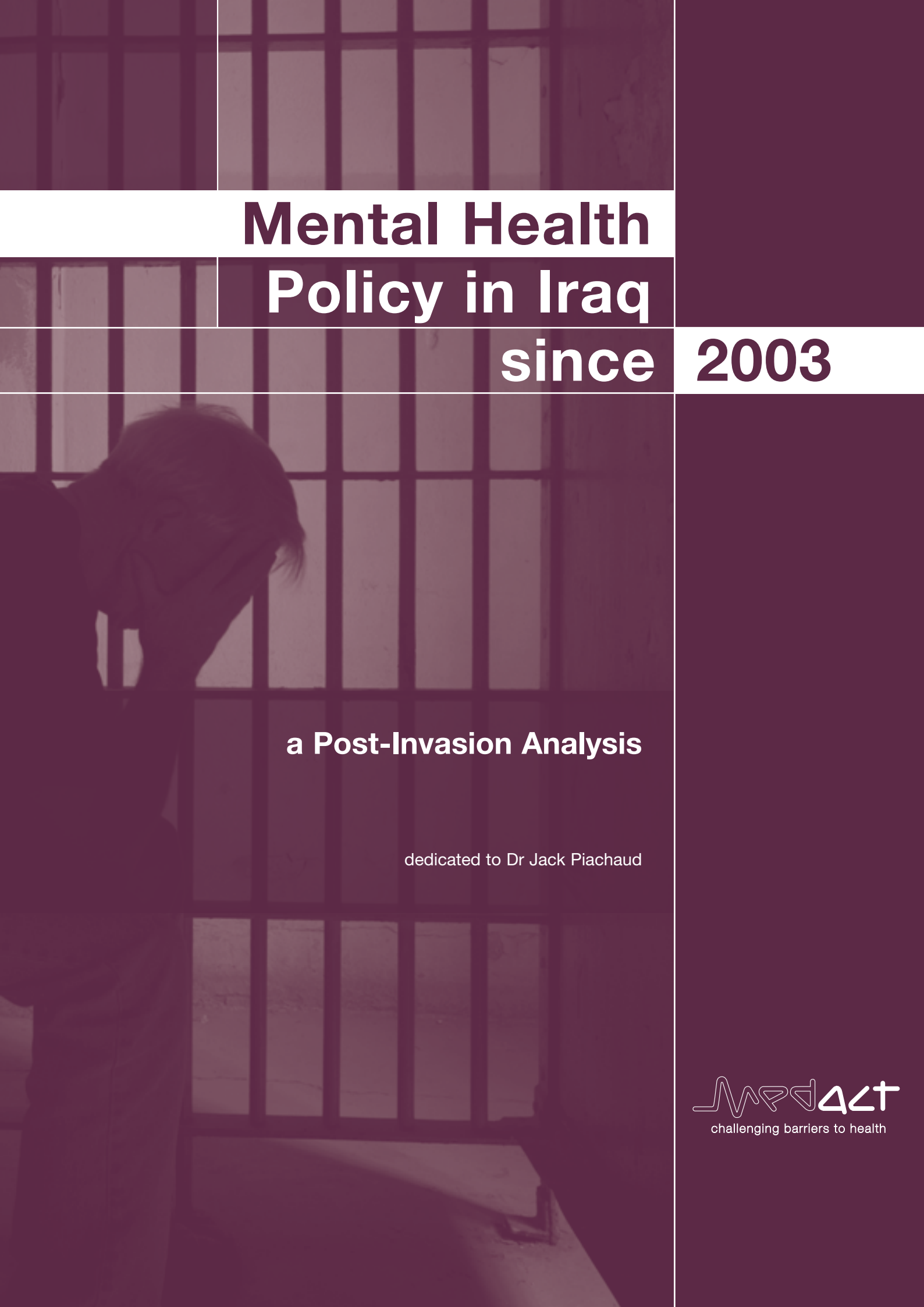

Mental Health Policy in Iraq since 2003

a Post-Invasion Analysis

dedicated to Dr Jack Piachaud

Medact
challenging barriers to health

This report originated with the work of Dr Jack Piachaud and Dr Sonali Sharma in 2007. During its development numerous people have shared their knowledge and expertise on mental health needs and services in Iraq. We are very grateful for all their input without which this report would not have been possible and hope we have presented things accurately – any mistakes or inaccuracies are the responsibility of the authors.

Tragically Jack died in 2009. This report is dedicated to him and his constant and inspiring work to improve things for those who suffer wherever and whoever they are.

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Introduction

This report provides a case study of the post-conflict rehabilitation of services and development of mental health policy following the invasion of Iraq in 2003. It illustrates common challenges faced in meeting mental health needs in post-conflict situations. In 2003 the health sector was already weakened and it was further devastated by the 2003 invasion; maintaining mental health as a health sector priority in the post-invasion years was a major challenge. In addition to conflict and security issues, rehabilitation had to take place against a fragmentation of power, frequent changes of leadership, a lack of an overall health policy, and insufficient funding. Considering this background there were considerable achievements, though these were insufficient to address the overall mental health burden. It is hoped that this case study of mental health policy and service rehabilitation in post-invasion Iraq will contribute to understanding the experiences faced in the Iraqi context, and contribute to the dialogue on best practice guidelines for other post-conflict situations.

Background

The mental health needs of those affected by conflict, particularly children, has received increased attention over the last 25 years. Mental health programmes are now recognized as an integral part of humanitarian and post-conflict response (Rubenstein & Kohli 2010), with ongoing debate as to the best and most effective programme strategies. Mental health services are only one part of a response to mental health needs, but they are an essential part which is sometimes neglected.

Mental health systems are often poorly resourced and limited in the care they can provide when conflict brings an additional burden. Average expenditure on mental health services in low and middle-income countries is less than 1% of the total health budget (Patel 2007). The importance of mental health policy development in resource poor settings and post-conflict contexts has been recognized (Jenkins 2003; Gureje & Jenkins 2007; Madeiros 2007) but is commonly not reflected in practice.

In 2003 the Iraqi population had already been through more than 30 years of an oppressive regime, the Iran Iraq war, and thirteen years of sanctions. The acute 'shock and awe' stage of the invasion was followed by continuing pervasive human rights abuses and daily violence, which have taken a toll both on individuals and society. By 2007 over four million people had left the country (UN 2007). Although the exact impact is unknown, the increased mental health burden is clearly high. Despite significant attempts by mental health professionals and others to meet the increased needs, overall there has been an inadequate response to this crisis.

Methodology

Information for this report was collected through key informant interviews, literature reviews and a review of policy documents. Sources used included scientific and psychiatric journal articles, news sources, 'grey' policy documents and other publications in the public domain. It was not possible to interview users of mental health services due to security issues, difficult access, and concerns that individuals may not wish to be identified. However it was possible to interview key stakeholders who were, and still are, involved in the Iraqi health services.

As in other post-conflict situations analysis is challenging with many stakeholders, patchy documentation and differing views on a complex array of issues, some of which reflect the socio-political context.

Mental Health in Conflict

The World Health Organisation (WHO) estimates that of those who experience traumatic events in times of armed conflict, 10% will have serious mental health consequences and another 10% will experience a decline in their social functioning (WHO 2001). Mental health can further deteriorate when communities are disrupted and people become disconnected from their known surroundings and personal histories.

The direct effects of conflict such as death and injury, living in an environment of fear and witnessing violent events, are compounded by the indirect effects such as damage to public infrastructure including health services, transportation, education, and employment. Displacement, forced migration, community disruption, and loss of social cohesion and social capital, all severely impact social well-being and can negatively influence mental health outcomes. Social problems such as domestic violence, drug abuse and alcohol consumption often escalate. Just as critical is the effect of conflict on planning, government action and policy making.

Best practice indicates that the response to mental health needs should be integrated into a variety of public services, and to be taken into account in strategies to address the underlying determinants of mental health, including issues related to reconciliation and justice (IASC 2007). Mental health services are only one but a key part of this response, and mental health professionals can act as advocates for mental health in other areas.

Mental Health in Iraq

The burden of disease

The exact burden of mental illness in Iraq since the invasion in March 2003 has been difficult to establish. The *Iraq Mental Health Survey 2006*/7 (MoH & WHO 2009) was carried out concurrently with the *Iraq Family Health Survey 2006*-7 (WHO 2007) by the Iraqi Ministry of Health and the World Health Organization. 9,345 households were visited and Composite International Diagnostic Interviews were successfully carried out in 4,332. Only adults were interviewed, and the questionnaire was designed to detect affective and anxiety disorders (so did not collect information on schizophrenia, somatisation, cognitive or personality disorders). Its results may also have been affected by population movements. It found that anxiety disorders of a lifetime, 12-month and 30-day prevalence were 16.56%, 11.09% and 7.14% respectively; there were clear gender and age effects with more women affected by mental disorders than men, and older people more affected than younger. Levels of anxiety and depression correlated with the number of traumatic events experienced but were not as high as might be expected in a situation of violent conflict.

Other studies found high rates of anxiety, depression and PTSD (Hussein & Sa'adoon 2006; WHO 2007; Razokhi et al. 2006). Substance abuse escalated, in particular prescription drug abuse (Al-Hasnawi 2005).

Access to care

The *Iraq Mental Health Survey 2006*/7 (MoH & WHO 2009) found that access to treatment for mental disorders was low (6.12% for any disorder), particularly given the high lifetime exposure to traumatic events (56.02%). Among primary health care patients in Al-Nasiriyah City in 2005 prevalence rates of anxiety and depression were 8.4% and 10.2% respectively (Hussein & Sa'adoon 2006). High rates of depression among adults and PTSD among adolescents were reported (WHO 2007)[2]. A survey of inpatients in Al-Rashad Hospital suggested that many patients were ready for community rehabilitation but there was a reluctance on the part of families to take in family members (Humaidi 2006). This is a common situation in many settings, given the burden associated with caretaking and the stigma of mental illness. In 2007 a survey of 10,000 primary school students in the Shaab section of north Baghdad, conducted by the Iraqi Society of Psychiatrists and WHO, found that at least 70% of students were suffering from trauma-related symptoms, a result they were so surprised by they repeated the survey with similar results (Palmer 2007).

Children and adolescents comprise 55% of the Iraqi population. In 2006 child mental health studies showed high rates of exposure to traumatic events, and 14-30% of school-aged children with symptoms of PTSD after exposure to a traumatic event (Razokhi 2006). The Association of Psychologists of Iraq (API) surveyed over 1,000 children across Iraq during a four-month period and concluded that '*92% of the children examined were found to have learning impediments, largely attributable to the current climate of fear and insecurity*.' (IRIN 2006). Other less structured surveys and literature reviews showed similar findings with children suffering from psychological issues such as learning impediments and substance abuse secondary to conflict (Al-Obaidi et al 2009). Teachers in Iraq have reported substantial mental health and behavioural problems in primary school children, indicating a need for school-based mental health programmes and teacher training (Al-Obaidi et al 2012).

Key informants indicate that **drug and substance abuse** has escalated since the 2003 invasion. Trends in drug abuse included an increase in the abuse of prescription drugs such as anti-cholinergics, anti-histamines, muscle relaxants, and inhalants (Al-Hasnawi 2005), which are more freely available initially due to looting of pharmacies, then due to porous borders and weak law enforcement. A retrospective study of addicted inpatients at Ibn-Rushd Hospital Baghdad found that drug addiction had increased significantly more than alcohol abuse between 2002-2004 (Aqrawi & Hussain 2010); all patients were male, aged between 21-30 years, single and unemployed. Despite the religious ban on alcohol more recent reports suggest that alcoholism is on the rise with violence, poverty and unemployment implicated as the reasons for this increase (IRIN 2007).

In 2007 the **suicide** rate was reported as 6.88 per 100,000 people (Jacob 2007). However data is scarce and there is likely to be under-reporting. Reports from key informants and grey policy documents indicate that suicide rates are approximately 10% among psychiatric patients in Baghdad. Key informant interviews indicate that self-mutilation rates, suicide attempts and completed suicides are high in Kurdistan.

There is a level of **stigma** associated with mental illness in Iraq. This leads users to seek care from primary care doctors, interns and neurologists rather than psychiatrists, or to rely on local religious and cultural healers for assistance. Coordination is poor between traditional and allopathic systems. Families and communities are often left to do the best they can to care for sufferers. Users of the mental health system are mostly the severely mentally ill (Humaidi 2006).

A report by WHO and the Iraqi MoH in 2006 (WHO/MoH 2006) found that in the previous five years only 2% of all health **research** in Iraq was on mental health. However the Journal of Muslim Mental Health dedicated an entire issue to mental health in Iraq in 2006 (Al-Jadiry & Rustam 2006).

The History of Mental Health Services in Iraq (see Table 1)

In the 1960s and 1970s, Iraq's health care system was considered a model for the region. It was supported by infrastructure that provided sanitation, water, logistics and communication, and a road network that facilitated good access to services. Prior to 1991 the health care system served 97% of the urban and 79% of the rural population (WHO 2005). Health care, including mental health services, was financed through oil revenues and to a lesser extent taxation with services free of charge to the public. During the 1960s and 1970s mental health services were established in general hospitals, and school mental health programmes and public awareness campaigns were developed (Sadik & Al-Jadiry 2006).

The Iran-Iraq war (1980-88), and Iraq's invasion of Kuwait (1990) and the subsequent UN imposed sanctions, increasingly constrained public spending on health care in Iraq. Health expenditure fell from 3.72% of GDP in 1990 to 0.81% in 1997 (Iraq MoH 2004; EMRO 2006), and health infrastructure also deteriorated. The mortality rate for infants and children more than doubled between 1984-9 and 1994-9 (Ali & Shah 2000).

Between 1997 and 2001, the health system changed from a government-funded to a self-financing system with an end to free health care (WHO 2005), with the exception of Psychiatric and Fever hospitals which were excluded from this scheme. Hospital ownership remained in the hands of the Ministry of Health, but health care became increasingly privatized.

Mental health care in Iraq pre-2003 was hospital-based with an emphasis on long-term institutional care. From 1980 onwards mental health was a low priority and, apart from through the hospital-based system of care, psychiatrists had limited influence on national policy. During this time many practitioners were forced into private practice as funding for health declined, or left the country for political reasons.

Table 1. History of Mental Health Services: 705AD - post invasion 2003
(adapted from Sadik & Al-Jadiry 2006; SAMHSA 2005),

705 AD	First mental hospital in the world established in Baghdad.
1927	Baghdad Medical School established; modelled on UK system.
Early 1950s	Mental Health services established in Iraq with the opening of two psychiatric hospitals, both in Baghdad: Al-Rashad Hospital, a 1200 bed chronic care facility and Al-Rashid (now Ibn-Rushd Hospital), a 74 bed facility for acute psychiatric care.
1960s-1970s	Mental health centres and mental health units established in hospitals, school mental health and mental health programmes implemented.
1980s to 2003	Wars and UN imposed sanctions; general decline in health services, many psychiatrists and other doctors fled Iraq, plans for mental health strategies blocked by Iraqi government.
Immediately post-invasion 2003	Violence, looting, and destruction of health infrastructure further undermined health services; Al-Rashad, the 1200 bed chronic care psychiatric facility, looted and the patients fled.
	Many NGOs assisted with humanitarian needs.

Mental Health Services in Iraq since 2003

Post-2003 the Ministry of Health was in charge of health care delivery, the Ministry of Higher Education oversaw medical education and the Ministry of Labour and Social Affairs provided social services (Sadik & Al-Jadiry 2006).

Despite a new mental health strategy (see below), in practice mental health services continued to be dominated by long-term institutional care, and most inpatient psychiatric treatment was for severe and persistent mental illness. There were no daycare centres and minimal community residential facilities. Those suffering from mood disorders (which include depressive and bipolar disorders) were treated as outpatients. Multidisciplinary practice was virtually non-existent and there was little support for consumer groups, families or other carers (WHO / MoH 2006). Mental health care as part of primary health care was limited, and there were few mental health care professionals - such as mental health nurses, psychologists and social workers - outside of psychiatric institutions. However religious leaders and school teachers were recognized as key points of contact for people experiencing problems, and were targeted with mental health public education and awareness programmes (WHO/MOH 2006).

After 2003 health services were theoretically free at the point of use, as user fees were eliminated in line with the Coalition Provisional Authority's (CPAs) initial policy of free care. However in the absence of other income generating measures or increased budgets, this reduced the flexible income available to support salaries and for local purchasing, and user fees were informally reintroduced. By 2004 nearly half of total health expenditure came from out-of-pocket expenditure (WHO 2007)[3], and there was no social insurance (WHO MoH 2006).

Post-2003 medications were also theoretically free when available and supplied through the national health system by two state run pharmaceutical companies: Kimadia and Samara Drug Industries (Ministry of Health 2004). However they were frequently unavailable and illegally diverted from the public to the private sector and the black market. Equipment was also in short supply or outdated: some ECT machines were over 20 years old (SAMSHA News 2005).

In 2006 as well as the two public psychiatric hospitals in Baghdad, there were dedicated inpatient beds in 12 general hospitals nationally; 4 of these were in Baghdad. A study found that there were 5.4 inpatient psychiatric beds per 100,000 of population, and that the number of beds had increased by 32% in the previous five years (Ministry of Health 2004).

By 2008-10 another psychiatric hospital had been built in Baghdad and the number of general hospitals with psychiatric units had increased to 23.

In 2006-7 there were fewer than 100 psychiatrists in Iraq, or 1.6 mental health professionals per 100,000 population, and minimal ancillary staff to serve the population of 27 million (WHO MoH 2006). Most psychiatrists (92%) worked in both public and private practice; 2% worked only in the public sector and 5% worked only in private practice. The number of psychiatrists fell in 2006-7 - possibly to as low as 60 – at a time of continued death threats against, and targeting of, health professionals. There were few other types of mental health professionals. Less than 20% of primary care clinics were found to have mental health assessment and treatment protocols (WHO/MoH 2006).

In 2006 there was a programme of 3-4 weeks undergraduate training in psychiatry for medical students, and a 2 month training for medical graduates during their internship (Al-Jadiry & Rustam 2006). 7% of primary care providers received a two day course in mental health, including 1% of primary care nurses and 2% of other health care workers. 3% of the training budget for medical doctors, and 5% of the training budget for nurses was spent on mental health. The urgent need for other health professionals, including nurses, social workers, psychologists and primary care physicians, to be trained in mental health issues had been recognised.

Despite the difficult environment all Governorates had some psychiatric inpatient beds in general hospitals, and outpatient services existed within each region (WHO IMH 2006). Mental health in primary care was increasingly becoming a priority, with more dedicated education and training.

Encouragingly by 2010 the number of psychiatrists, nurses and psychologists had more than doubled.

Table 2. Mental Health Care Facilities in Iraq 2006
(adapted from Ministry of Health 2004, Sadik 2006, MoH 2010)

Inpatient		
	2004-6	2008-10
Psychiatric Hospitals	• 2 hospitals in Baghdad	3 hospitals
Al-Rashad: chronic care	• 1200 beds • average length of stay 10 years • 250 beds for forensic patients • 0.92 people treated per 100,000 of population • 46% stay under 1 year • 28% stay 1-4yrs	
Ibn-Rushd: acute care	• 74 beds including a 15 bed substance abuse unit	
General Hospitals with Psychiatric Units	• 12 hospitals – 4 in Baghdad – 8 in other Governorates	23 hospitals
Outpatient		
Outpatient Mental Health Facilities	• 25, 4 for children/adolescents	
Outreach and Psychosocial Support Centres	• 10 set up by National Council	
Residential Facilities for Mental Impairment	• 3 Facilities with one solely for under 18 year olds • 145 beds	
Psychosocial services	• Provided in < 20% of outpatient facilities	

Table 3. Distribution of Total Mental Health Beds across Type of Mental Health Facility 2006
(WHO/MoH 2006)

Type of Facility	Percentage Mental Health Beds
Psychiatric Hospitals	74%
Forensic Units	13%
Other Residential Facilities	7%
Inpatient Units in General Hospitals	6%
5.4 beds per 100,000 population	
97% of psychiatric beds are located in or near Baghdad	
Number of beds increased by 32% in previous 5 years	

Table 4. Number and Percentage of Health Professionals working in Mental Health Facilities in Iraq by Profession 2006 & 2010 (Sadik & Al-Jadiry 2006, MoH 2010)

	Percentage of Mental Health Workforce 2006	Number	
		2006	2010
Psychiatrists	33%	91	206
Other physicians	2%	7	
Nurses	53%	145	335
Psychologists	5%	16	47
Social Workers	9%	25	33
Other mental health	47%	128	

Table 5. Number of Health Care Professionals working across Mental Health Facilities by Type of Facility 2006 (WHO/MoH 2006)

	Psychiatrists	Non-Psychiatric Physicians	Nurses	Other Health Care Workers
Outpatient	64	None	48	25
Community Inpatient	9	None	45	27
Psychiatric Inpatient	18	3	52	76

The challenges for community care: a post-conflict example

As part of the move to community based care the closing of Al-Rashad Mental Hospital was discussed and the Director of the hospital spent a few months visiting community based services in London and the United States (SAMHSA 2006). These plans were made in the context of a lack of community health centres, vocational or rehabilitative services, homeless shelters or residential health programmes (Hamid & Everett 2007). However in February 2008 when the hospital still had 1,200 patients, two women who were carrying bombs that detonated in domestic pet markets in Baghdad killing 99 people were identified as having been treated at the hospital. The Minister of the Interior then ordered the homeless and mentally ill to be taken from the streets and cared for in institutions (Lannen & Khadim 2008; Kenyon 2008), including in Al-Rashad Hospital (Howell 2010).

Services for children and adolescents are commonly provided in out patient mental health facilities which serve the general population, and psychotropic drugs are still the most common therapeutic treatment. There is a recognized need for mental health services specifically for children, including behavioural, play and other forms of psychotherapy; also for policy and programmes for good practice in child protection, and training for paediatricians in child psychosocial issues (Al-Obaidi, 2011).

In collaboration with Uppsala University, the College of Medicine of the University of Duhok in the Kurdistan region provides child mental health training at community, undergraduate and postgraduate level (Ahmad A 2009).

Other Providers of Mental Health Services

Non-Governmental Organisations (NGOs)

Immediately after the 2003 invasion many NGOs – too many to name individually - both international and national, initiated programmes to try to meet the needs of the civilian population, including mental health and psychosocial programmes. However the bombing of the UN headquarters in Baghdad in August 2003, the subsequent departure of the UN agencies and the deteriorating security situation caused many international NGOs to leave.

NGOs that remained faced security issues, including in some instances a lack of respect for medical neutrality. They also had to deal with irregular funding and some pressure from government bodies. Some health workers attending mental health training outside the country were reported as experiencing serious security problems on their return to Iraq.

NGOs have played a key role in the care of victims of torture and related psychosocial issues. The Al-Fuad Centre for Rehabilitation of Torture Victims (FRCT) in Basra was set up by the International Rehabilitation Council for Torture Victims in 2005 (Al-Saffar 2005). The Heartland Alliance set up a Trauma Rehabilitation & Training Centre in Sulaimaniya in 2008 (Heartland Alliance 2008), and the Applied Mental Health Research Group from Johns Hopkins University initiated a programme including research in 2009 (USAID 2009).

NGOs have also assisted with policy development. In 2008 the International Medical Corps supported the Ministry of Health in drawing up a 5-year mental health strategy for Iraq (MoH 2008).

The Role of Religious and Traditional Healers

Many Iraqi civilians seek help from religious leaders as the first point of contact in the event of mental health problems. The important role of religion in this respect is recognised. While traditional practices have a role to play there is also concern that some - such as beating out the Djin (spirit) - are abuses of human rights, ineffective and can cause further damage to the individual. Nevertheless there is general recognition that collaboration between the different systems of healing can function in a complementary way to better meet the needs of those affected.

Insecurity, disruption to transport including lack of petrol, and other difficulties in using hospitals and clinics meant that the use of religious and traditional healers rose after 2003. Particularly in more rural areas, where services may be far away, these healers continue to play a critical role; as WHO stated, 'rural life in Iraq is strongly influenced by tribal traditions, long-held norms and religious teachings. Rural people tend to tolerate mental disturbances to a considerable degree, so long as these are not expressed in undue violence or uncontrolled over activity'(WHO 2003).

Mental Health Policy Development: Content and Process, Post-2003 Invasion

The development of mental health policy after the invasion was strongly influenced by the government in power, professional leadership and external support. Security issues and sectarian violence, lack of coordination, competing policy models for mental health, corruption and stigma posed grave difficulties in moving the agenda forward. This is consistent with the more general experience that war and violent conflict can paralyse government planning, action and policy making (Ugalde 2000).

Key components of mental health policy development post 2003 include:

- Lobbying, strategy development and planning at the level of the Ministry of Health
- Advocacy to prioritize mental health on the health agenda
- Efforts to shift away from long-term institutional care towards public and primary mental health care
- A goal of more equitable access to care
- An emphasis on capacity building

- A range of different international collaborations
- Increasing efforts to integrate mental health into primary care services, schools and other community services.

There have been a range of meetings, workshops and conferences in support of this process. The majority have been international and many have been held outside the country. Most have stressed the key components of mental health policy listed above. What has perhaps been missing is a discussion of the need for regulation of the private-for-profit sector, despite the fact that a large number of Iraqis use these services (Burnham et al 2011).

At the beginning of 2011 a meeting between the Federal Ministry of Health of Iraq, the Ministry of Health of the Kurdistan region and WHO was held in Amman, to discuss plans for the health sector as part of the public sector modernization programme (I-PSM) (WHO-EMRO 2011).

Political transitions

Political transitions of power within Iraq, particularly up to the first elections in December 2005, have affected both the content and timing of mental health policy development. The four phases of government which led to changes in leadership and a lack of continuity in development of policy were:

- Coalition Provisional Authority (CPA) post-invasion in 2003
- US-led Iraq Interim Government from 28 June 2004
- Iraq Transitional Government from 3 May 2005
- First elections on 15 December 2005 leading to an Iraqi cabinet and a four year government term from March 2006.

Leadership in mental health services

Varied leadership within the health sector played an influential role in developing mental health strategy and implementing policy.

During the CPA's tenure, power struggles between USAID and the Pentagon initially led to a rapid change of leadership in the health sector, loss of appropriate experience and expertise, and delays. A lack of post-conflict and regional expertise in the senior levels of the CPA meant that planning opportunities, and opportunities to establish methods of collaboration and standard setting, were missed. Crucial Iraqi expertise was sometimes sidelined and ignored in policymaking (Medact 2008; Chandrasekaran 2006).

The first Iraqi Interim Health Minister and the CPA declared mental health a key priority area in 2004 (Fleck 2004), and this led to specific appointments and the setting up of committees to take things forward. The first mental health budget was for US $2.5 million, or 0.32% of the total health budget drawn up by the CPA (Jones et al. 2006). Funds were put into mental health training, psychiatric units in hospitals, and site visits. An Iraqi expatriate psychiatrist was appointed to the new position of National Advisor in Mental Health in February 2004. International collaboration, inauguration of a National Mental Health Council, and formulation of a comprehensive National Strategy followed. By October 2004, a Mental Health Act was submitted and approved by the Cabinet. Mental health was on the map as a public health priority, although it still needed to be integrated into policy. This was a considerable achievement given the absence of overall policy in the health sector at this time.

With the high turnover of Health Ministers from 2004 to 2007, significant efforts were required to keep mental health on the agenda. Implementation of the Mental Health Act stalled, and mental health policy efforts fragmented, with the challenge of convincing each new Health Minister that it was a priority. In 2007 a psychiatrist was appointed Minister of Health and there were positive indications that the mental health system would be strengthened. Reliance on external support and funding became increasingly critical for the sustainability of mental health services.

There were also efforts to put specific areas of mental health on the agenda. Child and adolescent mental health, with an emphasis on preventive and family and school based services, was promoted (Al-Obaidi et al 2010). A mental health programme in northern Iraq emphasized the need to meet the needs of those affected by the Anfal, particularly women, also through community and decentralized facilities (WHO-EMRO 2009).

From Feb-Nov 2009 and as part of the Ministry of Health's ongoing strategy to integrate mental health into primary care, an interactive programme delivered training to 20% of primary centres across Iraq. Those who received the training showed a significant change in knowledge and practice when compared with those who had not (Sadik et al 2011).

The United Nations: the World Health Organisation (WHO)

WHO has played a very significant part in assisting with the assessment of mental health needs (including the 2006/7 Mental Health Survey), with the policy development process and service development, and with training for research.

WHO supported the Ministry of Health in convening expert consultations on mental health in Cairo in 2003 and 2005, and conducting epidemiological studies to better understand the mental health burden (Alhasnawi 2009). WHO and partner agencies helped ensure that there was a refurbished mental health centre in each Governorate.

On 17 June 2012 the Iraqi Minister of Health and the WHO Representative for Iraq signed a Country Cooperation Strategy to cover the period 2012-2017. Based on other UN agreements and the National Development Plan it aims to ensure that 'collaborative programmes are in line with national health policies and strengthen national capacity' (WHO-EMRO 2012) .

UNOPS is implementing an EU funded Programme for the Protection of Detainees and Torture Victims, which was set up to meet the psychological and medical needs of individuals who have suffered torture and violence (UNOPS 2008-11).

International collaboration and the role of external Influence

Immediately post-invasion, there was an outpouring of support from the international community and the Iraqi diaspora. The International Red Cross restored services in Al-Rashad Hospital, which was looted and damaged following the invasion (Humaidi 2006).

In early 2004 the United States Substance Abuse and Health Services Administration (SAMHSA), in collaboration with the CPA, supported mental health as a priority on the health agenda (Curie 2006). SAMHSA took the lead in convening two Action Planning Meetings in 2005 in Amman (SAMHSA 2006), and in March 2006 in Cairo (Benderly 2006). A multi-agency Iraq Planning Group on Iraq Mental Health was established by SAMSHA in 2004 to assist the Iraqi Ministry of Health to establish services; they also organized conferences and arranged visits for mutual learning, principally between Iraq and the United States (SAMHSA 2011).

In the United Kingdom, the Royal College of Psychiatrists convened an Iraq Sub-Committee (ISC) in 2005, which established a volunteer scheme sending mid-career level psychiatrists to Iraq to help with capacity building. A delegation to Iraq's Kurdistan region took place in July 2007 and established a formal link with the Kurdistan Regional Governorate. The ISC actively works to bridge the 'inside-outside anxiety' which can exist between those who have left and those who remain in Iraq; this has included setting up the Iraqi Mental Health Network email network in 2008. Under its Continuous Professional Development Programme the ISC has organized training in cognitive behavioural therapy, research methodology and psychosocial intervention, in collaboration with Kuwait and Jordan. They have contributed to a new curriculum for the Iraq Board of Training in Psychiatry, and supported a Standards and Quality project which highlighted patients' rights, and made practical recommendations about ECT (RC Psych 2012).

Many groups organized around the need for mental health and psychosocial services. Expatriate Iraqis who had longstanding concerns about the health sector saw the new government as an opportunity to return to help their country. Iraqi psychiatrists in the UK established the Iraqi Mental Health Forum to provide supervisory and technical assistance, programme development expertise and supervision for young service providers in Iraq.

According to the NGO Coordination Committee for Iraq, in 2007 there were 80 international and 200 national NGOs in Iraq. A small proportion focused on mental health. An apparent security risk for health professionals who had travelled abroad persisted after 2006/7 (Webster 2011).

Financial contributions supplemented the Ministry of Health budget from various sources. In 2004 Japan donated US$6 million for mental health services. Funding by AusAID for mental health projects in schools was cut in 2010 because of concerns about corruption; however no hard evidence of this has been produced. Funding continues to be compartmentalized, and there is a need for cross-sectoral working and better coordination between donors, NGOs and the Iraqi government.

Competing models of mental health care

There was a difference of opinion with regard to the most appropriate model of health care for Iraq. Different models proposed included a:

- Health Maintenance Organisation (HMO) model proposed by US officials
- population-based health approach supported by UK officials
- return to the pre-existing hospital-based system of care previously in place in Iraq.

The US-led CPA favoured capital programmes such as building new clinics, using external rather than local contractors (Chatterjee 2006) and with little coordination with existing Iraqi services. There was an initial perception that the system could be reconstructed from scratch rather than built on what remained. Insufficient account was taken of existing health infrastructure and local capacity. Needs assessments tended to be perfunctory and rarely took account of local perceptions when assessing levels of need and existing services. Reasons for a lack of local involvement included minimal use of lower level members of the MoH for technical advice, and a lack experience of health system functioning. Local experience was limited as power had been in the hands of a few in the previous government and was dispersed and frequently changed hands after 2003.

In response to a survey question on models of mental health care, respondents indicated that competing models of care were a source of power struggles within and between stakeholders. Policy advisors, including WHO and donors, endorsed reform and deinstitutionalization of the inpatient psychiatric hospital, Al-Rashad. The final agreement was for a public mental health model with an emphasis on primary care, multi-disciplinary teams, and links to the community (Humphreys & Sadik 2006).

Iraqi officials were fully aware of the benefits of community care, but were challenged by insufficient resources and established services to provide adequate community care (Hamid & Everett 2007). The volatile security environment and the perception that institutionalization was necessary for security were also obstacles. The attempt to close Al-Rashad Hospital described above illustrates the challenges of attempting a move away from inpatient care.

The government resources available for health rose from around 4% in 2003/7 to 8.4% in 2010. In 2010 total expenditure on health per capita was $247 (WB 2012). Given Iraq's revenue from oil and gas this level of expenditure should continue. The financial base for health services, and whether they should be funded through taxation, universal insurance or a private system, is still an undecided issue. The 2005 Constitution states that the government is responsible for regulating and ensuring the delivery of care to all citizens, and also recognizes the potential contribution of the private sector. In practice there has been a degree of privatization by default as government services have struggled to cope, meaning the government will need to play a crucial role in regulating the private sector in the future. This overall lack of clarity has made it harder for specific areas such as mental health to develop policy (Medact 2008).

The Country Cooperation Strategy with WHO (2012- 2017) aims to achieve the 'right to health for all Iraqis' (WHO-EMRO 2012).

Regulation

In 2008 a symposium on health system reconstruction in Iraq in Washington cited as one of its goals the promotion and facilitation of 'non-governmental organization (NGO), private sector, international donor and academic engagement in and partnership toward the Iraqi health sector'. Of the 'seven critical issues' addressed mental health was one; it was also given as an example of a service that 'should not be "outsourced"' (IoM/NAS).

As in many other situations where it is difficult for the state to provide services, there has been a passive expansion of the private sector in Iraq. There is an urgent need to regulate private services which are very likely to be of varying standards. Standards need to be established in common with the public sector if patients' rights are to be protected.

Lack of coordination

While coordination has improved the legacy of the first few years post 2003 has not helped the process. A lack of coordination between and within government and the many actors involved in mental health in Iraq has been reported at various levels; within the CPA, between the CPA and the Pentagon, with private contractors, between the Iraqi Ministries, and between donors and NGOs.

Insufficient coordination between UK and US officials within the CPA has been reported as creating difficulties in post-conflict reconstruction, with a lack of inclusion of other actors in a US dominated decision

making process, a general lack of organization, over-centralization, excessive red tape, high staff turnover, and initial turf battles between the US State Department and the Pentagon (International Crisis Group 2004). The latter led to a lack of a cohesive strategy for US reconstruction efforts (Graham 2007) with unclear decisions on funding.

Coordination between central government and local Governorates also presented some problems in areas such as the purchase of medicines, particularly as the centralised system was often disorganised. There was a lack of coordination between the Ministry of Health and the Ministry of Higher Education - responsible for capacity building and medical education – and no detailed workforce development strategy has emerged.

Violence and mismanagement in the health sector

Security is repeatedly cited as the main obstacle for health sector development. Sectarian violence and discrimination by political affiliation have been pervasive throughout the health sector. Death threats against doctors, kidnappings, extortion and murders posed a significant threat to the health workforce. Of the 34,000 doctors registered in Iraq before 2003, an estimated 10-17,000 fled and 250 had been kidnapped by 2007; an estimated 2500 have returned since 2009; estimates of how many were killed range from 200-2000 (O'Hanlon & Campbell 2007). In 2007 the number of psychiatrists was reported as being fewer than 60 for a population of 27 million. Post-graduate qualifications and training programmes in psychiatry suffered due to the severe shortage of mental health professionals.

In 2007 several newspaper reports and respondents alluded to the involvement of the senior level of the Ministry of Health in sectarian violence, corruption and alleged human rights abuses (Lennen & Khadim 2008; Kenyon 2008).

Mismanagement of funds allocated through international and national private contracts thwarted reconstruction efforts (Chatterjee 2007; U.S. Senate 2006). A lack of transparency, multiple contracting out from the international to the national level, funding misappropriations and diversion of supplies to the black market have all drained funds from the public system.

Perceptions of mental health

The stigma attached to mental illness in Iraqi society, as in the majority of societies, presents a challenge for de-institutionalization and community care, and affects the demand for psychiatric services, including their early access. On the other hand respondents to a survey carried out in Iraq in 2004 appeared to show that the public valued mental health services, which they indicated could be one aspect of material compensation for what they had suffered; they also thought the Iraqi state should provide mental health services as part of a reparations programme (International Centre for Transitional Justice 2004).

Perceptions of mental health have also meant services have not been a priority for some policy makers, and have influenced the position of psychiatry within medicine. Amongst health professionals many have seen disciplines such as surgery as offering better career prospects.

Considerable efforts have been made to reduce the stigma attached to mental health, including through mass media (Al-Uzri 2008). A survey of public perceptions of mental health in Iraq carried out in 2010 produced some positive results; however it also found that two thirds of respondents thought that mental illness was caused by something bad happening to the individual, and nearly two thirds thought that personal weakness was the cause (Sadik et al 2010).

Lessons Learned and Policy Recommendations

Lessons that can be drawn from this analysis of mental health policy in post-invasion Iraq include:

- security is a critical factor in a post-conflict context for policy development and implementation long after outright conflict has ceased
- mental health policy needs to be integrated within an overall national health policy, and will struggle to be effective if it is not
- a sustainable mental health strategy needs to be agreed and have the status to survive changes in leadership. Lobbying of ministers, political will, a clear national mental health plan, a budget, and appropriate support from the international community can aid in this process
- the mental health workforce should be expanded so that services can be scaled up using a variety of cadre including primary care workers, and non-medical/community workers. Clinical psychiatrists can contribute by transitioning their role from clinical work to training and building capacity. Integration of mental health at the primary care level with adequate supervision will provide a direct route to services for those in need
- local capacity, resources and knowledge should be respected and harnessed to formulate a system that meets cultural needs and regional demands. Post-conflict and regional experts should be consulted. Increased collaboration with the traditional community will assist access to and for those in need
- from the outset of a post-conflict transition it is important that national authorities have ownership of policy.
- there is an urgent need in Iraq to ensure that the growing private-for-profit sector follows national policy and is sufficiently regulated to ensure best practice. This will involve legislation and the development of regulatory bodies.

Please refer to Table 6 for more policy recommendations.

The process of mental health policy development in post-invasion Iraq has been fraught with challenges and obstacles, but has nevertheless achieved some notable successes, even if these have been difficult to follow through. Iraq's mental health system is still a work in progress, and collaboration with the international community continues. Post-conflict policy development is most successful if driven by best practice, local ownership, and through a public health process, not a politicised one. It is our hope that this study will provide insight and suggest some principles of reform to other policymakers and practitioners who are working in post-conflict settings, in devising strategy, strengthening systems, and implementing mental health policies.

Table 6. Policy Recommendations

Security is Key	• A secure environment is needed for effective policy to be implemented; mental health professionals have a role to play in promoting peace • In the absence of a secure environment security considerations need to be taken into account in all activities and by all actors
Mental Health as part of Public Health	• Mental health should be part of an overall health strategy 'owned' by the national government, and integrated into primary care • Political ideology needs to be pushed aside; the focus must be on the principles of promoting sound population-based mental health.
Mental Health as a Priority	• To ensure mental health is a priority for a new government political lobbying is necessary. Donor support may be helpful in this. • A sustainable, transparent and replicable process needs to be created to ensure continuity over changes in leadership.
Mental Health Sector Planning (continued opposite)	• Immediately post invasion, a minimum set of activities should be implemented based on an emergency scenario [see IASC guidelines]. • Local expertise, post-conflict and regional experts should collaborate in planning services, working within the existing system, and not imposing preconceived ideas. • A multi-disciplinary approach is important, and good coordination is crucial.

Mental Health Sector Planning (continued)	• Local rapid needs assessments can inform planning in the early stages. • Strategies should be based on mental health and psychosocial needs assessments and be as sustainable as is realistically possible in the post-conflict setting. • Local resources can be harnessed by creating links, offering collaboration and partnerships, and making an effort to understand the local context.
Health Care Financing	• A ring-fenced mental health budget is essential. • Accountability and transparency are needed. • Access to care for all should be a major consideration in which financing system to adopt.
A New Model of Care	• The agreed shift towards community-based care needs a multidisciplinary team for its implementation. • Psychosocial programmes with educational and outreach services need to be part of this. • Increased access to mental health services needs to be a primary goal. • The role of some psychiatrists can change from clinicians to trainers.
Better Management	• The Government needs to agree performance standards, and adequate remuneration. • The role of good management in the development of efficient services and good coordination needs to be recognised.
Clinical and Workforce Development	• Capacity building, and supportive supervision is vital. • The integration of mental health into primary care needs to be reflected in plans for the workforce. • The workforce can be expanded through mental health training for primary care providers. All staff including psychologists, clinical social workers, psychiatric nurses and paraprofessionals need effective support. • Plans need to include investment in education and research, and cross-collaboration between disciplines.
Invest from within Iraq	• It is essential to respect and support local leadership. • External experts need to work closely with local expertise.
Reducing Stigma	• Health promotion can be carried out through mass media to reduce stigma and increase access. • Religious and educational groups need to be involved in activities aimed at reducing stigma. • An emphasis on primary care, health education and health promotion will help reduce stigma.
Advocacy	• Advocacy for mental health services should come from all sectors. • Development of consumer groups and family/caretaker coalitions can help advocacy, as can related advocacy for human rights.
Psychiatry & Psychosocial	• Policy and planning needs to address both the prevention and treatment of mental disorders, and psychosocial issues such as social and political reconciliation.
Culture	• The culture of hierarchy within medicine needs to be addressed. • Teamwork, collaboration and trust should be promoted.
Global Networks	• Appropriate international support in resource-poor settings can be very effective. • Good coordination with the new government in power by outside actors is essential.
Religious and Traditional Healers	• Dialogue with community leaders and healers is essential for mental health needs assessment as is collaboration around services and education • Collaboration and linkages with the allopathic health sector can be very beneficial for those in need.

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