

The Hashemite Kingdom of Jordan

National Mental Health Policy

January 2011





His Majesty King Abdullah II

Foreword

Over the past decade, scientific evidence in mental health has grown significantly; the links between Mental Health and Health in general have been well established. The burden of neuropsychiatric disorders is known to be high worldwide and it is even higher in those areas which are affected by war, conflicts and its consequences.

It has become evident that mental disorders represent a neglected priority public health concern and that the emotional, social and economic related burden is enormous, and affects not only individuals, but their families and communities as well.

Data also suggest that despite the availability of cost-effective treatments, the majority of people who suffer from severe mental disorders do not receive any kind of care. Furthermore, the stigma and discrimination attached to mental disorders, and to people who suffer from them call for urgent and significant actions in mental health worldwide.

In Jordan, the mental health system needs to be strengthened and decentralized. Investing in community-based mental health services is necessary to reach people in need in the communities where they live, and to provide them with comprehensive and effective care. The adoption of the bio-psychosocial approach will orient the mental health services towards the recovery of people who suffer from mental disorders, their rehabilitation, empowerment and full integration in the community: this orientation will contribute to avoid the risks of poor care and chronicity.

During the past two years, joint efforts have been dedicated by the Ministry of Health and the World Health Organization in Jordan to develop pilot community mental health centers. This successful experience validates the approach and type of services needed to provide effective quality care for people with mental health problems, while at the same time respecting their dignity and protecting their human rights. Yet another important action to take is to move the psychiatric beds from large psychiatric hospitals (centralized in Amman) to small acute admission psychiatric units within general hospitals. It is well known that long-term admissions are not only unnecessary, but are harmful in terms of facilitating frequent and unnecessary relapses and labeling people with mental health problems as chronic patients.

The development of community-based mental health services and the integration of mental health into primary health care will contribute to scaling-up services for mental disorders and reducing the treatment gap, despite the shortage of mental health specialists. Considering its strong primary health care system, Jordan will particularly benefit from being among the first six countries in the world implementing the Mental Health Gap Action Program (mhGAP), launched by the World Health Organization in 2008 to reduce the treatment gap for mental disorders at the global level.

We look forward to having a mental health system that is person-centered in Jordan; it will involve users and their families in care delivery and service planning, will advocate for their rights, and will strongly support the newly-established National “Our Step” Users Association. It will also fight the stigma and discrimination attached to mental disorders and will prevent unacceptable violations of human rights.

This policy document shows the full commitment and determination of the Ministry of Health to undertake the necessary actions to face complex challenges, and to develop and strengthen mental health services in the Kingdom. The policy was developed by the National Steering Committee for Mental Health, which was formed in 2008 with the support of the World Health Organization Jordan Office. It is represented by the main stakeholders in Jordan, service users and family members.

Inspired by the vision of His Majesty King Abdullah II for the development of Jordan and abiding by His Majesty's directives that all concerned parties should work on improving standard of living and quality of services, the Ministry of Health and the National Steering Committee for Mental Health vow to carry this policy and plan from action to fruition.

The Ministry of Health, the World Health Organization and the members of the National Steering Committee for Mental Health are honored and privileged to receive the Patronage of Her Royal Highness Princess Muna Al Hussein. They all stand proud and are empowered by the generous support and genuine giving of Her Royal Highness.

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Members of the National Steering Committee:

Dr. Deifallah Al Lozi, H.E. Secretary General, Ministry of Health
Dr. Bassam Al Hijjawi, Director of Primary Health Care Administration, Ministry of Health
Dr. Mohammad Asfour, National Center for Mental Health, Ministry of Health
Dr. Nayel Al Adwan, National Center for Mental Health, Ministry of Health
Dr. Nabhan Abu Sleih, Head of Specialty, Ministry of Health
Dr. Jamal Al Anani, National Center for Addiction, Ministry of Health
Dr. Basheer Al-Qaseer, Mental Health Unit, Ministry of Health
Mr. Redwan Abu Dames, Legal Affairs, Ministry of Health
Dr. Amer Hyasat, Ministry of Social Development
Mr. Haytham Mehyar, Ministry of Social Development
Dr. Fairouz Alsayegh, Royal Medical Services
Dr. Hamdi Murad, Islamic scholar
Dr. Hanna Keldany, Secretary General of the Latin Diocese in Jordan
Dr. Asr Al Sharman, Representative of Health Committee in the Parliament
Dr. Moumen Al Hadidi, Representative of Forensic Medicine and Deputy of Medical Union
Dr Youssef Khader, Higher Council for Science and Technology
Dr. Hania Dawani, Jordanian Nursing Council
Dr. Tewfik Daradkeh, Jordan University for Science and Technology
Dr. Wissam Breik, Ahleyyah University, Faculty of Psychology
Dr. Abdul Majeed Samera'i, University of Jordan, child psychiatrist
Dr. Yahya Al Ali, Hashemite University, Faculty of Social Sciences
Dr. Abdulmanaf Al Jaderi, University of Jordan, Faculty of Medicine
Dr. Anwar Bteha, Jordan University for Science and Technology
Dr. Sahar Makhamreh, Al Balqa Applied University, Faculty of Social Work
Dr. Mohammad Jebiril, Hashemite University, Faculty of Occupational Therapy
Ms. Lina Wardan, University of Jordan, Faculty of Nursing
Dr. Mohammad Dabbas, Psychiatric Association
Dr. Zuhair Zakaria, Jordanian Psychological Association
Ms. Haifa Al Bashir, Jordanian Society for Psychological Rehabilitation
Mr. Fawwaz Ezzeldeen, Service User
Ms. Raghad Ibrahim Muhana, Service User
Dr. Nasser Al Deen Al Shreqi, Al Rasheed Hospital

Dr. Adnan Al Takriti, private sector, Psychiatry
Ms. Tala Al Kurd, private sector, Psychology
Dr. Hashim Ali El Zein El Mousaad, WHO Jordan Representative and Head of Mission
Dr. Anita Marini, WHO Jordan Emergency Public Health Officer for Mental Health

Editorial and technical coordination group:

Dr. Bassam Hijjawi, Director of the Primary Health Care (PHC) Administration – MoH
Dr. Basheer M. Al-Qaseer, Mental Health Unit, PHC - MoH
Dr. Nada Al Ward, Sub-regional Coordinator Displaced Iraqis Program, WHO Jordan
Dr. Anita Marini, Emergency Public Health Officer for Mental Health, WHO Jordan
Ms. Zein Ayoub, Technical Officer for Mental Health Program, WHO Jordan

Technical Assistance:

Dr. Shekhar Saxena, Director of Department of Mental Health and Substance Abuse, WHO / HQ
Dr. Michelle Funk, Coordinator of Mental Health Policy and Service Development, WHO / HQ
Dr. Mark Van Ommeren, Mental Health in Emergency Setting, WHO / HQ
Dr. Khalid Saeed, Regional Advisor for Mental Health and Substance Abuse unit, WHO / EMRO
Dr. Emmanuel Strel, WHO Consultant

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Abbreviations

AIMS 2.2	Assessment Instrument for Mental Health Systems
CBO	Community-based Organization
CME	Continuous Medical Education
CMHCs	Community Mental Health Centers
CMHSs	Community Mental Health Services
EMRO	East Mediterranean Regional Office
GAM	Greater Amman Municipality
GP	General Practitioner
IASC	Inter-Agency Standing Committee
JNC	Jordanian Nursing Council
JPA	Jordanian Psychological Association
JU	Jordan University
JUST	Jordan University of Science and Technology
MDTs	Multidisciplinary Teams
MH	Mental Health
mhGAP	Mental Health Gap Action Program
mhGAP-IG	mhGAP Intervention Guide
MHPSS	Mental Health and Psychosocial Support
MoE	Ministry of Education
MoIA	Ministry of Islamic Awqaf
MoH	Ministry of Health
MoHE	Ministry of Higher Education
MoJ	Ministry of Justice
MoL	Ministry of Labor
MoSD	Ministry of Social Development
NCCMS	National Centre for Crisis Management and Security
NCMH	National Centre for Mental Health
NGO	Non-governmental Organization
NSC	National Steering Committee

PHC	Primary Health Care
PKU	Phenylketonuria
RMS	Royal Medical Services
ToR	Terms of Reference
ToT	Training of Trainers
UN	United Nations
UNRWA	United Nations Relief and Works Agency
WHO	World Health Organization
WHO-HQ	World Health Organization Headquarters

Glossary

Mental Health: a state of well-being where individuals are able to realize their potential, cope with normal life-stressors, live productively and contribute to their community.

Mental Disorder: a clinically classified set of symptoms or behaviors that lead to disruptions in the well-being of individuals and in their personal, social or occupational areas of life.

Mental Health Policy: an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population.

Vision: a desirable image for the future of the mental health system in a country or region.

Value: a social, cultural or economically-relevant concept that guides attitudes, judgments and courses of action in a mental health policy.

Principle: a fundamental truth on which rules of conduct are based.

Mental Health Plan: a detailed pre-formulated scheme for implementing strategic actions that favour the promotion of mental health, and the prevention and treatment of mental disorders.

Mental Health Legislation: a set of laws that codify and consolidate the fundamental principles, values and objectives of the mental health policy, and guarantee that the dignity of patients is preserved and their fundamental human rights are protected.

Bio-psychosocial Approach: a holistic model of care that incorporates biological, psychological and social therapeutic interventions by multidisciplinary workers.

Multidisciplinary Team: mental health workers from diverse academic backgrounds (psychiatry, nursing, psychology, occupational therapy, social work) providing comprehensive, team-based bio-psychosocial interventions.

Deinstitutionalization Process: shifting the provision of mental health care from psychiatric institutions to comprehensive community-based services.

Community Mental Health Services: mental health community-based services that are close to where people live, such as outpatient clinics, psychiatric units in general hospitals and rehabilitation centers.

Community Mental Health Centers: outpatient mental health clinics providing comprehensive bio-psychosocial care through multidisciplinary workers.

Primary Prevention: strategies that intend to avoid the development of the onset of an illness.

Secondary Prevention: strategies that focus on early detection and aim to limit the effects of an illness after it manifests.

Tertiary Prevention: treatments that aim to reduce the negative impact of a determined illness by restoring function and reducing disease-related complications.

Summary of Current Situation: Mental Health Services in Jordan

Mental health (MH) services in Jordan are somewhat limited, relying mainly on expensive tertiary care in psychiatric hospitals instead of cost-effective primary health and community-based care. All psychiatric beds in Jordan are in governmental or private psychiatric hospitals. Secondary level outpatient clinics are located in comprehensive primary health care facilities and general hospitals, yet are primarily biologically oriented. The primary health care (PHC) system is widely distributed, encompassing all governorates including peripheral areas; however, the MH component is not integrated within its services. When analyzing the organization of MH services in Jordan using the World Health Organization (WHO) pyramid on the optimal mix of mental health services (Annex 1), we find that the pyramid is inverted in Jordan. Shifting focus from tertiary care to primary and community MH care would increase availability, accessibility and quality of care, in addition to bringing MH services closer to where people live and work. Community services would allow the provision of treatments in a least restrictive manner, and help to decrease stigma and violations of human rights.

In particular, community mental health services (CMHSs) for adolescents and children are unavailable at any level of care, except for one outpatient clinic at Jordan University (JU) Hospital and two outpatient clinics at the Royal Medical Services for severe cases.

Jordan is one of the safest countries in a region characterized by instability and conflict. During the last decade, continuous waves of refugees and displaced peoples have flowed into Jordan adding burden to the health system, in particular the MH system as MH problems are enhanced by wars and conflict. This has concurrently attracted a large number of international NGOs and UN agencies to Jordan, intervening in different fields including the mental health and psychosocial field. Due to short-term funding, the programs implemented by these NGOs and agencies are not always sustainable in the long-term.

In 2007, a mental health and psychosocial support (MHPSS) coordination group was established in Jordan, following the recommendations of the Inter-Agency Standing Committee (IASC) Guidelines. The aim of this group is to promote the IASC Guidelines in Jordan, to coordinate efforts of local and international bodies working in the MH and psychosocial field, to fill gaps in the MH system, and to monitor interventions according to the IASC Guidelines standards. Until recently, the MHPSS coordination group has been co-chaired by a UN agency and an international NGO. Currently, the Ministry of Health is assuming leadership for this group.

Challenges for Mental Health Policy

An analysis of available MH services and resources has been conducted through the implementation of the WHO Assessment Instrument for Mental Health Systems (AIMS-2) (Annex 2). The findings revealed a number of anticipated challenges relevant to policy development and implementation:

1. Multiple health providers

Several main health providers are available in Jordan. In order for the National MH Policy to attain a public health impact, the consensus and contribution of all of the following health providers in the development of the policy is necessary:

- Ministry of Health (MoH);
- Royal Medical Services (RMS);
- Private Sector;
- University Sector;
- United Nations Relief and Works Agency (UNRWA), which provides PHC services to Palestinian refugees;
- Other UN agencies and international and local NGOs.

2. Effective national governance for mental health

A number of different entities for MH are available at the Ministry of Health: Head of Mental Health Specialty; Mental Health Unit within PHC Administration; National Centre for Mental Health (NCMH) under the Hospitals Administration. However, there is no coordinated, unified and leading entity responsible for holding a MH budget, policies and decision making, and accountability for the implementation of the MH reform.

3. Allocation of financial resources

There is no specific and known budget dedicated for MH. It is fundamental to secure a budget dedicated to MH to achieve a sustainable and well-functioning MH system.

4. Attitudes towards mental illness

Negative attitudes towards mental illness and service users pervade all sectors of society, including the professional and political levels. This has a broad negative impact on several aspects:

- Placing MH as a priority in the national public health agenda.
- Allocation of adequate financial and human resources for MH.
- Integration of MH services into the general health care system.

Furthermore, the stigmatization of service users leads to much discrimination in various areas including work and education, thereby hindering the integration of service users (and sometimes their families) in the community. In addition, negative attitudes may deter or delay seeking treatments at MH services.

5. Consensus on a mental health model among mental health professionals

There is a discrepancy between the models adopted among MH professionals in Jordan, with most still employing the traditional biological approach and few applying the more comprehensive bio-psychosocial approach introduced in some pilot clinics in Amman and Irbid.

The former model of care does not facilitate the establishment of multidisciplinary teams (MDTs) in MH services and predominantly focuses on the role of psychiatrists; while the latter evidence-based bio-psychosocial approach is necessary in order to provide a multidisciplinary management of mental illnesses that addresses their bio-psychosocial etiologies. This approach emphasizes a holistic and recovery-oriented model of care, ensures continuity of care, and includes the rehabilitation of service users in personal, social and occupational areas. This aids in preventing the unnecessary “chronicization” of service users, and facilitates their integration in the community. It also acknowledges and values the important role of families and caregivers.

A successful implementation of the multidisciplinary, bio-psychosocial approach requires the acknowledgment of equal value, importance and working conditions for all professionals including psychiatrists, psychologists, nurses, occupational therapists and social workers. This will promote the required mutual understanding, respect and team work among the different professionals for the optimal delivery of MH care. In addition, it will help to shift from the current hierarchical and biologically-oriented system to the comprehensive multidisciplinary system of service delivery.

6. Shortage of human resources in mental health

The number of MH professionals in Jordan is very limited. Moreover, the ratio of human resources dedicated to MH and to general health is 1 to 50 professionals, reflecting the neglect of the MH field (Annex 3).

The shortage of human resources dedicated to MH at all levels of care and the shortage of specialists in the field represent some of the main challenges for a MH reform in Jordan. This extends to all MH professionals including psychiatrists, psychiatric nurses, psychologists, social workers and occupational therapists.

As such, there is a strong need for the recruitment, training and retainment of both new and current staff members, in addition to valuing the roles of nurses and psychosocial workers (psychologists, occupational therapists, social workers) by providing them with adequate working conditions, and accurate terms of reference that recognize them as specialists in their fields.

7. Availability of mental health services

The available outpatient MH services are geographically well-distributed across the country; nonetheless they are insufficient in quantity to meet the MH needs of the population. Inpatient services are currently only available in psychiatric hospitals and are all concentrated in Amman, where only 36% of the population lives. In addition, there are no community-based MH services for children and adolescents.

8. Availability of training opportunities

Opportunities for the training and supervision of students from various academic backgrounds (medicine, nursing, occupational therapy, psychology and social work) are limited to psychiatric hospitals which do not apply the recovery and bio-psycho-social models, and do not attract students to MH as a field of specialization. In addition, training and supervision in the multidisciplinary, bio-psycho-social approach is not well established due to the limited number of existing community MH services.

9. Integration of the mental health component into PHC services

Integrating the MH component into PHC services will initially add a considerable burden on PHC staff. This may lead to some resistance or a lack of commitment to the integration, thereby requiring increased support through recruitment, training and supervision of PHC staff and the provision of incentives.

10. Effective coordination within and among sectors

In Jordan, there is a lack of coordination between the multiple health providers, the MH sector and other sectors (particularly the Ministry of Social Development- MoSD and the Ministry of Labor- MoL), and between the public MH system and local and international NGOs and agencies. This poses a challenge to the provision of comprehensive care for people with mental disorders and to the continuity of their care. Furthermore, the lack of coordination does not facilitate filling the gaps in MH services, but rather enhances the duplication of services and the establishment of services that are neither sustainable nor needs-based.

11. Absence of mental health legislation

Currently, there is no MH legislation which supports and facilitates the implementation of the policy and plan.

12. Inconsistent supply of psychotropic medications at MH services

Currently, a rational list of psychotropic medications is available at MH services, and not an essential list of medications. Moreover, medications at the secondary level of care are not consistently nor continuously available.

(I) Vision

The provision of quality community MH services that are equitable, cost-effective and accessible to all people in Jordan, and are implemented within the general health system at all levels of care. Services reflect the comprehensive bio-psychosocial approach through multidisciplinary interventions, with emphasis on human rights, participatory approach and cultural relevance.

(II) Values and Principles

<i>Values</i>	<i>Principles</i>
1. Equity	<ul style="list-style-type: none">➤ People with mental disorders have the same fundamental civil rights as all citizens, and should not be discriminated against on the basis of their mental illness.➤ People with mental disorders should receive the same quality and standards of care as those with other illnesses.➤ The development of unique services that address the specific needs of people with mental disorders may be required depending on the nature of the mental disorder.
2. Accessibility	<ul style="list-style-type: none">➤ Mental health services should be accessible to all people regardless of gender, age, race, socioeconomic status, geographical location, disability or other conditions.➤ Mental health services should be available and accessible in the communities where people live, work and study.
3. Human Rights	<ul style="list-style-type: none">➤ People with mental disorders are entitled to their full human rights and freedoms, including the right to be treated with respect and dignity, the right to healthcare, marriage, employment, shelter and privacy.➤ People with mental disorders have the right to be treated in the least restrictive and least intrusive manner.➤ Mental health treatments should promote and protect the autonomy, liberty and self-determination of people with mental disorders.➤ Due to their possible vulnerability to human rights violations, people with mental disorders may require specific legal and quasi-legal frameworks to ensure that their human rights are

	protected and promoted. They may also require affirmative actions due to the widespread discrimination toward mental illnesses.
4. Holism	<ul style="list-style-type: none"> ➤ Human beings are unique and complex holistic beings, and their health is determined by biological, psychosocial and spiritual aspects. ➤ This complexity cannot be addressed solely by biological paradigms. A bio-psychosocial approach is required to respond to health needs. ➤ Mental health and psychosocial aspects across different life-stages (from pre-pregnancy until elderly) should be considered.
5. Quality Services	<ul style="list-style-type: none"> ➤ Mental health services should be implemented at the highest possible quality according to national and international standards, and should function on a multidisciplinary basis.
6. Cultural Relevance	<ul style="list-style-type: none"> ➤ The culture and context of people with mental disorders should be considered in all aspects of care planning and delivery.
7. Mental Health as Integral Aspect of General Health	<ul style="list-style-type: none"> ➤ Mental health services should be mainstreamed and integrated into the general health system at all levels of care and across the lifespan.
8. Participation (Service users and family)	<ul style="list-style-type: none"> ➤ It is essential that people with mental disorders and their families are actively involved in decision making (planning, intervention and evaluation) concerning mental health services.
9. Collaboration (Services, Agencies)	<ul style="list-style-type: none"> ➤ Interagency collaboration is pivotal to the comprehensive delivery of MH services. ➤ Mental health services provided within the health sector should be complimented with other sectors and areas (such as social services, justice, housing, family, employment). ➤ Inter and intra-sectoral collaboration is fundamental for the continuity of care.
10. Evidence-Based	<ul style="list-style-type: none"> ➤ Decision making regarding mental health services and related issues should be based on scientific research and evidence. ➤ Scientific evidence should be utilized to validate, evaluate and modify interventions, practices and services.

(III) Objectives

1. Reform the MH system by increasing emphasis on community-based care. This also includes integrating the MH component into PHC (Annex 1: WHO pyramid on optimal mix of MH services).
2. Support governmental leadership for the MH reform, and develop mechanisms of monitoring, evaluation and accountability.
3. Allocate adequate financial resources for the MH reform and MH services.
4. Develop human resources with a focus on recruiting, training and retaining MDTs.
5. Guarantee the continuity of a consistent supply and distribution of essential psychotropic medications.
6. Develop a pragmatic information system (national database) to support the continuity and quality of care, and to inform policy and decision making.
7. Develop quality child and adolescent MH services at the primary and secondary levels of care.
8. Establish interagency collaboration between identified national and international agencies and stakeholders.
9. Protect and promote the human rights of MH service users and their families.
10. Provide quality MH services which are close to where people live, work and study.
11. Enhance community MH literacy, with emphasis on changing negative perceptions toward MH issues.
12. Involve service users and their families in the planning, decision-making, and delivery of MH care.
13. Promote the mental health and psychosocial wellbeing of the Jordanian people.

(IV) Areas of Action

G o v e r n a n c e o f M e n t a l H e a l t h S e r v i c e s

This policy strongly advocates for establishing national central governance for MH, through the mental health ‘unit’ within the PHC administration in the MoH, to strengthen leadership in MH and to create a framework for decision-making and accountability. The unit will be a policy-making and budget-holding entity. It will address the identified need for a leading national MH authority and for coordinating the multiple MH ‘entities’ within the MoH (Mental Health Head of Specialty, Mental Health Unit within PHC Administration, National Centre for Mental Health).

The unit will have a governing function and an executive function. A national technical committee for MH representing key stakeholders in MH will be established to advise the MH unit and to support its governing function. The Head of the PHC administration at the MoH will chair the national technical committee. Key stakeholders are the MoH, MoSD, MoE, universities and relevant professional associations and councils. The executive function will be carried out by administrative and supporting staff. The unit will be accountable to His Excellency the Minister of Health, to service users and their families, and to MH and psychosocial professionals.

The terms of reference (ToR) for the MH Unit will be as follows:

1. Provide direction for MH in Jordan; develop national MH policies and plans.
2. Develop MH legislation and establish mechanisms for protecting and promoting the human rights of service users.
3. Lead and coordinate the MH sector within MoH and oversee the up-scaling of MH services.
4. Promote and follow-up on the implementation of the national MH policy and action plan.
5. Service planning and management.
6. Convene MH professionals across the country and call for national committees for various purposes (such as consultations and program implementation).
7. Establish mechanisms for the assessment, monitoring and evaluation of MH services.
8. Establish mechanisms to include service users and their families in the decision-making process.
9. Promote liaison among various sectors to coordinate interagency MH and psychosocial services.

S e r v i c e O r g a n i z a t i o n

This policy advocates for the inclusion of MH services in the health care plans of governmental, non-governmental and university sector insurance schemes. People who suffer from mental disorders will have free access to quality and effective MH services, regardless of the health care provider.

The WHO pyramid on the optimal mix of MH services is inverted for services in Jordan (Annex 1). This policy recommends the gradual shifting of service organization towards the WHO pyramid structure.

This policy promotes the adoption of a multidisciplinary bio-psychosocial model at all levels of care. This model will first be implemented at the newly-established services in pilot clinics (inpatient and outpatient services in Amman and Irbid), after which it will be disseminated to all MH services in the country. All services will be provided according to the bio-psychosocial and recovery-oriented approaches, in addition to establishing a referral and back-referral system among all sectors and levels of care.

Primary Health Care

This policy supports the integration of MH services into the PHC system according to the Mental Health Gap Action Program (mhGAP) launched by WHO-HQ in October 2008 (Annex 4), and introduced in Jordan in April 2010. At the PHC level, services will be provided to adults, children and adolescents. They will focus on early detection and diagnosis, basic psychosocial interventions, pharmacological treatment, referral, and follow-up. This will occur for eleven MH conditions included in the mhGAP, beginning with the conditions most relevant to Jordan which have been identified by the MoH to be: depression, unexplained somatic complaints and developmental disorders. MH care will be provided at PHC settings by specially trained family doctors, GPs and nurses. Supervision of these providers will be incorporated into the system.

Secondary Health Care

Inpatient:

At the secondary level of care, MH services will be delivered in every governorate in psychiatric inpatient units allocated within general hospitals for adult patients, and within general pediatric wards for adolescents and children. Inpatient units in general hospitals will be established by all health providers (MoH, RMS, universities, private sector) to address the MH needs of citizens throughout the Kingdom, starting with inpatient units in the University of Jordan (JU) teaching hospital in Amman, the University of Science and Technology (JUST) teaching hospital in Irbid (King Abdullah Hospital), and one MoH general hospital. Inpatient services will be limited to the short-term management of acute MH conditions, according to the bio-psychosocial model. As soon as the condition stabilizes, the patient will be discharged and back-referred to the community mental health centers (CMHCs).

All patients requiring inpatient care, regardless of which services they are referred to or the type of health insurance they have (governmental or non-governmental), will have free access to one of the four MH inpatient units closest to their homes (inpatient unit at the NCMH, JU Hospital, King Abdullah Hospital, and one MoH General Hospital). This can be negotiated and achieved through collaborative efforts of the MoH, the MoH Health Insurance Administration, university sector and the private sector, as the care provided in these four units is unavailable elsewhere in the MH system.

Outpatient:

Outpatient services will be delivered in outpatient clinics at general hospitals and CMHCs in the 12 governorates. A child and adolescent CMHC will be established to meet the country's needs for the referral of child and adolescent cases.

Community mental health centers are community-based, receiving referrals of potential users from all levels of care. They offer comprehensive multidisciplinary care according to the biopsychosocial model, and aim to rehabilitate and fully integrate users in their communities.

Community MH services invest in community resources and collaborate with community and religious leaders.

The efficiency of these centers can be increased by organizing a mobile team to manage emergencies that may occur after working hours, in order to decrease unnecessary hospitalization.

At these centers, continuity of care will be achieved through:

- Adoption of an efficient and effective filing system.
- Consistent assignment of specific psychiatrists to each center in order to avoid the current rotation of psychiatrists to various centers.
- A case management system that supports service users through the different levels of healthcare services, and links them to required services from other sectors (labor, housing, education, and social services).

Tertiary Health Care

Stand alone psychiatric hospitals will be downsized through the establishment and shifting of services to inpatient wards in general hospitals. The staff of psychiatric hospitals will be trained and supervised accordingly. New admission to psychiatric hospitals will be stopped and an individual discharge plan for each patient will suggest alternative services including family care. In addition, ameliorative actions will be dedicated to upgrading and improving the quality of the acute and chronic wards of current psychiatric hospitals (NCMH and Al Karama hospital).

H u m a n R e s o u r c e s

The MH workforce in Jordan is mainly composed of psychiatrists. Services rely heavily on psychiatrists in the private sector. Professionals of other disciplines (psychiatric nurses, psychologists, social workers and occupational therapists) are very few in numbers, are not considered as important or valuable as psychiatrists, and hence are not integrated in service delivery. Moreover, they receive inadequate working conditions and terms in most job contracts. Furthermore, the large presence of international NGOs and agencies offering more favorable working conditions lead to the recruitment of the most qualified and experienced psychosocial staff in this sector, rather than in the governmental public sector. Although the multidisciplinary approach has been introduced in the MH system through the three pilot CMHCs in Amman and Irbid, it has not yet been adopted and generalized in MH care delivery countrywide.

Recruitment and Retainment of MH Workers

This policy recommends the development and implementation of a recruitment plan for MH multidisciplinary workers (nurses, psychologists, social workers, and occupational therapists), in order to adequately staff CMHCs in all the 12 governorates and to support the deinstitutionalization process. Special emphasis will be placed on the recruitment of psychosocial staff with adequate job contracts, and of non-health workers (e.g. community workers) who can provide social services and support the integration of users into the community. A plan to retain staff in the MH field is advocated through the identification and allocation of incentives including job security, improved work conditions and opportunities for learning and self-development.

The preparation of MH workers, excluding psychiatrists, is limited to a bachelor degree education that includes the MH component within its curricula, however lacks adequate opportunities for clinical training and supervision. Since the MH reform involves the redirection of services and human resources from psychiatric hospitals to CMHCs, human resource development will focus on retraining staff to shift tasks accordingly, and to provide them with the necessary tools to carry out their modified roles according to the newly-reformed MH care models. In addition, emphasis will be placed on promoting licensing procedures for MH professionals.

This policy recommends the utilization of the mhGAP Intervention Guidelines (mhGAP-IG) as one component of the pre-service and in-service training for staff.

Pre-service training

This policy advocates for the revision of academic curricula in all MH related areas. The curricula will be based in scientific evidence and will focus on community-based multidisciplinary care, case management and recovery models, the provision of MH services in PHC, and the management of acute cases in inpatient units within general hospitals. This will prepare MH workers for the newly reformed services. Relevant and adequate clinical training in multidisciplinary-based services will also be required. A rapid spread of the multidisciplinary approach within MH services will allow the provision of proper clinical training opportunities for all learners. This policy recommends the establishment of graduate programs in all MH related disciplines which will also include the mhGAP-IG, and calls for universities to include these recommendations in their strategies in order to build MH capacity in the country and to respond to the MH needs of the community.

In-service training and supervision

Secondary care

Continuous learning will occur within MH services. The multidisciplinary approach will develop the competencies required to deliver comprehensive care to service users. To serve this purpose, a national, multidisciplinary, clinical training and supervision team will be established. It will set national standards and schemes for effective training, in addition to a monitoring and evaluation mechanism to ensure an appropriate level of acquired knowledge, competence, skills, and staff certification.

Primary care

Human resource development in PHC will focus on the following: first, an initial on-the-job training for family doctors, GPs, and nurses according to the mhGAP identified areas. Second, monthly on-the-job supervision provided by CMHC staff. Moreover, this policy advocates for the inclusion of MH rotations during internship training in PHC centers for doctors and nurses. It also supports the preparation of family doctors, GPs and nurses as trainers for other PHC staff on the mhGAP-IG through Training of Trainers (ToT) programs.

F i n a n c e

The implementation of this policy and associated action plan, and the provision of MH services require adequate, planned and foreseeable financial schemes. This policy calls for the allocation of a dedicated budget for the MH sector for the successful implementation of this policy and action plan. The proposed MH unit in the MoH will be responsible and accountable for this budget. It will support the implementation of the action plan and in general, the shift from hospital-based care to CMHCs (both inpatient and outpatient).

This policy calls all health providers in Jordan (MoH, RMS, university sector, private sector, UNRWA) to commit to dedicating a MH budget and allocating additional resources for MH in order to ensure the appropriate and complete implementation of the MH reform, which will include providing accessible quality MH services, MH insurance schemes and psychotropic medications across the country. The MoH will maintain the central coordinating role and will create, amend and modify all financial policies and procedures regarding the MH budget. It will also allocate and distribute funds and services across the country.

I n f o r m a t i o n S y s t e m

A MH information system is an essential element in the provision of care. It is important for documentation and record keeping, and may be used as an information resource. An efficient information system facilitates the storage and retrieval of essential information, and the measurement of MH indicators which will inform future policy development and service planning.

This policy calls for the development and adoption of a unified national patient record, as well as a joint classification system. The national patient record will be developed according to the newly adopted multidisciplinary perspective. It will be the source of information for a national electronic database, which needs to be developed and linked to the national general health database. Confidentiality of service user information will be promoted to the highest possible level.

This information system requires suitable infrastructure. Therefore, each CMHC at the primary and secondary levels of care will be provided with a computer and internet connection in order to

facilitate the establishment of the information database, the dissemination of information, and communication among professionals regarding MH care plans.

P r e v e n t i o n & P r o m o t i o n

High prevalence rates of specific MH disorders such as depression and developmental disorders are estimated in Jordan. The burden of these conditions, which are often preventable, entails significant emotional, social and economic consequences. Therefore, this policy urges the MoH and its health sector partners (RMS, Universities, private sector and UNRWA) to place depression and developmental disorders as a priority in psychosocial and MH prevention programs.

Prevention programs will target at-risk populations and they will be implemented mainly at the PHC level, including maternal and child health services. Depression will be tackled through secondary prevention evidence-based programs on early detection. Special attention will be dedicated to depression in women, with emphasis on post-partum depression.

Concerning developmental disorders in children, special emphasis will be placed on primary prevention, providing quality prenatal care, preventing obstetric injuries or harm of any kind, educating parents about child behaviors, medications, and home and work-related issues that may jeopardize the wellbeing and bonding between mothers and infants.

Moreover, resources and budgets will be allocated for the development of nutritional programs to enhance the wellness of fetuses and mothers during and after pregnancy, and provide the essential nutritional supplements required by pregnant and lactating mothers (as identified by relevant literature and experts in the field).

Furthermore, this policy recommends screening for Down Syndrome, Phenylketoneurea, Hypothyroidism and other possible congenital conditions (e.g. metabolic errors), and providing health insurance for mothers and affected newborns.

In addition, this policy specifically advocates for the creation of MH programs that promote the mental health and psychosocial wellbeing of children and adolescents, and identifies at-risk children and adolescents through the education of teachers and families, and the establishment of parent-teacher associations. The programs will focus on life skills and will be tailored to children and adolescents needs.

R e h a b i l i t a t i o n

Rehabilitation services will be delivered as part of the comprehensive MH services at all levels of care. This policy recommends the mapping of community resources not limited to MH services (e.g. community-based organizations, local associations, sport organizations, libraries,

etc.). This can empower service users and support their integration into the community. The findings of the mapping will be disseminated, and efforts will be dedicated to making these resources available and accessible to users within and outside the MH care system. Initially, the MDTs at the CMHCs will facilitate the introduction of service users to these community resources. The MoH is encouraged to subcontract specific community services according to the identified needs of service users.

Furthermore, this policy advocates for the establishment of a national NGO to support the rehabilitation and integration of MH service users into the community.

H u m a n R i g h t s a n d L e g i s l a t i o n

There is an absence of MH legislation in Jordan. Three articles on MH are included in the general health law, but are limited and unspecific. This policy recommends developing MH legislation that will ensure that all MH services uphold and promote the human rights of service users, their families and service providers. The legislation will also promote respect for confidentiality and the humanitarian and dignified treatment of service users. It will support an enhanced quality of services and will facilitate accessibility to these services.

Mechanisms of systematic monitoring and evaluation will be established to ensure adherence to human rights principles, to detect any violations, and to identify any weaknesses in these processes (for example by adapting the WHO checklist for monitoring psychiatric facilities; establishing a national/sub-national interdisciplinary monitoring committee to conduct random visits to monitor different MH services). This multidisciplinary human rights committee will also provide technical assistance to the National Centre for Human Rights on the specific issue of human rights and MH.

This policy advocates for the development of human resources to serve all processes in human rights protection and promotion, and to build further capacity on the Jordanian participants who are completing the International Diploma on Mental Health and Human Rights.

Furthermore, this policy recommends coordination with the Higher Council for the Affairs of Persons with Disabilities, the National Center for Human Rights and local human rights NGOs (e.g. Mizan Group), in order to further the Jordanian ratification of the UN Convention on the Rights of People with Disabilities.

A d v o c a c y

This policy recommends providing support and empowerment to the newly established association for service users: 'Our Step' Association for Psychosocial Support. This association will serve as a support group for users. It will provide opportunities for service users to identify their own needs, connect with their communities, advocate for their rights to work, vote, and live

with dignity, and to combat the stigma associated with mental problems. Furthermore, this policy advocates for the support of the Greater Amman Municipality (GAM) by providing a permanent venue for the association.

Awareness on MH, mental disorders and psychosocial aspects is low in the civil society and also among professionals and policy makers. As such, stigmatization and prejudice are associated with people who suffer from mental disorders and their families. Consequently, they are subjected to discrimination, isolation, neglect and their abilities are often extremely underestimated.

This policy recommends combating the stigma attached to MH problems through increasing awareness among the general population and health practitioners, and increasing the awareness of service users regarding their potential, abilities and rights. Awareness campaigns will focus on MH and psychosocial wellbeing, the nature of mental illnesses, the association between physical and mental health, and on the unjustified negative attitudes and discrimination towards people with mental problems in various areas (e.g. family, work, education, community).

P s y c h o t r o p i c M e d i c a t i o n s

Psychotropic medications are usually an essential component in the treatment of people with mental illnesses. Effective medications alleviate symptoms and restore the ability to function and lead productive lives. This policy emphasizes the necessity of adopting an essential list of psychotropic medicines, giving priority to locally produced medicines in order to ensure a continuous, consistent and affordable supply. Essential psychotropic medicines need to be continuously and consistently available at all the facilities providing MH services, including PHC centers and peripheral areas.

Psychiatrists in MH services, and family doctors and GPs in PHC settings will be trained and supervised to manage the prescription and monitoring of psychotropic medications. Protocols for correct prescriptions, safe administration and the monitoring of therapeutic effects and side effects will be developed.

R e s e a r c h

In Jordan, there is a dearth of research in MH, starting with epidemiological studies and extending to the evaluation of MH service accessibility and quality (including service user and family satisfaction), as well as the treatment gap for MH. This policy calls for the identification of priority areas in MH that require further research and that will be critical in informing future policy making.

This policy advocates for placing MH and related identified areas in the national research agenda and for building local capacity in mental health research.

Monitoring, Evaluation & Quality Improvement

This policy recommends the systematic monitoring and evaluation of all MH services. To serve this purpose, a comprehensive set of indicators (processes, performance, and clinical outcomes) will be developed. This policy acknowledges that MH service quality needs to be improved, especially in psychiatric hospitals. Quality improvement processes will include the development and implementation of standards of care; the development and adaptation of standards of practice by each national professional body; and the development and implementation of clinical protocols.

References

1. Chisholm D, Lund C, Saxena S. Cost of scaling up mental health care in low- and middle-income countries. *British Journal of Psychiatry*, 2007, 191: 528-535
2. Daradkeh TK, Alawan A, Al Ma'aitah R, Otoom SA. Psychiatric morbidity and its sociodemographic correlates among women in Irbid, Jordan. *East Mediterranean Health Journal*, 2006; 12 Suppl 2:S107-17
3. Funk M et al. A framework for mental health policy, legislation and service development: addressing needs and improving services. *Harvard Health Policy Review*, 2005, 6: 57-69
4. Funk M, Saraceno B, Drew N. Global perspective on mental health policy and service development issues: the World Health Organization angle. In: Knapp M, McDaid D, Mossialos E, Thornicroft G, eds. *Mental health policy and practice across Europe*. Open University Press/ McGraw Hill, 2007: 426-440
5. Funk M et al. Advocacy for mental health: roles for consumer and family organization and government. *Health Promotion International*, 2006, 21: 70-75
6. Funk M, Saraceno B, Drew N et al. Mental Health policy and plans: promoting an optimal mix of services in developing countries. *International Journal of Mental Health*, 2004, 33: 4-16
7. *National Team Report on Evaluation of Psychiatry Services and Psychiatric Patients*. Higher Council for Science and Technology, Amman, 2008
8. *National Report on Evaluation of Mental Health Services in Jordan*. Higher Council for Science and Technology, Amman, 2010
9. *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Setting*. Geneva, Inter-Agency Standing Committee, 2007
10. Knapp M et al. Economic barriers to better mental health practice and policy. *Health Policy and Planning*, 2006, 21 (3): 157-170
11. Kohn R, Saxena S, Levav I et al. The treatment gap in mental health care. *Bulletin of the World Health Organization*, 2004, 82: 858-66
12. Lancet Global Mental Health Group. Scale up services for mental disorders: a call for action. *Lancet*, 2007, published online September 4.
13. Mhaidat NM, Alzoubi KH, Al-Sweedan S et al. Prevalence of depression among cancer patients in Jordan: a national survey. *Support Care Cancer*, 2009, 17(11): 1403-7
14. Murthy R S, Lakshminarayana R. Mental Health consequences of war: a brief review of research findings. *World Psychiatry*, 2006, 5: 25-30
15. Patel V, Araya R, Chatterjee S et al. Treatment and prevention of mental health disorders in low-income and middle-income countries. *Lancet*, 2007, 370: 991-1005
16. Patel V, Kleinman A. Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*, 2006, 609-15
17. Prince M, Patel V, Rahman A et al. No Health without mental health – a slogan with substance. *Lancet*, 2007, 370: 859-877
18. Prior L. Community versus hospital care: the crisis in psychiatric provision. *Social Science and Medicine*, 1991, 32: 483-9
19. Saraceno B, van Ommeren M, Batniji R et al. Barriers to improving mental health services in low and middle income countries. *Lancet*, 2007, 370: 1164-1174

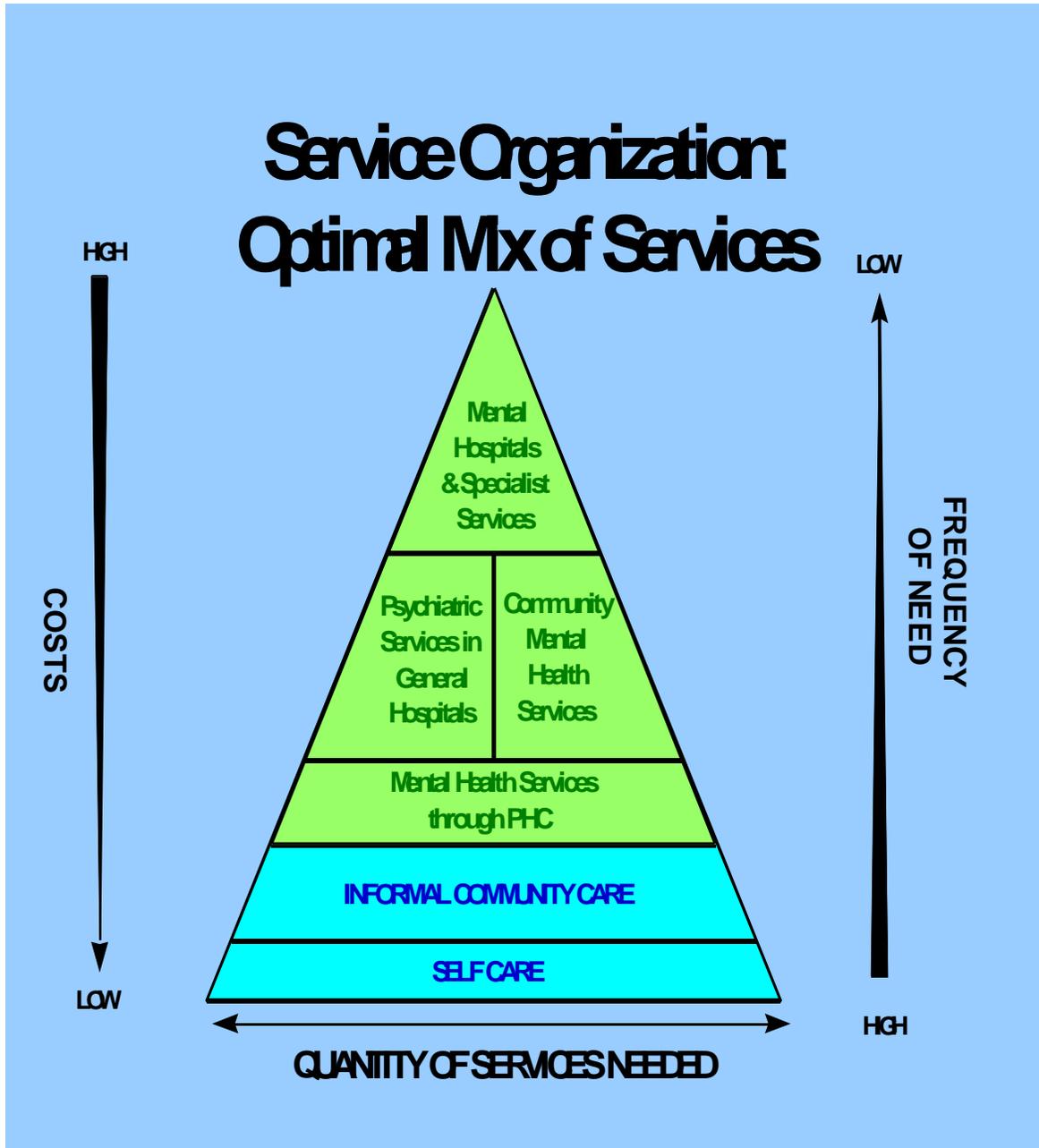
20. Saraceno B, Freeman M, Funk M. Public Mental Health. In: *Oxford Textbook of Public Health, 5th Edition*, (c) Oxford University Press, 2009, Section 9: 1081-1100
21. Saxena S et al. Resources for mental health: scarcity, inequity and inefficiency. *The Lancet*, 2007, 370: 878-889
22. Saxena S, Thornicroft G, Knapp M et al. Resource for mental health: scarcity, inequity, and inefficiency. *Lancet*, 2007, 370: 878-89
23. Ventevogel P. Mental Health and Psychosocial Support for Displaced Iraqis in Jordan. A Brief Assessment of Needs and Services. *Report of mission*. Amman, World Health Organization, 2008.
24. *Epilepsy in the WHO Eastern Mediterranean Region. Bridging the gap*. 2010, World Health Organization, Regional Officer for the Eastern Mediterranean
25. *WHO AIMS Report on Mental Health System in Jordan*. Amman, World Health Organization, Draft 2010
26. *Improving Health System and Services for Mental Health (mental health policy and service planning package)*. Geneva, World Health Organization, 2009
27. *Pharmacological treatment of mental disorders in primary health care*. Geneva, World Health Organization, 2009.
28. *Integrating mental health into primary care*. Geneva, World Health Organization, World Organization of Family Doctors, 2008
29. *mhGAP Mental Health Gap Action Program: Scaling up care for mental, neurological, and substance use disorders*. Geneva, World Health Organization, 2008
30. *WHO AIMS 2.2 general information*. World Health Organization, (http://www.who.int/mental_health/evidence/WHO-AIMS/en/ accessed 11 April 2008)
31. *Monitoring and evaluation of mental health policy and plans (mental health policy and service planning package)*. Geneva, World Health Organization, 2007
32. *Disease Control Priorities related to Mental, Neurological and Substance Abuse Disorders*. Geneva, World Health Organization, 2006
33. *Dollars, DALYs and Decisions: Economic Aspects of the Mental Health System*. Geneva, World Health Organization, 2006
34. *Economic Aspects of the Mental Health System: Key Messages to Health Planners and Policy Makers*. Geneva, World Health Organization, 2006
35. *Mental health in the Eastern Mediterranean Region (reaching the unreached)*. 2006, World Health Organization, Regional Officer for the Eastern Mediterranean
36. *Advocacy (mental health policy and service planning package)*. Update version. Geneva, World Health Organization, 2005
37. *Atlas: Child and Adolescent Mental Health Resources*, Geneva, World Health Organization 2005
38. *Atlas Project: Mental Health resources in the world*. Geneva, World Health Organization, 2005
39. *Child and adolescent mental health (mental health policy and service planning package)*. Update version. Geneva, World Health Organization, 2005
40. *Financing (mental health policy and service planning package)*. Update version. Geneva, World Health Organization, 2005
41. *Human resources and training (mental health policy and service planning package)*. Update version. Geneva, World Health Organization, 2005

42. *Information systems (mental health policy and service planning package)*. Update version. Geneva, World Health Organization, 2005
43. *Legislation and human rights (mental health policy and service planning package)*. Update version. Geneva, World Health Organization, 2005
44. *Mental health policy, plans and programmes (mental health policy and service planning package)*. Update version. Geneva, World Health Organization, 2005
45. *Organization of services for mental health (mental health policy and service planning package)*. Update version. Geneva, World Health Organization, 2005
46. *Promoting Mental Health. Concept, emerging evidence, practice*. Geneva, World Health Organization, 2005
47. *Psychotropic medicines (mental health policy and service planning package)*. Update version. Geneva, World Health Organization, 2005
48. *WHO AIMS 2.2*. World Health Organization, 2005
49. *WHO resource book on mental health, human rights and legislation*. Geneva, World Health Organization, 2005
50. *Prevention of mental disorders*. Geneva, World Health Organization, 2004
51. *Mental Health Policy Project (Policy and Service Guidance Package). Executive Summary*. Geneva, World Health Organization, 2001
52. *Mental Health Policy Project (Policy and Service Guidance Package). Executive Summary*. Geneva, World Health Organization, 2001
53. *World Health Report 2001. Mental Health: New Understanding, New Hope*. Geneva, World Health Organization, 2001
54. *Primary prevention of mental, neurological and psychosocial disorders*. Geneva, World Health Organization, 1998

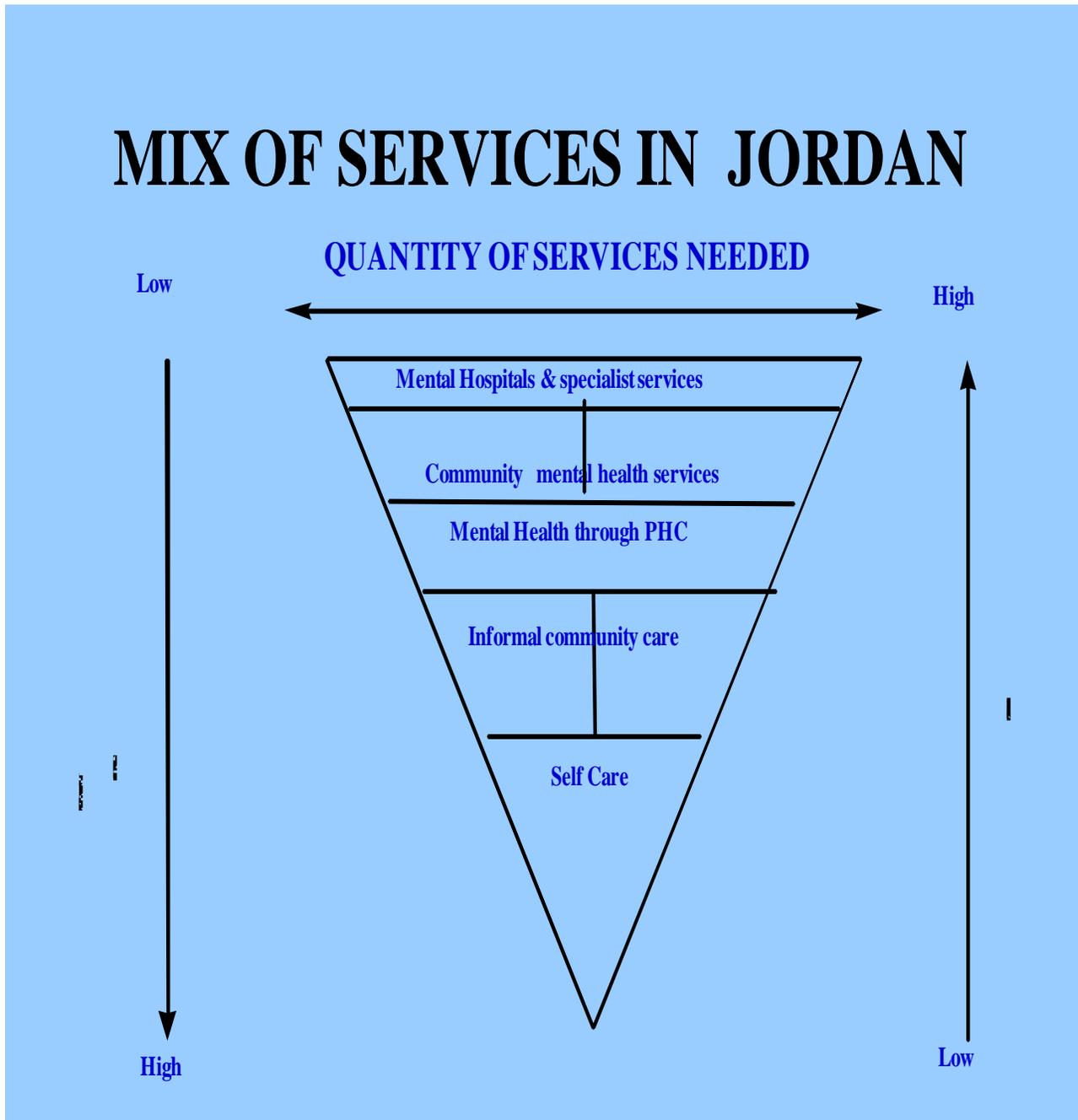
Annexes

Annex 1

WHO Pyramid on Optimal Mix of MH Services



Inverted Pyramid of MH Services in Jordan



Annex 2

WHO Assessment Instrument for Mental Health Systems (AIMS 2.2) Results

WHO-AIMS COUNTRY REPORT FOR JORDAN

Introduction

The Hashemite Kingdom of Jordan is located in the center of the Middle East with an approximate geographical area of 89,000 square kilometers and a population of 5.6 million (2006 Census), currently estimated at 6 million. According to World Bank 2009 criteria, Jordan is categorized as a lower-middle income country. Thirty-seven percent of the population is under 15 years of age, while 5% is above the age of 60. The country's official language is Arabic and the main ethnic group is "Arab". More than 95% of the population is Muslim and less than 5% is Christian. Approximately 78% of the population resides in urban areas (World Bank, 2010). Life and healthy life expectancy at birth is 71.6 and 60 years for males and 74.4 and 64 years for females, respectively. Approximately 5.1% and 13.7% of males and females, respectively, are illiterate.

In 2006, the health budget was calculated at 6.1% of Jordan's gross domestic product (GDP). Today, the total health expenditure is 9.8% of the GDP. The per capita total expenditure on health is \$178.5 USD. The per capita government expenditure on mental health is unknown.



Multiple main health care providers compose the health system in Jordan and individuals may seek care with any number of them. Approximately 60% of the general population is served by public facilities administrated by the Ministry of Health, and The Royal Medical Services serve 40% of the general population. Fifty percent of the population are served by the private sector, 5% are served by the University sector and the Palestinian refugees by the United Nationals Relief and Works Agency (UNRWA).

Source:

<http://www.memnav.com/w/maps/jordan/>

There are an estimated 197 hospital beds per 100,000 population across facilities administered by the Ministry of Health, Royal

Medical Services, University Hospitals and private hospitals. The total number of human resources at all facilities is unknown. However there are an estimated 24.5 physicians per 10,000 population employed by the public sector.

Data on primary care facilities are available for the public sector only. For primary care services administered by the Ministry of Health, there are 370 primary health centers, 58 comprehensive health centers and 243 peripheral health centers. There are 131 physician-based secondary (i.e. specialized) health care clinics and 677 physician-based primary health care clinics.

Despite the decentralization policy of the Ministry of Health, health resources remain centralized. According to the 2006 census, 70% of physicians are based in the Governorate of Amman, while only 36% of the population resides in the capital.

In Jordan, the mental health system is hospital-based. For the past two years, efforts have been directed towards shifting attention and resources to the community. Despite impressive achievements, overall mental health resources remain scarce and centralized.

This study was initiated by Dr. Nabhan Abu Sleih, Mental Health Advisor at the Ministry of Health and supported by Dr. Anita Marini, WHO Jordan Emergency Public Health Officer for Mental Health. Technical support was provided by WHO Mental Health Evidence and Research Team in Geneva, Dr Jodi Morris.

The preparation of this study would not have been possible without the collaboration of the Ministry of Health. We are grateful for the support to Ms Amy Marie Daniels. The study was funded by WHO.

The development of this study has also benefited from the collaboration with the main mental health stakeholders in Jordan (the Royal Medical Services, the Ministry of Social Development, the Ministry of Education, the Ministry of Higher Education, the Universities, the Professional Associations and the Private Sector).

Data was collected in 2010 and is based on the years 2009-2010.

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 Jordan. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Jordan to develop information-based mental health plans with clear baseline information and targets. 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.

In Jordan, there is no mental health legislation. However, three articles pertaining to mental health are included in the country's General Health Act.

Until recently, there was no Mental Health Policy in Jordan. A plan for service development was drafted in 1988 and included the following three areas: 1) the establishment of psychiatric outpatient clinics throughout the country, 2) mental health and psychiatry training for doctors, nurses and mental health workers and 3) the extension of mental health care to prisons. At present, the first and third areas have not been fully implemented and some efforts were dedicated to the second area only over the last two years.

In 2008 a National Steering Committee was established to develop a national policy and two-year action plan for mental health. Both documents are awaiting approval and endorsement by the Ministry of Health and they will be launched in January 2011.

The standards of mental health services may be evaluated through several means, including human rights monitoring. In Jordan, the National Centre for Human Rights and a few other non-governmental organizations (NGOs) carry out programs related to the monitoring of human rights in a number of contexts. Nonetheless, human rights standards have only been assessed in some mental health facilities and only a small fraction of mental health workers receive human rights training. No mental health facilities in Jordan receive regular annual human rights inspections and no mental health staff working in inpatient facilities have received any training on the human rights protection of patients in the last two years.

Within the Ministry of Health, the main authorities are the Mental Health Advisor and the Director of the National Centre for Mental Health: the largest governmental psychiatric hospital, which includes the National Center for Addiction and outpatient clinics. Although mental health services are organized in terms of service areas, the structure is very centralized.

In addition to mental health services provided under the Ministry of Health, universities and the private sector, there are also military services (Royal Medical Services). These services, previously accessible only to military employees, now serve approximately 40% of the population.

There are 64 mental health outpatient facilities in Jordan. Ministry of Health facilities (n=37) provide services to an estimated 2,187 users per 100,000 population. There are 8.27 beds per 100,000 population in Jordan's mental hospitals, which serve 45 patients per 100,000 population and have an occupancy rate of 97%. The most commonly assigned diagnosis at both outpatient facilities and mental hospitals is schizophrenia.

There is a lack of mental health training for primary health care workers and interactions between the primary care and mental health systems are rare. In 2010 Jordan was selected as one of the six countries for the pilot implementation of the mhGAP: a WHO global program which aims to reduce the mental health treatment gap between what is needed and what is available, integrating the mental health component into the PHC. While there are a large number of international NGOs and UN agencies providing psychosocial services, there are only a few local organizations providing these services and training for mental health staff on psychosocial interventions is rarely provided.

Exact numbers of human resources for mental health are unknown for both the public and private sectors. However, estimates based on existing data reveal that the numbers of mental health professionals per capita are relatively low; there are an estimated 1.09 psychiatrists, 0.54 other

medical doctors (not specialized in psychiatry), 3.95 nurses (both associated and registered nurses, not specialized in mental health), 0.27 psychologists, 0.3 social workers, and 0.09 occupational therapists per 100,000 population. Additionally, human resources are unevenly distributed, as a large proportion of mental health professionals work in mental hospitals near the capital city, where only 36% of the population live.

There are no mental health family associations in Jordan. The first user association (Our Step) has just been established. In addition, public education and awareness campaigns are rare. There are no coordinating bodies overseeing any mental health awareness campaigns and there is a lack of collaboration between the mental health and other relevant sectors.

Epidemiological studies for both clinical and community samples are not frequently conducted, although there have been 25 studies on mental health topics in Jordan published and indexed in PubMed in the last 5 years.

Strengths & Weaknesses of the Mental Health System in Jordan

Summary

Use of the WHO-AIMS permits a comprehensive assessment of the mental health system of Jordan and elucidates both the strengths and weaknesses of the present system.

There is no a national authority for mental health in Jordan, that has a governing role, is policy making and budget holding (Domain 1). While no formal mental health policy has ever existed, a plan was drafted in 1988 that prioritizes the improvement of community mental health services, mental health service provision in primary care and the advocacy and promotion of mental health. Nonetheless, clear weaknesses of the mental health system include a lack of definitive policy and legislation to protect the rights of individuals living with mental illness and to promote equity in access to care and treatment of such populations.

An inventory of mental health services (Domain 2) in Jordan shows that most facilities are outpatient clinics and that most of the care is provided in the community, although it is mainly biological care (provision of medicines). For each mental hospital in the country, there are 16 outpatient facilities that serve individuals with mental illness. Nonetheless, the number of mental health hospital beds has increased in the last five years, which suggests that efforts to push mental health services into the community have not been wholly successful. Furthermore, over 50% of individuals treated in mental hospitals stay for more than 10 years, suggesting that programs to integrate individuals with severe and persistent mental illness into the community are inadequate. While a majority of individuals treated at mental health facilities are able to access psychotropic medicines on a continuous basis, there is next to no provision of psychosocial interventions for these populations. There is also evidence to suggest that disparities in the quality of care both within government mental health facilities and comparing public with private facilities exist. Lastly, mental health facilities and services and training dedicated specifically for children and adolescents is lacking.

An assessment of mental health in primary care (Domain 3) suggests that there is great potential to improve the integration of mental health services with primary care. The primary care system in Jordan is highly developed and organized, supporting the efficient integration of mental health interventions in primary care. Nonetheless, there is virtually no interaction between the primary care system and mental health professionals and primary care professionals receive little initial and refresher training on mental health topics.

Data on the number of human resources for mental health in Jordan (Domain 4) indicate that there is a considerable variety of professionals (e.g. psychiatrists, psychologists, nurses) providing mental health services in Jordan and that they are distributed throughout mental health inpatient and outpatient facilities, although there is a higher concentration of nurses in inpatient facilities. Furthermore, a very small percentage of trained psychiatrists ever emigrate to other countries within 5 years of training. While a majority of mental health professionals receive refresher training on the appropriate use of psychotropic medications, there is very little refresher training on psychosocial interventions or on child and adolescent mental health issues. Lastly, there are a plethora of NGOs providing psychosocial services. However there is only one user organization and no family organizations for mental health in the country.

Findings from Domain 5 show that Jordan's mental health system collaborates with a number of agencies or institutions to provide public education and awareness campaigns that support a variety of population groups (e.g. children, women) and target a wide range of professionals' (e.g. teachers, social service staff). Despite these efforts, formal collaboration in the form of laws, administration or programs with other sectors is lacking. Fortunately, there is a mechanism for individuals to obtain social welfare benefits due to a mental disorder. However less than 5% of individuals who receive such benefits qualify due to their mental illness, suggesting that processes to enhance the enrolment of individuals with severe mental illness in such social service programs could be improved.

Findings from the assessment of mental health monitoring and research (Domain 6) illustrate that all mental hospitals and a larger majority of outpatient mental health facilities in Jordan are collecting and transmitting essential mental health data.

Comparisons with other Eastern Mediterranean countries

The 2009 WHO publication, "Mental health systems in selected low- and middle-income countries: a WHO-AIMS cross-national analysis" provided a summary of the mental health systems of developing countries and made a number of comparisons across income levels and WHO regions (WHO, 2009). The following Eastern Mediterranean (EMRO) countries and territories were included in the report: Afghanistan, Egypt, Iraq, Iran, Morocco, Tunisia, West Bank and the Gaza Strip.

The following are some of the key differences between components of the mental health system in Jordan and those of the other EMRO countries assessed:

- The average estimated number of mental health professionals per 100,000 population in EMRO is slightly less than the total in Jordan (5.1 vs. 6.2).

- Jordan is comparable to other EMRO countries in the percentage of undergraduate training devoted to mental health for doctors and nurses.
- Compared with other EMRO countries, a higher proportion of nurses and a lower proportion of doctors in Jordan receive refresher training in mental health.
- Compared with other EMRO countries, a larger proportion of psychiatrists in Jordan work in public mental health facilities.
- A considerably larger number of nurses per capita graduated in the last year compared with the other EMRO country average.
- The proportion of mental health professionals receiving refresher training across a number of topics in Jordan is comparable to EMRO averages. However there is considerably higher rational use of psychotropic drugs training but less training in child mental health issues in Jordan.
- The ratios of psychiatrists and nurses working in or near the largest city to those working in the entire country are greater for the EMRO region compared with Jordan.
- The percentage of the daily minimum wage needed to purchase antipsychotic medication is less in Jordan compared with the EMRO average and it is the same as the EMRO average for antidepressant medication.

Next Steps in Strengthening the Mental Health System

Based on the domain summaries and a critical assessment of the strengths and weaknesses, the following are possible next steps for the long term improvement of Jordan's mental health system.

Domain 1

- Establish a national mental health authority with a governing and an executive role.
- Develop a national mental health policy (it will be launched in January 2011).
- Update previous mental health plan (it will be launched in January 2011).
- Create or enhance mental health legislation in the areas of access to least restrictive care, the rights of mental health consumers and their families, guardianship for individuals with mental illness, voluntary and involuntary treatment, law enforcement and other judicial system issues for people with mental illness, mechanisms to oversee involuntary admissions and treatment practices and mechanisms to implement mental health legislation.
- Establish a national review body on human rights and develop a strategy for the ongoing review/inspection of and training of health professionals on the human rights protection of patients.

Domain 2

- Reduce length of stay for mental hospital patients by developing and improving initiatives to integrate individuals with severe and persistent mental illness into the community.
- Enhance the provision of psychosocial interventions, according to the bio-psychosocial model, for patients treated at both outpatient and inpatient mental health facilities.

- Develop secondary level community-based mental health services: both inpatient and outpatient, according to the bio-psychosocial approach.
- Develop and expand curricula and training on mental health of children and adolescents.
- Develop child and adolescent community-based mental health services.

Domain 3

- Increase the training in mental health for primary care staff, through the implementation of the mhGAP.
- Enhance the interaction between the primary care system staff and mental health professionals in the areas of training, co-coordination of activities and referral issues.

Domain 4

- Increase the number of psychosocial staff and the level of cross-training of psychologists and other mental health professions in evidence-based psychosocial interventions.
- Promote the establishment of family organizations and support the just established user association “Our Step”.

Domain 5

- Strengthen the collaboration with other sectors through the development of joint programs and the establishment of formal mechanisms for intersectoral cooperation, especially with social and educational services.

Domain 6

- Improve the mental health information system, the data collection and the monthly reporting.

Annex 3

Human Resources for Mental Health and General Health in Jordan

Human Resources	Rate per 100.000 population
General Health Professionals	52.7
Mental Health Professionals: <ul style="list-style-type: none">• Psychiatrists• Nurses (not specialized)• Psychologists• Social Workers (not by education)• Occupational therapists	1.09 3.95 0.27 0.30 0.09

Annex 4

Mental Health Gap Action Program (mhGAP) Information

Executive summary

Mental, neurological, and substance use (MNS) disorders are prevalent in all regions of the world and are major contributors to morbidity and premature mortality. 14% of the global burden of disease, measured in disability-adjusted life years (DALYs), can be attributed to MNS disorders. The stigma and violations of human rights directed towards people with these disorders compounds the problem. The resources that have been provided to tackle the huge burden of MNS disorders are insufficient, inequitably distributed, and inefficiently used, which leads to a treatment gap of more than 75% in many countries with low and lower middle incomes.

In order to reduce the gap and to enhance the capacity of Member States to respond to the growing challenge, the World Health Organization (WHO) presents the Mental Health Gap Action Programme (mhGAP). mhGAP provides health planners, policy-makers, and donors with a set of clear and coherent activities and programmes for scaling up care for MNS disorders.

The objectives of the programme are to reinforce the commitment of all stakeholders to increase the allocation of financial and human resources for care of MNS disorders and to achieve higher coverage with key interventions especially in the countries with low and lower middle incomes that have large proportions of the global burden of these disorders.

Since countries with low and lower middle incomes have most of the global burden, and because they have limited human and financial resources, a strategy that focuses on these countries has the potential for maximum impact. mhGAP provides criteria to identify the countries which contribute most to the burden of MNS disorders and which have a high resource gap.

This programme is grounded on the best available scientific and epidemiological evidence about MNS conditions that have been identified as priorities. It attempts to deliver an integrated package of interventions, and takes into account existing and possible barriers for scaling up care. Priority conditions were identified on the basis that they represented a high burden (in terms of mortality, morbidity, and disability); caused large economic costs; or were associated with violations of human rights. These priority conditions are depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. The mhGAP package consists of interventions for prevention and management for each of these priority conditions, on the basis of evidence about the effectiveness and feasibility of scaling up these interventions. mhGAP

provides a template for an intervention package that will need to be adapted for countries, or regions within countries, on the basis of local context.

The obstacles that hinder the widespread implementation of these interventions must also be considered, together with the options that are available to deal with them. mhGAP provides a framework for scaling up the interventions for MNS disorders, taking into account the various constraints that might exist in the country.

Success in implementation of the programme rests, first and foremost, on political commitment at the highest level. One way to achieve this is to establish a core group of key stakeholders who have multidisciplinary expertise to guide the process. Assessment of needs and resources by use of a situation analysis can help to understand the needs related to MNS disorders and the relevant health care, and thus to guide effective prioritization and phasing of interventions and strengthening of their implementation. Development of a policy and legislative infrastructure will be important to address MNS disorders and to promote and protect the human rights of people with these disorders.

Decisions will need to be made as to how best to deliver the chosen interventions at health facility, community, and household levels to ensure high quality and equitable coverage. Adequate human resources will be needed to deliver the intervention package. The major task is to identify the people who will be responsible for the delivery of interventions at each level of service delivery.

Most countries with low and middle incomes do not assign adequate financial resources for care of MNS disorders. Resources for delivery of services for these disorders can be mobilized from various sources – e.g. by attempts to increase the proportion allocated to these conditions in national health budgets; by reallocation of funds from other activities; and from external funding, such as that provided through developmental aid, bilateral and multilateral agencies, and foundations.

The mhGAP framework also includes plans for monitoring and evaluation of programme planning and implementation. Selection of inputs, processes, outcomes, and impact indicators, together with identification of tools and methods for measurement, are an integral part of the process.

The essence of mhGAP is to establish productive partnerships; to reinforce commitments with existing partners; to attract and energize new partners; and to accelerate efforts and increase investments towards a reduction of the burden of MNS disorders. Scaling up is a social, political, and institutional process that engages a range of contributors, interest groups, and organizations.

Successful scaling up is the joint responsibility of governments, health professionals, civil society, communities, and families, with support from the international community. An urgent commitment is needed from all partners to respond to this public health need. The time to act is now.

Annex 5

Relevant Medicines on the WHO Model List of Essential Medicines (2009)

Psychotherapeutic medicines	
<input type="checkbox"/> chlorpromazine	injection: 25 mg (hydrochloride)/ml in 2 ml ampoule; oral liquid: 25 mg (hydrochloride) / 5 ml; tablet: 100 mg (hydrochloride).
<input type="checkbox"/> fluphenazine	injection: 25 mg (decanoate or enantate) in 1 ml ampoule.
<input type="checkbox"/> <i>haloperidol</i>	injection: 5 mg in 1 ml ampoule; tablet: 2 mg; 5 mg
<input type="checkbox"/> <i>amitriptyline</i>	tablet: 25 mg (hydrochloride).
fluoxetine	solid oral dosage form: 20 mg (present as hydrochloride).
carbamazepine	tablet (scored): 100 mg; 200 mg
lithium carbonate	solid oral dosage form: 300 mg.
valproic acid	tablet (enteric coated): 200 mg; 500 mg (sodium valproate)
<input type="checkbox"/> <i>diazepam</i>	tablet (scored): 2 mg; 5 mg
clomipramine	capsule: 10 mg; 25 mg (hydrochloride).
Antiparkinsonism medicines (to deal with potential extra-pyramidal side effects of anti-psychotics)	
<i>biperiden</i>	injection: 5 mg (lactate) in 1 ml ampoule; tablet: 2 mg (hydrochloride).
Anticonvulsants/antiepileptics	
carbamazepine	oral liquid: 100 mg/5 ml; tablet (chewable): 100 mg; 200 mg; tablet (scored): 100 mg; 200 mg.
<i>diazepam</i>	Gel or rectal solution: 5 mg/ml in 0.5, 2 ml and 4ml tubes
<input type="checkbox"/> lorazepam	Parenteral formulation: 2 mg/ml in 1 ml ampoule; 4 mg/ml in 1 ml ampoule.
<i>phenobarbital</i>	injection: 200 mg/ml (phenobarbital sodium); oral liquid: 15 mg/5 ml (as phenobarbital or phenobarbital sodium); tablet: 15 mg-100 mg (phenobarbital).
phenotyn	capsule: 25 mg; 50 mg; 100 mg (sodium salt); injection: 50 mg/ml in 5 ml vial (sodium salt); oral liquid: 25-30 mg/5 ml; tablet: 25 mg; 50 mg; 100 mg (sodium salt); tablet (chewable): 50 mg.
valproic acid	oral liquid: 200 mg/5 ml; tablet (crushable): 100 mg; tablet (enteric coated): 200 mg; 500 mg (sodium valproate).

= similar clinical performance within a pharmacological class.

Annex 6

Suggested Roles & Responsibilities of the Main Sectors

1) Ministry of Health (MoH):

- a. Provide direction for MH in Jordan; develop national MH policies and plans.
- b. Develop MH legislation and establish mechanisms for protecting and promoting the human rights of service users.
- c. Regulate the practice of mental health workers in collaboration with respective professional bodies.
- d. Promote and follow-up on the implementation of the national MH policy and action plan.
- e. Service planning and management.
- f. Convene MH professionals across the country and call for national committees for various purposes (such as consultations and program implementation).
- g. Establish mechanisms for assessment, monitoring and evaluation of MH services.
- h. Establish mechanisms to include service users and their families in the decision-making process.
- i. Promote liaison among various sectors to coordinate interagency MH and psychosocial services.

2) Royal Medical Services (RMS):

- a. Participate actively in the MoH mental health unit through membership in the technical taskforce.
- b. Participate in establishing MH legislation and promoting human rights through the organization of seminars.
- c. Participate actively in implementing the mental health policy.
- d. Participate in identifying indicators for MH systems.
- e. Participate in the prevention, assessment and management of developmental disorders, and contribute to developing relevant protocols.
- f. Receive and treat patients from civil institutions, including children and the elderly, in outpatient clinics and inpatient wards.
- g. Conduct training and teaching courses for students and MH workers including nurses, medical students, psychologists, social workers and occupational therapists.
- h. Implement capacity building and training programs on child MH for teachers and school staff members.

3) Ministry Of Social Development (MoSD):

- a. Integrate MH into the social welfare policy.

- b. Identify social determinants of mental health and establish programs to promote social welfare and protect vulnerable individuals and families.
- c. Develop programs and social measures to protect and support people with mental health problems, and implement programs and services to integrate them into their communities.
- d. Participate in addressing and combating the stigma related to mental health problems.
- e. Strengthen and further develop social services for people who suffer from mental health problems.

4) Ministry of Education (MoE):

- a. Integrate MH into the education policies and curricula in school programs.
- b. Set standards for the required credentials of school psychologists and school counselors.
- c. Collaborate on policies and activities with both the MoH and MoSD on devising policies and programs on shared issues and concerns.
- d. Develop capacity building and implement training programs on child MH for teachers and school staff members.

5) Ministry of Higher Education (MoHE):

- a. Include MH as an integral part of university education policies and curricula.
- b. Collaborate on policies and activities with both the MoH and MoSD on devising policies and programs on shared issues and concerns.
- c. Develop and implement capacity building and training programs on adolescent and young adult MH for professors and staff members.

6) Ministry of Labor (MoL):

- a. Adopt an interest and an action plan for the employment of people with MH problems, in collaboration with MoH and MoSD.
- b. Educate labor inspectors about MH conditions at the work place.
- c. Deliver MH prevention and awareness programs at the work place.
- d. Monitor any practice of discrimination against people with mental disorders at the work place and develop appropriate complaints and response mechanisms.

7) Ministry of Justice (MoJ):

- a. Promote quality MH services in prisons and correctional centers.
- b. Include a mandatory training course in MH for all security staff.
- c. Provide training courses on early detection of MH problems and develop referral mechanisms for detention center staff and police officers.

- d. Maintain and monitor human rights conditions in prisons and correctional centers, as they represent the minimal measures for protecting MH conditions.
- e. Facilitate the provision of MH experts in the courts when needed.

8) *Ministry of Islamic Awqaf (MoIA):*

- a. Integrate MH in the agenda of MoIA
- b. Contribute to the development of the mental health system in Jordan through the implementation of the policy and plan.

9) *Academic Institutions:*

- a. Include MH and mhGAP-IG as an integral part of education programs and graduation requirements.
- b. Encourage the inclusion of MH services as placements for field training and voluntary work for students.
- c. Collaborate with community institutions through action plans to build the capacity of front-line workers, service users, and informal family care through trainings and workshops.
- d. Build capacity of academics, workers, and students.
- e. Implement counseling programs through university student unions.
- f. Adopt and collaborate with practitioners and other relevant entities on research in MH and related areas.

10) *UNRWA:*

- a. Collaborate in implementing the National MH Policy and Plan with governmental bodies and other NGOs.
- b. Integrate the MH component in its PHC services.
- c. Develop and participate in awareness campaigns to fight the stigma related to mental disorders.
- d. Build capacity of teachers on child mental health issues.

11) *Local NGOs, Foundations and CBOs:*

- a. Collaborate in implementing the National MH Policy and Plan with governmental bodies and other NGOs.
- b. Develop and participate in awareness campaigns to fight the stigma related to mental disorders.
- c. Implement rehabilitation, vocational, and recreational programs for service users and their families.

- d. Develop programs to integrate service users in their communities and the work place.
- e. Implement family counseling and psycho-education programs for service users and their families.

12) International NGOs and Agencies:

- a. Build partnerships with governmental bodies, including the MoH and MoE.
- b. Pilot programs in MH at all levels of care.
- c. Augment national and international networking with other agencies for technical development.
- d. Build capacity of local staff and community-based organizations.
- e. Support and fund MH service delivery.

13) National Centre for Crisis Management and Security (NCCMS):

- a. Integrate the MH component in the strategy for the centre.
- b. Develop human resources in MH for all stages of emergency and crisis preparedness, response and recovery, in order to respond to the needs of affected communities.
- c. Collaborate with the Jordan IASC advocates group to integrate the IASC guidelines into strategies.
- d. Prepare an information package or plan for MH during emergency preparedness and response.

14) IASC Guidelines Jordan Advocates Group:

- a. Coordinate with the NCCMS.
- b. Prepare orientation and training materials on the IASC Guidelines.
- c. Promote awareness on the issue of MH in emergency response.
- d. Build capacity of emergency workers on MH.
- e. Contribute to the process of institutionalizing the IASC Guidelines in the country.

15) Higher Health Council:

- a. Introduce the MH component in the public health agenda of the council.
- b. Identify and address the MH and psychosocial aspects in various health issues (e.g. chronic diseases).
- c. Collaborate with other bodies and institutions on MH.

16) Professional Associations:

- *Jordanian Psychiatric Association:*
 - Promote MH awareness and education through lectures, seminars and conferences, and through contacts with the media.
 - Promote and contribute to the implementation of the MH policy.
 - Advocate for MH to be a priority in the public health agenda.
 - Advocate for MH to be part of the general health system.
 - Develop plans and activities to attract medical students to the specialty of psychiatry.

- *Jordanian Psychological Association:*
 - Support the efforts of the MoH, MoE, and MoSD in their endeavor to improve the MH system and implement the MH policy.
 - Support the development of criteria for positive MH practices.
 - Advocate for MH promotion in all prevention efforts on the national level.
 - Uphold the responsibility in licensure plans and programs for school counselors and psychologists.
 - Participate with stakeholders in planning habilitation and rehabilitation programs for patients and their caregivers.
 - Support and assist in fundraising activities, rehabilitation programs and school psychological services.
 - Provide technical input and assistance in the development of training programs for concerned parties.
 - Train professionals on the early detection of threats to MH.

- *Jordanian Association of Social Workers:*
 - Monitor the living and work conditions of persons with mental disorders.
 - Support rehabilitation programs for persons with mental disorders.
 - Set regulations regarding criteria for licensing social workers and an accountability system for professional practice.
 - Liaise between the families of service users and professional parties, including MoSD.
 - Liaise with the MoL and employment agencies to guide the beneficiaries and their caregivers towards work environments.
 - Monitor stressors and stress sources in the community and in the lives of service users, and coordinate with professional parties in planning to minimize the impacts of these stressors.

- *Jordanian Nursing Council (JNC):*
 - Contribute to and promote the implementation of the MH policy.
 - Develop and implement MH programs in all concerned agencies and associations.
 - Develop a national education scheme for MH nursing.
 - Accredite credentials of specialties for MH services.

- Develop a training scheme/ packages for MH nurses.
- Provide continuing nursing education for nurses.
- Human resource development of mental health nurses.
- *Jordanian Medical Association:*
 - Strengthen the MH component in medical training.
 - Integrate the mhGAP-IG in the curricula for GPs and family doctors, in addition to the pre-specialization practical experience curriculum.
 - Provide CME for MH training and refresher trainings.
 - Promote psychiatry as field of specialization.
- *Occupational Therapist Association:*
 - Collaborate with other parties for the implementation of the MH policy and plan.
 - Support the development and adoption of criteria for MH service delivery, based on the MH policy.
 - Promote strengthening the MH component in educational curricula.
 - Assist and support occupational therapy programs with emphasis on mental health services, and community-based rehabilitation.
 - Prepare an information package for occupational therapy mental health services.
 - Provide technical input and assistance in developing and implementing MH training programs for occupational therapists, other service providers, service users and their families.
 - Uphold responsibility in MH occupational therapy licensure based on qualification, training and examination.
 - Provide community-based programs to decrease stigma and enhance community integration of service users.
 - Disseminate MH occupational therapy practice at all levels of care throughout all sectors.

17) Community and Religious Leaders:

- a. Raise awareness on MH issues.
- b. Build capacity of community and religious leaders in identifying and referring people with MH problems.
- c. Utilize worship places to provide support to individuals and families.
- d. Collaborate with governmental bodies on the issue of MH.

18) Users Association:

- a. Network with different institutions to integrate service users in the community.
- b. Raise awareness about mental disorders and fighting stigma in the community.
- c. Provide support groups for service users.
- d. Provide psychosocial education programs for service users.

- e. Advocate for the human rights of people with mental problems.

19) Human Rights NGOs:

- a. Integrate the MH component in the NGO agenda.
- b. Build technical capacity in MH and human rights.
- c. Empower service user associations.
- d. Facilitate reporting mechanisms for people with mental health problems.

20) National Centre for Human Rights:

- a. Integrate the MH component in the centre's agenda.
- b. Contribute to the development of MH legislation.
- c. Establish a taskforce for monitoring human rights violations in MH.
- d. Build technical capacity in MH and human rights.
- e. Empower service users associations.
- f. Facilitate reporting mechanism for people with mental health problems.

21) Media:

- a. Assign a representative to follow-up on the National MH Policy and Plan activities.
- b. Collaborate in implementing innovative programs to portray an accurate image of MH.
- c. Collaborate with other institution in Jordan to develop MH education programs directed toward children, adolescents, and adults.
- d. Implement talk-shows and programs to raise awareness about MH promotion and early detection.

Annex 7

National Steering Committee Members

Dr. Deifallah Al Lozi, H.E. Secretary General, Ministry of Health
Dr. Bassam Al Hijjawi, Director of Primary Health Care Administration, Ministry of Health
Dr. Mohammad Asfour, National Center for Mental Health, Ministry of Health
Dr. Nayel Al Adwan, National Center for Mental Health, Ministry of Health
Dr. Nabhan Abu Sleih, Head of Specialty, Ministry of Health
Dr. Jamal Al Anani, National Center for Addiction, Ministry of Health
Dr. Basheer Al-Qaseer, Mental Health Unit, Ministry of Health
Mr. Redwan Abu Dames, Legal Affairs, Ministry of Health
Dr. Amer Hyasat, Ministry of Social Development
Mr. Haytham Mehyar, Ministry of Social Development
Dr. Fairouz Alsayegh, Royal Medical Services
Dr. Hamdi Murad, Islamic scholar
Dr. Hanna Keldany, Secretary General of the Latin Diocese in Jordan
Dr. Asr Al Sharman, Representative of Health Committee in the Parliament
Dr. Moumen Al Hadidi, Representative of Forensic Medicine and Deputy of Medical Union
Dr Youssef Khader, Higher Council for Science and Technology
Dr. Hania Dawani, Jordanian Nursing Council
Dr. Tewfik Daradkeh, Jordan University for Science and Technology
Dr. Wissam Breik, Ahleyyah University, Faculty of Psychology
Dr. Abdul Majeed Samera'i, University of Jordan, child psychiatrist
Dr. Yahya Al Ali, Hashemite University, Faculty of Social Sciences
Dr. Abdulmanaf Al Jaderi, University of Jordan, Faculty of Medicine
Dr. Anwar Bteha, Jordan University for Science and Technology
Dr. Sahar Makhamreh, Al Balqa Applied University, Faculty of Social Work
Dr. Mohammad Jebiril, Hashemite University, Faculty of Occupational Therapy
Ms. Lina Wardan, University of Jordan, Faculty of Nursing
Dr. Mohammad Dabbas, Psychiatric Association
Dr. Zuhair Zakaria, Jordanian Psychological Association
Ms. Haifa Al Bashir, Jordanian Society for Psychological Rehabilitation
Mr. Fawwaz Ezzeldeen, Service User
Ms. Raghad Ibrahim Muhana, Service User
Dr. Nasser Al Deen Al Shreqi, Al Rasheed Hospital
Dr. Adnan Al Takriti, private sector, Psychiatry
Ms. Tala Al Kurd, private sector, Psychology
Dr. Hashim Ali El Zein El Mousaad, WHO Jordan Representative and Head of Mission
Dr. Anita Marini, WHO Jordan Emergency Public Health Officer for Mental Health