Strengthening mental health care in the health system in the occupied Palestinian territory

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The authors describe a programme in a rural area of the West Bank (occupied Palestinian territory) developed in 2005 by Médicos del Mundo Spain, in coordination with the World Health Organization and the Ministry of Health. The main features include: 1) working with the Palestinian Authority in order to reinforce the existing public health system, rather than developing a parallel one; 2) providing a building, and other long lasting material resources, to the Community Mental Health Centre and the public health system; 3) supporting the incorporation of human resources in mental health teams in the public system; and 4) providing capacity building for mental health and primary care teams, through intensive on the job training, and providing didactic material for mental health and primary care professionals. The integration of mental health care into primary health care structures in conflict settings provides the opportunity of addressing severe and common disorders in their current situation.

Keywords: community mental health services, integration of mental health into primary care, occupied palestinian territory, political violence, public health

Context

Approximately 3.8 million people living in the occupied Palestinian territory (oPt, West Bank (WB), Gaza, and East Jerusalem) exist in chronic conflict, living under Israeli military occupation since 1967. Gaza is next to the Mediterranean Sea, with about 1.5 million people living within 360 sq km, divided into five governorates. The West Bank comprises an area of 5,800 sq km, with 11 governorates and 2.3 million people. In 2002, Israel started the construction of a separation wall between the West Baml and Jerusalem. Around 225,000 Palestinians live in East Jerusalem (Palestinian Central Bureau of Statistics (PCBS), 2007). Fifteen percent of Palestinians live in 27 refugee camps, where poverty and unemployment rates are high (United Nations Relief and Works Agency, 2011). These camps were supposed to provide temporary shelter for the displaced from the Arab/Israeli war in 1948, however, during the occupation in 1967, the numbers grew. Around 500,000 Israelis live in settlements and outposts in the West Bank, and Jerusalem (Office for the Coordination of Humanitarian Affairs (OCHA), 2011). This is illegal under international law, and the camps are often located in strategic areas with water resources and agricultural land (Palestinian monitor factsheet, 2010). Since 2006, Internal Palestinian political division led to one party ruling Gaza, and another party the West Bank. Israel controls the airspace, territorial waters, natural resources, movement of people and macro-economic instruments

that enable economic autonomy (Mushasha & Dear, 2010). In 2007, in Gaza, Israel began a strong blockade that left it isolated, reducing the supply of basic goods (such as food, money, fuel, glass, and medication) and restricting the movement of people, in and out of the area. In more than 60% of the West Bank territory, Israel retains control over security, planning and zoning. It is estimated there 22% of the population faces food insecurity in the West Bank (World Food Programme, 2010).

Mental health problems should be framed within an historic context covering the location where the person lives (Martín-Baró, 1990). The political, cultural and social dimensions should also be taken into account when assessing any psychological dysfunction caused by exposure to traumatic events (Blanco, Diaz & del Soto, 2006). Check points, construction of the wall, the siege of the Gaza Strip, fragmentation of territory, and the illegal annexation of east Jerusalem by Israel has all undermined the Palestinian social fabric, and has had negative consequences on the psychological wellbeing of the population. This ongoing structural violence, along with home demolition, settlements, military incursions, and the Palestinian political polarisation, has led to collective distress. Most Palestinians have experienced physical and psychological violence, and have had their human rights undermined; deprived of freedom of movement, existing under curfews, being shot or bombed. Giacaman et al. (2007) found that collective exposure to trauma and violence was a strong predictor of a depressive-like state. Social suffering affects mental and somatic health (Giacaman et al., 2010; Martín-Baró, 1990). Mental health cannot be understood using a pure medical perspective with only medical indicators. During conflicts, a framework that includes a human rights perspective and an orientation to social justice is needed (Moran et al., 2011). Worldwide around 2–3% of the population have severe and disabling mental health disorders, which are expected to rise to 3–4% after severe trauma or loss (World Health Organization (WHO), 2005). Another important feature to consider is that 75% of the population in the occupied Palestinian territory is less than 30 years old, and only 3% is more than 65 years old. Therefore, it can be assumed that there will be a high presentation of mental illnesses that are typically highly prevalent among younger people, such a first episode psychosis (WHO, 2006). In the oPt, children and adolescents have lived all of their lives in conflict, and are chronically exposed to traumatic events and violence that affect their mental health status. The severity of the traumatic situation, the coping strategies of the child and the ways mothers respond to life threatening situations were found to be the main determinants for the mental health status of the children (Qouta, Punamaki & El-Sarraj, 2003).

Exploratory mission of Médicos del Mundo

The Spanish section of the nongovernmental organisation (NGO) Médicos del Mundo (MdM) launched its first mental health programmes during the Bosnian war in 1994 (Díaz del Peral et al., 2002; Fernández-Liria, & González-Aguado, 1995). From this first mental health project the main components have remained the same: a community oriented public health approach, with strong psychosocial elements, to target people with severe mental health disorders and their families, to engage health workers, and to strengthen the public health system to work towards sustainability.

Two exploratory missions to the oPt, in 2004 and 2005, found inequitable distribution of health facilities between and within the West Bank and Gaza Strip (Mataria et al., 2009), (Table 1). A Steering Committee for Mental Health, consisting of the Ministry of Health (MoH), NGOs, United Nations agencies and international donors, developed a plan for the organisation of mental health care services in the occupied Palestinian territory (Strategy Operational Plan (SOP), 2004.)

Table 1. Mental health system in the occupied Palestinian territories in 2004 and 2011

- **Policy, plans and programmes:**

2004 – A SOP was officially adopted in 2004 along with a five year implementation plan.

2011 – The SOP 2011–2013 is approved.

- **Legislation:**

2004 – There is no specific mental health legislation, but the Palestinian National Health Plan of 1994 considered mental health as a priority area.

2011 – Creation of a National Technical Committee to develop a code of ethics and to finalise a law on mental health started in 2001.

- **Organisation**:

2004 – Two departments: CMH that falls under the authority of PHC, and the Psychiatric hospital under the authority of Hospital administration.

2011 – In the WB, a Mental Health Unit that falls under the authority of PHC. In Gaza a Mental Health Directorate independent of PHC authority, and at the same level.

- **Outpatient clinics and CMHC:**

2004 – 42 public and private. Nine in the WB and four in Gaza are from MoH, 37% of users are estimated to be female and 15% to be children and adolescents.

2011 – In Gaza, six CMHC and one for children. In the WB there are six CMHC and one for children.

- **Mental hospitals:**

2004 – Two public, one in Gaza and one in the WB.

2011 – Two public, one in Gaza and one in the WB that are being improved in terms of human rights and recovery promotion.

- **PHCC from MoH:**

2004 – 44 in Gaza and 329 in the WB.

2011 – 110 in Gaza and 370 in the WB.

- **Advocacy:**

2004 – A nucleus of family associations.

2011 – Family associations has been established and a representative is involved in trainings, in the groups and committed to develop the mental health system.

- **Human resources:**

2004 – Working in public MH, NGO, private sector in the WB and Gaza:
32 psychiatrists, 12 medical doctors, 125 nurses, 36 psychologists, 40 social workers, 8 occupational therapists and 15 other health workers.

Table 1. (Continued)

2011 – Working in MoH in Gaza: 18 psychiatrists, 50 nurses, 30 psychologists, 17 social workers, and 2 occupational therapists. In the WB: in Gaza: 17 psychiatrists, 91 nurses, 15 psychologists, 22 social workers, and 5 occupational therapists.

- **Trainings:**

2004 – No specific trainings in mental health care.

2011 – Specific training in mental health care and development of postgraduate mental health programmes in different universities.

- **Monitoring and research:**

2004 – Basic system is in place.

2011 – An information system is being developed.

- **Psychotropic medicines:**

2004 – Essential drugs are available, but can be only be provided at the MH outpatients clinics.

2011 – There are pilots projects in some PHCC for GPs to detect common MH disorders, and to prescribe drugs.

- **Mental health financing and budget:**

2004 – 2,474,435.38 USD spend on MH services. It is 2.5% of health expenditures, from which 73% of it is used in the Psychiatric hospitals.

2011 – Approximately 3,400,000.00 Euros for MH services.

Sources: WHO-AIMS (WHO, 2009) Report 2005, Steering Committee on Mental Health (SOP) 2005, 2011–2013).

MdM agreed with MoH and WHO to begin work in one of the priority areas, Salfeet, which is one of the 11 governorates in the West Bank (Table 2), and signed an agreement with the MoH for a pilot project to upgrade the skills of the mental health (MH) professionals, health staff and to improve infrastructure. In line with the key mental health needs of the Palestinans (see Table 3), the programme aimed to: 1) transform the existing outpatient clinic into a Community Mental Health Centre (CMHC); 2) recruit human resources, initially by MdM, that could be transferred to MoH after a given period of time; 3) provide capacity building, through training, for staff of Primary Health Care Centres (PHCCs) and in-service training for the Mental Health Team (MHT). The latter implied working on daily basis in the CMHC with the MHT to improve clinical and organisational skills that could lead to a community based model for developing new services, such as rehabilitation and community awareness, and implementing working procedures in collaboration.

Mental health resources in the implementation area

Salfeet Governorate is an area full of internal blockades created by different Israeli checkpoints, roadblocks and checkpoints. It has 16 settlements, and more than 10 settlement outposts. The Palestinian population is almost twice as large as the Israeli settler population (62,125 vs. 35,000). Construction of the wall is ongoing, and according to the Palestinian Ministry, if completed would take approximately 45.3% of the area of Salfeet. This area is mostly rural, and exposed to land confiscation and violence arising from the occupation and internal

Table 2. Mental health system components addressed by the MdM intervention project

- **Policy, plans and programmes:**

Participating in the thematic group led by the Mental Health Unit to review the SOP 2004, from a technical aspect, in order to develop the next one.

- **Outpatient clinics and CMHC:**

Under consensus and agreement with the MoH, to reinforce MH care of PHC and MH structures in Salfeet. Under the frameworks of: SOP 2004, Inter-Agency Standing Committee (IASC) 2007 and WHO guidelines.

- **PHCC from MoH:**

The programme works towards integration of MH in primary health care. The attitude towards MH, and training needs of PHC staff was assessed and training given. Communication of MHT with PHC doctors and nurses was promoted.

- **Advocacy:**

A photo exhibition of mental health in the occupied Palestinian territories is being exhibited in different cities of Spain since 2009, showing the burden that people with severe MH disorders have to face, and also how political violence affects the human rights of Palestinians. Also advocacy was done to show the need for a psychiatrist to be available for more than one day a week, and on regular basis.

- **Human resources:**

A psychologist, an occupational therapist and a social worker were contracted to be part of the MHT.

- **Training:**

Trainings were provided for PHC staff, MHT of Salfeet, and also extended to MH professionals in the WB. In service training for the MHT was done, and there were also trainers for PHC trainings.

- **Monitoring and research:**

Register of information at the CMHC was improved.

- **Psychotropic medicines:**

Only once were some psychotropic drugs made available, as they usually run out of them for weeks, so relapses can be expected.

Table 3. Key points of mental health needs in the occupied Palestinian territories

- To increase quality and access to treatment, to decrease stigma and involve the community in the recovery process of people who have severe mental health disorders.
- To prevent, detect and treat common mental health disorders.
- A public health approach, based on the frameworks of social justice, quality of life, human rights and human security.
- A social and political response to the consequences of the conflict in the low quality of life and wellbeing of the general population.

conflict. With regard to mental health care services, in 2006 Salfeet PHC Directorate had one full-time social worker, one part-time psychologist, and one psychiatrist visiting once per week. They shared one room, which made it difficult for some patients to talk about sensitive issues as all professional were there at the same time, and to define roles for the professionals.

Since the second Palestinian uprising against the Israeli occupation in late 2000 (the 'second Intifada'), curfews, army check points, road barriers, detentions, and the separation wall caused mobility problems, and many cases were treated with medication only, or remained untreated. The health care staff in the centre were used to a medical psychiatric approach, based on the prescription of drugs with limited psychosocial intervention. MHT at the PHCCs level received patients without an appointment system, and general practitioners and nurses rarely referred cases to the MHT. Despite this, Palestinian society has many protective factors that help maintain good mental health, such as the support and importance of extended family, a deep national feeling, and high literacy rates.

Why work with public institutions instead of local NGOs?

Armed conflict has long term psychological and psychosocial impacts that affect both individuals and community bonds (Martín-Baró, 1990). On the other hand, resilience and community capacity for overcoming negative impacts also play important roles. The involvement of communities and local authorities is important for successful multi-sectorial coordinated actions and sustainability in emergency settings (IASC, 2007). Policy makers can strengthen the services, as well as improve the legislation to ensure the human rights of people with mental disorders. Communities can help in the recovery process, and be a source of support for mentally ill people and also for people who are under duress, but whose reactions are adaptive to the circumstances they face. The skills of the Palestinians professionals will remain, even if ministries face changes and they are dependent on external funding.

Mental health care programmes, provided by NGOs from developed countries in conflict or post conflict settings, often have a strong emergency perspective. Too often, the interventions that were started have to stop, once the immediate emergency is over. Moreover, such programmes can have the tendency to focus on mental health problems that have a direct relationship with the emergency, and may overlook people with severe mental disorders. Emergency programmes tend to work in relative isolation to the existing public system, and sometimes compete with it for scarce human resources. While short term mental health support is important, especially for vulnerable groups, the authors believe that the bulk of resources should be used to (re) construct community based mental health services. It is also important to lobby governments and funders to do the same, to ensure enduring access to care for people with pre-existing mental health conditions, as well as those who develop mental health problems as a result of an emergency (WHO, 2010).

The approach of MdM has been to create a strong partnership with the MoH, in order to improve the public health care service provision. Working with public institutions also allows continuity to the service users. Strengthening the general health care system will benefit those whose mental health condition is directly related to the conflict, as well as those who have a severe mental

disorder that is not directly related to it. MdM works to upgrade public health care services through empowering local professionals, enhancing local capacities, and community interventions that help restore the resilience mechanisms of individuals and the community. Additionally, in this particular project, working to reinforce the infrastructure, as the primary health care centres are often the first point of help for people with mental health and psychosocial problems.

Implementation of the programme

The programme strategy included: developing a CMHC; improving the access and quality of the CMHC in Salfeet; having individual, family, and community interventions; raising awareness; and being culturally appropriate. These goals are necessary in order to meet the challenge of preventing and addressing MH needs in a population suffering from severe and common mental disorders, as well as the psychosocial problems that arise from conflict. This model was designed to respond to the current situation, and also to prepare the PHCC for MH problems that could arise due to a sudden escalation of tension (Figure 1).

The main components presented in the project, that were taken into account from the components developed in the SOP (above), are listed below.

1. At the CMHC level:
   Provide infrastructures needed to develop a CMHC; provide technical support at the clinical and organisational level; train the staff; and increase human resources.

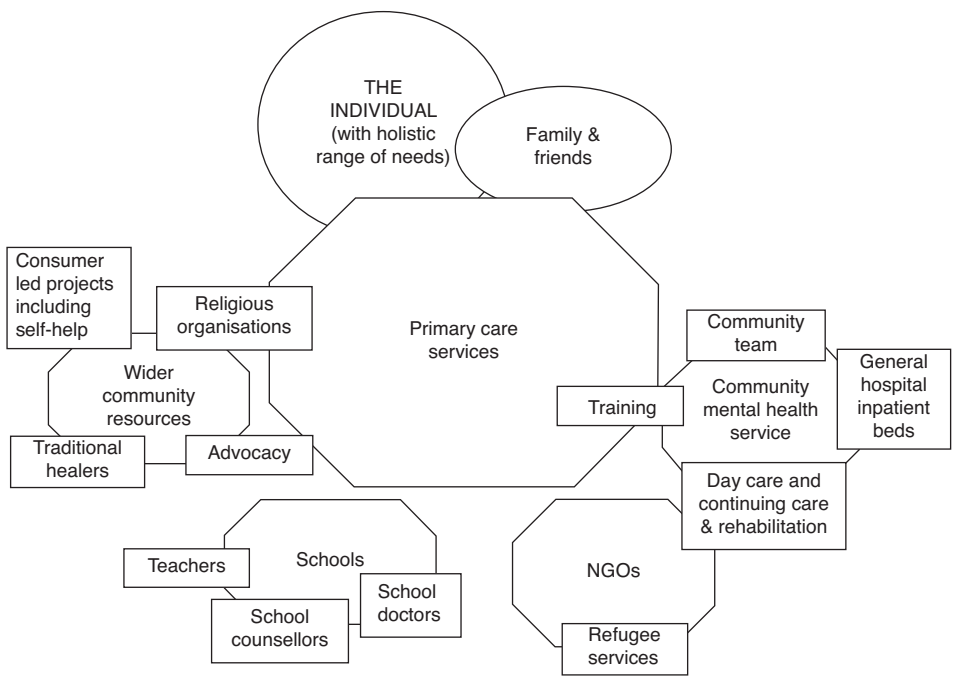

Figure 1: Components of a whole system of mental health care for individuals in the occupied Palestinian territories, based on the strategy of the SOP (Steering Committee on Mental Health, 2004).

2. At the PHC staff level:
   Work on the awareness of health staff; train the PHC staff to increase their capacity to detect, help, and refer people with mental problems; and to make materials available to them.
3. At the community level:
   Increase awareness in the community of mental health issues, media, and policy makers on MH; strengthen the partnership with other NGOs and UN organisations working in the field; build a holistic approach involving local organisations and institutions; link activities with schools; and provide support for families and caregivers.

Methodology

The programme was a participative effort involving members of the MHT, the director of the PHCC in the district, and the staff of the PHCC. The MHT underwent in-service training with an expatriate psychologist, who accompanied them on home visits, trained with local and international trainers, participated in awareness programmes, and aided in the translation and creation of materials in Arabic. An expatriate psychologist and a translator worked with the team on daily basis. The role of the expatriate was to follow up on the skills and knowledge given at the trainings, to provide technical support, and to facilitate the development of the service towards a community based care model.

This was done in two phases. The main difference between the phases was a greater emphasis on crisis intervention during the second phase due to the emergency situation in Gaza at that time.

First phase

The first phase started at the end of 2006, and lasted till September 2008. During this phase there was attention focussed on the technical and organisational aspects, and training of mental health professionals (both through formal trainings, as well as through informal 'on the job training'). The construction of a building for the Community Mental Health Centre was begun in this phase. In the meantime, a mobile clinic provided mental health services and a home visit programme was started. At the end of 2007, MdM hired a social worker, an occupational therapist, and a psychologist, on contract. After a year, these staff were transferred successfully to the Ministry of Health.

The staff translated training materials, such as *'ICD-10 PC Diagnostic and Management Guidelines for Mental Disorders in Primary Care'* (WHO, 1996) and *'Interview skills for psychotherapists'* (Fernandez-Liria & Rodriguez Vega, 2002).

The mental health team also trained general health workers in communication skills and started awareness raising activities through informative talks with religious leaders and local organisations. They also distributed brochures, launched a radio programme, and encouraged people with mental disorders to volunteer in community activities. Rehabilitation activities started in 2008 at the centre, and were developed by the MHT to extend into the community and involve patients in job creation programmes.

Second phase

The second phase lasted from September 2008 to October 2009, with follow-up occurring until September 2010. In this phase of the project, the socio-economic and security conditions in the area deteriorated. The siege over the Gaza Strip worsened the humanitarian situation because fuel and gas were not allowed into the Gaza Strip. In December 2008 and January 2009, during operation 'Cast Lead' – the Gaza

War, in which the Israeli army bombed and invaded the Gaza Strip - 1,380 Palestinian citizens from Gaza were killed. Many people in Salfeet had family in Gaza and were concerned about the situation. Additionally, at this time, local Israeli incursions into Salfeet district increased in frequency.

The programme adapted its activities to this new situation and provided mental health care information through the primary health care centres, school counsellors, and local organisations about healthy coping strategies. Additional training in crisis intervention was done for the PHC staff, and the programme released a booklet about crisis intervention.

In October 2009, the project ended. The foundations for integration of mental health care services into PHC structures were in place, and the Palestinian professionals could follow up independently.

Achievements

The MHT at the CMHC has become a reference in the West Bank for a community based model. Changing the attitude on mental health care was one of the many challenges undertaken, and an assessment among general health staff was done in 2007. This was repeated in 2008. In 2007, the staff perceived they had a low level of knowledge and training in mental health care and had feelings of fear and stigma about users with mental illness. In the second round of interviews, the self-perceived knowledge and skills were much higher than in the first round. Also, their attitude to mentally ill users changed, focussing more on respect and help than fear and stigma (Carreño et al., 2008). In addition, the MHT and PHC staff lobbied for service improvements and support of the integration strategy. The annual reports the team began in 2008 show how the number of new users to the mental health services has increased over the years of the project, from less than 20 in 2007 to more than 140 in 2010. Additionally, visits to psychiatrists have increased from around 1,500 visits in 2007 to nearly 2,500 during 2010. The improvements in the documentation process are building a strong commitment with the services users, and families and communities are more involved in the recovery process, further demonstrating the success of the project.

The perception of the PHC Director of the governorate is that communication skills have improved in the PHC staff. Awareness of mental health issues also increased, as did the recognition knowledge of common mental disorders. WHO continues to develop these programmes and work in the district. The programme also established links with schools through the school programme of the MoH. In general, mental health is being considered as a more prominent and relevant concern in health care clinics, and the directorate of PHC takes an active role in disseminating information and involves the doctors and nurses.

Limitations and challenges

Some problems arose during the implementation of this project. Within the political context, the health care workers strike, and operation *'Cast Lead'* in Gaza, affected the programme implementation. Another problem was that the professionals sometimes resisted implementing some new procedures that required a change from the previous manner of working. They were, for example, hesitant to record non-pharmacological interventions in the files, or to schedule follow up appointments.

MdM Spain initially focused on strengthening the MHT, and developing the services at the CMHC, as a way to empower the team and to prepare them to lead and continue the integration of PHC structures. Due to

the emphasis on the capacity building of the mental health team, some of components of integrating mental health care into primary care were not as well developed by the end of the project. For example, there were no regular meetings between the mental health team and the general health staff to review the cases of people who might have mental disorders. The referral system between the general health services and the mental health team needs to be improved. It proved to not have been possible to engage a psychiatrist for a minimum of two days per week, or to involve the psychiatrist in aspects other than the medical pharmacological aspects of service delivery. The authors tried to implement a family meeting in order to involve a large number of families in the recovery process and support them in understanding the illness, the relapses, and their role throughout this process. However, it was not possible to hold regular meetings until 2010, when this activity received the financial and technical support of WHO, which is supporting the Family Associations group in the oPt.

What we can learn from the experience in Salfeet?

In the humanitarian context, amidst conflicts and crisis, the challenge of developing the health care system lies in the professionals living in the oPt, specifically the Palestinian professionals working in the public health care system. The foreign NGOs should act as facilitators for this process and leave ownership of the programme to the local health care system and the local professionals. International aid can then be seen as an opportunity to improve or transform existing structures of the health care system, enabling them to deal with mental health problems during and after a crisis situation.

Using highly specialised trainers, who are often not available for long stays in the field, for the intensive activities, with longer deployments of more junior expatriate professionals, allows for good training and ensures follow-up and on the job training.

The role of international aid should be to support local people with respect, keeping in mind that one of the most undermining elements in conflicts is the loss of dignity. Dignity is important for both the local professionals, and for the population. As the professionals live in the same conflict area as the rest of the population, it is important to realise the complexity of the context where they live, and to recognise the importance of fostering resilience and coping skills. Dignity is also essential for users of mental health services. Their dignity is undermined not only by the conflict, but also by the stigma of having a mental disorder. Promoting self-respect and community awareness, addresses not only the mental illness but also the social suffering, and helps to frame a public health perspective into a human right approach.

The development of services is a continuous process. The project developed in Salfeet did not have a real end point. The Palestinian professionals involved in the project will still be present during the next few years to continue developing the services. The commitment, support, and understanding of mental health by the directors of PHCCs are therefore essential.

Political action can make mental health services sustainable in the oPt. Otherwise, the public health care system as a whole, and mental health care in particular, will not overcome its fragility, as it depends on donor funding. Working to restore normal life, dignity, and a context free of political violence is working for mental health.

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