Mental health and conflict in the Middle East

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For the past decade, overt unrest and danger have typified daily life for many families in Iraq and Afghanistan, while in Egypt under the former regime a superficial appearance of political stability lay over a sense of deep discontentment. What impact does living in those circumstances have on mental health? We asked psychiatrists with personal knowledge of events in three countries that have recently been riven by war and revolution to discuss their experiences. Because so few objective data are available on the impact of stress in any of the three regions reviewed, the authors have inevitably relied in large part upon anecdote and upon news reports from the internet.

Afghanistan did not possess any dedicated mental health services until recently, as Drs Rahimi and Azimi describe in their historical review. Within the past 30 years much progress has been made, but the impact of the Soviet invasion, the period of Taliban rule and the subsequent attempts by Western powers to create stability led to a roller-coaster ride. It is telling that there are still no community mental health teams functioning in the country.

In Iraq, Drs Al-Uzri, Abed and Abbas describe continuing problems, with a high level of violence and trauma, with major mental health consequences. We should not forget that the international sanctions preceding the overthrow of Saddam Hussein devastated the ability of doctors in Iraq to provide adequate medical care, but it seems there has been some improvement in the past 5 years. Following the US-led invasion, and the breakdown of law and order throughout the country, many doctors emigrated for their own safety. It is heartening to learn they are beginning to return.

Finally, we have seen dramatic changes in Egypt since the 'Arab spring' last year. Early hopes of an orderly change to democratic rule are still not certain to be met, but the outcome of the presidential election is encouraging. Since the overthrow of Mubarak, a failure of coherent government has resulted in reduced safety for ordinary citizens, with many terrorist incidents and a surge of criminal activity throughout the country. Dr Nagy gives us a personal account of the difficulties faced by her patients at the present time. While Egypt formerly provided good mental healthcare for many of its citizens, the future is far from predictable.

MENTAL HEALTH AND CONFLICT IN THE MIDDLE EAST

War and the crisis of mental health in Afghanistan

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Mental health and psychiatric services in Afghanistan have gone through various stages of development and crisis but the long-term impact of recent wars and conflict on the country's mental health services has not been evaluated. What is obvious is the shortage of trained mental health professionals in the country.

Mental health services in Afghanistan have suffered from the continuous crisis in its recent history, and a few times were hit so badly as to stop functioning altogether. At their inception, psychiatric services started as a custodial in-patient care unit at Ali Abad Hospital in 1933. The main purpose of this unit was to provide teaching for students of the newly established medical school in Kabul as well as psychiatric services for the entire country. This

unit trained many renowned neuropsychiatrists in the country over the years and has continued teaching medical students at Kabul Medical University. At the same time, the unit attracted stigma and among the public there was a general fear that patients in this hospital were dangerous and therefore that people, especially children, should be kept away from this place. Patients were kept on a couple of locked wards and behind bars, with minimal facilities. The most catastrophic event occurred when one in-patient who had escaped from the hospital to the town jumped in front of a car which turned out to be carrying the Prime Minister of Afghanistan at the time. Angry, he ordered the removal of these patients from the city. A large number of patients from the hospital and the city were taken to a suburb of Kabul, Qala-e Zaman Khan, and buried alive. The rest were transferred to a 'secure' place in Jalal-Abad city, capital of Nangahar Province, where most of them were kept in chains for decades (Burna-Asefi, 1988).

Introduction of modern mental health services

With the return in 1985 of Dr Burna-Asefi (after 27 years of working in the UK), a psychiatrist who had trained in the UK, the Department of Mental Health was opened in the Ministry of Public Health, which replaced what was previously known as the Mental Hygiene and Rehabilitation Department. Kabul Psychiatric Hospital, with an open-door policy, was opened and community psychiatric services were introduced.

Despite the unwillingness of the regime at the time, mental health services developed to a high standard in a short period, mostly due to Burna-Asefi's efforts and the team he created of committed colleagues who devoted themselves to this work. Other services and initiatives such as supportive out-patient psychotherapy groups, 'day hospital' services that exist even now, the first national mental health programme, a mental health act, a detoxification centre and the recruitment of non-medical staff (e.g. psychologists, social workers and occupational therapists) in mental health facilities were introduced for the first time in the country and a close, cooperative relationship was built with the World Health Organization (WHO). However, the new psychiatric hospital was housed in a small dilapidated building that had previously belonged to an electronics factory, with no metal bars on windows or locks on the doors. Although the open-door policy was seen as frightening at the time and resisted by some people initially, it was finally accepted as a new method of patient care. A large number of medical and non-medical staff were sent to neighbouring countries as well as eastern Europe for short-term training while intensive 'in-service training' courses were introduced in the capital and major cities in Afghanistan. The first mental health outreach service was opened in Dasht-e Barchi, west of Kabul, in the 1980s, but was terminated after the mujahideen took Kabul. Mental health services were beginning to integrate

with primary healthcare and a few beds were opened in general hospitals both in Kabul and in a few other provinces. Despite continuous fighting between the mujahideen, the Soviet army and the then Soviet-backed government in Kabul from 1975 to 1992, mental health teams and facilities continued to function in Kabul and some major cities, but were by no means sufficient to meet the needs of the country.

Time of crisis

Mental health services had experienced great difficulties before the 1980s but with the April revolution in 1979 and occupation of the country by the Soviet Union the problems deepened. However, a major crisis took place with the defeat of the Soviet-backed government in 1992, from which services did not recover until the fall of the Taliban. What had been developed over the years (especially from 1985 to 1992) collapsed suddenly when the mujahideen took control of Kabul. Government was then in the hands of different factions of the mujahideen; lawless armed groups also became active and a full-blown civil war and criminal activities erupted in Kabul. Nearly all health facilities – including the mental health hospital, central office and four community centres – were looted, occupied by armed groups and ruined during the internal fighting. Patients who could escape left the hospital; the few patients with chronic conditions such as intellectual disabilities who remained in Marastoon, the long-stay sheltered accommodation facility, were subjected to atrocities, including the rape of female patients (Anderson, 1993). The first and the only detoxification centre, which had been opened in a rented building in Qala-e Jawad, was initially taken over by the owner but was later closed.

Most mental health staff, particularly senior staff, left Kabul to take refuge in safer provinces or left the country altogether. The brain drain was the biggest loss in a country that at best had only one trained psychiatrist and few core members of the mental health team who had developed leadership and management skills by being in the business for a long time. Some locally trained doctors working in the psychiatric hospital left to work for non-governmental organisations (NGOs) and international organisations in non-medical capacities. Those who stayed in the profession to keep nominal services going had to cope with financial difficulties and multiple traumas experienced directly by themselves or by their family members. The situation worsened during the Taliban era, when nearly all health services, including mental health services, were reduced to a minimum or became non-existent, although the Mental Health Act was revised in 1997, with the omission of only a few sentences.

Current situation

Since the fall of the Taliban, mental health services have slowly started to take shape again. In 2005 the Mental Health Department reopened at

the Ministry of Public Health but now under the Department of Preventive Medicine, that is, at a lower level than previously. Although the numbers of doctors working in psychiatry and of allied mental health professionals as well as the number of NGOs providing mental healthcare have increased over the past decade compared with the 1980s, the need for mental health and substance misuse services has also increased, to the extent that both government and private sectors, with the help of international donors, are still unable to meet the mental health needs of the public. The absence of mental health services for children and women remains one of the chief challenges.

Currently, there are around 60 locally trained psychiatrists working in the country but no trained psychiatric nurses; nor are there postgraduate courses for allied mental health professionals. All nurses in the mental health facilities are general nurses who are self-taught and gained their experience working in the facilities, until last year, when a UK-trained nurse took up the challenge of training the 17 nurses at Kabul Psychiatric Hospital.

There are around 30 drug detoxification centres in the country, each with a capacity of around 10–20 beds, mostly supported by international donors and run by the Ministry of Health and NGOs. The treatment offered in drug detoxification centres is usually symptomatic, with no community follow-up or psychosocial rehabilitation services. The relapse rates of drug misuse and psychiatric disorders must therefore be high, although there are no reliable statistics. Although the national Basic Package of Health Services has included a mental health component with a strong emphasis on bio-psychosocial counselling, there are still no community mental health teams functioning in the country.

Despite all the improvements, vast challenges still remain, including:

- the high prevalence of psychiatric disorders, particularly post-traumatic stress disorder and unrecognised depression
- the ready availability of narcotics, which has led to a sudden rise in drug addiction in the country
- the shortage of qualified mental health workers.

Until recently, heroin addicts gathered in large numbers under the bridges of Kabul city, which caused a public outcry. A government campaign to remove them as well as a very cold winter last year and a high volume of rain this spring helped to disperse them. No methadone replacement therapy exists for heroin users in the country except for a small pilot project run by Medicine de Monde.

Kabul Psychiatric Hospital is currently receiving financial and technical support from a project funded by the European Union (EU) but it is still in need of qualified staff.

Psychiatric education

Neuropsychiatry is taught at undergraduate level to medical students in years 4 and 5 and behavioural science is taught in the first year. A 3- to 5-year postgraduate training programme was introduced in all medical branches, including psychiatry, by the Ministry of Public Health, which is currently running in the psychiatric hospitals in Kabul and in the psychiatric wards of some regional/provincial hospitals. However, the country is in dire need of qualified psychiatrists and other mental health professionals to support these programmes.

Legislation and government strategy

Although a Mental Health Act was drafted in the 1980s it still has not been translated into practice. Patients are treated and kept in hospital mostly at the request of their relatives, who have to stay with them to stop them from leaving hospital. There is no legal protection for either staff or patients.

The Ministry of Health has developed a national mental health strategy at an estimated cost of \$40 million over 5 years, which needs to be raised by the ministry, and this represents yet another challenge.

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International Links: Faculty of Psychiatry of Intellectual Disabilities

Members of the College's Faculty of Psychiatry of Intellectual Disabilities are involved in sharing their skills and expertise in projects in low- and middle-income (LaMI) countries that work with people with intellectual disabilities. International Links is a subgroup of the Faculty that facilitates coordination within the College through its links with the International Affairs Committee. It is in the process of capturing the wealth of work that members are engaged in.

The group conducted a survey of Faculty members in 2012 that revealed their involvement in projects in 24 countries. As would be expected, the countries reflect the backgrounds and interests of the members of the Faculty, with many working in India and Pakistan. From the survey we know that the members have good links with non-governmental organisations (NGOs) and academic departments in African countries. Contact with central and eastern European countries is an emerging interest of some members. The level of involvement in projects ranges from direct clinical care to project development.

International Links plans to consolidate its contacts within the College and with colleagues and services in LaMI countries. It intends to offer routes to new members to assist them in joining current projects and in developing new ones. Members will share their clinical, leadership and managerial skills to advance projects by assisting in funding applications, to apply new perspectives to current projects and to ensure the perpetuation of existing work. The group will host a one-day conference of members in October 2012 to consult on the factors important in consolidating the work of International Links.

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