

Psychosocial disability in the Middle East

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30 May 2018

Question

- 1) *What are the current best estimates of psychosocial disability in the following countries in the Middle East and North Africa: Lebanon, Jordan, Occupied Palestinian Territories (OPTs), Iraq, Syria and Yemen?*
 - a. *What factors influence prevalence of psychosocial disability in each of these countries, and is conflict an important factor?*
 - b. *What forms of psychosocial disability are prevalent in MENA countries and how might they differ by country?*
 - c. *How might prevalence and form of psychosocial disability differ across the following demographic characteristics: gender, age, religion, ethnic group?*
 - d. *What is the state of provision, both state and non-state, for those with psychosocial disabilities in these countries, and does eligibility and access to provision/services vary across demographics (e.g. age, gender, religion or ethnic group)?*

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The K4D helpdesk service provides brief summaries of current research, evidence, and lessons learned. Helpdesk reports are not rigorous or systematic reviews; they are intended to provide an introduction to the most important evidence related to a research question. They draw on a rapid desk-based review of published literature and consultation with subject specialists.

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1. Overview

Where the term psychosocial disability was used in the literature it often was not defined. Among experts some felt it wasn't an important distinction, one said it was a term rarely used in the field and a few agreed a broad definition that recognises exclusion. The Convention on the Rights of Persons with Disabilities¹ highlights the barriers to participation in society in its definition of disability. This also suggests, for the purpose of identifying data on psychosocial disability, a focus on identifying those experiencing challenges rather than recording diagnoses. However, a distinction between psychosocial wellbeing and mental health conditions is not necessarily reflected in data reporting. This distinction and what it means for data gathering is an interesting and important area for discussion but unfortunately beyond the scope of this report. To provide as much data as possible this helpdesk includes prevalence information under a broad definition of mental health conditions. One expert in the field expresses that someone with a mental health condition does not necessarily have psychosocial disability but there will be close correlation. Data describing mental health conditions is currently more widely available, and so useful for reporting in a rapid review. There is further debate about what constitutes a 'condition' or a group of 'disorders', which is also beyond the scope of this review.

Gater et al. (2015) note that routine information systems for mental health in the Eastern Mediterranean Region countries are lacking. One-third of countries in the region had not published a mental health information report in the past 2 years and half were unable to provide financial information.

WHO disease burden estimates from 2015 (see section 2) provides data on substance use disorders, depressive disorder, anxiety disorders and idiopathic intellectual disability for all countries but the OPTs. Iraq show the highest burden followed by Yemen, Syria, Jordan and Lebanon. Data for OPTs is not available. Depressive disorders represent the highest burden followed by anxiety disorders. Estimates from individual countries often date back ten or more years. Approximately 25% of the Lebanese population were reported to have a mental disorder in 2008. One-month prevalence of major depressive episodes in Palestinian adults is 24%. An Iraq mental health survey in 2006/6 found 68% of those with mental disorders had suicidal ideations.

Conflict and associated trauma has a major detrimental impact on psychosocial wellbeing, particularly post-traumatic stress. Other factors affecting mental health were little discussed in the literature identified for this brief report.

Gender disaggregated data suggests higher substance misuse amongst men and higher rates of both depression and anxiety among women. Autism and Asperger's is higher among men and boys more commonly have behavioural disorders compared to girls. Age disaggregated data for Lebanon show greater burden of mental disorders among 15-49 year-olds.

Section 5 gives a brief overview of the information found on service provision in each country. A general move away from psychiatric hospitals towards integrated service provision is common.

¹ <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-1-purpose.html>

Community-based services are also described. Lebanon seem to have better state-run services where other countries rely on NGOs and international organisation.

2. Prevalence and different forms of mental health conditions and psychosocial disability

WHO disease burden estimates 2015²

Table 1 shows that overall, mental disorders are distinctly higher in Iraq, where 773.2 DALYs are lost. Yemen have the next greatest burden, 519.2; followed by Syria, 377.0; Jordan, 160.9; and Lebanon, 136.3. Data for individual disorder show a relatively similar size and shape of distribution.

The greatest burden measured by disability-adjusted life years (DALYS) are depressive disorders, followed by anxiety disorders, then drug use disorders.

Table 1: Disability adjusted life years, 000's, 2015³

		Lebanon	Jordan	Iraq	Syria	Yemen
Mental and substance use disorders		136.3	160.9	773.2	377.0	519.2
Depressive disorders		45.0	52.0	228.4	124.6	166.0
a.	Major depressive disorder	37.7	44.3	195.3	106.2	141.4
b.	Dysthymia	7.3	7.6	33.1	18.4	24.6
Bipolar disorder		8.9	9.7	39.5	22.9	32.3
Schizophrenia		9.4	10.2	40.8	23.2	27.6
Alcohol use disorders		2.3	2.6	14.0	6.0	13.2
Drug use disorders		13.1	17.7	109.4	31.0	41.2
a.	Opioid use disorders	11.8	16.1	105.1	28.4	38.1
b.	Cocaine use disorders	0.2	0.2	0.7	0.4	0.3
c.	Amphetamine use disorders	0.4	0.5	0.8	0.7	0.3
d.	Cannabis use disorders	0.3	0.4	1.7	0.9	1.4
e.	Other drug use disorders	0.4	0.5	1.0	0.6	1.1

² http://www.who.int/healthinfo/global_burden_disease/GHE2015_DALYs-2015-country.xls?ua=1

³ Data unavailable for OPTs

Anxiety disorders		27.5	28.5	140.7	69.9	98.6
Eating disorders		1.2	1.4	5.5	2.1	2.7
Autism and Asperger syndrome		7.5	10.1	47.6	24.8	35.9
Childhood behavioural disorders		6.7	10.6	63.2	29.2	38.7
a.	Attention deficit/hyperactivity syndrome	0.5	0.8	3.1	1.9	2.4
b.	Conduct disorder	6.2	9.9	60.2	27.3	36.3
Idiopathic intellectual disability		7.1	9.6	48.0	24.0	36.1
Other mental and behavioural disorders		7.7	8.5	36.0	19.4	27.2

Regional estimates from different sources

Table 2 shows conditions treated by International Medical Corps. This is different to prevalence data but gives some idea of what is going on in these countries.

Table 2: Descriptive Statistics: 6357 Mental Health cases managed by International Medical Corps in Various Regions of the Syria Response (Hijazi & Weissbecker, 2015)

Gender (n)	Syria	Lebanon	Turkey	Jordan	Total
Male	73	1950	368	1011	3402
Female	110	1661	277	907	2955
Age Groups (n)*					
Children, under 18 years ¹	75	549	199	353	1176
Adults, above 18 years	108	3062	446	1565	5181
UNHCR Categories of Mental Illness (%)					
Severe Emotional Disorders	61%	59%	23%	74%	
Psychotic Disorders	4%	16%	16%	9%	
Epilepsy	14%	5%	40%	7%	
Developmental Disorders	11%	5%	8%	6%	
Other Disorders	2%	6%	9%	1%	
Behavioral Disorders	8%	4%		3%	
Alcohol & Other Substance Abuse Disorders		2%	1%		
Other Psychological Complaints		2%	1%		
Medically Unexplained Somatic Complaints		1%	2%		
Total (n)	183	3611	645	1918	

The WHO Strategy for mental health and substance abuse in the Eastern Mediterranean Region 2012–2016 (HWO, 2011) reports that psychological distress rates vary between 15.6% and 35.5% in the region, with higher rates in countries under complex emergency situations. The

most frequent disorders are depression and anxiety. And as a whole, mental and substance use disorders account for 12% of DALYs lost.

Lebanon

The Ministry of Public Health mapping in 2015 states that the latest mental health disorder estimates are from 2007 (Ministry of Public Health, 2015). Approximately 4.6% of the Lebanese population had experienced a severe mental disorder (including depression and anxiety) (Karam et al., 2008). Around 25.8% had at least one of the mental disorders and 10.5% had experienced more than one. Depression was the most prevalent of the disorders (lifetime prevalence of 9.9%). Anxiety disorder was the most common (16.7%), followed by mood disorders (12.6%), impulse control disorder (4.4%) and substance misuse (2.2%). 4.3% experienced suicidal ideation and 2% attempted suicide.

Syria

Table 4 above shows data collected by trained International Medical Corps (IMC) staff. Of mental health cases managed in Syria, 61% were severe emotional disorders, 11% were developmental disorders, 4% psychotic disorders, and 8% were behavioural disorders. Epilepsy is grouped here as a mental health disorder.

A review of the situation in Syria emphasises the importance of recognising wide range of mental disorders such as exacerbations of pre-existing mental disorders, problems prompted by the conflict and displacement, and problems related to the post-emergency context, such as living conditions (Hassan et al, 2015).

Jordan

IMC reports in Jordan that of the mental health cases managed, 75% are severe emotional disorders, 9% psychotic disorders, 6% developmental disorders and 3% behavioural disorders (Table 4).

The WHO-AIMS mapping for Jordan (WHO-AIMS, 2011) shows schizophrenia and delusional disorders to be the most commonly treated in mental health services. Mood disorders made up 35.5%. The remaining 14% were substance use disorders, neurotic, stress-related or somatoform disorders, disorders of adult personality or behaviour, and other conditions, including epilepsy and mental retardation.

OPTs

An academic study looking at the burden of mental disorders in the Eastern Mediterranean region found Palestine had the largest burden of mental disorders between 1990 and 2013 (Charara, 2017). A field assessment of health conditions in 2015 identifies depression, anxiety disorder and psychological distress as the most common mental disorders (Manenti et al., 2016). An academic study investigating major depression episode (MDE) in Palestinian adults found one-month prevalence to be 24.3% and lifetime prevalence to be 10.6% (Madianos et al., 2012). A cross-sectional household survey looking at exposures to traumatic events and mental health among refugee children in Bedouin communities in the West Bank identified a 44% prevalence rate of psychiatric disorders (Massad et al., 2017).

Iraq

A 2007/8 survey carried out by the Iraq Ministry of Health estimates lifetime prevalence of any disorder to be 18.8% (Alhasnawi, 2009). The most prevalent conditions were anxiety (13.8%) and MDD (7.2%). Twelve-month prevalence of any disorder was 13.6%.

An extensive survey carried out by well-trained staff found in 2006/7 found that among those with any mental disorder in Iraq, 68.39% expressed suicidal ideas (WHO, 2009).

A pilot study of university students from Baghdad University found 22.9% of the respondents had symptoms of post-traumatic stress disorder (PTSD) (Al-Shawi et al., 2011).

3. Factors influencing prevalence

There is no question that the experience of war will affect the mental health of the population involved. To what extent is difficult to ascertain. The disorders that are more closely related to trauma, such as PTSD, are naturally higher in these countries. Some disorders may be, for example, biochemical rather than environmental and in these cases less affected by trauma. The causes of mental health problems and psychosocial disability are many and varied and are still under investigation within the psychology discipline.

Karam et al. (2006) estimate that those experiencing exposure to war-related events are 3.1 times more likely to experience mood disorders and 2 times more likely to experience anxiety disorders.

WHO make projections of disorder rates in the adult population affected by an emergency⁴ with severe disorders at 2-3% before the emergency rising to 3-4% after, mild or moderate mental disorder from 10% to 15-20%, and normal distress from no estimate to a large percentage. This suggests that severe disorders are little affected by conflict situations, mild/moderate disorders more affected and normal distress considerably influenced by traumatic experiences.

Analysis of people from multiple countries who have been subjected to torture and other traumatic events found variable rates but averages of 30.6% for PTSD and 30.8% for depression (Steel et al., 2009). Torture was found to be the strongest factor contributing to PTSD. After that cumulative exposure to traumatic events had the greatest effect followed by time since the event and then assessed level of political terror. For depression, the most significant factors were number of events experienced and time since the conflict. Reported torture and residency status were also significant factors.

The Lebanon Mental Health and Substance Use Analysis notes that factors such as poverty, conflict, displacement, gender-based violence, low education levels, and chronic physical health conditions make substance misuse more likely (Ministry of Health, 2015).

Academic research on post-conflict communities found experience of violence and armed conflict associated with higher rates of mental disorders (de Jong et al., 2003). Risk ratios ranged from 10.03 (PTSD in Palestine) to 2.10 (anxiety in Algeria).

⁴ http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/

Lebanon

Estimates of population exposure to conflict gives an idea of those affected by war and the consequent impacts on mental health. There are estimates suggesting approximately 70% of the Lebanese population were exposed to one or more war events, including 60% of children ages 0–10 (Benedek & Ursano, 2008).

Research among 135 survivors of torture and arbitrary detention in Lebanon showed that their main needs are psychological in nature, and it is these problems that have prevented survivors from reintegrating in society (Daunay, 2011).

Karam et al. (2006) assessed the state of mental health in Lebanon and finds the number of war-related traumatic events experienced is highly correlated with number and severity of mood, anxiety or impulse control disorders.

Syria

Save the Children research on the impact of war on mental health interviewed children in Syria. Half said they did not feel safe at school or playing outside (McDonald et al., 2017). Interviews and focus groups found that 78% of children feel grief and extreme sadness some or all of the time and almost all adults said children had become more nervous or fearful as the war has gone on. 51% of parents said children are turning to drugs to cope with the stress. 84% of adults and almost all children describe the ongoing bombing and shelling as the primary cause of psychological stress in children's daily lives.

Interviews with Syrians identified three categories of stressors: (Hijazi & Weissbecker, 2015)

- Security and protection risks such as infiltration of armed groups, and difficulties obtaining legal status in host countries.
- Access and availability of basic services and resources (such as education, employment, and health).
- Tensions within families, communities and sects in Syria, and tensions with host countries for displaced Syrians.

A large-scale review finds the effects of conflict on Syrian mental health and psychosocial wellbeing to be profound (Hassan et al., 2015). This review agrees with the three categories of stressors above and also highlights the effects of anxiety over the current situation and uncertainty about the future. The Hassan et al. review finds limited data on Syrian people with psychosis or substance misuse so cannot draw conclusions on the influence of conflict on these conditions.

Jordan

Jordan are host to large numbers of refugees. UNRWA estimates⁵ 1.9 million registered Palestinian refugees in 2010, and tens of thousands of Lebanese and Iraqi refugees. Reports on the psychosocial needs of these displaced populations estimate over 50% of Iraqi families

⁵ <https://www.unrwa.org/userfiles/20100628261.pdf>

display eight or more indicators of distress in their new lives (IOM, 2008). Between 60-80% of those with direct exposure to traumatic events had depression and/or anxiety. A WHO, JHU and UNICEF (2009) survey finds 16% of adult refugees with depressive symptoms and 44% with severe emotional distress. The instability, insecurity and volatility hosting refugee populations can also contribute to mental ill-health in the host community, according to Jordan's 2004 Human Development Report⁶.

A large-scale report of displaced Syrians in Jordan found 15% had spent the 2 weeks preceding interview so afraid that nothing would calm them (El Chammay et al., 2013). 28.4% had felt so angry that nothing could calm them. 26.3% did not want to carry on living. 18.8% felt unable to carry out essential activities for daily living, a statistic which highlights the disability aspect of mental health.

A WHO Profile describing mental health in Jordan notes the cycle that can exist between poverty and mental health (Hijiawi et al., 2013). Being in poverty with less education and employment opportunities and adverse living conditions leads to a higher risk of mental disorders. Then these disorders make people less able to work or less employable where stigma exists. The lack of employment deepens the poverty. The Profile notes the pockets of severe poverty within Jordan which increase risks of mental illness.

OPTs

An academic study of Bedouin communities, among the most vulnerable in Palestine, found exposure to traumatic events, fair/poor maternal self-rated mental health, and younger age were positively associated with child mental health problems (Massad et al., 2017).

A field assessment in the OPT confirmed the occupation itself as a major cause of mental health problems (Manenti et al., 2017). The imprisonment of Palestinians in Israeli jails was found to affect not only the prisoner but also their families. A large proportion of the male population had spent time in confinement with long-term effects on their mental well-being. The prisoners' children experienced chronic stress, trauma, loneliness and loss of faith in adults. The psychological damage is likely to have a long-term health impact.

A Medical Aid for Palestinians (2017) briefing describes the political and social conditions which undermine psychological wellbeing. An estimated 86% of adolescents had heard or seen artillery shelling or jetfighters and 67% had witnessed deaths as a result of rocket attacks (Aziz & Vostanis, 2014). Most adolescents report symptoms of PTSD, 30% meet the criteria⁷ for full diagnosis. Rates of 54% of PTSD among children have been recorded in bombarded areas of Gaza (Murthy and Lakshminarayana, 2006). The WHO estimated up to 20% of the Gaza population (360,000 people) developed mental health conditions immediately after the 2014 attack.

Medical Aid for Palestinians (2017) note to consider not just those with clinically significant psychological conditions. It is likely that all people in the densely populated areas experience

⁶ <http://hdr.undp.org/en/content/jordan-human-development-report-2004>

⁷

http://www.emro.who.int/images/stories/palestine/documents/Joint_Health_Sector_Assessment_Report_Gaza_Sept_2014-final.pdf

chronic stress, fear and diminished quality of life as a result of military attacks. In addition it is likely that PTSD is not just about past stress but ongoing and cumulative stress.

Giacaman et al. (2007) interview adolescents and find a strong relationship between the level of exposure to violent events and self-reported depressive symptoms. El Khodary and Samara (2018) confirms this relationship and reports 88% of students sampled had experienced personal trauma and 84% had witnessed trauma to others.

A study of the effects of social media on mental health in the OPT finds high use of Facebook associated with higher levels of emotional discomfort (Nazal et al., 2018).

Iraq

The 2009 Iraq Mental Health Survey (Iraq, 2009) compares to a control group and confirms experience of traumas results in systematically higher prevalence of 12-month and life-time prevalence of mental health problems.

Yemen

A briefing paper highlights the traumatic experiences of many Yemenis and the likely effects on mental health (Al-Amman et al, 2017). The authors note a lack of research and advocacy on this in Yemen.

4. Differences across demographics

Some data were available disaggregated by gender and by age. Data disaggregated by religion or ethnic group were not available.

The gender-disaggregated data (see Table 3) shows that:

- Mental and substance use disorders rates are higher amongst men than women in all countries except Lebanon where females have higher rates than males.
- All countries have higher rates of depressive disorders amongst women rather than men.
- There appears to be little difference in rates of bipolar, schizophrenia or idiopathic intellectual disability between men and women.
- Alcohol use disorders are higher among men. Drug use disorders are distinctly higher among men.
- Greater prevalence of anxiety disorder is found among women.
- Men have higher prevalence of autism and Asperger’s in all countries.
- Boys more commonly have behavioural disorders than girls.

Table 3: Disability adjusted life years, per 1000 population, 2015 by gender

	Lebanon		Jordan		Iraq		Syria		Yemen	
	M	F	M	F	M	F	M	F	M	F

Mental and substance use disorders	66.4	69.9	83.3	77.6	397.1	376.2	191.2	185.8	264.3	254.9
Depressive disorders	19.0	26.0	23.6	28.4	93.5	134.9	54.4	70.2	73.0	92.9
Bipolar disorder	4.1	4.8	4.6	5.1	18.4	21.1	10.6	12.3	15.1	17.2
Schizophrenia	4.9	4.4	5.4	4.8	20.7	20.1	11.8	11.4	14.3	13.3
Alcohol use disorders	1.7	0.6	1.9	0.8	7.8	6.2	4.1	1.8	9.1	4.1
Drug use disorders	9.6	3.5	12.9	4.9	85.0	24.4	24.2	6.8	31.3	9.9
Anxiety disorders	8.8	18.7	10.2	18.3	45.2	95.6	24.6	45.3	34.6	63.9
Eating disorders	0.3	0.9	0.3	1.0	1.4	4.1	0.6	1.5	0.7	2.0
Autism and Asperger syndrome	5.5	2.0	7.6	2.5	35.3	12.3	18.5	6.3	26.7	9.2
Childhood behavioural disorders	3.9	2.8	6.4	4.2	42.1	21.2	17.8	11.4	23.9	14.7
Idiopathic intellectual disability	3.5	3.6	4.8	4.7	24.3	23.8	12.2	11.9	17.9	18.2

Age disaggregated data were extracted for Lebanon to give a picture of age effects. The same data are available for Syria, Jordan, Iraq and Yemen but time did not allow for extraction from all countries.

Of note from age disaggregated data in Lebanon (table 4):

- DALYs for mental and substance misuse are far greater between ages 15-49.

- Depressive disorders are highest amongst 30-49 year olds and then 15-29 year olds.
- Schizophrenia is distinctly higher in the 30-49 age group.
- Anxiety disorders have the greatest effect among 15-29 year olds and then 30-49 year olds.

Table 4: Disability adjusted life years, per 1000 population, 2015, Lebanon, by age

Age	5-14	15-29	30-49	50-59	60-69	70+
Mental and substance use disorders	12.3	47.4	46.2	15.1	8.5	6.2
Depressive disorders	1.8	14.6	16.5	5.8	3.6	2.7
Bipolar disorder	0.2	4.0	3.3	0.8	0.4	0.2
Schizophrenia	0.0	1.9	4.7	1.6	0.8	0.4
Alcohol use disorders	0.0	0.8	0.9	0.3	0.2	0.1
Drug use disorders	0.0	4.8	5.0	1.6	0.9	0.7
Anxiety disorders	3.3	10.3	8.5	2.6	1.5	1.1
Eating disorders	0.1	0.7	0.4	.	.	.
Autism and Asperger syndrome	1.4	2.5	2.0	0.7	0.4	0.3
Idiopathic intellectual disability	1.5	2.6	1.9	0.5	0.3	0.2

Looking at International Medical Corps case management in Syria, Lebanon, Turkey and Jordan Hijazi & Weissbecker (2015) find more men are seeking services than women (54% and 52% men for Lebanon and Jordan respectively), except for Syria where more women (60.1%) seek mental health services. Syria have a notably high percentage of children receiving services, 69% (18% in Lebanon, and 23% in Jordan). This be because there are fewer social outlets and activities in Syria.

Lebanon

Research since 2003 shows an upwards trend in drug use in Lebanon, particularly amongst youth (15-24 years) (Ministry of Public Health, 2015). The Global School Health Survey (GSHS) data shows that around 15.2% of the students surveyed had serious suicidal ideations, 11.6% made a plan about how they would attempt suicide, and 13.8% attempted suicide one or more times in the year preceding the study (Global School Health Survey, 2005 & 2011).

Karam (2012) found 9.3% of the elderly population suffer from a mood disorder and 3% had suicidal ideation. A recent community-based epidemiological survey finds mental disorders to be lower in older adults compared to younger adults (Karam et al., 2016). The authors suggests there may be study factors which contribute to under-diagnosis in older adults.

A situation assessment finds 65.1% of prison inmates diagnosed with lifetime substance dependence (Karam et al., 2010).

Syria

A report on the sociocultural background of the Syrian population and the cultural aspects of mental health and psychosocial wellbeing suggests how vulnerable groups are likely to be at risk but evidence is lacking (Hassan et al., 2015). There are gender aspects affecting different mental states. Other groups highlighted in the report as more likely to be affected are sexual and gender-based violence survivors, LGBT people, torture survivors and the elderly. The situation is particularly difficult for children. Their problems include: fears, difficulties sleeping, sadness, grieving and depression, aggression or temper tantrums, nervousness, hyperactivity and tension, speech problems or mutism, and somatic symptoms. Violent and war-related play is seen.

OPT

Research in east Jerusalem has shown that the psychological toll of demolitions and forced evictions hits women harder than men (Manenti et al., 2016). Higher rates of mental illness are found in widows and urban residents (Madianos et al. 2012).

Research with adolescents in Palestine found boys experienced more personal trauma, witnessing trauma, and seeing demolition of property than girls (Giacaman et al., 2007). Girls reported greater experience of stressful life events, exposure to trauma that was not war-related, PTSD, and depression. The same study found that big family size and low family income increased the severity of effects of stressful life events and exposure to trauma.

Iraq

A 2007/8 survey found panic disorder and post-traumatic stress disorder, lifetime-to-date prevalence, 5.4-5.3 times as high at comparable ages in the youngest (ages 18-34) as oldest (ages 65+) cohorts (Alhasnawi, 2009).

A rigorous health survey was carried in Iraq in 2006/7 with some demographic disaggregation (WHO, 2009). Women showed higher prevalence of severe depressive episode and phobias. Older women have higher prevalence of affective disorders than other age groups. The oldest age category for men and women had the highest rate for severe depressive episodes. Amongst women the 18-34 age group has higher prevalence of obsessive-compulsive disorders. Panic disorder and generalised anxiety disorder are higher in the south/centre than the Kurdistan

region. Higher values are also seen in the group widow/divorced/separated, and unemployed or retired. Show the highest values for severe depressive episode, episode, any affective disorders and mild depressive episode. Substance use is higher among men and in rural areas. The prevalence of suicidal ideas is higher in females compared to males.

Research on PTSD amongst students in Baghdad found no differences between age and sex (Al-Shawi et al., 2011).

5. Provision for those with psychosocial disabilities

The WHO-AIMS assessment system⁸ for mental health projects an overall treatment gap of more than 90% for mental and substance use disorders in the Eastern Mediterranean region (Ministry of Public Health, 2015). An overview of mental health service provision in the Eastern Mediterranean region suggests inadequate resources have been designated in this area (Gater & Saeed, 2015). An average of 2% of health budgets are spent on mental health compared to 5-10% in systems that are more comprehensive.

A research article in the Eastern Mediterranean Health Journal advises on how to meet the expectations of the Global Mental Health Action Plan 2013–2020 (Ivbijaro et al., 2015). Innovation for evidence-based healthcare provision to move towards universal health coverage is emphasised. Successful models for local integrated services must be scaled up. Effective leadership with high-level commitment and collaborative relationships across is essential. Broad recommendations for Eastern Mediterranean Health Ministries include embedding MHPSS in health and preparedness plans, national guidelines, health workforce capacity building, and utilising emergency response opportunities (Tol et al., 2011).

The Global Inter Agency Standing Committee (IASC) guidelines⁹ (2007) also recommend Mental Health and Psychosocial Support (MHPSS) coordination groups that work across and report to different clusters. Coordination group should map activities and services, coordination of efforts, information sharing, technical support and discussion forums, and donor advocacy. Coordination varies greatly depending country context. Syria and Jordan have active MHPSS formal working groups engaged in mapping of MHPSS activities (Hijazi & Weissbecker, 2015).

An intervention with potential global reach is a guided multimedia self-help package, Self-Help Plus.¹⁰A pilot in Uganda is awaiting results and further trials with refugee populations are planned.

International Medical Corps

International Medical Corps co-leads national level MHPSS coordination groups in Jordan together with WHO, in Lebanon (north) and Syria with UNHCR.

⁸ http://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf

⁹ http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

¹⁰ <http://www.mhinnovation.net/innovations/self-help-plus-sh-guided-multimedia-psychosocial-self-help-package>

International Medical Corps has provided psychological first-aid¹¹ (PFA) trainings in various settings including Jordan, Lebanon, Turkey, Syria, Libya, and Gaza (IMC, 2015). A Training of Trainers program is currently underway in Lebanon.

The IMC work on integration of mental health services with primary health care has been recommended by WHO and IASC. For cost-effectiveness, non-specialized health care providers are trained to identify and manage priority conditions making mental health care more widely available, accessible, and less stigmatizing. IMC integration works with national governments, adapts training materials to the local context, and supports institutional changes. Capacity building for evaluating results to inform policy, practice and scale-up is also important.

International Medical Corps, with the collaboration of local partners, has been integrating mental healthcare into the primary healthcare infrastructure in Syria, Lebanon, Turkey, Jordan, and Iraq (among others). The programme¹² had 624 clinical & non clinical staff trained in identification, management, and referral of mental health cases in 2015, and 72,143 people receiving mental health and psychosocial support in 2015. When supporting mental health facilities, International Medical Corps uses guidance from the WHO Quality Rights Toolkit¹³ for assessing and improving quality and human rights in mental health and social care facilities.

IMC activities and achievements in the region include: (IMC, 2015)

- Piloting of an innovative mhGAP e-learning program in Jordan, which uses an internet platform and self-study modules in addition to face-to-face workshops
- Mental Health Primary Healthcare (MH PHC) integration program in Lebanon is now informing national mental health policy
- Evaluations of MH PHC integration programs have shown improved knowledge, practice and attitudes among trained health care providers, improved facility integration and better referral pathways.
- Use of a Community Based Rehabilitation (CBR) approach supports people to live and work in their communities to the greatest extent possible with access to educational, vocational, employment, and recreational opportunities and activities.
- Involving sufferers in the design, implementation and evaluation of MHPSS programmes. People recovering help to reach out to those in need.
- IMC has developed mental health case management systems in Jordan, Southern Turkey, Syria, Lebanon, Gaza, Libya, Ethiopia and Haiti. Evaluation in Jordan found improved mental health and reduced use of prescription medications.
- IMC implement Early Childhood Development programmes with maternal support in Jordan, Syria, Lebanon, Gaza. And Youth Empowerment Programmes in Jordan, Syria and Lebanon.

¹¹ http://www.aaptuk.org/downloads/Psychological_first_aid_Guide_for_field_workers.pdf

¹² <http://www.mhinnovation.net/innovations/integration-mental-health-and-psychosocial-support-services-primary-healthcare-middle>

¹³ http://www.who.int/mental_health/publications/QualityRights_toolkit/en/

- Mapping of which donors are carrying out which activities in which country¹⁴
- IMC Gaza support the Gaza Community Mental Health Program Rehabilitation Center., with a focus on staff and community capacity building.

Lebanon

In 2014, the first National Mental Health Programme was launched by the Lebanese Ministry of Public Health, in collaboration with WHO, UNICEF, and IMC. Progress has seen the coordination of more than 62 organisations working in response to the Syrian crisis (El Chammay et al., 2016).

Activity in Lebanon

- Training on suicide risk management has been delivered.
- Task forces have been strengthened.
- An online platform of resources has been made available.
- A national referral system between MHPSS and the protection sector is being established for timely crisis management.
- Integration of mental health into primary care is being scaled-up through training and supervision.
- A pilot project to improve mental health services using the WHO Quality Rights Toolkit and engagement of the private sector has shown good results.¹⁵
- An electronic mental health intervention is being tested in Lebanon called “Khoutweh Khoutweh”.¹⁶ Remote guidance is delivered by phone by a trained non-specialist e-helper.

The success of Lebanon's mental health system is suggested to come from: utilisation of the momentum and increased interest created by the Syrian crisis; avoiding parallel care systems; effective collaboration between different agencies; national consensus; and high-level political support (El Chammay et al., 2016). There is a marked improvement since a study 10 years ago found very few who experienced a mental disorder had ever received professional treatment and those that sought it were to expect a 6-28 delay before receiving treatment (Karam et al., 2008).

The Mental Health and Substance Use Situation Analysis (Ministry of Public Health, 2015) is less positive about the state of care noting the dominant private sector has prioritised specialised care rather than integrated care. NGOs in Lebanon have been active in addressing issues related to substance use disorders through a variety of interventions such as prevention, rehabilitation, abstinence, and harm reduction. Multiple approaches are being implemented such as life skills education, peer-to-peer education, road shows, general awareness campaigns and rehabilitation. However, harm reduction services are limited.

¹⁴ <https://internationalmedicalcorps.org/wp-content/uploads/2017/07/International-Medical-Corps-2015-Mental-Health-and-Psychosocial-Support-Capacities-and-Experiences.pdf> see page 8

¹⁵ <http://www.mhinnovation.net/innovations/qualityrights-lebanon>

¹⁶ <http://www.mhinnovation.net/innovations/step-step-e-mental-health-lebanon>

The latest WHO-AIMS report (WHO-AIMS, 2015) records:

- 42 mental health outpatient facilities in Lebanon servicing 75 users per 100,000 population (28.52 beds per 100,000 population)
- Five mental hospitals, serve 47.41 patients per 100,000 population with 97% occupancy rate.
- Eight community-based psychiatric inpatient units with 1.5 beds per 100,000 population.
- Lack of mental health training for primary health and integration with mental health systems rare.
- Human resources working in public mental health facilities, NGOs, and private practice is 15.27 per 100,000 population. 1.26 psychiatrists, 0.87 other medical doctors (not specialized in psychiatry), 3.26 nurses, 3.42 psychologists, 1.38 social workers, and 1.06 occupational therapists, working in mental health per 100,000 population.

Syrian refugees are in need of psychosocial support in Lebanon. Focus group discussions identify barriers such as real or perceived fear of being mistreated (El Chammay, Kheir, and Alaouie, 2013). Most activities targeted women and children rather than men or young male adolescents. Assessment of support services notes a lack of clarity as to what is called psychosocial activities and how these might link to other services or to the humanitarian response. Staff training levels vary and human resources need to be strengthened. Most services are provided in community mental health centres or by multidisciplinary teams based in PHC centres.

Mapping assessment of MHPSS services for Syrians displaced in Lebanon in 2015 reports an increase in psychological intervention activities in many areas from two years previous (Ministry of Public Health, 2015). Child protection and gender based violence activities are most common (200), followed by strengthening of community and family support (180). Information dissemination activities have seen a large increase. Overall, resources are very limited, especially in the border areas (WHO-AIMS, 2010).

The Substance Abuse Response Strategy 2016-21¹⁷ is seen as a response to increasing prevalence of substance misuse in Lebanon. It provides a participatory framework and road map for all actors in the field. It assigns a key role to the Ministry of Social Affairs.

Early reports¹⁸ from a study to map the mental-health needs of Lebanese Youth suggests only 6% of youths that need help sought it.

Jordan

Recent information on mental and psychosocial healthcare provision in Jordan was not found within the scope of this rapid review. A WHO-AIMS (2011) assessment and the 2011 WHO

¹⁷ http://www.mindbank.info/download_file/6410/7dc0278690b14c659155b6dde1534ff351b3ca68

¹⁸ <https://www.chronicle.com/article/Study-To-Map-Mental-Health/242821>

Mental Health Atlas¹⁹ note lack of legislation and outline activity. Hijawi et al., (2013) estimate a treatment gap for severe mental disorders of 73.8%.

A pilot project following an influx of displaced Iraqis drew on short-term humanitarian funds to set up community-based mental healthcare (WHO, 2013). The community-based clinics helped an estimated 3,550 people in need from 2009 to 2011. Success prompted a national mental health policy and establishment of a Mental Health Unit within the Ministry of Health.

The United Nations Relief and Works Agency for Palestine Refugees deliver health services in Jordan (Hijawi et al., 2013). Staff in these services have received WHO Mental Health Gap Action Programme training.²⁰ Together with approximately 80 registered NGOs, a parallel mental health system exists for non-Jordanians but does not have long-term sustainability.

Health care professional interviewed in the Baga'a camp hosting Palestinian refugees all cite underfunding as the most common barrier to treatment (McKell et al., 2018). Other barriers were sex, stigma, religion and culture.

The WHO Mental Health profile (Hijawi et al., 2013) finds mental health poorly integrated within general health structures. There is a lack of coordination between the multiple health providers, and between the mental health sector and other sectors. There is also lack of coordination between the public mental health system and NGOs that provide a range of mental health interventions. Human resources, budgets and training are insufficient. Access to psychotropic medicines are available to Jordanians with health insurance (approximately 80% of the population). These medicines are unaffordable for those without insurance or for non-Jordanians.

OPTs

The National Mental Health Strategy for the period 2015-2019²¹ was formulated in collaboration with different Ministries and Agencies. It draws on the WHO Regional Framework to Scale up Action on Mental Health in the Eastern Mediterranean Region and the WHO Mental Health Action Plan.²² It aims to coordinate services with a multisectoral approach. It also takes into consideration the specific political and socio-economic context of the region. Emphasis is on promotion, prevention, treatment, rehabilitation, care and recovery.

A mixed-methods study assessing the mental health system in Gaza (Saymah et al., 2015) reports that deinstitutionalisation is occurring but legislation is lacking. Integration of mental health care into primary health care has not been fully achieved. Underfunding is a problem. Human rights protection of service users is needed.

A review of mental health needs and services (Marie et al., 2016) finds a need to raise awareness of mental health to improve service integration. Basic human rights needs must be met to improve the mental health of those in OPTs.

¹⁹ http://www.who.int/mental_health/evidence/atlas/profiles/jor_mh_profile.pdf?ua=1

²⁰ http://www.who.int/mental_health/mhgap/en/

²¹ <https://www.mindbank.info/item/6103>

²² http://applications.emro.who.int/dsaf/EMROPUB_2016_EN_18700.pdf?ua=1

A Health Sector Assessment describes Primary Health Care clinics provided by the Ministry of Health which identify and manage common mental disorders (Health Cluster, 2014). Additionally, six Community Mental Health Centres each serve a population of 200,000-350,000. They also serve as training venues for primary intervention services. There is provision of in-patient care in a mental health hospital with 30 beds.

The Assessment also describes mental health services provided by UNRWA and various NGOs. UNRWA provides psychosocial counsellors. The NGO-run Gaza Community Mental Health Programme (GCMHP) operates three community mental health centres. Other NGOs focus on psychosocial support providing non-specialised mental health services through counsellors and social workers. There are stock problems with many psychotropic drugs. The conflict interferes with the running of services. Mental health emergency teams based in general hospitals support in times of crisis.

Médecins du Monde France (MdM) are running psychosocial health programmes aimed at preventing or limiting the psychosocial impacts of occupation related violence in Palestine (Goupil-Barbier, 2016). The team intervened in 53 critical incidents between May and September 2016. The majority of interventions relate to Israeli Security Forces (ISF) use of force (62%), followed by settlers' violence incidents (32%) and demolitions (4%). 29% of individuals attended to needed Psychological First Aid and 78% showed severe signs of acute stress.

The WHO Building Back Better report (WHO, 2013) was positive in its outlook. It reported significant improvements in the mental health system despite ongoing occupation and conflict. It describes The Palestinian Ministry of Health's new vision moving towards community-based mental healthcare and services becoming more integrated. In 2010, more than 3000 people were managed in community-based mental health centres across the West Bank and Gaza Strip.

Iraq

Mental health reform has been ongoing in Iraq since 2004 (WHO, 2015). Priorities include developing community services, reducing institutional psychiatric hospitals, developing care units in general hospitals, and integrating mental health care into primary health care. Significant progress has been made to create a community-based mental health system. Community mental health units are resourced within general hospitals. Mental health training is received by a large percentage of practitioners.

Medicins Sans Frontieres report on the challenges of providing mental healthcare in Iraq (MSF, 2012). They report only four psychiatrists per one million residents and a significant gap for those experiencing conditions which are not treated with hospitalisation. A mental health survey in Iraq (WHO, 2009) finds that for 12-month and lifetime prevalence of mental health disorders low rates of treatment were received. 2.2% reported receiving treatment for emotional problems (Alhasnawi et al., 2009).

MSF has been working with the Ministry of Health to implement psychological counselling services and develop a counselling model to allow scale-up activities. Between 2009 and 2012, over 25,000 counselling sessions were provided by MSF-trained MoH counsellors. Analysis of patient data for 2012 found a notable reduction in psychological symptoms from admission to their last visit.

Syria

IMC are providing some mental health services through a stepped care model, starting with lower level management (social and community workers), and receiving referrals to specialised services as needed (Hijazi & Weissbecker, 2015). The services combine assessment, care planning and coordination, evaluation, and advocacy for services. Existing capacity is low meaning international agencies and NGOs are needed to build and provide comprehensive services.

A briefing informed by stakeholders working in Syria describes innovative NGO-supported MHPSS services emerging in countries surrounding Syria and operating most effectively when integrated with existing primary health care provision (RSM & LSHTM, 2015). The report recommends use of mobile phones for training and direct patient consultations with mental health specialists abroad. Monitoring and evaluation is needed as well as increased funding.

There are field-case examples of the community-based integrated approach being used to support displaced Syrians in Turkey, Iraq and Syria (Hughes et al., 2016). The mhGAP Intervention Guide and complementary materials were used for training. Further work needs to be done to demonstrate impact.

Yemen

Recent evidence on psychosocial support services in Yemen was not identified within the scope of this report. The Mental Health Atlas 2011 states that an officially approved mental health policy does not exist.

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Suggested citation

Bolton, L. (2018). *Psychosocial disability in the Middle East*. K4D Helpdesk Report. Brighton, UK: Institute of Development Studies.

About this report

This report is based on fifteen days of desk-based research. The K4D research helpdesk provides rapid syntheses of a selection of recent relevant literature and international expert thinking in response to specific questions relating to international development. For any enquiries, contact helpdesk@k4d.info.

K4D services are provided by a consortium of leading organisations working in international development, led by the Institute of Development Studies (IDS), with Education Development Trust, Itad, University of Leeds Nuffield Centre for International Health and Development, Liverpool School of Tropical Medicine (LSTM), University of Birmingham International Development Department (IDD) and the University of Manchester Humanitarian and Conflict Response Institute (HCRI).

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