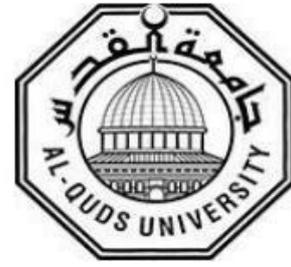


**Deanship of Graduate Studies
Al-Quds University**



**Client's Perception of Quality of Services Towards
Patients with Mental Illness Treated at Palestinian
Governmental Community Mental Health Centers**

Hanan Mohammad Khader Abu Eid

M.Sc. Thesis

Jerusalem-Palestine

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**A thesis is submitted in Partial fulfillment of
requirement for the degree of Master in Community
Mental Health/ Psychotherapy/ School of Public
Health/Al-Quds University**

2019/1441

Al-Quds University
Deanship of Graduate Studies
Master in Community Mental Health/ Psychotherapy



Thesis Approval

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Prepared by: Hanan Mohammad Khader Abu Eid

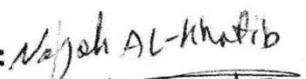
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1.Head of Committee: Dr. Najah Al –Khatib

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Signature: 

Jerusalem- Palestine

2019/1441

Dedication

To my beloved ones...

Declaration:

I certify that this thesis submitted for the degree of Master, is the result of my own research, except where otherwise acknowledged, and that this study (or any part of this study) has not been submitted for a higher degree to any other university or institution.

Signature:

Hanan Mohammad khader Abu Eid

Date: 18 / 01 /2020

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Abstract

Mental illness is well-recognized as a global health problem (WHO, 2016). The number of people diagnosed with mental illness is growing worldwide. People with mental disabilities all over the world experience violations of their rights, stigma, and discrimination in all spheres of life. This study is one of the first studies in Palestine (to the knowledge of the researcher) that attempts to identify the personal experiences of patients with mental health problems with health practitioners during their therapeutic process and provide a more comprehensive understanding of what people with mental disorders encounter through their journey to treatment.

Aim: To explore the experiences of patients with mental disorders concerning the clinical practices of mental health practitioners towards patients with mental illness treated at Palestinian governmental community mental health centers.

Method: A qualitative research design was utilized to achieve this purpose. The data was gathered between the middle of August 2018 through at the end of December 2018. A convenience sampling method was used in this study and the researcher reached out to 30 patients with mental disorders of both sexes between the ages of 18-60 years of age. A semi-structured interview was utilized in this study. The data was collected using an interview guide. The data were transcribed and coded in order to categorize and organize the data transcription into themes and sub-themes. The interpretation of data involved identifying the reoccurring themes as well as highlighting the similarities and differences in the data.

Findings: Analysis of the participants' characteristics showed that 43% of the participants were males. Their ages ranged between 18 to 60 years of age. They are all residents of either Ramallah or Hebron.

Fifty-three percent of the participants did not know their rights as patients, 47% knew the following rights: the right to be treated, the right to privacy and confidentiality, the right to respect and to receive treatment without interruptions, the right to have efficient time in the therapeutic session, and the right to be treated with dignity.

In regards to patients' rights violations; 66.6% of the participants reported that their rights have not been violated. The rights that had been violated according to 44.4% of the participants included encountering a situation where they felt degraded, disrespected, and ignored by health practitioners, loss of confidentiality while receiving treatment,

interruptions, and violation of their right to invest the therapeutic time in the best possible way.

Two forms of therapy were provided at Palestinian CMHCs; 80% of the participants received medical services (medication), while 20% of them received two types of therapy: medication and individual counseling/psychotherapy. The great majority, 93%, of the participants was involved in the therapy, and they expressed their involvement in therapy by complying with taking the medications.

The CMHC's facilities are limited to the existence of a waiting room, bathrooms, and lack of a cafeteria and public parking. Over half of the participants (60%) were satisfied with the service received from the CMHC's.

Conclusion: This study concluded that the legal rights of people with mental illness in any health facility can be violated easily if the culture of patient rights is absent in the therapeutic setting. The findings from this study need greater attention from the Palestinian Ministry of Health and policymakers, mental health professionals, caregivers, and NGOs to raise awareness of people with mental illness about their rights. This is so that they can exercise as well as prevent violations of their rights.

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List of Abbreviations/ Acronyms

Abbreviations	Meaning of abbreviations
DSM5	Diagnostic and statistical manual of mental disorders – the fifth edition
NSDUH	National Survey on Drug Use and Health
CMH	Community mental health act
UDHR	The Universal declaration of human rights,1984
WHO	World Health Organization
UN	The United Nation
EIPR	Egyptian Initiative for Personal Rights
NHS	The National Health Service
MHP	The mental health professional
CMHC	Community Mental Health Center
CMHSs	Community Mental Health Services
CTOs	Community treatment orders
MHPS	Model of mental health professional support
MHP	Mental Health Professional
SMI	Severe mental illness
UNRWA	The United Nations Relief and Works Agency
GBD	(Global burden of disease study) – institute for Health Metrics and Evaluation
WPA	World Psychiatry Association
HCPC	Health & Care Professions Council

Chapter 1

1.1 Introduction

1.2 Problem statement

1.3 Justification of the Study

1.4 Main Objective

1.5 Specific Objectives

1.6 Research Questions

1.7 Definition and terms

1.1 Introduction

This chapter presents an overview of the proposed study, including the background, problem statement, justification of the study, main objectives, specific objectives, research questions, study feasibility, and study limitations.

Background

Mental illness is well-recognized as a global health problem (WHO, 2016). The number of people diagnosed by mental illness is growing in the world. It is estimated that over one billion people globally have been living with a mental illness (GBD, 2016). Nowadays, Mental Disorder is defined by the (Diagnostic and Statistical Manual of Mental Disorders DSM5 –5th edition) as a disorder characterized by clinically significant disruption in an individual's cognition, emotional regulation, or actions that indicates a deficiency in the underlying psychological, physiological, or developmental processes.

According to the American psychiatric association, mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and / or problems functioning in social, work or family activities. <https://www.psychiatry.org/patients-families/what-is-mental-illness>

Mental illness refers collectively to all diagnosable mental disorders. There are many forms of mental illness, such as psychotic disorders, non-psychotic disorders, and the most common disorders in the CMHCs are depression, bipolar disorder, obsessive spectrum disorders, personality disorders, addiction, eating disorders, sleep disorders, schizophrenia, and neurological disorders (Leighton & Dogra, 2009).

Mental illness is a disease that causes disturbances in thought, emotions and behavior and the disturbances' severity differs from one person to another. Mental illness symptoms can come and go throughout a person's life, and can vary depending on the disorder (Seeman, 2012). Some of these disorders are mild and only interfere with daily life in limited ways, while other mental health conditions are so severe that a person may need hospital care (Leighton & Dogra, 2009).

Usually there are some risk factors which already may exist before the illness is diagnosed. These risk factors shall include social, biological and psychological factors. One of the main risk factor is the psychological predisposing / risk factors, including low self-esteem, lower IQ, personality features, attachment style, and experienced abuse and neglect (Sirey,2008).

Social and economic circumstances are also important risk factors correlated with more vulnerability to mental illness; good parenting, social support of family and friends and the economic security have an important role to insure the positively engagement at the individual social surroundings (Lopez et al.,2006).

Environment is another risk factor; gender inequalities, poor access to basic services, injustice and discrimination, in addition to that; exposure to wars or disaster increase the possibility to developing mental illness (Schmidt, 2007).

The history of dealing with individuals suffering from mental illnesses began in ancient times when people were locked away in lunatic asylums where they were continuously mistreated, shackled, and routinely beaten, due to their false believes about the existence of evil and bad spirit in their bodies (Aadland, 2000).

People with mental disabilities all over the world experience violations of their rights, stigma and discrimination. This situation emphasizes the need to set rules to protect people

who lost part or all of their cognitive functionality from being mistreated, and to ensure that they will be offered full rights, and treated with dignity (Bhugra, 2016).

Violations of the rights of people with mental health disorders differ across cultures / countries. For instance, in high-income countries, more funds are dedicated to treating mental illness than in low-income countries (Drew et al., 2011). Subgroups of individuals with mental disorders are at an increased risk of violation. For example, those of different ethnicities and races are more likely to suffer discrimination and women are more likely to be exploited sexually and even sterilized without consent (Hunt & Mesquita, 2006).

Internationally, on 17th December 1991, the UN assembly adopted resolution 46/19 of principles for protection of persons with mental illness and improvement of mental health care. These principles recognize the idea that mental illness requires the specific protection of human rights relying on the fact that they may lack capacity or adequately to assert these rights for themselves (Appelbaum, 1997).

According to the National Survey on Drug Use and Health (NSDUH), the prevalence of mental illness in 2016 was 18.3% among American adults who experience mental health problems annually, while the prevalence of serious mental illness was 4.2% among adults. A survey carried out in 2014 by the National Centre (NatCen) for social research in England, estimated that 1 in 6 adults has a mental disorder. (Mental Health and Wellbeing in England Adult Psychiatric Morbidity Survey 2014).

According to Ghanem et al., (2009), 12 millions of Egyptians have a psychiatric illness, prevalence incidence 17%. In 2018 the rate increased to 25% according to the National Mental Health Survey issued from the Ministry of Health in Egypt. Another study conducted in Morocco by Kadri et al., (2010), they found that mood and anxiety disorders

are the most common disorders among a sample of 5498 patients with mental health problems. Due to that study 40.1% had at least one current mental disorder, the most common was major depressive disorder (26.5%), and anxiety disorder was found in 37% of the sample.

In the Palestinian context, the mental health care is provided by the Palestinian government since 1993. As widely known, the Palestinian government had inherited the health system from the Israel military administration health services as it was and tried to improve it. In regard to the mental health care, the Palestinian Ministry of Health provides services for people with mental health condition through 16 specialized psychiatric and community health centers in West Bank. In addition; there is the non- governmental sector which provides some kind of mental health services (Giacaman et.al, 2009).

The incidence rate of mental illness in Palestine during the year of 2017 is 117.2 per 100.000 populations according to the Palestinian health annual report. According to the same reference; 83.530 individuals visited the community mental health centers in the West Bank (Palestinian Ministry of Health, 2017).

The Vision of the national health strategy (2017 – 2022) aims to reach to a holistic health system, which works on improving the quality of health services provided by governmental and non-governmental sector and providing adequate infrastructure (Palestinian Ministry of Health, 2016).

1.2 Problem statement:

As widely known the criteria of considering the country as a title for civilization is related to how this country deal with people who have any kind of disabilities, especially mental illness. Palestinians live in difficult conditions suffering from the Israeli occupation and the

deficit of resources. Despite of that, the level of mental health services should be promoted and this demands working on evaluating the quality of services in order to raise the level of professionalism of mental health practitioners.

The Palestinian Ministry of Health (2017) showed in the annual health report that the incidence rate of mental disorders in the West Bank increased steadily from 105.1 per 100.000 in 2015 to 117.2 in 2017. The increasing percentage of the new cases of mental illness emphasized the need for improving the mental health services in order to create the best environment for recovery.

For many centuries, people with mental health problems had experienced violation of their basic rights within and out of care facilities (Mfoafo & Huls, 2014). People with mental illness experience discrimination in multiple areas included the access to education, employment opportunities, the establishment of a family and having children, and isolation from their community (WHO, 2017).

In addition, the violations of the rights of patient with mental illness have been occurred in the very institutions that are meant to support individuals with mental health issues. Individuals were subjected to inhuman conditions that include maltreatment, violation, restriction of movement, unconsented treatment (ECT), and being institutionalized for long periods of time (Yamin & Rosenthal, 2005).

According to a Report on mental health and human rights published by the UN Human Rights office in January 2017, the life expectancy of people with mental illness has been reduced in the light of its connection with poor physical health condition. The report pointed out that 20-year drop for men and 15 years for women in comparison with the general population (UN, 2017).

In light of that, mental illness requires the specific protection of human rights relying on the fact that they may lack capacity or adequacy to assert these rights for themselves (WHO, 2005).

Nowadays, it is important to focus on the issue of human rights and humanitarian care for individuals with mental illness. The literature reveals the lack of studies in Palestine that evaluate the quality of mental health services, including ethical and legal issues in clinical practice; ethics codes and human rights.

Therefore, this study highlighted the importance of exploring the experiences of people with mental illness in regards to ethical and legal standards of clinical practice; codes of ethics and human rights that are practiced by mental health professionals (MHP) in the Palestinian governmental community mental health centers.

In addition, this study is an important reference to those interested in evaluating national health care through comprehensive analysis of the dynamic of mental health care in Palestine.

1.3 Justification of the Study

1. The lack of studies in Palestine about the personal experiences of patients with mental health problems with the mental health practitioners during their therapeutic process is what make this study significant.
2. This study is a reference, explaining the current situation and presenting recommendation to develop the clinical skills of health practitioners, in order to provide the mental health care with the best atmosphere that guarantees the dignity of the patient.
3. The current study explored the experiences of patients with mental illness from their perspective on specific issues related to the code of ethics and the rights of patients, in

order to get a better understanding of what code of ethics exists in Palestine for protecting people with mental illnesses. In addition, it investigated if the code of ethics is in accordance with universal codes of ethics relating to the care of people with mental illness.

4. The conclusion of the study will provide a more comprehensive understanding of what patients with mental illness face on their journey to recovery.

1.4 Main Objective

The main aim of the study is to explore the experiences of patients with mental illness in regards to the clinical practices of mental health practitioners towards patients with mental illness in the Palestinian governmental community mental health centers (Client's perception of quality of services).

1.5 Research Questions:

The following research questions had guided this current study:

1. What is the knowledge that the participants have about the rights of patients with mental illness in general and the following right in specific; the right to know the nature of their mental health problem, treatment plan, privacy, confidentiality and patient respect.?
2. How do the participants view the clinical practices of mental health practitioners?
3. What do the participants think about the therapeutic environment?
4. Are the participants satisfied with the care provided by the mental health practitioner?
5. What services do the participants receive from the Palestinian governmental community mental health clinic?

1.6 Definition and terms

- **Quality of care**

Quality healthcare is defined as “consistently delighting the patient by delivering safe, effective and efficient healthcare services in compliance with the current clinical guidelines and requirements that meet the needs of the patient and satisfy providers (Mosadeghrad, 2013).

- **Mental illness**

“Mental disorder is a syndrome characterized by clinically significant disturbance in individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. (Diagnostic and statistical manual of mental disorders – fifth edition, p20.2013).

- **The mentally ill patient**

A Person who receiving mental health care, and includes all persons who admitted to a mental health care (UN resolution 46/19, 1991).

- **Mental health practitioner**

“Are those who are working as medical doctor, clinician, psychologist, nurse, social worker or others. They are trained and qualified people with specific skills relevant to mental health care” (UN resolution 46/19, 1991).

- **Community mental health center**

Community mental health center can be defined as a place that provide psychiatric services to the patient within their community environment with an aim to achieve full social integration (Brown, 2012).

- **The clinical practices**

Defined as either the field of principal professional clinical activity or the primary area of responsibility, depending on the profession. It may be described in terms of the particular discipline, skills or knowledge field of the profession, whether general or specialized; or described in terms of the principal client group; or described by the principal activity of an institution, or section of an institution, where clinical practice takes place (Australian Institute of Health and Welfare, 2005).

Chapter II: Literature Review

2.1. Introduction

2.2. Background

2.3. Historical overview of mental illness

2.4. International human rights for patients with mental illness

2.5. Mental illness legislations in Arab sector

2.6. The fundamental ethics in clinical practice

2.7. The therapeutic environment characteristics

2.8. Community mental health centers' provision

2.9. Mental health morbidity in Palestine

2.10. Patient's satisfaction theories

2.11. Previous studies

2.1. Introduction

This chapter discusses the literature review related to mental illness, the historical point of view and the understanding of mental distress. Internationally and locally; a group of human rights related to people with mental illness are presented.

An overview about the fundamental ethics needed in clinical practice, the therapeutic environment characteristics and its effects on the individuals' mental health state, the provision of the community mental health centers, mental health morbidity in the Palestinian occupied territories, and also the theories of Patient's satisfaction are presented. Finally, the previous studies that assessed the all to topics above are presented in the last section of the chapter.

2.2 Background

The term mental disorder is currently defined by the Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM 5) as a syndrome marked by a clinically significant impairment in an individual's cognition, emotional regulation, or actions that represents disturbances in the mental functioning of the underlying psychological, physiological, or developmental system (DSM 5th,2013).

Mental disorders are directly affecting the individuals, families and communities. The existence of a person with mental illness in a family is a family experience that is shared by all members, but each family member deals with this experience in his or her own way. It often changes the members' lives and relationships forever. (Awad and Voruganti, 2008).

Stigma is often associated with mental illness and is proposed as a central concern for people with mental illness (Mc Nair BG, et. al, 2002). As it is known, the stigma of mental illness varies from one culture to another, as well as alters according to different people

with different attitudes. Stigmatizing attitudes inhibit help seeking, increase the psychological burden and affects personal relationships (Corrigan, 2004).

2.3 Historical overview of mental illness

Mental illnesses have existed since the dawn of time. Various interpretations have been worked out to define and explain the causes of mental illness. It was widely believed that mental illness has a religious reason and is supernatural in origin. It was common in ancient times that abnormal behavior was interpreted as a sign of demonic possession or retribution from God, so the treatment that was used in that period was also religious in nature. Exorcism has been one of the methods that were used by religious leaders to treat people with mental illness to get the demons out of their bodies through prayer or beating (Grob, 1991).

Historians have concluded that trepanation (trephination) was used even in prehistoric times and was considered one of the earliest forms of treatment. It was used to treat those who had psychotic features. Trepanation was an operation which involved opening a hole in the skull by using a stone instrument or auger in order to release the evil spirits (Comer, 2013).

Some changes in thinking occurred in the 4th century B.C. when Hippocrates introduced the concept of disturbed physiology as the basis for all illnesses. Hippocrates' theory was an early vision of the idea that physiological disturbances played a role in the development of mental illness (Ahonen, 2013).

The Middle Ages witnessed the building of mental hospitals across Arab countries. In 707 A.D., Caliph Al-Waleed Ben Abd Al-Malek established the first psychiatric hospital in Damascus and he customized a financial budget for spending on the patients in the hospital as well as outside when they returned to their homes. This was similar to what civilized

societies do nowadays. After that, in Baghdad, a department for treating mental illness was established in 765 A.D. (Dols, 1987).

According to Dols (1987), brothers Saint Jean De Diew, after visiting Egypt, were impressed with the humanistic approach in dealing with people with mental illness. Later on, they took the idea of the psychiatric hospital to Valence in France and established Charenton hospital. In that period, it was known that the Arab hospitals were interested in working on the beauty of the hospital through designing beautiful gardens and fountains, in addition to serving a healthy nutritional system.

For the first time in Western Europe and America, several reformers advocated for the idea of mental hospital asylums for treating patients with mental health problems. Several institutions were established in Spain and London during the period from 1407 to 1483. The idea of asylums was mainly based on a belief that patients should be isolated from society and placed in facilities designed specifically to take care of them. They were mainly located in remote locations out of the cities in order to be out of sight (Ritter and Lampkin, 2011).

Allderidge (1979) described these early hospitals as staff-centered institutions where the care staff had an unclear role in the treatment of the patients. Their roles included how to maintain daily routines as well as to ensure the patients were calm and adapted to the rules. The patient seldom met professionals and the patients were treated as incurable.

The institutionalization vision came to light in the early 18th century. Public asylums were established in Britain, France, and the United States after acting laws and legislations for the care of patients with mental disorders were put into place. The asylums were overcrowded and the number of patients kept growing, especially after the Second World War. The inpatient care model was being criticized from various interest groups and there

was a growing interest in the media to report on cases of abuse in psychiatry (Teed and Scileppi, 2007).

In European communities, Until the mid- 1800s people with mental health problems were hidden from society, kept in dark enclosed spaces, chained, without adequate clothing, and abused physically and sexually (Comer, 2010).

A major shift occurred in the 1950s that was based on the belief that psychiatric patients deserved a higher quality of life, which did not previously exist in the inpatient care model. During that period, two major factors came together and paved the way to make a huge change in the general view of treating people with mental illness. The medicine revolution in psychiatry, especially in the twentieth century, has contributed significantly in decreasing inpatient care facilities, in conjunction with the social and political climate around that time; both of them were factors that influenced the gradual transition to community care, a shift known as deinstitutionalization or DE hospitalization (Weinstein, 1982).

Meanwhile, periods of transition have created the conditions to move beyond the point of support on the political and decision-making levels. New antipsychotic drugs such as chlorpromazine and its effectiveness in dealing with the positive symptoms of schizophrenia allowed patients with psychotic features to function more effectively. Patients were not cured, but the symptoms of their illness had decreased to the degree that a hospital stay was not as necessary (Ritler and Lampkin, 2011).

In the early 1960s, a large number of patients were discharged to continue treatment at outpatient clinics. However, there was no proper preparation or reintegration for an easier transition of patients to society. The patients were naïve concerning their psychosocial skills and the readiness of the communities was insufficient. Some of the patients were discharged to their families; others transited to a supportive housing arranged for patients

discharged. Unfortunately, there were not enough centers of this type to accommodate the number of patients being discharged. As a result of the lack of adequate institutions, some of the discharged patients became homeless with mental illness or were re-hospitalized frequently, a phenomena called the “revolving door syndrome” (Tuner, 2004).

In 1963, a community mental health act (CMH) was signed by the President of the United States, John F. Kennedy. This action was based on a belief that all people, including those with mental illness, had a right to lead dignified lives and to contribute and take part in society. A new orientation was adopted in relation to service delivery where it has become community- based. Service delivery to clients has been modified to eliminate long-term custodial care and new perspectives for dealing with mental illness were discovered (Cutler et al., 2003).

Federal funding was provided for building community mental health (CMH) centers and research facilities in the United States. The purpose of the CMH Act was to build mental health centers to provide community-based care as an alternative to confining those with a mental illness into institutions. At the centers, patients could be treated while working and living at home (Kelly, 1966).

The concept of community mental health had a general theme, which was that intervention should be holistic and take into account the holistic care of clients’ physical, mental and social conditions. This meant that service providers should all adopt an ecological model of social planning in order to have a better understanding of clients’ behaviors and needs (Teed and Scileppy,2007).

2.4 International standard for the protection of the rights of individuals with mental illness.

Human rights have begun to be discussed after the end of the Second World War. In 1948, the Universal Declaration of Human Rights (UDHR) was adopted by the Third General Assembly of the United Nations. The Declaration contains 31 articles which emphasize that all human beings are born free and equal in rights and dignity (UDHR, 1948). The starting point for the development of international human rights for patient with mental health issues emanated from considering all individuals as complete human beings who are entitled to rights.

As well known, mental illness requires the specific protection of human rights. This is based on the fact that people with a mental illness may lack the capacity or adequacy to assert these rights for themselves (WHO, 2005).

People with mental health problems are often exposed to a wide range of human rights violations. They often do not receive the necessary care, services and support to live a normal life. They are also denied basic human rights such as founding families, attending school, seeking employment, facing discriminations and are prohibited from voting (Mfoafo, 2014).

According to the World Health Organization, mental health is the most neglected area of health policy and programming. Twenty-five percent of all nations in the world have no mental health law; more than 40% of countries have no mental health policy and over 30% have no mental health program (WHO, 2001).

In 1990, Latin America started to coordinate and pool their efforts in order to improve the treatment provided to people with mental illness. On November 14, 1990, the regional conference on the restructuring of psychiatric care in Latin America conducted, and resulted in the adoption of the Caracas Declaration (Minoletti et al.2012).

The declaration has become a guide for reconstructing mental health services based on scientific evidence and respect for human rights. The declaration included several points. One of these was psychiatric care reconstruction based on primary health care. Another was to enhance the use of alternative service models, including community-based interventions and reintegration of those with mental illness into society. Another important point was to safeguard the human rights of people with mental illness while delivering mental health treatment and care to them. It also stressed the importance of redrafting the national legislation as needed in order to guarantee the protection of these rights.

On December 17th, 1991, the UN Assembly adopted resolution 46/19, which included principles for protecting people with mental illness and improvement of mental health care. The resolution elaborated on a range of terms and definitions in order to facilitate this. Twenty-five principles were set out and adopted by the UN General Assembly. The draft resolution contained eight terms and definitions to demonstrate and emphasize easy use to the reader; they included counsel, independent authority, mental health care, mental health facility, mental health practitioner, patient, personal representative, and the review body.

The declaration presented a group of rules necessary for the protection of people with mental illness, such as guaranteeing the fundamental freedom and basic rights related to the access to the best mental healthcare without any kind of discrimination and with dignity and humanity; protection of minors which may sometimes require designation of a personal representative other than a family member, and living in the community without discrimination and work involvement.

On the determination of mental illness, the declaration emphasized that it should be according to mental health status and internationally accepted medical standards. Standards of care were also mentioned in the declaration and emphasized that every patient shall be given medication only for therapeutic purposes, protected from harm, including unjustified

medication; abuse by other patients or staff, in addition to any act causing mental distress or physical discomfort.

Principle No. 12 (notice of rights), addressed the importance of informing the patients with mental illness as soon as possible about their rights and how to exercise them, using language that is easy to understand (UN Resolution No. 46/19,1991).

In regard to admission principals, the UN declaration in principles number 15 and 16 emphasized the admission of people with mental illness. It stated intervention and medication should be administered in the same way as any access to any other facility for any other illness (UN Resolution No. 46/19, 1991).

Concerning involuntary admission, several detriments have been developed by the UN to organize involuntary admissions. An involuntary admission is conducted by authorized and qualified mental health practitioners in cases of serious likelihood of immediate or imminent harm to that person or other people, and only if the purpose is to help the patient to recover (UN Resolution No. 46/19, 1991).

Treatment shall be given to a patient with his or her informed consent and based on an individually prescribed plan, discussed with the patient, reviewed regularly, and provided by a qualified professional staff with applicable standards of ethics for mental health practitioners. This declaration also focused on the conditions in mental health facilities as well as emphasized the patients' right to full respect for his or her recognition, privacy, confidentiality, freedom of religion or belief as well as the freedom to accept or reject communication with others in the facility. The environment in the mental health facility should include rehabilitation facilities for occupational, recreational and leisure activities (UN Resolution No. 46/19, 1991).

All the principles mentioned above needed the states' efforts in promoting compliance with these principles in order to reach the implementation phase. Countries and governments

also had an obligation to monitor the care provided, inspect the mental health facilities, resolve complaints and for the institution to enforce appropriate disciplinary measures for professional misconduct or violation of the rights of a patient.

In 1996, another declaration was adopted in Madrid and approved by the World Psychiatric Association. https://cdn.doctoronly.co.il/2011/11/1996_DECLARATION-OF-MADRID.pdf

Madrid's declaration emphasized several distinct points. One of these was to provide psychiatric services with the provision of the best treatment for mental disorders within a scientific framework, ethical principles and the rehabilitation of individuals with mental illness. Another was to stress the psychiatrist's duty to keep pace with scientific advances in order to convey updated knowledge to others. Another principle was to accept the patient as a partner based on mutual trust and respect, which includes providing the patient with the relevant information in order to allow him or her to make free and rational decisions. One more important area was that psychiatrists should make family consultations and seek legal counsel in the event that a patient is unable to exercise proper judgment in order to safeguard the patient's rights related to attaining treatment due to the patient's will, unless withholding treatment would endanger the patient's life or others surrounding him or her.

The declaration also stated that in some cases, psychiatrists are requested to assess a person in third party situations. The psychiatrist's duty here requires informing and advising the person about the purpose of the intervention as well as the use of the findings before giving information to third parties.

In addition, an important principle that stressed confidentiality was that information obtained in the therapeutic context is to be kept in confidence and used only and exclusively for therapeutic purposes. Breach of confidentiality is only appropriate in specific contexts such as serious physical or mental harm to the patient or others

surrounding him/her as in the case of child abuse. In regards to research on different areas concerning mental health, it was stressed that psychiatrists should follow national and international rules for the conduct of research.

In Israel (1996), the legislative council enacted the Patient's Right Law, to protect the rights of every person who requested medical care. A set of norms and codes of conduct concerning patients' rights has been established in a binding way on all those practicing medicine, in order to define and regulate the relationship between people who required medical treatment and members of the medical staff who provided it.

https://www.google.com/url?sa=t&source=web&rct=j&url=https://mobile.nevo.co.il/&ved=2ahUKEwjlk9GJ6uzlAhVJwMQBHfv_BdkQFjAAegQIBxAD&usg=AOvVaw1Ee1ZIU G0fOI2xBrE48TJM&cshid=1573841941907

In order to improve the mental health services provided to people with mental problems, the WHO made ten recommendations (2001). The first two focused on treatment and included providing treatment in primary care as well as providing psychotropic care. The next three concentrated on change within the community and included providing care in the community, educating the public, and to involve communities, families and consumers. The rest focused on larger-scale changes and included establishing national policies, programs and legislations, developing human resources, linking with other sectors, monitoring community mental health, and supporting more research.

2.5. Mental illness legislations in the Arab world:

The history of Arab psychiatric institutions dates back to 707 A.D. People in Egypt and Levant used to call psychiatric hospitals “Bimaristan”, which is a Persian word.

In Egypt, patients with mental disorders were detained in Bimaristans for prolonged and indefinite periods of time under Law 141/1944 which was the first legislation on mental

health for that period. This was before the introduction of psychotropic drugs in psychiatry (Abdul Aziz, 2011).

The last decades had witnessed a strong development in human rights in general, and the rights of persons with disabilities in particular. In 2009, a new law was enforced by the Egyptian parliament entitled the “Law for the Care of patients with mental illness”. Seven areas were addressed in the act. These included the scope of application and definitions, the establishment of regional councils for mental health, the admission criteria to psychiatric facilities, and the treatment of patients with mental disorders. Section V of the act contains provisions related to the protection of the rights of individuals with mental illness. The remaining sections dealt with the establishment of a mental health fund and the sanctions regime. The law aimed at establishing a basic criterion for managing the admission of the patients with mental health problems and safeguarding of their rights (EIPR, 2009).

In Jordan, mental health services were associated with the Palestinian mental health system until 1967. Bethlehem hospital in the West Bank used to serve patients with mental disorders from all the Levant including Jordanians. Soon after the separation, the Jordanian Ministry of Health started to establish facilities to deal with the gap that resulted and to meet the needs of the region such as the establishment of a psychiatric hospital in Amman and a number of clinics in various parts of Jordan (Hijiawi et al.2013).

Regarding the mental health policies, there has not been any specific legislation for mental health in Jordan. The year 2008 witnessed the implementation of Public Health Law Number 47. The law contained 16 chapters related to public health issues. Chapter four of that law dealt with mental health and addiction issues, and includes four articles concerning the following aspects: people with mental illness admitted to general hospitals which have a psychiatric unit equipped and staffed by a mental health team, the criterion

for voluntary and involuntary admission to a psychiatric hospital or psychiatric units, the establishment of a complaints system, and patient's discharge procedures (Sarhan and Alqam,2013).

In Saudi Arabia, the Saudi Commission published a Code of Ethics for Healthcare Practitioners for Health Specialties in 2014. The Saudi healthcare system is a part of the Kingdom's systems and the Islamic Sharia was adopted in the entire system. The publication included 15 chapters that targeted a group of issues related to clinical practices in the therapeutic setting. Healthcare practitioners were targeted in the first six chapters concerning the ethics needed in the field of healthcare, the duties of health practitioners toward patients, the community, themselves and colleagues. The next four chapters targeted ethics in relation to religious rulings, teaching, and learning of patients, documentation processes, and financial affairs. The last chapters discussed the ethics related to conducting biomedical research, dealing with communicable diseases, incurable diseases and emergencies. Finally, the ethics of dealing with life-threatening situations were presented in this code (Saudi Commission for Health Specialties, 2014).

Domestically, Palestine was exposed to many political, historical and social changes before and after the British Mandate to the present because of the occupation. Mental health legislations drew upon the Othman as well as British and Israeli influences.

In 1993, a peace process began between Israel and the Palestine Liberation Organization (PLO), later renamed the Palestinian Authority. One year later, the first official national plan was published in order to regulate the health sector and mental health placed as one of the priority areas of concentration (Palestinian Council of Health, Planning and Research Centre, 1994).

On December 27, 2004, the Palestinian Public Health Law was adopted by the Palestinian Legislative Council. Item number 60 of chapter 8 was about patient rights in health institutions. <https://www.site.moh.ps/index/ArticleView/ArticleId/75/Language/ar>

The Palestinian Public Health Law stressed an array of rights for patients. These include access to immediate care in emergencies as well as receiving a clear explanation of the proposed treatment and the right to consent to or to refuse treatment. In addition, patients have the right to approve or deny participation in research and training conducted in health institutions, respect for privacy, dignity, culture and religious beliefs, and submission of complaints against the health institution or any of its employees. (Palestinian Ministry of Health, 2004)

Item number 61 of chapter 8 of the Palestinian Public Health law provided information on examining complaints seriously. The item emphasized that the health institution should pay attention to the complaint submitted to it and takes appropriate measures.

In addition, a poster that lists patients' rights is hanged on a wall in the reception hall of Ramallah's Public Health Building (public health clinics). The following is a list of these rights:

- The patient has the right to receive decent and respectful care that suits customs and traditions.
- The patient has the right to be adequately cared for based on his needs with no discrimination in receiving health care.
- The patient has the right to identify the physician, nurses and caregivers with their job titles.
- The patient has the right to be adequately informed about the diagnosis of his illness and treatment plan with the use of clear and understandable terms and vocabulary and to ask any questions in this regard with translation services as required.

- The patient has the right to be adequately informed about the reason for undergoing the various medical examinations and treatment and who will conduct them.
- The patient has the right to maintain his/her privacy and to be protected in an atmosphere free of any form of aggression. He also has the right to refuse to talk to or be interviewed by anyone who doesn't have any relation with the health foundation.
- The patient has the right to have a person of the same sex where needed (for exposing some parts of his/her body for examination and treatment if necessary).
- The patient has the right to preserve the privacy and confidentiality of his/her information, medical and social data to only those who have a direct relationship with his treatment or for medical review and improvement of performance and quality. The disclosure of any patient-specific information requires written consent by him/her unless the patient's life is in imminent danger, according to legal procedures such as legal incapacity (less than 18 years) or in the case of infectious diseases.
- The patient has the right to be followed up with health treatment and to be informed if the case requires a transfer to any institution outside the medical center according to the regulations of the Ministry of Health.
- The patient has the right to be informed of applicable laws and regulations in the medical center that relate to treatment and duties towards the health center and its employees. The patient also has the right to identify the entities that can resort to them either to inquire or complain.
- The patient has the right to know the therapeutic and educational institutions that are directly related to his/her treatment.
- The patient has the right to approve or refuse any participation in medical research that may affect his/her health care.

Unfortunately, in the Palestinian society there is no mental health act that will govern practice of professionals and fulfill the rights of people with mental health problems.

2.6. The fundamental ethics in clinical practice

Ethics in clinical work plays a crucial role in safeguarding the rights of persons with mental illness. Ethics and clinical practice are associated with clinical work. From the moral philosophers' perspective, ethics is concerned not only with the question of whether an action is right or wrong but also covers the motives and consequences of the action in terms of whether it is good or bad (Bloch and Pargiter, 2002).

It is axiomatic that health care facilities have emphasized the importance of ethical principles through their mission statements and procedures. Ethical standards have been established to demonstrate a number of common values, guidelines or ethical principles, such as respect for patient rights, beneficence, nonmaleficence, fairness, patient independence, privacy and permission to observe (Forehand, 2000).

Beneficence is defined as an obligation and commitment to help those in trouble, protect patient's rights, provide treatment for people who need it, and act in the best interest of the patient. Beneficence is considered one of the fundamental ethics that is expected to be given in a health care setting and especially in the context of the practitioner-client relationship. Patients assume that health practitioners are there for their benefit and will act with charity and kindness toward them (Morrison, 2006).

Nonmaleficence is essentially the ethical principle of doing no harm based on the Hippocratic Oath, 5th century BC. In 1943, Ludwig Edelstein Translated the Oath into the English language. "I will prescribe regimens for the good of my patients to my ability and my judgment and never do harm to anyone." <https://www.aapsonline.org/ethics/oaths.htm#hippo>

Customarily, physical damage is considered to be the only damage since it is visible and its damage is clear, however it can also come in several invisible forms. An example of this is inadequate staff or a lack of equipment that affects the quality of service delivery (Morrison, 2006).

Theories of justice use the term justice to mean fairness in treatment. Injustice in this context occurs when similar cases do not receive similar treatment (Jones and Barhelt, 2009). Justice known as a moral obligation and commitment to behave based on fairness and equity. In the area of health care, the patient has the right to be treated equally, fairly, and with respect. This includes equal access to treatment without any forms of discriminations due to age, sex, social status, ethnic and cultural background, religion, etc. (Kemparaj and, Kadalur,2018).

Cohen and Ezer (2013) viewed the concept of respecting patient rights in two significant areas: respect patient autonomy and respect patient privacy. The autonomy of the patients in the case of mental illness is a commitment to preserve the individual's right to direct the course of his own medical care. Autonomy is limited when exercising causes harm to another person or can hurt the patient (Cohen and Ezer, 2013).

Health practitioners respect the privacy of the patients and request private information when it is beneficial and needed for the therapeutic process, and in a confidential setting that ensures patient privacy. Promoting and protecting the privacy of individuals is based on principles that refer to the application of human rights in the context of patient care. It implies data collection, security, the use of information, and disclosure of personal information. According to Cohen and Ezer (2013), three aspects are considered as the main areas of privacy for people accessing health care facilities, which are the privacy of personal space, the privacy of their bodies, and the privacy of personal information.

Mental health practitioners (MHP) have an ethical and legal obligation to protect the rights of patients in clinical practice, obtain permission from patients prior to allowing any person to observe clinical sessions, review clinical session transcripts or view recording of sessions within the training environment (Varghese ,2015).

Confidentiality refers to health practitioner's responsibility of not disclosing information learned during the clinical work to anyone without the patient's permission. It also involves asking questions pertaining to confidential information in front of others including relatives. The right to information prevents publishing case records without hiding the identity of the patient in addition to obtaining his permission. A breach of confidentiality can occur only on two grounds: when it is in the public interest or as part of a court order (Delany, 2007).

Delany (2007) stressed the importance of two important points. First, record and documentation should be kept in a secure place and only authorized persons should have access to them. Second, the patient should be informed of the limit on confidentiality at the beginning of the health practitioner-patient relationship and again as necessary.

In the UK, the Department of Health (DH) published a Code of Practice in order to be a guidance tool for health practitioners about best practice in the area of the confidentiality of patient information. The code ensured that all patient information should be processed fairly and by the law, and developed a confidentiality model to meet these purposes; this includes the following:

- Protect - look after the patient's information.
- Inform- ensure that patients are aware of how their information is used.
- Provide choice - allow patients to decide whether their information can be disclosed or used in particular ways.
- Improve- always look for better ways to protect, inform, and provide choice.

(DH – NHS Confidentiality Code of Practice, p10. 2003).

2.7 Interactions and communication needed in the clinical setting

Over the ages, several terms had been used to define the concept of therapeutic relation, the therapeutic alliance, the working alliance, and the helping alliance, all of them used to describe the interactions between the health practitioner and the client. The therapeutic relationship is the most significant part in therapy, and affects the quality of therapy's outcomes (Brein, 2009)

The concept of the therapeutic alliance has its origin in psychodynamic theorists; Freud was one of the first to speak about the “sympathetic understanding” of the client that lead to “beneficial transference” and positive outcomes when interpreted by the therapist. Greenson had developed the concept of the working alliance and it was defined as a reality-based collaboration between the therapist and the client. In (1951), Carl Rogers speaks about the importance of unconditional acceptance of the client, empathy, and congruency in therapy that widely known today as the client-centered concept (Horvath et al., 1993).

According to humanistic and existential psychotherapies, developing the alliance through reflective listening, demonstrating respect, and honesty, helps in eliciting trust and confidence (Hewitt and Coffey, 2005).

According to Baillie (2009), there is a group of interactions that help people to feel comfortable respected and value therapy. Baillie stressed the importance of being aware and used these interactions to help people to feel comfortable. Eight types of interaction are highlighted: sensitivity, empathy, developing relationships, conversation, professionalism, family involvement (if desired by the patient), friendliness and reassurance, and humor (if used sensitively and appropriately).

Feeling in control was also emphasized by Baillie, and he named a group of communication styles which help people to feel in control that the mental health practitioner should take into consideration: explanations and information giving, informed consent, offering choices and negotiating, and enabling independence.

Finally, Baillie emphasized the communication that helps people to feel valued such as listening, giving time, being kind, considerate and helpful, showing concern for patients as individuals, being courteous, which means addressing people by their preferred name, introducing self, being polite and respectful, including respect for the culture and religious beliefs.

In 2001, The Health Quality Council of Alberta (HCQA) has been developed a ReLATE training tools to help the MHP's in building a positive patient-provider relation The RELATE acronym is as follows:

R- Respect: attach great importance to respecting the dignity and privacy of the client/family
E- Explain: commitment to providing explanations about who you are and what you want to do.

L- Listen: emphasize the importance of listening to what the client/family are really saying

A- Ask: commitment to ask questions aimed at clarifying what you have heard

T- Try: trying to be flexible with clients and offer alternatives

E- Emphasize: emphasize on the relation between the stress and the illness.

2.8. The therapeutic environment

In the late 1960s, environmental psychology started to be recognized as its own field. It was known to entail ecological. Environmental psychology focuses on the relation between the person and their surroundings, both built and natural environment. As is widely known

today, the environment has a great effect on human performance and health state, both positively and negatively (Ackley et al.,2017).

The environment of a healthcare facility is known today as the therapeutic milieu, and it is considered an important factor in relieving stress, enhances human wellbeing, and improves patients' and staff satisfaction (Ulrich, 1997). Recently, increased attention has been paid to use design and architecture in building healthcare facilities, to create places and spaces that encourage healing and recovery (Dijkstra et al.,2008).

The institution design reflects its philosophy of care and the proper environment plays an important role in the patient recovery process. In light of that, the philosophy behind establishing community mental health centers was the integration of people with mental illness in a natural environment like any other facility for any other illness. Providing treatment for people with mental illness in primary care facilities became an urgent need for dealing with stigmatization and discrimination (Devlin and Arneill, 2003).

The physical environment of the therapeutic room is considered one of the most important things to consider when designing a therapeutic setting. The physical environment relevant to planning or establishing therapeutic rooms should include comfortable seating, carpeting, the use of artworks, natural or soft lighting, plants, large windows and views of nature, heating and air-conditioning system (Phelps et al., 2008).

Since the integration of mental health services into primary health care, CMHC's (outpatient clinics) have become as well as any health clinic in primary care. According to WHO (2008), the essential infrastructure for health centers should be existed, and based on the following standards:

- Location: being close to the place of residence of the population in which they serve and being close to public transportation with adequate parking facility (in an easily

accessible area). There must be at least one entrance to the center, which has a ramp facilitating easy access for handicapped patients.

- Waiting area: large enough to receive patients, comfortable seating (chairs with arms), well-ventilated, adequate lighting, and space for children to play.
- Water supply: To provide safe drinking water, sufficient quantities for handwashing, personal hygiene, laundry, cleaning, and food preparation.
- Individual counseling space: It requires auditory and visual privacy.
- Group counseling space: Large room for group counseling, support groups, and peer education.
- Ventilation: Well-ventilated areas.
- Latrines /toilets: for staff and patients (separate toilets are required for male and female), and another one for young children. (Basic requirements for latrines: Water points, soap, and adequate drainage)
- Hygiene – both personal and institutional: provide cleaning supplies to make sure the health-care environment is visibly clean and free from dust and soil.
- Fire safety: Fire extinguisher or sand.

Finally, Safety in the therapeutic environment should be taken into account, when designing a therapeutic space for the care of people with mental illness. The furniture should be selected carefully and should be difficult to use as weapons, aimed at protecting the patients as well as protecting the MHP staff. The physical environment should be safe and free of all sharp instruments, so it cannot be used as potential weapons (WHO, 2019).

2.9. Community mental health centers (CMHC)

CMHC is a therapeutic setting built and staffed to offer a comprehensive, integrated, and continuous care for people who are dealing with psychological problems (Schmidt, 2007).

The mental health services are delivered in the communities of those who are suffering from mental health problems, to offer comprehensive and preventative services to every person in need. The creation of such a system should be capable of upholding, supporting, and maintaining recovery through early engagement with patients' collapses. This plays an important role in improving the quality of service (Weinstein, 1982).

According to Hartzler et al. (2018), the main goals of community mental health are to keep up and promote mental health, to help early identification and intervention in maladaptive disorders, and to ease the rehabilitation of chronic patients.

Care is delivered within the CMHC's in the context of preventative care. There are three levels of prevention: primary prevention, secondary prevention, and tertiary prevention. The first level works on the prevention of the occurrence of illness by targeting people at risk to develop mental disorders. The CMHC's have an essential role in primary prevention, where the CMHC's staff work on reducing risk factors and enhance protective factors, in order to help people in crisis to overcome their problems, to strengthen their ego, and to learn better ways of coping. The second level places great emphasis on early case findings and immediate interventions to help clients and their families in providing support during periods of increased stress or aggravation of symptoms of mental illness. The third level includes treatment and rehabilitation services for people who have been diagnosed with psychiatric illnesses. Continuity of care needs to be available as a part of the mental health services that extend to home services, family services, and residential placement (Teed and Scilepi, 2017).

CMHC has a group of functions such as providing medication, monitoring side effects of drugs, following up with clients and conducting referrals if necessary, providing psychotherapy for patients and their families, rehabilitation programs for chronically ill patients, occupational therapy, and recreational programs. Also, education to the

community about mental health, illness, symptoms of relapse, and possible causes of mental disorders should be enforced. (Teed and Scileppi, 2007)

There are three main goals of CMH, which are: maintenance and promotion of mental health, early identification, and intervention in maladaptive disorders, and rehabilitation of chronic patients. People with mental illness have multiple needs that must be achieved in order to facilitate their recovery journey. A set of services are provided at the CMHC's, in order to cover the patients' needs such as diagnostic services, rehabilitation programs (vocational placement training), consultation and educational programs. (Bloom and Williams, 1994).

CMH care requires the diversity of mental health professionals (a team of specialists), varying in education, certifications, and specialties working together to meet the purpose for which it was established. A group of practitioners need to be present and should include a psychiatrist, psychologist, nurse, social worker, physician, occupational therapist, and recreational therapist. According to this diversity, the roles and responsibilities of the CMH team differ due to the different specialties available (Baillie, 2009).

The psychologists have the role of assessing mental health problems based on the scientific knowledge that guides them to understand the mental health status of individuals, helping the patient to gain insight into his feelings and reactions using various techniques. These include traditional psychotherapy methods as well as helping the staff to understand and cope with their reaction to patients' and patients' behaviors (Hartzler et al.,2018).

In addition to the work of psychologists, social workers have significant roles with those who have mental health problems, and with his or her significant others during the illness. They are primarily responsible for ensuring that patients have appropriate care and support in place after they are discharged, helping the patient and significant others to plan for the rehabilitation program, exploring all avenues for financial help if needed and utilizing

these sources, facilitating access to community resources that may be value to the patient and his family, serving as a communication link for other therapeutic team members, and referring clients from one institution to another (Teed and Scileppi, 2007).

Since ancient times, psychiatrists have been the only mental health professional who patients and their families have resorted to in order to treat the mental illness. Prescribing medication and monitoring the response it has on the patient is considered one of the main functions of the psychiatrist. Anyone taking psychoactive drugs should see a psychiatrist in order to evaluate the effectiveness of the drug being taken for treatment. The psychiatrist's responsibilities include admitting and discharging clients, initiating treatment plans, prescribing medication, conducting multidisciplinary rounds and team meetings, conducting physical evaluations, and conducting mental status examinations of the patients. (Hibbert et al.2004).

Psychiatric nursing is also one of the necessary specialties in the CMHC's. A psychiatric nurse is a specialized practitioner in the field of mental health and cares for the individual with mental illness of all ages, and their families. The psychiatric nurses have a group of roles, including performing physical exams, recording patient medical histories, administer medicines and monitoring treatment plans, evaluate responses to treatments and medications, diagnosing health issues, and train patients and their significant others on how to manage illnesses and disease prevention (Chaudry et al.2000).

Occupational therapy is a discipline that aims to help individuals with disabilities, injuries, or impairment to develop the skills needed to live life to its fullest extent potential. A set of services is provided by the occupational therapist in the areas of education, work, skills training, health and wellness, and adaptation. Recovery-Oriented approaches that support mental and physical health through various models of community- based habilitation and rehabilitation. The main tasks of the occupational therapist include: working with

individuals to develop skills needed for independent life, providing educational programs to address assertiveness, self-awareness, interpersonal and social skills, providing training programs in activities of daily living such as the hygiene practices, conducting functional evaluations in all aspects of individual' life, and provide guidance and consultation in all employment settings, including supportive employment.

In response to the growing need for community- based services, different models of community care have been developed such as the Training in Community Living Model (TCL), the broker service model, the assertive community treatment model (ACT, or PACT), and etc. A brief description of some of these models is presented below.

The Training in Community Living Model (TCL) has been adopted in Wisconsin (the 1970s). TCL is a program of care, providing in the patient's community to prevent them from being isolated from their traditional, natural and social environment. Three areas are targeted during therapy to guarantee the continuity of care, providing medical care, providing psychological care and rehabilitation services. At this time TCL had been evaluated and its results were being very positive. Patients who were treated by using the TCL model showed more community adjustment in several areas such as employment, social relationships and maintained an independent living for longer periods which has had the effect of reducing hospitalization (Thornicroft et al., 2016).

Another is the broker service model. One of the case manager models that emphasis on assessing patients needs,referring to appropriate services, and coordinating ongoing treatment monitoring. The primary role of the case manager is to connect the patient to the services needed, and coordinate the various service providers. The functions of brokered case management include evaluation, planning, service linking, monitoring and advocacy.

Lastly, the Assertive Community Treatment Program (PACT), which was developed to meet the needs of patients with more severe psychiatric impairments as a comprehensive and specialized care package. A multidisciplinary team, usually composed of a psychiatrist, a nurse, and at least two case managers, delivers the PACT program. Positive findings had been found in PACT research in the following areas: independent living, reducing the level of hospitalization and a better quality of life.

2.10. Mental health in Palestine

The history of Palestine has been marked by various conflicts all over the centuries. The challenging political context has an array of effects on Palestinians' mental well-being and lifestyles as a result of being under continuous conditions of war. In addition, Palestine is a low-income country with scarce resources. It is a country that is also seeking independence (Giacaman et al., 2010).

The majority in Palestine suffers from the ongoing psychological burden because of the occupation and its practices. In 2009, the International Journal of Mental Health Systems published an article entitled: Trauma-related psychological disorders among Palestinian children and adults in Gaza and West Bank, 2005-2008. It was found that among 1254 patients, 23.2% have PTSD, 17.3% anxiety disorder, and 15.3% depression. In Gaza Strip, among 500 Palestinian, 90% of them have PTSD symptoms, 36.7% met the criteria of DSM-IV for PTSD, and 38.4% have a depression (El-Deeb, 2017). According to Jabr (2013) meeting the need for mental health care for the population in Palestine is an ongoing struggle, in light of the dismemberment of the Palestinian lands.

After the Oslo agreement and the establishment of the Palestinian authority in the occupied Palestinian territory in 1994, the first official national plan was published in 1994 in order

to regulate the health sector. The 1994 Palestinian health plan placed mental health as one of the priority areas of concentration (The Palestinian Ministry of Health, 1994).

The Palestinian health plan included an array of points. The first was to ensure active participation of primary health care providers. The second was linking people in need with appropriate services. The third was coordination and referral of a patient with psychiatric, behavioral, and emotional disorders to primary health care for evaluation and treatment. The fourth was making specialized psychiatric consultation and services widely accessible. And finally, follow up and continuing care in clinics or home settings as an alternative to institutional care was stressed.

The mental health situation in Palestine is well known for its lack of public mental health services. Due to WHO (2002), there is an insufficient amount of public mental health services linked to the absence of mental health policy and the shortage of resources. In addition, it was found in the first situation analysis undertaken by the WHO that the inpatient care model still existed during that period at the psychiatric hospitals, while community mental health provision was tremendously erratic and took a biomedical-oriented approach.

The Palestinian Ministry of Health operates two psychiatric hospitals, one in Bethlehem with 150 beds serving the West Bank, and one in Gaza City with 41 beds serving the Gaza Strip. In 2004, the Ministry of Health operated 13 mental health outpatient clinics, nine of them in the West Bank and four in the Gaza Strip. The state of the Palestinian health system remained highly fragmented and under-resourced over a period of several years which led to the establishment of international partnerships with the Ministry of Health (Giacaman et al., 2010).

According to the same reference, in 2002, the Palestinian ministry of health received both technical and financial support by the WHO, and other international donors such as the

Italian cooperation and the French cooperation in order to develop mental health services based on the recommendations of the WHO Report (2001).

In 2005, the Palestinian legislative council adopted the modified public health law as an initial step to develop national health policies. A contribution agreement was signed with the European Union in December 2005 for 3.4 million euro with an implementation period of 3 years. The start-up phase was delayed because of the political situation in 2006. The project started in December 2007 and ended on May 31, 2011 (WHO, 2006).

The international partnership drafted and adopted a set of principles for the development of mental health services in Palestine based on the WHO's recommendations (2001). There were many important principles included. One was a multi-track approach targeting the elements of development, policy development, infrastructure development and human resources development at several levels. In addition, there was the conceptualization and implementation of the WHO recommendations according to the nature of Palestinian culture and needs. Another was the coordination and cooperation between international donors to fulfill the needs and avoid duplication of services as well as the operation of the bio-psychosocial approach to mental health care (WHO, 2006).

A steering committee was created in 2003 in order to advise the Ministry of Health and all parties involved. A strategic operational plan was developed and signed in 2004 with the aim of developing services that are available locally, easily accessible, destigmatizing and accepted within local communities, able to provide comprehensive support and treatment, and finally the ability to ensure the maintenance of people to contact their families, friends and their social system (WHO, 2006).

The next step in the Strategic Operational Plan (SOP) was the implementation of the community mental health policy through targeting five areas related to improving the quality of mental care provided by the Palestinian Ministry of Health. The five areas are

community mental health service development, training and education, family association and service user associations, public education, and research. The SOP calls for many things including the creation of a single, independent mental health directorate in the ministry of health as well as the establishment of a regional mental health service system. The vision of the project was that each region should have the community mental health service that consists of a community mental health team, acute inpatient beds, day care service, rehabilitation care and the ability to respond suitably to the mental health needs of children and the elderly (WHO, 2006).

The Bethlehem Psychiatric Hospital and three district community mental health centers were targeted for development in the first phase of the WHO project, which were in Ramallah, Hebron, and Gaza City. Achievements of the first phase were related to development of the program and included service development, public education, training, professional development, and user involvement (WHO, 2006).

Service development worked on through several means. One of these was a twinning project between the three cities in Palestine and three United Kingdom National Health Service (NHS) trusts, Hertfordshire, Plymouth and Cornwall through in-service education exchange programs, study visits and consultancy work which was a joint learning and development collaboration in community mental health (WHO, 2006).

Between Bethlehem hospital, Cornwall trust, and recovery and hearing voices groups in Scotland, other partnerships took place and strengthened over several years.

Other collaborations took place and expanded over several years between Bethlehem hospital, Cornwall trust and the recovery and hearing voices groups in Scotland. Another was through data collection and monitoring, which was developed by the MSD (WHO, Geneva). Another was the provision and education of psychotropic medication in its use, and was kept with the Ministry of Health in compliance with specific needs. Another was

the development of an operational policy for community mental health services. Finally, a rehabilitation assessment form was developed (WHO, 2006).

Another means by which service development was conducted was through public education, which took several steps. Public education material about mental health issues, treatment and human rights were developed and distributed. Diverse workshops related to raising awareness about mental illness were provided for different target groups in schools, health facilities and police centers (WHO, 2006)..

Another way service development took place was through training. The staff of the CMH centers and psychiatric hospitals has received an intensive in –service training by the United Kingdom, Italy, and France. The staff have spent some time in the United Kingdom to receive training and support in CMH teamwork. Long term training in France for Palestinian psychiatrists has been established. (12 Palestinian psychiatrists took part in this training), the twinning of St. Anne’s with Bethlehem Psychiatric Hospital resulted in a multidisciplinary group of hospital staff receiving two months of training at St. Anne’s. A community mental health training manual and workbook were developed (WHO, 2006)..

Professional development was another method of service development. In May 2005, a total of approximately fifty psychiatrists from public mental health attended seminars about the role of psychiatry in a modern mental health system in Ramallah and in Gaza City, which resulted in paving the way for future training initiatives. A forum to address the psychiatrist’s role within the community-based approach to mental health care was created. In May 2006, additional seminars were held for psychiatrists in order to explore the continuing development of the psychiatrist’s role. Specific workshops for pharmacists and psychiatrists on the proper use of psychotropic medication were held. A seminar was held with stakeholders in Hebron to discuss the organization’s cooperation in order to provide holistic services (WHO, 2006)..

User involvement was an important aspect of service development. A training held by recovery experts from the United Kingdom entitled “Hearing Voices” was implemented in Bethlehem and Gaza psychiatric hospitals, and at Ramallah and Gaza CMH centers. Family associations, organizations and committees have been established in Ramallah, Hebron and Gaza to facilitate the integration of people with mental problems in the society and for advocacy purposes to reduce the effects of stigma. Supportive family groups were established and led by social workers and psychologists from CMH centers and from the psychiatric hospitals and met twice per month. In addition, team meetings were held every two weeks to exchange experiences and resolve problems (WHO, 2006).

2.11. Patient satisfaction

Internationally, the interest in patient satisfaction increased markedly after considering it as an indicator of quality of care provided. There are different definitions for patient satisfaction due to different backgrounds and experiences. For the time being, there is no universal model to explain how patients become satisfied. Many things are combined together and form patient’s satisfaction such as a patient’s expectations, attitudes and prior experiences (Pelz, 2002).

Kotler defined satisfaction as: “a person's feeling of pleasure or disappointment resulting from comparing a product's perceived performance or outcome, in relation to his or her expectations” (Kotler, 2003 p. 61)

According to Keegan and Mcgee (2003), patient satisfaction reflects the total experience of health care. Satisfaction involves intellectual, emotional, psychological factor and previous experience, expectation of the patient. He views it as an attitude- a person’s general orientation toward a total experience of health care.

Halstead (1993), views satisfaction as the result of a comparison between prior experiences and perceive the actual outcome. In this sense, patients with different experience backgrounds would have different evaluation on the same performance. It has been described as “the extent of an individual’s experience compared with his or her expectations”

- **Theories of satisfaction**

There have been multiple models developed to explain individual satisfaction in several areas. One of these theories was the performance theory, which views patient’s satisfaction in relation to actual performance and treatment outcome. Performance theory means that patients have their own expectations that gained from prior experiences. Level of patient satisfaction is highly influenced by the quality of care provided and outcomes of the care (Aragon, 2013).

The theories of expectancy assume that there is a relationship between satisfaction and the fulfillment of expectations. Expectations play a central role in several theories of health behavior, including expectancy value theory, which emphasizes that patient’s value, beliefs, and prior expectations concerning care, have an impact on patient's satisfaction. Besides, Bandura’s social-cognitive theory, is concerned with how an individual’s beliefs influence behavior (Batbaatar et al., 2015).

Expectations-confirmation theory or Expectancy disconfirmation theory, assumes that there is an association between expectations and perceived performance, which lead to confirmation or disconfirmation of values, beliefs, and attitudes, which in turn influence patient satisfaction. This theory sets out that patients form expectation of their treatment outcome even before the treatment. The expectation level becomes a standard that used to evaluate the outcomes. Confirmation occurs in case the treatment outcome matches the expectation. Disconfirmation occurs where there are differences between expectations and

outcomes. If the outcomes are better than what the patient had expected, a positive disconfirmation occurs, which results in satisfaction (Brien,2009).

According to Ompson and Sunol (1995), there are four types of expectation. The first was ideal expectation, which referred to a patient's desired outcome. The second was predicted expectation, which referred to a patient's anticipated outcome. The third was normative expectation, which occurs when patients are unwilling or unable to articulate expectations. The fourth was unformed expectations, which represents what the outcome should be.

Parasuraman et al., (1991), view that satisfaction can be achieved only if the objective outcomes fall in the zone between normative and minimum predicted expectation (zone of tolerance). Zone of tolerance defined as the range between the adequate and desired levels of service expectations.

Yet another theory was the primary provider theory. This theory concluded that overall patient's satisfaction is influenced by a group of factors such as the primary care provide, the amount of time the patient waiting for the provider, and satisfaction with provider assistant. The theory influences by patient-centered measures exclusively where only patients judge the quality of service and other judgments are irrelevant. Besides, the characteristics of health provider are important influences on satisfaction. This including personality trait, technical aspects of clinical practice, and specific professional skills related to empathy, concern, caring, warmth and sensitivity. (Aragon, 2013).

2.12 Previous studies

The study of Doshi, Sudha and Wall (2006) was titled: "**Mentally ill patients' experiences and opinion on seeing medical students**". The study conducted in the UK with an aim to explore the opinions and experiences of mentally ill inpatients in a psychiatric hospital that facilitates teaching medical students. Forty-three patients who were able to consent participated in the study. The findings showed that most of the patients agreed to be involved in medical education, but they did not prefer to discuss their personal issues or stress-related issues in front of the medical students. Also, results indicated that patients placed importance to students seeing real patients and they were happy and benefitted from being seen by medical students. Most of them had experienced anxiety before the student-patient interview which was evident during the interview.

The study of Yaghobian et al. (2014), "**Association between Awareness of Patient Rights and Patient's Education, Seeing Bill, and Age: A Cross-Sectional Study**". The study aimed at assessing the awareness of patients of their rights in teaching hospitals of Sari. Four hospitals belonging to Mazandaran University of Medical Sciences participated in this study, 336 patients interviewed. The study found that 63.4% of participants had not seen the bill of patients' rights. 58.9% had poor knowledge, 12% had intermediate knowledge, and 29.1% had good knowledge. A significant relationship was found between awareness of the bill, and the patient's education, seeing the bill, and age ($p < 0.0005$). The study concluded that patients are not sufficiently aware of their rights.

The study of Mohammed et al., (2018): "**Awareness and practice of patient rights from a patient perspective: an insight from Upper Egypt**". A cross-sectional study conducted in Egypt, aimed at assessing the patients' awareness of their rights, the predictors of knowledge of patients' rights and the degree of adherence to these rights by the medical team from the patients' perspective. The study found that the majority of

patients were unaware of their rights at a level of 76%. The education of patients was associated with their knowledge score significantly. The majority of patients (98.1 percent) stated that they were not informed by the medical team about the treatment options available.

The study of by Lawn, et al. (2015): **“Examining the presence and consequences of moral framings in patients’ and mental health workers’ experiences of community treatment orders”**. A qualitative study was conducted in Australia, and aimed to understand the meaning of community treatment orders (CTOs), how they are constructed and experienced from the perspective of patients on CTOs and workers directly administering CTOs. Ten mental health workers and 8 community mental health patients participated in this study. The findings showed that the moral framing in relation to constructions and evaluations of the CTO experience was presented as positive, negative or justifiable. Most patient participants appeared to use moral framing (ethical frame of reference for services) in order to understand why they were placed on a CTO and convey the lessons they have learned. Worker participants appeared to use moral framing, empathy, belief of patients’ positive right to services and treatment, and positioning themselves in the patients’ shoes as a way of behaving virtuously toward them. The study concluded that the experiences of CTOs are dependent upon empathy and reflection on the relationship between what is done and how it is done.

The study of Nurjannah, et al. (2014): **“Human rights of the mentally ill in Indonesia.”** The study aimed to understand the provision of mental health care in Indonesia. Grounded theory methods were used in order to study 49 participants and included health professionals, non-health professionals and individuals living with a mental disorder. The participants were interviewed in 2011 and 2012. The findings indicated that there were 4 main factors influencing care-providers’ decision-making: competence, willingness,

available resources and compliance with institutional policy. In addition, health professionals were found to be influenced most strongly by institutional policy when deciding whether to accept or shift responsibility to provide care while non-health professionals based their decisions largely on personal circumstances. Unmatched decisions can increase risks of human rights violations. The study concluded that the institutional policy was important and needs to be underpinned by legislation to protect human rights.

The study of Gonzales, et al. (2014): **“Ethical behavior in clinical practice: a multidimensional Rasch analysis from a survey of primary health care professionals of Barcelona.”** The study aimed to assess the ethical behavior in clinical practice of primary health care professionals in Barcelona. Four-hundred-fifty-two professional participated in this study. The researchers used a Rasch multidimensional model (self-administered questionnaire) in order to examine the level of ethical endorsement of the items and ethical performance of health care professionals. The results of the study indicated that nurses had greater ethical performance than other professionals. The professionals with effective knowledge of ethical norms had a higher level of ethical performance. In issues relevant to patient autonomy and respecting patient choices, the finding showed that the level of ethical performance was lower and professionals found it extremely difficult to endorse avoiding interruptions when seeing patients.

The study of Loch et. al. (2009): **“Stigma toward schizophrenia: do all psychiatrists behave the same?”**. The study conducted in Brazil, 1400 psychiatrists participated in this study by answering a questionnaire addressing four stigma dimensions: stereotyping beliefs assessment, restrictions to civil rights, perceived prejudice, and social distance. The results indicated that the psychiatrists’ community in this study was divided into three patterns of stigma. The first was no stigma profile, which represented 23.8% of the sample

who believed that negative stereotypes were less present in the individual with schizophrenia. There was disagreement with involuntary admission and with restricting voting rights. The second was unobtrusive stigma profile, which represented 33.3% of the sample who agreed with involuntary admission. They believed that the population had stigmatizing views on schizophrenia and demonstrated the highest willingness to engage in social situations with individuals with schizophrenia. The third was great stigma profile, which represented 42.3% of the sample, most often endorsed the idea that negative stereotypes were highly present and positive stereotypes were less present in individuals with schizophrenia. They agreed with revoking driver's licenses and restricting voting rights. They most often selected the option of "never" engaging in the specified social situations. The study concluded that the majority of psychiatrists were categorized as fitting the "great stigma" profile. They were the ones who showed the worst stigmatizing beliefs in all dimensions, displayed the lowest level of social distance, and mostly agreed with involuntary admission.

The study of Thompson and McCabe (2010), "**The effect of clinician-patient alliance and communication on treatment adherence in mental health care**". The study aimed to assess the impact of clinician-patient alliance and communication on adherence in mental health, identifying the specific mechanisms that mobilize patient engagement. A systematic search was conducted in a group of information banks such as PubMed, Psych Info, Web of Science, Cochrane Library, Embase, Cinah, and in relevant journals, grey literature and references. Six-thousand-six-hundred-seventy-two titles were examined and 23 studies met the inclusion criteria for the review.

The results showed that 17 studies reported positive associations with adherence; ten studies examined the association between clinician-patient alliance and adherence, twelve studies assessed the clinical communication styles and messages and one study examined

the association between objectively rated communication and adherence. Narrative synthesis was used to present the following findings: Clinician-patient alliance and communication are associated with more patient adherence. Observation researches emphasized that communication would better facilitate the application of findings in clinical practice. Making agreements related to the tasks of treatment, utilizing collaborative styles of communication, and discussion of treatment may be important for clinicians to promote cooperation.

The study of Ashmore and Carver (2017) **“Informal mental health patients: what are they told of their legal rights?”** The study aimed to determine what written information is given to informally admitted patients in England and Wales regarding their legal rights in relation to freedom of movement and treatment. Data was collected by gathering information leaflets that had been published in trust websites related to National Mental Health Services in England and health boards in Wales. Content analysis was used to analyze the data collected. The study results indicated that 27 out of 61 organizations for inpatient care provided written information in the form of a leaflet and 6 provided public access to the information leaflets through their website.

The study of Abo Seedo (2007) **“Evaluation of integrated mental health counseling into primary health care from point view of clients”** The study aimed to examine the effectiveness of integrated mental health counseling into primary health care centers in Gaza city from perspective of clients. Participants recruited from Ard El Insan clinics, 40 women who attending to psychological department participated in this study. The study found that there are statistical differences between average scores of women who received less than 6 sessions of counseling and women who received more than 7 sessions (in benefit of the second group). Eighty-seven point four percent of participants were satisfied with mental health services received from primary health care centers.

The study of Dastan and Kilic (2013) **“The educational needs of the patients who take treatment in psychiatric clinic in Kars”**. This study aimed at determining the educational needs of the patients who take treatment in psychiatric clinic in Kars, Turkey. Two types of research methods used in this study; descriptive and cross-sectional. The sample study was 50 patients, who has interviewed for twenty minutes. The study found that there is a greatest need for health education in specific areas such as “Anger, violence, assaultive behavior”, “Sleeping problems”, “Problems with concentration” and “Patients self-help organizations”. The study concluded that it is supposed to meet the patients’ needs for information, in order to increase understanding of their illness condition, encourage health promoting behavior, and to cope with the symptoms of the illness.

The study was of Sharif et al. (2012) entitled **“Effect of a psycho-educational intervention for family members on caregiver burdens and psychiatric symptoms in patients with schizophrenia.”** The study conducted in Iran, aimed to explore the effectiveness of family psycho-education in reducing patients’ symptoms and on family caregiver burden. Seventy Iranian outpatients with schizophrenia participated in this study. Their caregivers attended 10 sessions of psycho-education immediately after intervention and one month after intervention. The findings showed that in comparison with the control group, the case group showed significantly reduced severity of symptoms and caregiver burden both immediately after intervention and one month later.

The study of Davis, Pendry, Savill, and Doherty (2011) **“An outcome evaluation study of a psycho-educational course in a primary care setting”**. The study conducted in Netherlands and aimed to determine whether a psycho-educational group may be a workable alternative to individual counseling by assessing the clinical effectiveness of it and by examining the group outcomes in comparison with individual treatment outcomes. Fifty-seven participants attended a psycho-educational course (pre- and post-intervention).

A comparison was made with a second group of 58 participants who received individual counseling. The study provided data over a 36-month period. The findings showed that the participants reported significantly lower levels of psychological distress after attending the psycho- education course. These results are comparable to outcomes measured in the same service for individual counseling, which indicate that group interventions could be considered as an alternative to individual counseling, thus increasing cost-effectiveness and reducing waiting times.

The study of Hasselt, Oud and Loonen (2013) **“Improvement of care for the physical health of patients with severe mental illness (SMI): a qualitative study assessing the view of patients and families.”** The study conducted in Netherlands and aimed to discover the view of patients with SMI and their families on the current organization of care and how this care may be improved. Ten patients with SMI and 13 family carers were interviewed in order to explore their needs in regard to caring for the physical health of patients with SMI and to explore the deficiencies they had experienced. The study found three themes for the improvement of the physical care of patients with SMI: the reduced ability of patients with SMI to seek their own physical health interests requires health care that is customized to these needs, the lack of coordination and collaboration between mental health care professionals and general practitioners hamper the optimal care, and finally, the implementation of monitoring and supporting a healthy lifestyle.

The study of Hasler, et. al (2004) **“Patient satisfaction with outpatient psychiatric treatment: The role of diagnosis, pharmacotherapy, and perceived therapeutic change”** The study conducted in Canada, aimed to assess patient satisfaction following psychiatric treatment for non- psychotic, non -substance-related disorders. The outpatients who received eight or more therapy sessions were mailed questionnaires one year after completing treatment. The results indicated that the patients diagnosed with somatoform,

eating, and personality disorders were less satisfied than patients diagnosed with affective, anxiety, and adjustment disorders. The study indicated that patients' satisfaction was not related to pharmacotherapy itself. On the other hand, symptom reduction and changes in the interpersonal field were considered as important outcomes associated with patient satisfaction.

The study of Iyendo et al. (2016) **“The therapeutic impacts of environmental design interventions on wellness in clinical settings”** A narrative review was conducted in Turkey and aimed to document the role of physical environmental factors in clinical environments and their impact on patient and staff wellness with a particular focus on physical and mental healthcare. The study found that physical environmental factors in the hospital design facilitated user satisfaction because they conveyed positive distractions for patients and staff in terms of views of pleasant outside prospects, artwork and music. This provided for enhancement in efficiency and better outcomes. The study concluded that well-designed physical settings play an important role in the healing process of patients in health care facilities.

Chapter III: Methodology of the Study

3.1 Introduction

3.2 Study Design

3.3 Setting of the study

3.4 Study Population

3.5 Study Sampling method and size

3.6 Inclusion criteria

3.7 Exclusion criteria

3.8 Study Instruments

3.9 Reliability & Validity of the instrument

3.10 Data collection Process

3.11 Data Analysis

3.12 Ethical Considerations

3.1 Introduction

This chapter discusses the design of this study, the setting, the study population and the sample with its inclusion and exclusion criteria. Also, the instruments used in the data collection. In addition, the data collection process, content analysis, instrument validity and reliability, and the ethical considerations of this study were discussed.

3.2 Study Design

The qualitative research design was used in the study. In-depth individual interviews (Semi- structured) were conducted with patients with mental illness in their homes in order to explore the experiences of the individuals with mental illness in regards of the ethical and legal considerations in the clinical practice; codes of ethics and human rights that are practiced by the mental health practitioners in Ramallah and Hebron governmental community mental health centers (Earl, 2014).

Qualitative research is known as induction, whereby data is collected relating to a specific area of study, and from this data the researcher constructs different concepts, assumptions and possible theories (Given, et al., 2008). Moreover, makes it possible to describe the life experience of the participants in which researchers use observation and interactive interviews to collect data (Bryman, 2004).

There are different types of qualitative research such as ethnography, historical, phenomenological, narrative, explorative, case study and grounded theory (Bryman, 2004).

The existences of these multiple types of research return to the differences in purpose, approach and process.

There are many advantages of using a qualitative research according to Marczyk et al. (2005). Each of them is elaborated below:

- The qualitative design is considered an appropriate design to explore and investigate the experience of individuals.
- The qualitative approach was considered more relevant to undertake this research as it allows greater capacity to gain more depth and meaning based on an individual's experiences with mental illness and its implications
- The qualitative approach is considered the best method to explore the research problem that has not been clearly defined. This type of studies used when there are a few or no earlier studies to rely on to predict outcomes. This approach aims to gather information that will help to define problems in order to have a better understanding of it.

In this study, the explorative research was utilized to explore the research problem that has not been clearly defined (Kothari, 2004). This type of studies used because there are a few studies in Palestine to rely on to predict outcomes. The aim of an exploratory study is to gather information that will help to define research problems in order to have a better understanding of them (Marczyk et al, 2005).

The exploratory research attempts to collect information from groups about subjects in order to systematically, factually and accurately describe specific interesting characteristics or conditions that exist today (Hensley, 2006).

3.3 Setting of the study

The study was conducted at Ramallah and Hebron governorates. In Ramallah city there is one center that provide mental health services to the population of Ramallah governorate. The CMHC is located in the building of the public health clinics. The mental health team consists of seven health professionals: two psychiatrists, one psychologist, one nurse, and three social workers.

In 2019, the estimated population of Ramallah city according to the Palestinian Central Bureau Statistics (PCBS) was 340,475. The Palestinian MoH declared in 2018 that the estimated mental illness incidence rate in Ramallah reached to 119.1 per 100.000 populations (The Palestinian Ministry of Health, 2018).

In Hebron city there are two centers that provide mental health services and serves the population in Hebron governorate. One of them in Hebron city and the other one in Dora. The Hebron CMHC is located in a building shared with dental services. The mental health team consists of five health professionals: a psychiatrist, two psychologists, a nurse, and two social workers.

In 2019, the estimated population of Hebron city according to the Palestinian Central Bureau Statistics (PCBS) was 743,121 (PCBS, 2019). Due to the health annual Palestine report (2018), the estimated incidence rate in Hebron was 99.6 per 100.000 populations (The Palestinian Ministry of Health, 2018).

The researcher presents these statistics in order to provide a deeper understanding of the estimated prevalence of mental illness in these areas (PCBS, 2017).

3.4 Study Population

The target population of this study included all the patients with a diagnosed mental condition from 18- 60 years' old whom experienced being treated in the governmental CMHCs in Ramallah and Hebron governorates.

In 2015, the Palestinian ministry of health declared in the health annual report that 85.173 individuals visit the community mental health centers in the West Bank and Gaza strip. (The Palestinian Ministry of Health, 2015)

The statistics published during the past three years in the West Bank shows that 2.712 new patients were registered in 2016 and 3.013 in 2017 with a marked increased incidence rate has reached to 117.2 per 100.000 populations. The distribution by sex shows that 59.4% of recorded of new cases were males (The Palestinian Ministry of Health, Health Annual Report, 2016, 2017).

The latest data showed that 3.156 new patients were registered in 2018 with a marked increased incidence rate has reached to 119.7 per 100.000 populations (The Palestinian Ministry of Health, Health Annual Report, 2018).

3.5 Study Sampling method and size

The study included 30 participants of patients with mental illness of both sexes from 18-60 years' old those who have been receiving treatment from the Palestinian governmental CMHCs in Ramallah and Hebron governorates, by using a convenience sampling method. Half of the participants were from Ramallah governorate and the others were from Hebron governorate.

The researcher tried to get approval from the Palestinian ministry of health to conduct the study in the Palestinian governmental CMHCs. The request was disapproved, so the investigator used an alternative approach to conduct the study. The participants were recruited through personal effort. The researcher used the social network that she has, contacted with persons and professionals in the mental health field that she knows from Ramallah and Hebron governorate in order to access the participants.

3.6 Inclusion criteria:

1. Patients with mental illness who lived in Ramallah and Hebron governorates.
2. Patients with mental illness who are treated in Palestinian governmental community mental health centers.
3. Patients with mental illness who are within the age group between 18-60.

3.7 Exclusion criteria:

1. Patients with mental illness who are living in the other parts of Palestine.
2. Patients with mental illness who are less than 18 years old.
3. Patients with mental illness who are in acute stage or psychotic state.
4. Patients with mental illness with first admission experience.

3.8 Study Feasibility

1. The proposal was submitted to the research ethics committee and approval was obtained.
(See appendix C)
2. The participants' consent was obtained verbally as all the participants were provided with the information sheet about the study including the aim of this study; objectives, procedures, and they were informed that they had the right to refuse to participate in the study or to stop being participated in any phase of the research.
3. The researcher guaranteed the confidentiality and privacy of participants by assuring that the information will not be available for anyone who is not directly involved in the study other than the main researcher and supervisors. The name of the participants was not required. The records are stored in a secured area with access limited to the researcher, and the records will be destroyed as soon as the research ended.

4. The researcher has a working experience in mental health field for 12 years in Jerusalem area.
5. The interest and knowledge of the researcher helped in the process of conducting this research.

3.9 Study Limitations

Despite the feasibility of this study, each study has its limitations (Delany, 2007, Patton, 1990). The following are some of these limitations: -

- Lack of generalizability is one of qualitative research characteristic, due to its small sample size and no randomization of the sample.
- Research quality depends heavily on the participants' abilities and is more easily influenced by the personal biases and idiosyncrasies of the participants.
- Safety factors – interviews were conducted in the houses of the participants.

3.10 Description of the socio-demographic characteristics.

Descriptive analysis was used to classify participants ' socio-demographic characteristics and frequencies.

3.10.1 The socio-demographic characteristics of the participants

- **Gender**

Thirty patients with mental disorders accepted to be part in the study; 57% of them were females, and 43% were males (see figure 3.1).

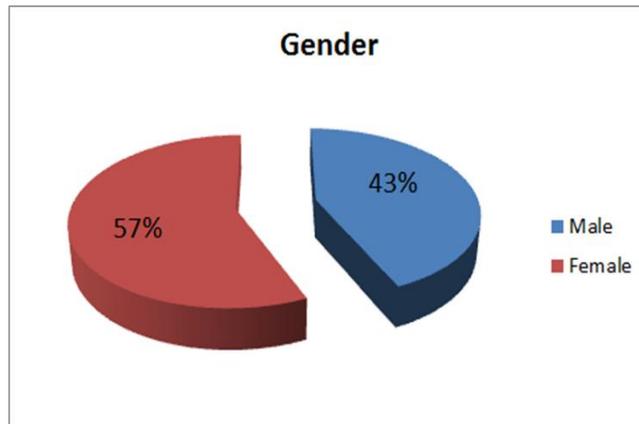


Figure (3.1): The distribution of the participants by their gender

- **Age**

The ages of the participants were recorded into four groups; the group (18-30years) was (34%), the group (31-40years) was (30%), the group (41-50years) was (23%), and the group (51-60years) was (13%). (See figure 3.2).

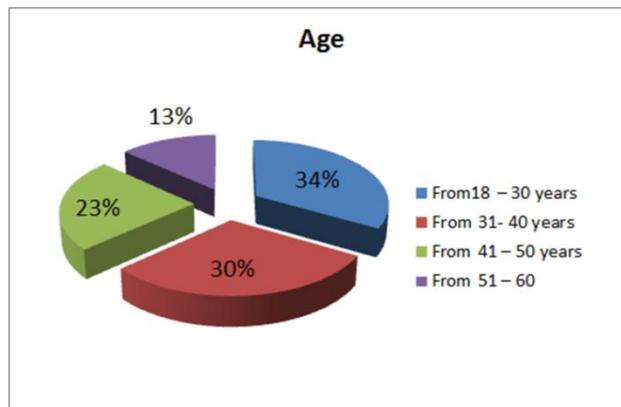


Figure (3.2): The distribution of the participants by the age

- **Residential areas**

As figure(3.3) shows, the distribution of the participants was recorded into two groups in relation to the residential areas: the first group was for the participants who live in the village and their percentage was (53%), while (47%) was for the participants who live in the city (See figure 3.3)

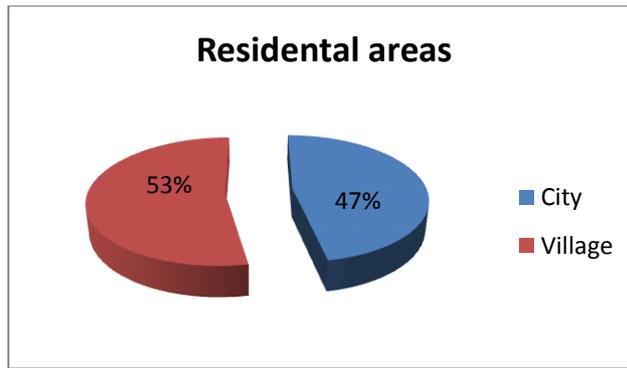


Figure (3.3): The distribution of the participants by residential areas

- **Marital status**

The finding of the study indicated that 57% of the participants were married, 33% were single, and 10% were divorced (See figure 3.4).

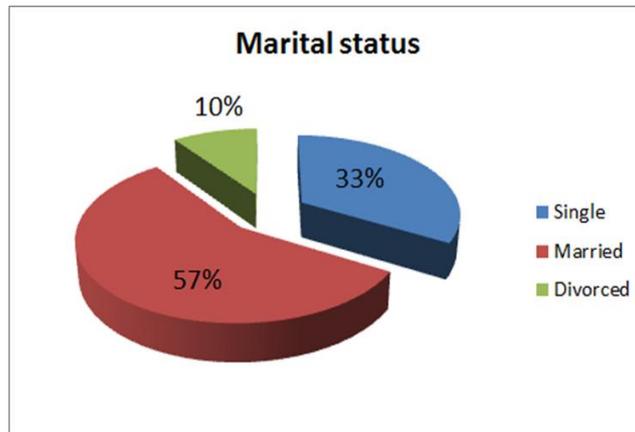


Figure (3.4): The distribution of the participants by marital status

- **Educational level**

The data analysis showed that the ratio of the participants who had a university / college degree was (44%), where (30%) of them finished the secondary level of education, (23%) reached the preparatory level, and the smallest ratio was 3% for the participants who were illiterate (see figure3.5)

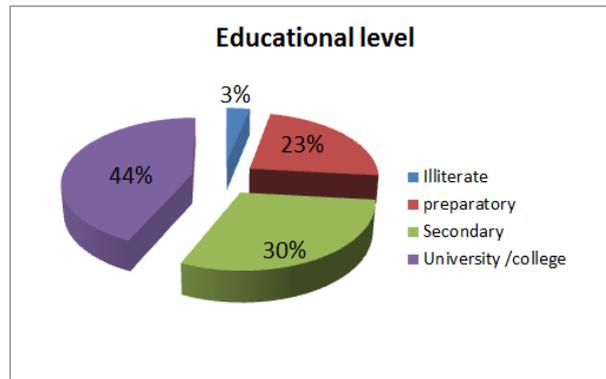


Figure (3.5): The distribution of participants by the educational level.

- **The occupational status**

The finding indicated that (33%) of the participants were housewives, (27%) of them were unemployed, (20%) were laborers, (13%) were working in the private sector and (7%) were working in the public sector. (See figure3.6)

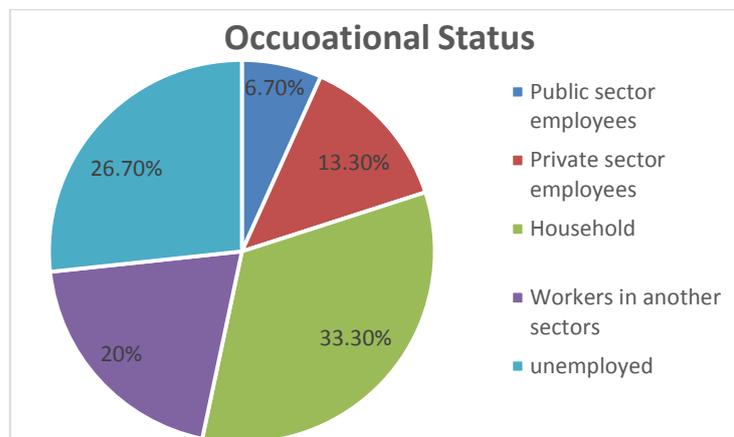


Figure (3.6): The distribution of participants by occupational status.

- **Family size**

As shown in figure (3.6), the family size of the participants was as follows: 50% of the participants belong to the group of (3 and below), (47%) of them belong to the group 4 -6), and the smallest ratio was (3%) for the participants who belong to the group of (7 and above). See figure (3.7)

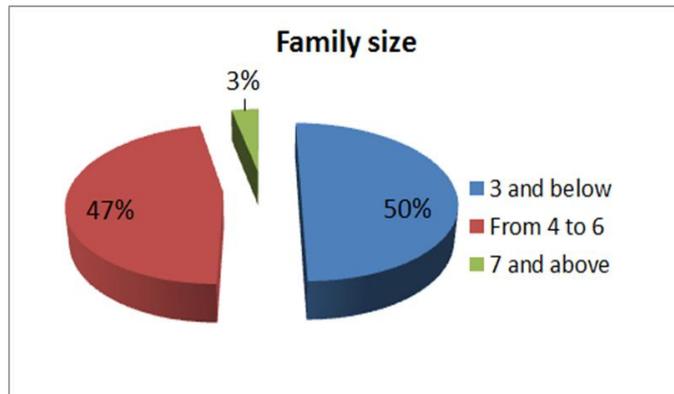


Figure (3.7): The distribution of participants by family size.

3.10.2 Non-demographic characteristics of the participants

- **Type of house**

As shown in figure (3.4), 70% of the participants live in independent homes while the others live in family of origin house (see figure 3.8).

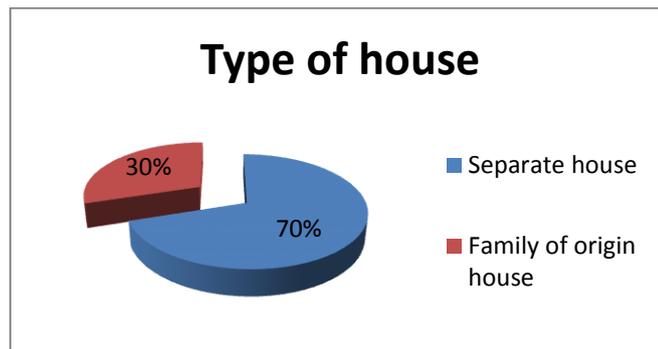


Figure (3.8): The distribution of the participants by the type of house

- **Whom did the participants live with:**

The data analysis showed that 56% of the participants were living with their families of origin, 37% were living with their nuclear family, and 7% of the participants were living alone. (See figure 3.9)

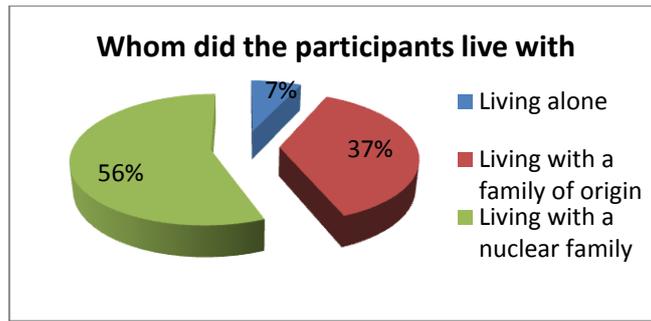


Figure (3.9): The distribution of the participants by whom did the participants live with

- **Clinical diagnosis**

The data analysis showed that (40%) of the participants had been diagnosed with one of the mood disorders, (23.33%) had been diagnosed with schizophrenia, (13.33%) had been diagnosed with anxiety disorders, (10%) had been diagnosed with obsessive compulsive disorder, (6.66%) had been diagnosed with PTSD, and (3.3%) had been recorded for those who had been diagnosed with one of the following disorders: hypochondria, and epilepsy. (See figure 3.10)

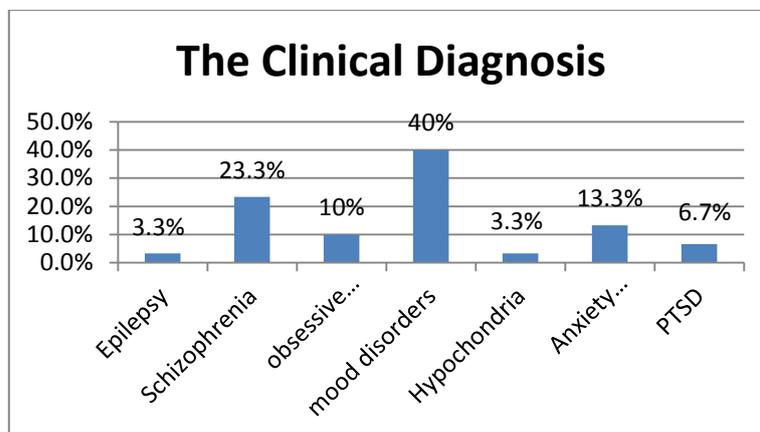


Figure (3.10): The distribution of the participants by the clinical diagnosis

- **The duration in years for clinic review**

The finding indicated that 60% of the participants had been received treatment at the clinic since 5years and above, and 40% of them had been received treatment at the clinic since 3years and below (See figure 3.11).

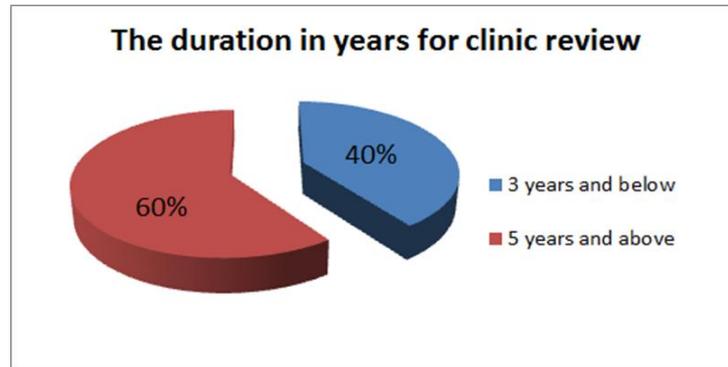


Figure (3.11): The distribution of participant by duration in years for clinic review.

- **How did the participants come to the clinic?**

The finding indicated that 83% of the participants used public transport in order to come to the clinic and 7% of them came to the clinic by walking and the same ratio was recorded for participants who came to the clinic by taxi, and 3% of them came to the clinic by using other ways such as using the family car. (See figure 3.12)

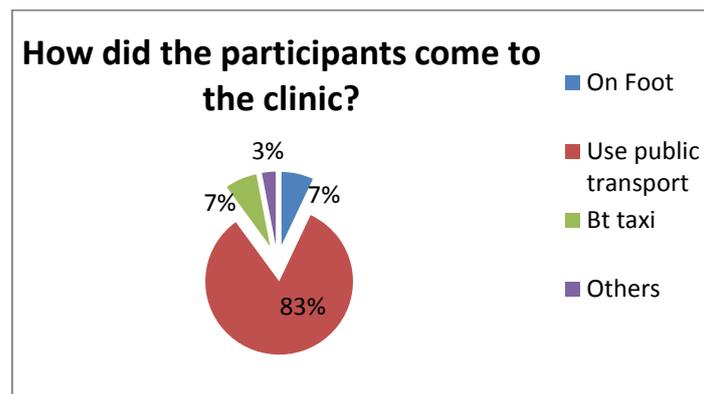


Figure (3.12): The distribution of participant by how did they come to the clinic.

- **The reservation system**

The finding indicated that 53% of the participants reported that the pre-reserve system is available in the clinic while 47% of them reported that the pre-reserve system is not available in the clinic. (See figure 3.13)

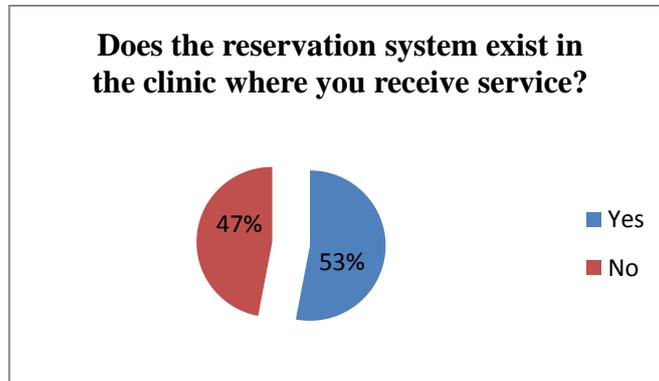


Figure (3.13): The distribution of participant by their answers in relation to the reservation system.

3.11 Study Instruments

An interview guide was developed for this study and included questions related to the Client's perception of quality of services, clinical practice that they experience with mental health practitioners. The interview guide also included a demographic data sheet contains the following: age, gender, place of residency, marital status, occupational status, and family size, educational level, reservation and the payment system. All these data were collected at the beginning of the interview in order to identify characteristics of respondents.

In regard to the clinical practice, the interview guide included eight core areas. Each of them helps to develop a broader understanding of clients' experiences with Mental health practitioners in the Palestinian context. The core areas of the interview guide are elaborated below.

- The nature of the procedures for patient's reception; in this area there are three questions related to; Reception procedures: which practitioner received the participant upon arrival to the clinic, View of the Participants' reception procedures and waiting period.
- The rights of patients with mental illness in general and the following right in specific; the right to know the diagnosis and treatment plan, privacy, confidentiality and patient respect. In this part there are four questions related to; knowledge of patient's rights in general, the rights that participants know about, the source of knowledge of the participants about their rights, the violation of participant's right in the past, and the means of violation of the rights of participants.
- The therapeutic environment: participant's view of the center location suitability, the availability of the facilities in the center, the comfort of furniture in the waiting room, the center's temperature according to weather, the hygiene level of the center facilities, and the availability of the Personal hygiene materials
- The psycho-education process: education about medication, and education about psychiatric illness (the causes and symptoms).
- The therapeutic process nature, in this section there is a group of question in regard to; the therapeutic process type, therapeutic session duration, whether the Participants know about their medical diagnosis or not, consistency between the real diagnosis and perceived diagnosis, participants 'knowledge of therapeutic plan, whether the therapeutic plan had been discussed with the participants, the participant's approval of treatment, whether the participants sign a consent form, whether the participants is involved in therapy or not, in what way the participants were involved, who was involved in treatment, and the reasons that make the participants followed –up in CMHCs.

- The services provided by Ramallah and Hebron governmental community mental health centers.
- The participants' level of satisfaction with the care provided by the mental health practitioners

3.12 Reliability & Validity of the instrument

One of the main concerns of quantitative research is to make sure that the data are collected in a valid and reliable manner. Researchers of qualitative design pay attention to the quality of information that underlines their conclusions (Teddlie and Tashakkori, 2000). All qualitative research involves assuring the accuracy of recordings and pre-testing the truthfulness of analysis claims. Validity and reliability of this research is a concern to the core of the interpretation of observation that aims to investigate talk in interaction not as screen on which are projected through other processes but as a phenomenon in its own right (Schegloff, 1992). It is an interpretation of observations, and the issue that the observations stand for or represented (Alkula et al., 1994). Kirk and Miller define reliability as the degree to which the finding is independent of accidental circumstances of the research (Silverman, 2000).

Reliability is related to assuring the quality of field notes and guaranteeing the public access to process of their production. This had been done by the recording interviews and transcripts accordingly. The quality of the recording, technical quality of recording and the adequacy of transcripts have important implications for the reliability of conversation in qualitative research (Silverman, 2001).

The validity and reliability include credibility by increasing prolonged engagement in the field or with participants and to report any personal and professional information that may have affected data collection and interpretation either positively or negatively (Patton,

1990). Also, it includes dependability (having two researchers in order to examine the process and the product of research). This indicates the transferability, which includes the ability to use the result by having a rich description of the phenomena by using convenience sample (Porter, 2007).

The interview guide of this study had been examined by three academic staff that are qualified and experienced in the subject under study to add or suggest new questions and to test its content validity. A Tape recorder had been used to record the interview after the participant agreement (Silverman, 2000).

3.13 Data collection Process

The data was collected by using individual interviews and particularly semi- structured interviews. The purpose of such kind of interviewing is to access the perspective of the person being interviewed (Patton, 1990).

Semi-structured interviews was utilized because it is a comprehensive way to collect limited data, set flexible questions, use time effectively and allowing new questions to be brought up during the interview through probing methods (Silverman, 2000). An interview guide was used in this study which increases the comprehensiveness of the data and makes data collection somewhat systematic for each respondent to tell their story and talk freely about their experiences (Milkkelesen, 2005).

Piloting the interview guide has been done through interviewing five patients with mental illness from Ramallah governorate who have similar characteristics of the target population to examine the clarity and the simplicity of the language.

After getting the approval from the Faculty of Public Health and the Faculty of Graduate Studies in Al-Quds University, the process of interviewing patients with mental illness was

started. The data were collected by using individual interviews and particularly semi-structured interviews.

The researcher contacted social networks; family, relatives, friends and colleagues who work in this field and have knowledge of such people with mental illness; they contacted them and asked them to participate, and those who agreed to participate in the research were contacted to interview them and they had been interviewed at their homes.

The researcher has maintained the confidentiality and privacy of the participants by ensuring that information is not accessible to anyone who is not specifically involved in the study other than the primary researcher and supervisor. The names of the participants were not required. Records were kept in a secure area with limited access to the researcher and the records were destroyed as soon as the data analysis was completed. The data collection process took almost 5 months during the middle of August 2018 and the end of December 2018. The participants were very helpful and cooperative.

3.14 Data Analysis

Once the data was fully transcribed, coding the data began and used in order to categorize and organize the data transcription into themes and sub-themes which come out through the coding process.

The study instrument includes two types of questions; closed and open ended questions. In light of that the researcher used more than one to analyze the data transcription. In closed ended questions such as questions No. 1,12,13,14,15,16,19, and 26, the answers were very clear and the researcher analyzed them through frequencies and percentages.

In open ended question such as question No. 11,17,22,23,24,25,27,28, and 30, Thematic and content analysis were used in order to identify the common themes, topics, ideas and patterns of meaning that come up repeatedly.

The interpretation of data involved identifying the reoccurring themes, highlighting the similarities and differences in the data. The final stage of data analysis has worked on data verification; process of rechecking the transcript and codes again to test the validity of understanding.

Chapter IV: Results

4.1 Introduction

4.2 The results of the study

4.2.1 The result of research question number one

4.2.2 The result of research question number two

4.2.3 The result of research question number three

4.2.4 The result of research question number four

4.2.5 The result of research question number five

4.1 Introduction

As mentioned in the previous chapter, an explorative study was utilized and a sample of 30 patients with mental disorders from Ramallah and Hebron governorates were targeted. Data was collected by using a socio-demographic questionnaire and an interview guide. This section addresses the results of the study in relation to research questions. The results of the study are presented below.

4.2 The results of the study in relation to research questions

4.2.1 The results of research question number one: What does the participant know about the rights of patients with mental disorders in general and the following rights in specific; the right to privacy, and the right to confidentiality?

Table (4.1) The knowledge of the participants about the rights of patients with mental illness.

Themes	Categories	Frequency	Percentage %
Knowledge of patients' rights in general	- Yes, I know	14	47%
	- No, I don't	16	53%
	Total	30	100%
The source of knowledge of the participants who knew about their rights	Self-knowledge	13	93%
	Previous experience at Israeli hospitals	1	7%
	Total	14	100%

As shown in table (4.1), 53% of the participants did not know their rights that were developed by the United Nations (UN) Principles for the Protection of Persons with Mental Illness; 47% of the participants have knowledge of their rights in general.

The source of knowledge for those that resulted informed, was classified into two groups: 93% of the participants reported that their source of knowledge was “self-knowledge” resulting from past reading and academic education, while one participant said that he gained his knowledge from his previous experience at Israeli hospitals.

Table (4.2) Perception of the rights as reported by those who answered “yes” (N=14).

Themes	Categories	Frequency	Percentage %
The right to be treated	Participants who know this right	7	50%
	Participants who did not mention this right	7	50%
The right for privacy	Participants who know this right	6	42.8%
	Participants who did not mention this right	8	57.1%
The right to confidentiality	Participants who know this right	6	42.9%
	Participants who did not mention this right	8	57.1%
The right to respect	Participants who know this right	3	21.4%
	Participants who did not mention this right	11	75.6%
The right to be treated with dignity	Participants who know this right	1	7.1%
	Participants who did not mention this right	13	92.9%
The right to receive treatment without interruptions	Participants who know this right	3	21.4%
	Participants who did not mention this right	11	75.6%
The right to have efficient time in the therapeutic session	Participants who know this right	2	14.2%
	Participants who did not mention this right	12	85.7%

The rights that the participants knew of in the therapeutic process were classified as follows: 50% of the participants knew their right to be treated, while 42.8% of them knew they have a right for privacy, and the same ratio was recorded for the participants who knew of their right to confidentiality. A percentage of 21.4 were recorded for the participants who know their right to be respected and for the right to receive treatment without interruptions; 14.2% of the participants knew of their right to have enough time in the therapeutic session, while 7.1% of them knew of their right to be treated with dignity.

Table (4.3) The violation of participants' rights

Themes	Categories	Frequency	Percentage %
Participant said that their rights have not been violated	No	20	66.6%
Participant said that their rights have been violated	Yes	10	33.3%
Total		30	100%
The meaning of the rights violation as reported by those who said that their rights have been violated	Loss of privacy	3	30%
	Loss of confidentiality	6	60%
	Interruptions	5	50%
	Loss of respect	4	40%
	Degrading of the patient	2	20%
	Ignoring of the patient by the psychiatrist	1	10%

In regards to violation of the patients' rights, 66.6% of the participants reported that their rights have not been violated. On the other hand, 33.3% of the participants reported that their rights have been violated.

Of the participants that stated that their rights have been violated, 44.4% of the total population, 60% stated that they experienced the loss of confidentiality while receiving treatment.

One of the participants said on this issue: “I heard the doctor and the employees talking about other patients, so there is a possibility that they talk about me”

A second participant said: “The most disturbing thing is when I am in the room and one of the employees comes in to talk with the doctor about another patient. So, what prevents them from speaking about me the way they speak about others?”

Moreover, 50% of those who reported that their rights have been violated said that there were interruptions, which violated their right to receive treatment without interruptions.

One of the participants said on this issue: “The doctor answers the phone while I am in his room.”

A second participant said: “When the health employees enter the room and ask about private matters, the doctor answers them.”

Forty percent of the participants reported that they have been in a disrespected situation.

To illustrate, one of the participants said on this issue: “Sometimes the doctor ignores me. As I speak with him he ignores me, but he sometimes responds to a telephone call so I have to wait for him to finish his call.”

A second participant said: “The employees speak among themselves the way neighbors talk and gossip; I see them in the 10 minutes while I am waiting for the doctor, they don't respect the patients.”

Thirty percent of the overall ratio of 44.4% reported that their right for privacy has been violated.

One of the participants said on this issue: “I feel ashamed and insulted when they call out to the patient in a loud voice; I think they should find a way to enter the doctor’s room without calling patients’ names.”

In addition, 20% of the participants stated that they had been in a situation where they felt degraded and disrespected.

One of the participants said on this issue: “Sometimes I feel that they are degrading my value when they tell me to take the red or the blue pill. I know the names of the medicine; there is no need to tell me that in colors.

Ten percent of the participants reported that they had been ignored by the psychiatrist.

One of the participants said on this issue: “Sometimes the doctor ignores me. As I speak with him, he ignores me. He also sometimes answers his phone so I will have to wait for him to finish his call”.

Table (4.4): The right to privacy in practice

Themes	Categories	Frequency	Percentage %
Participants’ view of privacy while receiving treatment	Participants agreed that there is privacy during treatment	6	20%
	Participants stated that there was no privacy during treatment	24	80%
Total		30	100%
The existence of unknown people in the therapeutic room	Yes	30	100%
Ethics related to the presence of others in the therapeutic session			
Permission was given by participants for other people to be present in the therapeutic room	Participants stated that permission was not sought	30	100%
Participants were informed of people’s roles in the therapeutic room	Participants stated that they were not informed	30	100%
The participants’ knowledge of their right to refuse the presence of others	- Yes, I knew	5	16.6%
	- No, I didn’t	25	83.3%
		30	100%

In regard to the participants’ view of the existence of privacy while receiving treatment, two points of view were founded. It was found that 77.66% of the participants stated

that privacy did not exist while receiving treatment while 23.3% of them said that they had privacy while receiving treatment.

As shown in table (4.6), all the participants stated that there were people who did not know them in the therapeutic room while they were present (interruptions).

For ethics related to the presence of others in the therapeutic session, all the participants stated that none of the health practitioners had obtained the patient's permission nor informed them of the people present in the therapeutic session. Moreover, 83.3% of the participants stated that they did not know about their right to refuse the presence of people they do not know while 16.6% reported that had the knowledge of their right to refuse the presence of people they do not know in the therapeutic room.

Table (4.5): The right to confidentiality

Themes	Categories	Frequency	Percentage %
Whether the participants believed that their files are confidentially kept or not	- Yes	20	66.6%
	- No	5	16.7%
	- Do not know	5	16.7%
	Total	30	100%
The filing system	Registration room	16	53.3%
	Computer	6	20%
	Floor below	2	6.7%
	Doctor's room	3	10%
	Do not know	3	10%
	Total	30	100%
Confidentiality related to who has access to the files of patients	Employees of the clinic and students	18	60%
	Employees of the clinic	12	40%
	Total	30	100%
Access to proceedings of the session and health status			
Issues discussed in the therapeutic room remain secret	Yes	20	66.6%
	No	10	33.3%
	Total	30	100%
Therapeutic team kept information of participant's health status confidential	Yes	20	66.6%
	Do not know	10	33.3%
	Total	30	100%
Perception of 33% of the participants about meaning of the violation (N= 10).			
The participants' meaning of the violation	- Interruptions	10	100%
	- Breach confidentiality by health practitioner	5	50%

The data analysis showed that 66.6% of the participants reported that their files were confidentially filed while 16.6% of them stated that they did not believe that their files were confidentially filed. Also, 16.6% of them did not know whether their files were confidentially filed or not.

One of the participants said on this issue: "Anyone can see the files, whether they are students or employees."

A second participant said: "Because I myself, when I am in the center, they do not keep my secret and privacy. So how will they keep my file?"

With regards to where files are saved, 53.3% of the participants reported that their files are kept in the registration room / files room, while 20% reported that the files were kept on the computer. In addition, 6.6% of the participants said that their files were saved in the doctor's room while 10% reported that their files were saved in the floor below the clinic. However, 10% of the participants stated that they did not have any knowledge about where the files were saved.

Regarding the access to proceedings of the session and health status, 60% of the participants reported that all the staff in the clinic and students in training had access to their files while 40% of them reported that all the staff in the clinic had access to their files.

In relation to the issues that had been discussed in the therapeutic room, 66.6% of the participants reported that the issues discussed in the therapeutic room remained confidential while 33.3 % of them did not think so and attributed it to two reasons mentioned in the table below.

Concerning the safekeeping of patient information, 66.6% of the participants stated that the therapeutic team kept their secrets and information while 33.3% of participants did not believe that the team kept their information.

All the participants who did not believe that the issues discussed in the therapeutic room remained confidential (N=10) attributed their view to the interruptions that have existed and violated their right to receive treatment without interruptions.

One of the participants said on this issue: "all the times that I was in the center, there were people who interrupt my session with the doctor (patients and workers). This bother me a lot but I can't say anything."

A second participant said: “the doctor does not respect that this time is dedicated to me. The interruptions exist through answering phones and other similar things.”

Fifty percent of 33.3% have attributed their view to breach of confidentiality by health practitioners.

One of the participants said on this issue: “I usually don't speak too much. This prevents the employees from talking about me. I hear them talking about the patients between themselves.”

A second participant said: “It does not remain confidential because the employees speak among themselves as neighbors talk and gossip; I saw them in the 10 minutes while I am waiting for the doctor. They do not respect the patients.”

A third participant stated: “Sometimes I heard employees talking about other patients who have created problems at the clinic. The employees talk about the patients among themselves, so I'm not sure they will not talk about me.”

4.2.2 The results of research question number two: How do the participants view the clinical practices of mental health practitioners?

Table (4.6) The reception procedures

Themes	Categories	Frequency	Percentage%
Reception procedures: which practitioner admitted the participant upon arrival to the clinic?	- Social workers	19	63.4%
	- Psychologist	6	20 %
	- Do not know	4	13.3%
	- Varied from time to time	1	3.3%
	Total	30	100%
View of the participants' reception procedures	- Positively	16	53.3%
	- Negatively	9	30%
	- Not decided	5	16.7%
	Total	30	100%
The reasons for participants' views regarding the reception procedure			
The positive view of the participants	- Sense of gratitude related to receiving treatment free of charge	16	100%
The negative view of the participants	- Lack of privacy, confidentiality and interruptions	9	100%
The average waiting time for participants visiting the community mental health centers in Ramallah and Hebron.			
The average waiting time	- 5-10 minutes	17	56.7%
	- 20-30 minutes	4	13.3%
	- An hour or more	7	23.3%
	- Varies according to number of patients waiting	2	6.7%
	Total	30	100%

As shown in table (4.6), 63.3% of the participants reported that they were admitted by social workers while 20% reported that they were admitted by psychologists. On the other hand, 13.3% was recorded for participant who reported that they were admitted by those who work in the clinic without knowing their job title. Also, 3.3% was recorded for the participants who reported that it was varied from time to time.

Regarding the participants' view related to how they view the reception procedures at the CMHCs in Ramallah and Hebron, various points of view have been expressed. It was found that 53.3% of the participants viewed the reception procedure positively while 30% of the participant viewed it negatively. However, 16.6% were undecided as to whether they had a positive or negative experience.

In regard to the reasons for participants' views regarding the reception procedure, table (4.6) indicates that all the participants who have a positive view regarding the reception procedures attributed it to a sense of gratitude related to receiving treatment free of charge.

One of the participants said on this issue: "They are treating me without paying money. I feel gratitude for this."

A second participant said: "The treatment is free of charge and I have to be grateful for this. I can't manage this alone because of my financial situation".

On the other hand, all the participants who had a negative view regarding the reception procedures attributed it to the lack of privacy, confidentiality and the presence of interruptions that existed in their therapeutic experiences with health practitioners.

One of the participants said: "The situation is bad, they let me enter the social worker room and then she started to ask me questions about myself in front of everyone including social workers and patients. So if I want to speak, I can't".

A second participant said: "Very bad! I eagerly waited to get out of the clinic. They asked me questions in front of people that I do not know. They speak to me when the door is open to the waiting room where patients are waiting. The entire time, I told them that everything was okay, whether or not I really was okay."

A third participant said: “Bad! I do not like to be in the clinic, but I have to go. I found myself there exposed. They talked to me when I was in the corridors without pay attention if there was someone around.

Regarding the average waiting time for participants visiting the community mental health centers in Ramallah and Hebron, the finding showed that 56.7% of the participants reported that the waiting period ranged between 5 -10 minutes while 23.3% of the participants reported that they waited for an hour or more. Moreover, 13.3% of the participants reported that the waiting period ranged between 20-30 minutes. On the other hand, 6.6% of the participants stated that the waiting period varies according to the number of patients who were waiting in the clinic.

Table (4.7): Form of therapy provided at community mental health centers in Ramallah and Hebron

Themes	Categories	Frequency	percentage%
The therapeutic process type	- Drug therapy only	24	80%
	- Individual Counseling and drug therapy	6	20%
	Total	30	100%
Duration of the session with the psychiatrist	Ten minutes and below	21	70%
	More than ten minutes	9	30%
	Total	30	100%
Duration of the session with the social worker	Five minutes	22	73.3%
	Ten minutes	8	26.7%
	Total	30	100%
Duration of the session with the psychologist	Half an hour	5	83.3%
	An hour	1	16.7%

The table above shows that 80% of the participants received a drug therapy while 20% of them received two types of therapy; drug therapy and individual counseling / psychotherapy.

In regard to the clinical practices of mental health practitioners related to the therapeutic session duration, the finding showed that the therapeutic session with a psychiatrist classified through two groups due to session duration. It was found that 70% of the participants reported that the session duration was about ten minutes and below, while 30% of them reported that the session duration was more than ten minutes.

In regards to the duration of the therapeutic session with the social worker, it was ranged between five to ten minutes. It was found that 73.3% of the participants reported that the session duration was about 5 minutes while 26.7% of them reported that session duration was about 10 minutes.

In addition, the data analysis showed that 83.3% of those who were seen by a psychologist reported that they had received both types of therapy (drug therapy and individual counseling / psychotherapy) had reported that the session duration was about half an hour while 16.7% of them reported that session duration was about an hour.

Table (4.8): The participants’ awareness level regarding their health condition (mental illness)

Themes	Categories	Frequency	Percentage%
Whether the participants knew about their psychiatric diagnosis or not	Yes	26	86.7%
	No	4	13.3%
	Total	30	100%
Consistency between the real diagnosis and perceived diagnosis in those who answered yes	Consistent	26	86.7%
	Non –Consistent	4	13.3%
	Total	30	100%
Participants’ knowledge of therapeutic plan	Yes I knew	30	100%
Whether the participants were involved in therapy or not	Yes	28	93.3%
	No	2	6.7%
	Total	30	100%
The ways in which the participants were involved	Compliance with medication	28	93%
	Compliance with psychiatrist’ orders	2	6.7%
	Total	30	100%
Who was involved in treatment	Psychiatrist	24	80%
	Psychiatrist and social worker	3	10%
	Psychiatrist and psychologist	3	10%
	Total	30	100%

The data analysis showed that 86.6% of the participants knew their psychiatric diagnosis and the consistency between the real diagnosis and perceived diagnosis in those who knew was 100% while 13.3% of them did not know the psychiatric diagnosis.

All the participants reported that they had knowledge about their treatment plan, and 93.3% of them stated that they were involved in therapy, while 6.6% did not know.

The way the participants were involved was divided into three categories: the vast majority, 93.3% of the participants, complied with taking their medication, 10% complied with the counselor's instructions, and 6.6% complied with the psychiatrist's orders.

The findings showed the team involved in treatment was classified into three categories; 80% of the participant reported that the psychiatrist was the only one involved in the participants' treatment. Also, 10% of them reported that the psychiatrist and the social worker were involved in their treatment, and 10% reported that the psychiatrist and the psychologist were involved in their treatment.

Table (4.9): Ethical practices of mental health practitioners related to the therapeutic process in practice

Themes	Categories	Frequency	percentage%
Education about medication	Participant received education about medication	12	40%
	Participant did not receive education about medication	18	60%
	Total	30	100%
Education about psychiatric illness (the causes and symptoms)	Participant received education about psychiatric illness	19	63.3%
	Participant did not receive education about psychiatric illness	11	36.7%
	Total	30	100%
Whether the therapeutic plan was discussed with the participants	Discussed	20	66.7%
	Were not discussed	10	33.3%
	Total	30	100%
The participant's approval of treatment	Yes	20	66.7%
	No	10	33.3%
	Total	30	100%
Whether the participant signed a consent form	No	30	100%

Regarding the psycho-education process, the data analysis showed that 60% of the participants were educated about their psychiatric medication while 40% of them were not educated about it. In addition, 63.3% of the participants were educated about the causes and the symptoms of their psychiatric illness while 36.6% of them were not educated about either.

The table above shows that 66.7% of the participants reported that the therapeutic plan was discussed with them and they were treated with their consent. On the other hand, 33.3% of the participants reported that the therapeutic plan was not discussed with them and they were treated without their consent. In addition, all the participants reported that they did not sign a consent form.

4.2.3 The results of research question number three:

How do the participants view the therapeutic environment?

Table (4.10): The participants' view about the therapeutic environment

Themes	Categories	Frequency	percentage%
Participant's view of the center's location suitability	Suitable	28	93.3%
	Unsuitable	2	6.7%
	Total	30	100%
Reasons behind the unsuitability of the center's location	The center is far from the main street	2	100%
The existing facilities at the community mental health centers			
Waiting room	Yes	30	100%
Bathrooms	Yes	30	100%
Cafeteria	No	30	100%
Public parking	No	30	100%
Drinking water	Yes	13	43.3%
	No	17	56.7%
	Total	30	100%
Disposable Cups for drinking water	No	11 of those who said that water is available in the center)	84.6%

As shown in the table above, 93.3% of the participants reported that the clinic is located in a suitable place while 6.6% of the participants reported that the location of the clinic is unsuitable and attributed this to the center's location; they considered it far from the main street.

All the participants stated that the existing facilities at the centers had been limited to the existence of a waiting room and bathrooms while lacking a cafeteria and public parking. In addition, 56.6% of the participants reported that drinking water was not available at the center while 43.3% of them reported that it was available.

Table (4.11): The characteristics of the existing facilities at the community mental health centers

Themes	Categories	Frequency	percentage%	
The comfort of furniture in the waiting room	Comfortable	12	40%	
	Uncomfortable	14	46.7%	
	Undecided- normal	4	13.3%	
	Total	30	100%	
The center's temperature according to the weather	Appropriate	13	43.3%	
	Inappropriate	17	56.7%	
	Total	30	100%	
The hygiene level of the center facilities	Good	14	46.7%	
	Bad	16	53.3%	
	Total	30	100%	
	Participants stated that the bathrooms in the clinic are Abandoned	15	50%	
The availability of personal hygiene materials	Toilet paper	Yes	15	50%
		No	15	50%
		Total	30	100%
	Bidet	Yes	15	50%
		No	15	50%
		Total	30	100%
	Hand soap	Yes	12	40%
		No	15	50%
		Sometimes	3	10%
		Total	30	100%

The findings showed that 46.6% of the participants reported that the furniture is uncomfortable while 40% reported that the furniture is comfortable. Also, 13.3% of the participant expressed an average amount of comfortability of the furniture.

In regards to the temperature of the clinic, 56.6% of the participants stated that the temperature in the clinic is inappropriate in various seasons while 43.3% stated that the temperature is appropriate.

Moreover, 50% of the participants stated that the bathrooms in the clinic were abandoned and lacked toilet paper, hand soap and bidet. On the other hand, 50% of the participants stated that hand soap is available.

Forty percent of the 50% stated that the toilet paper and bidet are available. However, 10% stated that toilet paper is not available at all times.

The hygiene level in the facilities is about a topic that was asked about, and it was found that 35.3% of the participants reported that the level of hygiene was bad, while 46.6% reported that it was good.

4.2.4 The results of research question number four:

Are the participants satisfied with the care provided by the mental health practitioner?

Table (4.12): The participants' level of satisfaction with the care provided at the community mental health centers in Ramallah and Hebron

Themes	Categories	Frequency	percentage%
Participants' satisfaction level	Satisfied	18	60%
	Dissatisfied	9	30%
	Partial satisfaction	3	10%
	Total	30	100%
The reasons for satisfaction	Free medication	13 of satisfied	43.3%
	Good quality of service	5 of satisfied	16.7%
The reasons for dissatisfaction	The lack of individual counseling	5 of dissatisfied	16.7%
	The lack of marital/ family counseling	1 of dissatisfied	3.3%
	Dissatisfaction with treatment result	2 of dissatisfied	6.7%
	Degrading of patient's value	1 of dissatisfied	3.3%
The reasons for the partial satisfaction	Lack of privacy and confidentiality	1 of those who partial satisfaction	3.3%
	- Need for other services	2 of those who partial satisfaction	6.7%

In terms of participants' satisfaction, 60% of the participants reported that they were satisfied with the service provided, 30% were dissatisfied, and 10% were partially satisfied.

The reasons for the participants' satisfaction were classified into two points. It was found that 43.3% of the participants were satisfied because the medication was provided free of charge, while 16.7% of them reported that they were satisfied because the quality of service.

On the other hand, 16.7% of the participants who stated that they were dissatisfied with the service provided attributed it to the lack of individual counseling,

One of the participants said on this issue: “I am not satisfied because I do not want just medication. I need someone to talk with. Here they provide nothing but medication.”

A second participant said: “I am not satisfied; the medication alone does not treat me. Sometimes I need someone to advise me and tell me what I should do. In the clinic, the counseling session should be available, but in the event that I ask for it from the social worker, there would no place to sit with her because all the rooms are always being used. One day, I asked the social worker for a session and she told me to wait until a room becomes available. I was waiting for half an hour and then I left.”

While 6.7% of the participants attributed their dissatisfaction to treatment results, 3.3% of them owed it to the lack of marital or family counseling.

One of the participants said on this issue: “I am not satisfied. They should provide better service. In the past; I used to have problems with my wife and my children. I found no one to help me and my family. Currently, I feel helpless. Before, I was working but now I do not work. The clinic provides us with medication but we need more.”

Also, 3.3% of the participants attributed their dissatisfaction to feelings of degrading the patient’s value.

One of the participants said on this issue: “I am not satisfied because we as patients have a feeling of marginalization and neglect compared to other clinics. No one looks at us in the same way as looking at other patient from other clinics. This includes the employees who work with us in the mental health clinic.

The reasons for the partial satisfaction were classified into two points. It was found that 3.3% of the participants who reported about their partial satisfaction attributed it to the lack of privacy and confidentiality.

One of the participants said on this issue: “I am not completely satisfied with the way they provide the service; there is no privacy or confidentiality and this annoys me a lot.”

Also, 6.7% of the participants attributed their partial satisfaction to their needs for other services.

One of the participants said on this issue: “It’s better than nothing, but they should take into consideration our needs for other services that are not limited only to the need for medication.”

4.2.5 The results of research question number five:

What services do the participants receive from the Ramallah and Hebron governmental community mental health centers?

Table (4.13) The services provided by Ramallah and Hebron governmental community mental health centers

Themes	Categories	Frequency	percentage%	
Medical services	Medication	30	100%	
	Reports	7	23.3%	
	Medical transfers	4	13.3%	
Therapy types	Individual counseling/ psychotherapy	Yes	6	20%
		No	24	80%
		Total	30	100%
	Group counseling/ psychotherapy	Yes	1	3.3%
		No	29	96.7%
		Total	30	100%
	Family counseling/ psychotherapy	No	30	100%
	Occupational therapy	No	30	100%
	Other services	Vocational training	No	30
Psychological examinations		No	30	100%
Psychological reports		No	30	100%

The study examined the services provided in both centers. All the participants stated that they had received medication from the centers. In addition, 23.3% stated that they

had received reports services. Also, 13.3% stated that they had received medical transfer services.

In addition, 20% of the participants stated that they had received individual counseling / psychotherapy services at the centers while 80% of the participants reported that they did not receive it.

The vast majority, 96.6%, stated that they did not receive group counseling / psychotherapy services, while 3.3% of the participants stated that they did.

The findings indicate that none of the participants received any of the following: family counseling/ psychotherapy, occupational therapy, vocational training, psychological examinations and psychological reports.

Chapter V: Discussion & Recommendations

5.1 Introduction

5.2 The discussion of research question number one

5.3 The discussion of research question number two

5.4 The discussion of research question number three

5.5 The discussion of research question number four

5.6 The discussion of research question number five

5.1 Introduction

This chapter discusses and interprets the main findings of the study with respect to the literature review studies previously conducted. In addition, the characteristics of the participants and their answers to the questionnaire items are discussed.

5.2 The knowledge of the participants about the rights of patients with mental illness in general.

The study finds that over half of the participants (53%) did not know their rights while the others stated that they have knowledge about their rights. This is in line with a literature review conducted in Egypt by Mohammed et al, (2018). They found that the majority of the patients, 76%, were not aware of their rights. Another study in Iran found that the majority (58.9%) of study sample had poor knowledge about their rights (Yaghobian et al.,2014).

The results of the current study showed that over half of the participants did not know their rights which may indicate that they were not informed about their rights by the mental health team at the CMHCs or by any member of their families. Also it's possible that they were informed about their rights but in case of some of mental disorders such as the psychotic disorders may affect the people' perception, consciousness and their ability to understanding the meaning of the rights concept and this may lead them to give answers not accurate or reliable. This highlights the importance of giving written information regarding the legal rights to people with mental illness at the first contact with the health practitioners. The purpose of this is to educate them about their rights and to improve their capacity to exercise these rights.

The rights of patients with mental health problems are guaranteed by several conventions and declarations all over the world that stipulates the importance of human

rights education and raising awareness of people suffering from mental illness. Principle 12 in the UN Resolution 46/19,1991, addressed the importance of informing patients with mental illness as soon as possible about their rights and how to exercise them using language that is easy to understand. According to WHO (2001), mental health is the most neglected area of health policy and programming. This affects the quality of service provided to people with mental illness and is related to the lack of a clear vision for mental health care.

In 2010, The Pharmacy Board of Australia published a code of conduct for health practitioners in order to improve the quality of service, and to ensure greater respect for human rights. The Pharmacy Board emphasized on the importance of informing the health user about his/her rights at the first contact with the health practitioners. According to the first Palestinian National Health Plan (1994), educate the public on mental health issues is a priority areas and it also continues to be considered one of the priority areas in following health plans.

These findings above raise concern about those who do not know their basic rights as patients because this means that they cannot determine if these rights are violated or not. Also, they cannot take advantage of these rights. It is difficult to pinpoint what is happening in these centers for there to be such a gap of knowledge regarding the patients' rights. If the rights of these people were violated, they themselves will not know.

During the researcher internship at two governmental CMHCs in the 2018, she found that one of the centers has a poster listing the patients' rights and obligations on the wall of the entrance of the primary health care building where the CMHC is located while the other one does not have. However, this is not sufficient to improve the capacity of those with mental disorders in exercising their rights.

The researcher views that there is a need to develop a clear vision that emphasizes the importance of embracing and fostering a patient rights culture, especially among those having mental illness. This requires action at all levels, governmental and non-governmental. The MOH has to intensify their efforts to strengthen the culture of human rights through formulating a national code of ethics and conduct for health practitioners, monitoring the implementation, and developing a judicial proceeding for professional misconduct or violation of the rights of a patient.

5.2.1 Perception of the rights as reported by those who answered that they know their rights.

It was important to know about which rights the participants knew to be their rights in order to find out the magnitude of the problem. The findings indicated that among the participants who reported that they know their rights, 50% of them knew of their right to be treated, 42.8% knew about their right to privacy and confidentiality, 21.4% knew about their right to respect and to receive treatment without interruptions, 14.3% knew about the right to have efficient time in the therapeutic session, and 7.1% of the participants knew they had the right to be treated with dignity.

The findings indicate that the participants are somehow oriented. It is possible that they were informed about their rights by someone. Another interpretation could be that the participants are well educated and maybe they gained that information during their education (44% of them with an academic degree). This could also be attributed to their interest in human rights issues, and maybe they gained that information through reading books, leaflets or media.

Having the efficient time in the therapeutic session is considered the heart of therapy because this allows the patient to ask freely about his psychological condition (Aadland, E.

2000). However, the great majority of the participants (85.7%) among those who said they know their rights did not know that they had the right to have enough time in the therapeutic session. This led to negligence of the importance of identifying the illness symptoms, evaluating the psychological condition, explaining the therapeutic plan and follow up with the patient.

In regard to the source of the participants' knowledge about their rights. The vast majority (93%) stated that the source of their knowledge was "self-knowledge". None of the participants said that they gained that information from the CMHCs' team members, which points to the importance of having a CMHC's vision supported the need of educating people with mental illness about their accrued rights in the therapeutic context. Educating people with mental illness about their rights is considered one of the main tasks of the mental health team (Pharmacy Board of Australia, 2010). To reach this, the mental health team should be qualified, and trained, and should believe in the importance of individual rights.

The researcher views that there is a dire need to intensify the MOH's efforts to develop ministerial guidelines, stresses the need to inform the users of mental health services about their basic rights at the beginning of the therapeutic relationship with MHP, and from time to time during the therapeutic process. Additional efforts must be made to disseminate the culture of rights; preparation and distribution of information leaflets, TV programs, organization of workshops and meetings for the families of individuals with mental illness about the basic rights as human beings firstly and then consequently their rights as patients.

5.2.2 Participants' perception of the availability of the following rights during receiving treatment: the right to privacy, confidentiality?

In regard to the right to privacy, it was found that 77.66% of the participants stated that privacy was non-existent while receiving treatment. This violation of their most fundamental rights, rise serious concerns and call for change on this regard.

All the participants stated that people they did not know interrupted the therapeutic session by entering the room while they were present. It could be indicated that there is a violation of the right to privacy by the mental health staff members, or others that must be taken into account from the moment the patient enters a center until the moment of discharge from the therapeutic zone.

All the participants stated that none of the health team had obtained the patient's permission nor informed them about the people present in the therapeutic session. According to Health & Care Professions Council, the right to privacy included receiving treatment in a manner that guarantees the privacy of the patients. The right to be alone with the health practitioner in a therapeutic room organized for delivering therapeutic services ensures the patient's right to refuse or accept the existence of others from his/her family, or from any other party to be present in the therapeutic setting. Any violation of these rights is considered a violation of the patient's privacy (HCPC, 2012).

Eighty three point three percent of the participants stated that they did not know about their right to refuse the presence of people they do not know in the therapeutic setting. This means that the majority of the participants did not know this part of their rights by themselves and maybe none of the health team at the CMHC's has explain to them about their right which indicate to the scope of the problem.

Generally, every patient in any health facility has the right to accept or reject the presence of others in the therapeutic session, and it is required from the mental health

practitioner to ensure obtaining informed consent of the patient. Therefore, it is essential for mental health practitioners who work at CMHC's to respect the patient's rights and obtain their consent if students or trainers exist in the therapeutic room.

Every government must commit to establish a code of ethics for all the ministries that are administered. The MOH is one of these ministries that require establishing a code of ethics and conduct for all of the mental health practitioners according to their specialty. Also, there is a need to develop detection mechanisms for non-compliance which is a necessity to ensure that the therapeutic environment is free of any kind of patients' rights violation.

Conducting more studies on this topic is important to develop a broader understanding of how the therapeutic sessions are held at all CMHCs.

In regard to the right to confidentiality, 66.6% of the participants believed that their files were confidentiality preserved. This could mean that they have kind of confidence in the filing system. It could be possible that they are educated about the filing system and the level of confidentiality for records by the MHP's at the CMHC's.

On the other hand, 16.6% of the participants believed that their files were not confidentially preserved, while 16.6% of them did not know whether their files were confidentiality preserved or not. Many interpretations could be possible for these findings. Some mental disorders have symptoms which are psychotic in nature such as paranoid schizophrenia, delusional disorder, etc., which could lead to lack of trust. It could also be possible related to their own personal experiences with the health team if they had been experienced in the past the violation of their confidentiality, which may lead them to lack confidence in the whole system. In addition, there is possibility that they are fairly ignorant on the subject not educated about it by the team of the CMHC's.

In regard to filing system, 53.3% of the participants reported that their files were kept in the registration room /files room, 20% reported that the files were kept on the computer, 6.6% of the participants said that their files were saved in the doctor's room and 10% reported that their files were saved in the floor below the center. However, 10% of the participants stated that they did not have any knowledge about where the files were saved.

The findings above indicate that there is a difference in the filing system between the two centers. Over half of the participants reported that their files were kept in the registration room which indicates that there is a manual method of documenting the proceedings of the therapy (records keeping), while the other center has an electronic method.

Some of the participants' answers were not relevant, such as mentioning that their files were saved in the floor below the clinic. This could be attributed to a lack of understanding on their part, or to limited capacities, lack of concentration, confusion and state of disturbances resulting from the mental illness. This requires that the health practitioners make further efforts to simplify things in order to help the patients develop a state of awareness as much as possible.

In regard to the access to proceedings of the session, health status and the safekeeping of patient information, 66.6% of the participants stated that the therapeutic team kept their information confidential and the issues discussed in the therapeutic room remained confidential. This may indicate that they are confident that no one of the health practitioners will disclose their secrets. Maybe they are informed by the practitioners about the basic code of ethics for health professionals.

On the other hand, 33.3 % of the participants did not believe that the issues discussed in the therapeutic room remained confidential, and they did not think also that the

therapeutic team kept their information confidential, and attributed it to two reasons; interruptions, breach of confidentiality by health practitioners.

As is widely known, a therapeutic alliance has never occurred without establishing a relationship between the healthcare professional and the client in order to allow him/her to explore the safety concept. Safe space is strongly linked with the confidentiality concept and results in establishing a trust relationship between the client and the healthcare professional (Department of Health, 2003).

All the participants reported that all the staff in the clinic had the ability to access and read their files, which is a common practice in hospitals and clinics especially public ones. Any staff members can see the files if he/ she is working with the patient. It is assumed that all mental health workers or staff is capable to protect patients 'secrets and data as a basic code of ethics for health professionals. Inform the users of the CMHC's about the code of ethics related to privacy and confidentiality is highly important, helps them to feel safe and secure, and also has an impact on achieving positive outcomes in therapy.

5.2.3 The violation of participants' rights

This part aimed to interpret the findings related to participants' meaning of the violation of their rights and how violation occurred. The study found that 66.6% of the participants reported that their rights have not been violated. This is good indicator which means that they received good service at the CMHC's (rights- based), and free of human rights violation.

Of the participants that stated that their rights have been violated which constituted 44% of the total population, 70% (7participants) of the participants stated that they encountered a situation where they felt degraded, disrespected, and ignored by health

practitioners. It could indicate that their right to be treated with respect and dignity has been violated. It could be that none of the health team has listened to their concerns, asked for their opinions, or involved them in treatment and decision making as possible. The first article of the Universal Declaration of Human Rights obliges the all, including the public health- care workers to respect the dignity of all human being (UN General Assembly, 1948). Each MHP has responsibility for ensuring that the rights of all patients are respected, and they are treated with dignity. To reach this, the MHP should be qualified, professional and believe in rights- based service delivery.

In addition, 60% (which constituted 5 participants) said that they experienced the loss of confidentiality while receiving treatment. It's possible that there were people who do not know in the therapeutic room, and they think that they will breach the confidentiality. May be they are suspicious and do not trust the team. It could be that they do not know that there is a code of ethics for MHP to ensure the confidentiality of their clients. Maybe none of the health team at the CMHC's has explained to them that everything you said in the session will be confidential. Also, it could be related to pathological symptoms of some mental disorders have such as the psychotic disorders.

Moreover, 50% (which constituted 5 participants) of the participants who stated that their rights have been violated, said that there were interruptions in the therapeutic room. This violates their right to privacy and the right to invest the therapeutic time in the best possible way. The care provided should be patient- centered care, which emphasize on the patient's right to be the center of the health practitioner's attention for the entire session.

According to Williams (2004), interruption affects the quality of care provided, breaks the flow of the session, distracts the patient's attention, annoys them, and increases the possibility to create negative feelings such as the feeling of being unimportant or

valuable. This highlights the importance of taking steps to prevent interruptions during the therapeutic session, in order to ensure that the therapeutic atmosphere is existed. Interruptions could be addressed by using signs such as “do not disturb” to inform everyone in the CMHC’s; patients and staff members, cellular phones should have the ring off, etc.

Thirty percent (3 participants) reported that their right to privacy has been violated. It could be possible that there were people who do not know in the therapeutic session (students). Maybe they had been asked about personal things in front of others which let them feel that their privacy had been violated. This is in link with literature conducted in the UK by Doshi et al. (2006). They found that patients did not prefer to discuss their personal issues in front of the medical students. Also, most of them had experienced anxiety before the student-patient interview which was evident during the interview.

According to Cordinhoto et al. (2009), three things should be taken into consideration to provide good care. First, the existence of a specialized, qualified, and trained team of mental health practitioners who are able to deliver the service within the standard of professionalism. Second, a team of specialists aware of and adhere to the professional values. Third, the workers must believe in delivering care in a humanistic way that ensures the dignity of their patients.

Another interpretation could be related to the nature of the CMH centers’ infrastructure. The CMHC’s lacked of the therapeutic room for conducting therapeutic sessions. The two centers have a number of rooms organized to be offices but used also for therapeutic purposes. Many of the MHP’s sharing a room with another staff member which violate the privacy of their client. An appropriate infrastructure should exist in the therapeutic setting in order to enhance service delivery and to exercise

professionalism. The infrastructure includes having enough therapeutic rooms for all staff members to allow them to exercise their work professionally.

The WHO published an interview with Dr. Bassam Ashhab, who was psychiatrist and director of the community mental health department, mentioned this problem in his talk as a problem that existed five years ago, stating: *“most of the public community mental health centers were functioning as clinics rather than community mental health centers. Each ‘center’ consisted of three rooms or less, and the psychiatrist, psychologist and social worker had to exchange the rooms between them when they were seeing a patient. For the staff and patients, this caused feeling of instability, disorganization and insecurity”* (WHO,p 30. 2006).

This indicates that the problem is still exist and needs to be tackled. If the infrastructure is fairly good at the center, it is essential to check other aspects related to the qualification of the mental health practitioners, evaluate the situation of the CMHC, and develop programs aimed to keep them up to date in the best practice is approved internationally. The purpose of this is to provide a good quality of service that is free of violation in all of its forms.

Almost half of the participants in this study reported that their rights have been violated. Determining the scope of the problem is so important in order to tackle it. People with mental illness all over the world are vulnerable to abuse, mistreatment, stigmatization, discrimination and violation of their basic rights (Comer, 2011). This situation emphasizes the need to set rules to protect people who lost part or all of their cognitive functioning from being mistreated, and to ensure that they will be treated with dignity.

5.3 How do the participants view the clinical practices of mental health practitioners?

5.3.1 The reception procedures

The findings related to procedure of patient admission to the Palestinian CMHCs indicated that more than one health practitioner took over the task of patient admission to the CMHC. Sixty-three percent of the participants reported that they were admitted by social workers, 19.9% reported that they were admitted by psychologists, 13.3% reported that they were admitted by those who work in the clinic without knowing their job title, and 3.3% stated that it varied from time to time.

As is well known, each staff member in the CMHC has a specific job which is integrated with the functions of the other staff members in order to provide comprehensive care (Bloom and Williams, 1994). The findings above give us an indication that there is an overlap of roles between the CMHCs' practitioners and an absence of a case manager. This may be due to the lack of a clear job description for everyone who works in the centers.

Several conventions and declarations all over the world guarantee the rights of people with mental disorders. The right to information had been mentioned in the UN Declaration of Human Rights in 1984, The UN Convention of the Rights of Persons with Disabilities, The UN Principles for the Protection of Persons with Mental Illness, the Improvement of Mental Health Care (MI Principles, 1991), Caracas Declaration, and Madrid Declaration.

These declarations stipulate the importance of human rights education and raise awareness of people with mental illness in order to increase their insight and achieve the effective involvement in therapy. In order for this to be achieved, , it is required from the MHP on continually informing people with mental illness about their rights in order

for them to be actively and effectively involved in the process of therapy (Martin, 2000).

In regard to the participants' view, various points of view have been expressed. It was found that 53.3% of the participants viewed the reception procedure positively and attributed it to a sense of gratitude related to receiving treatment free of charge. On the other hand, 30% of the participants viewed it negatively and attributed it to the lack of privacy, confidentiality and the presence of interruptions that existed in their therapeutic experiences with health practitioners. Also, 16.6% were undecided as to whether they had a positive or negative experience.

As mentioned before in the discussion of research question number one, there is a relation between the patients' knowledge of their rights and their ability to evaluate the services received. In light of the findings above, over half of the population linked the process of service evaluation with the fact that treatment is free of charge. The right to treatment is considered one of the basic rights that all humans have. Those who do not know his/her right to free treatment will evaluate services with a lower point of satisfaction (Brdekin, Guilfoyle and Hall, 1993). As it is well known, ensuring the privacy and the confidentiality of patients for each stage of treatment is highly linked with the positive outcomes related to patient's service evaluation (Barak et al., 2001).

The study investigated the average waiting time for participants visiting the CMHCs. The findings indicate that 56.6% of the participants reported that the waiting period ranged between 5 -10 minutes, 23.3% reported that they waited for an hour or more, 13.3% of the participants stated that the waiting period ranged between 20-30 minutes, and 6.6% said that it was not accurate and related to the number of patients who were waiting in the clinic.

Over half of the research population stated that the waiting period ranged between 5 -10 minutes, while the rest of the study population reported that it ranged between 20 -30 minutes to an hour or more.

5.3.2 Form of therapy provided at both CMHCs - therapy's approach

The findings indicate that there are two forms of therapy delivered at both CMHCs. Eighty percent of the participants reported that they received medical services, while 20% of them received two types of therapy: drug therapy and individual counseling. This means that the therapy's approach adopted in these centers is medically oriented, and it could be related to several causes, including the caseload volume at the CMHC's, psychiatrist's beliefs and attitude in treatment, and the shortage of psychiatrists and psychologists in Palestine, as well as shortage of practitioners with relevant clinical skills in counseling and psychotherapy for the individuals, couple, family, and group therapy.

None of the participants received any of the following services; family counseling/ psychotherapy, occupational therapy, vocational training, psychological examinations and psychological reports. This is in line with a literature review conducted in the West Bank, Palestine by Marie et al. (2016). They found that mental health care in Palestine need development; increase the availability and the quality of mental health services, to better meet the needs of people with mental health problems.

This affects the capacity of people with mental illness to manage their illness, and its symptoms. Moreover, individuals with mental illness have a strong need for receiving psycho- social programs and rehabilitation services, aimed at developing their functionality, and enabling them to integrate into the community. Non- delivery of such services will decrease the possibility of integrating them into the community.

According to Hughes (1994), people with mental illness have several needs, both medical and non-medical, in order to achieve and emphasize the continuity of care. The continuity of care cannot be achieved merely by providing medical services, but it also requires providing several types of community based mental health services which are currently known as the rehabilitative services.

Generally, the function of CMHC is to provide medical and non-medical care (comprehensive care) for people with mental illness in the context of their environment, aimed at reducing the level of hospitalization and to help them integrate effectively into society. The efficacy of this has been proven by a number of models of service delivery such as the Training in Community (TCL) Model, and the Assertive Community Treatment (ACT) Program. These models are kind of service delivery that developed in the 1970s to provide a range of medical, psychological, and rehabilitative services to people who were at risk for re-hospitalization. The evaluation results of these models emphasized the efficacy of this approach in helping people with mental illness cope with the illness and manage their lives (Test, 1992).

According to a study conducted in Australia by Flannery et al. (2011) to identify best practice in the field of mental health service delivery models. They found that in order to provide a comprehensive, integrated care model of CMHSs, a range of components should be existed, which are: provision of acute and emergency response, continuity of care - community based, the availability of a rehabilitation team, and build a partnership with general health practitioners and human services agencies.

Over half of the participants did not receive psycho- education about the illness they had, which affects their ability to manage their illness and their lives. Educating people with mental illness about their psychiatric illness is the basic tenet of mental health care; it gives them the opportunity to identify the early warnings and help them to manage

their psychiatric illness. A study conducted in the UK by Davis et al. (2011). They found that attending a psycho-education course before initiating therapy had a significant effect on reducing the level of psychological distress of patients. Another study was conducted in Iran by Sharif et al. (2012) found a significant effect of family psycho-education in reducing patients' symptoms and on family caregiver burden.

In order to offer a variety of services, the therapeutic environment must be available and appropriate. As indicated earlier that both CMHC's lacked of therapeutic rooms for providing therapeutic services such as individual counseling /psychotherapy, group counseling / psychotherapy, or any kind of rehabilitative services. Moreover, both centers have offices that used for multiple purposes, including the therapeutic one. In turn, this affects the quality of care provided, and does not meet the multiple needs of people with mental disorders.

In the field of mental health, rehabilitative services help people with mental illness to meet their needs for assistance with social relationship, vocational skills, and self-care. If all these needs are achieved, a favorable environment will be available for them to restore their ability to live and manage their lives effectively (Test, 1990).

All the data presented above gives us indications of the magnitude of the problem and also gives us an interpretation for adopting the medical approach in treatment of the patients who come to the CMHC. Medical model preferred also because people tend to look for simple solutions to complex problems, in a search for a magic pill.

5.3.4 The participants' awareness level related to the health condition (mental illness).

The study findings indicate that 86.6% of the participants knew their psychiatric diagnosis and the consistency between the real diagnosis and perceived diagnosis in

those who knew was 100%, while 13.3% of them did not know their psychiatric diagnosis. According to the non-demographic characteristics of the study sample related to type of medical diagnosis, 60% of them had a non-psychotic disorder diagnosis, while 40% had a psychotic disorder diagnosis. The capacity of people with mental illness to understand their illness, diagnosis, and treatment depends on the kind of illness, severity of the disability, and the impaired body part (Banerjee, 2004).

For the involvement of participants in therapy, 93% of the all participants reported that they were involved in therapy; the great majority of them expressed their involvement in therapy by complying with taking the medication. This finding emphasizes that the approach adopted in therapy at the CMHC's is medically oriented, which affected the ability of the participants to understand the real meaning of patient involvement in therapy and restricted it to compliance with medication.

All the participants had knowledge about the treatment plan and the team involved in therapy, 80% of the participants stated that the psychiatrist was the only one involved in the treatment, 10% reported that the psychiatrist and the social worker were involved, and 10% said that the psychiatrist and the psychologist were involved. The great majority of the participants' view that the psychiatrist was the only one involved in their treatment.

This can be explained by the fact that people like to be seen by doctors, and the fact that the CMHC centers are doctors- centered which indicate to the magnitude of the problem that need to be tackled.

The quality of these information indicates to the absence of a clear mental health policy that emphasized the importance of meeting the multiple needs of people with mental illness that goes beyond the need for the psychotropic drugs to the need for providing a

comprehensive treatment. According to WHO (2005), mental health policy is one important way to improve the lives of people with mental disorders.

Sixty-seven percent of the participants reported that the therapeutic plan was discussed with them and they were treated with their consent, 63.3% of the participants were educated about the psychiatric illness (causes, symptoms and medication). This is a good practice which means that those participants had been informed about their right to consent to treatment, educated about the illness, pathological symptoms, and medication by the staff members at the CMHC's.

Education is one of the most important tasks of MHPs that support and encourage people with mental illness to be involved in therapy in order to achieve good outcomes (Duncan, 2010). According to Haddad (2002), educating the MHSs users about the illness, plays an important role in increasing their ability to manage the illness, improve the quality of life, and helps them to effectively integrate into society.

All the participants reported that they did not sign an informed consent form. As far as the researcher knows, the Palestinian MOH and its facilities used an informed consent form. It is possible that they were not signed an informed consent form, and this raise concerns about the form of care delivered to them. It is patient- centered care or not?

Another interpretation could be that one of his family members had been signed on his behalf if he unable to give informed consent. Moreover, it could be that they signed the consent form without being fully aware of what they are signing? This highlights the need to inform the people with mental illness about the procedures before obtaining their informed consent. Provide them with sufficient information in a language which is easy to understand to ensure that they are aware of the purpose of the procedure. Aware of what they are signing for? And what is written in the form?

With regard to the duration of the therapeutic session, 70% of the participants reported that the session duration with the psychiatrist was about ten minutes and below, while 30% reported that session duration was more than ten minutes. To discuss this issue, the researcher presents information gained during the period of the internship in the Palestinian CMHCs. The daily average of patients that visit the CMHCs was between 60 and 70 patients. Moreover, the CMHCs do not have a reservation system because of the huge case load. In light of that, what is the maximum number of patients that a psychiatrist can see per day? Psychiatrists, who are seeing 60 – 70 patients per day, can give 8.5 minutes or less to each patient if there are no interruptions during the sessions. If there are interruptions, service time will automatically decrease. It is impossible to provide psychiatric services with that kind of average time per patient in light of acute shortage of psychiatrists.

According to the Royal College of Psychiatrists (2014), psychiatrist has an important role in promoting and ensuring the participation of patients in treatment. The patient has the right to be involved in treatment, and for that, psychiatrist must explain to them the illness and its modes of treatment, the advantages and disadvantages of each one, give them the time to ask about their health conditions to enhance the involvement of patients in therapy. This highlights the need for making changes in the way service is delivered. Ten minutes is not enough to check up with patients to see how things are going with them, engage in discussion about what other interventions may help such as improving sleep, exercise, nutrition, social activity and etc.

As regards the duration of the session with the social worker, 73.3% of the overall ratio of 20% reported that the session duration with the social worker was about 5 minutes, while 26.7% of them reported that session duration was about 10 minutes. This means that these sessions is not therapeutic sessions that work on tackling the issues that

concern patients. It could be kind of follow up procedure that used by social workers to record some details related to patient's health condition before seeing the psychiatrist. It is also possible that the way the social workers work is affected by the unavailability of therapeutic rooms in the CMHC's. Every staff member including social workers, need some kind a therapeutic environment to provide a good quality of care.

According to 20% of the participants who reported that they received counseling services, 83.3% of them stated that the duration of the session with the psychologist was about half an hour, while 16.7% reported that session duration was about an hour. The majority received 30 minutes of counseling which is not enough time to work on complex issues and emotional difficulties. It could be related to the unavailability of therapeutic rooms, and to the fact that the staff members at the CMHC's have to exchange the rooms between them when they want to see a patient, which affect the way they work, and the quality of service delivered. This highlights the importance to tackle these issues as soon as possible. The Palestinian MOH should take action on a priority basis to improve the infrastructure of these centers, being in mind meeting the standards of therapeutic design of mental health facilities in order to improve service delivery.

The vast majority of the participants did not obtain any other services beside the medical therapy, which means that the care provided at the Palestinian CMHCs does not meet the needs of the most vulnerable group in society. A comprehensive care must be existed to meet the needs of people with mental illness, especially in the field of developing mechanisms for coping with the burden of mental illness, development of life skills that include interpersonal communication, and social interaction. According to WHO (2001), the principles of care are embodied in diagnosis and intervention, continuity of care, a wide range of services, partnerships with patients and families, involvement of the local community, and integration into primary health care.

5.4. The participants' view about the therapeutic environment

The findings indicated that (93.3%) of the participants reported that the CMHC is located in a suitable place, while (6.6%) which constituted two participants reported that the location of the clinic is unsuitable and attributed this to the center's location being far from the main street. The vast majority of the participants had a positive view with regard the location of both CMHCs. This could be related to the ease of transportation available in both areas. One of the centers is situated in the building of the primary health care facilities that is located no further than 300 meters from the main street while the other one is situated in downtown of the city in a building on the main street. This increases the willingness of individuals with mental illness to seek care, and promotes their integration into local communities which is good compared to the previous period where people with disabilities were isolated from society and placed in facilities that were located in remote locations outside of the cities 5(Taggart et al.,2008).

5.4.1 The existing facilities at the Palestinian CMHCs.

The study examined the type of facilities that exist in the both CMHCs. All the participants stated that the facilities are limited to the existence of a waiting room, bathrooms, and lack a cafeteria and public parking. The findings indicate that the Palestinian CMHC's have some of the necessary facilities, and lack of other necessary infrastructures to provide kind of high quality of care, which is not compatible with patient- centered health care.

According to Rajendra (2012), creating spaces for patients and their caregivers to park, have a great impact on their physical and mental wellbeing. Health care users have a lot of difficult issues to deal with, which means that it does not make sense to add

additional stress to their care experience. Enhancing the experience of mental health services' users should be the first priority for managers of any healthcare facilities, in order to facilitate access to health services without any kind of barriers.

Fifty percent of the participants stated that the bathrooms are abandoned and lacked the following: toilet paper, hand soap and a bidet. In addition, 40 % of the participants reported that hand soap was available while 10% stated that it was sometimes available. Fifty three point three percent of the participants reported that the level of the hygiene was bad. Forty six point six percent of the participants reported that the furniture is uncomfortable, while 40% reported that it is comfortable, and 13.3% said that it is neither comfortable nor uncomfortable. In regard to the temperature at the CMHCs, 56.6% stated that it was inappropriate in various seasons.

The findings above showed that there is a clear division of participants' views in relation to the existing facilities as well as the extent of use. This division could be attributed to the differences in the status of both centers. One of the centers is newly built and is undergoing maintenance. On the other hand, the other one is situated in an old building that lacked maintenance work for so many years.

According to the WHO (2005), the provision of a safe and hygienic environment is considered a health concern. Chapter five, article 5.3.1 of the WHO resource book on mental health, human rights and legislations, stressed the significant role of the therapeutic environment in enhancing the well-being of patients in health care facilities. Fifty-six percent of the participants stated that drinking water was not available at the center. However, 84.6 % of those who stated that drinking water was available at the center said that the center was lacked disposable cups to drink water. This violates one of the basic rights of care users. Provision of water in primary care centers is one of the

main roles of the Palestinian MOH, and it was incumbent on them to ensure the provision of it.

According to Pressley & Heesacker (2001), Ulrich et al. (2003), Stevenson (2000), Devlin & Arneill (2003), and Schmidt (2007), physical environments can influence the individuals' affect and behavior, and it plays an important role in the patient recovery process. This is in line with a literature review conducted in Turkey by Onosahwo et al, 2016. They found that a well- designed setting had a significant role in the healing process of patients in health care facilities.

In light of the study findings and in light of the literature review conducted in this field, how can the physical environment influence the service users in both centers? How can they deal with the unavailability of human basic needs which include food, drink, and warmth? Institutions lacking adequate health care and facilities to prevent the spread of infectious diseases may not have sufficient facilities to maintain a minimum sanitation and hygiene standard.

5.5 The participants' level of satisfaction with the care provided at both CMHCs.

In terms of participants' satisfaction, 60% of the participants reported that they were satisfied with the service provided and attributed it to two points: 43.3% of them attributed it to the fact that treatment was free of charge while 16.7% of them attributed it to the good quality of service. This is in line with a study conducted in Gaza by Abu Sedu (2007). The researcher found that 87.4 of the clients were satisfied with mental health services provided by the primary health care centers.

The findings indicate that over half of the participants were satisfied with care received, and it was found that the majority of them attributed their view to the fact that treatment

was free of charge. It is possible that they received a good quality of service but the most important matter to them is the fact that treatment was free of charge. This could be related to their inability to afford treatment according to their low economic status. This is in line with a study conducted by Lopez et al. (2006); that found the majority of people with mental illness face many barriers in attending school and finding employment, which affects their economic status. As it is widely known, mental illness is closely linked with poverty (WHO, 2007).

Locally, the poverty rate increased to 29% in the year of 2017. Thirteen point nine percent of individuals who was living in the West Bank suffered from poverty in the year of 2017, and 5.8% suffered from deep poverty (PCBS, 2018). This highlights the need to improve the economic conditions of people with mental illness to guarantee decent living conditions.

Only a very small percentage of participants 16.7% expressed their satisfaction with care provided, and contributed it to receiving a good quality of service. It could be related to meeting the needs of the participants; medical and non- medical. A study conducted in Ethiopia by Woldekidan et al. (2019) found that 77.6% of the participants were satisfied with the outpatient care, and it was related to receiving a useful advice and explanations from the MHPs, and it was related to receiving a useful advice and explanations from the MHPs.

The participants in both studies attributed their view of satisfaction to different factors. This is normal and meaningful- related to differences in participants' perceptions of their personal experiences.

On the other hand, 30% of the participants were dissatisfied with the service provided. The reasons for participants' dissatisfaction were classified into four categories: 16.7% attributed their dissatisfaction to the lack of individual counseling, 6.7% attributed it to

dissatisfaction with the outcomes of their treatment, 3.3% owed it to the lack of marital / family counseling, and 3.3% attributed their dissatisfaction to feelings of degradation of the patient's value.

This is in line with a study conducted in Canada by Hasler et al. (2004). It was found that patients' satisfaction was not related to pharmacotherapy itself, and that the reduction of pathological symptoms and changes in the interpersonal area were considered as important outcomes associated with patient satisfaction. This highlights the importance of meeting the non- medical needs related to development of interpersonal skills that allow them make changes in their lives.

In addition, 10% of the study population was partially satisfied. The reasons for partial satisfaction were classified into two points: 3.3% attributed it to the lack of privacy and confidentiality while receiving treatment and 6.7% attributed it to their needs for other services.

This is in line with a study conducted by Seila, et al. (2008), which looked at the quality of care perceived by patients and how it affected their level of satisfaction. They found that there is an association between lower patient satisfaction and the following items: ineffective communication, poor interpersonal empathy, and longer outpatient waiting time. Another study was conducted by Hasler, et al. (2004). They found an association between the reduction of symptoms and changes in the interpersonal field (treatment outcomes) with patients' satisfaction. According to Aragon (2013), level of patient satisfaction is highly linked with the quality of care provided and outcomes of the care.

5.6 Recommendations

5.6.1 Recommendation for Policy makers

- Develop policies and legislation on mental health that uphold human rights and the development of community care – Mental Health Act.
- Devote more attention to mental health, and increase funding and human resources for improving the mental health services provided.
- Ensure that policies in the field of the primary health care, act to promote mental health and protect human rights
- Set codes of ethics, conduct, and practices for mental health workers at all the health facilities
- Develop mechanisms for monitoring and evaluating the therapeutic process in all mental health facilities for ensuring that the rights of patients are respected.
- Continuous professional development - provider training courses to all the health workers on mental health issue, and the provision of care within a human rights framework.
- Encourage and support the research work on the topic of the current research, or any topics that stems of interest to health professionals from this topic.

5.6.2 Recommendation for Health care workers

- Mental health professionals in Palestine should give attention to promote and protect the rights of people with mental disorders.
- Advocate patients' rights; provide support, counseling, and psychotherapy if needed to those who experienced violation of their rights in the therapeutic setting.
- Mental health professionals should increase their knowledge and capacity about the updates in the field of treatment and care of people with mental health issues in order to provide a good quality of care.

- Knowledgeable in international human rights law and national laws that promote and protect the rights of disabled peoples.
- Commit to work within the framework of patient's rights; respect the dignity, freedoms, and encourage the autonomy of their clients.
- Adopt the policy of involving people with mental health issues in creating their treatment plan due to its positive impacts on the recovery process.
- Work on encouraging the involvement of families in the treatment and care of their relatives to facilitate a better understanding of the illness, and to provide support to people with mental disorders.
- Educate the clients about mental health conditions, and raise awareness of the rights of people with mental disorders.

5.6.3 Recommendation for further studies

- Conduct further quantitative and qualitative studies to explore the experiences of the patients with mental disorders in other Palestinian governmental community mental health clinics.
- Conduct more researches to find out if people with mental illness are informed about their legal rights in the therapeutic facilities.
- Conduct quantitative researches on larger samples, in order to determine the magnitude of rights violations of people with mental disorders in Palestine.
- Conduct more qualitative studies to determine the forms of rights violations of people
- Conduct more studies of similar types that are reaching to people with poor compliance or those who left services to switch to private clinics.

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Appendix A: Study instrument- Arabic version



جامعة القدس

دائرة الصحة العامة

برنامج الصحة النفسية المجتمعية / مسار العلاج النفسي

"الممارسات الاكلينيكية للعاملين الصحيين اتجاه المرضى النفسيين الذين يتلقوا العلاج في مراكز الصحة النفسية الحكومية الفلسطينية"

عزيزتي المبحوثة / عزيزي المبحوث:

تحية طيبة وبعد...

تقوم الباحثة بدراسة ميدانية حول الممارسات الاكلينيكية للعاملين الصحيين اتجاه المرضى النفسيين الذين

يتلقوا العلاج في مراكز الصحة النفسية الحكومية الفلسطينية، وذلك لنيل درجة الماجستير في تخصص الصحة

النفسية المجتمعية - مسار العلاج النفسي من جامعة القدس، لذا أرجو من حضرتكم التعاون بالأجابة على اسئلة

المقابلة، مع تأكيدي لكم بأن جميع البيانات سيتم التعامل معها بسرية تامة وسوف تستخدم لغايات البحث العلمي فقط.

مع العلم أن لك الحق في عدم المشاركة أو الانسحاب في أي وقت رغبت بذلك.

شاكرة لك حسن تعاونك ولك فائق التقدير والاحترام.

الباحثة: حنان أبو عيد

اشراف: الدكتورة نجاح الخطيب

القسم الأول: البيانات الديمغرافية: الرجاء وضع اشارة (✓) في المربع للخيار الذي يمتلكك:

1. الجنس:

ذكر أنثى

2. الحالة الاجتماعية:

اعزب/عزباء متزوج/متزوجة مطلق/مطلقة

أرمل/أرملة

3. أين تسكن؟

بيت مستقل بيت العائلة

4. مع من تعيش؟

لوحيد

مع أسرتي (الاسرة الأصلية)

مع زوجتي وأولادي

5. عدد افراد الاسرة بما فيهم أنت/ي:

3 افراد فاقل 4-6 7 فما فوق

6. مكان السكن:

مخيم مدينة قرية

7. العمر بالسنوات:

18 - 30 سنة 31 - 40 سنة 40 - 50 سنة

50 - 60

8. المستوى التعليمي:

لا أقرأ ولا أكتب اعدادي ثانوي

كلية / جامعة دراسات عليا فأعلى

9. التشخيص المرضي حسب الملف :

10. منذ متى و انت تراجع بالعيادة؟

3 سنوات فما دون

3-5 سنوات

5 سنوات فأكثر

11. الى أي مدى أنت راضي عن مكان العيادة؟

12. كيف تأتي للعيادة؟

سيراً على الأقدام (الأسباب) _____

استخدم المواصلات العامة: في حال كانت هذه هي الاجابة؛ كم وسيلة نقل تحتاج لتصل الى العيادة؟

تكسي طلب (الأسباب)

13. مع من تأتي الى العيادة؟

دائما آتي لوحدي للعيادة

أحيانا آتي لوحدي

دائما آتي برفقة أحد من أسرتي

14. هل تأتي عادة لمراجعة الدكتور بنفسك؟

دائما آتي بنفسي

أحيانا آتي بنفسي للمراجعة

قليلا ما آتي بنفسي للمراجعة

دائما آتي برفقة أحد من أسرتي

15. هل تتناول أدوية لعلاج مرضك؟

نعم لا

في حال كانت الاجابة نعم؛ من أين تحصل عليها؟

- هل تم تقديم شرح لك عن الدواء؛ فوائده وآثاره الجانبية؟

- من قدم لك هذه المعلومات؟

16. هل تحصل على خدمات أخرى بجانب العلاج الدوائي؟

نعم لا

في حال كانت الاجابة نعم؛ حدد ما هي هذه الخدمات؟ يمكن أكثر من اجابة

جلسات مع الاخصائي/ة الاجتماعي/ة

جلسات مع الاخصائي/ة النفسي/ة

خدمات تأهيل وتدريب

أمور أخرى

17. كيفية استقبال المريض

- من يستقبلك بالعيادة عندما تذهب لطلب العلاج؟

- صف كيف يكون الاستقبال؟

- كم من الوقت انتظرت حتى تتلقى الخدمة المطلوبة؟

18. سبب القدوم للعيادة

- ما سبب قدومك الى العيادة؟

- هل تأتي بشكل منتظم؟

في حال كانت الاجابة نعم: - مرة بالشهر

- كل شهرين

- كل 3 أشهر

- أكثر من 3 شهور

19. هل نظام الحجز المسبق موجود في العيادة التي تتلقى الخدمة بها؟

20. هل تدفع مقابل الخدمة وفي حال كانت الاجابة نعم؛ كم تدفع؟

21. كم تبلغ مدة الجلسة مع الطبيب، الاخصائي/ة الاجتماعي/ة ، الاخصائي/ة النفسي/ة؟

22. حقوق المريض النفسي - العقلي

- هل لديك معرفة ما هي حقوقك كمريض؟

في حال كانت الاجابة نعم ؛ ما هي هذه الحقوق؟

- ما مصدر معرفتك بهذه الحقوق؟

- هل شعرت ببوم ما أنه تم انتهاك حق من حقوقك كمريض؟ في حال كانت الاجابة نعم وضح

نعم لا

23. من يكون بغرفة المعاينة عندما تكون موجود؟

- هل لاحظت وجود أشخاص لا تعرفهم مسبقا بالغرفة العلاجية؟

في حال كانت الاجابة نعم: هل تم استئذائك لأن يكونوا بالجلسة؟

- هل تم تعريفك بهم وبسبب وجودهم؟

- هل يدخل أحد الغرفة وانت موجود (يقاطع الجلسة)؟

- هل الخصوصية برأيك موجودة؟

- هل تعرف أن لك الحق في رفض وجود أشخاص لا تريد أن يكونوا موجودين؟

24. هل سبق وتم كتابة تقارير عن وضعك الصحي؟

في حال كانت الاجابة نعم؛

- ما نوع التقرير؟

- من طلب التقرير؟

- ومن استلمه؟

25. السرية

- أين يحفظ الملف الخاص بك؟

- من يستطيع الوصول اليه وقراءته؟

- هل تعتبر ان ملفك محفوظ بشكل سري؟ نعم لا

في حال كانت الاجابة لا، لماذا؟

- هل تعتقد أن ما يقال ويحدث بالغرفة العلاجية يبقى سرا؟ نعم لا

في حال كانت الاجابة لا، وضح؟

- هل تعتقد أن الفريق العلاجي (طبيب/أخصائي نفسي/ أخصائي اجتماعي/.....) يحافظ على أسرارك

والمعلومات حول وضعك الصحي؟

نعم لا

في حال كانت الاجابة لا، وضح؟

26. البيئة العلاجية

- برأيك هل العيادة موجودة بمكان ملائم؟

- هل يوجد غرفة انتظار في العيادة؟

- هل الأثاث بغرفة الانتظار مريح؟

- هل درجة حرارة الغرفة ملائمة صيفا وشتاء؟

- ما هي المرافق العامة في العيادة؟

حمامات

كافيتريا

مواقف عامة للسيارات

مياه صالحة للشرب (cooler)

- هل المرافق العامة نظيفة؟

نعم لا

- هل يوجد مواد خاصة بالنظافة الشخصية في الحمام

* ورق تواليت نعم لا

* صابون نعم لا

* شطافة نعم لا

27. التتقيف حول المرض الذي لديك

- ماذا الذي تعرفه عن مرضك؟

- من أين حصلت على هذه المعلومات؟

- هل تم اخبارك ما هو المرض الذي لديك؟

نعم لا

في حال الاجابة نعم، من الذي اخبرك عن مرضك؟

- ما هو التشخيص المرضي: _____

- هل تم شرح أسباب المرض لك؟

نعم لا

في حال كانت الاجابة نعم، ما الاسباب التي ذكرت لك عن مرضك؟

- هل تم شرح أعراض المرض لك؟

28. العلاج الخاص بك

- هل لديك معرفة بخطة العلاج الخاصة بمرضك؟ نعم لا

في حال كانت الاجابة نعم، ما هي خطة العلاج؟

- من وضع خطة العلاج الخاصة بك؟

- هل تم مناقشة خطة العلاج معك؟ نعم لا

- هل وافقت على خطة العلاج؟ نعم لا

- هل وقعت على خطة العلاج بنفسك؟ نعم لا

في حال كانت الاجابة لا من قام بالتوقيع نيابة عنك.

- هل تعتبر نفسك شريكا بالعلاج وكيف؟

- من يشارك في علاجك داخل العيادة؟ يحتتمل أكثر من اجابة

طبيب نفسي اخصائي اجتماعي ممرض

اخصائي تأهيل اخصائي نفسي آخريين

29. الخدمات المقدمة

- ما هي الخدمات التي تقدم من قبل العيادة لك؟

لا	نعم	نوع الخدمة
		ارشاد /علاج نفسي فردي
		ارشاد /علاج نفسي جماعي
		ارشاد أسري
		علاج دوائي
		تقييم نفسي بواسطة اختبارات نفسية
		تأهيل نفسي ومجتمعي
		تتقيف وتوعية
		تأهيل مهني
		تقارير
		تحويلات
		نشاطات ترفيهية
		خدمات طبية مختلفة (علاج طبي)

30. هل انت راضي عن الخدمة المقدمة ولماذا؟

لا

نعم

Appendix B: Study instrument- English version



Al Quds University

Department of Public Health

Community Mental Health Program – Psychotherapy Track.

**Client's perception of quality of services towards Patients with Mental Illness
Treated at Palestinian Governmental Community Mental Health Centers**

Dear participant,

The researcher is conducting a study on the clinical practices of health practitioners towards patients with mental illness treated at Palestinian governmental community mental health centers, in order to obtain a Master's degree in the field of community mental health –psychotherapy track. So I hope you will cooperate in answering the interview questions.

The data will be treated with strict confidentiality and it will be used for research purposes only.

Thank you for your cooperation.

With all due respect,

Researcher: Hanan Abu Eid.

Subversion of Dr Najah Al Khatib

Section 1: Demographic data: please put a (✓) in the box for the option that represents you:

1. Gender:

- Male
- Female

2. Martial State:

- Single
- Married
- Divorced
- Widows/widowers

3 .Where do you live?

- Family home
- Separate household

4. Who are you living with?

- Alone
- With my original family
- With partner and children

5. Number of family members including you:

- 3 individuals and less
- 2-6 individuals
- 7 individuals and more

6. Place of residence:

- City
- Village

7. Age in years

- 18-30 years
- 31-40 years
- 41-50 years
- 50-60 years

8. Educational level:

- Illiterate
- Preparatory
- Secondary
 - College/University
 - Postgraduate and above

9. Medical Diagnosis:

10. How long have you been followed- up in the clinic?

- 3 years and less
- 3-5 years
- 5 years and above

11. How satisfied are you about the location of the clinic?

12. How do you come to the clinic?

- On foot (Reason) _____
- Use public transport: if this the answer, How much transportation do you need to reach the clinic? _____
- By taxi (Reason) _____

13. With whom do you come to the clinic?

- I always come by myself to the clinic.
- I sometimes come alone.

- I always come with one of my family.

14. Do you usually visit the clinic by yourself?

- I always come by myself.
- I sometimes, come by myself to review.
- I rarely come by myself to review.

15. Do you take medications to treat your illness? * Yes * No

- If the answer is yes, where do you get it? _____
- Have you been provided with an explanation about the medicine, its benefits and effects? _____
- Who gave you this information? _____

16. Do you receive any other services besides medication? * Yes * No

- If the answer is yes, define what these services are? (You can choose more than one answer)
 - Sessions with the social worker
 - Sessions with the psychologist
 - Rehabilitation and training services
 - Other services

17. The reception procedures

- Who receive you at the clinic when you go for treatment?
- Describe how the reception is?
- How long did you wait until you receive the service?

18. The reason for coming to the clinic

- Why did you come to the clinic?
- Do you come regularly?
-

If the answer is yes:

- Every month
- Every 2 months
- Every 3 months
- More than 3 months

19. Does the reservation policy exist in the clinic where you receive service?

20. Do you pay for the service and if the answer is yes, how much do you pay?

21. How long is the session with the doctor, social worker, and psychologist?

22. The rights of mentally ill patients

- Do you know what your rights are as a patient?

If yes, what are these rights? _____

- What's the source of your knowledge of these rights? _____
- Did you ever feel that one of your rights was violated as a patient? * Yes * No

If yes, explain. _____

23. Who is in the therapeutic room when you are in?

- Have you ever noticed people you don't already know in the therapeutic room?

If yes, have they been authorized to be in your session?

- were you ever informed about who are these people, and about the reason for their existence in the therapeutic session
- Does anyone enter the room once you are there (interrupts the session)?
- Is privacy available?
- Do you know that you have the right to refuse the presence of people you don't want them to be?

24. Have you ever been reported on your health status?

If the answer is yes, then:

- What type of report?
- Who requested the report?
- Who received it?

25. Confidentiality

- Where is your file saved?
- Who can access and read it?
- Do you consider that your file is kept secret? * Yes * No

If the answer is no, explain why?

- Do you think that what is said and happen in the therapeutic room remains secret?
* Yes * NO

If the answer is no, explain?

- Do you think that the Therapeutic team (doctor/ psychologist/ social worker/...) keeps your secrets and information about your health states? * Yes *No

If the answer is no,

explain. _____

26. Therapeutic

environment

- Do you think the clinic is in an appropriate place?
- Is there a waiting room in the clinic?
- Is the furniture in the waiting room comfortable?
- Is the room temperature suitable for summer and winter?

- What are the public facilities in the clinic? (More than one answer can be chosen)
- Bathrooms
- Cafeteria
- Public car parks
- Cooler
- Are public utilities clean? * Yes * No
- Are toiletries available in the bathroom?
 - Toiletries paper
 - Soap
 - Bidet

27. Psycho – education about mental illness

- What do you know about your illness?
- Where did you get this information?
- Have you ever been told about your psychiatric diagnosis? * Yes * No
- If the answer is yes, who did inform you about it?
- What is the psychiatric diagnosis?
- Did you receive explanations about the causes of mental disorder? *Yes *No

If yes, what are the reasons for your illness? _____

- Did you receive explanations about the symptoms of mental disorder? *Yes
*No

If yes, what are the reasons for your illness? _____

28. Your therapy

- Do you know about your treatment plan? *Yes *NO

If yes, what is? _____

- Who developed your treatment plan? _____

- Has the treatment plan been discussed with you?
- Have you approved the treatment plan? * Yes *No
- Have you signed the treatment plan by yourself? * Yes *No

If the answer is no, who signed instead of you? _____

- Do you consider yourself a partner in the treatment and how?
- Who is involved in you treatment in the clinic? (More than one answer can be chosen)
 - Psychiatrist
 - Psychologist
 - Social worker
 - Nurse
 - Specialist rehabilitation
 - Others

29. Services provided.

- What services are provided for you by the clinic?

Service type	Yes	No
Individual counseling/psychotherapy		
Group counseling/psychotherapy		
Family counseling		
Pharmacotherapy		
Psychological evaluation by psychological tests		
Psychological and social rehabilitation		
Education and awareness		
Vocational training		
Reports		
Medical transform		
Entertainment activities		
Medical services(Medical treatment)		

30. Are you satisfied with the provided service and why? * Yes * No

Appendix C: Ethical Approval

Al-Quds University
Jerusalem
Deanship of Scientific Research

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ



جامعة القدس
القدس
عمادة البحث العلمي

Research Ethics Committee
Committee's Decision Letter

Date: 22/5/2018
Ref No: 43/REC/2018

Dear Dr. Najah Al-Khatib, Miss Hanan Abu Eid,

Thank you for submitting your application for research ethics approval. After reviewing your application entitled "**Clinical practices of health practitioners towards patients with mental illness at the governmental community mental health clinics: patient's perspective**" the Research Ethics Committee confirms that it is in accordance with the research ethics guidelines at Al-Quds University. Please inform us if there will be any changes in your research methodology, subjects, plan and we would appreciate receiving a copy of your final research report.

Thank you again and wish you productive research that serves the best interest of your subjects.

عمادة البحث العلمي
Scientific Research Deanship
Dina M. Bitar PhD



Research Ethics Committee Chair

Cc. Prof. Imad Abu Kishek - President
Cc. Members of the committee
Cc. file

الممارسات الاكلينيكية للعاملين الصحيين اتجاه المرضى النفسيين الذين يتلقوا العلاج في مراكز الصحة النفسية

الحكومية الفلسطينية

إعدادُ الطالبة: حنان محمد خضر أبو عيد

إشراف: د. نجاح الخطيب

الملخص

يعد الاضطراب النفسي مشكلة صحية عالمية (منظمة الصحة العالمية، 2016). عدد الأشخاص المصابون باضطرابات نفسية يتزايد مستمر في جميع أنحاء العالم. كما ويعاني الأشخاص ذوي الإعاقة في جميع أنحاء العالم من انتهاكات لحقوقهم والتمييز ضدهم في شتى مجالات الحياة نظرا لفقدان البعض منهم لجزء أو كل قدراته المعرفية. هذه الدراسة من أوئل الدراسات في فلسطين (على حد علم الباحثة)، والتي تحاول التعرف على التجارب الشخصية للأشخاص المصابون باضطرابات نفسية مع الممارسين الصحيين في عيادات الصحة النفسية المجتمعية أثناء تلقيهم العلاج (الخبرة العلاجية). كما وتضيف الدراسة فهما أكثر شمولية حول ما يواجهه هؤلاء الأشخاص من تحديات وصعوبات خلال سيرهم نحو التعافي.

منهجية الدراسة: تم استخدام منهج البحث الكيفي لتحقيق الهدف من هذه الدراسة. تم جمع البيانات خلال الفترة الزمنية ما بين آب 2018 – وكانون الثاني 2018. كما وشملت العينة على 30 شخص من هؤلاء المصابون باضطرابات نفسية من كلا الجنسين ضمن الفئة العمرية ما بين 18-60 سنة، والذين يتلقون العلاج بمراكز الصحة النفسية المجتمعية التابعة للحكومة الفلسطينية في كل من مدينتي رام الله والخليل. لاختيار المبحوثين تم استخدام العينة الملائمة (Convenience Sample) وهي أحد أنواع العينة الغير الاحتمالية (Non-Probability Sample). اعتمدت الباحثة دليل المقابلة ((An Interview Guide)) لجمع البيانات، ومن ثم تم تحليل البيانات باستخدام طريقة التحليل الموضوعي (Thematic analysis).

النتائج: أظهرت نتائج الدراسة أن 53% من المبحوثين لا يعرفون حقوقهم كمرضى، في حين 47% من المبحوثين لديهم معرفة بالحقوق التالية: الحق بتلقي العلاج، الحق بالحفاظ على الخصوصية والسرية التامة، والحق في المعاملة باحترام وتلقي العلاج دون حدوث مقاطعة (Interruption) للعملية العلاجية، الحق في استثمار الوقت بالجلسة العلاجية بأفضل طريقة ممكنة، والحق بالعلاج ضمن معايير المحافظة على كرامة الانسان.

وفيما يتعلق بانتهاك حقوق الأفراد بالبيئة العلاجية، أفاد 66.6% من المبحوثين بأن حقوقهم لم تنتهك. الحقوق التي تم انتهاكها وفقاً لـ 44.4% من المبحوثين تضمنت الآتي: التعرض لمواقف شعروا فيها بالإهانة، عدم الاحترام، التجاهل من قبل الممارسين الصحيين، عدم وجود خصوصية وسرية أثناء تلقي العلاج، حدوث مقاطعة للعملية العلاجية (Interruption)، وانتهاك حقهم في استثمار الوقت العلاجي المخصص لهم بأفضل طريقة ممكنة.

نوعين من أنماط العلاج قدم للمبحوثين بمراكز الصحة النفسية المجتمعية. أظهرت الدراسة أن غالبية المبحوثين (80%) قد تلقوا فقط العلاج الطبي (الأدوية النفسية) من عيادات الصحة النفسية المجتمعية، في حين تلقى 20% من المبحوثين نوعين من العلاجات وهما: العلاج الطبي والإرشاد النفسي. كما وتعتبر غالبية العظمى من المبحوثين (93%) انها طرف مشارك في عملية العلاج، وقد فسروا ذلك بأنهم ملتزمون بالعلاج الدوائي.

يرى (93.3%) من المبحوثين أن الموقع الجغرافي لكلا المركزين مناسب وسهل الوصول اليه. المرافق في كلا المركزين اقتصر على وجود غرف انتظار ومرافق صحية، في حين افتقر كلاهما الى وجود كافيتيريا ومواقف عامة للسيارات. أكثر من نصف عينة الدراسة (60%) راضون عن الخدمة التي تلقوها من عيادات الصحة النفسية المجتمعية، ونسبوا ذلك لأمرين: مجانية العلاج (72.2%) وجودة الخدمة (27.8%).

الخلاصة: خلصت هذه الدراسة إلى أن الحقوق الانسانية والقانونية للأشخاص المصابين بأمراض عقلية في أي مرفق من مرافق الصحة العامة قد تنتهك بسهولة، إذا تغيبت ثقافة حقوق المريض في البيئة العلاجية. تحتاج نتائج هذه الدراسة إلى مزيد من الاهتمام من قبل المنظمات الحكومية وغير الحكومية، للعمل على وضع برامج تهدف الى رفع مستوى الوعي لدى الأشخاص المصابين باضطرابات نفسية حول مفهوم الحقوق لتمكينهم من ممارستها. كما وتعتبر هذه خطوة وقائية لحمايتهم من التعرض لأي شكل من أشكال الانتهاك لحقوقهم. مخرجات هذه الدراسة تؤكد على أن هناك حاجة كبيرة لإجراء المزيد من الدراسات الكمية والكيفية، للتعرف على حجم الظاهرة، ومن أجل تحسين مستوى الخدمات المقدمة بمراكز الصحة النفسية المجتمعية، والذي بدوره يزيد من مستوى رضا المنتفعين من هذه المراكز عن العلاج المقدم لهم.