

**WHO-AIMS REPORT ON**  
**MENTAL HEALTH SYSTEM**  
**IN IRAQ**

2006



**World Health  
Organization**



**Ministry of Health  
Iraq**

**WHO-AIMS REPORT ON**

**MENTAL HEALTH SYSTEM**

**IN IRAQ**

*A report of the assessment of the mental health system in Iraq using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).*

*(Baghdad, Iraq)*

2006



**Ministry of Health  
Iraq**

*WHO, Iraq*

*WHO, Regional Office for the Eastern Mediterranean*

*WHO Department of Mental Health and Substance Abuse (MSD)*

*This publication has been produced by the WHO, Iraq in collaboration with the WHO, Regional Office for the Eastern Mediterranean and WHO, Headquarters. At WHO Headquarters this work has been supported by the Evidence and Research Team of the Department of Mental Health and Substance Abuse, Cluster of Noncommunicable Diseases and Mental Health.*

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*World Health Organization 2006*

## Acknowledgement

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system of Iraq.

The project in Iraq was coordinated by Salih Al-Hasnawi, Psychiatrist, DG in MOH, member of National Mental Health Council together with Muhammad Lafta, Psychiatrist; National Mental Health Council. The project was supported by Naeema Al Gasseer, the representative of WHO Iraq and Sabah Sadik, the national mental health adviser, Ministry of Health (MOH), Iraq.

The project was also supported by R. Srinivasa Murthy and Mohammad Taghi Yasamy, WHO, Regional Office for the Eastern Mediterranean and Professor Abdul Monaf Al Jadiry.

The preparation of this study would not have been possible without the generous support of the Japanese government through the UNDG Iraq Trust Fund. We are grateful for the continuous collaboration with the Iraqi Ministry of Health (MOH), the National Mental Health Council, Directorate of Planning-Statistical Unit, and Directorate of Health in all governorates and the support and help of Abdul Munaf al Jadiry Nagam Al Kafajy, Rownaq Aqrawi.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to WHO-AIMS (WHO, 2005) for full information on the development of WHO-AIMS at the following website: [http://www.who.int/mental\\_health/evidence/WHO-AIMS/en/index.html](http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html)

The project received financial assistance and/or seconded personnel from: The National Institute of Mental Health (NIMH) (under the National Institutes of Health) and the Centre for Mental Health Services (under the Substance Abuse and Mental Health Services Administration [SAMHSA]) of the United States; The Health Authority of Regione Lombardia, Italy; The Ministry of Public Health of Belgium and The Institute of Neurosciences Mental Health and Addiction, Canadian Institutes of Health Research.

The WHO-AIMS team at WHO Headquarters includes Benedetto Saraceno, Shekhar Saxena, Tom Barrett, Antonio Lora, Mark van Ommeren, Jodi Morris, and Grazia Motturi. Additional assistance has been provided by Anna Maria Berrino.

The WHO-AIMS project has been coordinated by Shekhar Saxena.

## Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Iraq. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Iraq to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

The National mental health council was established in 2004, which is implementing plan, policy and legislation addressing main mental health issues. There is no specific budget allocation for mental health in Iraq.

The majority of beds in the country are provided by mental hospital followed by inpatient units in general hospitals. The majority of users are treated in outpatient facilities and in mental hospital. The average proportion of female users in all mental health facilities is 38% of the population. The percentage of children and adolescents is generally low in all facilities. Schizophrenic disorders are the most common diagnostic group in all mental health facilities. Psychiatric beds located in Baghdad are more than four times of psychiatric beds in other part of the country and this prevent the access for rural users.

Three percent of the training for medical doctors is devoted to mental health, in comparison to five percent for nurses. Seven percent of Primary care doctors and one percent of nurses have received at least 2 days of refresher training in mental health in 2004. Only doctors can prescribe psychotropic medications in primary care settings.

In terms of human resources, there are only 91 psychiatrists 7 assistant psychiatrists, 145 nurses and 16 psychologists, 25 social workers. Last year 625 doctors, 665 nurses, 11 psychiatrist and 2 psychologists graduated.

The national mental health council oversees public education and awareness campaigns. There is no legislative support for people with psychiatric problems. In addition, there are no formal collaborations with departments or agencies outside of the health system.

A defined list of individual data is collected by the department of planning (statistical unit) of the Ministry of Health. All the facilities had transmitted their data to this department during the last year.

There have been fundamental changes in mental health system in Iraq since the collapse of the previous regimen:

- the establishment of the national mental health council, which has a multidisciplinary approach and includes many representatives of related ministries,
- the development of services and the increase of human resources through numerous professional development activities,
- the new Mental Health Act, for the first time in the country, has already been approved by the cabinet. The code of practice is to be finalised soon and the Mental Health Act enacted,
- a new policy, which integrates mental health and substance abuse, services within the primary care services.

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## WHO-AIMS COUNTRY REPORT FOR IRAQ

### Introduction

Iraq is a country with an approximate geographical area of 438,393 square kilometres and a population of 27.139.585 million people (WHO, 2005). The main languages used in the country are Arabic, Kurdish, (Bahdinani and Sorani) and the main ethnic groups are Arab, Kurdish, Turkmen. Religious groups include Muslims and Christians. The country is a lower middle-income group country based on World Bank 2004 criteria.

The proportion of population under the age of 15 years is 41% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The life expectancy at birth is 59.1 years for males and 63.1 years for females (WHO, 2004). The healthy life expectancy at birth is 49 years for males and 52 years for females (WHO 2004). The literacy rate is 54.9% for men and 23.3% for women (UNESCO/MOPH, 2004).

The health system in Iraq consists of primary care, secondary care and tertiary care and each professional has the chance to work both in government-administered facilities and in private practice.

The health sector in Iraq has deteriorated dramatically since 1980s until now, due to known causes. Reform of health system started after the collapse of the previous regimen.

The advisory committee and the mental health program in primary health directorate were responsible for the mental health, before the fall of past regime. The National Mental Health Council is the responsible for all aspects of mental health.

The proportion of the health budget to GDP is 3.2% (WHO 2004). Per capita total expenditure on health is 79 international Dollars and the per capita government expenditure on health is 31 international Dollars (WHO 2004).

There are 136 hospital beds and 19 general practitioners per 100,000 population. 2.3% of hospital beds are in the private sector. In terms of primary care, there are 915 governmental physician-based primary health care clinics in the country (not applicable in private system) and 834 non-physician-based primary health care clinics (not applicable in private system)

Data was collected in 2005 and is based on the year 2004.

## **Domain I: Policy and Legislative Framework**

### **Policy, plans, and legislation**

Iraq mental health policy was last revised in 2004, and includes the following components: developing a community mental health services, downsizing large mental hospitals; developing mental health component in primary health care; human resources; advocacy and promotion, human rights protection of users, equity of access to mental health services across different groups; financing; quality improvement and monitoring system.

In addition, a list of essential medicines is present. These medicines include antipsychotics, antidepressants, anxiolytics, mood stabilizer and antiepileptics.

The last revision of the mental health plan was in 2005. This plan contains the following components: developing community mental health services; downsizing large mental hospitals; reforming hospitals to provide more comprehensive care; developing a mental health component in primary care; human resources; mental health advocacy and promotion; equity of access to mental health services across different groups; financing; quality improvement and monitoring system.

In addition, a timeframe and specific goals are identified in the last mental health plan. A national mental health council and district mental health committee were identified as goals and achieved in 2004.

There was no disaster/emergency preparedness plan for mental health until 2004.

A draft of mental health legislation was introduced in 2005, to the parliament, it was approved by the Cabinet, and the code of practice is on its way. This mental health act focuses on access to mental health care including access to the least restrictive care; rights of mental health service consumers, family members, and other care givers; competency, capacity, and guardianship issues for people with mental illness; voluntary and involuntary treatment; law enforcement and other judicial system issues for people with mental illness; mechanisms to oversee involuntary admission and treatment practices; mechanisms to implement the provisions of mental health legislation.

The mental health legislation was achieved with collaboration of ministry of justice and was reviewed by most psychiatrists in the country. A new legislation for drug control is still under review in the office of prime minister.

### **Financing of mental health services**

The percentage of expenditures on mental health, and consequently the percentage for mental hospitals, is unknown. In Iraq, the financing system in MOH does not separate the mental health budget from other health sectors budget. The budget is specified for each directorate, since mental hospitals are parts of MOH its operational annual budget is known to be \$ 1077188. These budgets have not included medications, (which are supplied centrally), human resources development, reconstruction and renovation.

In term of affordability of psychotropic drugs, all National Health Service is free and potentially everyone can get free medications. However, in reality, this may not happen because of the limited supply of medicines. An example of the supply problem is that there was no antiepileptics for two months in 2004. For those who pay out of pocket, the cost of antipsychotic medication is 300 I.D per day (10% of one-day minimum wage), equal to 20 cents, and antidepressant medication is 225 I.D per day (8% of one-day minimum wage), equal to 15 cents. There is no social insurance in Iraq.



**Human rights policies**

A national human rights review body is authorized by the new legislation, but it is not yet implemented. No review/inspection of human rights protection of patients currently exists. When the new mental health legislation is enacted, these protections will be part of mental health system in Iraq.

There was also no training, meeting, or other type of working sessions on human rights protection of patients for mental hospitals staff and the staff of inpatient psychiatric units and community residential facilities staff.

## **Domain 2: Mental Health Services**

### **Organization of mental health services**

The national mental health authority exists and it provides advice to the government on mental health policies and legislation. The mental health authority is also involved in the service planning, service management and co-ordination, monitoring and quality assessment of mental health services. Mental health services are not organized in terms of catchments/service areas.

The National Mental Health Council in the Ministry of Health oversees activities of the National Mental Health Authority. It contains members from a variety of other ministries as well as the Ministry of Health including:

- Ministry of Higher Education [MoHE]
- Ministry of Labour and Social Affairs [MoLSA]
- Ministry of Justice [MoJ]
- Ministry of Human Rights [MoHR]
- Ministry of Interior [MoI] and Ministry of Education [MoE] was established in February 2004.

### **Mental health outpatient facilities**

There are 25 outpatient mental health facilities available in the country, of which four are for children and adolescents only. None of outpatient facilities provides follow-up care in the community and no facility has mental health mobile teams.

Fifty percent of the outpatient visits are provided to people with a diagnosis of schizophrenia, schizotypal and delusional disorders. In addition, 22% of the visits are provided to people with mood disorder diagnoses. A total of 44% of outpatient visits are by women and 6% are children and adolescents.

The average number of contacts per user is not available. The problem of data collection in outpatient facilities is due to the registration of attendances, which depends on the contact and not on the patient. Moreover, in the registration data the age may be missed so the number of users, which are children and adolescents, is not accurate.

In terms of available treatments, less than 20% of the outpatient facilities offer psychosocial treatments. The availability of psychosocial treatments is largely dependant on the personal interest of psychiatrists and this program is not a part of the mental health system. Medication availability is problematic as was discussed before.

### **Day treatment facilities**

There are no-day treatment facilities available in the country,

### **Community-based psychiatric inpatient units**

There are nine community-based inpatient units available in the country for a total of 0.4 beds per 100,000 populations. None of these beds is for children and adolescents only. A total of 39% of

admissions to community-based psychiatric inpatient units are female and 1% of admissions are children/adolescents.

The diagnoses of admissions to community-based psychiatric inpatient units were primarily from the following two diagnostic groups: schizophrenia (69%) and other diagnosis, such as epilepsy, organic mental disorders (15%).

Data was obtained directly from directorate of planning MOH, and from DOH. Data on days spent in hospital and readmission rate are not available.

### **Community residential facilities**

There are no community residential facilities available in the country.

### **Mental hospitals**

There are two mental hospitals in the country (in Baghdad) with a total of 5.4 beds per 100,000 populations. These facilities are organizationally integrated with mental health outpatient facilities. None of these beds in mental hospital is for children and adolescents only. The number of beds has increased by 32% in the last five years.

The patients admitted to mental hospitals belong primarily to the following two diagnostic groups: schizophrenia, schizotypal and delusional disorders (75%) and mental and behavioural disorders due to psychoactive substance use (11%). The number of patients in mental hospitals was 3220 (12 per 100,000 population) last year. The proportion of female users is 33%.

The average number of days spent in mental hospitals during the last year was 338.7 days: 92% of patients spent 1-4 year (this is not clear, if 92% of patients are there for 1-4 years, the average duration cannot be 95 days) and 8% spent less than one year. No patient spent more than three years because, in the last war with the loss of security and extensive looting, all the patients left the hospital and most of furniture, equipments and instruments were stolen. Within 1-2 months, many patients returned to hospitals forced by their family, or religious leaders. For this reason, the total length of stay in the hospital before April 2003 is not available.

The problem of medication supply is the main obstacle for availability of psychotropic medication which is provided free of charge to patients in hospitals.

The data was collected from MOH, Al Rashad mental hospital and Ibn Rushed mental hospital (both in Baghdad).

### **Forensic and other residential facilities**

In addition to beds in mental health facilities, there are also 250 forensic beds in one mental hospital (forensic unit in Al Rashad hospital in Baghdad). Forensic inpatient unit treats 0.92 persons per 100,000 population. Forty-six percent of them spend less than one year and 48% stay 1-4 year. This length of stay is due to the obligatory release order by ex-regime, which issued an order that covered all criminals including all offenders in forensic unit, so no offender stays more than 3 years.

There are three residential facilities for people with mental retardation; one is specifically for youth aged 17 years and younger. The total number of beds in all the residential facilities is 145.

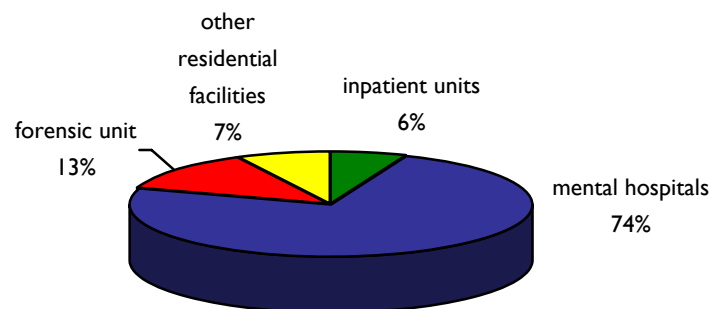
### **Human rights and equity**

Involuntary admissions are allowed only to the forensic unit in mental hospital, which is at Al Rashad Hospital. Eight percent of all admissions to mental hospitals are involuntary. Patients' restraining or secluding is out of MOH rules and it occurs only occasionally.

Ninety-seven percent of psychiatric beds in the country are located in or near the largest city: such a distribution of beds prevents access for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

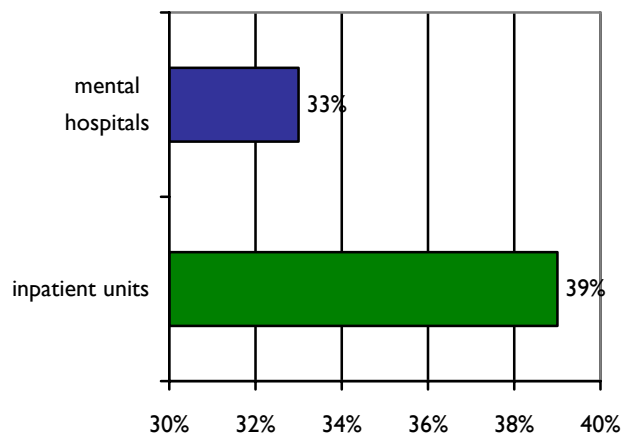
### **Summary Charts**

*Graph 2.1: Beds in mental health facilities and other residential facilities*



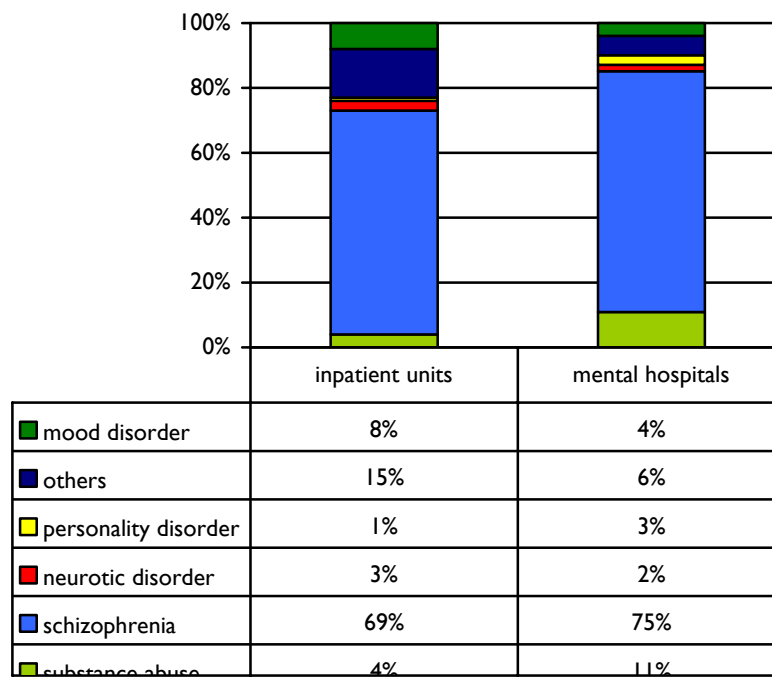
The majority of beds in the country are provided by mental hospital, followed by forensic unit.

*Graph 2.2: Percentages of female users treated in mental health facilities*



The proportion of female users is highest in inpatient community-based units and lowest in mental hospitals.

Graph 2.3: Patients treated in mental health facilities by diagnosis



Schizophrenic disorders are the most prevalent disorders in both the facilities.

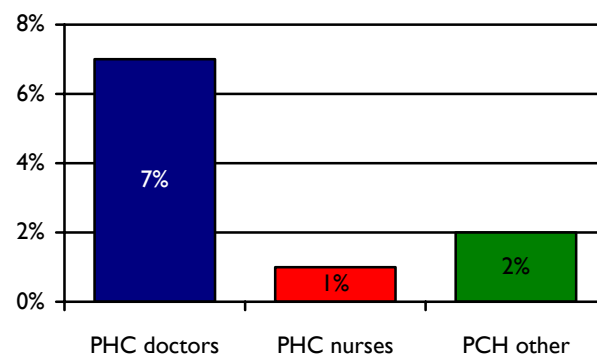
## Domain3: Mental Health in Primary Health Care

### Training in mental health care for primary care staff

Three percent of the training for medical doctors is devoted to mental health, in comparison to 5% for nurses. There is no estimate for non-doctor/non-nurse primary health care worker training. In terms of refresher training, 7% of primary health care doctors have received at least two days of refresher training in mental health, while 1% of nurses and 2% of non-doctor/non-nurse primary health care workers have received such training.

The data was collected from MOH, directorate of planning, directorate of primary health care, mental health council, governorate of DOH.

*Graph 3.1: Percentage of primary care professionals with at least 2 days of refresher training in mental health in the last year*



### Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. In terms of physician-based primary health care clinics, less than 20% has assessment and treatment protocols for key mental health conditions available. The numbers of physician-based primary health care clinics that make regular referrals to mental health professionals is unknown, as their referrals depend on the personal interest of physicians.

### Prescription in primary health care

Nurses and non-doctor/ non-nurse primary health care workers are not allowed to prescribe psychotropic medications. Primary care doctors are allowed to prescribe psychotropic medications with restrictions. The primary health care doctors are only allowed prescription of tricyclic antidepressants (amitriptyline), chlorpromazine and carbamazepine.

Less than 20% of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic). Psychotropic medication is available in afternoon public clinics (governmental) which provide treatment services only, but no preventive services.

## Domain 4: Human Resources

### Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 populations is 1.6. The breakdown according to profession is as follows: 0.33 psychiatrist, 0.02 other medical doctors (not specialized in psychiatry), 0.53 nurses, 0.05 psychologist, 0.09 social worker, 0.47 other mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors).

In Iraq we have a dual system of work: the health staff is allowed to work in the national services in the morning and in private practice in the evening, 2% of psychiatrists work only for government administered mental health facilities, 5% work only private, and while 92% work for both the sectors. A total of 186 of psychologists, social workers, nurses and occupational therapists work only for government administered mental health facilities.

Regarding the workplace, 64 psychiatrists work in outpatient facilities, 9 in community-based psychiatric inpatient units and 18 in mental hospitals. No other medical doctors, not specialized in mental health, work in outpatient facilities, none in community-based psychiatric inpatient units and three work in mental hospitals. (Psychiatrists work in outpatient and community based inpatient and mental hospital at the same time)

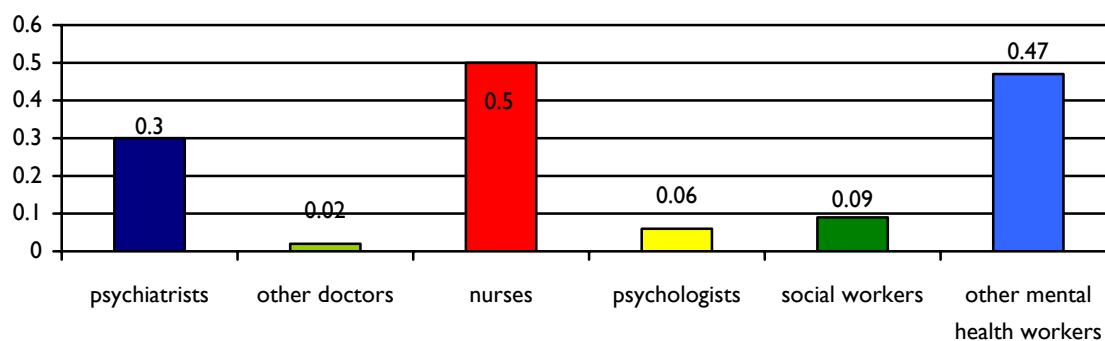
Regarding the nurses, 48 work in outpatient facilities, 45 in community-based psychiatric inpatient units and 52 in mental hospitals. Eight psychologists, social workers and occupational therapists work in outpatient facilities, 5 in community-based psychiatric inpatient units and 28 in mental hospitals.

As regards other health or mental health workers, 25 work in outpatient facilities, 27 in community-based psychiatric inpatient units and 76 in mental hospitals.

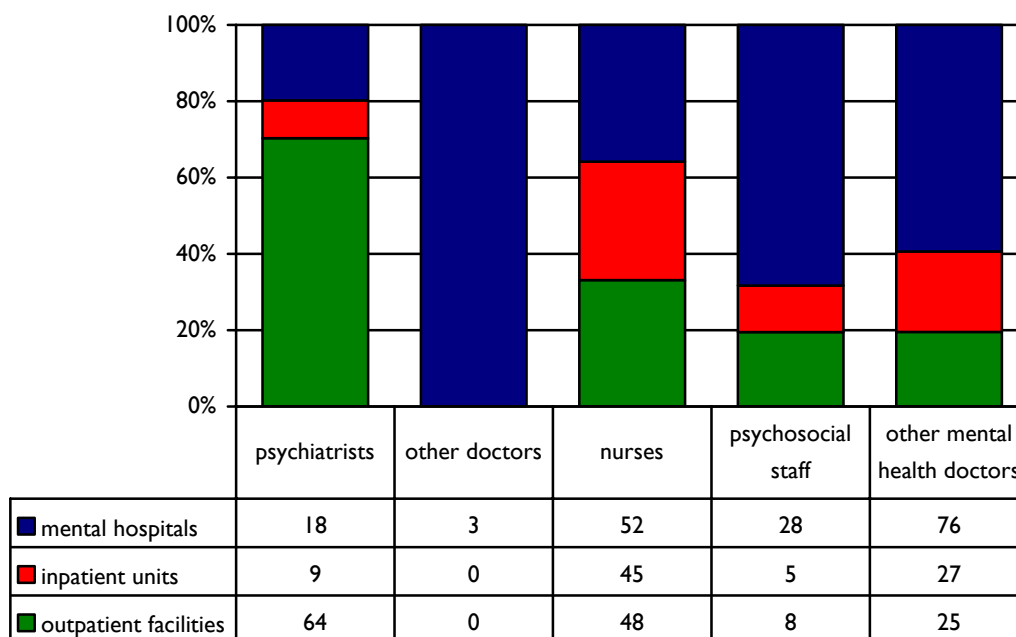
In terms of staffing in mental health facilities, there are 0.08 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.01 psychiatrists per bed in mental hospitals. As for nurses, there are 0.38 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.04 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 0.27 per bed for community-based psychiatric inpatient units, and 0.07 per bed in mental hospitals.

The distribution of human resources between urban and rural areas is unequal: more than twice as many psychiatrists (2.18) and nurses (2.23) per capita work in urban versus rural areas.

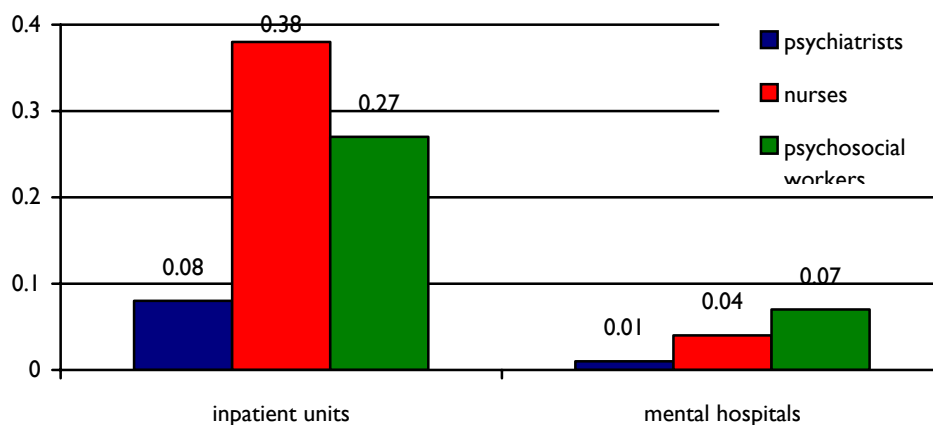
*Graph 4.1: Human Resources in mental health (rate per 100,000 population)*



Graph 4.2: Staff working in mental health facilities (percentage in the graph, number in the table)



Graph 4.3: Ratio Human Resources/Beds



The ratio human resources/beds is the lowest for psychiatrists.

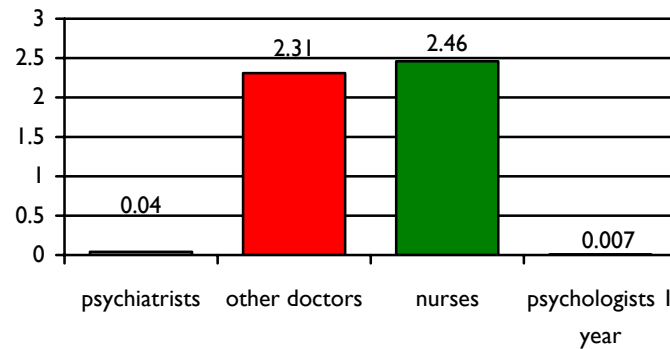
### **Training professionals in mental health**

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 11 (0.04 per 100,000 population), 625 other (not specialized in psychiatry) medical doctors (2.31 per 100,000 population), 665 nurses (2.46 per 100,000 population), 2 psychologists (0.007 per 100,000 population), no social workers, and no occupational therapists (graph. 4.4).

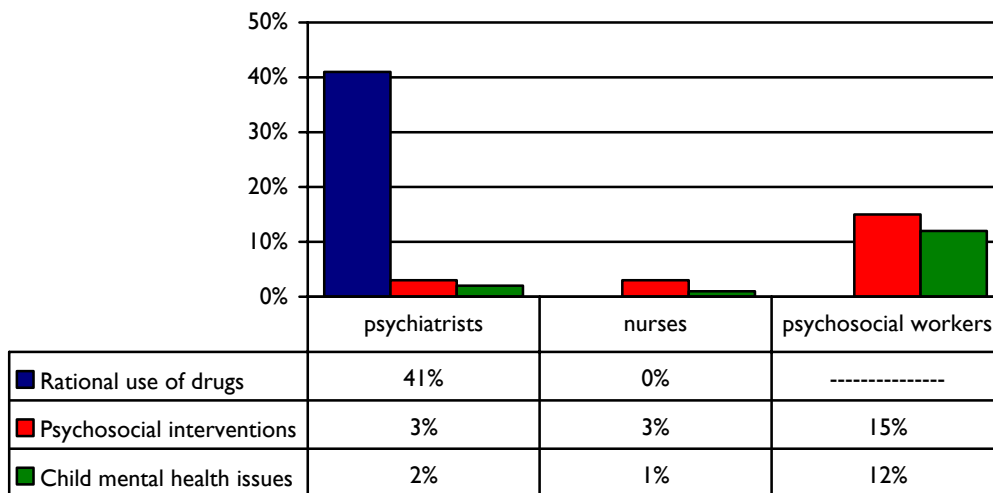


Some (21-50%) psychiatrists immigrate to other countries within five years of the completion of their training. Graph 4.5 shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

Graph 4.4: Professionals graduated in mental health (rate per 100,000 population)



Graph 4.4: Percentage of mental health staff with 2 days of refresher training in the past year



*Psychosocial staff = psychologists, social workers, and occupational therapists*

*Others = other health and mental health workers*

### **Consumer and family associations**

There are no user/consumer and family associations. There are three NGOs in the country involved in individual assistance activities such as counselling or support groups. One NGO provides psychosocial support to victims of torture, working with primary health care services in rural area and training health staff. The others work mainly with children and teachers.

## **Domain 5: Public Education and links with other Sectors**

### **Public education and awareness campaigns on mental health**

The mental health council oversees publication and awareness campaigns on mental health. Government agencies (i.e. mental health council) have promoted public education and awareness campaigns in the last years. These campaigns have targeted the following groups: teachers, religious leaders

There have been public education and awareness campaigns targeting professional groups, health care providers, teachers, and social service staff.

Mental health program in directorate of primary health care had many mental health educational courses before the establishment of the National Mental Health Council

### **Legislative and financial provisions for persons with mental disorders**

At the present time, there is no legislative or financial support for the following: provision for employment, provision against discrimination at work, and legislative or, financial provisions for housing.

There is financial support under certain conditions for some physically handicapped and some mentally retarded people with obvious physical disability through the ministry of social affairs.

### **Links with other sectors**

There are formal collaborations with the primary health care directorate, community care, substance abuse committee, education and criminal justice system. In terms of support for child and adolescent health, 8% of the primary and secondary schools have either a part-time or full-time mental health professional (social adviser), and less than 20% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

The percentages of prisoners with psychosis and the corresponding percentage for mental retardation are unknown. As for training, no police officers, judges, and lawyers have participated in educational activities on mental health in the last five years, although training on the mental health law is planned for judicial professionals (only 15 police officers participated to a training course in substance abuse in Amman). In terms of financial support for users, none of the mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. The number of people receiving social welfare benefits for a mental disability (mental retardation with apparent severe physical disability) is unknown by ministry of social affairs.



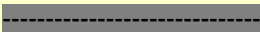
## Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities is available. As shown in the table 6.1, the extent of data collection is consistent among mental health facilities.

The government health department received data from all mental health facilities. However, no report was produced on the data transmitted to the government health department.

In terms of research, 2% of all health publications in the country were on mental health in the last five years. The research focused on epidemiological studies in community and clinical samples, non-epidemiological clinical and questionnaire assessments of mental disorders, in pharmacological and electroconvulsive therapy.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

	Mental Hospitals	Inpatient Units	Outpatient Facilities
N° of beds	100%	100%	
N° inpatient admissions/users treated in outpatient facilities	100%	100%	100%
N° of days spent/user contacts in outpatient facilities	100%	100%	NA
N° of involuntary admissions	NA	NA	
N° of users restrained	NA	NA	
Diagnoses	100%	100%	100%

## Future areas for Mental Health IN IRAQ

The following are the summary activities identified by mental health professionals and public health planners in various consultations, including the two 'Action Planning' meetings in Amman (2005) and Cairo (2006).

### 1. Public Mental Health education and self-care

- Fighting stigma and discrimination
- Increasing resilience of the population through self-care advocacy
- Psychosocial support for traumatised population

### 2. Integration of Mental Health with Primary Health care

- Training in essential mental health care for all categories of health personnel
- Provision of essential psychiatric medicines at all health facilities
- Support of mental health professionals

### 3. Human Resources Development

- Human resource development for mental health care- improving undergraduate level training of all health personnel, the training of specialists and specialties, clinical psychologists, psychiatric social workers, psychiatric nurses and rehabilitation workers
- Encourage employment in the mental health field and establish appropriate training and degree programmes
- Setting up of a National Institute of Mental health
- Incentives for psychiatrists and mental health workers
- Support for participation in international conferences, symposia and workshops

### 4. Psychiatric Services

- Mental Health infrastructure at different levels- National level, Medical College level, Governorate level, district level
- Establishment of a multidisciplinary team approach including social workers, nurses, primary care professionals, psychologists, occupation therapist in addition to psychiatrists
- Family and community level interventions for mental health
- Transitional facilities for care of chronic patients
- Substance abuse services
- Specialised services for children and elderly
- Equipments and essential psychiatric medicines

### 5. Intersectoral involvement in Mental health

- Integration of mental health care through educational system
- Better communication between mental health professionals, courts and justice department

### 6. Research

- Training programmes in research methodology
- Support from research projects
- Ethics committee

### 7. Administrative Supports

- National Coordinating body for mental health and research
- Monitoring mental health of the community
- Mental health directorate in MOH, Iraq

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Iraq. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change.

Iraq is a country with an approximate area of 438 thousand sq. km and a population of 25,856 million.

The National Mental Health Council was established in 2004, to develop policy and plans along with legislation. There is no specific budget allocation for mental health in Iraq. The majority of beds in the country are provided by mental hospital followed by inpatient units in general hospitals.

The majority of users are treated in outpatient facilities and in mental hospital. Schizophrenic disorders are the most common diagnostic group in all mental health facilities. Three percent of the training for medical doctors is devoted to mental health, in comparison to five percent for nurses.

There are only 91 psychiatrists, 145 nurses and 16 psychologists, 25 social workers. Last year 625 doctors, 665 nurses, 11 psychiatrist and 2 psychologists graduated.

There have been changes in mental health system in Iraq since 2003:

- the establishment of the National Mental Health Council,
- the development of services and the increase of human resources,
- the approval of a new mental health law,
- policy, which integrates mental health and substance abuse, services within the primary care services.