INTRODUCTION

The Iraqi people have suffered from a variety of war-induced mental disorders, as a result of over thirty years of international and internal armed conflict and living under Saddam Hussein’s Ba’ath regime. In a nation that has a rich history of education and medical advancement, the most recent period of conflict has had dire effects on the Iraqi population and medical community. Iraq now finds itself in the midst of a civil war with increasing violence and an ever weakening infrastructure and access to basic medical services. The population has been subjected to constant conflict, murder, violent attacks, torture, kidnappings, and other crimes, making the need to create a strong, adequately structured, properly funded, and staffed mental health system all the more vital in its transitional and post-conflict stage. Although the United States’ “war” is over in Iraq, conflict for Iraqis is still part of their everyday life, and until the country becomes stable and secure, implementing infrastructure, such as community-based mental health program will remain difficult.

International human rights and international humanitarian law provide an overarching framework under which to evaluate and propose mental health laws and systems. In order for the mental health programs in Iraq to succeed, two things need to occur. First, a program needs to be implemented and funded that is tailored to the situation of the Iraqi people, with due regard to the state of internal and international armed conflict that they have endured for the past thirty years. Second, as the country goes through the process of transitional

* Kari Kammel holds a J.D. from DePaul University College of Law, an M.A. in International Human Rights Law from The American University in Cairo, and an A.B. from The University of Chicago. I would like to thank Professor M. Cherif Bassiouni for his comments, as well as Dr. Sabah Sadik for his comments and assistance.
justice, a lasting solution needs to be created to address and take care of
the mental health problems that have resulted from trauma and war.

This article is divided as follows: Part I gives a background and
history of mental health law and mental health issues in Iraq; Part II
provides an overview of international legal obligations regarding
mental health, Part III argues the need for a specifically tailored mental
health system for Iraq; Part IV addresses the rebuilding of the mental
health of the Iraqis in the context of transitional justice; and Part V
concludes the article with the concerns in creating a mental health care
system in Iraq.

I. BACKGROUND: HISTORY OF MENTAL HEALTH LAW
AND MENTAL HEALTH ISSUES IN IRAQ

In ancient times, the civilizations of the Sumerians, the
Amorites, the Hittites, the Assyrians, and the Chaldeans occupied what
is today modern Iraq. Following the period of rule by the Persians,
Greeks, and Macedonians, the Islamic civilization made great
contributions to the science of medicine. During the Abbasid Islamic
period, pioneers of medicine and psychiatry, such as Ibn Sina, Ibn
Rushd, and Al-Razi made monumental contributions to the medical
field, including the establishment of some of the first mental hospitals
providing patients with humane treatment. During the medieval

1 See M. Cherif Bassiouni, Post-Conflict Justice in Iraq, 38 CORNELL INT’L L. J. 327,
328, n. 1 (2003) [hereinafter Bassiouni, Post-Conflict Justice in Iraq]; see also
GEORGE ROUX, ANCIENT IRAQ, 66-84 (3d ed. 1993). The Sumerians ruled beginning
in approximately 5000 B.C.E.; the Amorites from 1900-1600 B.C.E.; the Hittites
from 1600-1100 B.C.E.; the Assyrians from 1200-612 B.C.E.; the Chaldeans from
612-539 B.C.E. Id. at 66, 104, 179-94, 377-379 tbls. IV-VIII.
2 ROUX, supra note 1.
3 Keith Humphreys & Sabah Sadik, Rebuilding Iraq’s Mental Health System, 39
PSYCHIATRIC NEWS 24 (April 2, 2004).
4 Ibn Sina was also known as Avicenna and died in 1037. Dr. Sabah Sadik, National
Advisor for Mental Health in Iraq, Mental Health Programmes In Iraq, Progress
Report (March 2006) [hereinafter Sadik, Progress Report] (on file with Author);
Abdul-Monar Al-Jadiry & Hussain Rustam, Mental Health Education and Training in
Iraq: An Overview, 1 J. MUSLIM MENTAL HEALTH 117, 118 (2006); Healing Minds:
World Health Organization Iraq, Mental Health Progress Report 2004-2006 4 (WHO
5 Al-Razi was also known as Rhazes and died in 925. Sadik, Progress Report, supra
note 4; Al-Jadiry & Rustam, supra note 4, at 118.
6 Sadik, Progress Report, supra note 4; Michael W. Dols, Historical Perspective: The
Treatment of the Insane, 1 J. MUSLIM MENTAL HEALTH 185, 186 (2006) [hereinafter
Dols, Historical Perspective]; Michael W. Dols, Origins of the Islamic Hospital:
Islamic period, the *bismaristan* or *maristan*, was the special portion of the hospital for the insane. Medieval Islamic hospitals in Baghdad used Galenic medicine and also used music therapy and other techniques to treat mental disorders. During the Ottoman period in the eighteenth and nineteenth centuries and into the twentieth century, the dynamic development of mental health treatment that characterized the Medieval Islamic period did not advance or continue. After the fall of the Ottoman Empire at the close of World War I, the British and the French divided the former Ottoman territories, spreading their influence over the Middle East. The British created the modern state of Iraq into the British Mandate from three former Ottoman provinces: Mosul, Baghdad, and Basra. However, the British Mandate in Iraq only lasted from 1919 until 1927, with the Iraqis winning their independence from colonial rule. In November of 1927, the Baghdad University Medical College was founded and modeled on the British system, implementing the same curriculum as Edinburgh University in the United Kingdom. Although the British system used therapies such as psychopharmacology, electric convulsive therapy, and insulin-induced comas, the cultural barrier and lack of resources prevented them from being adapted in Iraq. As is still the case today, many Iraqis believed that individuals were possessed by *jinna* or spirits, instead of having mental problems, and turned to religious or superstitious remedies.
Throughout Iraq, as in most of the Middle East, mental illness carried, and still carries, a stigma.\textsuperscript{16}

In the early 1950s, modern psychiatric services began appearing in Iraq,\textsuperscript{17} and European-trained Iraqis replaced British faculty in the medical colleges.\textsuperscript{18} In the early 1950s, Drs. Jack Aboud and Ali Kamal were at the forefront of establishing the Al-Rashad Mental Hospital in Baghdad.\textsuperscript{19} Following this period in the 1960s through the 1970s, the mental health system developed with the creation of psychiatric units in general hospitals, mental health programs in schools, and public awareness campaigns, producing some of the most advanced health care in the Middle East.\textsuperscript{20} The Iraqi government began sending medical professionals to the United Kingdom to receive additional training, and established psychiatric units in hospitals, outpatient clinics, community-based services, and more medical schools in the provinces.\textsuperscript{21} Until the Iran-Iraq War of the 1980s, Iraq was one of the leaders of the developing world in health care spending.\textsuperscript{22}

However, beginning in the 1980s, Iraq's public health services deteriorated or were destroyed, including mental health programs and facilities.\textsuperscript{23} The Hussein regime not only entered into a series of wars beginning with the Iran-Iraq war\textsuperscript{24} and culminating in the two Persian Gulf wars,\textsuperscript{25} but also instituted a systematic and systemic regime of oppression and violence.\textsuperscript{26} An estimated two million children died as a result of the twelve year UN-led sanctions, which caused economic,
social, scientific isolation and deprivation, resulting in the collapse of
the public and mental health programs and facilities.27 Before the UN
sanctions, Iraq had “one of the most sophisticated and efficient health
systems in the Middle East with a national budget of US$450 million.
By 2002 spending had fallen to $22 million due to both the sanctions
and the previous regime’s slashing of the health care budget.”28

The sanctions also severely depleted human and material
resources. The most destructive factor was the ‘brain drain,’ in which
many of Iraq’s medical doctors and experts fled Iraq for fear of their
lives or those of their families.29 The health care professionals faced
the threat of kidnapping, intimidation, deprivation of control,
restrictions on travel and education, lack of access to journals,
conferences, education, and colleagues.30 At the same time, the
medical societies within Iraq were controlled by the Hussein’s Ba’ath
party through the Minister of Health, where spying was widespread.31
Additionally, problems in the condition of mental institutions increased
exponentially. According to former interim Minister of Health, Dr.
Khudair Abbas, “patients with mental health problems had been kept
under prison-like conditions and many escaped when their institutions
were looted and vandalized last year. Inhumane treatment of patients
was symptomatic of Saddam Hussein’s dictatorship, which tortured and
murdered thousands of Iraqi citizens.”32 Thus, the mental health
problems caused by the wars were compounded by the regime’s
treatment of patients as well, resulting in a serious health crisis.

27 Daniel Allen, Beginnings of Mental Health Services Emerge in War-Torn Iraq, 9
MENTAL HEALTH PRACTICE 6 (November 2005).
28 Christine Aziz, Struggling to Rebuild Iraq’s Health-Care System, 362 THE LANCET
1288 (Oct. 18, 2003).
29 Charles G. Curie, Health Diplomacy in Action: Helping Iraq Rebuild Its Mental
30 Humphreys & Sadik, supra note 4; see also Nellie Bristol, Iraq’s Health Requires
Continued Funding Commitment, 368 THE LANCET 905 (Sept. 9, 2006) (stating from
April 2003 to May 2006, 102 doctors were killed and 162 nurses were also killed;
some estimates indicate that over 250 Iraqi doctors have been kidnapped); see also
Aaron Levin, Iraq Tackles Daunting Task of Rebuilding MH System, 41 PSYCHIATRIC
NEWS 5 (March 3, 2006); Muhammad Lafta & Anand Pandya, Verbal and Physical
Aggression Against Resident Physicians in Two General Hospitals in Baghdad, 1 J.
MUSLIM MENTAL HEALTH 137 (2006) (discussing aggression against physicians by
patients and their families).
31 Christine Lehmann, International News: Iraqi M.D.’s Want to Bring Democracy to
32 Fiona Fleck, Mental Health a Major Priority in Reconstruction of Iraq’s Health
System, 82 BULL. OF WORLD HEALTH ORG. 555 (July 2004).
In 2002, following the fall of the Hussein regime, the United States installed a provisional government. In September of 2003, a new Iraq government was formed, at which time the Minister of Health Dr. Abbas declared mental health a priority of the new government. The Minister of Health chose Dr. Sabah Sadik, as the National Advisor for Mental Health and the leader in reconstruction of the mental health programs in Iraq. Under Sadik’s leadership, the National Council for Mental Health (“National Council”) was formed with the assistance from other ministries in the Iraqi government including the Ministry of Health, the Ministry of Higher Education, the Ministry of Labor and Social Affairs, the Ministry of Justice, the Ministry of Human Rights, the Ministry of Interior, and the Ministry of Education. By June of 2005, the Minister of Health approved a structure for the National Advisor’s Office. Sadik’s office also established several committees for reviewing, updating and monitoring medicine at all levels, as well as conducting Assessment Instruments for Mental Health Systems (“AIMS”) surveys in order to create a centralized database of resources. The initial AIMS report was finalized in December of 2005. The Ministry’s current goals include integrating mental health into primary care, building mental health units in hospitals, and introducing a new mental health reform law. As of June 2007, training programs have been set up through Sadik’s work and since the passage of the Mental Health Act; however, doctors including psychiatrists continue to leave the country.

In addition to the role of the Ministries, Iraqi physicians have been proactive in establishing strategic short and long-term plans for mental health care in their country. In 2004, Iraqi physicians began working with their counterparts from the United Kingdom, the United States, and Japan in a series of conferences in Iraq and other

---

33 The Coalition Provisional Authority (“CPA”) was created by the US to administer Iraq under the control of the Department of Defense. See Bassiouni, Postconflict Justice in Iraq, supra note 1, at 15.
34 Sadik, Progress Report, supra note 4.
35 Id.
36 Id.
37 Id. at 2.
38 Levin, supra note 30; Allen, supra note 27, at 6.
40 Lehmann, supra note 31.
locations. In late 2004, individual professionals outside of Iraq began to help the effort to rebuild the system including those from Italy, Slovenia, Sweden, the United Kingdom, the United States, and several Iraqi expatriates. Since 2004, conferences and training sessions persist, despite the security issues and violence that continues to plague the country.

The shortage of qualified and capable medical professionals is one of the biggest problems facing the fledgling Iraqi mental health system. One of the main problems mentioned above, the 'brain drain,' created a vacuum of qualified individuals to work with mental health patients. In addition, the United States directly contributed to the shortage of medical professionals by purging all Ba'ath Party members, the process of de-Ba'athification. The U.S. Army and Coalition Provisional Authority (CPA), led by Paul Bremer, implemented a policy in 2003 of ridding all the Ba’ath Party members of their jobs. The CPA succeeded in removing at least eight members of the Iraqi Society of Psychiatrists (ISP) from their positions. For professionals working during the Hussein era, membership in the Ba’ath party was necessary to maintain employment, to be promoted, or to work in state universities. If any professionals committed crimes as part of the membership, then they should have been tried in a court, not simply removed. The policy of the CPA contributed to the problem of ‘brain drain’ in Iraq. However, only recently, in January of 2008, the Iraqi parliament government reversed this policy after pressure from the United States, but not until after irreversible damage was done.

International organizations, such as the World Health Organization, have been working with the National Council to create a

---

41 Id.
42 Humphreys & Sadik, supra note 4.
43 Lehmann, supra note 31; CPA/ORD/16 May 2003/01.
45 Sadik, Progress Report, supra note 4.
46 Jonathan Steele, US decree strips thousands of their jobs: Anti-Ba’athist ruling may force educated Iraqis abroad, THE GUARDIAN, supra note 44; Lehmann, supra note 31. CPA officials note that the purge only affected between 15,000-30,000 Iraqis, which, according to their estimates, make up only 5% of the total Ba’ath party. Id. However, Husam al-Rawi, a professor at Baghdad University's Department of Architecture and low ranking Ba’ath party member estimated the number at 80,000.
national database for the mental health workforce. However, the current workforce is almost non-existent. The health care workforce in Iraq differs from the United States system, where the medical staff work for national facilities in the mornings and privately practice in the evenings. The national database results showed that the total number of mental health care workers was 1.6 per 100,000 people. Additionally, most of the mental health care workers work in the urban areas, exacerbating the problems of the rural poor. According to a 2004 study, the number of trained mental health care workers and facilities remained severely low, especially for a total population around 28 million. Additionally, the life expectancy was 51 years for males and 61 for females. By July of 2006, the numbers had not improved and there was still only between 80 to 100 psychiatrists in Iraq to care for the entire population.

The mental health care system currently in place is outdated by modern standards. It still has long-term institutional care, which the mental health profession has been shifting away from, lack of multi-disciplined professionals, and still relies on abuse-prone medications. Additionally, laws that include compassionate treatment of mentally ill

---

49 *Id.*
50 *Id.*
51 *Id.*
52 Humphreys & Sadik, *supra* note 3. Psychiatrists number between 75-91 total: 2% work only for government, 5% only for private clinics; 92% in both; 86 work in outpatient facilities, 28 in general hospital psychiatric inpatient units; 18 in mental hospitals. Allied Healthcare Professionals number 186 psychologists, social workers, nurses and occupations therapists who only work in Government. The numbers are unknown for NGOS or for-profit mental health facilities, and private practices. There are 145 nurses total and only a handful of psychologists, social workers & occupational therapists: 8 in outpatient, 5 in community based psychiatric inpatient units; 28 in mental hospitals. *Id.* The current mental health facilities in Iraq consist of two mental hospitals, both located in Baghdad: Al-Rashad, which has 1200 beds, and Ibn-Rushed, which has 70 beds. In addition to the mental hospitals, general hospital mental health units exist in Baghdad (4) and eight in other governorates. *Id.*
53 But see CIA World Factbook, Iraq (2008), available at https://www.cia.gov/library/publications/the-world-factbook/geos/iz.html (estimating in 2008 that life expectancy for males is 68 years and for females is 70 years, which is considerably higher than other sources).
54 *Id.*; see also Levin, *supra* note 30, at 4.
55 Humphreys & Sadik, *supra* note 3. Medications such as benzodiazepines and anticholinergics are still used. *Id.*
and substance-addicted patients do not exist. Since 2003, the violence in Iraq has increased and, therefore, "severely obstructed access to primary care all over the country," which in many places, especially outside of Baghdad, is where mental health services are available.

The need for mental health legislation has plagued Iraq over the years. During the Hussein regime, multiple attempts to create legislation were blocked. But, since the fall of the regime, the path for legislation opened up. The first meeting of the National Council for Mental Health was held on March 23, 2004. A working committee for the National Adviser, Dr. Sadik, was recruited consisting of two psychiatrists, a senior social worker, a senior nurse, a senior psychologist, and administrative staff. After creating a draft with the input of judges and lawyers from the Ministry of Justice, a final draft of the Mental Health Law was submitted and approved by the Cabinet in 2004. Dr. Sadik noted that although the legislation has been implemented, due to the security situation, implementation has not occurred.

II. INTERNATIONAL LEGAL OBLIGATIONS REGARDING MENTAL HEALTH

Under international law, nation-states are bound by international covenants and conventions that they have signed and ratified, as well as by customary international law. International conventions that are pertinent to mental health issues arise from the human rights law framework. In addition to these sources, several non-binding recommendations by United Nations' bodies and other international organizations aid in interpreting the conventions. However, enforcement of these conventions are problematic usually

---

56 Humphreys & Sadik, supra note 3; but see Mental Health Act of Iraq, 2004 (English translation on file with author).
58 Bristol, supra note 31, at 905.
59 Humphreys & Sadik, supra note 3.
60 Id.
61 Id.
62 Interview with Sabah Sadik, National Advisor for Mental Health, Iraq (April 17, 2008).
due vagueness, a broad scope, or in the cases of recommendations, their non-binding nature.63

The basic human rights documents contain provisions that are fundamental to an individual’s mental health. Iraq and other states aiding the reconstructing of mental health system, should look to these documents as guidelines, as well as other international organizations and non-governmental organizations (NGOs) aiding this process. The United Nations’ Charter states in its preamble that it seeks “to reaffirm faith in fundamental human rights, in dignity and worth of the human person.”64 The Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights (“ICCPR”),65 and the International Covenant on Economic, Social and Cultural Rights (“ICESCR”)66 all protect the basic rights of individuals. Iraq is party to these conventions and is bound to uphold the rights set forth in the conventions.

For example, economic, social, and cultural rights are included, especially those that are applicable to populations that are deemed vulnerable, such as persons with mental disabilities.67 In the ICESCR, Article 12 says that everyone has the right to the “enjoyment of the highest attainable standard of physical and mental health.”68 This language mirrors the language of the constitution of the World Health Organization (“WHO”), which states that “[t]he enjoyment of the highest attainable standards of health is one of the fundamental rights


68 ICESCR, supra note 66, at art. 12.
of every human being without distinction of race, religion, political belief, economic or social conditions." The highest standard of attainable health should include at a minimum the following: access to appropriate and professional services, the right to individualized treatment, the right to rehabilitation and treatment that enhances autonomy, the right to least restrictive services, the right to community based services, and informed consent and the right to refuse treatment.

Several other declarations and principles are important when looking at Mental Health issues. Although not binding, guidelines for creating national legislation should be followed and also can be used as an interpretive guide for conventional rights. Both the Declaration of Cooperation: Mental Health of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations and The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care ("MI Principles") are such documents. The MI Principles mandate protection against "harm, including unjustified medication, abuse by other patients, staff or others . . . ." They also place community involvement at a high level by recognizing that all people "with a mental illness shall have the right to live and work, to the extent possible in the community" as well as

---


70 Rosenthal & Sundram, supra note 65, at 496


73 Rosenthal & Sundram, supra note 65, at 499; MI Principles, supra note 71, at 9(1), 11(11).


75 Rosenthal & Sundram, supra note 65, at 501-02; MI Principles, supra note 71, at principles 11, 15, 18; ICCPR, supra note 65, at art. 7

76 Rosenthal & Sundram, supra note 65, at 478.


78 MI Principles, supra note 71.

79 Id. at 8(2); Rosenthal & Sundram, supra note 65, at 489.

80 MI Principles, supra note 71, at 3; Rosenthal & Sundram, supra note 65, at 489.
having the "right to be treated and cared for, as far as possible, in the community in which he or she lives."81

Additionally, several other international documents address mental health, such as the U.N. Standard Rules on Equalization of Opportunities for Persons with Disabilities,82 the United Nations Committee on Economic, Social, and Cultural Rights' ("ECOSOC") General Comment No. 5,83 which ensures full range of human rights for persons with disabilities and standard rules are particularly valuable as reference guide, and General Comment No. 14, which addresses the right to the highest attainable standard of health.84 Additional United Nations guidelines include Guidelines for the Establishment and Development of National Coordinating Committees on Disability: Guidelines for the Development of Organizations of Disabled Persons,85 Report of the Working Group on the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, and the Vienna Declaration, which re-emphasizes the protection of the people with mental and physical disabilities under international human rights law.86 Additionally, the U.N. Human Rights Commission adopted resolution 2000/51, which "urges the Governments to cover fully the question of the human rights in persons with disabilities in complying with the reporting obligations under the relevant United Nations instruments."87

The WHO, the United Nations branch for health issues, also published Mental Health Care Law: Ten Basic Principles, Division of Mental Health and Prevention of Substance Abuse,88 the Twenty-Five Questions and Answers on Health and Human Rights,89 Guidelines for

---

81 MI Principles, supra note 71, at 7(1); Rosenthal & Sundram, supra note 65, at 489.
83 General Comment No. 5, supra note 72; Rosenthal & Sundram, supra note 65, at 482. The ECOSOC committee recognized the MI Principles, the Standard Rules, and the UN's Guidelines for National Coordinating Committees. Id.
84 General Comment No. 14, supra note 74, at art. 12 (on the right to the highest attainable standard of health). Rosenthal & Sundram, supra note 65, at 482.
89 World Health Organization, Twenty-Five Questions and Answers on Health and Human Rights (July 2002).
the Promotion of Human Rights of Persons with Mental Disorders, and the Division of Mental Health and Prevention of Substance Abuse.\textsuperscript{90}

The rights set forth above provide a "powerful, but often neglected, tool to advance the rights and freedoms"\textsuperscript{91} of those with mental illness in Iraq. Both the Iraqi government and any occupying power, such as the U.S., are bound by them. They are protections from abuse against those with mental disabilities and a guideline for those who are creating new laws and systems in Iraq.

III. RECONSTRUCTING THE MENTAL HEALTH SYSTEM: THE NEED FOR A SPECIFICALLY TAILORED PROGRAM

The reconstruction of Iraq’s mental health system is a complex problem that needs to be tailored to the Iraqis with regard to the series of international and internal armed conflicts, as well as cultural factors. Substance abuse is also a related issue that needs to be addressed. Additionally, the United States’ responsibility in this process, both financially and in training medical staff, will be examined. It is important to note that violence affects not only individuals, but also families, communities, and social institutions\textsuperscript{92}—groups that must be considered in Iraq’s mental health system.

A. Vulnerable Groups in Conflict Periods

During periods of conflict, several groups of individuals are especially vulnerable such as children, women, elderly, disabled, and those with severe physical and mental disorders.\textsuperscript{93} In addition to these vulnerable groups, individuals in psychiatric institutions perhaps are among the most vulnerable because they do not live with their families, they are less likely to receive help from community members because

\textsuperscript{90} Guidelines for the Promotion of Human Rights of Persons with Mental Disorders, and the Division of Mental Health and Prevention of Substance Abuse, WHO/MNH/MND/95.4.

\textsuperscript{91} Gostin & Gable, supra note 67, at 20.

\textsuperscript{92} Kenneth Miller et al., Beyond Trauma-Focused Psychiatric Epidemiology: Bridging Research and Practice with War-Affected Populations, 76 AMER. J. ORTHOPSYCHIATRY 409, 416 (2006) [hereinafter Miller et al.].

of social stigma, and they are too dependent on custodial care. Survivors of extreme stressors such as war, genocide, persecution, political repression, torture, ethnic cleansing or terrorism in developing countries are prone to a range of additional vulnerability factors, such as increased economic hardship, lack of skills fitting the new environment, marginalization, discrimination, acculturation, poor physical conditions and a collapse of social networks.

For vulnerable groups, such as children or women, trauma-related stress is particularly high in armed conflict. In one study by the Ministry of Health in Iraq, over 70% of primary school students in Baghdad were affected by trauma-related stress. Furthermore, most of these children remain untreated. Currently, women also have an extremely vulnerable position in Iraq. Because of the present violence and security problems, they fear things such as kidnapping and rape.

Illustrative of the problem with psychiatric institutions during conflict is after the 2003 U.S.-led invasion of Iraq, the Al-Rashad hospital was looted and its 750 patients were released into the streets as vagrants. Consequently, the vulnerable groups consist of both permanently mentally disabled and others in the population who are at a more severe risk of mental disorders as a result of the conflict.

B. Mental Disorders Associated with Conflict

In general practice, anxiety and depressive disorders are the most common mental health problems in all regions in the world. Other war-torn countries such as Angola, Afghanistan, Cambodia,
Somalia, Burundi, Rwanda, Sierra-Leone, Kosovo, Chechnya have experienced "prolonged human destabilization and psychosocial dysfunctioning caused by traumatic events." In a study of primary care patients in the city of Al-Nasiriyah in Iraq during 2005-2006, Hussein and Sa’adoon of the Thi Qar Faculty of Medicine found there was a high prevalence of anxiety and depressive orders, with many of the patients having both, and women having a higher prevalence. In conflict zones, the population experiences a wide-variety of mental disorders varying from Post-Traumatic Stress Disorder to suicide, as well as pre-existing mental conditions that exist across the population.

The World Health Organization (WHO) has provided eight principles in dealing with populations that have been exposed to extreme stressors that occur in emergency situations: (1) contingency planning before the acute emergency, (2) assessment before intervention, (3) use of a long-term perspective, (4) collaboration with other agencies, (5) provision of treatment in primary health care settings, (6) access to services for all, (7) training and supervision, and (8) monitoring indicators. In addition, the WHO also stresses the importance of mental health professionals working closely with other disciplines, especially in the context of social intervention.


WHO, Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors, Geneva 2003, WHO/MSD/MER/03.01; Van Ommeren, et al., supra note 104 at 72, Table 1; see also Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations, World Health Organization, Geneva 2001, WHO/MNH/MHP/99.4 (describing methods to use in working with displaced populations in humanitarian crises resulting from war and conflict); Declaration of Cooperation: Mental Health of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations, World Health Organization, Geneva 2001, WHO/MNH/MHP/99.3.

Van Ommeren, et al., supra note 104, at 72.

C. The Role of Culture

Within any community affected by war, culture plays a significant role in the structure and methodology of the mental health programs that are implemented, as well as how individuals respond to the program and the mental health professionals from their community and the international community.

Culture is defined by the WHO as "a cognitive map to make sense of the world and guide behavior." "Patients of different ethnic background may show a different response to both psychological and pharmacological treatments." Mental health workers need to be aware of the influence of culture on psychiatric disorders. Awareness is not only important, but "[e]ffective training incorporates an understanding of how local culture influences survivors' experiences of trauma, suffering, recovery, and resources, including the idioms used to express distress."

Religious or socially shared beliefs can also play a role in either protecting individuals or leaving them more vulnerable to the adverse effects of war. However, most studies of war-affected communities,

---

108 Id. at 6.
109 Id. at 8-9. The Guidelines also note the importance of including traditional healers, especially in developing a “culturally appropriate curriculum.” Id. at 9.
111 Ivbijaro, et al., supra note 110, at 49.
112 Id. at 51.
114 Miller, supra note 92, at 414.
with few exceptions, give little attention to this factor. Some important factors of inquiry exist in working with war-affected populations including examining local idioms of distress, identifying local mental health concerns and priorities, understanding the effects of organized violence on multiple levels, understanding local patterns of help-seeking behavior and identifying local resources that can promote healing and adaptation, and identifying effective intervention strategies. In Iraq, the situation is extremely complex due to the diversity among its people. “Contemporary Iraq is profoundly plural in its languages, religions, ethnic groups, cuisines, rituals, and ideological orientations. . . .” It is especially important to note that the society is not homogeneous, in order to appropriately create an effective system.

In many conflict zones, the survivors are often of a different ethnic or socio-economic group from those who seek to aid them. Mental health services often exclude certain groups of the population because: “[M]any mental health professionals are not adequately trained to deal with certain types of people; many survivors are stigmatized (especially rape survivors); many survivors are too poor to pay for services or too afraid to travel to access services; many survivors do not trust or understand the rationale of modern psychosocial or mental health support.” In areas of conflict, frameworks, or organizational structures, need to be created, such as the organization of mental health care within the primary care system.

115 But see, VICTOR FRANKL, MAN’S SEARCH FOR MEANING (1963) (noting the protective function of religion among Jewish inmates in the Auschwitz concentration camp); A. Dawes, The Effects of Political Violence on Children: A Consideration of South African and Related Studies, 25 INT’L J. PSYCHOLOGY 13, 13-31 (1990) (documenting the work of South African psychologist who noted the ability of detained black youth who were tortured to buffer their stress through shared ideological convictions); R. Punamäki, Political Violence and Mental Health, 17 INT’L J. MENTAL HEALTH 3, 3-15 (1989) (noting Palestinian women who had deep political beliefs reported lower levels of distress); Miller, supra note 92, at 414.

116 Miller, supra note 92, at 414.

117 Id. at 414-19.

118 King-Irani, supra note 11, at 95.

119 De Jong et al., Terrorism, supra note 95, at 8.

120 Id.

1. Post-Traumatic Stress Disorder—A Western Construct

Because in the past sixty years, most of the world’s 250 conflicts have taken place in non-Western countries, the need is paramount for mental health professionals to be trained in methodologies that are effective in the socio-cultural environment where they are working, which is not necessarily a Western model. Post-conflict research on mental health has shown the hyper-diagnoses of Western disorders such as post-traumatic stress disorder (PTSD). In researching war-affected populations, the traditional approach of focusing on PTSD and other Western psychiatric disorders, an approach referred to as trauma-focused psychiatric epidemiology (TFPE), is of limited to value to community-based mental health and psychosocial organizations that are dealing with much more serious consequences of war.

The attention given to PTSD has been at the expense of addressing other mental health problems. For example, in psychopathology studies done in post-conflict Algeria, Cambodia, Ethiopia, and Gaza, PTSD had a three to ten-fold increase among individuals who had been exposed to violence, as well as a 1.2 to 6-fold increase among mood disorders and non-PTSD anxiety disorders. In these areas, culture also plays a vital role, because it develops coping strategies in the form of mourning, healing, purification, reconciliation, and commemoration rituals.

In a study on Afghanistan, PTSD was generally reported by Afghans when they were specifically asked about symptoms. However, these symptoms may have “little meaning within Afghan culture, and Afghans—who have survived more than 23 years of war and repression—are much more likely to describe their war-related

---

122 M. Cherif Bassiouni, Searching for Peace and Achieving Justice: The Need for Accountability, 59 LAW & CONTEMP. PROBS. 9, 10 (Fall 1996) (hereinafter Bassiouni, Searching for Peace).
123 De Jong, Terrorism, supra note 95, at 8.
124 See e.g. Miller, et al, supra note 92, at 409.
125 Miller, et al., supra note 92, at 409. Psychiatric epidemiology is the study of the prevalence, correlates, and causes of psychiatric disorders within a population, while traumatology is the study of psychological trauma. Id. at 411. See also Van Ommeren, et al., supra note 104, at 71.
126 De Jong, Terrorism, supra note 95, at 8.
127 Id. at 9.
128 Id.; De Jong, Public Mental Health, supra note 95.
129 Miller et al, supra note 92, at 412.
distress in terms of *jigar khun* (dysphoria associated with experiences of loss and other hardships), *asabi* (a combination of nervousness and anger), and *fisha-e-bala* (feeling highly pressured or stressed) than PTSD.\(^{130}\)

Problems with the TFPE approach often arise from the use of Western diagnostic categories on a non-Western population, which is what makes up most of war-affected areas.\(^{131}\) The validity of these categories is rarely challenged, nor is the extent to which they are culturally meaningful or viewed as a priority by community members.\(^{132}\) However, PTSD has been documented in different cultural settings in numerous studies of war-affected populations,\(^{133}\) and in Iraq specifically, high rates of depressive and anxiety orders have been shown as well.\(^{134}\) The diagnoses of PTSD remains important, but it must not be overemphasized in the Iraqi context.

An alternative to TFPE is the social constructivism approach, which does not search for a universally valid definition of mental health and disorder, but explores the variety of ways cultures understand and express psychological well-being and distress.\(^{135}\) Mixed methodology using both quantitative and qualitative methods,\(^{136}\) such as free-listing techniques, ethnography, and questionnaire-based surveys, has been used among Iraqis,\(^{137}\) Afghans,\(^{138}\) Sierra Leonean refugees,\(^{139}\) Vietnamese refugees,\(^{140}\) and Rwandan and Ugandan survivors.\(^{141}\)

---

\(^{130}\) Id.

\(^{131}\) Id. at 411.

\(^{132}\) Id.; see also Van Ommeren, et al., supra note 104, at 71 (discussing the failure of foreign clinicians to consider pre-existing community resources).


\(^{134}\) Hussein & Sa’adoon, supra note 57, at 175.

\(^{135}\) Miller et al., supra note 92, at 413. The social constructivist approach uses more exploratory research methods that identify culturally specific values, beliefs and behavioral systems, while still using quantitative data. *Id.*


2. The Stigma of Psychological Services in the Arab Culture

The imposition of Western mental health programs on Arab populations has often been problematic. Unfortunately, research on mental health issues among Arabs is almost non-existent. Arab populations have viewed traditional Western mental health services warily and in an unfamiliar light. For example, one scholar noted that this imposition had failed in the occupied Palestinian territories, because counseling was not a culturally familiar activity and the energy of people in a crisis was focused on survival. "Ethnic Arab clients, like those in other non-Western societies, find psychiatric and psychological intervention and family and martial therapies stigmatizing." Thus, the mental health services must be tailored with this in mind.

In Arab communities, the mentally ill are often associated with the supernatural. Mental health problems can arise from "the intervention of supernatural elements such as spirits or the participation

140 T. Phan et al., An Ethnographically Derived Measure of Anxiety, Depression and Somatization: The Phan Vietnamese Psychiatric Scale, 41 TRANSCULTURAL PSYCHIATRY 200, 200-228 (2004).
142 Ronald Hall & Jonathon Livingston, Mental Health Practice with Arab Families: The Implications of Spirituality vis-à-vis Islam, 34 AMER. J. FAMILY THERAPY 139, 140 (2006); Alean Al-Krenawi & John Graham, Culturally Sensitive Social Work Practice with Arab Clients in Mental Health Settings, 25 HEALTH & SOCIAL WORK 9, 9-10 (Feb. 2000).
143 Derek Summerfield, What Exactly is Emergency of Disaster "Mental Health"? 83 BULL. WORLD HEALTH ORG. 76 (Jan. 2005).
144 Al-Krenawi & Graham, Culturally Sensitive Social Work Practice with Arab Clients in Mental Health Settings, supra note 142, at 9, 12; see also Mohamed A. Sayed, Conceptualization of Mental Illness within Arab Cultures: Meeting Challenges in Cross-Cultural Settings, 31 Social BEHAVIOR & PERSONALITY 333 (2003).
145 Al-Krenawi & Graham, supra note 142, at 17.
of other people with the supernatural through such avenues as the evil eye or sorcery.\textsuperscript{146}

Additionally, those with mental illness often tend to somatize\textsuperscript{147} their psychological symptoms.\textsuperscript{148} Because of this, Arabs are inclined to turn towards traditional healers, which are seen as more legitimate and not stigmatizing, instead of psychiatrists or other mental health workers.

Arab traditional healers include . . . \textit{al-fataha} or female fortune tellers; the \textit{khatib} or \textit{hajjab}, male healers who produce amulets that are worn on the body to ward off evil spirits; the \textit{Dervish}, male or female healers who treat mental illness using a variety of religious and cultural rituals; and \textit{moalj belkoran}, male Koranic healers who use Islamic Scripture as a basis of warding off evil spirits.\textsuperscript{149}

These traditional healers are still used today in Iraq and other Arab countries. Although, it may run contrary to accepted medical treatment, this cultural/religious treatment must not be ignored. In fact, it must play a vital role in the healing process in order to avoid alienating large portions of the population who believe and utilize traditional healing methods.

One of the most important ways of dealing with the stigma of mental illness is to integrate "mental health services into nonstigmatizing frameworks or physical settings, such as general medical clinics."\textsuperscript{150} "Contrary to a Western therapeutic emphasis on the individual, all interventions with Arab clients need to be couched in the context of the family, extended family, community, or tribal background."\textsuperscript{151} By thus shifting the emphasis on the individual to the community and integrating the traditional healers with modern community-based health care, the stigma is reduced, if not eliminated.

\textsuperscript{146} Id. at 17 (citations omitted); \textit{see also} Sayed, \textit{supra} note 144, at 333-34; A. Okasha, \textit{Mental Health Services in the Arab World}, 25 \textit{ARAB STUDIES QUARTERLY} 39, 41 (Fall 2003).

\textsuperscript{147} Sayed, \textit{supra} note 144, at 338 (defining somatization as "the expression of emotional problems in bodily symptoms").

\textsuperscript{148} Okasha, \textit{supra} note 146, at 41 (stating that this tendency seems to protect the patient from the stigma of mental illness, but directs the individual towards traditional healers); Sayed, \textit{supra} note 144, at 338-39.

\textsuperscript{149} Al-Krenawi & Graham, \textit{supra} note 142, at 18 (citations omitted).

\textsuperscript{150} Id. at 12.

\textsuperscript{151} Id. at 13.
In Iraq, the stigma associated with mental health services is an issue that needs to be considered and adequately addressed in the rebuilding of the mental health system. The 2006 WHO Progress Report noted that “[p]rograms aimed at fighting the stigma attached to mental illness and substance abuse is an important part of the mental health Program. Stigma can limit the utilization of the various mental health initiatives.” Thus, not only should awareness be brought to the cultural stigma associated with mental disorders and treatment, but it should be combated in a context appropriate manner.

D. Shift from Institutions to Community-Based Mental Health Care

The shift in the mental health professional community in the past fifty years has been from large psychiatric institutional hospitals to units in general hospitals and community settings. However, there have been some fundamental mistakes in some countries as a result of over-simplification of the process, such as discharging patients without adequate preparation and outpatient care. When the process is oversimplified, there is rise in social disintegration, homelessness, incarceration, and loss in quality of life. In post-conflict and transitional countries, such as Kosovo, and in Iraq, mental health services are severely deficient because of the lack of infrastructure and community mental health services.

Within the community setting, social therapy is also of importance. One expert has noted that social therapy is the best for acute stress rehabilitation including providing safety, reuniting families, creating effective systems of justice, offering opportunities for work and study, reestablishing religious, political, social, and cultural systems. Although most Western programs have failed to comprehend or include the importance of the community in promoting mental health, survivors improve or fail to improve based on the ability to reestablish their social networks.

152 WHO, Progress Report, supra note 4, at 22.
153 Humaidi, supra note 19, at 177.
154 Id. at 178.
155 Id.
156 Weine, supra note 133, at 19; see generally TRAUMA, WAR, AND VIOLENCE: PUBLIC MENTAL HEALTH IN SOCIO-CULTURAL CONTEXT (Joop de Jong ed. 2002).
157 Derrick Silove, The Best Immediate Therapy for Acute Stress is Social, 83 BULL. WORLD HEALTH ORG. 75 (January 2005).
158 Summerfield, supra note 143.
In the case of the former Yugoslavia, instead of rebuilding or beginning construction of similar large psychiatric institutions that existed before the war, the countries that were part of the former Yugoslavia aimed at wide-scale and comprehensive reform of its mental health system. The new system is based on community mental health centers, which are close to where people live and have mental health promotion, prevention, treatment, and rehabilitation for those individuals with severe mental diseases.

In the aftermath of the conflict in the former Yugoslavia, Kosovo had large public mental health problems ranging from a lack of psychiatrists to no community mental health clinics. Similar to Iraq, in Kosovo mental illness was shameful to a family. When families did attempt to get assistance for a sick family member, they reached out to traditional healers or local religious persons, as opposed to mental health professionals. In the post-conflict period, a collaborative initiative between Americans and Kosovars focused on training for the existing mental health professionals in family systems and developing a family oriented mental health service. The mental health projects in Kosovo had two aims: to provide a community based mental health care system and to have trained mental health professionals implement community and family-based skills. The program used in the Kosovo study was a "psycho-educational multiple-family group program [that] helped Kosovar mental health to reach a position of hope for providing adequate public mental healthcare for the severely mentally ill."

Also in a study done on mental health and its association with hatred and revenge among Kosovar Albanians, the study concluded that the "increasing prevalence of PTSD indicates

---

159 Abdulah Kucukalic et al., Regional Collaboration in Reconstruction of Mental Health Services in Bosnia and Herzegovina, 56 PSYCHIATRIC SERVICES 1455, 1455-57 (Nov. 2005).
161 Weine, supra note 133, at 18.
162 Id.
163 Id. at 19.
164 Id.
165 Id. at 20.
166 Id. at 25.
persistent mental illness that may contribute to feelings of hatred and revenge and the potential violence resulting from these feelings."\(^{167}\)

The situation in East Timor is analogous to Iraq as well. In that context, "[s]erious questions have been raised about the legitimacy of importing Western-based mental health services into traditional societies recovering from war and mass conflict."\(^{168}\) By 1999 in East Timor, there had been more than twenty-four years of internal conflict and oppression including "massacres, torture, extra-judicial killings, scorched earth policies and mass internal displacements."\(^{169}\) The conclusion of the East Timor study was that "where mental health services are established in post-conflict settings, families, aid agencies, the police and other key institutions tend to identify and refer people at great social risk."\(^{170}\)

As shown by the situation in other post-conflict areas and with respect to the Arab culture in Iraq, a community-based program dealing specifically with the needs of the Iraqi people is paramount. By utilizing a community-based program, the stigma associated with mental health care will be reduced.

Under the current leadership, community-based mental health system has been a priority.\(^{171}\) However, the movement in Iraq towards a community-based approach of treating mental illness will be difficult. In a study by Naama Humaidi of the Al Rashad Teaching Hospital, 65% of admitted patients were ready to be rehabilitated in the community; however, most did not have the needed support in place for such a transition for various reasons.\(^{172}\) The study further found that 72% of the patients had lost family support because of stigma.

\(^{167}\) Barbara L. Cardozo et al., Mental Health, Social Functioning, and Feelings of Hatred and Revenge of Kosovar Albanians One Year After the War in Kosovo, 16 J. TRAUMATIC STRESS 351, 359 (Aug. 2003).

\(^{168}\) Derrick Silove et al., Indices of Social Risk among First Attenders of an Emergency Mental Health Services in Post-Conflict East Timor: An Exploratory Investigation, 38 AUST. & N. ZEALAND J. OF PSYCHIATRY 929 (2004); see also Derrick Summerfield, Critique of Seven Assumptions Behind Psychological Trauma Programmes in War-Affected Areas, 48 SOCIAL SCIENCE & MEDICINE 1449, 1449-1462 (1999).


\(^{170}\) Silove et al., supra note 168, at 932.

\(^{171}\) Fleck, supra note 32, at 555.

\(^{172}\) Humaidi, supra note 19, at 181.
association with mental illness, the location of the hospital, financial hardship, lack of security, no permanent cure, or poor patient/visitor services. This shift will require training of both mental health providers and community and family members in understanding mental illness in the context of Iraq. Although this shift will be difficult, Iraq and the U.S. are bound to give the “highest standard of attainable health.” The community-based mental health structure will give individuals the easiest access to services, a requirement of the MI Principles. Consequently, the implementation of a community based system will make the right to mental health in Iraq an attainable goal.

E. Substance Abuse

As early as 1965, Iraq had promulgated policies regarding narcotics and substance abuse; and in 1986, a therapeutic and essential drugs policy was added. Since the conflicts began, drug abuse has increased. In addition to the mental health legislation passed in 2004, substance abuse legislation has also been developed in collaboration with WHO and submitted to the Iraqi parliament. Finally, Iraq has become a member of the United Nations Office on Drugs and Crime (UNODC).

F. The Role of the United States

The United States has been involved both militarily and financially in the rebuilding of Iraq’s health care system, including mental health care. However, it has been rife with mismanagement and poor planning, which has come at the cost of a lack of primary care and basic medical needs to the Iraqi population.

The involvement of the U.S. military in a humanitarian capacity was a mistake with great impact on the population. Its involvement

173 Id. at 182. The study additionally noted that families 84% of the families did not want the patient discharged even after improvement. Id.
174 Id.
175 ICESCR, supra note 66, at art. 12.
176 MI Principles, supra note 71, at principles 3, 8, 9, 11, 15, 18; see also General Comment 14, supra note 74; ICCPR, supra note 65, at art. 7.
177 WHO, Progress Report, supra note 4, at 5.
178 Id. at 20.
179 Id.
was criticized by relief organizations because of the insecurity it creates by "blurring the lines between civilian and military function. . . ." 180

Confusion first arose when the humanitarian planning team claimed to the international relief organizations that it was the official humanitarian liaison for the US government . . . . The situation was further complicated by the fact that the humanitarian planning team, citing secrecy, refused to disclose crucial information needed for planning not only to international relief organizations but also to other US military, government, and civilian agencies working on humanitarian relief. 181

The NGO and others the international community were concerned by the neutrality of US armed forces 182 and that "much of the humanitarian planning by the largest potential donor, the US government, was done by military authorities in secrecy." 183

The failed assumptions of the Department of Defense that the Americans would be seen as liberators led to "widespread looting and social disorder, which [ . . . ] led to destruction of public facilities and disruption of essential public services. In many areas, hospitals, clinics, pharmaceutical stores, public-health departments, laboratories, and administrative offices were ransacked, causing the collapse of the already tottering health system." 184 The result only contributed to the already poor situation facing the Iraqi population.

181 Id.; see also The Lancet, Act Now to Secure Iraq’s Health, 362 THE LANCET 1249 (Oct. 18, 2003).
182 Burkle & Noji, supra note 180, at 1372.
183 Id.
However, because the United States and the United Kingdom formally stated to the UN that they were occupying powers, the United States "has a responsibility to restore and maintain law and order and public life in areas its military effectively controls." Thus, the United States is under an obligation to restore and maintain the mental health system and help facilitate new laws.

Even non-military contributions were poorly planned, such as the $10 million donation by USAID to primary care provider development and $4.5 million for training of staff in these locations. However, experts say that "more public health activities would have been possible if the reconstruction had not focused so heavily on building new clinics."

Further, "[r]ecent government reports outline mismanagement of US reconstruction and delayed and shoddy work on both health-care clinics and hospitals." As of June 28, 2006, out of "the original 150 clinics planned by the USA, only two are fully operational."

Perhaps what has been the most successful of U.S. involvement has been the work between the mental health specialists in the U.S. The Substance Abuse and Mental Health Services Administration ("SAMHSA") and the U.S. Department of Health and Human Services ("HHS") have played a more positive role with the Iraqi National Council, through teleconferencing and stakeholder events.

The goals of the SAMHSA and the Iraqi Ministry of Health have included: policy and administrative infrastructure development,


\footnotesize{186} Paust, supra note 185, at 3; Hague Convention IV, Laws and Customs of War on Land: 18 October 1907, 36 Stat. 2277, 1 BEVANS 631, 205 Consol. T.S. 277, 3 MARTENS NOUVEAU RECUEIL (ser. 3) 461, Jan. 26, 1910. Annex, Art. 43 (requiring the occupying power to "take all measures in his power to restore, and ensure, as far as possible, public order and safety, while respecting, unless absolutely prevented, the laws in force in the country.").

\footnotesize{187} Bristol, supra note 30, at 906 ("However, experts say more public health activities would have been possible if the reconstruction had not focused so heavily on building new clinics. This approach resulted in the misapplication of millions of dollars that did little to bolster public health.").

\footnotesize{188} Id.

\footnotesize{189} Id. at 906.

\footnotesize{190} Id. More than 88% of the US $750 million appropriated for health activities by the USA has been obligated, and 65% has been spent, according to the Special Inspector General for Iraq Reconstruction. Id.

\footnotesize{191} Sadik, Progress Report, supra note 4.
knowledge enhancement, training and education in mental health treatment, re-establishment of connectivity and information dissemination to advance community-based applications, and a new infrastructure for research. In addition, and perhaps more importantly SAMSHA will be working with Iraq to generate national policies that support mental health care and public initiatives to change the Iraqi view of mental illness. In pursuing the goal of supporting the progress of Iraq’s mental health system, the focus needs to be not only on monetary assistance and mental health training, but also transitional justice.

IV. REBUILDING THE MENTAL HEALTH OF IRAQIS & TRANSITIONAL JUSTICE

Transitional justice may be the best solution for dealing long term with the war-affected Iraqi population. Mental health illness often has social and political roots, and social reform, such as public recognition and justice, for victims of war could be the best solution. The path to justice, and eventually peace, is through “the law and legal institutions.” In the restructuring of mental health system in Iraq, it seems “appropriate to go beyond the ‘binding of wounds’ and the tradition for mental health work to be morally and politically neutral and to promote the wider rights of those seeking help or treatment.” Pursuing this agenda is always a struggle, and “all too frequently the power-holders and the servants of power-interests have prevailed, even over elementary fairness and basic rights.”

In conflicts across the globe, it is estimated that between “1948 and 1998, there have been approximately 250 conflicts whose estimated number of victims range from 70 million at the low end to 170 million at high end.” In all of these conflicts, there is a framework of international law that applies in order to protect human

---

192 Curie, supra note 29, at 110.
193 Id.
194 Derek Summerfield, War and Mental Health: A Brief Overview, 321 BRITISH MED. J. 232, 234 (July 22, 2000). The terms post-conflict justice and transitional justice are used interchangeably.
196 Summerfield, supra note 194, at 234.
197 Bassiouni, Realpolitik, supra note 195, at 542.
198 Id. at 550.
interests.\(^{199}\) Although the legal framework is essentially the same, every conflict is *sui generis* and has its own peculiarities.\(^{200}\) Regardless of the type of conflict, securing an end to ongoing violence and repression has often come at the political price of impunity.\(^{201}\) In ending conflicts, the goal and meaning of "peace" can range from the ending of hostilities to reconciliation and forgiveness among social groups, as well as regime change.\(^{202}\) In order to avoid future conflicts, peace must mean justice in the form of prevention, deterrence, rehabilitation, and reconciliation.\(^{203}\) However, in achieving peace, the concept of post-conflict justice is often sacrificed to the *realpolitik*, which wants to reach "political settlements without regard to a post-conflict justice."\(^{204}\) and continues its "unilateral quest for power and accumulation of wealth continues to be one of the avowed goals."\(^{205}\) "Thus, the international community has yet to accept what the French philosopher Pascal urged: 'In times of peace, nations must do to each other the most good, and in times of war, the least harm.'"\(^{206}\)

\(^{199}\) Id.


\(^{203}\) Id.


\(^{205}\) Bassiouni, *Realpolitik*, supra note 195, at 546.

\(^{206}\) Id.
A. The Impact of War

In areas of the world that have been affected by war, there are many factors that must be considered. In most conflict zones, the conflict is internal in nature, which involves a regime oppressing its own population, often the poor or ethnic minorities. Internal conflicts have occurred all over the world and often consist of the ruling regime generating control through terror as a result of extrajudicial executions, torture, disappearances, sexual violence and the intent to destroy social, economic, and cultural life. Saddam Hussein’s Ba’ath regime is estimated to have killed over 500,000 Iraqis from 1968 until 2003. Many who were executed or disappeared at the hands of the regime are unknown because there has never been an investigation. The two wars of aggression of the Saddam Hussein

207 There are two types of armed conflict that humanitarian law applies to: international and non-international. International armed conflict applies to all cases of declared war involving two or more states, even if one of them does not recognize a state of war. The 1949 Geneva Conventions cover international armed conflicts. See Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (Geneva I), 75 U.N.T.S. 31, Oct. 21, 1950; Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea (Geneva II), 75 U.N.T.S. 85, Oct. 21, 1950; Geneva Convention relative to the Treatment of Prisoners of War (Geneva III), 75 U.N.T.S. 135, Oct. 21, 1950; Geneva Convention relative to the Protection of Civilian Persons in Time of War (Geneva IV), 75 U.N.T.S. 287, Oct. 21, 1950.

Non-international armed conflicts take place on the territory of a state between the state’s armed forces and dissident armed forces or other organized armed groups which exercise control over part of the state’s territory to enable them to carry out sustained and concerted military operations. Protocol I and II and Common Article 3 apply to non-international armed conflict. See Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I), 1125 U.N.T.S. 3, entered into force Dec. 7, 1978; Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), 1125 U.N.T.S. 609, Dec. 7, 1978; Geneva I, supra, art. 3; Geneva II, supra, art. 3; Geneva III, supra, art. 3; Geneva IV, supra, art. 3. An internal armed conflict is limited to situations of internal disturbances and tensions, riots, isolated and sporadic acts of violence and other acts of a similar nature that are not considered armed conflicts and are not covered by the Geneva Conventions or their additional protocols.

208 Summerfield, supra note 194, at 232.

209 Bassiouni, Searching for Peace, supra note 122, at 10.

210 Summerfield, supra note 194, at 232.

211 Bassiouni, Postconflict Justice in Iraq, supra note 1, at 15.

212 Id. Some of the more well-known deaths include 8,000 Kurds in 1983, approximately 182,000 Kurds in the Al-Anfal campaign of 1987-1988, the gassing of
regime, the Iran-Iraq War and the Gulf War, resulted in the death of an estimated one million Iraqis. United Nations sanctions only added to these numbers by causing the deaths of over 500,000 children, elderly and sick. There have been an estimated 654,965 Iraqi deaths between March 2003 and July of 2006. This era of violence on many levels has only compounded the mental problems that the population is facing.

In studying the impact of war on individuals, the focus has historically been on soldiers, including the recent studies, literature, and news on American Iraq War Veterans. In fact, the few studies from conflict zones have only been on refugee populations who have fled to the West.

In Iraq, the goal of post-conflict justice is to respond to the violations of the previous regime, deal with the victims of the violations, and become a democratic and rule of law-based society.

4,000-5,000 Kurds in Halbja, and the forced removal of 140,000 Shi’a from the Iranian border. Id.


Professor M. Cherif Bassiouni posits several goals that should be included in post-conflict justice: enhancing social reconciliation and avoiding vengeance, restoring an independent judiciary and a sustainable modern legal system, sustaining democracy, territorial integrity and stability based on the principles of the rule of law, creating a precedent in the Arab world for holding officials responsible for systematic repression and abuse, prosecution of perpetrators in the Ba’ath regime, providing victims with reparation and other remedies, and establishing a historical record of past violence. These factors are essential in order to not only rebuild and restructure the mental health system, but to alleviate the mental health disorders caused by war.

B. The Problem of Impunity

Impunity is one of the major hurdles to achieving post-conflict justice. The exemption from accountability, penalty, or punishment for perpetrators of illegal acts defines impunity. "If people believe there can be no justice, they resign themselves to political realities, adapt, and adjust in order to survive. . . . Impunity serves to perpetuate the reign of terror and silence, preempting demands for greater social equality and justice." Impunity also has the capability of inciting hatred through mob violence, something that has occurred in the former Yugoslavia and Rwanda. The effects of post-conflict impunity on individuals, families and communities can be psychologically destructive. Impunity can also "discourage visions of hope, structural change, participatory democracy, and justice."

220 Id. at 16-17.
222 Opotow, Psychology of Impunity, supra note 221, at 203, (citing J. Patrice McSherry & Raúl Molina Mejía, Confronting the Question of Justice in Guatemala, 10 SOCIAL JUSTICE 1, 14 (1992)).
224 Opotow, Psychology of Impunity, supra note 221, at 210; David Becker et al., Therapy with Victims of Political Repression in Chile: The Challenge of Social Reparation, 46 J. SOCIAL ISSUES 133 (1990); Elizabeth Odio Benito, Justice for Peace: No to Impunity, in REIGNING IN IMPUNITY FOR INTERNATIONAL CRIMES AND
Accountability is the antithesis of impunity and falls into the categories of truth, justice, and redress. Accountability methods include prosecutions (both national and international), investigatory commissions, truth commissions, national lustration mechanisms, civil remedies, and reparations.

Law, the role of the legal process, and the international justice system can play important roles as therapeutic agents, especially in redressing politically motivated crimes such as torture and oppression. Rehabilitation also plays a vital role in redress and includes addressing the need for medical and psychological services, as well as restoration, both legally and politically, of a person’s name and civil rights. Medical and psychological services include rehabilitation and compensation for victims of trauma.

In the post-conflict period, several countries included health care as a form of rehabilitation, such as Chile and South Africa.


225 Opotow, Psychology of Impunity, supra note 221, at 210.

226 Bassiouni, Accountability for Violations, supra note 200, at 26; Bassiouni, Searching for Peace, supra note 122, at 19.

227 National lustration is a purging process in which individuals who supported or participated in violations committed by a prior regime are removed or barred from their positions, positions of authority, or elective positions. Bassiouni, Searching for Peace, supra note 122, at 22-23.

228 Bassiouni, Accountability for Violations, supra note 200, at 27; Bassiouni, Searching for Peace, supra note 122, at 22.


231 Id. at 109.

232 The Corporation for Reparation and Reconciliation administered medical benefits including psychological counseling. Roht-Arriaza, Civil Society, supra note 230, at 110; see REPORT OF THE CHILEAN NATIONAL COMMISSION ON TRUTH AND RECONCILIATION (Phillip Berryman trans. 1993).

233 The South African Truth and Reconciliation Commission’s Reparation and Rehabilitation Committee proposed emotional interventions and community rehabilitation programs aimed at both individuals and communities. Roht-Arriaza,
Further, it is important that in the rebuilding process in a post-conflict setting, people at all levels of society are included in order to be consistent with the United Nations definition of a culture of peace.\(^{234}\)

V. CONCLUSION

The goal of rebuilding Iraq's mental health system and addressing the mental health issues resulting from war need to be approached cautiously with due regard to Iraq's history and the current climate of violence and insecurity. The current crisis that is marked by a lack in all things medical—workforce, drugs, supplies, facilities—needs to improve before any real changes can occur. Under international human rights law, the rights of individuals and responsibilities of governments in the area of mental health provide a framework for Iraq, the U.S., and others who are assisting in the rebuilding process to create a structure that is most beneficial to those with long term mental disabilities and the victims of war. The U.S. in particular needs to ensure through collaboration with the Iraqi Ministry of Health that resources are being managed efficiently in order to best serve the population.

While it is important to look at other areas that went through conflict, the situation in Iraq is unique and needs to be addressed as such. The particularly vulnerable groups, the pre-existing and war-related mental disorders, and the culture all need to be examined carefully in order to create a new system that will be able to maximize the health care quality and accessibility of the Iraqis. More importantly, the shift towards a community-based mental health program may prove to be the most effective tool in the rebuilding of the system. In rebuilding its mental health system, Iraq faces several challenges ahead, such as creating a system that can deal with the past and current violence, in the context of the country's history and culture. Before it can even deal with much of what this paper discussed, the problems of violence and insecurity must end. Until then, many of these goals will be unattainable. Finally, throughout the rebuilding

---

process, the goals of post-conflict justice must be minimally, sought after, and ideally, achieved. In order to achieve any improvement in Iraq’s health programs, justice and peace must be found through accountability.