COUNTRY PROFILE

Mental health services in Libya

Abdul Hakim Rhouma,[1] Nusrat Husain,[2] Nadeem Gire[3] and Imran Bashir Chaudhry[4]

[1]EIS Speciality Doctor, Lancashire Care NHS Foundation Trust, UK, email hakim70@doctors.org.uk

[2]Consultant EIS, Lancashire Care NHS Foundation Trust; Honorary Senior Lecturer, University of Manchester, UK

[3]EIS Research Assistant, Lancashire Care NHS Foundation Trust, UK

[4]Lead EIS Consultant, EIS, Lancashire Care NHS Foundation Trust; Honorary Professor, General Adult Psychiatry, University of Manchester, UK

Despite all the internal and external criticisms of mental health services in Libya, they remain underdeveloped across the country. The World Health Organization has made efforts to improve the country's mental health services; however, until a stable government is formed, patients with mental illness will continue to be deprived of their basic needs.

Libya has a geographical area of just under 1 760 000 km^2 and a population of around 6 155 000, according to the World Health Organization (WHO, 2012). The country is in the upper middle-income group, with an annual gross domestic product (GDP) in 2013 of US$75.46 billion (World Bank, 2013). The total expenditure on health is only 3.9% of GDP (WHO, 2012).

The infant mortality rate is estimated to be below 20 per 1000 live births and the mortality rate for the under-5s is below 10 per 1000 live births (WHO, 2012). Disability-adjusted life-years (DALYs) from non-communicable diseases such as depression and anxiety have increased since 1990 (Mokdad *et al*, 2014).

To the best of our knowledge there are no research projects on the burden of mental disorders specific to the Arab world (Okasha *et al*, 2012).

Mental healthcare system

The first general hospital which had a mental health unit was established in eastern Libya in 1950 at Al-Marj Khadini, a small town situated 100 km from Benghazi. The unit was under the supervision of one foreign doctor and a few unqualified nurses. However, in 1974 the first psychiatric hospital, Dar Al-Shafa, was created 15 km from Benghazi, with 200 beds (El-Badri, 1995).

Mental health services in Libya were woefully inadequate before and after the civil war following the Arab Spring of 2011 (Abuazza, 2013). Some areas lack mental health services altogether. Okasha *et al* (2012) reported that per 100 000 population, the country had approximately 0.2 psychiatrists, 5 psychologists, 0.05 psychiatric nurses and 1.5 social workers. The number of psychologists is relatively high because it includes therapists, nurses and social workers interested in psychosocial interventions.

The mental healthcare that does exist in Libya is mainly in the form of highly centralised institutional in-patient services. There are two hospital services for the entire population, located in two large cities; they have a total of nearly 2000 beds (Abuazza, 2013).

Patients usually present at a very late stage of illness, and most admissions are involuntary. Patients' family members or other carers normally try to manage the situation without seeking any help, due to stigma. It is more acceptable for spiritual healers to be considered as the first option. The next step is usually the patient's general practitioner (GP), because it is seen as less stigmatising. Psychiatrists are generally the last resort for patients and family.

Specialisation

There is no formal psychiatric training scheme for clinicians. Qualified doctors usually work as GPs and specialists at the same time, without having to go through a formal training programme such as for the MRCPsych.

Children with behavioural or mental health problems will usually be seen by a paediatrician rather than a psychiatrist (Salam *et al*, 2012). A survey of young children in Benghazi found that mental health problems such as depression and anxiety affected significantly more girls than boys (Salam *et al*, 2012). Unfortunately, there is no system in place for the early detection and management of children with emotional or mental health disorders.

Mental health policy and legislation

Libya has a mental health policy but it is not clear when it was formulated. Libya is one of few Arab countries to have a mental health act; it came into effect in 1975 but has never been reviewed. However, in practice the act is rarely used; what happens is, rather, usually dictated by the family's wishes (El-Badri, 1995) and common law has also been used to detain people against their will.

Libyan society is characterised by large family units; the family will be quite involved in a patient's care and well-being, at times with high expressed emotions. When the patient cannot be managed at home the family seeks professional help and brings the patient directly to hospital, facilitating admission and treatment. Does this mean that the mental health law needs to be modified? Family support is a blessing for the patient but at times it can cause delay in treatment and so prolong untreated illness. It is therefore imperative that there are ongoing mental health awareness campaigns and psychoeducation to reduce stigma and improve awareness.

A national mental health programme was established in 1988 (Okasha *et al*, 2012). Libya's National Centre for Disease Control, with the Ministry of Health, aims to launch a 4-year mental health strategy for 2015–2019 (WHO, 2013).

Human rights violations

Violations often occur in psychiatric institutions through inadequate, degrading and harmful care and treatment as well as unhygienic and inhumane conditions. Tripoli's psychiatric hospital, for example, had not been well maintained: it was found to be unhygienic and patients were administered electroconvulsive therapy without anaesthesia (Abuazza, 2013). Patients are detained for long periods without the appropriate mental health act paperwork being completed and are denied basic human rights. There is no managerial tribunal or mental health tribunal to review the need to continue involuntary hospitalisation.

Challenges

Non-communicable diseases are one of the biggest challenges facing health decision makers, particularly in World Health Organization Eastern Mediterranean countries (Boutayeb *et al*, 2013).

Libya is experiencing political instability with the transitional government struggling for more than 3 years to restore security, rule of law and public services. Health services had suffered over the years due to lack of medical leadership, government bodies and regulatory bodies to monitor the quality of health services. Exposure to violence and terror of all kinds will increase the incidence of problems such as post-traumatic stress disorder, and is likely to lead to a substantial mental health burden (Charlson *et al*, 2012).

Education and research

Research and development have been grossly neglected, there being no specific centre for research equivalent to the UK's National Institute for Health Research. A big gap in research output between high- and low-income countries constrains improvements in public health and mental health policy and practice in low- and middle-income countries, where there is perhaps the greatest unmet need (Boutayeb *et al*, 2013).

Culture and religion

Domestic violence is frequently encountered in primary care. Physical abuse is seen as the right of a male member of the family to 'teach' a female appropriate behaviour and rectify any perceived misconduct. Women are very reluctant to seek psychiatric help for the fear of being shamed by their in-laws, their husbands marrying a second wife, divorce and losing custody of their children (Ghuloum, 2013).

Arab patients and their families may attribute behavioural symptoms to bad spirits (*jinn*) or attribute undesirable thoughts and wrongdoings to temptation by the Devil. Patients and their family prefer to seek help from spiritual healers for black magic (Okasha *et al*, 2012).

The way forward

A road map for health in the Arab world is urgently needed (Mokdad *et al*, 2014). Emphasis needs to be put on developing leadership and management skills to be able to move forward. Stakeholders, consumers and health authorities need to work as one team and agree on the most important priorities for re-engineering the health system in Libya (WHO, 2012).

Some positive steps have already been taken. The 4-year mental health strategy for 2015–2019, mentioned above, is set to transform Libya's institution-based approach to a community-based approach, making mental health services available to the most remote and underserved areas of the country (WHO, 2013).

The Ministry of Health needs to create a service evaluation group, in consultation with mental health providers. This group should critically evaluate the quality of the care provided and implement the necessary changes.

Services should be patient-centred and staffed with qualified health professionals. School-based preventive interventions are particularly likely to be of benefit in post-conflict settings, as the effect of war can propagate across generations (Tol *et al*, 2014).

In conclusion, there is a need for research and development in the field of mental health systems in Arab countries and a need to increase awareness of mental health problems.

References

Abuazza, A. (2013) The Arab Spring movement: a catalyst for reform at the psychiatric hospital in Tripoli, Libya. *International Psychiatry*, **10**, 56–58.

Boutayeb, A., Boutayeb, S. & Boutayeb, W. (2013) Multi-morbidity of non-communicable diseases and equity in WHO Eastern Mediterranean countries. *International Journal for Equity Health*, **12**, 1–13.

Charlson, F. J., Steel, Z., Degenhardt, L., *et al* (2012) Predicting the impact of the 2011 conflict in Libya on population mental health: PTSD and depression prevalence and mental health service requirements. *PLoS One*, **7**, 1–11.

El-Badri, S. M. (1995) Psychiatry in Libya: Eastern Region. *Psychiatric Bulletin*, **19**, 48–49.

Ghuloum, S. (2013) Gender differences in mental health in the Middle East. *International Psychiatry*, **10**, 79–80.

Mokdad, A. H., Jaber, S., Aziz, M. I., *et al* (2014) The state of health in the Arab world, 1990–2010: an analysis of the burden of diseases, injuries, and risk factors. *Lancet*, **383**, 309–320.

Okasha, A., Karam, E. & Okasha, T. (2012) Mental health services in the Arab world. *World Psychiatry*, **11**, 52–54.

Salam, A. A., Alshekteria, A. A., Mohammed, H. A., *et al* (2012) Physical, mental, emotional and social health status of adolescents and youths in Benghazi, Libya. *East Mediterranean Health Journal*, **8**, 586–597.

Tol, W. A., Komproe, I. H., Jordans, M. J., *et al* (2014) School-based mental health intervention for children in war-affected Burundi: a cluster randomized trial. *BMC Medicine*, **12**, 56.

WHO (2012) *Global Health Observatory*. World Health Organization. Available at http://www.who.int/countries/lby/en (accessed June 2016).

WHO (2013) Mental health and psychosocial support programme in Libya: 'building back better'. Online at http://www.who.int/features/2013/mental_health_libya/en (accessed June 2016).

World Bank (2013) Country at a glance. Online at http://www.worldbank.org/en/country/Libya (accessed July 2014).