Establishing a mental health system in the Occupied Palestinian Territories

Rita Giacaman[1], Neil Arya[2] and Derek Summerfield[3]

[1]Institute of Community and Public Health, Birzeit University, Ramallah, West Bank
[2]Faculty of Health Sciences, McMaster University, Canada
[3]Institute of Psychiatry, London, UK

What is the violation?

There are currently nine psychiatrists and at most 15 clinical psychologists in the West Bank, who serve 2.7 million people. The only in-patient facility is Bethlehem mental hospital (which had 250 patients and 75 staff when subjected to missile attack by the Israeli army on 1 April 2004).

What is 'mental health' during the societal crisis and upheaval occasioned by war? Perhaps the primary psychological effect of war on victims generally is through their witnessing the destruction of a social world embodying their history, identity, values and roles of everyday life. Such suffering has largely to be resolved collectively, in this same social world, albeit one which has been intentionally weakened. Thus, as the World Health Organization and other authorities confirm, the major thrust of humanitarian interventions must be towards the depleted social fabric and its institutions, for herein lie the sources of resilience and capacity for recovery for all (Kawachi & Berkman, 2000). Beyond that, history has shown that social or political reform is the best medicine, and for victims of oppressive violence this means acknowledgement and justice (Summerfield, 2002).

The mental health of war-affected populations attracted little attention until 20 years ago, since when terms like 'psychosocial', 'trauma' and 'counselling' rapidly became points of reference in assistance programmes imported into war zones, and elsewhere for refugee services. This development reflected a globalisation of Western cultural trends towards the medicalisation of distress and the rise of psychological therapies. The assumption that Western mental health technologies had universal validity, and were relevant to or wanted by the largely non-Western populations affected, has been the subject of critical review. Indeed, even in the West itself, the evidence base for the efficacy of mental health services in assisting recovery from highly aversive events like war and atrocity is not compelling (Summerfield, 1999).

West Bank and Gaza: current social context

Since Israeli military re-occupation began in September 2000, everyday social, economic and cultural life has become increasingly difficult for all Palestinians. Military checkpoints that split villages and towns into ghettos, curfews, closures, raids, mass demolition of houses, land expropriation and the indiscriminate use of lethal force (over 3200 civilians have been killed) are pushing Palestinian society and its civil institutions towards breakdown. Over the next three years, by World Bank estimates, the numbers of people subsisting at or below poverty level (US$2 per day) tripled, and is now 60% of the total population (Barghouti, 2004).

The construction of the new separation wall deep into Palestinian territory has added to the sense of crisis, as well as further damaging the functioning of an already hugely stretched health system (a violation of the Fourth Geneva convention) by cutting off both primary health clinics and hospitals from the populations they are meant to serve (Palestinian Environmental NGOs Network, 2003).

While there is a dearth of data across the population, studies of children and adolescents show high levels of distress and hopelessness (Giacaman et al, 2005), and post-traumatic stress disorder (Thabet & Vostanis, 2000), as well as anecdotal evidence of increasing violence in the home and in schools – as noted in conflict zones elsewhere (Jewkes et al, 2002).

Current mental health provision in the West Bank and Gaza

There are currently 57 institutions offering mental health or psychosocial services. The Ministry of Education, which serves one million schoolchildren, employed 382 counsellors in the West Bank and 150 in Gaza in 2003. The Ministries of Health and of Social Affairs also provide services, and the United Nations Relief and Works Agency employed 55 school counsellors in West Bank and 85 in Gaza during the same year. There are also at least six international non-governmental organisations operating, some working with local groups and others independently. Finally, there are a number of local, small-scale groups with considerable experience of the communities they serve (Giacaman & Mikki, 2003).

There are currently nine psychiatrists and at most 15 clinical psychologists in the West Bank, who serve 2.7 million people. The only in-patient facility is Bethlehem mental hospital (which had 250 patients and 75 staff when subjected to missile attack by the Israeli army on 1 April 2004). Many of the counsellors or other psychosocial providers have been based on projects funded and formulated from abroad. Interviews with counsellors in training suggest that they feel a lack of clarity about their role, as that training often has an emphasis on individual

therapy and emotional ventilation, when the latter is unfamiliar in this cultural milieu. Reservations about counselling are expressed fairly widely within the community and there is an issue of stigma. In schools, pupils would often rather go to a teacher.

In summary, these developments betray a lack of planning based on need assessments, a lack of evaluation and the lack of an overall strategy. Many projects have been driven by international agencies, each with its own agenda and focus, with too much emphasis on bio-psychomedical approaches – a short-term technical fix – and too little on the strengths and (war-induced) weaknesses of the local situation, and on local priorities and traditions. This has little in common with World Health Organization (WHO) perspectives on best practice in emergencies. The WHO has just published a consensus statement which questions the public health value of post-traumatic stress disorder as a concept, of vertical trauma-focused services, and of a separate psychosocial field in war-affected, low-income countries (Van Ommeren *et al*, 2005).

Mental health and the Palestinian primary healthcare model

The Palestinian primary healthcare (PHC) model was started in the late 1970s in the face of the suspicions both of the Israeli authorities and of a local medical establishment sceptical about the shift of focus from clinic to community. By the 1980s, Palestinians could boast a PHC system which was one of the best in the Arab world, and one which had addressed the common imbalance in provision between urban and rural/social disadvantaged areas (Barghouti & Giacaman, 1990). Planning and implementation drew on grassroots opinion within communities, including women's and youth groups, to ensure that developments would be maximally acceptable and sustainable. Services needed to be able to evolve as circumstances dictated in a politically brittle environment. Officially recognised training schemes for a new type of worker – the community health worker – were started and there was in-service training on PHC approaches for newly qualified doctors. The onset of the first intifada in 1987 necessitated new initiatives in physical rehabilitation to accommodate large numbers of young men sustaining major disability as a result of Israeli army gunfire. This included the training of community-based rehabilitation workers (Giacaman, 2001).

The WHO has always emphasised that in developing countries mental health should be viewed as an integral part of public health and social welfare programmes, and not as a specialist activity, set apart. Until recently, PHC workers in the West Bank and Gaza were only informally drawn in to provide assistance. Their input was seen as being a form of social work rather than mental health work, and it did not involve Western-style counselling; instead it focused on family problems, for example, or women who had been abused. It is only now that there are moves to put such work on a more formal

conceptual and practical basis within the PHC system, and within the training of community health workers. The question, then, is how 'mental health' is to be understood and addressed in this particular cultural context at this point in its history. Further, such an understanding must also take account of an oppressed and impoverished social context.

There is evidence from other low-income countries of the role of social support in preventing disorders like depression, and a balance needs to be struck between local, time-honoured understandings and approaches, and those drawn from Western mental health, including counselling, medication and specialist referral (McKenzie *et al*, 2004). If the roles and functions that ordinary people have been playing were to be recast as professional activity (which has arguably happened in Western societies), local modes of mutual support and coping may be by-passed for little gain. Community voices must be at the heart of striking the balance if service developments are to mean more than the mental health melee described above has done.

There may also be lessons to be drawn from work elsewhere, like the three-tiered community-based rehabilitation model developed in India. There, case workers are drawn from the populations they serve and initiatives are planned in a forum called a village health group. Compared with out-patient treatment, this model led to better outcomes for disability and compliance with treatment (Chatterjee *et al*, 2003).

The PHC system is short of funds (particularly of funding not dependent on external donors), is under a Palestinian Authority too weak and fractured to focus on anything except survival, and is under daily assault by the Israeli military occupation described above. The work of 25 years is gravely threatened, as is, therefore, the mental health of over three million people who depend on the PHC system.

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ASSOCIATIONS AND COLLABORATIONS

The American Psychiatric Association

Michelle B. Riba,[1] Steven S. Sharfstein[2] and Allan Tasman[3]

[1]President 2004–05, Board of Trustees, American Psychiatric Association; Clinical Professor, Associate Chair for Integrated Medical and Psychiatric Services, Department of Psychiatry, University of Michigan, email mriba@umich.edu

[2]President Elect, American Psychiatric Association; President and Chief Executive Officer, Sheppard Pratt Health System; Clinical Professor and Vice Chairman, Department of Psychiatry, University of Maryland

[3]Past President, American Psychiatric Association; Professor and Chair, Department of Psychiatry and Behavioral Science, University of Louisville (KY) School of Medicine

For contributions to the 'Associations and collaborations' column, please contact John Henderson, email john.henderson53@btopenworld.com

Website: www.pscyh.org.

The American Psychiatric Association (APA) is a medical specialty society that represents nearly 36 000 psychiatrists from the United States and Canada, as well as around the globe. It is the longest serving medical specialty society. As a leader in the mental health field, the APA continually supports the diagnosis and treatment of patients with mental illnesses, including substance use disorders, and also supports prevention and research. The APA acts as an advocate for psychiatrists and their patients.

The APA works to secure increased funding for psychiatric research and education. It also lobbies for parity of health insurance coverage for mental illnesses, for patient protection against abuses by managed-care organisations, as well as for the protection of confidential medical records.

The APA, which is accredited by the Accreditation Council for Continuing Medical Education, supports the education, training and career development of psychiatrists and other physicians. It offers educational programmes that support lifelong learning through annual scientific meetings, journals and other publications.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the APA, remains the world's gold standard for the diagnosis of psychiatric illnesses. The APA's *Practice Guidelines* show how evidence-based guidelines should be developed. That publication also helps guide clinicians in making scientifically sound decisions in the evaluation and treatment of patients with mental disorders, and it is recognised by the American Medical Association.

The APA also defines and supports professional values, by publishing primers on ethics and working with psychiatrists to provide the highest level of care.

A brief history

Founded in 1844, the APA formed from a group of 13 superintendents from the then 24 mental hospitals in the United States who met in Philadelphia and established the Association of Medical Superintendents of American Institutions for the Insane. The Association's objectives were 'to communicate their experiences to each other, to cooperate in collecting statistical information relating to insanity and assisting each other in improving the treatment of the insane'.

That same year, the first psychiatric journal, the *American Journal of Insanity*, was published in June by Amariah Brigham, superintendent of the Utica State Hospital in New York state.

In 1851, the Association adopted proposals by Thomas Kirkbride, MD, superintendent of the Pennsylvania Hospital for the Insane, for the design and organisation of mental hospitals. These policies dictated the architecture of state hospitals in the United States for more than 50 years.

Some 45 years after the Association's founding, the name was changed to the American Medico-Psychological Association; physicians working in mental hospitals or private offices became eligible for membership in 1892. The Association increased its scope by acquiring the *American Journal of Insanity* from Utica State Hospital to be its official journal.

In 1917, during the First World War, the Association officially adopted the *Statistical Manual for the Use of Hospitals for Mental Diseases* as a system for uniform statistical reporting. Over the next three years, the National Committee for Mental Hygiene (publisher of the *Manual*) successfully introduced the new classification and statistical system into mental hospitals throughout the country.