

# **PLAN ON THE ORGANIZATION OF MENTAL HEALTH SERVICES IN PALESTINE**

by the

**STEERING COMMITTEE ON  
MENTAL HEALTH**

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**The Department of Mental Health and Substance Abuse, WHO, Geneva, has - in collaboration with the WHO Office in West Bank and Gaza – supported the Steering Committee in developing the technical contents of this plan. The Department endorses the plan and will provide technical assistance for its implementation.**

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## EXECUTIVE SUMMARY

According to WHO's Global Burden of Disease 2001, 33% of the years lived with disability are due to psychiatric disorders. This growing burden amounts to a huge cost in terms of human misery, disability and economic loss. The widening recognition of mental health as a significant international public health issue has led to the growing need to demonstrate that investment of resources in service development is not only required, but also worthwhile. There is growing economic evidence to support the argument that interventions for schizophrenia, depression and other mental disorders are not only available and effective, but are also affordable and cost effective.

The Palestinian Authority has, therefore, decided to develop a national mental health service organization plan as a key priority area for health services development.

This draft strategic services plan for mental health has been informed by the work of a Steering Committee which includes representatives of the Ministry of Health, key local and international non-governmental organisations (NGOs), the World Health Organisation (WHO) and the Italian and French governments.

The key themes in the strategy were established through two conferences held in July 2003 in Gaza City and Ramallah on the West Bank attended by many local people. Specific objectives of the plan are to overcome current fragmentation of services and to improve the current organisation and to improve collaboration between all service sectors.

Palestine has a significantly young population with approximately three-quarters of people currently under the age of 30. The two Intifadas have had a significant effect on the Palestinian population. Due to the present situation travel and communications are severely disrupted and many Palestinians are unable to work. High numbers of people have experienced either direct or indirect trauma including a high proportion of children.

The international evidence for prevalence of mental health disorders underlines the importance of developing comprehensive community services to support the significant proportion of people with mental illness that can and do recover.

Some core services for community mental health already exist in most places across the West Bank and Gaza provided by the Ministry of Health, NGOs and other organisations. There is a good infrastructure of primary health care services in every town and village organised on four levels. There are also a range of other informal health care providers and a large number of counsellors who work within Palestinian schools. These existing services provide a good foundation for the further development of effective and comprehensive community mental health care.

Any mental health service system should be developed upon a sound base of values and principles. The Steering Committee has been able to agree on a common set of values and principles to underpin this strategy. The aim is to develop services that are:

- available locally and easily accessible
- able to provide comprehensive support and treatment
- destigmatising and acceptable to local communities
- able to ensure that people maintain contact with their families, friends and their social system.

It is proposed that regional mental health service systems be established in Palestine. Each region should have a community mental health service which will consist of:

- a community mental health team and centre (the focal point and single point of access)
- acute inpatient beds
- day care service
- rehabilitation and continuing care accommodation (possibly to be developed and provided in conjunction with local NGOs)
- means to respond to the mental health needs of children and young people
- means to respond to the mental health needs of older people

There are currently significant inconsistencies in the distribution of mental health service resources across the West Bank and Gaza. Redistribution of existing mental health resources, particularly those in the psychiatric hospitals in Bethlehem and Gaza, will be necessary to achieve the vision set out in this strategy.

One valuable role of the Ministry is to be proactive with other sectors, including the NGO sector. This is important to maximize the use of available resources to the maximum benefit of the population at large.

The contents of this strategy closely reflect the ten recommendations contained in the World Health Report 2001, which are to:

- Provide treatment in primary care
- Make psychotropic drugs available
- Give care in the community
- Educate the public
- Involve communities, families and consumers
- Establish national policies, programmes and legislation
- Develop human resources
- Link with other sectors
- Monitor community mental health
- Support more research

# 1. INTRODUCTION

## 1.1 Background to this Report

- 1.1.1 The Ministry of Health in Palestine has developed a policy for improving health services to the people of Palestine. Mental health service development is a key priority area. Therefore, in March 2003, the Ministry of Health of the Palestinian National Authority appointed a Steering Committee for Mental Health to prepare a report on Mental Health Development and Organisation in Palestine. The brief for this group included the formulation of recommendations for the planning and service organisation of mental health. The present report presents a strategic services organisation plan for 5 years.
- 1.1.2 This draft strategic services plan will be given wide-spread circulation and after consultation will be followed by a detailed implementation plan giving realistic timetables for a year by year programme of action.
- 1.1.3 The Steering Committee set about the task with the World Health Organization (WHO). In 2003 the WHO published a mental health *'Policy and Service Guidance Package'* which provides a useful template for this work.
- 1.1.4 The WHO Office in Jerusalem organised and facilitated two stakeholder conferences in Ramallah and Gaza City, in July 2003. Around 150 people attended the two events including clinicians, professionals, managers, policy makers, representatives of non-governmental organisations (NGOs) and international experts from WHO.
- 1.1.5 The purpose of these conferences was to bring together a wide range of people who could inform a vision for mental health development, service organisation and their ideas of how this could be implemented over time. The conference featured presentations by local and international mental health professionals. Groups of delegates worked together to discuss the vision and principles that would underpin the plan and strategy and a range of services that would meet the needs of people with mental health problems in Palestine. The results of these two conferences have greatly influenced this strategy.
- 1.1.6 Representatives of WHO also met separately with key Ministry of Health policy makers and professionals in Palestine to explore local issues in more depth. The strategy also draws upon the experience of those involved in the development of community mental health services in other parts of the world.
- 1.1.7 An draft of this plan was discussed at two conferences held in Gaza and Ramallah in January 2004. The two conferences were attended by more than 100 Ministry of Health staff and their feedback was incorporated into this final draft. A summary of this feedback is in appendix 3.

## 1.2 Strategic Objectives

1.2.1 A national mental health policy is an essential instrument to ensure clarity of vision and purpose in the improvement of the mental health and psychological well being of the citizens of any country. In 2001, the WHO found that 40% of the 181 countries in the world had no mental health policy and this has been a major barrier.

1.2.2 The overall objectives of any national mental health policy should be:

- **Improving the mental health of the population** – providing opportunities through service provision for people with mental health problems to have an improved quality of life and to be regarded as valuable citizens in the community.
- **Responding to individual peoples needs and expectations** – the intention of this objective is to achieve respect for persons with mental health problems and for their individual needs to be recognised and services tailored to meet these needs.
- **Equity of service provision** – this objective implies cost-effectiveness, availability of basic services e.g. pharmacology, parity with other health services, geographical equity of service provision and a reasonable mental health budget as a proportion of the general health budget allocation.
- **Safeguarding human rights** – the achievement of this objective would require modern, national mental health legislation to be implemented, public awareness campaigns, an advocacy system and a programme to combat stigma.

1.2.3 The WHO Guidance (2003) includes a framework for the organisation of mental health services. The framework states that *‘the organisation of services is a critical aspect of policy because services are the ultimate means through which effective interventions for mental health are delivered. Services in the community through to more specialized services need to be coordinated, allowing for referrals and back referrals at each level of the health system in order to promote continuity of treatment and care. Links between health services and the non-health sector, for example, housing and social services, must also be established. The exact form of services will vary considerably according to the cultural, social, political and economic context.’*

1.2.4 This plan covers people of all ages who have a mental health problem ranging from those with severe and persistent mental illness to those non-diagnosable psychological problems in the general population. It does not include people with a learning disability.

### **1.3 Specific Objectives for Palestine**

1.3.1 The need for a national mental health plan has been recognised by the Palestinian Authority. The specific objectives for the development of this plan are as follows:

- To develop a framework of shared vision and values for mental health care in Palestine
- To overcome current fragmentation of services and to improve the current organisation of services
- To develop a community mental health system building on the existing experience of service development
- To provide more specialist services to address specific mental health needs across the population
- To improve collaboration between all service sectors i.e. government run mental health services, non-governmental organisations etc.
- To improve the skills and competence of those involved in delivering mental health care in Palestine
- To review current mental health legislation in Palestine
- To improve outcomes for mental health service users and their families

## 2. GEOGRAPHY AND DEMOGRAPHY

### 2.1 Geography and History of Palestine

2.1.1 The present Palestinian occupied territory includes the two geographically separate areas of the West Bank and Gaza Strip. These lie between the Mediterranean Coast and the Jordan River, at the crossroads between Africa and the Middle East. The area features several famous cities including Jerusalem, Bethlehem, Hebron, Jericho, Nablus and Gaza. The area has a rich history. Roman Emperor Constantine built the Church of the Holy Sepulchre in Jerusalem in the year 348. Moslem Caliph Abdul elmalik built the Dome of the Rock in 691. There is the famous Abraham Mosque in Hebron, Christian sites in Bethlehem, archeological sites in Nablus and religious and cultural sites in Jerusalem. The area has been the source of inspiration for many artists, writers, poets, musicians and world leaders.



2.1.2 The West Bank lies within an area of 5,800 sq. Km west of the River Jordan. It has been under Israeli Military Occupation since June 1967. The West Bank is divided into three geographical regions. The North including the districts of Nablus, Jenin, Tulkarem, Tubas, Qalqilia and Salfit; the Center including the districts of Ramallah and Jerusalem; the South including Bethlehem and Al-Khaleil; the sparsely populated Jordan valley including Jericho. Many areas of the West Bank have diversified communities. There are observable differences in the life styles and living conditions of the different socio-economic groups, religious affiliations, urban, rural and refugee communities in Palestine. Up to sixty per cent of the population lives in approximately 400 villages and 19 refugee camps. The remainder live in cities including Nablus, East Jerusalem and Al Khaleil.

2.1.3 Gaza strip is a narrow piece of land total area 360 sq. Km lying on the coast of the Mediterranean Sea. The area has a dense population mainly concentrated in the cities and small villages. The main source of income for the Gaza population was working in Israel, in addition to the export of agricultural products via Israel.

## 2.2 Population Data

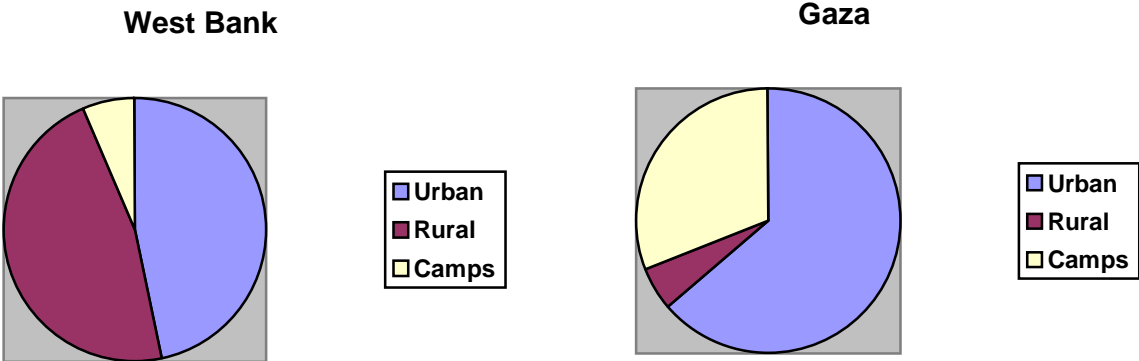
2.2.1 Recent population estimates for Palestine are as follows:

Governorate	Total Population	Urban	Rural	Camps
Jenin and Tubas	279500	93572	133674	10937
Tulkarem	156200	72651	64175	19374
Qalqilia	86300	52530	33770	-
Salfit	57300	15849	41451	-
Nablus	304300	127297	145482	31521
Ramallah and Al-Bierah	256500	87585	152649	16266
Jerusalem (J2)	133700	53949	72714	8210
Jericho	39000	18281	13406	7313
Bethlehem	161600	55091	93042	13467
Hebron	481400	323402	145654	13578
<b>WEST BANK</b>	<b>1955800</b>	910669	919226	125905
North Gaza (Jabalya)	236300	145912	12913	77475
Gaza city	446400	362080	7440	76880
Deir Al-Ballah	182900	56762	6307	119831
Khan Yunis	245600	170798	31168	43635
Rafah	150700	62792	13814	74094
<b>GAZA STRIP</b>	<b>1261900</b>	799831	71570	390498
<b>PALESTINIAN TERRITORY</b>	<b>3217700</b>	1707049	994337	511373

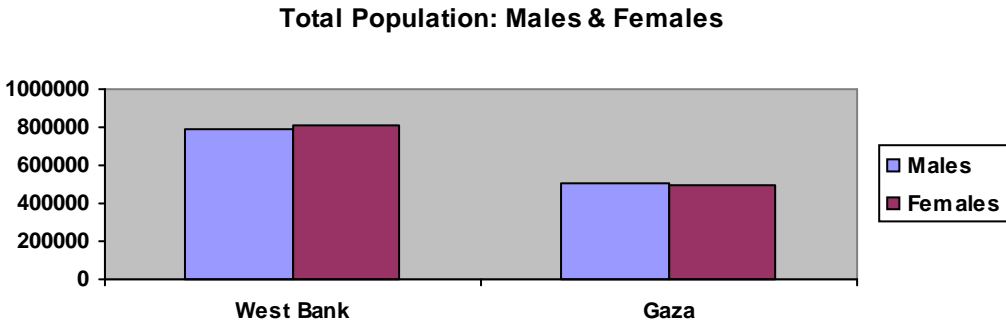
Table 1: Total Population by Governorate. Source: PCBS, 2002

In addition the total Al-Quds (East Jerusalem) population of 380,000 would bring the total population size of Palestinian people in Gaza, the West Bank and Al-Quds to ca 3,5 million. There are also at least one million Palestinians living within Israel and a further 4.7 million living in other countries within the region and elsewhere.

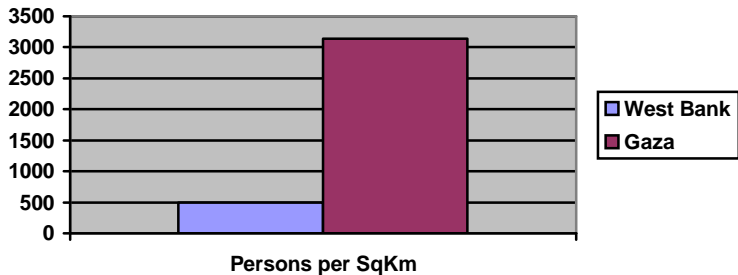
2.2.2 These population data demonstrate significant differences in the proportion of the people living in urban, rural and camp settings.



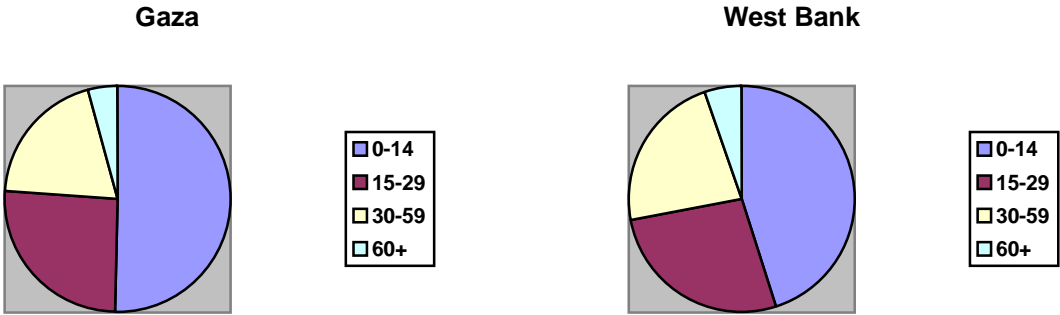
2.2.3 The population data for the West Bank and Gaza demonstrates approximately a similar number of females and males:



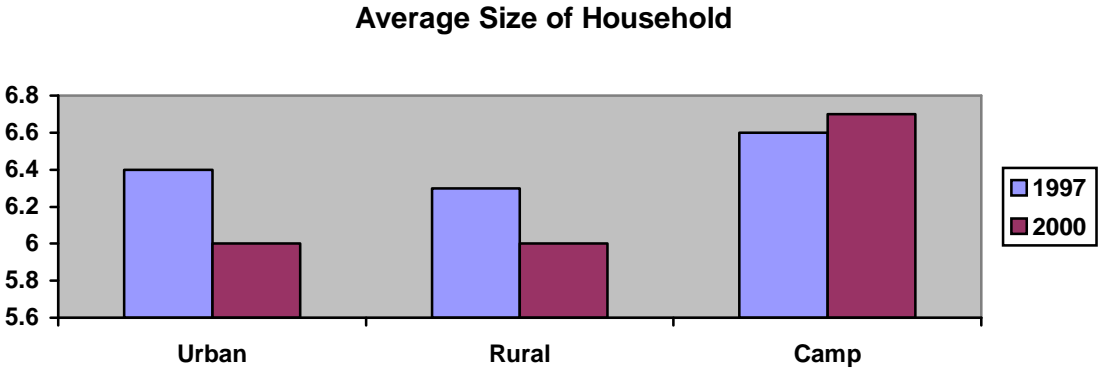
2.2.4 Population densities in Palestine are reported to be as follows:



2.2.5 The Health Management Information System Directorate (HMIS) of the Ministry of Health in Palestine, produces an Annual Report on *'The Status of Health in Palestine'*. This report documents population the following age demographics for the populations of the West Bank and Gaza. This demonstrates a significantly young population with around three-quarters of the population in both the West Bank and Gaza currently under the age of 30.



2.2.6 The Palestinian Central Bureau of Statistics has produced a pocket book of *'Health and Demographic Indicators of Census, Health and Demographic Surveys Data'*. This reports the following trends in the distributions of Palestinian Types of Households:



**2.3 Effects of the Intifada**

2.3.1 The Palestinian population has lived through several consecutive wars (1948, 1956, 1967) and long periods of unrest. The first of the two Intifadas (Uprising of the Palestinian people against Israeli occupation) started in December 1987. The continuing effects of occupation have caused a great deal of suffering and worsening economic conditions for both refugee and non-refugee populations.

- 2.3.2 Coupled with increased levels of tension and unrest, by 2003, economic hardship has reached an unprecedented level for this region. This has been attributed to a variety of factors including the adverse effects of the Gulf crisis, restrictions on movement of the population and extended curfews. Per capita gross domestic product declined by half between the beginning of the *Intifada* and July 1990.
- 2.3.3 The present Intifada, the Al-Acqsa Intifada, has left many Palestinians unable to work. According to Miftah (Palestinian Initiative for the Promotion of Global Dialogue) the unemployment rate in the West Bank and Gaza Strip, was estimated at 53% with a 47% decrease in per capita income. The percentage of Palestinians now living below the poverty line is 64%. This contrasts with 21.1% of the population living below the poverty line prior to the beginning of the Al-Acqsa Intifada in September 2000. More recent reports have estimated the unemployment rate in 2003 to be as high as 70%.
- 2.3.4 In the Ministry of Health Annual Report on *'The Status of Health in Palestine, 2001'* it is reported that around 20% of crops in Gaza have been flattened for security reasons. 320,000 olive and other trees have also been destroyed. As agriculture represents a significant proportion (as high as 60%) of the local economy, this is likely to have a significant impact on livelihoods of the population affected.
- 2.3.5 The ongoing conflict has had a detrimental effect on the community, communications and transport infrastructure in Palestine. 36,000 people have had their homes either destroyed or partially destroyed, there are severe restrictions on travel and movement with approximately 120 Israeli checkpoints throughout the West Bank and Gaza, making travel between some towns and cities virtually impossible. These factors have also had a significant impact on the ability of people to access many health services.
- 2.3.6 The State of Health in Palestine 2001 reports significant effects of the *Intifada* on the population of Palestine. The number of deaths and injuries associated with the current Intifada that occurred between 29 September 2000 when the current crisis began and 25 August 2003 were as follows:

Region	Population	Injuries		Deaths	
		Number	Rate/ 1,000	Number	Rate/ 100,000
West Bank	2,102,360	25,285	12	1,457	69.3
Gaza Strip	1,196,591	11,452	9.6	1,159	96.9
<b>Palestine</b>	<b>3,298,951</b>	<b>36,737</b>	<b>11.1</b>	<b>2,616</b>	<b>79.3</b>

A high proportion of these injuries have occurred in people under the age of 29. It has also been reported that 14% of casualties have become permanently disabled.

- 2.3.7 It has been noted that a high percentage of Palestinian children experience mental and behavioural problems and this has been linked to the prolonged conflict.

- According to Abu Hein et al. (1993) and other data high proportions of Palestinian children had been tear gassed, 42% had been beaten, 19% detained or had their house raided.
- Thabet et al. (1998) found that 21.5% of the 9-13 year-old children in the Gaza Strip showed anxiety problems. In a longitudinal study of children aged 7-13 years, 11% reported moderate to severe post-traumatic reactions and parents rated 21% of children with mental health problems.
- In 1997, between the two Intifadas, a population-based study (N=585), involving fully structured diagnostic interviews, was carried out among adults in Gaza. Data were collected by the Gaza Community Mental Health Programme (an NGO) and analyzed by a WHO Collaborating Centre. The data show that in the previous 12 months before the interview 10.6% of the population met criteria for DSM-IV PTSD, 12.3% met criteria for another DSM-IV anxiety disorder, 4.8% met criteria for DSM-IV mood disorder, and 4.8% met criteria for DSM-IV somatoform disorder. (Ivan Komproe, PhD, Transcultural Psychosocial Organization, written communications, 2003).

2.3.8 Significant levels of mental distress have also been observed among specific population groups including children, young people, women and ex-prisoners. The following figures were reported by the Gaza Community Mental Health Programme at the Gaza Mental Health Conference in July 2003:

- 21% Children under 12 have anxiety disorders
- 37% of children reported traumatic events
- 63% of women reported traumatic events
- 29% of young people felt hopeless and depressed
- 40% of ex-prisoners reported PTSD, marriage problems, etc.

2.3.9 The Palestinian Ministry of Social Affairs has reported that in 2001 110 children (under the age of 18) were killed and 6,160 were injured. A Palestinian poll revealed that 69% of children between 4-14 years suffer from psychological disorders. In the first five months of the Al Aqsa Intifada ways in which the rights of children were abused were:

- The use of excessive force
- Disregarding the definition of the child
- Violating the right to life
- Violating the right to physical and psychological well-being
- Violating the right to protection from torture
- Violating the right to education

## **2.4 Indicators of Mental Health Need**

2.4.1 The World Health Report 2001 produced by WHO, reviews a variety of factors which determine the prevalence, onset and course of mental and behavioural disorders. These include social and economic factors, demographic factors

such as age and sex, serious threats such as conflicts and disasters, the presence of major physical diseases, and the family environment.

- 2.4.2 . Most studies show an association between indicators of poverty and the risk of mental disorders, the most consistent association being with low levels of education (Patel & Kleinman, 2003). There is weak evidence to support a direct association with income levels. Factors such as the experience of insecurity and hopelessness, rapid social change and the risks of violence and physical ill-health may explain the greater vulnerability of the poor to common mental disorders. The direct and indirect costs of mental ill-health worsen the economic condition, setting up a vicious cycle of poverty and mental disorder (Patel & Kleinman, 2003). Conflicts and disasters take a heavy toll on the mental health of the people involved with between a third and half the affected persons suffering from mental distress. The most frequent diagnosis made is post-traumatic stress disorder (PTSD) often along with depressive and anxiety disorders. In addition, most individuals report psychological distress that does not amount to disorders.
- 2.4.3 The overall prevalence of mental and behavioural disorders does not seem to be different among men and women. However, anxiety and depressive disorders are more common among women, while substance use disorders and anti-social personality disorders are more common among men (Gold, 1998). Almost all studies show a higher prevalence of depressive and anxiety disorders among women, the usual ratio being between 1.5:1 and 2:1. These findings have been seen in most developed and developing countries. Sex differences in depression are strongly age-related; the greatest differences occur in adult life, with no reported differences in childhood and few in the elderly.
- 2.4.4 Schizophrenia and bipolar affective disorder do not show any clear differences of incidence or prevalence, although schizophrenia does have an earlier onset and a more disabling course among men. Co-morbidity is more common among women than men, most often co-occurrence of depressive, anxiety and somatoform disorders.
- 2.4.5 Age is an important determinant of mental disorders. In western societies, a high prevalence of disorders is seen in old age. Besides Alzheimer's disease, elderly people also suffer from a number of other mental and behavioural disorders. In particular, depressive disorder is common among elderly people, especially those with physically disabling disorders.
- 2.4.6 The presence of major physical diseases affects the mental health of individuals. Most of the seriously disabling or life-threatening diseases, including cancers in both men and women, have this impact.
- 2.4.7 A variety of family and environmental factors have also been associated with onset of mental disorders. It has been observed that an accumulation of life events (bereavement, business failure, humiliation etc.) often precedes the onset of mental and physical disorders.

2.4.8 Social factors such as urbanisation, poverty and technological change have been associated with the development of mental and behavioural disorders. The nature of modern urbanisation is thought to have negative consequences for mental health through the influence of life stresses and adverse life events such as overcrowded and polluted environments, poverty and dependence on a cash economy and reduced social support.

## **2.5 Mental Health Needs of the Population**

2.5.1 Considered together, the international evidence for increased prevalence of mental health disorders and the demographic and environmental evidence described in this report suggest a higher than average incidence of common mental disorders (including PTSD) in the Palestinian population. Specific indicators of high population mental health need in the Palestinian population are as follows:

- The continuing conflict situation in Palestine
- A significant proportion of the population living as refugees in camps (particularly in Gaza)
- A high population density in Gaza
- High levels of unemployment, social deprivation and poverty – especially for those living in camps
- Significant direct experience of trauma, injury, humiliations and bereavement to individuals (and other violations of human rights)

The likely implications of these environmental factors would be higher levels of depressive and anxiety disorders and other disorders related to trauma (e.g. PTSD).

2.5.2 Palestine currently has a significantly young population with three-quarters of the population in the West Bank and Gaza under the age of 30 and a very small proportion over the age of 60. The obvious current implication of this would be a high rate of presentation of mental illness that is typical among younger people, e.g. first episode psychosis. This would also imply a low rate of presentation of mental illness that is typical among older people e.g. dementia and depression in old age etc. Future implications are that in a fast growing adult population it is likely that there are more people with associated mental health needs.

2.5.3 There are many positive demographic characteristics of the Palestinian population which should have a positive and protective effect on the mental health of its citizens. These include the high levels of social capital, for example a supportive extended family culture, the importance of religion, a strong sense of national identity, purpose and unity and very high rates of literacy.

2.5.4 Even in the face of the obvious trauma and suffering experienced by the population, affected citizens are not necessarily helpless people who are

totally dependent on help from others. Trauma survivors are often people with strong survival power and services need to look to build upon the positive survival and coping capacities that are present.

- 2.5.5 The WHO report *'Investing in Mental Health'* has shown that there are significant social and economic implications of a high prevalence of mental illness. Worldwide, 33% of the years lived with disability are due to psychiatric disorders. These include loss of productivity by both patients and their families, social isolation, family breakdown and low educational achievement. These factors have significant associated welfare costs, which far exceed the costs of mental health service provision. The provision of good mental health services along with prevention and promotion programmes have been shown to result in considerable economic savings to society.
- 2.5.6 People with mental health problem are also more likely to engage in risk taking behaviours such as attempted suicide and self-harm, and substance misuse. There is also a significant wider burden on general health care services, particularly primary care, with people consulting with somatising mental health conditions. It is known that mental health problems in parents can have a range of detrimental effects on children.
- 2.5.7 With treatment, a significant proportion of patients with mental illness can and do recover. There are obvious ethical and human rights reasons to provide care and treatment for the mentally ill. However, there are also demonstrable economic, social and public health benefits to a country in investing in effective mental health services.

### **3. CURRENT MENTAL HEALTH SERVICES**

#### **3.1 Overview**

3.1.1 The Ministry of Health (MOH) is the main statutory health provider in Palestine responsible for supervision, regulation, licensure and control of the whole health services. Other health providers include the Military Medical Services, health services belonging to national and international non-governmental organisations (NGOs) and some private health sector (for profit) organisations.

#### **3.2 Government Run Mental Health Services**

3.2.1 In the West Bank there are mental health clinics in Ramallah Jerusalem, Jericho, Hebron, Nablus, Tulkarem, Salfit, Qalqilia and Jenin. Staffing in these clinics range from the equivalent of only one full-time member of staff in Jericho to five full-time staff in Nablus – including two psychiatrists, two psychologists and a social worker. Mental health resources are concentrated at the Bethlehem Psychiatric Hospital where there nearly 100 staff working.

3.2.2 In Gaza there are four Government run community mental health services in Jabalya, Gaza City and Khan Younis. In addition, there is a child mental health clinic with four staff in Gaza City. The largest resource is the Gaza Nasr Hospital in Gaza City where there are 35 staff working.

3.2.3 Government run services in both the West Bank and Gaza also have a key role in training mental health professionals.

3.2.4 The WHO in collaboration with the Palestinian Authority are developing an atlas of existing mental health service provision by geographical region. More detailed information on services is included in appendix 1.

#### **3.3 Non-Governmental Organisations (NGOs)**

3.3.1 NGOs have pioneered provision of preventative and mental health services. NGOs include:

- A Al Ehsan Centre for Mentally Disabled (Hebron) (Rehabilitation)
- Al Qattan Foundation for Children
- Bethlehem Arab Society for Rehabilitation (BASR)
- Community Training Center for Crisis Management
- Culture and Free Thought Society
- Gaza Community Mental Health Programme (GCMHP)
- Guidance and Training Centre for the Child and the Family (Bethlehem)
- Health Care Committees (HCC)
- Health Services Council (HSC)
- Juzoor
- Medicines sans Frontiers (Hebron)
- Mentally Retarded Society - Shamas Centre
- National Plan of Action for Palestinian Children

- Palestinian Counselling Centre
- Palestinian Happy Child Centre
- Palestinian Red Crescent Society
- The Palestinian Center for Resolving Community Disputes
- Treatment of Torture Victims (Ramallah)
- Union of Health Work Committees (HWC)
- Union of International Churches
- Union of Palestinian Medical Relief Committees (UPMRC)
- YMCA Rehabilitation Centre
- Youth Union

3.3.2 The National Plan of Action for Palestinian Children has a specific Website that summarizes information on organizations that specifically aim to address the psychosocial needs of children (<http://www.npasec.org/DisplayOrg.asp>)

3.3.3 The Palestinian Red Crescent Society run a family centre in Hebron, various activities for children and 21 primary health care centres throughout the West Bank each with a social worker and some with psychologists (12 in total across the West Bank). The mental health programme is headed by an experienced psychiatrist.

3.3.4 Guidance and Training Centre for the Child and the Family (Bethlehem) a NGO run psychiatric service with a focus on children.

3.3.5 A key NGO offering community mental health services in the Gaza Strip is the Gaza Community Mental Health Programme (GCMHP), which was established in 1990 to address population mental health needs in the midst of significant social upheaval. GCMHP has adopted a community based approach which not only offers clinical services but also works on public awareness efforts to combat the stigma of mental illness as well as preventative measures. GCMHP engages in advocacy, lobbying for such issues as the prevention of torture and the empowerment of women. GCMHP employs 45 professionals at four clinics and four womens centres across Gaza. Each clinic has a community mental health team consisting of psychiatrist, psychologist, GP, social worker and psychiatric nurses. Also supporting units are available which employ an occupational therapist, a physiotherapist and an EEG technician. Their priorities are women, children, victims of torture and other human rights violations, training and education.

### **3.4 UN Organisations**

3.4.1 The United Nations Relief and Works Agency for Palestinian Refugees in the near East (UNRWA) provides education, health and relief and social services to 3.8 million Palestinian refugees in Jordan, Lebanon, Syria, the West Bank and the Gaza Strip. Its overall health programme accounts of 18% of its budget. In May/June 2002, UNRWA Gaza started a programme in prevention in mental health, to answer the needs of the refugees during the second Intifada. It involves 66 counsellors working in schools, medical centres and community centres in the camps. Activities are at the level of prevention and

patients are referred when professionals in mental health are needed. The link with resources in the community is developed. The counsellors are mainly involved in group counselling with parents, teachers, children, adolescents. A significant number of refugees attend the government-run mental health clinics.

- 3.4.2 UNRWA have reported plans to develop a crisis intervention service by hiring 14 mental health counsellors and, through NGOs, 15 community mental health activists. They also state that they will contract private psychiatrists and psychologists to accept referrals of clients that cannot be managed by mental health counsellors. UNRWA have indicated that they will pay for the first twelve sessions of treatment.
- 3.4.3 UNICEF programme initiatives focus on training and education of parents, teachers, school counsellors and social workers on first aid psychological support for children. They are also establishing hotlines with psychological assistance by and for young people in co-operation with NGOs. They are also providing reading, learning and self-expression material for young people.

### **3.5 Primary Care Services**

- 3.5.1 There are approximately 600 general practitioners in primary health care centres across the West Bank and Gaza provided by the Ministry of Health, NGOs and the private sector. Of these, 329 are provided by the Ministry of Health in the West Bank and 44 in Gaza.
- 3.5.2 Primary health care is organised on four levels:
- Level 1** – in small rural communities below 1,000 population, village health workers are employed. These health workers are trained in basic health care e.g. child health, child vaccinations. The centres are visited twice monthly by a general practitioner and a nurse.
- Level 2** – primary health care clinics cover populations of between 1,000 – 3,000 patients. A nurse is present all week and general practitioners visit between 2 – 4 days per week.
- Level 3** – covers populations of between 3,000 – 10,000 people. The clinic will have a full-time doctor and at least two nurses one of whom will specialise in prevention. At this level some secondary specialist services are available (for example, diabetes) but not all specialties.
- Level 4** – populations of 10,000 and more based in the main towns. Primary health care centre with more than one doctor and full primary health care team. Also, specialist services are available (for example, orthopaedics, ophthalmology etc).
- 3.5.3 A significant proportion of the work at all levels of the primary care system will include mental health care. However, specific mental health clinics are currently only held in a minority of centres. Up to 40% of referrals to mental health clinics in primary care are for people with epilepsy. The majority of primary care staff have little or no training in mental health care and

recognition of mental health problems. Since the Al Acqsa Intifada, and the associated problems with travel, there is evidence that increasing numbers of people with both common and serious mental illnesses are being managed in primary care alone sometimes with telephone support and case discussion from psychiatrists.

### 3.6 Role of Other Informal Care Providers

3.6.1 In many countries, pathways to care will include traditional healers and alternative health workers. These traditional health workers are an important resource and are often highly valued by service users and their families.

3.6.2 It is essential that these services are incorporated into a whole system of mental health care. However, for this to have maximum effect they need to work in a co-operative way with mainstream mental health services and have appropriate arrangements for governance, quality assurance and accreditation.

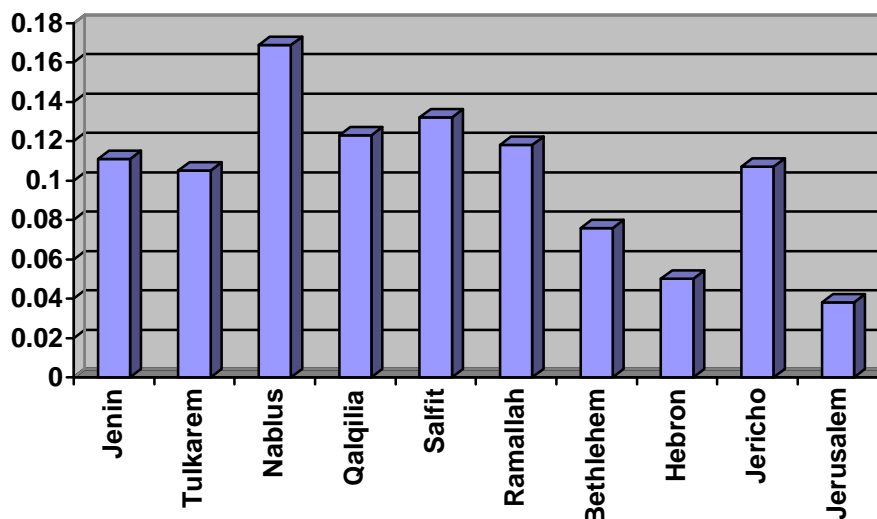
### 3.7 Cost of existing services

3.7.1 Financial data from the Ministry of Health reports the annual expenditure on government run community mental health services in the West Bank only in 2002 to be 694,478 NIS (\$157,836 USD). This is reported in more detail in the following table as a proportion of the overall spend on primary health care services.

DISTRICTS	POPULATION	MENTAL HEALTH COSTS	PRIMARY HEALTH CARE COSTS	ALL PATIENTS	MENTAL HEALTH PATIENTS	%	MENTAL HEALTH COSTS (NIS)	MENTAL HEALTH COSTS (USD)
Jenin	230,000	112,432	3,500,000	346,760	11,143	3.2	112,471	25,562
Tulkarem	129,000	60,020	2,300,000	226,206	5,903	2.6	60,020	13,641
Nablus	251,000	187,027	3,200,000	220,083	12,863	5.8	187,028	42,506
Qalqilia	69,000	37,403	1,500,000	117,140	2,921	2.5	37,404	8,501
Salfit	47,000	27,331	1,300,000	107,971	2,270	2.1	27,331	6,212
Ramallah	205,000	106,601	3,750,000	211,312	6,007	2.8	106,602	24,228
Bethlehem	132,000	44,055	1,900,000	103,032	2,389	2.3	44,055	10,013
Hebron	390,000	85,575	6,100,000	337,236	4,731	1.4	85,575	19,449
Jericho	32,000	15,125	1,400,000	64,792	700	1.1	15,125	3,438
Jerusalem	114,000	18,865	1,350,000	67,121	938	1.4	18,866	4,288
<b>TOTAL</b>	<b>1,599,000</b>		<b>26,300,000</b>	<b>1,801,653</b>	<b>49,865</b>	<b>2.8</b>	<b>694,478</b>	<b>157,836</b>

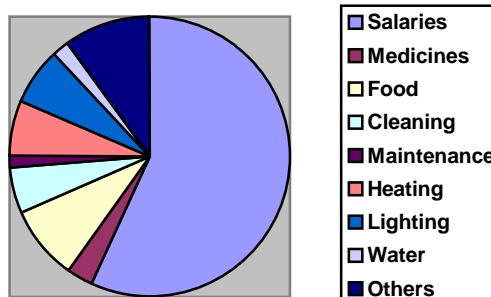
3.7.2 The following graph shows the mental health costs in primary health care per head of population and by district in 2002 in US Dollars.

**Mental Health Costs (USD) in PHC by District per head of population**



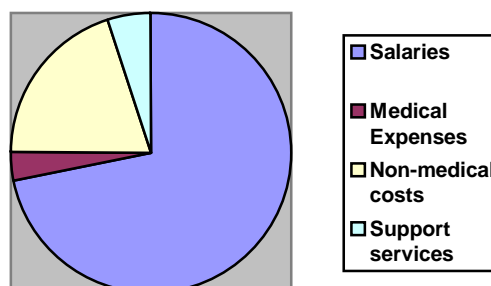
3.7.3 Current costs for the Bethlehem Psychiatric Hospital (180 occupied beds) are reported to be 82% of the total mental health spend in the West Bank:

	NIS	USD	% of total
<b>Salaries</b>	1,845,310	419,389	56.8
<b>Medicines</b>	93,718	21,300	2.9
<b>Food</b>	279,178	63,450	8.6
<b>Cleaning</b>	171,222	38,914	5.3
<b>Maintenance</b>	44,000	10,000	1.4
<b>Heating</b>	208,000	47,273	6.4
<b>Lighting</b>	217,000	49,318	6.7
<b>Water</b>	68,855	15,649	2.1
<b>Others</b>	320,245	72,783	9.9
<b>TOTAL</b>	<b>3,247,528</b>	<b>738,075</b>	<b>100.0</b>



3.7.4 Current costs for the Gaza Nasr Hospital (24 occupied beds) are reported to be as follows:

	NIS	USD	% of total
<b>Salaries</b>	649,500	147,600	72
<b>Medical Expenses (e.g. drugs)</b>	28,600	6,500	3
<b>Non-medical costs</b>	181,600	41,300	20
<b>Support services</b>	45,700	10,400	5
<b>TOTAL</b>	<b>905,400</b>	<b>205,800</b>	<b>100.0</b>



### **3.8 Human Resources**

- 3.8.1 Although within the Ministry of Health there is the full range of professionals required to develop a modern community mental health service there is a shortage of key professionals in all the disciplines. Other countries have experienced similar shortages of trained staff and this is recognised as a major problem within the Ministry of Health. A solution to this might be to introduce incentives to attract more doctors, psychologists, nurses and social workers to a career in mental health.
- 3.8.2 At present opportunities within the West Bank and Gaza for continuing professional education and training are limited for all professions from doctors to primary care workers to school counsellors. An education and training plan will be developed as part of the implementation plan for this strategy. A key priority for this strategy will be the training and further development of the staff in the Bethlehem and Gaza Psychiatric Hospitals.
- 3.8.3 As part of this education and training plan it might be helpful to establish a multidisciplinary University Diploma in Community Mental Health within the West Bank and Gaza. Another essential step could be to establish a training scheme and appropriate qualification for psychiatric nursing. There is already a generic masters degree available in community health for which it would be essential to introduce at least one module on mental health.
- 3.8.4 The French Government have funded a training programme in France for seven doctors to be nominated by the Ministry of Health. They are also planning to train 30 people from a range of professional backgrounds in groups to work in community mental health centres. The Italian Government are also planning to train community mental health staff from Tulkarem. It is therefore important that WHO prioritises the training of hospital staff as many of them will work in the community in the future.

## 4. VALUES AND PRINCIPLES.

- 4.1 Any mental health service system should be developed upon a sound base of values and principles. These should guide the development of a strategic plan, as well as its implementation and how the service is evaluated.
- 4.2 WHO has produced the following summary of examples of values and principles in mental health policies:

### EXAMPLES OF VALUES AND PRINCIPLES IN VARIOUS INTERNATIONAL MENTAL HEALTH POLICIES\*

(WHO, 1987; WHO, 1996; Canada, 1988; Canada, Alberta, 1993; Pakistan, 1998; United Kingdom, 1999; Thornicroft, 1999; Freeman, 1999; Chile, 2000)

#### 1. Improving the health of the population

<i>Values</i>	<i>Principles</i>
<b>PSYCHOLOGICAL WELLBEING</b>	<ul style="list-style-type: none"> <li>• Mental health promotion should be integrated into social and educational services</li> <li>• Inter-sector collaboration and linkage with community development should be done</li> </ul>
<b>MENTAL HEALTH INDIVISIBLE FROM HEALTH</b>	<ul style="list-style-type: none"> <li>• Mental health should be integrated into the general health system</li> <li>• Admissions for mental disorders should be done in general hospitals</li> </ul>
<b>COMMUNITY CARE</b>	<ul style="list-style-type: none"> <li>• People with mental disorders should be cared for in the least restrictive facility</li> <li>• Provision of community care alternatives should be tried before using inpatient care</li> </ul>

#### 2. Responding to people's expectations

<i>Values</i>	<i>Principles</i>
<b>COMMUNITY PARTICIPATION</b>	<ul style="list-style-type: none"> <li>• Consumers should be involved in the planning, delivery and evaluation of services</li> <li>• Mutual aid and advocacy groups should be encouraged</li> </ul>
<b>CULTURAL REALISM</b>	<ul style="list-style-type: none"> <li>• Different cultures should contribute with their visions</li> <li>• Traditional healers and informal sectors should play a significant role</li> </ul>
<b>PROTECTION OF VULNERABLE PEOPLE</b>	<ul style="list-style-type: none"> <li>• Human rights of persons with mental disorders should be protected</li> <li>• Women, children, elderly and the very poor should be the target of special mental health strategies</li> </ul>

#### 3. Providing financial protection

<i>Values</i>	<i>Principles</i>
<b>ACCESSIBILITY AND EQUITY</b>	<ul style="list-style-type: none"> <li>• All people should have access to services regardless of geographic, racial or social condition</li> <li>• Mental health services should have parity with general health services</li> </ul>

\*The provided examples are NOT specific recommendations for action

- 4.3 At the conferences held in Ramallah and Gaza City in July 2003, participants at the workshops reinforced the importance and relevance of the values and principles outlined above to the mental health needs of people in Palestine.

Key principles when organising mental health services were considered by participants in the workshops. The outputs of these workshops are described at appendix 2. The values and principles discussed included:

- a) **Accessibility:** essential mental health care should be available locally so that people do not have to travel long distances
- b) **Comprehensiveness:** mental health services should include all facilities and programmes that are required to meet the essential care needs of the populations in question
- c) **Co-ordination and Continuity of Care:** especially for people with severe mental disorders it is extremely important that services work in a co-ordinated manner and attempt to meet the range of social, psychological and medical care needs. This requires input from services that are not directly related to health, e.g. social services and housing services.
- d) **Effectiveness:** service development should be guided by evidence of the effectiveness of particular interventions.
- e) **Equity:** People's access to services of good quality should be based on need. In order to ensure equity it is necessary to address issues of access and geographical disparities.
- f) **Respect for human rights:** services should respect the autonomy of persons with mental disorders, should empower such persons to make decisions affecting their lives and should use the least restrictive types of treatment.

4.4 Workshop participants also emphasised the following practical and general aspects of mental health service development in Palestine.

#### Practical Aspects

1. To move the focus of work from the hospital to the community
2. To move the attention from the illness alone to the person and the social disability
3. To move from the individual to collective interventions, including the social context of the patient
  - To use a multidisciplinary approach
  - To downplay the totalising value of biological treatments alone and to psychotherapy alone, they are a needed but not the only answers to a problem and not the reason for how to organise the service
  - To promote the patient's self-help resources and the self-help resources of the families
  - To fight the stigma and to promote cultural actions that change the social perception of mental illness
  - To strongly advocate for non-professional activities and collaboration
  - To support organisations promoting solidarity within the civil society
  - To keep the doors open

4. The services need to be defined for a clear catchment area, with the full responsibility for all mental health in the area
5. The intervention should be practically oriented based on emotional involvement, the importance of small matters and basic needs can never be stressed enough

#### General Aspects

6. To work for legal and administrative changes in order to promote and protect patient's rights
  7. Social and political actions which enable vulnerable persons to live and achieve as good a life as possible, including housing, work and vocational training
  8. To work with local administrative authorities on how to best improve the organisation of services
- 4.5 All mental health systems should have at their heart the principle of responding at some level to the full spectrum of an individual's needs. The system must take a holistic approach. This should take account not only of mental illness but also physical health, and the other various social dimensions of an individual's life: including where they live, their family and friends, what they do with their day etc.
- 4.6 A mental health system must be firmly based on the principle that with appropriate treatment and care, people with mental illness can and do recover. The World Health Report 2001 shows that of those with depression up to 60% of patients recover and that up to 77% of patients with schizophrenia live without relapses.
- 4.7 This draft plan on the organization of mental health services in Palestine has been built upon these values and principles and will set the objective for the course of action required to implement new services.

## 5. STRATEGIC SERVICES PLAN

### 5.1 Introduction

5.1.1 The objective of this strategy is to set out a comprehensive, integrated plan that can meet the needs of all people with a mental health problem in Palestine. This should take account of the special circumstances of the population based on the needs assessment outlined in section 2 of this document.

5.1.2 There is a need to engage the full range of stakeholders to obtain their ideas and suggestions about how the strategy might be broadened. This would include other service users, families and care-givers as well as other NGOs, UN organisations and private mental health care providers who can contribute to meeting the mental health needs of people in Palestine.

5.1.3 Over the past thirty years many countries have been developing community based services and as a consequence reducing and replacing outdated and ineffective large institutional psychiatric hospital services. This is has been an important policy decision in order to meet the needs of the population and the desires and expectations of service users. To achieve this objective services need to be organised to ensure that they are:

- available locally
- easily accessible
- able to provide comprehensive support and treatment
- acceptable to local communities
- destigmatising
- able to ensure that people maintain contact with their families, friends and their social system

5.1.4 The main strategies that are required to achieve this objective are:

- a) Developing a community mental health system by changing the care and treatment in large psychiatric hospitals to the community e.g. care in general hospitals, primary health care, patients living in the community under the care of a community mental health team etc. This process of deinstitutionalisation is essential to achieve the main objective.
- b) Developing local comprehensive mental health service systems
- c) Integrating mental health care with local primary care services
- d) Developing partnerships between public services, community resources and community organisations
- e) Public education and public health interventions for mental health
- f) Recognising the natural strengths that individuals have to aid their own recovery and making use of these through the organisation of self-help approaches for service users and their families.

## 5.2 Developing a Community Mental Health System

5.2.1 In most countries community mental health services cannot be developed without a redistribution of resources (financial and human) from the institution. It is likely that few of the resources that will be required to establish new community services in Palestine will be found through any other means.

5.2.2 The most practical and cost effective way to develop the community mental health service described in this report is to begin to stop admitting new patients and gradually taper down and eventually close the Bethlehem psychiatric hospital on the West Bank. New community mental health services will need to be developed before the closure of any part of the hospital. This will require detailed planning on a year by year basis, widespread consultation and policies that protect the employment of the current staff.

5.2.3 It has been shown across the world that stand-alone mental hospitals are not the preferred service option and present a number of barriers to effective treatment and care:

- They are associated with a number of human rights violations
- Living conditions are often sub-standard
- Stigmatisation and isolation of people with mental disorders is sustained
- They tend to deliver poor outcomes

5.2.4 A comprehensive community mental health system should consist of the following components:

- Local Community Mental Health Services able to provide assertive community treatment
- Acute inpatient and crisis care
- Day care
- Rehabilitation and continuing care accommodation (possibly developed and provided in conjunction with local NGOs)
- Supported employment opportunities and help with accessing ordinary employment
- Independent support services for patients including self-help initiatives such as 'Clubhouse Model' etc.
- Support services for caregivers
- Supported housing
- Specialist services for children
- Specialist care for the elderly

5.2.5 The role of Bethlehem and Gaza mental hospital staff will be to provide a proactive role in the development of the new services. These staff will provide an active focus within the hospital to ensure the clear vision for the future and will facilitate the positive attitude and benefit to community mental health. Also, the process of deinstitutionalisation will require:

- Analysis of the present resources in the institution
- Assessment of the needs of existing inpatients and the level of support that they will require in the community

- Admission to long-stay wards stopped
- Double running costs for new services before resources can be released from the hospital
- Human resource policy
- Training programme for the present hospital staff
- The development of effective community mental health teams that can reduce the need for hospitalisation when people are in crisis
- A unified system of management for both the development of services and the downsizing of the hospital
- A programme for the rehabilitation of long-stay patients in the hospital
- Education of the public to accept the need for long stay patients to live in supported accommodation in the community

### **5.3 Developing local comprehensive mental health service system**

5.3.1 There are many advantages to providing mental health services based in the community:

- Enhances continuity and comprehensiveness of care
- Addresses the essential elements of a comprehensive psychosocial rehabilitation strategy that includes social reintegration, employment, housing and general welfare
- Improves outcomes and cost-effectiveness of treatments, particularly when informal mental health services such as traditional healers, families, self-help groups and volunteers workers are given adequate direction, support and opportunities to develop.

### **5.4 Developing mental health care in local primary care services**

5.4.1 It is universally recognised that the majority of people with mental health problems seek support and treatment in the first instance through primary care services. It has been shown that it is possible and indeed often more desirable, for the mental health needs of the majority of people to be met through primary care.

5.4.2 The advantages of this have been shown to be:

- better geographical accessibility
- less stigmatisation of people with mental disorders by managing mental disorders like other illnesses
- improving screening, detection and treatment rates of mental health problems
- a more efficient use of health service resources – cost-efficiency savings due to shared infrastructure
- a more holistic approach and enhanced quality of patient care
- better management of the physical health needs of those with mental illness – including better adherence and clinical outcomes for a range of co-morbid disorders such as diabetes and heart disease
- more appropriate referrals

5.4.3 A well developed primary care mental health service should be able, with support from specialist mental health services, to provide some psychological interventions and manage the use of a range of psychotropic medication. The use of telephone consultations between primary health care clinicians and specialist mental health services are beneficial. Existing communications should be continued, reinforced and enhanced between primary and secondary care.

5.4.4 In order to do this, it is essential that primary care teams have effective training, communication, links and support from specialist mental health services.

## **5.5 Developing partnerships between public services, community resources and community organisations**

5.5.1 It is impossible for the health sector in any country to meet the varied and complex needs of people with mental health problems on its own. Collaboration between mental health, general health and the non-health sector is necessary to develop a broad range of flexible types of support for patients. These should include the provision of appropriate social interventions, supported housing and projects to promote the mental health of the general population. One valuable role of the Ministry is to be proactive with other sectors, including the NGO sector. This is important to maximize the use of available resources to the maximum benefit of the population at large.

5.5.2 It is, therefore, necessary to consider the contribution that should be made by other sectors to achieve a comprehensive service system. These will include:

- Welfare organisations
- Religious organisations
- Traditional healers
- Education
- Housing
- Social care
- Private organisations
- Charities
- Employment agencies
- NGOs
- A variety of UN organisations

5.5.3 Whilst acknowledging the importance of a diversity in the approach and provision of individual service providers, it is essential that all organisations working in the mental health service system are united in their purpose, vision and values for the benefit of all of the people in Palestine.

5.5.4 Government departments other than those responsible for health care will have a part to play to realise the objectives of an effective mental health policy. In particular the Ministry of Social Affairs and the Ministry of Education.

- 5.5.5 A number of NGOs in Palestine play a significant role at present in the provision of continuing care and rehabilitation mental health services (see section 3). A particularly valuable contribution of NGOs in other countries is in the provision of flexible supported accommodation for people with long-term mental health needs. In other countries, it has been shown that the residential needs of long-stay patients in large psychiatric hospitals can be met by services provided by NGOs. This experience has also demonstrated that despite the initial anxieties of both patients and staff in these institutions, there has been high levels of satisfaction with the outcomes of this type of re-provision.
- 5.5.6 There is no history in Palestine of NGOs providing alternative accommodation for long-stay patients in large psychiatric hospitals. These organisations will, therefore, be invited to define their contribution and role in delivering the objectives of this strategy. These will include the role of The Red Crescent Society, The Gaza Community Mental Health Programme and other key NGOs. It will also include the role of other UN organisations including UNRWA.
- 5.5.7 Community and patient groups can themselves be an important resource and setting for improving the treatment and care provided to people with mental illness. The role of the community can range from the provision of self-help and mutual aid to lobbying for changes, carrying out educational activities, participating in the monitoring and evaluation of care and advocacy to change attitudes and reduce stigma. There are already some examples of this type of activity in Palestine. Support should therefore be given to stimulate the continued development and creation of such local groups. An example of the sort of resource that could be established is the 'Clubhouse Model' a vocational project run by patients and their families.

## **5.6 Trauma**

- 5.6.1 As reviewed above, conflict increases the risk of common mental disorders (including PTSD), mental distress and a range of social problems. In a country exposed to ongoing conflict, the appropriate mental health response has to be carefully planned. In general, experience shows that trauma related-problems are best managed when their care is integrated in existing services, such as primary care services, the education system, and general (mental) health services.
- 5.6.2 It is clear that the NGOs and the public sector are an invaluable community resource in Palestine providing care and support to the community which should improve the resilience of individuals to the trauma that they undoubtedly face. It is important that this generic role of the NGOs and the public sector is sustained. In Palestine both Ministry of Health and NGOs could play a more significant role in training relevant staff in the primary health care, education and general mental health systems to provide trauma related care.

5.6.3 During conflict, disaster or other emergency, the following issues need to be addressed

- a) A coordination mechanism for activities in the mental health (including psychosocial) system to avoid fragmentation and wastage of resources
- b) Liaison with other sectors to ensure that a number of social interventions are implemented
  - provision of information on the crisis
  - normal cultural and religious events are maintained
  - children and adolescents continue to receive access to formal or informal schooling and to normal recreational activities
  - participation of unemployed adolescents and adults in concrete, purposeful, common interest activities;
  - social activities to include isolated persons in social networks;
  - economic development initiatives. Examples of such initiatives include income-generating activities when markets will likely provide a sustainable source of income.
- c) Organization of services to ensure that individuals experiencing acute mental distress after exposure to traumatic stressors have access to psychological first aid at health services and in the community (see 5.6.4).

5.6.4 Psychological first aid in the immediate aftermath of exposure to trauma should be available. Whether among the general population or among aid workers, acute distress immediately after exposure to traumatic stressors is best managed following the principles of psychological first aid (NIMH, 2002). This entails basic, non-intrusive pragmatic care with a focus on: listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm. This can be taught quite easily to both volunteers and professionals. Professionals in existing systems (all levels of general health services, mental health services, relevant staff in education system, NGOs) should be trained in psychological first aid.

5.6.5 There a variety of ill-advised interventions in the immediate aftermath of exposure to trauma.

- Health workers are cautioned to avoid inappropriate, widespread prescription of benzodiazepines because of the risk of dependence.
- Because of possible negative effects, it is not advised to organize forms of single-session psychological debriefing that push persons to share their personal experiences beyond what they would naturally share during the immediate aftermath of exposure to trauma.

5.6.6 Care should also be available in the months and years after exposure to trauma. This care should be available in the general mental health system, primary health care system and the education system. The capacity of specialist mental health services should be developed to provide care and treatment for those who develop severe trauma related mental health problems for which there are recognised treatments available.

## **5.7 Public Education**

- 5.7.1 It is important to recognise the potential for the development and delivery of a national programme of public mental health prevention, promotion and education. This may include mental health programmes in schools, anti-stigma campaigns and the possible use of culturally based media interventions to stimulate positive reactions to common mental health problems in the wider community. The Ministry of Health Education Department will obviously need to play a key role in ensuring the dissemination of positive health messages rather than an illness focused approach.
- 5.7.2 Given the significantly young population in Palestine, it is particularly important that a comprehensive mental health education programme is undertaken through schools and other education providers. This will include ongoing training, development and supervision for teaching staff and the large number of school counsellors in recognising mental health problems at an early stage, understanding the needs of those with mental health problems and promoting good mental health for all.
- 5.7.3 It is essential that effective links and systems for shared care be developed between those working with young people and local mental health care providers. The focus of these links should be on promoting early recognition, intervention, support and understanding for those with mental health problems. The development of these links should be underpinned by a joint policy which should be developed by the Ministries of Health, Education, Planning and Social Welfare in the Palestinian Authority.

## **5.8 Quality**

- 5.8.1 It is essential that in addition to development of the mental health service infrastructure, thought is also given to the establishment of robust arrangements to ensure in services. This would include the development and implementation of clinical and operational policies and protocols to underpin the activity of both new and existing services. The development of clinical protocols is of particular importance to primary health care clinicians to inform identification, diagnosis, management, treatment and onward referral.
- 5.8.2 Effective implementation of both psychosocial and biological approaches in mental health services will require, in particular, robust arrangements for professional supervision.
- 5.8.3 Education of mental health service staff should include the basic principles of service and quality improvement. These tools can be used in the implementation of a quality strategy and to support the continuous improvement of services.

## **5.9 Mental Health Legislation**

- 5.9.1 Legislating in the area of mental health is an important aspect of policy and service development. Legislation can provide longer-term consistency and continuity to policy directions. It can also:
- Codify and consolidate the fundamental principles, values, goals and objectives of mental health policies and programmes.
  - Provide a legal framework to ensure that critical issues such as access to care, high quality of care, integration of people with mental disorders into the community and mental health promotion are addressed.
  - Protect and promote the rights, needs and interests of people with mental disorders and tackle the stigma and discrimination they experience.
- 5.9.2 In order to determine what should go into mental health legislation for Palestine it would be important to:
- Ascertain the mental health realities of Palestine (e.g. barriers to implementation of policies and programmes).
  - Examine the effectiveness of any existing legislation and other laws that affect the mental health of people in Palestine.
  - Review other countries' mental health legislation and relevant international standards in order to determine which specific components need to be integrated into national law.
- 5.9.3 Any legislation developed should be consistent with the *UN Principles for the Protection of the Rights of Persons with Mental Illness and the Improvement of Mental Health Care* (1991). Additionally, legislation should address civil, economic, social and cultural rights, and can incorporate promotion and prevention issues. It is essential that a wide variety of actors be included in the drafting process, to ensure that the legislation adequately reflects national priorities and requirements. Thus, those responsible for drafting legislation need to:
- Appoint a multi-sectoral drafting committee
  - Initiate a process of consultation with all relevant national and local level actors (e.g. through publication of legislation, soliciting of written responses, holding consultative meetings or public hearings).
- 5.9.4 Adoption of the legislation should be supported by rallying public support for mental health legislation through media campaigns, workshops and seminars that involve and support mental health advocacy groups and organisations.
- Consulting members of the executive branch of the government and legislature and different political parties and ministries. This could take the form of organising regular meetings and sending periodical documents to sensitise, inform and solicit opinion.
  - Providing stakeholders with a cost breakdown to demonstrate the feasibility of implementing the legislation.
- 5.9.5 The development of national mental health legislation is such an important aspect of development that it will need to be addressed as an initiative in its own right.

## 5.10 Access to Psychotropic Medication

5.10.1 The WHO Essential Drugs List currently includes those drugs necessary, at a minimum level, for the satisfactory management of mental and neurological disorders. Nevertheless, patients in poor or developing countries should not be deprived, on economic grounds only, of the benefits of advance of psychopharmacology. It is necessary to work towards making available, to all, the best drugs for the treatment of the condition.

## **5.11 Regulation and Accreditation of Mental Health Service Providers**

5.11.1 It is important that arrangements are sought for the regulation and accreditation of both governmental and non-governmental mental health service providers. Such arrangements should inform decisions about the allocation of international funds to organisations wishing to provide mental health care in Palestine. *A Code of Conduct for Psychosocial Interventions* has been developed involving a wide range of statutory and non-statutory agencies, government departments and international agencies. Arrangements for wide implementation and scrutiny of the implementation of this document will have to be identified.

5.11.2 Proper multi-agency codes of conduct for mental health care providers should be developed .

## **5.12 A Compendium of Mental Health Resources in Palestine**

5.12.1 A compendium should be developed detailing the range of services and resources available to support people with mental health problems in Palestine. The purpose of this would be to encourage co-ordination of agencies and to support primary and specialist services to meet the needs of patients. This compendium should describe the nature of the services on offer and how they may be accessed. Copies of this compendium should be disseminated widely particularly to primary care and to a wide range of both governmental and non-governmental organisations. The possibility of making such a compendium available on the internet should be considered. Clear arrangements should be made from the outset for the compendium to be further developed and updated on a regular basis.

## 6. THE FIVE YEAR PLAN

### 6.1 A Regional Mental Health Service System

6.1.1 This strategy is based upon the development of a comprehensive mental health service system based around a small number of distinct geographical regions. A map outlining the suggested configuration for these regions is as follows:



6.1.2 The purpose of this regionalised structure is to support the creation of a more locally accessible and comprehensive mental health service system.

6.1.3 It is proposed that four regional mental health service systems be established; three in the West Bank (North, Centre and West) and one in Gaza. Given the large dispersed population in the North, it is also recommended that mental health services in the North be arranged around three sub-localities of Jenin, Nablus and Tulkarem, each with its own community mental health centre, daycare and inpatient provision.

6.1.4 Each of the four regional mental health service systems (three in the West Bank and one in Gaza) should have its own management structure, led by a Regional Director of Mental Health Services. Each regional mental health service system should also have its own nominal budget based on the relative

needs of its population. It is therefore important that both hospital and community mental health systems are managed as one integrated service both at a national and regional level. It is proposed that regional budgets would be the responsibility of a Regional Director of Mental Health Services. The first step to achieving these regional budgets would be to sectorise existing financial and human resources in the Bethlehem psychiatric hospital corresponding to each regional area.

6.1.5 Each region should have community mental health services which will consist of:

- A community mental health team (with satellite centres)
- Acute inpatient and crisis service
- Day care service

The regions suggested for the West Bank cover large geographical areas. Community teams working in these areas will require access to facilities for clinical activities in areas remote from their main base. For example, in the North region those working in the community mental health services in Jenin, Tulkarem and Nablus should also be able to use local satellite facilities in Tubas, Qalqiliya and Salfit. In the Centre region, the community mental health service in Ramallah will also use satellite facilities in Jericho. In the South region the community mental health service in Hebron will need to use satellite facilities in Bethlehem. Satellite facilities outside of the main towns might simply comprise a room located in a primary health care centre which is available for community mental health staff to use for clinical and administrative activities on a sessional basis.

6.1.6 Staff in community mental health services should have the means to offer support to people either at home or in as local a setting as possible. Access to transport for staff is essential given the wide geographical areas that they must cover. For example, access to a car for each community mental health centre.

6.1.7 The core community mental health team, acute inpatient beds and day care should, if possible, be based together. The acute inpatient and crisis care component should be open 24 hours a day, seven days a week. The advantages of this configuration would be:

- to facilitate continuity of care by inpatient, daycare and community teams
- to enhance opportunity for day-to-day communication between all the teams which will enhance continuity of care for patients.
- to enable flexible use of specialist staff skills across service settings
- cost effectiveness – sharing of staff cover and facilities where necessary
- to enable staff to respond to crises 24 hours a day, 7 days a week

6.1.8 Ideally the mental health services should be located as part of a general hospital site. If this is not possible, some components could be located as part of a level 4 primary health care site. (In that case, only the (24 hours open) acute inpatient care would be located in general hospitals. The advantages of

locating the community mental health service with general health services would be:

- access to medical treatment and diagnostic facilities
- to reduce stigma
- to facilitate liaison psychiatry
- to facilitate access to educational resources for staff

6.1.9 The focal point and single point of access for each service system should be through the community mental health team.

6.1.10 These locally based services also need to address the essential elements of a psychosocial mental health rehabilitation model through partnerships with agencies that can support social reintegration, employment, housing and general welfare.

6.1.11 Rehabilitation and continuing care accommodation should be developed in each regional service system. (possibly to be developed and provided in conjunction with local NGOs).

## **6.2 Children, Older People and Refugees**

6.2.1 Almost half of the population of Palestine is under the age of 15. This has important implications for the development of mental health services. For example, severe disorders such as schizophrenia typically begin in late adolescence or early adulthood. It is also inevitable that the ongoing problems in Palestine will also have a detrimental effect on the mental health of young people. There is strong evidence that early detection and treatment of any mental illness will lead to better outcomes particularly in young people. It is also the case that late detection and treatment will lead to poor outcomes, particularly for those with severe mental illness.

6.2.2 It is important that regional mental health service systems are equipped to respond to the mental health needs of children and young people. There should not be any younger age limit to access these services. Regional mental health service systems should (a) develop key expertise in relation to child and adolescent mental health and (b) ensure that the service environment and services provided are appropriate for the care of children. Expertise in child and adolescent mental health should be developed through the relevant local agencies including NGOs, UN organisations, schools and other education agencies and primary health care services e.g. the Guidance and Training Centre for Children and Families. It may be desirable to consider some specialist residential services for children and/or adolescents (supported residential facilities available to provide support and care to children away from their usual environment in order to support caregivers and children). It will be vital that a broad range of agencies combine and pool their resources in order to provide as comprehensive a service as possible.

6.2.3 Relatively small numbers of older people (over the age of 60) are present in the population of Palestine. Older people in Palestine have endured many

years of trauma and upheaval with associated effects on their mental health and well being. It is also known that a significant proportion of any elderly population will develop dementia and other organic mental illness. The priority for meeting the needs of older people with mental health problems in Palestine should be to:

- support and improve the care provided to older people by their families
- incorporate better mental health assessment and management in general health services including primary care
- organise respite care to relieve family members who are the principle care givers.

However, given the small numbers of older people, it would be important to integrate care for older people with mental health problems within the community mental health services.

6.2.4 There should be no older age limit to access to the regional mental health service system. These services should also work with appropriate governmental and non-governmental agencies to provide as comprehensive and integrated services as possible to older people with mental health problems.

6.2.5 There are a range of NGOs, relief and UN organisations working with the refugee community in Palestine. It is important that efforts are made to ensure that the work of these organisations embraces the range of services described in this strategic plan. This may involve the education and training of staff to respond appropriately to mental health needs of refugees. In the longer term, it may also require the development of a national system to accredit these organisations as competent to support the mental health needs of refugee communities.

### **6.3 Functions and Responsibilities of Primary Care Services**

6.3.1 Successful delivery of this strategy is dependent on the parallel development of both primary and secondary mental health care services. The functions and responsibilities of primary care at all levels as part of the mental health service system in each region will need to include:

- Identification, assessment and treatment of common mental health problems.
- Identification and initial treatment planning for severe mental illness
- Provision of some psychosocial interventions
- Supervision and follow-up treatment of those with serious mental illness who do not need the full resources of the community mental health team
- Liaison with community mental health teams and NGOs using established referral protocols

### **6.4 Functions and Responsibilities of Mental Health Service Components**

6.4.1 The following table outlines the corresponding functions and responsibilities of the individual components of each regional mental health service.

<b>Service Component</b>	<b>Key functions and Responsibilities</b>
Community Mental Health Team (8.00am – 8.00pm)	<p>For those with severe and enduring mental illness who cannot be managed by primary care alone</p> <ul style="list-style-type: none"> <li>• Providing assessment, treatment and ongoing support using specialist interventions including individual and group therapy, psychological therapies, psychological support, rehabilitation and advocacy.</li> <li>• Prevention of relapse and admission to hospital</li> <li>• Education and training including support to primary health care professionals</li> <li>• Research</li> <li>• Responding to and resolving mental health crises in the community including out-of-hours with access to short-term observation facilities</li> <li>• Giving advice on the management of mental health problems to other professionals – in particular advice to primary care</li> <li>• Early intervention</li> <li>• To educate families and encourage self-help groups</li> <li>• Enabling appropriate referral</li> <li>• In-reach to inpatient care and liaison with general hospitals</li> </ul>
Acute Inpatient	<ul style="list-style-type: none"> <li>• Providing short-term humane treatment and care for patients in the most acute and vulnerable stages of their illness</li> <li>• Provide a safe and therapeutic setting for inpatients</li> </ul>
Day Care	<ul style="list-style-type: none"> <li>• Provide day care for both inpatients and patients from the community (those with severe and enduring mental illness)</li> <li>• Provide social, recreational and occupational therapies and activities</li> </ul>
Rehabilitation and Continuing Care Accommodation	<ul style="list-style-type: none"> <li>• Providing residential care for people with the most severe mental illness who require long term care and support</li> <li>• Provision of rehabilitation and resocialisation for those who have experienced long term institutionalization</li> <li>• Provided in partnerships with NGOs</li> </ul>
NGOs	<ul style="list-style-type: none"> <li>• Provision and development of specialist services</li> <li>• Distribution of medication</li> <li>• Provision of long-stay care</li> </ul>
Private Sector Services	<ul style="list-style-type: none"> <li>• Accept referrals to provide appropriate mental health services</li> <li>• Refer persons requiring other care to relevant government services</li> <li>• Supporting multi-agency training programmes</li> </ul>
Wider Community Resources	<ul style="list-style-type: none"> <li>• Links between the mental health service system and schools and other agencies working with young people</li> <li>• Development and promotion of various self-help approaches in the wider population</li> <li>• Acknowledged role for traditional healers and alternative therapists</li> <li>• Supporting and enhancing the essential role of families and friends in supporting the recovery of the individual. This may be through the development of family support groups.</li> <li>• Recognising and supporting the key role that women have in the family structure</li> <li>• Supporting the development of consumer led projects and activities including self-help groups</li> <li>• The development of social support and empowerment projects. These may include the establishment of local social firms / employment projects.</li> <li>• Opening up the facilities offered by regional community mental health services for use by a wider range of community groups and activities – as a means of destigmatising local services and enhancing collaboration</li> </ul>

6.4.2 It is important that local operational policies are established for the individual components of each regional mental health service system and that these should make full use of the best available evidence for service operation and intervention. Operational policies should include local clinical governance arrangements for regular review, evaluation and quality improvement of local services.

## 6.5 Projected Services Required by Region

6.5.1 There are currently significant inconsistencies in the distribution of mental health service resources across the West Bank and Gaza. Figures available estimating the number of registered patients demonstrate inconsistencies with twice as many patients per head of population in touch with services in Gaza compared to the West Bank. In the West Bank, 76% of existing staff resources are at Bethlehem Psychiatric Hospital. The reasons for these inconsistencies are historical.

6.5.2 The following table represents a crude apportionment of existing staffing and demonstrates how staffing could be reconfigured in a more equitable way. Numbers of acute inpatient beds and rehabilitation and continuing care beds have been estimated based on current occupancy at Bethlehem Psychiatric Hospital which may be reduced with strengthened community services. This configuration was suggested by the Steering Group Committee at a meeting in Geneva in September 2003. There are 320 beds in psychiatric hospitals and 14 in general hospitals. Of the 320 beds, only 56.25% are occupied. Therefore, only 180 patients on average are in hospital in any one time. Of these 180, approximately 100 are long stay. This leaves, on average 80 acute short-stay patients in hospital at any one time.

Region and Governorates	Population / Registered Patients (ref: Dr. EL Ashhab)	Existing Staffing and Services	Reconfigured Staffing, Acute and Rehab Beds (also see notes in section 6.5.3)	Core Team and Satellites
<b>North</b> <ul style="list-style-type: none"> <li>Jenin</li> <li>Tubas</li> </ul>	Total pop'n 231,000  6% Camps 56% Rural 38% Urban  Registered Patients = 4,409	1 psychiatrist 1 social worker (both based in Jenin)	17 staff  7 Acute Inpatient Beds  11 Rehab and Continuing Care Beds	Mental Health Services Centre based at: <b>Jenin</b>  <i>(funded by French Government)</i>
<ul style="list-style-type: none"> <li>Tulkarem</li> <li>Qalqiliya</li> </ul>	Total pop'n 198,000  8% Camps 40% Rural 52% Urban  Registered Patients = 4,112	So far identified: - 1 psychiatrist - 2 psychologists - 1 four bedded general psychiatric unit in Tulkarem. (Mental health team manage patients both in hospital and the community).  - 0.5 psychiatrist - 1 psychologist - 1 social worker based in Qalqilya	15 staff  6 Acute Inpatient Beds  9 Rehab and Continuing Care Beds	Mental Health Services based at: <b>Tulkarem</b>  <i>(funded by Italian Government)</i>

Region and Governorates	Population / Registered Patients (ref: Dr. EL Ashhab)	Existing Staffing and Services	Reconfigured Staffing, Acute and Rehab Beds (also see notes in section 6.5.3)	Core Team and Satellites
<ul style="list-style-type: none"> <li>Nablus</li> <li>Salfit</li> </ul>	<p>Total pop'n 298,000</p> <p>9% Camps 52% Rural 39% Urban</p> <p>Registered Patients = 6,419</p>	<p>So far identified:</p> <ul style="list-style-type: none"> <li>- 0.5 psychiatrist</li> <li>- 1 psychologist</li> <li>- 1 social worker based in Salfit</li> </ul> <ul style="list-style-type: none"> <li>- 2 psychiatrists</li> <li>- 2 psychologists</li> <li>- 1 social worker</li> <li>1 four bedded general psychiatric unit in Nablus. (Mental health team manage patients both in hospital and the community).</li> </ul>	<p>22 staff</p> <p>9 Acute Inpatient Beds</p> <p>14 Rehab and Continuing Care Beds</p>	<p>Mental Health Services based at: <b>Nablus</b></p> <p><i>(funded by French Government)</i></p>
<p><b>Centre</b></p> <ul style="list-style-type: none"> <li>Ramallah &amp; Al-Bireh</li> <li>Jerusalem District</li> <li>Jericho</li> <li>(excluding East Jerusalem – popn 355,000)</li> </ul>	<p>Total pop'n 351,000</p> <p>7% Camps 56% Rural 37% Urban</p> <p>Registered Patients = 2,438</p>	<p>CMHT comprising:</p> <ul style="list-style-type: none"> <li>0.5 psychiatrist</li> <li>1 psychologist</li> <li>2 social workers</li> <li>1 nurse based in Ramallah</li> <li>0.25 psychiatrist</li> <li>0.5 social worker based in East Jerusalem</li> <li>0.25 psychiatrist</li> <li>0.5 social worker &amp; Full-time outpatient clinic with 1 GP based in Jericho</li> </ul>	<p>26 staff</p> <p>11 Acute Inpatient Beds</p> <p>16 Rehab &amp; Continuing Care Beds</p>	<p>Mental Health Services based at: <b>Ramallah</b></p> <p><i>(capital costs funded by WHO)</i></p>
<p><b>South</b></p> <ul style="list-style-type: none"> <li>Hebron</li> <li>Bethlehem</li> </ul>	<p>Total pop'n 522,000</p> <p>4% Camps 37% Rural 59% Urban</p> <p>Registered Patients = 2,412</p>	<p>210 bedded hospital (70% occupancy) in Bethlehem (90 clinical staff + support staff)</p> <p>Child CMHT in Bethlehem (5 staff)</p> <p>Full-time outpatients in Hebron – 1 psychiatrist</p>	<p>40 staff</p> <p>16 Acute Inpatient Beds</p> <p>18 Rehab and Continuing Care Beds</p>	<p>Mental Health Services based at: <b>Hebron</b></p> <p><i>(capital costs funded by WHO)</i></p> <p>Existing outpatient clinic at Bethlehem Hospital should be upgraded and developed to become a community mental health centre for Bethlehem.</p>
<ul style="list-style-type: none"> <li>North Gaza</li> </ul>	<p>Total pop'n 250,483</p> <p>55% Camps 20% Rural 15% Urban</p>	<p>CMH center inside NGO clinic</p> <ul style="list-style-type: none"> <li>1 Physician</li> <li>2 Nurses</li> <li>1 Rehab. Worker</li> <li>1 Clerk</li> </ul> <p>acute cases referred to mental health hosp. in Gaza</p>	<p>12 staff.</p> <p>Acute cases referred to hospital.</p> <p>Satellite center in Beit Hanoun</p>	<p>Need for fund</p>

Region and Governorates	Population / Registered Patients (ref: Dr. EL Ashhab)	Existing Staffing and Services	Reconfigured Staffing, Acute and Rehab Beds (also see notes in section 6.5.3)	Core Team and Satellites
• Gaza	Total pop'n 469,122 40% Camps 60% Urban	I 1 CMH center 1 Physician 2 Nurses 1 Rehab. Worker 1 Clerk II CMH center for children 0.5 Physician 1 Rehab worker III Psychiatric Hospital, 24 hrs work, 7 days/week. 40 beds 42 staff	I CMH center for adults and children in Sourani clinic 16 staff including the existing. II 22 beds for acute cases, establishment of CMH based work at hospital with day care center with the use of existing staff.	(capital costs for centre in Gaza City funded by WHO)  Inpatient beds based at: <b>Gaza City</b>
• Der Al-Balah	Total pop'n 192,655 68% Camps 24% Urban 8% rural	CMH center 0.5 Physician 1 Nurse acute case referred to hospital	10 staff acute cases referred to Gaza MH hospital	
• Khanyounis	Total pop'n 258,458 19% Camps 61% Urban 20% rural	CMH center (provide MH services to Khanyounis & Rafah). 1 Physician 3 Nurses 1 Social worker 1 Rehab. Worker 2 Clerks	I- CMH 14 staff including the existing CMH center II- Inpatient services 8 beds in Khanyounis gov. hospital 19 staff	Fund needed for CMH center
• Rafah	Total pop'n 158,592 60% Camps 32% Urban 8% rural	NA	CMH center 10 staff ( the staff will be allocated between Khanyounis and Rafah)	(capital costs for community mental health centre in Rafah funded by Italian Government)

The French Government are also funding a children's community mental health centre in Hebron.

6.5.3 The table showing relocation of resources assumes no transfer of staff or funds from the West Bank to Gaza.

The numbers of rehabilitation and continuing care beds have been reduced and separate consideration should be given in the implementation plan as to where all patients have come from and possibilities for relocation. It is, however, assumed that NGOs could raise funds and provide accommodation and daycare with support for at least a third of the present inpatients and future long-stay clients. If this is not possible, and for the short-term rehabilitation and continuing care beds may need to remain at Bethlehem and staffing reconsidered.

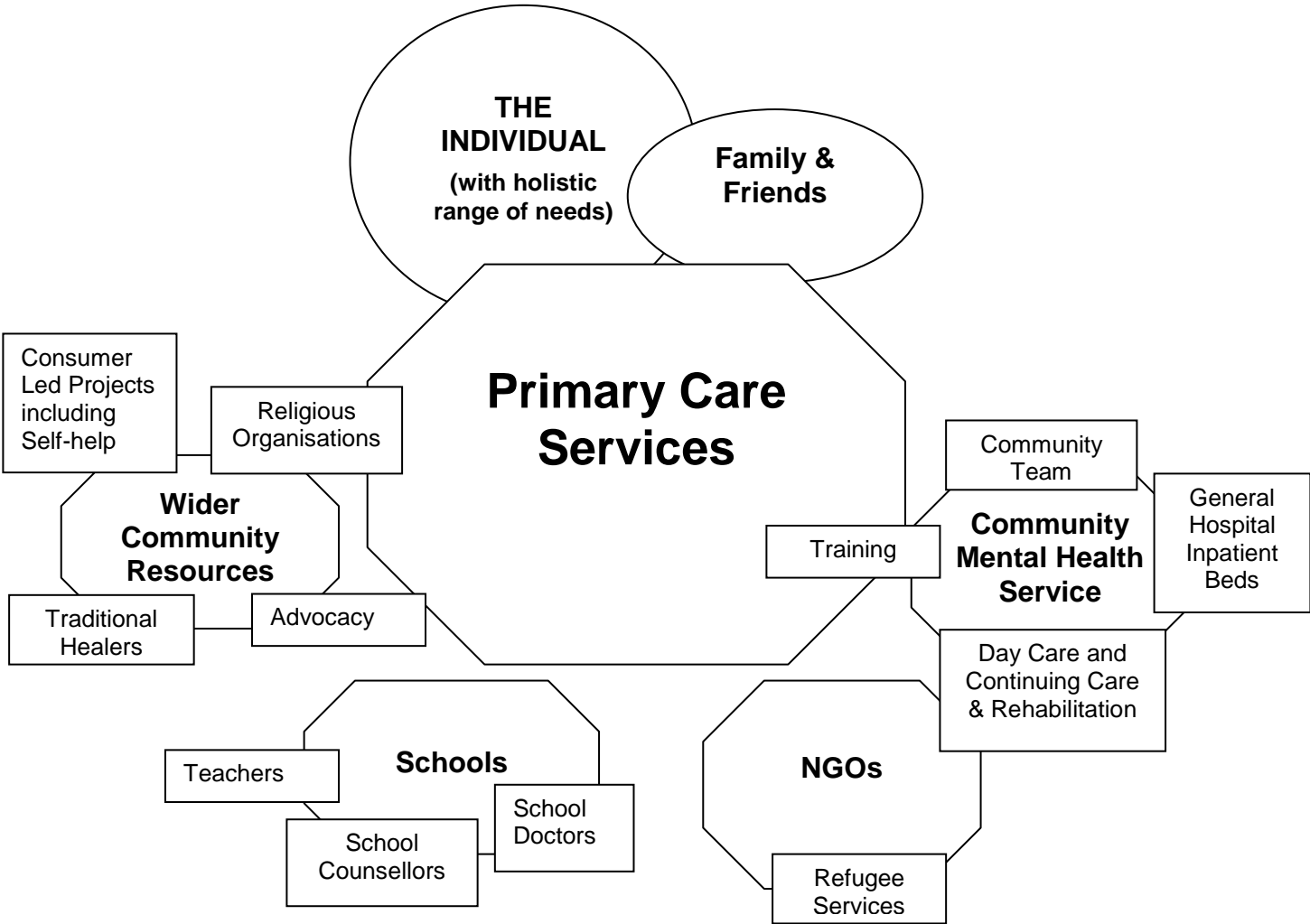
There is a, however, a real opportunity for NGOs to raise additional resources for this neglected long stay client group in Bethlehem. If services for one third

of patients can be reprovided for in this way, the potential effect of this would be to increase the resources available to acute inpatient care and community mental health teams.

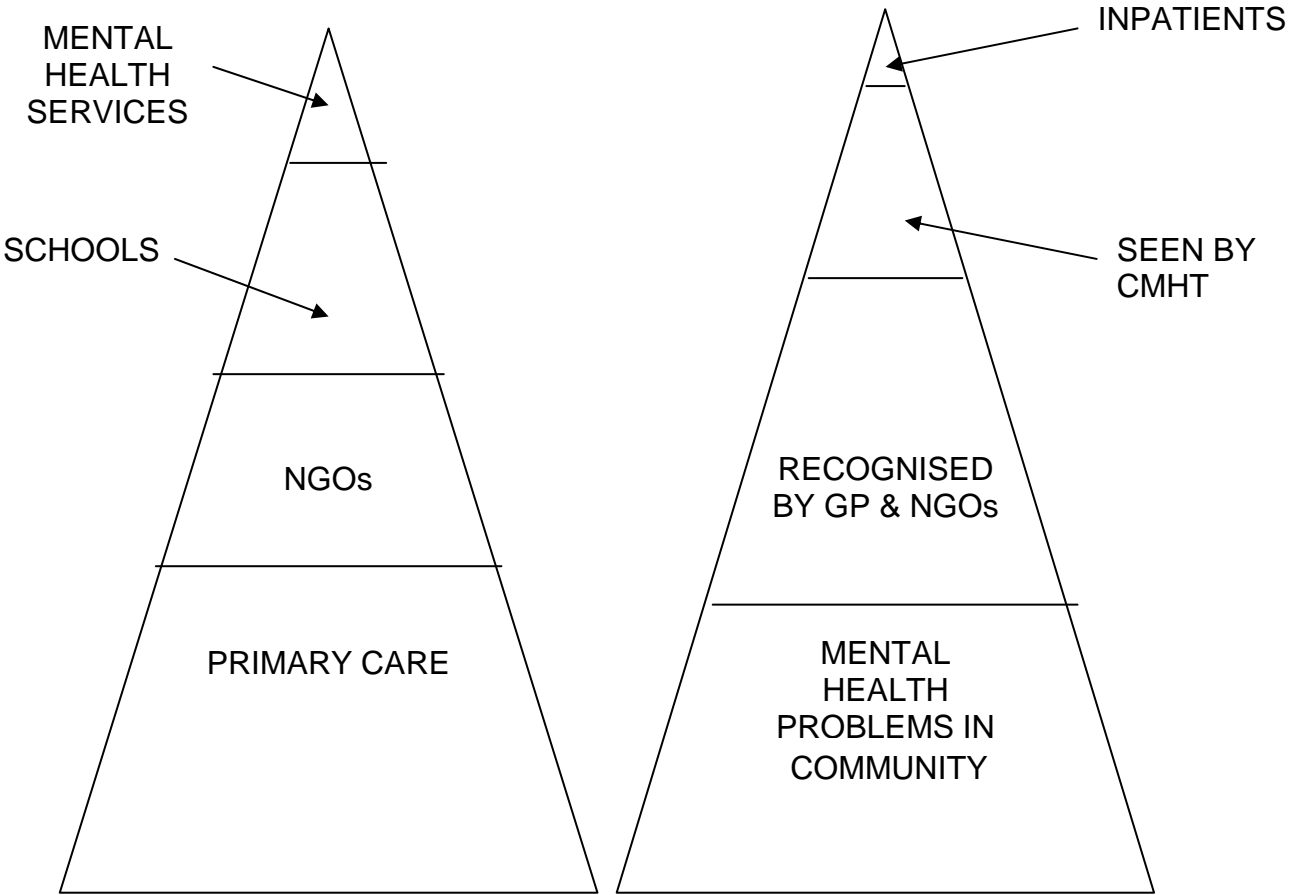
6.5.4 The Steering Group has recommended that the hospital beds and staffing would be reconfigured as follows with some additional posts:

- Community Mental Health Services Centres with acute / crisis beds will be established on two sites with associated staff providing support to both inpatient and community services in the following locations:
  - 22 beds in Gaza City (in General Hospital in West of City)
  - 8 beds in Khan Younis
- It is expected that support will be available from general hospital services to support staff managing psychiatric acute / crisis beds on general hospital sites.
- Community mental health services are already established in Jabalya, Gaza City (East Gaza and Hospital Outpatients), Deir Al-Balah and Khan Younis. These should be developed into community mental health teams within their own centres. In addition, the Italian Government are funding the capital costs for a new centre in Rafah.
- In the longer term it may be possible to locate the beds and community mental health team bases together on general hospital sites and include day hospital provision.
- It was agreed that in the short term, the community mental health team base in East Gaza needs to be upgraded.
- The Palestinian Red Crescent Society have offered to make available their premises for teams in Gaza City and Khan Younis. There is no base at the moment in Rafah although the Palestinian Red Crescent Society are planning to locate mental health bases in Jabalya and Rafah and have offered to share premises.
- Also, the Gaza Community Mental Health Programme have offered the use of its premises for relocated staff.

6.6 The following diagram summarises the various components of a whole system of mental health care for individuals in Palestine based upon this strategy:



**6.7** The following diagram describes the distribution of resources in Palestine against the needs of the population. As can be seen, mental health services across the world only treat a minority of people identified as having mental health problems.



Illustrative Distribution of Staff Resources in Palestine

Distribution of Mental Health Needs

- 6.8. Given the scale of the changes that are proposed in this plan, it is essential that an effective management structure is established within the Ministry of Health and within the regions. It is therefore recommended that the existing arrangements within the Ministry be changed to establish a mental health directorate incorporating both community and hospital responsibilities. This directorate would then oversee and guide the development of services, manage the overall budget, provide effective leadership, and ensure the coordination between all relevant agencies. The importance of developing the appropriate partnerships between the Ministry of Health and other sectors is also crucial to the success of the implementation of this plan. It is therefore also essential this new directorate be given the authority to establish effective partnership working with other government departments.

## **7. IMPLEMENTATION**

For any strategic service strategy to be of use to improve the mental health of people a robust, affordable implementation plan has to be produced. This should be the responsibility of the national Steering Committee. To achieve this, its membership should be strengthened. The intention is to produce this once there is top level commitment to the plan and widespread stakeholder agreement. It is proposed that this should be constructed using the headings that are listed in appendix 4.

# APPENDICES

## Appendix 1

### Steering Committee Members

#### Ministry of Health Representatives

- Abdul Jabber Al Tibi, Director General PHC, Gaza (chairman)
- Asa'ad Ramlawi, Deputy Director PHC, West Bank
- Ayesh Samour, Director of Mental Health, Gaza
- Bassam Al-Ashhab, Director of Mental Health, West Bank
- Reyad Al- Aqra' Director of Gaza MH hospital
- Issam Banoura, Director of Beit-Lehem MH hospital
- Walid Shaqura, Director of ICD- MoH

#### NGO Representatives

- Fathi FleiFeil, Palestinian Red Crescent Society
- Eyad El Sarraj, Chairman+, Gaza Community Mental Health Programme
- Viveca Hazboun, Guidance and Training Centre, Bethlehem

With the technical assistance of WHO representatives, Italian government representative and French Government representative.

## Appendix 2 –Draft Atlas of Government Run Mental Health Services in Palestine

The following list and table outlines existing mental health service provision by geographical region. The contents of these charts have been compiled from a variety of written and verbal sources and are likely to be incomplete.

### *Gaza North (Jabalya)*

- *Government.* Community Mental Health Service (1 doctor, 1 social worker, 2 nurses, 1 EEG technician, 6 days per week, 6.5 hours per day, 1 room and hall + EEG room, 500 clients, 15 new cases per month, 25 home visits per month, 4 visits to social associations per month, 4 counselling meetings per month, 100 EEG records per month)
- *Gaza Community Mental Health Programme.* 3 psychologists, 1 social worker, 2 nurses, 2 doctors, 1 occupational therapist

### *Gaza East (Gaza City)*

- *Government.* Community Mental Health Service (1 doctor, 1 rehab trainer, 2 nurses, 6 days per week, 6.5 hours per day, 3 rooms inside PHC building, 600 clients visits per month, 20 new cases per month, 50 home visits per month, 6 visits to social associations, 4 counselling meetings per month)
- *Government.* Child Mental Health Clinic (1 doctor, 1 rehab trainer, 2 nurses, one room in PHC centre (not equipped), 80 new clients per month, 15 new cases per month, 5 home visits per month, 4 visits to schools per month, children gardens)
- *Government.* Gaza Nasr Hospital in Gaza City (approximately 30 beds, 8 doctors, 4 psychologists, 1 social worker, 22 nurses, average length of stay <1 month, focus on treatment of acute cases)
- *Gaza Community Mental Health Programme.* 1 psychiatrist, 4 psychologist, 1 assistant pharmacist, 1 EEG technician, 2 physiotherapist, 1 social worker, 2 nurses, 2 doctors, 2 telephone counsellors.

### *Middle and South Gaza*

- *Government run community mental health service.*
- *Gaza Community Mental Health Programme.* 3 Psychologist, 1 psychiatrist, 1 doctor, 3 social worker, 4 nurses.

All Gaza Community Mental Health Programme clinics are out- patient, and they provide service for about 1200 new cases every year.



### Mental Health Resources in the West Bank - Sept 2003

	RAMALLAH	JERUSALEM	BETHLEHEM	JERICO	HEBRON	NABLUS	TOULKARIM	SALFIT	KALKILIA	JENIN	Total
Pop 2002	200000	380000	162000	43000	482000	305000	151000	53000	82000	280000	2138000
Villages	74	46	67	18	150	62	42	23	28	119	629
GP Clinics	38	2	15	9	38	34	24	15	12	35	222
GPs MOH	40	9	17	10	40	35	26	12	12	37	238
Nurses	73	20	34	18	95	74	63	26	27	73	503
GPs (District)	225	259	118	Jer	312	384	164	N	40	158	1660
Psychiatrists	1/2	1/4	-	1/4	1	2	1	1/2	1/2	1	7
Psychologists	1	-	-	-	1	2	2	1	1	-	8
SW	1	1/2	-	1/2	1	1	-	1	1	1	7
No. Pt. Registered	2699	69	-	187	3147	4236	2699	486	1167	3447	18137
New Pt. 1.1 - 30.6.03	33	7	-	8	37	82	44	54	15	141	421
Attendance 1.1 - 30.6.03	2191	57	-	190	2412	5647	2767	772	1345	4409	19790
No. of schools	138	139	83	13	248	177	97	46	59	184	1184
School Counselors	44	28	42	11	92	59	30	18	21	59	404
MOSA											
Ex. Detainee Min.	2	-	2	-	2	2	2	-	-	2	12
UNRWA Clinic	?	11	?	?	7	12	?	?	?	?	30
MO		14	?	?	7	12	?	?	?	?	33
Psych + SW		9	?	?	10	9					28
PRCS	10	-	4	1	8	5	2	-	1	7	38
NGO xx	7	6	7	4	8	10	-	5	2	7	56
Private											
Psychiatrists	2	2	1	-	2	3	1	-	-	1	12
Psychologists	3	3	1	-	-	-	-	-	-	-	7
Neurologists	2	1	1	-	1	2	1	-	-	2	10
Neurosurgers	3	-	-	-	4	2	-	-	-	-	9
<b>BGH</b>	Psychi 2	Trainee 8	SW 8	Psycho 2	Nurses 77	Inpt 200 ± 20	outpt 200 monthly	Add. 500 yearly			

## **Appendix 3 - Feedback from Workshop Participants at Initial Conferences in Ramallah and Gaza City on Values and Principles that a Mental Health Policy Should be Based Upon**

### **Gaza Group 1**

- 1) Education, for everyone everywhere, surrounding mental health issues.
- 2) Improve cultural aspects of MH.
- 3) Increased emphasis on human rights and privacy
- 4) Mental health acts and laws that are active in the field.
- 5) High level of integration between all care-givers in the psychiatric/psychological fields.
- 6) Acceptance of all people with mental illness.

### **Gaza Group 2**

- 1) Community diagnosis
  - specific
  - general
  - prevalence of different mental disorders
- 2) National guidelines concerning mental health disorders (including clear terminology)
- 3) Effective integration of MH in PHC system
- 4) Emphasis on the family in coping with mental illness and in participating in case management.
- 5) Reinforce cooperation and coordination between different national organizations and community associations

### **Gaza Group 3**

- 1) Community participation
- 2) Social equity
- 3) Collaboration
- 4) Human rights
- 5) Combat stigma
- 6) Accessibility for all
- 7) Multi-professional training / community –based approach
- 8) Prevention and promotion
- 9) Acceptability
- 10) Clear idea of who is who
- 11) Coping with traumatic experience

### **Gaza Group 4**

- 1) Patient and family participation in treatment.
- 2) Dignity of patients
- 3) Respect of the culture of the population concerned.
- 4) Privacy
- 5) Good relationship between the patient and the MH professional(s)
- 6) Flexibility

- 7) Capable and efficient professionals
- 8) Advocacy
- 9) Honesty
- 10) Economic status
- 11)Empathy.

### **Gaza Group 5**

#### Values

- 1) Confidentiality
- 2) Respect
- 3) Understanding
- 4) Patience
- 5) Honesty
- 6) Cooperation
- 7) Justice
- 8) Devotion and dedication

#### Principles

- 1) Adequate and qualified MH workers
- 2) Protection of human rights
- 3) Well-established MH Centers
- 4) Safety for patients and staff
- 5) Services free of charge
- 6) Well-equipped facilities
- 7) Multidisciplinary approach

#### **Appendix 4 – Feedback from Final Conference (January 2004)**

The participants at the conferences agreed with the overall aims of the draft plan. Although specific comments on the plan were made and have been incorporated into the final version, the following key principles were unanimously agreed:

- The development of community mental health centres as outlined in the plan
- The development of acute rehabilitation and continuing care beds on a regional basis
- Better integration between hospital and community services
- Better co-ordination between Government-run services, NGOs and other sectors
- Continuing education and training for professionals
- Existing resources to be protected during a period of change

There were detailed discussions about the management arrangements necessary to implement this plan. It was agreed that it is of fundamental importance to bring together management of both hospital and community services under a single directorate within the Ministry of Health.

It was also agreed that the Steering Committee should be strengthened to include the Hospital Directors and should be mandated to be responsible for the implementation of this plan.

## **Appendix 5 - Implementation**

### 1.1 Consultation, Dissemination and Promoting Local Ownership

#### 1.1.1 Dissemination Process

#### 1.1.2 Promoting Stakeholder Ownership

#### 1.1.3 Political Support and Agreement (including Inter-Government Collaboration)

### 1.2 Management Structure and Management of Change

#### 1.2.1 Capacity for Change Management

#### 1.2.2 National and Regional Management Structure

#### 1.2.3 Ministry of Health Role and Responsibilities

#### 1.2.4 Management of Change

#### 1.2.5 Community Mental Health Services and deinstitutionalization of Bethlehem and Gaza Hospitals

#### 1.2.6 Human Resources Policy

This will include:

- Establishment of a community mental health development programme within the hospitals.
- A programme of rehabilitation of long-stay patients
- Staff development

### 1.3 New Investment

#### 1.3.1 Re-engineering

#### 1.3.2 New Capital Investment

#### 1.3.3 New Revenue Investment

#### 1.3.4 New Resource Commitment from Key NGOs

### 1.4 Training, Skills and Professional Development

### 1.5 Time-scales and Sustainability

### 1.6 Training for Practitioners

It is essential that a training programme is developed that provides practitioners from primary and secondary care services in Palestine with the opportunity to gain first hand experience of the day-to-day operation of community mental health services. This could be achieved through the temporary placement of teams of practitioners with existing community services abroad. It is also essential that the educational value of such placements is enhanced through a structured programme of teaching and peer support. Wider value of this training could be established through model which aims to cascade knowledge and skills

to a wider group of practitioners in Palestine. Planning and definition of the focus of any training programme should be informed by an analysis of training needs of practitioners to implement this plan and lessons learned from the pilot community mental health service centres in Palestine.

#### 1.7 Evaluation of Service Development

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