refugee diaspora. Even worse, in some ways, is the abandonment (or even the targeting) of psychiatric patients, whose hospitals have been destroyed and whose carers have long since fled. In this issue we review the crisis in three countries affected by civil war: Libya, Syria and the Sudan.

Libya went through a convulsive, although relatively brief, civil war that began in February 2011 and ended in October of that year. As Dr Abuazza writes, decades of neglect had left the mental health system in that country in bad shape. There are now just two functioning psychiatric hospitals. The impact of the civil war was to drive many doctors out of the country and few mental health professionals remained to cope with patients. Although matters are beginning to turn around for the better, those seeking help have not only overwhelmed services in those hospitals but they have spilled over into neighbouring countries too, such as Egypt.

Drs Abou-Saleh and Mobayed report on the conflict in Syria, a situation that has persisted now since March 2011 and shows no sign of abating. General medical care has suffered terribly. The authors report that children in particular are affected, because armed groups (especially government forces) have specifically targeted them. Post-traumatic stress disorder (PTSD) could be a problem for up to 60% of adults and an even higher proportion of children. Active destruction of psychiatric facilities has been witnessed.

Finally, Drs Ali, Saeed and Sultan give us an account of the outcome of 22 years or more of conflict in Sudan, where the effects of civil war have been compounded by famine. The proportion of the population affected by PTSD is similar to that in Syria, studies suggest, but in other respects the situation differs from that in Middle Eastern states, perhaps especially in the south. There is a cultural reluctance to acknowledge the extent of mental health problems, because of the stigma. Spiritual healers still play a major role. Yet, as in Libya and Syria, there is a growing call for help from the international community to provide mental health management, both to those within the country and to the refugee populations across borders.

CONFLICT AND MENTAL HEALTH IN NORTH AFRICA AND THE MIDDLE EAST

THEMATIC PAPER

The Arab Spring movement: a catalyst for reform at the psychiatric hospital in Tripoli, Libya

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The assistance of Dr Fahmy Bahjat, mental health consultant to the World Health Organization mission in Libya, in the preparation of this paper is gratefully acknowledged.

Decades of neglect have left the mental health system in Libya in bad shape. Services for the entire population are scarce, highly centralised and provided only through two psychiatric hospitals in the two biggest cities of the country. There are virtually no other mental health services anywhere else in Libya. Even the most basic of services, such as the availability of psychotropic medication for people with severe mental illness, are scarce outside Tripoli and Benghazi. This paper reviews the state of the country's mental health services since the civil war of 2011 and highlights a new fourfold approach taken by the management of the psychiatric hospital in Tripoli.

A major problem faced in Libya in relation to the country's mental health services is that the two main psychiatric hospitals, in Tripoli and Benghazi, have their own limitations, especially a shortage of doctors. This shortage has arisen largely because, during their medical training, students in Libya no longer receive education in psychiatry as part of their curriculum; there are various reasons for this situation in different universities across the country. Also, there is no postgraduate training scheme for psychiatry as a specialty. This lack of an infrastructure for psychiatry as a specialty discourages graduates from working in the field as trainees or consultants. Unfortunately, psychiatric nurses, psychologists and social workers are in no better position. There are no specialist training programmes and they receive no clinical training as part of their education. All these limitations have contributed to a situation in which there are very limited human resources and service provision in mental health.

The lack of psychiatric care was a challenge even before the liberation of Tripoli in 2011. During the

https://doi.org/10.1192/S1749367600003842 Published online by Cambridge University Press

internal conflict the weaknesses of the system were exposed by traumatic events; moreover, there was a flood of people with experience of significant psychological and social suffering. The civil war led to a substantial increase in the numbers of new patients as well as a relapse in the condition of former patients whose condition had been stabilised before the fall of the Gaddafi regime.

The Benghazi and Tripoli psychiatric hospitals represent the cornerstone of the country's specialist mental healthcare. They were opened about three decades ago, with approximately 200 beds each. They were established with a view to treating and caring for all people with various mental health disorders across the whole country. There are no other public mental health services, apart from a few satellite clinics (reportedly totalling four); there is questionable availability of mental health professionals and psychotropic medications outside of the psychiatric hospitals. There are no private psychiatric hospitals.

The buildings and the grounds at the Al Razi psychiatric hospital in Tripoli have not been well maintained. The furniture and equipment are in an unacceptable condition. Most of it has not been repaired or replaced for many years. This situation is not supportive of the proper care and rehabilitation of patients. Patients attending Al Razi hospital represent 60–70% of all mental health service users in Libya. Many other patients attend services in neighbouring countries (principally Egypt and Tunisia).

No rehabilitation programmes exist at either psychiatric hospital for patients on the wards; there are few if any activities to fill the patients' days. There is limited communication with staff, and little contact with the outside world. Management of patients relies mainly, and at most of the times of the day, on the use of medication and maintenance regimes. Where patients remain in hospital over many years they should be encouraged to participate in activities of daily living and self-care, as such rehabilitation regimes are essential to avoid institutionalisation and the loss of hope they might have that eventually they will be able to live a proper and useful life outside the hospital. Even the hospital staff are demoralised.

Innovation in response to crisis

During 2011 there was a flow of hundreds of people with war-related psychological symptoms to the limited mental health facilities. There were many reports across the country that service providers were not able to cope with the urgent needs because of deficient human resources and the lack of a suitable care system. Due to the overwhelming situation, which was unique in many ways, the management at the psychiatric hospital in Tripoli instituted major reforms in the first 6 months following the liberation of Tripoli in August 2011, against all the odds.

They took a fourfold approach: improving the basic services at the hospital: initiating a capacity-building programme; introducing a rights-based approach to mental health practice; and establishing a community-based approach to services.

Improving the basic services at the hospital

The management at Al Razi hospital established a new department for patient care. The main task for this department was to create hospital policies, procedures and guidelines, and to implement a new system for documentation, including medical records. It also implemented critical incident review and analysis.

A new department for hospital renovation and development was established. This was tasked with providing rapid renovation of the hospital and with taking the appropriate measures to ensure staff and patients adapted to these changes, while making sure that service interruption was avoided whenever possible.

An information technology department was introduced. This was something the hospital had been deprived of for decades. The amount of work accomplished by this department was extensive. One of its major achievements was the installation of closed-circuit television (CCTV) cameras in all the hospital departments to reduce the impact of low staffing; it also helped the nursing staff to observe the patients. Previously, the layout of the buildings prevented patients being visible to the staff. This surveillance system has minimised the number of in-patient critical incidents. A photo identification system was established for all hospital staff, which can be used to access doors, the internal intranet and the telephone network. Also, a pager system was introduced to facilitate staff communication. These achievements had a beneficial impact upon the care of both out-patients and in-patients.

A new multidisciplinary team approach to patient management was introduced, in which medical staff were divided into three units, each led by a consultant psychiatrist.

A new out-patient department was opened with large waiting areas for patients and several interview rooms. The task of renovating and running the out-patient department was given to a group of motivated nursing staff. Patient feedback reflected great satisfaction with these changes.

An additional temporary acute admissions unit with 20 beds was opened to cope with the large number of patients with acute presentations requiring admission. This unit was closed after the crisis had been dealt with.

A new rehabilitation unit was opened, with 40 beds, attached to a new occupational therapy department. The rehabilitation unit supports the transfer of long-stay patients from the acute admissions unit.

A subacute unit of 16 beds was opened, with a gym and physiotherapy unit; it was designed to facilitate the rehabilitation of patients into the community following an acute admission.

The 40-bed acute admissions unit was renovated and seclusion rooms were constructed according to

https://doi.org/10.1192/S1749367600003842 Published online by Cambridge University Press

international standards, to replace the malpractice of restraining patients who had become aggressive.

The establishment of several new departments has solved some of the problems of service provision but has also created pressure because of the need to staff these units. The problem was partially addressed through the employment of 50 new nursing staff and more than 50 new care assistants.

The capacity-building programme

The hospital recruited 23 new doctors, who signed contracts and started working as trainees in psychiatry. Five have gone on to pass the first part of the Arab Board examination in psychiatry.

An agreement was made to link to regional excellence centres for capacity-building programmes, which support study tours in neighbouring countries. A programme of twinning Libyan hospitals with other psychiatric hospitals in the region has now been running for over 6 months.

Visiting professors and trainers were invited back to the country, including expatriate Libyan mental health professionals. The World Health Organization has supported training within the hospitals. Short courses have been established both for general doctors and for the team working at the hospital, to bridge the gap in human resources.

In order to get psychiatrists from all over the country together, the hospital has supported the establishment of a professional organisation, the Libyan Psychiatric Association; previously psychiatrists came under the Libyan Neurology Association. Furthermore, the Libyan Board for Psychiatry Training is now in the process of establishment and official training in psychiatry is expected to begin in 2014.

Introducing a rights-based approach to mental health practice

The malpractice of administering electroconvulsive therapy (ECT) without anaesthesia was stopped and it is given now only with general anaesthesia. Guidelines on the use of seclusion and restraint have been drawn up. Seclusion rooms have been introduced, based on international standards, to replace physical restraints.

Patient complaints are now collected and reviewed by dedicated staff.

A community-based approach to services

Teams at the hospital supported the launch of the first psychiatric out-patient department at the Tripoli central hospital. Outreach services have been started to support local prisons, as well as centres for people with intellectual disabilities and a nursing home for elderly people.

In order to open up the hospitals to the community, a day care unit has been established. This is designed to provide services for in-patients; here, they can learn new skills away from the hospital culture. Other service users from the community together with family members will become involved too, thus bridging the former gulf between the community and the hospital.

Conclusion

All these reforms at the hospital are associated with a larger and more ambitious reform process in the national mental health system in Libya, which is supported by the World Health Organization in partnership with the Libyan Centres for Disease Control and Ministry of Health. This process was initiated in late 2011, and includes the introduction of capacity-building programmes for multidisciplinary professionals, initiating community mental health services, supporting mental health and launching advocacy and awareness programmes for mental health such as ongoing training for general practitioners, psychologists and social workers.

THEMATIC PAPER

CONFLICT AND MENTAL HEALTH IN NORTH AFRICA AND THE MIDDLE EAST

Mental health in Syria

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This paper begins by outlining the nature of the present conflict in Syria. It goes on to describe the psychological consequences of this conflict and the present state of the mental health services in the country.

The Syrian conflict

Syria has been in a state of conflict for over 2 years. What started as a civil protest against decades of oppression and human rights violations by the Syrian regime rapidly escalated into a humanitarian and

https://doi.org/10.1192/S1749367600003842 Published online by Cambridge University Press