

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN WEST BANK AND GAZA**



**World Health
Organization**



**Ministry of Health
Palestinian National
Authority**

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN WEST BANK AND GAZA

A report of the assessment of the mental health system in West Bank and Gaza using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

West Bank and Gaza

2006



**Ministry of Health
Palestinian National
Authority**

*WHO West Bank and Gaza Office
WHO Regional Office for the Eastern Mediterranean
WHO Department of Mental Health and Substance Abuse (MSD)*

This publication has been produced by the WHO, West Bank and Gaza Office in collaboration with the WHO, Regional Office for the Eastern Mediterranean and WHO, Headquarters. At WHO Headquarters this work has been supported by the Evidence and Research Team of the Department of Mental Health and Substance Abuse, Cluster of Non-communicable Diseases and Mental Health.

For further information and feedback, please contact:

- 1) Dr. Bassam Al-Ashhab, bassam_ashab@yahoo.com and
Dr. Ayesh Samour, ayesh_samour@hotmail.com*
- 2) Othman Karamah, WHO Jerusalem Office, oka@who-health.org*
- 3) Shekhar Saxena, WHO Headquarters, saxenas@who.int*

(ISBN)

World Health Organization 2006

Suggested citation: WHO-AIMS Report on Mental Health System in West Bank and Gaza, WHO and Ministry of Health, West Bank and Gaza, 2006.

(Copyright text as per rules of the WHO Office)

Acknowledgement

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system of West Bank and Gaza.

This project in West Bank and Gaza was implemented by the Mental Health team of WHO West Bank and Gaza Office (Othman Karameh, Bradley Brigham, John Jenkins, Rajia Abu Sway and Karam Abu Hadi and Mahmud Daher)

The project was also supported by Mohammad Taghi Yasamy, WHO, Regional Office for the Eastern Mediterranean.

The preparation of this study would not have been possible without the collaboration of the Palestinian Ministry of Health (particularly Bassam Al-ashhab, Ayesh Samour, Mohammad Aletiani, Ryad Al Aqraá and Essam Bannura), Ministry of Education, UNRWA, UNDP, National Secretariat of the Palestinian Children, Alquds, Bethlehem and Islamic Universities, Ibn-Sina School of Nursing, World Bank and WHO.

The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

For full information please refer to WHO-AIMS (WHO, 2005) on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

The project received financial assistance and/or seconded personnel from: The National Institute of Mental Health (NIMH) (under the National Institutes of Health) and the Center for Mental Health Services (under the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States; The Health Authority of Regione Lombardia, Italy; The Ministry of Public Health of Belgium and The Institute of Neurosciences Mental Health and Addiction, Canadian Institutes of Health Research.

The WHO-AIMS team at WHO Headquarters includes: Benedetto Saraceno, Shekhar Saxena, Tom Barrett, Antonio Lora, Mark van Ommeren, Jodi Morris and Grazia Motturi. Additional assistance has been provided by Kaia Jungjohann

The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in West Bank and Gaza. The goal of collecting this information is to improve the mental health services available to the Palestinian population and to provide a baseline for monitoring the change and evolution of the mental health system. Among its uses lie the monitoring of progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

The mental health policy (MH Services Organization Plan) for West Bank and Gaza was formulated in 2002 – 2003, and officially adopted by the Palestinian Ministry of Health (MoH) in 2004. It includes the following components: 1) developing community mental health services, 2) downsizing large psychiatric hospitals, 3) developing a mental health component in primary health care, 4) developing human resources in mental health related disciplines, 5) financing, 6) quality improvement, 7) monitoring systems, 8) involvement of users and families, 9) advocacy and promotion, 10) human rights protection of patients, and 11) equity of access across different groups. Essential medicines and an essential drug list, including psychotropic drugs, are available. These include 1) antipsychotic, 2) anxiolytic, 3) antidepressants, and mood stabilizers. Although there is no mental health legislation, the existing public health law provides for, and covers, certain basic and minimum aspects related to mental health matters.

Two and a half percent of governmental health care expenditure is directed towards mental health. Of all expenditure spent on the public mental health system, 73% is directed to psychiatric hospitals. In terms of affordability of mental health services, 100% of the population has free access to services and to essential psychotropic medicines.

There are no human rights organizations working for mental health issues. Inpatient facilities, day care and residential facilities specifically for community-based inpatient psychiatric units are also not available in the territory.

Currently, the national mental health authority is divided between two different departments in the MoH, which creates fragmentation. The Community Mental Health Department (CMHD) falls under the authority of the Primary Health Department, while the psychiatric hospitals are part of the Hospitals Department. Despite this division, the CMHD and psychiatric hospitals work together to advise on mental health policies and legislation, in service planning, monitoring and quality assessment and in coordination of mental health services. As part of the current WHO/MoH Community Mental Health Project, this collaboration will be strengthened.

There are 42 outpatient mental health facilities available in The West bank and Gaza . These outpatient facilities treat 33,167 users in 2004 (911.8 users per 100,000 population). The users treated in outpatient facilities are primarily diagnosed as suffering from neuroses, stress-related disorders and somatoform disorders (35%); and other disorders like epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorders (35%); mood disorders (12%); schizophrenia (12%); and approximately 6% are diagnosed with personality or substance abuse disorders.

There are two psychiatric hospitals available in the territory, for a total of 319 beds (8.76 beds per 100,000 population). Twenty-seven percent of patients spend less than one year in the psychiatric hospital, 12% spend 1-4 years, 17% spend 5-10 years, and 44% percent of patients spend more than 10 years in mental hospitals.

Concerning training, only one percent (1%) of the training for medical students is devoted to mental health, in comparison to 9 % percent for nursing students.

In terms of refresher training, neither primary health care doctors nor nurses have received refresher training in mental health. While 27% of non-doctor/non-nurse primary health care workers have received such training. Police officers, judges or lawyers have not received any educational activities on mental health. Assessment and treatment protocols for key mental health conditions are not available.

The total number of human resources working in mental health facilities or private practices is 268 (7.31 per 100,000 population). The breakdown, according to profession is as follows: 32 psychiatrists (0.87 per 100,000 population); 12 other medical doctors, not specialized in psychiatry (0.32 per 100,000 population); 125 nurses (3.43 per 100,000 population); 36 psychologists (0.98 per 100,000 population); 40 social workers (1.09 per 100,000 population); 8 occupational therapists (0.21 per 100,000 population); 15 other health or mental health workers (0.41 per 100,000 population).

There is one governmental department (part of the Ministry of National Economy) responsible for user/consumer protection in addition to a number of NGOs in the territory. Beside that there are 150 family members that represent the nucleus for the growing Family Associations for mental health service users.

There are coordinating bodies overseeing the public education and awareness campaigns on mental health/psychosocial and mental disorders. Ministries of Health and Education, national and international NGOs, professional organizations and international agencies including UNICEF and WHO, Italian Cooperation, French cooperation, and others have all promoted public education and awareness campaigns in the in the last 3 years.

A formally defined list of individual data items that should be collected by all mental health facilities exists. Compliance by NGOs is weak. Research activities related to MH are limited and basic in nature.



WHO-AIMS REPORT FOR WEST BANK AND GAZA

Introduction

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in the occupied Palestinian territories (oPt). The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Background Information

In 1947 the United Nation passed the partition plan that divided historic Palestine into two states, a Jewish state and Arab state with Jerusalem and Bethlehem under special international law/regime. In 1948 the state of Israel was established, the Arab one was not. Instead the two areas that supposedly should have formed the Arab state, namely The West Bank and Gaza, were annexed to Jordan and Egypt respectively. In 1967 Israel occupied both of these areas and applied its military administration and assumed its legislative, executive and judicial powers.

In 1991 a Middle East Peace Conference, under the auspices of international community, convened in Madrid. This was followed in 1993 by the “Oslo Agreement” between the Palestinian Liberation Organization (PLO) and Israel. The Agreement establishes the Palestinian Authority (PA) which formed an Interim self government in 1994 in certain areas of West bank and Gaza. {It is worth noting that The West Bank and Gaza remain occupied territory under the International Law}.

The West Bank and Gaza comprise two areas geographically separated. These areas are of 6,170 square km of which 5800 square km are in West Bank and 365 square km in Gaza.

The nascent Palestinian Authority divided West Bank and Gaza into 15 governorates, 10 in West Bank and 5 in Gaza. A governor heads each of these. The governorates are subordinate to the Ministry of Local Government and cooperate with the mayors and heads of village councils in their respective districts.

Demography

The total population of The West Bank and Gaza is 3,637,000 million with 60% of the population living in 400 villages and 27 refugee camps. Forty- seven percent of the population is under 15 years of age and 2% are above 60 years of age with a median age of 16.7. Arabic does the official and main language and Arabs constitute the main ethnic group. Religious groups include Muslims and Christians in addition to a very small Jewish minority (in the Nablus district).

The crude birth rate has declined over the years from 46.5/1000 in 1995 to 28.6 /1000 in 2004. The crude death rate in the territory is 2.8 per 1000 and the infant mortality rate is 25/1000.

The population growth rate is decreasing. It stands at 2.6% (in 2004). Fertility rate is also decreasing progressively from 4.34 in 2000 to 4.19 in 2004. Life expectancy is 74.1 years for females and 71.1 years for males. The adult literacy rate is 91%.

Health System Structure

The Ministry of Health (MoH) is the governmental agency responsible for health and health care services in the oPt. Apart from its role as the policy and planning body, the MOH is by far the largest provider of primary and secondary health care services. In addition to the MoH, three other important providers exist. These are the United Nation Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), NGO s and the private sector.

More than 19,544 people are working in the health sector with 56.92% employed by the MoH, 43 % by the nongovernmental (NGO) sector. Accurate figures regarding the private sector is not available.

The governmental mental health services in West Bank and Gaza are provided through the Ministry of Health Mental Health (Primary Health Care Department and Hospitals Department) which is responsible for policy making, organization, programming, and implementing the services, in addition to providing some coordination at different levels and activities among different providers.

As mentioned above, organizationally, the Ministry of Health's mental health service has two structures, the community services, which are part of Primary Care services section, and the hospital services, which is part of secondary care services. The community services are comprised of 15 out-patients governmental community centres/clinics scattered in the 15 districts/ localities. In addition, there are more than 20 other clinics managed by NGOs and the private sector.

There are two government-run hospitals with 319 beds, one in Bethlehem City and the other in Gaza City.

Health Status of the Population

The Palestinian health system is in the evolution/development stage. Compared with other WHO/EMRO countries the health indicators are good. The epidemiological transition is prevailing. Behavioral illnesses, chronic diseases of the cardiovascular system and mental health illnesses are slowly replacing infectious disease profile. Diabetes, cancer and accidents are the most common health problems.

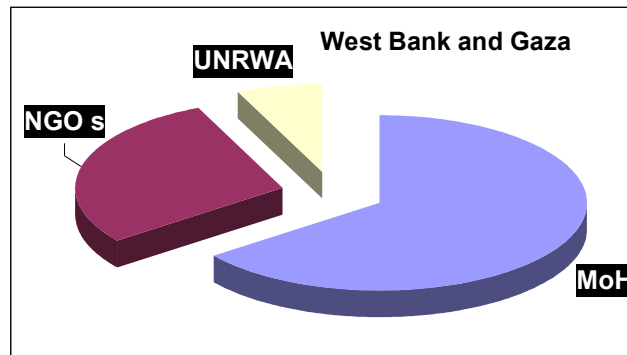
Health care services

A. Primary Health Care Services

The MoH provides for 56.5 % of primary health care services, followed by NGO s with 36.2 % and then by UNRWA with 7.3%. The total number of Primary Health Care centres in the territory is 731. The MoH operates 413 centres, NGO operates 265 centres

and the rest (53) are operated by UNRWA. There are tens of private settings operated by private organizations and individuals. The ratio of primary health care physicians is 17.2/100,000.

Figure A: Share of services by different providers



B. Secondary care services/hospitals.

There are 77 hospitals in West Bank and Gaza. The total number of beds is 4824 with a ratio of 13.26/10,000 (807 persons/bed). The MoH operates 22 general hospitals and is the largest provider of secondary health care services representing 55.6 % of the total secondary services. The average length of stay in Governmental hospitals is 2.6 days and the occupancy rate of 81.1%

Psychiatric services are provided only by MoH in two hospitals in the West Bank with 280 beds and 39 beds in Gaza. The average length of stay is 72.2 days and the occupancy rate is about 52.3%. NGOs operate 31 general hospitals with 1565 beds. UNRWA operates one hospital with 63 beds. The private sector operates 23 hospitals with 461 beds.

C. Tertiary Care Services

Makased hospital in Jerusalem is the main referral hospital for the West Bank. The private sector is another major provider of tertiary care services, especially advanced diagnostic services. The main provider of Emergency Medical Services is the Palestinian Red Crescent Society (PRCS).

Health Finance and Economy

The West Bank and Gaza is a lower middle income economy. Agriculture contributes about 7% of the total GDP; the industrial sector contributes about 17%, trade 13.6%, tourism about 11% and transportation 5.4% of the GDP. The Gross National Production was USD 3,705,000 million in 2003. The GDP was USD 869 Per Capita in 2003. The MoH expenditure as percentage GDP is 3.02. Three main sources of health finance exist: these are general taxation 60%, health insurance premiums 25-30% and co-payments about 8.4 % of the total. Donor contribution continues to be an important source of support to the MoH budget. The MoH is receiving its allocated funds through budgetary process from the Ministry of Finance. The per capita health expenditure is USD 122 of which USD 26.3 are spent by the MoH. Recent survey indicates that 56% of the population is poor and 23% is extremely poor.

The data was collected in 2005 and is based on the year 2004.

Domain 1: Policy, Plans, and Legislation

The mental health policy (Mental Health Service Organisation Plan, SOP) for West Bank and Gaza was officially adopted by the MoH in 2004 and includes the following components: 1) developing community mental health services, 2) downsizing large mental health hospitals, 3) developing mental health component in primary health care, 4) development of human resources, 5) financing, 6) Quality improvement, 7) monitoring system, 8) involvement of users and families, 9) advocacy and promotion, 10) human rights protection of patients, and (11) equity of access across different groups.

It is worth noting that a policy plan for the oPt has recently been developed. However, it will take years before such policy is implemented on the ground and makes a positive impact on services.

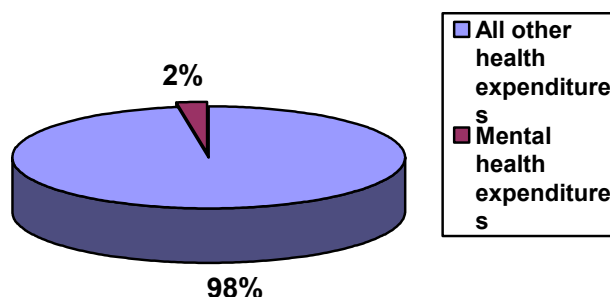
Essential medicines, including essential psychotropic medications, are present in the territory. This includes: antipsychotic, anxiolytic, antidepressants, and mood stabilizers. Although there is no specific mental health legislation, the old public health law provides for and covers certain basic and minimum standards related to mental health issues. There is no disaster/emergency preparedness plan for Mental Health.

A 5-year implementation plan accompanies the SOP. The plan contains the same components as the mental health policy but also includes a budget, timeframe, and specific goals. Some of the goals identified in the last Mental Health plan have been reached within the last calendar year.

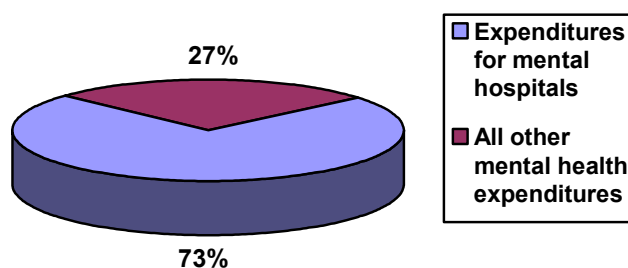
Financing of mental health services

There is no specific/defined budget for mental health services in the territory. The overall MoH budget is USD 98,421,543.00 USD of which only USD 2,474,435.38 USD is spent on Mental Health services. These figures are based on a recent study done by WHO office in Jerusalem which is based on data collected from the MoH. It is estimated that 2.5% of health care expenditures of the MoH are directed towards mental health. Of which 73% is spent on psychiatric hospitals. In terms of affordability of mental health services, the population has free access to services and to essential psychotropic medicines. For those that have to pay for their medicines out of pocket, the cost of antipsychotic medication is two USD per day (23% of daily minimum wage), and the cost of antidepressant medication is USD 1.33 per day (15% of daily minimum wage). All mental disorders are covered in social insurance schemes.

**GRAPH 1.1 HEALTH EXPENDITURE
TOWARDS MENTAL HEALTH**



**GRAPH 1.2 MENTAL HEALTH
EXPENDITURE TOWARDS MENTAL
HOSPITALS**



Human rights policies

Human rights organizations exist in oPt. However, there is no national or regional human rights review body which has the authority to oversee and inspect mental health facilities and impose sanctions on those facilities that persistently violate patients' rights.

There are currently plans for developing legislation that will be submitted before the legislative council which would make such reviews mandatory for all mental health facilities. In terms of training, no mental staff had training or other type of working session on human rights in the year of assessment.

Domain 2: Organization of Mental Health Services

Currently, the national mental health authority is divided between two different departments in the MoH which creates fragmentation. . The Community mental health Department falls under the authority of Primary Health Care while the psychiatric hospitals falls under the Hospitals administration. Despite these divisions, the CMHD and psychiatric hospitals provide advice to the government on mental health policies and legislation. They are also involved in service planning, monitoring, quality assessment and coordination of mental health services. Mental health services are organized in terms of catchment/service areas. All districts are covered by mental health (clinics) with one hospital in each of the two regions of the territory.

Mental health outpatient facilities

It was estimated that there are 42 public, and private outpatient mental health facilities available in the oPt, of which 7 % are for children and adolescents only. It is estimated that about 37% of all users are female and about 15% are children and adolescents. These out patient facilities treat 33167 users (911.8 users per 100,000 population). The diagnoses of users treated in outpatient facilities are primarily diagnosed as neurotic, stress related and somatoform disorder (35%) and other disorders (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorders) (35%).

The average number of contacts per user is 4 visits per year. Sixty percent of outpatient facilities provide follow-up care in the community centres but no facility has mobile teams.

In terms of available treatments, up to 50% of the users of outpatient facilities in the last year had received one or more psychosocial interventions. All outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a near-by pharmacy all year long.

Day treatment facilities

There are no day treatment facilities available in the oPt. The aforementioned SOP 5-year plan will consider the development of some of treatment facilities if there are funds available.

Community-based psychiatric inpatient units

There are no inpatient units in the oPt neither for elderly or adult. In the Five Years Plans are their in the future to have inpatient units in general hospitals.

Community residential facilities

There are no community residential facilities available in the territory. There are future plans to have community residential facilities in the territory for mentally ill users. Some mentally and chronically ill patients (people with mental retardation) are residents of residential facilities which are not specific for mental health.

Mental hospitals

There are two mental hospitals available in the oPt for a total of 319 beds (8.76 beds per 100,000 population). Both hospitals are organizationally integrated with mental health outpatient facilities. There are no beds in mental hospitals reserved for children and adolescents, only but separate sections for males and females are available. The number of beds has decreased by 11% in the last five years. These facilities treat 879 users (24.17users per 100.000 population). Thirty seven percent of patients are female. The patients admitted in mental hospitals belong primarily to the following two diagnostic groups: schizophrenia (50%) and mood/affective disorders (25%). On average patients spend 69.27 days in mental hospitals. More than 27% of patient spend less than one year in mental hospital, 12% spend 1-4 years, 17% spend 5-10 years, and 44% of patients

spend more than 10 years in mental hospitals. The occupancy rate in mental hospitals is 52%.

Few patients (1-20%) in mental hospitals received one or more psychosocial interventions in the past year. All mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility.

Forensic and other residential facilities

In addition to these facilities there are 6 residential facilities for people with mental retardation of any age and three facilities for people with substance abuse.

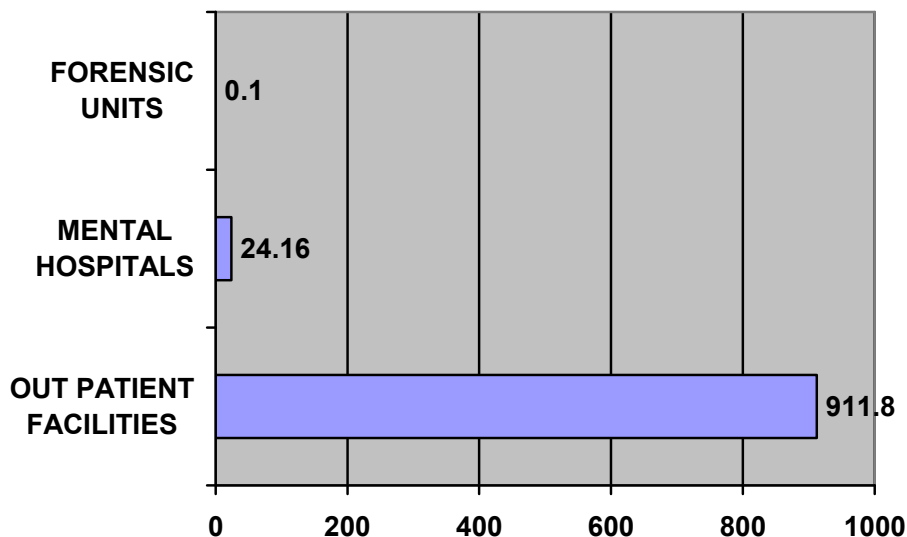
There are 7 forensic beds in mental hospitals. Some beds in the mental hospital are used by forensic patients when necessary. By the end of the year of the study (2004) five patients were admitted, four (80%) of them were for more than ten years and one between 1-4 years in forensic beds.

Human rights and equity

About 40% of all admissions to mental hospitals are involuntary. Between 6-10% of patients were restrained or secluded within the last year in mental hospitals. 87.7% of the psychiatry beds in the oPt are located in or near the largest city. Such distribution in the current political situation prevents access for rural and other users of services.

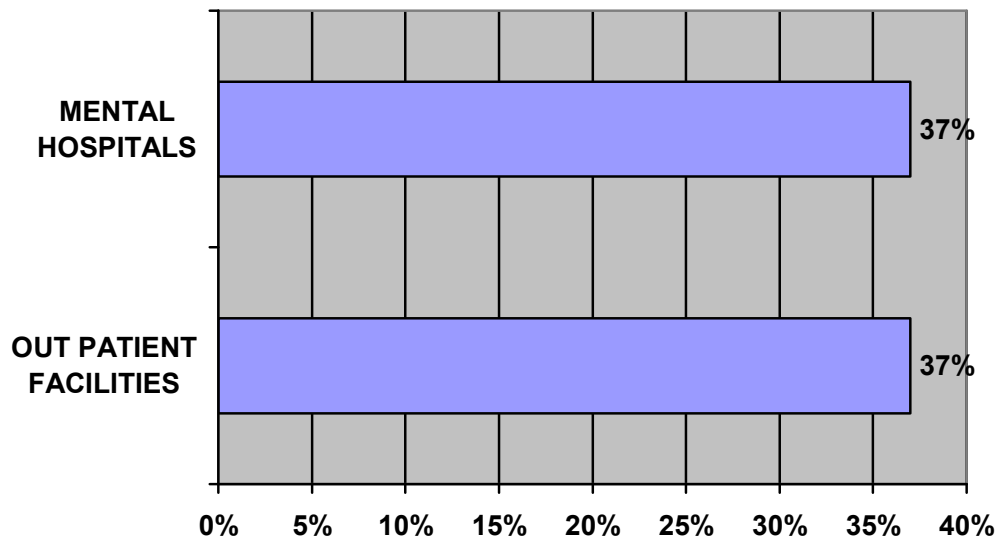
GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)

Summary
Charts



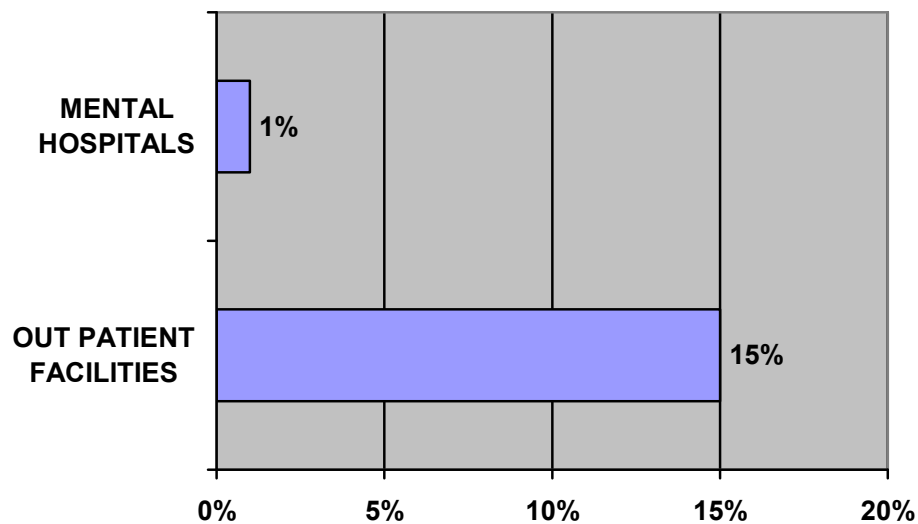
Graph 2.2: The majority of the users are treated in outpatient facilities, while the rate of users treated mental hospital is lower

GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



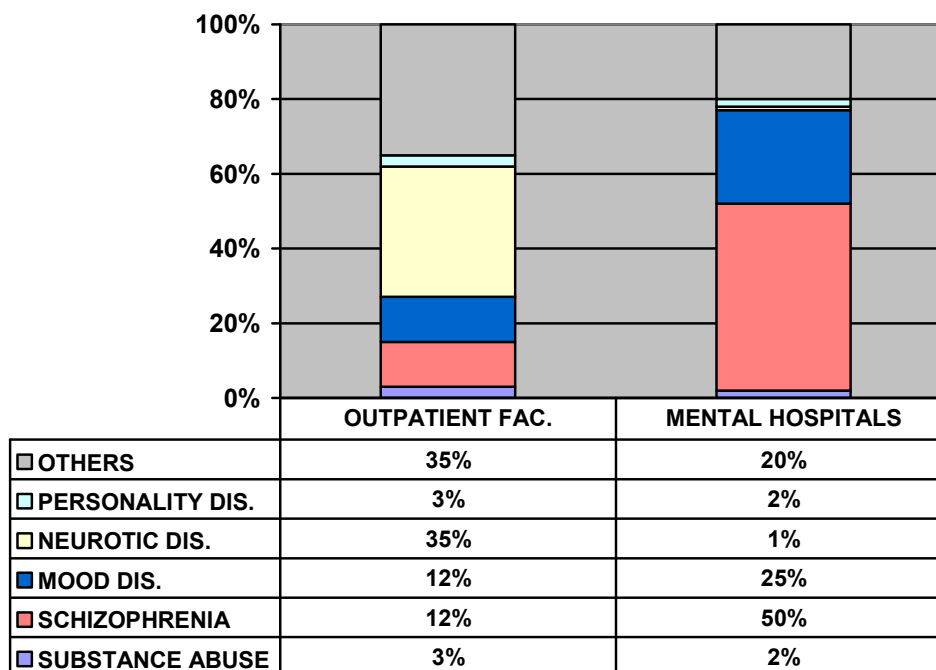
Graph 2.3: Female users make up approximately 37% of the population in all mental health facilities in the territory

GRAPH 2.4 - PERCENTAGES OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES



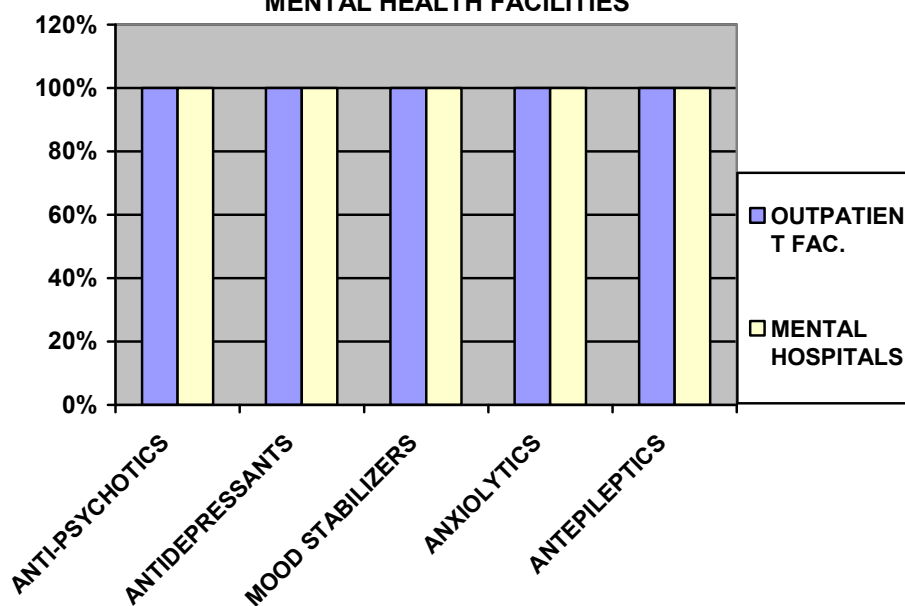
Graph 2.4: The percentage of users that are children and/or adolescents varies substantially from facility to facility. The proportion of children users is highest in mental health outpatient facilities and about 1% in mental hospitals.

GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS

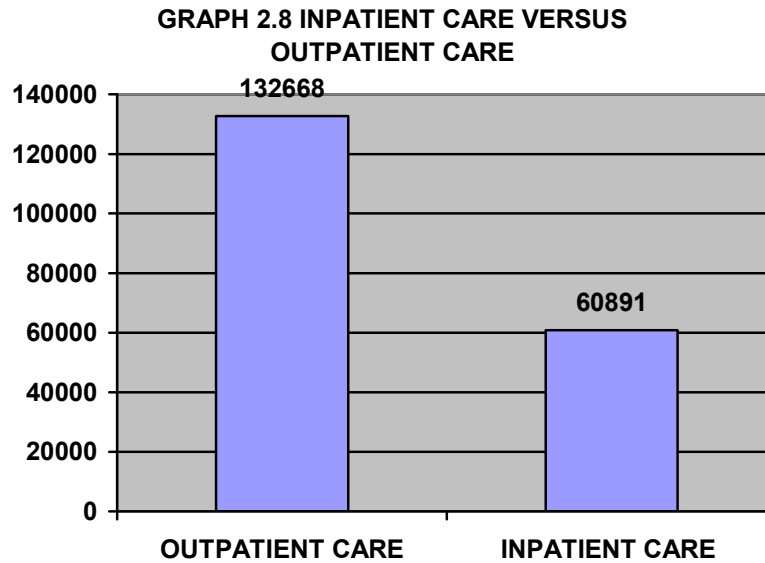


Graph 2.5: The distribution of diagnoses varies in different facilities, so while the diagnoses of neurotic disorders, mood disorders and "other" diagnoses are most prevalent in outpatient facilities, schizophrenia and affective disorders diagnoses and "other" diagnoses are most frequently made in mental hospitals.

GRAPH 2.7 - AVAILABILITY OF PSYCOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



Graph 2.7 Psychotropic drugs are largely available in both outpatient and mental health facilities



Graph 2.8: The ratio between outpatient care contacts and days spent in mental hospitals is an indicator of extent of community care: in this territory the ratio is 1.48 outpatient visits for every inpatient day.

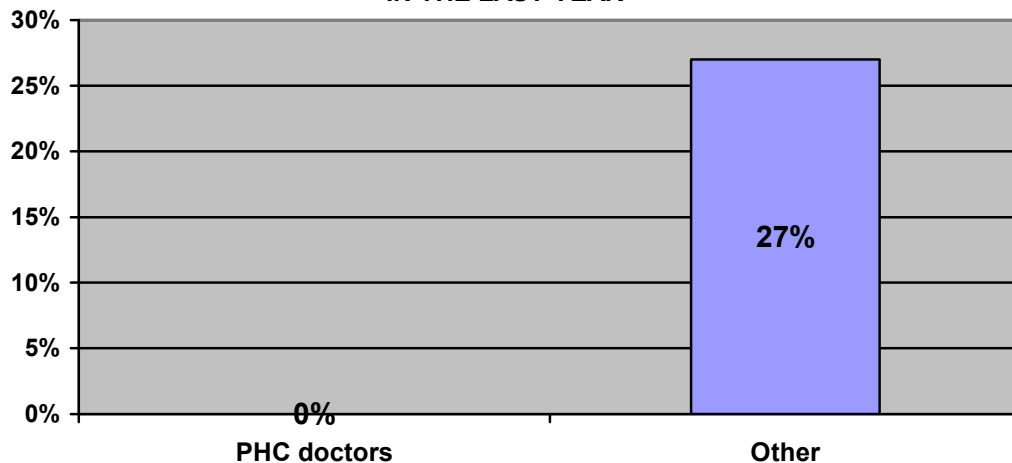
Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

Only 1% of the training for medical doctors students is devoted to mental health, in comparison to 9 % percent for nursing students.

In terms of refresher training, neither primary health care doctors nor nurses have received refresher training in mental health, while 27% of non-doctor/non-nurse primary health care workers have received such training.

GRAPH 3.1 - % OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR

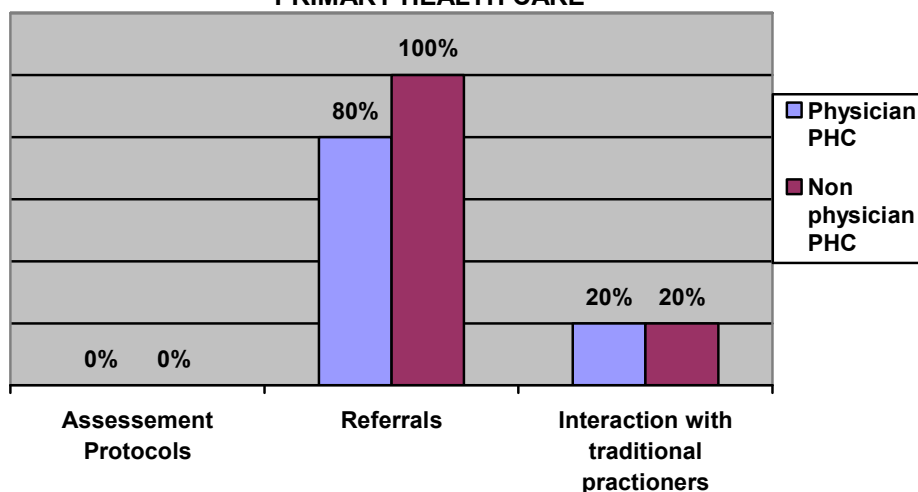


Mental health in primary health care

Both physician based and non-physician based PHC clinics are present in the territory. Assessment and treatment protocols for key mental health conditions are not available. All or almost all physician-based primary health care clinics refer cases to mental health professional. Most of these clinics, however, make more than one referral per month to a higher level of care.

As for professional interaction between primary health care staff and other care providers, the majority of primary care doctors (between 80-100%) have interacted with a mental health professional at least once in the last year. Only a few of physician-based PHC facilities (between 1-20%) have had interaction with a complimentary/ alternative/ traditional practitioner, same applies for the non-physician based clinics, and the majority of mental health facilities.

GRAPH 3.2 - COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE



Prescription in primary health care

Non-doctor primary health care workers are not allowed to prescribe psychotropic medications. In contrast, primary health care doctors are allowed to prescribe without restriction. As for availability of psychotropic medicines, all physician-based PHC clinics (80-100%) have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a nearby pharmacy all year long.

Domain 4: Human Resources

Number of human resources in mental health care

The total number of human resources working in public mental health facilities, NGO and private practice is 268 (7.31 per 100,000 population). According to profession the breakdown is as follows: 32 psychiatrist (0.87 per 100,000 population); 12 other medical doctors not specialized in psychiatry (0.32 per 100,000 population); 125 nurses (3.43 per 100,000 population); 36 psychologists (0.98 per 100,000 population); 40 social workers (1.09 per 100,000 population); 8 occupational therapists (0.21 per 100,000 population); 15 other health or mental health workers, including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors (0.41 per 100,000 population).

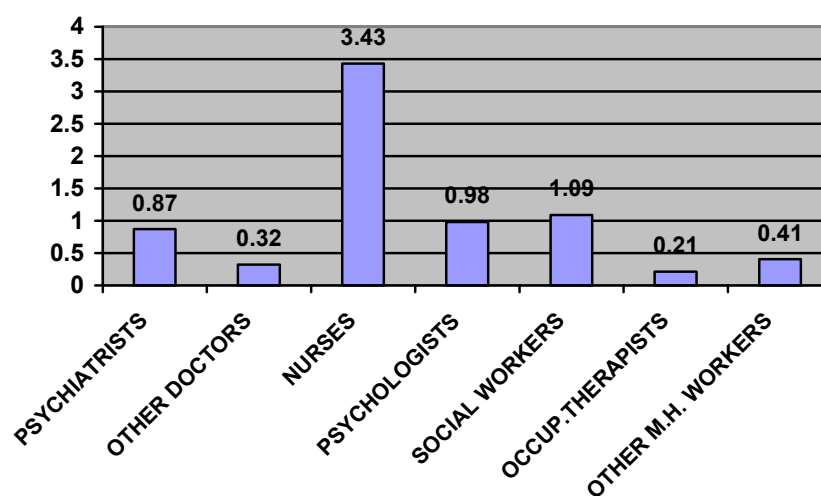
None of the psychiatrists work only for government administered mental health facilities, while 47% work for NGOs/for profit mental health facilities/private practice, and 53% work for both sectors. Sixty-four percent of psychosocial staff (psychologists, social workers, nurses and occupational therapists) work only for government administered mental health facilities, 28% work only for NGOs/for profit mental health facilities/private practice, while 8% work for both sectors.

Regarding the workplace, 28 psychiatrists and 3 of other medical doctors, not specialized in psychiatry, work in outpatient facilities, 4 psychiatrists and 9 of other medical doctors, not specialized in psychiatry, work in mental hospitals.

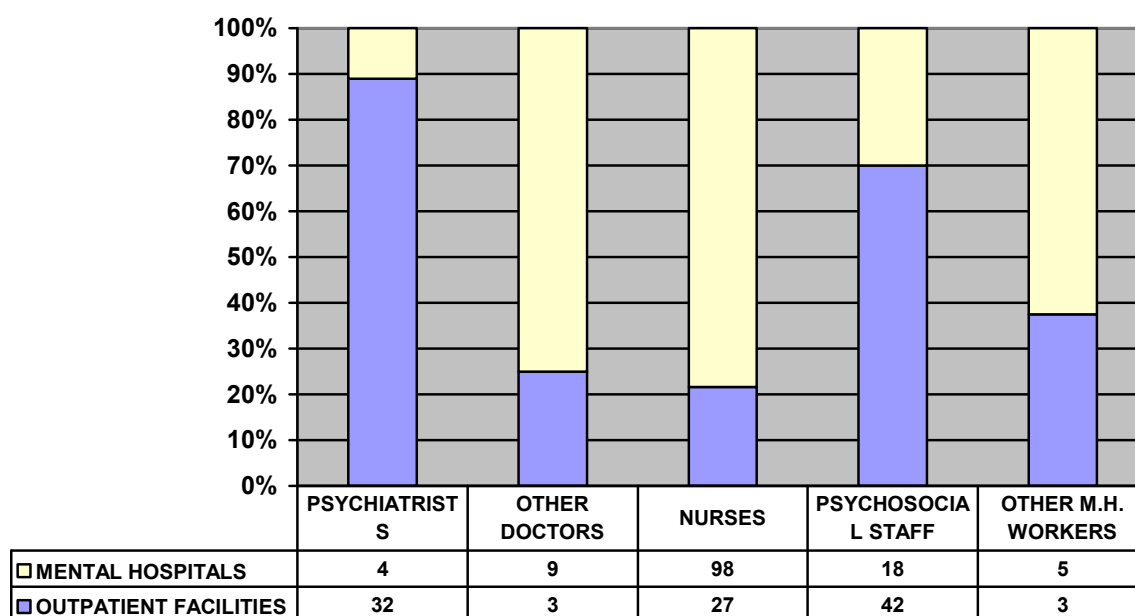
Concerning nurses, 27 work in outpatient facilities and 98 in mental hospitals. Forty-two psychologists, social workers and occupational therapists work in outpatient facilities and 18 in mental hospitals. With regards to other health or mental health workers, 3 work in outpatient facilities and 5 in mental hospitals. In terms of staffing in mental health facilities there are 4 psychiatrists per bed (0.01 per 100,000 population) and 98 nurses (0.31 per 100,000 population) in mental hospitals.

Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 23 per bed (0.08 per 100,000 population) in mental hospitals.

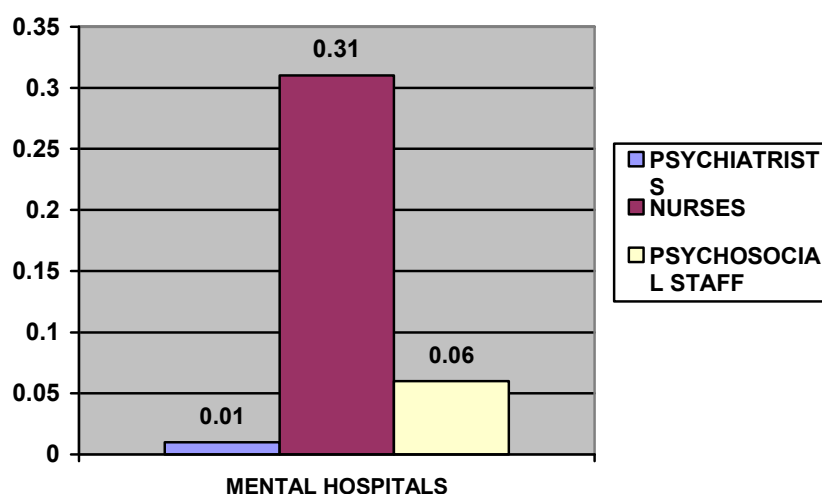
GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



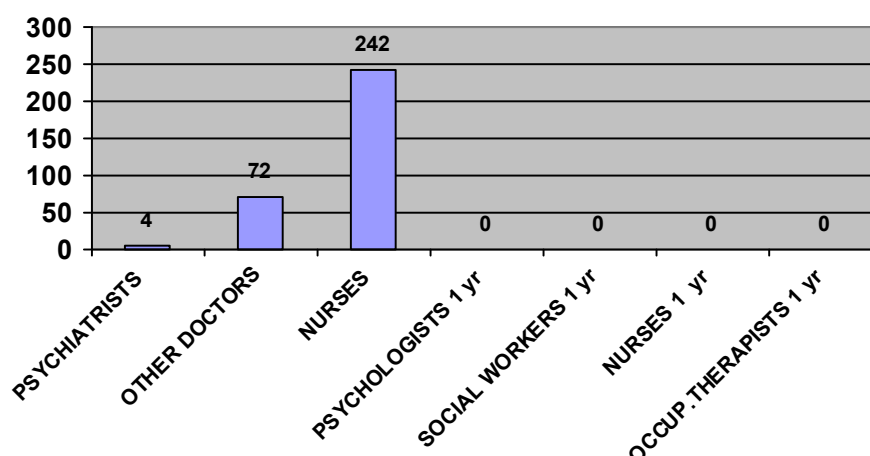
GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS



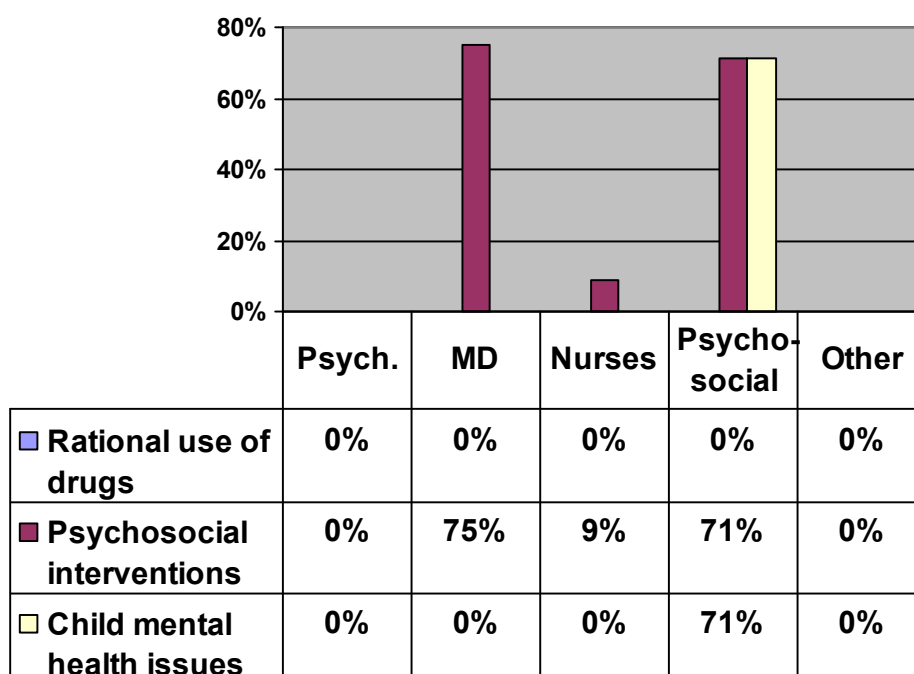
Training professionals in mental health

The number of professionals graduated last year in academic and educational institutions is as follows: 4 psychiatrists (0.1 per 100,000 population); 72 other medical doctors, not specialized in psychiatry (1.97 per 100,000 population); 242 nurses (6.65 per 100,000 population), 0 psychologists with at least 1 year training in mental health care, 0 social workers with at least 1 year training in mental health care, 0 occupational therapists with at least 1 year training in mental health care, 0 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). None of the psychiatrists have immigrated to other countries within five years of the completion of their training.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH



GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



Psych = psychiatrists; MD =other medical doctors not specialized in psychiatry; psychosocial staff = psychologists, social workers, and occupational therapists. Others = other health and mental health workers

Consumer and family associations

There is one governmental department (part of the ministry of National Economy) responsible for user/ consumer protection in addition to a number of NGOs in the territory. Beside that there are 150 family members that represent the nucleus for family associations for mental health users. All these user associations are still nascent department/organisations. No governmental financial support to these organizations is available.

These organizations have not been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years.

While there is no interaction between mental health facilities and consumer associations, some mental health facilities have had interaction with family associations.

In addition to consumer and family associations, there are more than 70 NGOs in the oPt involved in individual assistance activities such as counselling, housing, or support groups.

Domain 5: Public Education and Links with other Sectors

Public education and awareness campaigns on mental health

There are coordinating bodies overseeing the public education and awareness campaigns in mental health/psychosocial and mental disorders. Ministries of Health and Education, NGOs, professional organizations and international agencies including UNICEF and WHO, Italian Cooperation, French Cooperation, and others have all promoted public education and awareness campaigns in the last five years. These campaigns have targeted some health care providers, teachers and the general population but not children, adolescents, women, trauma survivors or other vulnerable groups.

Legislative and financial provisions for persons with mental disorders

At the present time there are no legislative provisions to provide support for users: 1) concerning a legal obligation for employers to hire a certain percentage of employees who are disabled, 2) provisions concerning protection from discrimination (dismissal, lower wages) solely on the account of a mental disorder. 3) Provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders.

Links with other sectors

In addition to the lack of legislative and financial provisions there are no formal collaborations with the departments/agencies responsible for primary health care, HIV/AIDS, reproductive health, substance abuse, child protection, education, employment or housing or welfare. In terms of support for children and adolescent health, 1424 (65%) of primary and secondary schools have either a part-time or full-time counsellors and 50-80% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

There is no information regarding the prisoners with psychosis or with mental retardation. Regarding mental health activities in the criminal justice system, mental health professionals are providing services whenever a request by the prison department is submitted. As for training, no police officers, judges and lawyers, have participated in educational activities on mental health in the last five years. In terms of financial support for users, there is no access to programs outside the mental health facility providing outside employment for users with severe mental disorders.

Finally, a small but unknown numbers of people who receive social welfare benefits do so for a mental disability.

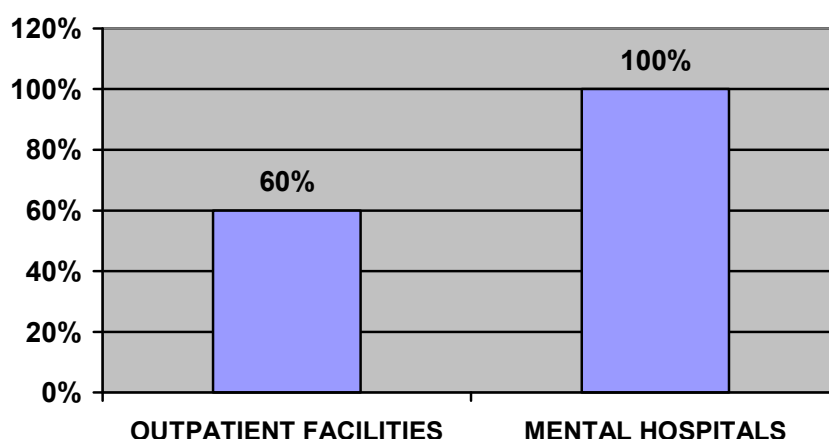
Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. This list includes the number of beds, admissions, length of stay, and patient diagnoses. The government health department received data from 100% of mental hospitals and 60% of mental health outpatient facilities. Based on this data, a report was published which including some comments on the data. In terms of research, a small percentage of all health publications in the territory were on mental health. This research focused on the following topics: non epidemiological studies and psychosocial interventions.

Table 6.1 - % of M Health facilities collecting and compiling data by type of information

TYPE OF INFORMATION COMPILED	MENTAL HOSPITALS	OUTPATIENT FAC.
N° of beds	319	NA
N° of inpatient admissions/users treated in outpatient facilities.	100%	60%
N° of days spent/user contacts in outpatient facilities.	100%	60%
N° of involuntary admissions	100%	NA
N° of users restrained	100%	NA
Diagnoses	100%	60%

GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT



Strengths and weaknesses

There is an approved policy plan in the oPt and the stages of implementation have begun. There is a relatively good number of mental health centres distributed in the territory in addition to the two hospitals in the West Bank and Gaza, one in each of the main two regions of the territory. This situation is currently cumbersome, due to the fact that these outpatient facilities and hospitals are under separate structures within the MoH, and still these facilities do not yet fulfil the criteria for community mental health services.

Most resources for mental health are dedicated to the psychiatric hospitals. Access to services and to essential medication is guaranteed by the MoH, but there are no inspection boards/ mechanisms to protect human rights of patients. Training needs, both for mental health workers and for other health professionals, are high. There is a need to implement, over time, all the components of the mental health policy plan, including the reorganization of the services according to its recommendations.

Compared to neighboring countries, the West Bank and Gaza has, through the technical assistance and funding support of WHO, Italian Cooperation and French Cooperation (in the form of 3 long-term MH projects being implemented with the MoH) are in the process of implementing a well-developed a mental health policy. This policy now needs to be fully supported and enforced by legislation and review bodies. A five-year implementation plan for the policy document is under development.

As a result of the above-mentioned WHO project with the MoH, three pilot community mental health centres have been established, equipped, opened and are functioning in a satisfactory manner. A long-term in-service training plan is underway, the number of users is reported to be increased, the attitude to patients is changing, home visits are increasing and the general atmosphere has improved.

Although there are some positive changes, there are still a lot of difficulties facing the implementation of the SOP. These include the need for the support of decision and policy makers and a strengthened commitment to the new approach to mental health and mental health professionals. These also include the absence of the needed structure within the MoH for mental health, and some resistance on the part of certain professionals towards the new mental health strategies. The scarcity of financial and human resources is also factors that severely impede mental health development in the territory.

The WHO AIMS has already been useful in the following aspects:

- 1- Contributing to the overall plans for the coming five years;
- 2- Upgrading of the plans for the reorganisation of mental health services
- 3- Development of future budget of the services;
- 4- Planning the in service training and abroad training with French and Italian Co operations;
- 5- Initiation of activities for upgrading the mental health information systems;
- 6- Development of nucleus for family association;

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in West Bank and Gaza. The collection of this information aims at improving the overall Palestinian mental health system and providing a baseline for monitoring the change and evolution of the system.

There are two psychiatric hospitals in the West Bank and Gaza, and a relatively good distribution of mental health centres throughout the area (1 per district). These facilities offer almost 100% of the population free access to services and free essential psychotropic medications.

The financial resources allocated to mental health services are relatively small: 2.5% of the overall Ministry of Health (MoH) budget is spent on mental health services, of which 73% is used up by Psychiatric hospitals.

Compared to neighboring countries, West Bank and Gaza has a well developed and officially approved mental health policy plan.

The beginning stages of the implementation of this policy plan have already led to some positive outcomes however; there are still many difficulties and challenges faced in this process. These include the need for increased support of decision and policy makers, the absence of the needed structure within the MoH for mental health, and some resistance on the part of certain professionals towards the new mental health strategies. The scarcity of financial and human resources is also factors that severely impede mental health development in the country at the present time.