to offer services based on the population's felt needs and to implement actions based on informing the population about mental disorders, their expression and treatment.

Discussion

That part of the Mexican population living in inequity and poverty experience many stressful situations, such as instability, lack of safety, violence, desolation and family problems, resulting in frequent emotional distress. It is important to distinguish between this emotional distress as a natural response to adverse situations (and to treat it as such) and 'psychiatric disorder'. On the other hand, poverty also increases the risk of the occurrence of mental disorders, which need proper detection and treatment to reduce the burden they place on this population.

The main questions arising are:

- where to draw the line between distress and disorder
- how to deal with emotional distress without pathologising suffering yet preventing the risk of mental disorders from increasing
- how to increase awareness among mental health professionals regarding the population's distress, concerns and needs, which are not always described in psychiatric manuals
- how to sensitise and educate people of low SES about mental disorders to reduce the period of latency between the onset of the disorder and their seeking care.

Achieving better mental health coverage entails both increasing the supply of services, especially in primary care, and adapting them to the population's needs, which are clearly linked to social and economic inequities, gender discrimination, violence and other health conditions. In this respect, as Desjarlais *et al* (1995) suggest, 'the link between the social context and public health is a social event and should be acknowledged as such'. Thus, no mental health strategy can be proposed outside a state policy that guarantees minimum conditions of well-being for vulnerable groups in relation to the satisfaction of basic needs, such as food, housing and the right to education and health.

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COUNTRY PROFILE

The country profiles section of *International Psychiatry* aims to inform readers of mental health experiences and experiments from around the world. We welcome potential contributions. Please email ip@rcpsych.ac.uk

Psychiatry in Kuwait

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This paper describes the historical background, development and current status of psychiatric services in Kuwait. In addition, present practices and the outlook for further development of services are outlined.

Kuwait is a rich oil-producing country with a gross domestic product (GDP) of US$74.6 billion and an area of 17 820 km^2. The mid-year population of Kuwait in 2007 was 3 399 637, of whom 30.75% were Kuwaitis, while expatriates, mainly from the Indian subcontinent (39%) and other Arabs (22%), made up the rest (Public Authority for Civil Information, 2007).

The Ministry of Health (MOH) has, over the years, been the principal care provider in the country. Although a number of private hospitals (albeit regulated by the MOH) have taken up some of the load, delivery of psychiatric services is limited to the MOH hospitals. The health services are provided through five general hospitals (one for each health region), nine specialised hospitals, 78 primary healthcare clinics and 38 diabetes clinics, distributed uniformly across the country (Ministry of Health, 2006).

Prevalent beliefs and practices

Like all Arab communities, Kuwaitis believe in spiritual (*jinni*) possession, the 'evil eye' and sorcery; these are not

uncommonly invoked to explain changes in human behaviour (El-Islam, 1982). For example, obsessional ruminations are invariably attributed to the devil. Faith healers ('sheikhs' or 'masters') are the first source of help chosen by many Kuwaitis. They may recite Koranic verses, tie written verses to the patient's body in the form of amulets or offer the 'washings' of the verses (written on a plate) for drinking. Elaborate anti-sorcery practices by native healers involve the use of 'traces' of material that belong to the victim, to negotiate disengagement by the responsible adverse spirit. Cautery is used to counter painful conditions and also to drive away the *jinni*, presumed to have overwhelmed the minds of psychotic individuals. Many patients afflicted with mental illness never get to see a psychiatrist and are instead dealt with by faith healers.

Historical background

The MOH in 1950 first decided to provide psychiatric care for people who are mentally ill. The first asylum was built in Sharq, a district next to Kuwait City. An Egyptian psychiatrist and some Lebanese and Palestinian nurses were entrusted with responsibility for providing custodial care for patients with a mental illness, who were often chained. Shortly after his appointment, the same psychiatrist escorted a patient for treatment to the Al-Asfouria Hospital in Lebanon, one of the modern hospitals at the time. Having witnessed the humane treatment being given to patients there, he decided to introduce similar trends in the management of psychiatric patients in Kuwait. In 1954/55, a barrack-style facility, named the Hospital for Mental and Neurological Diseases, was opened in Sulaibikhat Governorate, to which all psychiatric patients were transferred. Extensions to the hospital over the next decade increased the number of beds from 100 to 400. There were, though, only eight psychiatrists and one assistant registrar to staff the facility.

The psychiatric services remained more or less unchanged during the 1970s. Two major developments took place during the mid-1980s. First, an Amiri Decree (Law No. 74) led to the opening of a 60-bed drug addiction treatment centre. Secondly, the MOH agreed to set up out-patient psychiatric clinics in all the general hospitals.

By the end of 1989, the psychiatric services had begun to look fairly comprehensive. The hospital had more than 400 beds, and provided both an out-patient clinic service 5 days a week and ran a round-the-clock emergency service. Unfortunately, the psychiatric services, like all other institutions of the country, suffered a major setback on 2 August 1990 when Iraqi forces invaded the country. The addiction centre was demolished, all but severely disturbed patients were sent home, the hospital services were restricted to the minimum basic level and the staffing level was reduced to about 10%.

After the liberation of Kuwait on 24 February 1991, the hospital was in moribund state: it had no water supply and no air-conditioning system, and there was severe air pollution resulting from the burning of oil wells by the retreating Iraqis. The country's infrastructure had been ruined. Within 2 months, however, the MOH managed to recruit the necessary staff, and the delivery of the basic medical and psychiatric services was resumed. A specialist centre, the Al-Riggai Centre for Post Traumatic Stress Disorder (PTSD), was established and a Danish group was recruited to identify, evaluate and help patients suffering from PTSD.

In 1993, the main psychiatric hospital was renovated and the addiction centre reopened. Hospital services were regulated by dividing the staff into five units, each responsible for about a fifth of the population of the country. A forensic psychiatry unit was opened. The out-patient clinics in the general hospitals were resumed. A sleep laboratory with an electroencephalogram facility was established. The social services and psychology departments evolved over time, and began making substantial contributions to the delivery of services at all levels.

In 1996, the UK-based Priory Group was hired for 4 years to upgrade services. It was a welcome change. A rehabilitation unit was established. The hospital's policies and procedures were documented. A department of audit and quality assurance was established. The Royal College of Psychiatrists was approached for accreditation of the services, which prompted multiple visits by College delegates.

The Department of Psychiatry

The Department of Psychiatry, Faculty of Medicine, Kuwait University, established in 1984, is currently staffed by one associate professor, two assistant professors and two technicians. The Department's responsibilities include undergraduate and postgraduate teaching; conducting, supervising and promoting research; and the provision of clinical services in MOH hospitals. It provides block teaching to sixth-year undergraduate medical students, who attend psychiatric rotation in groups of 30–32 for 6-week periods three times a year. Consistent with the curriculum reform programme initiated in the year 2003 by the Faculty of Medicine, the Department has introduced a system of objective structured clinical examination (OSCE) and a clinical problem-based short-essay paper in its teaching programme. The teaching consists of 24 didactic lectures, 25 case conferences in which students are encouraged to present patients and 16 hours weekly of tutor-supervised contact with patients. The assessment procedures include in-course assessments (30%), consisting of a multiple-choice question (MCQ) paper and six OSCE stations, and an annual examination (70%), consisting of an MCQ paper, short-essay questions, eight OSCE stations, and a long case presentation.

The Department, assisted by two senior registrars, eight registrars, one psychologist and a social worker, provides comprehensive psychiatric services to its designated catchment area. Additional hospital-based responsibilities of the Department include organising the programme of continuing medical education (CME) and promoting research.

Training opportunities

Psychiatry has been the least favoured field for most young local graduates. Nonetheless, the recent improved provision described in the next section seems to have attracted a number of local young graduates. Four graduates, having successfully completed their residency programme abroad, have already returned and joined the MOH. Three more young Kuwaiti undergraduates are undergoing their residency

programmes in Canada. Another is currently doing her internship at Harvard Medical School. All of them completed the 1-year internship at the psychiatric hospital before proceeding abroad for higher psychiatric training. The recruitment of suitable supervisory senior staff and the documentation of general psychiatry and its sub-specialty training posts should lead to the development of a local postgraduate training scheme in the country.

Current status of services

The psychiatric services took a quantum leap with the completion of a new extension to the hospital in 2005. A new block with 262 beds (bringing the hospital's total to 691) was added and the old drug addiction treatment centre with 100 beds was replaced by a newly built facility with 225 beds. In addition to the existing forensic psychiatry and rehabilitation units, child and family, and old age psychiatry out-patient services were set up. The hospital staff offers advisory, supervisory and consultancy services to the Ministries of Social Affairs, Education and the Interior. The Ministry of Social Affairs has developed institutions for geriatric patients and those with intellectual disability. The Ministry of Education has developed special schools for children with intellectual disability. The Ministry of the Interior has set up a once-weekly out-patient clinic for detainees. All in all, the hospital runs 23 extramural psychiatric clinics organised by the respective ministerial facilities.

Human resources and adequacy of services

The main psychiatric hospital is staffed by 100 psychiatrists, 61 psychologists, 7 social workers and 451 nurses (Ministry of Health, 2006). There are 20.32 psychiatric and 6.61 substance misuse beds per 10 000 population, and 0.29 psychiatrists, 0.18 psychologists, 0.02 social workers and 1.32 psychiatric nurses per 10 000 population. This is grossly insufficient. Moreover, community psychiatric services are virtually non-existent. The services are restricted to the main psychiatric hospital, albeit with some out-patient clinics in general and specialist hospitals. The provision of services at primary health and community level is absent.

Psychiatric research in Kuwait

The Department of Psychiatry, together with the hospital staff at the MOH, has largely been responsible for psychiatric research in the country. It has generated more than 50 publications in peer-reviewed international journals during the past 10 years. The research areas have varied with epidemiological, social and biological psychiatry constituting the dominant themes.

Outlook

The past decade has witnessed substantial development of psychiatric services in Kuwait. The hospital delivers fairly comprehensive psychiatric and substance misuse services and a number of sub-specialties have been established. Psychiatry in Kuwait is regarded as a small specialty and there is room for development of allied disciplines, including psychology, social work and occupational therapy. The decentralisation of services to the level of general hospitals, polyclinics and setting up community psychiatric services and the drafting of a mental health act are some of the areas requiring much needed attention. The recruitment of suitably qualified staff to develop the general and the sub-specialty services and set up postgraduate training facilities is needed.

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COUNTRY PROFILE

Psychiatry in Ireland

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Ireland is the third largest island in Europe and the twentieth largest island in the world, with an area of 86 576 km^2; it has a total population of slightly under 6 million. It lies to the north-west of continental Europe and to the west of Great Britain. The Republic of Ireland covers five-sixths of the island; Northern Ireland, which is part of the United Kingdom, is in the north-east. Twenty-six of the 32 counties are in the Republic of Ireland, which has a population of 4.2 million, and its capital is Dublin. The other six counties are in Northern Ireland, which has a population of 1.75 million, and its capital is Belfast. In 1973 both parts of Ireland joined the European Economic Community. This article looks at psychiatry in the Republic of Ireland.