Mental Health Delivery in Libya

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SUMMARY
The armed conflict in Libya has caused deaths and injuries to civilians, significant displacement and disruption of social and health services and damage to infrastructure. The World Health Organization launched mental health provision assessment project to support the Ministry of Health of Libya to resolve increasingly unmet mental health and psychosocial needs of the conflict affected eastern region where the violence is ongoing. The assessment was carried out in March 2015 and involved the evaluation of the current status, utility and integrity of mental health facilities and service provision and development, at primary and secondary level. The assessment also covered social and psychological resources, the availability of psychotropic drugs and strategic mental health planning and educational programmes. Several issues of concern were identified in particular the premises used for care and service provision, shortage of trained staff and psychotropic medication and lack of training and educational programmes. Proposals and recommendations were made accordingly to promote capacity building, and community based service delivery.

1. INTRODUCTION
Since the Libyan uprising in 2011, violence has caused inconceivable suffering and destruction and relentlessly impacted on general and public health infrastructure and social network of the Libyan society. A new wave of violence has erupted over the past several months and continued in different parts of the country with devastating consequences for civilians particularly in the eastern region. The United Nations reported that fighting between rival armed groups in Libya has left nearly 290,000 people effectively displaced across the country (UNHCR 2014)\(^1\). The intense fighting has worsened the humanitarian situation, and caused food, water, electricity and medical supplies and equipment shortages (UNOCHA 2014)\(^2\). Continuity and sustainability of health service delivery in many parts of the country particularly Benghazi is at risk of being compromised despite the endless efforts of the Libyan MoH to uphold service delivery under the most difficult circumstances. A number of hospitals have been damaged in the fighting. Some were forced to close including the main psychiatric hospital in Benghazi where one school has now become a psychiatric ward to more than 280 patients. Staff in various medical facilities in Benghazi have been working under extreme conditions and many have reported threats against them. International aid agencies have pulled out of Libya as the security status has grown increasingly precarious. The UN has issued a humanitarian appeal for Libya requesting additional funding to continue helping hundreds of thousands of people affected by the crisis in the country.

1.1. Context
One of the persistently unmet humanitarian needs is the mental health and psychosocial need of the conflict affected population in different parts of the country. The epicenter of the ongoing conflict is Eastern Libya (population of 2 million)\(^3\) where conflict is ongoing in Benghazi and its suburbs and around western and eastern cities including Sirte and Darna, and has been generating new displacement for the past several months. The Ministry of Health (MoH) of Libya needs to be supported to cope with existing and growing load of mental health and psychosocial problems.
2. ASSESSMENT RATIONALE AND OBJECTIVES

2.1. Assessment of the mental health situation in Eastern Libya during the ongoing conflict and the post-war period and the evaluation of the following:

2.1.1. The integrity of mental health facilities, the number and range of clinicians related to the delivery of mental health care including secondary services (psychiatrists, allied health, nurses) and pertinent primary care clinicians. The assessment also covered social and psychological resources, but most importantly the availability of psychotropic drugs and mental health issues and educational programmes.

2.1.2. Assessment of the prevalence of stress responses sufficiently significant to reduce functionality. This will be undertaken through targeted nationwide, community-based project assessing the point prevalence among Libyan people, especially children.

2.1.3. Assessing the availability of neuropsychiatric medications at different levels of care according to the needs and responsibilities of that level. This should particularly included medication availability for acute and chronic patients.

2.1.4. Proposing replacement medication protocols for addiction patients.

2.2. Identification of urgent rehabilitation needs of the existing mental health facilities such as psychiatric hospitals and psychiatric wards and outpatients in general hospitals (linked to 2.1.1.)

2.3. A plan for reactivation and empowerment of educational and urgent training programmes directed to mental health personnel to raise standard and update knowledge. This should include the integration of mental health education and services into primary health care centers to achieve a community directed service.

3. METHODOLOGY

The approach to achieve these three major goals is consistent with evidence-based practice and World Health Organization (WHO) technical guidelines on mental health and psychosocial support and data collection taking into account any existing data from WHO’s work in Libya\(^4\) and other reference work concerned with mental health service development in Libya\(^5\). The initial assessment was conducted by the author during the month of March 2015 in collaboration with the Libyan MoH and its related departments. The satisfactory and timely completion of this work in Libya will depend on the phase of the crisis and social and political stability and resources that will promote the accomplishment of the required changes. In any case, there is a need to give this project a precedence and facilitate its implementation by the MoH with the right support from the WHO and other organizations to improve and develop mental health services in Libya to the expected standard. This is likely to be a phased, two year project.

Assessment of specialist mental health and secondary services in Eastern Libya and evaluation of the integrity of mental health facilities, the number of mental health professionals, and the availability of psychotropic drugs, identification of urgent rehabilitation needs and the mental health educational and training programmes were considered a priority. This included current service provision to patients and primary care resources.
3.1. Generally, the assessment process involved acquisition of official reports, face to face, telephone and electronic communication and data gathering through WHO focal points, discussions, site visits and several official meetings and interviews with key stakeholders.

3.2. Assessing the availability of psychotropic medications at different level of care involved working collaboratively with bodies and agencies responsible for the provision and distribution of such medication as well as responsible staff from mental health facilities and MoH.

3.3. Proposing replacement medication protocols for addiction patients will be considered at the next phase and would require the formation of working groups and the drafting of suitable and appropriate protocols under the guidance and supervision of the Author. Replacement treatment for addiction is usually indicated and delivered within evidence based and multimodal framework involving biopsychosocial approach.

3.4. Epidemiological information about prevalence of stress related mental health problems among Libyan people is essential to inform policy and public health practice. It is likely to be a one year project and will be considered in the next phase. There is a lack of published information of the prevalence of mental disorders in Libya. Therefore, implementation of screening programme for both psychopathology and the consequent impaired functionality is required. Research has demonstrated that the level of functional impairment is most relevant to determining and prediction of treatment needs and outcomes (Winters et al 2005). The screening programme would involve the use of a number of appropriate mental health screening tools for children and adults that will be specified in the study protocol at a later date. Screening measures provide quick, reliable, cost-effective means of assessing at-risk people including children without exhausting resources. These tools will be carefully chosen for this Libyan study for their validity and utility. Effective means of identifying PTSD among trauma-exposed youth and adult in the country is imperative for preventing detrimental effects of enduring distress and impairment. Health care providers in Libya can promote better health outcomes for their patients by having the opportunity to undertake basic actions including screening and identification of PTSD, discussing the results with their respective teams, initiating a referral to appropriate services and providing educational materials, and arranging follow up with the patient. Using one of the selected tools for a nationwide survey involving multiple community and primary healthcare centers covering the main regions in the country could be undertaken to identify psychological distress among adults in primary care settings including high risk groups for example emergency and field hospital workers. Schools could provide a representative sample of younger population but not all schools are currently functioning due to the conflict involving many regions in Libya. In addition, some of these tools could be introduced to various primary care and similar health facilities in the community nationwide, to provide data base for follow up studies and further research. The author will prepare the study protocol including methodology and tools and lead the investigation in due course.
4. MAIN FINDINGS AND RECOMMENDATIONS

Generally, there is no national mental health policy or action plan in Libya to guide the integration of mental health services into primary health and mandate the change from mainly centralized hospital care to community based services. Further, the existing mental health services have been marred by many longstanding problems, including underdeveloped community and specialized services, shortage of trained workforce, and lack of modern facilities\(^5\). There is no policy or legislation to regulate admission to psychiatric hospital and safeguard patients rights. These problems continue to pose a real challenge to workers and health care providers in the country\(^5\).

The assessment report of the current status of the Psychiatric Hospital and its services in the city of Benghazi which has been badly affected by the hostility, was prepared after visiting these places and discussing issues of concern and solutions with a number of doctors and with the mental health hospital director, his deputy and assistant managing director and director of the hospital management of the ministry of health. A number of longstanding problems as well as current issues have been identified some of which were of both complex and urgent nature particularly the closure of the main and only psychiatric hospital that provides in-patient care for the whole of the eastern region of the country for safety reasons which resulted in moving current patients into a local school. Other issues of concern include inadequate and inefficiently run outpatient clinics, shortage of psychotropic medication, and lack of trained staff. These issues are outlined and discussed sequentially below.

4.1. In-patient mental health services

Worsening of the security situation in Benghazi led to the closure of the main psychiatric hospital urgently and a local school was used to house more than 280 patients many of them suffer from chronic and serious mental illness. The current premises is clearly inappropriate for several reasons including lack of beds, overcrowding, lack of designated area to care for acute cases separately causing serious safety concerns, and lack of privacy for many patients. In addition, there is shortage of staff as many stopped coming to work during the conflict for their own safety and other various reasons, and those who have reported to work have been working under enormous pressure due to overcrowding and inability to enforce any rules or policies to maintain standards as families, court and armed groups have often demanded that patients be admitted. One can only imagine the negative effects of such bad condition and lack of appropriate therapeutic milieu on patients and staff alike. It is worth mentioning that following the closure of the hospital, addiction services is no longer provided as Benghazi Psychiatric Hospital is the only place that provides treatment for addiction in Libya.

Several attempts have been made to find a suitable place to relocate the patients on a temporary basis, and some other alternatives have been discussed and considered by the MoH and related parties. This position was deemed both urgent and complex due to the escalation of violence which spread to several areas of the city. In the process to resolve this matter, the author and a representative doctor from the hospital acted as facilitators and sought the cooperation and coordination between the relevant parties for instance MoH, the local city council and the Ministry of Social Affairs and other interested parties. It was suggested that a committee with representatives from these parties should be formed to oversee a swift resolution of this problem.
4.2. Outpatient mental health services

There is only one outpatient clinic located in one of the local primary health care centers that was operational at the time of the visit. The clinic was run in the morning only by two doctors using a single office. There are no subspecialties clinics as there are no mental health facilities and services for child and adolescent, forensic, or older people. The number of patients seen daily are between 60 and 105. The number of prescriptions issued daily is between 90 and 135. Under normal circumstances, many patients go directly to the main psychiatric hospital on a daily basis for consultation, treatment and admission. In addition, there is not enough space in the centre to allocate more rooms for psychiatrists or other clinicians for example psychologists or social workers. This is clearly not sufficient to meet the needs of patients in this region of the country. The ongoing conflict has severely impacted on many aspects of daily lives of most civilians in the city, and it is predicted that many people will experience stress reactions with consequent increase in common and severe mental disorders. Mentally ill patients are particularly vulnerable and should not be denied access to care and medication. Therefore there is an urgent need to establish and activate more psychiatric clinics in primary health care centers and polyclinics including Al Keish, Al Fwayhat, Al Majouri, the Gardens Health Centre and the Libyan Red Crescent Health Centre. Attempts should be made to reopen the previous mental health clinics that were operational in the past in Benghazi medical centre and child and adolescent clinic in Benghazi children's hospital. It is imperative at this critical time to recruit specialized staff from one of the neighboring Arab countries to run the child psychiatry clinic in the Benghazi children's hospital. The closure of these two clinics was indicative of increasingly shrinking and deteriorating mental health services in Benghazi city and its suburbs over the past two decades. I believe that the activation of these clinics is both practical and feasible and consistent with the desired model of integration of mental health services into primary and community based care. The restoration of these clinics and the expansion of services in the community will enable patients to access mental health clinics easily and help to reduce stigma associated with mental illness. Similarly, out-patient clinics could be opened in the outskirts of Benghazi, and other cities for instance Tokara, Al Marj, Al Bayda and so on using the city of Ajdabiya mental health clinic as an example which is currently providing outpatient mental health care within the general hospital of the city (Emhemed Maqaryaf Hospital). There are some other issues related to the appropriate running of these clinics such as lack of training and supervision, and lack of other psychological and psychosocial modalities of treatment. However, these paramount issues can be addressed in due course and should not be a deterrent or barrier to the move towards community based mental health service. The issues of training, supervision and multidisciplinary team approach will be emphasized in the appropriate sections below.

4.3. Medical and allied mental health staff

It was documented in the Benghazi psychiatric hospital director's report that many employees have been absent from work during the ongoing conflict for various reasons leading to shortage of staff at all levels including medical staff. This state of affairs reflects the deterioration of mental health services in the city of Benghazi and its inability to provide the desired care to its people during these dire circumstances. Furthermore, there is clustering of skills in hospital and inpatient service with disproportionate distribution and lack of skill mix in other areas particularly community and outpatient services. There is no clear service delivery model, for example, case management and multidisciplinary team approach. Also there are no measures to assess the outcome of the services provided to patients and its quality and no procedure to evaluate the performance of clinicians and staff and their efficiency.
Moreover, there is a striking lack of training and supervision of mental health staff from and within all disciplines including psychiatrists (junior and senior), psychologists, social workers and psychiatric nurses, which is necessary for professional development and safe and evidence based practice.

In Benghazi psychiatric hospital, there is a large number of psychologists (40) but they lack the required skills to provide other treatment modalities especially cognitive behavioral therapy and the like. There is equally a large number of social workers (18) but none is trained as therapist (occupational or counselor or family therapist). Similarly, there is an excess of health assistant/workers (50) who are unskilled and untrained staff members often assume the psychiatric assistant role but regarded by a number of hospital officials as too many and of little use. There are (18) psychiatrists at least 8 of them are junior but there are no postgraduate and specialized staff training or sub specialization in other branches of psychiatry including child and adolescent mental health, liaison and maternal mental health, forensic and older people. There are (73) nurses but many lack training in mental health nursing and do not speak the language of the patients (Arabic). There has been an ongoing shortage of nurses particularly with mental health training and Arabic speaking background.

Therefore, there is an urgent need to establish capacity building strategy and start training programmes for all mental health staff at all levels. This can be organized locally in collaboration with the WHO and may be considered as requirement for remuneration. The aim is to enable mental health staff to develop and strengthen the skills, competencies and abilities required for the provision of services that are currently unavailable or very limited such as psychiatric subspecialties and adjunctive treatment and therapeutic modalities other than medication.

4.4. Psychotropic medications

There is a severe shortage of medications for several months and the current supply will run out soon including sedatives, antidepressants, mood stabilizers, and antipsychotic medication which has been made worse by the escalation of the violent conflict. For a number of times some essential medications mostly sedative injections were secured by the hospital administration through charity and donations, according to the report of the director of the hospital.

Imperative work to safeguard the constant provision of medicines is urgently required and should be one of the main priorities to resolve mental health service issues. Regular and predictable supply of psychotropic medications is an indispensable component of the appropriate provision of mental health treatment and continuing care for patients to prevent recurrent episodes of mental illness and reduce the impact on wellbeing. It is also necessary for the MoH to create a mechanism to control and monitor the issuing and dispensing of medicines and to promote good prescribing practice as soon as possible for example the establishment of pharmaceutical database and audit system that can be electronically linked locally, regionally or nationwide in the near future.
4.5. Rehabilitation needs
The main goal of rehabilitation is to restore ability for independent living, and effective life management and socialization. There is a considerable shortage of trained staff as outlined above particularly staff that have the skills to undertake any patient oriented needs and occupational assessment and rehabilitation programme in Libya especially trained and qualified social workers and occupational therapists. Therefore there is a lack of any rehabilitation programmes with evident discrepancies between existing and expected rehabilitation standards.

There is a need to draw up a plan of psychosocial rehabilitation and introduce and activate rehabilitation policies and procedures to enhance recovery, community integration and better quality of life for people with serious and chronic mental illness. The plan should cater for both rehabilitation needs within mental health facilities including Benghazi psychiatric hospital and those that are pertinent to community based care and should clearly define the role of multidisciplinary team. These include patient-tailored rehabilitation programmes, addressing daily living skills, budgeting, self-care, social support system, education, employment, social and occupational skills. It has been suggested that best results are achieved when service and support activities are designed to be integrated with the person's actual daily activities. Rehabilitation services can be provided within a specific unit or in a facility setting or in the community at large or at home. It can also be offered in addition to, or independently or integrated with psychopharmacology and other forms of psychiatric treatment.

The development of necessary components of community mental health services should be part of current strategic planning for mental health. The central components of clinical community services include crisis assessment and treatment teams, continuing care, dual diagnosis and mobile support, primary mental health and early intervention teams. A worldwide commonly adopted model is the mental health psychosocial rehabilitation and support services comprised of
• Home Based Outreach Support ie treatment and support are usually provided at home
• Residential Rehabilitation aimed at patients who require continued support in order to regain independence and develop skills that facilitate independent living
• Day Programmes including patient operated programmes and self-help services
• Family Support and Education including Planned Respite
• Supported Housing, Work and Education Support and combating stigma and discrimination
5. OVERVIEW OF PROPOSED TRAINING AND EDUCATIONAL PLAN

This is likely to be a two year job. Establishment of national mental health strategy as part of the general health policy documents and health service delivery guidelines is urgently needed in Libya to empower all health workers and promote education and training and inclusion of mental health issues. Specific training programmes should be aimed at mental health workers at all levels and from all disciplines including nurses and should contain the essential elements of multimodal treatment options mainly psychological and social interventions, rehabilitation, psychosocial counselling and community-based psychosocial interventions. The adoption of the "Recovery Model" as part of the training and educational programme is worth considering as this is a client centred approach. Clinical supervision is crucial to promote professional development and to emphasize and facilitate the use of non-pharmacological approaches to common mental disorders. Educational programmes at primary, secondary and tertiary levels should be introduced. Training in basic psychiatry and psychosocial assessment and interventions should be available to general mental health workers at all levels. Establishment of undergraduate and postgraduate training courses and degrees in mental health should be part of the strategic mental health planning in collaboration with the local colleges and clinical schools and universities. Establishment of specific programmes and procedures to regulate and monitor continuing professional education, development and supervision. Training workshops and regular in-service schemes should be part of mental health policies and work requirement. Training should cover a variety of pertinent domains and skills specifically multidisciplinary team work, recovery skills training, best practice in case management, services for children youth, and families, older people and maternal mental health and forensic, addictions, patients at high risk or with high needs, crisis prevention, early intervention, risk assessment and management (violence and suicide) and supported housing. Incentives and reward system such as credit points should be considered for participating in continuing professional development schemes and having supervision.

5.1. Proposed discipline specific training programmes

The objective of the training programmes is to help in the process of capacity building and improving service delivery and standard and also in decentralisation of mental health services in this region or throughout the country. These programmes can be arranged to run independently or simultaneously and should attract a variety of staff disciplines or groups and within each staff group potential candidates will be targeted to develop an area of desired skills further in the future through higher studies, for example, child psychiatry for doctors and cognitive behaviour therapy for psychologists and family therapy for social workers and so on. It should be made clear that the centre of attention of the training programme is capacity building and the development of much needed skills in special areas, namely psychiatric subspecialties, psychological treatment and child and family and occupational therapy. The discipline specific programmes (see the 3 proposed programmes below) will be organised in collaboration with the MoH and the WHO and any other interested international and local agencies. The programme will be organised for a period between 6 and 12 months depending on the staff disciplines involved and length of the modules. Curriculum, local and international tutors, trainers and visiting mentors can be arranged accordingly. The programme will lead to the awarding of a recognised certificate or diploma that would have certain remuneration merits and should count towards eligibility for further studies or qualifications.
5.1.1. A specific training and educational programme can be organised and coordinated locally aimed at primary health care doctors including junior psychiatrists, and should be directed to new graduates that could be recruited specifically from the eastern region and outskirts of Benghazi and other cities in Libya such as Tobruk, Darna, Al Bayda, Al Marj, Ajdabiya, and Sirte. The aim is to solicit doctors from areas currently deprived from trained mental health doctors and psychiatrists so that when they finish their training they can take up psychiatry as their future career and return to work in their place of origin ie their cities. The curriculum should incorporate in the first stage of the training the theory and practice of general psychiatry and its branches and various treatment modalities as well as the importance of peer review groups, continuing professional development schemes and supervision. In the second stage the focus should be on specific psychiatric branches or subspecialties such as child or forensic psychiatry to lay the foundation for the individuals who would like to take up any of these subspecialties as a career.

5.1.2. A similar training and educational programme can be organised locally in parallel or subsequently for psychologists and social workers. This training programme module should include cognitive behaviour therapy, group therapy and group facilitation, family and child therapy, addictions and motivational interviewing and psycho-educational groups. Participants need to learn the required skills in applicable psychometric assessment tools and scales and to recognise the importance and values of peer review groups, continuing professional development schemes and supervision.

5.1.3. Similarly, a training and educational programme for nurses in mental health care, should include modules in basic general psychiatry and case management, multidisciplinary team approach, recovery model, psychotropic medications, assessment of mental state and risk assessment and management, de-escalation and calm and restraint technique and one to one nursing and the importance of having supervision.

CONCLUSION
The existing mental health services in Libya are both inadequate and unsatisfactory. This dismal situation has been complicated and made worse by ongoing hostility that impacted on all aspects of Libyan society and infrastructure. There are significant mental health and psychosocial needs that are still not met particularly within the eastern region of the country that have been badly affected by the continuing conflict. Many drawbacks have been highlighted throughout the assessment findings, including unsuitable centralised secondary care and limited primary service provision, as well as restricted psychosocial resources and trained workforce. Urgent and wide-ranging intervention is required to deal with serious service provision and related needs such as the premises, psychotropic drugs, rehabilitation, and human resources and training.
6. REFERENCES
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