Toward multidisciplinary and integrative MHPSS services in the Kurdistan Region: highlighting the role of clinical social work as a bridging field (Discussion Paper)

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Abstract

The mental health psychosocial support field is moving toward integrative work; clinicians and scholars reiterate the importance of an interactive approach as it allows services to be adapted to the unique needs and backgrounds of the clients. Additionally, now, more than ever, multidisciplinary work is highly recommended to achieve significant results and provide much-needed comprehensive services. These services range from community-based psychosocial support activities to highly specialized interventions. Although progress has been made toward having experts from fields such as clinical psychology and psychotherapy in the Kurdistan region, gaps still remain, especially in terms of closing the gaps that exist in providing services. The emergence of social work is an essential step towards having effective and trained social workers who function as case managers and case workers. However, this paper argues that the field of clinical social work is required in the Kurdistan Region since it allows us to connect the specialized psychotherapy provision to social work functions. Clinical social workers possess significant similarities and differences with clinical psychology. Clinical social workers take a more holistic approach to their intervention. They also consider how society and the environment influence the client's well-being; this is highly relevant to the Kurdistan Region as its population has a traumatic history, and the region has prolonged conflict. This paper highlights the necessity of clinical social work and its role in moving toward a more integrative and multidisciplinary approach to MHPSS services.

Keywords: Clinical social work, MHPSS, Kurdistan Region, Integrative approach, Multidisciplinary

Background

The Kurdish people of the Kurdistan Region have undergone a history of persecution, conflict, and violence. During the tenure of the previous regime of Saddam Hussein in Iraq, Kurds faced killing, genocide, torture, and ethnic cleansing. An instance that captures this in great detail was the Anfal genocide campaign, which occurred from 1986 to 1989 and led to the killing, disappearance, and mass burial of 182,000 Kurds (European Asylum Support Office, 2021). In 1988, the Ba'ath government attacked the town of Halabja with chemical weapons, which immediately claimed the lives of 5000 people, and thousands are still suffering to this day from the long-lasting effects of the exposure (Moradi et al., 2019). The Kurdish uprising, which took place in 1991, led to the expulsion of Iraqi forces from the region; however, this was not the end of the suffering of the Kurdish people. Fearing retaliation and under the threat of chemical weapons use by the government of Iraq, the majority of Kurds were forced to leave their homes in a mass fleeing humanitarian crisis, which captured the attention of the world, and as a result, a no-fly zone was established to allow the return of the Kurdish population from the borders of neighboring Turkey and Iran (Reliefweb, 2003).

Following this, the region experienced an economic blockade, which led to a worsened economic situation in which resources were scarce (Gunter, 1993). The region also experienced a civil war between the two major political parties, which started in 1994 and ended in 1998 (Arif & Mokhtar, 2022). In 2001, with the formation of Ansar AL-Islam, which was a jihadist group, the region was faced with the threat of Islamic terrorism. The group committed several terrorist acts and atrocities in the region and had ties with Al Qaeda. Its terrorist activities remained active, but by 2006, it was largely dismantled due to attacks by US-led coalitions and the local forces. The group was disbanded in 2014 (Stanford University, 2018). In 2014, the region faced the threat of the Islamic State of Iraq and Syria (ISIS), which attacked and captured several Iraqi regions, including the city of Mosul. During this time, the Kurdish armed forces, known as Peshmerga, began to engage in combat against ISIS militants. In the war against this malevolent enemy, the Kurdish Peshmerga forces faced the task of defending a frontline that was approximately 1046 kilometers wide. The Peshmerga forces suffered heavy casualties against ISIS; in the years of the war, over 1,800 Peshmerga soldiers lost their lives, while more than 10,000 were injured (Abdul Rahman, 2018).

These brief historical highlights show that the Kurdish population of the Kurdistan Region has experienced decades of conflict and unrest. These events, along with their socio-political implications, also carry mental health implications, especially by creating a surge of mental

health services throughout the region to address the psychological aftermath. Namely, crisis situations, especially humanitarian crises, increase the likelihood of mental health issues, subsequently increasing the demand for relevant services. This necessitates a scientific discussion on the models of care that exist throughout the region: what services are provided, who provides them, what the theoretical foundation of these services is, and what kind of gaps exist. Furthermore, societies that have undergone decades of conflict, specifically from low and middle-income countries, require localized and contextualized models of care. This paper is a theoretical attempt at identifying gaps and highlighting the role-specific disciplines and approaches to work in order to address the present gaps.

Mental Health and Psychosocial Support (MHPSS)

The reference group for mental health and psychosocial support in emergencies by the Inter-Agency Standing Committee (IASC), first introduced the term MHPSS in 2007 as an attempt to move beyond the restricted view and conceptualization of psychiatry for mental health needs. It was a way to unite clinical and psychosocial approaches to addressing humanitarian needs (Ubels et al., 2022). This new approach highlighted that psychiatric problems are only one aspect of the MHPSS needs, and these issues can be mitigated if other aspects are addressed, which include basic needs of food, shelter and security, and social needs for connection and justice (Jones & Ventevogel, 2021). Consequently, the IASC published an intervention pyramid to facilitate approaching MHPSS needs. Using a pyramid indicates that as we move toward the upper layers, the number of individuals requiring the service decreases, whereas the bottom layers require a larger number of individuals. At the bottom, there is the “social considerations in basic safety and security” layer. This layer refers to advocacy for basic services that are safe, socially appropriate, and allow the protection of the dignity of individuals. The second layer from the bottom is ‘strengthening community and family supports,” which includes activation of the present social networks through recreational activities and centers, such as child-friendly spaces. The third pyramid is “focused non-specialized support.” This refers to psychosocial support activities to address basic emotional and practical support needs. The final layer is composed of “specialized services” aimed at the provision of mental health services by professionals (World Health Organization, 2023).

Nevertheless, the IASC MHPSS pyramid is aimed at providing servicing during emergencies and humanitarian settings. The International Red Cross and Red Crescent Movement has

provided an MHPSS pyramid that is appropriate to larger contexts. As we move to the top of the pyramid, the percentage of people requiring support decreases; however, the level of training, supervision, skills, competency, and academic background increases (Andersen et al., 2022). At the bottom of the pyramid, there is the "basic psychosocial support" layer. This layer attempts to promote positive mental health, resilience, social interaction, and social well-being. Activities that aim to address the aforementioned factors, including psychological first aid and recreational activities, can be integrated into the health, protection, and education sectors. The second layer is "focused psychosocial support," which focuses on the promotion of positive mental health, well-being, and prevention activities. While the first layer targets %100 of the affected population, this second layer focuses on groups, families, and individuals at risk. Examples of the second layer include peer support and group work. The third layer of the pyramid is composed of "psychological support, which focuses on activities aimed at the prevention and treatment of individuals who experience more complicated psychosocial distress or are at risk of developing mental health conditions. Examples of this include counseling and therapy. The top layer of the pyramid is the "specialized mental healthcare" part. This layer includes specialized clinical care and treatment for people with chronic mental health conditions. Examples of this intervention can be treatment centers for survivors of torture or individuals with long-term addiction problems (International Committee of the Red Cross, 2019).

The failures of the medical model

The medical approach to mental health has followed two models. Traditionally, the biomedical model orientation of psychiatry was a reductionist and physicalist understanding of the issues related to mental health. This traditional biomedical model asserted that biological processes are seen as the underlying causes of mental health disorders; although the social and psychological play a role, they do it through biological means. Huda (2021) further discusses that psychiatry has adopted the biopsychosocial model. This orientation recognizes that social and psychological factors are independent and important causal factors, although the model fails to provide an explanation for the interaction between the factors to produce certain outcomes. However, for psychiatrists, the biological aspect comes first, as suggested by the model's name. Moreover, authors such as Reed (2005) suggest that in practice, the biopsychosocial model has become the bio-bio-bio model, highlighting the over-medicalization of mental health disorders that have plagued the field of psychiatry. This is highlighted by the rapid increase in anti-depressant medication, which has been shown to have tripled from 1998 to 2018 (Bogowicz,

2021). This persists despite a recent systematic umbrella review that has shown that the main areas of serotonin research provide no consistent evidence for the existence of an association between depression and serotonin on which the selective serotonin reuptake inhibitor groups of anti-depressants are based on the theory that the depression is related to serotonin (Moncrieff, 2022).

The concept of the "Bio-Bio-Bio" model in psychiatric practice, as proposed by Reed (2005), holds relevance to the contemporary psychiatric approach in the Kurdistan Region. The medicalization of even the mildest forms of psychosocial distress or medicalizing individuals who are going through familial or social problems is indicative of the narrow view of psychiatry to mental disorders. Therefore, for the most part, psychiatry in the Kurdistan Region takes the traditional biomedical approach to mental health as indicated by the psychoeducation the psychiatrists provide on mental health problems and the amount of prescription. Unfortunately, this topic has not been subject to a systematic investigation in the Kurdistan region, and the remarks here are based on unsystematic clinical observations. Thus, this topic should be addressed through systematic studies because the trends of over-medicalization and bio-bio-bio orientation are prevalent in the United States and the United Kingdom; it can be argued that they are also true for the Kurdistan Region, whose education is based on the western models.

Clinical Psychology in the Kurdistan Region

The field of clinical psychology, according to the American Psychological Association (APA), is defined as “The field of Clinical Psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as to promote human adaptation, adjustment, and personal development. Clinical Psychology focuses on the intellectual, emotional, biological, psychological, social, and behavioral aspects of human functioning across the life span, in varying cultures, and at all socioeconomic levels” (APA, 2012). Pomerantz (2020) reports that this definition showcases the growth of the field over the last century. However, it does not indicate that clinical psychologists pertain an equal amount to each component of the definition, but in general terms, their work does cover all these aspects. In the Kurdistan Region, the field of clinical psychology grew with the establishment of the clinical psychology program at Koya University. Although it was an undergraduate program, it followed a scientist-practitioner model that focused on both research and practice. Later, a master’s program was established at the University of Duhok; this program was a practice-orientated

master of arts in Psychotherapy. Despite the growth in the number of clinical psychologists, the lack of regulations and ethics codes still remains an issue.

As evident from the definition, clinical psychology focuses on multiple aspects of human functioning and acknowledges the influences and inter-relations these factors hold in both negative and positive mental health outcomes. This indicates that clinical psychology moves away from the narrow medical model of conceptualizing mental health. Page et al. (2022) propose that clinical psychology follows a science-informed model of practice. This allows for the viewing of the clients through a lens of evidence-based literature and clinical experience. Additionally, clinical psychology is highlighted by collaborative work between the practitioner and the clients, and this pertains to collaborative assessment, formulation, treatment planning, process-informed treatment delivery, and treatment measuring. This indicates that in the clinical psychology model of care, collaboration is an essential feature that is associated with positive outcomes (Ribeiro et al., 2013). This allows for professional functioning as a practitioner to ensure clients make scientifically informed decisions rather than making decisions for the clients, which is prevalent in the medical model in the Kurdistan Region. It is worth mentioning that clinical psychology usually functions in the top layer of the MHPSS pyramid of care which is composed of specialized care.

Clinical Social Work: Bridging the gap

In the Kurdistan Region, clinical psychology and social university departments exist. They are also individuals with postgraduate degrees in both respective fields. The Department of Clinical Psychology contributed to improving the equality of mental health services by preparing individuals with a strong basis in clinical psychology who are well-placed to pursue post-graduate degrees. Although the model of work in which clinical psychologists engage is psychiatrists-centered. On the other hand, the Department of Social Work will play an important role in preparing individuals to function effectively as social workers and case managers; prior to the establishment of these entities, these roles were played by individuals from irrelevant fields, including law, languages, engineering, etc. Despite these improvements, gaps still exist in the model of care, one of which can be addressed through the presence of clinical social work graduates.

The profession of clinical social work is essential in healthcare, as it aims to prevent and treat mental health and healthcare issues. Its main focus is on behavioral and biopsychosocial problems and disorders. It is important to understand individuals within their broader

environmental contexts, prioritizing client rights. Moreover, it seeks to promote strong therapeutic relationships between practitioners and clients. The knowledge base of clinical social work is broad and includes theories of biological, psychological, and social development, cultural competency, interpersonal relationships, family and group dynamics, mental disorders, addiction, impacts of illness, trauma, or injury, and the influence of physical, social, and cultural environments. This knowledge is obtained through social work graduate education and is combined with direct-practice skills that are developed during a minimum of two years of post-graduate experience under clinical supervision. The purpose of this supervised practice period is to prepare clinical social workers for independent practice as well as eventual state licensure as clinical professionals. Following this, practitioners may choose to enhance their skills in advanced clinical practice or specialize in specific areas of focus (American Board of Clinical Social Work, n.d.).

As it relates to the Kurdistan Region, the field of clinical social work can play an important role in the model of care for private and public mental health practice as well as the services that are provided by civil society organizations. One of the crucial aspects of clinical social work is viewing mental health issues in a broader environmental context. This can be especially helpful with clients who are experiencing various social and familial problems along with their mental health issues. This can also be the case with clients who have experienced or are at risk of violence, especially gender-based violence, which is an all-encompassing issue that influences different aspects of life. Clinical social workers can function effectively with these clients and address their comprehensive needs more effectively. This can also address the limitation in the number of clinical psychologists in the region since a clinical social worker can play the role of a social worker and clinical psychologist at once, but it can also be a crucial addition to the model of care, especially when dealing with clients from collectivistic cultures such as the Kurdistan Region. Thus, clinical social work can function on different levels of the pyramid of MHPSS care.

Multidisciplinary work and an integrative approach

We highlighted that the psychiatric model of approach to addressing mental health needs can be argued to be inadequate. This emphasizes the need for a collaborative multidisciplinary approach that should be considered as an essential model of care in the Kurdistan Region. In terms of the model of care that currently exists in the Kurdistan region as it relates to MHPSS can be categorized into four domains: primary care, mental health hospital care, private centers,

and NGOs. Concerning primary care, mental health is usually ignored and huge gaps currently exist. The presence of clinical psychologists is relatively non-existent in primary care, and psychiatrists playing a systematic role is also a rare occurrence. This has led to a situation in which suicide attempt cases, panic attack cases, and other mental health conditions, which usually end up in primary healthcare, are mismanaged. An example of this would be primary healthcare personnel judging, blaming, and lashing out at individuals who have attempted suicide. Furthermore, screening for mental health conditions is also absent, and usually depends on the observations of minimally trained doctors in these matters. The dearth of culturally adapted screening tools is also a huge issue in the way of conducting accurate screening for mental health problems. When individuals in primary care are identified to require mental health support, they may be referred to public mental health hospitals. Although the services of these hospitals are more comprehensive, huge gaps still remain. For example, mental health hospitals are managed by psychiatrists and, consequently, follow a biologically heavy medical model characterized by over-diagnosis, over-pathologizing, and over-medicating. Psychologists are present in mental health hospitals; however, most of them are not highly trained and qualified clinical psychologists and do not possess the skills to perform systematic psychotherapy. A significant number of these psychologists have degrees in educational psychology, sociology, and general psychology, which does not qualify them or give them the necessary competencies to perform their functions. Another issue is that the hospitals are mostly visited by individuals with disorders of psychosis and addiction and do not reach individuals with a broad variety of mental health conditions.

One trend that has picked in the Kurdistan Region is the opening of mental health centers. These centers are also managed by psychiatrists as they are the only ones who can obtain the proper licensing to open clinics and centers, and psychologists are devoid of this fundamental right. Thus, the issue of the dominance of the biomedical model arises again, and this is the case with these centers. Another issue is that these centers rarely have social workers who function as social workers and case managers, which is an important step toward providing comprehensive care. Additionally, clinical supervision that is provided by qualified clinical supervisors is rare; at best, the psychologists are supervised by psychiatrists who are untrained in the modalities of psychotherapy. The services of these centers also lack proper care coordination, communication, and referral. The last domain through which MHPSS care is provided is through NGOs. The NGOs are a step closer to providing holistic services as they employ case managers, lawyers, and psychologists and provide all these services in coordination. The NGOs also employ

psychosocial support interventions to raise awareness and act as preventative measures. Nonetheless, the MHPSS care provided by the NGOs still carries several gaps. Namely, NGOs may hire unqualified individuals due to nepotism and corrupt recommendations and have them function as psychologists or social workers. The instances of language teachers, engineers, or sociologists functioning as psychologists are not uncommon. Another issue is that the NGOs are mostly focused on numbers to achieve their grant targets rather than the quality of their services. Care coordination is another challenge for the NGOs as the different usually compete rather than cooperate; this is the result of a larger issue, which can be referred to as the culture of self-assertion and competition. Thus, the MHPSS services that exist in the Kurdistan region lack a standard model to operate on and do not possess the required integrative and multidisciplinary features that are required for modern care.

In their paper, Ee et al. (2020) provide an integrative, collaborative model of care for people with mental health problems. The authors of this paper propose an integrative collaborative care model that provides practical clinical methods for managing patients with high comorbidity in collaborative care settings. The model is based on qualitative research that was conducted during the development of Australia's first academic integrative healthcare center. The integrative, collaborative care model places emphasis on delivering holistic care that is client-centered. This is achieved through the collaboration of healthcare professionals and the active involvement of patients, as well as their families or carers. Obtaining healthcare for individuals with mental health conditions and physical comorbidities involves lifestyle medicine, which plays a significant role. To understand various factors, such as physical activity levels, dietary habits, social support, and preferences for treatment, a comprehensive lifestyle and social history is acquired. In order to make informed decisions, it is necessary to discuss the potential risks and benefits of available treatments, including complementary and integrative therapies, and obtain informed consent.

In terms of facilitating team-based care, Ee (2020) Collaborative care enhances conventional healthcare by involving a team of healthcare professionals who communicate and work together to provide care for the client. The team may consist of doctors, nurses, psychiatrists, psychologists, and other specialists, as well as complementary therapy practitioners, if necessary. It is essential to carefully define each practitioner's scope of practice and implement appropriate credentialing, especially for professions without mandatory regulatory standards. The authors propose that effective multidisciplinary teamwork requires the following components: (1) Care coordination: This involves designating a person who ensures that the patient's requirements are

met and helps them access relevant services. This person can be a practice nurse, mental health nurse, or health advocate, and their role includes coordinating referrals for comprehensive care. (2) Improving interprofessional communication: This can be achieved by using shared medical records whenever possible, facilitating communication through "warm handovers" and secure messaging, considering case conferencing, joint consultations, and corridor consultations. Regular multidisciplinary team meetings are also recommended. (3) Other interventions for enhanced team-based care: This involves using "shadowing," experiential sessions, and in-service sessions for practitioners to present information about their modality to the team. (4) Physical integration of primary and secondary healthcare: This component recommends having an on-site psychiatrist consultation available in the same center as primary care and allied/complementary health practitioners, creating an opportunity for joint case-conferencing. Although the above model focuses on primary care, it holds significant implications for providing MHPSS services in the Kurdistan region. The principles and features of this model can be integrated with the International Red Cross and Red Crescent Movement's MHPSS framework to generate a working model of care that can implemented and studied through empirical investigations. For any framework to be successful, it should have several key features and behold the practitioners to various principles. The first important feature of this model is to direct the practitioners toward helping their clients to reach informed decisions about the care they want to receive and making the clients a significant part of the decisions, planning, and referral processes through collaboration. Second, the practitioners should employ a culture of cooperation and strive toward care coordination through systematic documentation, case conferencing, and report-sharing. Having regular multidisciplinary team meetings is also an important part of ensuring quality coordination. Finally, in order to achieve all of this and provide high-quality services, the roles and qualifications of each profession must be identified. Based on these features, the Red Cross and Red Crescent Movement's MHPSS framework functions as a guide toward more comprehensive care. In this regard, clinical psychologists and psychiatrists can play a significant role in the upper layer of the pyramid, which is composed of specialized care. Social workers play a crucial role when it comes to the bottom two layers of the pyramid, namely basic psychosocial support and focused psychosocial support. Meanwhile, clinical social work can function across different layers of the pyramid, overlapping with the other aforementioned fields. Clinical social work can function in the specialized mental health care layers of MHPSS care, which is also the layer of clinical psychology. However, clinical social workers can also function in the psychological support layer of the pyramid, further

highlighting its bridging role. It can be seen how clinical social work connects social work and clinical psychology and can play a crucial role in addressing service gaps.

Conclusion

This present paper highlighted the current trends in the approaches to addressing MHPSS needs. There is a call for working toward holistic approaches when addressing mental health needs since these issues can be influenced by many factors and the interaction between these factors. It is also important to move from the medical model of medicalization of every aspect of human suffering. Work needs to be done to generate collaborative, integrative, and multidisciplinary models of care to address the holistic nature of MHPSS needs. In this aspect, the field of clinical social work can play an important as it views mental health issues in a broader context and addresses different levels of MHPSS care.

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Abstract (Kurdish)

بواری خزمەتگوزاری دەروونساغی و پاڵپشتی دەروونی-کۆمەڵایەتی بەرەو کاری یەکخراو هەنگاو دەنێت؛ پراکتیزەکاران و توژەران گرنگی ڕێبازێکی کاری یەکخراو دووپات دەکەنەوە چونکی یارمەتیدەر دەبێت لەوەی خزمەتگوزارییەکان لەژێر ڕۆشنایی پێویستی و پاشخانەی چارەسەرخوازاندا بگونجێندرێت. پتر لەمە، ئێستا، زیاتر لە هەموو کات، کاری فرەپسپۆڕیی پێشنیازکراوە بۆ بەدەستهێنانی ئەنجامی بەرچاو و پێشکەشکردنی خزمەتگوزاری گشتگیر کە پێویستییەکی زۆر بۆی هەیە. ئەم خزمەتگوزارییانە لە پاڵپشتی دەروونی-کۆمەڵایەتی نێو کۆمەڵگەکانەوە بۆ دەستێوەردانە زۆر تایبەتمەندەکان لەخۆ دەگرێت. هەرچەندە، لە هەرێمی کوردستاندا بەرەوپێشچوون بەدی کراوە لە زیادبوونی پسپۆڕانی بوارەکانی دەروونزانیی کلینیکی و چارەسەری دەروونی، وەلێ هێشتاکە کەلێنی بەرچاو بوونیان هەیە، بە تایبەت لە پڕکردنەوەی ئەو کەلێنانەی لە پێشکەشکردنی خزمەتگوزارییەکاندا هەن. دەرکەوتنی بواری کاری کۆمەڵایەتی هەنگاوێکی گرنگ بەرەو بوونی کارمەندی کۆمەڵایەتی کاریگەر و ڕاهێندراو کە دەتوانن وەکوو بەڕێوبەری کەیس و کارمەندی کەیس کارکردەیی خۆیان بەجێ بگەیەنن. وەلێ، ئەم توژینەوە هەوڵ دەدات ئاماژە بەوە بکات کە لقی کاری کۆمەڵایەتی کلینیکی یەکێکە لە بوارە پێویستەکان چونکە ڕێگە دەدات چارەسەری دەروونی تایبەتمەند بە ئەرکەکانی کاری کۆمەڵاتییەوە ببەستێنەوە. کار کۆمەڵایەتی کلینیکی جیاوازی و هاوشێوەیەی بەرچاوی لەگەڵ دەروونزانیی کلینیکیدا هەیە. کاری کۆمەڵایەتی کلینیکی بەشێوەیەکی زیاتر گشتگیر کار دەکەن. هەروەها، لە کارەکەیاندا سەرنج دەخەنە سەر ئەوەی کۆمەڵگە و ژینگەی چواردەور چۆن کاریگەری لەسەر باشبوونی چارەسەرخوازان جێ دەهێڵێت کە ئەمەیش زۆر پێوەندیدارە بە هەرێمی کوردستانەوە چونکی دانیشتووانەکەی مێژوویەکی لێوالێو لە زبەری دەروونی هەیە و ناوچەکە ئەزموونی ناکۆکی جەنگی درێژخایەن کردووە. ئەم توژینەوەیە پێویستی کاری کۆمەڵایەتی کلینیکی و ڕۆڵی ئەم بوارە پیشان دەدات لە هەنگاونان بەرەو بەردەستبوونی خزمەتگوزاری دەروونساغی و پاڵپشتی دەروونی-کۆمەڵایەتی بەشێوەیەك کە کاری یەکخراو و فرە-پسپۆڕیی تێیدا ڕەنگ بداتەوە.