nursing homes are situated in the urban areas.

There are no national epidemiological data on mental health problems in Nepal, but data from other developing countries can help estimate the situation reasonably well.

Box 1 Health-related facts and figures about Nepal

National health budget for 2007/08	US$187 million
Current per capita health expenditure	US$6.9
Health budget as a proportion of national budget	
2007	5%
2009 (projected)	7%
WHO-recommended EHCS (essential healthcare services) package (minimum)	US$35
Number of registered doctors in Nepal	6719
Number of doctors employed by the government	1259
Doctor:population ratio	1:5000
Total number of registered nurses	11 637
Maternal mortality ratio/100 000 live births	
1996	539
2009 (projected)	300
Infant mortality rate/1000 live births	
2001	64
2009 (projected)	45

Box 2 Mental health services and resources in Nepal

Population	28 million
Mental health budget as a proportion of the total health budget	0.8%
Number of psychiatrists	39
Numbers of psychiatric beds	
government sector	94
medical college hospitals	196
private hospitals/nursing homes	25
non-governmental organisations	70
total number of psychiatric beds	385
Psychiatric bed:population ratio	1:70 129
Child psychiatrists	0
Old age psychiatrists	0
Neurologists	8
Clinical psychologists	> 9
Psychiatric nurses	48
Psychiatric social workers	0
Occupational therapists	1
NGOs in mental health	> 8

According to the largest international psychiatric epidemiological study so far, by Wang *et al* (2007), unmet needs for mental health treatment are especially worrying in low-income countries. That study, which involved almost 85 000 people in 17 countries, revealed that at least two-thirds of people who are mentally ill receive no treatment. One Nepalese study indicated a high point prevalence (35%) of 'conspicuous psychiatric morbidity' (Upadhyaya & Pol, 2003). Common mental illnesses recorded at a recent mental health camp in eastern Nepal included depressive illness, anxiety disorders, schizophrenia, bipolar affective disorder, substance misuse and dementia (Jha, 2007); the camp was also inundated by people with learning disability, epilepsy and complaints of headache. Most people still think that mental illness means becoming crazy or lunatic, being possessed by spirits or losing control of oneself (Regmi *et al*, 2004). Although such perceptions are changing, the majority of the public and even of mental health professionals still believe that mental illness is caused by bad fortune (Shyangwa *et al*, 2003).

The number of psychiatrists has grown from one in 1961 to 40 at present. Although the increase looks dramatic, it is less than one psychiatrist per year. Even in relation to South Asian countries with a comparable cultural and political history, Nepal is under-resourced in terms of mental health staff and services (Box 2). There are fewer than 400 psychiatric beds, only 39 psychiatrists and 48 psychiatric nurses, for a population of some 28 million. There are neither child nor old age psychiatrists, nor any psychiatric social worker in the country. The total number of professionals working in mental health facilities, including the private sector, is only 0.59 per 100 000 population (World Health Organization, 2006).

Mental health policy

The national mental health policy and plan were developed and adopted by the Nepalese Ministry of Health in 1997, but, over 10 years later, they still exist only on paper. The policy nevertheless is meant to ensure the availability and accessibility of mental health services for the entire population, through an integrated mental and general health system, to prepare an adequate mental health workforce, to formulate mental health legislation and to improve mental health awareness among the general public.

On the positive side, there has been some improvement in terms of postgraduate psychiatric training and the introduction of mental health topics in the curriculum of community health workers. Other developments include programmes for traditional healers on orientation and sensitisation to mental disorders and epilepsy.

Mental health legislation and human rights

There is at present only a draft Mental Health Act in Nepal, and existing practices are based on obsolete laws. The draft Act has created a risk of introducing mental health legislation without the resources necessary to implement it and safeguard human rights. It has a provision for the detention of people who are mentally ill, for assessment and treatment at the only mental hospital, in Kathmandu. Moreover, as happens in some parts of India, treatment and restraint of acutely disturbed unwilling patients are being done in a way which is full of good intentions but which is not technically legal and which is fraught with possibilities of human rights violations (Kala & Kala, 2007).

There are no psychiatric services in any prison and no separate forensic psychiatric service in the country (World Health Organization, 2006).

Medical education

Medical education started in Nepal in 1978 and the first batch of doctors graduated in 1984. Until 1996, there were only two medical schools; now there are 12 of them (including private schools), which produce over 1000 doctors a year. Several schools run postgraduate medical programmes, but only two have facilities for higher psychiatric training. The quality of these training programmes, including their research components, requires improvement to suit local needs.

In terms of training for primary care staff, only 2% of the training for both medical doctors and nurses is devoted to mental health. One non-governmental organisation is running a community mental health service in seven of the

75 districts of the country. In these seven districts, primary health workers receive regular refresher mental health training (World Health Organization, 2006).

Mental health services

The World Health Organization (2001) has recorded extremely low levels of mental health service in most developing countries, and Nepal is no exception. A recent assessment of Nepal's current mental health system revealed that the services are not organised in terms of catchment areas (World Health Organization, 2006). There are 18 out-patient facilities, 3 day hospitals and 17 psychiatric in-patient units, in addition to one mental hospital, to serve the entire country.

As the community mental health services are conspicuous by their absence, there is no follow-up care. Community mental health services are limited to a small area in Nepal. The United Mission to Nepal (UMN) initiated community work in 1984 and carried out a series of successful community surveys and training programmes (see, for instance, Wright *et al*, 1989). The development of a national community mental health programme is the most important issue for the Ministry of Health to address. While the importance of psychosocial rehabilitation is recognised, its practice is extremely limited. Similarly, there are no specialist psychiatric services for children or older people, and for those with substance-related disorders the only specialist provision is a de-addiction ward at Tribhuvan university teaching hospital, Kathmandu.

Challenges and outlook

The near-term future of Nepalese psychiatry does not look bright. If basic mental healthcare is to be brought within reach of the mass of the Nepalese population, this will have to be done through the implementation of the national mental health policy. The World Health Organization (2006), in conjunction with the Nepalese Ministry of Health, has mapped out mental health services and resources for the first time. This is a welcome development and may pave way for future initiatives.

Finally, people affected by the decade-long Maoist civil war, especially women and children, may present with trauma-related psychiatric problems requiring culturally sensitive interventions. Nepal would require international help and support to carry out relevant research to understand and address new and existing mental health challenges.

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COUNTRY PROFILE

United Arab Emirates (UAE)

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This paper will focus on the current state of mental health services in the United Arab Emirates (UAE) and reflect on the various public health, socio-economic and psychosocial factors that have a major impact on the mental health needs of the population. It is to be borne in mind that the services described in this paper are in a state of rapid change, as the country is witnessing one of the fastest rates of development in the world.

Society and culture

Situated in the Arabian Gulf, the UAE has an approximate area of 84 000 km^2 and a population of 4.1 million (UAE Census, 2005). Males constitute 67.6% of the population and females 32.4%; 20% are under the age of 15 years and only 1.8% are aged over 60 years (UAE Census, 2005). The literacy rate is 75.6% for men and 80.7% for women. Only 21.9%