Iraqi, American Psychiatrists Exchange Ideas

BY LORINDA BULLOCK

FROM A MEETING SPONSORED BY SAMHSA

WASHINGTON – Like the United States and other countries around the world, Iraq suffers from a shortage of psychiatrists. But in Iraq, the situation is particularly dire: The country has only about 100 psychiatrists to serve a population of 30 million people, experts say.

That sobering statistic compelled psychiatrists such as Dr. Rebwar Ghareeb Hama of the General Hospital of Sulaimani, Kurdistan, to participate in the Iraq-SAMHSA Partnership on Behavioral Health program. The Substance Abuse and Mental Health Services Administration and the Iraqi government were part of the initiative developed in 2004 to help Iraq reestablish its behavioral health service system.

"We are only a few psychiatrists serving about 2 million people inside Sulaimani," said Dr. Hama, who was part of the team focused on integrating trauma services into primary health care centers. "We have no clinical psychologists, no clinical social workers, so with these short limits, we want to teach or to train nonexperts inside the health centers like general practitioners [and] nurses to identify those people inside the community … and when they find difficulties in managing them, refer them to our centers inside the psychiatry department in the general hospital."

After 6 weeks of observing how various mental health care services are provided in the United States, Dr. Hama and 23 other psychiatrists from Iraq were headed home, armed with new strategies and ready to implement local programs they have designed with the help of their American colleagues.

This group is the second set of psychiatrists and other health professionals from Iraq selected to participate in the program. Their time of intensive training and conferences culminated in a closing session Oct. 21 at the Iraqi Cultural Center, where they presented action plans for their war-weary population, ranging from the implementation of an Iraqi Mental Health Act, to ramping up efforts to improve substance-abuse treatment programs for adults and posttraumatic stress disorder treatment (PTSD) programs for children. The first group participated in the program in 2008.

In the plan developed by Dr. Hama's team (which included three other doctors from Kurdistan), they want to create small, multidisciplinary teams of three people – a general practitioner, a nurse, and "medical staff" – and teach them how to identify patients with PTSD. These teams will be trained in 12 health centers in Sulaimani, he said.

'The people will listen to [teachers and religious leaders]. Training those teachers will be very helpful.'

DR. HAMA

Dr. Hama added that his team wants to train both religious leaders because of their influence in the community and teachers, who will often be the first to notice children suffering from PTSD or other problems. "The people will listen to them. Training those teachers will be very helpful to share all of these programs with a huge number of the population."

In addition to Dr. Hama's team, the other five concentrated on school-based mental health services; forensic, trauma, and substance abuse treatment services; and services for mothers and children with chronic psychiatric disabilities. The projects represented areas across Iraq that included Maysan, Baghdad, Baqubah, Mosul, and Kurdistan.

Each group had a specific area of interest and visited host sites, which included the Johns Hopkins University, Baltimore; the Maryland Department of Health and Mental Hygiene; the National Center on Trauma-Informed Care, Alexandria, Va.; Children's National Medical Center, Washington; INOVA Fairfax (Va.) Comprehensive Addictions Treatment Services; and University of California, Los Angeles, Integrated Substance Abuse Program.

Planning group leaders Dr. Allen R. Dyer, chair of the department of psychiatry at East Tennessee State University, Johnson City, and Dr. Anita S. Everett were each assigned to work with one of the groups. They both felt that the program was more about sharing ideas than forcing the American way of practicing medicine onto the Iraqis.

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Several Iraqi mental health professionals spent 6 weeks visiting facilities in the United States.

"We don't feel like we've been exactly teaching them how to do certain things based on the way we do, but rather, exposing them to the way we do things here so they can take that back," said Dr. Everett of the department of community and general psychiatry at Johns Hopkins.

Dr. Everett, who was a planning group leader for the forensic services team, explained that she was able to share insight on such issues as patient confidentiality, documentation, and medical records, as well as on performance improvement projects and child-abuse reporting. "There's a whole variety of things you can't really teach about so much as have an immersion experience," she said.

As a planning group leader, Dr. Dyer, also of the International Medical Corps, said his aim was to help the psychiatrists from Iraq "develop the skills they need to move forward." For his part, Dr. Hama remains optimistic – despite the difficulties he is sure to face when he returns home. "We must try our best, working hard to serve our people," he said. "They are our people, and they are suffering. We must help them." ■

Shortage of Providers in Rural Areas May Affect Suicide Rate

BY DOUG BRUNK

FROM THE ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Suicides in the United States tend to occur more often in rural compared with urban locations, but findings from a new study suggest that the relative scarcity of mental health care providers in rural areas may factor in to the association.

"More than 600 counties in the United States don't have any health care provider, and 1,600 counties don't have a mental health care provider," Dr. Dale D'Mello of the department of psychiatry at Michigan State University, Lansing, said during a press briefing held at the annual meeting of the American Psychiatric Association.

"One recent study found that the distribution of health care providers is imbalanced in rural compared with urban areas.

"We also know that the prevalence of conditions like depression is equal in urban and rural areas."

To examine the association between population density, the availability of mental health providers, and suicide rates in each state, Dr. D'Mello and his associates evaluated National Center for Health Statistics and Bureau of Census Data information from the year 2004. Suicide rates were defined as deaths per 100,000 population.

They correlated these data with the population density (persons per square mile) and the number of mental health providers per 100,000 population.

Dr. D'Mello reported that a significant powerful negative correlation was observed between the rate of suicide and population density.

For example, Alaska, the state with the lowest population density (1.2 people/square mile), also has the highest suicide rate (23.1 deaths/100,000 population). On the other hand, the District of Columbia, which has the highest population density (9,316 people/square mile), has the lowest suicide rate (5.3/100,000 population).

"The other states start off between these two extremes," Dr. D'Mello said. "I work in Lansing, Michigan, but I do telepsychiatry in a county 200 miles away that's rural. I'm interested in this area, because the suicide rate in [that] population is twice that of people I see face-to-face in Lansing."

VITALS

Major Finding: Alaska, the state with the lowest population density (1.2 people/square mile), has the highest suicide rate (23.1 deaths/100,000 population. Conversely, the District of Columbia, which has the highest population density (9,316 people/square mile), has the lowest suicide rate (5.3 deaths/100,000 population).

Data Source: National Center for Health Statistics and Bureau of Census Data from 2004.

Disclosures: Dr. D'Mello disclosed that he is a member of the speakers' bureau for Pfizer, AstraZeneca, and Schering.

Similar and striking significant negative correlations were observed between the distribution of psychiatrists, psychologists, and social workers and suicide rates.

Certain economic and cultural factors also may contribute to the higher rate of suicides in rural population, he said. "Economic causes include the recent change in the rural economy from agriculture to manufacturing, resulting in a disproportionate burden of rural poverty in most countries around the globe," he said.

As for cultural factors, Dr. D'Mello continued, "there are a large number of books and papers written about the rural culture as being different from urban culture, focusing on the male farmer – the importance based on self-reliance and independence in forming the identity of the male farmer, and the fact that health is correlated with productivity. When productivity declines, a crisis occurs."

One possible solution to improving mental health care for people in rural settings, he concluded, is to deliver mental health care in primary settings, "integrating the delivery of mental health and medical health. This has occurred in many cases across the country," Dr. D'Mello said. ■