Mental health and psychosocial support in conflict situations in the Eastern Mediterranean Region: ideals and practice

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In the Middle East mental health and psychosocial support systems are underdeveloped. Seven critical factors are identified that hinder the initiation of well functioning mental health and psychosocial intervention programmes: 1) shortage of national professional leadership; 2) absence of infrastructure to support mental health and psychosocial programmes; 3) stigma around mental disorders; 4) multiple models of inter- vention; 5) lack of funding; 6) competing interests of non governmental organizations (NGOs) and UN organizations; and 7) insufficient political will and instability. Some of these obstacles will be addressed by the availability of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, but there is also a need for focussed and planned action to address the other factors.

Keywords: Inter-Agency Standing Committee (IASC), guidelines, mental health, psychosocial support, Eastern Mediterranean Region, obstacles

Introduction

During the last few years, a large number of books and documents have addressed the effects of war on mental health.[2] These combined efforts point to the significant impact of conflict and war on the mental health of survivors. Therefore, the develop- ment of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* is a major advance in this field.

Studies of the general population consistently show an increase in the incidence and preva- lence of mental disorders after war and violent conflict (Srinivasa Murthy, 2007). Women are more affected than men. Other vulnerable groups include: children, the elderly and the disabled. Further prevalence rates are associated with the degree of trauma and the availability of both physical and emotional support. A wide variety of psycho- social interventions ranging from skills for personal care to professional interventions like cognitive behaviour therapy have been used to mitigate the effects of war (Ritchie, et al., 2006). The following commentary addresses the relative failure of professionals and planners to implement mental and psychosocial interventions in countries during conflict. The observations are based on the author's personal experience of work- ing in the Eastern Mediterranean Region over a 4-year period (2003–2007).

A number of well conducted studies have documented the mental health impact of violent conflict on the general population in Middle Eastern countries such as: Afghanistan, Iran, Iraq, Lebanon, Palestine, Somalia, and Sudan (Srinivasa Murthy & Lakshminarayana, 2006) Unfortunately,

the expression of major concern found in these studies is not followed by sufficient actual interventions (WHO Eastern Mediterranean Regional Office (EMRO), 2002). In fact, the amount of intervention programmes addressing multiple mental health needs in the countries of the Middle East is either very insignificant or totally absent. As a result of reviewing the situation over the last five years, the following seven factors outlined below have been identified as major obstacles for the initiation of well functioning mental health and psychosocial intervention programmes.

Shortage of national professional leadership

The presence of active and motivated leaders among mental health professionals is an important prerequisite for the development of programmes in countries in conflict. For example, following the war with Iraq the authorities in Iran launched a national level mental health care programme, as well as the infrastructure for addressing the disaster/ conflict related mental health interventions. This response was driven by a large number of mental health professionals and the medical universities. A similar situation occurred in Lebanon. In contrast, in countries with limited or no mental health leadership, such as Afghanistan, Somalia and Sudan, in spite of decades of conflict no significant psychosocial or mental health programmes have come into force. Furthermore, this has not happened in spite of the availability of epidemiological studies in these countries highlighting the magnitude of the need.

Absence of infrastructure to support mental health and psychosocial programmes

Although psychosocial interventions should be mainly non institutional and community based, there is also a need for a specific mental health infrastructure to support psychosocial programmes. In the absence of such an infrastructure either as a result of destruction or because it never existed, psychosocial programmes do not take off. On the other hand, it is also important to note that in some countries, conflicts have sensitised the population and politicians to initiate mental health programmes. For example, in Afghanistan as a result of the need felt by the population, mental health was mentioned as one of the elements of the Basic Package of Health Services. However, it must also be said that, unfortunately, implementation of the mental health component is still in its preliminary phases.

Stigma over mental disorders

In all countries of Middle East, the stigma attached to mental disorders and the largely 'deviant' model applied to look at mental disorders, has been a barrier to population based initiatives towards self care, strengthening of resilience and promotion of appropriate coping strategies. Professionals in countries like Palestine, Iraq, and Sudan have pointed out this barrier to developing community based psychosocial interventions. Instead of an over emphasis on severe and often stigmatized mental disorders, there is an urgent need to focus on the larger psychosocial needs of the populations living in conflict situations. Such a shift could reframe emotional reactions as 'normal' reactions to an abnormal situation.

Multiple models of interventions

Until the guidelines were released in 2007, psychosocial interventions in countries in conflict have used a very wide variety of interventions, varying in focus, length of intervention, personnel involved and the role of the community. The lack of uniform messages and interventions has confused communities (Giacaman, 2004). It is expected that the guidelines may clear this hurdle.

Lack of funding

This has been an important factor as to whether programmes are implemented and sustainable. For example, in July 2003, a consultation on rebuilding mental health services in countries in conflict was organized in the WHO EMRO. All of the countries in conflict, like Afghanistan, Iraq, Sudan, Somalia and Palestine, were present. However, it was only in Iraq, that a well planned mental health programme took root, due to the availability of a 5 million US Dollar grant from the government of Japan. Without similar funds, in spite of many missions by professionals, no meaningful programmes have emerged in Afghanistan, Sudan, or Somalia.

Competing interests of NGOs and UN organizations

The need for a coherent approach to mental health and psychosocial interventions has been repeatedly emphasized. For example, the evaluation of the psychosocial services and mental health care in the occupied Palestinian Territories noted: *'there is no coherent approach to assessment and intervention. There is also insufficient evidence of the effectiveness of these approaches, within a Palestinian context'* (Giacaman, 2004). The guidelines, accepted by NGOs and UN organizations, should address this problem to some extent.

Insufficient political will and political instability

Souter, et al. (2006) examined the 15 countries of the WHO Eastern Mediterranean region that are included in the failed states index and found a correlation between a high position on the index and low numbers of mental health staff. The five eastern Mediterranean countries with the highest position in the failed states index (Sudan, 3; Iraq, 4; Somalia, 5; Yemen, 8 and Afghanistan, 11) had the smallest numbers of mental health staff. The results indicate that when a state and society are struggling to keep their integrity, mental health is not a priority. Realistic strategies from mental health advocates are needed to develop mental health services in such countries.

Only two of the seven obstacles (*'multiple models of interventions'* and *'competing interests of NGOs and UN organizations'*) will be addressed by the availability of the guidelines. There is need for focussed and planned action to address the other factors by:

- large scale anti-stigma programmes in the community,
- rebuilding of mental health infrastructure;
- building of national level leadership among mental health professionals;
- the investment of international funds for mental and psychosocial programmes and
- the creation of peace conditions.

These are continuous challenges in countries in conflict in the Middle East.

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[1] These views expressed are those of the author and not necessarily those of the organizations that he has worked with in the past.

[2] Among these are publications by the World Psychiatric Association (López-Ibor, J. J., Christodoulou, G., Maj, M., Sartorius, N., & Okasha, A., 2004) by the World Bank (Baingana F. & Bannon, I, 2004; Baingana, F., Bannon, I., & Thomas, R., 2005), by the United Nations (Green, B. L. et al., 2003) UNICEF (2005) the Harvard Trauma Group (Mollica, R. F., Guerra, R., Bhasin, R., & Lavelle, J., 2004) and a special issue of the International Review of Psychiatry in June 2007, on '*mass violence and mental health*'.

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