

# COMMUNITY MENTAL HEALTH DEVELOPMENT

*In the occupied Palestinian territory: A Work in Progress with WHO*

**WHO Office for West Bank and Gaza**  
Old Nablus Road, Sheikh Jarrah, P.O. Box 54812, Jerusalem  
Tel: +972-2-5400595, Fax: +972-2-5810193  
© World Health Organization, 2006



**World Health  
Organization**

West Bank & Gaza Office  
September 2006

**The World Health Organisations involvement in  
Community Mental Health Development  
in the  
occupied Palestinian territory  
a work in progress with WHO**

*“Mental health is much more than the absence of a diagnosable mental illness. It is a state of emotional and psychological well-being allowing for the realization of a person’s potential and optimal functioning in daily life. It is a capacity to interact with others and the environment with a sense of well-being.”*

*“Key determinants of mental health include physical security, social support networks, employment, access to education and healthcare and to opportunities for self-actualisation.”*

*WHO World Health Report 2001*

# Contents

My home address has changed  
And my meal time...

The amount of my tobacco has changed too.  
And the colour of my clothes, face and shape...

Even my beloved moon here  
Has become more beautiful and bigger

The smell of land: perfume  
The taste of the nature: sugar

As if I am on the roof of my old house  
And a new star is fixed in my eyes.

*Mahmud Darwish, Palestinian poet*

<b>Introduction Benedetto Saraceno</b>	<b>5</b>
<b>Introduction Ambrogio Manenti</b>	<b>8</b>
<b>1 Background</b>	<b>10</b>
1.1 Demographic	10
1.2 Current situation	11
1.3 Implications for mental health	13
1.4 Situation analysis	14
1.5 Palestinian Authority Ministry of Health	15
1.6 The 1994 Palestinian National Health Plan	16
1.7 Mental health services today	17
<b>2 Project development</b>	<b>19</b>
2.1 Background	19
2.2 International Partnership	20
2.3 Project objectives	23
2.4 Steering committee	24
2.5 Strategic Operational Plan	25
<b>3 Implementation plan</b>	<b>29</b>
3.1 What has happened so far	29
3.1.1 Service development	29
3.1.2 Public education	32
3.1.3 Training	34
3.1.4 Professional development	35
3.1.5 User involvement	37
3.1.6 Carer associations	38
3.1.7 General	41
3.2 What needs to be done	41
3.2.1 Service development	41
3.2.2 Public education	42
3.2.3 Training	43
3.2.4 Professional development	43
3.2.5 User involvement	44
3.2.6 Carer associations	44
3.2.7 General	45
<b>4 Conclusions</b>	<b>46</b>



Appendices

One - Steering Committee for Mental Health: Terms of Reference	48
Two - Mental Health Directorate within the Palestinian Ministry of Health	51
Three - Main direct donors to WHO’s Community Mental Health Project	53
Four - Staff working in mental health facilities in oPt	54
Five - Patients treated in mental health facilities by diagnosis in oPt	55
Six - Interview with Dr. Bassam Ashhab, Director, Community MHD	56
Seven - Interview with Dr. Issam Bannoura, Director, Bethlehem Hospital	58
Eight - Bethlehem Psychiatric Hospital, Dr. Ivona Amleh	60
Nine - Impressions of Ramallah, Liz Bateman, Hertfordshire NHS Trust	62
Ten - The theory of recovery, Dr. Ivona Amleh	64
Eleven - Working with Voices, by Ron Coleman & Mike Smith	66

Acknowledgements	67
------------------	----

Introduction

The Mental Health Project described in this publication started in 2002 and was promoted by the World Health Organization (WHO) in order to provide technical cooperation with the Palestinian Ministry of Health.

We describe here a four year project which has become increasingly complex, involving different partners and stakeholders: first of all, the Palestinian Ministry of Health which made this project possible and the many mental health professionals from West Bank and Gaza who contributed to its implementation; secondly, the French and Italian Cooperation which contributed substantial technical expertise and financial support. Finally, during these four years WHO utilized a number of experts, mostly from the United Kingdom, who brought to the project innovative expertise from community mental health programmes in the United Kingdom.

This is a project that appears very solid as it is well founded in Palestinian reality, supported by Palestinian health authorities, carried out by Palestinian professionals and advised by a broad spectrum of foreign experts. It is solid also because it has brought different perspectives, such as experience from France, Italy and the United Kingdom. The project is also a good example of collaboration between the different levels of WHO: headquarters, regional office and country office. Indeed, it is rare that a country office takes mental health issues so seriously, investing substantial resources, time and expertise.

The project has two main components that include a mental health policy and five-year implementation plan and the development of community mental health services, including two in the psychiatric hospitals of Bethlehem and Gaza.

The third important component of the project is the development of human resources which includes training of health workers in the occupied Palestinian territory both locally and abroad (in France, Italy and the United Kingdom).

The project addresses the general public through the development of anti-stigma initiatives and campaigns and the establishment of family associations and service users groups. It is quite innovative, in that not only the family

component was promoted (groups have been established in Bethlehem, Ramallah and Hebron) but also the service users' component through the support of the groups of "Hearing Voices"; these groups have played a very important role in steering the situation in the psychiatric hospital in Bethlehem.

This project is multidimensional and very much inspired by the public health perspective. This perspective has actually led to the choice of integrating the activities focusing on trauma with the broader mental health system. In fact, there was and still is a clear need to link a short-term trauma approach with a long term service-building approach.

Sometimes, in our WHO experience, we have noticed that, unfortunately, in countries exposed to dramatic and repeated trauma in conflict or post-conflict situations, many mental health programmes tend to focus exclusively on trauma care. Organizing services based on the delineation of catchment areas is key to ensuring wide access to basic services and is strongly preferable to organizing based on disease categories (or based on specific vulnerabilities), which tends to lead to fragmented, vertical services.

All of this becomes particularly important in emergency settings. Indeed, the development of a multitude of specialized trauma-focused services should be avoided without first having a basic, functioning mental health system in place. Trauma-focused care is important but is best integrated into existing systems, most notably general mental health services. Vertical and separate

Trauma activities which are not integrated into the normal mental health system could create an inappropriate situation of parallel services: those for trauma receiving attention and funds from the international community while the normal services remain forgotten, outmoded and essentially of bad quality. That is the reason why the mental health project in occupied Palestinian territories strongly aims to keep together the short-term and long term perspectives.

A very important characteristic of this project is its comprehensiveness - from policy conception to planning, service delivery and the building of infrastructure.

Such a complex project, that encompasses policy, organizational, infrastructure and education issues, needs to be assessed. This is the reason why WHO initiated in the territory the WHO Assessment Instrument for Mental

Health Systems (WHO-AIMS) to ensure the monitoring and evaluation of the mental health project on the ground.

I believe that this Mental Health Project has put mental health in the public health national agenda and I strongly believe a mental health directorate should be established soon within the Ministry of Health in order to keep continuity and coordination of all these activities.

In general, I think this is a successful story where complexity has not been an excuse for useless over-complication. Of course, the project requires additional financial support for a number of years in order to make it sustainable. Establishing innovative mental health systems requires long term support and the difficult environment of the occupied Palestinian territory does not help. We hope that WHO's role in this Mental Health Project will also contribute towards building peaceful and healthy communities.

**Benedetto Saraceno**

*Director, Department of Mental Health and Substance Abuse  
WHO, Geneva*

# Introduction

The mental health programme, managed by WHO in the West Bank and Gaza with the support of the headquarters Mental Health and Substance Abuse department, started more than three years ago. It is receiving essential support from ECHO and the Italian Cooperation.

The programme is inspired by values and principles, including the social inclusion of vulnerable people, equity and sustainability. It has been articulated in a complex set of activities, representing an important step towards the improvement of the mental health services in the occupied Palestinian territory.

The programme has already achieved several objectives that were set out at the beginning of the project, in terms of mental health policy and planning, service delivery, training and community involvement.

These significant results, described in this publication, have been strictly connected with the overall strategies which have characterized the mental health programme such as:

- synergy between the response to immediate needs (emergency) and a long term vision (development);
- combination of policy (theory) with pilot activities (practice);
- collaboration among donors (such as WHO, French Cooperation, Italian Cooperation, Medicos del Mundo) under strong technical leadership;
- promotion of the integration between public (MoH) and non-profit sectors (NGOs) as essential step towards a welfare mix for vulnerable people;
- international partnerships between mental health services of the occupied Palestinian territory, the UK and Italy.

This innovative approach, with some key outcomes already realized, means that this mental health programme could be considered a significant and considerable example of good cooperation and coordination. Therefore it should be known and followed by other health programs and other sectors in and outside oPt.

**Ambrogio Manenti**  
Head of Office  
WHO West Bank and Gaza



Map of the occupied Palestinian territory



# 1 Background

## 1.1 Demographic

The occupied Palestinian territory includes the two geographically separate areas of the West Bank and Gaza Strip. The areas feature several historical cities including East Jerusalem, Bethlehem, Hebron, Jericho, Nablus and Gaza City.

The West Bank and the Gaza Strip have been under Israeli military occupation since 1967 and, for Palestinians, travel between the two entities is rendered impossible. Thus, the two communities remain isolated from each other and many families remain split.

The West Bank comprises an area of 5,800 sq. km. west of the River Jordan, and consists of diversified communities. The population of the West Bank is 2.3 million persons (47% urban, 47% rural and 6% in refugee camps). There are observable differences in the lifestyles and living conditions of the different socio-economic groups, religious affiliations, urban, rural and refugee communities.

The Gaza Strip is a narrow piece of land with an area of 360 sq. km, lying along the coast of the Mediterranean sea. The area has a very dense population, due to



Hebron checkpoint

the tiny area and the lack of freedom of movement. The population of 1.3 million is mainly concentrated in cities, towns and refugee camps.

Because three quarters of the Palestinian population is under the age of 30, with a very small proportion over the age of 60 years, it can be assumed that there would be a high presentation of mental illness that is typical among younger people (such as first episode psychosis) and a low rate of presentation of mental illness more typical among older people (such as dementia and geriatric depression).

Due to the social structure of Palestinian society, and its emphasis on the extended family, even the severely mentally ill tend to remain in the family environment and are cared for by relatives. This may in part account for a relatively low (45-55%) occupancy level in the psychiatric hospitals. It also reinforces the need to strengthen community-based outpatient services, as well as to build support systems for the families of those suffering from mental health problems.

## 1.2 Current situation

Since the outbreak of the second intifada (Palestinian uprising against the Israeli occupation) in September 2000, the West Bank and Gaza Strip have been the focus of intensive Israeli military operations, severe restrictions on the movement of goods and people, curfews, sieges, house demolitions, land confiscation, settlement expansion and by-pass road construction.

Since the summer of 2002, the Government of Israel has also been pursuing the



Gaza port



construction of a Separation Barrier, parts of which are being built on West Bank land east of the Green Line, and in some instances encircling whole communities in the process.

These measures have serious consequences on the day-to-day life of Palestinians. By isolating Palestinian communities from one another and fragmenting the territorial landscape of the occupied territory, they have generated dramatic economic, social and personal hardships that will leave their mark on the region for years to come.

As an illustration of the above, according to the World Bank:

- The real growth rate in the West Bank and Gaza declined from 6.3% in 2005 to 4.9% in 2006; (World Bank Quarterly Report, April 2006).
- The average Palestinian daily income is now less than 2 US dollars per day. The poverty rate was 31% in 2000 and stood at 51% in 2006; (World Bank Quarterly Report, November 2005).



*The Separation Barrier - Kalandia Refugee Camp*

- Unemployment is significantly high at more than 23% (double that of the pre-Intifada level); (Palestinian Central Bureau of Statistics Report, 2005).
- Labour access to Israel has decreased from 146,000 during the third quarter of 2000 to 67,000 in the second quarter of 2005; (World Bank - West Bank and Gaza Update Report, April 2005).
- Real GDP per capita declined by 27% in 2006 and the personal income by 30%. The main reasons are being the restriction of movement, goods, suspending the revenues and the direct handling of exports and imports by the Israeli Authority. (World Bank - West Bank and Gaza Report, April 2006).

### 1.3 Implications for mental health

Currently, there are very few reliable mental health data, such as incidence and prevalence, for the occupied Palestinian territory. (This should be remedied to a significant extent through the epidemiological study planned through the WHO Project in 2006 and 2007).

Anecdotal evidence from many mental health sources leads to the conclusion that the high levels of acute and chronic stress in the occupied Palestinian territory, due to the socio-political situation, render the entire Palestinian population more vulnerable to mental health problems and, in particular, to a higher incidence of symptoms of anxiety and/or depression amongst the general population.

Research from around the world has demonstrated that those individuals with a predisposition to severe mental illness (e.g. schizophrenia, bipolar disorder) are more likely to develop the disorders, or to see their symptoms worsen, if living in stressful conditions.



*The Separation Barrier - Bethlehem*

In 1997, between the two Intifadas, a population-based study (n=585 adults), involving fully structured diagnostic interviews, was carried out among adults in Gaza. Data, collected by the Gaza Community Mental Health Programme, shows that in the previous 12 months before the interview the percentages of the adult population meeting the criteria for the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition (DSM-IV) were:

- 10.6% post traumatic stress disorder (PTSD)
- 12.3% met the criteria for anxiety disorder
- 4.8% met the criteria for mood disorder
- 4.8% met the criteria for somatoform disorder. (Ivan Komproe, PHD, Transcultural Psychosocial Organization, written communications, 2003)



The mental health of Palestinian children and adolescents is of particular concern, as young people living in war zones are at high risk of developing emotional problems. The ongoing conflict, repeated traumas, the humiliation, and the poverty were and still are the constant environmental factors affecting individuals and communities.

Recent studies in the occupied Palestinian territory have shown that the stressors present in every-day Palestinian life due to the Israeli occupation (severe restrictions on freedom of movement, unemployment, lack of access to education and healthcare, etc.) seriously impact on personal, familial and community functioning.

A Quality of Life survey – recently conducted by WHO (WHO, Community & Public Health Institute “Birzeit University” and Palestinian Central Bureau of Statistics - “Quality of life survey in WB and Gaza”, 2006) revealed that: About 1 in 4 Palestinians (25.6%) feels their quality of life is poor or very poor; 1 in 5 (21.2%) suffers a lot or extremely from physical health problems that negatively influences their ability to function and affect their life quality; about 4 in 10 feel frustrated (38.3%), anxious (38.2%), fed up with life (37.9%), and, in greater proportion, bored (46.7%).

Almost 1 in 2 Palestinians is dissatisfied a lot or extremely with their living environment, while 1 in 3 Palestinians suffers a lot or extremely from financial problems. In particular, almost 1 in 2 Palestinians (49.7%) would not be able to bear sudden medical expenses. Nearly half of the respondents seriously fear losing their home (45.5%), losing their land (46.1%), to be displaced or uprooted (44.5%).

Preliminary research has shown a significant increase in emotional, physical and behavioural symptoms in the population affected by the ‘Wall’ that is currently being constructed. For example, research carried out by the Palestinian Counselling Centre in Qalqiliya area, showed that:

- 52% of those surveyed had thoughts of ending their life
- 92% feel no hope for the future
- 100% reported feeling stressed
- 84% expressed feelings of constant anger because of circumstances beyond their control. (The impact of Israel’s Separation Wall on Palestinian Mental Health: A Study in the Qalqilia District, Palestinian Counseling Center, 2005)

Feelings of insecurity have also increased in the areas directly affected by the Separation Barrier (90% compared to 75% in other areas of the West Bank).

## 1.4 Situation analysis

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

### Firyal Khader Yasin

#### *Master student in Community Mental Health program Head Nurse in Bethlehem Psychiatric Hospital*

For a long period, the psychiatric hospital in Bethlehem was neglected from all directions (the Ministry of Health, international funders, local NGOs). This caused us to feel totally isolated, neglected and marginalized - even though we are dealing with a very sensitive, stigmatised and vulnerable people population who need an enormous amount of support from the community and us. Working in the new programs gave us positive motivation in continuing our jobs, in realizing just what an important field we are working in, and the richness of new and alternative methods to be learned and implemented within the context of our work.

mental disorders are not only available and effective, but are also affordable and cost effective. (WHO Report, “in Mental Health”, 2003).

In 2002, the first situation analysis undertaken by WHO in West Bank and Gaza revealed no mental health policy and a lack of public mental health services.

The mental health system was still more hospital-based than community-based. Psychiatric hospitals in Bethlehem and Gaza were still the main assets to mental health care, while community mental health provision was extremely patchy and rooted in a traditional and biomedical-oriented approach.

Services were fragmented, under-developed, poorly resourced and, in many areas, no services were available. Mental health human resources were extremely scarce, and existing staff were over-worked, burnt out, poorly trained and demotivated.

The public were unaware of the nature of mental illness, had misconceived views and held very stigmatising and fixed beliefs surrounding mental illness.

There was a lack of knowledge of mental health at primary health care level, no referral system or cooperation between different parts of the public health sectors or between the public health sector and the private sector or NGO sectors.

Some non-governmental organizations were, indeed, providing good mental health services but in an uncoordinated way; therefore these fragmented good practices were not able to influence the general mental health system and actually were leaving untouched the culture of public sector services.

In this situation a traditional and sometimes archaic, biomedical model was prevailing and actually preventing innovative approaches taking place. This led to a lack of an integrated service system and waste of resources in some situations, as the real needs of people with mental health problems were not addressed.

In addition, the 2002 situation analysis revealed no concept of holistic mental health care, high levels of stigma and no consumer support or advocacy groups.

Last but not least, the general situation of West Bank and Gaza was obviously not conducive to good mental health for the population, including mental health workers.

## 1.5 Palestinian Authority Ministry of Health

With the establishment of the Palestinian Authority in 1994, the first Palestinian Ministry of Health was established. Among the enormous challenges the nascent Ministry of Health faced were:

- the severe shortages of human and financial resources
- no history of service provision
- the deeply imbedded legacy of the Israeli Civil Administration.

In the area of mental health, the Ministry of Health received much advisory assistance from Dr. Eyad Sarraj and the Gaza Community Mental Health Program. As a result, mental health was named as a health priority in the occupied Palestinian territory – with an emphasis on community-based mental health services.

The public mental health system established at that time grew to consist of 15 embryonic community mental health centres – one in each district of the West Bank and Gaza - as well as psychiatric hospitals in Bethlehem and Gaza City.

## 1.6 The 1994 Palestinian National Health Plan

The 1994 Palestinian National Health Plan listed mental health as one of the priority areas of concentration. This is a clear and important indication of the fact that the once-neglected and stigmatised area of mental health has been highlighted and emphasized by Palestinian health authorities from the beginning of the existence of the Palestinian Authority.

The 1994 Palestinian National Health Plan included the goal to reduce the level of disability caused by mental illness. It also contained the policy objective that by 1998 the community would be served by a system of services appropriate to the needs of all persons at risk of, or suffering from, mental or emotional disturbances or disabilities.

The following strategies were included:

- to ensure an active participation of primary health care providers in identification and management;
- to link persons in need with appropriate services;
- to improve coordination and referral of patients to primary health care for psychiatric, behavioural and emotional disorders;
- to make specialized psychiatric consultations and services widely available and accessible;
- to improve follow up and continuity of care in clinics or home settings before and after, and as an alternative to, institutional care.

Despite this commitment on paper, for practical and logistical reasons, the mental health system in the occupied Palestinian territory remained highly fragmented and under-resourced over the subsequent years. This state of affairs led to establishment of the International Partnership with the Ministry of Health, in order to address the need for the development of the Palestinian mental health system in a comprehensive, multi-faceted manner, leading ultimately to a community-based approach to mental health provision. While this development process remains in its early phases, it is actively moving forward – the intention of all stakeholders being the continuation of this concerted, incremental effort over the years to come.

## 1.7 Mental health services today

The total number of patients in touch with the public mental health services is around 33,000, with approximately 132,000 outpatient clinic visits annually.

- 48% of the users are adult male
- 37% are adult female
- 15% are children. (Ministry of Health- HMIS, “Health Status in Palestine”, 2004). There is an average of four visits per user.

There are a total of 42 outpatient mental health facilities available in the country. These outpatient facilities treat 911.8 users per 100,000 population.

According to the most recent Ministry of Health data, the users treated in outpatient facilities are diagnosed with:

- neuroses, stress related and somatoform disorders (35%)
- epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorders (35%)
- mood disorders (12%)
- schizophrenia (12%)
- mental health and behavioural disorders due to psychoactive substance abuse (3%)
- disorders of adult personality and behaviour (3%). (Ministry of Health - HMIS, “Health Status in Palestine”, 2004)

The hospital services in Gaza and the West Bank had 879 admissions in 2004, of which:

- 40% are involuntary admissions
- 6-10% of patients are restrained or secluded
- 44% are kept for more than 10 years in the hospitals
- 37% of users are female
- 31,794 outpatient attendances occurred in the two hospitals
- average occupancy rate for the two psychiatric hospitals is 52%. (Ministry of Health- HMIS, “Health Status in Palestine”, 2004)

According to the most recent data available from the Ministry of Health, in 2004,

72,072 visits were made to community mental health centres compared to 63,953 in 2003. (Ministry of Health- HMIS, “Health Status in Palestine”, 2004)

According to 2004 data, the total number of human resources working in mental health facilities or private practice was 7.31 per 100,000 population. (Ministry of Health- HMIS, “Health Status in Palestine”, 2004)

As part of the Project, WHO and the Ministry of Health have utilized the WHO-AIMS instrument for collecting data relating to the structure of the Palestinian mental health system.

WHO-AIMS is a data/information-based assessment designed to identify gaps and weaknesses in a mental health system, in order that more relevant public health actions can be sought, planned for and taken.

Over time, this tool will be used to monitor the evolution of the Palestinian mental health system, through the regular re-collection re-examination of data on a yearly basis. Among a variety of other useful information, in 2005, WHO-AIMS showed the following for the occupied Palestinian territory:

- there is no specifically defined budget for mental health services costs in the country;
- expenditure on public MH services amounts to approximately 2.51% of the overall expenditure on governmental health services;
- 73% of this 2.51% was spent on the hospital services, with the remaining 27% going to the community services;
- current governmental insurance schemes cover all mental disorders.

## 2 Project Development

### 2.1 Background

Over the past several years, WHO and many governments around the world have described and adopted a more enlightened and humanistic approach to national mental health policies, service development and treatments for people with mental health problems.

There has been growing evidence that community-based mental health services, together with modern treatment methods, not only improve the quality of life for service users and their carers, but are also cost effective.

This approach, coupled with the Palestinian Ministry of Health’s own stated commitment to adopting a community-based approach to mental health care, provided for a timely convergence of interests and objectives, leading to the design of the Project.

WHO’s direct involvement with the Palestinian Ministry of Health in the area of mental health began in 2002. This involvement was an immediate result of the mental health Global Action Programme that was established in the same year by the WHO’s Department of Mental Health and Substance Abuse.



Bethlehem Psychiatric Hospital, 2005. (Photo by Raed Bawayeh)



**The World Health Organisation recommendations for the development of comprehensive mental health services are:**

- 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.

This programme represents WHO's concerted effort to implement the ten recommendations of the World Health Report 2001 concerning the priorities of a comprehensive community mental health system.

The programme is based on the following four strategies, designed to enhance the mental health of populations:

- increasing and improving information for decision-making and technology transfer to increase country capacity;
- raising awareness concerning mental disorders, through education and advocacy for more respect of human rights and less stigma;
- assisting countries in designing policies and developing comprehensive and effective mental health services;
- building local capacity for public mental health research in poor countries.

Upon the establishment of the mental health Global Action Programme, WHO launched a series of pilot programmes worldwide (in Albania, Mozambique, Sri Lanka and the occupied Palestinian territory), all of which are embedded in the mental health Global Action Programme framework.

## 2.2 International Partnership

In 2003 the Ministry of Health and WHO joined forces with the French Cooperation and the Italian Cooperation to design seven complementary community mental health projects – through both technical and financial support - to allow for the actual implementation of the Strategic Operational Plan, once officially adopted by the Ministry of Health in February 2004. This follows the logic that any policy, once developed and adopted, should be implemented if it is to serve any purpose and that



*Stakeholder meeting in Gaza, 2004*

any development process, whenever possible, should be based on well-informed policy, to guide and give legitimacy to the actions taken.

These initiatives (which are individual projects but are referred to, collectively, as the 'International Partnership') represent a long term commitment to the overall development and reorganization of the Palestinian mental health system towards a community-based approach to mental health care.

The projects are based on the objectives of the Ministry of Health. Having established a Community Mental Health Department with very limited human and financial resources in 1995, the Ministry of Health was seeking to develop this department and its services, as well as to see the roles of the psychiatric hospitals evolve, in order that a comprehensive community mental health approach be adopted as the Palestinian mental health system.

The communal effort of the International Partnership is based on a process that attempts to harness the available technical and financial assistance available to mental health in such a way that, as far as is possible, the objectives and actions of each implementing partner are based on the same plans and principles and are complementary to each other.

The projects are thus planned incrementally and are strategically interlinked so that all activities, no matter which project implements them, represent building-blocks of the same overall vision. Given the fact that it is envisaged that the entire mental health

system reorganization process will take five to ten years, a long term commitment of time and resources is also an essential part of this cooperation.

The innovative approach of the International Partnership to these ends is based on the following principles.

- A ‘multi-pronged’ approach, targeting several different, but interrelated, elements of development simultaneously (e.g. policy development, infrastructure development, human resources development on many different levels, public education, families and consumers associations, etc.) based on the ten WHO recommendations for community mental health development in any country.
- Conceptualising and operationalizing these WHO recommendations according to Palestinian culture, context and needs, and based on the Ministry of Health’s view of community mental health development.
- Cooperation and coordination between the different international donors and implementing partners and the Ministry of Health, with each project adopting complementary responsibilities, to fulfil all needs, avoid duplication and gaps, and truly advance the process in a well-informed and logical fashion.
- Operationalizing the biopsychosocial approach to mental health care. This approach refers to the provision of comprehensive care to those seeking mental health treatment – through the availability of a range of services that address, simultaneously, the medical, psychological and social needs of the individual and family.

As part of the WHO Project, Palestinian public mental health services have become part of the International Mental Health Collaborating Network. This network involves the community mental health services from Lille (France), Trieste (Italy), Hertfordshire, Cornwall, Plymouth (United Kingdom), Asturias (Spain) and Stockholm (Sweden), with others joining to promote together this holistic approach to mental health care – “Whole Life, Whole Systems”.

The principles behind the International Partnership provide a good illustration of the way in which WHO’s recommendations and scenarios can actually be operationalized. Of course, it must be recognized that the simultaneous implementation of three separately administrated development projects is very challenging, not least because the implementing agencies are functioning under different bureaucracies and depend on different donors.

Thus, the translation of the underlying principles into reality is often hampered by differences in implementation rates between the three projects and by a certain degree of unpredictability. However, given the complexity of the situation, these challenges are to be expected, and do not detract from the fact that all three projects continue to follow the same path forward towards the same objectives leading, ultimately, to a comprehensively developed community mental health system in the occupied Palestinian territory.

### **Dr. Sylvie Mansour, Mental Health Project Manager, French Development Agency, says:**

These activities, which could well have been isolated events, are fortunately part of a more general movement towards development of the Palestinian public mental health system. Due to the simultaneous interest in this process of WHO and the Italian Cooperation, a relationship of coordination and cooperation was established between the three implementing partners and the Ministry of Health in 2003. Thanks, in particular, to the influence of WHO, the legitimacy that it represents and the recent publications in the area of community mental health development, allowed for a basis from which to formulate our joint work and complementary



*Dr. Mansour at Hebron Community  
Mental Health Center*

responsibilities. This commitment consists not only of developing the existing services in order to ensure better access to care and better quality of care, but also to establish a coherent long term policy for the mental health sector. The dedication to this process shown by the Director of the Mental Health and Substance Abuse Department (MSD, WHO Headquarters, Geneva) and its staff, and the regular participation of these international community mental health experts in the Project, gave the three implementing partners and the Ministry of Health the needed momentum to carry this multi-faceted development process forward.

## **2.3 Project Objectives**

### **Overall objective:**

To work with the Palestinian Ministry of Health, and other relevant actors in the mental health / psychosocial fields, towards the overall upgrading and improvement of the mental health services available to the Palestinian people.

The Ministry of Health is currently emphasizing mental health as a priority, given the historic lack of appropriate services combined with the present socio-political crisis -- which further deteriorates the health services’ capacity to cope with mental health problems and increases the needs of the population in terms of mental health care.

### **Specific Project Objective:**

In order to reach the above goal, the project’s specific objective is the reorganization, improvement and expansion of the current mental health services, according to a community mental health approach, at the primary, secondary and tertiary levels of health care. This will allow health services to better cope with mental health problems and issues, and to improve the needed comprehensive services and support available to sufferers and their families.



### Outcomes and Benefits:

- modernization of services;
- increase in available services;
- multi-disciplinary, holistic care available;
- easier access to services, less stigma surrounding the seeking of services;
- shift in treatment focus from maintenance to rehabilitation;
- shifts in attitudes and practices in order to move away from the exclusion and stigmatisation of the mentally ill towards social acceptance and inclusion;
- increased quality, effectiveness and efficiency of services;
- improved working conditions for mental health staff;
- moving away from institutionalisation towards community care for vulnerable groups;
- setting an example for the mental health system as a whole, and for other sectors;
- functioning as a model for the region and for other countries worldwide.

## 2.4 Steering Committee

A National Steering Committee for Mental Health was created in March 2003, in order to advise the Minister of Health and all the agencies and organizations involved in different mental health activities. This body became the authoritative entity that was capable of understanding the overall situation of the territory's needs and contributing to a more rational and harmonious utilization of the scarce resources and expertise.

The Steering Committee is an advisory body that promotes, organizes and oversees the implementation of the service organization's plan for mental health. Since the beginning, WHO was appointed as the secretariat of the Steering Committee. It is worth noting that the membership of the Steering Committee was not limited to representatives from the Ministry of Health, but also included representatives from NGOs relevant to mental health as well as representatives from the French and Italian Cooperation. The United Nations Refugee and Works Authority (UNRWA) was also a member of the Steering Committee.

The composition of the Steering Committee reflects the variety of perspectives and the openness of the Palestinian Authorities in bringing into an important advisory body contributions from different national and international agencies.

The purpose of the Steering Committee was, and remains, to oversee and advise on the various steps and components of the community mental health development process in the occupied Palestinian territory and to represent, through an on-going array of contacts, the wider mental health and mental health-related community.



*The Strategic Operational Plan is signed by the Minister of Health in Gaza, 2004*

## 2.5 Strategic Operational Plan

The national strategic policy plan (Strategic Operational Plan) was developed by the Steering Committee in 2003 - 2004, in collaboration with other mental health stakeholders through a series of participatory workshops. The document was authorized and signed by the Minister of Health and the International Partnership in 2004.

The Strategic Operational Plan sets out clear visions and principles upon which community mental health services should be planned and developed. It also describes the importance of how and why all mental health service providers should work collaboratively to achieve a comprehensive mental health service system. The Strategic Operational Plan is accompanied by a detailed service development plan over a five year period.

The process of developing this policy document brought the mental health community, NGOs and all the health providers together in a common purpose. This resulted in renewed faith and revitalized the energy for developing mental health services in occupied Palestinian territories.

The activities carried out thus far have demonstrated that the Strategic Operational Plan can be implemented throughout West Bank and Gaza over time. This work-in-progress has given the mental health community new hope and renewed energy to work towards better mental health care for the Palestinian people.

The Strategic Operational Plan emphasizes that any mental health service system should be developed upon a sound base of values and principles. The aim is to



develop services that are:

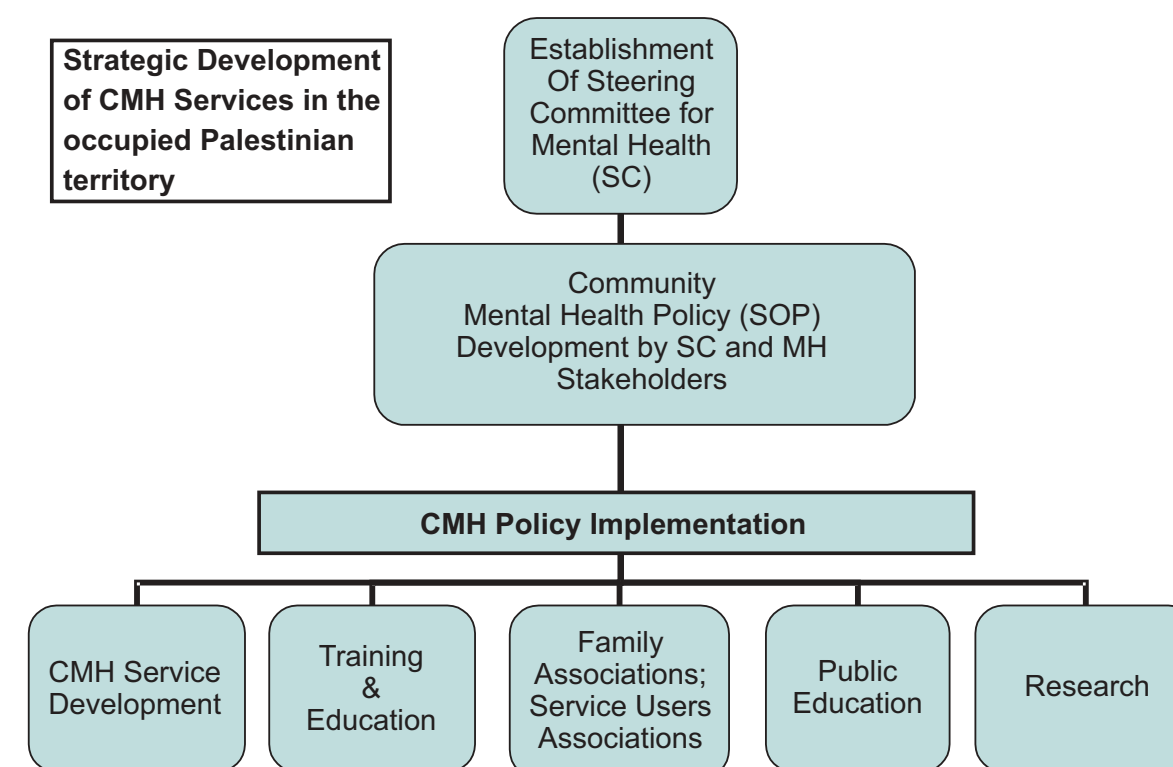
- available locally and easily accessible
- able to provide comprehensive support and treatment
- destigmatising and acceptable to local communities
- able to ensure that people maintain contact with their families, friends and their social system.

The Strategic Operational Plan calls for, among many other things, the creation of a single, independent Mental Health Directorate in the Ministry of Health, incorporating the community mental health centres, psychiatric hospitals and all decision-making processes regarding mental health.

According to the five year implementation plan that accompanies the Strategic Operational Plan, this Directorate should be in place in late 2006 or early 2007. The establishment of this Directorate is considered crucial to the success of the community mental health development process.

**Dr. Sylvie Mansour, Mental Health Project Manager, French Development Agency, considers the following to have been essential to this process:**

- The combination of policy work and technical support. Any such initiative limited to the definition of a new mental health policy would have led simply to yet another document written by outside experts – and such documents are already stacked on the shelves of the Ministry and gathering dust. On the other hand, limiting involvement to technical support would have served only to renovate the façade of a structure with very weak foundations. The combination of the two approaches thus seems a highly appropriate, practical and ethical choice to all involved.
- The establishment of the Steering Committee for Mental Health, chaired by the Ministry of Health, was certainly an important development allowing for the consolidation of energy and intentions allowing for common reflection and action, even if the Committee's tasks are rendered difficult by several constraints, which will be discussed below.
- On a different level, more informal, but very regular involvement of 'technical experts' involved in the projects and representing the three 'implementing partners' allowed for the creation of a space for reflection. To this each brought one's own experience, emphasizing the quality of the programme rather than the visibility of the donors. These meetings also often developed into 'self-help groups' at those discouraging times of crisis.



*Strategic Development of CMH Services in the occupied Palestinian territory*

Other complementary components of the community mental health development process as laid out in the Strategic Operational Plan include:

- training and education of mental health and primary health care professionals;
- mental health services development and enhancement;
- public education;
- establishing links and referral systems between all relevant stakeholders both locally and internationally;
- research, monitoring and evaluation.

The specific objectives of the Strategic Operational Plan are detailed as follows:

- to develop a framework of shared vision and values for mental health care in the occupied Palestinian territory;
- 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 the occupied Palestinian territory;



*Stakeholder meeting in Ramallah, 2004*

- to review current mental health legislation in the occupied Palestinian territory;
- to improve outcomes for mental health service users and their families.

The Strategic Operational Plan calls for regional mental health service systems be established in the occupied Palestinian territory. Each region should have a community mental health service that 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.

## 3 Implementation plan

Still in its early stages, the Project has nonetheless already led to significant progress in the functioning of the Palestinian mental health system, both in terms of actual changes on the ground, and of intensive strategic planning laying out the incremental developmental steps needed over the long term, in order to reach the Project's objectives over the coming few years.

As the Project enters its second phase in 2006, the immediate goal is to bring the positive developments and lessons learnt from the previous phase into the next phase in the process, thus building on an already well-established momentum.

This section serves as a 'snapshot', giving an overview of the progress made thus far on the ground and future plans and direction. The experiences and lessons learnt in planning and implementing this initiative will be valuable not only in informing the future of the Project itself but also, very importantly, in providing an effective and adaptable model for similar endeavours in other parts of the world.

### 3.1 What has happened so far

#### 3.1.1 Service development

Due to a severe lack of resources on every front the previous community mental health centres were generally based in two unequipped rooms, with under-trained teams and generally functioned as nothing more than outpatient clinics.



*Ramallah Community Mental Health Center*



A priority has been community mental health services development. The first step was to establish pilot community mental health centres from existing Ministry of Health community mental health centres.

This included construction of and equipment for new premises and long term training and team development support to the multidisciplinary community mental health teams.

In the first phase of the WHO project three district community mental health centres were targeted for development (Ramallah, Hebron and Gaza City).

New premises were built, community mental health teams were increased through agreements with the Ministry of Health and a long term training plan is now being implemented. Simultaneously, the Italian Cooperation and French Cooperation developed projects in Tulkarem, Nablus and Rafah.



Ramallah Community Mental Health Team

### Twinning arrangements with the UK

In 2003, an agreement was made between three United Kingdom NHS trusts - Hertfordshire, Plymouth and Cornwall - and three cities in the occupied Palestinian territory, Ramallah, Hebron and Gaza City.

This established a two-way partnership of learning and development in Community Mental Health. The long term commitment was given by all six localities to develop good quality and modern mental health services. This took the form of in-service training exchange programmes, study visits and consultancy work, therefore the principle of twinning was established. A mutual respect and long term relationship has been created in order that each place can benefit from each other's experience.

At the same time a similar initiative has been created between Bethlehem Hospital, Cornwall Trust and the recovery and hearing voices groups in Scotland. These twinning relationships will be expanded and strengthened over the years to come.

This model of development will continue and be extended to other places in the occupied Palestinian territory and the United Kingdom over the next few years as it has proved to be a successful way of developing and sustaining good practice. The United Kingdom NHS has agreed wholeheartedly to this twinning program and it is giving the staff time free of charge for this initiative.

Other achievements include:

- data collection and monitoring using the WHO-AIMS instrument developed by the MSD (WHO, Geneva);
- the provision of psychotropic medication, and training in its use, according to needs determined with the Ministry of Health;
- development of an operational policy for community mental health services;
- development of a rehabilitation assessment form and assessment of all long term patients (almost 100 individuals).



The opening of Gaza Community Mental Health Center



### Nadia Mahmoud Sarahneh, Social Worker at the Community Mental Health Centre in Hebron, says:

I started working in the Community Mental Health Centre, which was opened in October 2004. I live 5 kilometres from the centre. I need three transports every day to get to work due to the Israeli checkpoints that can make you wait for hours, or be closed at any minute due to so called “security alerts”. This makes my days very unpredictable.

As a first step in working as multidisciplinary team, we divided the area into three geographical areas serviced by the teams, each consisting of a psychiatrist, a social worker and a psychologist. In the Hebron area, we have a total of 3410 cases.

### Patient Case Study – Thawra, by a Psychologist at the Community Mental Health Center in Hebron

T. is 33 years old and has been diagnosed with post-partum depression. She had her last baby in April 2004. Shortly after this, she began seeking treatment at the Hebron Community Mental Health Centre. Her symptoms were severe and she needed intensive care. She badly needed someone to listen to her, to talk to someone who understood what she was going through, someone to share her crisis with. She suffered from very strange ideas and needed someone to help her understand and solve her problems.

Her treatment coincided with the opening of the new Hebron Community Mental Health Centre, sponsored by WHO. This new arrangement was a blessing for her and for the other patients who previously generally suffered from the shortness of the sessions due to lack of space and lack of staff, in addition to the ‘clinical’ environment in the old site.

T. has expressed her admiration for the new place and how it provides her with security and no interruptions during sessions. She is also very happy with the wider range of services available to meet her needs. What we would achieve in the old clinic in three months, we are now able to achieve in one month in the new Centre. For T, we were able to increase her number of sessions and to introduce her to new relaxation techniques.

Over time, T improved significantly, and she now only comes for regular consultation.

### 3.1.2 Public education

A variety of public education materials (posters, billboards, newspaper inserts, TV documentary and radio spots) have been developed and distributed.

Various workshops have been provided for different target groups (such as teachers, social workers, police).

A long term public awareness campaign has been planned and implemented.



Billboards in Ramallah, Anti-Stigma Campaign

### Drama Group: Bethlehem Hospital

The Drama Group at Bethlehem psychiatric hospital evolved as a part of the joint WHO and Ministry of Health Anti-stigma and Public Education campaign, which started in 2004.

A group of 13 people from the hospital (five chronic patients and eight staff members) started working with the international concept of “Theatre as a Platform”, through the Palestinian Ashtar Theatre. Theatre as a Platform is part of the Brazilian “Theatre of the Oppressed”, founded by director, Augusto Poal.

The goal of this type of theatre is to allow the audience to interact directly with the actors in order to create an atmosphere of equality and public awareness. The audience plays an active role instead of a passive one, in order to empower the oppressed through drama and to try to change their reality into different scenarios.



Drama group at Bethlehem Hospital



The goals of this initiative in Bethlehem are to:

- let patients and staff create jointly something artistic for the purpose of campaigning and raising awareness surrounding mental health issues;
- combat the stereotypes and misconceptions held in the general community regarding issues of mental health and mental illness.

To date, this group has performed five times: twice in the Bethlehem hospital for all hospital staff, once for patients' families and three times for local NGOs.

The group is very committed to continue what they have started and believe in the importance of their work. Their future plan is to target schools, public theatres, universities, etc., based on the belief that reducing stigma in the community is a long and continuous process.

### 3.1.3 Training

Intensive in-service training has been provided for staff of the community mental health centres and psychiatric hospitals by the United Kingdom, Italy, France and locally.

Palestinian staff spend long periods in the United Kingdom services receiving training and support in community mental health teamwork and United Kingdom staff work in the Palestinian services for the same purposes. To date approximately 120 community mental health centre and hospital staff have benefited from this training.

#### **Nadia Mahmoud Sarahneh, Social Worker at the Community Mental Health Centre in Hebron, says:**

We have received in-service training by British mental health professionals, focused on multidisciplinary teams, case management, operational procedures in community mental health centres, professional roles, the Recovery approach, etc.

Missions of French psychiatrists to the occupied Palestinian territory have occurred since 1994 and have increased in frequency since 1998. These exchanges have led to the establishment of long term training in France Palestinian psychiatrists. To date, 12 Palestinian psychiatrists have taken part in this training.

At the same time, missions to the occupied Palestinian territory have been carried out by members of the team of the St. Anne's psychiatric hospital in France, which resulted in the twinning of St. Anne's with the psychiatric hospital in Bethlehem. This twinning has now seen a multidisciplinary group of hospital staff receiving two months training at St. Anne's.

Palestinian community mental health staff have also benefited from training in Trieste, Italy and through community mental health experts from Trieste and Udine providing in-service training in the occupied Palestinian territory.

Other initiatives have included:

- a range of workshops and seminars for all public mental health staff, as well as NGO staff and staff from other ministries;
- development of a community mental health training manual and workbook;
- variety of short and long term skills-based training for different disciplines;
- working with the concepts of recovery and hearing voices with both staff and service-user groups;
- increase and strengthening of community mental health teams, with extensive support towards multidisciplinary team building;
- proposal developed for post-graduate program in community mental health in local universities.

### 3.1.4 Professional development

Seminars entitled "The Role of Psychiatry in a Modern Mental Health System" were held in Ramallah and in Gaza City in May 2005. All psychiatrists and trainee psychiatrists from the public mental health services attended (a total of approximately 50), and Dr. Saraceno facilitated the events.

These seminars were designed to complement the mental health training that has already occurred in the occupied Palestinian territory, and to set the stage for future training initiatives. Psychiatrists were exclusively targeted in this instance as it was



*Dr. Benedetto Saraceno giving presentation for psychiatrists in Ramallah, 2005*

considered that this was an opportune moment to create a forum in which to address, specifically, the psychiatrist's role within the community-based approach to mental health care.

At the end of the Ramallah event, a short statement was drawn up by the participants, which reiterated the important recommendations already detailed in the mental health policy document which was developed in 2004. This statement reads:

*The participants in this seminar, along with WHO, recommend that mental health services should be able to address the complex needs of people with mental health problems. To achieve this, services at all levels (namely hospital, community and primary health care) must adopt a bio-psychosocial approach to care, treatment and rehabilitation of individual service users and their families.*

*Therefore, services should provide:*

- *medical and psychiatric treatment*
- *psychological interventions*
- *social support.*

*The mental health services should also establish partnerships with a variety of other organizations, in order to allow for holistic care of those seeking treatment, leading to better health and social inclusion.*

Further seminars have been held for psychiatrists in May 2006 to explore the continuing development of the role of the psychiatrist. A specific workshop was held for pharmacists and psychiatrists. The focus of this was on the proper use of psychotropic medication.



Dr. Ivona Amleh, psychiatrist, giving presentation for MoH GPs and Nurses in Hebron, 2006

A seminar was held in Hebron with stakeholders, to discuss collaboration between organisations in order to provide a holistic service to meet the broad range of needs of people with mental health problems.

Fifty people attended from 15 organisations and the conclusion was to work together more to build an integrated system.

These seminars will be followed up over the long term with a variety of planned training initiatives, continuing to target the staff of the psychiatric hospitals and community mental health centres.



Bethlehem Psychiatric Hospital, 2005. (Photo by Raed Bawayeh)

### 3.1.5 User involvement

Hearing Voices training has been carried out in the two psychiatric hospitals and at Ramallah and Gaza community mental health centres. Hearing Voices groups have also been established at these places.

To date, recovery programmes have been started in the Bethlehem Psychiatric Hospital and in the Ramallah and Hebron community mental health centres.

This process was begun and receives the continuous support of recovery experts from the United Kingdom, which is followed up on a constant basis by WHO's Palestinian mental health team.

Future plans include expanding this programme to all public community mental health services, as well as to other mental health stakeholders.



**Firyal Khader Yasin,  
Head Nurse, Bethlehem Psychiatric Hospital, says:**

We have received very interesting training on how to deal with the patients who hear voices. For me, it was truly remarkable how the patients responded to this approach and interacted with us.

I felt that, for the first time, we entered their world and began to understand what they are going through inside their minds -- that we are no longer standing there as an audience but, on the contrary, we are part of their world.

### 3.1.6 Carer associations

Family organizations have been established in Hebron, Ramallah and Gaza. A Family Committee for Advocacy has also been set up.

Pilot initiatives, aimed at establishing work with the families of those suffering from mental health problems, and organizing these family members into groups who meet regularly have been set up in:

- Hebron Community Mental Health Centre
- Bethlehem Psychiatric Hospital
- Ramallah Community Mental Health Centre.



Bethlehem Family Association Activity, 2006

The belief is that a very important role can be played by families in the process of mentally ill people.

Families can create a safe atmosphere by supporting and protecting their ill family members – facilitating the process of re-becoming an integrated member of society and reducing the instance and effects of stigma.

Another very important role that families can play is in the area of advocacy. This advocacy can target different, but related, areas, such as: legislation to protect the human rights of the mentally ill in society; improving the quality of services available; spreading awareness surrounding mental illness and how to deal with it, combatting myths; etc.

### Family Association Frameworks

This initiative was begun in 2004 and has proven to be much more successful than originally anticipated. Supportive family groups, which meet every two weeks, are led by social workers and psychologists from the community mental health centres and the hospital. Team meetings are held every two weeks in order to resolve problems and exchange experiences.

Aims that are achieved through these meetings include:

- exchange of experiences surrounding dealing with a mentally ill family member;
- a forum for ventilation and expression concerning the challenges faced;
- how to work towards recovery with the ill family member;
- discuss ways of his or her integration within the family and society;
- discuss stigma, how it affects the family and the patient and how to reduce its effects.

**Shadi Jaber, Palestinian psychologist and organiser and facilitator of  
Families' Association Groups, says:**

Although the number of participants is still limited in my view (mainly due to financial constraints and restrictions of freedom of movement) this activity is highly appreciated by families, who are very keen to continue. Family members have expressed the following:

- Many families believe that this is the only place where they feel open and can openly talk about their suffering, as it is very difficult to communicate with others in the society who either can't understand what they are going through, or react with a stigmatising attitude.
- Many families expressed better understanding of the illness after they joined the family association activity, and felt that they have developed a better way of dealing with their ill family members.
- Many wives of men suffering from mental health problems have expressed their relief and that they are more comfortable in their relationship with their husband, as they now know better how to deal with them. In addition, the meetings allow them to 'debrief' concerning the depressing factors and frustrations that they face in their day-to-day lives.

### A patient's father comments on the Hebron Families' Associations

SM, a retired teacher from Hebron City is a regular member of the Family Association group from community mental health centre. He is now an active member of the Family Group Committee, an offshoot of the Association which is in the process of taking on an advocacy role.

As a Friends and Family Committee member, SM strongly recommends the following in order to benefit those suffering from mental health problems:

Help the general public to understand that mental illness results from a variety of contributing factors on so many levels: the socio-political situation, the Israeli occupation, poverty, violence and oppression, etc.

It is our responsibility to provide ordinary people with a better understanding of those suffering from mental illness, so that everyone knows how to better cope and live with them.

We badly need to involve religious leaders in this process, so that we can ensure that the subject of mental illness is included in sermons and religious speeches.

We need to involve different Ministries in this effort, such as the Ministry of Education to work with students, teachers, deans, etc. so that they have a better understanding mental illness, and the Ministry of Social Affairs in order to mobilize the important role that they have to play in the care and support of people with mental illness.

Mobilize opportunities for employment and / or financial support of sufferers, in order that they are no longer in a position of dependency, which definitely worsens and increases their symptoms.

## Friends and Family Committee

This Committee was established one year after the first family groups began to meet – based on the initiative of the Association members themselves. In the course of that first year, family members and the team discussed, brainstormed and identified many factors that were needed in order to effectively support mentally ill people. In addition, they identified the urgent need for legislation and regulations regarding the structure of the mental health services and to protect the human rights of the mentally ill in society.



*Friends and Family Committee*

### Shadi Jaber, Palestinian psychologist and organiser and facilitator of Families' Association Groups, says:

We can say that the establishment of the Friends and Families Committee is one of the most important initial steps taken in the community mental health services development process as, previously, there was no group advocating for the rights of the mentally ill.

### 3.1.7 General

A proposal and plan has been established for the setting up of a single mental health directorate at the Ministry of Health.

There are on-going current and projected costings of the Palestinian mental health system. Three different projected scenarios are now in place and will be included in the five year plan.

## 3.2 What needs to be done

Future plans for the development of the Palestinian mental health system include:

- strengthening the existing public services
- human resources development
- improving the links between the different public services
- improving the links with services offered by other sectors
- improving the quality of care and follow-up
- families and consumers associations
- research
- raising public awareness.

### 3.2.1 Service development

Although in the process of improving, due to on-going efforts, currently the mental health system remains fragmented between the services offered through the Community Mental Health Department (which functions under the Primary Health Care Department), the psychiatric hospital services (which fall under the administration of the Hospital Directorate) and the various services provided by NGOs or through other ministries.

More work needs to be done to build partnerships between stakeholders at all levels. In addition, links with those services offered by the NGO community and through other ministries remain weak. This situation is gradually changing and improving, as the necessary networks are being established.

There are currently significant inconsistencies in the distribution of mental health service resources across the West Bank and Gaza. Redistribution, over the next



several years, 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. Creating and formalizing relationships and protocols with stakeholders from the NGO community, services offered by other ministries, the private sector, etc. will be an essential part of the long term community mental health development process – leading to the availability of holistic, comprehensive services for those seeking mental health treatment.

Priorities for service development are:

- development of community mental health centers in other regions of the occupied Palestinian territory;
- training development of community mental health teams in other regions of the occupied Palestinian territory;
- development of new acute units in general hospitals in WB & Gaza;
- develop a national rehabilitation programme for service users with the support of WHO;
- development of day care services in ( Ramallah, Hebron, Bethlehem and Gaza);
- rehabilitation training and units established in the psychiatric hospitals;
- continued monitoring and development of mental health information systems using instruments such as WHO-AIMS;
- establishment of a mental health Resource and Research Centre in Ramallah;
- epidemiological study to be carried out in 2006/7;
- further provision of psychotropic medications.

**Nadia Mahmoud Sarahneh, Social Worker at the Community Mental Health Centre in Hebron, says:**

We still definitely need lots of empowerment and support on the professional level such as counselling skills, books and journals and a car, which could facilitate our home visits, etc.

### 3.2.2 Public education

It is necessary to work with other stakeholders to put into place a concerted, long term campaign based on established needs. Other requirements are for:

- continued development of materials and media tools
- production of a documentary film
- development and implementation of a National Public Education Plan



*Dr. Iyad Azzeh, psychiatrist, giving a presentation at a Stakeholder meeting in Hebron, 2006*

### 3.2.3 Training

The following initiatives are planned:

- a series of three month skills based training courses for community mental health centre, hospital and NGO staff (in priority areas such as cognitive-behavioural therapy; family work; supportive counselling, etc.);
- further training in rational use of psychotropics;
- development of post-graduate programmes (certificate, diploma, degree) in community mental health in Palestinian universities;
- development of a psychiatric nursing curriculum with Ibn Sina Nursing College;
- training at primary health care level through a variety of International Partnership coordinated activities, as well as joint work with UNRWA and other UN agencies;
- establishment of a mental health diploma within the Ministry of Health for primary care workers.

### 3.2.4 Professional development

Continued in-service training and team-building will take place in partnership with the UK and Italy with further development of twinning with UK services.

Professional development courses will continue.



Training at Bethlehem Psychiatric Hospital, 2005

The community mental health training manual and workbook will be finalised.

A community mental health professional newsletter and website will be developed.

### 3.2.5 User involvement

Hearing voices and recovery support groups for patients will be established in other hospitals and in community mental health centres.

Service user groups will evolve into national NGOs, with international links.

### 3.2.6 Carer associations

Families Associations will be established in each district in the occupied Palestinian territory.

Families Associations will evolve into national NGOs, with international links.

The Friends and Families Committee should be developed through an independent body, and needs long term financial and technical support. In the meantime, this should be taken on board by WHO, until the necessary resources are established.

## Patient's Father: Comments on Families' Associations

### Hebron

SM believes that his 19 year-old daughter's illness – she has been diagnosed with schizophrenia -- is a test from God of his humanity, ethics and determination, and he has strong faith in his daughter's recovery. He does everything that he can to help her in this process.

He says "Mental illness is like a predator, and those affected are victims of these diseases. My daughter changed from a very normal person to a very strange person with delusions, odd imaginings and strange behaviours. Often she ends up screaming as she doesn't know or understand her surroundings. My daughter has become a heavy burden on the family because of her need for continuous medication at specific times, the level of daily care needed, etc. But, as families, neighbours and society, we should never forget that these people are part of our lives, part of our community, and should be treated with respect and kindness. We should do everything in our power to ensure their integration into family and community life as effective contributors to society. We must do everything in our power to stop the stigma and stop ignoring, humiliating and ridiculing them."

### 3.2.7 General

Future activities will include:

- continued twinning of Palestinian and United Kingdom services, as well as with Italian and French services;
- establishment of the necessary links between the Ministry of Health services and services provided by NGOs including other ministries;
- regional stakeholder workshops;
- development of the necessary protocols to establish these networks and referral systems;
- using the costing exercise to inform services development on the ground over the next 5 years;
- strategic, gradual establishment of the Mental Health Directorate through a series of planning exercises. Mental Health Directorate up and running in early 2007;
- working to ensure that the WHO-AIMS serves the purpose of monitoring and evaluation of the progress of the mental health project on the ground. Data collection and comparison will take place on a yearly basis.



# 4 Conclusions

The reorganization and upgrading of the Palestinian public mental health system will be a long process requiring sustained and coordinated commitments from all parties involved (Ministry of Health, donors and implementing partners, other stakeholders).

Despite the many challenges faced, the concerted efforts of the International Partnership have, to date, laid the groundwork necessary to bring this process forward over the years to come. This has been accomplished through a strategic approach, addressing several key areas simultaneously, while at the same time remaining flexible enough to constantly adapt to the changing realities on the ground and arrive at solutions to the many challenges faced.

The continued support of the international community to this endeavour over the coming years, as well as the gradual hand-over to the Ministry of Health, are essential to the change process and its sustainability. It is hoped that, through the demonstrable successes detailed in this document and in the future, further funding and technical support from international partners will be available on a constant basis over the next 5 – 10 years.

It should be kept in mind that in any country in the world this would be a difficult task, but in the occupied Palestinian territory this is further compounded by the occupation, economic hardship, individual suffering, restrictions on freedom of movement and stress and trauma. This has had a significant detrimental effect on the well-being of the population and on mental health. This socio-political situation also presents many challenges to the implementation of the Project components.

Dr. Sylvie Mansour, Mental Health Project Manager, French Development Agency, says the three actors involved with the Ministry of Health are each subject to different constraints, which often makes adhering to a common plan of action a difficult endeavour: for example one hasn't had the time to properly develop a planned activity, but must use the funds according to a strict deadline; another has a well developed plan, but the funds remain delayed, and other such problems, due to the different bureaucracies which are, by necessity, involved in such programmes of cooperation.

The enormity of the task at hand makes the prioritisation of areas of work very difficult. For example, with a limited budget, it is impossible to resolve all of the training and education challenges facing Palestinian mental health professionals. In this context, how can the prioritisation of the training of psychiatrists, psychologists, social workers, psychiatric nurses, etc. be best addressed, when a multidisciplinary approach to mental health care is deemed essential.

Another challenge rests in the necessity to consult with, as far as is possible, mental health professionals on the ground, without at the same time slowing a process of which the main objective is to arrive at a consensus as rapidly as possible concerning the decisions that need to be taken surrounding the national mental health policy – for today and the future.

A further priority is to reconcile a psychosocial approach to mental health care with the field of psychiatry. Over the past years, the Palestinian context has been polarized between two types of programmes: curative psychiatry on the one hand (concerning, particularly, the treatment of adults with serious psychiatric problems), and psychosocial work on the other hand, focusing mainly on work with children and women within the context of Israeli occupation and socio-political conflict.

This polarization causes stereotyped perceptions from each camp:

- psychiatry should be practiced in community mental health centres crucial component of psychosocial work;
- the organization of recreational activities for children does not constitute psychosocial work (even if these activities are important for the mental health of children and their mothers).

Community mental health development in the occupied Palestinian territory faces a long road ahead. However, a brief detour to other Arab countries (for example, Lebanon, Algeria, Tunisia) shows that the occupied Palestinian territory already has a network of community mental health centres that the others could envy, even if these centres still function in very difficult material conditions, with limited and under trained personnel. The long term commitment of the International Partnership is crucial to the continued improvement of this difficult situation.

Finally, a crucial aspect of this process is that all successes and lessons learnt from these efforts will serve to inform and facilitate similar endeavours in other regions and countries of the world.

## Appendix One - Palestinian Steering Committee for Mental Health: Terms of Reference

The Steering Committee was established in March 2003 in order to advise the Ministry of Health and other agencies and organizations involved in different mental health activities, concerning mental health services organization and development, including overall aims of implementation.

### The Steering Committee is chaired by the Ministry of Health, with WHO acting as the Secretariat.

1. As per a recent decision by the Ministry of Health, the Steering Committee hereby replaces, and encompasses the activities of, the previous Thematic Group for Mental Health. A membership list is attached.
2. The primary function of the Steering Committee is to promote, organize and oversee the implementation of the Mental Health Services Organisation Plan developed in 2003 – 2004. This will be done via a Task Force appointed from within the Steering Committee, whose responsibility it is to develop a five year Strategic Operational Plan implementation plan, and which reports directly back to the Steering Committee for approval of all developments and decisions.
3. The Steering Committee acts as an advisory body to the Ministry of Health in all concerns surrounding mental health services development and policy. All decisions arrived at through the Steering Committee are to be considered only as recommendations to the Ministry of Health.

### Concerning the five year Strategic Operational Plan Implementation Plan, the Steering Committee performs the following functions and has the following obligations:

4. To assign all tasks and responsibilities as necessary according to the Implementation Plan, and to follow up, monitor and evaluate these obligations.
5. To develop and implement strategies for closer cooperation and collaboration between all actors in the mental health related fields, in order to establish the necessary networks and referral systems allowing for holistic care of those suffering from mental health problems.
6. To follow the establishment and implementation of a multi-tiered plan for the development of mental health training and education resources in the occupied Palestinian territory and abroad.
7. To work with the necessary authorities in order to locate and place the human resources necessary to a community-based approach to mental health care.
8. To develop strategies designed to empower the mentally ill and their families,

and to raise general awareness and acceptance amongst the general population concerning mental health and mental illness.

9. To identify the priorities for mental health improvements, for better services and community integration.
10. To suggest strategies, objectives and plans of action for the improvement of the mental health services, with a community based approach.
11. To advise the Ministry of Health and interested NGOs on how to plan and merge new projects into the aims of the vision and the mental health policy.
12. To initiate and support the process of preparing a proposal for mental health legislation and for guidelines for patients' rights.

### Practical Considerations

13. All Task Force decisions must be cleared by the Steering Committee.
14. The Steering Committee will meet once every two months (unless decided otherwise on a situational basis) in order to follow up the incremental five year implementation plan, to monitor and evaluate its progress and make necessary adjustments, as well as dealing with any other necessary business.
15. The Steering Committee reports directly to the Sector Working Group, at each of its sessions. Steering Committee reports are transmitted by the Steering Committee Chairman and/or WHO.
16. The Steering Committee is chaired by the Ministry of Health.
17. The Steering Committee's Secretariat is the World Health Organisation (WHO). WHO is responsible for collecting and distributing Steering Committee minutes / summaries.



## Steering Committee Membership

### Ministry of Health

Director of Primary Health Care, Gaza (Steering Committee Chairman)

Dr. Walid Shakoura, Director, Department of International Cooperation

Ms. R. Sulieman, Deputy Director, Department of International Cooperation

Dr. B. Ashhab, Director of Community Mental Health Department, West Bank, Facilitator for West Bank

Dr. H. Ashour, Manager of Ramallah Community Mental Health Centre

Dr. A. Samour, Director of Community Mental Health Department, Gaza

Dr. I. Bannoura, Director, Bethlehem Psychiatric Hospital

Dr. R. Al-Aqara, Director, Gaza Psychiatric Hospital

### NGO Representation

Training and Guidance Centre

Gaza Community Mental Health Programme

Palestinian Counselling Centre

### International Representation

French Cooperation

Italian Cooperation

World Health Organisation (WHO) – Steering Committee Secretariat

UNRWA

Other bodies (such as universities, etc.) can be invited on a case by case basis, depending on the need.

## Appendix Two - Mental Health Directorate within the Palestinian Ministry of Health

The Strategic Operational Plan recognizes that, in order to successfully achieve the ambitious and complicated objectives laid out in the document, it is necessary to strengthen the mental health presence in the Ministry of Health. Based on this reality, the Strategic Operational Plan calls for the establishment of a single Directorate of Mental Health within the Ministry of Health. In addition, the funding that will be made available to the mental health system development process in 2006 through WHO, stipulates the establishment of such a body as a condition of this cooperation (and provides support for the necessary elements of implementation of the Directorate of Mental Health).

Currently, public mental health services are fragmented between the Community Mental Health Department, which functions under the umbrella of the Department of Primary Health Care, and the psychiatric hospitals (Bethlehem and Gaza), which fall under the Ministry of Health's Hospitals Department. This arrangement has become untenable, due to the progress made in the last two years towards the eventual comprehensive mental health system in the occupied Palestinian territory, with the necessary direct links between the hospital system and community mental health. As this system continues to develop and strengthen, the need for these links will increase further as a unified mental health system falls into place. Thus, a single entity overseeing the public mental health system as a whole is a necessity, for both practical and professional reasons.

### Purpose and Functions

The rationale for such a new Directorate includes the need to:

- oversee the entire process of reform of the mental health system as a whole;
- manage the change and development of new and existing mental health services;
- make appropriate and timely decisions;
- ensure integration of hospital and community services and therefore continuity of care for service users and their families;
- introduce a system of monitoring and evaluation of services;
- oversee the implementation of a training and education strategy;
- plan and introduce new mental health legislation;
- develop standards and a system of accreditation for professionals;
- develop and improve the mental health workforce (numbers of psychiatrists, psychologists, social workers, nurses, etc.);

- develop programmes for public education, reduce stigma and provide advocacy for mental health;
- build alliances with other organizations, ministries and local communities.

The Department of Mental Health should be led by a Director General of Mental Health who, ideally, should be directly accountable to the General Director of the Ministry of Health. The Director General should be supported by a team of senior positions, such as

- Deputy Director
- Training and Education Officer
- Governance Officer (professional standards, accreditation, information, evaluation, legislation, etc.)
- Community Development and Organizational Liaison Officer
- Administrator
- Secretary.

Exact titles, functions and job descriptions will be drawn up and finalized by the Steering Committee for Mental Health.

Given the need to improve the integration of services at all levels, and to manage the expanded and more complex regional and local services, it will also probably be necessary to develop a regional management structure that will reflect this new need and task. This will support the creation of a more accessible, local and comprehensive mental health service system.

The exact structure and staffing of the Mental Health Department will be determined over the course of 2006. A draft structure has already been provided by the Ministry of Health and will be discussed in the next meetings of the five year plan Task Force and the Steering Committee.

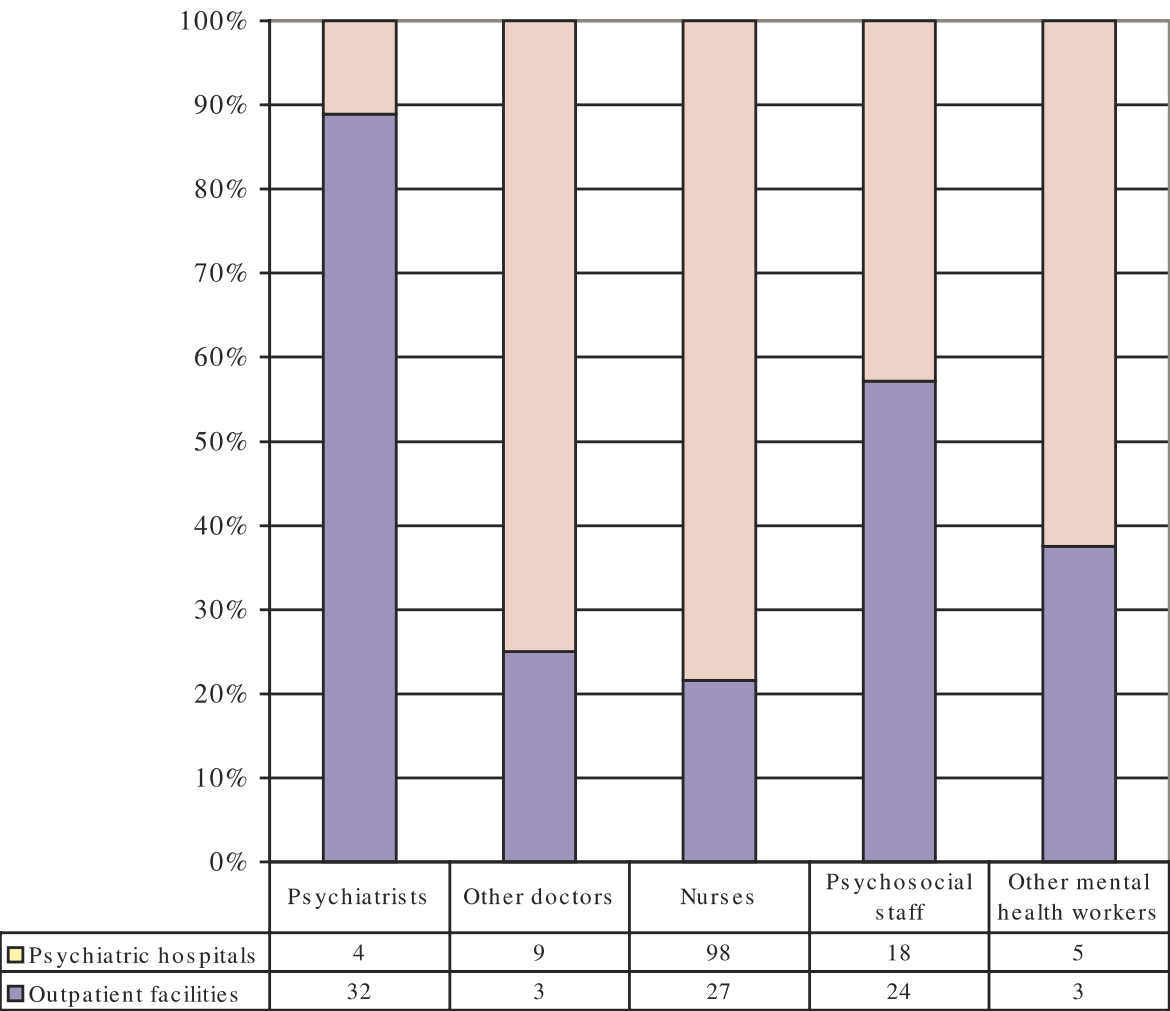
### Appendix Three - Main direct donors to WHO’s Community Mental Health Project

Thus far, the main direct donors to WHO’s Community Mental Health Project in the occupied Palestinian territory are:

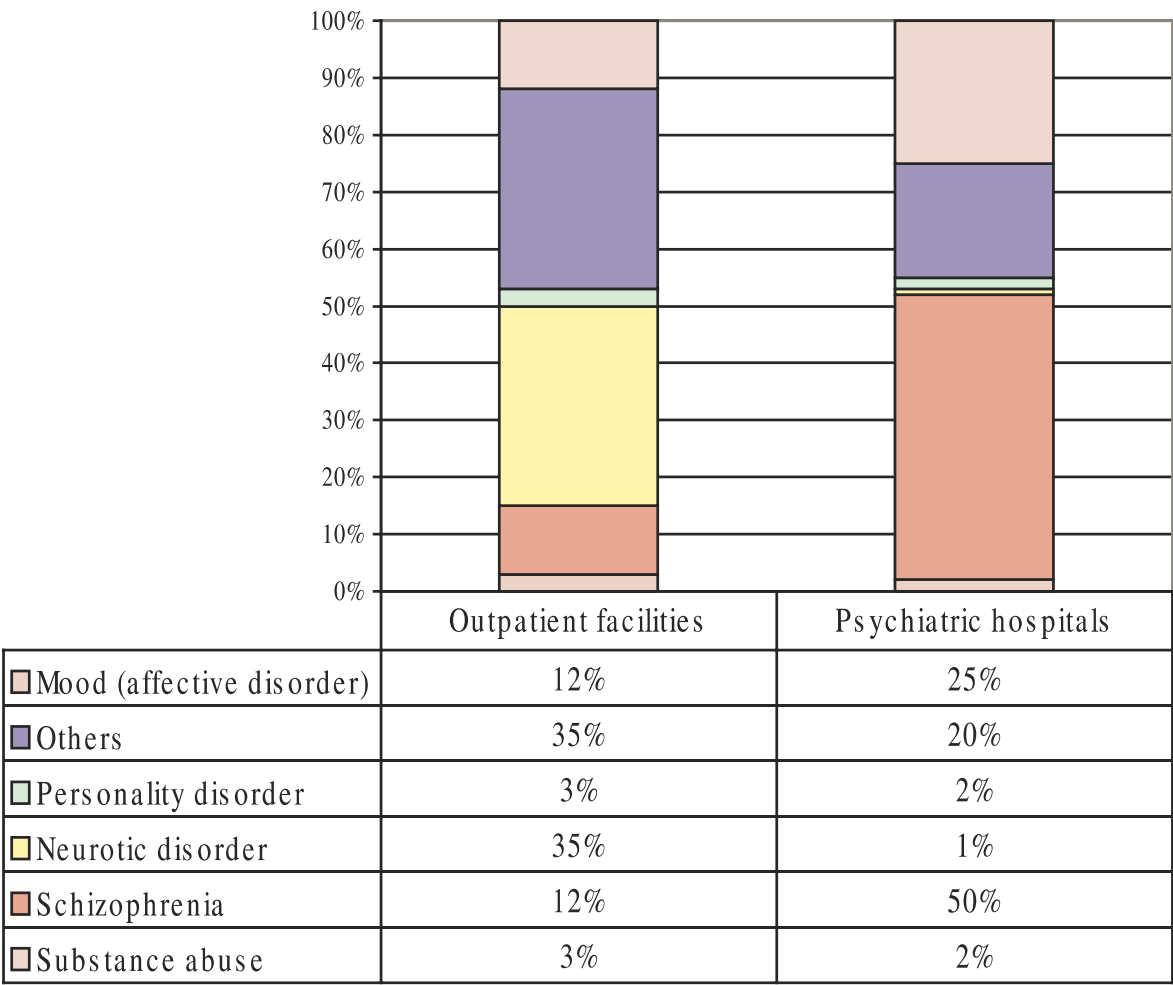
European Commission Humanitarian Office	(2003 - 2004)	<b>Euro 1,067,000</b>
Mental Health and Substance Abuse Department,	(2002 – 2005)	<b>US\$ 495,000</b>
WHO Geneva (through Italian government funding)		
Mental Health NHS Trusts (United Kingdom Twinning Partnership) (in kind, through technical assistance missions, including locum and secondment costs, and twinning initiatives with United Kingdom services)	(2003 – 2005)	<b>US\$ 120,000</b>
United Nations Trust Fund for Human Security (funded by Japanese government)	(2006 – 2007)	<b>US\$ 270,000</b>



Appendix Four - Staff working in mental health facilities in oPt



Appendix Five - Patients treated in mental health facilities by diagnosis in oPt



## Appendix Six - an Interview with Dr. Bassam Ashhab, Psychiatrist, Director of Community Mental Health Department (Ministry of Health)

### How would you describe the Palestinian mental health system 5 years ago?

Despite efforts to the contrary, the development of mental health services has not been a priority within the Ministry of Health. As a result, for several years the mental health system lacked many essential elements, as follows:

Most of the public community mental health centres were functioning as clinics rather than community mental health centres. Each 'centre' consisted of three rooms or less, and the psychiatrist, psychologist and social worker had to exchange the room between them when they were seeing a patient. For the staff and patients, this caused feelings of instability, disorganization and insecurity.

The human resources available to the mental health services were extremely limited, and it was not possible to hire new staff to help with the case overload.

There are no incentives or reinforcements for mental health staff (professional development, promotion, salary increase, etc.).

There is no Mental Health Directorate in place to provide the necessary managerial and administrative functions, and to plan and follow up the mental health staff and services.

There is a managerial and practical fragmentation between the psychiatric hospitals (administrated by the Hospitals Department of the Ministry of Health) and the community mental health centres (administrated by the Primary Health Department of the Ministry of Health) which has caused miscommunication, difficulties in coordination and misunderstandings.

### Besides the effects of lack of prioritisation and resources, what other difficulties do the mental health services, staff and service users face in the occupied Palestinian territory?

There are many external factors that affect our jobs and the services we provide. The main problem is the conditions in which people are forced to live in the occupied Palestinian territory, due to the Israeli occupation. For example, checkpoints, the Separation Barrier that is separating people and families from each other, the confiscation of lands, demolishing houses, the shelling of the Palestinian Authority infrastructure, all have impacted negatively on people's mental health and their ability to access mental health services.

As in any other society, Palestinian mental health patients, their families and mental health professionals themselves suffer from being stigmatised in dealing with the subject of "mental illness". Therefore there is a need to organize a national, systemized awareness-raising campaign that will help people to understand and to not be afraid of being mentally ill, or having a relative who is mentally ill and to seek

the suitable treatment from professionals instead of seeking help from traditional healers.

### You spoke about the situation within the mental health system five years ago, and you mentioned that change is in progress. Can you elaborate more?

After signing the mental health policy document (SOP) in 2004, between the Ministry of Health, WHO, French and the Italian Cooperation, the first progressive step was the expanding of three pilot community mental health centres in Hebron, Ramallah and Gaza City with the support of WHO, and the funds of ECHO.

New staff were recruited for these Centres and several training initiatives were carried out.

Anti-stigma and public education activities started, which involved several activities such as local newspaper inserts, posters, radio and television programmes and a theatre group.

Families Associations were established in the Hebron and Ramallah Centres and Bethlehem psychiatric hospital.

These accomplishments represent a strong beginning – and there is still a major need for systemic development of the mental health structure and services. Much more training is needed, rehabilitation of patients should become a priority, and a psychiatric nursing programme should be established.

### What are the future goals of the Mental Health public services?

For the necessary development to take place within the public mental health services, it is essential that a Mental Health Directorate be established, which can support and manage all public mental health services (both hospital and community mental health) under one umbrella -- devoted exclusively to this sector. It seems a simple goal, but one that we have been requesting for years from the Ministry of Health without success. Fortunately, the development of this Directorate is a component of the next phase of the WHO / Ministry of Health Project. With the support of the International Community over the past 2 years we have started a difficult journey in our long and serious commitment to developing mental health services in the occupied Palestinian territory. Therefore, it is now an optimal time for us to organize ourselves and establish our own Directorate.



## Appendix Seven – an interview with Dr. Issam Bannoura, Psychiatrist, Director of Bethlehem Psychiatric Hospital

### Is Bethlehem Psychiatric Hospital the only hospital in the West Bank that deals with mentally ill patients?

Yes, Bethlehem Psychiatric Hospital was established in 1944. The hospital has 280 beds and currently has about 160 inpatients, chronic and acute. In the past few years, we have been making an effort to lessen the number of newly admitted patients. We also have an outpatient clinic that provides services for people coming from different towns from the West Bank. The hospital employs 140 staff, half of which are nurses.

### What kind of patients do you deal with, and what are the most common problems?

Most of the cases that we deal with have serious psychiatric problems such as schizophrenia, mood disorders, obsessive/compulsive disorder, phobias, etc. Our treatment methodology is based mainly on whatever medical treatment is necessary, coupled with psychological treatment and support. In addition, we have the Occupational Therapy Unit, which is geared towards the rehabilitation of the patients.

### What developments have been made recently in the hospital?

Over the past two years, there have been a variety of new programmes introduced at the hospital, through the support of WHO, through the implementation of the Palestinian mental health policy document that was agreed on and signed by Ministry of Health, WHO, the French and the Italian Cooperation.

Several training missions have been implemented through the WHO Mental Health Project. Much of this has been done through a partnership with UK services who have sent British community mental health experts to cover different mental health subjects with our teams, for example therapeutic skills, community-based treatment, rehabilitation, case management, the roles and responsibilities of mental health professionals, multi-disciplinary teamwork, and so on.

In addition, new activities such as Families' Associations, Hearing Voices support groups, recovery support groups and the drama/theatre group have been established.

All of these activities have given us support and have empowered the staff in learning new ways of approaching and dealing with patients and their problems. It also gives us a new perspective and a different attitude towards psychiatry in general.

### What are the future goals for the hospital?

As agreed in the SOP, the hospital will continue its efforts to lessen the number of new admissions of patients, and to upgrade the quality of the outpatient clinic, so that it develops into a community mental health centre.

It will be necessary to integrate some of the hospital's human resources into the different community mental health centres. This is especially true of nurses, since there is currently a lack of nurses in the centres.

We also need to develop acute units in the regional general hospitals, also using the human resources of the psychiatric hospital.

If we are to accomplish this in the relatively near future, we will need more support from the Ministry of Health for mental health in general, through the establishment of an independent Mental Health Directorate. We also need to further empower and develop all of the community mental health services in order to reach a point where referrals to the psychiatric hospital are rarely necessary.

For the time being we need to improve the quality of life of the patients, to continue with all of the new programmes mentioned above and expand them to reach a greater number of service users and their families. We also need to improve our efforts in rehabilitation and in expanding the roles of nurses to encompass much more than a purely medical role.

## Appendix Eight - Bethlehem Psychiatric Hospital, my personal view, Dr. Ivona Amleh, Psychiatrist

When I started to work in the Bethlehem Psychiatric Hospital (Bethlehem Psychiatric Hospital) in 1999, as a psychiatrist born and educated in Croatia with very poor competence in Arabic, the situation was initially quite absurd – a psychiatrist who does not speak the language of her patients. But traditional Arab cordiality and hospitality, and a curiosity about foreigners, helped a lot.

My first impression regarding the situation was that the hospital was in a nice setting, surrounded by a large park. However, the condition of the buildings themselves was very poor. Only two sections (Acute Male and Convalescent Male) had relatively satisfactory environmental standards, while the rest (Chronic Male, Chronic, Convalescent and Chronic Female sections) were inadequate, old and in ill repair. However, very soon I got used to this obsolete environment and discovered that, inside that visual frame, the roles, relationships and practices were very much comparable to situations I had faced in the psychiatric wards in Croatia. Regarding the differences in management, I found at that time that the use of neuroleptics was apparently higher (a possible contributing factor was the poorer quality of the drugs), that ECT was used more frequently (due to lack of patience in waiting for the positive effects of treatment) and that the time spent by the doctor in talking to the patient was very short, directed mostly at identifying psychopathology and to order treatment to combat symptoms. Regarding the policy of restraint, the practice was (and still is), in addition to reasonable sedation, the use of seclusion in a single room. In very rare cases bed restraints are used.

Living in the occupied Palestinian territory is in many ways like living under permanent restraint (due to the Israeli occupation and its effects on all aspects of daily life), and being a mental health professional here means providing mental health services while being personally constantly exposed to conditions of chronic stress. I will mention, with a touch of irony, that one of the only positive aspects of the socio-political situation in the occupied Palestinian territory is that, from time to time, agencies from the international community decide to assist us, donate goods and support development.

So, it happened that in 2000 Bethlehem Psychiatric Hospital was assisted by ECHO and Handicap International, and the Female Convalescent Unit was renovated (since then, the conditions in the Acute Female Unit deteriorated so much that we were forced to move that Unit into the renovated Convalescent ward, creating overcrowded conditions but providing the patients with a safer and more decent place in which to receive treatment). The British Council supported the reconstruction of a part of the hospital's main building, transforming it into the current Occupational Therapy Unit.

WHO started its project with the Ministry of Health, aimed at implementing community-based mental health care in the occupied Palestinian territory, in 2003. Initially, this initiative was viewed by some hospital staff with the fear that the intention was to close the Bethlehem Psychiatric Hospital in the near future. Since then, these

fears have subsided, but certain scepticism regarding the ultimate success of this new approach to mental health care is still present, particularly amongst the 'older generation'.

As part of the WHO / Ministry of Health project, some new activities and approaches were introduced to our hospital. These have included Family Association groups which hold regular meetings, a Recovery programme as a new vision in our approach to our patients (mental health workers from different disciplines as personal supporters to patients, helping them to achieve their personal goals and to live a satisfying and productive life despite their illness), Hearing Voices groups and, finally, the Drama Project, in which the patients and staff perform jointly and communicate with the audience in order to break barriers, reduce stigma and find joint solutions.

All of these activities are still in the embryonic phase, but are progressing well. Their primary importance currently is in creating a new atmosphere through demonstrating alternative approaches to mental health care – and this is especially important for younger staff members to learn new methods in dealing with psychiatric patients, rather than traditional approaches. Some of these programmes are challenging the classical roles of mental health workers in our hospital, which were clearly defined and had not changed very much over the last decades. Now they deal with the patient and the other members of the mental health team differently, in order to arrive at the best possible treatment for the patient. The only possible way for this reform is a slow evolution, demonstrating with consistency and constancy that changes are for the benefit of all involved – mental health workers, our patients, their families and society.

### My vision for the Bethlehem Psychiatric Hospital over the next decade

I think that the Bethlehem Psychiatric Hospital generally offers to our patients a solid standard of classical psychiatric and medical care, in spite of the shortage of qualified staff and the lack of availability of up-to-date treatments. We definitely lack human resources and need to work on developing and promoting the skills of our teams. Another urgent element that should be taken into consideration is the need of renovating all of the wards that remain below health standards. Other immediate needs include a day care unit, a Rehabilitation Unit and programme, and sports facilities, which are all part of the future plans of the WHO / Ministry of Health project. These developments will definitely affect positively the mental health of our patients and strengthen our roles as their caregivers.



## Appendix Nine - “Impressions of Ramallah”, by Liz Bateman, Locality Manager, Hertfordshire Partnership National Health Service Trust

I first visited the Community Mental Health Team in Ramallah in May 2004 and returned again in September 2004. I plan to return as often as possible over the next several years.

I have worked in mental health in England for 24 years and trained as a social worker in Oxford. I currently manage mental health teams in Hertfordshire, which is about 30 kilometres from London.

When offered the opportunity to spend some time with staff working in West Bank, I was excited and honoured but did not really know what to expect.

Mental health services in England are well developed and staff work in multidisciplinary teams but liaise closely with other agencies such as housing, social services and welfare benefits.

Staff also have access to training and education programmes as well as supervision and appraisals.

The clients who use the services are not basically different from the people who use the mental health services in Ramallah. They all need advice, support and treatment to help them manage and cope with their mental health difficulties.

However this is where the similarities end and during my first visit the West Bank I realised that even though our services in England are better developed, I had a great deal to learn from the staff in Ramallah.

I would like to share with you what I learned and the lasting impressions I have.

I learned about dedication and commitment. I met staff who had to face closures and checkpoints to get to work. I talked with a social worker who travelled on foot and on a donkey to visit someone in a crisis.

I was impressed with staff who remained cheerful and optimistic despite working in unsatisfactory conditions.

I discovered the importance of the role of the family in supporting people with mental health problems and the fact that mental health services cannot refer clients on to other agencies such as housing and that there are no welfare benefits.

I tried to imagine how staff in England would react to working in these situations.

In Ramallah, I did not find dissatisfied or unhappy staff. I met lively, positive and hospitable people, keen to share their experiences but also eager to learn new skills and ways of working.

I know that we came to the West Bank to deliver a training programme but I believe

that we gained as much as we gave.

Since returning to England I think often about the people that I met and hope that next year they will be able to come to England to share some of their positive attitudes with staff here.

Clearly there is a long way to go before there are fully functioning community mental health centres in the West Bank but it is imperative that we acknowledge the work that is already taking place and the staff who are working under extremely difficult circumstances to provide services.

I would like to thank all whom I met for making us so welcome and for teaching us so much. I am looking forward to coming back to the occupied Palestinian territory and to welcoming you to England.

## Appendix Ten - The theory of recovery, Dr. Ivona Amleh, Psychiatrist, Bethlehem Psychiatric Hospital

What comes to your mind when we mention the word “recovery”? Is it not an idea of something hope-installing, enabling, awakening, regaining? We all have suffered in our life some traumatic events, losses, injuries, illnesses, and every one of us is able to recognize what was the most helpful for ourselves in achieving the wellness again, feeling recovered. Usually there was an inter-play of our inner strengths and the support of our surroundings that made the recovery happen.

But, if we turn to the field of severe mental illness, historically (and even in our days), people with such illness were not expected to recover. There is a certain public view of people diagnosed as mentally ill as being unable to take control over their own lives and, ultimately, as dangerous, resulting in often negative public and public services responses. Fortunately, there is a significant movement in mental health field which started in the 1980s and 1990s in western societies, and which involved mental health professionals and service users working together on challenging task – recovery even in the presence of severe mental illness. In order to achieve this ambitious goal, not only new practices were developed, but also traditional concepts of recovery needed to be redesigned.

What is the meaning of recovery in classical psychiatry? The two main tendencies in defining and understanding it are clinical recovery and social recovery. Clinical recovery implies that there is absence or reduction of symptoms and that recovery occurred because of effectiveness of the clinical treatment (like drugs, electro-convulsive therapy, psychotherapeutic methods). Social recovery implies that following the episode of mental health problem the person is again able to get back to the previous level of functioning regarding the person's roles, activities and relations.

The new concept of recovery is not concerned only with successful medical treatment and effective functioning within society, it wants more – it calls for personal recovery. Personal recovery is centred to the person's wellness and not to the illness itself; it is focused on personal development, not only on care. It means that the person (the patient) is asked about his/her needs and how those needs may be met. The mental health professionals are not there to decide what is the best for the person, they work with him or her, not for him or her. The person's own point of view is respectfully appreciated, the person is encouraged to take responsibilities, to be in control of decisions about his/her own life. The person has to take the active role in his own recovery, to guide this process, to discover his/her more active self, to develop new coping strategies. Furthermore, the person has to reflect about himself and to reach an insight in the past and current difficulties as well as to work on important relations in his/her life. Personal recovery requires self-confidence, self-esteem, self-awareness and self-acceptance. It requires the person to understand and to own his mental health problem as the best way to live with it or to overcome it.

Recovery is both the goal and the process; it is a long journey that may even last for years, but its ultimate point should be the person's final exit from psychiatric services. This journey involves the person in question but also many significant others from the person's surroundings. The role of the mental health professional is to be a reliable and constant supporter and facilitator, assisting the person in different stages of the recovery process. On this journey the service users and service providers are equal partners, who have different, but mutually valuable, expertise to offer. The service user is an expert of experience, and the service provider is an expert by profession – together, sharing the same commitment and belief, they can arrive at the breakthrough steps.

Any mental health problem has its starting point. The same is the case for recovery – it has to start at a certain point. Or, in words of one of the recovered patients whom I personally met, “Recovery begins the moment when you realize that it is possible!”



## Appendix Eleven – resume from *Working with Voices: Victim to Victor*, by Ron Coleman and Mike Smith (P & P Press Fife, 1997)

Discussions surrounding the development of social and democratic psychiatry in the latter part of the 20<sup>th</sup> century commonly refer to the need for a “paradigm shift”. A paradigm shift simply means the change in fundamental beliefs about something that alters the way we see the world. For more than 100 years, clinical psychiatry has regarded the phenomenon of hearing voices as an illness. This means that all symptoms are seen as a result of an existing illness within the person of which the origin is still unknown.

The ‘Hearing Voices’ approach deals with three misconceptions that people and professionals tend to hold, as follows: Hearing voices is solely the consequence of an existing illness within the person, most likely being schizophrenia, an illness of unknown origin; Schizophrenia is a diagnosis of an illness not related in an understandable manner with the life history of the person.

The person hearing voices is powerless against those voices and the voices are not owned by the person. Meanwhile, in fact, the voices are a person’s own experience, understandable from personal traumas or over-powering problems with life.

When the voice-hearing experience begins, there can be a multitude of responses. The very first reaction is at an emotional level -- whether this be positive or negative. It is not surprising that such a personal experience involves what can be considered to be the extremes of emotions.

Therefore, according to this approach, the most important focus is to work with voice hearers who have trouble coping with their voices and need support in overcoming the consequent powerlessness, in order to be able to begin living again. In addition to the support needed to deal with voices, the focus is also on becoming stronger in one’s own identity. Finally, it is important to assist the person in accepting that what “has happened has happened” – he or she should not feel guilty about it, but rather it needs to be placed into the context of his or her life history.

A crucial strategy to this approach is also to select positive voices and listen and talk only to them, and to try to understand them.

People can and do learn to cope with their voices and find a kind of equilibrium. In this state of balance, people consider the voices as part of themselves and their lives, and capable of having a positive influence. During this phase, the individual is able to choose between following the advice of the voices or their own ideas, and can say, “I hear voices and I accept it”.

## Acknowledgements

### Publication of this document:

The mental health team in the WHO office for oPt:  
Ms. Bradley Brigham, Ms. Rajiah Abu Sway, Dr. Othman Karamah, Ms. Areefa Abu Hadid, Mr. Shadi Jaber, Mr. Mahmoud Daher  
With editorial assistance from Mr Tony Day

### Technical advice:

The WHO department of mental health and substance abuse – Geneva,  
Dr. Benedetto Saraceno  
Dr. Shekhar Saxena  
Mr. Mark Van Omerren

### Technical advice support and consultancy:

The National Institute for Mental health – England  
Dr. John Jenkins  
Dr. John Mahoney

### ***WHO wishes to gratefully acknowledge the work, support and collaboration of the following:***

- Palestinian Ministry of Health  
Primary Health Care Directorate  
Mental Health Department: Dr. Bassam Ashab, Dr. Ayesh Samour, Dr Issam Bannoura, Dr. Riyad Al-Aqra’
- Dr. Sylvie Mansour – French Cooperation
- Dr. Mohamad Mandour – Italian Cooperation
- European Commission Humanitarian Aid Office – ECHO
- British and Italian Mental Health Consultants
- Mental Health Steering Committee
- Palestinian NGOs in oPt
- Palestinian Universities (Al-Quds University and Birzeit University)
- Other Palestinian Ministries (Ministry of Education and Ministry of Social Affairs)

***WHO wishes to acknowledge the generous funding by ECHO and the Italian Government given to the project over the last few years without which this work in improving Mental health services in the oPt would not have been possible***

WHO is grateful and would like to pay particular tribute to Bradley Brigham who as a Project Manager for Mental Health has given important service over the last 3 years and personal dedication in improving mental health services in oPt



*Damascus Gate- Jerusalem, 1927.( Elia Photo Studio)*



Cover photo: Elia Photo Studio

