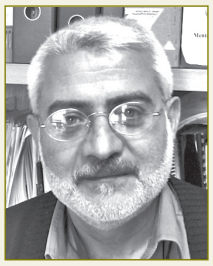
Mental health beyond the crises

In some parts of the world it is only during or after an emergency that people with mental health disorders get any treatment at all and often the help on offer is not what they need, Dr Mustafa Elmasri tells Fiona Fleck that the international community needs to rethink its emergency mental health relief.



Courtesy of Mustafa Elmasri

Dr Mustafa Elmasri

Dr Mustafa Elmasri is a psychiatrist in Gaza with two decades of experience working in conflicts and war, and their painful aftermath. He earned his Medical Degree from Alexandria University in 1983, Diploma in Psychotherapy from Tel Aviv University in 1996 and Diploma of Psychiatric Practice in 1997 from the universities of London and Egypt's Ain Shams. He started his career as a doctor in Gaza in 1986 and started working in mental health care in 1992. From 1998–2000, he worked with genocide survivors in Cambodia, 2000–2003 with terrorized civilians in Algeria and 2005–2006 with Darfur refugees in Chad. Since 2008, he has been working with the World Health Organization to integrate mental health services into Gaza's primary health care.

Q: Much of your work has been in the Middle East and northern Africa, what kind of mental health care is provided in these countries?

A: It differs from country to country, but on the whole there is a lack of psychosocial expertise. Mental health care in many of these countries is based on traditional classical psychiatry but often they have very few psychiatrists. Psychosocial work is done mainly by small local and international nongovernmental organizations (NGOs). There is practically no civil society – although that may be changing now – so much of the mental health care response in emergencies is dependent on external initiatives and funding, which are precarious. This leads to mistakes. For example, in Gaza, people came in on emergency projects after the recent war (2008–9) working directly with local people and undermining the local services. I worked with young local counsellors and saw how their work and ambitions were damaged by these short-term emergency projects.

Q: Is this typical?

A: It happens after each disaster. You have a rush of interested donors, but usually these projects and interventions are short-term and, therefore, counterproductive. Whatever emergency response is needed, it should come from within the existing health system, a structure that will exist after you leave and it should not be in the form of highly sophisticated interventions by foreigners for "poor local people".

Q: Are the locals also unhappy about this?

A: People in need are usually happy to receive assistance, but in some cases it is not effective and quite inappropriate. For example, in former Yugoslavia in the 1990s, foreign NGO staff were chased out of villages because so many people were coming in. During the recent war in Gaza, far too many international NGOs came in. They recruited staff and trained them for a few days on some aspects of trauma work, sent them around the place going from house to house looking for traumatized people. Of course, families rejected this psychological help when what they really needed was help with basic needs, such as shelter and medical care. Young counsellors working single-handedly with no team support stood helplessly offering what was not in demand. Usually trauma and stress counsellors work in a crisis team and offer services as part of a comprehensive framework. It is not surprising that the NGOs had to bring in another wave of psychologists to work with the counsellors themselves.

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Q: What is your approach?

A: I work with the local experts and structures regardless of their knowledge and expertise. The split between emergency and development projects is a business distinction that obscures the fact that every population is in a constant process of change and development. The idea of "emergency relief" is totally distorted in the psychosocial sector because it's often only after a disaster that people get help when they needed it before. Gaza was under siege before and remains so after the war. But emergency relief was tagged to the war and has dwindled since. Six months of funding was allocated to 200 local NGOs working in the field, but none to the Ministry of Health's mental health services.

Q: Does cultural background play a role?

A: Every mental health intervention should be adapted to the culture, today this is a given. Even if you are prescribing medication, you must take into consideration cultural beliefs on medicines. The same with psychotherapy. As trainers, we need to adapt our approach to the people we want to help. Some schools of psychotherapy are more appropriate than others. For example, cognitive behavioural therapy is usually suitable for people from Arabic-speaking cultures. It is based on evidence and rational thinking, which are part of the Arab Islamic value-system – when your beliefs are the main basis for your behaviour and when you believe that what you do will have an impact in this life and the after life.

Q: Describe your work and your life in Gaza?

A: We are integrating mental health care into the primary health care structure. The target is the wider population with mainly stress but also other common

mental disorders among people who would not normally approach the mental health services. We are working with institutions to produce more mental health specialists who are badly needed in this community. We are also training nurses, psychologists and social workers. We also use other psychotherapy methods, such as cognitive behavioural therapy and other psychosocial interventions, including social work, community intervention and family psycho-education. Life here in Gaza is tough but it is a life at home with family and friends.

Q: Can you give examples of this work?

A: In Gaza, local universities produce BA level graduates of psychology, sociology and medicine with very little if any clinical experience. At present we do not have programmes for clinical psychology. Specialists are overworked and underpaid in the Ministry of Health and many are attracted by the NGO and private sectors, usually working with very narrow and pre-specified target groups within the population. But these projects do not help the many people with mild to moderate mental illness not directly related to war and trauma, and the people with severe mental illness who do not approach or receive effective mental health services. Our approach is to develop the capacity of mental health workers within the existing mental health and primary care services to provide competent and continuous help, regardless of the episodic escalations of war and violence.

Q: It's against IASC (Inter-Agency Standing Committee) guidelines, why do we continue to see psychotherapists parachuting into emergency situations?

A: I encountered this phenomenon in Cambodia. People seemingly dropped from the sky and tried to communicate directly with the local people, to help them with their mental health problems, but it was useless. Perhaps this was because there were very few local psychologists or doctors, but I found it was better to train social workers in counselling and behavioural techniques of psychotherapy. Another example, we know now that single session debriefing is harmful, but in Gaza after the last war international NGOs sent in psychologists to debrief health and emergency staff in single-group sessions.

Q: What was your experience in Cambodia?

A: There were psychiatrists and psychologists from different parts of the world communicating through interpreters. My interpreter had to change some words because they were culturally inappropriate. International specialists should not provide direct clinical care of local people but should work with and support local care providers. Even if their local colleagues have limited experience, international specialists can train and mentor them, and give them confidence. It's not a good idea to just drop in from the sky like a prophet, promise a lot of things and leave when the funding runs out. It means broken hearts and unfinished business – and these people have suffered enough already from loss and empty promises. They need long-term working relationships beyond the emergency situation, to help them build on the expertise you transfer.

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Q: What about countries with little or no mental health experts?

A: Development is a natural phenomenon that you can assist or hinder, not something you plant or create. I worked with Darfur refugees in Chad. It is one of the poorest countries in the world and had one psychiatrist for the whole population. The challenge was to start mental health and psychosocial services from scratch. So I trained traditional healers, local nurses and medical assistants. People outside were concerned about the atrocities they had witnessed and the horrors they had experienced and there were cases of post traumatic stress disorder (PTSD) and other stress-related mental illness. But my first year involved establishing a clinical service for people with severe mental illness and children with epilepsy, some of whom had never been seen by medical personnel before. It was also essential to work with the host population as they perceived the refugees as receiving better support and care, while sharing their resources (land, wood, animals). So interventions were usually placed within the Chadian health system providing services for both camp refugees and the local population in nearby villages. The clinics became meeting places where the refugees and locals could share the pain and the cure.

Q: How did you do this?

A: Surveying traditional healing systems among refugees from Darfur in Chad, I collaborated with the faqihs (experts on Islamic law) from both the refugee and local Chadian communities, who treated medical and psychological illness. I trained them to identify epilepsy and psychosis, and refer these cases to the clinic. We also shared experiences on how we dealt with stress and mild mental illness, and learned from each other. It may sound odd or funny, but it is neither. Traditional healers were the key partner beyond the patients and their families in gaining an understanding of the psychological experience and access to social support structures. As part of our collaboration, I referred mild cases of stress and somatization disorder to the healers and they also organized group chanting and prayer groups for my patients.

Q: Are the survivors of horrific experiences scarred for life?

A: Not necessarily. Human beings are adaptable. With proper help and support many people can overcome the illness part of the trauma. Memories will remain painful, but people get on with their lives and re-build their world. In Algeria I saw how people returned to their lives, sometimes mentally more robust. We should not try to heal the historical part of trauma, it is a person's choice whether to forgive and forget or to demand compensation. Our task is to treat the illness and help the person function normally again. ■