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Evaluation of Mental Health Services In Gaza Strip, Palestine 1999

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Dedication

I would like to dedicate this work to my dear daughter, Farah and her mates, Palestinian children.

Acknowledgement

I am pleased to acknowledge the continuous encouragement and support of Dr. Yehia Abed in supervising this study. I wish also to thank Dr. Abdel Azziz Thabet for his support and help.

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Abdel Rahman Omer

Abstract

This study aims to provide an overview of the status of mental health services in the Gaza Strip. Mental health organizations and organizations contributing to mental health in the Gaza Strip were surveyed by two well-structured questionnaires about their mental health services and professionals working in these organizations.

There are five major mental health organizations: Public Mental Health Hospital (MOH), Community Mental Health Department (MOH), The Gaza Community Mental Health Program (NGO), Military Medical Services and UNRWA Health Department. Moreover, supports and inputs to mental health services come from a wide variety of reported nineteen organizations contributing to mental health services.

In Palestine, like different Arab countries, the ratio of mental health services to population, the space allocated to the study of mental health in medical curricula, are only a few of the health concerns.

The continuos Israeli occupation, the absence of an Independent State, and consequent instability in Palestine has created a situation where NGOs continue to play a major role in the provision of health services. The public expenditure on mental health of the total health budget in Palestine is not available and seems to be very poor. Mental hospital beds are about 7% of all hospital beds available. In Gaza Strip, most of mental health services are distributed inequally in different governorates and concentrated in Gaza City with percentage about 52.5% of total organizations (38.5% mental health services and 59.3% supporting services). In North Gaza, 12.5% (23.1% mental health services and 7.4% supporting services), In Gaza Midzone 10% (0% mental health services and 14.8% supporting services), in KhanYounis 15% (23.1% mental health services and 11.1% supporting services) and in Rafah 10% (15.4% mental health services and 7.4% supporting services).

The ratio of population per mental bed is 8,763 in Palestine and 29,182 population per bed in Gaza Strip. There are (39) beds in the only mental health hospital in Gaza City, with about 2.1% of all hospital beds and with a ratio of (0.1) psychiatrist and (0.3) mental health beds per 10,000 population. In 1999, there are 11 psychiatrists working in the five mental health organizations; with a ratio of 1 per 103,466 inhabitants.

In Palestine, there are several reasons to low affordable and effective mental health care, the main ones being: the low priority generally given to mental health, traditional centralization of mental health services in large psychiatric institutions and poor strategies. The need for community mental health services in the Gaza Strip is dire. It is increasingly evident that mental health care should no longer be provided in centralized institutions nor should its provision be concentrated in the hands of a limited number of mental health specialists. If basic mental health care is to be more accessible to a large population, it must be done through non-highly qualified and non-specialized community health workers at all levels from PHC workers, nurses and physicians to those out side the health service such as teachers. This indicates the urgent need for allocation of more resources both human and financial for the provision of community mental health services.

الخلاصة

تهدف هذه الدارسة إلى تقييم خدمات الصحة النفسية في قطاع غزة. ولهذه الغاية تم تصميم استبيانين لجمع البيانات اللازمة للدراسة . الاستبيان الأول صمم لجمع البيانات عن المؤسسات التي تقدم خدمات الصحة النفسية والخدمات المساندة للصحة النفسية لمعرفة إمكانيات هذه المنظمات والأنشطة والخدمات التي تقوم بها. أما الاستبيان الثاني فقد ركز على جمع البيانات من المهنيين العاملين في هذه المؤسسات عن تخصصاتهم ومؤهلاتهم العلمية ومستوى تدريبهم. هناك خمس مؤسسات تقدم خدمات الصحة النفسية بقطاع غزة وهي : مستشفى الطب النفسي، دائرة الصحة النفسية المجتمعية في وزارة الصحة، برنامج غزة للصحة النفسية المجتمعية وهو منظمة غير حكومية ، الخدمات الطبية العسكرية ودائرة الصحة التابعة للأونروا. أما المؤسسات الداعمة للصحة النفسية، فقد استجاب تسع عشرة مؤسسة من مجموع 31 مؤسسة تقدم خدمات داعمة للصحة النفسية من المنظمات الغير حكومية المنخرطة في أشكال العمل المجتمعي والتي تم التعرف عليها من دليل الأمم المتحدة للمنظمات الغير حكومية بغزة 1998.

إن تناسب خدمات الصحة النفسية المتوفرة في فلسطين وفى سائر البلاد العربية إلى احتياجات السكان وكذلك الحيز المخصص لدراسة الصحة النفسية في مناهج المعاهد الطبية والنفسية لا يتمتعان بالوزن الكافي من اهتمامات المعنيين بهذا الشأن.

ليس معروفا على نحو دقيق حجم الإنفاق على الصحة النفسية من إجمالي الإنفاق العام على الصحة في فلسطين، ولكن ظاهر الأمور يشير إلى المحدودية الكبيرة لهذا الإنفاق. إن نسبة الأسرة بمستشفيات الطب النفسي تشكل 7% من إجمالي الأسرة المتوفرة فى المستشفيات في فلسطين. وفي قطاع غزة هناك توزيع غير متساوي لخدمات الصحة النفسية والخدمات الداعمة لها في المناطق المختلفة، حيث تتركز معظم هذه الخدمات (52.5%) في مدينة غزة، بينما تحظى منطقة شمال غزة بنسبة 12.5% ، و المنطقة الوسطى 10%، وخانيونس 15% ورفح 15%. تبلغ نسبة أسرة الطب النفسي للسكان في فلسطين سريرا واحدا لكل 8,763 نسمة، بينما تبلغ النسبة فى قطاع غزة سريرا واحدا لكل 29,182 نسمة. هنالك 311 سريرا في مستشفيي الطب النفسي في فلسطين منها 39 سريرا في مستشفي الطب النفسي الوحيد بقطاع غزة. وتشكل هذه الأسرة في قطاع غزة ما نسبته 2.1% من إجمالي أسرة المستشفيات، وبذلك يكون هناك 0.3 سرير طب نفسي متوفر لكل 10,000 نسمة . أما نسبة الأطباء النفسيين لعدد السكان فتمثل 0.1 طبيب لكل 10,000فنسمة . في عام 1999 كان هناك 11 طبيباً مختصاً في الطب النفسي وهو ما يمثل نسبة طبيب واحد لكل 103,466 نسمة .

هناك أسباب متعددة لمحدودية وتدنى مستوى خدمات الصحة النفسية فى فلسطين، لعل أبرزها عدم تمتع الصحة النفسية بالأهمية اللائقة في قائمة الأولويات لصانعي السياسات بالإضافة إلى الإستراتيجية الضعيفة في هذا المجال والاتجاه إلى مركزة و مأسسة خدمات الطب النفسي في المستشفيات والمؤسسات الصحية.

كل ما سبق يوضح مدى الحاجة الملحة لتقوية خدمات الصحة النفسية في قطاع غزة وهذا لن يتأتي في ظل الإمكانيات المحدودة بدون التوجه إلى خدمات الصحة النفسية المجتمعية لتلبية احتياجات السكان المتزايدة في هذا المجال.

- **List of Abbreviations**

AL Shams	Society for the care of the handicapped-AlShams
Al-Amal	Al Amal Institution for the orphans,
BA	Bachelor of Arts (First university certificate)
CMHD	Community Mental Health Department
CTC	Community training center and crisis management.
DSCRS	Down's Syndrome Children's Right to live Society
ECT	Electro Convulsive therapy
EEG	Electro-encephalography
EL Wafa	El-Wafa Elderly Nursing Home
EMHJ	Eastern Mediterranean Health Journal
EMR	Eastern Mediterranean Region
GCMHP	Gaza Community Mental Health Program
Hope	Hope and Life association (Anti-drugs and Addiction)
Mg-CRC	Al Magazi Community Rehabilitation Center
MH	Mental Health
MMS	Military Medical services
MOE	Ministry of Education
MOE	Ministry of Education
MOEn	Ministry of Environment
MOH	Ministry of Health
MOSA	Ministry of social Affairs
NCCR	National Center for Community rehabilitation
NGO	Non Governmental Organization
NHP	National Health Plan
NSR	The National Society for Rehabilitation
PADC	Palestinian anti-drug abuse council
PARD	Palestinian Association for Rehabilitation of the Disabled.
Pav	Palestine Avenir
PCSPH	Palestinian Committee for Social and Psychological Health
PhD	Doctor of Philosophy
PMHH	Public Mental Health Hospital
PRCS	Palestinian Red Crescent Society
SPHCP	Society of Physically Handicapped people
UNRWA	United Nations for Work and Relief Agency for Palestinian Refugees
UNRWA E	UNRWA Education Department-Counseling section
WHC-Bj	Women's Health Center-Burej
WHO	World Health Organization

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Chapter 1

Introduction

Introduction

Mental health is often one of the most neglected areas of the health services (Wig 1989). This attitude is based on deeply held fears and prejudices against mental illness found in many communities, mixed with ignorance, wrong information and social stigma.

In many countries, even the health administrators still think that mental illnesses are not common in developing countries. Many of them believe that for these illnesses, the modern health services have nothing to offer. According to the World Health Organization (WHO) estimation, at least 300 million people are mentally ill in the world; 50 million or so have serious mental illness, and three quarters live in the developing countries (Wig, 1989). It is estimated that more than 1500 million people suffer from mental, neurological, and psychological disorders. A considerable proportion of these disorders could be avoided by the use of effective, affordable, and simple methods (WHO 1998). Most mental and neurological disorders have multiple and interacting causes with biological, psychological, and sociocultural components. A major finding of the Global Burden of Disease Project (GBDP) was the importance of mental disorders as a cause of disease burden, accounting for a quarter of the world's disability, and 9 percent of the total burden (Andrews et al 1998).

Existing systems for the delivery of mental health care have largely failed to meet the needs of most of world's population. Many of the systems are centralized, hospital-based and disease oriented. Such care is often inconsistent with the principle of social equity, particularly in developing countries (WHO 1990)

Over the past two decades, a revolution has taken place in the ideas about how services should be provided for mentally ill people. There has been a change from thinking in terms of providing centrally based hospitals specializing in mental illness with some community-based adjuncts to one that is nearly all community based in concept, placing as little restriction as possible on the patient's normal life.

Mental health services in Palestine are very limited and largely ineffective in addressing the psychosocial needs of the population. The continuos occupation, oppression, violence, and constant devastation directed against the Palestinian people for decades have a severe impact on the whole state of mental health among Palestinian people. Due to the lack of organized data on the psychiatric morbidity of the Palestinian population, the bulk of people who need some form of mental health care are difficult to estimate. It is believed that 30-40,000 is incapacitated by various mental and psychological problems, the majority of them do not seek help, fearing the stigmatization associated with specialized psychiatric care (Afana 1995). If the numbers of people affected by psychological disorders associated with physical disease or injuries and those affected by drug and substance abuse are added to the previous figures, it looks apparent that mental health

services are faced with a huge burden. In spite of remarkable developments mental health services witnessed in Gaza Strip the last two decades, there is much to be desired to meet the mental health needs of the population. It is crucial to mention that in Gaza Strip the ratio of psychiatrics to the general population is around 1:104,000 which makes the need for accessibility to mental health services more profound.

Chapter 2

Demographic profile

2. Demographic profile (MOH 2000)

2.1 Geographical Distribution:

Palestine comprises two areas separated geographically: the West Bank and Gaza Strip. West Bank lies within an area of 5,800 sq. Km^2 west of the river Jordan. It has been under Israeli Military Occupation, together with East Jerusalem since June 1967. The West Bank is divided into four geographical regions. The North including the districts of Nablus, Jenin and Tulkarem, the Center including the district of Ramallah and Jerusalem, the South including the Bethlehem and Al-Khaliel districts, and the sparsely populated Jordan valley including Jericho. Many areas of the West Bank have diversified communities. There are observable differences in life styles and living conditions not only among classes or socio-economic levels and religious affiliations, but also among urban, rural and refugee camp communities with their respective subdivisions. Up to sixty percent of the population lives in approximately 400 villages and rural refugee camps, and the remainder in urban refugee camps and cities of which Nablus, East Jerusalem and Al Khaleil are the most populous.

Gaza strip is a narrow piece of land lying on the coast of the Mediterranean Sea. Its position on the crossroads from Africa to Asia made it a target for occupiers and conquerors over the centuries. The last of these was Israel who occupied the Gaza strip from Egyptians in 1967. Gaza Strip is a very crowded place with area 360 sq. Km^2, the population is mainly concentrated

in the cities, small villages, and eight refugee camps that contain two thirds of the population. The main income source for Gaza population was work in Israel, in addition to the poor agriculture products that have to be exported via Israel. Part of the refugee population was moved from camps to new areas. Apart from the weak economic situation and its consequences for the public health, the population of Gaza as all Palestinian population have lived through several consecutive wars (1948, 1956, 1967) and long stressful periods (the Israeli occupation). During the years from 1987 to 1992, Intifada -the Palestinian uprising- erupted spontaneously. It was led by children and youth, which chose to face the Israeli occupation with stones, burning tires and roadblocks.

2.2 Palestinian economy

According to Palestinian Monetary Authority (PMA) the Gross National Product (GNP) in Palestine has been subjected to high fluctuations during the last five years. The GNP per capita, decreased from 1,938.6 US$ in 1998, to about 1,771.5 in 2000. GNP per capita in Gaza Strip is half of that of West Bank (World Bank 1998). Gross Domestic product (GDP) in 2000 is 4,450.8 while it was 4,218.3 in 1998. GDP per capita was about 1,540 US$ in 1998 and 1,484.5 in 2000. The number of workers in Israel (in thousands) decreased from 126.1 in 1999 to 112.9 in 2000. And the workers in Palestine (in thousands) also decreased from 667.0 in 1999 to 575.9 in 2000 due to the political situation that prevailed in Palestine. The PMA reported the unemployment rate at (14.1%) in 2000, it is unstable and with constant

fluctuation due to political situation and the occupation's practices including closure of Palestinian regions and cities, and other constraints' activities.

In Gaza Strip, The unemployment rate is actually double that of West Bank.

2.3 General Educational Indicators:

The census results showed that for the scholastic year 1998/1999 the repetition rate was 2.45% while the dropout rate was 1.95%, these rates vary according to grade level. For example, the repetition rate was low in the lower grades (about 1.2%) and it increased rapidly in the middle elementary grades (grades 4-7) to reach 3.5% then decreased in the higher grades. The dropout rates increases rapidly from lower to higher grades, from 0.25% in the first elementary grade to 1.3% in the 6th elementary grade, then jumped to 8.5% in the first secondary grade. It is noted that dropout rate among boys in the lower grades is higher than girls, up to the 10th elementary grade. However in 1st and 2nd secondary grades the dropout rate among girls becomes higher than boys.

Also, the average number of students per teacher in schools varies according to supervising authority, it is 24.2 students/teacher in the government schools, 37.6 in the UNRWA school, 15.3 in private schools and 21.4 child per teacher in kindergartens.

The average number of student per class in Gaza Strip varies from stage to another and from supervising authority to another. It reached 45.7 in the basic stage and 39.1 students per class in the secondary stage. While by supervising authorities it was in basic stage as follows 42.5 in government schools, 49.9 in UNRWA schools, and 26.6 students per class in private

schools. In secondary stage, it is 39.4 in governmental schools and 23.4 in private schools. On the other hand, the census results reveal that classroom area per student varies according to stage and region, whereas it was 1.08 square meter per pupil in the basic stage in the West Bank school and 1.12 square meter in Gaza Strip for the same stage. In the secondary stages, the area per student in the West Bank was 1.5 square meters and in the Gaza Strip it was 1.23 (MOE 2000)

2.4 Demographic Trends

2.4.1 Population size and structure

The mid year population size of Palestine in 2000 is estimated at 3,150,056. Out of which 1,590,945 (50.5%) are males and 1,559,111 (49.5%) are females. The total population in Palestine is nearly equals the total population in Lebanon, which is estimated at 3,236,000.

2.4.2 Age and sex distribution:

Age distribution of the population has important implications on the health status of the population, due to the different health needs, the differential patterns of health care utilization and the different health status among the various age group.

Population pyramid shows age and sex distribution of population, (46.9%) is under 15 years. This pattern is more pronounced in the Gaza Strip, where (50.2%) are under 15 years, while it is (45%) for the West Bank. The age group under five years old still constitutes the largest proportion with

percentage (18.5%) of population. The ages 60 years and over constitute (4.7%) of population.

2.4.3 Distribution by refugee status

According to the United Nation Relief and Work Agency (UNRWA) report in 2000 the total number of refugees is (1,428,891), where (837,750) are residencies in Gaza Strip, at percentage of (58.6%) and (591,141) residencies in West Bank with percentage (41.4%). Refugees make up a much larger percentage of the population in Gaza Strip than West Bank (65.1% Vs 26.5%). Most refugees still live in overcrowded camps with substandard dwelling and sanitation conditions, which have a negative impact on health status. UNRWA is responsible for PHC service provision for refugees, the number of people in Gaza Strip who can make use of UNRWA services is much higher than in the West Bank. Any way the refugees can access to all health services provided by MOH.

2.4.4 Population Density:

Population density in the Gaza Strip is very high compared with the density in West Bank and the neighboring countries. Density rate is about 3,161 inhabitants per one square kilometer in Gaza Strip, and about 347 inhabitants per one square Kilometer in West Bank. Actually, it must be taken into consideration that a sizable area of the Gaza Strip and the West Bank is still occupied by Israeli settlers. Therefore, the actual density rates are higher than the estimated figures.

2.4.5 Dependency

Dependency ratio is calculated as the number of persons below fifteen and above sixty-five per 100 persons aged (15-64) years. In 2000, the dependency ratio for Palestine is 100.6% (112.8% for Gaza Strip Vs 94.3% for West Bank). The dependency ratio in Palestine is the highest among all other neighboring countries,

2.4.6 Population Growth

The estimated population growth in Palestine has been declined from (5.2%) in 1995 to (3.1%) in 1997 and 1998. In 2000, it is (3%) for Palestine.

2.4.7 Crude birth rate (CBR):

CBR is the number of live births per 1000 population per year. Despite progressive decline over the years in CBR, it is still high in Palestine compared to other countries. CBR declined from 46.5\1000 in 1995 to 34.5\1000 in 1998 and 33.2 in 2000.

2.4.8 Life expectancy

According to PCBS the average life expectancy at birth of the Palestinian population is 71.82 years in 2000, while it was 71.50 years in 1998. As in most countries, the life expectancy at birth in 2000 for women is higher than for men (73.43 Vs 70.27 year).

Chapter 3

Methodology

3. Methodology

3.1 Aim of the study

The aim of this study is to evaluate the mental health services in the Gaza Strip.

3.2 Type of the study:

This is a descriptive study where all mental health organizations and other organizations contributing to mental health are included in the study. The activities and mental health teams of those organizations were described in detail. Two structured questionnaires were used to collect the required data. The questionnaires were tested at GCMHP and CMHD. Ten professionals of both organizations were included in a pilot study. Recording, adding and deletion of some questions were carried out. A team of mental health experts including the supervisor and the advisor reviewed the questionnaires and a final redesign was set. An informed consent was attached with each questionnaire. The data were coded, entered and analyzed by using the Statistical Package for Social Sciences (SPSS). Frequencies are used as a statistical tool to measure each variable separately.

3.3 Study methods

1. Reviewing retrospectively the available documents of mental health providers and other relevant studies.

2. Interview of all mental health professionals using a structured questionnaire (professionals' questionnaire) in order to determine their qualifications, training and experience. The questionnaire consists of demographic data and other data related to health professional's education, qualifications, country of study, experience, training, specialty and high studies.

3. Other questionnaire (Facility managers' questionnaire) was provided for managers of all mental health organizations. This questionnaire provides information on structures and activities of these organizations.

The researcher visited and collected the data by himself from the directors of all these organizations. Meanwhile, the professionals' questionnaire was distributed by the directors to all the professionals in their organizations.

3.4 Objectives

1. To identify the available mental health services.
2. To identify mental health professionals.
3. To review the reported magnitude of mental health problems.
4. To provide recommendations for decision-makers to improve mental health services.

3.5 Target population

Mental heath care professionals working in mental health organization and other organizations contributed to mental health in Gaza Strip.

3.6 Sample size

All mental health and contributing to mental health providers are reviewed. Five mental health organizations responded (100%). Where 31 organizations contributing to mental health was identified from the United Nations Directory of NGOs in Gaza Strip that is published in 1998. Only 16 out of them have responded (51.6%). In addition to 2 other governmental organizations (MOS and MOE) and UNRWA Education Department

All health professionals working in the domain of mental health are chosen. Administrators of all organizations are excluded from the study.

In UNRWA health department, a sample of 30 health workers including physicians, nurses, pharmacists and other paramedicals from all UNRWA health centers who had got training on mental health issues were nominated by the Gaza field health programs manger of UNRWA; out of them 25 have responded.

Chapter 4

Literature review

4.1 Introduction:

The positive dimension of mental health is stressed in the world health organization (WHO) definition of health as contained in its constitution:

Health is state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Mental health and well-being have nearly always had a lower priority than physical disease, despite their significant impact on mortality and morbidity. According to the WHO, globally the percentage of the population suffering from severe mental disorders at any time is 1%, while 10%-15% suffer from minor psychiatric disorders (Mohit A et. al 1999).

4. 2 Definition of mental health and mental illness

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 1999).

A current definition of mental illness is provided by the American Psychiatric Association (APA): "mental illness is an illness with psychiatric or behavioral manifestation, and / or impairment in functioning due to social, psychological, genetic, physical, chemical, or biologic disturbance" (Kaplan 1991).

Recently psychiatrists have made an integrated effort to define mental health and normality. It was understood implicitly that mental health could be defined as the opposite of mental illness.

With such an assumption, absence of gross psychopathology was often equated with normal behavior. This assumption was doubted by many recent trends. Psychiatrists made more concerted efforts to provide more precise concepts and definitions of mental health and normality. The different theoretical and clinical concepts of normality seem to fall into four functional perspectives. Each perspective is unique and has its own definition. The four perspectives complement each other and together represent the integrity of the behavioral and social science approaches to normality. The four perspectives of normality are: normality as health, normality as utopia, normality as average, and normality as process (Kaplan 1991).

4.2.1 Normality as health

The first perspective is the traditional medical psychiatric approach to health and illness. This perspective views health to equal normality. Behavior is considered within normal limits when no manifest psychopathology is present and so the lack of signs and symptoms indicates health. Health in this perspective refers to a reasonable, rather than an optimal, state of functioning.

4.2.2 Normality as utopia

This perspective views normality as an optimal harmony of the diverse components of the mental apparatus that culminates in optimal functioning of

the ideal person. This approach can be related directly to Sigmond Freud who defined the normal ego as an ideal fiction.

4.2.3 Normality as average

This perspective is commonly used in normative studies of behavior and based on the mathematical principle of the bell-shaped curve. The middle range of the curve is considered as normal and both extremes are deviant. Variability in this approach is described only within the content of total groups, not one person. In this model, the types of characters can be statistically measured.

4.2.4 Normality as process

This perspective stresses that normal behavior is the end result of interacting systems. This definition means that temporal changes are essential to a complete definition of normality. This perspective focuses changes or processes, rather than a cross-sectional definition of normality. Most typical concept of this perspective is Erikson's conceptualization of epigenesis of personality development to attain mature adult functioning.

In recent years, a great progress has been made to distinct sharply between psychotic and personality disorders, and exact criteria have been developed in this respect to verify particular diagnoses.

4.3 Classification of mental and behavioral disorders

4.3.1 WHO international classification

Work on assessment, diagnosis, classification, and nomenclature of mental disorders has long been a major concern in the work of the World Health Organization (WHO) Program on Mental Health (WHO 1998). In 1992, after more than a decade of development and testing, WHO published the ICD–10 classification of mental and behavioral disorders: Clinical Descriptions and Diagnostic Guidelines. This publication represented a significant advance towards the achievement of a "common language" for use by mental health professionals and other workers worldwide. It provides clinical descriptions, diagnostic guidelines, and codes for all mental and behavioral disorders commonly encountered in clinical psychiatry. This publication was developed from chapter V of the Tenth Revision of the International Statistical Classification of Disease and Related Health Problems (ICD–10). The classification divided disorders into ten groups according to major common themes or descriptive likeness which makes it more convenient for practical use. For each disorder, there is a full description of the main clinical features and all other important but less specific associated features.

A set of diagnostic instruments for use by clinicians and researchers in different cultures and settings has also been produced, together with training materials intended to facilitate use of the classification.

The ICD-10 Classification of Mental and Behavioral Disorders has been produced in several versions, each of which is intended for a particular purpose and aimed at specific users. The main versions are:

1. **Clinical Descriptions and Diagnostic Guidelines (CDDG)** This version is an assembly of detailed specifications of the main clinical features of mental and behavioral disorders intended for general clinical, educational and service used by psychiatrists and other mental health professionals.

2. Diagnostic Criteria For Research (DCR)

It is a set of specified, operational criteria and rules intended for diagnostic purposes in research on mental and behavioral disorders.

3. Multiaxial Presentations of the ICD-10

These are classificatory Systems for the assessment of different attributes of the patients' clinical condition, designed for use in adult psychiatry and child and adolescent psychiatry.

4. ICD-10 Primary Health Care Version (ICD-10 PHC)

This contains a simplified list of psychiatric conditions accompanied by guide lines about diagnosis and management for use in primary health care.

4.3.2. Classification of the American Psychiatric Association (APA) – Diagnostic and Statistical Manual of Mental Disorders (DSM):

The first edition (DSM-I) was published by the American Psychiatric Association (APA) in 1952, and there have been four editions since that time: DSM-II, published in 1968; DSM-III, published in 1980; DSM-IIIR which is a revised third edition published in 1987; and the DSM-IV published in 1993.

The major reason for publishing the DSM-IV is to make the diagnostic systems used in the U.S.A. compatible with ICD-10 to ensure a uniform reporting of national and international health statistics (Kaplan 1991). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is the official diagnostic nomenclature of the American Psychiatric Association (APA). It contains sets of criteria for determining the presence of various mental disorders in individuals with disturbances of thought, emotion, or behavior. The diagnostic criteria are largely based on the presence, duration, and cause of various physical and psychological sings and symptoms. DSM-IV disorders are defined on the basis of available clinical knowledge. The DSM-IV contains an introduction, sets of instructions for use of the manual, diagnostic descriptions for mental disorders and appendices. The diagnostic descriptions are divided into 17 categories based on shared features. A standardized, self-explanatory outline is used to describe mental disorders.

The Multi-axial Assessment, a complete DSM-IV diagnostic formulation contains assessment based on five axes, each of which refers to a different domain of information.

1. Axis I is the site for recording most clinical diagnosis.
2. Axis II is the site for recording personality disorders and mental retardation.
3. Axis III is the site for recording general medical conditions that have relevance to the diagnosis or treatment of disorders on axes I or II. Axis IV is a list of relevant psychosocial and environmental problems.
4. Axis V is a scale (Global Assessment of Function-GAF) for rating the overall functional level.

Each disorder in DSM-IV is associated with a discrete set of criteria that is necessary for making a diagnosis.

4.4 Measures used in mental health

A wide variety of psychological measures are used in psychiatry and community mental health work. Psychiatric rating scales, also called rating instruments provide a method of quantifying aspects of a patient's psyche, behavior, and relationship with individuals and society. Many psychiatric rating scales have been developed which are able to measure carefully chosen features of well-formulated concepts. Without these scales, quantitative data in psychiatry are quite crude which don't allow reliable comparison and communication. Rating scales can be specific or comprehensive, and they can measure both internally experienced (e.g.

mood) and externally observable (e.g. behavior) variables. Specific scales measure discrete thoughts, mood, or behaviors, such as obsessive thoughts; comprehensive scales measure broader abstractions, such as depression and anxiety. The broadest type of rating scales measures overall severity of illness, such as the Global Assessment of Function Scale (GAF Scale). This scale comprises axis V in DSM-III-R.

There is a number of formalized measures that can be utilized in developing the work of community mental health services. These standardized measures may be categorized into five types.

4.4.1 Diagnostic and clinical functioning measures

These measures assist in the diagnosis of social functioning level and assessing different sizes of community groups. A famous measure in current use is the General Health Questionnaire, which is aimed at identifying and assessing the psychiatric conditions that are not psychotic. The Brief Psychiatric Rating Scale is well known in the field and had good reputation for its reliability and validity in assessing severity of symptoms and the way these symptoms have changed over time (Puckett 1993).

4.4.2 Social functioning measures

Social functioning measures are necessary to create a base line from which to chart changes in attainments, to plan systematic rehabilitation and to decide priority in the allocation of resources. A social functioning scale can also be used to compare client's problem and may be a form of planning

future developments in this service. The World Health Organization's Psychiatric Disability Schedule (WHO 1988), provides a detailed coverage of social role performance that can be rated in an objective fashion. It provides full details for scoring and interpreting the results. The emphasis upon social functioning allows for better comparison between the needs of persons suffering from psychiatric disorders and these measures promote more effecting social planning.

4.4.3 Measures for specific target groups

There are many commonly used measures for potential target groups in community mental health services. The main areas of concern in community mental health are chronic schizophrenia, anxiety, depressive groups, and families in treatment.

4.4.4 Positive mental health measures

Positive mental health measures received little interest in the past, but with growing emphasis upon preventive education, they need more publicity. Measures are available to test the mental health of community groups and these can be useful in evaluating the impact of program designed to improve mental health (e.g. Index of Psychological Wellbeing).

4.4.5 Community assessment measures

Various forms of measures exist to assess the psychiatric morbidity in the community mental health service area, to determine the mental health of

target group, or to assess the attitudes towards the psychiatrically ill in the services particular geographical area (e.g. General Health Questionnaire).

4.5 Social factors and mental illness

Most mental disorders have not been associated with specific causes. Probably the causes are complex – as in human development. The right mix of biological, environmental and life experience produces "mental health" and imbalances or deficiencies singly or in combination produce the so called "mental illnesses".

It is undeniable that social factors, both positive and negative, can have an effect upon both the prognosis and causation of psychiatric conditions. The link between social factors and psychiatric illness is mediated through unidentified intervening variables, the individuals nervous system, and further unidentified intervening variables before becoming manifest as a form of psychiatric illness. It is difficult at present therefore to measure precise effects of social factors upon individual mental ill-health.

Social factors which are fairly easily measured are first identified, for example social class, as contrasted to factors that are some what difficult to identify, for example the emotional climate within the sufferer's family. Both sets of factors may well equally influence causation or outcome in mental illness.

4.5.1 Social factors that are fairly easily measured.

- **Social class**

Almost all-mental disorders appear to occur more frequently and to be more severe in the socio-economically deprived segment of the population. The discrepancy between the rates for rich and poor is probably less in the affective disorders and in the most severe types of mental retardation, and is most marked in the milder types of mental retardation and in schizophrenia. The link between social class and schizophrenia was demonstrated in a number of studies, with exceeding chance of expectation in the lowest social classes more than highest social groups (Henderson et al 1998).

An intense debate arose about this subject. Freeman (1984) Suggested in his work that it is not simply being in the lowest social class by itself that causes the condition of schizophrenia, but additional factors increase the existing potential vulnerability of the individual sufferer, such as the lack of reasonable financing position and the degree of social stress experienced by the individual (Puckett 1993). In the studies quoted by Freeman (1984), it was discovered that the incidence of schizophrenia was the same in all social classes, and it was the prevalence that was making the difference. It would appear therefore that the poor people with schizophrenia were not given the adequate treatment and therefore the overall total was much greater.

In other word, poorer people don't have the same equity of access as those who are rich people.

- **Gender**

The sex distribution of the major groupings of mental illnesses shows considerable variations. Illnesses characterized by antisocial behavior, particularly aggression, are much more common among males (Henderson et al 1998).

In psychopath and criminal behavior males greatly outnumber females. Among alcoholics and other drug abusers, the male / female ratio is about 5:1. Mild mental retardation is usually more prevalent in males, in a ratio of about 1.5:1. Schizophrenia appears to strike the two sexes approximately equally, but the affective disorders are twice as common among females (Henderson et al 1998). There is a preponderance of females more than males in psychiatric hospital admission, some times 40 percent than males (Puckett 1993), this is explained by the much higher rate of depression amongst females than males. High rates of depression amongst women may be partially a consequence of the harsher effects of industrialization upon females.

- **Urbanization**

Great social changes are taking place in both industrialized and developing countries. While industrialized countries run a rapid automation in production and services, developing countries are at a more fundamental stage of transition, from traditional to more modern ways of life. Rapid urbanization is always accompanied by mechanization in industry and different social

institutions, often seem to develop independently, and this leads to change challenges and stresses that are reflected in the health status of different social groups (Lieberman 1975).

A large number of studies have shown proportionately more chronically mentally ill persons in the centers of cities as opposed to outlying suburbs. The major reason for this is the existence of cheaper boarding – house types of accommodation, which over time tend to decay in favor of a higher accommodation standard available in outer suburbs. Even when city-center renewal takes place, the residue of homelessness amongst the mentally ill simply accept the conditions of homelessness. A significant study in New Zealand comparing controlled groups of women in urban and rural areas found no difference in psychiatric morbidity. A study by Warner suggests the social networks in rural areas may be more supportive than those in urban centers. It may be that rural and urban areas have other factors that make differences in rates of psychiatric illness. For instance, in the Republic of Ireland the rural areas have the highest hospitalized rates for the mentally ill, but such findings, may be explained by other historical and cultural factors, including migration. In some rural areas, there is greater dependence upon the weather, and geographical isolation may incline towards loneliness and depression. (Puckett 1993).

- **Unemployment**

Unemployment is now commonly cited as a reason for the apparent increase in mental illness. A study by Brenner in the USA showed the effects of a one percent increase in unemployment on other areas of society, for example recording an increase of 4.1 percent in suicides and 3.3 percent in first admissions to psychiatry hospitals, as well as other adverse social effects. Brenner repeated his study in 1987 in Sweden where presumable social data is better detailed. The main findings of his last study entails that a six-year post-depression effect follows an economic recession (Puckett 1993). During the first two years of recession, there is an increase in suicide rates and other violent deaths as a result of criminal aggressions. After the two years following the recession, a second effect occurs where both physical and mental health deteriorates. Brenner's study therefore provides hard evidence that unemployment is a crucial variable in deteriorating health.

Unemployment is therefore seen as a number one mental health menace (Henderson et al 1998).

- **Migration**

A number of studies reveal that some migrant groups have a higher rate of schizophrenic breakdown than the host population. The process of migration itself may provide a source of stress producing breakdown in the predisposed groups (Henderson et al 1998). The groups that suffer torture and forced migration are often vulnerable to more complex mental problems. In 1997,

the Human Rights Foundation of Turkey conducted a study on the Kurdish people who was evacuated and displaced from his villages in the eastern part of Turkey to Istanbul in the nineties (Karali 1997). Some of the immigrants were affected deeply by the events. The most common psychiatric disorder amongst them was major depression, and the second was PTSD. The psychological characteristics of the migrated group were observed as : hopelessness about future was frequent, depression and anxiety scores were higher, PTSD and depressive syndromes were more frequent and depression always accompanied PTSD.

- **Season of birth effect**

A surprising finding in recent years has been the link of rate of schizophrenia with the season of birth. Findings demonstrate that the birth of persons with schizophrenia in the winter and spring seasons of the year are more than the expected rate by 5-10 percent. It is thought that environmental factors are implicated, although clearer reasons are not established (Puckett 1993).

4.5.2 Characteristics that are harder to measure

These characteristics demonstrate how subtle forms of social influence may be related to psychiatric illnesses.

- **Stigma, labeling and alienation**

Stigma and labeling have been popular concepts with sociologists. Stigma may cause isolation to the mentally ill and their families, but it is difficult to

verify that it is itself the cause of the condition. Sociologists have argued that labeling a human as a schizophrenic encourages him to behave and show "craziness". Social isolation has been considered to be a factor in mental illness, but again it is much more likely to be a consequence than a cause. Actually social isolation may act as a vicious-crircle factor. Alienation from the dominant social group may be the cause of a number of deviations as crime, suicide or mental illness (Henderson 1998).

- **Social disintegration**

Social scientists have often argued that stable and cohesive societies produce better rates of mental health, while disintegrated societies will be characterized by higher rates of psychiatric morbidity. There appears to be as yet no firm conclusion on the effects that social disintegration may have on psychiatric morbidity (Henderson 1998).

- **Emotional atmosphere in the family environment**

Family functioning varies enormously over time, and family members are more likely to move into more disadvantageous modes of functioning during times of stress. Different studies showed that indifferent, uninvolved and neglected parenting tended to increase aggression, low self-esteem, poor self-control and disturbed parent-child relationships in the Children. Long-lasting changes in the family functioning are also more likely to occur in the families with parental psychiatric disorder and include marital disharmony,

marital violence, child sexual or physical abuse and substance abuse (Gopfert 1996).

The risk of disturbed child development is greatly increased by marital conflict. More over, it was observed that some schizophrenics relapse, more quickly than others when discharged home. Some family environments may there fore be most deleterious than others, despite the buffering effects of neuroleptic drugs. Family atmospheres in which responses to sufferers are ones of rejection or hostility, or where there is emotional over-involvement, are likely to be those that will impair the sufferer mental health (Suvisaari et al 1998).

- **Effects of stress**

Stress affects every one and, although it can serve as a useful stimulus, excessive stress can lead to physical and mental illness. The degree of stress experienced by individuals may explain why some particular persons break down, even though others in the same social class, gender or work group may not. To help the health sector to assess the consequences of stress on peoples' lives, the World Health Organization (WHO) has developed methods of measuring changes in mood and function and a measure of "Quality of life" (WHO 1997). The psychological and behavioral manifestations of stress may take different forms and be of varying intensity. Among the most commoly measured long-term manifestations of stress are

self-reported psychosomatic complaints, psychiatric symptoms or complaints about well-being.

- **Social networks**

The number of people that this person is in contact with and the quality of such contact may have a considerable effect upon level of mental health. Relations have been established between social networks of people with psychiatric illnesses and their utilization of mental health services. There is sufficient evidence to suggest that large social networks and adequate social supports are associated with less likelihood of hospital admission. More over, available data suggest a positive effect of social support on outcome (Becker et al 1997). Quality of life appraisal tends to improve in social networks but such increases may level off to an optimal level of network size.

- **Depression and the environment**

Probably most progress in relating psychiatric morbidity to social factors has been achieved with depressive disorders in females, so that depressive conditions were claimed widely to be a result of social circumstances. Apart from the research into female depression, the connection between social factors and mental illness is still difficult to determine.

An interesting study (Puckett 1993) reviewed the mental health of women in New Zealand in 1990. The main finding of this study showed that psychiatric morbidity was affected by a variety of factors; having poor physical health,

having difficulties with alcohol, having been physically / sexually abused as a child, coping with children without adequate child care assistance, lacking public or private transport, and having poor health and welfare services.

This indicates that a range of biological, environmental and social factors are responsible in producing psychiatric illnesses.

4.6 Mental illness and culture

Culture determines the external expression of individual mental life as represented by customs, manners, skills, language, parent-child interaction, beliefs, and social life. Cultures differ in their definitions of health, illness, and healing and also differ greatly in child-rearing patterns, social models and expectations, role opportunities, and other variables. Cultures are traditional in that social practices are passed from generation to generation. Culture also encompasses the notion of a group of persons sharing a system of action and beliefs capable of persisting larger than the life span of any one individual. In that sense, every culture is historical and genetic (Kaplan 1991).

4.6.1 Cultural aspects of mental illness

Every culture possesses a value system of good, bad, desirable, and undesirable behavioral patterns. The influence of culture on the reporting and presentation of symptoms must be considered especially in relation to the way mental illness may express itself (Dwairy 1995).

Whilst many of the major Western psychiatric conditions appear to exist globally, the way in which symptoms may be expressed can be rather different. There are different cultural explanations of mental illness as well as different forms of treatment depending on the individual culture.

4.6.2 Culture change and culture shock

Individuals respond to culture change either by moving into a different culture or by staying out while the culture changes around them. When the change is acute and sweeping as occurs in migration, refugees, and colonization; the adaptive mechanisms of individuals, and of their social support may be overwhelmed. Clash of cultures and the resultant culture shock is characterized by anxiety or depression, a sense of isolation, de-realization, and depersonalization. Studies have demonstrated a higher rate of psychiatric hospitalization in the United States for immigrants, especially young men, than for native-born (Kaplan 1991).

4.6.3 Culture – bound syndromes

Some mental disorders are found only in certain cultures or among certain groups. The notion of culture-bound syndrome is conceptually simple but operationally complex. As culture is the matrix in which all biological, psychological and social functioning operates, it means that all mental syndromes are, to some extent, culture-bound. Yet, there is a controversy about the validity of culture-specific mental illness. Critics of the culture bound syndromes argue that such conditions are merely variants of an

underlying mental disorder, and if observers do more effort and care they will find evidence of such condition anywhere. Amok, which is a disorder characterized by sudden outburst of homicidal aggression is believed to be a culture – bound disorder of Malay Peninsula, Java and Philippines cultures was observed to exist amongst aboriginal group in parts of Australia. Western psychiatrists, for example, tend to view mental syndromes in western societies as culture-free; but bulimia is as shaped by western culture as koro is by oriental culture. The symptoms of anorexia nervosa are related to cultural expectations of weight and body image in modern western industrial society (Puckett 1993).

4.6.4 Culture differences in the explanation of mental illness

In modern western society culture, mental illness is explained on rational basis as the results of biological or psychosocial maladjustments. In other cultures the explanation is invariably one of supernatural nature. The supernatural explanation was actually dominant in the western societies as well before the coming of a rational, scientific basis to social order. Supernatural causes of mental illness can be divided between those caused by discarnate spirits and those caused as a result of supernatural manipulation by those living in contact with the subject concerned.

AL-Krenawi & Graham (WHO 1996), describe the work of the spiritist movement among the Bedouin Arabs in the Negev region, attempting to develop cooperation between traditional healing and modern practice in the

field of mental health. The khatib or hajjab are male healers who produce amulets that are worn on the body to repel off evil spirits. Ritual treatments are based on ancient practices: books that originated in Egypt and Morocco describe how to prepare amulets, indicate the process for placing them on patients, and reproduce the Koranic verses that are intoned during treatments. The dervish treats mental illness using a variety of religions and cultural rituals. Women and men become dervishes by virtue of having received Baraka, or a blessing from God, which is endorsed by a recognized dervish. Diagnosis commonly involves the laying on the hands or contact with an item of clothing or some other personal belonging; a trance occurs, during which the dervish detects the presence of the jinn (evil spirit) and identifies the etiology of the problem. According to the symptoms observed, the dervish classifies the patient as having either a markob (Demonic possession or psychosis in modern scientific terminology) or a darbaat blaad (an attack from evil spirits inhabiting the earth). Giving such specifically spiritual or supernatural causes, treatment mainly consists of exorcism, countering the influences of sorcery, resolving the problems of departed ancestors, and solving the problems of the subject having broken tribal taboos (WHO 1996).

4.7. Mental disorders and genetics

4.7.1 Behavioral genetics

The task of psychiatric genetics is twofold. For any given abnormal behavioral trait, investigations in population genetics have to demonstrate the

existence and relative distribution of hereditary influences on a disorder and to determine the mode of inheritance of these influences (Kaplan 1991).

Genetic effects on behavior are demonstrated by different genetic studies.

1. Pedigree and family risk studies use a family tree to show the occurrence of traits and diseases within a family. This helps to assess whether genetic factors are involved and, if so, the mode of inheritance of a trait or disease.

The frequency of the disease in relatives of the proband is then compared to the frequency of the same disease in the general population.

2. Adoption studies

Adoption studies using twins reared together or apart are used to distinguish the effects of genetic factors from environmental factors in disease. Twin studies may involve monozygotic twins or dizygotic twins. If the disorder is genetic in origin, it is expected to occur more often in monozygotic twins than in dizygotic twins. If both twins have a trait, they are concordant for that trait. Heritability is the degree to which genetic factors are responsible for an illness. Most of the family risk studies and adoption studies agree that schizophrenia has a strong tendency to run in families. Endogenous depression tends to be associated with familial aggregation (Andrew 1998). There is also good agreement across all studies of anxiety neurosis in families that the condition is familial. Phobic disorders also appear to be familial, while hysteria has no genetic basis.

Although environmental factors are most likely affect the expression of genetic factors in schizophrenia, these factors are probably outweighed by genetic influences. Genetic factors appear to be involved in the etiology of both unipolor and bipolar affective disorder. The concordance rate for bipolor disorder is higher than that for unipolar disorder. Intelligence quotient (IQ) is concordant in about 85% of monozygatic twins given if they are raised apart, mean while IQ is concordant in about 50% of diazygotic twins. Evidence indicates that genetic factors play a role in antisocial, obsessive compulsive, schizotypal, histrionic, and schizoid personality disorders. Alzheimer's diseases appear to have a genetic component. In many cases, there is a family history of this disease. Actually, there is a high concordance rate for Alzheimer's disease in monozygotiz twins.

Tourette's syndrome, Huntington's disease, Wilson's disease, and infantile autism also have genetic components. Studies indicate that a genetic component is involved in alcohol abuse. The concordance rate for alcoholism in monozygotic twins may be as much as two times greater than in dizygotic twins (Shanner 1997).

4.7.2. The Biological approaches

The search for biological markers aims to establish signposts on the connecting pathways between abnormal genes and abnormal behavior. Biological approaches move nearer to the primary gene products to dissect out the genetics of psychiatric disorders more effectively (Kessler et al 1986).

The vast advancement nowadays in brain imaging technologies and in neurochemistry and neurophysiology of the nervous system would enhance dramatically the search for biological markers in psychiatric disorders in a consistent and reliable way. Computed tomography (CT) assesses the structure of the brain and identified some abnormalities in schizophrenia, where as positron emission tomography (PET) assesses both the structure and some aspect of brain function (e. g. blood flow). Magnetic Resonance Imaging (MRI) and evoked potentials (Eps) and polysomnography are widely utilized in clinical settings (Kaplan 1991).

4.7.3 Genetic markers

Exciting prospects have been opened up by the revolutionary advances in the mapping of the human genome (organisms complete set of genes). The development of techniques using recombinant DNA promise to provide many new markers, which will ensure extensive mapping of the human genome. Restriction fragment length polymorphisms (RFLPs) which depend on normal variations in DNA sequences have already allowed the mapping of the gene for Huntington's chorea, which is located on chromosome 4, (Kaplan 1991). Other RFLPs studies have suggested chromosome 21 as a site for the genetic defect in Alzheimer's disease. The X chromosome and chromosome 11 in bipolar disorder and chromosome 5 in schizophrenia.

The concept of genetic engineering has generated a great deal of excitement in the field of genetics as regards the ability to modify DNA and RNA so that

both the messages and the expression of the messages can be manipulated experimentally. Through the extensive advance in genetic markers and genetic engineering, it may be possible to identify and localize the genes involved in a disease process, allowing the molecular and pathophysiological nature of disease to be understood, potentially treated, and perhaps prevented. Currently, the principal preventive role for psychiatric genetics is in the offspring counseling and advice to psychiatric patients, their families, and prospective spouses. The role of the genetic counselor is educational to verify and dispel mistaken beliefs, for example, that all offspring of a patient with serious mental illness are necessarily afflicted by "hereditary taint", which is not true. Effective prevention can ultimately occur only when we understand the diathesis, comprehend the stress, and are able to usefully evaluate the ways in which biological, genetic, and environmental factors interact to produce mental disorder. (Kessler 1986).

4.8 Prevention of mental and neurological disorders

The prevention of a considerable proportion of mental, neurological and psychosocial disorders is now possible in an attempt to avoid the impact of such illnesses. It is estimated that at least half of all such disorders in developing countries can be prevented by methods that are simple; effective and that cost little (WHO 1990). There are three levels of prevention: Primary prevention, secondary prevention and tertiary prevention. Primary prevention focuses on identifying current harmful influences and on supporting helpful environmental influences. Secondary prevention means intervening as early as possible to reduce the impact of a psychiatric illness, meanwhile tertiary prevention aims at reducing the residual defect of a chronic mental illness either by preventing complications of the illness or by rehabilitation of the patient or by a combination of the two. Primary prevention is considered the true prevention in the sense that its aim is to stop a psychiatric illness from occurring at all (Puckett 1993). It comprises those measures applicable to a particular disease or group of disease in order to intercept their causes before they affect people. Primary prevention should be differentiated not only from treatment and rehabilitation, but also from health promotion, which consist of procedure serving to enhance the quality of life, general health and well-being (WHO 1998).

Most mental and neurological disorders have multiple and interacting causes, with biological, psychological and sociocultural components. Much of the preventive work should be done by the general health services and through the intervention of other governmental sectors, such as employment/industry,

education; environment and social services, as well as non-governmental community based organizations, such as health support groups; charity groups, clubs and other bodies. The primary prevention of mental illness puts particular emphasis on the education of families, children; teachers and other influential members of the community who have a vital complementary role to that of the general health services (WHO 1990)

4.9 Treatment in mental illness

Treatment of mental illness is concerned with the early case findings, prompt diagnosis and treatment of medical and psychological problems before they overwhelm the person and become resistant to early intervention. Many mental health problems are poorly defined and as yet lack specific treatments. In mental health, non-specific treatment is often the only treatment available (Lieberman 1975). There is a wide variety of treatment approaches in mental illness.

4.9.1 Biomedical approach

The discovery of phenothiazines in 1952 provided a powerful tool for psychiatrists to cure psychotic diseases and reduce the number of asylum patients. Psychopharmacology has added a great deal to the list of specific therapy in the past four decades. Specific therapies include neuroleptics, antidepressants, mild tranquilizers and many other psycho-pharmaceutical preparations. Many mental health workers believed deeply that the elimination of psychiatric disorders was just round the corner. However,

some leading psychiatrists noted that exclusive reliance on the biomedical model leads to elevation of psychotic symptoms solely by means of heavy dosages of medication, rather than the consideration of factors for the potential of personal growth. Moreover, the long use of neuro-leptics in Schizophrenia may precipitate the often-irreversible complication of tardive dyskinesia appearing in some 10-40 percent of patients taking this form of therapy (Alanen et al 1986). Heavy medications may also lead to negative psychological effects, for example lack of motivation and social isolation (Puckett 1993). Nowadays, most professionals prefer the use of drugs with other treatment approaches to improve the efficacy of treatment. Electro-convulsive therapy (ECT or shock) is also considered a modality of more or less specific somatic therapy.

4.9.2 Psychological approaches

Psychotherapy is a process where by a socially sanctioned healer seeks to help persons overcome or alleviate psychologically caused distress and disability by a systematic procedure linked to a theory of the source and nature of the sufferer's difficulties. There are more than 100 alleged forms of psychotherapy, all of them, with the exception of behavioral therapeutic approaches, fall into one of two broad categories: dynamic or experiential The basic concepts of dynamic psychotherapy rest in the role of the unconscious and defence mechanisms to explain behavior.

Experiential psychotherapy evolved from the concepts of fragmentation of the self, existential despair, and the lack of unity with one's own experiences (Kaplan 1991).

The focus of the therapy is on the present and the mode of change is in the immediate experience of one's emotions. Some critics argue that psychotherapists are not concerned with economic conditions of their clients that are responsible on many of their problems. The attitude of the patient and the skill of the therapist rather than the ideology are usually the major factors in producing change. Despite differences in theoretical orientation, a primary goal of Western psychotherapy is to enhance self-actualization of the individual. To achieve this the therapist helps the patient to become aware of repressed emotions and needs (Dwairy 1995). Many varieties of cognitive-behavioral therapy exist and some cognitive-behavioral treatment programs were developed to address the cognitive distortions and deficits identified in depressed children (Harrington 1998).

4.9.3 Social approaches

In contrast to psychological approaches, which deal with intrapsychic phenomena and interpersonal problems, the social approaches to mental illness treatment attempt to modify attitudes and behavior by altering the environmental factors contributing to the patients mal-adaptation. Researchers in this field emphasized the need for psychotherapeutic treatments to reduce the need for heavy neuroleptic medication. The provision of psychotherapeutically oriented community ward as inpatient

beds are always required in practice. The assistance of close relatives to maintain a positive attitude towards the client was found to be crucial to the prognosis. The use of trained volunteers can fulfil a crucial role in the care of the mentally ill by undertaking an essential therapeutic intervention, which will relieve the pressure on full-time professional staff and utilize valuable natural resources within the community. Self Help groups form a very significant part of the essential recovery process from a mental illness. These are usually sponsored by non-governmental agencies for the aim of helping people with a particular type of difficulty.

4.9.4 Behavioral approaches

Behavioral therapy has its foundations in theories of the learning process. The role of the behavior therapist is that of a teacher who tries to make change in the patient's mal-adaptation. The specific problem and the factors that precipitate this problem must first be identified. The focus of behavior therapy is on the present life problems and direct change, by positively reinforcing desired behavior produced by the client (Puckett 1993).

4.9.5 Treatments mostly identified with community mental health

- **Crisis intervention**

It is believed that individuals are more motivated to change in crisis more than at other less stressful periods. Long experience with crises intervention model indicates that it has fostered two significant developments in

Community mental health practice. First, it has emphasized the importance of a short time frame work in dealing with persons exposed to hazardous life circumstances. It has urged the change of professional practice to ensure that time-limited help would be made available on immediate and intensive basis during the first days following the crisis. Second, the model defines crisis as a period of opportunity as well as danger, and links the chance for improved mental health with the quality of the person's immediate coping and problem solving reactions (Caplan 1986). Crisis intervention method appears to make for the best use of limited resources.

- **Brief problem-solving treatment**

Howton and Catalan have developed this approach from the crisis-intervention theory (Puckett, 1993). It can be applied to almost any type of counseling situation and not limited to times of crisis. In this method, the client fully collaborates in description of his problems to the therapist. This enables the therapist to assess the problem and set priorities for action. Counseling may get into a deeper stage if a good relationship between client and helper is reached. The helper may be able-with caution-to diagnose the inconsistencies in the clients behavior compared with their expressed attitudes (Counselor confrontation), and suggest possible motivations for certain behaviors exhibited by the client (interpretation).

- **Family dynamics and general systems theory**

The Family is the primary group in which most children in most societies are nurtured physically and emotionally, and made ready for entry into the larger

social system of the community. The family not only produce food, shelter, clothing, and love, it also determines the major elements of health: genetics inheritance; primary physical and psychosocial environment; and skills to cope with the physical and social environment of the community (Liberman 1975). Much work into the family as a system was stimulated by the work of some anti-psychiatrists. The focus of family therapy is still concerned with the family as a system. It can be argued that any treatment is incomplete without attention to the family – in person, by the responsible therapist. In more recent years, intervention centered around the concept of "expressed emotion" has been attempted in families of schizophrenics. Which indicates that relapse of schizophrenia is more likely if patients live with relatives who are excessively critical or over-involved. The more patients are exposed to high levels of expressed emotion, the more likelihood they have relapsing.

- **Outreach**

Outreach approach entails going outside the usual forms to seek out the needs where they exist. The functional catchment area of outreach teams such as social clubs for the alienated young unemployed, who may also be suffering from psychiatric illnesses, was found to be fruitful in primary prevention and early detection and treatment of mental illnesses. Workers who are attached to police services could find much opportunity for outreach work to potential clients (Morrice 1976).

- **Theoretical models for community mental health**

Research in community mental Health has developed some new models for working professionals. Those models try to enable workers to go more deeps in understanding the nature of mental problems and various ways mental illness manifests itself. One model portrays how clients may enter one of five levels of psychological disturbance, how services each level may be and how various types of therapies may be used in response to the illness (Tyrer 1987). The operation of such a model requires considerable teamwork among community, primary care, social agencies, and hospital staffs.

4. 10 Mental health services

4. 10.1 Historical background

Mental health care have been the subject of considerable change overtime. In the medieval period, mysticism prevailed and there was little emphasis on institutions, except for the dangerously mentally ill. Quite often, the mentally ill could be treated humanely and sometimes they were taken to healing shrines in an attempt to cure them. By the seventeenth century, a more tolerant view of mental illness and other forms of social deviation prevailed (Wing 1978). The main regard was focused on the moral aspect of conduct. The mentally ill together with the beggars, the profane, libertines, and dabblers in sorcery were regrouped without differentiation and banished into the closed world of the custody mental hospital. At the beginning of the seventeenth century, the Poor Law was introduced in England. Accordingly, the mentally ill and all types of paupers were forced by local authorities to serve in the workhouses. Much of the spirit of public psychiatry tended to follow this unfortunate precedent.

A major factor in the early development of public measures for handling persons with mental illness and mental retardation was protection of the community from unacceptable or irrational behavior. As a result, in most countries of the world, a substantial institutional system developed as a repository for these persons extruded from the community. For many years,

prior to new advance in the treatment for the mentally ill, these institutions constituted an" all or none" resource. Either the mentally ill stayed home without any care, or he was put in an institution where total maintenance was provided. Once there, he was likely to remain; whatever skills he once possessed died in isolation (Ganser 1975).

4.10.2 Deinstitutionalization movement

Discharging of large numbers of patients from public psychiatric hospitals back to the community to receive care in outpatient facilities is the process known as deinstitutionalization.

After World War II, and the experience of providing mental health services for the military, considerable new knowledge became available. Gradually, from the 1940s, the process of deinsitutionalization began. This process was greatly accelerated by the breakthrough in the development of psychotropic drugs in the mid-1950s for relieving symptoms of mental illness, and alternatives to institutional care became better understood. By the early 1960s community care programs were organized on a large scale in America and the Western industrial countries, and the role of the mental hospital was still accepted alongside with the community approach (Jones 1979). The impetus for continuation of deinstitutionalization was enhanced more by the pressures of the public and politicians against the mental hospital system and the disturbing reports about the miserable situation of the mentally ill patients. Governments also became pressured by the increasing economic burden of

mental hospital system and by the advance in social sciences and the growing antipsychiatric lobby that argued for a community based system.

In the United States, there were 8500 inpatients in the mental hospitals in 1860 and by 1960 a grand total of 535,000 had been reached. It is significant to notice that only 132,164 inpatients were in hospitals by 1980 as a result of the continuance of de-institutionalization process (Puckett 1993).

Mental health services have almost certainly changed more than those of any other branch of medicine since 1948. Over 150.000 mental hospital beds in the early years of the National Health Services in Britain (NHS) have fallen drastically in number, and have largely been redistributed into general hospitals and other settings. Despite some oppositive attitudes to the deistitutionalization movement, a wide number of studies have demonstrated the possibility of treating seriously psychiatric ill people entirely in the community, and patients with their relatives preferred this approach.

The trend to desert out mental hospitals has been hard on the chronic patients, particularly the elderly, their families, and the whole community. Many of these patients continued to receive psychiatric treatment and rehabilitative services in various aftercare clinics. Others were placed in new institutions, such as halfway houses, board and care facilities, and public housing units.

Many of them had to be re-hospitalized, and a revolving-door policy emerged with up to 80 percent of patients being readmitted within two years of discharge (Kaplan 1991). Several studies have demonstrated that without an active, multifaceted, round-the-clock care system for all aspects of the patients care, the chronic mental patients will regress in the community as they did in the state mental hospitals. Some studies indicated an increase in stress on the caring families and a high proportion of chronic patients down drifted into even more stressful and miserable environments with significant increase in numbers of homeless persons (Weller 1989). Weller, who was a vigorous opposition of de-institutionalization in Britain, demonstrated an inverse correlation between psychiatric bed provision and the prison population, homicide, suicide, and general death rates. Some people believed that the problems of the chronic mentally ill were not solved and other problems have been created by de-institutionalization.

4.10.3 Community Mental Health

As a result of the powerful de-institutionalization movement, many countries of the Western World, particularly the United States, Britain, Italy, and Australia attempted a major dismantling policy. Inspite of the reformers intentions, mental hospitals have remained in all mental health systems. It is estimated that these institutions take in a million people in Europe, under various statutory provisions. Community mental health services have proliferated around the mental hospital on a specialist basis which has given

rise to fragmentation and creating a circuit in which community services and detention processes complement each other and reciprocally maintain themselves in being (Leonardis 1986).

In the United States of America, the congress passed the Community Mental Health Centers (CMHC) Act in 1963. The act provided funds for the construction of CMHCs with specified catchment areas of 75,000 to 200,000 population each. Each CMHC must provide five basic psychiatric services: inpatient care, emergency services on 24-hour basis, community consultation, day care (including partial hospitalization programs, half-way houses after care services and a wide range of outpatient services), and research and education. By the early 1980s , there were about 800 CMHCs in operation. Due to the severe financial constraints, the CMHCs function in the U.S.A. is severely limited. State mental hospitals in the U.S.A. still utilize the majority of state allocated mental health financing (Kaplan 1991).
The nature of the community mental health role was and is still perceived in different ways and approaches by professional writers and mental health researchers and agencies.

Early at the beginning of de-institutionalization, Gerald Caplan stressed the value of a preventive approach rather than just reacting to mental illnesses once they are presented (Caplan 1986). Other researchers proposed a wide range of services that community mental health services could provide. These services include preventive activities, programs of rehabilitation for the

seriously mentally ill, promotion of mental health throughout the community, utilization of a particular community's strengths and support systems, the use of cost-effective methods in improving mental health (such as working with groups of sufferers, families, and appropriate target groups), case-management services, physical support services, medical care and mental health care as required. The community mental health movement views community mental health as a total system, rather than a single service. It should be concerned with the prevention and treatment of mental disorders and with the rehabilitation of former mentally ill persons through the use of organized community programs. It approaches individual patients through the resources of the community.

The Italian experience of deinstitutionalization and reform of mental health services was actually unique and much different from the United States and most European countries experiences, were dinstitutionalization has been reduced to dehospitalization. The Italian reform attracted international recognition as being the only instance of an industrial society eliminating detention in a mental hospital from its range of mental health agencies and services (Leonardis 1986).

Franco Basaglia in particular had thrown open the doors of psychiatric clinics in Italy. Franco Basaglia began working at the Trieste Psychiatric Hospital in August 1971. He set about forming a team from the young doctors, psychologists, social workers, volunteers and students who had been drawn

to Trieste by the influence of the current critical hypothesis on psychiatry and "total institutions" in politics, the media and public opinion (Dell' Acqua et al 1985).

Franco Basaglia's point of departure was his realization that the psychiatric hospital had absolutely no therapeutic or healing value, that it, in fact, produced illness.

In order to care for the other in a humane way, it was necessary to redefine relationships, discover new spaces, and make the subject emerge (Dell' Acqua et al 1995). The creation of a therapeutic dimension in the psychiatric hospital was impossible without first destroying the hospital itself. The changes carried out by Basaglia and his team were focused around three major themes: shutting down of the psychiatric hospital, the construction of an alternative network of services, and the "Patient not the illness" was situated at the center of the search to create therapeutic, rehabilitative and emanicipatory processes, which are the creation in praxis of the user's active participation in the services. The laws which have reformed psychiatric care in Italy have brought about profound changes. Individuals affected with mental disorders to day have access to therapeutic, rehabilitative and emancipatory programs, with their full rights intact, in the concrete reality of their daily lives, and within their family and social environments. Nowadays, approximately 15.000 guests still present in the 57 psychiatric hospitals in Italy will be transferred by year's end to residencies and family groups and

will finally return in many cases after an entire lifetime, to their home and communities. In the 1970s, there were 120.000 inmates and 90 psychiatric hospitals (Dell'Acqua 1991).

Many of the general public will be highly puzzled by the seemingly paradox of studies demonstrating successful and highly desirable effects of the community mental health approach compared with other studies seemingly indicating the extreme hazards of caring for the mentally ill in a community that does not really appear to want them.

In 1998, the Prism psychosis study was conducted in England with the production of 10 papers providing a comprehensive picture of all aspects of community care for severe mental illness (Tyrer 1998).

The major finding of the Prism study is that standard case management is at least as good as intensive case management in its general effects on symptoms and disability and for people with lower levels of impairment is sometimes superior (Wykes et al 1998). As a natural consequence of this, the cost advantages found in the previous studies of intensive case management and assertive community treatment were not shown in the Prism study.

As admissions were similar in both teams, intensive case management was significantly more expensive than standard management and offered no

apparent advantages whatsoever (Wykes et al 1998). Other results of the Prism psychosis study suggest that both intensive and standard community care are effective in improving the lot of the average patient with a psychotic disorder and that no special advantages are offered by the intensive services (Szmukler et al 1998). In fact, that is somewhat paradoxical effect of the intensive service apparently creating increased dependence in those that are less psychotic and increasing rather than reducing the incidence of violence. This is the main single point of concern over community care. Most of the public would prefer patients who are disturbed to be placed in an institution away from them rather than disturbing their own lives, even if they are more satisfied with living in the community than in the hospital (Tyrer 1998). In Australia and New Zealand, assertive and intensive community treatment for the seriously mentally ill have rarely been fully integrated into a comprehensive catchment area community and hospital mental health service. 64 clients of suburban Sydney with a serious mental illness who had previously experienced repeated hospitalizations without benefit, were provided with an innovative assertive community mental health service. Following the implementation of the service, on-going evaluation revealed 62% decrease of psychiatric bed days occupied by these clients. The number of clients admitted decreased, client functioning improved, and symptom severity decreased, to a significant degree (Hambridge et al 1994).

In China a retrospective study conducted in Nanjing compared the two-year outcome to 78 schizophrenic patients who attended four enterprise-based

sheltered workshops (experimental group) with that of 78 schizophrenic patients who attended an out-patient clinic (control group).

Despite the experimental group had a longer course of illness and more prior hospital admissions than the control group, at the end of the two years patients treated in enterprise-based sheltered workshops had significantly less psychological dysfunction and less severe psychiatric symptoms. Moreover, compared with the control group, over the two-year period a smaller proportion of the experimental group experienced a clinical relapse or hospital readmission (Luo et al 1994).

4.10.4 Forms of community care for the mentally ill

- **Community mental health centers (CMHCs)**

The increasing development of comprehensive community mental health services for the mentally ill over the past years has initiated dramatic changes in mental health administration and planning. These changes require accommodation to community participation, consumer satisfaction, decentralization, and new organizational relationship with other public and private services systems.

The nucleus of work in the community has been in many areas the community mental health center (CMHC), which has been the focal point of

care outside the hospital services. Working in the community enables the therapist to see and treat individuals in their social context.

The community services usually provide an out-of-hours crisis services, which allow clients to gain assistance and treatment when they feel in urgent need. Such access binds the staff and clients and their families together and facilitates what is called "the therapeutic alliance".

The primary worker in the CMHC provides the basic therapeutic care for clients and arranges referrals to other required services. The community center allows its staff to relate to community individuals when a need arises, creating a model for effective social intervention on a larger scale.

The organization and philosophy of a CMHC, which has to provide a comprehensive, curative and rehabilitation service for all potential cases in its catchment area, should be based on the principles of non-selection of demands, non-hospitalization, high degree of flexibility and mobility, and the involvement of multiple resources in the therapeutic and support programme (Mezzina et al 1995).

There have been a number of approaches to what exactly community services should provide. In the United States of America, the Congress legislation in 1963 called for five required services by each CMHC. Later on, the public law required the addition of services for children, services for the

aged, screening before hospitalization, follow-up services for those discharged from hospitals, transitional housing services, alcoholism and drug abuse services. A more specific list of needs has been researched by the Medical Research Council (MRC) Social Psychiatry Unit in London (Pucket 1993). The needs have been classified into clinical problems and social problems. The clinical problems indicate the need for intensive medically based services with in the community setting.

The social problems for those who have persistent symptoms and limited social skills indicate the need for residential accommodation. This is especially necessary for those highly dependent persons with little family support, poor physical health, disruptive behavior and poorly controlled psychiatric symptoms. Provisions on a larger scale are needed for the rehabilitation of majority of sufferers from a chronic form of psychiatric illness, oftenly schizophrenia, who require more social support and comprehensive care. The requirements are divided into day center care, residential care, work placements and opportunities. In the United States the core and cluster model has been developed, which requires the presence of a CMHC but which also includes intensive services on site such as food cooperatives, adult education classes and workers support group. Creative opportunities in the day center care are of utmost importance in providing clients with a purpose for living, especially most of them will be jobless. Creative writing, creative arts, and educational and cultural programs represent other forms of intervention to empower and develop subjects (Mezzina et al 1995). Social

coops are today an important tool for emancipation, with the possibility of working and acquiring a social role other than that of being "mentally ill", has radically transformed the field and prospects of rehabilitation. Mental health associations have been created composed of patients, family members and ordinary people and "social enterprises". They develop projects and foster expectations to create work opportunities for thousands of young operators who are motivated to work in this sector (Dell'Acqua 1991).

- **Intensive case management**

Recently, intensive case management (ICM) has been increasingly and systematically adopted by western countries mental health systems as a system of service delivery. Despite the good work of community mental health centers, there has been an emphasis on engaging mental workers, oftenly of varying background, to undertake the work as brokers to some specific services needed by the client in order to achieve better rehabilitation. Sometimes the term "care management" is preferred as a more neutral term, as some clients don't accept to be described as " a case" (Puckett 1993). In this form of community mental health care, work is conducted in the client's home or other suitable setting and is definitely not "office-based".

The methods of intervention take place in real-life settings, clients are selected on the basis of high priority, and crises are anticipated and prevented. The average ratio of staff to clients is one to ten, teamwork amongst the staff is emphasized and staff need to be tenacious in dealing

with difficult bureaucracies. Usually, the staff work is closely and in partnership with the family of the client and if a crisis occurs, the response needs to be rapid. If re-hospitalization is considered necessary, the case manager will operate closely with the inpatient staff.

Intensive case management is perceived as being successful though actually more expensive than traditional forms of care. Behavioral health care has changed dramatically in recent years with the growth of managed care. A particularly important type of managed care is a carve-out, in which mental health and substance abuse care are administered separately from medical care (Schoenbaum et al 1998). Implementation of behavioral health care carve-out may be accompanied by substantial reductions in inpatient utilization and payments for treatment of mental illnesses (Merrick 1998).

Managed behavioral health care vendors use care management techniques, including utilization management and exclusive provider networks, as a mechanism for controlling claims costs (Huskamp 1998).

Critics of managed care are concerned that the use of care management techniques by vendors who face financial incentives to control costs will result in under-treatment or poor quality of care. The humanitarian aspects of care are threatened particularly by the increasing time and financial pressures exerted by managed care (Spiggle 1998).

The quality of the clinician-patient relationship may be affected as increasing demands for paperwork and record keeping compete with the time spent with patients. Although implementation of managed care can substantially reduce treatment costs, concerns have been raised about its potential effect on severely ill populations (Young 1998). Some researchers indicate that community forms of service organization may have some modest indirect positive effects upon individual outcomes, but there direct effects are at the service level in terms of improved access to and continuity of care. The current confusion about the role of case management, both in terms of its definition and its effects, also reflects precisely this distinction between the active treatment and the treatment delivery process (Thornicroft et al 1998). Although many believe that intensive case management has led to less frequent hospitalization and to a higher quality of client life, it seems that case management remains not well-defined, poorly described and its full characteristics un-researched.

- **Alternative primary health care model**

1. Mental health and primary health care

Psychological disorders are among the most common reasons for seeking consultation in general practice. It is estimated that nearly 77% of all psychiatric consultations are actually carried out by PHC physicians (Al Haddad 1999).

promotion should necessarily include concern for psychological wellbeing and the quality of mental health and emotional health. Mental health should receive special attention in every aspect of health care and should be integrated within primary health care (WHO 1990).

2. Scope of mental health in primary health care

Mental health as a component of primary health care comprises two distinct areas which are often confused. The first emphasizes the practical relevance of psychosocial and behavioral science skills in general health care. These skills are vital to improve general health care facilities and activities. They are also very essential in promoting mental and emotional health and so enhancing the quality of life. Traditionally, these skills have rarely been considered a task of health care workers, and this needs to be changed (WHO 1990).

The second area is concerned with the control of mental and neurological diseases. In general, this area is better understood by health professionals, ad has often been regarded as too highly specialized for general health workers. However, scientific research suggests that general health workers can manage many mental and neurological disorders.

General health personnel can do well in the prevention as well as diagnosis and treatment (including rehabilitation) of people with mental and neurological disorders. Mental illness does not always need specialized

treatment, and even severe mental illness can be managed without hospitalization.

Training primary health care workers and equipping them to deal with mental health problems avoids wastage of effort and cost. Moreover, the responsibility for mental health is not an additional burden for primary health care services, on the contrary, it increases and improves their effectiveness.

A variety of treatments suitable for use within a primary health care system are available for mental illnesses. They have been proved to be inexpensive and effective. The role of mental health specialists in this approach should be focused on providing supervision and training. This supervision of primary health care workers by mental health specialists is an essential component of the process. The increasingly prominent role of the family physician in delivering mental health care can be enhanced by collaborative action with local mental health services (Kates et al 1997).

A Canadian programme achieved this by bringing mental health counselors and psychiatrists into the offices of 87 family physicians in 35 community activities in Southern Ontario. The programme made mental health care more available and accessible, increased continuity of care, and led to a decreased and more efficient use of other mental health services. Psychiatric disorders are frequent among young adolescent primary health care attendants, usually associated with physical symptoms and health risks.

They are often not recognized during consultations. Attention to mental health problems of adolescents in primary care would seem highly appropriate and have beneficial effects for physical and mental health (Kramer et al 1998).

Common mental disorders (CMD) are an important cause of morbidity and disability in primary care attenders in Africa. A case-control study carried out in three types of primary care services in Harare, Zimbabwe, revealed significant results. The main finding indicates that intervention at the primary care level should be targeted at CMD cases who are likely to be persistently ill. The trend noticed is that the recognition of morbidity by health care workers is associated with an improved outcome. This suggests that recognition of CMD by general health workers might lead to therapeutic benefits. Using local relevant terminology for mental disorders have added effect of improving outcomes in this group of patients. Further policy initiatives to provide economic and social support may help reduce the chronicity of CMD (Patel et al 1998).

Primary prevention of a considerable proportion of mental, neurological and psychosocial problems is possible by methods that are simple, effective and with little cost. Much of the preventive activities should be done by general health services and workers in collaboration with other sectors and agencies. The primary prevention of mental illness emphasizes on the education of families and children. Teachers and other influential members of the

community play a vital role complementing the role of general health workers (WHO 1990).

3. Involving the community

As stated in the declaration of alma Ata (1978), health care systems must involve the community at every level of planning and development. Health care should be based on the actual needs of the community. Mental health services are sensitive to the needs of the population served if the public is actively involved the community should participate in decisions concerning its mental healthcare and program's, instead of having them defined solely by professionals. Community participation implies that individuals and families assume responsibility for their own health and welfare and for the whole community. They should develop capacity to participate in the assessment of health situations, in the definitions of problem, and in setting priorities (WHO 1990). The principles of good health are concerned with the recognition and satisfaction of community needs, attitudes and aspirations. No area in health care is more relevant to these principles than mental health care.

Mental health professionals have been often distant from the community they serve due to physical seclusion of mental health care facilities. In the community approach, mental health workers should be part of the community they serve. They should know what the community identifies as problem areas and initiate constant dialogue with key community groups to identify community concerns. Mental health professionals should carefully define the

role of traditional healers and integrate this within the community mental health care.

Moreover, they must integrate the contributions of other community groups such as teachers, local leaders, police officers, social workers, and spiritual leaders in mental health care. Several cooperative forms can be effective in this respect such as: self help groups, problem solving groups and common interest groups. Expressed simply, community participation is an alliance of great importance between people, policy makers and health workers for a common purpose (Nakajiima 1992).

- **Contributions to mental health from other sectors**

The efficient delivery of mental health care requires involving other sectors in the community to contribute in meeting mental health needs. Workers in education, police, social work and community welfare and development have an importance role to play in supporting mental health care. Intersectional collaboration, involving governmental and non-governmental organizations, is very important in the development of national mental health policies and program's. Within the public service agencies, schoolteachers and police officers have regular and close contact with the community and can contribute much to the community mental health. Schools offer an excellent opportunity and can be instrumental in the promotion of mental health and prevention of mental disorders (WHO 1991). Teachers can have a significant influence on the school pupils and their families in the promotion of general and mental health principles.

A number of developing countries introduced school mental health program's into the health education program's in schools. The health education material would concentrate on several simple messages to schoolchildren such as: smoking, drug abuse and tolerance for the disabled. The teachers are trained and supplied with guidelines to recognize the relevance of psychosocial factors in child development and emotional factors in learning. They should also be able to detect and cope with the children's emotional and behavioral problems (WHO 1990).

The policemen control various social situations including disturbed families, abusers of alcohol and drugs victims of crime. They can play an important role in the detection and management of mental disorders if they are taught about mental health principles and how to apply them in dealing with the community.

Non governmental organizations (NGOs) are directly or indirectly involved in a variety of social and community services, often including health services. NGOs are usually deeply committed and well accepted by the communities they serve. This enables NGOs to play a pioneer role in offering a variety of services such as running mental health program's counseling, rehabilitation, accommodation and employment.

Intersectoral collaboration implies the necessity of establishing national mental health coordinating groups representing the health system, education, police, social welfare, NGOs and all other concerned sectors. The coordinating groups should continue developing, monitoring, modifying mental health program's and play their role in policy-making.

4.11 Mental health and mental health services in Gaza Strip

4.11.1 Common mental disorders in the Gaza Strip

Situational analysis

Palestinians have been the victims of more than 50 years of aggression, occupation killing, deportation, detention, torture, breaking bones, confiscation of land, demolishing homes, and violation of all their basic human rights and national aspirations. The oppression against the Palestinian people have been continuos and immense to affect all the population and each individual Palestinian. During the "Intifada" the Israeli authorities have escalated its collective brutal punishment of the Palestinian people in Gaza and West Bank. Oslo peace accord triggered a lot of hopes and high expectations among Palestinians despite all there sufferings, wounds, and suspicions. Regretfully, the implementation of the Oslo peace accord by the Israeli government during the past 5 years seemed to be a punishment against the hopes and choice of Palestinians who are eager to peace and justice. The Palestinian populations in the Gaza Strip suffered much more due to besiege and closure in a narrow space with overpopulation, unemployment, poverty, and various social and political adversities. Surviving in such adversities with continuous suffering and uncertainty have a severe impact on whole aspects of mental health of the Palestinian people. The primary victims of such adversities have been Palestinian children and adolescents, who constitute about 50% of the total population. A study of 238 children of 9-13 years old was conducted in Gaza

Strip (Thabet et al 1998) revealed that 21.5 % of children suffered one way or another from anxiety, and their teachers reported high rates of mental health problems in the children (43.4%). Another study of 239 children showed that 39% of children had moderate to severe PTSD reactions after exposure to trauma (Thabet A et al 1999).

Prevalence of mental disorders in the Gaza Strip

Mental Health services did not exist in Gaza until 1970, when an outpatient clinic was opened in the main general hospital (El-Sarraj et al 1984). At present time, there is still lack of organized data on the status of mental health among Palestinians (National strategic Health Plan. Palestine, 1999-2003). There are little available epidimiological data on the psychiatric morbidity, prevalence, incidence, and distribution of mental disorders in the Gaza Strip. Despite the advances achieved in mental health research and mental health care in Gaza over the past years, the bulk of people who need some form of mental care is difficult to estimate. It is believable that 30-40,000 are incapacitated by various mental and psychological problems; the majority of them don't seek help, fearing of stigmatization associated with specialized psychiatric care (Afana 1995). In 1998, the public mental health services including Al-Nasr psychiatric Hospital and other three governmental community mental health clinics in khanyounis, Sabha, and Beitlahia have treated 30,000 people. Of these 19179 cases were met in the community mental health clinics with 36 % suffering different psychotic disorders, 23 % mood disorders, 24% anxiety disorders, 1 % organic mental disorders, 7%

substance abuse disorders, and 9 % mental retardation and developmental disorders (Samour 1999). The Gaza Community mental health program (GCMHP) which adopts a community approach mental health saw 1153 new cases in 1997, of which 16% suffered anxiety disorders, 18% organic mental disorders 19% childhood disorders, 17% mood disorder, 4% somatoform disorder, 4%psychosis, 1% personality disorders, 1% drug abuse, 16% undecided, and 4% other cases (GCMHP 1998).

A recent epidemiological study on the prevalence of stress related psychiatric disorders among Palestinians in the Gaza Strip was conducted by the GCMHP teams. This study is a part of a multi-site trans-cultural research program for the identification, management and prevention of psychological and mental health problems of refugees and victims of organized violence (GCMHP 1998). The study included a sample of 600 individuals representing different locations of the population in the Gaza Strip. The results of the study revealed that the lifetime prevalence of stress related psychiatric disorders is 34.2% with more prevalence in males than females and refugees than citizens. Post-traumatic stress disorder (PTSD) was the most frequent stress-related diagnosis found in the sample (19.5%), with more frequency in males (23.7%) than females (15.8%) and refugees (24.7%) than citizens (11.7%). It was significantly less frequent in the younger age group (16-22 years) than other age groups, (12.4% compared to 22 % in the older age groups). Resettlement areas had the highest frequency of PTSD (30.8%) compared to cities (13.2%) and camps (22.1 %). Other risk factors for PTSD were unemployment, evidence of child

maltreatment, trauma experienced before 12 years of age and after 12 years of age, and family history of mental illness. Major depression lifetime diagnosis was found 17.6% of the sample. Although males had a higher prevalence than females in depression, the difference was not statistically significant (19.7% males; 15.8% females). Refugees had higher rate (20.5%) than citizens (13.6%) Among the important risk factors associated with depression, the study revealed the importance of daily hassles suffered by camps inhabitants in positive correlation with depression, followed by trauma before 12 years of age, and unemployment in the 40-60 age group. PTSD was the only diagnosis in 7.8% of the whole sample. Morbidity of PTSD with other mental disorders was found in 55% of the cases (30.4% with major depression, 26.5% with anxiety, and 19.6% with somatoform disorders). The prevalence of all anxiety disorders was 13.2%.

Palestinian children mental health

Children constitute 50% of the Palestinian society. The status of the Palestinian children has always been on Par with, or worse than, that of the Palestinian community in which they live (Abu Hein 1997). The extent of Palestinian children exposure to traumatic events is horrific even at the statistical level. According to a survey conducted by Gaza Community Mental Health Program (GCMHP) of 2779 children, 92.5% were exposed to tear gas, 42% were beaten, 55% have witnessed beating, 4.5% have had their bones broken or had severe injury, 85% were exposed to night raids, and 19% were detained for short periods of time (El Sarraj 1993). For more

than 30 years since the Israeli occupation in 1967, Palestinians in the Gaza Strip and West Bank have been exposed to continuos severe sufferings and stressful situations. Such stressful situations and experiences dramatically increased during the Intifada, which resulted in a variety of mental health problems and diseases such as anxiety, post-traumatic stress disorder, and depression (Thabet 1995). In a recent study to estimate the rate of posttraumatic stress, reactions in Palestinian children who experienced war traumas, and to investigate the relationship between trauma-related factors and PTSD reaction (Thabet et al 1999), the researchers examined a sample of 23, children of 6 to11 years of age. The study revealed high rates of post-traumatic stress reactions in Children of primary school age that had experienced war. Of those examined, 73.2% reported PTSD reactions. Children of refugee camps were more likely to experience PTSD. This result may reflect mediating adversities of the refugee population such as relocation and disruption of school life or peer relationships. It could also reflect higher exposure to life events such as house demolition (Thabet et al 1999).

A study of the relations between the level of traumatic experiences, degree of active participation in the Intifada, and cognitive and emotional responses among 108 Palestinian children of 11-12 years of age in the Gaza Strip showed significant results (Qouta et al 1995). The more traumatic experiences the children had and the more they participated in the Intifada, the more concentration, attention, and memory problems they had. Intifada participation decreased self-esteem and increased neuroticism and risk taking. The highest level of neuroticism was found among active boys who

were exposed to many traumatic experiences (Qouta et al 1995). Children's active participation in the Intifada could not protect them from developing emotional problems as was assumed before. (Qouta et al 1995). In addition to the divasting effects of war trauma on Palestinian children, other social adversities have a serions impact on their lives. According to a study conducted in Gaza to investigate the rate and nature of anxiety symptoms and disorders in children, and their relation to social adversities (Thabet et al 1998), children reported high rates of significant anxiety problems (21.5%) and their teachers reported high rates of mental health problems in children (43.4%). Anxiety problems, particularly negative cognitions, increase with age and were significantly higher among girls. Low socioeconomic status was the strongest predictor of general mental health problems and living in camps was strongly associated with anxiety problems (Thabet et al 1998). Most important victims of political suffocation in the Palestinian community are children, and this is obvious in child labor (Abu Hein 1997). A study of 300 randomly selected male children working in different arias of the Gaza Strip showed that a large percent (33%) of children laborers work in mechanical job in garages and a total of 55% work in difficult and dangerous jobs that might lead to permanent handicaps for soft developing bodies (Abu Hein 1997). The growing child labor force in the Gaza Strip is an immediate and necessary result of poverty and unemployment due to the suffocation imposed by Israeli authorities.

It is currently estimated that 3% of the population of Palestinian children under the age of 15 years are disabled. Many of these disabilities are a

direct result of Intifada related injuries and the remaining disabilities are the result of preventable causes if appropriate parental, environmental, and health awareness and care services were available (Arafat 1997).

Palestinian women mental health

Palestinian women often believed to be suffering from the effects of three major realities: being female, living in a restricting male-biased and dominated culture, and living under the Israeli military occupation. They are after all, not very different from most other women whether in the Middle East or other parts of the world (Sansur 1995). The Palestinian women constitute half of the Palestinian population. They from 9.4% of the labor force in Gaza. Of those, 23% work in the services sector, 13.5 % in industry, 15.8% administrative field, and 11.7% in other auxiliary fields. Only 2% of Palestinian women labor force work in Israel and the settlements. A study on the experience of GCMHP clinics with women's mental health problems in Gaza over the period from 1992-1994 revealed that a significant number of women suffer mental disorders (El-Masri 1995). In the period mentioned 6,534 new patients were seen of these 1,792 were adult females over 18 years of age. The percentage of women kept increasing from 33% of total adults in 1991 to 45 % in 1994. Single adult females were 18% of total adult females, while single males were 29%, divorced women were 5%, and widowed 5%. About 20% of females had some form of mood disorder compared to only 13% of males, 15% of females had a somatoform disorder compared to only 6% of males. The most common disorder met in these

women was major depression, which is related to stressful life circumstances. 5% of females presented with some from of psychotic disorders compared to 9% of males, while surveys show equal prevalence of chronic psychotic disorders in both sexes. Living in an extended family, early marriage, social inferiority, lack of education, and different political adversities are all risk factors for the mental health of Palestinian women (El-Masry 1995). Another study of 500 Palestinians at random in the West Bank and Gaza Strip, showed 40-50% of women with various manifestation of psychological distress (Sansur 1995). Symptoms of depression, somatization disorder, and obsessive compulsive behavior were more common among the women interviewed than the other categories and were more significantly correlated with various aspects of women's lives. Older urban women of poor education and socioeconomic status were more symptomatic than other groups. Chronic life events of social or economic nature were no less important than those life events directly related to occupation in their impact on the women's mental health (Sansur 1995).

Palestinian detainees mental health

Since the Israeli occupation of the Gaza Strip and West Bank in 1967, the Israeli authorities kept increasing its brutal practices against the Palestinian people. No Palestinian City was excluded from having a detention center for interrogation, investigation and detention. Between 1967 and 1987, approximately one half million Palestinians endured detention in Israeli jails for varying terms ranging from few days to life in prison (Abu Hassan 1997).

During the years of the Intifada (1987-1993), the Israeli detained about 175,000 Palestinian citizens (Abu Hassan 1997). Despite the signing of Oslo accord and other agreements by both Palestinian and Israeli officials, there are still more than 3000 Palestinian detainees kept in the Israeli jails, suffering from extremely difficult living and mental conditions (Abu Hassan 1997). From the first moment of arrest, the physical torture begins. The prisoner is hand cuffed, his head is covered with a bag, often beaten, and cursed at by the interrogators (Francis, 1997). More than 90% of torturers use the "al-shabh", Where the prisoners legs are tied to small tool and his hands are tied behind the back with a bag put over his head (Francis 1997). One of the most damaging forms of physical torture is "shaking" where the interrogator shakes the prisoner violently from his collar for over a minute (Francis 1997). Psychological torture which was allowed by Landau commission and legislated by the Israeli high court includes, prevention from sleep for long periods, confinement in a narrow cell, deprivation of food, exposure to loud music, degrading the dignity of the detainee, threatening to cause disability, threatening the detainee with rape, sexual abuse and the rape of his wife or relatives. Other methods used by the Israeli include holding the detainee with traitor, exposure to extreme temperatures, preventing from using the toilet, and exposure to lye detection devices (Abu Hassan 1997). The trauma of torture derives its specificity from the goals that torture pursues. Besides the extortion of information and terrorizing the entire community, torture aims at the complete control, humiliation, and destruction of the personality and identity of the victim by systematically breaking up the

person's defense and coping mechanisms (Patsalides 1997). Imprisonment and torture belong to frightening events that are, according to the diagnostic criteria of the American Psychiatric Association, out side the range of normal experience and which are psychologically damaging (Qouta et al 1997). Research have confirmed a link between exposure to torture and subsequent disorders including depression, anxiety, post traumatic stress disorder (PTSD), antisocial behavior, and non-specific physical complaints. More over, researchers agree that psychological harm may not occur with out the survivor appraising the experience as overwhelming and exceeding his or her capacity to cope (Qouta et al 1997). In a study of prison experiences and coping styles among Palestinian men in Gaza Strip, the researchers interviewed 79 Males ex-prisoners who were imprisoned during the Israeli occupation, and about half of them during the Intifada (Qouta et al 1999). The study revealed seven different types of prison experiences, one only of them characterized by suffering and disillusionment was exclusively negative. The other experiences included relatively rewarding perceptions and described imprisonment either as a struggle, heroism, and the duty of a man, a road to development, growth in insight, or a return to religion. In the sample studied, perceiving imprisonment, as a developmental task was the most frequent and return to religion was the least frequent. The more torture and ill-treatment men reported the more often they perceived imprisonment as suffering and ill treatment, and the less they emphasized religious commitment. Torture and ill-treatment experiences were associated with coping styles characterized by wishful thinking, avoidance, and self-controlling. Those who showed wishful

thinking and avoidance were associated with high level of neuroticism, and those who perceived imprisonment as growth in personal insight suffered more from neurotic symptoms than other ex-prisoners. The findings suggest that psychological well being depend on both the major normative demands of one's age and culturally and socially accepted values. The age-graded tasks for young men in the Palestinian society relate to participating in the struggle for national independence. Hence denial, avoidance, and wishful thinking were not either socially or developmentally accepted coping modes, and they were related to poor mental health. Also, tendency to appraise imprisonment as a search for insight, as opposed to heroic and practical perception, was associated with poor mental Health.

Substance abuse problems in the Gaza Strip

One of the most serious consequences of the Israeli occupation and the chronic sufferings of the Palestinian people has been the spread of drug abuse in the Gaza Strip and West Bank. Before the Intifada in 1987, the drug abuse problem has reached its height and variety of substances abuse spread like marijuana, alcohol, cocaine, heroin, and sedative – hypnotic drugs (Thabet et al. 1992). Many people believe that the Israeli authorities have intentionally encouraged the dissemination of illicit drugs throughout the West Bank and Gaza Strip within a planned policy to destroy the Palestinian individual and society (GCMHP 1997). No doubt that the work of hundreds of thousands of Palestinian laborers inside Israel, surrounded by a subculture engaged widely in drug use, have affected largely the Palestinian society in

this respect. With the eruption of the Intifada, it was observed that the number of hard substance abuse cases dropped dramatically (Thabet et al 1992).

The impression of local health workers was that the Intifada has been socially therapeutic. Depression or hopelessness have appeared to be replaced by national pride and optimism (El-Sarraj 1990). Moreover, the Intifiada activists combated drug dealing and abuse, shattering the network of collaboration between Israeli and Palestinian drug dealers, and inducing the fear of punishment into both dealers and users (GCMHP 1997). The said above explains the considerable decrease in drug abuse problems during the Intifada Years. With the impairment of the peace process after the Oslo accord, the prevailing political suffocation, unemployment, widespread PTSD, poverty, and frustration have significantly aggravated the problem of substance abuse. It is observed that the number of dug abuse cases who came for detoxification were increasing steadily in the Gaza Strip, giving the impression that the number of drug abusers are more than expected (Thabet et al 1992). Unfortunately, the information available on the nature and extent of drug abuse problems in the Gaza Strip is far from adequate. Although the general upward trend is clear, estimates of consumption are uncertain and information on the prevalence of particular problems including dependence is very hard to obtain. There are many reasons to this, some of which refer to the illegal nature of the substances. A statistical data about the exact number of substance abusers in Gaza never existed (Thabet et al 1992). Some reports indicate that well over 5,000 people in Gaza abuse drugs

(GCMHP 1997). The total number of drug abusers who asked treatment in the community mental health clinics of the ministry of health (MOH) in 1998 was 785 persons. Of those, 186 cases were heroin abusers, 135 cases were hashish abusers, 84 stimulants, 110 tranquilizers, 275 multiple substances, and 5 cases alcoholics. The geographic distribution shows that most drug abusers live in the south of the Gaza Strip (376 cases), 212 cases in the north, and 197 cases in Gaza City (Smour 1999).

The outcomes of treatment in the community mental health department clinics of MOH show that 32 cases were cured without relapses, 125 cured with few relapses, 270 cases have recurrent relapses, and 358 without any change (Samour 1999). The Gaza Community Mental Health Program (GCMHP) has 250 cases of drug abusers. The success rate of treatment is 44 % (11.2% cured and 32.8% improved), 29.1% no change, 10.8% relapsed, 7.2% dropped out, 4.8% closed files, 3% died, and 1.2% referred else where (GCMHP 1997). In a study of 1992 to explain the type of other drugs abused with heroin in the Gaza Strip (Thabet et al 1992), a sample of 120 male drug abusers who are treated at the (GCMHP) was examined. The researchers tried to sort out type of other substances used at Gaza Strip, route of administration, and any correlation between drug abuse and other psychosocial factors. The median age of the sample cases was 30 years, 95 % of them were married, 4% were single, and 1% was divorced.

Geographically, 58% of cases were from Gaza City, 21% from South area, 14% from middle area, and 5% from North area. 38% of the cases were jobless, 45% unskilled workers, and 25% were professionals. From the total

number, 85% abused heroin, 59% hashish, 34% benzodiazepines, 17.5% alcohol, 9% analgesics containing codeine, 5% methadone, 5% cocaine, 3% anti cholinergic drugs, and only one case abused pethidine. Those who abused more than one substance at the same time mounts to 70% of all cases. Only 30% of abusers used heroin alone. As regards the route of administration, 90% used the inhalation method, 37.5% by oral ingestion, and 12.5% used the intravenous injection route. The fact that all the heroin abusers are males in this sample does not mean that there are no female abusers, but most probably the stigma of shame attached to drug addiction prevents the families from bringing female addicts to therapy (Thabet et al 1992).

4.11.2 Mental Health Services Available In Gaza Strip

Introduction

The development of mental health services in Gaza Strip has been shaped by different political, socio-demographic, and cultural factors. The consumers of these services are the traumatized generations who have suffered the turmoil of wars, occupation, the Intifada and now the state of uncertainty during the transitional period.

Mental health Services did not exist in Gaza Strip until 1970, when an out-patient clinic was opened in the main general hospital (El Sarraj1984). Patients were treated by a general practitioner who had only 6 months

training in psychiatry. Psychotic patients were referred to the Bethlehem mental hospital, which was the only available facility for hospitalization.

Mental health services have witnessed remarkable developments in Gaza Strip in the last two decades

Existing mental health services

Governmental Sector

1. El Naser psychiatric Hospital

The Palestinian Ministry of health (MOH) runs a psychiatric hospital in Gaza Strip (El Naser Psychiatric Hospital)

The hospital came into operation in 1978 with 12 beds capacity. It was a part of ophthalmology hospital. The number of medical staff was then 3 doctors. The staff became 4 doctors in 1994 and the capacity has been increased to 34 bed. Rehabilitation of the hospital is going on these days and it is planned to increase its capacity to 52 beds, of which 11 beds are specialized for drug detoxification department. This hospital has now a staff of 8 trained physicians, 3 psychiatrists, 7 psychologists, 2 social workers, 23 nurses, a pharmacist, E.E.G technician and 29 administrative staff and laborers. The hospital has 39 beds with outpatient clinic in Gaza City .the occupancy rate of hospital is 60-70%. The mental health work in the hospital tends to adhere to the medical model with psychiatrists usually having the leading role. The public mental health hospital provides inpatient, outpatient, occupational and rehabilitation, detoxification and forensic psychiatric services. The policy of the hospital is one of short-term hospitalization with average length of stay

16.1 days. Training activities in the hospital include postgraduate training program, undergraduate training of medical students, training courses for PHC physicians and auxiliary nurses training program (MOH 1999).

2. Community mental Health Department-MOH

The Mental Health Department in the Palestinian Ministry of health was established in Gaza in 1994 as a division of PHC directorate. Since 1996 this department runs 4 community mental health centers in Gaza Strip:

- Sabha Community Mental Health Center, this center had been established in 1995 in Gaza City. It has a staff of one-trained physician, 1 psychologist, 1 Social worker, 2 nurses, 2 rehabilitation trainers, and a clerk. Up to date, this center treated 4415 cases (Samour 1997).
- Khan Younis Community Mental Health Center, this center was opened in Khan Younis in January 1996. It covers the mental health services in south of Gaza Strip. The Staff consists of a general practitioner, 2 nurses, 1 Social worker, pharmacist, clerk and other administration staff. The total number of visits to this center in 1998 was a bout 9,000 case.

- El Rimal Child Psychiatry clinic: this clinic was opened in Gaza Strip in 1994. It works for two hours weekly. The cases seen are referred from schools, doctors and other organizations for initial assessment.
- Beit Lahia Community Mental Health center: this is a part time clinic in north of Gaza which opens three days weekly. It is covered by a trained physician, a psychologist and E.E.G technician from the team of Gaza Mental

Health center. There is only an out patient clinic which serves the population of the north of Gaza (150,000) and the daily visitors are not less than 50 cases.

3. Military Medical Services:

The military medical services were established in 1994 by the return of the Palestinian police and military forces at the start of the Palestinian Authority. It has a mental health unit situated in Ansar Camp in Gaza. The mental health unit consists of 2 psychiatrics, 3 psychologists and 1 social worker. It has an out patient clinic that serves the military personnel, their families and the prisoners. The clinic receives about 30 cases daily.

Non-Governmental Sector

The Gaza Community Mental Health Program

The Gaza Community Mental Health Program (GCMHP) is a Palestinian, non-governmental, non-profit institution specializing in mental health concerns. It is one of the leading mental health organizations in Palestine. The program was established in 1990 to address the mental health needs of the community in Gaza Strip It is being funded by a number of international organizations (e.g. Amnesty International, United Nations Fund for Human Rights, Medicine Sans frontiers and charitable bodies in Europe and North America). GCMHP has a board of Directors, which overlooks the activities of the Program and sets general policy. The clients pay minimal fees for therapy and medication and the cases that cannot afford the fees are totally

exempt. GCMHP aims to be a comprehensive Community based, mental health program. There are different specialized departments covering different aspects. GCMHP clinic in Gaza, Khan Younis and Jabalia extend their services to all sectors of society emphasizing on women, children, drug abusers, victims of human rights violations, as will as dealing with different psychiatric disorders (GCMHP 1997).

Of the 93 staff in the GCMHP, there are 3 psychiatrists, 4 trained physicians, 10 psychologists, 4 social workers, 2 physiotherapists, 6 nurses, 1 occupational therapy and E.E.G technician.

Clinical work remains the heart of the GCMHP's sustained efforts to heal the wounds and meet the continued and changing need of the Palestinian community. About 1200 new clients are referred annually. The total number of follow up patients who received treatment in 1996 was 1923 with an average of 4 visits per patient. During 1997, there were 2200 patients with an average of 4.6 visits per patient. Of those, 58.2% were males and 41.8% females in 1996 and 59.9% males and 40.1% females in 1997. In 1996, 41.1% of patients were under 18 years of age. In 1997 this proportion stayed roughly the same as 39.1% of patients were under 18.

Counseling remains the most common from of therapy provided at GCMHP. Most patients receive supportive therapy especially chronic cases. In addition, cognitive therapy, cognitive–behavioral therapy, play therapy and occupational therapy are provided by the program staff. Each clinic of the GCMHP has a pharmacy to provide prescribed psychotropic drugs to chronic cases at an affordable price.

GCMHP has a special project for empowerment and rehabilitation of women where they are trained in leadership, literacy, counseling, public hygiene, legal rights and in a variety of vocational skills.

GCMHP aims to raise the scientific Knowledge and practical skills of its staff by hosting experts from different countries to train the staff and evaluate their work. The program provides out-service training for people working in mental health related fields like education and social work. This is made through courses, workshops, seminars, lectures, and study days.

Currently and for the first time in Palestine and the region, a two-year Post-Graduate Diploma in Community Mental health is being offered in Coordination with the Islamic University of Gaza and the participation of seven international universities.

The Research Center in the GCMHP has conducted a number of research projects regarding the size and distribution of mental illness in Gaza and the effects of different types of trauma and violence on the mental health of Palestinian children and families. A number of research papers have been published in international journals. In 1995, the GCMHP video center began work and produced numerous documentary films about Gaza, GCMHP, children, women and survivors of human rights violations.

Since 1993, GCMHP organized 3 international conferences, which were excellent opportunities for local and international experts to meet and exchange information and research on mental health issues.

UNRWA Health Department

The United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) has a health care program which is primarily community health oriented. The program provides basic health care for the eligible Palestine refugee Population. In the early years of its mandate, UNRWA did not give adequate recognition and planning to mental health programs, because it was preoccupied with other priorities such as communicable disease control and maternal and child health services. In 1989, the departments of health, Education and relief Social services adopted a joint plan concerning the mental health project. Indeed, the first practical step to implement a mental health project was in June 1990, when UNRWA concluded an agreement with Gaza Community Mental Health Program (GCMHP) where by the (GCMHP) agreed to provide medical consultations to patients referred from UNRWA health centers and to train UNRWA doctors on early detection of mental and psychological disorders with special emphasis on children suffering from post-traumatic stress disorders. Training was organized for medical officers, staff nurses, social workers and teachers in separate groups and multi-disciplinary teams in close coordination with GCMHP. A mental health specialist was appointed in charge of the mental health project in Gaza. New posts of school counselors were established by the Education department with a norm of one counselor per ten schools. The Relief & Social services Department provided day care to mentally handicapped children through the community based rehabilitation centers. In

the 1st of January 1994, a Community Mental Health Program for the Gaza strip began with funding by the Italian Government. The program activities included regular visits by the specialist and his team to all health centers, identification, diagnosis and management of mentally ill refugees. Difficult cases were refereed to GCMHP and to Government Mental Hospital. School mental health and other Community activities were done by the program. Due to shortage of allocated resources and the recruitment freeze which was applied in UNRWA in the context of austerity and deficit reduction measures, the impact of the program continued to be limited and it could not meet its stated objectives. In 1996, a decision to discontinue the program was made and the posts of community mental health officer and senior staff Nurse were deleted to establish more needed posts instead. Accordingly all psychotropic drugs were deleted from the Medical Supplies Catalogue of the UNRWA (UNRWA 1996).

Private Sector

Most psychiatrics in the Gaza Strip run a private clinic in the afternoon after their morning practice within other sectors. Now, there are 6 private clinics adhering to the medical model of practice in mental health.

- **Contributions to mental health from other sectors**

Contributions and support to mental health services come from a wide variety of governmental and non-governmental agencies and organizations. The Ministry of Education–Division of Educational Counseling in Gaza Strip

provides school guidance and counseling services to the school children through 98 counselors specialized in psychology and social sciences and distributed all over the schools of the Ministry in Gaza Strip.

The Ministry of Social Affairs- Directorate of Social Welfare and Rehabilitation provides supportive services to the adolescents suffering behavioral problems through the al-Rabieh Association which take care of delinquents.

There are other five vocational training centers for Youths in Gaza, Beit lahia, Dir-Albalah, Khan Younis and Rafah. The number of clients who benefit from these internal and external activities is about 1200 boy and girl Youths. The staff of the Directorate of Social welfare and Rehabilitation consists of 2 psychologists, 13 social worker, 6 behavioral guidance, 1 nurse and 113 teachers and trainers.

The UNRWA Education Department runs a school guidance program and the Relief and Social Services Department provides day care to mentally handicapped children through its rehabilitation centers.

Palestine Avenir Society provides multiple service for the care of disabled children specially in the area of cerebral palsy and ability development. Palestinian Committee for Social and Psychological Health runs a psychological counseling clinic and provide other services especially in the area of research and mental health education. The Palestinian Red Crescent Society has established a center in Khan Younis (Al Amal Center) specialized in the care of mentally retarded children and ability development programs. The Community Training Center and Crisis Management is

interested in the mental health of most vulnerable population to mental problems mainly children, women and the youth. It runs different activities focusing on psychosocial counseling, community training, mental health education and crisis management.

A good number of other local NGOs have some contributions to mental health by running either a general service or they choose a special area in the mental health field. They provide modest range of supportive services to elderly patients, mentally retarded children, orphans, disabled, combating smoking, Anti-drug abusers, ex-prisoners, health education, social & physical rehabilitation, women empowerment and traumatized children. Although recently a medical faculty was initiated in the West Bank, currently no such school exists in Gaza.

Palestinian Universities do not teach clinical psychology or psychiatric social work. The existing faculties train educational psychologists and social workers. The curriculum is Knowledge based and gives little attention to clinical skills (Afana 1997). In the Gaza strip, GCMHP offers the Post-Graduate Diploma in Community Mental Health. Recently, the school of Public Health of Al-Quds University in collaboration with the Ministry of Health initiated a program to grant a Post-graduate Master of Community Mental Health in Gaza.

- **Traditional healers (Folk therapy)**

In the Arab culture, mental illness is considered a major stigma. Many people still believe that it is caused by the devil's possessing the body and that its cure is dependent on God's will. Many Moslems believe in the Koran

as the main method of treatment. The traditional belief system and the increase in rates of psychiatric morbidity ensure brisk business for traditional healers (Al Saraj 1984). Sufferers, by seeking the help of traditional healers, avoid the stigma of being psychiatric patients, and also receive an explanation consistent with their beliefs. Unfortunately, only some of the cases with which the psychiatrists have failed are cured by the traditional healers, others are made much worse. The patient is usually taken to a sheikh (religion healer) who reads a few phrases from the Koran and writes a few more phrases on a paper that should be kept with the patient so as to protect him from the devil. In some cases, beating is used to expel the devil from the body. Other healers use herbal mixtures, some even use the old method of cautery to remove the devil. Such attitudes towards mental disorders are common not only in the general population but also among some managers, planners, policy makers and health workers. These attitudes are not always expressed openly, but they constitute a major obstacle to the development of rational mental health services (Afana 1997). As in the majority of developing countries, mentally ill patients in Arab countries tend to somatise their psychological symptoms. This presentation of mental illness reflects on the pattern of consultation. Patients tend to pass through different health care providing filters before reaching the mental health clinic or hospital. Out of every 1000 citizens 315 have psychiatric symptoms: 230 consult a general practitioner (GP), 101 are identified and diagnosed, 17 are referred to a psychiatrist and only 6 are admitted to hospital. The real challenge for mental health professionals is the first filter.

Cultural beliefs about possession and the impact of sorcery or the "evil eye" affect people interpretation of symptoms. In this context the first resort for the families of mentally ill patients is not necessarily a general practitioner, but traditional healers who acquire special importance because of their claim to deal with superstitious and the unknown (Okasha A 1999).

In Palestine, like all Arab countries, traditional healers form part of the informal health care sector. Although there is no interaction between the medical profession and traditional healers in the majority of Arab countries, in Jordan an informal, unorganized relationship does exist, and in Saudi Arabia they constitute, part of the mental health staff, using religious texts and recitation in case management. Traditional healers do and will continue to provide some form of intervention in the lives of the mentally ill and their families, particularly where access to mental health services at the community level is limited. Emphasis should therefore be given to the study of the positive and negative impacts of traditional healers, to define their roles and to ensure that their activities are governed by an authorized and recognized organization.

- It is apparent from the previous literature review the impact of the tremendous stressful situation and suffering on the general and mental health of the Palestinian people. Under such conditions of occupation, oppression, poverty, unemployment, over-population and uncertainty, the mental health needs, especially of vulnerable groups such as children, women, the elderly and refugees, which are hardly met even in normal

circumstances, are almost completely neglected. The emerging priorities of mental health in developing countries including Palestine are problems of youth, children, women, refugees and the elderly. Hard political situation and trend of events in Palestine show that these priorities need to be addressed swiftly. The major question will be whether the available services could meet this overload?

Chapter 5

Results

5.1 Distribution of mental health organizations and organizations contributing to mental health.

5.1.1 Distribution of mental health organizations and organizations contributing to mental health by governorate in the Gaza Strip, 1999

Table 1 shows distribution of mental health services and other supporting services contributing to mental health in the Gaza strip. Out of 40 centers, there were 21 (52.5%) located in the Gaza governorate, and about 4-6 (10-15%) in each of the other governorates. In Midzone, there is no mental health service.

Table 1 Distribution of mental health services and other supporting services contributing to mental health by governorate in the Gaza Strip, 1999

Governorate	Mental H Services		Supporting services		Total	
	No	%	No	%	No	%
North	3	23.1	2	7.4	5	12.5
Gaza	5	38.5	16	59.3	21	52.5
Midzone	0	0.0	4	14.8	4	10.0
Khan Younis	3	23.1	3	11.1	6	15.0
Rafah	2	15.4	2	7.4	4	10.0
Total	13	100.0	27	100.0	40	100.0

The five major mental health organizations in Gaza Strip are Community Mental Health Department-MOH, Gaza Community Mental Health Program, Military Medical Services-Mental health Section, Public Mental Health hospital-MOH and UNRWA Health Department.

5.2 Mental health organizations

The results in this chapter will focus on the five major mental health organizations in Gaza Strip. Details of organizations contributing to mental health will be described later.

5.2.1 Professionals

a. Distribution of professionals at different Mental Health organizations

Table 2 and annex 1 show distribution of professionals at different mental health organizations. There are five mental health organizations in the Gaza strip with a total of one hundred and eleven professionals. There were 38 professionals (33%) in the public mental health hospital (PMHH); Out of those 8 (21%) are physicians, 20 (53%) nurses, 5 (13%) psychologists, 2 (5%) social workers and 1 (3%) EEG technician. 30 (27%) in the Gaza Community Mental Health Program (GCMHP), out of those 6 (20%) physicians, 6 (20%) nurses, 12 (40%) psychologists, 1 (3%) social worker, 2 (7%) occupational therapists, 1 (3%) physiotherapist, and 1 (3%) EEG technician. 25 (23%) in UNRWA health department, out of those 10 (40%) physicians, 12 (48%) nurses, 2 (4%) physiotherapists and 1 (4%) X-ray technician. 14 (13%) in Community mental Health department-MOH, out of those there are 3 (21%) physicians, 2 (14%) nurses, 3 (21%) psychologists, 4

(28%) social workers, 1 (8%) occupational therapist and 1 (8%) EEG technician. 4 (4%) in the Military medical services-Mental health section respectively, out of those 1 (25%) physician and 3 (75%) psychologists. Respondent rate was 78%. In this study, the lowest response rate was in GCMHP (62.5%).

Table 2 distribution of respondents among professionals at different Mental Health organizations

Organization	professionals	Respondent	Respondent rate	%
Community Mental Health Department-MOH	16	14	87.5	11.2
Gaza Community Mental Health Program	48	30	62.5	33.6
Military Medical Services-Mental health Section	5	4	80	3.5
Public Mental Health hospital-MOH	44	38	86	30.8
UNRWA Health Department	30*	25	83	21.0
Total	**143**	**111**	**78**	100.0

- This is a sample of health workers at UNRWA health department in the Gaza Strip where mental health is integrated within PHC.

- **5.2.1.2 Distribution of professionals at Mental Health Organizations by different health providers**

Table 3 shows distribution of professionals at mental health organizations by different health providers. There were 56 (51%) in governmental health sector; 30 (27%) in NGOs health provider; 25 (23%) in UNRWA health provider.

Table 3 Distribution of professionals at Mental Health organizations by different health providers

Mental health provider	Number	%
Government	56	50
Non-government	30	27
UNRWA*	25	23
Total	**111**	**100**

* This is a general sample of the health workers at UNRWA who had been trained during mental health program in 1994-1995 and which was discontinued in 1996.

5.2.1.3 Distribution of professionals at Mental Health Organizations by age group

Table 4 shows distribution of professionals at mental health organizations by age group. There were 43 (39%) aged 26-35 years; 41 (37%) aged 36-45 years; 17 (15%) aged over 46 years. 10 (9%) were of unknown ages.

Table 4 Distribution of professionals at Mental Health Organizations by age group

Age group	Number	%
26-35	43	39
36-45	41	37
> 46	17	15
Missing	10	9
Total	**111**	**100**

5.2.1.4 Distribution of professionals at mental health organizations by sex

Table 5 shows sex distribution of professionals at Mental Health Organizations, where 79 (71%) were males. Table 6 shows distribution of sex for professionals by Mental Health Organizations. Female professionals constituted about one third of professionals at community mental health department, public mental health hospital in the MOH and at UNRWA health department. At Gaza community mental health program, females' constituted 17% of professionals, while at Military mental health services there were no female professionals.

Table 5 Distribution of professionals at Mental Health Organizations by sex

Sex	Number	%
Male	79	71
Female	32	29
Total	**111**	**100**

Table 6 Distribution of professionals by Mental Health Organizations and sex

Organization	Male		Female		Total	
	No	%	No	%	No	%
Community Mental Health Department-MOH	9	64	5	36	14	100
Gaza Community Mental Health Program	25	83	5	17	30	100
Military Medical Services-Mental health Section	4	100	0	0	4	100
Public Mental Health hospital-MOH	25	66	13	34	38	100
UNRWA Health Department	16	64	9	36	25	100

5.2.1.5 Distribution of professionals at Mental Health Organizations by specialty

Table 7 shows distribution of professionals at Mental Health Organizations by specialty. There were 28 (25%) physicians; 40 (36%) nurses; 23 (21%) psychologists and 7 (6%) social workers. 3 (3%) professionals were of each of occupational therapists, physiotherapists and EEG technicians. Only one (1%) was X-ray technician.

Table 7 Distribution of professionals at Mental Health Organizations by specialty

Specialty	Number	%
Physician	28	25.2
Nurse	47	42.3
Psychologists	20	18.0
Social worker	6	5.4
Occupational Therapists	3	2.7
Physiotherapists	3	2.7
X ray technicians	1	0.9
EEG technicians	3	2.7
Total	**111**	**100.0**

5.2.1.6 Distribution of professionals at Mental Health Organizations by type of first university certificate

Table 8 shows distribution of professionals at Mental Health Organizations by type of first university certificate. There were 51 nurses out of those 18 (16.2%) had B.A. and 29 (26.1%) diploma degree in nursing. 28 (25%) had B.A. in medicine, 20 (18%) B.A. in psychology, 6 (5%) B.A. in sociology. Three professionals (3%) had B.A. in rehabilitation and three (3%) in physiotherapy.

Table 8 Distribution of professionals at Mental Health Organizations by type of first university certificate

Certificate	Number	%
B.A. of Medicine	28	25.2
B.A. of Psychology	20	18.0
B.A. of Sociology	6	5.4
Diploma of nursing	29	26.1
B.A. nursing	18	16.2
B.A. Rehabilitation	3	2.7
B.A. physiotherapy	3	2.7
Diploma X ray technician	1	0.9
Diploma EEG technician	3	2.7
Total	**111**	**100.0**

5.2.1.7 Distribution of professionals at Mental Health Organizations by type of high university certificate

Table 9 shows distribution of professionals at Mental Health Organizations by type of high university certificate. Out of 40 professionals 18 (45%) had high study in community mental health, 11 (27%) in psychiatry, 3 (8%) in psychotherapy, 0ne (3%) in occupational therapy and 7 (18%) in different fields of high studies.

Table 9 Distribution of professionals at Mental Health Organizations by type of high university certificate *(N=40)*

High certificate	Number	%
Psychiatry	11	27.5
Community mental health	18	45
Psychotherapy	3	7.5
Occupational therapy	1	2.5
Others	7	17.5
Total	**40**	**100**

5.2.1.8 Distribution of professionals at Mental Health Organizations by degree of high university certificate

Table 10 shows distribution of professionals at Mental Health Organizations by degree of high university certificate. Out of 40 professionals 28 (70%) had

diploma degree, 7 (18%) had Master degree, 4 (10%) had participation certificate and only one had PhD degree. These high studies are in different fields of mental health.

Table 10 Distribution of professionals at Mental Health Organizations by degree of high university certificate *(N=40)*

Type of certificate	Number	%
Participation	4	10
Diploma	28	70
Master	7	18
PhD	1	2
Total	**40**	**100**

5.2.1.9 Distribution of professionals at Mental Health Organizations by training

Table 11 and annex 1 show distribution of professionals at Mental Health Organizations by training. Only 68 (61%) had training courses. In the Community mental health department, 11 (79%) were trained. In Gaza community mental health program, 23 (77%) were trained. In Military medical services 2 (50%) were trained. Meanwhile at UNRWA health department only 5 (25%) were trained on mental health activities.

Table 11 Distribution of professionals at Mental Health Organizations by training

Training	Number	%
Trained	68	61
Non trained	43	39
Total	**111**	**100**

5.2.1.10 Distribution of professionals at Mental Health Organizations by country of study, training, and experience

Table 12 shows distribution of professionals at Mental Health Organizations by country of study, training, and experience. There were 58% of professionals who studied and got training in Palestine, 28% in Arab countries, 9% in foreign countries and only 5% in Israel.

Table 12 Distribution of professionals at Mental Health Organizations by country of study, training, and experience

Country	First University		High study		Training		Experience		Total	
	No	%	No	%	No	%	No	%	No	%
Palestine	43	39	21	53	32	65	92	83	428	58
Arab countries	60	54	11	27	7	10	17	15	201	28
Foreign countries	7	6	4	10	22	15	2	2	68	9
Israel	1	1	4	10	7	10	0	0	33	5
Total	**111**	**100**	**40**	**100**	**68**	**100**	**111**	**100**	**730**	**100**

5.2.1.11 Training materials attained by mental health professionals working in different mental health organizations, 1999

Table 13 shows training material attained by mental health professionals working in different mental health organizations, 1999. There were 17 professionals trained on anti-drugs and addiction, out of those 7 (41%) were working in PMHH, 6 (35%) in CMHD, 3 (18%) and 1 (6%) in the GCMHP and MMS respectively. Training on psychotherapy included 50 professionals, out of those 24 (48%) were working in GCMHP, 15 (30%) in the PMHH, 8 (16%) in CMHD, and 3 (6%) in the MMS. Training on community mental health included 64 professionals, out of those 35 (55%) were working in PMHH, 15 (23%) in the GCMHP, 8 (13%) in the CMHD, and 6 (9%) in the UNRWA health department. Training on counselling included 5 professionals, all of them in CMHD. Training on crisis management included 8 professionals, 6 (75%) of those in the GCMHP and 2 (25%) in the PMHH. Training on EEG included 8 professionals equally distributed between CMHD and GCMHP. Training on occupational therapy included 7 professionals 5 (71%) in GCMHP and 2 (29%) in the CMHD. Training on rehabilitation and care of hanicapped included 13, out of those 6 (46%) in GCMHP, 5 (38%) in the PMHH, and 2 (16%) in the UNRWA health department. Training on ability development included only 2 professionals in the CMHD. Training on PTSD included 9 professionals, out of those 4 (44%) in the PMHH, 3 (34%) in

GCMHP, and 2 (22%) in the CMHD. Training for trainers and on data collection included 16 professionals, out of those 9 (56%) in GCMHP, 4 (25%) in the PMHH, and 3 (19%) in CMHD. Training on gender education included 4 professionals distributed equally between GCMHP and CMHD. Only two professionals at GCMHP were trained on forensic mental health and only two professionals of PMHH were trained on ECT. Training on human rights included 4 professionals, out of those 2 (50%) in GCMHP and one professional in each of MMS and PMHH.

As shown in the table, training of the UNRWA health department professionals was limited on training in community mental health 6 (9%) and rehabilitation and care of handicapped 2 (16%) of the total professionals trained on these fields.

Table 13 training material attained by mental health professionals working in different mental health organizations, 1999

Materials	CMHD		GCMHP		MMS		PMHH		UNRWA H D		Total	
	No	%	No	%	No	%	No	%	No	%	No	%
Anti drugs and addiction	6	35	3	18	1	6	7	41	0	0	17	100
Psychotherapy	8	16	24	48	3	6	15	30	0	0	50	100
Community mental health	8	13	15	23	0	0	35	55	6	9	64	100
Counselling	5	100	0	0	0	0	0	0	0	0	5	100
Crisis Management	0	0	6	75	0	0	2	25	0	0	8	100
EEG	4	50	4	50	0	0	0	0	0	0	8	100
Occupational therapy	2	29	5	71	0	0	0	0	0	0	7	100
Rehabilitation and care of handicapped	0	0	6	46	0	0	5	38	2	16	13	100
Abilities development	2	100	0	0	0	0	0	0	0	0	2	100
Post Traumamtic stress Disorder (PTSD)	2	22	3	34	0	0	4	44	0	0	9	100

Trainer and data collection	3	19	9	56	0	0	4	25	0	0	16	100
Gender education	2	50	2	50	0	0	0	0	0	0	4	100
Forensic mental health	0	0	2	100	0	0	0	0	0	0	2	100
ECT	0	0	0	0	0	0	2	100	0	0	2	100
Human rights	0	0	2	50	1	25	1	25	0	0	4	100

5.2.2 Distribution of activities

5.2.2.1 Services provided by different mental health organizations in the Gaza Strip, 1999

Tables 14,15,16 show services provided by different mental health organizations in the Gaza Strip, 1999. As regards to diagnostic activities that are provided for the clients, clinical interview is carried out by all organizations. Psychological testing and EEG are done by all organizations except UNRWA health department. X-ray and laboratory diagnoses are carried out by all organizations except GCMHP. As regard to curative services, drug therapy is provided by all organizations. Psychotherapy is provided by all organizations except MMS and UNRWA. ECT is provided only by PMHH. Only PMHH and GCMHP provide detoxification for the drug addicts. All organizations provide preventive activities except MMS. Occupational and rehabilitation services are provided only by GCMHP. The PMHH and MMs provide Forensic mental health. PMHH, GCMHP, and CMHD provide training on mental health. Research activities are carried out only in the GCMHP.

Table 14 Diagnostic services provided by different Mental Health Organizations in Gaza Strip, 1999

Organization	Interview	Psychological testing	EEG	X ray & lab
PMHH	Yes	Yes	Yes	Yes
GCMHP	Yes	Yes	Yes	No
CMHD	Yes	Yes	Yes	Yes
MMS	Yes	Yes	Yes	Yes
UNRWA	Yes	No	No	Yes

Table 15 Mental Health Management services provided by different Mental Health Organizations in Gaza Strip, 1999

	Curative				Preventive	Occup. & Rehab
Organization	Drug	Psych	ECT	Detoxification		
PMHH	Yes	Yes	Yes	Yes	Yes	No
GCMHP	Yes	Yes	No	Yes	Yes	Yes
CMHD	Yes	Yes	No	No	Yes	Yes
MMS	Yes	No	No	No	No	No
UNRWA	Yes	No	No	No	Yes	No

Table 16 Other Mental Health services provided by different Mental Health Organizations in Gaza Strip, 1999

Organization	Forensic	Training	Research
PMHH	Yes	Yes	No
GCMHP	No	Yes	Yes
CMHD	No	Yes	No
MMS	Yes	No	No
UNRWA	No	No	No

5.2.2.2 Number of beneficiaries from services per month at different Mental Health Organizations

Table 17 shows the approximate number of beneficiaries from services per month at different Mental Health Organizations. A total of 14,350 beneficiaries benefited from different mental health organizations monthly. Out of them 5,000 beneficiaries (34.8%) attended at CMHD clinics, 4,300 beneficiaries (30%) benefited from GCMHP, 3,000 (20.9%) attend the clinic of PMHH, 1200 (8.4%) benefited from UNRWA health centers and 850 (5.9%) benefited from MMS clinics.

Table 17 Number of beneficiaries from services per month at different Mental Health Organizations

Organization	Beneficiaries	%
Community Mental Health Department-MOH	5,000	34.8
Gaza Community Mental Health Program*	4,300	30.0
Military Medical Services-Mental health Section	850	5.9
Public Mental Health hospital-MOH	3,000	20.9
UNRWA Health Department	1,200	8.4
Total	**14,350**	**100.0**

5.3 Organizations contributing to mental health services

5.3.1 Distribution of professionals at organizations contributing to Mental Health services

Table 18 shows distribution of professionals at organizations contributing to Mental Health. There were 19 organizations working in this field that were chosen for this study. 193 health professionals are working in these organizations. 34 (17.6%) are working in Palestinian Red Crescent Society-Al Amal City Center of Ability Development (PRCS), 22 (11.4%) in El-Wafa Elderly Nursing Home (EL Wafa), 20 (10.4%) in Ministry of Education-Counseling Department (MOE), 18 (9.3%) in Ministry of social Affairs-Directorate of Social welfare and Rehabilitation (MOSA), 16 (8.3%) in Down's Syndrome Children's Right to live Society (DSCRS), 15 (7.8%) in The National Society for Rehabilitation (NSR), 13 (6.7%) in Palestine Avenir (Pav), 11 (5.7%) IN Society of Physically Handicapped people (SPHCP), AND 8 (4.2%) in the Palestinian Committee for Social and Psychological Health. (PCSPH). About 1-4 (1-2%) are working in each of the following organizations; Al-Amal Institution for the orphans, Society for the care of the handicapped-AlShams (AL Shams), Al Magazi Community Rehabilitation Center (Mg-CRC), National Center for Community rehabilitation (NCCR), Women's Health Center-Burej (WHC-Bj), UNRWA Education Department-Counseling section (UNRWA E), Hope and Life association (Anti-drugs and Addiction) (Hope), Palestinian Association for Rehabilitation of the Disabled

(PARD), Community training center and Crisis Management (CTC) and Palestinian Anti-drug Abuse Council (PADC).

Table 18 Distribution of professionals at organizations contributing to Mental Health services, 1999

Organization	Professionals	%
AIO	5	2.6
AL Shams	5	2.6
Mg-CRC	4	2
CTC	2	1
SPHCP	11	5.7
Pav	13	6.7
MOSA	18	9.3
NCCR	6	3.1
PADC	1	0.5
PCSPH	8	4.2
DSCRS	16	8.3
WHC-Bj	1	0.5
EL Wafa	22	11.4
UNRWA E	4	2.1
MOE	20	10.4
PRCS	34	17.6
NSR	15	7.8
Hope	3	1.6
PARD	5	2.6
Total	**193**	**100**

5.3.2 Distribution of professionals at organizations contributing to Mental Health by gender

Table 19 shows gender distribution of professionals at organizations contributing to Mental Health where males constitute 111 (58%).

Table 19 Distribution of professionals at organizations contributing to Mental Health by gender.

Gender	Number	%
Male	111	58
Female	81	42
Total	**192**	**100**

5.3.3 Distribution of professionals at organizations contributing to Mental Health by profession

Table 20 shows distribution of professionals at organizations contributing to Mental Health by profession. There were 43 (22.4%) social workers, 31 (16%) occupational therapists, nurses and psychologists constitute equally 22 (11.5%) for each, 17 (8.9%) physiotherapists, 5 (2.6%) were physicians, and only 1 (0.5%) was x-ray technician. 51 (26.6%) were cosidered others and most of them are heath educators and teachers.

Table 20 Distribution of professionals at organizations contributing to Mental Health by profession

Profession	Number	%
Physician	5	2.6
Nurse	22	11.4
Psychologists	22	11.5
Social worker	43	22.4
Occupational Therapists	31	16.1
Physiotherapists	17	8.9
X ray technicians	1	0.5
Health educators	25	13.0
Teachers	26	13.5
Total	**192**	**100**

5.3.4 Distribution of professionals at organizations contributing to Mental Health by training

Table 21 shows distribution of professionals at organizations contributing to Mental Health by training. Out of 192 professionals there were 129 (67.2%) who had training in different fields of mental health care.

Table 21 distribution of professionals at organizations contributing to Mental Health by training

Training	Number	%
Trained	129	67.2
Non trained	61	31.8
Missing	2	1
Total	**192**	**100**

5.3.5 Training materials attained by mental health professionals working in organizations contributing to Mental Health, 1999

Table 22 shows training materials attained by mental health professionals working in organizations contributing to Mental Health, 1999. There were 34 (20%) who had training in rehabilitation and care of handicapped, 24 (14%) had training in each of counseling and crisis management, about 17 (10%) had training in each of sign language and mental health education, 12 (7%) had training in gender education. About 6-8 (4-5%) had traing in each of anti drug and addiction, psychotherapy, community mental health, abilities development, human rights, social support, and communication skills. Only one (0.5%) professional had training on posttraumatic stress disorders.

Table 22 Training materials attained by mental health professionals working in organizations contributing to Mental Health, 1999

Materials	Total	%
Anti drugs and addiction	8	5
Psychotherapy	6	4
Community mental health	7	4
Counseling	24	14
Crisis Management	23	14
Rehabilitation and care of handicapped	34	20
Abilities development	4	2
Post Traumatic stress Disorder (PTSD)	1	0.5
Gender education	12	7
Human rights	7	4
Sign language	17	10
Mental health education	15	9
Social support	5	3
Communication skills	7	4
Total	**170**	100

Chapter 6

Discussion

6. Discussion

Introduction:

This paper aims to provide an overview of the status of mental health services in the Gaza Strip. Mental health organizations and organizations contributing to mental health in the Gaza Strip were surveyed by two structured questionnaires about their mental health services and professionals working in these organizations.

Several organizations and agencies participate in the provision of mental health services in the Gaza Strip. There are five major mental health organizations: Public mental health hospital (MOH), Community mental health department (MOH), The Gaza Community mental Health program (NGOs), Military medical Services and UNRWA health department.
Moreover, supports and inputs to mental health services come from a wide variety of reported nineteen organizations contributing to mental health services, including the Ministry of Education, Ministry of Social Affairs and UNRWA Education department. These two types of organizations make up the body of mental health services in the Gaza Strip.

In Palestine, like different Arab countries, the ratio of mental health services to population, the space allocated to the study of mental health in medical curricula, are only a few of the concerns expressed by colleagues.

In all Arab countries health services are provided by both the public (government) and private sectors. In some countries insurance systems contribute to the provision of services. The proportional use of the different health providers varies from country to country, depending on prevailing economic polices. Non governmental organizations (NGOs) have come to be recognized as important players in the provision of health services, especially in countries where there is internal instability. For example, in Lebanon, because of internal instability, but since 1990 when large-scale fighting ceased, their role has diminished. In Palestine, the continuos Israeli occupation, the absence of an Independent State, and consequent instability has created a situation where NGOs continue to play a major role in the provision of health services.

6.1 Mental Health Resources

6.1.1 Mental health facilities

According to the World Health Organization (WHO), public expenditure on mental health should not be less than 10% of the total health budget, with 75% of services equally distributed throughout the different regions of the country. Of the total general hospital beds available, 25% should be allocated to mentally ill patients, and the nearest mental health facility should not be more than an hour's drive from potential users. WHO also recommends a ratio of 0.25-1.0 psychiatrist per 10 000 population & 0.5-0.8 mental health beds per 10 000 population (Okasha A 1999).

In Palestine, the public expenditure on mental health of the total health budget is not available and seems to be very poor. Mental hospital beds are about 7% of all hospital beds available. In Gaza Strip, most of mental health services are distributed inequally in different governorates and concentrated in Gaza City with percentage about 52.5% of total organizations. In North Gaza, 12.5%. In Gaza Midzone, there is no single mental health service. In KhanYounis 15% and in Rafah 10%.

In all Arab countries the ratio of psychiatric beds to population leaves much to be desired. The ratio of population per mental bed is 7,000 in Egypt, (7,142) in Jordan, 8,763 in Palestine and 29,182 population per bed in Gaza Strip. There are (39) beds in the only mental health hospital in Gaza City, with about 2.1% of all hospital beds. And with a ratio of (0.1) psychiatrist and (0.3) mental health beds per 10,000 population. In Bethlehem Psychiatric hospital of the West Bank, there is 280 beds with a ratio 1.4 bed per 10,000 population

The average need for mental health beds has been estimated by WHO for patients with a duration of stay of less than 6 months to be 3.3 beds per 100 000 population, for patients hospitalized from 6 months to 1 year, 1.6 beds per 100 000, for stays of 1-2 years, 1.6 beds, and for 2-3 years 1.3 beds (Okasha 1999). In Palestine, the average length of stay in mental hospital is 81.6 (191.6 day in West Bank and 16 day in Gaza Strip). The high length of stay in Bethlehem hospital is due to the referral of chronic cases in Palestine to that hospital.

6.2 Mental Health Teams

The number of professionals working in mental health is far below that required to meet the Arab region's needs. The ratio of psychiatrists per population are 1/130,000 in Egypt, 1/60,000 in Jordan, 1/45,000 in Lebanon, Palestine 1/223,900. In 1999, there are 11 psychiatrists with a ratio of 1/103,466 working in the five mental health organizations in Gaza Strip.

Numbers of clinical psychologists are 211 in Egypt, 30 in Jordan, Lebanon 19 and Palestine 6 (Okasha 1999). In 1999, there are 23 general psychologists in Gaza Strip working in the five major mental health organizations.

Numbers of social workers are 300 in Egypt, 100 in Jordan, Lebanon 38 and Palestine 13 (Okasha 1999). In 1999, there are 7 social workers in Gaza Strip working in the five major mental health organizations

Numbers of psychiatric nurses are 1355 in Egypt, 100 in Jordan, Lebanon 187 and Palestine 5 (Okasha 1999). In 1999, there are 40 psychiatric nurses in Gaza Strip working in the five major mental health organizations

Mental health professionals are distributed in the five major mental health organizations in the Gaza strip with a total of one hundred and eleven professionals. There were 38 professionals (33%) in the public mental health hospital (PMHH); Out of those 8 (21%) are physicians, 20 (53%) nurses, 5 (13%) psychologists, 2 (5%) social workers and 1 (3%) EEG technician. 30 professionals work (27%) in the Gaza Community Mental Health Program (GCMHP), out of those 6 (20%) physicians, 6 (20%) nurses, 12 (40%) psychologists, 1 (3%) social worker, 2 (7%) occupational therapists, 1 (3%)

physiotherapist, and 1 (3%) EEG technician. 25 professionals (sample of total workers) (23%) work in UNRWA health department, out of those 10 (40%) physicians, 12 (48%) nurses, 2 (4%) physiotherapists and 1 (4%) X-ray technician. 14 professional (13%) work in Community mental Health department-MOH, out of those there are 3 (21%) physicians, 2 (14%) nurses, 3 (21%) psychologists, 4 (28%) social workers, 1 (8%) occupational therapist and 1 (8%) EEG technician. 4 professional (4%) in the Military medical services-Mental health section. Out of those 1 (25%) physician and 3 (75%) psychologists.

This indicates the urgent need for allocation of more resources both human and financial for the provision of mental health services.

6.3 Community based approach of mental health services

WHO has long stressed the need for mental health care to be decentralized and integrated into PHC, with the necessary tasks carried out as far as possible by general health workers rather than by specialists in mental health (WHO 1990). The existing systems for delivery of health care, including mental health care, have largely failed to meet the needs of most of the world's population.

The main bulk of mental health services in Gaza Strip come from the governmental sector (50%), NGOs (27%) and 23% from UNRWA health sector. The mental health workers at UNRWA had been trained during mental health program in 1994-1995, which was discontinued in 1996.

Mental health services have witnessed remarkable developments in Gaza Strip in the last two decades, yet the main resources are characterized by being institution based where 55% of total mental health professionals are working in governmental hospital and Military health services. Although mental health is supposed to be integrated within PHC in UNRWA but actually their role is limited to drug prescription and referring mental cases to governmental mental health hospital and GCMHP.

The community mental health department of the MOH runs 5 mental health clinics in PHC and treats more than 400 new cases and about 22,000 consumers annually. A team of 2 psychiatrists, two nurses and 3 psychologists and 4 social workers do these activities in CMHD. Apparently, this shows the limited resources of this department, the exhaustion of the staff and the wide gap with the enormous mental health needs of the population.

The mental health work in governmental services in Gaza Strip tends to adhere to the medical model with psychiatrics usually providing the leadership.

A good number of local NGOs have embarked on mental health programs. They run either a general counseling service or they choose a special area in the mental health field (i.e. substance abuse, psychogeriateric, disabled, women empowerment, children, training and research, etc.). They are active and have nicely advertised programs. They emphasize their aim in helping the children, the women and political victims.

The GCMHP is one of the leading NGOs in the field of mental health in Palestine. About 30 professionals are working in this program. Of these, there are 3 psychiatrics, 12 community mental health workers and 3 psychotherapists. This program aims to be a comprehensive community based mental health provider emphasizing on women, children, drug abusers, victims of human rights violations, as well as, dealing with different psychiatric disorders.

As mentioned above other several NGOs and agencies add inputs to mental health. More often there are parallel services with duplication and one can not generalize about the standard of care of these organizations. Absence of legislative evaluation means resources may not be used efficiently, therefore each institution has to be evaluated individually and their role has to be acknowledged.

In Palestine, there are several reasons to low affordable and effective mental health care, the main ones being: the low priority generally given to mental health, the traditional centralization of mental health services in large psychiatric institutions and poor strategies–whether for lack of awareness among health workers and policy-makers or because of poor organization and financing of services, lack of quality assurance and lack of essential psychotropic drugs. There is also the stigma of mental illness, which often inhibits sufferers from seeking treatment, and may even limit the willingness of mental health care providers to intervene.

In short terms, mental health depends on some of social justice, and mental illness, given its scale, must be treated at primary level where possible. Much

of the preventive work will be in the area of poverty reduction and conflict resolution.

The current emphasis in the planning of mental health programs is on the rehabilitative and out-patient care in the community as opposed to the historical emphasis on hospital care.

The need for community mental health services in the Gaza Strip is dire. It is increasingly evident that mental health care should no longer be provided in centralized institutions nor should its provision be concentrated in the hands of a few mental health specialists. If basic mental health care is to be more accessible to a large population, it must be done through non-highly qualified and non-specialized community health workers at all levels from PHC workers, nurses and physicians to those out side the health service such as teachers. The non specialized workers can be supported by mental health professionals but their work must be to support the patient's social networks. Community mental health workers could supplement the overburden of psychiatrics in meeting the population needs.

6.4 Mental health Policy

A strong mental health program is an essential component of any effective health care system, where a mental health policy and related mental health program are lacking, high priority must be given to their development as an integral part of the overall national health program (WHO 1990).

The majority of Arab countries have mental health programs, but few Arab countries have mental health policy.

A survey by post conducted by Dr. A. Okasha revealed that "while all nine Arab countries, that responded to the survey questions have mental health programs, only five have a documented mental health policy (Egypt, Bahrain, Republic of Yemen, AUE and Morocco). In Palestine and other Arab countries as Libya and Tunisia, mental health policy forms a part of general health policy (Okasha A 1999).

The Palestinian National Strategic Health Plan (1999-2003) included a lot of mental health statements, objectives and national priorities to improve mental health care and develop an appropriate Palestinian model for mental health services and therapy. Statement of national health goals and standards are aimed at clarifying the purposes and priorities for health programs. They seek to stimulate and reinforce the consideration and endorsement of desired ends and of appropriate action needed to achieve them. Such declaration is hoped to result in formulation and adoption of related policies, strategies, and implementation actions that will give direction to health activities. Failure to rationalize health goals and to set standards for health service leads to wasteful duplication and lost opportunities. A principal role of the government is to offer policy leadership. Goals and standards can provide benchmarks against which to measure progress and to extend accountability in the use of available resources.

The precise details of any national mental health policy will vary according to philosophies, ideals, and circumstances of the particular country. However general policy principles may include the following:

- Mental health services should be integrated as far as possible with general health services.
- Mental health care should be established in PHC setting and promoted by trained general health workers.
- Appropriate training in mental health and psychosocial skills for all health personnel and many that work in other sectors (education, social welfare, police forces and community development).
- Promoting health attitudes in young people.
- Management of health problems related to alcohol and drug abuse.
- Ensure the rights of the mentally ill in treatment and support.
- Mentally ill individuals should have treatment within their own communities using local resources.

6.5 Mental Health legislation

Many Arab countries do not have a mental health act or similar legislation specifically dealing with mental health. Egypt is the only exception where there is a mental health act since 1944. In Lebanon, Tunisia and Bahrain mental health is dealt with as a part of global health legislation. In Jordan, there are two legislative provisions relating to mentally ill. In Morocco and Bahrain, specific legislation is being drafted. In Saudi Arabia, there is a project underway to regulate the practice of the profession based on the

principles of Shariah (Islamic jurisprudence). In the United Arab Emirates (UAE) mental health is regulated by a ministerial decree which has less force than legislation. In Libya mental health is covered by general principles of law. In the Republic of Yemen, no specific legislation exists (Okasha A 1999).

In Palestine, no mental health act exists and the general health legislation are not unified. The occupation of the major part of Palestine in 1948 and the later occupation of Gaza Strip and West Bank by Israel in 1967 did not enable the Palestinian people to develop relevant laws and legislation. The changes in administration of the Palestinian lands have been severely reflected on the health laws and legislation applied in different areas throughout West Bank and Gaza Strip. Most of health legislation developed in the Gaza Strip under the Egyptian administration is different from those developed in the West Bank under the Jordanian administration. The Palestinian National Authority has been working intensively since 1994 to draft a unified Palestinian legislation (MOH 1999).

The development of the health laws and legislation that can ensure unity, equity, and social justice to all Palestinian citizens is one of the prominent national priorities of the Palestinian Ministry of health

In all Arab countries including Palestine, most of the existing laws dealing with mental health are old and were done prior to the development of concepts of community psychiatry and integration of mental health into the general health system (Okasha A 1999).

The need for mental health legislation and the need to review existing health legislation to go with the modern concepts of mental health are a top priority. It is an essential prerequisite for defining the roles and authorities of professionals, related institutions and to protect the rights of the mentally ill. Mental health legislation should seek to:

1. Define the minimum responsibilities of government and the authority, responsibilities and liability of the members of the profession.
2. Specify the role of mental health providers.
3. Set out the rights of patients including the right of treatment and individual human rights and the means by which these rights are protected.
4. Set out the rights and obligations of the family and the community.
5. Define the legal basis for service development to ensure that the patient, the family and the community receive appropriate support.
6. Provide guidelines for medico-legal purposes such as criminal responsibility and financial affairs.
7. Ensure the provision of better, more affordable and accessible services.
8. Provide legal support to activities related to promotion of mental health and prevention of mental illness and define government responsibilities in these areas.
9. Provide guidelines for the use of different methods of treatment in order to prevent abuse.

6.6 Conclusion:

Palestine, and especially Gaza Strip is in dire need for mental health care facilities .The continuing effects of Israeli occupation, aggression, closure, demolition, insecurity, humiliation, poverty and instability in the region complicates the prevailing stressful atmosphere. Despite the advances made in mental health care in Gaza Strip over the past years, mental health services are not able to meet the tremendous psychosocial need of the population. Because of the limited availability of resources and tight budgets, traditional mental health care alone can not hope to make a significant impact on a problem of such dimensions.

The out line of the present status of mental health services in Gaza Strip and whole Palestine clearly indicates the need for changing the approach to address the mental health needs of our population.

The movement towards community based mental health care to meet mental health needs has become increasingly accepted as an integral part of most mental health care systems all over the world.

A number of general policy principles should guide mental health planning. Policy needs to be based on a decentralized net work of services, integration of mental health into general health policy, comprehensiveness of policy outcomes, and equity. People should have equal access to health care, which requires an equitable distribution of resources.

The policy should be sustainable. The element in ensuring sustainability is the participation of the community in its formulation. Community and civil

society participation of health policy, particularly its mental health policy is essential to the credibility of policy and for the support by the patients, their families and the community in which they live.

A mental health policy should target the prevention and treatment of mental disorders and their associated disabilities, ensuring availability of minimal mental health care to the vulnerable and under privileged.

The need for mental health legislation is an essential prerequisite for defining the responsibilities and authority of professionals and institutions and to protect the rights of the mentally ill.

Finally, there is an urgent need for Palestine to allocate more resources, both human and financial to the provision of mental health services.

Of major concern is the need for an integrated approach by Palestinian policy makers, the legislative and judiciary to develop comprehensive mental health policies and legislation which reflect local culture and which respect and protect the human rights of the mentally ill.

6.7 Recommendations

1. Develop a Palestinian model of mental health services and therapy based on integrated and comprehensive approach to community mental health.
2. Maximize the use of PHC facilities for mental health services.
3. Upgrade community mental health centers to become comprehensive providers.
4. Provide adequate training and training of trainers to mental health personnel including community mental health.
5. Develop specific legislation and legal framework to protect the rights of mentally ill.
6. Improve accessibility to integrated and comprehensive mental health service and the equity in distributing mental health centers.
7. Develop national strategy for cooperation and coordination of mental health services between public sector, NGOs, UNRWA and private sector.
8. Promote mental health in schools, mental health education and net working.
9. Develop community support for mentally ill patients.

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Annex1 distribution of professionals at different Mental Health Organizations *(N=111)*

	CMHD		GCMHP		MMS		PMHH		UNRWA H D		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
1. Professionals *(N=111)*												
Physician	3	21	6	20	1	25	8	21	10	40	28	25
Nurse	2	14	7	24	0	0	22	60	12	48	43	38
Psychologists	3	21	12	40	3	75	5	13	0	0	23	21
Social worker	4	28	1	3	0	0	2	6	0	0	7	6
Occupational Therapists	1	8	2	7	0	0	0	0	0	0	3	3
Physiotherapists	0	0	1	3	0	0	0	0	2	8	3	3
X technicians	0	0	0	0	0	0	0	0	1	4	1	1
EEG technicians	1	8	1	3	0	0	1	3	0	0	3	3
Total	**14**	**100**	**30**	**100**	**4**	**100**	**38**	**100**	**25**	**100**	**111**	**100**

2. Age groups *(N=103)*

26-35	5	36	15	50	3	75	15	50	5	20	43	42
36-45	7	50	14	47	1	25	8	27	11	44	41	40
>45	2	14	1	3	0	0	7	23	7	36	19	18
Total	**14**	**100**	**30**	**100**	**4**	**100**	**30**	**100**	**25**	**100**	**103**	**100**

3. Certificate *(N=78)*

BAC of Medicine	3	21	6	20	1	25	8	21	10	40	28	35
BAC of Psychologic	3	21	9	30	3	75	5	13	0	0	20	26
BAC of Sociology	3	21	2	6	0	0	1	3	0	0	6	8
BAC nursing	0	0	3	10	0	0	12	32	3	12	18	23
BAC Rehabilitation	1	7	2	6	0	0	0	0	0	0	3	4
BAC physiotherapy	0	0	1	3	0	0	0	0	2	8	3	4
Total	**10**	**100**	**23**	**100**	**4**	**100**	**26**	**100**	**15**	**100**	**78**	**100**

4. High study *(N=40)*												
Psychiatry	1	7	3	10	1	25	5	13	1	4	11	28
Community mental health	1	7	12	40	0	0	5	13	0	0	18	45
Psychotherapy	0	0	3	10	0	0	0	0	0	0	3	7
Occupational therapy	1	7	0	0	0	0	0	0	0	0	1	2
Others	2	14	4	13	0	0	3	3	0	0	7	18
Total	**5**	**100**	**22**	**100**	**1**	**100**	**11**	**100**	**1**	**100**	**40**	**100**
5. Trained perssonel *(N=111)*												
Trained	11	79	23	77	2	50	27	71	5	25	68	61
Non-trained	3	21	7	23	2	50	11	29	20	75	43	39
Total	**14**	**100**	**30**	**100**	**4**	**100**	**38**	**100**	**25**	**100**	**111**	**100**

6. Experience years *(N=86)*

1-3	7	50	4	13	1	25	14	37	5	20	31	46
4-6	0	0	2	7	1	25	8	21	0	0	11	16
7-10	2	14	5	17	0	0	5	13	0	0	12	18
>10	2	14	12	40	0	0	0	0	0	0	14	20
Total	**11**	**100**	**23**	**100**	**2**	**100**	**27**	**100**	**5**	**100**	**68**	**100**

Annex 2 training material attained by mental health professionals working in different mental health organizations, 1999

Materials	CMHD		GCMHP		MMS		PMHH		UNRWA H D		Total	
	No	%	No	%	No	%	No	%	No	%	No	%
Anti drugs and addiction	6	35	3	18	1	6	7	41	0	0	17	100
Psychotherapy	8	16	24	48	3	6	15	30	0	0	50	100
Community mental health	8	13	15	23	0	0	35	55	6	9	64	100
Counselling	5	100	0	0	0	0	0	0	0	0	5	100
Crisis Management	0	0	6	75	0	0	2	25	0	0	8	100
EEG	4	50	4	50	0	0	0	0	0	0	8	100
Occupational therapy	2	29	5	71	0	0	0	0	0	0	7	100
Rehabilitation and care of handicapped	0	0	6	46	0	0	5	38	2	16	13	100
Abilities development	2	100	0	0	0	0	0	0	0	0	2	100
Post Traumamtic stress Disorder (PTSD)	2	22	3	34	0	0	4	44	0	0	9	100

Trainer and data collection	3	19	9	56	0	0	4	25	0	0	16	100
Gender education	2	50	2	50	0	0	0	0	0	0	4	100
Forensic mental health	0	0	2	100	0	0	0	0	0	0	2	100
ECT	0	0	0	0	0	0	2	100	0	0	2	100
Human rights	0	0	2	50	1	25	1	25	0	0	4	100

Annex 3 Services provided by different mental health organizations in the Gaza Strip, 1999

Organizations	Diagnostic					Curative			Prevent	Occup&Reh	Forensic	Training	Reseai
	Interview	Psych Test	EEG	Xray & lab	Drug	Psych	ECT	Detoxifi					
PMHH	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N
GCMHP	Y	Y	Y	N	Y	Y	N	Y	Y	Y	N	Y	Y
CMHD	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	N
MMS	Y	Y	Y	Y	Y	N	N	N	N	N	Y	N	N
UNRWA	Y	N	N	Y	Y	N	N	N	Y	N	N	N	N

Annex 4 distribution of professionals working in organizations supporting Mental Health by training, 1999

Profesion	AIO	Alsh ams	Mg-CRC	CTC	SPH CP	Pav	MOS A	NCC R	PAD C	PCS PH	DSC RS	WHS -Bj	El Wafa	UNR WA E	M OE	PRC S	NSR	Hope	PAR D	Total
Trained	0	4	4	2	9	3	13	5	1	3	12	1	5	4	1	10	0	2	0	**61**
Not trained	5	1	0	0	2	9	5	1	0	5	4	0	16	0	19	23	15	1	5	**129**
Total	**5**	**5**	**4**	**2**	**11**	**12**	**18**	**6**	**1**	**8**	**16**	**1**	**21**	**4**	**20**	**33**	**15**	**3**	**5**	**190**

Annex 5 distribution of served people in organizations supporting Mental Health, 1999

Service	AIO	Alsh ams	Mg-CRC	CTC	SPH CP	Pav	MOSA	NC CR	PAD C	PCS PH	DSC RS	WHS-Bj	El Wafa	UNRW A E	MO E	PRC S	NSR	Ho pe	PA RD	Total
Out patients clinic	0	50	37	75	200	600	543	3	45	80	200	1200	0	NA	NA	375	307	70	80	**3933**
Internal patients	110	0	0	0	0	0	300	0	0	0	0	0	28	NA	NA	4	0	0	0	**442**
Out-reach services	0	0	0	0	200	300	345	0	3	0	3	164	0	NA	NA	0	75	10	0	**1100**
Total	**110**	**50**	**37**	**75**	**400**	**900**	**1188**	**3**	**48**	**80**	**203**	**1364**	**28**	**NA**	**NA**	**379**	**382**	**80**	**80**	**5475**

NA = Not available

Annex 6 distribution of professionals working in organizations supporting Mental Health by target group, 1999

Target group	AIO	Alsh ams	Mg-CRC	CTC	SPH CP	Pav	MOSA	NC CR	PAD C	PCS PH	DSC RS	WHS -Bj	El Wafa	UNR WA E	M OE	PRC S	NSR	Hope	PAR D
Public									y							Y		y	
Women				Y								y				Y			
Children			Y	Y		Y										Y	Y		
Disabled					Y						Y					Y	Y		Y
Elderly													Y						
Orphans	Y															Y			
Mentally retarded																	Y		
Delinquents							Y												
Ex-prisoners										Y									
Youths				Y						Y									
Others							Y							Y	Y				

Blank=No

Annex 7 distribution of professionals working in organizations supporting Mental Health by profession, 1999

Profession	AIO	Alsh ams	Mg-CRC	CTC	SPH CP	Pav	MOS A	NCC R	PAD C	PCS PH	DSC RS	WHS -Bj	EI Wafa	UNRW A E	MO E	PRC S	NSR	Hope	PAR D	Total
Physician	0	0	0	0	0	0	0	0	0	2	0	0	3	0	0	0	0	0	0	5
Nurse	0	2	0	0	2	3	1	0	0	1		0	7	0	0	6	0	0	0	22
Psycholg.	0	0	0	2	1	1	2	0	0	2	0	1	0	0	8	2	1	2	0	22
S. worker	0	0	0	0	2	0	14	0	0	3	2	0	0	0	12	8	2	0	0	43
Occup.Th	0	0	4	0	2	6	0	0	0	0	0	0	1	0	0	10	4	0	4	31
Phys.th	0	0	0	0	4	2	0	0	0	0	1	0	5	0	0	4	1	0	0	17
X tech	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Administat.	5	3	0	0	0	0	1	6	1	0	13	0	5	0	4	4	7	1	1	51
Total	5	5	4	2	11	12	18	6	1	9	16	1	21	0	24	34	15	3	5	192

مؤسسات تعمل في مجال الصحة النفسية

1. المؤسسات التي تقدم خدمات صحة نفسية في قطاع غزة، 1999

الرقم	اسم المؤسسة	الوزارة التابع لها	التلفون	العنوان
1-	مستشفى النصر للصحة النفسية	وزارة الصحة	2862848	غزة النصر
2-	دائرة الصحة النفسية المجتمعية	وزارة الصحة		غزة
3-	وحدة الأمراض النفسية	الخدمات الطبية العسكرية	2829034	معسكر. أنصار
4-	برنامج غزة للصحة النفسية	منظمة غير حكومية	2865949 2824072	غزة
5-	دائرة الصحة بالانروا	وكالة الغوث		غزة

2. أسماء المنظمات الغير حكومية التي تقدم خدمات داعمة للصحة النفسية، قطاع غزة 1999

الرقم	اسم المؤسسة	جهة الاتصال	التلفون	العنوان
1	جمعية أطفالنا للصم	جيرالدين الشوا	2828495 2865468	غزة ش. فلسطين
2	جمعية العطاء للمعاقين حركيا	نعمة الحلو	2457789	جباليا تل الزعتر
3	مركز تأهيل الشلل الدماغي الهيئة الخيرية	عبلة الشوا	2864010 2827705	غزة الرمال
4	مركز تنمية الطفل الهيئة الخيرية	د. محمود دولة	2866881 2862072	غزة ش. الثلاثيني
5	مركز التدريب المجتمعي و إدارة الأزمات	د.فضل أبو هين	2848404 2833997	غزة
6	المركز الاجتماعي لتأهيل المعاقين	حسن ابو حسين	2457023	جباليا المعسكر
7	اتحاد لجان العمل الصحي	د. رباح مهنا		غزة
8	جمعية الحياة لتأهيل مصابي الحبل الشوكي	ناهض عيد	2821439	عزة الشجاعية
9	جمعية تأهيل المعاقين	فتحي نصر	2458807	جباليا العودة
10	جمعية المغازي للتأهيل المجتمعي	علي منصور	2531395	المغازي المعسكر
11	المركز الوطني للتأهيل المجتمعي	فاطمة الغصين	2827817	غزة الجلاء
12	الجمعية الوطنية لتأهيل المعوقين بقطاع غزة	د.محمد زين الدين	2861266	غزة الرمال
13	الجمعية الفلسطينية لتأهيل المعاقين	نبيل ابو علي	2824886	غزة معسكر الشاطئ
14	مركز رفح لتأهيل المعاقين	درويش ابو شرخ	2136779	رفح ش.صلاح الدين
15	مركز الإرشاد التربوي	حسام حمدونة	2457785	جباليا البلد
16	جمعية الحق في الحياة للأطفال المنغولين	عدالة ابومدين	2868340 2824004	غزة ش. الرشيد
17	جمعية رعاية المعوقين في قطاع غزة	د.حاتم ابوغزالة	2823212	غزة الرمال

18	جمعية المعاقين حركيا	خالد ابو زيد		286249	غزة الرمال
19	جمعية الوفاء لرعاية المسنين	تيسير البلتاجي		2827155	غزة الخط الشرقي
20	معهد الأمل للأيتام	عبدالوهاب العفيفي		2861434	غزة ش. الوحدة
21	تحاد لجان الإغاثة الصحية	عبدالهادي أبو خوصة			غزة
22	جمعية الحياة والأمل لمكافحة المخدرات	محمد ابو سالم		2826283	زة تقاطع الوحد/النصر
23	رابطة مكافحة التدخين والعقاقير الخطرة	وليد القدوة		2826913	غزة الدرج
24	جمعية مبرة الرحمة للأطفال	زياد الظاظا		2822208	غزة الخط الشرقي
25	المجلس الفلسطيني لمكافحة المخدرات	نائل الشلايلة		2456356	غزة المنشية
26	جمعية مبرة فلسطين للرعاية	جميلة عليوة		2457075	بيت لاهيا
27	مؤسسة الثقافة والفكر الحر	ماجدة السقا		2051299	خانيونس
28	مؤسسة فلسطين المستقبل	نادية السراج		2841509	غزة الرمال
29	مركز صحة المرأة	فريال ثابت			البريج
30	الجمعية الفلسطينية للصحة النفسية	د. ممدوح جبر			غزة الرمال
31	مدينة الأمل لتنمية القدرات	د.فتحي عرفات			خانيونس مدينة الأمل

3. مؤسسات رسمية تقدم خدمات داعمة للصحة النفسية في قطاع غزة، 1999

1	دائرة الإرشاد النفسي	وزارة الشؤون الاجتماعية			غزة
2	دائرة الإرشاد التربوي	وزارة التربية و التعليم			غزة
3	برنامج الإرشاد التربوي	الانروا			غزة

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وزارة الص

السيد/ مدير مؤسسة _____

التاريخ : / /

تحية طيبة وبعد,

يقوم الأخ د. عبد الرحمن عمر بعمل رسالة الماجستير في الصحة العامة و يتناول في أطروحته موضوع الخدمات الصحية النفسية في قطاع غزة و عليه نرجو من سيادتكم مساعدته وتسهيل مهمته للحصول على المعلومات اللازمة و التي ستبقى ضمن نطاق البحث فقط.

و تقبلوا فائق الاحترام.

المشرف الأكاديمي
منسق برامج الماجستير جامعة القدس- كلية الصحة العام

د. عبد العزيز موسى ثابت

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مدرسة الصحة العامة الفلسطينية
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وزارة الصحة
جامعة القدس

رقم الاستبيان

استبيان لحصر العاملين في الطب النفسي والصحة النفسية بقطاع غزة
والتعرف على الطاقات البشرية المتوفرة في هذا المجال

يستهـــــدف:

هذا الاستبيان حصر العاملين في الطب النفسي والصحة النفسية بقطاع غزة والتعرف علـ
خصائص الطاقات البشرية المتوفرة في هذا المجال بهدف تحسين هذه الخدمة الحيوية لأبناء شـع
والاستبيان جزء من دراسة مقدمة لجامعة القدس – مدرسة الصحة العامة لنيل درجة الماجستير ف
الصحة العامة.

سنكون شاكرين لكافة الأخوات والأخوة على مساهمتهم في تعبئة الاستبيان وإعطاء المعلوم
اللازمة بكل موضوعية، مؤكدين على أن كافة المعلومات التي سترد في هذا الاستبيان سيتم التعـ
معها للغايات التعليمية المرجوة من الدراسة، ولن يتم أي تطرق للأسماء، وسيتم التعامل معها بك
سرية، مؤكدين في نفس الوقت حق كل من يساهم في ملئ الاستمارة بكتابة أو عـــدم كتابـــة اس
الشخصي. هذا وسيتم تزويد جميع المؤسسات المشاركة بملخص عن نتائج هذه الدراسة.

د. عبدالرحمن برق

اسم معبئ الاستبيان:.....

التـاريـــخ / /1999

الأخوات والأخوة .... المحترمين

تحية طيبة وبعد ،،،،

نرجو التكرم بالإجابة على الأسئلة التالية :-

أولاً : معلومات شخصية :

1. الاسم (اختياري) : .....

2. تاريخ الميلاد : / / 199

3. مكان العمل الحالي : ..... تليفون : .....

4. الجنس : ☐ ذكر ☐ أنثى

5. تبعية المؤسسة التي تعمل بها : ☐ حكومية ☐ منظمة غير حكومية ☐ وكالة غوث ☐ خاصة

إذا كانت حكومية(رجاء ذكر الوزارة أو المؤسسة التي تعمل بها)

.....

6. المهنة : ☐ طبيب ☐ ممرض ☐ أخصائي نفسي ☐ أخصائي اجتماعي

☐ أخصائي تأهيل بالعمل ☐ أخصائي علاج طبيعي ☐ فني أشعة

☐ فني رسم دماغ ☐ فني مختبر

☐ غيرها (الرجاء التحديد).....

7. الوظيفة الحالية : .....

8. عدد سنوات الخبرة في مجال العمل : ..... 9. بلد الخبرة : .....

10. مكان إكتساب الخبرة : ☐ مستشفى طب نفسي ☐ مركز إرشاد نفسي ☐ عيادة نفسية مجتمعية

(يمكن اختيار أكثر من مكان) ☐ عيادة خاصة ☐ أخرى(الرجاء التحديد).....

ثانياً : المؤهلات العلميـــة :

1. الشهادة الجامعية الأولى

☐ بكالوريوس طب ☐ ليسانس علم نفس ☐ ليسانس علم اجتماع

☐ بكالوريوس تمريض ☐ بكالوريوس تأهيل ☐ بكالوريوس علاج طبيعي

☐ أخرى (رجاء التحديد) .....

2. مكان أو بلد الدراسة : ..... 3. الجامعة أو المعهد: .....

3. عدد سنوات الدراسة : ..... 5. سنـــــة التخـــرج: .....

ثالثاً : دراسات عليا في مجال الطب النفسي والصحة النفسية :

1. نـــــوع الدراســـــة :

☐ طب نفسي ☐ صحة نفسية مجتمعية ☐ علاج نفسي ☐ تأهيل بالعمل ☐ علاج طبيعي

☐ تمريض ☐ أخرى (رجاء التحديد) .....

2. الشهادة العلمية التي تم الحصول عليها:

☐ شهادة مشاركة ☐ دبلـــــوم ☐ ماجستير ☐ دكتوراه

3. مكان أو بلد الدراسة : ..... 4. الجامعة أو المعهد: .....

5. عدد سنوات الدراسة : ..... 6. سنـــــة التخـــرج: .....

رابعاً : الدورات التدريبية في مجال العمل :

تاريخ الدورة	مكانها	مدة الدورة	مـــــادة التدريب

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حضـــرة / .... حفظـــ اللـــه

تحيـــــة طيبـــة وبعـــــد ،،،

يستهدف النموذج المرفق مسح المؤسسات التي تقـــدم خدمـــات الطب النفسي والصحة النفسية لأبناء شعبنا في قطـــاع غـــزة، وطبيعـــة الأنشطة والخدمات التي تقدمها في هذا المجال.

وهذا النموذج جزء من دراسة مقدمة لجامعة القدس – مدرســـة الصحة العامة الفلسطينية لنيل درجة الماجستير في الصحة العامة.

إن الهدف من هذه الدراسة هو التعرف على المؤسسات العاملـــة في مجال الطب النفسي والصحة النفسية ودراسة الأنشطة والخدمات التـــي تقدمها بهدف التوصل إلى تحسين خدمات الطب النفسي والصحة النفســـية لأبناء شعبنا في قطاع غزة.

إنني إذ أشكر لكم تعاونكم الصادق لتعبئة هذا النموذج وإعطـــاء المعلومات اللازمة، لأؤكد لكم على أن كافة المعلومات التي سترد في هذا النموذج سيتم التعامل معها للغايات التعليمية المرجوة من الدراسة، وسيتم تزويد كافة المؤسسات المشاركة بملخص عن نتائج هذه الدراسة.

وتفضلوا بقبول فائق التقدير والامتنان ،،،

د. عبدالرحمن برقاوي

نموذج لمسح المؤسسات التي تقدم خدمات الطب النفسي والصحة النفسية للمواطنين في قطاع غزة، والأنشطة والخدمات التي تقوم بها في هذا المجال

رقم مسلسل : ..... اسم معبيء النمـــوذج : .....التاريخ : / / 199

أولاً : معلـومات عامة عن المؤسسة :

1. اسم المؤسسة : .....

2. صفة المؤسسة : ☐ حكومية ☐ وكالة غـــوث ☐ أهليـــة ☐ خاصـــة

☐ أخـــرى (رجاء التحديد).....

3. إذا كانت المؤسسة حكومية فأي وزارة تتبع : .....

4. عنـــوان المؤسسة : ..... تليفون :.....

5. واسطة الاتصال المسؤول في المؤسسة: .:.....

6. مراكز تقديم الخدمات التابعة للمؤسسة : 1- .....

.....2-

..... 3-

.....4-

ثانياً : العاملون في المؤسسة لدعم الصحة النفسية :

1- عدد العاملين في المؤسســة : .....

2- فئات العاملين في المؤسســة :

التخـــصص	عـــدد العاملين
1- أطبـــاء	
2- أخصائي نفسي	
3- أخصائي اجتماعي	
4- أخصائي تأهيل بالعمل	
5- أخصائي علاج طبيعي	
6- تمريض	
7- تخطيط دماغ	
8- أشعة	
9- مختبرات	
10- صيدلة	
11- إداريين	
12- فئات أخرى	

ثالثاً : الخدمات التي تقدمها المؤسسة لدعم الصحة النفسية للمواطنين :

	وصف الخدمة
1- خدمات تشخيصية	
2- خدمات علاجية	
3- خدمات تأهيل	
4- خدمات وقائية	
5- مساعدات وخدمات أخرى	

رابعاً : فئات المستفيدين من خدمات المؤسسة :

☐ لعموم الجمهور ☐ نساء ☐ أطفال ☐ معاقين ☐ مسنين ☐ أيتام

☐ متخلفين عقلياً ☐ احداث

☐ أسرى سابقين ☐ فئات أخرى (رجاء التحديد) .....

خامساً : المنطقة / المناطق المستهدفة بخدمات المؤسسة :

.....

.....

سادساً: أيام تقديم الخدمات :

☐ نهاري ☐ ليلي ☐ 24 ساعة

سابعاً : المستفيدين من خدمات المؤسسة:

1- عدد المستفيدين من الخدمات الخارجية يومي / شهري .....

2- عدد المستفيدين من خدمات داخل المؤسسة شهري / سنوي .....

3- عدد المستفيدين من خدمات متنقلة بيتي / مناطق .....

ثامناً : عدد المحولين من المؤسسة لجهات أخرى:

شهرياً: .....

تاسعاً : الجهات التي تقوم المؤسسة بتحويل حالات لها:

1. .....
2. .....
3. .....
4. .....
5. .....

عاشراً : المقابل المالي للخدمات التي تقدمها المؤسسة للمواطنين:

☐ مجـاني ☐ رسـوم رمزيـة ☐ رسـوم كاملـة