

Child and adolescent mental health in Iraq: current situation and scope for promotion of child and adolescent mental health policy

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Violence and instability in Iraq have had highly detrimental effects upon Iraqi children and adolescents. This article summarises the magnitude of Child and Adolescent Mental Health (CAMH) problems, and the available services in a country suffering from severe and extended conflicts, war, and international isolation. Possible interventions to promote child and adolescent mental health are discussed, including feasible CAMH policy, mental health plans and strategies. Barriers to successful implementation of CAMH services are identified and possible solutions are suggested.

Keywords: armed conflict, children and adolescents, intervention, Iraq, mental health, mental health policy, violence

Background

Raising awareness about child and adolescent mental health needs within a community and among policy and decision makers, is often challenging even in peaceful times, let alone in times of wars and disasters (Fayyad, Salamoun, Karam, Karam, Mueimneh & Tabet, 2008). Their needs in times of crisis are likely to be complex, and intimately connected with the basic needs of security, food, shelter, education and family connection. Addressing these requires a holistic, rights based approach that can provide resources to meet their basic

needs, advocate for their security and protection, as well as recognise and meet the needs of more vulnerable children, or refer them to other agencies with appropriate resources (Jones, 2008).

Half of the, approximately 30 million, population of Iraq are children and adolescents (Central Organisation for Statistics and Information Technology (COSIT) 2009). In recent decades, wars, international sanctions, internal unrest, and massive civilian displacements within, and beyond, its borders have dominated the history of Iraq. Since the 2003 invasion of Iraq, hundreds of thousands of Iraqi citizens, including many children and youths, have died and thousands have suffered serious injuries. Kidnapping for ransom, loss of parents, and displacement have undermined the fundamental security of Iraqi children; impacting an estimated two million Iraqi child refugees (Colville, 2007). Malnutrition, deterioration of education, a high and increased rate of truancy, child labour, trafficking of children and involvement of children with militia and insurgency groups threatens the wellbeing of Iraqi children (AlObaidi, Jeffery, Scarth & Albadawi, 2009b). Furthermore, religious and political persecutions accompany continuing civil disorder in Iraq (UNICEF, 2008).

It is clear that the recent armed conflict in Iraq has had a profound impact on children's physical and mental health, but the origins of the problems facing Iraqi children have their roots in the immediate decades prior to 2003. The cumulative effects of this history have left Iraqi children in dire circumstances. For example, according to Awqati, Ali, Al-Ward, Majed, Salman and Al-Alak (2009), access to health services for children under five is severely limited, especially in rural areas. As a result, under-five child mortality in Iraq is one of the highest in the Middle East region.

According to the already established evidence from other conflict and disaster settings (Panter-Brick, Eggerman, Gonzales & Safdar, 2009; Kar, Mohapatra, Nayak, Pattanaik, Swain & Kar, 2007), intensive and continuous exposure of children, adolescents (and their caregivers) to multiple stressful events in conflict and disaster settings is a major risk factor to the mental health of children and adolescents. Additionally, Tol, Komproe, Sussanty, Jordans, Macy and De Jong (2009) note that exposure to violence is a risk factor for adverse outcomes of child development in low-income settings, and that childhood mental health problems are difficult to address within the contexts of ongoing poverty and political instability.

The magnitude of child and adolescent mental health (CAMH) problems in Iraq

Children exposed to armed conflicts are more likely to develop mental disorders (Attanayake, McKay, Joires, Singh, Frederick Burkle Jr & Mills, 2009). Living with the constant risk of harm during exposure to armed conflicts has unique emotional, social, trans-generational and ideological

influences on child development (Punamaki, 2008).

It is difficult to obtain precise numbers on the prevalence, severity, and basic needs that are not met in order to treat child and adolescent mental disorders in Iraq because of the following factors: a) shortage of human resources; b) lack of funding; c) lack of research tools; d) lack of training of local professionals to conduct research; e) low priority of data collection by state agencies; f) poor CAMH awareness; and g) threats related to the safety of research teams in insecure areas.

In spite of the difficulties of conducting research in the contexts of armed conflict, research literature does exist. For example, Ahmad, Mohamed and Ameen (1998) reported a high prevalence of posttraumatic stress symptoms among a sample of displaced children living on the Iraqi-Turkish border in Kurdistan (North of Iraq) in the aftermath of 1991 Gulf war. Twenty percent of these children reportedly met the DSM-III-R criteria for posttraumatic stress disorder (PTSD). In 2005, PTSD was reported among 14% of children living in Baghdad, and 30% of those living in Mosul (Razoki, Taha, Taib, Sadik & Al Gasseer, 2006). Jones (2003) provided an account of children's worries and fears facing daily hazards and discomforts in internally displaced persons (IDP) camps in the north of Iraq.

Data from a cross-sectional study in the city of Mosul, in the northern part of Iraq, revealed that mental disorders were found among 37.4% of children and adolescent patients attending primary health care (PHC) facilities. The most common disorders included PTSD (10.5%), non-organic enuresis (6%), and separation anxiety disorder (4.3%). Depression was reported in only 1.5% cases. Additionally, there were

9.4% cases of comorbidity (PTSD and depression) (Al-Jawadi & Abdul-Rahman, 2007).

In 2006 at Nassiriya, a city in southern Iraq, attention-deficit hyperactivity disorder (ADHD) was found among 15% of school children (Sadik, Al-Sayyad & Sadoon, 2008). This result was above the global prevalence rate for ADHD, which is 8–12% (Bidermann & Faraone, 2005). Allwood, Bell-Dolan and Abdul-Rhman (2000) discussed the contribution of trauma in developing behavioural problems (including over activity) among children and adolescents.

In a study conducted at the child psychiatric department of a general paediatric hospital in Baghdad during 2005, the distribution of diagnoses included: anxiety disorders (22%), behavioural problems (hyperkinetic and conduct disorders) (18%), non-organic enuresis (15%), stuttering (14%), epilepsy (10%) and depression (1.3%) (AlObaidi et al., 2009c). In contrast, in the first year after the Kosovo war, Jones et al. (2003) identified the following distribution of diagnoses in war effected children: stuttering (1.1%), fits (1.7%), stress-related disorders (21.4%), non-organic enuresis (6.5%) and mood disorders (4.5%).

Many reports have indicated problems of drug and sexual abuse amongst children and adolescents in Iraq (AlObaidi et al., 2009b). However, it is difficult to know the real scope of this problem. AlObaidi, Scarth and Dwivedi (2009c) suggested there were only 1.3% cases of drug abuse registered among clinical sample of children and adolescents in Iraq. The large, unexplained variations in prevalence rates identified through trauma focused psychiatric epidemiology may be attributable to differences in context, methodology, or both (Rodin & van Ommeren, 2009). As Gupta (1997)

noted, quantitative surveys with children in emergency situations are often focused on pathological symptoms using non-validated symptom checklists. Symptom checklists do not allow children to express decreased feelings of wellbeing, nor to identify their perception of causes of their problems, i.e. sadness, nightmares, hyper arousal or lack of energy (Jones & Kafetsios, 2005). Furthermore, a focus on pathology prevents children from expressing their other psychosocial needs or protection concerns. Thus, quantitative surveys should use culturally validated instruments, and attend to the actual context, nature of the event, and the socio-cultural political milieu in which event occurs.

Also, the diagnostic categories, such as PTSD, do not capture the complexities of the multiple possible consequences of war on children's mental health functioning. For example, Kos & Zemljak (2007) stated that the term 'traumatisation' only covers one part of the wide range of adversities affecting the mental health and psychosocial wellbeing of children, and their families in Iraq.

Child and adolescent mental health services in Iraq

Professional care for the mentally ill in Iraq began about 60 years ago with the establishment of mental hospitals, scattered throughout the country. Mental health was introduced in general hospitals just three decades ago (Sadik & AlJadiry, 2006). Currently, there are only two state psychiatric hospitals located in Baghdad, and 22 psychiatric units attached to general hospitals in governorates across Iraq. Interest in the mental health of children and adolescents is a comparatively recent phenomenon in Iraq (AlObaidi, AlYaseen & AlAni, 2009a). Consequently, there are no separate inpatient

mental health services for children and adolescents, and CAMH services are usually provided in outpatient mental clinics for the general population. Psychiatric drugs are almost exclusively the mode of therapeutic intervention. One small CAMH clinic was established in the Central Child Hospital in Baghdad after 2003, but with very limited resources. There are a number of institutes for children with special needs and residential houses for orphans. However, the lack of resources and staff training may undermine the provision of services in these institutions. Behavioural, play and other forms of psychotherapy are not routinely practised. General psy-

chiatrists and a small team of psychologists and social workers assist the Iraqi juvenile justice system. However, they have no specialised training in the treatment and rehabilitation of youthful offenders. There are no CAMH services in Iraqi schools.

Two international non governmental organisations (NGOs) have focused some of their work on CAMH. Psychotherapy for children is provided by Diaconia, mostly in the North, and INGO International Medical Corps focused on the rehabilitation of orphanages and providing mental health training for primary health care doctors, mostly in Central Iraq (Table 1).

Table 1. CAMH facilities in Iraq at the moment*

Type of facility	Details about facility	CAMH services
State mental hospital	Two hospitals in Baghdad providing inpatient and outpatient mental health services for adults	Only outpatient CAMH services integrated within adult mental health services
Psychiatric department at general hospital	22 psychiatric units attached to general hospitals all over the country	Outpatient CAMH services integrated within adult mental health services
State paediatric hospital	Nearly one in each governorate (four in Baghdad) providing health care for children	No CAMH services within paediatric hospitals Only one CAMH clinic attached to the Central Child Hospital in Baghdad
State Institute for children with special needs and residential house for orphans	Available in all governorates.	CAMH services are questionable due to lack of resources and training
Private house for children with special needs	No documented figure (probably 15 all over country)	Same problems of the state institutes. Little supervision
Juvenile justice system	—	Not well established
Schools	—	No available CAMH services
Non-governmental organisation	Diakonia INGO International Medical Corps	Psychotherapy for children Rehabilitation of orphanages Mental health training of primary care doctors

Human resources are another challenge facing the delivery of CAMH services in Iraq. Among the approximately 100 psychiatrists in Iraq, none of them are formally trained in CAMH. Other mental health, human resources include: only seven general practitioners practicing mental health; 145 psychiatric nurses; 16 psychologists; and 25 social workers (WHO, 2009), (Table 2).

Additionally, there is a general lack of mental health awareness in Arab countries, and low priority is given to mental health within general health care policies. This is the case in the majority of developing countries (Al-Sharbati, Al-Hussaini & Antony, 2003; Murthy, 2008). However, the picture is even gloomier in countries like Iraq, where there are almost no proper CAMH services, in spite of the additional needs caused by wars and economic sanctions. The stigma associated with mental health problems is also a very challenging issue, especially in low and middle income countries (including Iraq), where there may be considerable indifference, and a lack of scientific knowledge about mental health

issues (Syed, Hussein & Abdul Wahab Yousafzai, 2007).

Scope of promoting child and adolescent mental health in Iraq

Iraqi mental health care providers operate under extremely difficult circumstances and are poorly equipped to help the most vulnerable members of the society. Thus, it is not surprising that promoting CAMH and establishing CAMH services in Iraq presents a great challenge.

Child and adolescent mental health policy

A recent survey has revealed that no country in the world has a clearly defined mental health policy pertaining uniquely to children and adolescents (Shatkin & Belfer, 2004). Several different systems of care (e.g. education, welfare, and health) may need to be involved to ensure that mental health services for children and adolescents are effective. Guidance in developing CAMH policies and plans is crucial to prevent the health system from becoming fragmented, ineffective, expensive or inaccessible (WHO, 2005). CAMH policy should

Table 2. CAMH human resources in Iraq at present*

Type of human resources	Number within mental health services	Training in CAMH
General psychiatrist	100	No formally trained CAMH psychiatrists
Paediatrician	0	Limited training in CAMH
Primary health care and community doctor practising mental health	7	Limited training in CAMH
Psychologist	16	No formally trained CAMH psychologists
Social worker	25	Limited training in CAMH
Psychiatric nurse	145	Limited training in CAMH.

* Source: Sadik & AlJadiry, 2006; WHO, 2009.

present the values, principles and objectives of improving the mental health of children and adolescents, and reducing the burden of child and adolescent mental disorders in the population.

Iraq needs an independent CAMH policy focusing on key issues, and ensuring that the needs of children and adolescents are not lost within the broader mental health policy. An Iraqi CAMH policy is needed to minimise the effects of violence by promoting the development of CAMH services, to deliver comprehensive, integrated, community based approaches to prevention and treatment services, focused on the most common mental health problems in Iraq.

A series of steps needs to be taken in Iraq to develop a child and adolescent mental health policy. These steps include:

- 1) Conducting a needs assessment through rapid population assessments, including interviews with health workers, educators, clergy, law enforcement officials, children, adolescents and their parents;
- 2) Gathering more evidence for effective strategies currently in place, e.g. information about successfully implemented CAMH pilot projects;
- 3) Consensus building and negotiation with all key stakeholders (academic and educational institutions, different ministries, community mental health professionals, consumer groups, NGOs, parents and family members, professional associations, international agencies, etc.);
- 4) More exchanges with other countries, especially with those similar to Iraq in areas such as economic development, health system organisation and governmental arrangements;
- 5) Setting out the vision, values, principles and objectives of the policy;
- 6) Determining areas of action (financing, inter sectoral collaboration, legislation and human rights, advocacy, information systems, research and evaluation of policies and services, quality improvement, organisation of services, promotion, prevention, treatment and rehabilitation, improving access to and use of psychotropic medicines, and human resource development and training).

The magnitude of CAMH needs and the limited availability of CAMH services require preventive and community based services, including CAMH interventions focused on empowering families, teachers in school based mental health promotion programmes, and community health workers. CAMH capacity needs to be present within the entire health system, with a particular focus on low cost, universally available resources. This will require recognition that mental health underlies, and is integral, to an individual's overall health and sense of wellbeing. It is necessary to create a cadre of health professionals within the primary health care setting who have at least basic CAMH knowledge/skills to ensure the success of CAMH promotion and early intervention efforts.

Comprehensive and culturally appropriate CAMH services are needed to address a wide range of child problems, such as learning disabilities. These services should be developed by local professionals, and should be built upon existing local infrastructure. Such services can also have an educational role in '*de-pathologising*' normative responses to disaster (Jones, Rrustemi, Shahini & Uka, 2003).

Sensitive subjects, such as, for example a higher risk of sexual violence and/or incest in war and conflict related environments,

need to be addressed, and health workers need to be prepared to deal with such problems. Moreover, purchase of psychotropic drugs, e.g. sleeping pills and tranquilisers, in the black market that are used without formal prescription is worth attention, particularly because of the possible development of dependency syndrome. Salient mental health issues also include severe stress due to exposure to, and witnessing, violence, grief and bereavement issues related to the death of a family member or a friend, and the erosion of family cohesion due to migration of family members.

CAMH plans and strategies

Once a mental health policy is in place, the next step would be to develop a mental health plan to implement its objectives. A set of strategies should be put in place for each area of action. For example, in the area of inter sectoral collaboration, regular meetings should be established between key managers in health and education systems, and workshops for educators should be organised to facilitate implementation of appropriate school based interventions for children and youth suffering from mental health problems.

Extensive clarification of mental health and psychosocial care issues and education about causes of mental health problems play a crucial part in reducing stigma attached to mental health disease (Jordans, Tol, Komproe, Lasuba, Ntamutumba, Susanty, Vallipuram & de Jong, 2008). For example, media are a strong tool for increasing mental health public awareness by reaching a large number of people through radio and TV programmes, as well as printed media. Another useful tool for mental health education are self help groups for a general population.

The *IASC Guidelines on Mental Health and Psychosocial Support in Emergencies* (2007) suggest a pragmatic approach to conducting a needs assessment of children in crisis, and emphasise a need for a coordinated process that avoids multiple assessments. This approach should engage both the community and stakeholders.

There are a number of potential strategies for CAMH promotion that focus on building capacity of CAMH services, educating parents and families, and linking schools health systems with the community. These include both planning and implementation of mental health interventions. CAMH capacity building must also focus on the detection and treatment of mental disorders for which there is an evidence base, and on the utilisation of wider public health strategies for mental health prevention and promotion. Mental health capacity needs to be built across the whole health system, with the emphasis on low cost, universally available, and accessible services.

In the area of legislation and human rights, an Iraqi Child Protection Act should fill the gap and ensure that children are brought up in a protective and healthy environment focused on the best interests of the child (AlObaidi et al., 2009b).

In the area of research and evaluation, the strategy may focus upon conducting an outcome study of the effectiveness of primary health care interventions for child and adolescent mental health problems. The extent of media coverage and the amount of humanitarian support children receive should also be addressed.

Resilience has frequently been viewed as a unique quality of certain people with exceptional emotional strength (Bonnano & Mancini, 2008). It has been suggested that further research on war affected children should pay particular attention to their

coping mechanisms and the meaning events have on them as individuals, the role of their family relationships and caregivers, health resources, and social support available to them in their peer and extended social networks. Cultural and community influences, such as attitudes towards mental health and healing, as well as the meaning given to the experience of war itself are also important aspects of the larger social ecology (Betancourt & Khan, 2008). The promotion of resilience does not lie in an avoidance of stress, but rather in encountering stress at a time, and in a way, that allows self confidence and social competence to increase through mastery and appropriate responsibility (Rutter, 1985). Recent research has consistently shown that across different types of potentially traumatic events, including bereavement, serious illness, and terrorist attack, upwards of 50% of people have been found to display resilience. Factors that promote resilience are heterogeneous and include a variety of person centred variables (e.g. temperament of the child, personality, coping strategies, etc.), demographic variables (e.g., male gender, older age, greater education), and socio contextual factors (e.g., supportive relations, community resources) (Bonnano & Mancini, 2008).

In the area of organisation of services, an in service training programme could be designed and implemented for primary care level workers, and a system could be introduced whereby psychiatrists and psychologists volunteer half a day per week providing consultation/liaison services for primary care staff. The mental health services for children and adolescents should be separated from adult psychiatry and should be implemented by multidisciplinary teams that should address issues like programme planning, education, development of services, collaboration with other health

sectors, and establishment of the leadership structure (Jones & Shahini, 2004).

The educational sector is a natural milieu for extending mental health services, and evidence has accumulated that mental health interventions in school settings can be effective (Rones & Hoagwood, 2000; Tol et al., 2009).

Raising CAMH awareness among the general population, creation of parent training programmes, and a balanced appraisal concerning the use of psychotropic medications in the treatment of children, can all be useful tools in developing CAMH services for children with serious mental, behavioural, and developmental disorders. Political, social and cultural literacy are essential, because to help a child in crisis one needs to understand the child's world and his/her perspective. Actually, it is almost always a combination of psychological and non-psychological interventions, addressing different issues (shelter, family connection, justice and reconciliation) that may be the most helpful to a child in the longer term. It is important to establish child and family mental health and psychosocial programmes in conflict, post conflict and disaster areas to address all of these issues (Jones, 2008).

It is recommended for a psychosocial stimulation to be combined with emergency nutrition programmes, as there is clear evidence to show that combined interventions in early childhood promote better longer term cognitive development, and better growth of children (Walker, Wachs, Gardner, Lozoff, Wasserman, Pollitt et al., 2007). There is also evidence that nurturing parental behaviour at this early age may increase the resilience of children to stress during their lifetime (Leckman, 2007).

Evidence concerning the mental health of young refugees and asylum seekers is less

comprehensive than that of adult refugees (Lau & Thomas, 2008). Given that nearly two million children have been displaced from their homes in Iraq, all key mental health players should address this issue as a priority. Finally, indicators, targets and activities should be set for each proposed strategy, and costs, available resources and a budget should be determined.

Barriers and solutions

It is very important to identify both barriers and solutions related to successful implementation of CAMH policy in Iraq. Possible barriers obviously include insufficient human and financial CAMH resources, shortage of epidemiological data and data on the effectiveness of CAMH pilot projects in Iraq, as well as continuing violence and misconceptions about CAMH in Iraq.

The training of primary health care professionals has proven to be an efficacious (Budosan & Jones, 2009) and potentially cost effective solution to the shortage of mental health professionals in developing countries (Chisholm, Sekar, Kumar, Saeed, James, Mubbashar & Murthy, 2000). Involvement of the community is essential to the success of these programmes, and school mental health programmes have evoked a great interest amongst teachers and other members of local communities (Töl et al., 2009).

It is also important to form a network of child mental health professionals who are currently working individually, improve their communication, and build a referral system to enable more efficient use of their time, and facilitate planning of mental health interventions for children (Syed et al., 2007).

The lack of adequate statistical data and research findings makes it difficult to plan

CAMH services. Also, the Iraqi school system is currently lacking a mental health philosophy, and Iraq teachers are not trained to identify children with learning and emotional problems.

Given the stigma associated with mental disorder and the small number of trained mental health professionals in Iraq, there is an urgent need to develop efficient interventions aimed at prevention and/or early treatment of CAMH problems that can be implemented by non-specialist health workers in primary health care settings (Belfer & Saxena, 2006; Patel, Flisher, Nikapota & Malhotra, 2008). There may be an even greater need for school and community based CAMH programmes (Mishara & Ystgaard, 2006).

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