A PROPOSED APPROACH FOR MANAGEMENT OF COMMUNITY MENTAL HEALTH PROJECTS IN AREAS OF POLITICAL CONFLICT

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Abstract

Background: The burden of mental disorders in post-conflict areas is higher than in countries where there is no conflict. Post-conflict areas lack the resources to respond to such high burden, resulting in a treatment gap. This study explored the potential for mental health reform in Gaza. **Design:** Mixed methods study. **Methods:** The WHO-AIMS questionnaire was used to assess mental health services in Gaza and documentary analysis was conducted to evaluate the Mental Health Policy and Plan. Healthcare professionals' mental health training needs were identified and policy makers, healthcare professionals, service users and carers took part in focus groups to elicit their perspectives on mental health reform. Framework analysis was used to identify recurrent themes. **Results:** Psychotherapy, recovery, family intervention and crisis management were rated priority training areas. Poor coordination between governmental and non-governmental organisations and short-term funding were identified as main barriers to mental health reform. Service users and carers felt excluded from service delivery and development and suggested possible models of partnership working with service providers to address exclusion. **Conclusion:** Meaningful mental health reform in post-conflict areas requires inclusive policy development, targeted staff training, improved coordination between different service providers, and partnership working between service providers and service users and carers.

Dedication

To my supervisor, Dr Lynda Tait, for her support and patience.

AND

To my father, Mustafa Saymah, for his love and encouragement.

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I am immensely grateful to the enormous support and guidance I received from my supervisors, Dr Lynda Tait and Dr Maria Michail. Without their knowledge, mentorship, and advice, I would not have accomplished this hard work. I would also like to thank Dr Sayeed Haque for providing statistic advice and guidance and thanks also to Dr Jonathan Ives for providing guidance on qualitative analysis. I would like also to express my personal gratitude to Professor Eman Gaad who made the first contact between me and the University of Birmingham.

I am grateful to the Ministry of Health in Gaza, especially to members of the Training and Education Department at the Mental Health Directorate, for all the assistance and support they provided. Finally, I am grateful to my colleagues at the World Health Organization office in the occupied Palestinian territories for their support, encouragement, and understanding.

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List of Abbreviations

CIDI	Composite International Diagnostic Interview
CMHD	Common Mental Health Disorders
DSM	Diagnostic and Statistical Manual
GCMHP	Gaza Community Mental Health Programme
GHQ	General Health Questionnaire
ICD	International Classification of Disease
mhGAP	Mental Health Gap Action Programme
MoH	Ministry of Health
NGOs	Non-Governmental Organisations
OCHA	United Nation office for Coordination of Humanitarian Affairs
oPt	occupied Palestinian territories
PHC	Primary Healthcare
PLO	Palestinian Liberation Organisation
PNA	Palestinian National Authority
PTSD	Post-Traumatic Stress Disorder
SPSS	Statistical Package for the Social Sciences
SUI	Service Users' Involvement
TNA	Training Needs Analysis
UN	United Nations
UNRWA	United Nation Relief and Works Agency
USD	United States Dollars
WHO	World Health Organization

WHO-AIMS	World Health Organization- Assessment Instrument for Mental Health Systems

CHAPTER ONE: INTRODUCTION

1.1. Introduction

The burden attributable to mental disorders is high in Low and Middle Income Countries (LMICs) and post-conflict areas (Lopez et al., 2006; Mollica et al., 2004; WHO, 2008a; Murthy and Lakshminarayana, 2006), which is consistent with research showing that regions in conflict have a higher prevalence of mental disorders than regions where there is no conflict (Baxter et al., 2013; Ferrari et al., 2013; Mollica et al., 2004). Despite the high burden of mental disorders, the ability of mental health services to respond to such high burden in those countries is insufficient (Saraceno et al., 2007; Saxena et al., 2007; WHO, 2008c). Lack of resources has been identified as the main challenge to the scaling up of mental health services in post-conflict areas and LMICs (Saraceno et al., 2007; Saxena et al., 2007; WHO, 2008c). Although some post-conflict areas and LMICs demonstrate an innovative use of available scarce resources (Mbatia and Jenkins, 2010; WHO, 2013), the influence of emergency response programmes on improving mental health service development and delivery needs further research (Jenkins et al., 2011a; Tol et al., 2011). The question of how to improve the use of existing resources to assist in reforming mental health services in post-conflict areas and LMICs is not yet answered by the literature.

In this thesis, this question is answered by providing the Gaza experience, a post-conflict area and LMIC, as a model of developing an approach of multifaceted and comprehensive mental health reform. The current study provides a thorough investigation of the (1) assessment of mental health services in Gaza using the WHO-AIMS questionnaire, (2) policy development, by analysing the mental health

policy and plan, (3) clinical intervention, by assessing professionals' training needs, and (4) health services and community involvement, by exploring policy makers, health professionals, service users' and carers' views on current mental health services in Gaza and the potential for mental health reform. The mixed methods data were triangulated to provide an integrated model of involving all mental health stakeholders in reforming mental health services in one of the post-conflict areas in the world.

1.2. Research Background

1.2.1 Background to the Political Conflict in Gaza

The Palestinian-Israeli conflict started following World War I. After the Ottoman Empire collapsed, Palestine came under the United Kingdom mandate according to the Sykes-Picot agreement. During this period, the United Kingdom's mandatory government produced the Balfour Declaration of 1917 that promised to give the immigrant Jewish population a state in Palestine. Since then, the conflict between Palestinians and Jewish that erupted in 1920 has continued through several waves until 1939 (Beinin and Hajjar, 2001).

The United Nations (UN) resolution in 1947 proposed a partition plan of Palestine into two states: one for Palestinians and one for Jewish. Palestinians rejected this resolution and, as a result, a massive civil war between Jewish settlers in Palestine and Palestinians began. As a result of the war in 1948, between the Jewish population and the Palestinian population, who were supported by five Arab league countries, the Jewish people won the war and announced the independence of the

state of Israel on May 14, 1948. This war, known by Palestinians as Al Nakba (the catastrophe), enabled the Israelis to take the majority of Palestinian land, which resulted in the displacement of half the Palestinians inside Palestine and half in other surrounding Arabic countries (Al-Majdal, 2006).

After the 1948 war, Israel controlled all historical Palestine, except the West Bank, East Jerusalem, and Gaza. Palestinians who were uprooted from their cities and villages during the war in 1948 resettled in the West Bank, Gaza, Jordan, Syria, and Lebanon. A truce between the new state of Israel and Arabic countries was announced in 1949. This truce between Arabs and Israelis remained effective until 1967. During this period, 1949-1967, the West Bank was controlled by Jordan, and Gaza was controlled by Egypt (Beinin and Hajjar, 2001).

The Six-Day war erupted in 1976; Israel occupied the West Bank, including East Jerusalem, Gaza, the Golan Heights of Syria, and Sinai of Egypt. The UN Security Council responded by producing another resolution, 242, demanding that Israel withdraw from all land they occupied in the Six-Day war. Israelis ignored the 242 resolution, as they did with other UN resolutions demanding Israel reconsider their violations of the International Humanitarian Laws (Beinin and Hajjar, 2001). Since then, the UN began to use the term “occupied Palestinian territories” (oPt) to describe the land occupied by Israelis in 1967, including the West Bank, East Jerusalem and Gaza (United Nations, 2008).

In 1987, the first Palestinian uprising “intifada” erupted in the West Bank and Gaza. This civil resistance to Israeli occupation remained until 1994. During the first intifada, 1,551 Palestinians and 422 Israelis were killed and thousands of Palestinians were arrested by Israel (Btselem, 2010).

In 1993, the Palestinian Liberation Organisation (PLO), which was founded in 1964 to liberate the historical Palestine from Israel and return Palestinian refugees to their homeland, signed the Oslo accords with the Israeli government. This first peace agreement between Palestinians and Israelis began to be effective in 1994, when Israel handed over the civil administration of Gaza and Jericho to the newly established Palestinian National Authority (PNA). A few years later, the PNA expanded their civil administration authority to other cities in the West Bank, but Israel reserved control over borders, security, water and airspace (Beinin and Hajjar, 2001).

The faltering of the peace negotiations between the PNA and Israel, the delay in resolving the key conflicting issues such as the occupation by Israelis in East Jerusalem, refugees right to return, Israeli settlement in the West Bank and Gaza, and the delay in handing over the control of water and borders to the PNA, led to the second intifada in 2000 (Al-Majdal, 2006).

The Second Intifada, “Al-Aqsa Intifada‟, began in 2000, in the West Bank and Gaza after the visit of the Israeli Prime Minister, Ariel Sharon, to the most sacred mosque in Jerusalem, Al-Aqsa mosque. In 2002, Israel reoccupied all cities in the West Bank

and established checkpoints between cities and villages in the West Bank and Gaza. Moreover, in 2002, Israel started to construct the isolation wall to isolate Israeli cities from the West Bank that resulted in the confiscation of Palestinian land and the displacement of Palestinian villagers and farmers in the West Bank (OCHA, 2012b).

In 2005, Israel implemented a disengagement plan that involved a one-sided military and the settlement withdrawal from Gaza. While Israel, according to the disengagement plan, preserved no military or civil presence in the Gaza Strip, Israel maintained control over the airspace, sea, borders and commercial crossings between Israel and Gaza (OCHA, 2009).

In 2006, Hamas, a radical Islamic resistance movement, won the Legislative Council's election and formed the Palestinian government. The international community and Israel imposed a siege on Gaza after Hamas rejected to recognise the right of Israel to exist. In late 2008, Israel launched a 22 days war on Gaza resulting in 1,419 Palestinians killed and many thousands injured (PCHR, 2009). Following the war in 2008, a transient cease-fire was announced between Hamas and Israel that ended in November 2012, with a new war continuing for eight days. The total number of Palestinians killed in this war was103 and 1,399 persons injured, and 450 houses destroyed (OCHA, 2012a).

1.2.2 Background to the Health System in Gaza

The Gaza Strip has a total population of 1,672,865; the male population is 849,577, while the female population is 823,288 (Palestinian Central Bureau of Statistics,

2012). At the end of 2011, 43.8% of the population in Gaza were under 14 years of age, while the percentage of the older adults aged 65 years and above was 2.3% (Palestinian Central Bureau of Statistics, 2011). The socioeconomic situation has deteriorated in Gaza since 2007 because of the impact of the siege on economic and social conditions (Giacaman et al., 2009). The percentage of the population in Gaza who live below the poverty line is 38.8% (Palestinian Central Bureau of Statistics, 2012). The unemployment rate rose from 28.7% in 2011 to 31% in 2012 (Palestinian Central Bureau of Statistics, 2012).

There are no ethnic minorities in Gaza; the ethnic group is Palestinian Arab, and the majority are Muslims/Sunni, while 0.07% are Christians (Palestinian Central Bureau of Statistics, 2011). Although the spoken language is Arabic, English and Hebrew are widely understood. The literacy rate of the total population is 92.4% (Palestinian Central Bureau of Statistics, 2011). The West Bank and Gaza is classified by the World Bank as a low-middle income country (World Bank, 2010).

The health status of Palestinians has improved over the last decade. Life expectancy for males has increased from 69.0 in 1997 to 70.2 in 2008 (Ministry of Health, 2011). In addition, life expectancy for females has remained stable over the last decade at 72.9 years (WHO, 2012). Non-communicable diseases replaced communicable diseases as the main cause of morbidity and mortality in the oPt (Ministry of Health, 2008). The leading cause of mortality in the oPt is consistent with other LMICs; cardiovascular diseases are the main cause of morbidity and mortality (38.2%),

followed by perinatal conditions (9.7%), cancer (9%) and accidents (8.9%) (WHO, 2012).

Health services in the oPt have experienced many developments in the last two decades. Health services in the West Bank and Gaza were managed by the Israeli military administration between 1967 and 1994. This period was characterised by a shortage of staff, hospital beds, medication and specialised health services (Giacaman et al., 2009). A remarkable development of health services was achieved after the PNA was established in 1994. The Palestinian Ministry of Health (MoH) commenced an immediate reform of health services supported by considerable financial support from the international donor community (Hamdan and Defever, 2003).

Health services are provided by four main stakeholders in Gaza: the MoH, United Nations Relief and Works Agency (UNRWA), Non-Governmental Organisations (NGOs) and the private sector (Lubbad, 2008). The MoH in Gaza runs 55 Primary Healthcare (PHC) centres and 1,584 hospital beds (Ministry of Health, 2011). The hospital care provided by the MoH represents 57% of all hospital beds, while the MoH manages 416 of 654 PHC centres in Gaza and the West Bank (Giacaman et al., 2009). Likewise, mental health services in Gaza are provided by the MoH, UNRWA, NGOs and the private sector and are based on the medical model of care (Lubbad, 2008). A comprehensive investigation of the mental health services in Gaza is presented in Chapter four.

1.2.2.1 Financing Health Services

Various resources contribute to financing the Palestinian health budget including: taxes, health insurance premiums, out of pocket payments, donation and loans (Ministry of Health, 2008). Most of this budget is supported by donor agencies (Sayigh, 2007). The MoH estimates the expenditure of the governmental sector on health to be 40%, while the other 60% of the health budget is covered by out of pocket and other donations (Ministry of Health, 2011). The estimated funds provided by the international donor community to the PNA between 1994 and 2000 was 840·5 million United States Dollars (USD) (Sayigh, 2007). The PNA expenditure on health was estimated to be 10.5% of the total PNA budget in 2009 (Ministry of Health, 2011).

1.2.2.2 Challenges of Health Sector Reform

Although the health system in Gaza and the West Bank has experienced enormous development since 1994, many challenges remain. The Israeli occupation of the Palestinian land in the West Bank and Gaza remains the major challenge to the reform of health services in the oPt. Palestinians do not have control over water, land, and environmental threats (Giacaman et al., 2009). The entire control of Israel of all social determinants of health in the oPt makes health reform, based on a public health approach, difficult to achieve (Giacaman et al., 2009).

The fragmentation of services and resources is another main challenge to reforming health services in the oPt. This is because the development and provision of health services in the oPt depend on international donations (Ministry of Health, 2011),

which enhance the influential role of donors in the design of health policies (Hamdan and Defever, 2003). This considerable role of donors in designing the health service could contribute to the fragmentation of services, taking into consideration the different interests of donors (Giacaman et al., 2009). The fragmentation comes from funding different health priority areas and different service providers without ensuring an active coordination mechanism to regulate the collaboration between them (Giacaman et al., 2009).

Although the financial aid provided to the PNA is substantial for health service development and provision, the impact of this support on addressing the roots of health problems is limited because the Israeli occupation controls most of the social determinants of health in the oPt (Giacaman et al., 2009). For example, the PNA has no control over water or borders, which may increase the risk of many communicable diseases (Giacaman et al., 2009). The limited impact of the international financial aid to the PNA is a result of the failure of this aid in promoting the prevention and protection from existing health threats (Batniji et al., 2009).

1.3 Conceptual Framework

The current study conceptualised mental health reform in post-conflict areas and LMICs from a human rights based approach in the development of health programmes (UNOHCHR, 2000). Figure 1.1 shows the main elements of the conceptual framework, the “Right to Health Approach” (UNOHCHR, 2000).

I used this conceptual framework as a research tool to help me to link back to the relevant literature, find meaning in my data, and to provide structure to my findings. In other words, the “Right to Health Approach” (UNOHCHR, 2000) helped me to organise my thinking and helped me to use a structured approach to communicate my findings (Creswell & Plano Clark, 2011). I acknowledge that there can be limitations to using a conceptual framework, for example, interpreting findings from someone else’s perspective, and thus risking limiting the results. Therefore, my awareness was raised to be open to new, and to look for new, or unexpected events in the data (Creswell & Plano Clark, 2011).

The “Right to Health Approach” (UNOHCHR, 2000) encourages governments in LMICs and post-conflict areas to develop innovative strategies to improve the availability, accessibility, acceptability, and quality of mental health services (UNOHCHR, 2000). The human rights approach to health establishes the ground for non-discriminatory health services that emphasise supporting service user participation and enhancing social inclusion and equal opportunities for service users and carers (UNOHCHR, 2000). Additionally, the “Right to Health Approach” promotes the equitable accessibility to quality and sustainable health services especially for marginalised groups, such as mental health service users and carers (UNOHCHR, 2000).

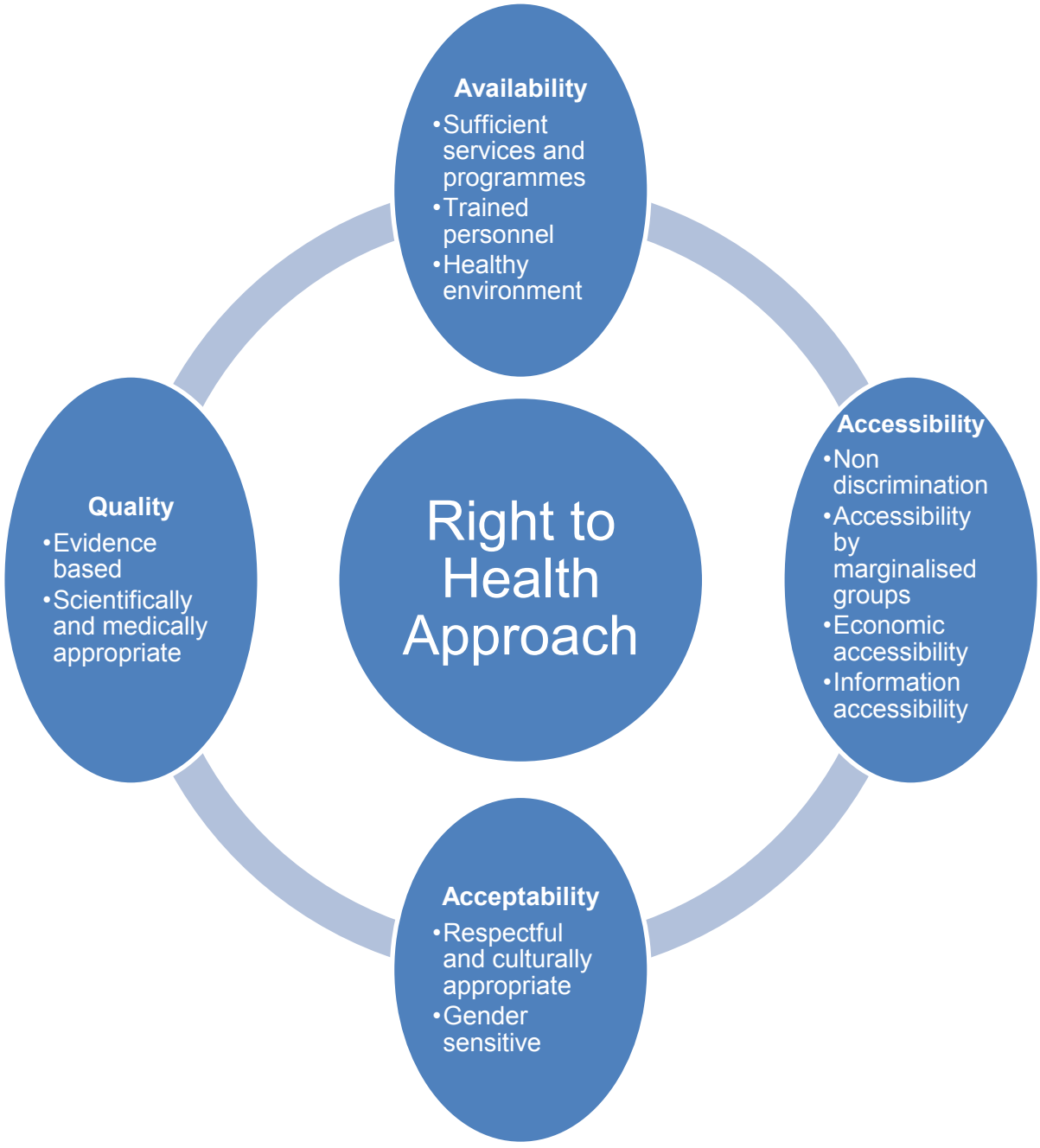

Figure 1.1 Right to Health conceptual framework

1.4 Statement of the Problem

The relationship between conflict and mental health services development is a complex one. There is evidence that conflict increases the burden of mental disorders (Mollica et al., 2004; Murthy and Lakshminarayana, 2006), including reducing the socio-economic status of individuals who experience it (Miller and Rasmussen, 2010). However, conflict can result in the increase of the allocation of resources from international donors to psychosocial and mental health programmes (WHO, 2013), but the strategy for using those resources to develop mental health systems in post-conflict areas is unclear (Jenkins et al., 2011a; Knapp et al., 2006).

Most of those increased resources are directed to providing quick, short-term, humanitarian response programmes that do not aim to support the existing mental health systems in countries that lack adequate resources to respond to the growing mental health needs after conflict (Tol et al., 2011; van Ommeren et al., 2005). Furthermore, the strategy of providing short-term, out-of-the-system, programmes disturbs the natural development of existing mental health systems, because skilled mental health workers leave the governmental service to work for NGOs (Wessells, 2009), without clear evidence of the impact of such short-term programmes on reducing the burden of mental disorder (Jenkins et al., 2011a).

NGOs provide substantial support to mental health service delivery in LMICs and post-conflict areas; however, this role has been an area of debate. While NGOs demonstrate a crucial role in mental health service delivery in many LMICs and post-conflict areas (Okasha et al., 2012; Saxena et al., 2007; WHO, 2013) the role of

NGOs in supporting the development of mental health services is questionable (Lund et al., 2010; Petersen et al., 2011a; Silove, 2005; Somasundaram, 2007). Few studies have investigated the relationship between NGOs and governmental services in the development and delivery of mental health services in post-conflict areas (Alonso and Brugha, 2006; De Vries and Klazinga, 2006). This study therefore provides answers to why NGOs and governmental services do not work together in post-conflict areas, and also suggests methods of collaboration between both sectors.

In this thesis, it is argued that the strategy of emergency response, which deals with mental health needs, like any other quick relief response, does not contribute to an effective scaling up of mental health systems in post-conflict areas and LMICs. Although conflict can generate opportunities for establishing more psychosocial and mental health response programmes and activities (WHO, 2013), the inappropriate distribution and utilisation of such resources impedes the development of mental health services. This thesis assumes that a better use of resources is possible if the mechanism of short-term, quick response programming can be embedded into the longer-term development of the system. As a result, the strategies of coordination and collaboration between governmental services and NGOs can be enhanced and the partnership between service providers and service users can be established.

Service users and carers are an invaluable yet unused resource in mental health service development and delivery. Although the experience of involving service users and carers in high-income countries still faces many challenges (Rutter et al., 2004;

Tait and Lester, 2005), the contribution of service users and carers to effective service development and delivery is evident (Cleary et al., 2006; Doughty and Tse, 2011; Lammers and Happell, 2004; Simpson and House, 2003). However, few studies have highlighted the experience of service users' and carers' involvement in mental health services in LMICs and post-conflict areas. Moreover, little is known about the views of service users and carers on mental health programmes and services in LMICs and post-conflict areas. The current study argues that the lack of involvement of service users and carers to service development and delivery adds to the challenges faced by governments in post-conflict areas and LMICs in reforming mental health services. This research provides a comprehensive analysis of reasons for excluding service users and carers from all activities related to service development and delivery. Furthermore, this research presents, for the first time, suggested methods for developing partnerships and collaboration between service providers and service users to improve the quality of mental health services in a post-conflict area and LMIC.

1.5 Rationale of the Study

There is an urgent need to develop mental health services in Gaza to respond to the increasing burden of mental disorders resulting from the population's ongoing exposure to violence. The current mental health services in Gaza are fragmented between governmental and NGOs services, which makes mental health reform more problematic. The global investigation of barriers to service development in other countries identified a lack of resources, lack of skilled mental health workers and under-involvement of service users and carers in service development and delivery

as the main gaps for successful mental health reform in post-conflict areas and LMICs. Existing research in post-conflict areas and LMICs captures examples of successful contributions to mental health reform, but lacks evidence on the comprehensive management of complex barriers to mental health development in such countries.

This study fills this research gap by providing a comprehensive and systematic investigation of all mental health stakeholders' views on mental health reform in Gaza. This investigation may lead to an innovative approach to addressing the main gaps in mental health reform by identifying ways to make better use of resources, identifying training needs for mental health professionals, and exploring the views of service users and carers to suggest methods for involving them in service development and delivery.

It is expected that the findings of this study will provide useful suggestions for mental health service planners and decision makers in Gaza, and in other post-conflict areas and LMICs, to help to avoid future shortcomings in the development and delivery of mental health services.

Thus, it is necessary to adopt a mixed methods study design that captures a range of views and information that can identify barriers and facilitators to mental health reform that may be transferable across mental health services in other post-conflict countries.

1.6 Aims of the Study and Research Questions

The primary aim of the current study is to describe the current mental health system in Gaza and provide new information on ways of reforming mental health services in a post-conflict area, such as Gaza, so that those services are more accessible and responsive to the needs of service users and carers, more acceptable to mental health practitioners and policy makers, and more sustainable in the long-term.

In order to address the aim of this study, the following questions have been developed within the theoretical foundation, the "Right to Health" framework (UNOHCHR, 2000), presented in Chapter two, and are addressed in the current study:

1. What are the current characteristics of the mental health system in Gaza in relation to policy development, service development and delivery, and availability of human resources?
2. What are the approaches that have been used to develop mental health policies and mental health plans for service development and delivery in Gaza, and how does the process of formulation, and the contents of both mental health policy and mental health plan, meet the international standards set by the WHO?
3. How do mental health professionals describe: 1) their self-perceived level of possession of mental health skills and knowledge competence, 2) the support they receive in using and implementing such skills, and 3) priority areas for mental health training and their preferred approach to training?

4. In the light of ongoing conflict in Gaza, what are the views of mental health policy makers and mental healthcare professionals on major mental healthcare challenges and what are their suggested strategies for reforming mental health services in Gaza?
5. What are the service users' and their family members' (carers) views on: 1) current mental health services, 2) mental health reform, and 3) involving them in planning and implementing mental health services in Gaza?

1.7 Study Limitations

The current study was implemented by a single researcher who carried out the data collection and analysis. The implementation of such a comprehensive study that includes qualitative and quantitative data gathering and analysis by a single researcher could introduce bias to this study (Bryman, 1998).

The researcher is a well-known mental health practitioner in the place where the study was implemented; the background of the researcher could introduce bias to this research (Bryman, 1998). Being a colleague of mental health professionals and policy makers could drive those interviewed in this study to hide or modify important information. Similarly, given that the interviewer is a mental health practitioner, interviewing service users and carers might have affected the credibility of the information revealed; service users and carers might have preferred to hide information as they might have experienced a feeling of power imbalance.

Using a mixed methods research approach is the most appropriate way to examine research questions that cannot be answered by using only a quantitative or a qualitative method (Creswell and Plano Clark, 2011). The current study uses a mixed method approach to enable the gathering of data from various sources, and employs a triangulated discussion of findings that provides a comprehensive view on reforming mental health services in Gaza. However, using a mixed method approach can affect the value of both quantitative and qualitative methods by mixing ontological and numeric data together (Bazeley, 2004; Kelle, 2006). Taking this risk into consideration, the transferability of the study's findings to other post-conflict areas and LMICs should be tackled with caution.

The analysis of the mental health policy and plan by using experts as focal points could introduce bias to this study. The views provided by focal points could reflect personal attitudes and judgments.

Focus groups are an important part of data collection in the current study. Focus groups encourage dynamic interaction between participants that facilitates insights into perceptions and attitudes, including dissent between participants (Kitzinger, 1994; Morgan, 1996). However, there is a risk that participants who dominate the discussion will hinder the participatory flow of information. Such possible unequal distribution of opportunities for all participants to provide their positions, experiences, and attitudes could introduce bias to the findings of the focus groups.

1.8 Methodology and Research Methods

This is a study in which a convergent mixed methods approach was used to collect and analyse both qualitative and quantitative data (Creswell and Plano Clark, 2007; Johnson et al., 2007; Morse, 2003). This approach allows a parallel model of collecting and analysing data while the triangulation of the findings occurs in the interpretation and conclusion phases. The justification for using this convergent model was to gather diverse and complementary information from various resources that facilitate answering the research questions.

The methods of data collection include using self-reported questionnaires, identifying focal points to provide information on the current mental health system in terms of policy development and service delivery, and conducting focus groups. Although the methods used were the most appropriate to answer the research questions, a number of methodological limitations, as presented in the previous section and discussed in more detail in Chapter five, may have introduced bias, affecting the overall findings.

1.9 Overview of the Thesis

Chapter one provided the background to the research problem and introduced the research context, emphasising the importance of conducting this study, and described the primary research aim and research questions. Potential study limitations and the research methods used were also presented.

Chapter two presents a review of the relevant literature on mental health reform in post-conflict areas and LMICs. The first section provides an overview of the global

mental health burden. This section was organised into three parts: the first part discusses the burden of mental disorders in LMICs, the second part explores the mental health burden in post-conflict areas, and the last part provides an overview of the burden of mental disorders in Gaza as the place where the current study was conducted. The second section presents the current position of mental health system development in post-conflict areas and LMICs. The third section discusses the global experience of involving service users and carers in service development and delivery. The fourth section reviews different challenges for reforming mental health services in post-conflict areas and LMICs. The final section presents lessons learned and successful models of mental health reform in some post-conflict areas and LMICs.

Chapter three presents the design, methods, instruments, participants, and procedures used to collect and analyse data. Chapter four presents research findings, starting with a description of the mental health system in Gaza and a policy analysis, followed by a training needs analysis for mental health professionals, and finally presenting the qualitative analysis of the focus groups.

Chapter five discusses and interprets the research findings by providing a triangulation of findings while discussing the practical implications and contributions of the findings toward further understanding of mental health service development.

1.10 Conclusion

This chapter presented the background context of this research and provided an overview of the main components of this thesis. This chapter emphasised the purpose and rationale for conducting this study. It also presented the main aim of the study and research questions, and provided a brief description of the methods used to answer those questions. In addition, this chapter briefly presented the limitations of this study and an overview of the structure of the thesis. A description of study publications and outputs follows. The following chapter provides a review of the literature relevant to mental health reform in post-conflict areas and LMICs in order to provide the theoretical justification for conducting this research.

1.11 Paper Publications and Presentations

Mustafa El Masri, **Dyaa Saymah**, Mahmoud Daher & Fuad Al Aisawi. (2014). Integrating mental health-care in primary health care (PHC) services in the occupied Palestinian territory: prevalence of mental health problems among patients attending Government PHC in Gaza. **The Lancet** (in publication).

> As corresponding author, this research was shaped by identifying the limited evidence base concerning mental health problems in Gaza in the literature review of my work.

Saymah, D., Tait, L. and Michail, M. (2015). An overview of the mental health system in Gaza: an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). **International Journal of Mental Health Systems**. 9, 4. (see Appendix One)

WHO. (2014). **Shell-shocked Gazans seek to expand mental health services in wake of conflict.** Geneva, World Health Organization.

This WHO report is a direct response to my work on ways of scaling-up and improving mental health services in Gaza, particularly in response to the consequences of conflict. The acceptance of my findings by a United Nations authority on global health, which sets the research agenda and standards for healthcare, is a major impact and output from my work on strengthening mental health care in Gaza to respond to the increasing mental health burden.

Mustafa El Masri, **Dyaa Saymah**, Mahmoud Daher & Fuad Al Aisawi. (2013). Integration of mental health-care with primary health-care services in the occupied Palestinian territory: a cross-sectional study. **The Lancet,** 382, Supplement 4: S9.

As corresponding author, this work was shaped by the identification of the limited evidence base concerning mental health problems in Gaza in the literature review of my work.

Ashour, H., Khodjaeva, N., **Saymah D**., Abu Sway, R., Laurance, T. (2013). "West Bank and Gaza Strip." In JoAnne Epping-Jordan (ed.) **Building back better: sustainable mental health care after emergencies.** Geneva: World Health Organization.

My contribution to this chapter was a major output from the qualitative phase of my research and key parts of the literature review.

Saymah, D., Michail, M. and Tait, L. (2013). Reforming mental health care inside the occupied Palestinian territories: an analysis for human resource development needs. **The Second Public Health Conference, Public health in Palestine: challenges, research, and implications, Al-Quds University,** Abu Dis, 25 April 2013.

This paper was a major output from the quantitative phase of my work. Discussion of the results with global mental health experts helped shape the presentation of results.

Dyaa Saymah. (2012). Why change the system? Learning from service change experiences, Gaza, Palestine. **The International Conference, Why Change? Creativity and Innovation in Mental Health Development,** Italy, 26th-27th October 2012.

The paper presented at this conference focused on major achievements of the mental health reform in Gaza, Palestine, and the main gaps of mental health service development and delivery, as identified by the outputs from my WHO-AIMS questionnaire and qualitative analysis phase.

Saymah, D. (2010). Mental health in Palestine. **North Essex Partnership NHS Foundation Trust,** Anglia Ruskin University and North Essex Partnership NHS Foundation Trust, 23 June 2010.

This delegation visit provided an opportunity to discuss mental health services in Palestine, a low-middle income country, in comparison with mental health services in the UK, classified as a high-income country.

Saymah, D., Michail, M. and Tait, L. (2010). Developing a new vision for restructuring mental health services in an area of political conflict. **Scientific International Network on Migration, Social Medicine & Global Mental Health,** Stockholm, Sweden, 24th-26th May 2010.

This paper provided an early opportunity to discuss my research proposal, including confirming the relevance of my research questions, rationale, methods and data analysis, with international conference delegates from different research disciplines with global mental health expertise. The acceptance of this paper at a distinguished international conference demonstrated the significance of my work in both a local and wider context.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews the literature on mental healthcare reform in post-conflict areas and Low and Middle Income Countries (LMICs). The first section provides an overview of the global burden of mental disorders in LMICs and post-conflict areas, and specifically in Gaza, where this study takes place.

There is an increasing emphasis on the importance of scaling up and improvement of mental health services in LMICs and post-conflict areas as a result of the Lancet's series of publications on global mental health in 2007 (Patel et al., 2008). However, scaling up of mental health services in LMICs and post-conflict areas, defined as considerably increasing the volume of services to meet the high burden of mental disorders in those areas, is frequently difficult due to a shortage of human and financial resources (Saraceno et al., 2007). The World Health Organization (WHO) launched the mental health Gap Action Programme (mhGAP) in 2008 as an initiative to encourage governments in LMICs to develop mental health resources to improve their ability to respond to the high mental health burden (WHO, 2008c).

The second section explores the mental healthcare system development in post-conflict areas and LMICs, and does so by describing the opportunities and challenges of system development. The third section highlights the experience of service users and carers in high-income countries due to the lack of documented experiences of service users' and carers' involvement in LMICs. In the fourth section the main challenges facing mental health service development in post-conflict areas

and LMICs are considered. The final section of the literature review presents lessons learned from examples of successful mental health reform in post-conflict areas and LMICs.

The gaps in the available literature are identified from the review and discussion of the available empirical evidence that addressed various aspects of mental healthcare reform in post-conflict areas and LMICs. This discussion of the current research gaps considers the burden, challenges, potential resources, and ways of improvement, and specific needs for further research.

2.2 Global Mental Health Burden

The global burden of disease report, published in 2004, was influential in demonstrating the huge burden of mental disorders worldwide (Patel, 2007). The second application of this global burden of disease framework estimated that neuropsychiatric disorders, especially uni-polar depression, accounted for 11.1% of the total burden of disease (Lopez et al., 2006). The contribution of mental disorders to the global burden of disease increased to 13% in the WHO update of the 2004 global burden report (WHO, 2008a). According to this updated WHO report, mental disorders account for 16.6% of the burden of disease in middle-income countries and 8.8% in low-income countries (WHO, 2008a). However, despite such high burden of mental health problems, most mental health needs are still unmet (Patel, 2007).

2.2.1 Mental Health Burden in Low and Middle Income Countries

Although epidemiological studies measuring prevalence rates of mental disorders in LMICs are few, and the findings across studies sometimes inconsistent, these studies reveal high prevalence rates of mental health problems (Amoran et al., 2007; Gureje et al., 2006; Ovuga et al., 2005; Roberts et al., 2009; Tanios et al., 2009). A review conducted by Tanios et al. (2009) analysed 32 studies conducted in Arabic speaking Middle Eastern countries that had used either the International Classification of Diseases (ICD) (Pavillon and Maguin, 1993) or the Diagnostic and Statistical Manual (DSM) screening instruments for mental disorders (Cooper and Michels, 1981). The prevalence of anxiety disorders ranged from 7% in Saudi Arabia to 54.4% in Egypt, while the average prevalence rate in Palestine was 21.5% (Tanios et al., 2009). Although the review reported a high disparity between Saudi Arabia as a high-income country and Egypt and Palestine as LMICs, anxiety rates in both Egypt and Palestine were higher than average anxiety rates in other LMICs (Tanios et al., 2009). For example, the prevalence rate of mental disorders in Nigeria was 12.1% in general, and anxiety disorders were the most frequent (Gureje et al., 2006).

Considerable variation between studies in depression rates has also been reported (Amoran et al., 2007; Ovuga et al., 2005; Roberts et al., 2009). The prevalence of depression in Nigeria was 5.2% (Amoran et al., 2007), while rates of depression in Uganda were 17.4% (Ovuga et al., 2005) and 49.9% in South Sudan (Roberts et al., 2009). The discrepancy in the prevalence rates of mental disorders among different studies appears to be the result of using different screening instruments. For example, some studies used questionnaires (DSM based questionnaire (Cooper and

Michels, 1981), and the Beck Depression Inventory (Beck and Steer, 1984)), while other studies used screening interviews based on the Composite International Diagnostic Interview (Robins et al., 1988). However, despite the discrepancy in findings, the prevalence of mental disorders in LMICs is considerably high compared to the availability of mental health resources to address such burden (Patel, 2007).

2.2.2 Mental Health Treatment Gap

An important contributor to the high burden of mental disorders in LMICs is the high treatment gap (Patel, 2007; WHO, 2004c). The treatment gap is the estimated number of persons who suffer from mental health problems that require treatment but do not receive mental healthcare (WHO, 2008c). The mental health survey consortium reported that 76.3% to 85.4% of serious mental health cases in LMICs received no treatment in the 12 months preceding the implementation of the study, while the percentage of cases receiving no treatment in a high-income country, like the United Kingdom, was 35.5 to 50.3% (WHO, 2004c).

This high percentage of the reported treatment gap in LMICs (Patel, 2007; WHO, 2004c), may reduce the chance of recovery for a large number of people with mental health problems (WHO, 2008c). This reduced chance to receive treatment may lead to an increase in the severity of symptoms, an increase in the probability of developing severe disturbance in function and, as a result, may increase rates of chronic disability (WHO, 2008c). It has been suggested that there is a need to provide accessible, community-based services to reduce the high mental health burden as a priority in order to reduce the disability rates for disorders that are

treatable (WHO, 2008c). It therefore appears that delays in reforming mental healthcare could have serious implications for quality of life and the achievability of scaling up mental health services in the future (Funk et al., 2010). However, responding to the high burden of mental disorders in LMICs, by scaling up mental health services, requires a comprehensive understanding of the context in LMICs that contributes to the development of mental disorders (Patel, 2007).

2.2.3 Factors Associated with Mental Health Burden in Low and Middle Income Countries

Poverty is widely recognised as one of the main determinants of poor mental health in LMICs (Boyce et al., 2009; Lund et al., 2010; Saraceno and Barbui, 1997). Lund et al. (2010) reviewed studies that explored the link between a range of poverty indicators, such as annual income and unemployment, and Common Mental Health Disorders (CMHD). Most of those studies reviewed by Lund et al. (2010) reported positive associations between poverty and CMHD. This association between poverty and poor mental health has also been reported by Boyce et al. (2009), who found that income level is one of the most consistent predictors of mental health status in LMICs. This makes sense, as people living in poverty are more exposed to social exclusion, high stressors, reduced social capital, malnutrition, obstetric risks and increased risk of violence and trauma (Saraceno and Barbui, 1997). In the light of this work, attempts to reform mental health services in LMICs need to carefully explore how poverty and other social determinants contribute to the burden of mental disorders. For example, improving equal opportunities of people with mental health problems to employment and housing as a strategy to reduce the impact of poor

social determinants on mental health wellbeing could be considered when reforming mental health services (Funk et al., 2010).

In addition to poverty, education level and other socio-economic factors, such as food security and gender, are considered to be main determinants of poor mental health in LMICs (Lund et al., 2010). Boyce et al. (2009) identified low education level as a strong predictor of CMHD, and reported also a strong association between CMHD and other socio-economic factors such as food security.

As mentioned previously, gender is considered one of the predictors of poor mental health (Boyce et al., 2009; Lund et al., 2010). According to Das et al's (2007) survey, CMHDs were higher among females in four of the five LMICs included in the survey, with higher mental health problems among widowed and divorced women. Socio-economic situations have been found to have a significant impact on the wellbeing of women as well (Lund et al., 2011). Women of low socio-economic status in Pakistan are three times as likely to develop postnatal depression (Lund et al., 2011). I argue that such findings can contribute to a better understanding of the magnitude, and the roots, of mental health burden in LMICs that can draw the attention of policy makers to the holistic nature of the problem, which is not limited to the medical paradigm alone.

Understanding the link between mental health and various socio-economic determinants may help to improve accessibility to mental health services. Access to basic mental health services by poor people and people living in rural areas needs to

be improved (Funk et al., 2010; WHO, 2008b). It has been suggested that integrating mental health services into general health and primary care services is key to ensuring improved accessibility (WHO, 2008c). Most importantly, considering the strong association between socio-economic factors and poor mental health (Lund et al., 2011; Saraceno and Barbui, 1997), it has been suggested that mental health services need to be mainstreamed with relief, labour and housing services (Funk et al., 2010). Policy makers need to consider that improving mental health may lead to improved productivity and this may lead to improved socio-economic status (Funk et al., 2010). Therefore, policy makers should be encouraged to prioritise mental health reform as one of the developmental aims in LMICs (Funk et al., 2010).

2.2.4 Mental Health Burden in Post-Conflict Areas

Studies have shown that exposure to conflict and war creates multiple social and health consequences that contribute to more mortality and disability than any disease (Do and Iyer, 2009; Murthy and Lakshminarayana, 2006). Conflict can leave an irreversible impact on the individual, families and societies as survivors of conflicts are forced to face a new reality that is characterised by loss of friends and relatives, loss of properties and re-experiencing painful memories of traumatic events they have lived (Murthy and Lakshminarayana, 2006). In addition to the severe mental health consequences of conflict, survivors of conflict are also subjected to a deterioration in their standard of living, such as increased poverty, social marginalisation, isolation, inadequate housing, and changes in family structure and functioning (Miller and Rasmussen, 2010). The negative consequences of exposure to conflict creates a state of high stress that leads to the development of mental

health problems (Do and Iyer, 2009). The increased deterioration of mental wellbeing will also, in turn, contribute to a decline in living standards (Funk et al., 2010). This research on the mental health burden in post-conflict areas is informative about the interactive relationship between conflict, living standards, and the development of poor mental health status, which contributes to an increased burden of mental disorders.

Quantifying the mental health burden associated with conflict is important to understanding the need for appropriate mental health interventions. The WHO estimated that exposure to traumatic events can lead to the development of severe mental disorder among 10% of the population who live in armed conflict, and another 10% of the population will develop behavioural problems that can significantly affect their functioning (WHO, 2001). Taking into consideration that many nations and communities are exposed to armed conflicts, and many of them are continuing in nature, indicates how conflict contributes to the growing burden of mental disorders in post-conflict areas. For example, over 80% of the population in 22 countries of the Eastern Mediterranean Region of the World Health Organization (EMRO) have experienced conflict situations (Ghosh et al., 2004).

As a result of the associated relationship between conflict and mental disorder, mental disorders are more prevalent in post-conflict areas than in more stable countries (Mollica et al., 2004). This finding has been confirmed by a large study conducted by the social development department of the World Bank, which examined the most prevalent mental disorders in five post-conflict areas around the world: the

Thai-Cambodian border, Algeria, Ethiopia, Gaza, and Uganda (Baingana, 2003). This study revealed a 17% prevalence of psychopathology among the population not exposed to violence as opposed to 44% among those who experienced violence (Baingana, 2003). It should be noted that despite the agreement of most of the literature on the increased prevalence of mental disorders in post-conflict areas, available prevalence studies are limited in number and sometimes highly inconsistent (Tanios et al., 2009).

2.2.5 Prevalence of Mental Disorders

Post-Traumatic Stress Disorder (PTSD) and depression are the most common mental disorders examined in the literature; generalised anxiety has been less frequently examined (Murthy and Lakshminarayana, 2006). PTSD is relevant to conflict settings as the diagnostic criteria of PTSD depends upon screening the after-effect of exposure to a traumatic event (Cooper and Michels, 1981). Depression is also important because it is a leading cause of disease burden (Lopez et al., 2006). Reviewing the literature shows that other important CMHDs are screened less frequently, such as somatoform and other anxiety disorders; the reason for less screening of these disorders is not clear in the literature. Moreover, the impact of conflict on people who have been diagnosed with severe mental illness, especially schizophrenia, is not addressed adequately by the literature (van Ommeren et al., 2005). Therefore, the following four literature reviews have been chosen to present the magnitude of the burden of PTSD and depression in post-conflict areas.

Prevalence rates of PTSD and depression have been analysed in five post-conflict countries (Mollica et al., 2004). The studies selected in this review used the same screening instruments: Harvard Trauma Questionnaire (Mollica et al., 1992); Hopkins Symptoms Check List (Mollica et al., 1987); General Health Questionnaire (Goldberg et al., 1997); and the Composite International Diagnostic Interview (Robins et al., 1988). The prevalence rates of PTSD ranged from 4.6% to 37.2%, while the prevalence rate of depression ranged from 39% to 67.9%. This review revealed high prevalence rates of both disorders compared to more stable countries, like the United States, where the prevalence rate of PTSD was 7.8% and the prevalence rate of depression was 16.2% using the same screening tools (Mollica et al., 2004).

A brief literature review measured the impact of war on the general population, refugees and vulnerable groups by analysing published literature in 12 post-conflict areas around the world (Murthy and Lakshminarayana, 2006). Most of the studies reviewed used community-based surveys. Findings revealed high prevalence rates of PTSD (87% among child refugees in Iraq and 48% among the general population in Cambodia). The prevalence rate of depression was also high (67.7% in Afghanistan and 16-42% in Lebanon). The review also reported that women were more affected than men and vulnerable groups, such as children, the elderly and people with disability, were more affected compared to the general population (Murthy and Lakshminarayana, 2006).

A literature review conducted by the World Bank to measure the prevalence of mental disorders among refugees in five post-conflict areas (Thai-Cambodian border,

Algeria, Ethiopia, Gaza, and Uganda) revealed 15% to 53% suffer from PTSD in the five countries included in the review (Baingana, 2003). The highest prevalence rate of depression was reported in Uganda, which affected 71% of the population. The review also reported that victims affected by the conflict developed impaired social functioning, which negatively affected them for an estimated five years after the end of the conflict (Baingana, 2003).

The final literature review reported PTSD rates among children and adolescents in war affected countries in the Middle East (Dimitry, 2012). Most of the studies reviewed used self-reported, parent-reported, and teacher-reported questionnaires. The prevalence rate of PTSD was estimated to be 23-70% in Palestine, 10-30% in Iraq and 5-8% in Israel. Additionally, the review revealed a significant association between exposure to conflict and the development of emotional and behavioural problems in children. Also, the high anxiety or depression symptoms among mothers were associated with a higher possibility of the development of depression and anxiety symptoms in children and adolescents (Dimitry, 2012).

These four literature reviews were characterised by a focus on specific mental disorders such as PTSD and depression. As mentioned previously, the studies reviewed used common screening surveys but their results were unsupported by qualitative research or observation studies. It was noticed that the studies reviewed focussed less on the adult population, which may provide an impression that prevalence rates of PTSD and depression were higher among specific vulnerable groups (such as children, women and refugees) more than the general population.

This focus on specific vulnerable groups may also explain the inconsistency of prevalence rates among different studies, because the characteristics of study samples differ from one study to another. Most importantly, despite the inconsistent prevalence rates between studies, significantly higher rates of PTSD and depression were reported compared to the prevalence rates reported for both disorders in more stable countries, such as the United States. This appears to show that conflict can increase the prevalence rates of PTSD and depression.

Reviewing the literature shows that prevalence rates of anxiety and somatoform disorders were less common in the published literature in post-conflict areas. However, high prevalence rates of both disorders have been reported in the few published studies found. For example, the prevalence rate of anxiety has been reported to be 72.2% in Afghanistan (Murthy and Lakshminarayana, 2006). Also, post war anxiety has been reported to be one of the highest risk factors for increased prevalence rates of anxiety in Arabic countries (Tanios et al., 2009). Additionally, the same review (Murthy and Lakshminarayana, 2006) reported a prevalence rate of 41% for somatisation in Sri Lanka after the conflict. These reported prevalence rates, although they are less common, are important to helping researchers and policy makers reduce the over-emphasis on PTSD, and to develop a more holistic view of the impact of conflict on the general population in terms of the prevalence of mental disorders. Such a holistic view is important because it could be translated into appropriate programmes that take into consideration the magnitude of the problem, as well as potential resources and mediating factors.

2.2.6 Daily Stressors and Mental Disorders

Many factors can mediate the relationship between war exposure and the development of mental suffering. Miller and Rasmussen (2010) found in a study of mental health needs for Darfurian refugees in neighbouring Chad that, despite the high level of extreme violence to which the refugees had been exposed, daily stressors related to a lack of basic needs and safety in the camps, which were better predictors of PTSD than war exposure. Another study by Al-Krenawi et al. (2007) on the impact of political violence on Palestinian youth in the West Bank found that family violence against children and violence between siblings better predicted children's mental health status than their level of exposure to political violence. Moreover, daily stressors in Afghanistan were found to be associated with developing general stress, depression and functional impairment, more than war exposure, which correlated directly to the development of PTSD (Miller et al., 2008). Understanding the role of mediating factors helps in developing a deeper insight into the problem, instead of limiting the mental health burden in post-conflict areas solely to exposure to political violence.

2.2.7 Mental Health Burden in Gaza

Gaza is an area of ongoing political conflict; a place where it is important to highlight the urgent need to reform mental health services to respond effectively to the mental health burden (WHO, 2012). A comprehensive overview of the mental health burden in Gaza is still lacking. Therefore, this section examines the prevalence of the most commonly reported mental health problems in Gaza according to recent studies. This section begins by presenting the prevalence of mental health problems among the

most vulnerable groups such as children, adolescents, adults, and persons with disabilities. Limitations in the literature and specifically reliability in measuring the actual burden of mental health problems in Gaza will also be presented.

2.2.7.1 Mental Health Problems among Children

In recent years, research studies have examined the burden of mental health problems in Gaza, and have shown that children are the group most affected (Khamis, 2005). Children are highly exposed to various traumatic events in Gaza (Dimitry, 2012; Thabet et al., 2008; Thabet et al., 2002). The link between exposure to violence and the development of PTSD among children in Gaza is well established (Dimitry, 2012; Thabet et al., 2002). Therefore, the majority of studies in Gaza focus on measuring the prevalence of PTSD as a major indicator of the impact of conflict on children's wellbeing.

Studies that have examined the prevalence of PTSD, however, provide conflicting evidence because of the high discrepancy between prevalence rates. For example Qouta et al. (2003) reported that 54% of the children in Gaza suffered from severe symptoms of PTSD, 33.5% from moderate and 11% from mild or doubtful symptoms. A higher prevalence rate of PTSD, 70.1%, was reported by Thabet et al. (2008) in children living in areas affected by ongoing political violence. Both studies by Qouta (2003) and Thabet (2008) used self-reported or parent-reported data without corroborating those data by other sources, such as observation of behaviour.

Other studies showed lower prevalence rates of PTSD. For example, an epidemiological survey conducted in four post-conflict areas, including Gaza, reported a PTSD rate of 17.8%, by using the Composite International Diagnostic Interview (Robins et al., 1988), in children in Gaza (de Jong et al., 2001). Another survey (GCMHP, 2010c) measured the wellbeing of children in Gaza one year after the war in 2008/2009, using the self-reported Gaza traumatic events checklist (Thabet et al., 2002), which revealed that an average of 10.6% of children exhibited severe reactions to traumatic experiences, with no significant sex or age differences (GCMHP, 2010c).

Although epidemiological research focuses on measuring the prevalence rate of PTSD to describe the impact of the ongoing conflict on children's wellbeing in Gaza, other aspects of children's wellbeing need to be investigated to provide a more extensive view of child suffering. The impact of exposure to violence was not limited to PTSD, children's emotional and behavioural wellbeing were affected as well (Thabet et al., 2006). Gaza Community Mental Health Programme (GCMHP) revealed that 14% of children, included in a study evaluating intervention programmes with kindergarten children, suffered from emotional problems (such as attachment problems, anger and disruptive behaviour) while 46% of them developed peer relationship problems, 33.8% hyperactivity and 15.1% multiple-social problems (GCMHP, 2010a). It was reported that conflict could also affect the quality of life for children (Massad et al., 2011; Qouta et al., 2007). As reported by their mothers, 65% of preschool children in Gaza suffer from severely impaired psychosocial and emotional functioning (Massad et al., 2011). Moreover, exposure to traumatic events

in mid-childhood can increase the risk of developing PTSD and depressive symptoms in adolescence (Qouta et al., 2007). Taking into consideration the ongoing nature of the political conflict in Gaza, a special focus on adolescent mental health should therefore be considered by mental health practitioners and researchers.

2.2.7.2 Mental Health Problems among Adolescents

Adolescents are also among the most affected vulnerable groups in Gaza (Elbedour et al., 2007; Espie et al., 2009); however, they are less targeted than children by researchers in Gaza. As with studies on children, most of the research studies on adolescents focused on PTSD as the most common indicator of the consequences of exposure to political violence. As observed with the PTSD studies focused on children, inconsistent prevalence rates were reported in the studies targeting adolescents. A study by Elbedour et al. (2007) examining the reaction to violence among adolescents living in Gaza, using diagnostic criteria from the DSM (Cooper and Michels, 1981), reported that 68.9% among participating adolescents had PTSD. It should be noted that the participants included in this study were adolescents who live in one of the most affected areas in Gaza, where the possibility of being exposed to violence is considerably higher, and may have resulted in a higher rate of PTSD. When compared to the findings of another study conducted by Espie et al. (2009), the prevalence of PTSD among adolescents in Gaza and the West Bank was 25.8%. It is important to note that Espie et al. (2009) used both questionnaires and semi structured interviews in the same study to diagnose PTSD, which may lead to more reliable data by using two sources. The discrepancy between study findings, most likely affected by the recruitment methods of the study sample, reflects the difficulty

in generalising the prevalence rate to the whole population in the Gaza Strip. Regardless, both studies revealed high prevalence rates of PTSD that still demonstrate the negative impact of political violence, especially on children and adolescents. PTSD may also lead to other serious mental health conditions that can increase the mental health burden in a post-conflict area like Gaza.

2.2.7.3 Post-Traumatic Stress Disorder and Co-Morbidity

Although PTSD was the focus of research that measured the impact of political conflict, some studies focused on other mental health problems that are co-morbid with PTSD (Al-Krenawi et al., 2009b; GCMHP, 2010a). For example, GCMHP reported that PTSD was found to have significant co-morbidity with mood, anxiety and somatoform disorders (GCMHP, 2010a). Compared to Jewish Israeli adolescents who were also exposed to traumatic incidents, Palestinian adolescents reported higher levels of mental health symptoms and PTSD symptoms as well as co-morbidity with other problems in family functioning, social functioning and aggression (Al-Krenawi et al., 2009b). More specifically, Palestinian adolescents exposed to greater political violence reported higher levels of co-morbidity between PTSD symptoms and various mental health symptoms (somatisation, obsession-compulsion, depression, anxiety, hostility, paranoid ideation and psychoticism) (Al-Krenawi et al., 2009b). Such findings emphasise the need to capture the variance in mental health problems in Gaza that extends beyond the diagnoses of PTSD if the mental health burden is to be adequately understood and addressed.

Although the impact of violence on vulnerable groups such as children and adolescents warrants careful study, it is important not to overlook the impact of political violence on adults, families and on society as a whole.

2.2.7.4 Mental Health Problems among the General Population

Reviewing the literature shows that very few studies have investigated the impact exposure to political violence has on entire family networks and the general population in Gaza. Thabet et al. (2008), using the PTSD Checklist, reported that 60% of parents in Gaza developed PTSD symptoms that were clinically significant. Furthermore, a study that took place one year after the war in Gaza, during 2009, measured the after-effect of the war on the family unit (GCMHP, 2010a). The prevalence of Post-Traumatic Stress (PTS) among the Gaza families was reported to be 45% (GCMHP, 2010a). While the study carefully considered the impact of the political conflict on the whole family, the study measured the general stress levels without examining the prevalence rates of mental disorders, and without considering the impact the stress levels had on the emotional and social functioning of families. However, the findings of those studies call for more attention to be paid toward including the adult population when assessing the impact of war or political violence on the whole population.

Similarly, reviewing the literature shows that the mental health burden among adults in Gaza has not received much attention in the literature. One of the few studies conducted by the WHO in 2009 (El Masri et al., 2014) examined the prevalence rate of mental health problems among adults attending primary healthcare centres using

the General Health Questionnaire (GHQ-12) (Goldberg et al., 1997). The prevalence of mental health problems was 37.8%; lower educational level, unemployment and being affected by a chronic illness were among the factors associated with psychological distress (El Masri et al., 2014). According to the same study, the rate of psychiatric problems was higher than those found in other countries where the population was not exposed to a recent disaster, but comparable to results obtained from populations following large-scale disasters (El Masri et al., 2014).

The continuous political violence in Gaza over the last three decades has increased the number of people with physical disabilities from all age groups (Palestinian Central Bureau of Statistics and Ministry of Social Affairs, 2011). Special attention has been giving to this vulnerable group in order to assess their physical and psychological needs.

2.2.7.5 Mental Health Problems among Persons with Disability

The prevalence of mental health problems among people with physical disabilities is significantly high. Using the Beck Depression Inventory (Beck and Steer, 1984) and the GHQ-12 (Goldberg et al., 1997), with samples of people who developed physical disability during the war in Gaza in 2009, 79.9% of persons involved in this study, from all age groups, reported psychiatric morbidities (depression and anxiety) (GCMHP, 2010b). PTSD was found to be highly prevalent among adolescents with permanent disability, as 76.5% of adolescents living in Gaza and the West Bank have developed this disorder (Khamis, 2008). This prevalence rate is considered significantly high compared to other western, post-conflict countries like Northern

Ireland, where 52% of people with disabilities experienced a great deal of stress (DHSSPS, 2004).

2.2.7.6 Prevalence Study Limitations

It is noticeable that knowledge of the impact of violence on the mental health and wellbeing of the population in Gaza has been developed over the last two decades. However, substantial challenges still obstruct the ability to determine the precise prevalence of mental health problems in Gaza. Most research has focused on the epidemiological symptoms of PTSD and related common post-trauma conditions, such as major depression and anxiety. The prevalence of PTSD among children in Gaza varied according to when the study was conducted, and depended upon the methodology and instruments used. Furthermore, the manifestation of high levels of distress after an emergency in a community is considered a normal response, while the same level of distress in a stable setting would likely indicate a sign of pathology (Tol et al., 2011). Therefore, surveys conducted after high scale violence in Gaza need to demonstrate that they are able to distinguish between mental disorders and non-pathological distress. This may be yet another explanation for the inconsistency in different PTSD rates reported in different studies.

Overall, the instruments used in the studies assessing the prevalence of mental health problems in Gaza mostly lacked the ability to measure the level of disability caused by the development of trauma-related symptoms. The methods used to collect data were usually quantitative; the majority of surveys used various local and international tools to measure initial reactions either as symptoms or disorder. The

risk of using internationally developed tools, if they are not adapted to the context in Gaza, could provide confusing measures as the presentation of symptoms of mental disorders differs between cultures. Therefore, the reliability of the prevalence rates of mental disorders using internationally imported tools may be questionable. Furthermore, no research addressed the impact of violence on people with severe mental illness, such as schizophrenia or bipolar disorder, and how their level of functioning was affected by living in a conflict area.

2.2.8 Summary

This section provided a brief summary of the burden of mental disorders in LMICs, post-conflict areas and, in particular, within Gaza. The descriptive analysis of the mental health burden in LMICs and post-conflict areas is important to understanding the burden of mental health in Gaza, as Gaza is a LMIC and a post-conflict area.

There is clear evidence that the mental health burden in LMICs is huge despite the discrepancy of varying prevalence rates of mental disorders reported in different LMICs. Moreover, the burden of mental disorders in LMICs is associated with other socio-economic factors such as poverty and lower education. Understanding the social determinants of mental health in LMICs is essential for understanding the roots of the problems and therefore developing strategies for addressing them.

The burden of mental health in post-conflict areas was evident in the literature. There has been a well-established link between exposure to traumatic events and the development of mental health suffering in post-conflict areas. There was a focus on

measuring the prevalence rates of PTSD and depression by most studies as key indicators for assessing the impact of conflict on mental health. A comprehensive review of the literature calls for a more holistic view when it comes to understanding the burden of mental health in post-conflict areas beyond the prevalence rates of PTSD and depression. This entails underlining the link between developed dysfunction and the social, economic, and psychological repercussions of conflict.

The burden of mental health in Gaza is evident in the literature as evidenced by the reported prevalence rates of PTSD and trauma-related stress in children, adolescents, families and other vulnerable groups such as people with disability. However, the published prevalence rates varied extensively, suggesting that studies need to adopt consistent methodology to measure the burden of mental health after conflict. Nevertheless, the studies reviewed provided preliminary evidence of the extent to which exposure to violence impacts on the overall mental health of the population of Gaza. The findings highlighted the research gaps indicating that further research is urgently needed.

The current study will suggest recommendations for reforming mental health services in Gaza, as the burden of mental disorders is extensive; and calls for urgent measures and programmes for scaling up mental health services to respond to the needs of the population.

2.3 Mental Health Systems in Low and Middle Income Countries and Post-Conflict Areas

This section provides a general overview of the development of mental health systems in LMICs and post-conflict countries. In addition, the development of mental health policies, plans, and legislation as a fundamental step toward developing successful mental health systems is discussed. Moreover, essential pillars that affect the development of mental health systems in LMICs and post-conflict areas such as costs allocated for system development, political will, moving toward community services, and how conflict can affect the process of system development, are examined. Main obstacles are identified that can delay mental health system development, especially barriers to implementing community-based programmes. Furthermore, the specific problems related to service development in post-conflict areas, such as the role of NGOs in system development, and how this role complements versus hinders the national system's effort in reforming mental health services, are also discussed.

2.3.1 Policy, Plans and Legislation Development in Low and Middle Income Countries and Post-Conflict Areas

Developing a mental health policy and plan is crucial for reforming mental health services worldwide (WHO, 2004a). Such policies can obligate governments to create a clear road map for developing mental health services (WHO, 2004a). It can also stimulate international support for accelerating the implementation of such policies (Jenkins et al., 2011b). For example, the well-integrated and multi-faceted mental health policy programmes in Kenya and Zanzibar have contributed to the

development of mental health services (Jenkins et al., 2011b; Kiima and Jenkins, 2010). The policy in both countries included well-integrated and coordinated programmes with other non-health sectors (such as education and social welfare), in addition to planning for sustainability from the beginning of developing the policy (Jenkins et al., 2011b; Kiima and Jenkins, 2010). However, many other LMICs still do not have a mental health policy despite its key role in developing mental health services (WHO, 2011b). Two out of 20 countries, participating in a survey intended to examine mental health development in Arabic countries, do not have a mental health policy (Okasha et al., 2012). Additionally, 58% of African countries and a highly populated LMIC like India still have no dedicated mental health policy (WHO, 2011b), which would delay mental health reform in those countries.

Therefore, examining the mental health policy and plan development is important for understanding the mental health service development in Gaza. The current study will focus on analysing the policy development as a part of reviewing the mental health system development in Gaza.

The presence of mental health legislation can support and enhance the proper implementation of mental health policy (WHO, 2005c). Such legislation, or any legally prescribed mechanism, can help to achieve the goals of the mental health policy by providing a legal framework for the implementation of such goals (WHO, 2005c). However, more than 60% of low-income countries have no dedicated mental health legislation (WHO, 2011b). Moreover, six out of 20 Arabic countries do not have any mental health law (Okasha et al., 2012). Okasha et al's study focused on examining

the existence of mental health policy and legislation in 20 Arabic countries. Although the existence of policy or legislation documents are key pillars for developing mental health services (WHO, 2005b), Okasha et al's survey did not examine their effective implementation and the value of such documents in the countries they studied. Therefore, examining the existence of policy and legislation documents is one step toward examining the policy development in a country (WHO, 2005b). Other steps include periodic assessment for measuring the impact of both documents as well as the provision of information to policy makers on the required changes and development of such documents (WHO, 2005c). Hence, the process of developing such important documents, which should include the participation and consultation of all stakeholders, can enhance the overall success and impact of policies and legislation on mental health reform (WHO, 2009).

The process of formulating a mental health policy is a key predictor of the effective implementation of the policy (WHO, 2009). The process of formulating a mental health policy involves the effective national authority's involvement and commitment, the consultation and involvement of all main stakeholders and the exchange of experiences with others (WHO, 2009). The process of developing mental health policies in Ghana, South Africa, Uganda and Zambia was limited to the senior Ministry of Health workers, and problematically failed to involve or consult other key stakeholders outside the health sector, especially service users and carers (Omar et al., 2010). Consequently, Omar et al's study concluded that the implementation of mental health policies in all African countries included in the study was not

successful, and the ineffective process of developing the policies was associated with their unsuccessful implementation.

According to Omar et al's study, poor policy can lead to poor commitment by mental health stakeholders and therefore will lead to poor implementation. Therefore, reviewing both the content of the policy and the process of developing the policy are key factors in predicting the success of the policy implementation of any given country (WHO, 2009). The current study will bridge this research gap by providing a thorough analysis of the mental health policy and plan in Gaza. This analysis will help health planners to identify the gaps in policy development and implementation as part of promoting mental health reform. One of the most important indicators that the review of policy and plan development will focus on is the successful transition from institutionalised services to community-based care.

2.3.2 Trends toward Deinstitutionalisation

Mental hospitals are still the main provider for in-patient care worldwide (Morris et al., 2012). Furthermore, mental hospitals are the main provider of mental healthcare in LMICs (Saxena et al., 2011). Although the World Health Report called for shifting mental healthcare from large institutions to the community (WHO, 2001), decreasing the number of mental health beds in LMICs, in the period from 2005-2011, has shown slow progress compared to high-income countries (Morris et al., 2012).

In order to promote a shift toward community-based care, the WHO launched the mhGAP as a global action plan for improving mental healthcare in LMICs (WHO,

2008c). The mhGAP aimed to reduce the treatment gap in LMICs by integrating mental health into the general health system and to re-distribute the scarce mental health resources that are mainly available in mental hospitals (Saxena et al., 2011; WHO, 2008c). Therefore, the deinstitutionalisation toward community services cannot be attained without increasing community-based resources instead of investing in mental hospitals (de Jong and Komproe, 2002). Understanding why health planners and authorities in LMICs are reluctant to downsize the role of mental hospitals and re-distribute resources to community-based care is important. Essentially, three major reasons that contribute to the delay in reforming mental health systems in LMICs and post-conflict areas are identified in the literature: costs (Knapp et al., 2006; WHO, 2011b), political will (Aviram, 2010; Giacaman et al., 2011; Jenkins et al., 2011a), and the role of donors and Non-Governmental Organisations (NGOs) (Tol et al., 2011; Wessells, 2009).

2.3.2.1 The Cost of Reform

One of the potential reasons for the delay in de-institutionalising mental health services is the cost of closing large mental hospitals and establishing new outpatient and community-based facilities (Knapp et al., 2006). Many LMICs invested in upgrading their mental hospitals, and this may make policy makers unwilling to close them (WHO, 2008c). The low health expenditure directed toward supporting mental health services in LMICs might deter policy makers from supporting deinstitutionalisation (Saraceno et al., 2007). According to WHO (2011b), the median health expenditure directed toward mental health in low-income countries is 0.5% of

the health budget as opposed to 77% used for supporting mental hospitals (WHO, 2011b).

2.3.2.2 The Impact of Conflict on Political Will

Policy makers in post-conflict areas under-prioritise mental health reform, as they are busy with other emergency response issues (Aviram, 2010). It is uncommon to find mental health reform at the top of the health agenda in a place needing emergency support (Jenkins et al., 2011a). As a result, mental health reform, as a developmental project, needs to wait until the situation is more secure and stable (Giacaman et al., 2011). The reasons for the unsuccessful implementation of reform initiatives for mental health services in Israel have been attributed to prolonged political conflict that drives policy makers to focus on addressing more existential concerns, and deinstitutionalisation of mental health services does not appear to be one of them (Aviram, 2010).

2.3.2.3 The Impact of Conflict on Donors' Support

The urgent needs resulting from conflicts drive donors to focus on short-term interventions that maintain basic needs (Wessells, 2009). Noticeably, countries affected by conflicts have many challenges to face that are perceived as more important than changing the approach to mental health service provision (Tol et al., 2011). Furthermore, the state of insecurity and instability as a result of conflict can be another reason behind the donors' reluctance to support developmental projects such as deinstitutionalisation of mental health services, as was the case in the West Bank and Gaza (Giacaman et al., 2011).

2.3.3 Community-Based Intervention in Low and Middle Income Countries and Post-Conflict Areas

It has been suggested that community-based mental health interventions are the most appropriate solution for promoting accessibility and equality of mental health services in LMICs and post-conflict settings (WHO, 2001, 2008c). Furthermore, because they are more cost-effective, community-based approaches can provide more appropriate solutions for LMICs, where the shortage of resources is evident (Saxena and Maulik, 2003). Moreover, moving toward community-based mental healthcare is important and relevant to LMICs as such approaches tend to better respect human rights, promote international support, increase accessibility to services and enhance good quality care by promoting cost-effective services (Wiley-Exley, 2007). Similarly, community mental healthcare has been recommended as one of the best approaches in post-conflict areas because it reaches a larger target population and provides preventive and promotional public mental health activities at the same time (Somasundaram, 2007). According to Somasundaram, using a community-based approach after the conflict in Sri Lanka was useful in creating public awareness, training grassroots workers, encouraging traditional practices and rituals, promoting positive family and community relationships and processes, rehabilitation and networking with other organisations (Somasundaram, 2007). Nevertheless, many LMICs and post-conflict countries do not adopt a community approach to providing mental healthcare (Jenkins et al., 2011a; Saxena et al., 2007).

Many efforts are still required to reduce the gap between needs and resources in LMICs and post-conflict areas (WHO, 2008c). For example, this gap between the

mental health burden and resources has been described as the worst, compared to other health domains (Patel et al., 2009). Only 52% of low-income countries have developed community-based mental health services compared to 97% of high income countries (Saxena et al., 2007). Assuming that resources are not significantly improved in LMICs because of the huge financial problems these countries face, an efficient utilisation of community resources for improving accessibility to mental health services is urgently needed. However, the suitability of a community-based approach to different cultures in LMICs and post-conflict areas is an area for further research.

There is a consensus that a community-based approach to providing mental health services is the most appropriate to LMICs (WHO, 2008c). This approach has demonstrated its ability to promote accessibility and equity for mental health service users (WHO, 2001) and promotes cost-effectiveness of mental health services (Saxena and Maulik, 2003). However, the cultural suitability of the community-based approach still needs more research. Because of the community bonds in LMICs, the community-based approach has the potential to be an effective means of implementation, although it was developed in western countries where the culture is different (Wiley-Exley, 2007). However, there is a gap in the literature on defining how a community-based approach could work in LMICs. Furthermore, the question of how service users and their families perceive and respond to community-based approaches in LMICs remains unanswered. The current study will fill this gap by providing a comprehensive overview of service users' and carers' views on a community-based approach to mental health care in Gaza.

2.3.4 The Role of Conflict on Re-Shaping Service Delivery

Conflict can act as a catalyst for the implementation of mental health and psychosocial activities in post-conflict areas (WHO, 2013), although not directed toward developing the existing mental health systems (Knapp et al., 2006). International donors respond to emerging mental health and psychosocial needs resulting from exposure to armed conflicts or natural disaster as a priority humanitarian response (Tol et al., 2011; Giacaman et al., 2011). In a systematic review, it was reported that at least 226·1 million USD had been spent on programmes that included mental health and psychosocial activities for post humanitarian responses between 2007 and 2009 in LMICs (Tol et al., 2011). The same study revealed that the majority of that funding was provided to support programmes implemented outside the national health, education, and protection systems such as out-of-system NGOs focusing on short-term relief. Only 8.1% of this funding was spent through the national health and education services, 5.2% through medical services and 2.9% through primary education (Tol et al., 2011). This out-of-system expenditure means that what the existing national system received from this money was very little to help them upgrade their capacities to respond to mental health and psychosocial needs. This indicates clearly the difficulty of using such invaluable resources to improve the performance of the national mental health system. However, it can be argued that funding psychosocial and mental health programmes would promote community-based mental healthcare, although psychosocial programmes may work outside the national system.

Post-emergency interventions usually take place within the community; however, the contribution of such interventions to promoting community mental health services is questionable (Tol et al., 2011). Post-conflict responses focus on targeting the maximum number of the affected population at risk of developing mental disorders (Wessells, 2009). However, most post-emergency practices that take place are not supported by scientific evidence (Tol et al., 2011). Moreover, Tol et al reported that most post-emergency interventions involve psychosocial activities and lack specialised mental healthcare. For example, counselling, social support, structured social activities, provision of information, psycho-education and raising awareness are activities provided in the community and depend on grassroots intervention to implement them (Tol et al., 2011).

However, the impact of post-emergency interventions in decreasing the burden of mental health problems in humanitarian settings needs more research (Jenkins et al., 2011a). The psychosocial programmes implemented after the crisis in Croatia were successful in promoting a peer support approach among participants but failed to integrate this success in enhancing the community-based services in the country and failed to maintain sustainability after the fund was finished (Budosan and Stipancic, 2010). The current study will answer some questions that have yet to be answered in the literature regarding the relationship between psychosocial activities provided after an emergency and community-based mental health practice. Taking into consideration that most psychosocial activities are provided by NGOs, the role of NGOs in post-emergency response will also be addressed in this study.

2.3.5 The Role of Non-Governmental Organisations in Service Delivery

NGOs have become an integral part of mental health service delivery in many LMICs and post-conflict areas (Saxena et al., 2007; Okasha et al., 2012). NGOs are active in most LMICs and provide various mental health services (Saxena et al., 2007). NGOs can provide valuable services in areas of advocacy, promotion and rehabilitation of mentally ill individuals, and successfully involve families in the care of people with mental health problems (Saxena and Maulik, 2003). Furthermore, NGOs are considered to be an important actor in healthcare provision in Arabic countries exposed to internal conflicts, especially in Lebanon in the late 1980s and currently in the occupied Palestinian territories (Okasha et al., 2012). The strong presence of NGOs indicates the important potential role that NGOs can play in any mental health reform in such countries. Nevertheless, how NGOs can best play this role is still an unanswered question.

The role of NGOs in developing the mental health systems in LMICs and post-conflict areas has long been an area of intense debate. Despite the intrinsic role of NGOs in service provision in LMICs and post-conflict areas, it has been suggested that the NGO-driven development model is not the best choice for sustainable reform as such models are not integrated into the healthcare system to ensure a continuum of care (Petersen et al., 2011a). For example, the role NGOs played in Bosnia Herzegovina and Kosovo was described as a temporary ambulatory mental health activity, focusing mainly on traumatisation that creates parallel systems that would impede the development of the public system (De Vries and Klazinga, 2006).

Moreover, NGOs can affect the development of the national system negatively by consuming resources that should be directed toward the national system and also by creating the possibility for skilled mental health workers to leave the national system to work with the NGOs (Wessells, 2009). In order to understand the controversial role of NGOs in shaping the mental health agenda in post-conflict places, three factors need to be investigated: how NGOs can be affected by international support, how they perceive their role in system development and their collaboration with the public sector.

2.3.5.1 Non-Governmental Organisations and International Support

Funding NGO-driven programmes out of the national system is one of the key problems that make the NGOs' role a subject for debate (Tol et al., 2011). NGOs receive a good chunk of international funding directed toward relief services in LMICs and especially for countries exposed to political violence (Tol et al., 2011). Therefore, donors play a key role in setting up the priorities for main mental health interventions in any post-conflict area (Wessells, 2009). The tendency for donors to provide rapid response and time bound funding that prioritises short-term programmes makes them favour supporting NGOs rather than the public sector. This un-balanced support to NGOs could affect the role of the existing public sector that would result in delaying mental health reform.

Moreover, this parallel funding mechanism raises questions about the impact of such programmes in terms of their sustainability in the long-term (Tol et al., 2011). For example, NGO programmes and structures that are internationally supported tend to

collapse after the funding stops, which affects the sustainability of the services provided by them (Somasundaram, 2007). Often, NGOs stop their service provision and support at a point when mental health intervention is needed most, because victims of conflict need long-term support (Silove, 2005). This short-term, unsustainable support causes more harm by raising victims' expectations for longer-term support while this does not happen because NGOs tend to leave when their funding stops (Wessells, 2009).

2.3.5.2 Non-Governmental Organisations' Role in System Development

Although NGOs are an embedded part of service provision in any post-conflict area, their role in mental health system development is still unclear (Jenkins et al., 2011a). The few examples of international NGOs contributing to mental health reform were exceptional experiences (WHO, 2013). The NGOs' role is limited mostly to service provision, especially when it comes to the initial response following massive disasters (Wessells, 2009). Therefore, there is a gap in the literature in defining the role of NGOs in contributing to mental health reform in post-conflict areas. The current study will fill this research gap by providing answers about the reasons for the lack of NGOs' participation in mental health system development. Moreover, this study will provide recommendations on how to utilise the governmental and NGOs' resources more effectively for the development of mental health services in low-resourced areas.

2.3.5.3 Relationship between Non-Governmental Organisations and the Governmental Sector

The relationship between the governmental sector and NGOs in most post-conflict areas and LMICs is more competitive than collaborative (Jenkins et al., 2011a). The fragmentation of financial and human resources without proper coordination is the biggest obstacle toward reforming mental health systems in any post-conflict area (Wessells, 2009). However, NGOs are considered non-specialised mental health providers, and that their role is limited to providing psychosocial interventions in times of crisis (Tol et al., 2011). Therefore, developing the mental health system remains the responsibility of the regulator of health services; that is the governmental health sector in most countries. This ambiguity of defining roles and responsibilities makes the effective coordination between the public and NGO sector hard to achieve, although this coordination is necessary in all post-emergency responses (Wessells, 2009).

2.3.6 Summary

This chapter section provided an overview of ways of developing mental health systems in LMICs and post-conflict areas. The role of policy and legislative development appears to be important to the scaling up of mental health service development in low resourced areas. Many LMICs still need to develop their policy framework, and some other LMICs need to revise their policies because the approach taken to develop their policies was not inclusive of all stakeholders, and ultimately led to the ineffective implementation and delayed development of mental health services. The current study will provide a thorough review of the mental health

policy and plan in Gaza to capture the main gaps in policy development that require urgent intervention by policy makers.

The progress toward community mental healthcare and deinstitutionalisation of mental health services is slow in LMICs. The shortage of resources dedicated to mental health is not the barrier toward deinstitutionalisation insomuch as is the reluctance of, and resistance to, change by policy makers. Finally, mental health reform tends to be a lower priority in conflict areas. This presents yet another barrier to deinstitutionalisation.

NGOs are essential players in mental health service delivery in post-conflict areas. The role NGOs play in mental health service delivery in post-conflict areas is substantial. However, their role in service development is not well explored within the literature. The current study will fill the gap in research by investigating the potential role of NGOs in contributing to service development in post-conflict areas by exploring the possibility for a more complementary relationship with the governmental sectors that is based on the clarification of roles and better utilisation of resources.

2.4 Service Users' and Carers' Involvement in Mental Health Services in Low and Middle Income Countries and Post-Conflict Areas

This chapter section provides an overview of the experience of involving service users and carers in mental healthcare in post-conflict areas and in LMICs. Because the literature on Service Users' Involvement (SUI) in LMICs and post-conflict areas is

limited, this section is focused on the global experience of SUI, which includes high-income countries.

The experience of service user and carer associations is more advanced in high-income countries. Overall, service user associations exist in 83% of high-income countries compared to 49% in low-income countries (Morris et al., 2012). Similar associations established in low-income countries tend to have fewer members, and are not well-connected to the national health services in their countries (Morris et al., 2012). Nevertheless, investigating the experience of SUI in high-income countries is important as it provides the opportunity to learn from the benefits, challenges, and barriers of SUI experience, which can inform LMICs and post-conflict areas. Of course, cultural differences as well as existing disparities related to resources and experience must be taken into consideration with LMICs and in post-conflict areas.

This section highlights the experience of SUI from the perspective of managers and policy makers, mental health professionals, service users and carers. Additionally, this section investigates barriers to SUI and ways for improving the experience of the involvement of service users and carers.

2.4.1 What Does Service Users' Involvement Mean?

Although the term SUI is common in the literature and policy documents, especially in more developed countries, the meaning of SUI can be an area of debate. Defining the meaning of SUI is important, as frequently both service providers and service users do not agree on what the process of SUI encompasses. Difficulties defining the

process of SUI are evident in the literature (Bennetts et al., 2011). The process of SUI, as described in the literature, involved different levels of involvement. Tobin et al. (2002) provided a focused scope of the process of SUI that was limited to service planning, service development and participation in quality improvement. Chamberlin (2005) also provided a broad definition of SUI that involved participation in service delivery, service design, providing training and participating in service evaluation and research.

2.4.2 Why the Involvement of Service Users and Carers is Important

Many governments, especially in high-income countries, call for improving service users' and carers' participation in mental healthcare as an essential part of any service development plan (WHO, 2010). Although the evidence of positive impact of SUI is limited (Rutter et al., 2004; Thomas et al., 2010), many research studies have provided examples of useful experiences of SUI (Owens et al., 2011; Patton, 2013; Simpson and House, 2002). One review investigated the impact of mental health services led by service users in high-income countries, and reported comparable outcomes to professional-led mental healthcare in relation to providing traditional mental health services (Doughty and Tse, 2011). According to Doughty and Tse's review, the mental health services led by service users showed better outcomes in some particular areas such as improving employment for service users and reducing the length of hospitalisation. Although the review by Doughty and Tse included only high-income countries, and therefore cannot be generalised to lower resourced countries, the positive outcomes of SUI have good potential of being developed and replicated in lower resourced countries.

Furthermore, the meaningful involvement of service users has shown a positive impact on service delivery and development (Owens et al., 2011; Patton, 2013; Simpson and House, 2002). A qualitative study explored the value of SUI in six Mental Health Trusts in the UK and reported a benefit of direct involvement of service users in service development (Robert et al., 2003). Although Robert et al.'s (2003) findings cannot be generalised to other mental health facilities in the UK, their research provided a model of useful SUI in professional teams, which led to positive results. Furthermore, Patton (2013) explored the involvement of service users in acute admission care by interviewing nurses working in acute admission units in Ireland; despite the limitation of generalising the findings of the study to other mental health facilities, it demonstrated the service users' ability to be involved in their own care.

Additionally, the involvement of service users and carers in mental healthcare can enhance respect of human rights and recovery (Storm and Edwards, 2013). Service users, who are the hub for any mental health services, should contribute to improving the services they receive (Tait and Lester, 2005). Overall, they are considered to be the experts of their own mental disorder (Tait and Lester, 2005). The expertise they have in understanding the experience of mental ill health can improve services, and add a useful resource to mental health services (Thomas et al., 2010). However, the experience of service users' and carers' involvement in high-income countries appears to have its advantages and disadvantages; it involves successes and challenges, indicating that the initiative for service users' and carers' involvement is still at its initial stages of development.

2.4.3 Overview on the Experience of Carers' Involvement

Although there is a paucity of research investigating carers' involvement in mental healthcare, there has been growing evidence on the useful impact of carers' involvement in service development and delivery (Cleary et al., 2006; Lammers and Happell, 2004). The involvement of carers in policy development in Australia was reported to be useful (Hayman and Fahey, 2007), especially since the family frequently plays a crucial role in taking care of family members with severe mental illness. Similarly, families in LMICs play a central role in taking care of, and making decisions that affect, service users as well as that most service users in these countries live with their families (Chatterjee et al., 2009). Similarly, in high-income countries, service users expect their carers to provide them with the support they need to overcome their suffering, and to help them access mental healthcare (Goodwin and Happell, 2007).

However, service users have sometimes expressed some caution with the level of carers' involvement. For example, research has shown that service users sometimes complain about the dominant role of carers in making decisions on behalf of service users (Lakeman, 2008). Dening (1998) warned of the overlap between service users' and carers' roles. Furthermore, the WHO called for the establishment of separate associations for service users and separate organisations for carers (WHO, 2010). Both have different needs, experiences, and different agendas that may make carers not representatives of service users (WHO, 2010). Some service users believe that their family members do not understand their suffering or their experience of mental disorder (Lakeman, 2008), which makes it difficult for carers to participate in taking

decisions that affect service users' care plans. It is essential that service users' and carers' roles be well defined, especially in LMICs where the role of the family is typically dominant. This role definition would help to ensure greater autonomy and privacy for service users when it comes to making decisions related to their treatment plans. The current study will explore the perception of the carer's role in the treatment process from service users' and carers' views.

2.4.4 Overview on the Experience of Service Users' Involvement

The experience of SUI in high-income countries is a critical aspect of mental healthcare (Simpson and House, 2002), but many challenges remain (Drew et al., 2011; Tait and Lester, 2005). There is growing recognition and a focus on the need to promote the involvement of service users and carers to improve the quality and delivery of mental health services (Wallcraft et al., 2011; WHO, 2010). The WHO regional office for Europe emphasised the need to involve service users and carers in service development and delivery, and considered it one of the four key priorities for the WHO in Europe (WHO, 2010). Furthermore, the World Psychiatric Association provided ten recommendations for enhancing partnership possibilities between service providers and service users (Wallcraft et al., 2011). This partnership is based on respecting human rights, which promotes meaningful participation of service users and carers in all levels of policy and service development that should be supported by mental health organisations and mental health professionals (Wallcraft et al., 2011).

However, health policies in many European countries do not actively support SUI; only a few European countries, out of 42 countries providing baseline information to the WHO, systematically and meaningfully involve service users and carers to help ensure quality assurance for the provision of mental health services (WHO, 2010). The UK is one of the few European countries that has developed legislative requirements that promote service users' engagement in healthcare policy according to the WHO baseline data (WHO, 2010). However, the translation of such legislation into practice is not well-applied (Rutter et al., 2004; Tait and Lester, 2005). There is a clear discrepancy between policy and practice. A contributing factor to this discrepancy appears to be the lack of understanding, and minimal interactions between policy makers and service users, considered next.

2.4.5 Mental Health Workers' Response to Service Users' Involvement

2.4.5.1 The Response of Managers of Mental Health Services

SUI includes involving service users and carers in tasks that used to be implemented solely by service managers and planners. These tasks include service planning, service development and evaluation of services for quality improvement. However, sharing tasks and responsibilities can lead to role confusion between service managers and service users (Bennetts et al., 2011). This role confusion is biased toward service managers as they have the authority to share the responsibility of decision-making (Bennetts et al., 2011). For example, service managers of two Mental Health Trusts in London considered consulting service users on service planning an option they had the right to use or not to use (Rutter et al., 2004). According to Rutter et al., this belief was indicated by the propensity of managers to

maintain control over decision-making. This attitude by managers of mental health centres, in one of the leading countries in SUI initiatives, exemplifies the difficulty service users encounter to occupy an equal space in the decision-making process. The situation would be expected to be more difficult in countries that had not developed a policy that supports SUI, such as LMICs.

Similar attitudes by managers of mental health services were also reported in other countries, although they demonstrated leading positions in initiating services that involve SUI (Thomas et al., 2010). For example, although the health policy in Wales supports SUI in all levels of service development, service users' and carers' contributions to decision-making were not genuinely considered by mental health managers and professionals (Thomas et al., 2010). The perception of service managers and providers towards SUI in Australia revealed a conflict regarding losing power over service users and carers (Bennetts et al., 2011). According to Bennetts et al., there is a conflict between social initiatives that involve service users and medically oriented mental health managers. Taking into consideration that the medical model is still dominant in mental health services in Gaza (Afana et al., 2004; Lubbad, 2008), the initiatives for service users' and carers' involvement may be a challenge for service managers and providers. The current study will explore these challenges and ways of overcoming them.

2.4.5.2 The Response of Mental Health Professionals

The attitude of mental health professionals toward SUI is also debated within the literature. Service user groups in the UK considered the resistance of mental health

professionals to SUI as a substantial barrier to effective SUI (Crawford et al., 2003). Some mental health professionals in the UK experience difficulty in sharing decision making with service users they considered as not eligible enough for this task (Rutter et al., 2004). Other mental health professionals, according to Rutter et al.'s study, were concerned about the practicalities of SUI, such as venues and discourse, rather than the ultimate value of sharing decision-making with service users.

Mental health professionals have different views on the appropriate involvement level for service users and carers. Many can accept some level of SUI, when the SUI involves sharing decision-making related to treatment plans, but they do not show the same level of acceptance when it comes to sharing their core responsibilities, such as service planning, with service users and carers (Bennetts et al., 2011). Such attitudes by managers and mental health professionals is another explanation for why there is a gap between policies and legislation on one hand, and the day-to-day practice of SUI on the other hand. However, the attitude by mental health professionals and managers is not the only challenge that service users and carers face for achieving useful involvement. Many other factors play a role, and some of them are related to service users themselves.

2.4.6 Barriers for Service Users' Involvement

Given the lack of research that details the challenges of SUI in LMICs and in post-conflict areas, this section emphasises challenges for the involvement of service users and carers in more developed countries, in order to approximate the main difficulties service users and carers in LMICs face. Despite the disparity in the

development of mental health services between high-income and LMICs, service users and carers can face common challenges wherever they live. Therefore, the following paragraphs will discuss the most common challenges for SUI, and include a discussion of the challenges related to service users themselves, as well as the community perception of service users' and carers' participation.

2.4.6.1 Service Users' Ability to Participate

Although legislation and policy recognise the importance of service users' and carers' involvement in many high-income countries (WHO, 2010), some questions remain related to the service users' ability to participate in activities related to policy and service development (McDaid, 2009). Some service users, as well as mental health workers, expressed significant concerns related to the service users' ability to participate effectively in service development (Simpson and House, 2003). The perceived doubt of the service users' ability to participate, according to Simpson and House's review, results from the burden involvement can cause, which might be perceived as a stressful task by service users. Service users in Finland expressed a similar attitude (Laitila et al., 2011). Service users preferred to trust the decisions made by professionals regarding their treatment, rather than participating in making decisions related to their care plans (Laitila et al., 2011). This was reportedly because they had less trust in their own decision-making abilities (Laitila et al., 2011). Understanding and examining the hesitance of service users to participate in their own treatment plan warrants further research. The current study addresses this gap by providing the views of service users and carers on their participation, and considers how their participation can be better facilitated.

Many factors play a role in service users' lack of motivation and willingness to participate actively in service and policy development. Service users are people with particular circumstances. The development of their physical and mental wellbeing, the effect of medication and the progress of their recovery are essential factors for motivating service users to participate (Laitila et al., 2011). More importantly, service users attributed the main reasons for not being involved actively in mental health planning to other factors related to service users' lack of awareness of their rights when there is a conflict with mental health professionals (Jones et al., 2009). Furthermore, mental health professionals who provide child and adolescent mental health services in Norway reported three primary barriers that hindered the participation of service users in activities related to service development (Richter et al., 2009). First, they noted an overall lack of trust in the services provided as well as observing that service users did not always have the self-confidence to participate. Second, sometimes service users were too vulnerable to participate because of their own suffering with their illness. Finally, when recovery was made, or the services were no longer required, there was a tendency to cut contact due to the stigma attached to mental illness (Richter et al., 2009).

2.4.6.2 Social Stigma

The high stigma attached to mental illness is another critical reason for service users' reluctance to participate in activities related to service development or delivery (McDaid, 2009). Participating in activities that promote SUI in both policy and service development may involve carrying out activities inside or outside mental health facilities. These activities publically expose service users or carers and may result in

their being recognised by other people who can see them as users of mental health services. This exposure to the public can make them vulnerable to stigma and community discrimination (Assefa et al., 2012). For example, service users in Finland were not willing to participate in activities that would expose them to the public (Laitila et al., 2011). Furthermore, service users are not only at risk of discrimination and stigma from the community, but somewhat surprisingly from mental health workers as well (Rutter et al., 2004). For example, many mental health professionals in England felt embarrassed to work closely with service users in activities inside community mental health centres because of their unpredictable behaviour (Rutter et al., 2004).

2.4.7 How Service Users and Carers Can be More Involved

As discussed throughout this section, the involvement of service users and carers in all stages of service development and service provision is still largely symbolic (Tait and Lester, 2005), and not focused on effecting meaningful change that would involve carers and service users strategically in service development (Horrocks et al., 2010). The ineffective participation of service users happens because efforts to involve them on both a policy and practical level have not been implemented appropriately to fulfil the policies of SUI (Tait and Lester, 2005). The inappropriate involvement of service users calls for investigating the main methods for achieving their involvement to improve mental health services. The literature reviewed investigated useful recommendations for improving service users' and carers' involvement. These recommendations encompass three primary areas, and can be summarised as follows: improving the policy framework, educating mental health

professionals and service users on appropriate involvement, and improving the communication between service providers and service users.

2.4.7.1 Improving Policy Frameworks for Service Users Involvement

SUI needs to be supported by clear policy guidelines in order to achieve effective implementation (WHO, 2010). Although improving policies to promote SUI might not be enough for achieving the required change, policy development is a substantial and important step towards protecting the right of service users and carers to be legitimately involved in all aspects of service development (Wallcraft and Bryant, 2003). Therefore, policy makers in all countries need to update their policies to allow and support SUI (WHO, 2010). This commitment by policy makers should not stop with the development of policy guidelines; this commitment should be followed by developing means of accountability and operational support to accomplish effective SUI (Department of Human Services, 2009). Such means of accountability should involve close monitoring of genuine involvement of service users and carers in developing mental healthcare plans, services, and policy and by facilitating the SUI through operational policies of mental health facilities (Department of Human Services, 2009).

2.4.7.2 Education about Service Users Involvement

The reviewed literature showed that mental health professionals do not have enough knowledge of what SUI can entail (Horrocks et al., 2010), nor are service users aware of the rights and responsibilities of SUI in service development or delivery (Jones et al., 2009). Moreover, service users, in many cases, do not know what it

means to be involved in service development and delivery. They are not aware of the existing rules and regulations (Laitila et al., 2011). Therefore, mental health professionals and managers agreed that change cannot take place until both service users and service providers are educated on SUI (Bennetts et al., 2011). The best method of providing an effective educational training is to bring all parties together to ensure a thorough discussion and understanding of the process of service users' and carers' involvement (Bennetts et al., 2011).

2.4.7.3 Improving Communication

Sharing of information and good communication and coordination are the most common demands which service users and carers need from mental health services (Noble and Douglas, 2004). Inappropriate communication between service providers and service users minimises the possibility for effective involvement of service users in service development (Simpson and House, 2003). Without open and transparent communication between mental health workers, especially psychiatrists and nurses (Bennetts et al., 2011), and service users and carers, the policy guidelines will stay as rigid guidelines that mental health workers will agree to without genuinely implementing them. Open communication and respect, while providing a comfortable space for disagreement and dialogue, can be the only guarantee for any SUI process to be successful (Bennetts et al., 2011; Wallcraft et al., 2011).

2.4.8 Summary

This chapter section described the experience of service users and carers in participating in service development and delivery. The experience of SUI in LMICs is

less advanced than the experience of SUI in high-income countries, although SUI in high-income countries still faces many challenges. The literature revealed a huge gap in investigating service users' views and perceptions on mental health services in post-conflict areas and LMICs. The current study will provide a wealth of information and analysis on the experience of service users and carers with mental health services and the potential role they can play to improve the mental health services in post-conflict areas and LMICs.

Due to the lack of studies that explored the experience and challenges of SUI in LMICs and post-conflict areas, this section discussed the experience of SUI in high-income countries because the experiences of SUI are well documented in these countries. The discussion of SUI in high-income countries provides a global perspective on the changing experience of SUI. This discussion is relevant for policy makers and service users in LMICs, who may face similar challenges, and can benefit from the lessons learned and challenges faced for service users and carers in high-income countries.

The literature revealed that social stigma and discrimination are challenges that service users and carers face globally. However, how to address the challenges of lack of appropriate involvement of service users and carers in mental healthcare in post-conflict areas and LMICs is still an unanswered question. This study will thoroughly investigate the barriers that confront service users and carers in fully participating in designing, developing and evaluating the mental health services they receive from mental health service providers in Gaza.

2.5 Challenges to Mental Health Development in Low and Middle Income Countries and Post-Conflict Areas

2.5.1 Introduction

The challenges of developing and delivering mental health services in LMICs and post-conflict areas are various and interlinked. Many of these challenges were discussed in earlier literature review sections, especially in the section on mental health systems development in LMICs and post-conflict areas and in the section on service users' and carers' involvement in LMICs and post-conflict areas. The focus of the literature review in this section is on additional challenges that affect the development and delivery of mental health services in LMICs and post-conflict areas.

This section discusses four main challenges: the lack of skilled mental health workers and the reasons for their scarcity in LMICs, the under-funding of mental health services and its consequences on service development, weak leadership in the mental healthcare sector and its impact on developing mental healthcare in a way that is better integrated into community-based services, and, finally, the role of stigma in obstructing opportunities for mental healthcare development, which also encompasses difficulties in accessing mental healthcare. Although challenges for scaling up mental health services are interconnected, this chapter section discusses these main challenges separately for more emphasis.

2.5.2 Lack of Skilled Human Resources

There is broad agreement that a lack of human resources is the main challenge for providing mental health services in post-conflict areas and LMICs (WHO, 2007).

Mental health workers are the key resource for providing mental health services (WHO, 2005b). The lack of skilled mental health workers, especially in countries with a high mental health burden, such as post-conflict areas and LMICs, affects the accessibility and administration of quality mental health services for people in need (Saraceno et al., 2007). The shortage of skilled mental health professionals affects not only the delivery of mental health services, but it also affects service development (Saraceno et al., 2007). Policy and service development cannot be achieved if well-trained mental health professionals, who are supposed to take the lead in service development, are not available or not distributed equally (Saraceno et al., 2007).

The distribution of mental health human resources demonstrates a high inequity between LMICs and high-income countries (WHO, 2011b). In a review of human resource studies in 58 LMICs, 67% of these countries do not have enough psychiatrists, 95% have a shortage of nurses, and 79% do not have enough social workers and psychologists (Bruckner et al., 2011). Although Bruckner et al.'s review provided approximate figures on the gap of mental health human resources in LMICs, these figures are based on estimates of workload in mental health facilities that cannot be generalised to all LMICs. Additionally, the availability of psychiatrists in low-income countries is 0.05 for every 100,000 population and the availability of psychiatric nurses is 0.16 per 100,000 population (Saxena et al., 2007). According to Saxena et al. (2007) review, the availability of psychiatrists and psychiatric nurses is 200 times higher in high-income countries. This huge gap between low and high-income countries is another indicator of the enormous lack of human resources in LMICs. This accumulated insufficiency of human resources appears to be a result of

different economic and social difficulties that LMICs encounter, as demonstrated in the literature reviewed in the following sections.

There are different reasons for the shortage of mental health human resources in LMICs and post-conflict areas. For example, one of the main reasons is the reluctance of health professionals to specialise in mental health due to the perceived low status of mental health professions and the stigma attached to mental health practice in LMICs (Minas, 2012). Another important reason for the lack of human resources is that governments and donors in LMICs do not address this problem seriously (WHO, 2007). The tendency of many governments, donors and international organisations is to increase their investment in building new facilities rather than in building the capacity of mental health workers or increasing the number of skilled mental health professionals (WHO, 2007). Moreover, developing human resources needs the financial support of governments to invest in mental health services and this does not exist in LMICs (Morris et al., 2012). Each of these underlying reasons explains the lack of mental health services in LMICs and post-conflict areas, and is discussed further in the following sections.

2.5.3 Economic Barriers

The financial resources spent on mental health services in LMICs are very low compared to high-income countries (WHO, 2011b). A third of low-income countries have no specific budget for mental health (WHO, 2008c). Thus, lower-income countries spend less as a proportion of the total health budget on mental health compared to middle and higher income countries (Saxena et al., 2007). The situation

is similar in LMICs affected by conflict. For example, Raja et al. (2010) reported that the total expenditure on mental health in Sri Lanka represents 1.7% of the total health budget. Although the calculation depends on counting the ring-fenced budget, and excludes other government expenditures on mental health as well as contributions from international donors, this percentage still provides an indicator of the low priority mental healthcare is given in a country exposed to conflict, where the needs are arguably higher as a result.

There are various reasons for low spending on mental health by LMICs and post-conflict areas. Knapp et al. (2006) provides four reasons for the under-funding of mental health services in LMICs. First, countries are poor and cannot allocate enough resources for financing mental health services. Second, mental health is not a high priority for governments and donors. Third, leadership in the mental health sector in LMICs is weak, and fourth, the stigma attached to mental health services discourages policy makers and donors to invest their resources in mental health. Furthermore, policy makers and donors believe that mental health services are not cost-effective and are therefore not interested in funding mental health services (Raja et al., 2010). Competition with NGOs, who frequently provide mental health services in post-conflict areas, makes it more difficult for governments to secure funds for their mental health activities (Raja et al., 2010). Although the findings of Raja et al.'s study were based on the comparison between four LMICs, the impact NGOs have on the mental health sector may differ from one country to another, depending upon the social and financial factors and the need for humanitarian intervention, which makes the generalisation of findings difficult.

Funding NGOs to provide mental healthcare in LMICs, and especially in post-conflict areas, raises the question about the value of such spending. Most of the funds received by NGOs go toward bilateral, parallel activities outside the national mental health system (Tol et al., 2011). Another criticism is the scalability of these activities, as NGOs are seldom able to respond to all of the mental health needs in a country (Jenkins et al., 2011a). Moreover, the amount of funding spent by NGOs is not enough to make a sustainable and effective improvement to service delivery because the funds are very low compared to the governmental budget (Raja et al., 2010). According to Raja et al.'s study, by investigating the expenditure of a large mental health NGO like Basic Needs in Ghana, Uganda, Sri Lanka, and Lao PDR, the total expenditure in the four countries represents only an average of 3.8% of the national mental health budgets in the four countries. Therefore, despite the possible effective contribution of NGOs in supporting the under-resourced mental health systems, the contribution they provide is too small to create a substantial reform or to replace the governmental budget.

2.5.4 Lack of Leadership

Leaders of national mental health services in post-conflict areas and LMICs have many tasks and responsibilities to achieve that require more than clinical skills (WHO, 2007). Those leaders are expected to increase funding for mental health by enhancing advocacy and introducing evidence-based, cost-effective services (Minas, 2012). In particular, they need to convince health leaders, who are overwhelmed with many priority health issues, to support mental health development in LMICs and post-conflict areas (Minas, 2012). Achieving those tasks requires specialised skills in

policy development and implementation that most national mental health leaders in LMICs do not have (Minas, 2012). Moreover, one of the main tasks for leaders in LMICs is to promote community-based services and reform the institution-based services in mental hospitals (WHO, 2007). Such tasks need a broader and population based vision that can be improved if mental health leaders are trained in public health (WHO, 2007). This WHO recommendation was based on a broad range of expert opinions on scaling up mental health services in LMICs, although many of those experts are based in high-income countries.

National mental health leaders in LMICs need to have a public health vision in order to reform mental health services toward more integrated and broadly accessible services (WHO, 2007). Saraceno et al. (2007) surveyed a range of opinions from international health experts and leaders in LMICs. Although the findings of this survey were based on expert opinion and not on examining the level of public health skills among national mental health leaders, these experts reported that many national mental health leaders in LMICs do not have public health skills. The lack of public health skills may be one of the most important reasons underlying the slow progress in developing mental health services in LMICs (Saraceno et al., 2007). For example, it has been suggested that the lack of effective mental health leadership in LMICs is related to the traditional process of upgrading senior psychiatrists to mental health leaders (Saraceno et al., 2007). Most of those senior psychiatrists tend to focus on narrow clinical practices and ignore a broader public vision of mental health services (Saraceno et al., 2007). Therefore, without training mental health leaders on public health, the integration of mental health into general healthcare would be an

elusive goal (Saraceno et al., 2007) From reviewing the literature, it appears that upgrading psychiatrists, without public health skills, to manage the mental health services tends to worsen the existing isolation and low prioritisation of mental health services.

2.5.5 Stigma

The stigma associated with mental disorders and mental health services in LMICs and post-conflict areas is linked to the low priority given to developing mental health services (Saraceno et al., 2007). Although mental health is under-prioritised in many LMICs and post-conflict areas for many reasons (WHO, 2008c), stigma is a major reason for this low prioritisation because stigma affects individual and community responses to mental health (Saraceno et al., 2007). Stigma can increase the government's low prioritisation of mental health development by promoting the perception among some policy makers that mental health is a private issue and should be tackled away from public services (WHO, 2007). This concept of the private nature of mental health is reinforced by the social stigma attached to poor mental health (WHO, 2007). Therefore, the idea of private responsibility for mental health can create an excuse for governments in LMICs to decrease their funding and support to mental health.

The stigma associated with mental disorders in LMICs and post-conflict areas is also connected to reduced resources for mental health (Saxena et al., 2007). The review conducted by the WHO (2007) revealed that most international health experts interviewed in this review identified stigma as one of the key barriers for securing

funding for mental health. The traditional stereotyped view of mental health services being linked to poor prognosis and the absence of cost-effective interventions can discourage national policy makers from funding mental health services (WHO, 2007). This stigma attached to mental health services not only affects national governments in supporting mental health, it also affects the population's willingness to receive mental health services.

Stigma is considered one of the key barriers to seeking mental health services in LIMCs and post-conflict areas (Al-Krenawi et al., 2009a). In a community-based survey conducted in Nigeria, more than half of the population believed that service users should be treated only in psychiatric hospitals (Gureje et al., 2005). Such findings reflect the population stigma in accepting community-based mental health services. Therefore, the social stigma attached to mental health services prevents people who are in need of mental health services from accessing mental healthcare although it is available (Gureje et al., 2005). Another community-based survey conducted in Israel, which is a high-income post-conflict area, revealed that only 13% of the population agreed to seek mental health services if they experienced anxiety or low mood because of the stigma associated with accessing mental health services (Struch et al., 2007). Additionally, Assefa et al. (2012) reported that half of patients with schizophrenia in Ethiopia stopped their treatment because of the stigma associated with mental health services. It should be noted that the representation of patients with schizophrenia is problematic in Assefa's et al's study, as they recruited only patients who attended outpatient facilities. Many patients with schizophrenia are treated in mental health institutions in Ethiopia (Assefa et al., 2012).

2.5.6 Summary

This chapter section provided an overview of the main challenges that face the development of mental health services in LMICs and post-conflict areas. The challenges affecting the development of mental health services are interconnected. The lack of skilled mental health workers is due to the under-spending on mental health development by the government and the stigma associated with mental health that prevent health professionals from pursuing mental health training programmes. The low resources dedicated to mental health is linked to stigma attached to mental health services and also to the lack of effective mental health leadership. Stigma associated with mental health services contributes to increasing the treatment gap in LMICs and post-conflict areas by preventing people from seeking mental health services.

Reviewing the challenges to reforming mental health services in LMICs and post-conflict areas revealed a gap in providing practical solutions for addressing those challenges. The current study will fill this gap by examining the main challenges for mental health reform in Gaza and providing practical recommendations on overcoming these challenges, taking into consideration the successful experiences of reforming mental health services in low-resourced countries and in areas affected by conflict.

2.6 Models of Successful Mental Health Reform in Post-Conflict Areas and Low and Middle Income Countries

This chapter section discusses good practices that led to mental health reform in some post-conflict areas and LMICs despite the challenges encountered. By providing an analysis that summarises the common factors that helped these countries develop their mental healthcare systems, this section provides evidence on reforming mental health services despite the challenges discussed in the earlier chapter sections. This section emphasises the experiences of reform by discussing six common themes that appeared to provide effective solutions to the problems hindering mental health reform in post-conflict areas and LMICs.

2.6.1 Multi-Faceted Programmes

Programmes that appeared to suggest that successful mental healthcare reform was possible adopted strategies for parallel and multilevel development of their mental healthcare systems, which focused on developing policy, service delivery and community involvement on different levels simultaneously. For example, Tanzania was successfully able to integrate mental health into all levels of service delivery and also integrate mental health as an embedded component of health policy, which promoted long-term commitment by the government for sustaining the developments achieved (Mbatia and Jenkins, 2010). A similar approach was adopted in China. Although the reform process was still at its beginning stages, the development of policy and service delivery was concurrent and promoted the possibility for long-term development (Liu et al., 2011). Both examples illustrate the possibility of a multi-layered approach to the development of mental health services in LMICs. The current

study will investigate a multi-layered approach to reforming mental health services in Gaza by exploring possibilities for development on policy level, clinical practices and community development.

2.6.2 Decentralisation of Services

The lack of human and financial resources drove some countries to redistribute the scarce resources available toward more community-based interventions. For example, the trend toward decreasing the dependency on mental hospitals and investing the resources in community-based care is evident in Latin American countries (Caldas de Almeida, 2013). Brazil developed a good model for community-based initiatives, which included psychosocial community centres and a return home programme for the treatment of people with severe mental illnesses away from mental hospitals (Mateus et al., 2008). Furthermore, South Africa provided another model of decentralisation, although this model still faces challenges, by shifting the momentum of mental healthcare from the tertiary to the secondary and primary levels (Petersen and Lund, 2011). The primary challenge of a decentralised approach is to strengthen and restructure the resources in the primary and secondary level of healthcare to respond to a population's needs when the tertiary healthcare level is no longer available (Saraceno et al., 2007).

2.6.3 Task Shifting

The shortage of skilled mental health workers in post-conflict areas and LMICs led many countries to assign some mental health activities to non-mental health workers (Araya et al., 2009; Bolton, 2013). The principle of task shifting is to create additional

human resources by the provision of training and supervision. Those non-mental health workers can be nurses, teachers, or community workers. Training community mental health workers on evidence-based psychotherapy contributed to compensating for the shortage of psychiatrists in Iraq (Bolton, 2013). Moreover, the primary healthcare nurses in Ethiopia were trained to provide community education and could also prescribe psychotropic drugs to overcome the shortage of doctors (Araya et al., 2009).

The most common example of task shifting was the integration of mental health into primary healthcare (WHO, 2008c). Many LMICs have started to train primary healthcare doctors and nurses on mental health so they can provide mental healthcare for people who have CMHD (Eaton et al., 2011). The experience of providing mental healthcare by primary care nurses and doctors has proved successful and improved accessibility to mental health services in Egypt (Jenkins et al., 2010). Moreover, the successful integration of mental health into primary care helped decrease the treatment gap in South Africa (Petersen et al., 2011b), in Uganda (Ovuga et al., 2007; Petersen et al., 2011b) and in a small scale project in Darfur (Souza et al., 2009). The utilisation of primary care doctors and nurses for the provision of mental healthcare received more attention by policy makers in LMICs after the WHO emphasised the model's effectiveness for helping national health systems to overcome the shortage of mental health specialists in LMICs (WHO, 2008c).

2.6.4 National Ownership

Sustainable mental healthcare reform should be led by the national health services (WHO, 2013). There are a number of examples where international organisations have played an important role in the development of mental health policy and services. However, such assistance risks collapse if they are not sustained by the national systems (Jenkins et al., 2011a). International organisations played a key role in establishing the mental health system in Kosovo and Burundi (WHO, 2013). Ultimately, these organisations handed their work over to the national authorities in both countries to take over the reform process (WHO, 2013). International organisations were able to provide meaningful technical support to the government in Afghanistan to enhance its mental health policy development (Ventevogel et al., 2012). This collaboration was effective in prompting the government to commit to a long-term development of mental healthcare services (Ventevogel et al., 2012). It is important to note that the literature reviewed recorded no instance of when the creation of parallel structures by international organisations in post-conflict areas led to mental health reform.

2.6.5 Coordination

Good coordination between different governmental and NGO service providers was a key factor in ensuring the appropriate use of resources in post-conflict areas (WHO, 2013). In Afghanistan, the community mental health services started by international NGOs provided fragmented services (WHO, 2013). When the role of the government was strengthened, the policy development and coordination between different service providers was improved (WHO, 2013). Improved coordination between different

stakeholders in Afghanistan contributed substantially to the development of mental health policy and to better access of mental health services (WHO, 2013). In Iraq, coordination was enhanced by the creation of a national mental health council formed in 2004 (WHO, 2013). This council included all relevant mental health stakeholders who contributed to policy development, the effective coordination of services, as well as this council provided technical support to the Ministry of Health in Iraq (WHO, 2013). Kosovo provided yet another example of a successful integration model, where the coordination strategies in the country's mental health action plan successfully clarified and assisted with the coordination of tasks and responsibilities between NGOs, international donors and governmental services (WHO, 2013).

2.6.6 Advocacy

Advocacy is an essential step for promoting mental health services and protecting the rights of service users, carers, and providers (WHO, 2013). The role of advocacy in encouraging governments to develop mental health services and also in supporting health-seeking behaviour was evident in some post-conflict areas and LMICs (Eaton and Agomoh, 2008; WHO, 2013). For example, in Jordan several NGOs established successful mental health programmes for Iraqi refugees (WHO, 2013). These NGOs were able to demonstrate the positive results of their interventions. The subsequent media and donor attention they attracted as a result was the impetus behind the Jordanian government re-examining and reforming their mental healthcare services nationally (WHO, 2013). Furthermore, psycho-education efforts on a community level were successful in Nigeria, which contributed to an

increase in seeking mental health services by the local community, which successfully decreased the treatment gap in the country (Eaton and Agomoh, 2008).

2.6.7 Summary

Despite the many challenges to mental health development in post-conflict areas and LMICs, there have been successful experiences of mental health development. Although every experience of mental health reform is unique, there are many lessons learned that have relevance to other countries. The shortage of resources has not stopped some LMICs and post-conflict areas from developing their mental health systems by creating other potential resources and using every available opportunity to do so. In many of those countries, the resources for mental health were not increased; rather they were improved by redistribution through decentralisation and task shifting as well as by better coordination and the promotion of national ownership. These successes are evidence that it is possible to reform mental health services in resource-poor countries and countries affected by political conflict. The current study will provide further clarification on how a comprehensive model of mental health reform can work in post-conflict areas. The above lessons learned described successful experiences, but failed to denote how the whole system can be reformed. This study intends to fill this gap by involving all mental health stakeholders in the design of a proposed approach for mental health reform in a post-conflict area.

CHAPTER THREE: METHODS

3.1 Introduction

This chapter presents the study design and methods, study context, the ethical approval procedures, and considers the research relationship (i.e. reflexivity). Data were obtained from the following main sources: questionnaires, document reviews, key informant interviews, and focus groups; and the approaches taken to data collection and analysis using these research methods are also presented.

3.2 Research Design

This study used an investigative mixed methods approach to collect and analyse both qualitative and quantitative data (Johnson et al., 2007). A convergent parallel model was followed to collect and analyse qualitative and quantitative data concurrently and independently (Creswell and Plano Clark, 2011). The weights for data collection and analysis were equal QUAN+QUAL (Morse, 2003), as was the priority for gathering and analysing data (Greene et al., 1989). As illustrated in Figure 3.1, data were analysed separately for each quantitative and qualitative tool at the results stage. Data were combined at the results interpretation stage where the concurrent triangulation design was used to directly compare and contrast quantitative statistical results with qualitative findings and documentary analysis to provide valid and well-established conclusions about the requirements for mental health reform in Gaza. Research questions were therefore answered by using complementary methods of gathering information from all stakeholders of mental health services, which included service designers, service providers, and service users and carers.

Study Design

QUAN+QUAL

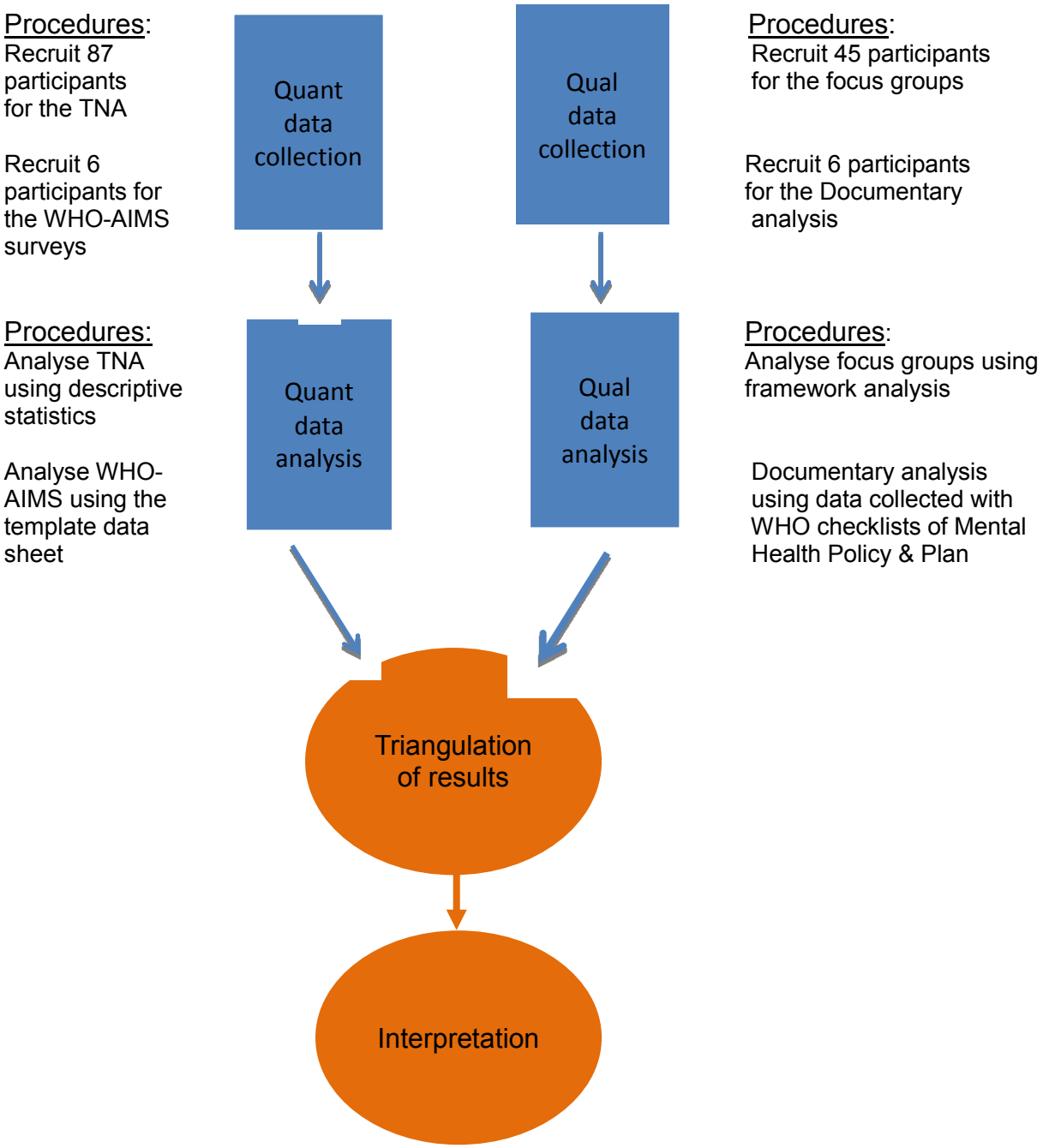

Figure 3.1 The mixed methods design of the study (Adapted from Creswell and Plano Clark (2011))

Because this is an applied field study, a pragmatic philosophical stance was used rather than ideological grounds, which integrates qualitative and quantitative methods into a single study to combine the best combination of methods to answer the study research questions (Creswell, 2003).

3.3 Rationale for Mixing Methods

The mixed method approach is used when one method cannot provide complete evidence to answer a research question (Creswell and Plano Clark, 2011). Specific strengths and weaknesses are associated with different research methods, and combining multiple methods can overcome any weaknesses inherent in using a single research method (Creswell, 2003). Since this study investigates different aspects of individual and organisational experiences in reforming the mental health system in Gaza, one approach alone cannot tell the whole story.

To ensure convergence and corroboration between data collected by different approaches, the specific mixed methods design (i.e. convergent parallel model) was chosen for this study to enable a triangulation of data at the interpretation phase (Greene et al., 1989). Moreover, the interaction between qualitative and quantitative approaches in this study followed an independent level of integration (Creswell and Plano Clark, 2011). This integration means that qualitative and quantitative strands are implemented separately and independently during the data collection and analysis phases. The triangulation of the results of the data analysis of the different data sets occurred only in the interpretation and conclusion phase. Triangulation as a

research technique is used to overcome shortcomings associated with data analysis, facilitating the ability to corroborate findings (Creswell, 2003).

3.4 Research Setting

The Gaza strip, where the study took place, part of the oPt, is described in the literature as a post-conflict area and is one of the low-middle income countries in the Middle East. The mental health services in Gaza are provided by four key actors. First, the government is the main provider and regulator of mental health services in Gaza. The governmental-run mental health services provide in-patient mental healthcare in the only mental hospital in Gaza with a capacity of 30 beds. In addition, the governmental sector runs seven Community Mental Health Centres (CMHCs) distributed all around Gaza. One of those centres is qualified to provide outpatient mental health services to children and adolescents. Every centre is located in one of the five districts in Gaza, except for Gaza City where three centres are located because of the high density of the population. One of those three centres located in Gaza City is specialised for child and adolescent mental health and the other two provide general community mental health services. Every centre serves between 200,000-350,000 populations.

Second, the United Nation for Relief and Works Agency (UNRWA) provides mental health and counselling services for Palestinian refugees in Gaza, which represent the majority of the population, through UNRWA health centres, relief centres, and schools. Third, Non-Governmental Organisations (NGOs) provide a broad spectrum of psychosocial and mental health services for the whole population in Gaza,

especially to individuals affected by trauma and the violation of human rights. Gaza Community Mental Health Programme (GCMHP) is a local mental health NGO working in Gaza from 1990, and was chosen to participate in this study because it is one of the main active NGOs in Gaza.

GCMHP provides community mental health services through three community centres located in three different districts in Gaza: Gaza City, Middle Area and Khanyounis. Those centres provide clinical and community services for service users with different mental health problems, including children and women. In addition, GCMHP provides training activities for mental health professionals and non-formal mental health workers. This NGO also undertakes research and surveys. The fourth provider of mental health services in Gaza is the private sector, which is limited to mental health private clinics and private clinical consultations.

3.5 Ethics and Permissions

The study was approved by the Helsinki Committee for Research Ethics in the Ministry of Health (MoH) in Gaza, in December 2010. In addition, the study was approved by the Ethical Review Committee of the University of Birmingham, in January 2011. Furthermore, written permissions were obtained from the Research Department of the Human Resource Directorate at the MoH in Gaza to administer the Training Needs Analysis (TNA) questionnaire to mental health workers at the seven CMHCs and the mental hospital in Gaza.

Similar approvals were also obtained to appoint focal points from the MoH to answer the WHO-AIMS questionnaire and the WHO checklist for documentary analysis. For people who were appointed from outside the MoH (such as local universities and the Ministry of Education) written approvals were obtained from their relevant departments to allow employees to participate in this study. For service users and carers, a recommendation was obtained from their case managers to confirm their eligibility to participate in the study. In addition, permission was obtained from the two service user and carer advocacy groups in Gaza to approve the participation of service users and carers in the focus groups.

3.6 Research Reflexivity

I was working as a mental health officer at the World Health Organisation (WHO) office in Gaza at the time the study was conducted. Before that, I worked as a mental health professional in several mental health facilities in Gaza. As part of my work at the WHO, I provided technical support to the MoH to help the government to develop mental health services. Therefore, I was a well-known colleague to most governmental mental health workers who participated in the current study. My professional background facilitated arranging and carrying out some research procedures, such as making appointments with policy makers for the focus groups, appointing focal points to answer the WHO-AIMS questions and appointing focal points to collect data for the documentary analysis of the Mental Health Policy and Plan. In contrast, the researcher's background was not known to service users and carers as the researcher's occupation did not include direct communication with service users and carers. Therefore, all research participants were well informed

about the goals of the research and the personal goals of the researcher by information sheets distributed to all participants and by oral description of the research goals by the researcher.

Additionally, because e the researcher's background and prior perceptions can influence the research process (Ruby, 1980), the researcher maintained continuous reflection on the influence of the researcher's characteristics and background on the data gathering and analysis to minimise study bias.

The trustworthiness of the qualitative part of this research was established by checking the coding of qualitative data with the main supervisor (LincoIn and Guba, 1985). Any disagreement in coding was discussed between the supervisor and the researcher and final consensus was achieved on all codes and categories. Entering transcripts into NVivo software was also carried out to enhance the trustworthiness of findings, and to aid data manipulation. In addition, the triangulation of data methods, where the data gathered by different methods were triangulated in data interpretation and discussion, was applied to enhance the credibility of study findings (Krefting, 1991).

3.7 WHO-AIMS Questionnaire

In order to determine the current characteristics of the mental health system in Gaza in relation to policy development, service development and delivery, and availability of human resources (Research Question 1), the World Health Organization-Assessment Instrument for Mental Health Systems (WHO-AIMS) questionnaire

(Version 2.2) was used to conduct a comprehensive assessment of the mental health system in Gaza (WHO, 2005a). This tool has been developed by the WHO to gather information on mental health systems, especially in Low and Middle Income Countries (LMICs), for the purpose of improving mental health services and strengthening mental health systems (WHO, 2005a). The ten recommendations proposed by the WHO report "Mental Health: New Understanding, New Hope" for improving mental healthcare in LMICs provide a scientific background for areas that need to be assessed and strengthened to improve mental healthcare (WHO, 2001). The ten recommendations for action that form the main areas for assessment of the WHO-AIMS questionnaire are: (1) provide treatment in primary care, (2) make psychotropic drugs available, (3) give care in the community, (4) educate the public, (5) involve communities, families and consumers, (6) establish national policies, programmes and legislations, (7) develop human resources, (8) link with other sectors, (9) monitor community mental health, and (10) support more research (WHO, 2001).

The WHO-AIMS questionnaire consists of six main domains: (1) policy and legislative framework, (2) mental health services, (3) mental health in primary healthcare, (4) human resources, (5) public education and link with other sectors, and (6) monitoring and research. The six domains include 28 facets and 156 questions (WHO, 2005a). Each domain contains sets of items and sub-domains to assess the system development in a particular area. Domain (1) contains five sub-domains and 21 items, domain (2) contains 11 sub-domains and 63 items, domain (3) contains three sub-domains and 19 items, domain (4) contains four sub-domains and 25 items,

domain (5) contains three sub-domains and 18 items, and domain (6) contains two sub-domains and eight items.

Because required information sometimes overlaps between one domain and another, the source of information and questions varied according to the information necessary. Therefore, I redistributed the questionnaire's questions into six different surveys according to the similarity of topics and the relevancy to the source of information. Survey (a) covered the mental health directorate and included 30 items; survey (b) covered services at the mental hospital and included 23 items; survey (c) covered services at CMHCs and included 19 items; survey (d) covered mental health services in primary healthcare and included 15 items; survey (e) covered research and mental health learning at the main university in Gaza and included four items; and survey (f) covered psychosocial and mental health services in the Ministry of Education and included four items (see Appendix Two). The total number of items was 95. After checking the relevance of questions to the mental health system in Gaza, 61 questions were excluded because they were not applicable. For example, many questions explore services provided by community-based psychiatric inpatient units or day treatment facilities or community residential facilities. All questions related to those facilities were removed because such facilities are not available in Gaza.

Grouping questions into six surveys was done to facilitate obtaining the information from the data sources. Such grouping is permitted by the guidelines for using the

WHO-AIMS; however, entering the data into the WHO-AIMS data sheet followed the order of the questions in the original instrument (WHO, 2005a).

3.7.1 Sampling

Based on the main topic in each of the developed surveys, a purposive sample of six focal points was recruited. The sampling followed the WHO-AIMS's guidelines (WHO, 2005a) that recommend selecting focal points who are professionals with access to all information that is needed, and it is preferable that they work in the governmental sector so that they have a comprehensive view on the development of their survey section.

3.7.2 Recruitment

Because four surveys investigate the development of the mental health system in the MoH in Gaza, four focal points from that Ministry were recruited. In addition, one focal point from the Ministry of Education and one focal point from the Islamic University of Gaza were recruited to answer questions on mental health in schools and mental health research, respectively.

The recruitment process followed the procedures and rules of recruitment for participating in research studies at the MoH in Gaza. Permission was obtained from the Directorate of Human Resources in the MoH in Gaza to recruit four focal points. This was followed by sending a separate letter for the recruitment of every focal point with an attachment of a copy of the written permission obtained from the MoH to implement this study, a copy of the questionnaire and a copy of the information

sheet. The letters were directed to general managers of the departments relevant to the implementation of the WHO-AIMS surveys (WHO, 2005a).

To appoint focal points to answer the survey questions on the mental health hospital, CMHCs and Mental Health Directorate, the General Director of Mental Health in the MoH was sent three separate letters to nominate three different focal points to answer the surveys. The General Director of Primary Healthcare was sent a letter to nominate one focal point to answer the primary care survey. The General Director of Counselling and Guidance at the Ministry of Education was sent a letter to nominate a focal point to answer the survey's questions on mental health in schools. The President of the Islamic University in Gaza was sent a letter to nominate a focal point to answer the survey questions on mental health research and mental health training at the university.

The recruitment of selected key focal points from different health and education backgrounds helped to provide a variety of views from health, research, education, and mental health professionals working in different settings.

3.7.3 Participants

The selected six focal points were among the senior technical level in each organisation/department that can access the information needed to complete the WHO-AIMS surveys (WHO, 2005a). From the MoH, the nominated focal points were: the Director of the Mental Hospital, the Director of CMHCs, the Director of the Mental Health Directorate and the Director of Primary Healthcare. From the Ministry of

Education, the selected focal point was the Director of the Psychosocial Counselling and Guidance Department. Finally, from the Islamic university, the selected focal point was the Director of the Mental Health Nursing Programme.

3.7.4 Research Procedures

The six developed WHO-AIMS surveys were handed to the nominated key participants in each setting. Meetings were organised with each focal point to describe the purpose of the study and their role in gathering and verifying the required information. I provided a comprehensive description of the WHO-AIMS 2.2 questionnaire (WHO, 2005a), with a particular focus on questions included in the surveys relevant to each participant. My contact details were circulated to each focal point to allow direct and continued communication with them. After completion of the surveys, I conducted another meeting with each of the key participants to double check the accuracy of the data gathered and to ensure the accuracy of data sources.

3.7.5 Data Analysis Plan

All data collected from the six participants in the surveys were entered onto the WHO-AIMS standardised data sheet that was developed by the WHO team for the WHO-AIMS 2.2 questionnaire (WHO, 2005a). Data were entered according to the order of questions in the original instrument and analysed by the researcher (WHO, 2005a). Based on an analysis of the data collected from the six participants, a final report describing the main findings was prepared by the researcher according to the WHO guide developed by the WHO team for writing the WHO-AIMS final report (WHO, 2005a).

3.8 Mental Health Policy and Plan (Documentary Analysis)

The mental health policy for Gaza and the West Bank was developed in 2004 and reviewed in 2009-2010. The mental health plan for Gaza was developed in 2010 and endorsed by the MoH in 2011. Both documents were examined by the researcher as secondary data sources to identify the gaps and strengths of mental health policy development in Gaza in order to answer Research Question 2: what are the approaches that have been used to develop mental health policies and mental health plans for service development and delivery in Gaza, and how does the process of formulation, and the contents of both mental health policy and mental health plan, meet the international standards set by the WHO?

The documentary analysis was conducted by the researcher of the mental health policy and mental health plan based on the data collected from the review committee participants who were recruited to complete the WHO checklists on the Mental Health Policy and Plan (WHO, 2009), detailed in Sections 3.8.2 and 3.8.3. The mental health legislation was not examined because there was no mental health legislation available in Gaza during the time the study was conducted.

3.8.1 Participants

The implementation of the mental health policy and plan evaluation took into consideration the WHO recommendation to have the WHO checklists completed by evaluators who were involved in the development of those documents (WHO, 2009). The members of both review committees involved in the evaluation process participated in the development of the mental health policy and mental health plan,

respectively. Therefore, the evaluation of both documents was undertaken in two separate meetings.

3.8.1.1 Mental Health Policy

The mental health policy was evaluated by a review committee that included: (a) the Director of Mental Health in Gaza, (b) the Director of the Training and Development Department at the Mental Health Directorate, and (c) the Director of Governance and Services at the Mental Health Directorate.

3.8.1.2 Mental Health Plan

The mental health plan was evaluated by a review committee that included: (a) the Director of Mental Health in Gaza, (b) the Director of the Training and Development Department at the Mental Health Directorate, and (c) the Head of Planning Unite at the MoH.

3.8.2 Research Procedures

The two separate meetings took place in the training venue at the Mental Health Directorate. Each meeting took 90-120 minutes. The participants signed two copies of the informed consent forms; they returned a copy to me and kept the other copy for their records.

The role of the researcher was to facilitate the discussion, ensure that the committee members formulate answers on all debatable issues, take written notes, and from those to prepare a draft report for discussion. At the end of each meeting, the

researcher presented the final document containing consensus answers to all the WHO checklist questions (WHO, 2009) for final verification and approval by committee members.

3.8.3 Data Analysis Plan

The documentary analysis of the mental health policy and mental health plan was conducted by the researcher using the WHO checklist for mental health policy and the WHO checklist for mental health plans that were used to collect data from the respective review committee participants described in Section 3.8.1 (WHO, 2009). Both checklists are designed to assess the adequacy of the process and content of developing the mental health policy and plan using specific criteria. The assessment of the process of developing both documents includes examining the process steps that have been followed that can determine whether the process will lead to a successful policy and plan. The documentary assessment includes the researcher examining whether content issues and appropriate actions are included in both documents (WHO, 2009).

The documentary analysis is also based on the researcher reviewing the process of developing the mental health policy and plan in terms of what kind of stakeholders participated and how many stages it took to develop the mental health policy and plan. These data were collected from the review committee participants described in Section 3.8.1. The following content items were examined by the researcher: (1) coordination and management; (2) financing; (3) legislation and/or human rights; (4) organisation of services; (5) mental health promotion and rehabilitation; (6) access to

essential psychotropic medicines; (7) advocacy; (8) quality improvement; (9) information systems; (10) inter-sectoral collaboration; (11) research and evaluation; and (12) human resources and training (see Appendix Three). The final conclusions represented the final consensus and comments of members of both committees, as well as the researcher's review of the documentary content. The analysis of the mental health policy identified areas where the policy met the WHO standards, gaps in service development and suggested strategies for future policy development (see Appendix Four)

3.9 Training Needs Analysis Questionnaire

I designed a self-assessment questionnaire to elicit data to identify the training needs of mental health professionals (see Appendix Five), because there was no suitable questionnaire available in Gaza in order to answer Research Question 3, how do mental health professionals describe: 1) their self-perceived level of possession of mental health skills and knowledge competence, 2) the support they receive in using and implementing such skills, and 3) priority areas for mental health training and their preferred approach to training? The specially constructed questionnaire sought to capture data on the self-perceived competence level, need for additional training, and support needs of mental health professionals.

3.9.1 Training Needs Analysis Questionnaire Development

I developed a structured, self-administered 68-item questionnaire to investigate the self-perceived competence level of mental health professionals in relation to knowledge, skills, and attitude domains of mental health practice. The empirical work

followed the psychometric principles of questionnaire development, including a literature review, conceptual refinement, item generation, content and face validation and piloting.

Key domain items were identified from two sources: (1) important domains for knowledge, skills and attitudes based on occupational standards for the practice of mental health, and basic core competencies that mental health professionals should possess for effective practice (National Mental Health Workforce Development Co-ordinating Committee, 1999); and (2) core competencies for providing crisis intervention services that contain basic competencies for providing disaster mental health services and formulation of action plans for crisis response (Everly et al., 2008).

The Training Needs Analysis questionnaire (TNA) contains 68 competency questions, which were mapped to 10 core competency domains: (1) communication, 14 items; (2) assessment of mental health needs, 11 items; (3) disaster preparedness and response, six items; (4) formulation of action plans, two items; (5) knowledge of mental health and mental health services, seven items; (6) provision of interventions, ten items; (7) practice safely and ethically, six items; (8) demonstrate culturally appropriate practice, four items; (9) compliance with legal responsibilities, one item; and (10) promote individual professional growth, seven items.

The questions were reviewed by mental health professionals and trainers to exclude questions that are not relevant to the context of mental health work in Gaza.

Additionally, the TNA questions were reviewed by mental health experts in research and training (Director of the Training Department at the Mental Health Directorate and a senior researcher from the Islamic University in Gaza). The TNA questions were therefore amended according to the suggested feedback of the reviewers, such as grouping some questions into one item and breaking down one item into more than one question.

Likert scale scores ranged from strongly agree (5) to strongly disagree (1). Higher scores reflect greater self-perceived level of possession of skill and knowledge competence. Four additional open-ended questions invited participants to: (1) suggest five priority areas for training; (2) identify five main barriers for receiving appropriate training; and (3) identify their preferred approach for the delivery of training. Participants were also asked to identify how they have developed their abilities in using the core competencies for their work as community mental health workers.

The questionnaire was created in English and translated into Arabic by two independent professional translators. The Arabic version of the questionnaire was back-translated into English by two other independent translators. After the questionnaire was refined based on the feedback provided by the content validity panel and by the pilot group participants, the final version of the questionnaire was sent to independent translators again to edit the language and the wording of the questionnaire. The final version of the questionnaire was then reviewed by the

Director of Mental Health and the Head Psychologists to ensure that questions would be fully understood by participants.

The questionnaire was sent to four experts in mental health training and research to assess the content validity. The content validity panel included: (1) Dr Samir Qouta, Head of Psychology Department at the Islamic University and senior researcher in the field of mental health and trauma; (2) Dr Mustafa Al Masri, Psychiatrist and Training Consultant at the WHO, senior researcher in the field of mental health and primary care, and a part time lecturer at the Islamic university; (3) Dr Ayesh Samour, Director of Mental Health Services at the MoH in Gaza, and senior trainer in psychiatry; and (4) Dr Khadra Al Amassi, Director of Training and Development Department at the Mental Health Directorate in the MoH, and senior trainer in psychiatry and primary mental healthcare.

3.9.2 Training Needs Analysis Questionnaire Piloting

The preliminary TNA questionnaire was piloted with a convenience sample of 15 mental health professionals to assess face validity. The Director of the Training Department and the Director of Mental Health Services in the Mental Health Directorate identified potential participants. The selection of the pilot group took into consideration the variety of all age groups, both genders, place of work and professional groups. Verbal consent was obtained for voluntary participation at this preliminary developmental stage. As a result of this feedback, revisions were made to the questionnaire as appropriate.

The main changes made to the questionnaire were changing the option “do not know” in the Likert scale to “neither agree nor disagree” and to place it in the middle between the agree and disagree options instead of placing it at the right side next to “not applicable”. The justification for implementing this change was that the participants in the pilot testing were confused whether or not to choose “disagree” or “do not know” when the questions related to knowledge competencies. For instance, if the competency question is investigating the participant knowledge of some specific topics in mental health and the participant decided that he does not have enough knowledge of this topic, s/he was confused if they should choose “disagree” or “do not know”. Other revisions were related to rephrasing some of the questions to make them clearer and simpler for participants. All suggested language and wording changes were implemented.

3.9.3 Participants

Participants for the TNA included all mental health workers in the governmental services; 105 mental health workers from all professional categories were recruited to complete the TNA questionnaire. Approval for administering the TNA was obtained from the Director of Mental Health Service in the MoH.

3.9.4 Research Procedures

The TNA questionnaire was administered to all mental health professionals who work in the governmental mental health facilities and comprised all professions, age groups and both genders. There were two reasons for deciding to include all mental health professionals working in the governmental sector. First, because the number

of mental health professionals was not very high, the random selection of participants could affect the representation of all professional groups. Second, governmental mental health workers were chosen because the governmental mental health service is the main provider of mental healthcare in Gaza. Therefore, any reform process should be undertaken mainly by governmental mental health workers.

The questionnaire was distributed to all workers in seven CMHCs and the only mental hospital in Gaza in the period between May 2011 and July 2011. An information sheet describing the objectives of the research and the procedures for involvement was distributed. In addition, the purpose and content of the TNA were explained carefully to all participants. There was an agreement with the training and development department at the mental health directorate that the findings of this study would be provided to the training and development department in order to help them assess the training needs of mental health professionals, and help them plan their training and education programmes in the future. Participants signed two copies of the informed consent form. After reading the information sheet and agreeing to take part in the study, participants returned a signed copy to me and kept the other for their record. The TNA took approximately 30-35 minutes to complete and took place inside the seven CMHCs and the mental hospital in Gaza.

3.9.5 Data Analysis Plan

To adjust for differences in the number of items in each of the TNA domains, total scores were calculated as follows: (1) summing the values for individual items of each scale; and (2) dividing by the number of scale items within each domain.

Comparable scores were therefore achieved across the ten domains. The internal reliability for each of the domain subscales was assessed using the Cronbach alpha coefficient. Alpha values of 0.7 and above are considered good through to excellent (Nunnaly, 1978).

The Statistical Package for the Social Sciences (SPSS) version 17 was used to perform all statistical analyses. Violation of the assumptions of statistical tests was checked and non-parametric analyses were considered appropriate due to the non-normality of the distribution of TNA scores. Descriptive statistics were used to describe the characteristics of the sample. Differences in TNA scores between two groups were analysed using Mann-Whitney U tests and between more than two groups by Kruskal-Wallis tests. Spearman's correlation was used to examine relationships between continuous variables. The chi-square test was used to assess categorical variables.

3.10 Focus Groups

Focus groups are defined as a research method based on collecting data from group interaction on a topic determined by the researcher (Morgan, 1996). The group interaction is a substantial element of a focus group as this interaction helps to highlight the participants' views, promote participants' own dialogues and allows participants to reconsider and rethink their prior understandings of their specific attitudes and experiences (Kitzinger, 1994).

The focus group, as a method for conducting interviews, was chosen for several reasons. First, to explore various perspectives on mental health services, focus groups are very useful for providing an exploratory analysis of the views of service planners, providers and consumers (Dean, 1994). Second, the study explores the views of both policy makers and mental health professionals and a focus group is useful when there is a power difference inside a group. This power difference helps to explore more differences and to reach consensus over topics of discussion (Morgan and Krueger, 1993). Third, as this study interviews service users and carers, focus groups can be the most appropriate choice for working with disempowered service users as the group setting can help them to reveal their concerns and negative feedback (Kitzinger, 1994).

3.10.1 Sampling and Recruitment

Three focus groups were conducted with the main stakeholders of mental health service delivery, which included policy makers and mental health professionals, to explore their views on mental health approaches in Gaza and suggested methods for reforming mental health services (See Table 3.1). These focus groups were undertaken in order to answer Research Question 4: In the light of ongoing conflict in Gaza, what are the views of mental health policy makers and mental healthcare professionals on major mental healthcare challenges and what are their suggested strategies for reforming mental health services in Gaza?

Four focus groups were conducted with service users and carers to explore their views on mental health services in Gaza and possible ways for the better

involvement of service users and carers in service development and delivery (See Table 3.2). These focus groups were undertaken in order to answer Research Question 5: What are the service users' and their family members' (carers) views on: 1) current mental health services, 2) mental health reform, and 3) involving them in planning and implementing mental health services in Gaza?

In deciding to conduct focus groups separately for policy makers and mental health professionals and service users and carers, I took into consideration the sensitivity of conducting focus groups together that might lead to professionals dominating the discussion or to service users and carers feeling uncomfortable or unwilling to express their views on services provided in front of potential therapists.

Sampling took into consideration the variety of views and opinions rather than the representativeness of professionals and service user groups. Therefore, a purposive sample of four CMHCs, one mental hospital, one mental health NGO and two service user and carer groups were sampled to provide a variety of mental health professionals, policy makers, service users, and carers. Fifteen mental health professionals and four policy makers were recruited from seven different mental health facilities to take part in three focus groups (See Table 3.1). Four participants were recruited from the mental hospital, eight participants were recruited from four governmental CMHCs, four participants were recruited from GCMHP (mental health NGO), and three participants were recruited from the mental health directorate.

Mental health professionals and policy makers were identified by the Director of Mental Health Services at the Mental Health Directorate, Directors of four CMHCs, the Director of the Mental Hospital, and the Director of GCMHP. Participants were selected from all professions working in mental health in Gaza, from both genders and all age groups. The Directors of CMHCs and the representatives of carer and service user groups in Gaza identified the service users and carers.

3.10.2 Participants

The first group of participants included 15 mental health professionals and four policy makers who participated in three focus groups (See Table 3.1). The policy makers who participated in the focus groups included the Director of Governmental Mental Health Services, the Director of the Training and Development Department, the Director of Services and Governance and the Director of GCMHP (mental health NGO). Mental health professionals were represented by two psychiatrists, one medical doctor, four psychologists, four social workers, and four nurses. Table 3.1 shows the distribution of policy makers and mental health professionals who participated in three focus groups.

The second group of participants were service users and carers who participated in four focus groups (See Table 3.2). The service users selected were receiving services from the governmental mental health services at the time the study was conducted. The service users were selected from various mental health diagnoses, both genders and from all age groups. After participants were nominated by the carer and service user groups, the case managers in the CMHCs were consulted to

confirm the eligibility of service users to participate in the study. Table 3.2 shows the distribution of 12 service users from seven mental health disorder categories and 14 carers who participated in four focus groups.

Table 3.1 Description of participants of the focus groups with mental health professionals and policy makers (n = 19)

Focus group	Number of participants	Number of policy makers	Number of mental health workers
Group 1	7	1	6
Group 2	8	2	6
Group 3	4	1	3

Table 3.2 Description of participants of focus group with service users and carers (n = 26)

Focus group	Number of participants	Service users	Carers
Group 1	5	2	3
Group 2	7	3	4
Group 3	6	3	3
Group 4	8	4	4

3.10.3 Topic Guide for Mental Health Professionals and Policy Makers

This focus group topic guide for mental health professionals and policy makers included the main characteristics of the mental health system in Gaza; how the existing policies and legislations affect the work of mental health professionals in Gaza; how the community-based approach functions in Gaza; possibility for development and challenges; main issues related to mental health human resource development in Gaza; the impact of the political conflict on developing the mental

health system and issues related to coordination and collaboration between different mental health providers in Gaza (see Appendix Six).

3.10.4 Topic Guide for Service Users and Carers

This focus group topic guide for service users and carers included key topics such as: service users' and carers' evaluation of the mental health services provided by the CMHCs; how service users and carers perceive their current role in service provision and planning and potential for improvement; how service users and carers view reforming mental health services in Gaza and what role they can play in the reform process; the role of service users and carers in advocacy activities for service users' and carers' rights and the potential and characteristics of the partnership process between service users and carers and mental health professionals and policy makers from their perspective for providing better mental health services (see Appendix Seven).

The focus group topic guides were refined regularly after each focus group in order to take into consideration emerging themes and areas needing more time for discussion.

3.10.5 Research Procedures

Seven focus groups were organised to involve 26 service users and carers, and 19 mental health professionals and policy makers. All seven focus groups took place in the period between March and November 2011. Each focus group involved 6-7 participants. Following the nomination of participants in both groups, each nominated

participant was sent a copy of the information sheet. Participants who agreed to take part in the focus groups were contacted to discuss the schedule of the focus groups and times that were convenient to each one of them. After finalising the timetable for the focus groups, all the focus groups took place in “Marna House”, a hotel venue, as agreed with participants. Each focus group took 60-100 minutes.

The rules and regulations for the focus groups were distributed at the beginning of each meeting, along with the topic guide that was prepared previously by the researcher. Two copies of the informed consent were signed by each participant, one of which was returned to the researcher and the second was kept by the participant. All focus groups were tape-recorded, verbatim transcribed, and saved in a password-protected file on the researcher’s computer. The participants were assured that their names and personal information would be kept anonymous and under no circumstances would their names or personal information appear in the final report. The possibility for participants to ask for an individual interview was always presented at the beginning of each focus group, but none of the participants made such a request.

3.10.6 Data Transcription

Data collection and transcription was carried out concurrently. I transcribed the audio-taped interviews for every focus group. Transcribing the data myself helped me to capture the true meaning of the participants’ words (Oliver et al., 2005). Transcribing the recordings gave me a chance to provide a true context to words that

described feelings, attitudes, and positions of participants by providing an insight to how they described their feelings and attitudes.

As focus groups were conducted in Arabic language, I typed the initial transcription in Arabic language. Following this, I sent the transcripts to every participant in the focus groups to check the accuracy of the information and to give them the chance to clarify their answers or amend some of the information they had provided.

After the first draft of the transcripts was developed, I removed all names of persons and places, to protect the participants' confidentiality. I translated the transcripts into the English language, and then I sent the transcripts to a professional translator to review the translation and back-translate it into Arabic to ensure the accuracy and relevance of the translation. All the data processing, management and analysis, was conducted using data management software NVivo. In addition, I added all my field notes and observations as an attached paper to every transcript to be used during the data analysis.

3.10.7 Data Analysis Plan

Framework analysis was developed in the 1980s for analysing qualitative data in applied policy research (Ritchie and Spencer, 1994). The main advantage of the framework analysis method is that it can provide a comprehensive and systematic procedural structure for data analysis. In addition, the framework analysis method allows flexibility in moving between one stage of analysis and another.

The five stages for analysing qualitative data using framework analysis are: (1) familiarisation: during this stage the analyst becomes familiar with variety, richness, and depth of the data that will be analysed. Such deep understanding of the data needs a process of reading and re-reading the data several times until the analyst feels familiar with the data, (2) identification of a thematic framework: in this stage the analyst tries to identify main concepts and themes; the codes emerging in this stage are still a subject for refinement in later stages, therefore the analyst should keep open and flexible at this stage (see Appendix Eight), (3) indexing: after identifying the initial thematic framework, the data will be indexed by rearranging data to fall under the themes identified in the thematic framework (see Appendix Nine), (4) charting: in this stage charts will be formed; in charting, data will be extracted from its original context and rearranged under their relevant themes as charts (see Appendix Ten), (5) mapping and interpretation: this is the final stage of the process, where data are interpreted, explained and associations can be made between themes (Ritchie and Spencer, 1994).

Since the main aim for conducting the focus groups is to explain and interpret how the mental health system operates in Gaza from the different views of mental health workers, policy makers, service users and carers, framework analysis was the best approach to choose. The use of framework analysis in this study helped to ensure that the analysis of data was systematic and verifiable, including providing a way to ensure a clear trail of evidence. The clear series of steps taken to analyse data using framework analysis thus allows an independent researcher to verify the findings, increasing study rigour (Ritchie and Spencer, 1994). Another reason for choosing

framework analysis for this study was because the data were descriptive and framework analysis is a suitable approach for analysing cross-sectional descriptive data (Ritchie and Lewis, 2003). Moreover, as qualitative data analysis can be time consuming and a difficult task for novice researchers, the systematic and flexibly interconnected five stages of the framework analysis approach can provide a comprehensive guide to manage and analyse data.

3.11 Enhancing Qualitative Data Validity and Reliability

Reliability in qualitative research is defined as the trustworthiness of observations or data gathering, while validity in qualitative research can be the trustworthiness of interpretations or conclusions (Stiles, 1993). I acknowledge that I am addressing a topic that is of professional and personal significance. Therefore, I followed good practice in managing and analysing the qualitative data to enhance the validity and reliability of the study.

To minimise any potential bias and subjective preconception interfering with data gathering and interpretation, I maintained the rigour of the research process by adhering to the following practices: (a) disclosure of orientation: I continued to develop a written journal of my expectations, values and preconceptions of the study. Having those orientations in my mind during data gathering and interpretation helped to keep me aware of my personal influence during the data interpretation, (b) explication of social and cultural context: I was aware that I share the same cultural and social context as the participants of this study as I live in the same area and I practise the same profession. This made me more aware of the importance to be

explicit about the social and cultural context of common assumptions that might seem familiar to me, (c) description of internal process of investigation: I kept a diary on how the investigation affected me and what part of the findings surprised me and what parts I found difficult to process, (d) engagement with the material: I kept a close interaction with the data, whether it was a text or audio-taped, all the time during the interpretation process by reading and re-reading the text, moving back and forth between text and audio-taped interviews and checking with participants to confirm my understanding of their participation, and (e) cycling between interpretation and observation: I kept reflecting on what I have understood from the discussion to participants, giving them the chance to correct me or to add more in-depth insight to the main discussion points (Stiles, 1993).

3.12 Summary

This chapter presented the research design and justified the choice of collecting quantitative and qualitative data from a pragmatic philosophical approach. Within this paradigm, an investigative mixed methods approach was adopted as this best meets the need to answer the research questions exploring the complexity of reforming mental health services in a post-conflict area. The chapter also described in detail the research methods, sampling and participants, and the procedures and instruments used to collect data. This chapter also provided a practical account of framework analysis used to analyse the qualitative data and described strategies used to enhance the quality of data and the rigour of the research.

The next chapter presents the results of the quantitative data and the qualitative findings.

CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter presents first the results of the quantitative analyses, followed by the qualitative findings. Briefly, quantitative data on the mental health system in Gaza were collected using the World Health Organization-Assessment Instrument for Mental Health Systems (WHO-AIMS; (WHO, 2005a)). This analysis is followed by the presentation of the results of the documentary analysis using the WHO Checklist for Mental Health Policy and Plans (WHO, 2009), and the statistical results from the training needs analysis conducted with mental health workers in Gaza. The findings from focus groups held with key stakeholders in mental health service development are presented next, beginning with the data collected from mental health professionals and policy makers, followed by the findings from service users and carers. Quotes from the focus groups have been chosen based on representativeness with either the participant's professional background or the service user and carer perspective.

4.2 WHO-AIMS

4.2.1 Introduction

The findings of this section answer Research Question one: What are the current characteristics of the mental health system in Gaza in relation to policy development, service development and delivery, and availability of human resources?

This section presents the results of the WHO-AIMS 2.2 questionnaire (WHO, 2005a). The investigation of the mental health system in Gaza, using the WHO-AIMS 2.2 questionnaire, took place in 2011 and examined the development of the mental

health system in the previous year of conducting the questionnaire. Therefore, the calendar year of 2010 is the timeframe for all figures and investigations presented in the results. Table 4.1 shows the main demographic characteristics of the six participants who completed the WHO-AIMS questionnaire.

Table 4.1 Distribution of participants according to WHO-AIMS survey topic

N	Participant	WHO-AIMS Survey
1	Director of Mental Health	Mental Health Directorate
2	Director of Mental Hospital	Mental Hospitals
3	Director of Mental Health Services	Community Mental Health Centers
4	Director of Primary Healthcare	Mental Health in Primary Healthcare
5	Director of Counseling and Guidance Department, Ministry of Education	Mental Health in Schools
6	Director of Mental Health Nursing Programme	Mental Health Research and Training at University education level

4.2.2 Policy and Legislative Framework

Palestine's mental health policy was last revised in 2010. The following components were included: (1) organisation of services: developing community mental health services, (2) organisation of services: downsizing mental hospitals, (3) organisation of services: developing a mental health component in primary healthcare, (4) human resources, (5) involvement of users and families, (6) advocacy and promotion, (7) human rights protection of users, (8) equity of access to mental health services across different groups, and (9) quality improvement. In addition, a list of essential medicines was present. These medicines include: (1) antipsychotics, (2) anxiolytics, (3) antidepressants, (4) mood stabilisers, and (5) antiepileptic drugs.

The mental health plan was drafted in 2010, during the year in which the study took place. It was consolidated and endorsed in 2011 and adopted by the Minister of Health in Gaza. This plan contains the same components as the mental health policy but also mentions reforming the mental hospital to provide more community-based services. In addition, there were well-defined goals and objectives and a timetable for implementing the activities. However, no budget was identified in the plan.

A draft Mental Health Act was produced in 2006. The Act was developed by one of the largest mental health NGOs in Gaza. The Legislative Counsel and the Ministry of Health (MoH) have not approved it. Therefore, there was no mental health legislation in Gaza.

4.2.2.1 Financing Mental Health Services

About 2% of the total healthcare budget is directed toward mental health by the MoH in Gaza. Of all the expenditure spent on mental health, 56% is directed towards the mental hospital with 44% of the budget directed towards Community Mental Health Centres (CMHCs). In terms of affordability of mental health services, the population has free access to most (at least 80%) essential psychotropic medicines. For those that have to pay for their medicines, the cost of antipsychotic and antidepressant medication is 5% and 7% of the minimum daily wage in Gaza, respectively.

It was difficult to calculate the Governmental expenditure on mental health because the financial support to the mental hospital, for example, is included in the total expenditure for hospitals. Moreover, we need to take into consideration that financing

mental health services does not come only from the MoH. Some international NGOs support some activities in the governmental mental health sector in Gaza by providing training and technical support. Those internationally funded programmes were not counted in the total expenditure of the health budget toward mental health services because those programmes were not sustainable and provide only training and technical support.

4.2.2.2 Human Rights Policies

A national human rights review body does not exist in Gaza. This means that authorities will not expect inspection visits to their facilities and no one will impose sanctions on mental health facilities when they violate service users' rights. The mental hospital in Gaza did not receive any reviews/inspections of human rights for the protection of patients. In terms of training, none of the staff working in the mental hospital received at least one day of training, meeting or other type of working session on human rights in the year of this assessment.

4.2.3 Mental Health Services

4.2.3.1 Organisation of Mental Health Services

A National Mental Health Authority exists, which provides advice to the government on mental health policies and legislation. The Mental Health Authority is also involved in service planning and monitoring and quality assessment of mental health services. The mental health services are provided through outpatient services and one mental hospital. Mental health services are not organised in terms of catchment/service areas.

4.2.3.2 Mental health outpatient facilities

There are seven outpatient mental health facilities available in Gaza; those facilities are referred to as Community Mental Health Centres (CMHCs). In 2010, these outpatient facilities treated 74.5 new service users per 100,000 population. Of all service users treated in CMHCs, 29% were female and 10% were children or adolescents. The service users treated in CMHCs are primarily diagnosed with neurotic disorders (18%) and schizophrenia (14%). There is only one outpatient facility qualified to provide services to children and adolescents that represents 14% of outpatient services provided.

All CMHCs provide follow-up care in the community, while none of the facilities provide mobile mental health teams. In terms of available treatments in 2010, most patients (51-80%) in CMHCs received one or more psychosocial interventions. Moreover, all CMHCs have at least one psychotropic medicine from each therapeutic class (i.e. antipsychotics, antidepressants, mood stabilizers, anxiolytics, and antiepileptics) available in the facility or at a near-by pharmacy throughout the year.

4.2.3.3 Mental Hospital

There is one mental hospital available in Gaza with a total of 30 beds, 1.89 beds per 100,000 populations. The number of beds has decreased by 17% in the last five years. The hospital is integrated organisationally with mental health outpatient facilities. There are no beds in the mental hospital reserved for children and adolescents only. The hospital treats 30.12 new users per 100.000. Among the new users admitted to the hospital in 2010, 55% of them were female and no children or

adolescents were admitted. The service users admitted to the mental hospital belong primarily to the following two diagnostic groups: schizophrenia (69%) and mood disorders (14%); on average, service users spend 8.68 days in the mental hospital. The majority (80%) of service users spend less than one year in the mental hospital, 20% spend 5-10 years, and none of service users spend more than 10 years. Few service users (1-20%) in the mental hospital received one or more psychosocial interventions in the past year. The mental hospital had at least one psychotropic medicine of each therapeutic class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility.

All of the psychiatric beds in Gaza are located in the only mental hospital located in Gaza City, which is the largest city in Gaza. The density of psychiatric beds in or around Gaza City is 2.94 times greater than the density of beds in the whole of Gaza. Such a distribution prevents equal access for the whole population in Gaza, especially for those who live in rural areas. Gaza has no linguistic or ethnic minorities. Therefore, there is no issue of inequity of access to mental health services for other minority service users.

There is a Christian minority living in Gaza; they are Palestinians and speak Arabic. The MoH, however, does not report the religion of service users who receive mental healthcare in service users' records, either in the mental hospital or outpatient facilities. Therefore, they do not have information on the percentage of Palestinian Christians in Gaza who receive mental healthcare.

4.2.4 Mental Health in Primary Healthcare

All facilities providing Primary Health Care (PHC) in Gaza are physician based. Of the 57 PHC clinics in Gaza, almost all of them (81-100%) have assessment and treatment protocols for key mental health conditions; however, only a few (1-20%) of those clinics make on average at least one referral per month to mental health professionals. In terms of professional interaction between PHC staff and other care providers, a few primary care doctors (1-20%) have interacted with a mental health professional at least once in the last year. None of the PHC clinics have had any interaction with a complimentary/alternative/traditional practitioner.

PHC doctors are allowed to prescribe psychotropic medicines with restrictions: (1) the prescription should be after consultation with psychiatrists; (2) the prescription should be in accordance with the guidelines that are available in most PHC clinics for the management of common mental health disorders in PHC; (3) the psychotropic medicines available in PHC are three antidepressants and one anxiolytic; and (4) the issuing of a prescription is only allowed for doctors who have received refresher training in mental health. Regarding the availability of psychotropic medicines, a few PHC clinics (1-20%) have at least one psychotropic medicine for most of the therapeutic categories (antidepressant, anxiolytic, and antiepileptic) available in the facility or at a near-by pharmacy all year long.

4.2.4.1 Training of Human Resources in Mental Healthcare

Concerning the undergraduate training for doctors and nurses in Gaza, 4% of the training for medical doctors is devoted to mental health, in comparison to 7% for

nurses, while non-doctor/non-nurse PHC workers receive no mental health training. Regarding refresher training, 30% of PHC doctors and 33% of nurses have received at least two days of refresher training in mental health, while non-doctor/non-nurse PHC workers have not received such training. It is notable that the training of medical doctors and primary care nurses in mental healthcare is an ongoing process aimed at integrating mental health into PHC. The training was started in 2008 by the MoH, with support provided by the World Health Organisation (WHO) and is continuing beyond the timeframe of conducting this study (2010).

4.2.5 Human Resources

The total number of healthcare workers in mental health facilities and private practice is 11.91 per 100,000 population. The breakdown according to profession per 100,000 population is as follows: 0.25 psychiatrists, 1.6 other medical doctors (not specialised in psychiatry), 4.8 nurses, 2.2 psychologists, 2.5 social workers, 0.5 occupational therapists, 36.4 other health or mental health workers (including auxiliary staff, non-doctor/non-physician PHC workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors). In this category of other health or mental health workers, all school counsellors and psychosocial counsellors working in the NGO and private sectors were counted. Table 4.2 shows the number of mental health professionals per professional group. Two of the psychiatrists work only for government administered mental health facilities, while the other two psychiatrists work only for NGOs/for profit mental health facilities/private practice, while no psychiatrists work for both sectors at the same time.

Table 4.2 Number of mental health professionals by discipline

Mental Health Professional	Number of Mental Health Professionals per 100,000
Psychiatrists	4
Medical Doctors	26
Psychologists	35
Social Workers	40
Nurses	76
Occupational Therapists	8
Other Mental Health Workers	577

Regarding the workplace, no psychiatrists work in outpatient facilities, two psychiatrists work within NGOs, and two psychiatrists work in the mental hospital. Of the 26 medical doctors who are not specialised in mental health, nine work in outpatient facilities, five work in NGOs and 12 work in the mental hospital. Regarding nurses, 29 work in outpatient facilities, 33 in the mental hospital and 14 work for NGOs. Thirty psychosocial staff (psychologists, social workers, and occupational therapists) work in outpatient facilities and 31 in the mental hospital, while 22 work for NGOs and the private sector. Figure 4.1 shows the percentage distribution of governmental mental health workers between outpatient facilities and the mental hospital. In terms of staffing in mental health facilities, there were 0.07 psychiatrists per bed in the mental hospital. Regarding nurses, there were 1.1 nurses per bed. For other mental healthcare staff (e.g. psychologists, social workers, occupational therapists, other health or mental health workers), there were 1.03 staff per bed in the mental hospital.

The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 1.48

times greater than the density of psychiatrists in all of Gaza. The density of nurses is 1.47 times greater in the largest city than the density in all of Gaza.

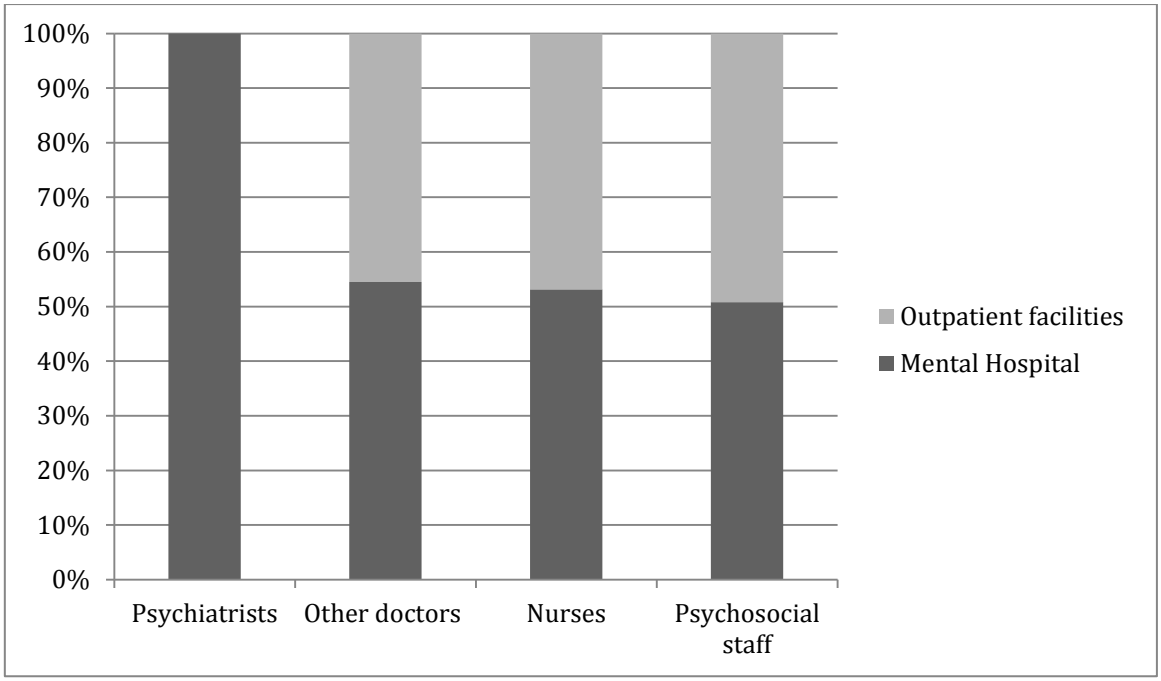

Figure 4.1 Percentage of mental health staff according to their place of work

4.2.5.1 Training Professionals in Mental Health

The number of professionals who graduated in 2010 in academic and educational institutions is as follows: 97 medical doctors (not specialised in psychiatry), 186 nurses (not specialised in psychiatry), 0 psychiatrists, 25 psychologists with at least one year of training in mental healthcare, 25 nurses with at least one year training in mental healthcare, 0 social workers with at least one year training in mental healthcare, and 0 occupational therapists with at least one year training in mental healthcare. Table 4.3 illustrates the number of mental health professionals trained by academic institutions in Gaza per 100,000 population. It is notable that some psychiatrists (21-50%) emigrate to other countries within five years of completing their training.

Table 4.3 Number of trained mental health professionals per 100,000 population

	Professionals graduate in mental health per 100,000
Psychiatrists	0
Medical Doctors	6.11
Nurses	11.7
Psychologists	1.57
Social Workers	0
Nurses+1year	1.57
Occupational Therapists	0

The numbers of doctors (not specialised in psychiatry) and nurses (not specialised in psychiatry) represent the number of doctors and nurses who graduated from medicine and nursing schools in Gaza in 2010. The training they received in both schools was undergraduate training with no specialisation in mental health.

4.2.5.2 Consumer and Family Associations

There are no service users who are members of service user associations and no family members who are members of carer associations. There are no official service user or carer associations in Gaza that have a legal or official representation in professional or legal activities. However, there are two advocacy groups for service users and carers that have been organised by social workers in Gaza City and they meet regularly in one of the CMHCs and the mental hospital in Gaza.

4.2.6 Public Education and Links with Other Sectors

There is no coordinating body in Gaza to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, and professional organisations have all promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following

groups: the general population, women, trauma survivors and other vulnerable groups. In addition, there have been public education and awareness campaigns targeting professional groups including teachers, healthcare providers, the complementary/alternative traditional sector, social services staff, leaders, and politicians and other professional groups linked to the health sector.

4.2.6.1 Legislative and Financial Provisions for Persons with Mental Disorders

The following legislative provisions exist to provide support for service users, but they are not activated, because the Palestinian Legislative Council is suspended since 2007 because of political conflict: (1) legislative provision for employment, and (2) legislative provision against discrimination at work. At the present time, there is no legislative provision for housing or financial support for discrimination in housing.

4.2.6.2 Links with Other Sectors

There are formal collaborations between the government department responsible for mental health and the departments/agencies responsible for: PHC, child and adolescents' health, substance abuse, child protection, education, welfare and criminal justice. In terms of support for child and adolescent mental health, all primary and secondary schools have either a part-time or full-time mental health professional and almost all schools (51-80%) have school-based activities to promote mental health and prevent mental disorders. Regarding training, no police officers and no judges and lawyers have participated in educational activities on mental health in the last five years. Mental health facilities do not provide financial support to service users or link them to employment programmes outside the mental health facilities.

4.2.7 Monitoring and Research

A formally defined list exists of individual demographic data items that should be collected by all mental health facilities. The mental health directorate received data from the only mental hospital in Gaza and all mental health outpatient facilities. However, no report was published on the data transmitted to the mental health directorate. The research focused on the following topics: epidemiological and non-epidemiological studies in community and clinical samples, services research, and psychosocial, biology and genetics psychotherapeutic interventions.

4.3 Documentary Analysis

The findings of this section answer Research Question 2:

What are the approaches that have been used to develop mental health policies and mental health plans for service development and delivery in Gaza, and how does the process of formulation, and the contents of both mental health policy and mental health plan, meet the international standards set by the WHO?

4.3.1 Analysis of Mental Health Policy

4.3.1.1 Introduction

The mental health policy for Gaza and the West Bank was developed in 2004, with support from the WHO. The policy focused on the organisation of mental health services in Gaza and the West Bank that were consistent with the WHO ten essential recommendations for developing mental health services (WHO, 2001). The policy received wide recognition from the MoH, the main donors of the Palestinian National Authority at that time, and also international and national NGOs in the field of mental

health. Five years later, the policy has undergone another review and update, as the former policy was time limited to five years. The review started in 2009, and the revised policy was drafted in 2010 and provided to the Minister of Health for approval and endorsement.

Despite the political split between Gaza and the West Bank at the time of reviewing and updating the policy in 2009-2010, the updated document still covers Gaza and the West Bank. However, because of the logistic and political barriers, both Gaza and the West Bank have separate committees for reviewing and updating the policy; both committees met and shared concepts and updates, with the support of the WHO that provided a key role in the coordination and facilitation to produce one unified policy for both territories.

This chapter section describes the comprehensive analysis of the process of revising and developing the policy in 2009-2010. The analysis also includes an assessment of the main content of the revised policy, using the WHO checklist for assessing mental health policy documents (WHO, 2009).

4.3.1.2 Process Issues

There was a high level committee to develop the mental health policy; this committee emerged from the national steering committee for mental health that is headed by the Minister of Health. The Minister of Health himself approved the revised policy.

The only needs assessment conducted for the development of the policy was based on reviewing studies and assessments for mental health problems in Gaza in the past ten years. Moreover, the review included assessing the progress of achieving goals and objectives of the previous policy. It is notable that no assessment studies were undertaken, particularly for the development of the policy; the review committee felt that the review of the existing studies would be enough to provide a needs assessment.

Regarding reviewing other policies in other countries that have similar cultural and economic backgrounds, only two mental health policies that were developed in near-by countries were examined as a part of developing the policy. Moreover, there was no exchange or consultation with other countries after the development of the policy. However, the WHO recruited a short-term international consultant to provide technical guidance and assistance in writing and proofreading the final English draft of the document.

The development of the policy was well consulted with other key providers of mental health services in Gaza. Many of the review committee members came from different departments of the MoH in Gaza. Representatives from PHC, the directorate of hospitals, the health information system and health planning unit were consulted during the development of the policy. The consultation also involved other UN agencies (e.g, UNICEF, WHO and United Nation Relief and Works Agency). Local NGOs were also involved and other ministries (including the Ministry of Youth, Ministry of Waqf [this ministry is responsible for organising the religious affairs of the

population in Gaza] and the Ministry of Media and Information). The private sector was not well represented, as it is a small sector in Gaza.

4.3.1.3 Content Issues

The policy has a realistic vision statement and clearly defined objectives, which were consistent with the vision, values and principles. Moreover, the key mental health policy issues are consistent with the health policy. The values and associated principles emphasised: (a) human rights, (b) social inclusion, (c) community care, (d) evidence-based practice, (e) inter-sectoral collaboration, and (f) equity with physical healthcare. To some degree, the values and principles emphasised integration of mental health in general healthcare, as the integration was mentioned in the context of the values and principles but was not directly indicated.

Areas for action were debatable, as they did not address all the objectives. For example, areas for action emphasised the organisation of mental health services comprehensively, while other important objectives like improving legislations and human rights for service users were not addressed.

Improving the quantity and quality of human resources was addressed comprehensively in the areas for action, including improving the infrastructure of working places. Increasing the number of human resources was addressed by identifying the number of human resources that need to be recruited. However, neither improving the recruitment process nor staff retention mechanisms were

addressed. Specifying areas for general and specialised training were also addressed in the areas for action.

The areas for action addressed issues related to the organisation of services to a great level, by promoting: (a) integration of mental health into general health services, (b) promoting a community oriented approach, and (c) promoting deinstitutionalisation. However, areas for action provided less support to other key areas such as: (a) improving the quality of services through promoting evidence-based practice, (b) prevention of mental disorders, and (c) promoting research and evaluation.

There were some other issues emphasised in areas for action without identifying a clear strategy for achieving them. Collaboration and coordination with other governmental ministries was mentioned in different places (e.g, crisis intervention, and child and adolescent mental health). In addition, different ministries were represented in the formulation of the policy. However, nothing was mentioned in the policy on how to organise this collaboration and no statements were mentioned for defining roles and responsibilities for each party.

Collaboration and coordination between governmental-run mental health services and NGOs was clearly mentioned in the objectives, as well as in many other places (executive summary, crisis intervention). Furthermore, a complete section of this policy was devoted to presenting the work of different NGOs in the West Bank and Gaza. However, nothing was mentioned in the policy related to strategies for

improving the coordination between government-run services and NGOs. The policy did not specify a dedicated position for coordinating different mental health functions and services and a multi-sectoral coordination body to oversee the implementation of mental health activities was not established. However, the management body in the mental health directorate is mandated to carry out tasks related to coordination and information management.

Another major missing item was financing the mental health activities. The areas for action in the policy did not address financing because the Ministry of Finance, which is responsible of financing health programmes, was not involved in the process of developing the policy. Moreover, the MoH depends on other external financial support that is not always guaranteed and is influenced by the political situation in the country.

Moreover, the areas for action did not provide any attention to the following: (a) legislation or human rights, although the main values and associated principles were addressing human rights, (b) access to psychotropic medicines, (c) advocacy and establishment of service user and carer associations and advocacy groups, (d) raising public awareness on mental health, (e) improving information management systems, and (f) collaboration with other health providers.

Regarding key groups that were targeted in the policy, these were: (a) people with severe mental illness, (b) children and adolescents, (c) people with common mental health disorders, and (d) people affected by trauma. However, the policy did not

address, or fairly addressed, the following groups: (a) older persons, (b) people with intellectual disabilities, and c) people with substance dependence.

Reasonable balance in relation to representation of different groups has not been achieved, as was noted that: (a) children and adolescents, people with common mental disorders and people affected by trauma were equally discussed in this policy while less attention was given to people with severe mental illnesses, (b) people with intellectual disabilities were not mentioned in the policy; this might be due to leaving this section to school mental health and also because there is a lack of trained workers in this area, and (c) substance dependence was separated in a standalone policy; this explains why it was not discussed in this policy.

4.3.2 Analysis of the Mental Health Plan

4.3.2.1 Introduction

After the MoH revised and updated the mental health policy in 2009-2010, the Ministry developed a mental health plan for two years, 2010-2012, aiming to achieve the objectives of the policy. The mental health plan was developed to cover Gaza only, while the mental health policy covered both Gaza and the West Bank. This one-sided policy development reflects the impact of the political separation between Gaza and the West Bank.

The plan was developed over a year, which included periodic meetings for the committee that was overseeing the development of the plan. Consultations with key experts were undertaken and two national-level consensus workshops were

organised for all mental health key stakeholders to discuss and revise the draft mental health plan. After the plan was revised upon suggestions from key stakeholders, the Minister of Health approved it. Subsequently, the Minister of Health appointed a monitoring committee to oversee the implementation of the plan.

This section provides a comprehensive analysis of the process of developing the plan and also content issues by using the WHO checklist (WHO, 2009) for analysing mental health plans.

4.3.2.2 Process Issues

The development of the mental health plan was carried out by the mental health steering committee led by the MoH. After the plan was drafted and discussed with key stakeholders, it was approved and adopted by the Minister of Health. The plan contains strategies and activities that are consistent with, and up-to-date with, the mental health policy to a great extent.

There was no situational analysis of the development of the mental health plan as the committee used the same situational analysis and needs assessment adopted for the development of the mental health policy, as it was recently updated. Moreover, no other plans developed in other countries with a similar cultural and demographic background were reviewed during the process of developing this plan. According to the committee who developed the plan, they did not find a well-developed mental health plan in other near-by countries to be reviewed.

There was a wide consultation with the following health departments during the development of the plan, such as: (a) PHC, (b) general hospitals, (c) health planning, (d), epidemiology and information, and (e) human resources. However, other divisions were not fully consulted, such as: (a) HIV/AIDS, (b) pharmaceutical, and (c) child health. The most important missing consultation was with the Ministry of Finance, as no representatives of the Ministry participated in the development of the plan. Instead, representatives of the "council of employees" participated in the preparations, as this is the responsible body for recruiting the governmental employees, including governmental mental health staff.

Other main members of the committee that oversaw the development of the mental health plan and participated in most stages of developing the mental health plan were: Ministry of Social Welfare, one local and one international mental health NGO, three local universities, Ministry of Youth, Ministry of Women, Ministry of Interns, Ministry of Education, Ministry of Waqf, Ministry of Detainees and X-Detainees Affairs, and one disability NGO. The most important missing civil society bodies were the private sector, representatives of service user and carer groups and the criminal justice system.

4.3.2.3 Operational Issues

There have been many concerns raised regarding operational issues for the development and implementation of the mental health plan. Allowing two years to achieve 28 strategies in a political conflict place was identified as ambitious and to some extent unrealistic. The tasks related to the 28 strategies have been distributed

to the MoH and other key stakeholders, including the NGO sector. However, the timeframe was very short to achieve such tasks. The strategies were well defined and each strategy was linked to clear activities, however, no indicators were developed to monitor the process and the outcomes of implementing those activities.

Regarding activities, the outputs for each activity were well identified and each activity was linked to organisations/departments that are responsible for developing and achieving this activity. However, two major concerns were reported: (a) most activities were linked to governmental sectors (mostly the MoH) with a smaller role for other main players, and (b) some activities were linked to responsible organisations without consulting those organisations if they were willing and capable to take such responsibility. The costs of the implementation of these activities were not identified and the funding sources were not well articulated. For those organisations responsible for implementing some activities, available funding was confirmed; however, the source of funding was not identified. Other organisations (e.g. universities) would have to look for funding in order to implement such activities.

The plan's key strategies were integrated into the general health plan. There were no documents for improving service users' rights or improving the rights of people living with disabilities in Gaza. Also, there was no poverty reduction plan or development plans in Gaza.

4.3.2.4 Content Issues

There have been three levels of coordination and management identified in the plan: (1) the mental health directorate is responsible for implementing all activities assigned to the MoH in the plan by implementing these activities and coordinating with other health departments, (2) the national steering committee for mental health is responsible for overseeing and monitoring the implementation of different strategies by other ministries and NGOs, and (3) a coordination and monitoring committee was established by the steering committee to oversee and monitor the implementation of the plan by different key stakeholders and report the progress to the steering committee in a periodic manner. A reporting system is already in place through the MoH. No reporting system has been identified for the coordination activities.

Reviewing the content of the plan, it was clear that some of the strategies were well defined, based on strong evidence, organised in a realistic plan and well supported by monitoring strategies. On the other hand, other strategies did not receive the same level of attention and were not well identified and supported.

In the presentation of this analysis, the well-supported strategies will be presented first, followed by less supported strategies.

The plan included comprehensive and clear strategies for the organisation of mental health services by: (a) promoting the integration of mental health into PHC, opening two mental health units in general hospitals and promoting rehabilitation services in

the mental hospital, (b) activities promoting community-based services and downsizing the only mental hospital in Gaza, and (c) activities to strengthen the role of CMHCs and building the capacity of community mental health workers. Although psychosocial rehabilitation was clearly identified in the tertiary level of care, it did not appear in the primary healthcare level or in the secondary care level.

A strategy for improving the coordination and the collaboration between the MoH, other ministries, NGOs and key health providers was identified. Activities mainly focus on planning and implementing joint projects, unifying resources and establishing a referral system. However, no coordination body has been identified within the plan.

A strategy for raising public awareness of issues related to mental health was well defined in the plan. The plan included clear strategies to promote prevention by improving school mental health services and the early detection of mental disorders. Moreover, the plan addressed clear strategies for advocacy and anti-stigma activities.

Further, the plan included strategies for reviewing the psychotropic list in the essential drug list. The plan called for developing strategies for drug supply and distribution on all levels. Moreover, the plan included promoting pharmaceutical services for mental health facilities, the establishment of guidelines for the rational use of psychotropic medicines, developing a strategy for supplies and distribution and reviewing and updating the essential drug list. However, the plan did not include

any activities for monitoring the distribution or procurement of psychotropic medicines.

The current information system was very poor. Therefore the committee that developed the plan decided that the improvement of the mental health information system should include establishing a new information management system and electronic patient file. However, the plan did not clarify how the suggested information system would feed into policy development or clinical practice.

Human resource development and training were also well-defined strategies. The plan indicated strategies for increasing the number of mental health workers in clinical settings, with detailed descriptions of their tasks and disaggregation of numbers and professional groups. The plan considered a relevant strategy for managing recruitment, but no strategies could be identified for the management of retention or deployment. Specialised training for further skills development was discussed in the plan. Local universities are requested by the plan to create new postgraduate programmes to facilitate specialisation and increase the practical training for medical and nursing students in mental health. No activities are taking place to review the undergraduate or graduate curricula. Other areas for capacity building and training were identified by the plan. There were also strategies for training health providers to develop their competencies at the level of: (a) PHC, (b) general hospital care, and (c) specialised care.

The plan paid special attention to improving the infrastructure to provide appropriate mental health services. At least two mental health centres need re-building and three require substantial renovation for enabling training activities.

Other strategies were unclear in terms of definitions and not supported by evidence. The activities identified in those strategies were not well defined, nor linked to a clear timetable, and not supported by financial resources.

Although the plan included some activities for developing a code of practice for mental health practitioners, it did not support strategies or activities to establish mental health legislation. Moreover, the plan did not support the formation of a human rights review body for individuals with mental illnesses. Despite that the plan called for establishing more service user and carer associations, it did not provide specific strategies for such establishment. This activity was not linked to a dedicated ministry or organisation and the plan did not state if the service user and carer associations should be involved in developing future policies and plans.

The plan did not indicate a separate and clear strategy for promoting quality improvement; however, it provided recommendations for developing guidelines and protocols to improve the quality of services provided by community mental health facilities and the mental hospital. The plan did not include strategies for improving capacity for research and evaluation although it included activities for addressing a list of priority research studies. No strategies were included for evaluating the implementation of the policy or the plan.

4.4 Training Needs Analysis

4.4.1 Introduction

The findings of this section answer the third research question presented in Chapter one: How do mental health professionals describe: 1) their self-perceived level of possession of mental health skills and knowledge competence, 2) the support they receive in using and implementing such skills, and 3) priority areas for mental health training and their preferred approach to training?

The Training Needs Analysis (TNA) questionnaire has been designed to assess the training needs of mental health workers. This is a self-administered questionnaire that measures participants' self-perceived competence level in practising the core competencies for community mental health. The first section presents the results on how participants perceived their competence in undertaking the core functions and skills. Lower self-perceived competence indicates a higher priority for additional training. Results are disaggregated according to the demographic characteristics of participants. The second section presents the training priorities identified by participants, exploring how participants from different professional groups, qualifications, and years of experience identify training priorities.

The third section presents the top barriers to receiving appropriate mental health training. The fourth section presents the results on how mental health workers prefer to receive training. The fifth section presents the results on how mental health workers in Gaza developed their competencies.

4.4.2 Demographic Characteristics of the Participants

As described in Chapter three, participants who completed the TNA included all mental health professionals working within the governmental sector, whether working in the mental hospital or in the CMHCs. Table 4.4 shows the demographic characteristics of the participants. Participants completing the TNA included 105 mental health workers; only 87 participants returned the questionnaire, with a response rate of 82.8%.

4.4.3 Perceived Competency Level

Table 4.5a and 4.5b present the median competency levels for the total TNA scale, in the ten core competency domains across professional groups as well as the Cronbach alpha coefficient for each domain. All scales demonstrated good reliability, with alphas ranging from 0.78 to 0.87 across the ten subscales domains.

The median competence level for all TNA domains was 37.77. The competence level varied with domains; the lowest competence level (3.50) was for crisis interventions, followed by intervention (3.60) and disaster preparedness (3.66), and the highest (4.00) for communication, assessment, safe practice, culturally appropriate practice, legal responsibility, and professional development activities.

Across the five occupational groups, there were significant differences in competence levels in assessment [$\chi^2(4, n = 79) = 14.34, p = .006$], disaster preparedness [$\chi^2(4, n = 86) = 9.70, p = .046$], and knowledge of mental health [$\chi^2(4, n = 85) = 12.82, p =$

.012]; the lowest to the highest levels for assessment and disaster preparedness were for medical doctors, social workers, nurses, psychologists and psychiatrists.

Table 4.4 Demographic characteristics of the study participants

Characteristic	Total Respondents N = 87 (%)	Mean (SD)
Age group		33.9 (7.7)
23-27 years	24 (27.6)	
28-37 years	35 (40.2)	
38-47 years	25 (28.7)	
48-57 years	2 (2.3)	
(*missing = 1*)		
Gender		
Female	44 (50.6)	
Male	43 (49.4)	
Professional Experience		
Years of professional experience in mental health	86	6.5 (5.9)
(*missing = 1*)		
Study Experience		
Years of study post first degree	87	1.5 (1.2)
Professional Groups		
Psychiatrist	4 (4.7)	
Medical Doctor	5 (5.8)	
Psychologist	23 (26.7)	
Social Worker	16 (18.6)	
Nurse	38 (44.2)	
(*missing = 1*)		
Qualifications		
Diploma	4 (4.7)	
Bachelor Degree	34 (39.5)	
Post Graduate Diploma	11 (12.8)	
Masters Degree	37 (43.0)	
(*missing = 1*)		
Practice Location		
Community mental health centre	48 (55.2)	
Psychiatric Hospital	39 (44.8)	
Place of Living		
North of Gaza	17 (19.8)	
Gaza City	44 (51.2)	
Middle Zone	13 (15.1)	
Khanyounis	8 (9.3)	
Rafah	4 (4.7)	
(*missing = 1*)		

In addition, the lowest to the highest levels for knowledge of mental health were medical doctors and social workers, followed by psychologists, nurses and psychiatrists. The correlation analysis showed a significant association between years of experience with increased levels of competence (rs[86] = .36, *p* = .002). The effect size of this relationship was small (Cohen, 1988), indicating that 12.9% of the variance in competence levels was explained by years of experience working in mental health.

Examination of possible gender differences on all the TNA competence domains were assessed using 10 Mann-Whitney U Tests. Median competence scores are summarised in Table 4.5. A Mann-Whitney U Test revealed a significant difference in total competence levels of males (Md = 39, *n* = 36) and females (Md = 36, *n* = 33), U = 397, z = -2.37, *p* = .018, *r* = 0.28. Mann-Whitney U tests indicated significant gender differences on Assessment (U = 480, z = -2.95, *p* = .003, *r* = 0.33), Crisis Intervention (U = 649, z = -2.55, *p* = .011, *r* = 0.27), Knowledge of Mental Health (U = 494, z = -3.72, *p* = .000, *r* = 0.49), Interventions (U = 534, z = -2.98, *p* = .003, *r* = 0.32) and Professional Development (U = 634, z = -2.38, *p* = .017, *r* = 0.25).

4.4.4 Results from the Open Response Section

The results from the open response section of the TNA questionnaire were analysed for the entire group as well as exploring the relationship between two categorical variables, where relevant.

Table 4.5 Competency levels for the 10 core competency domains across professional groups

(Table 4.5a) Competency levels for 4 core competency domains

	Core Competency Domains				
Professional group	Total N = 69 (alpha)	Communication N = 84 (alpha)	Assessment N = 79 (alpha)	Disaster Preparedness N = 87 (alpha)	Crisis Intervention N = 87 (alpha)
All participants	37.77	4.00	4.00	3.66	3.50
(n = 69)	(0.88)	(0.82)	(0.87)	(0.87)	(0.83)
Gender					
Females	36.63	3.92	3.77	3.50	3.00
Males	39.15	4.10	4.09**	3.83	3.50**
Prof groups					
Psychiatrists	45.10	4.11	4.55	4.00	3.75
Medical	32.44	3.86	3.32	1.83	3.00
Psychologists	39.08	3.93	4.05	3.83	4.00
Social Workers	36.33	4.04	3.45	3.66	3.25
Nurses	37.98	3.93	4.00	3.75	3.25
p value			0.006	0.046	

(Table 4.5b) Competency levels for 6 core competency domains

	Core Competency Domains					
Professional group	Knowledge of Mental Health N = 86 (alpha)	Interventions N = 83 (alpha)	Safe Practice N = 87 (alpha)	Culturally Appropriate Practice N = 87(alpha)	Legal Responsibility N = 86 (alpha)	Professional Development N = 85 (alpha)
All participants	3.71	3.60	4.00	4.00	4.00	4.00
(n = 69)	(0.82)	(0.85)	(0.78)	(0.83)	- [a]	(0.81)
Gender						
Females	3.28	3.30	4.00	4.00	4.00	3.85
Males	4.00***	3.90**	4.16	4.00	4.00	4.00
Prof groups						
Psychiatrists	4.14	4.00	4.25	3.75	4.00	4.29
Medical	3.14	2.70	3.67	3.75	3.00	3.57
Psychologists	3.86	3.75	4.00	4.00	4.00	4.00
Social Workers	3.14	3.30	4.25	4.00	4.00	3.86
Nurses	3.71	3.60	4.00	4.00	4.00	4.00
p value	0.012					

[a] This domain has only one item, *$p < .05$; **$p < .01$; ***$p < .001$

4.4.4.1 Top Training Priorities

Participants were asked to rank their top five priority areas for training. The response format was in the form of an open question to enable participants to express their preferential judgments when ranking their perceived order of training preference. A total of 46 training priority area responses were clustered into seven core competencies: communication skills, assessment, disaster management, knowledge and understanding, treatment modalities, practice safely and ethically and professional growth.

As Table 4.6 shows, the training needs that were considered the most important by participants are components of treatment modality interventions: psychotherapeutic approaches, recovery approaches, family intervention, managing difficult behaviours, drug abuse interventions, mental health rehabilitation, early detection of mental health disorders, psychopharmacology and community education. There was a definite preference for treatment modalities, chosen as first or second choice (98.08%).

A complete list of all responses indicating training area preferences is included in Appendix Eleven. Participants also preferred training in the skills necessary to work effectively within disaster management (crisis intervention and psychiatric emergencies, 29.88%), which is an unsurprising finding in the context of an area affected by conflict. Professional growth, assessment, and practising safely and ethically were not popular choices.

Table 4.6 Training needs ranked in order of preference

Training area N=87	***N* ranking**					**Total *N* (%) Ranking 1 or 2**
	Skills First choice	Skills Second choice	Skills Third choice	Skills Fourth choice	Skills Fifth choice	
Treatment modalities (intervention)	37	49	33	39	23	86 (98.08)
Disaster management	15	11	11	5	3	26 (29.88)
Knowledge and understanding	14	4	8	3	2	18 (20.68)
Communication skills	7	2	4	4	3	9 (10.34)
Professional growth	3	2	7	4	4	5 (5.74)
Assessment	2	6	3	1	1	8 (9.19)
Practice safely and ethically	2	1	1	0	0	3 (3.44)
Missing data	7	12	20	31	51	19 (21.83)

4.4.4.2 Priorities for Training by Professional Group

To examine first choice only training preference differences between healthcare workers, the number of healthcare professional categories were grouped into two categories representing medical (doctors, psychiatrists and nurses) and non-medical background (psychologists, social workers, occupational therapists). As shown in Table 4.7, the results of the chi-square analyses on first choice preferences for each training area suggest that there were no differences between healthcare professionals with medical versus non-medical background. As such, there were no differences between psychiatrists, medical doctors, psychologists, social workers, nurses or occupational therapists on the majority of responses to training preference core domains.

4.4.4.3 Priorities for Training and Years of Experience

To examine first choice only training preference differences between healthcare workers who have different lengths of professional experience, years of experience was collapsed into two variables, less than five years' experience and more than five

years' experience, and tested by chi-square analysis. As shown in Table 4.8, the results demonstrate that there is no significant difference between healthcare workers with different lengths of experience in their preferred training priorities.

Table 4.7 Training preference and medical background of healthcare professionals

Training priorities N=74	Medical First choice	Non-Medical First choice	χ2, 1 df	*p* value/effect size (phi)
Treatment modalities	2 (22.2%)	34 (48.6%)	1.30	*p* = 0.26 (-0.17)
Disaster management	2 (22.2%)	13 (18.6%)	0.00	*p* = 1.00 (0.03)
Knowledge & understanding	2 (22.2%)	12 (17.1%)	0.00	*p* = 1.00 (0.04)
Communication Skills	2 (22.2%)	5 (6.5%)	0.98	*p* = 0.32 (0.18)
Professional growth	1 (11.1%)	2 (2.9%)	0.09	*p* = 0.77 (0.14)
Assessment	0 (0.0%)	2 (2.9%)	0.00	*p* = 1.00 (-0.06)
Practice safely and ethically	0 (0.0%)	2 (2.9%)	0.00	*p* = 1.00 (-0.06)

Table 4.8 Training preferences and length of professional experience

Training priorities N= 86	<5 years First choice	>5 years First choice	χ2, 1 df	*p* value/effect size (phi)
Treatment modalities	21 (45.7%)	15 (45.5%)	0.00	*p* = 1.00 (0.00)
Disaster management	10 (21.7%)	5 (15.2%)	0.20	*p* = 0.66 (0.08)
Knowledge & understanding	8 (17.4%)	6 (18.2%)	0.00	*p* = 1.00 (-0.01)
Communication Skills	5 (10.9%)	2 (6.1%)	0.12	*p* = 0.73 (0.08)
Assessment	2 (4.3%)	0 (0.0%)	0.24	*p* = 0.63 (0.14)
Practice safely and ethically	0 (0.0%)	2 (6.1%)	0.93	*p* = 0.33 (-0.19)
Professional growth	0 (0.0%)	3 (9.1%)	2.21	*p* = 0.14 (-0.24)

4.4.4.4 Priorities for Training and Qualifications

Level of education categories were collapsed into two categories, undergraduate (diploma or bachelor degree) and postgraduate qualifications (postgraduate diploma, master's degree, PhD or Board Programme). Table 4.9 provides the results of chi-square analyses. Educational qualification was found not to be significantly related to

training preference except for treatment modalities, which was chosen more as the first choice by postgraduates and knowledge and understanding training chosen more by undergraduates.

Table 4.9 Training preferences and qualification group

Training priorities N= 86	**Undergraduate First choice**	**Postgraduate First choice**	**χ^2, 1 *df***	***p* value/effect size (*phi*)**
Treatment modalities	11 (31.4%)	25 (56.8%)	4.09	*p* = 0.04 (-0.25)*
Disaster management	7 (20.0%)	8 (18.2%)	0.00	*p* = 1.00 (0.02)
Knowledge & understanding	11 (31.4%)	3 (6.8%)	6.51	*p* = 0.01 (0.32)**
Communication skills	3 (8.6%)	4 (9.1%)	0.00	*p* = 1.00 (-0.01)
Others	3 (7.9%)	4 (8.3%)	0.00	*p* = 1.00 (-0.01)
Practice safely and ethically	2 (5.7%)	0 (0.0%)	0.78	*p* = 0.38 (0.18)
Professional growth	1 (2.9%)	2 (4.5%)	0.00	*p* = 1.00 (-0.04)
Assessment	0 (0.0%)	2 (4.5%)	0.31	*p* = 0.58 (-0.14)

4.4.4.5 Top Training Barriers

Participants were asked to identify the top five perceived barriers to receiving appropriate mental health training. The response format was in the form of an open question and participants were asked to rank training barriers according to importance. A total of 31 training barrier responses were clustered into four themes: administrative, logistical, socio-cultural and technical. A complete list of these barriers for training is included in Appendix Twelve. Table 4.10 shows all of the participant rankings of the training barriers chosen in order of preference.

Table 4.10 Ranked perceived barriers to training in order of preference

Barriers to Training	*N* ranking					Total *N* (%) Ranking 1 or 2
	Barriers First choice	Barriers Second choice	Barriers Third choice	Barriers Fourth choice	Barriers Fifth choice	
Technical barriers	31	26	21	16	10	57 (65.5)
Administrative barriers	30	27	18	14	10	57 (65.5)
Logistical barriers	21	22	20	10	4	43 (49.42)
Others	4	9	28	44	63	13 (14.94)
Socio-cultural barriers	1	3	0	3	0	4 (4.59)

As Table 4.10 shows, the results from the open response section of the questionnaire suggests that technical, administrative and logistical barriers are considered to be the most relevant to preventing appropriate mental health training. Technical barriers included insufficient qualified trainers (20.7%), administrative barriers included insufficient administration and lack of equal staff opportunities (17.2%), and logistical barriers included insufficient training tools (10.3%).

4.4.5 Preferred method of training delivery

Participants were asked to identify their preferred method of training delivery, and were asked to respond ‘yes’ or ‘no’ to five options according to whether they would be appropriate to their training needs: short-term courses (less than one month), long-term courses (1-6 months), postgraduate studies, in-service training and supervision and self-learning. Multiple responses were allowed. The responses to this question are shown in Figure 4.2. The three most preferred methods of training delivery were: postgraduate studies, long-term courses (1-6 months) and in-service training and supervision. Self-learning and short-term courses (less than 1 month) were the least popular.

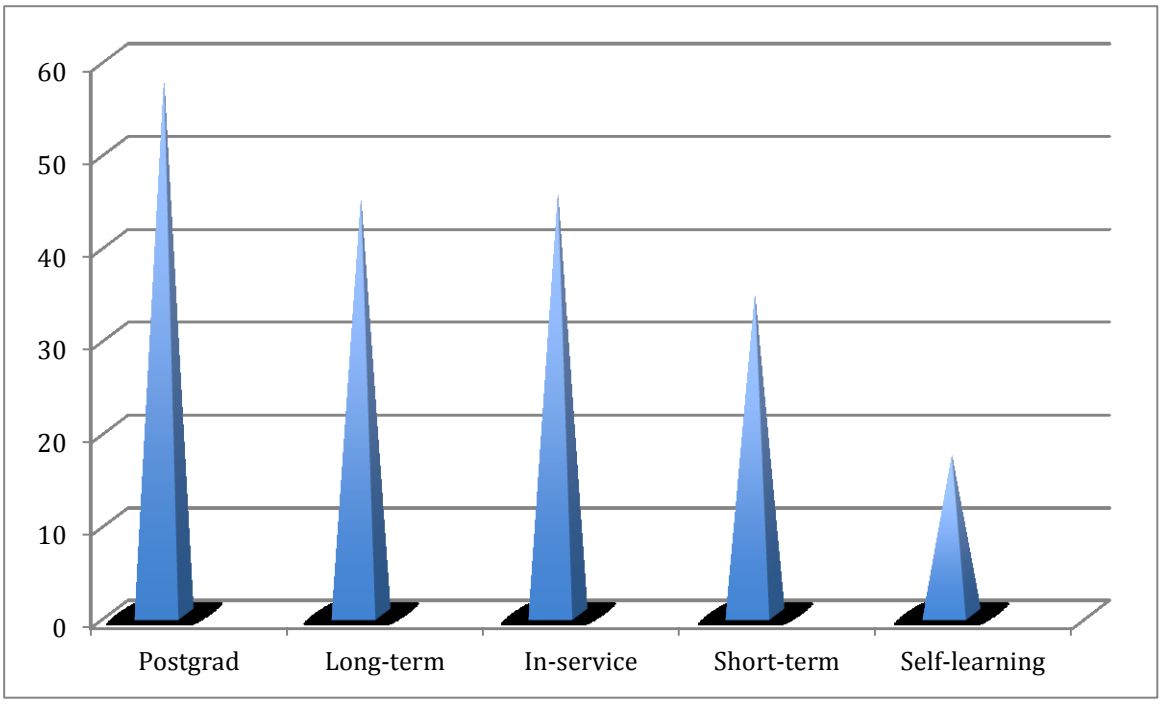

Figure 4.2 Preferred method of delivery of training

4.4.6 Method of Developing Core Mental Health Competencies

Participants were asked how they developed the following core mental health competencies: (1) interview skills, (2) assessment and case formulation, (3) treatment modalities, (4) ethical and cultural practice, (5) team work, (6) communication skills, (7) holistic approach, (8) recovery approach, and (9) emergency and crisis intervention. The six options were: (1) undergraduate studies, (2) postgraduate studies, (3) short-term courses, (4) long-term courses, (5) clinical and field practice, and (6) clinical supervision. The results to this question are shown in Table 4.11.

Table 4.11 Method of developing core mental health competencies

Core Competencies	Under graduate (%)	Post graduate (%)	Short-term (%)	Long-term (%)	Clinical/field practice (%)	Clinical supervision (%)
Interview skills N=87	21 (24.1)	25 (28.7)	19 (21.8)	9 (10.3)	13 (14.9)	0
Assessment/case formulation N=87	12 (13.8)	40 (46)	6 (6.9)	3 (3.4)	22 (25.3)	4 (4.6)
Treatment modalities N=86	4 (4.7)	36 (41.9)	5 (5.8)	6 (7.0)	34 (39.5)	1 (1.2)
Ethical/cultural practice N=86	42 (48.8)	12 (14)	3 (3.5)	1 (1.2)	27 (31.4)	1 (1.2)
Team work N=86	11 (12.8)	17 (19.8)	10 (11.6)	2 (2.3)	46 (53.5)	0
Communication skills N=86	9 (10.5)	14 (16.3)	32 (37.2)	4 (4.7)	26 (30.2)	1 (1.2)
Holistic approach N=82	9 (11.0)	27 (32.9)	5 (6.1)	4 (4.9)	36 (43.9)	1 (1.2)
Recovery approach N=75	7 (9.3)	34 (45.3)	3 (4.0)	4 (5.3)	25 (33.3)	2 (2.7)
Emergency/crisis intervention N=79	9 (11.4)	12 (15.2)	24 (30.4)	7 (8.9)	26 (32.9)	1 (1.3)

Results indicated that the majority of mental health workers developed their interviewing skills (28.7%), assessment skills (46%), therapeutic modalities (41.9%) and recovery approach skills (45.3%) through postgraduate training. The majority of workers developed their multidisciplinary teamwork skills (53.5%), holistic intervention skills (43.9%) and crisis intervention skills (32.9%) through clinical practice. The majority of workers developed their ethical intervention skills through first degree training (48.8%), while most of them developed communication skills through short-term courses (37.2%).

4.5 Focus Groups

4.5.1 Introduction

This chapter section presents the analysis of the focus groups, seen through the lens of the "Right to Health" conceptual framework depicted in Figure 1.1, Section 1.3 (UNOHCHR, 2000). Themes are explained with relevant quotes from participants. Seven focus groups were conducted with mental health professionals, policy makers, service users, and carers. Focus groups for service users and carers were separate from the focus groups for mental health professionals and policy makers. Therefore, the qualitative analysis is presented as follows: the first section presents the views and perceptions of mental health professionals and policy makers and the second section presents the views of service users and carers. The third section presents the analysis of common themes that were discussed among both focus groups.

4.5.1.1 Reflexivity

The research journal that I started at the beginning of conducting this research helped me to maintain an internal dialog with myself at all research stages, especially during gathering and analysing qualitative data. The research journal helped me to challenge my epistemological and ontological assumptions. Writing notes and ideas in a continuous manner provided me with more insight of my subjectivity in understanding and interpreting data that I gathered, and helped me to understand the research context and the value of the information provided by the participants.

Conducting focus groups with mental health professionals and policy makers was a challenge for me as a novice researcher and a colleague. It was not clear to me how they would perceive my role as a facilitator of the focus groups and to what extent they would feel comfortable to share their concerns and problems with me. Maintaining the research journal helped me to prepare myself mentally to facilitate the focus groups and also to obtain a deeper understanding of my role as facilitator that should not interfere with the process of sharing concerns and criticism of the current services by the participants.

> I do not know how mental health professionals and policy makers will perceive my role as a facilitator to the focus groups. Would they feel uncomfortable to share challenges and concerns with me, knowing that they know me as a mental health professional and a colleague? I need to keep reminding myself that I should not interfere with the discussion taking place and my facilitation should not lead them to hide or withhold important information. (April, 2011)

I also maintained writing field notes when I was facilitating the focus groups. Reflecting on the field notes in the research journal helped me to understand the value of the data and the attitudes of participants during the data analysis stage.

> Today, participants were talking about the mental health policy as if it does not exist. All mental health workers denied the implementation of the mental health policy in their day-to-day practice and criticised policy makers that they do not make more efforts to develop a well-structured mental health policy.

> Although I know that the mental health policy exists, I did not interfere in the discussion to correct this piece of information. For me it was not a matter of correct versus incorrect, it was about understanding how mental health professionals think about policy development and what the implications of the policy development are on their clinical and community work. (March, 2011)

Furthermore, the research journal helped me to prioritise the focus on key issues that I have not addressed in the topic guide. I maintained writing in the research journal after each focus group and reviewed my reflections before facilitating the next focus group. One of the main issues that the research journal helped me to discover was the perception of stigma among service users.

> One service user told me today that he does not prefer to receive mental health workers in his house because he is concerned about the neighbours' reaction if they know that he receives mental health services. This thought was striking to me; I checked with another service user in the group and she shared the same concern. Do mental health workers know about this? Do they consider the service users' acceptance to home visits before they conduct such an activity? This is a key issue to investigate. I need to discuss the acceptance to home visits with every service user in the next focus groups before formulating any conclusion about this issue. (October, 2011)

4.5.2 Mental health workers and policy makers

4.5.2.1 Introduction

The findings of this section answer Research Question four, presented in Chapter one: In the light of ongoing conflict in Gaza, what are the views of mental health policy makers and mental healthcare professionals on major mental healthcare challenges and what are their suggested strategies for reforming mental health services in Gaza?

This chapter section presents the views and perceptions of a group of mental health policy makers and professionals working in different mental health facilities in Gaza. Because a diversity of opinions are essential for enriching focus group discussions, a purposive sampling of participants was undertaken, which included various professional groups, ages, genders and places of work. Participants were therefore selected from four governmental CMHCs, the mental hospital, the governmental Mental Health Directorate and Gaza Community Mental Health Programme (GCMHP) as a mental health NGO.

Three focus groups took place between September and November 2011. Two of the focus groups took place with policy makers and mental health professionals working in the governmental sector. The third focus group took place with policy makers and mental health professionals from the NGO. The separation between both governmental and NGO sectors was intended to provide both participant groups the space to criticise and provide an opposing view on the services provided in the other sector. However,

views from both sides are compiled in the presentation of the results and in the discussion and interpretation phases.

The focus groups followed a flexible interview topic guide (Appendix Six) that involved six main topics for discussion: describing the characteristics of the mental health system, the implementation of policy and legislation in Gaza, the implementation of a community-based approach, the development of human resources in Gaza, the role of conflict in developing the mental health system and the most pressing needs for mental health professionals in Gaza. The analysis of the participants' discussion produced a number of themes and sub-themes, as shown in Figure 4.3, and representative quotes are provided to illustrate key themes.

4.5.2.2 Participants

Participants were distributed across three focus groups, 6-7 participants in each focus group. Participants' names are not revealed in the presentation and discussion of the findings to preserve their anonymity. Instead, a code number is given to each participant along with professional discipline, place of work, gender, and age.

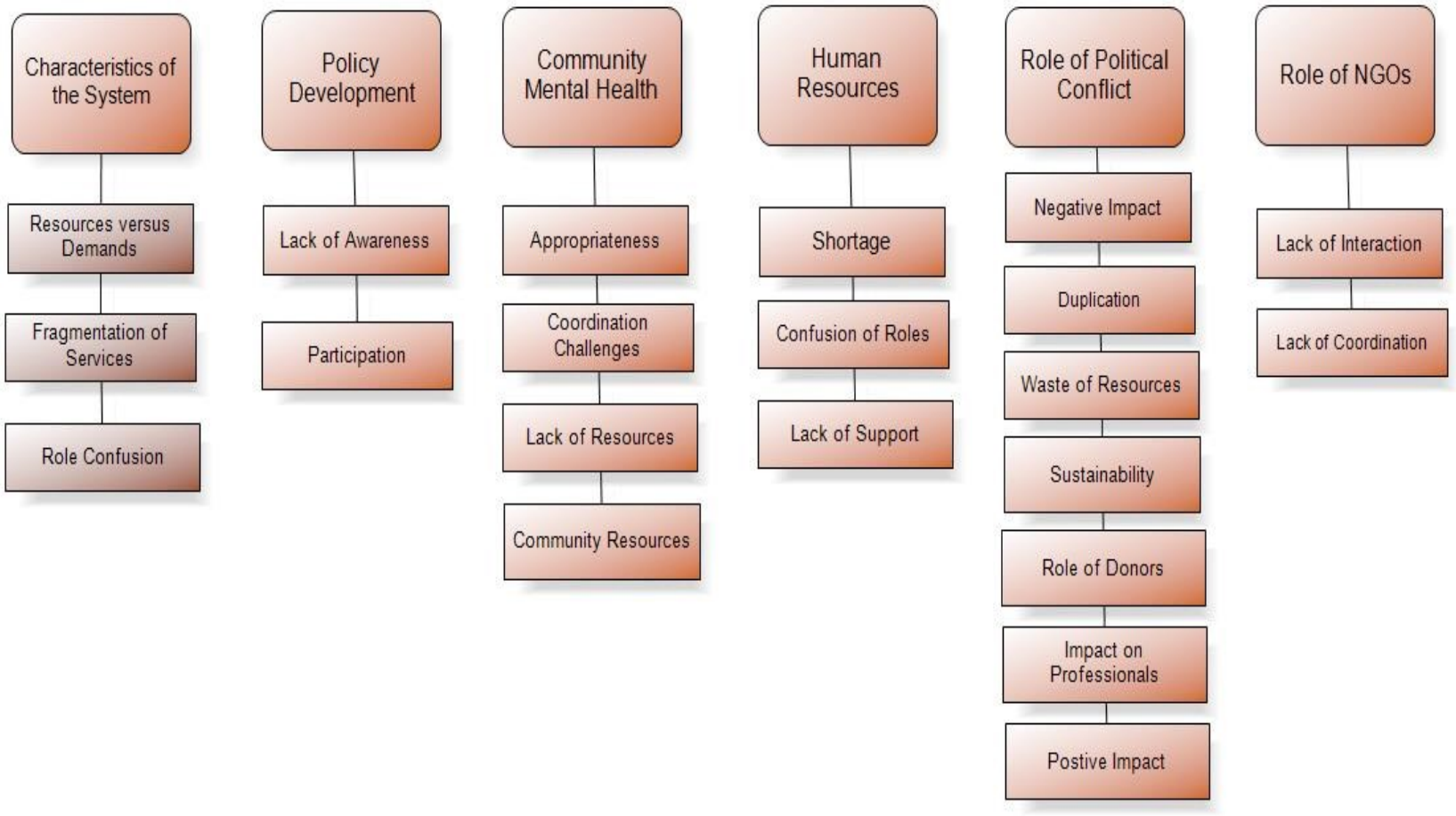

Figure 4.3 Themes and sub-themes for the focus group of policy makers and mental health professional

Table 4.12 shows the demographic details of participants from the government and NGO services.

Table 4.12 Policy makers' and professionals' demographic details

Profession	Code number	Place of work
Psychiatric Nurse	MH worker 1, Gov	CMHC
Social Worker	MH worker 2, Gov	CMHC
Director	Policy maker 1,Gov	Mental Health Directorate
Psychologist	MH worker 3, Gov	Psychiatric hospital
Doctor	MH worker 4, Gov	Psychiatric hospital
Psychologist	MH worker 5, Gov	CMHC
Social Worker	MH worker 6, Gov	CMHC
Social Worker	MH worker 7, Gov	Psychiatric Hospital
Social Worker	MH worker 8, Gov	CMHC
Psychologist	MH worker 9, Gov	CMHC
Psychiatric Nurse	MH worker 10, Gov	CMHC
Psychiatric Nurse	MH worker 11, Gov	CMHC
Doctor	MH worker 12, Gov	Psychiatric hospital
Director	Policy maker 2, Gov	Mental Health Directorate
Director	Policy maker 3, Gov	Mental Health Directorate
Director	Policy maker 4, NGO	GCMHP
Doctor	MH worker 13, NGO	GCMHP
Psychologist	MH worker 14, NGO	GCMHP
Psychiatric Nurse	MH worker 15, NGO	GCMHP

4.5.2.3 Characteristics of the System

Participants from all groups provided their views on the existing mental health system in Gaza. The description of the mental health system took into consideration that the mental health system means all mental health services provided by the government, NGOs, and the private sector. There was strong agreement among all participants that the mental health system in Gaza has not been sufficient to respond to the population needs. The participants explained that the resources for mental health in Gaza are insufficient to respond to the needs, the services are fragmented between different sectors and there is role confusion among different service providers.

Resources versus Demands

Most participants, especially from the NGO sector, described the unequal balance between resources and mental health needs in Gaza as the dominant feature of the mental health system. The demands for mental health services are higher than the current resources in the mental health system and this gap between demands and resources increases over time:

> *The need for mental health services is increasing every day, but in contrast, there are no efforts to develop the mental health human power to meet this growing need. (MH worker 14, NGO)*

The reason for this increase in the gap between mental health needs and available resources is the political conflict in Gaza. This political conflict in Gaza adds more demand for mental health services despite the short-term interventions provided by

humanitarian oriented programmes for responding to the mental health and psychosocial needs:

> *Therefore, whatever programmes that got funding after the conflict, it is still extremely below the needs of the population in Gaza. (MH worker 13, NGO)*

Fragmentation of Service

Participants from both groups, the governmental sector and the NGO, emphasised the fact that mental health services are fragmented between two main sectors, the governmental sector and the NGOs. This fragmentation of services and resources hinders the efforts to define the characteristics of the mental health system in Gaza:

> *I can't see a well-defined structure of a mental health system in Gaza. The characteristics of this system are not clear to me. (MH worker 14, NGO)*

Some participants attributed the fragmentation of mental health services in Gaza to the absence of regulations and protocols for all mental health providers. The absence of unified protocols and legislations leaves every key actor to establish their own system of service provision and service development:

> *I believe that mental health services in Gaza are still fragmented. This needs clear regulations from the MoH that include regulation protocols for both governmental and NGOs services, in this case when we will bring them up together we will have an integrated picture. (MH worker 10, Gov)*

Other NGO workers attributed the problem of fragmentation of services to historical roots. The government services and NGOs have never agreed on an integrated vision and plan for developing the mental health services in Gaza. This is not new for the mental health system in Gaza. This has been the case for services in Gaza for a long time:

> *This basically happens because from the early beginning we did not have any plans or a real assessment of our needs; we used to work on an ad hoc manner without proper long-term planning. I think this part of the system's problem that it never has a clear vision or planning on longer-term development. (MH worker 15, NGO)*

Role Confusion

It became clear from the discussion with NGO participants that part of the problem of the mental health system in Gaza is that the NGO sector is not aware of what role they can play in contributing to the development of the mental health system. The picture they provided was that there are two separate systems at work in Gaza without identified roles and responsibilities. At least for the NGO workers, they stated clearly that they have no idea how they can contribute to the development of the system in Gaza:

> *The other important thing is that the relationship between us and the governmental mental health services is vague and not well established. I cannot know now where is the role of GCMHP and where is the role of the governmental sector in developing the mental health system in Gaza… where we can work together and how! (MH worker 14, NGO)*

Moreover, NGO participants emphasised the significant role of their organisation in introducing community-based mental health services in Gaza. They considered this role as a huge contribution to the development of mental health services in Gaza, however, they still believed that the development of the system, as a national undertaking, is still the role of the government and the contribution of any NGO is considered a minor responsibility:

> *I would argue that GCMHP has contributed substantially to the development of the mental health system since 1990 till now… but on the other hand, developing the system on the national level should be the MoH role. We would of course contribute to it but it is still the Ministry's responsibility as they are the main health services provider. (policy maker 4, NGO)*

This policy maker continued to place responsibility on the government to lead the mental health system in Gaza toward a more integrated one. The NGO would follow if the government decided to take this role:

> *The first one I blame in this is the MoH, as this should be their role and they have never taken it. We have started to notice the MoH attempt to take the leadership flag in this area only in the last five years, but before that the Ministry was completely absent. (policy maker 4, NGO)*

4.5.2.4 Policy Development

Lack of Awareness

The majority of the participants working in the public and NGO sector reported their lack of knowledge of the existing mental health policy. Some of them believed that this policy does not exist; others believed that it exists but it has no connection to reality:

> *No one of the mental health workers here has any idea on the existing policy and legislations. (MH worker 1, Gov)*

> *Hmm ... well, on the national level I always hear about the national mental health policy but I never saw a practical connection with this plan to our work. I think it is a pure theoretical thing that it does not have any role in organising the mental health services in Gaza. (MH worker 15, NGO)*

On the other hand, policy makers argued that mental health policy exists and they work according to this policy, unlike most of the mental health workers who revealed a lack of knowledge of this policy:

> *There are existing policies. We used to work on such policy since 2004. (policy maker 4, Gov)*

Participation

All mental health workers interviewed in this study, whether they work in the governmental sector or in the NGO, confirmed that they had not participated in any activity in developing the mental health policy. Mental health professionals were not

represented as professional groups. Persons who participated in those activities were representatives of their organisations and not of their professional groups or professional associations. Even representatives of NGOs who participated in such activities do not discuss such developments with professionals working in those organisations:

> *Professionals in general have not been invited as professional groups to participate in such activities in general. Who participated in developing such policies and legislation were representatives of organizations rather than representatives for professional bodies. (MH worker 14, NGO)*

4.5.2.5 Community Mental Health

Appropriateness

Mental health workers provided different views on the suitability of a community-based approach to the culture in Gaza. There was a debate between who believed that the community-based approach could be an appropriate model of care for mental health in Gaza, while other mental health workers doubted the suitability of the community-based model to the culture and social norms in Gaza.

Mental health workers who believed that a community-based approach is an appropriate model claimed that although this approach was developed in western countries, it suits the eastern countries more because the social connections and the role of family and extended family are strong enough to support community-based activities:

I believe that we are more qualified than western people to implement the community-based approach, as we are living in a community that promotes social support and the family in our community plays a key role in one's life and this impacts the social connectedness among all individuals in our community. (MH worker 1, Gov)

The family role was seen as an important one: the family provides good care for service users and this makes families key players in any care provided to service users and they can be a good support for community-based activities:

Also families here care a lot when one of their members get any psychological problems and they do not abandon them. (MH worker 2, Gov)

I can notice that families get very happy when the mental health professionals come to visit them. (MH worker 12, Gov)

Other mental health workers did not believe that a community-based approach is appropriate to the culture in Gaza. Those workers believed that a community-based approach was exported from western countries without adapting and standardising it to the culture in Gaza, and that is a big mistake because people in Gaza will not accept it:

I think some programmes that were developed in other cultures and exported to be implemented in Gaza do not suit our culture. (MH worker 5, Gov)

Other mental health workers still believed that stigma is the main reason why a community mental health approach cannot be appropriate to the culture in Gaza:

> *Stigma is still there in people's mind and still the main barrier that prevents people from receiving services. Even when they accept the mental illness, you face always problems in family cooperation in the treatment process. (MH worker 13, NGO)*

Coordination Challenges

The majority of mental health workers identified the lack of coordination between the governmental and NGO sectors as the most important challenge toward implementing a community mental health approach in Gaza. The lack of logistic and human resources makes it hard for any sector to implement community-based activities. Sharing of resources and expertise is required, and this coordination and sharing of resources is not implemented on the ground:

> *I think the coordination on the ground is purely personal efforts. We use our personal relationships with other organisations to cooperate on some tasks or to refer cases because there is no referral system in place. (MH worker 1, Gov)*

Participants provided many examples and interpretations explaining the lack of coordination. One of the surprising examples that was given by a governmental mental health worker was that NGOs sometimes refuse to coordinate or collaborate with the government because of a no contact policy they have:

I tried once to coordinate with an NGO and I did not repeat this again... this organisation refused to cooperate with me because I work for the government, they said we cannot work with you; we have a no contact policy with the government. (MH worker 2, Gov)

Lack of Resource

Governmental mental health workers identified a lack of logistical resources as one of the main challenges they face in implementing any community mental health activities. The most frequently mentioned logistical barriers were a lack of vehicles for transportation and other toolkits:

The car is scheduled to be used by our centre every 3-4 days, and for the use of all the team members, this is not enough... how can I plan for community activities and implement them according to this situation. (MH worker 8, Gov)

Community Resources

Despite all the challenges discussed by mental health workers for implementing community mental health services in Gaza, many mental health professionals believed that the community in Gaza has many useful resources that they can use for providing community-based care. The most important community resource identified by mental health workers is families. The family of service users can play a key role in providing community-based care as families in the culture in Gaza take care of their siblings when they have a mental health problem and they devote many resources to their siblings to get better:

Therefore the family role is crucial in our work for a proper implementation of such an approach. The service users should get their appropriate places inside their families and their society. (policy maker 3, Gov)

Moreover, mental health workers believed that mental health professionals are one of the most important resources for community mental health. Although there is a shortage of staff, there are many well-trained staff who can provide quality community mental health services if they are appropriately organised by the mental health administration:

We have good human resources although it is not used in a proper way. (MH worker 1, Gov)

4.5.2.6 Human Resources

Shortage

The majority of mental health professionals and policy makers from both groups agreed that the number of available mental health workers is insufficient to address the needs of mental health services. Although the staffing of governmental mental health centres has improved remarkably in the past two years of conducting these focus groups, there are still severe shortages of mental health workers in different fields; in particular, psychiatry is the main field suffering from a shortage of staff:

We have a severe shortage in the number of psychiatrists, there is a shortage also of social workers... but we have enough nurses and psychologists. (policy maker 3, Gov)

Policy makers are satisfied with the number of psychologists and nurses, because the medical approach to mental healthcare in the governmental sector needs less human resources. However, if services are implemented by a community-based approach, this number of staff would not be enough:

> *The number could be enough at the time being because the activities we are carrying out do not require high number of professionals… simply because most of the work load is on the psychiatrists. But when we will follow good standards of care we will need double of the available numbers. (MH worker 11, Gov)*

NGO workers addressed the severe shortage of staff in all fields, which prevents them from responding to the needs of the population:

> *Even in other fields like psychology, nursing, and social work, the shortage is still severe, the number of qualified mental health staff is very low compared to needs. (MH worker 14, NGO)*

The distribution of staff was another problem, as even when there is enough staff in a certain mental health field, the distribution of those workers is not equal:

> *There is some differences here... there is enough number of workers in certain professions although the distribution is not appropriate. (MH worker 1. Gov)*

Confusion of Roles

In addition to problems related to staff availability and distribution, most of the mental health workers complained that they lack clear protocols and policies to organise the work inside the centre and clarify their roles. Even when protocols are available, they are not implemented because of lack of monitoring. For example, the case management system is part of the operational policy, which organises the work of the CMHCs; however, the case management approach is not implemented in these centres:

> *Not really... we sometimes work according to case management system but not as complete case managers, this approach is applied partially. In most cases, the case manager is responsible of the service user's case and he consults others... but we do not work on the case as a team. (MH worker 1, Gov)*

Other mental health workers confirmed that the multidisciplinary teamwork is not activated in the CMHCs:

> *The multidisciplinary teamwork is not applied as I think. (MH worker 11, Gov)*

It was suggested that role clarity was no better for NGOs and a multidisciplinary team approach has created role confusion and the system is not supporting such teamwork:

> *We claim that we have multidisciplinary teamwork, but practically speaking, we have a serious overlapping of roles between mental health*

professionals and we do not have a real multidisciplinary team system. (MH worker 14, NGO)

Lack of Support

The most pressing problem that mental health workers face in their day-to-day work or in their professional development is the lack of support by the administration of mental health services. Problems varied from lack of logistic support to bureaucracy and lack of motivation:

We have no logistical facilitations for doing our community work e.g. transportation; this prevents us from going to the field and doing our work properly. (MH worker 5, Gov)

The bureaucracy of the administration procedures can also prevent workers from undertaking their work on time:

Moreover, the governmental bureaucracy is one of the key factors; there is a series of procedures and approvals you should get in order to carry out any kind of activity. (MH worker 1, Gov)

Mental health workers also felt that the administration did not provide them with the required motivation and encouragement for pursuing their professional development:

The system is not encouraging, we work hard but we do not get any re-enforcement from the system. (MH worker 7, Gov)

4.5.2.7 Role of Political Conflict

Negative Impact

Mental health workers evaluated the role of the ongoing political conflict in Gaza as having a negative impact on the development of mental health services in general. Governmental mental health workers, whether they are professionals or policy makers, attributed the negative impact of conflict on the development of the mental health system to many factors that the conflict has produced. For them, the state of conflict and its consequences has not affected the normal development of the public system only, it has contributed to decreasing the quality of services provided to victims of political conflict and led to a fragmented national mental health system:

> *Therefore, such post-emergency projects implemented by different NGOs hindered the development of a strong mental health system in the governmental sector because the specialties services were left to the governmental sector which increase its load on the one hand, with no complementary services provided by the NGOs one the other hand. (policy maker 3, Gov).*

NGO staff, whose responsibility is to support emergency response programmes, as they implement these types of projects, shared similar views on the negative impact of conflict on the development of the mental health system in general:

> *The political situation has affected severely the development of the mental health services; I can always see the negative impact of it. As you can see now many NGOs are running mental health and psychosocial projects*

without trained human resources and without good planning or coordination with other main players. (policy maker 4, NGO)

When mental health workers from both groups were asked why they thought that conflict has a negative role in the provision and development of mental health services, they provided several examples of the negative role of post-emergency projects. These examples are outlined as follows:

Duplication

One of the most explicit examples of the coordination problem that is caused by the tendency of several service providers to help people affected by the conflict is the duplication of services, as many organisations provide the same services to the same affected groups, while many other affected groups do not receive any services:

I remember here one of the families that I met after the war, they used to be seen by seven different organisations at the same time which impacted the whole family in negative way. (policy maker 2, Gov)

According to the participants, the reason for this duplication of services is the nature of emergency response projects based on agreement between donors and implementing agencies to provide a specific number of activities in a limited period. This makes many of the NGOs, which implement most of the emergency funded projects, rush to the field and implement their activities to demonstrate their visibility without taking into consideration the duplication of services that this might cause:

We used to notice that there were many organisations that used to focus on a certain geographical area while other affected areas were never visited by any of them. (MH worker 1, Gov)

In the crises times, the NGOs get very active and they try in any way to show their abilities to provide good services by providing the highest number of activities they can for the purposes of marketing their services to get the maximum donation they can. The target here is not to provide a good quality mental health services... rather it is to obtain the maximum donation they can. (MH worker 6, Gov).

This duplication of services and its consequences was not only reported by governmental workers, NGO workers shared the same concerns:

This duplication in providing the services, which happens every time we have crisis, proves that those short-term crisis response programmes have never contributed to the development of the system. On the contrary, they have contributed significantly to make this weak system even weaker. *(MH worker 15, NGO)*

Waste of Resources

Interestingly, NGO workers viewed the resources and financial support allocated for NGOs in providing mental health and psychosocial services in post-emergency settings in Gaza as a waste of resources. This financial support provided to NGOs

during the last 20 years could have established well-resourced and a very advanced mental health system in Gaza:

> *If we can roughly calculate the amount of money that has been spent on emergency mental health programs in the last 20 years, that money can establish a very well equipped and advanced mental health system in Gaza that can be a model for all mental health services in the whole area. (policy maker 4, NGO)*

According to the participants, these funds on many occasions were not spent on responding to the most pressing needs or assisting in establishing a strong mental health system:

> *On the other hand, sometimes there is a misuse of such funds by the implementing organisations. Perhaps sometimes lots of money go to psychosocial and mental health activities but such money is not utilised in a way that the system can get advantage of it. For example, sometimes money goes for irrelevant training or improper intervention... etc. (MH worker 13, NGO)*

It was suggested that the waste of those resources has affected the poorly resourced governmental mental health system by creating a better–resourced parallel mental health system led by NGOs. This parallel system has also contributed to impacting the service provision by injecting unqualified mental health practitioners into the field without appropriate training or monitoring:

But unfortunately, this money has not only failed to achieve this, but also it has contributed to weaken the already fragile mental health system by creating lots of pseudo-professionals and pseudo-mental health and psychosocial organisations. (MH worker 14, Gov)

Sustainability

Sustainability of development was one of the concerns that both government and NGO participants agreed upon. Most of the emergency funded programmes start immediately after the end of conflict and last for a limited period and then disappear. This applies to programmes, logistics and human resources:

Even there were some professionals who came from different countries to provide mental health and psychosocial services for the affected population. This caused duplication in service provision and inability for sustaining such services over the long-term because all those services stopped shortly after the first response to the crisis. (policy maker 3, Gov)

Moreover, international resources are not equally distributed to sustain the development of services, even among NGOs. The international funded programmes focus on training and capacity building and ignore any investment in infrastructure:

Therefore, the international support for developing the mental health system is not equally distributed; they focus on human resources and ignore any infra-structural development. (MH worker 1, Gov)

There were also main concerns related to the sustainability of mental health and psychosocial services provided by NGOs in Gaza. Such services were characterised as emergency and short-term oriented and NGOs do not make efforts to sustain those programmes over the long-term:

> *Also the Palestinian professionals/NGOs were very concerned in securing money and resources in any available way and they did not think of sustainable investment in the system over the long-term and this leads to a state of dependence and lack of professionalism, which leads to what we are in nowadays. I do not know if this is one of their priorities (talking about NGOs)... I believe that their priorities are to secure funds for their ongoing activities even if this is only over the short-term and under any kind of conditions that donors would imply. (policy maker 4, NGO)*

Role of Donors

All mental health workers agreed that donors play a key role in directing the investment in mental health in Gaza. Donors identify their areas of interests and most NGOs follow, as donors are their only support. This can lead to negative consequences as it emphasises the split between the governmental sector and NGOs:

> *The donors were always happy with the strategy of the short-term funding as it does not employ any long-term commitment on them and they can withdraw whenever they want and go to other fields/other areas. (MH worker 15, NGOs)*

Donors' political agenda also affects the development of the mental health system on many levels. As the international community was boycotting the government in Gaza, many donors stopped supporting the MoH and started investing in small NGOs on short-term projects:

> *Sometimes funding the psychosocial and mental health activities and programmes in Gaza is a subject of the donors' political agendas and priorities. For example, after the boycott on the de-facto government in Gaza, many donors tended to stop funding the MoH and sent money directly to those new NGOs. (MH worker 13, NGOs)*

> *I remember, we were trying to contact one NGO for doing some coordination with them and they resist strongly to cooperate with us because they were afraid if they do any kind of joint activities with the MoH they will lose their chances to get funds or this will affect their chances for continuing to receive funds from donors. (MH worker 1, Gov)*

Impact on Professionals

The existing political violence has its negative impact, not only on the service provision and development, but also on the mental health workers themselves. The impact of conflict and restriction of movement stopped many policy makers and mental health professionals from pursuing their career development and follow up-to-date evidence- based practice:

> *The effect of political violence did not only affect the accessibility to resources... it also affected personal development among mental health*

professionals and policy makers and their creativity toward change and reform. (policy maker 4, NGO)

Positive impact

A number of mental health workers emphasised the positive impact of conflict by underlining the role of political conflict in generating more mental health programmes to respond to the high needs for mental health interventions. According to them, political conflict can stimulate an ethical response by the international community that results in providing a humanitarian response to victims. Mental health interventions can benefit from such humanitarian donations:

In times of high scale crisis, there would be a general empathy from the international community with the affected populations. This leads to an increase in the services and support to such communities in order to help them overcome the consequences of their crisis. (policy maker 3, Gov)

Other mental health workers emphasised the role of humanitarian response projects in providing more training opportunities for mental health workers, as they organised training activities as a part of their implemented programmes. In addition, establishing more mental health and psychosocial programmes helped in combating stigma attached to mental health services:

I see most of those efforts were positive in terms of organising many training and capacity building activities so many mental health professionals benefited from this. (MH worker 1, Gov)

Furthermore, the ongoing nature of conflict and increased number of humanitarian response programmes have enhanced the community in Gaza to receive mental health services and therefore reduced the impact of stigma associated with mental health disorders. (MH worker 13, NGO)

4.5.2.8 Role of Non-Governmental Organizations

The NGOs, both international and national, have become a key provider of mental health services in Gaza in the past 25 years. Defining the role of NGOs in mental health service delivery and mental health service development is becoming problematic, taking into account the regulatory role of the MoH as the main provider of mental healthcare. This section will address some of those enquires by presenting both governmental and NGOs' workers views on the role of NGOs in the Palestinian mental health system.

Lack of Interaction

Governmental mental health workers did not have enough interaction and sharing of information with the NGOs working in Gaza. The information they provided about the NGOs working in mental health in Gaza was inconsistent and participants expressed a lack of knowledge and interaction:

We are not so much aware of what is going on in the NGOs. (MH worker 12, Gov)

Governmental mental health workers also provided conflicting views on the services provided by NGOs in Gaza. Some of them considered those services as different to services provided in the governmental sector:

> *The governmental organisations provide completely different services than the NGOs and the coordination between the two bodies is mostly non-existent (MH worker 10, Gov).*

While other workers did not see significant differences between the two systems:

> *The system does not differ a lot in the NGOs, they lack skills as well. (policy maker 2, Gov).*

For the model of providing mental health services in the NGOs, most of the governmental mental health workers perceived the services provided by the NGOs as less advanced than mental health services they provide in the governmental facilities and the majority of governmental workers considered those services as social services more than mental health services:

> *I do not think NGOs adopt a community-based approach to providing the service; most of the services they provide are education and training services and community awareness programmes. (MH worker1, Gov).*

> *Regarding the NGOs, they provide limited and less comprehensive services; some of them provide psychological support services while others provide rehabilitation services. (MH worker 6, Gov).*

A few other governmental health workers believed that NGOs still provide non-medical community-based services that are different to the governmental services:

> *We have to say that in the NGOs sector, there is some system for organising counselling and therapy sessions. (MH worker 9, Gov)*

> *What kind of therapy you are talking about... give me just one kind of therapy they do. (Policy maker 2, Gov)*

> *There is no system for therapeutic intervention... but they organise counselling sessions. (MH worker 9, Gov)*

NGO workers disagreed with the view that NGOs provide different services than the government and considered the presence of NGOs as a key leverage in promoting community mental health in Gaza. They provided the role of GCMHP as a model that the government is trying to replicate in implementing a community-based approach. Such an innovative model promoted the idea of a community-based model of care:

> *I would like to emphasise what my colleagues said on the innovative role of GCMHP in introducing community mental health services to the services provision in Gaza for both health and social organisations. (policy maker 4, NGOs)*

Moreover, the presence of NGOs can promote service development by enhancing competition between different service providers that can improve the quality of services provided:

Also the establishment of many other NGOs to provide psychosocial and mental health services has encouraged the competition between different service providers... this competition has contributed to develop more advanced mental health services... but still needs to go a long way to meet the mental health needs of the population in Gaza. (MH worker 13, NGO)

While governmental mental health workers did not consider NGOs as advanced as they are in providing mental health services, most of them agreed that they have a key role in providing mental health services in Gaza:

I think that the existence of NGOs could contribute positively to service provision for people who need these services. (MH worker 2, Gov)

Lack of Coordination

In terms of services development, most governmental mental health workers did not believe that NGOs could play a key role in service development while they fail to coordinate with the MoH:

But in terms of development, I believe that the lack of communication between both governmental and NGOs sector can hinder any future development for the mental health system in Gaza. (MH worker 2, Gov)

Governmental workers believed that such coordination is vital for the system development because any progress in developing services that needs a national consensus will need coordination between the two parties:

Laws and legislations need consensus from all key players in this field, this kind of consensus is difficult to obtain because each organisation has different objectives and different mandates and most of NGOs follow their donors' agendas. (policy maker 1, Gov)

However, the lack of coordination is still the main obstacle toward developing mental health in Gaza. The coordination problem has been addressed by both groups, but the views and reasons for the existence of the coordination problem varied between government and NGO staff. Governmental workers considered that the lack of coordination was the NGOs' fault:

Mostly, the communication between governmental and NGOs is non-existent because the NGOs often tend to keep the information and do not share it with the governmental sector. (MH worker 2, Gov)

Most NGO workers tended to claim that the responsibility lay with the government, as they are the main provider of care:

Officially speaking, yes we sit with the MoH and share in formatting policies and making decisions... but practically speaking, the MoH does not want to work with NGOs; they refuse any kind of cooperation. (policy maker 4, NGO)

4.5.2.9 Training Needs for Mental Health Professionals

This section explores how both mental health professionals and policy makers identify the top priorities training needs for mental health workers in general. The

views presented in this section reflect both assessment of personal needs and the perception of training needs for other mental health workers, from different professional groups.

> *We need training in specialised mental health interventions, we need training in cognitive behavioural therapy, family therapy, exposure therapy .. mental health workers need more clinical skills in one to one intervention. (policy maker 1, Gov)*

> *We live in a country where the crisis is recurrent, our staff are not skilful in providing crisis intervention care, they also are not prepared to deal with the consequences of trauma .. this should be the top training needs. (MH worker 1, Gov)*

> *Social workers are the less professionals groups who receive training, this is unfair. In the future, the priority for training should be for social workers. (MH worker 6, Gov)*

4.5.3 Service Users and Carers

4.5.3.1 Introduction

The findings of this section answer Research Question 5, presented in Chapter one: What are the service users' and their family members' (carers) views on: 1) current mental health services, 2) mental health reform, and 3) involving them in planning and implementing mental health services in Gaza?

This chapter section explores service users' and carers' views on their involvement in mental health service delivery and development in Gaza. The group discussion included both service users and carers together to enrich the discussion between group members. Participants were selected in a purposive manner to ensure the variety of all age groups, place of living, both genders and most of the common categories of mental disorders.

The focus group followed a flexible topic guide (Appendix Seven) that involved five main topics for discussion; inviting service users and carers to provide their views on mental health services provided, exploring the existing roles for service users and carers in the treatment process, service users' and carers' views on reforming mental health services in Gaza, the role of service users and carers in advocating for service users' and carers' rights and, finally, discussing the possibility of forming a partnership with mental health service providers and ways of promoting this partnership. Figure 4.4 shows the themes and sub-themes for the analysis of the focus group of service users and carers.

4.5.3.2 Participants

Participants were distributed across four focus groups, 6-7 participants in each focus group. Participants' names are not revealed in the presentation of findings and also during the discussion of findings. Instead, a code number is given to each participant for identification in presenting the findings. Table 4.13 shows participant demographic details, including identification codes.

4.5.3.3 Evaluation of Services

Dissatisfaction

Most service users and carers expressed their dissatisfaction with the services provided by the CMHCs in various ways. Some of the participants expressed their frustration, as the services provided by CMHCs do not meet their expectations. Some of the service users stopped going to the centre because of the poor treatment they received but they returned after their symptoms became worse:

> *I have not received proper treatment here, I had stopped coming to this centre in the past but I came back after a while. (carer 5)*

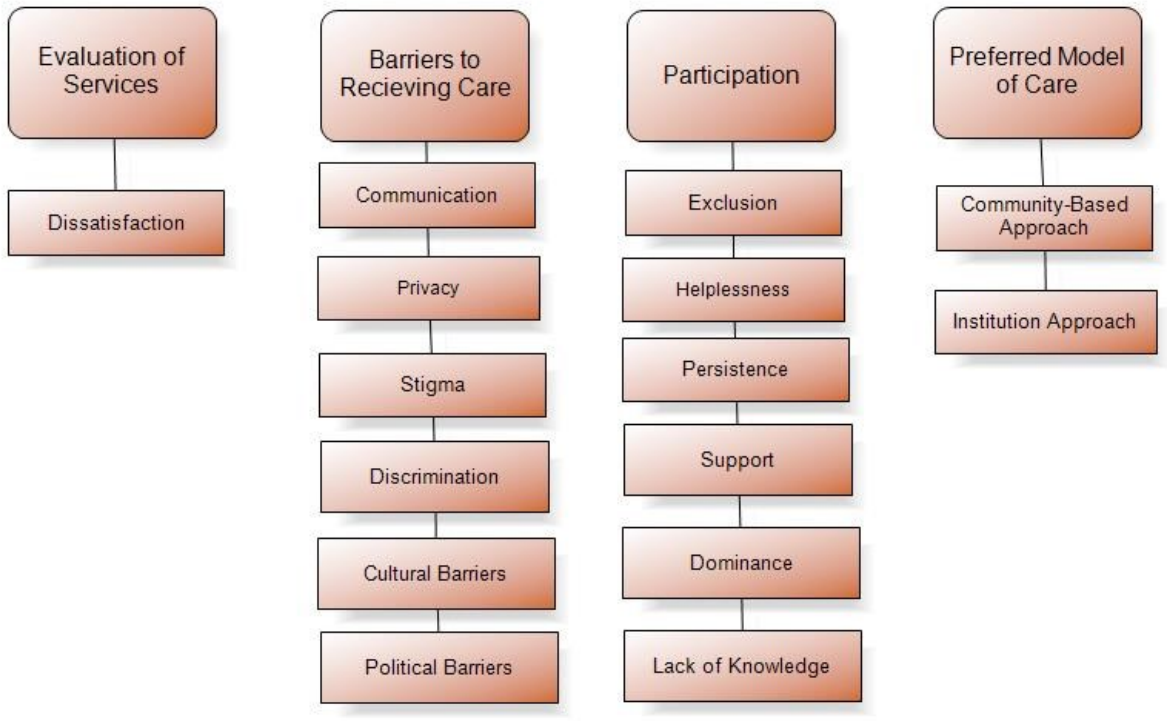

Figure 4.4 Themes and sub-themes for the focus group of service users and carers

Table 4.13 Service users' and carers' demographic details

Code	Category	Diagnosis	Place of living
Carer 1	Family member	Daughter- Schizophrenia	Gaza City
Carer 2	Family member	Sister- Bipolar disorder	Gaza City
SU 1	Service user	Schizophrenia	Gaza City
Carer 3	Family member	Sister- Schizophrenia	Gaza City
SU 2	Service user	Major depression	Gaza City
SU 3	Service user	Schizophrenia	Rafah
Carer 4	Family member	Husband- Schizophrenia	Rafah
SU 4	Service user	Stuttering	Rafah
Carer 5	Family member	Father- Conduct disorder	Rafah
Carer 6	Family member	Mother- Mood disorder	Rafah
Carer 7	Family member	Mother- Major depression	Rafah
SU 5	Service user	Major depression	Rafah
Carer 8	Family member	Daughter- Schizophrenia	Middle Area
Carer 9	Family member	Husband- Anxiety disorder	Middle Area
Carer 10	Family member	Daughter- Schizophrenia	Middle Area
Carer 11	Family member	Daughter- Autism	Middle Area
SU 6	Service user	Major depression	Middle Area
Carer 12	Family member	Mother- PTSD	Middle Area
SU 7	Service user	Schizophrenia	North Gaza
SU 8	Service user	Schizophrenia	North Gaza
SU 9	Service user	Schizophrenia	North Gaza
SU 10	Service user	Major depression	North Gaza
SU 11	Service user	Bipolar disorder	North Gaza
SU 12	Service user	Generalised anxiety disorder	North Gaza
Carer 13	Family member	Husband- Schizophrenia	North Gaza
Carer 14	Family member	Sister- Schizophrenia	North Gaza

Other participants indicated that they received the same pattern of care from the CMHCs all the time, however; they do not experience any progress in their recovery:

> *Whenever I want to take my daughter to the centre she refuses because she feels like she is not experiencing any progress. (carer 6)*

On the other hand, some of the service users and carers exhibited general satisfaction with the services and treatment provided by the CMHCs. The participants expressed their satisfaction by phrases such as:

> *Services here are good (carer 2), for us it is good so far (carer 7), I think the services here are okay. (SU 3)*

4.5.3.4 Barriers to Receiving Care

Service users and carers expressed their suffering resulting from lack of appropriate mental healthcare or the negative role the community played in discriminating service users that also prevented them from receiving appropriate mental healthcare. Because both kinds of barriers have their distinguishing characteristics, the views of service users and carers on clinical and community barriers are presented separately.

Communication

On the clinical level, the majority of service users and carers complained that a lack of appropriate communication between service users, carers and mental health professionals was the main obstacle in receiving mental healthcare inside the CMHCs. Service users expressed a great need for being listened to and receiving attention from their therapists:

> *As a patient I feel I need somebody to listen to me... to feel my pain... not to give me medication and go. I need some counsellor or psychologist to sit with and talk with about my problems... but this does not happen. (SU 1)*

Service users and carers expressed also their concerns on the time mental health professionals spend with them; this time was not enough for them to have a chance to speak with their therapists and express their feelings and suffering:

> *Doctors here see patients mostly for 5-10 minutes. This is absolutely not enough to understand the patient needs and suffering. (SU 2)*

> *I came on Thursday here to see the doctor... he did not listen to me... he just saw me and wrote my prescription... I did not even get the chance to speak to him. (SU 7)*

> *They just need to give us the time to listen to us... through this they can solve the problems of many patients. (SU 11)*

Privacy

Service users and carers identified a lack of privacy in the CMHCs when receiving mental healthcare as a top barrier for receiving appropriate mental healthcare. Service users emphasised the importance of having space so they can talk with their therapists about private issues that is lacking in most of the CMHCs.

The routine daily work in the CMHCs was described by service users as all service users having to queue outside the doctor's room and many times two or three service users are talking to the doctor at the same time. Furthermore, other mental health workers are present in the doctor's room and can listen to what service users tell their doctor:

The treatment here is very bad, we do not get any privacy, and all service users come to the doctor's room here where they sit with other nurses and sometimes cleaners. (SU 9)

Other service users and carers complained of placing the CMHCs in a PHC centre. Four out of six CMHCs in Gaza are located in PHC centres. Some service users perceived this as affecting their privacy as they do not want to be seen by other primary care patients who come to see the General Practitioners:

I have a problem with placing this community centre inside the primary care centre. We need a place for our own; we do not need to come here where we find lots of people who come to see the General Practitioner. (SU 7)

Stigma

Stigma and shame of receiving mental healthcare was identified by most service users and carers as a top barrier that affects the service users' willingness to receive mental healthcare and ultimately their recovery. The impact of stigma and shame of receiving mental healthcare affected service users and carers on different levels; service users and carers tend to keep the fact of receiving mental healthcare as a secret because they feel ashamed of revealing this to their close relatives and friends. Stigma prevents them from participating in many community-based activities and also stigma drives them to feel reluctant to receive home visits, as they do not want their surrounding neighbours to know that they receive mental healthcare.

Many service users and carers preferred to keep their journey with mental health services undisclosed. They believe that if people around them know about their mental health problems and that they receive care from mental health professionals, the whole family will be stigmatised and labelled as “crazy people”. Therefore, service users and family members create excuses so people around them will not know about their mental health problem:

> *When the mental health team came to visit us in our home all the neighbours asked me who are they and I told them they are my daughter’s colleagues at work... I cannot tell them that they are mental health team coming to look after my daughter. (carer 1)*

Moreover, many service users and carers expressed their concerns about participating in any activity that could expose them to the community as people with mental health problems:

> *If I go to the community and tell them about my illness they will label me as a “crazy person” ... no no I cannot do this to myself. (SU 1)*

Those service users and carers who reported their unwillingness to participate in such events expressed their concerns about the impact of such stigma on their family members, especially females who can be more affected by stigma than males. The gender issue has been raised by some service users and carers as a significant factor, as family members of female service users exhibited their inability to participate in advocacy activities because this would affect their female service users. This would not have the same impact if their sibling service users were males:

Hmm... no I think I will not be able to do that... I just cannot... you should understand that it is different for me because I am a mother of a female user, if it was my son who is sick I would think about that. (carer 6)

Surprisingly, many service users and family members expressed their concerns about having mental health workers visit them in their homes. Many service users in particular preferred to come to the CMHCs to receive mental healthcare. The reason for refusing the home visits was because of the fear of being seen by their neighbours and then being stigmatised as having mental health problems:

If the mental health team come to visit me at home and neighbours know that I receive mental health treatment... this would be a disaster. (SU 2)

For service users and carers, such home visits by mental health workers can affect the privacy of the whole family, as they will be labelled by the neighbourhood as a family with mental health problems:

For me I would prefer to come to the centre here rather than the team will come to my neighbourhood... I need to protect my privacy and the privacy of my family. (SU 7)

Moreover, many service users indicated that they are reluctant to visit CMHCs because they feel embarrassed to be seen by others and stigmatised by them as having mental health problems. Therefore, many service users tend to send one of their family members to collect the medication from CMHCs instead of going there themselves:

I send my wife sometimes to take the medication for me because I do not like to be seen coming here and receiving mental health services. (SU 2)

Discrimination

Service users and carers considered that the community in Gaza do not accept them and practise different levels of discrimination toward service users and carers. This discrimination was described by service users and carers by telling real life stories that illustrate different aspects of discrimination that service users and carers face. The main common patterns of discrimination that service users and carers described within the focus groups were summarised in three different ways. The community in Gaza do not accept service users and carers as part of the social fabric of the community, the community in Gaza do not promote social inclusion for service users by blocking work and training possibilities and, finally, the community does not promote social inclusion through blocking marriage possibilities for service users and their family members.

Most service users and carers perceived the community in Gaza as neglecting, refusing and disrespecting to service users and their family members. This discrimination of service users can be noticed on many levels by the day-to-day interaction with the community:

The society here does not respect people with mental health problems... they discriminate and humiliate them. (SU 12)

The impact of the community discrimination on service users and their family

members was clear, service users and carers considered the community's negative attitude as part of their problem and any initiatives for making them feel better should start by changing the community attitude toward them:

> *We need to treat the society first to accept us as mental health users. (SU 5)*

The community in Gaza blocks opportunities for work and rehabilitation for service users and sometimes their family members. Most employers tend not to recruit people who receive or have received mental health services, although they might possess the required skills for the job:

> *I am sure that the service users have such creativity and abilities... but they should give them the chance to demonstrate their abilities. (carer 12)*

> *Employers here do not encourage people with disabilities to work for them... on the contrary; they would avoid employing you only because you have a mental health problem or any kind of disability. (carer 13)*

Service users told many stories that described the extent of discrimination and exclusion from work and employment opportunities they faced personally. One of the service users described his experience with employers after he experienced a mental health problem:

> *I am a very skilful décor specialist but I do not get any work opportunities now because people think I am crazy. (SU 11)*

Another service user told her story about when she wanted to learn some handcrafting skills as a way to find a work opportunity:

> *I went once to a woman empowerment centre to learn some handcrafting skills. I was surprised that after few days they asked me to stop coming to the centre... I realised later that they did so because they heard that I was receiving mental health services. (SU 8)*

Furthermore, there were other kinds of social discrimination directed toward service users and their family members. The most pressing social discrimination discussed by service users and carers was the blocking of marriage opportunities. The community enforces some restrictions to get married to a person who has or used to have a mental disorder and most times the whole family is affected by this kind of social discrimination. As a result, people with mental health problems and their families do not get equal chances for marriage as other people who do not have mental health problems. Therefore, many service users keep their mental illness secret so his/her daughters and sisters will have a chance to get married:

> *I have my* daughters *who will become in the marriage age after a short while... nobody will come and ask my daughters for marriage if they know that I have a mental health problem and I receive mental health services. (SU 2)*

Cultural Barriers

Some service users and carers emphasised the role of cultural barriers in hindering the implementation of community-based services. Service users and carers

considered a community-based approach as a western-imported approach that is not appropriate for the culture in Gaza:

> *We are different than the west, in the west they have the concept of family doctor where the doctor can visit the family and deal with all health problems for all family members. We do not have such a system. (carer 11)*

Moreover, women are more restricted than men in engaging in activities that will be perceived as "culturally in-appropriate" by the community. Some service users and carers reported that involving female service users and female carers in any advocacy or community education activities can be perceived by the community as a "culturally in-appropriate" practice. As a result of implementing such activities, female service users and family members can be vulnerable to criticism and discrimination by the community:

> *No I cannot face the public... I am a woman… this means people will accuse me and my family. (SU 8)*

Political Barriers

Service users and family members emphasised the impact of political conflict in Gaza on different levels; such as service delivery, system development and adding more frustration and suffering to service users' and carers' lives. Carers and service users attributed the lack of medication in CMHCs to the current political situation, especially the siege that has been imposed on Gaza since July 2007:

We need also to take into account that services are linked with the political situation around... the availability of medication is linked with the siege imposed on Gaza. (carer 11)

Some service users indicated that due to the ongoing crisis situation in Gaza, people do not prioritise development of any field as they are overwhelmed by a crisis response:

We have a difficult political situation, we are in a siege since more than five years... people do not think of development here... everything is hard. (SU1)

4.5.3.5 Participation

Service users and carers provided different views on the current and potential role of service users in the treatment planning process. Most service users expressed their frustration of being excluded from playing any role in the treatment process and they also expressed their pessimism toward any potential possibility for playing any role. Most service users and carers felt that they are not given the chance to contribute to any stage of their treatment plans' development or to the development of mental health services and policies. The following paragraphs discuss reasons for service users' and carers' lack of participation in the treatment process.

Exclusion

It was clear that service users were not invited to participate in any activity related to the development of their care plans. This exclusion was exercised by both mental

health workers and sometimes family members of service users. Some carers expressed their negative views toward including service users in the treatment process and considered them as not qualified to take part in any decision making process. Such views were based on their personal experiences with their family members who have mental health problems, as they see the service users' role can be negative if they are included in the treatment process:

> *Service users cannot decide what is good and what is bad for them. (carer 11)*

> *No the patient has no role in the treatment process... as for my sister; she has no role and does not want to play any role in her treatment. (carer 2)*

The majority of service users and carers agreed that mental health workers do not consult them or support carers' and service users' participation in the treatment process. According to them, mental health workers do not ask service users for their opinion of their treatment plan. The only relationship between mental health workers and service users in CMHCs is prescribing medicines, and service users should accept this without discussion in most cases:

> *They will not accept this... they will not accept somebody to come and share with them their decisions. (SU 11)*

Similarly, mental health workers do not consult carers on any treatment plan. Mental health workers do not ask service users and their carers to sit together with mental

health workers to make decisions related to their treatment plan, although this is important for service users:

> *I would feel good if my family will sit with the doctor and share with him roles in my treatment process... it never happened here. (SU 12)*

This was also felt widely among carers who complained that they are not consulted and, therefore, they have no role in the treatment process:

> *But doctors here never consulted us on any treatment plan for my daughter... they just prescribe medication and go... no sessions and no home visits. (carer 8)*

Helplessness

Service users expressed their frustration and helplessness toward the current passive role they play in the treatment process. They also emphasised that the absence of the service users' role in the treatment process will continue if they are not empowered by mental health workers to play this role, mainly. All service users agreed that they play no role in their treatment process. They are all recipients to instructions they get either from their therapist or their caregivers. They are not consulted by their therapists at any stage of developing or evaluating their treatment plans:

> *Am here only as a receiver, I do not participate in any plans for my treatment. (SU 6)*

You ask if I can play a more important role... in order to do this I need someone to guide me... Otherwise I do not know what I can do. (SU 1)

Most importantly, some service users believed that their role is to take the medicines on time and to follow instruction. They did not know if they should be consulted by their therapist about their treatment options:

The patient role should be to take the medicines on time and implement the instructions that he receives from the therapist. (SU 4)

Moreover, this passive role for service users in the treatment process is expected to continue in the future unless there are substantial efforts by mental health workers and carers to educate service users on their possible role in the treatment process:

I have no role... I am a patient here, sometimes I am good and sometimes I feel terrible... they should tell us what to do. I cannot do this by myself... somebody should tell me what to do. (SU 8)

Persistence

In contrast, many service users and carers exhibited their willingness to participate in community-based activities to promote recovery from mental illness, whether this participation included advocacy activities or public education. Some service users and carers participating in this discussion emphasised their persistence and high motivation to participate in such activities that would expose them to the public despite the stigma they may face. Although service users and family members realised the potential community response to such activities, they prioritised the

service users' recovery over all other considerations:

> *We need to balance between the society stereotype toward mental illnesses and the interest of our patients. Getting our patients better by providing them the required treatment is more important than what people could say. (carer 10)*

Support

The emotional support carers provide to service users is seen by both service users and carers as an important role for carers in the treatment plan. Providing emotional care and understanding was seen as important for service users during their journey of recovery from mental illness. This support includes taking care of their emotional wellbeing and understanding their suffering:

> *Our role is to treat them with empathy and to take care of them and to understand what they are going through. (carer 2)*

> *Sometimes she is very depressed to the extent she does not want to leave the house, I keep supporting her to socialise and to go out for change like other girls of her age. (carer 6)*

Other carers perceived their role as providing financial support to service users as in most cases service users are unemployed and as they sometimes need to buy medicines from the private market:

> *I would also provide financial support to them because they do not have money at all. (carer 4)*

Most service users indicated that they feel more comfortable when their family members accompany them when they visit the CMHC. They feel empowered and not left alone to face the difficulty of the treatment process:

> *When my wife comes with me to the centre I feel more comfortable and do not feel alone.* (SU 10)

Dominance

A few carers and some service users considered service users were not eligible to participate in the development of the treatment plan and that this responsibility should be assigned to carers. Carers attributed this tendency to take over the role of service users to their belief that service users are vulnerable and cannot actively contribute to the development of their treatment plan:

> *I am taking over his role sometimes because of his condition. (carer 9)*

Other service users who participated in this discussion expressed their resentment of the tendency of carers to take their role in the treatment process, as they perceived it as imposed dominance:

> *I mostly cannot come here because my brother used to come to get the medication for me and he does not allow me to come. (SU 1)*

Lack of Knowledge

Some other carers reported that they do not know what role they can play in the treatment process as no one had educated them on the potential role of family members in the treatment process. They blamed mental health workers for excluding

them and keeping them unaware of the role that carers can play to help service users improve:

> *We, as family members, cannot identify how our role should be. This should come from the doctor, if they do not tell us what to do and how to do it, we will never know. (carer 14)*

4.5.3.6 Preferred Model of Care

Most service users and carers preferred the community-based approach as the model of providing mental healthcare to the institution-based approach.

Community-Based Approach

Most family members preferred receiving treatment at home or at CMHCs rather than sending their family members to the hospital to receive treatment. For them, being hospitalised is more stigmatising than receiving mental healthcare in the community:

> *For me I prefer that my daughter get her treatment in the house better than to be hospitalised. (carer 10)*

Despite the stigma of being visited by mental health teams that service users and carers expressed in earlier discussions, they emphasised the value of mental health professionals assessing the service user's conditions in their social context. This is important for a better evaluation of service users' situation that will help them to get better:

I see the community intervention as a key for all mental health professionals because they cannot understand the service users' condition if they do not visit them at home. (carer 12)

Institution Approach

Some family members and service users believed that there was a need for building more specialised mental health centres in Gaza, especially for people with severe mental illnesses. Carers who preferred establishing more long stay services attributed it to the need for specialised services for people with severe mental illnesses that they cannot take care of themselves nor can their families take care of them:

I would build a centre for patients like my sister, where they should stay and keep under treatment for sometimes where they learn how to take care of themselves and how to deal with their symptoms. (carer 2)

4.5.4 Common Themes

Figure 4.5 shows the themes and sub-themes of the analysis of common themes between policy makers and professionals' focus groups and the service users and carers' focus groups.

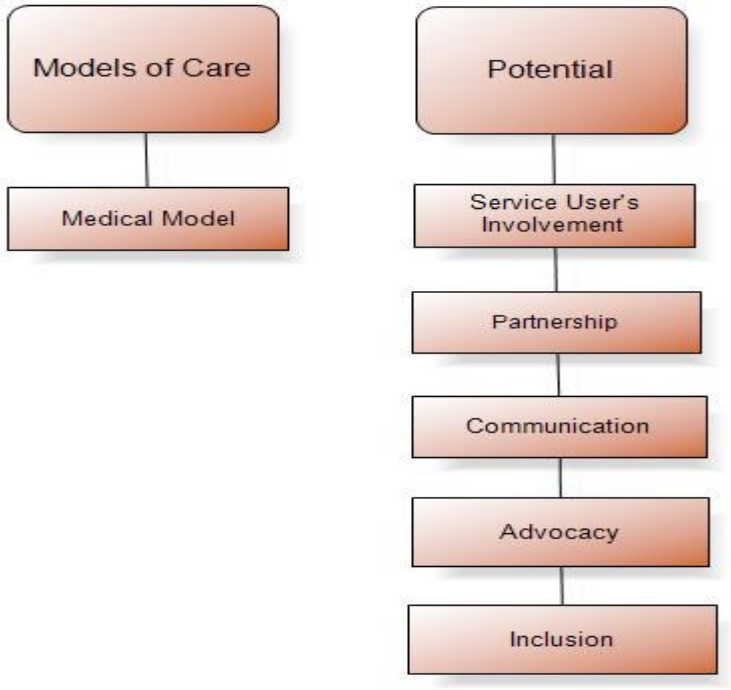

Figure 4.5 Common themes and subthemes

4.5.4.1 Models of Care

Medical Model

The definition of the model of mental healthcare in Gaza as a medical oriented model was a place for consensus by mental health professionals, policy makers, service users and carers:

> *The existing system in the community centres depends on the presence of specialists from all mental health professions and this gives the impression to the outside observer that the system is community-based mental health services. From the inside it is basically a medical oriented system than a community-based system. (MH worker 1, Gov)*

This has been also confirmed by the policy makers and by NGO participants, emphasising that the mental health services are provided through the medical model:

> *The work is based on the medical approach mostly, not less than 90% of services, and the percentage of community-based services is very little. (policy maker 2, Gov)*

> *The treatment given there is very medical and limited to the provision of medicines and sometimes without patient consent. (MH worker 15, NGO)*

Moreover, most service users and carers described the care provided in CMHCs as medically oriented services because they do not see doctors organise sessions, doctors only prescribe medicines to users:

> *I never saw a doctor sit with my daughter in a session. All what they do is to prescribe medicine and to renew it. (carer 8)*

Prescribing of medication became the only expectation service users and carers have from mental health workers:

> *The only relationship I have with the doctor here that he prescribes me my medication. (SU 9)*

Some participants, even though they admitted that most of the services are medically oriented, recognised efforts for implementing community-based programmes, although they are not the dominant model of care:

On the other hand we must acknowledge that there are some efforts here and there, I give an example of what we have done in the Nusseirat community centre, we have established some programmes and organised some home visits. (MH worker 1, Gov)

The dominance of a medical oriented model of mental healthcare in Gaza has been attributed to various factors. Participants in different focus groups identified the lack of core skills and competencies for implementing community-based activities among mental health workers as the key reason behind not adopting community-based services:

Further, there is a shortage of the professional skills that makes most of the workers avoid providing any community-based services. (policy maker 2, Gov)

Other participants attributed the reason for providing medically oriented services to the lack of basic resources that are needed for providing community-based activities:

The shortage of such logistic resources in terms of transportation and proper buildings and facilities are the main obstacle for the governmental sector to implement proper community-based programmes. (MH worker 6, Gov)

More interestingly, and in contrast with what service users reported, some mental health workers attributed the mental health workers' tendency to provide medical

oriented services to the service users' desire to take the medicine and expressed dislike of psychotherapy:

> *Service users themselves do not believe in talking therapy and that is why they tend to see the psychiatrists in order to get medication. (MH worker 10, Gov)*

4.5.4.2 Potential

Mental health workers provided suggestions for future planning to improve the implementation of community mental health services. The main suggestions offered were to improve coordination and find ways of dealing with stigma. Coordination and sharing of resources between the governmental sector and NGOs are key to improving the utilisation of services; without appropriate and effective coordination the fragmentation of services will continue:

> *The coordination here is a key. Different organisations should coordinate between each other to get the best of their resources. The work would become complementary between all main players with clear role distribution. We also need to continue building the capacity of other organisations so they could take part of this burden from our shoulders. (policy maker 1, Gov)*

Fighting stigma was highlighted as one of the important priorities for facilitating the acceptance of receiving community mental healthcare by service users and carers and by the community in general. There should be some alternatives such as finding

creative ways to deal with stigma in a way that ensures better access to services by service users and carers:

> *We have tried to overcome this by establishing a phone counselling service for people who cannot afford coming to our centres for any reason. This helps a lot. (MH worker 13, NGO)*

> *Just to add on this... I remember once at one of the women centres in one of the refugee camps. People have a high resistance toward family planning. So what happened is that they integrated family planning with psychosocial counselling with legal counselling and provided those services as a package in the centre, by the time people have started to accept the family planning services and their attitude has been changed toward family planning. (MH worker 15, NGO)*

Service Users' Involvement

Although service users and carers did not participate in activities related to policy development, the majority of mental health professionals and policy makers promoted the service users' and carers' participation in all activities related to policy development in the future. Also in all activities related to decision making:

> *As mental health workers; we should motivate service users and their families to actively participate in such activities. (MH worker 4, Gov)*

I support this… mental health workers should increase service users' and families' awareness of their rights and also by the family associations... they should be part of decision making. (MH worker 6, Gov)

It never happened. This is very important point as the service users and their families can be the best to evaluate the services provided by different organisations. (MH worker 14, NGO)

There were several reasons that explained why service users and carers did not participate in policy development although it is thought to be very important for them. Some mental health professionals believed that service users and carers never participated in any such activities simply because they have never been invited:

I think they have interest in this but nobody informed them of such activities. (policy maker 1, Gov)

Other mental health professionals believed that when the development of such a policy takes place, policy makers do not feel the need to invite either service users or carers or even mental health workers:

I believe that when mental health professionals have been asked to develop such policies, they do not feel there is a need to include service users and carers in the discussion. They consider themselves experts in identifying the service users' needs and priorities. This is an excuse for them to exclude service users and carers from such activities... they just do not feel they have to. (MH worker 6, Gov)

If mental health professionals are not included... you can imagine how service users and carers could be neglected. (MH worker 15, NGO)

However, most mental health workers agreed that the stigma attached to mental health is the main reason behind service users' reluctance to participate in such activities:

Some people find this participation useful and they feel they can play a good role in it and this will benefit them and their families. Others prefer not to participate because of the stigma issues. (MH worker 5, Gov)

I think this attitude came from the high stigma among service users and their families and also among the mental health workers themselves. (MH worker 2, Gov)

On the other hand, service users and carers provided practical suggestions that can improve the mental health services they receive in CMHCs to an acceptable level for them. These suggestions are:

Partnership

Partnership between service users, carers and mental health workers was the most frequent suggestion for improving mental health services. The partnership in providing mental health services within CMHCs, as shown in figure 4.6, includes the involvement of service users and carers in developing, implementing and evaluating treatment plans, by joint activities and sharing of opinion and information. The

possibility of implementing such a partnership was an issue for intense discussion. Some service users and carers believed that there is a chance for this partnership to take place:

> *Yes... there should be a potential for such partnership and I would definitely participate if they ask me to do. (carer 4)*

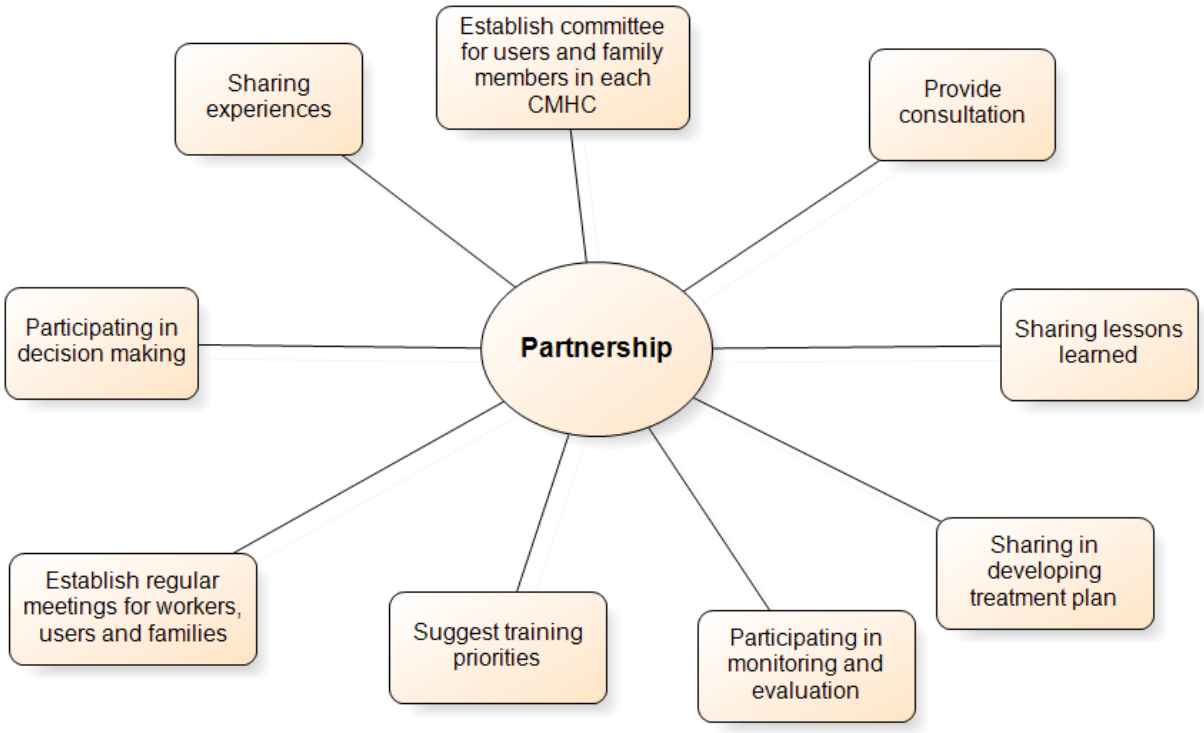

Figure 4.6 Suggested possibilities of the involvement of service users and carers

Other service users and carers did not see the possibility for this partnership to develop because mental health workers would not accept this partnership. It was felt that mental health workers would not allow carers and service users to share decision making with them because they feel they are more qualified to take such decisions:

They would not accept... they feel they are more educated than us. (SU 11)

On the other hand, service users and carers believed that this partnership would benefit service users and providers. Mental health workers can use this partnership to understand practical lessons from the lived experiences service users and carers developed with mental health interventions:

Of course they will... this is for their advantage... they will learn a lot from me and from service users and their families. (carer 5)

Therefore, service users and carers suggested different methods of partnership and collaboration between service users and carers and mental health workers and policy makers.

Communication

Most service users and carers addressed the need for improving communication with mental health workers as a substantial step toward improving the services provided by the CMHCs. They defined improving communication by showing more respect for service users and carers, increasing time spent with service users and carers and organising more therapy sessions for users:

If I will be a responsible person one day, the first thing I will do is that I will make sure that health professionals treat mentally-ill patients with respect. (SU 11)

The service user should sit with his doctor for enough time... the service user will feel he is respected. (SU 9)

Service users and carers suggested that mental health workers should improve the frequency and quality of the therapy sessions, which enables service users to spend adequate time with their therapists:

The second thing that I will enforce is conducting at least one session every 15 days in order to check how things are going with service users and how they are responding to treatment. (carer 8)

Advocacy

Most services users and carers valued highly the role of community education and advocacy for improving the services and living conditions for service users. There was a common feeling that no one takes the service users' and carers' voice to decision makers in the government or even to the policy makers in the community. Therefore, there should be particular attention given to increasing and emphasising advocacy and community education activities to improve the services provided to service users and carers:

They should take our voice higher to the Ministry and tell them about our needs and demands. (carer 1)

If they teach children from early childhood what are the human rights for people with mental health problems... this will solve the whole problem. (SU 11)

Inclusion

Both service users and carers believed that service users would not recover if they are excluded from work or training opportunities. In order to recover from their mental health problems, they need to feel reintegrated into their communities. This reintegration cannot happen without having real opportunities for work and training:

> *For example my daughter has schizophrenia and she graduated from the university with a very good average... they should support her and assist her in getting some work so she feels she is equal to other normal people. What is the benefit of taking medication and staying at home? (SU 1)*

4.6 Summary

The results of the WHO-AIMS questionnaire and the documentary analysis for the mental health policy and plan provided a comprehensive overview of the mental health system in Gaza. This analysis emphasised significant gaps in developing the mental health policy and plan. In addition, the WHO-AIMS analysis revealed poor funding of mental health services, a lack of skilled mental health workers and unequal distribution of human resources.

The analysis of the self-perceived competence level of mental health professionals revealed an urgent need for training on treatment modalities and disaster management, especially for medical doctors and social workers. Moreover, the postgraduate training was perceived as the most effective method for mental health training in Gaza.

The analysis of the health professionals' focus group findings revealed the mental health system failure to transform mental health services into community-based care. Moreover, the conflict in Gaza has a negative impact on reforming mental health services by enhancing the fragmentation of services, and creating a lack of coordination and a waste of resources. The analysis of the service users' and carers' focus groups demonstrated a total exclusion of service users in all mental health activities in Gaza, including participation in their care plans. The findings established the potential for effective service users' and carers' participation in mental health services development, suggesting various ways of forming partnerships between service users, carers and mental health professionals.

By using a mixed methods approach, the study has provided a comprehensive investigation of the mental health system in Gaza. The analysis of the results included information obtained from a policy level, and a clinical and community level. All mental health stakeholders provided their comprehensive views in this study.

A discussion of the statistical results and qualitative findings reported in this chapter is presented in Chapter five. The triangulation of the findings and their contribution to theory and practice, are also presented in that chapter.

CHAPTER FIVE: DISCUSSION

This chapter begins with a brief introduction to the research area and research problem, and provides an overview on the purpose of the current study and the methods used. This chapter then discusses in detail the overall study findings within the context of the literature presented in Chapter two, and in comparison to the findings of similar research. The clinical and practical implications of the study are then presented. In addition, the key contributions of this study to the body of knowledge about developing mental health services in areas of conflict and in low and middle-income countries (LMICs) are highlighted. Finally, the strengths and weaknesses of the study are discussed and ideas are suggested for further research, followed by study conclusions and key recommendations.

5.1 Introduction

Mental health service development in LMICs in general and specifically in countries affected by conflict situations are growing areas of research. Indeed, much effort has been directed towards calling for the scaling up of mental health services in LMICs (WHO, 2008c), as well as attempts to regulate mental health service delivery and development in post-conflict areas (IASC, 2007). However, mental health services in many post-conflict and emergency affected countries remain fragmented and inadequately resourced (Patel, 2007).

Low-resourced countries affected by conflict reported an added burden resulting from the increased prevalence of mental disorders (Mollica et al., 2004), demonstrating the importance of this study in researching ways to reform mental health services in

those areas. One response to this conflict is an increase in humanitarian assistance that includes the provision of psychosocial and mental health services (WHO, 2013). However, most of those humanitarian resources are not directed towards the longer-term development of the mental health system (Tol et al., 2011). Therefore, the philosophy of short-term humanitarian relief projects for mental health intervention needs to be revisited by policy makers and donors. This study contributes to the existing knowledge of how to develop mental health services in low resource and post-conflict areas by suggesting new ways of improving the organisation and utilisation of available resources that meet the four principles of the "Right to Health" approach, which are availability, accessibility, acceptability, and quality (UNOHCHR, 2000).

Although the involvement of service users and carers in the research and development of mental health services involves many challenges (Tait and Lester, 2005), the advantages of their involvement have been shown to be beneficial (Richter et al., 2009; Simpson and House, 2003). However, the involvement of service users and carers in the development, provision, and evaluation of mental health services in LMICs and post-conflict areas is not well explored. The current study demonstrated that service users and carers could provide essential expert opinion on existing mental health services and offered suggestions for improvement (Richter et al., 2009). Although service users' and carers' involvement in healthcare is not yet official policy in Gaza, service users and carers provided important views and insightful suggestions in the current study that could lead to a better

understanding in how to reform mental health services in Gaza, findings which may be transferable to other post-conflict areas and LMICs

5.2 The Main Purposes of the Study

The current study had two main purposes. The first was to describe the existing mental health system in Gaza as an area of conflict in terms of policy and service provision and to identify ways of improving mental health services. The second purpose was to use the findings of the study to provide useful suggestions to policy makers and service providers in a post-conflict area like Gaza on how to reform mental health services that will be more responsive to the needs of service users and carers, acceptable to practitioners and policy makers, and sustainable in the long-term. This study is unique, as it assesses and explores those areas in a population and country that are often overlooked in research on mental health topics, and adds to previous studies of mental health reform, thereby advancing the knowledge of the global mental health field.

The current study involved a comprehensive investigation and exploration of reforming mental health services in Gaza as an example of a post-conflict area and as a LMIC. One of the major strengths of the current study is that the triangulation of findings, generated by the mix of qualitative and quantitative methods (Creswell and Plano Clark, 2011; Denzin, 1970), provided the opportunity to compare findings from different tools and therefore to explore emerging common themes for suggested development as well as an exploration of similarities and contradictions from the focus groups with policy makers, healthcare professions, service users and carers.

The mixed methods used in the current study thus enabled a broader view on the barriers and possible solutions to improving mental health services in Gaza.

5.3 Triangulation and Interpretation of Findings

The triangulation of findings followed an a priori design, a convergent mixed method approach, which allowed the integration of data from different research methods (Creswell and Plano Clark, 2011; Denzin, 1970). According to this design, illustrated in Figure 5.1, each research question was answered by integrating and comparing qualitative and quantitative data from more than one research method, as the data collection plan supported gathering data from different resources to answer each research question. As well as drawing on the analytical framework (UNOHCHR, 2000) to guide the data analysis, the triangulation of quantitative results and qualitative findings allowed me to enhance the trustworthiness of the research study by establishing the credibility and confirmability of the findings (Krefting, 1991; LincoIn and Guba, 1985).

5.3.1 The Existing Mental Health Approach in Gaza

The interpretation of the findings in this section answers the first and second research questions, presented in Chapter one:

1. What are the current characteristics of the mental health system in Gaza in relation to policy development, service development and delivery, and availability of human resources?

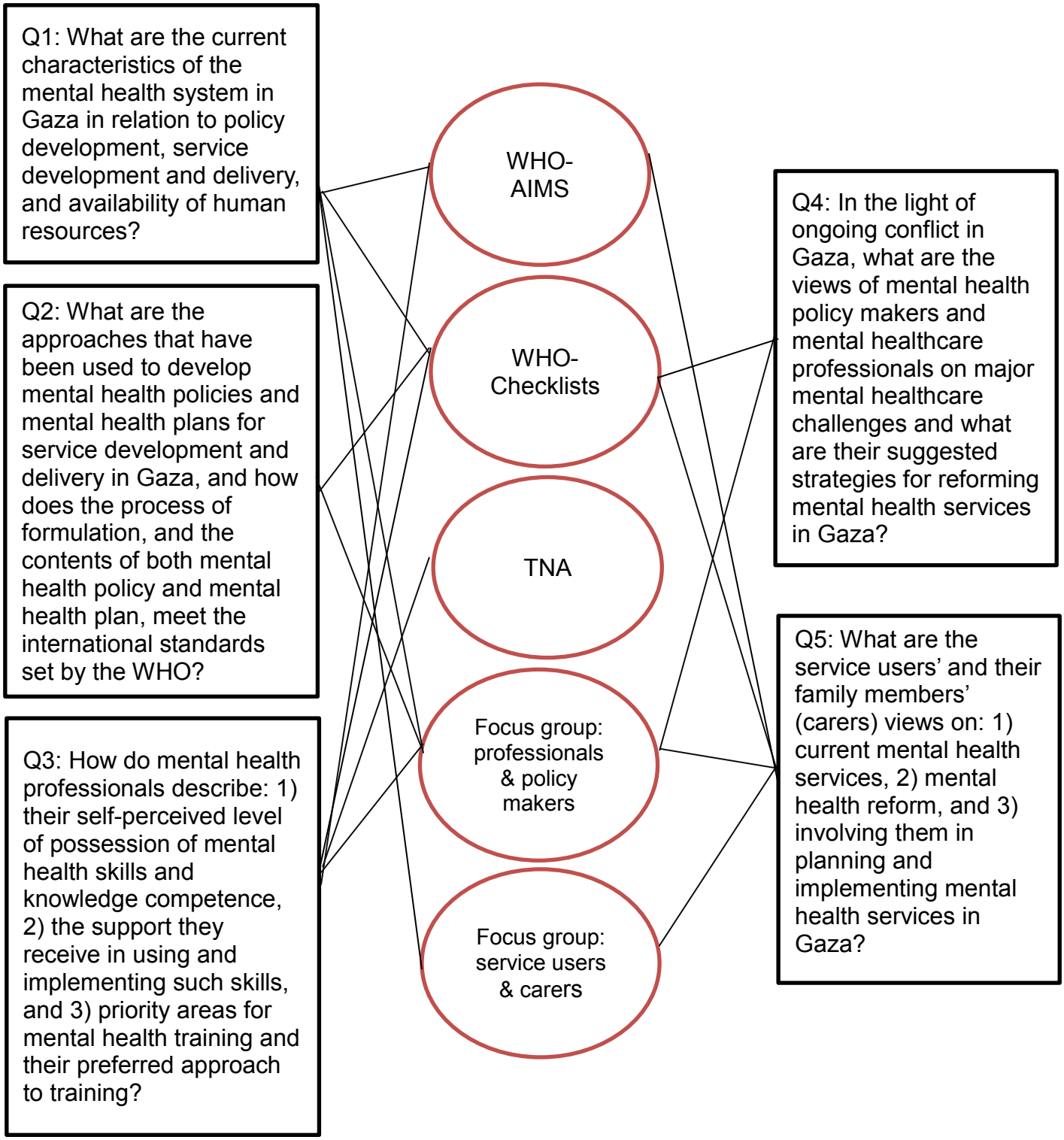

Figure 5.1 Triangulation design for the collection and analysis of mixed methods study findings

2. What are the approaches that have been used to develop mental health policies and mental health plans for service development and delivery in Gaza, and how does the process of formulation, and the contents of both mental health policy and mental health plan, meet the international standards set by the WHO?

5.3.1.1 Policy Development

The documentary analysis, using the WHO checklists (WHO, 2009) to guide the assessment of the mental health policy and plan, revealed that the development of mental health policy and mental health plan confirmed the Ministry of Health's (MoH) intention to organise mental health services to be more community-based, in line with WHO recommendations (WHO, 2001), although no evidence was found of an intention to close the mental hospital (Research Question 2).

The development of the mental health policy in 2004 helped the MoH to put mental health onto the health reform agenda and also to acquire support from international organisations (Patel et al., 2011), such as the WHO, to the development of mental health services in Palestine (WHO, 2004b). The role of policy development in improving mental healthcare is also evident in other low income countries, such as Zanzibar, where the policy facilitated the participation of key mental health stakeholders, which supported an effective use of the scarce resources in the country (Jenkins et al., 2011b). Similarly, the policy development in Kenya was effective in contributing to the long-term improvement of the mental health system, as it allowed the integration of mental healthcare into different levels of health services and

promoted collaboration among other social and education sectors (Kiima and Jenkins, 2010).

Regarding process issues, findings from the WHO Checklists (WHO, 2009) revealed that although both the mental health policy and plan were developed by a high mandated national committee, which involved key ministerial focal points and representatives of many other mental health stakeholders, other key stakeholders, such as family and user associations and the Ministry of Finance, did not participate (Research Question 2).

The findings revealed a lack of participation of service users and carers in policy development. This essential gap can adversely impact upon the effective implementation of the policy because it affects the acceptability of service development by such important stakeholders, according to the “Right to Health” model (UNOHCHR, 2000). In addition, service user experience of recovering from mental health problems is an important resource for helping to improve mental health systems and service redesign (Tait and Lester, 2005). However, the findings of the WHO-AIMS questionnaire (WHO, 2005a) in other LMICs, such as Ghana, suggest that service users and carers can be active participants in policy development and in advocacy (Roberts, et al., 2014).

This study’s findings on the lack of participation of key stakeholders in developing mental health policy and plans are consistent with Omar et al. (2010). Omar et al. (2010) reviewed the development and implementation of mental health policies in

Ghana, South Africa, Uganda and Zambia and found that the implementation of mental health policies was not effective in the four countries studied. For example, one of the main gaps in developing those policies was the exclusion of service users and limiting the participation and consultation to senior national health staff (Omar et al., 2010). However, the authors used semi-structured interviews with purposively selected participants, and a specific conceptual model, which was based on a framework approach for analysing the qualitative findings of the study, rather than the WHO-Checklists (WHO, 2009) that were used in the current study.

5.3.1.2 Structure of the Services

The results from the WHO-AIMS questionnaire (WHO, 2005a) on the structure of mental health services (Saymah et al., 2015), suggested a progressive transition of mental healthcare toward more community-based services (Research Question 1). This trend was supported by the decrease in the number of beds in the only mental hospital and the provision of mental healthcare within seven CMHCs distributed in all districts in Gaza. This noticeable trend meets the accessibility principle in the "Right to Health" approach (UNOHCHR, 2000). However, although the number of beds in the mental hospital had decreased, the hospital still consumed a large portion of the mental health budget and also a high number of mental health staff, which would affect the quality of services according to the "Right to Health" approach (UNOHCHR, 2000).

Furthermore, children who represent a majority of the Palestinian population in Gaza (Palestinian Central Bureau of Statistics, 2011) received inadequate attention from

mental health services, compared to adults. The WHO-AIMS questionnaire (WHO, 2005a) reported only one community mental health centre that specialised in providing mental healthcare to children and adolescents. According to the WHO-AIMS questionnaire (WHO, 2005a), counselling services are provided in schools by psychosocial counsellors. However, the presence of only one centre is insufficient to respond to the need for specialised mental health services for children and adolescents in Gaza.

The same inadequate attention to child and adolescent mental healthcare is evident in other LMICs, such as Ghana (Roberts et al., 2014), Uganda (Kigozi et al., 2010), and Brazil (Mateus et al., 2008). An assessment of the mental health system in Ghana, using the WHO-AIMS questionnaire (WHO, 2005a), revealed the low provision of child and adolescent care in mental hospitals (Roberts et al., 2014). Only 15 beds were dedicated to children and adolescents located at one of the three mental hospitals in Ghana, while there was no dedicated services for children and adolescents in outpatient services (Roberts et al., 2014). Similarly, an assessment using the same questionnaire revealed that there was an absence of specialised child and adolescent mental health services in Uganda (Kigozi et al., 2010), where children and adolescents were treated alongside adults. Mateus et al. (2008), also using the WHO-AIMS questionnaire (WHO, 2005a), identified a shortage of child psychiatrists in their assessment of Brazil's mental health system.

The identified biased distribution of resources towards a mental hospital, identified in the WHO-AIMS questionnaire (WHO, 2005a) assessment, is commonly found in

most LMICs: for example, the funding directed towards mental hospitals is 88% in Ghana (Ofori-Atta et al., 2010), 55% in Uganda (Kigozi et al., 2010) and 67% in the whole world (Morris et al., 2012). Both the Ofori-Atta et al. (2010) and Kigozi et al. (2010) studies used the WHO-AIMS questionnaire (WHO, 2005a) to estimate the percentage of funding directed to mental hospitals in Ghana and Uganda, while the global projection was derived from the WHO's Mental Health Atlas Project for 2011 (WHO, 2011b) that represents the average spending on mental hospitals in 184 countries in the world.

Despite the documentary analysis of the mental health policy and plan revealing a clear tendency by the MoH to organise mental health services towards more integrated community-based care, the focus group analysis revealed that most policy makers, mental health professionals, services users and carers defined mental health services in Gaza as medically oriented (Research Question 1). This view is consistent with a previous description of mental health services in Gaza, in 2001, as institution-based mental health services that were centred on medical services and provided by a mental hospital (Afana et al., 2004). The Afana et al. (2004) conclusion was based on interviewing key mental health and psychosocial stakeholders in Gaza. After ten years, the description of services remains the same, although many community centres have been established and the mental hospital downsized, in line with WHO recommendations (WHO, 2001).

The documentary analysis (WHO checklists, (WHO, 2009)) revealed a clear distinction between policy and implementation levels in Gaza (Research Question 2).

Although both the mental health policy and mental health plan's committees were established to take into consideration the representation of the main stakeholders, this representation was limited to policy and decision makers. All mental health professionals who were involved in the focus groups did not participate in, or were not consulted on, any activities related to the development of either the mental health policy or the mental health plan. This lack of service providers' participation can affect the ownership and implementation of the mental health policy and plan that would affect the acceptability and quality of the mental health policy according to the principles of the "Right to Health" approach (UNOHCHR, 2000). The assessment of the mental health policy development in South Africa, by implementing the WHO-AIMS questionnaire (WHO, 2005a) and the WHO-Checklists (WHO, 2009), as well as semi-structured interviews, revealed that one of the reasons for ineffective implementation of the national mental health policy was the exclusion of service providers in different provinces that affected the dissemination and the implementation of the policy (Draper et al., 2009).

5.3.1.3 Service Provision

The fragmentation of mental health services between the governmental and NGOs' services was one of the main characteristics of the mental health services in Gaza (Research Question 1) as described in the health professionals' focus groups. Although the findings of the WHO-AIMS questionnaire (WHO, 2005a) revealed a shortage of resources for mental health services, commonly found in other LMICs (Kigozi et al., 2010; Ofori-Atta et al., 2010; Roberts et al., 2014), the utilisation of the scarcely available resources in Gaza was not well coordinated between the

governmental services and NGOs. These findings confirm the theoretical discussion by Knapp et al. (2006) on economic barriers to acceptable mental health services in LMICs, in which the services in Palestine were described as fragmented. The fragmentation of services between governmental services and NGOs is common in other LMICs (Jenkins et al., 2011a). It is suggested that this organisational weakness has an impact upon a national mental health system if resources are wasted by short-term projects (Jenkins et al., 2011a); a conclusion based on a literature review analysis of the mental health and global development agenda.

The study findings from both the health professionals' and service users' focus groups suggested that implementing a community mental health approach to care could be appropriate in Gaza. It is essential that mental health intervention approaches are suited to the culture in Gaza to ensure their acceptability by people who utilise them, according to the principles of the "Right to Health" model (UNOHCHR, 2000). Although some mental health professionals, service users and carers challenged the sensitivity of a community-based approach, because it was imported from western countries, the majority of them considered that the successful implementation of the community-based approach in Gaza would be possible because the social connections and the role of the family are influential in Gaza. This is because family and community members can support the efforts of mental health workers in implementing community-based interventions.

The debate about the suitability of implementing a community-based approach to healthcare is comparable to another LMIC (Alem et al., 2008). Alem et al. (2008)

investigated the views of a group of purposively selected, highly qualified health professionals in Sub-Saharan Africa by a questionnaire that was developed to assess the readiness toward a community-based approach in mental healthcare. It was found that the healthcare professionals in Sub-Saharan Africa valued the consistency of community-based approaches with principles of care provision, but they emphasised the need to revise the community-based approach to be more sensitive to the culture in Africa, to ensure a smoother implementation of mental health services. The findings of the Alem et al. (2008) study, although confirming the findings of the current study, were based only on the views of selected service providers, while the findings of the current study were based on the views of service providers and services users, who are best placed to judge the suitability of services provided to them (Tait and Lester, 2005).

5.3.1.4 Availability of Human Resources

The findings from the WHO-AIMS questionnaire (WHO, 2005a) revealed that the number of mental health workers in Gaza is low compared to other LMICs (Kakuma et al., 2011; Mateus et al., 2008), although there was a substantial increase in the number of mental health workers in the two years preceding the implementation of the study (Research Question 1). The number of psychiatrists was particularly low, taking into account that psychiatrists are the key mental health service provider in a system dependent upon a biomedical approach to care. The MoH addressed this shortage by depending on medical doctors, who are not specialised in psychiatry, to replace the psychiatrists' role in many facilities. A shortage of appropriately trained mental health professionals may result in under or over-diagnosis, and consequently

unmet need. A sufficient number of appropriately trained mental health staff is essential to meet the availability and quality principle, according to the "Right to Health" approach (UNOHCHR, 2000).

The number of human resources in Gaza is comparable to many African and southeast Asian countries (Jacob et al., 2007). Furthermore, although the size of the mental health workforce in Gaza is higher than in a low income country like Uganda (Kigozi et al., 2010), it is considerably lower than the number of other middle income countries like Brazil (Mateus et al., 2008) and Vietnam (Kakuma et al., 2011). The current study's findings add to the findings of previous studies by comparing the availability of human resources in Gaza to the number of mental health professionals in other LMICs; all of those studies conducted in Uganda, Brazil and Vietnam used the WHO-AIMS questionnaire (WHO, 2005a) to assess the availability of mental health human resources.

Furthermore, policy makers and mental health professionals who participated in the focus groups confirmed the WHO-AIMS (WHO, 2005a) findings on the severe shortage of mental health human resources. They agreed with each other that there was a shortage of mental health staff, and felt that this severe shortage of human resources significantly affected the effective delivery of mental health services. Even if mental healthcare was integrated into primary healthcare, or school counsellors were assigned to manage mental health problems, the number of available mental health workers would not be enough to provide training and supervision for other healthcare staff and social workers who are not specialised in mental health (Eaton

et al., 2011). The lack of appropriate training and supervision would affect the quality of mental health services according to the “Right to Health” approach (UNOHCHR, 2000). Furthermore, the shortage of skilled mental health staff has been acknowledged as one of the main barriers to mental health service reform (Eaton et al., 2011; Saraceno et al., 2007). However, as indicated by the assessment using the WHO-Checklists of the Mental Health Plan in the current study, the MoH did attempt to address the shortage of human resources in the mental health plan by prioritising strategies for improving the availability of skilled mental health workers, although no mechanisms for this area of action were mentioned.

The WHO-checklist (WHO, 2009) assessment of the mental health plan also identified the minimum number of required human resources in all categories, although the number identified was considerably lower than the estimated target number of mental health human resources in Jordan or Egypt (Bruckner et al., 2011). Both countries are LMICs and similar to Gaza geographically and culturally. The target number of mental health workers in the Bruckner et al. (2011) study was estimated based on the WHO-AIMS questionnaire (WHO, 2005a) findings in 58 LMICs and the estimated burden of the main eight mental disorders prioritised by the Mental Health Gap Action Programme (WHO, 2008c), whose main objectives are to encourage mental health stakeholders to increase financial and human resources, particularly in LMICs.

5.3.2 Training Needs for mental Health Professionals

The interpretation of the findings in this section answers the third research question, presented in Chapter one: “How do mental health professionals describe: 1) their self-perceived level of possession of mental health skills and knowledge competence, 2) the support they receive in using and implementing such skills, and 3) priority areas for mental health training and their preferred approach to training?

The training needs of mental health workers in Gaza were assessed using a comprehensive assessment tool, developed specifically for this study, the Training Needs Analysis (TNA) questionnaire. Data from the WHO-AIMS questionnaire (WHO, 2005a), the WHO-Checklists (WHO, 2009), and findings from the focus groups with mental health professionals and policy makers also contribute to answering Research Question 3. Training needs were assessed quantitatively by identifying the perceived lowest confidence level in practising the core competencies for mental health, and qualitatively by what mental health workers identified as their top training priorities in response to open ended questions and by analysing the findings of the focus groups with mental health professionals and policy makers.

Findings from the TNA measure and the focus groups were consistent with each other, revealing that mental health workers needed further training in critical areas, such as disaster management and treatment modalities. The availability of well-trained health professionals is essential to improving the availability to health services as well as delivering appropriate mental health care, in line with the “Right to Health” approach (UNOHCHR, 2000) principles of accessibility and quality.

Although Gaza is a post-conflict area, the assessment of training needs revealed that treatment modalities and skills for providing crisis intervention and formulating crisis intervention plans (referred to as disaster management in Chapter four) were the top training needs for mental health workers in Gaza. The identification of crisis intervention as one of the top training priorities can be explained by the frequent demand for crisis intervention services because of the ongoing political conflict in Gaza.

The study findings are inconsistent, however, with the identified training needs for mental health workers in another LMIC (Kutcher et al., 2005). Kutcher et al. (2005) developed a competence-based mental health model for health professional training in LMICs and suggested that acute care for psychosis and improving the identification and management of depression are priority training needs for mental health workers in LMICs. The methodology of training needs assessment in the Kutcher et al. (2005) study was based on a theoretical model to assess health professionals' roles in service delivery and their anticipated required competence. However, the current study undertook an empirical analysis of mental health training needs of health professionals in Gaza and therefore provides an alternative methodology of assessing particular training needs for each mental health professional group in a post-conflict and LMIC, such as Gaza, resulting in a contribution to knowledge. It is acknowledged that this method also has limitations in terms of the willingness of participants to divulge knowledge or skill deficiencies. However, the findings merit consideration by mental health policy makers, and particularly by those involved in mental health postgraduate education.

The TNA and the focus group findings were also inconsistent with other training need priorities for mental health workers in high-income countries, where crisis intervention was identified as the third training priority (Clasen et al., 2003), as opposed to second in the current study. The Clasen et al. (2003) study used a competency-based training needs analysis instrument, which included 26 core competencies, similar to the one used in the current study. However, most of those competencies were relevant to inpatient mental health care rather than community-based mental health care, as developed for the current study. Such study findings suggest the need to take mental health demands into consideration when training needs are planned. High demand for crisis intervention in a post-conflict place like Gaza may have encouraged mental health workers to identify crisis intervention as one of the top two training priorities.

One of the important focus group findings was the provision of medical oriented services by mental health workers due to lack of skills in providing community-based services. In line with the "Right to Health" approach (UNOHCHR, 2000), such lack of skills substantially affects the availability and therefore the accessibility to evidence-based mental health services. Moreover, mental health workers who participated in the focus groups considered that the administration of mental health services did not support their need for training and capacity building. This lack of governmental support to professional development is common in most LMICs, as governments do not invest sufficient resources in scaling up mental health workforces (Clasen et al., 2003; WHO, 2011a). The WHO report (WHO, 2011a) was based on a review of secondary data reported in the WHO-AIMS report of 58 countries (WHO, 2005a) and

comparing it to the WHO Mental Health Gap Action Programme initiative (WHO, 2008c) to calculate the burden of common mental disorders and the readiness of mental health human resources to respond to such burden, while Clasen et al.'s (2003) study used a self-reported questionnaire developed for their study to investigate mental healthcare training needs and how much professionals within inpatient mental healthcare could benefit from competency training.

The findings from the TNA revealed that the shortage of qualified trainers was the main barrier to receiving appropriate mental health training. This finding was supported by the findings from the WHO-AIMS questionnaire (WHO, 2005a) that revealed a general lack of skilled mental health workers in Gaza. Another important barrier to training that was emphasised by mental health workers in the health professionals' focus groups was related to the impact of the conflict on scaling up of the mental health workforce. The ongoing siege and restriction of movement since 2007, that mental health workers and policy makers face in Gaza, blocked the possibility to obtain training outside Gaza; taking into consideration that some specialised mental health education programmes are not provided in Gaza, such as psychiatry training for doctors, therefore, the number of well-trained mental health professionals will decrease over time. Furthermore, a lack of interaction with international opportunities for training may affect the adoption of scientifically appropriate practices (evidence based practice) and therefore affect the quality of health services according to the "Right to Health" approach (UNOHCHR, 2000). This finding is unique to the current study, making an original contribution to knowledge,

as the context of the siege and its impact on mental health professionals' development has not been previously explored or discussed in similar studies.

The study results from the TNA highlighted the role of postgraduate training as a key approach for skill-based training. Mental health workers developed most of their core competencies through postgraduate training. They also identified postgraduate training as their preferred approach for future training. Such findings should encourage collaboration between governmental services and universities in considering the establishment of more skill-based postgraduate training.

Additionally, the documentary analysis (WHO Checklists, (WHO, 2009)) revealed that the mental health plan invited universities to establish specialised postgraduate programmes to improve training opportunities for mental health workers. However, there was no commitment from local universities to establish such programmes. The WHO encourages the establishment of postgraduate training courses to improve policy and legislation development among mental health leaders and practitioners (WHO, 2008b). Examples of the WHO supported postgraduate training courses are the International Diploma in Mental Health Legislation and Human Rights (WHO, 2008b), and the International Masters in Mental Health Policy and Services (NOVA University of Lisbon, 2012).

5.3.3 The Impact of Conflict on Service Development

The interpretation of the findings in this section answers the fourth research question, presented in Chapter one: In the light of ongoing conflict in Gaza, what are the views

of mental health policy makers and mental healthcare professionals on major mental healthcare challenges and what are their suggested strategies for reforming mental health services in Gaza?

The impact of political conflict on reforming mental health services in Gaza was explored in this study by analysing the views of service providers (mental health policy makers and mental healthcare professionals) to produce convergent findings on this issue and explore potential complementarity and dissonance in both viewpoints (Greene et al., 1989). The data from the WHO Checklists (WHO, 2009) also contributed to answering Research Question 4. This triangulation of findings contributes to enhancing the trustworthiness of the research (LincoIn and Guba, 1985).

The relationship between the governmental and NGO services in post-conflict areas has been described as competitive (Jenkins et al., 2011a) and one of the major barriers toward service development (Wessells, 2009). However, the role of coordination in service development between the governmental services and NGOs has not been explored empirically. Therefore, there was a need for an empirical study to explore the role of coordination in service development and the main barriers toward appropriate coordination between governmental services and NGOs in Gaza.

Findings from the focus groups revealed that mental health workers perceived the conflict in Gaza as having a negative effect on the development of mental health services in general. The negative impact of conflict on service provision was

attributed to the lack of coordination between key mental health and psychosocial providers. It was felt by focus group participants that the lack of coordination and regulation of service provision affected the quality of services provided to victims of conflict and led to a fragmented mental health system in Gaza. Surprisingly, NGO policy makers and healthcare staff who participated in the focus groups shared similar views to the governmental mental health workers on the negative impact of conflict on the development of the mental health system in general. The lack of an appropriate health environment can affect the availability of health services, according to the "Right to Health" approach (UNOHCHR, 2000).

5.3.3.1 Short-Term Humanitarian Response

Focus groups with mental health professionals and policy makers indicated that the short-term psychosocial and mental health projects implemented after conflict were highly criticised by both the mental health workers and policy makers. The short-term post-conflict projects were seen to contribute to the duplication of services by different NGOs who provide the same services to the same affected victims. Moreover, it was felt that the short-term humanitarian funded projects contributed to a waste of the few resources allocated for mental health service development as these resources are consumed in short-term interventions with no equivalent resources invested in the longer-term development of mental health services. The findings of the current study confirm other study findings (Tol et al., 2011) that reported a huge waste of financial resources spent out of national services, because they are consumed by short-term psychosocial programmes.

The participants' views of short-term projects are consistent with the suggestion that favouring short-term interventions negatively impact the comprehensive integration of post-conflict interventions on long-term service development (Jenkins et al., 2011a). According to van Ommeren et al. (2005), based on a round table discussion of published literature, such long-term investment can be the best method to support victims of conflict, because the consequences of exposure to conflict need long-term support services that cannot be addressed by short-term programmes (van Ommeren et al., 2005). This long-term development of services is also the most appropriate method of ensuring the availability of sufficient mental health services and programmes, to address the long-term mental health consequences of the conflict, which meets an essential principle of the "Right to Health" approach (UNOHCHR, 2000).

The findings of the focus groups with mental health professionals and policy makers revealed that NGOs, who provide most of the short-term psychosocial and mental health projects in Gaza, are flexible in following donors' priorities and preferences. The short-term intermittent funding may have driven NGOs to create mechanisms for surviving with short-term resources and staff, but not always successfully. For example, in a field report on the lessons learned in the aftermath of the Tsunami in Sri Lanka, it was noted that strategies for adapting short-term mechanisms for interventions were inappropriate, where NGOs used culturally irrelevant interventions provided by unskilled workers because of funding pressures (Galappatti, 2005). It is possible that these study results reflect suggestions that short-term intermittent

funding has driven NGOs to adapt to short-term psychosocial interventions (Tol et al., 2011; Wessells, 2009).

Furthermore, donors' misconception of the particular nature of psychosocial services has led them to deal with these services as any other relief services, such as distribution of hygiene kits and shelter (Wessells, 2009). According to Wickramage (2006), in a discussion paper highlighting inappropriate emergency response interventions in Sri Lanka after the Tsunami, the humanitarian response can be provided immediately and for a short period until victims adapt to the new situation, while psychosocial and mental health problems need long-term care (Wickramage, 2006). My work contributes to the theoretical literature about humanitarian response interventions by Wickramage (2006) and Galappatti (2005), as both theoretical papers are very relevant, and correspond, to the findings of this study. However, the current study's conclusions on this issue are based on empirical findings from the qualitative data collected from focus groups.

The political agenda of donors was also found to substantially affect the provision of mental health services. The study findings from the focus groups with mental health professionals and policy makers revealed one of the reasons for the lack of coordination between governmental services and NGOs, especially international NGOs, was the political boycott of international donors to the government in Gaza. Consequently, NGOs who were funded by those international donors were not allowed, by their donors, to contact governmental mental health services. This indirect negative role of donors has not been reported in any other literature exploring

the role of donors in supporting mental health services in humanitarian settings. It is possible that because of the unique political situation in Gaza, this uncommon intervention of donors has not been reported in other post-conflict areas.

5.3.3.2 Fragmentation of Resources

Although the role of NGOs in providing integrated mental health and psychosocial services was hard to identify in the mental health policy and plan (WHO Checklists, (WHO, 2009)), NGO workers, mental health professionals and policy makers in the focus groups reported that the NGOs' contribution as a service provider is a key element to mental health service provision in Gaza. Furthermore, the documentary analysis, using the WHO Checklists (WHO, 2009), revealed that the role of NGOs was addressed in the development of the mental health policy and plan; however, both documents failed to provide a clear strategy for utilising the substantial resources of NGOs in service development by a more integrative community-based approach. As a result, neither governmental workers nor NGO workers could identify the role of NGOs in reforming mental health services in Gaza.

Although collaboration between the government and NGOs was mentioned in the mental health policy, and there was a commitment to improving the quality of services, this role confusion between service providers would make it difficult to achieve the principles of quality and accessibility in the "Right to Health" approach (UNOHCHR, 2000). The same conflict of the NGOs' role identification was also found in two case studies of NGOs' interventions in Haiti after the earthquake (Zanotti, 2010). According to Zanotti (2010), NGOs can contribute substantially to improving

service provision in post-conflict situations only if they have financial autonomy, their intervention is based on a realistic needs assessment, and they demonstrate a long-term commitment to addressing such needs.

Consequently, the health professionals' focus group findings in the current study described the NGOs' current role in service development as a negative one, because it was suggested that the work of NGOs leads to duplication and a waste of resources. Those findings are in agreement with other studies that questioned the value of funding NGOs outside of national health and education systems (Tol et al., 2011). A systematic review and meta-analysis of 160 reports of psychosocial interventions and funding tracking reports in the period between 2007 and 2010 found that NGOs do not effectively address mental health needs (Tol et al., 2011). However, NGOs can play a positive role in helping governments to develop mental health services (Alonso and Brugha, 2006; Saxena and Maulik, 2003). For example, the findings from a participant observation study and policy analysis suggest that NGOs played a positive role in responding to population needs after the conflict in East Timor and handing over the service delivery to the national service afterwards (Alonso and Brugha, 2006).

5.3.4 Service Users' and Carers' Involvement

The interpretation of findings in this section answers the fifth research question, presented in Chapter one: What are the service users' and their family members' (carers) views on: 1) current mental health services, 2) mental health reform, and 3) involving them in planning and implementing mental health services in Gaza?

This study is the first to investigate service users' and carers' views on reforming mental health services in Gaza, which explored their experience in involving them in service development and delivery. Additionally, service users and carers provided important suggestions on how to improve the services provided to them, for example, by forming partnerships with service providers. This partnership is essential to protect the human rights of service users, facilitate more active participation of service users and carers in service delivery and development and improve the quality of mental healthcare (Wallcraft et al., 2011; WHO, 2010), to a degree that mental health services can be acceptable to service users and carers, according to the "Right to Health" approach (UNOHCHR, 2000).

Both the health professionals' and service users' focus group findings converged, revealing the importance of empowering service users and carers to enable them to contribute more effectively to mental health service development in the future. This study's findings confirm the findings of other studies, which report a useful role of service users' involvement in service development (Robert et al., 2003), and the ability of service users to be actively involved in mental health service delivery when they are empowered by mental health professionals (Patton, 2013; Doughty and Tse, 2011). The active involvement of service users and carers, particularly at the macro-level involvement in planning and evaluating services (Tait and Lester, 2005) could improve the quality, accessibility and acceptability to mental health services, in line with principles of the "Right to Health" approach (UNOHCHR, 2000). This is because they are considered to be experts on their illness and care, can increase

understanding of mental ill health, and may have different perspectives to service providers on the care that they need (Tait and Lester, 2005).

5.3.4.1 Involvement in Service Delivery

The findings from the WHO-AIMS questionnaire (WHO, 2005a) revealed the absence of service user or carer organisations in Gaza, thereby limiting the role of service users and carers in mental health service development. There are only two advocacy groups that represent service users and carers. Both groups were not officially established, and they were active only in Gaza City. However, the absence of legal representation for service users and carers was not the only reason for excluding service users and carers from mental health service development and delivery. According to the findings of the focus groups with service users and carers, the main reason behind the lack of service users and carers' participation was the resistance of mental health professionals to involving service users in their treatment process. Both service users and carers were not consulted about developing or evaluating their own care plans. The exclusion of service users and carers not only affects the acceptability of services, it also violates the right to information accessibility, according to the "Right to Health" approach (UNOHCHR, 2000).

One earlier study seeking the views of service users, using interviews, and the views of mental health professionals, using focus groups, found that such exclusion is not as common in more developed countries, such as Norway, where most service users participate in different activities related to their mental healthcare (Elstad and Eide, 2009). Both service users and mental health professionals in the Norwegian study

(Elstad and Eide, 2009) emphasised the valuable participation of service users in informing clinical intervention and service development. However, the process of involving service users and carers in other high-income countries, such as the UK, still encounters many challenges (Rutter et al., 2004). Using semi-structured interviews with mental health service managers and mental health staff and service users in two mental health Trusts in the UK, this earlier study concluded that the main barrier toward service users' participation was that decision-making in both mental health centres was controlled only by mental health service managers and mental health professionals (Rutter et al., 2004), thus echoing the focus group findings in the current study.

According to the documentary analysis (WHO Checklists, (WHO, 2009)) in the current study, service users and carers did not participate in mental health policy development in Gaza. In addition to the absence of service user and carer organisations in Gaza, mental health workers and policy makers in the focus groups disclosed other reasons to explain the service users' and carers' lack of participation. Policy makers admitted that service users and carers have never been invited to any policy development activity. Other mental health professionals believed that service users and carers were excluded because policy makers did not feel they needed their input to make decisions. This attitude of excluding service users and carers from policy and service development is against the principle of non-discrimination accessibility to services of the "Right to Health" approach (UNOHCHR, 2000).

The attitude toward excluding services users and carers from activities related to policy development appears to be common in other LMICs (Kleintjes et al., 2010). For example, the participation of service users and carers in the development of the mental health policy and legislation in South Africa was also limited (Kleintjes et al., 2010). Kleintjes et al. (2010) used similar methods to the current study: mental health policy and legislation in South Africa were analysed using the WHO-Checklists (WHO, 2009) and semi-structured interviews with mental health managers and mental health professionals. The main reasons for service users' exclusion in policy development in this previous research were the absence of a supportive environment created by the stigma attached to mental health and the lack of education directed to health service managers and professionals on service users' rights to participate in service and policy development (Kleintjes et al., 2010).

However, the focus groups in the current study revealed that all mental health policy makers and mental health workers demonstrated a positive attitude toward involving service users and carers in policy development and service provision. This good intention is expressed by policy makers and mental health professionals worldwide when they are asked about their views on service users' and carers' participation in policy development (Kleintjes et al., 2010; Wallcraft et al., 2011). The study by Wallcraft et al. (2011) aimed to produce recommendations to inform the World Psychiatric Association on best practices of partnership between service providers and users by a worldwide review of the literature and broad consultation with service users, carers, and health experts. However, the actual implementation of this partnership involved many obstacles related to service users' and carers'

representation, the ambiguity of the role service users and carers can play, and also the commitment of policy makers and mental health workers to such partnerships (Wallcraft et al., 2011). Therefore, ensuring effective participation of service users and carers in policy development requires, in addition to good intentions, clear role distribution, and commitment by both parties. For example, the documentary analysis in the current study (WHO Checklists, (WHO, 2009)) revealed that the mental health plan in Gaza called for the establishment of service user and carer associations; however, this activity was not linked to any implementation party and did not identify a clear strategy for achieving it.

5.3.4.2 Evaluation of Services

The current study provided the opportunity for service users and carers, for the first time, to express their views on the services they receive in the governmental Community Mental Health Centres (CMHCs). The study findings revealed a broad dissatisfaction with the services provided. The main factors that led to service users' and carers' dissatisfaction were the lack of appropriate communication with service providers and the lack of privacy inside the community centres, which is against the principle of respectful and culturally appropriate services according to the "Right to Health" approach (UNOHCHR, 2000). The lack of appropriate communication by mental health workers obstructed the potential for more positive interaction by service users and carers in their care plans. In previous research reviewing policy documents and relevant published literature on service users' participation in mental health service delivery, Storm and Edwards (2013) emphasised the importance of

teaching mental health workers communication skills in order to make the participation of service users and carers more achievable.

Moreover, according to service users in the focus groups, lack of privacy was another major barrier toward receiving effective mental health services inside the community centres. For example, the trend of the MoH in Gaza is to locate CMHCs inside primary care buildings. Some service users considered this integration of healthcare a violation of their privacy, as they preferred not to be seen by other primary care patients because of the stigma associated with mental illness (Corrigan, 2004; Meguid et al., 2011). This finding is consistent with previous research (Struch et al., 2007). Aiming to develop a national programme to combat stigma in Israel the researchers conducted 2,100 telephone interviews to obtain the views of service users in Israel (Struch et al., 2007). The service users in this study also preferred separate mental health facilities (Struch et al., 2007).

5.3.4.3 Community Attitude

Service users and carers identified stigma and community discrimination to be main barriers to receiving appropriate mental health services. Service users and carers have the right to non-discriminative accessibility to mental health services, in line with the principles of the “Right to Health” approach (UNOHCHR, 2000). The focus group findings of this study emphasised the enormous role of stigma in preventing service users and carers from accessing and participating in mental health services. For example, many service users expressed their concerns about being visited by mental health teams because they would feel ashamed if their neighbours found out that

they receive mental healthcare. Those home visits are not acceptable health behaviour, according to service users, because they are believed to be culturally inappropriate, which is against the acceptability principle of the “Right to Health” approach (UNOHCHR, 2000).

Such concerns were not known to mental health workers who participated in the focus groups and who believed that service users and carers appreciated home visits by mental health teams. It may be that the social connectedness and the crowded neighbourhoods in Gaza decrease privacy for service users. Taking into consideration that mental illness is highly stigmatised by communities (Corrigan, 2004; Meguid et al., 2011; Thornicroft et al., 2009), it is understandable that service users and carers try to avoid social stigma by keeping confidential their experiences with mental health services.

Similarly, stigma was identified as a main barrier to participation in community-based activities for service users and carers. Although service users preferred a community-based approach to mental health care, the findings of the focus groups revealed that service users and carers were reluctant to participate in activities that would make them vulnerable to community stigma and discrimination. Thus, they can participate in any community activity if their identity as service users is not disclosed, or they can participate in such activities if they feel protected from being stigmatised and marginalised by the community. This concept of a safe environment was expressed by a service user who said: “if you want to treat people from mental illness... you need to treat the community first”.

While service users and carers preferred a community-based approach to an institution based approach to mental healthcare, they differentiated between going to a community centre to receive care and receiving care within the community. The service users have the right to identify culturally accepted services, in line with principles of the “Right to Health” approach (UNOHCHR, 2000). Receiving care in a community centre was more acceptable than hospitalisation because community centres can be designed to more easily protect privacy. Unsurprisingly, the role of stigma as a barrier to accessing mental health services is common in Arabic countries (Meguid et al., 2011), as demonstrated in interviews with 347 non-medical psychiatric hospital staff using a self-reported questionnaire, and other LMICs that share similar cultural beliefs about mental illnesses (Kleintjes et al., 2013). Furthermore, globally, stigma is a strong contributor to adherence to treatment and achieving life-goals in high-income and lower-income countries (Corrigan, 2004; Meguid et al., 2011; Thornicroft et al., 2009).

Furthermore, service users and carers in the focus groups reported that the community in Gaza discriminates against and excludes service users and their family members on different levels. Service users and carers revealed discrimination in employment and marriage of family members of service users, as they also face similar treatment to service users by the community. In addition, it was reported that service users and their family members do not have equal opportunities in training, employment, and marriage. These focus group results on discrimination are comparable to study findings in other LMICs (Campbell, 2006; Drew et al., 2011). Service users interviewed in 18 LMICs perceived discrimination as one of the main

human rights violations they are exposed to (Drew et al., 2011). Campbell (2006), by providing a service user view on changing mental health systems, reported that the negative community attitude toward service users was the worst they could face in their experience with mental illness. Such community discrimination is common in most LMICs: many people with mental illness do not have equal opportunities for employment and for marriage as other individuals who do not have mental illness (Funk et al., 2010). The report by Funk et al. (2010) described the importance of linking mental health to the development agenda in suggesting that people with mental health problems lack opportunities to appropriate training and employment, as they are subjected to stigma and discrimination in the community, which results in increasing the economic burden of mental illness to both service users and their family members.

5.3.4.4 Service Users' Empowerment

The findings from the focus groups emphasised the importance of empowering service users and carers if the goal is to improve their participation in the future. Service users in particular expressed a great lack of enthusiasm toward a potential role they could play in the future, as they felt that their role was limited to complying with medication and adhering to doctors' instructions. Therefore, to encourage service user involvement in mental health service development, service users and carers need education and information on the possible role they can play in participating in their treatment plan and policy development, to conform to all four principles of availability, accessibility, quality and acceptability of the Right to Health approach (UNOHCHR, 2000). According to Kleintjes et al. (2013) service users' lack

of confidence to participate in policy development is common in other LMICs and is associated with stigma.

The results of the current study suggest that there is a huge gap between LMICs and high-income countries in service users' and carers' empowerment. While service users and carers in Gaza struggle to obtain basic services to maintain acceptable levels of wellbeing, service users and carers in high-income countries achieve a high level of involvement in providing consultations for services and training, and participating in research (Truman and Raine, 2002). Truman and Raine (2002) interviewed service users and health providers in the UK to evaluate the value of service user involvement in community mental health. However, based on observations in three controlled trials in Asia and Africa, service users and carers in LMICs are still far away from achieving comparable levels of involvement (Patel et al., 2011). Therefore, empowering service users and carers is crucial for ensuring better services, according to the quality principle of the "Right to Health" approach (UNOHCHR, 2000), and improved quality of life for them in the future. This could be the responsibility of mental health service planners and providers, human rights organisations, and civil society.

5.4 The Main Implications of the Study

The shortage of trained mental health workers is considered the main challenge for mental health in LMICs (Kakuma et al., 2011; Saxena et al., 2007). Therefore, improving the availability, distribution, and qualifications of mental health human resources is a priority for system development in Gaza. This study provided a

thorough assessment of mental health human resources in Gaza (Saymah et al., 2015) by assessing the availability and distribution of human resources using the WHO-AIMS questionnaire (WHO, 2005a). Furthermore, the education and training needs were assessed using a TNA questionnaire specifically developed for the current study, resulting in a contribution to knowledge. The findings of both instruments provided a clear identification of knowledge gaps in developing mental health human resources in Gaza.

The TNA questionnaire can be used by the MoH, NGOs and donors in Gaza as a useful tool for planning future human resource development and training activities. The universities in Gaza can also use the TNA findings to plan more responsive and integrated training and education programmes that could address the main gaps in mental health professional development. For example, most governmental mental health workers preferred postgraduate programmes as the best method for receiving training; they also reported that they developed most of their core competencies by postgraduate training. The importance of postgraduate programmes in mental health education (NOVA University of Lisbon, 2012; WHO, 2008b) should encourage universities in Gaza to establish more specialised postgraduate programmes in mental health.

The assessment of the mental health system, using the WHO-AIMS questionnaire (WHO, 2005a), and policy development, using the WHO checklist for mental health policy and plans (WHO, 2009), provided a comprehensive view on the strengths and weaknesses of the mental health system in Gaza. The shortage of mental health

resources is an important finding for the MoH to focus more attention on integrating mental health into PHC. Although integrating mental health into PHC was identified as the first specific objective for the mental health policy since 2004 (WHO, 2004b), and mental health plan since 2010, the findings of the WHO-AIMS questionnaire (WHO, 2005a) revealed that MoH had not established any programme to support the integration of mental health into PHC until the WHO recently started to support this programme technically and financially, with training.

Considering the identified weaknesses in the mental health system from the analysis of the process of developing the mental health policy and plan, it will be important for the MoH and the WHO to consider the main information gaps when reviewing both documents, especially during the planned review of mental health policy in 2015. The most important lesson to learn from the documentary analysis (WHO Checklists, (WHO, 2009)) of the development of the mental health policy and plan was the importance of involving services users and carers in all policy development activities in the future.

This study provided new information to the knowledge of reforming mental health services in a post-conflict area and LMIC, like Gaza, by providing service users' and carers' views on mental health services that they receive and their suggestions for improving those services. Mental health service users and carers provided valuable suggestions for mental health service planners and providers on how to improve mental healthcare in Gaza. For example, the community-based approach can be acceptable to service users only if their privacy and autonomy is protected. The

stigma associated with mental health is a key barrier toward seeking mental health and psychosocial services. Removal of this barrier calls for the need to develop community education strategies and policies in order to raise public awareness of mental illness (Pinfold et al., 2003). Even if mental health services are improved, if service users continue to face public stigma, they may always feel reluctant to seek mental healthcare.

The findings revealed a lack of the appropriate use of opportunities to develop mental health services in Gaza, which resulted from exposure to political conflict. Although conflict increases the burden of mental health disorders in all post-conflict areas (Mollica et al., 2004), it can also provide good opportunities for developing mental health services in some countries (WHO, 2013). This study provided important information for policy makers working in the NGO sector, and especially for humanitarian donors, to consider a revision of short-term interventions and to support more integrated and coordinated long-term development of mental health services. Based on the findings from the current study, another important recommendation for donors is that whatever the political situation is, they need to encourage NGOs to coordinate and collaborate with governmental sectors because this technical collaboration is key for sustainability of services.

Finally, the literature review revealed clear similarities of the challenges and opportunities for mental health reform in many post-conflict areas around the world (Tol et al., 2011; Wessells, 2009). The current study's findings from the comprehensive assessment of opportunities for reforming mental health services in

Gaza may be valuable to other post-conflict areas that are facing similar challenges. However, replicating the same model of reform should be tackled with caution because recommendations need to be adapted to a country's available resources and the cultural and social perspectives.

5.5 Original Contributions of the Study

In addition to the implications of the study findings on reforming mental health services in Gaza that were discussed in the previous section, the original contributions of this study to the knowledge of mental health service development in post-conflict areas and LMICs, as well as to practice, are:

1- Given the clearly developed need for the study, the implementation of the "Right to Health" approach (UNOHCHR, 2000) in mental health research was a unique contribution of this study. The conceptual framework organising the conceptualisation of the findings for this study extends the work of the UNOHCHR (UNOHCHR, 2000) by applying the "Right to Health" theory to reforming mental health services in Gaza. This study demonstrates that the "Right to Health" approach can be an appropriate and useful conceptual framework to guide mental health reform research. A conceptual understanding of the principles underpinning quality healthcare and sustainable health services is critical to developing meaningful plans for reforming mental healthcare in LMICs and post-conflict areas.

2- The TNA questionnaire, developed specifically for this study, based on assessing the perceived confidence level of mental health professionals in

practising the core competences in mental healthcare and inviting the participants to identify their top training priorities and main barriers toward receiving appropriate training, and preferred approach to training, was the first assessment tool to be developed to investigate mental health training needs in Gaza. It can be used within mental health services or by other researchers to assess the training needs for mental health workers in LMICs and post-conflict areas, since the current study tested the preliminary validity of the TNA that was found to be excellent. In addition, the TNA findings provide information that can be used to tailor teaching curricula, based on the needs of specific subgroups of mental health workers.

3- Treatment modalities and disaster management were the top training needs for mental health workers, as identified by combining the qualitative and quantitative findings of the TNA. Postgraduate programmes were the preferred approach to providing mental health training in Gaza. However, the findings of the focus groups with mental health professionals revealed a lack of support that mental health workers received from their administration to pursue training and education programmes. These findings are an important contribution to the knowledge of mental health human resource development in Gaza, and will have practical significance for improving mental health services. The findings of this study extend the findings of a previous study by Kutcher et al. (2005), who identified acute care for psychosis and management of depression as top training needs in LMICs. However, the importance of disaster management training is relevant to other post-conflict areas because of the increased need for such services. Additionally, these

findings have important implications to the development of mental health postgraduate education in Gaza. Universities in Gaza need to take into account the findings of the study's training needs assessment and incorporate the identified training priorities into their existing training curricular development for postgraduate programmes.

4- Lack of coordination between governmental and NGO services was the main barrier towards developing mental health services in Gaza. The poor coordination between governmental and NGO services was evident in other post-conflict contexts (Jenkins et al., 2011a; Wessells, 2009). However, the current study emphasised the role of lack of coordination beyond the duplication of service delivery and the fragmentation in service development. The findings of this study highlighted the role of poor coordination in the wasting of valuable human and financial resources. This is because most of the post-emergency humanitarian fund in Gaza is allocated to NGOs without clear coordination with governmental services, whose responsibility is to regulate mental health service delivery and policy development. The findings of this study can be used as an advocacy tool to convince policy makers from governmental and NGO sectors to establish coordination strategies within the national mental health policy and plan, which can regulate the relationship between both sectors to maximise the benefit of the limited available resources.

5- Providing mental health and psychosocial services by short-term humanitarian relief projects was not an effective strategy in Gaza. The evidence of the effectiveness of such time-limited projects is not clear (Jenkins et al., 2011a),

and they are not sustainable because they tend to leave the post-conflict area while people still need psychosocial and mental healthcare (Petersen et al., 2011a; Wessells, 2009). These findings confirm similar criticisms of short-term relief projects in other post-conflict areas (Jenkins et al., 2011a; Wessells, 2009), which can contribute to adding pressure on donors and policy makers to stop supporting short-term, post-emergency, intervention projects in mental health.

6- Stigma was a main challenge for service users seeking community-based mental health services in this study. The role of stigma in deterring patients from seeking mental health services was evident in other low-income as well as high-income countries (Corrigan, 2004; Meguid et al., 2011; Thornicroft et al., 2009). However, the findings of this study not only substantiate previous studies (Corrigan, 2004; Meguid et al., 2011; Thornicroft et al., 2009), but also demonstrate additional and unique issues concerning the role of stigma as a barrier to accessibility to mental health services in Gaza. Therefore, stigma should be given more attention in any mental health reform process. The findings suggest that there should be an established national, long-term, strategy for combating stigma, which should include community education and strategies to improve mental health literacy. Additionally, there should be short-term measures to provide acceptable mental healthcare by integrating mental health services into social, education and relief services.

7- The findings suggest that partnerships between service providers and service users in LMICs are possible if they involve service users and carers in service development and delivery. Partnerships between service users and providers

have been applied in high-income countries (Doughty and Tse, 2011; Patton, 2013). Although the current study did not investigate the effectiveness of such partnerships, because such partnerships did not exist in Gaza, the findings of this study suggest the possibility of developing such partnerships and suggested specific strategies for their achievement, which can be useful to health planners in Gaza and other post-conflict areas and LMICs. The findings of this study can therefore encourage policy makers in Gaza to establish an effective partnership between service users and providers. Furthermore, this partnership model can guide policy makers in other LMICs and post-conflict areas to promote service user involvement in the planning and delivery of healthcare programmes.

8- Conflict can be a catalyst for increasing resources for mental healthcare in post-conflict areas (van Ommeren et al., 2005; WHO, 2013). However, this study's findings suggest that an inappropriate use of resources can hinder opportunities for mental health reform. The entire method of post-emergency intervention should be evaluated by post-conflict countries to ensure that the post-emergency fund is used appropriately to support the sustainable development of the existing mental health system. The findings of the current study (WHO, 2013) suggest the establishment of a "building back better" strategy in each post-conflict area. According to this strategy: (1) the post-emergency support should follow the priorities of developing the existing mental health system in the affected countries, (2) well-established coordination and referral mechanisms between different key service providers should be established, and (3) the emergency response programmes should

support a sustainable vision of service development, and time-limited post emergency projects should establish a clear exit strategy to hand over the projects' resources and responsibilities to the existing governmental services (WHO, 2013).

9- The findings of this study emphasised the negative role of the political agenda of donors in preventing communication and collaboration between governmental services and NGOs. The political boycott imposed by most of the international donors on the government in Gaza discouraged many international NGOs, and local NGOs funded by international donors, to collaborate and coordinate with governmental health services. Such a political agenda of donors was highlighted by mental health professionals and policy makers as one of the main reasons for the lack of coordination between governmental services and NGOs. This study's finding is a new contribution to the literature on mental health development in post-conflict areas, as this problem was not investigated by previous research.

5.6 Study Limitations

Although the current study identified a number of challenges and offered suggestions for reforming mental health services in Gaza, as a post-conflict area, the implementation of the study included a number of limitations that were unavoidable at the time of conducting the study.

A single researcher conducted this study, including data gathering and analysis. The implementation of a study by a single researcher can introduce bias that could be

avoided if more than one researcher was involved (Bryman, 1998). On the other hand, there might be a benefit of having a single researcher conduct a study, especially if the study involves focus groups: a single interviewer can maintain the same communication pattern and consistency of handling focus groups as well as the transcripts so data gathered are more consistent.

Another potential limitation of this study concerns the background of the researcher. The researcher is a well-known mental health practitioner in Gaza, where the study took place. The researcher's background therefore could have introduced bias (Bryman, 1998). The researcher interviewed mental health professionals and policy makers, who were also colleagues; they might have felt they needed to hide, modify, or exaggerate facts. In addition, the researcher interviewed service users and carers. Taking into consideration that the interviewer is a mental health practitioner, this might have created a power imbalance that could have led to information being withheld or the participants feeling uncomfortable to reveal information that might be perceived as a criticism of mental health professionals. In order to overcome this potential source of bias, the researcher explained and emphasised his role as an independent researcher in all data collection processes. All focus group participants were encouraged also to talk openly and freely with each other about their challenges and any disagreements. It was explained that this openness would help the researcher to provide a more accurate description of the existing situation that could be translated to a set of useful recommendations to be provided to policy makers to guide them to develop mental health services.

There are some critiques of using a mixed method research approach (Bazeley, 2004; Kelle, 2006). While the aim of using mixed methods is to answer a research question that cannot be answered by only qualitative or quantitative methods, combining two methods can potentially negatively affect the value of both methods (Bazeley, 2004), attributable to a lack of definitional consensus on the relationship between qualitative and quantitative domains (Kelle, 2006). Since this study used a mixed method approach, there are some risks that the combination of the two methods used could affect the transferability of the research findings to other contexts. However, this study used a convergent model to mix both qualitative and quantitative methods (Creswell and Plano Clark, 2011). Using this model, data were gathered and analysed independently using qualitative and quantitative methods. Moreover, the findings of both methods were complementary and congruent with each other, and efforts were made to enhance the credibility and confirmability of the study findings by triangulation (LincoIn and Guba, 1985).

The guidelines for gathering information to complete the WHO-AIMS questionnaire (WHO, 2005a) and the WHO checklist (WHO, 2009) for the documentary analysis suggest appointing focal points from relevant organisations to complete the instruments. In this study, the MoH and other ministries and universities nominated senior level focal points to complete different questionnaires. Although the nominated focal points were relevant to completing the questionnaires, many questions required professional judgment on the current situation of service development. However, the single person judgment can potentially introduce bias to the study as this professional judgment could reflect personal views and attitudes. To overcome this

potential for bias, the researcher maintained continuous supervision and double-checked the accuracy and the source of information with participants.

Finally, the study involved conducting seven focus groups. Although focus groups were chosen to enrich the discussion through the group interaction afforded by focus groups (Kitzinger, 1994; Morgan, 1996), some participants can sometimes dominate discussions within focus groups. The researcher split participants into two categories, service providers, and service users, for the purpose of avoiding any power imbalance that might affect the natural flow of discussion and lead to dominance by service providers. The researcher was aware of the need to provide equal opportunities and space to every participant to provide his/her views. However, in some instances, some participants tried to dominate the discussion. Therefore, the researcher distributed the time equally between participants and encouraged all participants to provide their views.

5.7 Suggestion for Future Research

This study provided answers to several questions related to service development in areas that lack adequate human and financial resources to respond to the high burden of mental health problems in Gaza. However, the study findings also raised the following questions that could be answered in future research.

5.7.1 Methodology

The development of human resources is an essential area of research for developing mental health systems. The researcher developed a questionnaire to assess the

training needs of mental health professionals by assessing their subjective confidence in practising the core competencies for mental health. The researcher developed this questionnaire because the tools to assess training needs in more developed countries cannot be adapted to LMICs because of the differences in resources and qualifications. Also, no training needs analysis tool was available for assessing training needs in LMICs. Therefore, there will be a need in the future to develop standardised tools and instruments that can be used to assess training needs for mental health professionals in low resource countries. Further assessment of the psychometric properties of the TNA instrument developed in this study and its acceptability to mental health professionals in LMICs should be carried out to further evaluate its validity and performance.

5.7.2 The Role of NGOs in Post-Conflict Intervention

There has been a debate in the literature on assessing the role of NGOs in post-conflict interventions. The literature identified areas where NGOs can contribute to the promotion of mental health wellbeing (Saxena and Maulik, 2003; WHO, 2013), while other studies criticised supporting out-of-the system services that are led by NGOs (Jenkins et al., 2011a; Tol et al., 2011). The current study provided an important overview of the role of NGOs in service development and the difficulties in establishing a collaborative relationship with governmental services. However, a systematic assessment of the impact of post-emergency intervention programmes that are implemented by NGOs can be a fruitful area for future research because the impact of clinical and community-based interventions of NGOs in post-conflict areas is not well covered by the literature.

5.7.3 Role of Donors

This study emphasised the role of donors in supporting particular types of interventions over others. The study findings highlighted the indirect role of donors in directing the paradigm of service delivery and development as service providers tended to tailor their objectives to donors' priorities. The literature provided similar experiences in other post-conflict areas where donors direct the delivery and development of services (Wessells, 2009). The current study explored mental health professionals' and policy makers' perspectives on the role of donors. Moreover, the actual role of donors in identifying the priorities and the patterns of mental health service development and provision in LMICs and post-conflict areas needs to be further researched.

5.7.4 Involvement of Service Users and Carers

This study was the first of its kind to investigate the role of service users and carers in reforming mental health services in a post-conflict area and LMIC such as Gaza. Few studies in LMICs, compared to high-income countries, provided an insight into the experience of service users and carers in service delivery, evaluation, and development (Drew et al., 2011; Kleintjes et al., 2010). The lack of research studies investigating the contribution of service users and carers in LMICs and post-conflict areas may be explained by the lack of service user and carer organisations or advocacy groups that represent service users and carers. Therefore, further research is needed as mental health service development research can benefit from extending the assessment of the views of service users and carers in different LMICs to

identifying the reason for the lack of service user and carer associations in post-conflict areas and LMICs, compared to high-income countries.

5.8 Conclusions

This study investigated the possibility of reforming mental health services in Gaza, a post-conflict area and LMIC. The findings of this study addressed the same challenges of developing mental health services in other LMICs and post-conflict areas (De Vries and Klazinga, 2006; Saraceno et al., 2007; Saxena et al., 2007; WHO, 2007). However, this study added key information to the literature, to address important gaps in service development in LMICs and post-conflict areas, involving: 1) a comprehensive description of the current mental health system in Gaza, 2) an assessment of the Mental Health Policy and Plan in Gaza, 3) a training needs analysis, including TNA instrument, and 4) mental health policy makers and mental healthcare professionals' as well as service users and family members' views on mental health services in Gaza and suggestions for reform. Important findings concerned also the questionable value of short-term humanitarian response programmes, the ineffective coordination between governmental services and NGOs, and the waste of invaluable potential contributions of service users and carers in service provision and development.

The findings of this study can provide guidance to policy makers and health planners in LMICs and post-conflict areas on how to improve mental health services and policy development, while using the same, limited, mental health resources. Existing studies investigating mental health reform in LMICs and post-conflict areas provided

a general description of the main barriers toward deinstitutionalisation of services, but they failed to provide practical solutions to complicated problems of service development in such countries. This study is the first of its kind to find ways to solve a problem in the field of interest in providing a comprehensive description of the requirements for mental health reform in Gaza, and providing some novel findings that may be useful to other LMICs and post-conflict areas.

This section provides concise answers to research questions, using the same order of research questions presented in Chapter one. Additionally, this section provides a list of the main contributions of this study to practice and research knowledge. Finally, this section provides a list of detailed recommendations for policy makers, donors and mental health professionals, which is organised into short, medium and long-term expected timescales for implementation.

In this study the triangulation of findings were generated from a convergent mixed method approach to answering research questions (Creswell and Plano Clark, 2011). The first question: "**What are the current characteristics of the mental health system in Gaza in relation to policy development, service development and delivery, and availability of human resources?"** was answered by providing a description of the mental health services in Gaza from the WHO-AIMS (WHO, 2005a), an analysis of the development of the mental health policy and plan using WHO-Checklists (WHO, 2009), and also data generated by the focus groups with mental health professionals and policy makers and the focus groups with service users and carers. The most important finding of this assessment was that the mental

health services in Gaza are under-resourced and fragmented between the governmental and NGO sectors. Although the mental health policy and plan development supports deinstitutionalisation, the clinical services are still dominated by a medical model of care.

The second research question: "**What are the approaches that have been used to develop mental health policies and mental health plans for service development and delivery in Gaza, and how does the process of formulation, and the contents of both mental health policy and mental health plan, meet the international standards set by the WHO?"** was addressed by compiling findings from the analysis of the WHO-Checklists, and the focus groups with mental health professionals and policy makers.

The findings of this study addressed the disconnection between policy development and clinical practice in Gaza, as key mental health stakeholder participation (Ministry of Finance, service user and carer representatives, and mental health practitioners) in policy and plan development was limited. Furthermore, additional content should be added to the mental health policy and plan related to improving monitoring and evaluation mechanisms for mental health services, setting up a clear coordination mechanism to regulate the relationship between all mental health stakeholders in all activities related to service planning and delivery, and clearly identifying the role of NGOs in policy and plan development. The findings of this study can provide a useful guide to the "mental health policy task force" to inform future policy and plan review and updates.

The third research question: "**How do mental health professionals describe: 1) their self-perceived level of possession of mental health skills and knowledge competence, 2) the support they receive in using and implementing such skills, and 3) priority areas for mental health training and their preferred approach to training?"** was addressed by investigating the training needs of mental health workers using the TNA questionnaire developed by the researcher, by the WHO-AIMS questionnaire (WHO, 2005a), the WHO Checklist (WHO, 2009), and the focus groups with mental health professionals and policy makers.

The current study contributed to the mental health human resource development in Gaza by providing policy makers with a list of priority training needs, based on a competency-based assessment, and methods of developing such competencies. The identification of treatment modalities and disaster management as top training needs was one of the novel findings of this study. The potential reason for emphasising disaster management as a top training need is the high need for providing crisis intervention services in a post-conflict area, such as Gaza.

The fourth research question: **"In the light of ongoing conflict in Gaza, what are the views of mental health policy makers and mental healthcare professionals on major mental healthcare challenges and what are their suggested strategies for reforming mental health services in Gaza?"** was answered by triangulating the findings from the focus groups with mental health professionals and policy makers with the data from the WHO-Checklists (WHO, 2009). The new findings of this study are the exploration of the huge fragmentation of services between the governmental

and NGO sector because of the lack of coordination on the level of policy development and service delivery. Additionally, the short-term intervention programmes, although well-supported by donors, did not provide a valuable contribution to service development.

The involvement of service users and carers in this study was crucial to answering the fifth research question: "**What are the service users' and their family members' (carers) views on: 1) current mental health services, 2) mental health reform, and 3) involving them in planning and implementing mental health services in Gaza?"**, as well as the significant contribution to knowledge and mental health policy research in Palestine and in the surrounding Arabic countries. The answer to this research question was achieved by comparing findings from focus groups with service users and carers, focus groups with mental health professionals and policy makers, data from the WHO-Checklists (WHO, 2009), and data from the WHO-AIMS questionnaire (WHO, 2005a).

The findings of the current study emphasised the exclusion of service users and carers from all levels of service development and delivery, which made them dissatisfied with the services provided. The top two barriers toward effective service user and carer participation were the lack of appropriate communication inside the community mental health centres and the stigma and discrimination practised by the community against services users and their family members. Furthermore, service users and carers provided important suggestions where they can contribute to

improving service delivery, mainly by partnership with service providers and shared care, especially if supported to actively participate.

The findings of this study emphasised areas of consensus between mental health policy makers, mental health professionals and service users and carers. The most important cross cutting findings of this research were:

- The role of NGOs in policy and service development was unclear; a main contribution to this ambiguity is the absence of strategies that could organise the relationship between the governmental services and NGOs in both the mental health policy and the mental health plan.
- The community mental health services are the best approach for providing mental health care. However, the community-based service should not be provided in a way that exposes service users and their family members to stigma and community discrimination.
- Service users and carers identified stigma as a huge barrier toward seeking mental health care. While combating stigma needs a national-level, long-term, strategy, short-term strategies are needed to improve service utilisation. The government needs to invest further effort to integrate mental health services into other health, social and education services.

To conclude, the overall aims of this study were to describe the mental health system in Gaza and to identify ways of improving mental health services and, based on those findings, to provide recommendations to policy makers on how to reform mental health services. In researching these areas, I hope to initiate further research

and debate on reforming mental health systems in post-conflict areas and LMICs. The following section offers recommendations to improve mental health services in Gaza.

5.9 Key recommendations

The following key recommendations in relation to the development of community-based mental health services in post-conflict areas and LMICs are made based upon the wide range of activities and ideas that emerged from the current study findings (Table 5.1). The recommendations also align with the conceptual framework, the "Right to Health" approach (UNOHCHR, 2000), that is a rights based approach to healthcare to create a person-centred, whole person approach.

The key recommendations provided below in Table 5.1 are consistent also with WHO guidance for the development of community-based mental health services in LMICs, as well as scaling up services for individuals with mental health disorders (WHO, 2008c). The key recommendations are important steps that can be taken to improve mental health services in Gaza that will meet accepted international and local standards of mental health care (WHO, 2001).

This final section presents key recommendations in Table 5.1, which includes crucial activities and perspectives needed for successful mental health reform, with improvements prioritised under three headings: short-term recommendations (0-2 years), medium term (3-5 years), and long-term (6-10 years).

Table 5.1 Study Recommendations

N	What	When	By who
1	Service users and carers are currently marginalised in the development of mental health services. This is partly due to lack of clarity on the expected roles that they could take and lack of support to share their views on policy development. Improved clarity is needed about how service users and carers can be most effectively involved in developing the mental health policy and plans, as well as service development. Service users and carers should be fully supported and empowered to share their views and contribute to the decision-making processes involved in developing policy and services in line with accessibility and acceptability principles of the "Right to Health" approach.	Short-term	Mental Health Directorate
2	Improved financial support is necessary to address the call for structural reform of mental health services in Gaza. The Ministry of Finance has a key role in engaging with other mental health stakeholders and in developing the mental health policy and plans to improve the quality of health facilities and services to meet the standards of mental health care promoted by the "Right to Health" approach.	Short-term	Ministry of Health- Mental Health Steering Committee
3	Attention needs to be given to the effective implementation of the mental health policy and plans. This will require the involvement of all stakeholders, especially strengthening partnerships between all professionals, and to include those who deliver the service, to meet acceptability principles of the "Right to Health" approach.	Short-term	Ministry of Health- Mental Health Steering Committee
4	Examples of good practice and useful strategies should be disseminated about how to meaningfully involve service users and carers in their care plans, to meet accessibility to information in the "Right to Health" approach. This may involve training that could be jointly delivered by service users and carers.	Short-term	Mental Health Directorate
5	Improved infrastructure may be needed to address the problems of	Short-term	Mental Health Directorate

	lack of privacy in community mental health services that was of particular concern to service users and carers in Gaza. Respecting confidentiality is one of the key principles of the “Right to Health” approach and will help to make services more acceptable to service users and carers. Additional training may be needed to ensure all health professionals have a demonstrable competency in patient confidentiality.		
6	Mental health related stigma should be acknowledged by those who deliver services within the community. Service users and carers in this study were concerned about discrimination resulting from being identified as users of mental health services. Therefore, mental health programmes and activities should avoid exposing service users and carers to stigma and discrimination where home visits are involved. This can be achieved if mental health workers avoid using identification signs when they conduct home visits, e.g. do not use cars with the MoH logo or do not use employment identification cards in public. Implementing this recommendation would help to ensure the accessibility and acceptability of mental health services in the community, in line with the “Right to Health” approach.	Short-term	Mental health professionals working in the governmental or NGO services
7	Lack of coordination between key service providers was identified as one of the main barriers toward effective use of mental health resources. The future review of the mental health policy and plan needs to include clear and detailed strategies for coordination that identify the role of each organisation at all levels of service provision and development. The proposed coordination strategy would promote the availability of sufficient services and programmes, in line with the “Right to Health” approach. This strategy can include referral mechanisms, monitoring and evaluation mechanisms, applying for joint projects, and methods of sharing knowledge and information, and a clear exit strategy for short-term projects to support the national long-term development of the mental health system.	Short-term	The mental health policy task force
8	The role of NGOs in service development was unclear for	Short-term	The mental health policy task

	governmental services and NGOs. The ambiguous role of NGOs in service and policy development adds to the existing lack of coordination. Any revision of the mental health policy in the future should provide a clear and substantial space for the NGOs to contribute to service development, by distribution of the responsibility of different service development tasks between the governmental services and NGOs, in line with providing more accessible and acceptable mental health services according to the “Right to Health” approach.		force
9	The needs and priorities of service users and carers need to be communicated to service providers in order to improve the care provided by mental health services. There is no established strategy for communication between service users and providers. Joint committees and forums need to be established for open communication and sharing of views between service users and providers. Such communication would contribute to providing more acceptable mental health services according to the “Right to Health” approach.	Short-term	Mental Health Directorate
10	Service users and carers can contribute substantially to the development of mental health services. It is their experience and knowledge of mental health suffering and recovery that can contribute substantially to improving the quality of services, in line with the quality component of the “Right to Health” approach. This can be achieved by establishing a committee of service users and carers in each community mental health centre to provide consultations to both professionals and policy makers on intervention programmes and strategies, and on the development of care plans.	Short-term	Mental Health Directorate
11	Improved monitoring and evaluation mechanisms are essential to improving service delivery. Service users and carers emphasised the potential key role they can play in monitoring and evaluation of activities to improve service delivery. Service providers and policy makers should facilitate the participation of service users and carers	Short-term	Mental Health Directorate

	in monitoring and evaluation of mental health services to be medically appropriate, in line with the quality component in the “Right to Health” approach.		
12	Service users and carers are in a good place to identify where the skills and competencies of mental health workers meet their needs and where they do not. Service users and carers revealed that the identification of training needs of mental health workers should take into consideration the suggestions of service users and carers. Therefore, the participation of service users and carers in identifying training priorities for mental health professionals should be facilitated to improve the quality and availability of mental health services, according to the “Right to Health” Approach.	Short-term	Mental Health Directorate
13	Service users and carers can contribute significantly to advocating for the rights of service users and carers. Service users demonstrated the suitability of communicating their needs and demands within the community as they have the best knowledge of those needs and demands. Improved community awareness would improve the acceptability of mental health services by the community, according to the “Right to Health” approach. The mental health workers can involve service users and carers in joint advocacy and community education programmes and activities, because there is no independent structure of service users and carers to facilitate such participation.	Short-term	Mental Health Directorate
14	Mechanisms for improving the protection of service users should be established. The assessment of mental health services in the only mental hospital in Gaza revealed that there was no national human rights body to protect the rights of service users. A human rights committee should be activated to monitor any violations of service users’ rights, and to ensure a non-discriminative service in line with the “Right to Health” approach.	Short-term	Ministry of Health and the Independent Committee for Human Rights
15	The review of mental health spending in Gaza demonstrated that most of the resources are consumed by the only mental hospital. The	Middle-term	Mental Health Directorate

	transition toward community-based mental health services would need considerable revision to the distribution of resources between the mental hospital and the community mental health centers. More spending on the community-based facilities is required to facilitate the transition toward a community-based mental health system, which will improve the accessibility to mental health services according to the "Right to Health" approach.		
16	Treatment modalities and disaster management have been identified as priority mental health training areas by the majority of mental health workers who participated in this study. Appropriate measures should be taken to prioritise such training topics in the middle and long-term training plans for mental health workers. Well-trained mental health staff will improve the availability and quality of mental health services, according to the "Right to Health" approach.	Middle-term	Mental Health Directorate-Training and Development Department
17	The establishment of service user and carer organisations is needed to facilitate an active involvement of services users and carers in activities that promote service development and delivery. The health authorities in Gaza should facilitate the creation of such organisations to complement the activities provided by health providers.	Middle-term	Ministry of Health
18	The funding of mental health service development should be continuous and sustainable. The majority of health professionals questioned the value of short-term projects to respond to the after-effect of any emergency. Donors should be educated to stop funding short-term emergency response projects and to prioritise long-term development of the services to meet the quality and availability of services principles of the "Right to Health" approach.	Middle-term	Ministry of Health and World Health Organization
19	Mental health and psychosocial services should be mainstreamed in health, social and legal services to avoid stigma attached to mental health services and to improve the availability and accessibility to mental health services by the whole population to meet the "Right to Health" principles. Pupils could receive psychosocial counseling and resilience promotion activities in schools, people who are affected by	Middle-term	Ministry of Health, Ministry of Education and Ministry of Social Affairs

	conflict could receive mental health services with a package of social and legal services, while people who develop common mental health disorders could receive services from primary care.		
20	Empower service users and carers so they can contribute more effectively to improving service development and delivery in mental health in Gaza. The engagement of service users and carers in service delivery would improve the availability and quality of mental health services, in line with principles of the “Right to Health” approach. This could be achieved by involving service users and carers in training and research activities.	Middle-term	Mental Health Directorate and local universities
21	The number of mental health professionals should be increased to meet the demand of the transition of mental health services into community-based services, in line with improving the availability and quality of mental health services in the “Right to Health” approach. The WHO estimate of the target number of mental health workers for each professional group in LMICs could be a good model to follow (Bruckner et al., 2011). As Palestine was not included in this estimation study, the estimated target number of mental health professionals in Jordan could be taken into consideration as Jordan is the closest to Palestine in terms of demography and culture.	Long-term	Ministry of Health and Ministry of Finance
22	Postgraduate training was identified as the best approach to improve mental health professionals’ skills. Local universities in Gaza should establish more postgraduate training programs to address the mental health training needs in Gaza. The newly established, and existing, postgraduate programmes need to focus on top training priorities identified by this study. Therefore, postgraduate programmes should focus on training mental health professionals on different treatment modalities and crisis management skills.	Long-term	Mental Health Directorate and local universities
23	Combating stigma needs a long-term national program that uses evidence-based strategies to raise community awareness about mental health services and improve health-seeking behavior. Such a national level strategy would contribute to more culturally appropriate	Long-term	Ministry of Health, Ministry of Education, Ministry of social affairs, NGOs, local media and human rights

	mental health services that would meet the acceptability and accessibility principles of the “Right to Health” approach.		organizations
24	Mental health legislation is needed to promote the implementation of the mental health policy and plan, to meet all principles of the “Right to Health” approach. The health authorities should take steps toward developing mental health legislation on a national level.	Long-term	Ministry of Health and the Steering Committee for Mental Health
25	The development of community-based services should take into consideration the cultural sensitivity of service users and carers in Gaza. This requires the development of community-based programmes that do not expose the identity of service users and carers, to meet acceptability and confidentiality principles of the “Right to Health” approach.	Long-term	Mental health directorate

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APPENDICES

Appendix One: First Published Paper: An overview of the mental health system in Gaza: an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS)

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An overview of the mental health system in Gaza: an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS)

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Abstract

Background: Mental health system reform is urgently needed in Gaza to respond to increasing mental health consequences of conflict. Evidence from mental health systems research is needed to inform decision-making. We aimed to provide new knowledge on current mental health policy and legislation, and services and resource use, in Gaza to identify quality gaps and areas for urgent intervention.

Methods: As part of a mixed methods study, we used the World Health Organization's Assessment Instrument for Mental Health Systems Version 2·2 to collect data on mental health services and resources. Data collection was carried out in 2011, based on the year 2010.

Results: Gaza's mental health policy suggests some positive steps toward reform such as supporting deinstitutionalisation of mental health services. The decrease in the number of beds in the psychiatric hospital and the progressive transition of mental healthcare toward more community based care are indicative of deinstitutionalisation. However, mental health legislation in support of deinstitutionalisation in Gaza is lacking. The integration of mental health into primary healthcare and general hospitals has not been fully achieved. Mental health in Gaza is underfunded, human rights protection of service users is absent, and human resources, service user advocacy, and mental health training are limited.

Conclusion: Priority needs to be given to human rights protection, mental health training, and investment in human and organisational resources. Legislation is needed to support policy and plan development. The ongoing political conflict and expected increase in need for mental health services demonstrates an urgent response is necessary.

Keywords: Mental health systems, Mental health, Global mental health, Policy, Legislation, WHO-AIMS, Gaza

Introduction

Addressing the high global burden of mental disorders that are associated with substantial individual, social, and economic costs, especially in low- and middle-income countries (LMICs), and post-conflict areas, is an urgent priority [1,2]. Epidemiological evidence that the mental health burden is higher in conflict areas of the world compared to regions with no conflict is compelling [3-7].

According to data on the effect of the prolonged Israel-Palestine conflict, 68.9% of adolescents exposed to ongoing conflict and violence in Gaza have developed post-traumatic stress disorder (PTSD), 40.0% moderate to severe levels of depression, and 94.9% severe anxiety [8]. PTSD is even higher in boys injured during Al-Aqsa intifada (2000–2007),77% [9]. Although these prevalence estimates appear to be strikingly high, a systematic review of seventy-one eligible studies on the mental health of children and adolescents living in areas of armed conflict in the Middle East supports the high prevalence

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estimates, reporting PTSD to be between 23-70% in Palestine [10].

Mental illness contributes to a reduced quality of life and risk for early mortality [11]. In 2010, major depressive disorder rose by 37% of disability adjusted life years (DALYs) worldwide [12]. However, despite high levels of mental ill health and associated burden in LMICs, and post-conflict areas, and the fact that evidence-based, effective interventions can reduce this burden [13], treated prevalence rates in those areas are low, indicating a treatment gap and an urgent need for improvement in mental health care provision [14].

The landmark Lancet series on global mental health raised the profile of mental health systems in LMICs, with the aim to tackle the challenge of scaling up mental health services [1,2]. Calls for global action included recommendations for research to assess mental health systems especially within LMICs to advance global mental health provision to meet the needs of populations [13,15-17]. Yet limited systematic research has so far been conducted in LMIC and post-conflict areas.

Generating comprehensive baseline data on a country's mental health system is essential to contribute to developing policy and plans to strengthen and scale up services [1]. This paper is based on the analysis of the WHO-AIMS survey [18] to provide a comprehensive overview of current mental health policy, legislation and services in Gaza to answer our research question: What are the current characteristics of the mental health system in Gaza in relation to policy development, service development and delivery, and availability of human resources?

Methods

Study area

The Gaza Strip is located in the Middle East, with an approximate geographical area of 365 square kilometres, bordered by 40 kilometres of the Mediterranean Sea, between Egypt and Israel. At the end of 2013, the population of Gaza was 1,730,737 people (879,158 males and 851,579 females), 43.3% of whom were below the age of 15 years [19]. Gaza is classified by the World Bank as a LMIC [20]. In 2013, the unemployment rate was 32.6% and 38.8% of the population in 2011 lived below the poverty line [19].

Study design

This article presents results from a larger study using mixed methods to assess specific components of the mental health system in Gaza. The results reported here focus on an analysis of data collected using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2·2 [18].

Instrument

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) questionnaire (Version 2·2) was used to conduct an assessment of the mental health system in Gaza based on the year 2010 [18]. The WHO-AIMS tool is an evidence-based tool [21], incorporating ten recommendations proposed by the World Health Report 2001 [22].

The WHO-AIMS questionnaire [18] has six domains: (1) policy and legislative framework, (2) mental health services, (3) mental health in primary healthcare, (4) human resources, (5) public education and links with other sectors, and (6) monitoring and research.

Data sources

Purposive sampling was used to identify six informants, following the WHO-AIMS guidelines [18] that recommend selecting informants with access to all information that is needed to complete each of the six survey domains. Semi-structured interviews were conducted with four informants from the Ministry of Health, one informant from the Ministry of Education (mental health in schools), and one informant from the Islamic University of Gaza (mental health research).

Data collection

Ethical approval was granted by the Helsinki Committee for Research Ethics in the MoH, Gaza, and the Ethical Review Committee, the University of Birmingham. Participants were provided with instructions to complete independently the WHO-AIMS questionnaire [18]. Data collection was carried out in 2011, and the first author completed the WHO-AIMS survey instrument [18] with data collected from the six key informants. To ensure data quality, returned completed surveys were checked with the six informants in face-to-face meetings to ensure data accuracy and consistency.

Data analysis

All data were entered onto the WHO-AIMS standardised data spread sheet [18]. Descriptive statistical analyses were performed following the aggregation of numerical data. The final report on main findings conforms to the reporting guidelines of the WHO [22].

Results

The current status of mental health policy, plans, services and resources are presented for each of the six domains of the WHO-AIMS instrument [18].

Mental health policy and legislative framework

The Palestinian mental health policy was developed in 2004; last revised in 2010. The following components were included: (1) developing community mental health

services, (2) downsizing mental hospitals, (3) developing a mental health component in primary healthcare, (4) human resources, (5) involvement of users and families, (6) advocacy and promotion, (7) human rights protection of users, (8) equity of access to mental health services, and (9) quality improvement. In addition, a list of essential medicines was present, including: (1) antipsychotics, (2) anxiolytics, (3) antidepressants, (4) mood stabilisers, and (5) antiepileptic drugs.

The mental health plan was drafted in 2010, consolidated and endorsed in 2011, and adopted by the Minister of Health in Gaza. This plan contains the same components as the mental health policy but also mentions reforming the mental hospital to provide more community-based services. There were well-defined goals and objectives and a timetable for implementing activities, but no budget was identified.

A draft Mental Health Act was developed in 2006 by one of the largest mental health non-governmental organisations (NGOs) in Gaza. The Legislative Council and the MoH have not approved it. Therefore, there was no mental health legislation in Gaza.

Financing of mental health services

About 2% of the total healthcare budget was directed toward mental health by the MoH in Gaza. Of all expenditure spent on mental health, 56% was directed towards the mental hospital with 44% of the budget directed toward Community Mental Health Centres (CMHCs). At least 80% of essential psychotropic medicines are provided free of charge. However, when there are shortages in psychotherapeutic medications, the cost of private purchase of antipsychotic and antidepressant medication is 5% and 7% of the minimum daily wage in Gaza, respectively.

Human rights policies

A national human rights review body does not exist in Gaza. This means that there are no inspection visits to mental health facilities and no resulting sanctions in cases of violation of service users' rights. The mental hospital in Gaza did not receive any reviews/inspections of human rights for the protection of patients. Regarding training, none of the staff working in the mental hospital received at least one day of training, a meeting or other type of working session on human rights in the year this assessment took place.

Mental health services

Organisation of mental health services

A National Mental Health Authority exists, which provides advice to the government on mental health policies and legislation. The Mental Health Authority is also involved in service planning and monitoring and quality assessment of mental health services. The mental health services are provided through outpatient services and one mental hospital. Mental health services are not organised into catchment/service areas.

There are many local and international NGOs in Gaza. The majority of NGOs provide a broad range of psychosocial, trauma-focused, programmes, while few provide specialised mental health services. The UN agencies and most international NGOs provide technical and financial support to the local government and local NGOs by supporting service development, staff training, and sometimes directing funds from international donors to local NGOs to support the implementation of projects. The WHO office in Gaza is an example of an international organisation that provides substantial financial and technical support to the Ministry of Health in support of mental health service development, especially the integration of mental health into PHC. Few international organisations provide direct service delivery to the population in Gaza, such as Save the Children and Médecins Sans Frontières. UNRWA is the largest service provider among international organisations. UNRWA provides psychosocial and mental health activities in 245 schools, 22 health centres, and 8 community rehabilitation centres.

Mental health outpatient facilities

There were seven outpatient mental health facilities in Gaza, referred to as CMHCs. The first CMHC was established in 2004 and the last one in 2006. In 2010, those outpatient facilities treated 74·5 new service users per 100,000 population. Of all service users treated in CMHCs, 29% were female and 10% were children or adolescents. The service users treated in CMHCs were primarily diagnosed with neurotic disorders (18%), schizophrenia (14%), epilepsy (14%), mental retardation (13%), affective disorders (13%), organic disorders (7%), substance abuse disorders (4%), personality disorders (3%), and other mental disorders (14%). There was only one outpatient facility qualified to provide services to children and adolescents that represented 14% of outpatient services provided.

All CMHCs provided follow up care in the community, while none of the facilities provided mobile mental health teams. Regarding available treatments in 2010, most patients (51-80%) in CMHCs received one or more psychosocial interventions. Cognitive behavioural therapy is provided by psychologists; recovery interventions by mental health nurses; psychosocial rehabilitation by mental health nurses and social workers; dialectical behavioural therapy by psychologists and mental health nurses; and psychological first aid by psychologists, social workers and nurses.

Moreover, all CMHCs had at least one psychotropic medicine from each therapeutic class (i.e. antipsychotics, antidepressants, mood stabilizers, anxiolytics, and antiepileptics) available in the facility or at a nearby pharmacy throughout the year.

Mental hospital

There was one mental hospital available in Gaza, with 30 beds: 1·89 beds per 100,000 population. The number of beds decreased by 17% in the last five years. The hospital was integrated organizationally, with mental health outpatient facilities. There were no beds in the mental hospital reserved for children and adolescents only. The hospital treated 30·12 new users per 100,000 population. Among patients admitted to the hospital in 2010, 55% were females and no children or adolescents. The service users admitted to the mental hospital were primarily diagnosed with schizophrenia (69%) and mood disorders (14%); average length of stay was 8·68 days. The majority (80%) of service users spend less than one year in the mental hospital, 20% spend 5–10 years, and none spend more than ten years. In contrast to CMHCs, few service users (1-20%) in the mental hospital received one or more psychosocial interventions in the past year. The mental hospital had at least one psychotropic medicine of each therapeutic class available.

All the psychiatric beds in Gaza were located in the only mental hospital in Gaza City. The density of psychiatric beds in or around Gaza City is 2·94 times greater than the density of beds in the whole of the Gaza Strip. This distribution prevents equal access for the whole population in Gaza, especially for those living in rural areas.

Mental health in primary healthcare

All facilities providing primary healthcare (PHC) in Gaza were physician-based. Of the 57 governmental PHC clinics in Gaza, almost all (81-100%) had assessment and treatment protocols for key mental health conditions; however, only a few (1-20%) made at least one referral per month to a mental health professional. PHC doctors are allowed to prescribe psychotropic medicines with restrictions. A few PHC clinics (1-20%) had at least one psychotropic medicine for most of the therapeutic categories (antidepressant, anxiolytic, and antiepileptic) available in the facility or at a near-by pharmacy all year long.

Training of human resources in mental healthcare

Concerning undergraduate training for doctors and nurses in Gaza, 4% of the training for medical doctors was mental health related, in comparison to 7% for nurses, while non-doctor/non-nurse PHC workers received no mental health training. Only 30% of PHC doctors and 33% of nurses received at least two days of refresher training in mental health. It is notable that training of medical doctors and primary care nurses in mental healthcare is an ongoing process aimed at integrating mental health into PHC. Training was started in 2008 by the MoH, with support provided by the WHO.

Human resources

The total number of healthcare workers in mental health facilities and private practice was 11·91 per 100,000 population as follows: 0·25 psychiatrists, 1·6 other medical doctors (not specialised in psychiatry), 4·8 nurses, 2·2 psychologists, 2·5 social workers, 0·5 occupational therapists, and 36·4 other health or mental health workers (including auxiliary staff, non- doctor/non-physician PHC workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors). Table 1 displays the number of mental health professionals per professional group working within mental health facilities and private practice.

Figure 1 shows the percentage distribution of governmental mental health workers between outpatient facilities and the mental hospital. There were 0·07 psychiatrists and 1·1 nurses per bed in the mental hospital. For other mental healthcare staff (e.g. psychologists, social workers, occupational therapists, other health or mental health workers), there were 1·03 staff per bed in the mental hospital.

The distribution of human resources between urban and rural areas was disproportionate. The density of psychiatrists and nurses in or around the largest city was 1·48 and 1.47 times greater than their density in all of Gaza, respectively.

Training professionals in mental health

Table 2 displays the number of mental health professionals trained by academic institutions in Gaza per 100,000 population. It is notable that some psychiatrists (21-50%) emigrated to other countries within five years of completing their training. The number of doctors and nurses (not

Table 1 Number of mental health professionals by discipline working within mental health facilities and private practice

Mental health professional	Number of mental health professionals per 100,000
Psychiatrists	4
Medical Doctors	26
Psychologists	35
Social Workers	40
Nurses	76
Occupational Therapists	8
Other Mental Health Workers	577

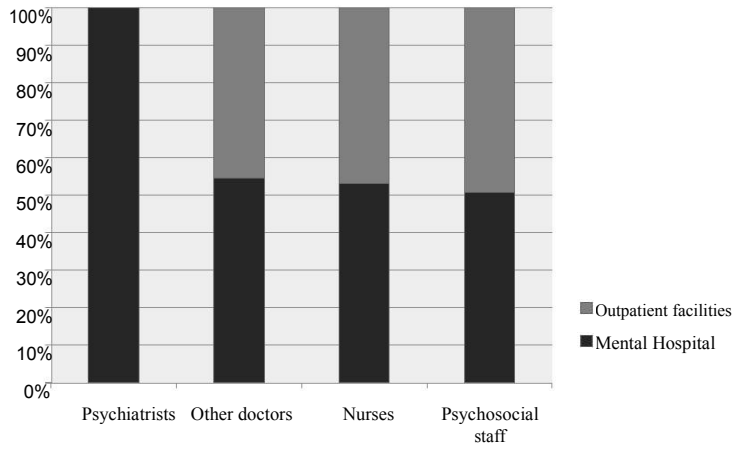

Figure 1 Percentage of mental health staff according to place of work.

specialised in psychiatry) represents those who graduated from medicine and nursing schools in Gaza in 2010. The training they received in both schools was undergraduate training with no specialisation in mental health.

Consumer and family associations

There was no official service user or carer associations in Gaza with legal or official representation in professional or legal activities. However, there were two advocacy groups for service users and carers organised by social workers in Gaza City and they met regularly in one of the CMHCs and the mental hospital in Gaza.

Public education and links with other sectors

There was no coordinating body in Gaza to oversee public education and awareness campaigns on mental health. Government agencies, NGOs, and professional organisations all promoted public education and awareness campaigns in the last five years. These campaigns targeted the general population, women, trauma survivors, and other vulnerable groups. In addition, there were public education and awareness campaigns targeting professional groups, including teachers, healthcare providers, the complementary/alternative traditional sector, social services staff, leaders and politicians, and other professional groups linked to the health sector.

There were formal collaborations between the government department responsible for mental health and the departments/agencies responsible for PHC, child and adolescent health, substance abuse, child protection, education, welfare, and criminal justice. Concerning child and adolescent mental health, all primary and secondary schools had either a part-time or a full-time mental health professional, and almost all schools (51-80%) had school-based activities to promote mental health and prevent mental disorders. Regarding training, no police officers, judges, or lawyers had participated in educational activities on mental health in the last five years. Mental health facilities did not provide financial support to service users or link them to employment programmes outside mental health facilities.

Table 2 Number of trained mental health professionals per 100,000 population

	Professionals graduate in mental health per 100,000
Psychiatrists	0
Medical Doctors	6·11
Nurses	11·7
Psychologists	1·57
Social Workers	0
Nurses + 1 year	1·57
Occupational Therapists	0

Monitoring and research

The mental health directorate received data from the only mental hospital in Gaza and all mental health out-patient facilities. However, no report was published on data transmitted to the mental health directorate. Research focused on epidemiological and non-epidemiological studies in community and clinical samples, services research and psychosocial, biology and genetics, and psychotherapeutic interventions.

Discussion

This is the first study to report on current mental health policy, legislation, and services in Gaza, and provides a baseline for future progress and comparison with other countries. Our findings indicate some progress in mental health reform among many challenges, including a progressive transition of mental healthcare toward more community-based services, with a reduction in the number of hospital beds, and slowly integrating mental health into PHC. Nevertheless, the hospital consumed a large portion of the mental health budget and mental health

staffing. This biased distribution of resources towards a mental hospital is common in most LMICs: funding from the mental health budget directed towards mental hospitals is 80% in Ghana [23-25], 55% in Uganda [26], and 67% in the whole world [27].

The integration of mental health into PHC began in Gaza in 2008, but by 2010 the provision of mental healthcare by PHC professionals was inadequate. Health planners and decision makers in Gaza need to continue the process of integrating mental health into PHC started by the MoH and the WHO. This integration could improve accessibility to mental health services by the population in Gaza, taking into consideration the shortage of specialised mental health professionals and the disproportionate distribution of mental health workers in rural areas.

Although the MoH started integrating mental health into PHC, mental health services need to be integrated into all health services. The study findings revealed the absence of community-based acute psychiatric units in general hospitals. The overdependence on the mental hospital in providing tertiary care could promote institutionalisation of mental health services and exhaust the financial and human resources allocated for mental health. The health authority in Gaza needs to promote the integration of mental health into secondary and tertiary health services and create more facilities for community-based rehabilitation in order to downsize the role of the mental hospital.

Other limitations of reform include a lack of mental health professionals, particularly psychiatrists who are key mental health service providers in a system dependent upon a biomedical approach to care, a lack of service user and carer representation in decision making or health planning activities, limited funding and human rights review bodies, and inadequate training of mental health staff.

The number of human resources in Gaza is comparable to many African countries [15]. Although the size of the mental health workforce in Gaza is higher than in low-income countries like Uganda [26], and Kenya [28], it is considerably lower than the number of other middle-income countries like Brazil [29], and Vietnam [30].

The lack of service user and carer participation in healthcare provision could lead to increased violation of human rights and discrimination of service users and carers. An empowering approach is needed if service users and carers are expected to contribute more effectively in providing suggestions for improvement or evaluating mental health services [31]. First, service providers need to improve communication with service users and carers, treat them as part of the decision-making process, and involve them in their care plans [32]. Second, the government needs to establish legal representation for service users and carers to ensure that they are represented in activities related to advocacy and policy and legislation development [33].

The absence of a Mental Health Act or any legislation mechanism for mental health practice in Gaza is in line with other developing countries without mental health legislation [17,33], but contrasts with other Middle Eastern countries such as Saudi Arabia that has recently ratified their Mental Health Act [34]. There was an attempt to develop legislation in Gaza but this was not completed because of political factors. The lack of human rights monitoring and absence of legitimate service user and carer representation call for urgent action to be taken by the authority in Gaza to build upon the Mental Health Act developed in 2006 and to enhance mental health legislation to protect the human rights of service users and carers.

The study findings revealed under-spending on mental health services by the health authority in Gaza, consistent with lower than needed mental health spending in other LMICs [17]. Since 2004, international donors financially supported the transition of mental health services toward a community-based approach. However, this financial support is time limited and not sustainable [35]. Therefore, the health authority in Gaza needs to increase their spending on mental health to sustain and expand the development of a community-based approach to mental health services.

Mental health reform in conflict and post-conflict countries is affected by the consequence of conflict on prioritising the health agenda. It is rare to find mental health reform at the top of the health planners' agenda in areas affected by emergency situations [36]. Contributory factors to this low priority are that unstable security situations discourage donors and policy makers from supporting the long-term development of mental health systems [37], and the tendency of policy makers to address more existential concerns that do not include mental health reform, which was the case in Israel [38]. Consequently, although the mental health burden in post-conflict areas is higher than in more stable countries [6,7,39], mental health services in most low-resourced and conflict-affected countries are still under-resourced and insufficient to respond to such high needs [16,17].

One of the main barriers toward developing mental health resources in post-conflict areas, and LMICs, is the low governmental spending on developing mental health services, which are biased toward institutionalised medical services. Although the mental health policy, plan and legislation were well-developed in Ghana, mental health services were also underfunded: only 1.4% of the health expenditure was spent on mental health [24]. The assessment of the mental health system in Ghana revealed a broad provision of mental health services in outpatient services, mental hospitals, community-based psychiatric units, residential facilities, and day treatment centres. However, the number of mental health workers was extremely unbalanced toward medical staff. For example, there were 19 psychologists compared to 1,068 mental health nurses [24]. Similarly, Uganda has taken substantial steps toward decentralisation of mental health

services. However, the governmental spending on mental health services does not exceed 1% of the governmental health budget and 55% of this fund was spent on mental hospitals [26].

Although resources for reforming mental health services in post-conflict areas are insufficient, there are positive examples of improving accessibility to mental health services: Darfur has successfully integrated the management of five common mental disorders into PHC [40] and, although spending on mental health services in Uganda was insufficient, mental health services were broadly integrated into PHC and general hospitals [26]. The experience of integrating mental health services in PHC in Darfur and Uganda demonstrates the potential for the decentralisation of mental health services in low-income, post-conflict settings.

Substantial progress has been achieved toward integrating mental health into PHC in Gaza. The MoH, supported by the WHO, is implementing a district level, stepped-care programme, aiming to integrate mental health into all 54 governmental PHC centres. At least 50% of this target has been achieved to date. One service user and carer organisation has been established: it is poorly funded, and more focused on advocacy and awareness raising, but its role in policy and service development is still uninfluential. The number of beds in the mental hospital was decreased from 30 to 24. One day care centre has been created inside the mental hospital in 2014; its focus is on occupational therapy and recovery, for people with severe mental illnesses.

Study limitation

The WHO-AIMS questionnaire [18] should be completed by key informants appointed from relevant organisations. Although participants in our study were relevant to completing the questionnaires, many questions required professional judgment on the current situation of service development. A potential limitation of this study, therefore, is that a single person judgment can potentially introduce bias as this judgment could reflect personal views and attitudes. Our solution was to check and confirm the accuracy and source of information with all six participants in face-to-face meetings.

Conclusion

The mental health system in Gaza has achieved substantial progress toward the de-institutionalisation of mental healthcare; however, many challenges remain. The ongoing political conflict in Gaza and associated increase in the need for mental health services should put more pressure on authorities in Gaza to invest more resources in mental health.

Establishing community mental health centres and downsizing the mental hospital should improve accessibility to mental health services in primary care and general hospitals. To achieve this, authorities in Gaza need to increase expenditure on mental health, and increase the number of skilled mental health professionals. Mental health policy and service development in Gaza should consider service user and carer human rights. This can only be achieved by developing mental health legislation to enhance mental health policy implementation, and by promoting service user and carer participation in all levels of policy and service development.

This study adds to the limited research on mental health reform in LMICs and post-conflict areas and provides important information on progress and gaps to inform policy makers and health planners on the distribution of scarce resources and priority areas for urgent intervention. Furthermore, the findings of the current study add to the knowledge base in developing mental health services in LMICs, and especially countries affected by conflict, by highlighting common gaps and the need for better use of available resources.

Competing interests
The authors declare that they have no competing interests.

Authors' contributions
DS conceived the idea for the study. He designed the study and data analysis plan. He collected data, analysed and interpreted the findings, and drafted the manuscript. LT contributed to the design of the study and data analysis plan. LT and MM supervised the study, contributed to the analysis and interpretation of findings, and made substantive intellectual contributions to the manuscript. All authors read and approved the final manuscript.

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Appendix Two: WHO-AIMS Surveys
http://www.who.int/mental_health/publications/who_aims_instrument/en/

Mental Health Directorate

ITEM 1.1.1	**Last version of mental health policy**
DEFINITION	Year of the last version of the mental health policy document (either as a separate mental health policy document or incorporated within a general health policy document).
MEASURE	Please state the year of the last version of mental health policy document: .....
NOTES	Mental health policy refers to an organised set of values, principles, and objectives to improve mental health and reduce the burden of mental disorders in a population.
ITEM 1.1.2	**Contents of the mental health policy**
DEFINITION	Components included in the mental health policy
MEASURE	**Please circle the appropriate answer/s:** **1. Organisation of services: developing community mental health services** **2. Organisation of services: downsizing large mental hospitals** **3. Organisation of services: developing a mental health component in primary healthcare** **4. Human resources** **5. Involvement of users and families** **6. Advocacy and promotion** **7. Human rights protection of users** **8. Equity of access to mental health services across different groups** **9. Financing** **10. Quality improvement** **11. Monitoring system** Y/N; UN = unknown; NA= not applicable
ITEM 1.1.3	**Psychotropic medicines included on the essential medicines list**
DEFINITION	Categories of psychotropic medicines included on the essential medicines list.
MEASURE	**Please circle the appropriate answer/s (Y= Yes, N= No, NA= not applicable)** **1. Antipsychotics (Y); (N); (NA)** **2. Anxiolytics (Y); (N); (NA)** **3. Antidepressants (Y); (N); (NA)** **4. Mood stabilizers (Y); (N); (NA)** **5. Antiepileptic drugs (Y); (N); (NA)**
NOTES	• Antipsychotics include chlorpromazine, fluphenazine, haloperidol; antidepressants include amitriptyline, clomipramine; mood

	stabilizers include carbamazepine, lithium carbonate, valproic acid; anxiolytics include diazepam; antiepileptic drugs include phenobarbital, carbamazepine, valproic acid. • Code Y if at least one medicine for a category is present on the essential medicines list. • Code N if there are no medicines within that category on the essential medicines list. • Code NA if there is no essential medicines list. • Essential medicines refer to the medicines that the region or country has adopted - often an adaptation of the WHO Model List of Essential Medicines.

FACET 1.2	**Mental health plan**
DEFINITION	Date, components included, and specification of strategies in the mental health plan.
ITEM 1.2.1	**Last version of the mental health plan**
DEFINITION	Year of the last version of the mental health plan.
MEASURE	**Please state the date of the last mental health plan produced: .....** UN = unknown; NA = not applicable (e.g. no mental health plan exists).
NOTES	A mental health plan is a detailed scheme for action on mental health which usually includes setting priorities for strategies and establishing timelines and resource requirements. A mental health plan usually includes action for promoting mental health, preventing mental disorders and treating people with mental illnesses.

ITEM 1.2.2	**Content of the mental health plan(s)**
DEFINITION	Components included in the mental health plan(s).
MEASURE	**Please circle the appropriate answer/s:** **1. Organisation of services: developing community mental health services** **2. Organisation of services: downsizing large mental hospitals** **3. Organisation of services: reforming mental hospitals to provide more comprehensive care** **4. Organisation of services: developing a mental health component in primary healthcare** **5. Human resources** **6. Involvement of users and families** **7. Advocacy and promotion** **8. Human rights protection of users** **9. Equity of access to mental health services across different**

	groups **10. Financing** **11. Quality improvement** **12. Monitoring system** Y/N; UN = unknown; NA = not applicable
NOTES	Describe the components of all mental health plans that are valid for the last year, independent of when the plan was made (e.g. if plans were made in 1995 and in 2000 and both are still in operation, please describe the components of both plans).

ITEM 1.2.3	**Strategies in the last mental health plan**
DEFINITION	Identification of strategies in the last mental health plan.
MEASURE	**Please circle the appropriate answer/s:** **1. Budget is mentioned in the last mental health plan.** **Yes No NA** **2. A timeframe is mentioned in the last mental health plan.** **Yes No NA** **3. Specific goals are mentioned in the last mental health plan.** **Yes No NA** **4. Have any of the goals identified in the last mental health plan been reached within the last calendar year?** **Yes No NA** Y/N; UN = unknown; NA = not applicable

ITEM 1.2.4	**Last version of a disaster/emergency preparedness plan for mental health**
DEFINITION	Year of the last version of a disaster/emergency preparedness plan for mental health in emergencies.
MEASURE	**What is the date of the last disaster/emergency preparedness plan for mental health in emergencies: .....** UN = unknown; NA = not applicable (e.g. no disaster/emergency plan for mental health exists).
NOTES	• A disaster/emergency preparedness plan for mental health is a detailed scheme for preparing for action on mental health in the context of a disaster/emergency. It usually sets priorities for strategies, establishes timelines and resource requirements. • The plan may be part of the mental health plan, the health plan, a disaster plan, or a separate document.

ITEM 1.4.1	**Functions of national-level or regional-level review bodies on human rights**

DEFINITION	Functions of national-level or regional-level review bodies assessing the *human rights protection of users* in mental health services.
MEASURE	**National-level or regional-level review bodies exist that have the authority to:** **Please circle the appropriate answer:** **Oversee regular inspections in mental health facilities** **Yes No NA** **Review involuntary admission and discharge procedures** **Yes No NA** **Review complaints investigation processes** **Yes No NA** **The review body has the authority to impose sanctions** **Yes No NA** **(e.g. withdraw accreditation, impose penalties, or close facilities that persistently violate human rights).** **Y/N; UN = unknown; NA = not applicable**
NOTES	If you are completing the WHO-AIMS for your country, please answer the question for national review bodies; if for a state, province, or designated administrative area please answer the question for regional-level review bodies.
ITEM 1.5.1	**Mental health expenditures by the government health department**
DEFINITION	Proportion of mental health expenditures from the total health expenditures by the government health department.
MEASURE	Proportion; UN = unknown; NA = not applicable.
NUMERATOR	**Please state the amount of money spent for mental health services by the government health department in Shekels: ...**
DENOMINATOR	**Total amount of money spent for health services by the government health department in Shekels:.....**
NOTES	This item covers expenditures on mental health services (i.e. money spent). It does not cover budget allocation. Budget allocation and expenditures may be different because allocated monies are often spent on other services.

ITEM 1.5.3	Mental disorders in social insurance schemes
DEFINITION	Coverage of mental disorders by social insurance schemes.
MEASURE	**Please circle the appropriate answer/s:** **A = no mental disorder is covered by social insurance schemes** **B = only (some) severe mental disorders are covered by social insurance schemes** **C = all severe and some mild mental disorders are covered** **D = all mental disorders are covered** **E = all mental disorders and all mental health problems of clinical concern are covered** **UN = unknown; NA = not applicable**
NOTES	• Social insurance schemes are a source of funding for mental healthcare. Everyone above a certain income level is required to transfer a fixed percentage of the income to the government–administered health insurance fund. In return, the government pays for a part or all mental healthcare. • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 1.5.4	Free access to essential psychotropic medicines
DEFINITION	Proportion of the population with free access (at 80% least covered) to essential psychotropic medicines.
MEASURE	Proportion: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the number of people with free access (at 80% least covered) to essential psychotropic medicines: .....**
DENOMINATOR	Number of people in the general population.
NOTES	• This item is specific for psychotropic drugs (in many countries psychotropic drugs are not covered by government or insurance schemes). • Free access to essential psychotropic medicines means that essential psychotropic medicines – once prescribed – are provided to people with mental disorders free of cost or with reimbursement equal or more than 80% of the retail price. The funding sources for free access/reimbursement may be the government or insurance schemes (employment, social, or private).

IF THE RESPONSE TO THE PREVIOUS ITEM WAS LESS THAN 100%, PROCEED TO THE NEXT ITEM. IF NOT, PROCEED TO DOMAIN 2.

ITEM 1.5.5	Affordability of antipsychotic medication
DEFINITION	Proportion of the daily minimum wage needed to pay for one day of

	antipsychotic medication by a user without any reimbursement, using the cheapest available antipsychotic drug.
MEASURE	Proportion: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the cost of one day of antipsychotic medication, using the cheapest available antipsychotic drug in local currency: .....**
DENOMINATOR	One day minimum wage in local currency.
NOTES	• Daily minimum wage**:** A minimum level of payment established by law for work performed. It is a time-based wage that usually applies to unskilled adults entering work for the first time. If the minimum wage is specified in hours, the daily minimum wage may be calculated by assuming an 8-hours work day and accordingly multiplying the hourly wage by eight hours. • For source of country minimum wage, consult Ministry of Labour or Ministry of Welfare or Bureau of Statistics or the ILO (stat@ilo.org). If minimum wage data are available only on a year basis, divide the yearly minimum income by 250 working days. Use the daily wage of a 'day labour' worker if no minimum wage exists. (A 'day labour' worker is an unskilled labour worker who is contracted and paid on a day-by-day basis). • The cost of the medicine is based on the retail price, paid by the user assuming no reimbursement from insurance or government schemes. • To determine the one day cost, use the medicine dosage recommended by Defined Daily Dose (DDD) system. The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults. The DDDs of the antipsychotic medicines in the WHO Model List of Essential Medicines (2003) are: 1. chlorpromazine (DDD 300 mg oral) 2. fluphenazine (DDD 1 mg depot) 3. haloperidol (DDD 8 mg oral) **4.** other antipsychotic drugs (specify the medicine and used DDD) (see, ATC Index 2004, **www.whocc.no/atcddd/).** • An example: the DDD of the antipsychotic chlorpromazine is 300 mg. In Albania using the local currency (lek) the unit cost for each 100 mg tablet of chlorpromazine is 2.8 lek. Thus, the DDD cost is 3 x 2.8 = 8.4 lek per day.

ITEM 1.5.6	**Affordability of antidepressant medication**
DEFINITION	Proportion of the daily minimum wage needed to pay for one day of

	antidepressant medication by a user without any reimbursement, using the cheapest available antidepressant drug.
MEASURE	Proportion: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the cost of one day of antidepressant medication using the cheapest antidepressant drug in local currency:.....**
DENOMINATOR	One day minimum wage in the local currency **(#)**
NOTES	• Daily minimum wage: A minimum level of payment established by law for work performed. It is a time-based wage that usually applies to unskilled adults entering work for the first time. If the minimum wage is specified in hours, the daily minimum wage may be calculated by assuming an 8-hours work day and accordingly multiplying the hourly wage by eight hours. • For source of country minimum wage, consult Ministry of Labour or Ministry of Welfare or Bureau of Statistics or the ILO (stat@ilo.org). If minimum wage data are available only on a year basis, divide the yearly minimum income by 250 working days. Use the daily wage of a 'day labour' worker if no minimum wage exists. (A 'day labour' worker is an unskilled labour worker who is contracted and paid on a day-by-day basis.) • The cost of the medicine is based on the retail price, paid by the user assuming no reimbursement from insurance or government schemes. • To determine the one day cost, use the medicine dosage recommended by Defined Daily Dose (DDD) system. The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults. The DDDs of the antidepressant medicines in the WHO Model List of Essential Medicines (2003) are: 1. amitriptyline (DDD 75 mg oral) 2. clomipramine (DDD 100 mg oral) 3. other antidepressant drugs (specify the medicine and used DDD) (see, ATC Index 2004, **www.whocc.no/atcddd/).**

ITEM 2.1.1	**Existence and functions of a national or regional 'mental health authority'**
DEFINITION	Existence and the specification of roles of a national or regional 'mental health authority'.
MEASURE	**Please circle the appropriate answer:** **1. A national or regional mental health authority exists. Yes No NA**

	2. The mental health authority provides advice to the government on mental health policies and legislation. **Yes No NA** **3. The mental health authority is involved in service planning.** **Yes No NA** **4. The mental health authority is involved in service management.** **Yes No NA** **5. The mental health authority is involved in monitoring and quality assessment of mental health services**. **Yes No NA** Y/N; NA = not applicable
NOTES	• The 'mental health authority' is an organisational entity responsible for mental healthcare within a region or country. The Department of Mental Health or the Mental Health Office in the Ministry of Health may be considered to be a 'mental health authority'. • Rate NA = not applicable if there is no 'mental health authority'.

ITEM 4.1.1	**Human resources in mental health facilities per capita**
DEFINITION	Number of human resources working in or for mental health facilities or private practice per 100,000 population by profession.
MEASURE	**Please state the number of human resources working for mental health facilities or private practice:** **1. Psychiatrists: .....** **2. Other medical doctors not specialised in psychiatry: .....** **3. Nurses:.....** **4. Psychologists:.....** **5. Social workers:.....** **6. Occupational therapists:.....** **7. Other health or mental health workers (including auxiliary staff, non-doctor/non-Physician primary healthcare workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors): .....**

	UN = unknown
NUMERATOR	**Number of human resources: .....**
DENOMINATOR	Total number of people in the general population divided by 100,000 **(#).**
NOTES	Include mental health staff working in government-administered, NGO, for-profit mental health facilities and private practice.

ITEM 4.1.2	**Psychiatrists working in various mental health sectors**
DEFINITION	Proportion of *psychiatrists* working in various mental health sectors
MEASURE	**Please state the number of psychiatrists working:** 1. **Only in or for government-administered mental health facilities: .....** 2. **Only in or for mental health NGOs/for-profit mental health facilities/private practice: .....** 3. **In or for both (a) government-administered mental health facilities and in or for (b) a mental health NGO/for-profit mental health facilities/private practice (i.e. this category is for *psychiatrists* combining work in a government-administered facility and work in one of the other sectors mentioned): .....** **UN = unknown**
NUMERATOR	**Number of psychiatrists working in each mental health sector: .....**
DENOMINATOR	Total number of *psychiatrists* working in mental health.

ITEM 4.1.3	**Psychologists, social workers, nurses, and occupational therapists working in various mental health sectors**
DEFINITION	Proportion of *psychologists*, *social workers, nurses*, and *occupational therapists* working in or for various mental health sectors.

MEASURE	**Please state the number of psychologists, social workers, nurses, and occupational therapists working:** **1. Only in or for government-administered mental health facilities: .....** **2. Only in or for mental health NGOs/for-profit mental health facilities /private practice: .....** **3. In or for both (a) government-administered mental health facilities and (b) a mental health NGO/for-profit mental health facility/private practice (i.e. this category is for professionals combining work in a government-administered facility and work in one of the other sectors mentioned): .....** UN = unknown
NUMERATOR	**Number of psychologists, social workers, nurses, and occupational therapists working in or for each mental health sector: .....**
DENOMINATOR	Total number of *psychologists, social workers, nurses*, and *occupational therapists* working in mental health.

ITEM 4.1.4	**Staff working in or for mental health outpatient facilities**
DEFINITION	Number of full-time or part-time mental health professionals working in or for *mental health outpatient facilities.*
MEASURE	**Please state the number of mental health professionals:** **1. Psychiatrists: .....** **2. Other medical doctors not specialized in psychiatry:.....** **3. Nurses: .....** **4. Psychologists, social workers, and occupational therapists: .....** **5. Other health or mental health workers: .....** **UN = unknown**
NOTES	Include mental health staff working in government-administered outpatient facilities, NGO outpatient facilities and for-profit mental health outpatient facilities. Exclude professionals engaged exclusively in private practice.

ITEM 4.1.7	**Psychiatrists working in or near the largest city**
DEFINITION	Per capita ratio of *psychiatrists* working in mental health facilities that are based in or near the largest city to the total number of *psychiatrists* working in mental health facilities in the country (or

	region).
MEASURE	Ratio: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the number of psychiatrists working in mental health facilities that are based in or near the largest city: .....** per 100,000 city population.
DENOMINATOR	**Number of psychiatrists working in mental health facilities in the entire country (or region): .....** per 100,000 city population.
NOTES	Choose the largest city in terms of population. Include the greater metropolitan area (agglomeration) of the city to determine the largest city. Exclude professionals engaged exclusively in private practice.

ITEM 4.1.8	**Nurses working in or for mental health facilities in or near the largest city**
DEFINITION	Per capita ratio of *nurses* working in or for mental health facilities that are based in or near the largest city to the total number of *nurses* working in or for mental health facilities in the country (or region).
MEASURE	Ratio: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the number of nurses working in mental health facilities that are based in or near the largest city: .....** per 100,000 city population.
DENOMINATOR	**Number of nurses working in mental health facilities in the entire country (or region): .....** per 100,000 country population.
NOTES	Choose the largest city in terms of population. Include the greater metropolitan area (agglomeration) of the city to determine the largest city.

ITEM 4.2.2	**Refresher training for mental health staff on the rational use of psychotropic drugs**
DEFINITION	Proportion of mental health staff working in or for mental health facilities with at least two days of *refresher training* on the rational use of psychotropic drugs in the last year.
MEASURE	**Please state the number of mental health professionals working in or for mental health facilities with at least two days of refresher training on the rational use of psychotropic drugs in the last year:** **1. Psychiatrists: .....** **2. Other medical doctors not specialised in psychiatry: .....** **3. Nurses: .....** **4. Other health mental health workers: .....** UN = unknown; NA = not applicable
NUMERATOR	Number of mental health staff by professional role working in or for

	mental health facilities with at least two days of *refresher training* on the rational use of psychotropic drugs in the last year.
DENOMINATOR	**Number of mental health staff by professional role working in or for mental health facilities:** **5. Psychiatrists: .....** **6. Other medical doctors not specialised in psychiatry: .....** **7. Nurses: .....** **8. Other health mental health workers: .....**
NOTES	One day training is equivalent to 8 hours.

ITEM 4.2.3	**Refresher training for mental health staff in psychosocial (non-biological) interventions**
DEFINITION	Proportion of mental health staff working in or for mental health facilities with at least two days of *refresher training* on *psychosocial* (non-biological) *interventions* in the last year.
MEASURE	**Please state the number of mental health professionals working in or for mental health facilities with at least two days of refresher training on psychosocial (non-biological) interventions:** **1. Psychiatrists: .....** **2. Other medical doctors not specialised in psychiatry: .....** **3. Nurses: .....** **4. Psychologists, social workers, and occupational therapists: .....** ***5.*** **Other health or mental health workers: .....** UN = unknown; NA = not applicable.
NUMERATOR	Number of mental health staff by professional role, working in or for mental health facilities with at least two days of *refresher training* on *psychosocial* (non-biological) *interventions.*
DENOMINATOR	**Number of mental health staff by professional role working in or for mental health facilities in the last year:** **1. Psychiatrists: .....** **2. Other medical doctors not specialised in psychiatry: .....** **3. Nurses: .....** **4. Psychologists, social workers, and occupational therapists: .....** ***5.*** **Other health or mental health workers: .....**
NOTES	• One day training is equivalent to 8 hours. • Examples of *psychosocial* (non-biological) *interventions* are psychotherapy, provision of social support, counselling, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments. Do not include intake interviews, assessment, and follow-up psychopharmacology appointments as

	psychosocial interventions. • *Refresher training* includes in-service training provided by facilities as well as "continuing education credits" provided by professional organizations.
ITEM 4.2.4	**Refresher training for mental health staff on child and adolescent mental health issues**
DEFINITION	Proportion of mental health staff working in or for mental health facilities with at least two days of *refresher training* in the last year on child and adolescent mental health issues.
MEASURE	**Please state the number of mental health professionals:** **1. Psychiatrists: .....** **2. Other medical doctors not specialised in psychiatry: .....** **3. Nurses: .....** **4. Psychologists, social workers, and occupational therapists: .....** ***5.*** **Other health or mental health workers: .....** UN = unknown; NA = not applicable
NUMERATOR	Number of mental health staff by professional role, working in or for mental health facilities with at least two days of *refresher training* on child and adolescent mental health issues.
DENOMINATOR	**Number of mental health staff by professional role working in or for mental health facilities in the last year:** **1. Psychiatrists: .....** **2. Other medical doctors not specialized in psychiatry: .....** **3. Nurses: .....** **4. Psychologists, social workers, and occupational therapists: .....** ***5.*** **Other health or mental health workers: .....**
NOTES	• One day training is equivalent to 8 hours. • Examples of training on child and adolescent mental health issues include training on assessment and treatment of psychiatric disorders, developmental issues, learning disabilities, etc. • *Refresher training includes* in-service training provided by facilities as well as "continuing education credits" provided by professional organizations.

ITEM 4.2.5	**Psychiatrists emigrated to other countries**
DEFINITION	Proportion of *psychiatrists* who emigrate to other countries within 5 years of the completion of their training.
MEASURE	**Please circle the appropriate answer:** **A= none (0%)** **B = a few (1 - 20%)**

	C = some (21 - 50%) **D = the majority (51 - 80%)** **E = all or almost all (81 - 100%)** **UN = unknown; NA = not applicable (e.g. no *psychiatrist* completed their training in the last five years)**
NOTES	In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 4.4.7	**Other NGOs involved in policies, legislation, or mental health advocacy**
DEFINITION	Number of **other** NGOs involved in policies, legislation, or mental health advocacy.
MEASURE	**Please state how many NGOs are involved in policies, legislation, or mental health advocacy: .....** UN = unknown; NA = not applicable
NOTES	• Other NGOs refer to non-governmental organisations that conduct activities related to mental health and employ at least one full-time staff member who is a mental health worker. Examples of such NGOs may include: centres that provide care to rape survivors; walk-in centres for homeless people; centres specialised in specific disorders; halfway houses for battered women. • Mental health advocacy refers to various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health. These typically include promotion of human rights of people with mental disorders, efforts to reduce stigmatising and discrimination and enhancing attention to the mental health needs and rights of general population.

ITEM 4.4.8	**Other NGOs involved in community and individual assistance activities**
DEFINITION	Number of **other** NGOs involved in community and individual assistance activities (e.g. counselling, housing, support groups, etc.).
MEASURE	**Please state how many NGOs are involved in community and individual assistance activities (e.g. counselling, housing, support groups, etc.): .....** UN = unknown; NA = not applicable.
NOTES	Other NGOs refer to those non-governmental organisations - that are neither *user/consumer* associations nor family associations - that conduct activities related to mental health and employ at least one full-time staff member who is a mental health worker. Examples of such NGOs may include: centres that provide care to rape survivors; walk-in centres for homeless people; centres specialised in specific

	disorders; halfway houses for battered women.

ITEM 5.3.1	**Provision of employment for people with severe mental disorder**
DEFINITION	Provision of employment for people with severe mental disorder through activities outside the mental health facility.
MEASURE	**Users have access to programmes that provide outside employment for users at:** **Please circle the appropriate answer:** **A= no mental health facilities (0%)** **B = a few mental health facilities (1-20%)** **C = some mental health facilities (21-50%)** **D = majority of mental health facilities (51%-80%)** **E = all or almost all (81%-100%)** UN = unknown
NOTES	• Exclude work that takes place on the premises of mental health facilities (e.g. sheltered workshops). • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 6.1.1	**Formally defined minimum data set items**
DEFINITION	There is a formally defined list of individual data items that ought to be collected by all mental health facilities.
MEASURE	**Please circle the appropriate answer:** **Yes No UN = unknown**

ITEM 6.1.5	**Data transmission from mental health facilities**
DEFINITION	Proportion of mental health facilities from which the government health department received data in the last year.
MEASURE	**Please circle the appropriate answer:** **1. Mental hospital Yes No NA** **2. Mental health outpatient facilities Yes No NA** **If yes, how many outpatient facilities: .....** UN = unknown; NA = not applicable
NUMERATOR	Number of mental health facilities which transmitted data to the government health department in the last year (for each type of facility).
DENOMINATOR	Total number of mental health facilities (for each type of facility).

ITEM 6.1.6	**Report on mental health services by the government health department**
DEFINITION	A report covering mental health data has been published by the government health department in the last year.

MEASURE	**Please circle the appropriate answer:** **A = No report** **B = Mental health data have been published in a report without comments on the data** **C = Mental health data have been published in a report with comments on the data** **UN = unknown**

Mental Health Hospitals

ITEM 1.4.2	**Inspecting human rights in mental hospitals**
DEFINITION	Proportion of mental hospitals with at least one yearly external review/inspection of human rights protection of patients.
NUMERATOR	**How many external reviews/inspections of human rights protection of patients have been conducted in the last year?** **……**
NOTES	An external review/inspection refers to a review that is conducted by an external body that is independent from the mental health facility.

ITEM 1.4.4	**Training staff in mental hospitals on human rights protection of patients**
DEFINITION	Proportion of *mental hospitals* with at least one-day training, meeting or other type of working session on *human rights protection of patients* in the last two years.
NUMERATOR	**Please state the number of training sessions, meetings, or other type of working sessions on human rights protection of patients, which lasted at least 1-day, that took place in the mental hospital in the last two years:** **…….**

ITEM 1.5.2	**Expenditures on mental hospitals**
DEFINITION	Proportion of mental health expenditures spent on *mental hospitals*
NUMERATOR	**Please state the amount of money spent on mental hospitals by the government health department in Shekels over the last year:.....**
DENOMINATOR	**Total amount of money spent for mental health services by the government health department in Shekels: .....**

ITEM 2.1.3	Mental hospitals organisationally integrated with mental health outpatient facilities
DEFINITION	Proportion of *mental hospitals* organisationally integrated with *mental health outpatient facilities.*
NUMERATOR	**Please circle the appropriate answer** **Are the mental hospitals organisationally integrated with mental health outpatient facilities:** **Yes No**
NOTES	• Rate not applicable (N/A), if *mental hospitals* do not exist • The two facilities are organisationally integrated if both of the following two conditions exist: a. A referral system between the two types of facilities is used to facilitate continuity of care; b. *Mental hospitals* and *mental health outpatient* facilities work in a coordinated manner.

ITEM 2.6.2	Availability of mental hospital beds
DEFINITION	Number of *beds* in *mental hospitals* per 100,000 population.
NUMERATOR	**Please state the number of beds in mental hospitals: .....**
DENOMINATOR	Number of people in the general population divided by 100,000 **(#).**

ITEM 2.6.3	Change in beds in mental hospitals
DEFINITION	Decrease/increase of the number of *beds* in *mental hospitals* in the last five years.
MEASURE	Proportion: UN = unknown; NA = not applicable
NUMERATOR	**Please state the number of beds in mental health hospital now: .....**
DENOMINATOR	**Please state the number of beds in mental hospitals five years before: .....**
NOTES	E.g. if the year of assessment is 2004, then one should compare with the number of beds in 1999.

ITEM 2.6.4	Gender distribution of patients treated in mental hospitals
DEFINITION	**Proportion of female patients treated in mental hospitals**
NUMERATOR	**Please state the number of female patients treated in mental hospitals: .....**
DENOMINATOR	**Total number of patients treated in mental hospitals: .....**

ITEM 2.6.5	Diagnosis of patients in mental hospitals
DEFINITION	Proportion of patients treated in mental hospital in the last year by ICD-10 diagnosis.
MEASURE	**1. Mental and behavioural disorders due to psychoactive substance use: ..... %** **2. Schizophrenia, schizotypal and delusional disorders: ..... %** **3. Mood [affective] disorders: ..... %** **4. Neurotic, stress related and somatoform disorders: ..... %** **5. Disorders of adult personality and behaviour: ..... %)** **6. Other (e.g., epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development) : ..... %** **If the proportions of each diagnosis are not available, please answer the questions below**:
NUMERATOR	**Number of patients treated in mental hospital for each diagnostic group:** **1. Mental and behavioural disorders due to psychoactive substance use: ……** **2. Schizophrenia, schizotypal and delusional disorders: .....** **3. Mood [affective] disorders: .....** **4. Neurotic, stress related and somatoform disorders: .....** **5. Disorders of adult personality and behaviour: .....** **6. Other (e.g., epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development) : .....**
DENOMINATOR	**Number of patients treated in mental hospital: .....**

ITEM 2.6.6	Involuntary admissions to mental hospitals
DEFINITION	Proportion of involuntary admissions to *mental hospitals.*
NUMERATOR	**Please state the total number of involuntary admissions to mental hospitals: .....**
DENOMINATOR	**Number of admissions to mental hospitals: .....**
NOTES	Involuntary admissions refer to admissions to mental health facilities that occur without the voluntary consent of the individual. Involuntary admissions are typically permitted in situations where a person with a mental disorder is likely to cause self-harm or harm to others or suffer deterioration in condition if treatment is not given. Involuntary

	admissions are typically ruled by mental health legislation.

ITEM 2.6.7	Long-stay patients in mental hospitals
DEFINITION	Proportion of long-stay patients by length of stay on 31 December of the last year in mental hospital.
MEASURE	**Length of stay:** **1. More than 10 years: .....%** **2. 5-10 years: ..... %** **3. 1-4 years: ..... %** **4. Less than 1 year: ..... %** **If the proportions of each diagnosis are not available, please answer the questions below**:
NUMERATOR	**Number of patients for each grouping of length of stay:** **1. More than 10 years: .....** **2. 5-10 years: .....** **3. 1-4 years: .....** **4. Less than 1 year: .....**
DENOMINATOR	**Number of patients staying in mental hospitals on 31 December of the last year:**

ITEM 2.6.8	Time spent in mental hospitals
DEFINITION	Average number of days spent in *mental hospitals.*
MEASURE	Number: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the cumulative number of days spent in mental hospital (total of all patients) in 2010: .....**
DENOMINATOR	**Number of patients treated in mental hospitals in 2010: .....**
NOTES	The cumulative number of days spent in mental hospitals is the sum of the number of days across all patients and across a mental hospital.

ITEM 2.6.9	Occupancy of mental hospitals
DEFINITION	Occupancy rate in *mental hospital*s.
MEASURE	Proportion: UN = unknown; NA = not applicable
NUMERATOR	**Please state the cumulative number of days spent in mental hospital (total of all patients) in 2010: .....**
DENOMINATOR	**Number of beds in mental hospitals times 365: .....**

ITEM 2.6.10	Physical restraint and seclusion in mental hospitals
DEFINITION	Percentage of *patients* who were physically restrained or secluded at

	least once in the last year in *mental hospital.*
MEASURE	**Please circle the appropriate answer:** **= Over 20% of patients were restrained or secluded** **= 11-20% of patients were restrained or secluded** **= 6-10% of patients were restrained or secluded** **= 2-5% of patients were restrained or secluded** **= 0-1% of patients were restrained or secluded** UN = unknown
NOTES	• A physical restraint is any manual method, physical or mechanical device, material, or equipment attached or adjacent to the user's body, which he or she cannot easily remove. Using force to hold a user and restrict movement constitutes restraint. Seclusion refers to the practice of placing a user in a confined space alone (e.g. in a locked room). • Include all the users who are physically restrained or secluded, irrespective of the duration of the restraint or seclusion. • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 2.6.11	**Children and adolescents treated in mental hospitals**
DEFINITION	Proportion of children and adolescents among *patients* treated in *mental hospitals.*
MEASURE	Proportion: UN = unknown; NA = not applicable
NUMERATOR	**Please state the number of patients 17 years of age or younger treated in mental hospital in 2010: .....**
DENOMINATOR	*Number of patients treated* in *mental hospitals* (**#)**
NOTES	Count *patients* aged 17 years and younger treated in both adult and specialised child and adolescents facilities**.**

ITEM 2.6.12	**Availability of mental hospital beds that are for children and adolescents only**
DEFINITION	Proportion of *mental hospital beds* that are for children and adolescents only.
MEASURE	Proportion: UN = unknown; NA = not applicable
NUMERATOR	**Please state the number of mental hospital beds that are for children and adolescents only: .....**
DENOMINATOR	Number of *mental hospitals beds* (**#**)

FACET 2.7	Forensic inpatient units
DEFINITION	*Beds* and *patients* in *forensic inpatient units*

ITEM 2.7.1	**Availability of beds in forensic inpatient units**
DEFINITION	Number of *beds* in *forensic inpatient units*, per 100,000 general

	population.
MEASURE	Rate per 100,000 general population: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the number of beds in forensic inpatient units: .....**
DENOMINATOR	Number of people in the general population divided by 100,000 **(#)**

ITEM 2.7.2	**Beds in forensic inpatient units by type of facility**
DEFINITION	Proportion of *beds* in *forensic inpatient units* by type of facility.
MEASURE	**Type of facility:** **1) Mental hospital: .....** **2) Forensic units in mental hospital: .....** **3) Forensic units in general hospitals: .....** **4) Prison mental health treatment facilities: .....** Proportion: UN = unknown; NA = not applicable
NUMERATOR	**Please state the number of beds in forensic inpatient units by type of facility above: .....**
DENOMINATOR	Number of beds in forensic inpatient units.
NOTES	Prison mental health treatment facilities are mental health treatment facilities that are located within prisons.

ITEM 2.7.3	**Long-stay patients in forensic units**
DEFINITION	Proportion of long-stay patients by length of stay on 31 December of the last year in forensic units.
MEASURE	**Please state the number of patients for each grouping of length of stay in 2010** **1. More than 10 years: .....** **2. 5-10 years: .....** **3. 1-4 years: .....** **4. Less than 1 year: .....** Proportion: UN = unknown; NA = not applicable.
NUMERATOR	Number of *patients* for each grouping of length of stay.
DENOMINATOR	Number of *patients* staying in forensic units on 31 December of the last year.

ITEM 2.9.1	**Availability of psychosocial interventions in mental hospitals**
DEFINITION	Percentage of *patients* who received one or more *psychosocial interventions* in mental hospitals in the last year.
MEASURE	**Please circle the appropriate answer:** **A = none (0%)**

	B = a few (1 - 20%) **C = some (21 - 50%)** **D = the majority (51 - 80%)** **E = all or almost all (81 - 100%)** UN = unknown; NA = not applicable
NOTES	*Psychosocial intervention* sessions should last a minimum of 20 minutes to be counted for this item. Examples of psychosocial treatments include psychotherapy, provision of social support, counselling, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments. Do not include intake interviews, assessment, and follow-up psychopharmacology appointments as psychosocial interventions.

ITEM 2.10.1	**Availability of medicines in mental hospitals**
DEFINITION	Proportion of *mental hospitals* in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) is available in the facility all year long.
MEASURE	Proportion: UN = unknown; NA= not applicable.
NUMERATOR	**Please circle the appropriate answer** **Is there at least one psychotropic medicine of each therapeutic category available in the mental hospital?:** **Yes No**
DENOMINATOR	Total number of *mental hospitals (* **#)**

ITEM 2.11.5	**Ethnic and religious minority group admissions to mental hospitals**
DEFINITION	Proportionate number of ethnic and religious minority group admissions to *mental hospitals* in comparison to their relative population size.
MEASURE	**In comparison to their relative population size, ethnic and religious minority groups make up: (please circle the most appropriate answer)** **A = Substantially larger proportion of admissions to mental hospitals** **B = Roughly equal proportion of admissions to mental hospitals** **C = Substantially smaller proportion of admissions to mental hospitals** UN = unknown; NA = not applicable
NOTES	In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 4.1.6	Staff working in mental hospitals
DEFINITION	Number of full-time or part-time mental health professionals per *mental hospital bed.*
MEASURE	**Please state the number of mental health professionals working in the mental hospital:** **1. Psychiatrists: .....** **2. Other medical doctors not specialised in psychiatry: .....** **3. Nurses: .....** **4. Psychologists, social workers, and occupational therapists: .....** **5. Other health or mental health workers: .....** Proportion: UN=unknown; NA= not applicable
NUMERATOR	Number of mental health professionals.
DENOMINATOR	Number of *mental hospital beds* (**#**)
NOTES	Include mental health staff working in government-administered mental hospitals, NGO mental hospitals and for-profit mental hospitals. Exclude professionals engaged exclusively in private practice.

ITEM 6.1.2	Mental health information systems in mental hospitals
DEFINITION	Proportion of mental hospitals routinely collecting and compiling data by type of information.
MEASURE	Is the mental hospital collecting data (for each type of information) routinely: **Please circle the appropriate answer** **1. Number of beds: Yes No** **2. Number of inpatient admissions: Yes No** **3. Number of days spent in hospital: Yes No** **4. Number of involuntary inpatient Admissions: Yes No** **5. Number of users who are physically restrained or secluded: Yes No** **6. Diagnoses: Yes No** Proportion: UN = unknown; NA = not applicable (e.g. no mental hospitals exist)
NUMERATOR	Number of *mental hospitals.*
DENOMINATOR	Total number of *mental hospitals* **(#)**
NOTES	Routine collecting and compiling data means that data are collected, compiled, and are available at one place in the hospital all year long.

Community Mental Health Centers

ITEM 2.1.2	Organisation of mental health services by catchment areas/service areas
DEFINITION	Catchment areas/service areas exist as a way to organise mental health services to communities.
MEASURE	**Existence of mental health catchment areas services:** **Yes No UN** Y/N; UN = unknown
NOTES	A catchment area/service area is a defined geographical area whose residents have access to basic mental health services from assigned facilities, which typically are located in (or near) the geographical area. All residents of a catchment area are expected to avail all basic services from assigned facilities.

ITEM 2.2.1	Availability of mental health outpatient facilities
DEFINITION	Number of *mental health outpatient facilities.*
MEASURE	**Please state the number of mental health outpatient facilities: .....** UN = unknown

ITEM 2.2.2	Users treated through mental health outpatient facilities
DEFINITION	*Number of users treated through mental health outpatient facilities*, per 100,000 general population.
MEASURE	Rate per 100,000 general population: UN = unknown; NA = not applicable
NUMERATOR	**Please state the number of users treated through mental health outpatient facilities in 2010: .....**
DENOMINATOR	Number of people in the general population divided by 100,000.

ITEM 2.2.3	Gender distribution of users treated through mental health outpatient facilities
DEFINITION	Proportion of female *users* treated through *mental health outpatient facilities.*
MEASURE	Proportion; UN = unknown; NA = not applicable
NUMERATOR	**Number of female users treated through mental health outpatient facilities in 2010: .....**
DENOMINATOR	*Number of users treated through mental health outpatient facilities* **(#)**

ITEM 2.2.4	Diagnosis of users treated through mental health outpatient facilities
DEFINITION	Proportion of *users* treated through *mental health outpatient facilities* by ICD-10 diagnosis.
MEASURE	1. Mental and behavioural disorders due to psychoactive substance use (F10-F19) 2. Schizophrenia, schizotypal and delusional disorders (F20-F29) 3. Mood [affective] disorders (F30-F39) 4. Neurotic, stress related and somatoform disorders (F40-F48) 5. Disorders of adult personality and behaviour (F60-F69) 6. Other (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development) (UN = unknown; NA = not applicable)
NUMERATOR	**Please state the number of users treated through mental health outpatient facilities for each diagnosis using ICD-10:** **7. Mental and behavioural disorders due to psychoactive substance use: .....** **8. Schizophrenia, schizotypal and delusional disorders: .....** **9. Mood [affective] disorders: .....** **10. Neurotic, stress related and somatoform disorders: .....** **11. Disorders of adult personality and behaviour: .....** **12. Other (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development): .....**
DENOMINATOR	**Number of users treated through mental health outpatient facilities: .....**
NOTES	ICD-10 refers to the International Statistical Classification of Diseases and Related Health Problems 10th Revision Version (http://www3.who.int/icd/vol1htm2003/fr-icd.htm).

ITEM 2.2.5	Mental health outpatient contacts
DEFINITION	Average number of contacts per *user* treated through *mental health outpatient facilities.*
MEASURE	Number: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the cumulative number of outpatient contacts provided in the previous year through mental health outpatient facilities (total of all users): .....**
DENOMINATOR	**Number of users treated through mental health outpatient facilities: .....**

NOTES	An outpatient contact is an interaction (e.g. an intake interview, a treatment session, a follow-up visit) involving a *user* and a staff member on an outpatient basis. The cumulative number of outpatient contacts is the sum of contacts across all *users* across all outpatient facilities. Includes: contacts provided by a staff member of the facility whether or not the contact occurs within the facility or at another location (e.g. at home).

ITEM 2.2.6	**Children and adolescents treated through mental health outpatient facilities**
DEFINITION	Proportion of children and adolescents among *users* treated through *mental health outpatient facilities.*
MEASURE	Proportion: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the number of users 17 years of age or younger treated through mental health outpatient facilities: .....**
DENOMINATOR	**Number of users treated through mental health outpatient facilities: .....**
NOTES	Count *users* aged 17 years and younger (i.e. those younger than 18 years old) treated in both adult and specialized child and adolescents facilities.

ITEM 2.2.7	**Availability of mental health outpatient facilities that are for children and adolescents only**
DEFINITION	Proportion of *mental health outpatient facilities for children and adolescents only.*
MEASURE	Proportion: UN = unknown
NUMERATOR	**Please state the number of mental health outpatient facilities for children and adolescents only:.....**
DENOMINATOR	**Number of mental health outpatient facilities:**

ITEM 2.2.8	**Provision of follow-up community care**
DEFINITION	Proportion of *mental health outpatient facilities* that provide routine follow-up community care.
MEASURE	Proportion: UN = unknown.
NUMERATOR	**Please state the number of mental health outpatient facilities that provide routine follow-up community care: .....**
DENOMINATOR	**Number of mental health outpatient facilities: .....**
NOTES	Routine follow-up community care means follow-up care provided outside the premises of the facility (e.g. follow-up home visits to check medication adherence, to ensure proper care for the user, to identify early signs of relapse, to assist with rehabilitation).

ITEM 2.2.9	Mental health mobile clinic teams
DEFINITION	Proportion of *mental health outpatient facilities* that have mental health mobile clinic teams that provide regular mental healthcare outside of the mental health facility.
MEASURE	Proportion: UN = unknown
NUMERATOR	**Please state the number of mental health outpatient facilities that have mental health mobile clinic teams that provide regular mental healthcare outside of the mental health facility: .....**
DENOMINATOR	Number of *mental health outpatient facilities* (**#)**
NOTES	Mental health mobile clinic teams provide regular outpatient clinics in different places to address inadequate physical access to mental health facilities. Includes extension clinics.

ITEM 2.9.3	Availability of psychosocial interventions in mental health outpatient facilities
DEFINITION	Percentage of *users* who received one or more *psychosocial intervention* in *mental health outpatient facilities* in the last year.
MEASURE	**Please circle the appropriate answer** **A = none (0%)** **B = a few (1 - 20%)** **C = some (21 - 50%)** **D = the majority (51 - 80%)** **E = all or almost all (81 - 100%)** UN = unknown; NA = not applicable
NOTES	*Psychosocial intervention* sessions should last a minimum of 20 minutes to be counted for this item. Examples of psychosocial treatments include psychotherapy, provision of social support, counselling, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments. Do not include intake interviews, assessment, and follow-up psychopharmacology appointments as psychosocial interventions.

ITEM 2.10.3	Availability of medicines in mental health outpatient facilities
DEFINITION	Proportion of *mental health outpatient facilities* in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) is available in the facility or in a nearby pharmacy all year long.
MEASURE	Proportion: UN = unknown; NA = not applicable.
NUMERATOR	**Please state the number of mental health outpatient facilities in which at least one psychotropic medicine of each therapeutic category is available in the facility or in a nearby pharmacy: .....**
DENOMINATOR	Total number of *mental health outpatient facilities* (**#)**

ITEM 2.11.2	Use of mental health outpatient services by rural users
DEFINITION	Proportionate use of mental health outpatient services by rural *users* in comparison to their relative population size.
MEASURE	**Please circle the appropriate answer** **In proportion to their relative population size, rural users are:** **A = Substantially under-represented in their use of outpatient services** **B = Roughly equally represented in their use of outpatient services** **C = Substantially over-represented in their use of outpatient services** UN = unknown; NA = not applicable
NOTES	• Use your own countries' definition for rural population. • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 2.11.3	Access to mental health services for potential linguistic minority users
DEFINITION	Percentage of *mental health outpatient facilities* that employ a specific strategy to ensure that linguistic minorities can access mental health services in a language in which they are fluent.
MEASURE	**Please circle the appropriate answer** **A = none (0%)** **B = a few (1 - 20%)** **C = some (21 - 50%)** **D = the majority (51 - 80%)** **E = all or almost all (81 - 100%)** UN = unknown; NA = not applicable
NOTES	• Strategies may be formal or informal and may include: (a) provision of translation/interpreter services, (b) scheduling staff to ensure that at any given time at least one staff is present who is fluent in the relevant minority languages, or (c) providing language training for staff in minority languages, etc. • Exclude facilities where there are no or few linguistic minority people in the population (i.e. facilities for which language is not an issue). • In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 2.11.4	Use of mental health outpatient services by ethnic and religious minority groups
DEFINITION	Proportionate use of mental health outpatient services by ethnic and religious minority groups in comparison to their relative population size.
MEASURE	**Please circle the appropriate answer** **In proportion to their relative population size, ethnic and religious minority users are:** **A = Substantially under-represented in their use of outpatient services** **B = Roughly equally represented in their use of outpatient services** **C = Substantially over-represented in their use of outpatient services** UN = unknown; NA = not applicable

ITEM 2.11.6	Differences between government-administered and for-profit mental healthcare facilities
DEFINITION	On average a substantial difference (i.e.. greater than 50%) between government-administered and for-profit mental healthcare facilities on selected indicators of care.
MEASURE	**Please circle the appropriate answer** **On average a substantial difference (i.e.. greater than 50%) on** **1. Average duration of the waiting list for an initial non-emergency psychiatric outpatient appointment Yes No UN NA** **2. Average number of minutes of an outpatient consultation with a psychiatrist** **Yes No UN NA** **3. Average number of beds per nurse in psychiatric inpatient facilities** **Yes No UN NA** Y/N; UN = unknown; NA = not applicable
NOTES	In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.3.3	Interaction of mental health facilities with complementary/alternative/ traditional practitioners
DEFINITION	Mental health facilities interacting with *complementary*

	alternative/traditional practitioners at least once in the last year.
MEASURE	**Please circle the appropriate answer** **A = none (0%)** **B = a few (1 - 20%)** **C = some (21 - 50%)** **D = the majority (51 - 80%)** **E = all or almost all (81 - 100%)** UN = unknown; NA = not applicable
NOTES	• Interaction includes meetings, review of individual cases, coordination of activities and of referral issues, as well as training complementary/alternative/traditional practitioners in relevant aspects of mental health. • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 6.1.4	**Mental health information systems in mental health outpatient facilities**
DEFINITION	Proportion of *mental health outpatient facilities* routinely collecting and compiling data by each type of information.
MEASURE	**Please circle the appropriate answer/s** **1. Number of users treated:** **How many outpatient facilities: .....** **2. Number of user contacts:** **How many outpatient facilities: .....** 3. **Diagnoses:** **How many outpatient facilities: .....** UN = unknown; NA = not applicable
NUMERATOR	Number of *mental health outpatient facilities* routinely collecting and compiling data (for each type of information).
DENOMINATOR	Total number of *mental health outpatient facilities* **(#)**
NOTES	An outpatient contact is an interaction (e.g. a treatment session, an intake interview) involving a *user* and a staff member on an outpatient basis.

Primary Healthcare

ITEM 3.1.2	**Refresher training programmes for primary healthcare doctors**
DEFINITION	Proportion of *primary healthcare doctors* with at least two days of *refresher training* in psychiatry/mental health in the last year.
MEASURE	Proportion: UN= not known; NA = not applicable.
NUMERATOR	**Please state the number of primary healthcare doctors with at least two days of refresher training in psychiatry/mental health in the last year: .....**

DENOMINATOR	**Please state the number of primary healthcare doctors working in primary healthcare clinics in the last year: .....**

ITEM 3.1.3	**Assessment and treatment protocols in physician-based primary healthcare**
DEFINITION	Availability of assessment and treatment protocols for key mental health conditions in *physician-based primary healthcare clinics.*
MEASURE	**Please circle the appropriate answer:** **Protocols are available in:** **A = No physician-based primary healthcare clinics (0%)** **B = A few physician-based primary healthcare clinics (1 - 20%)** **C = Some physician-based primary healthcare clinics (21 - 50%)** **D = The majority of physician-based primary healthcare clinics (51 - 80%)** **E = All or almost all physician-based primary healthcare clinics (81 - 100%)** UN = unknown; NA = not applicable
NOTES	• Assessment and treatment protocols include clinical guidelines, manuals, or videos on mental health for primary healthcare staff. They also include referral and back-referral procedures between *primary healthcare clinics* and mental health services. General mental health textbooks **are not** considered treatment protocols. • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.1.4	**Referrals between primary healthcare doctors and mental health professionals**
DEFINITION	Full-time *primary healthcare* doctors who make on average at least one referral per month to a mental health professional.
MEASURE	**Please circle the appropriate answer** **A = None (0%)** **B = A few (1 - 20%)** **C = Some (21 - 50%)** **D = The majority (51 - 80%)** **E = All or almost all (81 - 100%)** UN = unknown; NA = not applicable
NOTES	In the data entry file (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.1.5	**Interaction of primary healthcare doctors with mental health services**
DEFINITION	*Primary healthcare doctors* interacting with a mental health professional at least monthly in the last year.

MEASURE	**Please circle the appropriate answer** **A = None (0%)** **B = A few (1 - 20%)** **C = Some (21 - 50%)** **D = The majority (51 - 80%)** **E = All or almost all (81 - 100%)** UN = unknown; NA = not applicable
NOTES	• Interaction includes (face-to face or telephone) meetings, review of individual cases, co-ordination of activities and of referral issues, as well as mental health training sessions. • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.1.6	**Prescription by primary healthcare doctors**
DEFINITION	Health regulations authorise *primary healthcare doctors* to prescribe and/or to continue prescription of psychotropic medicines.
MEASURE	**Please circle the appropriate answer** **A = Not allowed** **B = Primary healthcare doctors are allowed to prescribe but with restrictions (e.g. they are not allowed to initiate prescription but are allowed to continue prescription, or they are allowed to prescribe in emergencies only)** **C = Primary healthcare doctors are allowed to prescribe without restrictions** NA = not applicable

ITEM 3.1.7	**Availability of medicines to primary healthcare patients in physician-based primary healthcare**
DEFINITION	*Physician-based primary healthcare clinics* in which at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) is available in the facility or in a nearby pharmacy all year long.
MEASURE	**Please circle the appropriate answer** **A = none of the clinics (0%)** **B = a few of the clinics (1 - 20%)** **C = some of the clinics (21 - 50%)** **D = a majority of the clinics (51 - 80%)** **E = all or almost all of the clinics (81 - 100%)** UN = unknown; NA = not applicable
NOTES	In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 3.3.1	Interaction of physician-based primary healthcare clinics with complementary/ alternative/traditional practitioners
DEFINITION	*Physician-based primary healthcare clinics* interacting with *complementary/ alternative/traditional practitioners* at least once in the last year.
MEASURE	**Please circle the appropriate answer** **A = none (0%)** **B = a few (1 - 20%)** **C = some (21 - 50%)** **D = the majority (51 - 80%)** **E = all or almost all (81 - 100%)** UN = unknown; NA = not applicable
NOTES	• Interaction includes meetings, review of individual cases, coordination of activities and of referral issues, as well as training complementary/alternative/traditional practitioners in relevant aspects of mental health. • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

Research

FACET 6.2	Mental health research
DEFINITION	Extent and content of mental health research

ITEM 6.2.1	Professionals involved in mental health research
DEFINITION	Mental health professionals working in mental health services who in the last five years have been involved in mental health research as a investigator or co-investigator (including through a thesis or dissertation): 1. *Psychiatrists* working in mental health services 2. *Nurses* working in mental health services 3. *Psychologists* working in mental health services 4. *Social workers* working in mental health services
MEASURE	**Please circle the appropriate answer** **Percentage of professionals involved for each professional category:** **1- Psychiatrists:** **A = none (0%)** **B = few (1-20%)** **C = some (21%-50%)** **D = the majority (51%-80%)** **E = all or almost all (81%-100%)**

	2- Nurses: **A = none (0%)** **B = few (1-20%)** **C = some (21%-50%)** **D = the majority (51%-80%)** **E = all or almost all (81%-100%)** **3- Psychologists:** **A = none (0%)** **B = few (1-20%)** **C = some (21%-50%)** **D = the majority (51%-80%)** **E = all or almost all (81%-100%)** **4- Social worker:** **A = none (0%)** **B = few (1-20%)** **C = some (21%-50%)** **D = the majority (51%-80%)** **E = all or almost all (81%-100%)** UN = unknown
NOTES	In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.
ITEM 6.2.2	**Proportion of health research that is on mental health**
DEFINITION	Proportion of indexed publications that are on mental health in the last five years.
MEASURE	Proportion: UN = unknown.
NUMERATOR	**Please state the total number of mental health publications on the country or region in the last five years as identified on PubMed: .....**
DENOMINATOR	**Total number of health publications on the country or region in the last five years as identified on PubMed: .....**
NOTES	• Studies need to involve respondents of the country or region. Investigators may be national or foreign researchers. • The website of PubMed is: **http://www.ncbi.nlm.nih.gov/entrez/query.fcgi**

ITEM 6.2.3	**Type of mental health research**
DEFINITION	Type of mental health research that was conducted in the last five years.
MEASURE	**Please circle the appropriate answer/s** **1. Epidemiological studies in community samples** **2. Epidemiological studies in clinical samples**

	3. Non-epidemiological clinical/questionnaires assessments of mental disorders **4. Services research** **5. Biology and genetics** **6. Policy, programmes, financing/economics** **7. Psychosocial interventions/psychotherapeutic interventions** **8. Pharmacological, surgical and electroconvulsive interventions** Y/N; UN = unknown
NOTES	• Studies need to involve respondents of the country or region. Investigators may be national or foreign researchers. • Include research that is published in 'grey' literature (not published in scientific journals), national or international indexed and non-indexed journals, government reports, books and (other) monographs.

Ministry of Education

ITEM 5.3.2	**Primary and secondary schools with mental health professionals**
DEFINITION	Proportion of primary and secondary schools with either a part-time or full-time mental health professional (e.g. *psychologist*, *social worker*, *nurse* specialised in mental health).
MEASURE	Proportion: UN = unknown
NUMERATOR	**Please state the number of primary and secondary schools with either a part-time or full-time mental health professional (e.g. psychologist, social worker, nurse specialized in mental health): .....**
DENOMINATOR	Total number of primary and secondary schools.

ITEM 5.3.3	**Promotion and prevention activities in primary and secondary schools**
DEFINITION	School-based activities to promote mental health and to prevent mental disorders
MEASURE	**Please circle the appropriate answer** **Promotion or prevention activities are provided in:** **A= no primary and secondary schools (0%)** **B = a few primary and secondary schools (1%-20%)** **C = some primary and secondary schools (21%-50%)** **D = majority of primary and secondary schools (51%-80%)** **E = all or almost all primary and secondary schools (81%-100%)** UN = unknown
NOTES	• Promotion and prevention activities include all organised activities

	aimed at promoting mental health and/or preventing the occurrence as well as the progression of mental disorders. Examples of activities include those aimed at improving: (a) social skills, (b) emotional communication, (c) stress management, and (d) skills for coping with adversity. • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 5.3.4	**Educational activities with police officers**
DEFINITION	Police officers participating in educational activities on mental health in the last five years.
MEASURE	**Please circle the appropriate answer** **A= no police officers (0%)** **B = few police officers (1%-20%)** **C = some police officers (21%-50%)** **D = majority of police officers (51%-80%)** **E = all or almost all police officers (81%-100%)** UN = unknown
NOTES	• Educational activities include training, educational meetings, or sessions to build practical skills. • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

ITEM 5.3.5	**Educational activities with judges and lawyers**
DEFINITION	Judges and lawyers participating in educational activities on mental health in the last five years.
MEASURE	**Please circle the appropriate answer** **A= no judges and lawyers (0%)** **B = few judges and lawyers (1%-20%)** **C = some judges and lawyers (21%-50%)** **D = majority of judges and lawyers (51%-80%)** **E = all or almost all judges and lawyers (81%-100%)** UN = unknown.
NOTES	• Educational activities include training, educational meetings, or sessions to build practical skills • In the data entry file: (a) indicate data source or (b) check relevant box if response is based on a best estimate.

Appendix Three: WHO Checklists for Mental Health Policy and Mental Health Plan
http://www.who.int/mental_health/policy/services/mhsystems/en/
WHO Checklist for Mental Health Policy

CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY			
Please use the following rating scale to rate each item: 1 = yes/ to great degree 3 = no/not at all 2 = to some extent 4 = unknown	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
PROCESS ISSUES			
1a. Was there a high-level mandate to develop the policy (e.g. from the Minister of Health)?			
1b. At what level has the policy been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health).			
2. Is the policy based on relevant data:			
-- From a situation assessment?			
-- From a needs assessment?			
3. Have policies relating to mental health that have been utilised within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant?			
4. Has a thorough consultation process taken place with the following groups:			
-- Representatives from the Health Sector, including planning, pharmaceutical, human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions.			
-- Representatives from the Finance Ministry?			
-- Representatives from Social Welfare and Housing Ministries?			
-- Representatives from the criminal justice system?			
-- Consumers, or representatives of consumer groups?			

-- Family members or their representatives?			
-- Other NGOs?			
-- Private sector?			
-- Any other key stakeholder groups? If so, please list them			
5. Has an exchange taken place with other countries concerning their mental health policies and experiences?			
6. Has relevant research been undertaken to inform policy development, (e.g. pilot studies)?			
CONTENT ISSUES			
1. Is there a realistic vision statement?			
2. Are values and associated principles, which inform the policy included?			
3. Do these values and associated principles emphasise and/or promote:			
-- Human rights?			
-- Social inclusion?			
-- Community care?			
-- Integration?			
-- Evidence-based practice?			
-- Inter-sectoral collaboration?			
-- Equity with physical healthcare?			
4. Have clear objectives been defined?			
5. Are objectives consistent:			
-- With the vision?			
-- With the values and principles?			
6. Are the areas for action clearly described to indicate the main policy directions and what will be achieved?			
7. Are the areas for action written in a way that commits the governments (e.g. do they state “will” instead of “should”)?			
8. To what extent do the areas for action comprehensively address			

coordination & management?			
(a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate mental health functions and services?			
(b) Does the policy establish or refer to a multi-sectoral coordinating body to oversee major decisions in mental health?			
9. To what extent do the areas for action comprehensively address **financing?**			
(a) Does the policy indicate how funding will be utilised to promote equitable mental health services?			
(b) Does the policy state that equitable funding between mental health and physical health will be provided?			
(c) If health insurance is utilised in the country, does the policy indicate whether/how mental health would be part of it?			
10. To what degree do the areas for action comprehensively address **legislation and/or human rights?**			
(a) Does the policy promote human rights?			
(b) Does the policy promote the development and implementation of human-rights-oriented legislation?			
(c) Is the setting up of a review body envisaged to monitor different aspects of human rights?			
11. To what extent do the areas for action comprehensively address **organisation of services?**			
(a) Does the policy promote the integration of mental health services into general health services?			
(b) Does the policy promote a community-oriented mental health approach?			
(c) Does the policy promote deinstitutionalisation?			
12. To what extent do the areas for action comprehensively address **promotion, prevention and rehabilitation?** Does the policy make provision for:			
(a) The prevention of mental disorders?			
(b) Interventions that promote mental health?			

(c) Interventions for the rehabilitation of people with mental disorders?			
13. To what extent do the areas for action comprehensively address **access to essential psychotropic medicines?**			
(a) Does the policy commit to improving availability of and accessibility to Essential Psychotropic medicines at all levels of care (e.g. cost issues)?			
(b) Does the policy emphasise the need for health workers working in facilities where essential psychotropic medicines are available to have appropriate training (for identification, prescription, monitoring of treatment and follow-up of patients)?			
(c) Does the policy identify a range of professionals allowed to prescribe essential psychotropic medicines at the different levels of the health service?			
14. To what extent do the areas for action comprehensively address **advocacy?**			
(a) Is the policy supportive of consumers and family organisations?			
(b) Is there emphasis on raising awareness of mental disorders and their effective treatment?			
(c) Does the policy promote advocacy on behalf of people with mental disorders?			
15. To what extent do the areas for action comprehensively address **quality improvement?** Does the policy			
(a) Make a commitment to providing high quality, evidence- based interventions?			
(b) Include a process to measure and improve the quality of services?			
16. To what extent do the areas for action comprehensively address **information systems?**			
(a) Will mental health information systems be set up to guide decision-making for future policy, planning and service development?			
17. To what extent do the areas for action comprehensively address **human resources and training?**			

(a) Does the policy commit to putting in place suitable working conditions for mental health providers?			
(b) Have appropriate management strategies been discussed to improve recruitment and retention of mental health providers?			
(c) Are training in core competencies and skills seen as central to human resources development?			
18. To what extent do the areas for action comprehensively address **research and evaluation?**			
(a) Does the policy emphasise the need for research and evaluation of services and of the policy and strategic plan?			
19. To what extent do the areas for action comprehensively address **intra-sectoral collaboration** within the health sector? Does the policy:			
(a) Emphasise collaboration with planning, pharmaceutical, human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions within the health sector			
(b) Contain clear statements of what role each department will play in each area for action?			
20. To what extent do the areas for action comprehensively address **inter-sectoral collaboration?** Does the policy			
(a) Emphasise collaboration with all other relevant government departments?			
(b) Emphasise collaboration with all relevant NGOs, including consumer and family groups?			
(c) Contain clear statements of what role each sector will play in each area for action?			
21. Have all of the following groups been considered:			
-- People with severe mental disorders?			
-- Children and adolescents?			
-- Older persons?			
-- People with intellectual disability?			
-- People with substance dependence?			
-- People with common mental disorders?			

-- People affected by trauma?			
22. Given the available resources, has a “reasonable balance” been achieved between the above groups?			
23. To what degree have the key mental health policy issues been integrated with/or are consistent with the country's			
-- Mental health law?			
-- General health law?			
--Patients’ rights charter?			
--Disability law?			
-- Health policy?			
-- Social welfare policy?			
-- Poverty reduction policy?			
-- Development policy?			

WHO Checklist for Mental Health Plan

CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN			
Please use the following rating scale to rate each item: 1 = yes/to a great degree 3 = no/not at all 2 = to some extent 4 = unknown	**Rating**	**If "yes" or "to some extent", please state how.** **If not, please state reason(s).**	**Action required (if any)**
PROCESS ISSUES			
1a. Was there a high-level mandate to develop the plan (e.g. from the Minister of Health)?			
1b. . At what level has the plan been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health)			
2. Does the plan include strategies and activities that are consistent with an existing and up-to-date policy?			
3. If no policy is available, does the plan include strategies and activities that are consistent with another official document(s) stating the direction(s) for mental health? Please provide relevant document(s).			
4. Are strategies and activities written in a way that commits the governments (e.g. do they state "will" instead of "should")?			
5. Has the plan been informed by:			
-- A situation analysis? and/or			
-- A needs assessment?			
6. Have effective strategies that have been utilised within the country and in other countries with similar cultural and demographic patterns been examined and integrated where necessary?			
7. Has a thorough consultation process taken place with the following groups?			
-- Representatives from the health sector, for example, including planning, pharmaceutical, human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions. ?			
-- Representatives from the Finance Ministry?			

-- Representatives from the Social Welfare and Housing Ministry?			
-- Representatives from the criminal justice system?			
-- Consumers or their representatives?			
-- Family members or their representatives?			
-- Other NGOs?			
-- Private sector?			
-- Any other key stakeholder groups? If so, please list them.			
OPERATIONAL ISSUES			
8. Have comprehensive strategies been identified for each priority area for action?			
Looking at strategies:			
9. ***Time frames****:*			
-- Are time frames provided for each strategy?			
-- Are the time frames reasonable and feasible?			
10. ***Indicators****:*			
-- Are there indicators for each strategy?			
-- If so, are the indicators appropriate for measuring the particular strategy?			
11. ***Targets****:*			
-- Are there targets for each strategy?			
-- If so, are the targets realistic?			
Looking at activities:			
12. Are clear activities defined for each strategy?			
13. Is the person/group/organisation responsible for each activity identified?			
14. Is it clear when each activity will start and finish?			
15. Are the outputs for each activity outlined?			
16. Have potential obstacles been identified?			
17. Costs and funding:			

-- Have the costs for achieving each activity been calculated?			
-- Is the funding for each activity available and allocated?			
CONTENT ISSUES			
18. Does the plan include relevant strategies and activities for **coordination & management?**			
(a) Are the composition and functions clearly defined for:			
-- The mental health coordinating body?			
-- The mental health focal point?			
(b) Is an adequate infrastructure in place/planned (including computers, Internet access and administrative support)?			
(c) Are regular meetings of the coordinating body scheduled?			
(d) Has a system of reporting to a high-level MoH official been set up for the mental health coordinating body?			
(e) Are coordination and management strategies and associated activities:			
-- Relevant?			
-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
19. Does the plan include relevant strategies and activities for **financing?**			
(a) Is it clear how services will be funded?			
(b) Is the plan clear as to whether/how user charges will be made?			
(c) Are financing strategies and associated activities			
-- Relevant?			
-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
20. Does the plan include relevant strategies and activities for **legislation and/or regulations on human rights?**			
(a) Where legislation and/or regulations are to be developed, have clear			

strategies/activities been specified for:			
-- The process of drafting the law(s)/regulations?			
-- Defining the content of the law(s)/regulations?			
-- Implementing the law(s)/regulations?			
(b) Where a review body to protect human rights is to be established, are clear strategies/activities specified for its establishment?			
(c) Are there any other strategies to protect and promote the rights of people with mental disorders?			
(d) Are the strategies on human rights and legislation and associated activities:			
-- Relevant?			
-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
21. Does the plan include relevant strategies and activities for **organisation of services?**			
(a) Are there strategies and associated activities for the provision of services at primary, secondary and tertiary levels, with continuity between them?			
(b) Are there strategies and associated activities for deinstitutionalisation?			
(c) Are there strategies and associated activities for developing community mental health services?			
(d) Has provision been made for psychosocial rehabilitation services at all levels of the health system?			
(e) Are the strategies on organisation of services and associated activities:			
-- Relevant?			
-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
22. Does the plan include relevant strategies and activities for **promotion, prevention and rehabilitation?**			
(a) Are there clear strategies and associated activities for the promotion of			

mental health?			
(b) Are there clear strategies and associated activities for the prevention of mental disorders?			
(c) Are the strategies on prevention, promotion and rehabilitation and associated activities			
-- Relevant?			
-- Evidence-based			
-- Realistic and possible to implement?			
-- Adequately funded?			
23. Does the plan include relevant strategies and activities for the **procurement and distribution of essential medicines**?			
(a) If psychotropic medicines currently are not included on the Essential Drugs List is there a strategy and associated activities to include them?			
(b) Does the plan incorporate strategies and associated activities to improve reliability of the supply and distribution system at relevant levels of health service where treatment is to be provided?			
(c) Are there strategies and relevant activities for monitoring the continuous provision and assessment of psychotropic medicines?			
(d) Are the strategies on the procurement and distribution of medicines and associated activities			
-- Relevant?			
-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
24. Does the plan include relevant strategies and activities for **advocacy?**			
(a) Is there a strategy with associated activities to support (technically and/or in practical terms) consumer groups, family groups and NGOs?			
(b) Is there a strategy and associated activities to involve consumers and family representatives in policy and service planning?			
(c) Are the advocacy strategy and associated activities:			
-- Relevant?			

-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
25. Does the plan include relevant strategies and activities for **quality improvement?**			
(a) Is there a strategy and associated activities for assessing quality?			
(b) Is there a strategy and associated activities for ongoing quality control of mental health facilities (e.g. standards)?			
(c) Is there a strategy and associated activities for accrediting facilities based on quality?			
(d) Are both hospital and community mental health facilities included in quality assessment?			
(e) Are the strategies on quality improvement and associated activities:			
-- Relevant?			
-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
26. Does the plan include relevant strategies and activities for **information systems?**			
(a) Have a strategy and linked activities been defined for:			
-- Reviewing the current mental health information system, and/or			
-- Improving the current mental health information system?			
(b) Does the strategy or linked activities include the systematic collection of mental health data from a range of sources at different levels of the health system (e.g. from general hospitals, primary healthcare and community levels)?			
(c) Is it clear how the information will feed back into:			
-- Policy development, mental health planning and service delivery?			
-- Clinical practice?			
(d) Are the strategies on information systems and associated activities:			
-- Relevant?			

-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
27. Does the plan include relevant strategies and activities for **human resources development and training?**			
(a) Is there a well-defined strategy with associated activities for assessing available personnel and competencies at different service levels?			
(b) Is there a strategy to improve the number of providers for mental health?			
(c) Are there relevant management strategies and activities to address:			
-- Recruitment?			
-- Retention?			
-- Deployment of staff?			
(d) Has provision been made for ongoing education, training and skills development?			
(e) Is there a strategy/relevant defined activities to introduce changes to undergraduate and graduate curricula of health and allied health workers?			
(f) Is there a strategy for training health providers to develop the appropriate competencies at the levels of:			
-- Informal community services?			
-- Primary healthcare services?			
-- General hospital care?			
-- Specialist care?			
(g) Are the strategies on human resources and associated activities:			
-- Relevant?			
-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
28. Does the plan include relevant strategies and activities for **research and evaluation**?			
(a) Are there strategies for improving capacity to conduct research and			

evaluation?			
(b) Will the research address practical issues for the country?			
(c) Has provision been made to evaluate the policy and plan?			
(d) Are research and evaluation strategies and defined activities:			
-- Relevant?			
-- Evidence-based			
-- Realistic and possible to implement?			
-- Adequately funded?			
29. Does the plan include relevant strategies and activities for intra-sectoral collaboration? (a) Is a structure planned/in place through which intra-sectoral collaboration could take place with the following departments within the health sector (b) Is collaboration with the following departments within the health sector included in the plan - Planning, - Pharmaceutical, - Human resource development, - Child health, - HIV/AIDS, - Epidemiology and surveillance, - Epidemic and disaster preparedness divisions.			
30. Does the plan include relevant strategies and activities for **inter-sectoral collaboration**?			
(a) Is a structure planned/in place through which inter-sectoral collaboration could take place?			
(b) Is collaboration with the following government departments included in the plan?			
-- Social services			
-- Justice			
-- Education			

-- Housing			
-- Corrections			
-- Police			
(c) Is collaboration with the following included in the plan?			
-- NGOs			
-- Consumer groups			
-- Family groups			.
(d) Are the strategies on inter-sectoral collaboration and associated activities:			
-- Relevant?			
-- Evidence-based?			
-- Realistic and possible to implement?			
-- Adequately funded?			
31. To what degree have the key mental health strategies been integrated into the country's existing strategic plans for::			
--Improving patients' rights?			
--Improving rights for people living with disabilities?			
-- Overall health?			
-- Social welfare?			
-- Poverty reduction?			
--Development?			

Appendix Four: Analysis of the Mental Health Policy According to the WHO-Checklists

Rating: 1 = yes/ to great degree. 2 = to some extent. 3 = no/not at all. 4 = unknown.

N	Content issues	Rating	If "Yes" or "To some extent", please state how. If "No", please state reasons.	Action required (if any)
1	Is there a realistic vision statement?	1	The vision statement corresponds with WHO guidelines of setting out the vision of mental health policy.	
2	Are values and associated principles, which inform the policy, included?	1	There were four values and principles included: Improving the mental health of the population, Responding to individual people needs and expectations, Equity of service provision and Safeguarding human rights. This corresponds with the WHO guidelines for setting out values and principles for mental health policy.	
3	Do these values and associated principles emphasise and/or promote human rights, social inclusion, community care, integration and evidence based practice?	2	The value and principles section does not emphasise integration directly. It is included in the context of other values.	Any revision of the policy in the future should ensure emphasising integration in values and principles.
4	Have clear objectives been defined?	1	The objectives are SMART and consistent with the vision and values and principles.	
5	Are the areas for action clearly described to indicate the main policy directions and what will be achieved?	2	Areas of action do not cover all objectives described in the policy. It focuses mainly on infra-structure and human resources.	More areas of action are needed to cover all policy objectives; such as integration of mental health into general health care, collaboration and coordination, develop mental health legislation, public awareness and improving information management.
6	Are the areas for action written in a way that commits the governments (e.g. do they state "will" instead of "should")?	2	Some of the areas of action were written in a way that commits the government and some did not. This might be attributed to the government dependency on external support- this is not 100% ensured.	The review of the policy should ensure an identification of areas of action that the government should be committed to develop with its own resources and other areas for action where the government would need external

				support.
7	To what extent do the areas for action comprehensively address **coordination & management?**	3	The policy mentioned the planned capacity building for the management body in the mental health directorate on several areas including coordination and information management, but there was no emphasis on coordination and management as a separate area of action.	A coordination mechanism between the government and other service providers should be developed to ensure better use of resources and avoid duplication.
8	To what extent do the areas for action comprehensively address **financing?**	3	There is no separate budget line for mental health in the health budget.	The Ministry of Finance should be part of any policy development activity and estimated costs of mental health programmes should be added.
9	To what degree do the areas for action comprehensively address **legislation and/or human rights?**	3	Legislation and human rights were emphasised in the objectives and values and principles but are left for future planning.	A separate area for action should be dedicated for developing mental health legislation.
10	To what extent do the areas for action comprehensively address **organization of services?**	1	Areas for action promote integrating mental health into PHC and open mental health units in general hospitals. The areas for action promote establishing more community mental health centres. Additionally, the areas for action promote the gradual closure of the psychiatric hospital in Gaza.	
11	To what extent do the areas for action comprehensively address **promotion, prevention and rehabilitation?**	1-2	This was included in areas for action dedicated to crisis intervention and child and adolescent mental health. In addition, the establishment of early detection programmes in schools and the development school mental health was included in areas for action addressing the organisation of services. But no separate areas for action dedicated to mental health prevention and promotion. Areas for action promote providing rehabilitation services at the tertiary level, such as mental hospitals.	Programmes addressing mental health prevention and promotion should be emphasised separately in areas for action. A more detailed action plan is needed for early detection of mental disorders and the development of school mental health.
12	To what extent do the areas for action comprehensively address **access to essential psychotropic medicines?**	3	The policy commits to updating the essential drugs list.	More emphasis on access to essential psychotropic drugs is needed.
13	To what extent do the areas for action comprehensively address **advocacy?**	3	Advocacy and raising awareness mentioned in the objectives but not the areas for action.	Advocacy should be emphasised in areas for action. Uses and carer associations can play a substantial role

				in advocacy. A clear strategy for using community resources, including user and carer associations, should be developed to promote mental health advocacy.
14	To what extent do the areas for action comprehensively address **quality improvement?**	2-3	Evidence based intervention mentioned in values and principles but not in areas for intervention. Improving quality has been mentioned in the values and principles but not in the areas for action.	Clear strategy for quality improvement, including mechanisms for monitoring and evaluation, should be formulated in the policy.
15	To what extent do the areas for action comprehensively address **information systems?**	3	Improving the information system has been identified as one of the objectives but nothing mentioned as an area for action because developing the information system needs many resources that are not available to the government at the time of developing the policy.	The policy should support a long-term plan for developing the mental health information system that can involve both governmental and NGOs' resources.
16	To what extent do the areas for action comprehensively address **human resources and training?**	1-2	The areas for action identify the number of mental health workers that need to be recruited. Strategies for improving recruitment have not been discussed in the policy. Further, nothing mentioned for retention of mental health workers. General and specialised training for health staff and mental health professionals was clearly mentioned in the policy.	A separate mental health human resource plan should be developed to be part of the policy development. The human resource plan can include strategies for staff recruitment, retention strategies and training plan.
17	To what extent do the areas for action comprehensively address **research and evaluation?**	2	Research and evaluation for improving services were mentioned in objectives and as an area for more training for mental health officers working in the mental health directorate.	A clear strategy should be formulated to link research with policy development. A list of priority research areas can be identified through this strategy.
18	To what extent do the areas for action comprehensively address **intrasectoral collaboration** within the health sector?	2-3	Nothing directly addressed collaboration with other health sectors. Good collaboration with PHC was emphasised.	Areas for action should include clear indications where the mental health directorate should collaborate with other health sectors to implement strategies.
19	To what extent do the areas for action comprehensively address **intersectoral collaboration?**	2	Collaboration and coordination with other governmental ministries has been mentioned in different places (e.g, crisis intervention, child and adolescent mental health). However, nothing was mentioned in the policy on how to organise this relationship. Collaboration and coordination	A mechanism for coordination between key service providers should be clearly formulated in the policy. This should include coordination between different ministries, the government services and NGOs and within NGOs. The

			between governmental run mental health services and NGOs was clearly mentioned in the objectives, it was also mentioned in many other places (executive summary, crisis intervention, etc). A complete section of this policy was dedicated to presenting the work of different NGOs in the West Bank and Gaza. However, nothing was mentioned in the policy related to developing strategies to improve the coordination between government run services and NGOs, or between different NGOs providing mental health services.	coordination mechanisms should identify tasks for each party and where they should work together.
20	Have all beneficiary groups been considered?	1-3	The following beneficiaries were considered: 1. people with severe mental illnesses 2. children and adolescents 3. people with common mental disorders 4. people affected by trauma The following beneficiaries were not adequately considered: 1. older persons 2. people with intellectual disabilities 3. people with substance dependence	The future revision of the policy should take into consideration the development of adequate strategies that focus on older persons, people with intellectual disabilities and people with substance dependence. Such strategies should facilitate the integration of such services into all mental healthcare programmes
21	Given the available resources, has a "reasonable balance" been achieved between the above groups?	2	People with intellectual disabilities were not mentioned in the policy. This might be due to leaving this section to school mental health and also because there is a lack of trained workers in this area. Substance dependence was separated in a stand-alone policy. This explains why it was not discussed in this policy. Children and adolescents, people with common mental disorders, and people affected by trauma were equally discussed in this policy. Lower attention was given to people with severe mental illnesses.	Groups that are not given enough balance because they were included in separate policies, a clear referral to such policies should be included. Furthermore, an integration of these services in other mental health programmes should be emphasised at any future revision of the policy.

22	To what degree have the key mental health policy issues been integrated with/or are consistent with the country's other policies?	3	Other policies do not exist to integrate mental health policy issues with.	Nothing can be done.

Appendix Five: Training Needs Analysis Questionnaire

Training Needs Analysis

For mental health workers in Gaza

HOW TO COMPLETE THIS QUESTIONNAIRE

This questionnaire should take no more than 30 minutes to complete. Please read each question and tick a box to indicate your answer. If you find the question is not applicable to your terms of reference or to your work environment please tick Not Applicable column. At the end of this questionnaire you will find some written questions asking you to list limited number of priorities and barriers. Please try to be concise and specific and adhere with the number of answers you are requested by the question.

HOW CAN I HELP YOU?

If you have any queries about the questionnaire, please do not hesitate to contact me on I am available during office hours, but if you call outside of these times, please leave a message, including your telephone number and I will call you back. If you would like this questionnaire in another format, please let me know or call me. Once you have completed the questionnaire please hand it back to me or return it to the centre administration where you work and I will come to collect it later.

Participant name: _____

Age _____ Place of living _____

Profession _____ Years of experience in mental health _____

Gender _____ Years of post-secondary school study _____

Last degree (qualification) _____

Work setting: Community centre ☐

Psychiatric hospital ☐

Both ☐

		I feel competent in this area					
N	**Capabilities**	**Strongly Agree**	**Agree**	**Can't decide**	**Dis-agree**	**Strongly Disagree**	**Not Applicable**
1. Communicate effectively as demonstrated by one's ability to:							
1.	Use language and terminology appropriate to the needs of the consumer, the group and the setting						
2.	Use appropriate communication style, level and medium for the consumer, the group and the setting						
3.	Be sensitive to and modify approaches for situations in keeping with cultural differences						
4.	Give and receive verbal and non-verbal communication in individual and group settings, with team members and others						
5.	Maintain objectivity and minimise bias						
6.	Liaise with family members and other resource persons						
7.	Liaise with related agencies						
8.	Demonstrate empathy with consumer, family, team members and appropriate others						
9.	Seek and accept critical feedback on understanding of imparted information from consumer, family, colleagues and others						
10.	Establish rapport						
11.	Establish realistic boundaries and expectations for the interaction						
12.	Provide a supportive environment and physical setting to support communication and foster motivation						
13.	Empower consumers, families, groups, team members and appropriate others						
14.	Recognise situations where information should be imparted to appropriate others						
2. Assess the need for and type of intervention (if any) as demonstrated by, but not limited to, the ability to:							
15.	Gather information by employing such methods as observation, self-report, other reports, and other assessments						
16.	Identify immediate medical needs, if any						
17.	Identify social and emotional needs						
18.	Determine level of functionality (e.g., the ability to care for self and others, follow medical advice and safety orders)						

N	Capabilities	Strongly Agree	Agree	Can't decide	Dis-agree	Strongly Disagree	Not Applicable
19.	Recognise mild psychological and behavioral distress reactions and distinguish them from potentially incapacitating reactions						
20.	Assess risk of harm to self and others and recognise the presence of alcohol and drug problems						
21.	Recognise the presence of co-existing disorders						
22.	Select and conduct an objective mental health status examination						
23.	Interpret and synthesise findings						
24.	Recognise the need for early therapeutic intervention in case of suicide or drug and alcohol problems						
25.	Recognise when referral is required						
3. Describe the following key terms and concepts related to disaster mental/psychosocial/behavioral health preparedness and response:							
26.	The nature, bio-psycho-social, and cultural manifestations of human stress and typical stress reactions						
27.	The phases of psychosocial disaster and recovery reactions at the individual and community levels;						
28.	The psychosocial effects of psychological trauma and disaster-related losses and hardships on individuals and communities;						
29.	Incident management structure and the role of disaster mental health in a multidisciplinary disaster response;						
30.	Disaster mental health intervention principles and phase-appropriate interventions;						
31.	Crisis intervention(s) with disaster-affected individuals and (sub) populations; and Individual and population-based responses before, during, and after a disaster (e.g., evacuation, shelter in place).						

N	Capabilities	Strongly Agree	Agree	Can't decide	Dis-agree	Strongly Disagree	Not Applicable
4. Formulate and implement an action plan (based upon one's knowledge, skill, authority, and functional role) to meet those needs identified through assessment and as demonstrated by, but not limited to, the behaviors listed below:							
32.	Initiate an action plan to include, but not be limited to, the ability to: 1. Provide appropriate stress management, if indicated; 2. Connect to available resources (e.g., food, shelter, medical, transportation, crisis intervention services, local counseling services, financial resources); 3. Connect to natural support systems (e.g., family, friends, co-worker, spiritual support); and 4. Implement other interventions as appropriate.						
33.	Evaluate and revise the effectiveness of an action plan considering changes in situation or disaster phase through methods such as observation, self-report, other reports, and other assessments						
5. Demonstrate knowledge and understanding of mental health, mental illness and mental health Services							
34.	Demonstrate knowledge of mental health and illness, treatments and services including alcohol and drug services.						
35.	Integrate knowledge of societal, cultural, psychological, environment, spiritual and belief systems that influence mental health and illness into practice.						
36.	Identify normal and abnormal patterns of human development and it is relation to common mental disorders						
37.	Describe the effects of mental illness/substance abuse on family						
38.	Demonstrate knowledge of current psychiatric medical diagnosis classification systems						
39.	Demonstrate knowledge of treatment modalities and case management techniques used in primary, secondary and tertiary mental healthcare						
40.	Use the mental health service and inter-sectoral agency linkages						

N	Capabilities	Strongly Agree	Agree	Can't decide	Dis-agree	Strongly Disagree	Not Applicable
6. Provide appropriate intervention for consumers							
41.	Use recovery approach as the guiding principle for planning of care and practice.						
42.	Work with consumers with dual diagnosis/co-existing disorders.						
43.	Manage difficult behaviour.						
44.	Administer calming and restraint techniques when encountered by challenging and threatening behaviour.						
45.	Recognise and respond to changes in the consumer, self and the environment.						
46.	Use a range of appropriate therapeutic modalities such as individual therapy, group therapy, family intervention/education, and pharmacology as described in the care management plan						
47.	Recognise the commonly used psychotropic medications and their side effects						
48.	Practise effectively in in-patient, home-based care, community and rehabilitation settings						
49.	Develop discharge plans with consumers, family and other team members						
50.	Demonstrate effective problem-solving skills						
7. Practise safely and ethically							
51.	Ensure the consumer's and his/her family's right to privacy.						
52.	Recognise ethical and safety dilemmas as they arise.						
53.	Consult with experienced mental health workers and appropriate others to resolve ethical and safety issues.						
54.	Ensure that each consumer of mental health services and their family is fully informed so that the consumer can optimise their decision making and options of choice						
55.	Appropriately challenge mental healthcare practices which could compromise patient safety, privacy or dignity						

N	Capabilities	Strongly Agree	Agree	Can't decide	Dis-agree	Strongly Disagree	Not Applicable
56.	Provide appropriate supervision for delegated tasks						
8. Demonstrate culturally appropriate practice							
57.	Recognise the impact of the mental health service on a consumer's belief system						
58.	Evaluate own practice in relation to cultural appropriateness.						
59.	Identify own cultural value base and its impact on that of the consumer.						
60.	Avoid imposing own belief system on to consumers and others and respect the differing values and beliefs of others						
9. Comply with legal responsibilities							
61.	Respect a consumer's right to complain, or refuse treatment or any part of any care without instilling fear of recrimination, penalty or withdrawal of emotional and physical support						
10. Promote individual professional growth							
62.	Identify own role and the roles of others in the mental health team						
63.	Recognise own professional abilities and learning needs						
64.	Participate in career development strategies (if available)						
65.	Participate in continuing education activities (if available)						
66.	Participate in regular ongoing clinical supervision (if available)						
67.	Acknowledge professional debate on mental health issues and accessing evidence-based resources to use it in my daily practice						
68.	Promote quality improvement strategies						

Identify top five priority areas for training whether mentioned in the above questions or not?

1- _____

2- _____

3- _____

4- _____

5- _____

Identify five main barriers to training?

1- _____

2- _____

3- _____

4- _____

5- _____

What is the most appropriate approach for you for delivering training?

☐ Short-term courses (less than one month)

☐ Long-term courses (from 1-6 month)

☐ Postgraduate studies

☐ In-service training and supervision

☐ Self-learning

☐ Others - please specify:

_____

_____

Please identify through the below table how have you developed your abilities in using the following competencies:

	Under graduate studies	Post graduate studies	Short-term courses (less than one month)	Long-term course (from 1-6 month)	Clinical and field Practice	Clinical Supervision
Interview skills						
Assessment and case formulation						
Treatment modalities						
Ethical and cultural practice						
Team work						
Communication skills						
Holistic approach						
Recovery approach						
Emergency and crisis intervention						

Others - please specify:

_____

_____

Appendix Six: Topic Guide for Mental Health Professionals and Policy Makers

1- Characteristics of the existing mental health system

I- What are the main components of the existing mental health system?

II- Is it more community-based or biomedical-based system?

PROBE: specific characteristics of governmental versus NGO systems.

III- Do you think the emergency response efforts affect the development of the mental health system in Gaza? Positively/negatively and how.

PROBE: Does donation and international aid play a key role in shaping the mental health system in Gaza? How?

2- Policy and legislations:

I- How do you view the existing policy and legislations? Do they support the development of mental health services?

PROBE: Identify both mental health practitioners' and policy makers' views on the existing policy and legislations.

II- Have service users been consulted on developing policies and legislations? If not, why?

III- What are the main gaps in the existing policies and legislations? Can you think of ways to overcome them?

3- Community-based approach:

I- What does applying a community-based approach to mental health in Gaza mean to you?

PROBE: Specify governmental vs NGO view on this.

II- What community resources do we have that would help to implement a community-based approach?

III- What are the main challenges for implementing a community-based approach? Can you think of how to respond to those challenges with the available resources?

IV- What are your views on the cultural appropriateness of using community resources for treating users in Gaza?

PROBE: Elaborate on the NGO experience in this.

4- Human resources:

I- If we plan to develop service provision to meet service users' needs, do we have enough human resources to do this?

II- What are the main challenges for mental health practitioners to carry out their duties whether they work in the clinic or in the field?

III- From your views, what are the most important core competencies for mental health professionals working in Gaza?

PROBE: The facilitator can provide the participants with a list of basic core competencies for all mental health professionals to

help them to identify what is relevant to mental health workers in Gaza.

PROBE: Does the existing system support the practitioners in undertaking their duties? Practitioners vs policy makers views on this.

PROBE: Governmental services vs NGOs' views on this.

V- What is the role of the existing system to develop the practitioners' skills and knowledge?

VI- Do you work in multidisciplinary teams? Please specify what do you mean by multidisciplinary teamwork?

5- Do you think mental health services are coordinated effectively with different main providers? If not, what are the main obstacles?

PROBE: Discuss if this will lead to duplication of the same services by different service providers.

6- From your views, what do you think are the most pressing needs for mental health professionals working in Gaza?

7- Closing issues:

I- Are there any issues that you would like to raise in relation to the main issues we have been discussing?

Appendix Seven: Topic Guide for Service Users and Carers

1- Evaluating the existing mental health services

I- How do you view the existing services you receive?

PROBE: The room will be open for personal experiences and stories if the participants feel fine to share them.

II- What are the main problems in mental health service provisions in Gaza?

PROBE: Discuss the accessibility of services, the infra-structure, the appointing system, the affordability of medication and the competency of service providers.

III- How could the services be more satisfactory for service users and carers considering the available resources?

PROBE: Provide specific examples on this.

2- The role of service users and carers in the treatment process:

I- What is the role of service users in their treatment process?

PROBE: Please provide specific examples from past experiences.

II- What is the role of carers in the treatment process?

PROBE: Please provide specific examples from your past experiences.

III- How do you think services users and carers can play a more active role in the treatment process?

3- The service users' and carers' views on re-shaping the mental health services:

I- If you were given the opportunity to re-design the mental health system in Gaza, what would it look like?

PROBE: Please consider the available resources and explain how they would be better used to meet the needs of service users and carers.

II- What are the main gaps of the existing MH system and how could you overcome them if you were in the place of policy makers?

III- Do you think the community-based approach is more convenient to service users and their families, and why? If not, please describe why? And what is the best approach from your point of view?

PROBE: Provide a brief and clear idea on what the community-based approach means.

4- Advocacy role of service users and carers

I- How do you think the community in Gaza views the needs and rights of services users?

II- What are the expected roles of services users and carers that can be played to increase the community awareness around service users' needs and rights?

III- How can the mental health service be improved if service users and carers could advocate for their needs and rights with service providers and with the community?

5- Collaboration with mental health service providers

I- What are the possibilities for working with service providers and policy makers to improve the existing services?

II- How do you think the service providers and policy makers can perceive any potential role for service users and carers to be included in planning, provision and evaluating the mental health services?

III- What do you think is the best way of working together with service providers and policy makers to improve the existing services?

6- Any other issues to be raised.

I- Are there any issues that you would like to raise in relation to the main issues we have been discussing?

Appendix Eight: Coding Hierarchy

A. Mental health professionals and policy makers

Name	Sources	References
1. Knowledge of the system	0	0
1.1 Personal efforts	2	3
1.2 Service classification	2	4
1.3 Do we have a system	2	6
1.4 Resources versus demands	1	5
1.5 Role confusion	1	5
2. NGOs	0	0
2.1 Knowledge	2	5
2.2 Models of care	2	13
2.3 Role in delivery of care	3	3
2.4 Role in service development	3	13
2.5 Reasons for poor coordination	2	3
3. Models of care	0	0
3.1 Medical model	3	18
3.2 Community-based model	2	4
3.3 Both of medical and community-based model	1	2
3.4 Why medical model	3	11
4. Role of crisis	0	0
4.1 Positive	3	4
4.2 Negative	3	25
4.3 Role of donors	2	6
4.4 Sustainability	3	12
4.5 Prospect for improvement	2	2
4.6 Duplication	3	9
4.7 Waste of resources	3	5
4.8 Impact on professionals	1	2
5. Policy development	0	0
5.1 Knowledge of existing policy	3	20
5.2 Exclusion of users	3	5
5.2.1 Reasons for users exclusion	3	12
5.2.2 Perception on users involvement	3	15
5.3 Challenges	2	6
5.4 Policy implementation	1	1
5.5 Participation	1	4
6. Community-based approach	0	0
6.1 Definition	3	14
6.2 Community resources	3	16
6.3 Challenges	0	0
6.3.1 Stigma	1	1
6.3.2 Coordination	3	11
6.3.3 Lack of awareness	2	2

6.3.4 Lack of legislation	2	2
6.3.5 Political will	1	2
6.3.6 Accountability	1	1
6.3.7 Bureaucracy	2	4
6.3.8 Logistics	2	6
6.3.9 Job description	2	2
6.3.10 Availability of staff	2	2
6.4 Cultural appropriateness	1	1
6.4.1 Positive	2	8
6.4.2 Negative	2	6
6.5 Prospect for improvement	1	5
7. Human resources	0	0
7.1 Shortage	3	9
7.2 Distribution	2	2
7.3 Obstacles	0	0
7.3.1 Logistics	2	5
7.3.2 Bureaucracy	1	2
7.3.3 Coordination	1	1
7.3.4 Plans	1	1
7.3.5 Acceptance	1	1
7.3.6 Job security	1	1
7.4 Training needs	3	10
7.5 System support	0	0
7.5.1 Yes	2	2
7.5.1 No	2	5
7.6 Case management	3	9
8. Pressing needs	0	0
8.1 logistics	3	7
8.2 Incentives	3	7
8.3 Capacity building	2	5

B. Service users and carers

Name	Sources	References
Politics	3	4
1. Potential for improvement	0	0
1.1 Partnership	4	23
1.1.1 Positive	3	8
1.1.2 Negative	2	6
1.2 Collaboration	2	2
1.3 Promote community education	3	6
1.4 Inclusion	2	6
1.5 Recreation	1	1
1.6 Regular therapy sessions	2	8
1.7 Improve communication	3	8

1.8 Improve users and families awareness	2	5
1.9 Promote advocacy	3	8
2. Evaluation of services	0	0
2.1 Unsatisfied	3	14
2.2 Satisfied	4	13
2.3 Medical model	2	5
3. Preferred model of care	0	0
3.1 Community approach	2	10
3.2 Institutionalisation	3	4
4. Cultural barriers	0	0
4.1 Cultural differences	2	3
4.2 Gender	1	1
5. Barriers of receiving services	0	0
5.1 Lack of communication	4	21
5.2 Lack of continuity of care	1	3
5.3 Lack of resources	1	1
5.4 Loss of trust	2	3
5.5 Maltreatment	1	3
5.6 Lack of privacy	2	8
5.7 Lack of appropriate assessment	1	1
6. Barriers related to the community	0	0
6.1 Discrimination by the community	4	20
6.2 Lack of empathy	2	7
6.3 Lack of understanding	2	2
6.4 Stigma	4	24
6.5 lack of employment possibilities	1	1
7. Family perception of their role	0	0
7.1 Support	4	14
7.2 Dominance	2	2
7.3 Discrimination	2	4
9.4 Lack of knowledge	2	2
8. Users perception of their role	0	0
8.1 Helplessness	4	14
8.2 Exclusion	4	22
9. Positive participation	0	0
9.1 Willing for participation	2	9
9.2 Persistence	2	3
9.3 Recovery	3	7

Appendix Nine: Examples of Transcript Excerpts

What are the main gaps of the existing mental system and how could you overcome them if you were in the place of policy makers?

SU 8: As he said .. respect is the most important thing .. they don't treat us with respect here.

Maltreatment

Carer 14: I was in Algeria for a long time, there was a friend of mine who was receiving treatment from the mental health facility there .. they used to have a good rehabilitation program .. the center used to help the patient by placing him in a paid job .. work is essential for any human being. My sister is very good in hand crafting, if she will be engaged in any paid work she will be much better.

Carer 13: Employers here don't encourage people with disability to work with them .. on the contrary, they would avoid employing you only because you have mental health problems or any kind of disability.

Discrimination

SU 8: I went once to a woman empowerment center to learn some handcraft skills. I was surprised that after some days they asked me to stop coming to the center .. I realised that they did so because they heard that I am receiving mental health intervention.

Discrimination

Carer 14: As you hear .. the main gap here that the mental health centers are places for drug distribution .. the main issue for the mentally-ill patients .. as you heard .. is to feel that they are a human being, services here do not help them to re-integrate in their community again, they do not help them to get some paid work .. this is the real therapy for them.

Medical model

SU 9: The first and most important thing that doctors here should listen to us and should listen to our families as well .. it is not our responsibilities to sort out problems .. we have enough problems

Lack of communication

that we come to the center here to find some solutions for them .. how can we solve the problems of the system .. how come !!!

SU 7: I agree .. but I also see that the current system is better than before .. maybe another one would feel different .. but for me I feel that there is some improvement we can feel over time.

Satisfied

SU 9: Yes, I don't say that there is no improvement .. in the past they were treating us at the same place where drug users are treated .. it was very difficult, now it is better, but there are still many problems that need to be solved.

Do you think the community based approach is more convenient to service users and their families and why? If not, please describe why? And what is the best approach from your point of view?

SU 11: Everything can work in this society ..

Carer 14: It is possible that people can accept and adopt it .. but this should be accompanied by a strong political will.

Community approach

SU 12: The society here does not respect people with mental health problems .. they discriminate and humiliate them.

Discrimination

Carer 13: People do not hear about mental health services and mental health centers .. how they would provide community services depends on community resources.

SU 9: I don't think this system would work here .. we are a different culture .. I can understand that the family doctor would come to the house to treat people when they have a medical condition .. but for mental health .. I don't think so.

Cultural difference

SU 10: I do prefer to stay home than to go to hospital for treatment.

Community approach

SU 7: Hmm … The issue of receiving treatment at home would not work in all cases .. I do believe that the community or home has a substantial role in improving the situation of the mentally ill patients .. but I also believe that hospitals and mental health

Institutionalisation

212 centers have the most important role .. the family and community
213 roles are supportive but they don’t cure mental illness

Appendix Ten: Examples of Data Charting

A. Charting of qualitative analysis for service users and carers- theme 7. Barriers of receiving care

Participants	7.1 Lack of communication	7.2 Lack of privacy	7.3 Discrimination by the community	7.4 Stigma	7.5 Cultural differences	7.6 Politics
1: SU 11	Many of the users' problems are not solved because mental health professionals do not listen to them	NC	The community in Gaza practice different kinds of discrimination on service users and their family members. The community do not support social inclusion for service users	Stigma prevents families from seeking mental health care for their siblings	NC	The political situation in Gaza has its negative impact on the development of the services provided for service users. If the political situation was more stabilised, the chance for service development would be higher
2: SU 9	Mental health professionals do not listen to users or their family members. This disappoints users because	Placing the community mental health centers inside primary care centers would affect	The community in Gaza practises different discrimination types on service users	Service users do not feel comfortable to receive mental health workers at their home because of the stigma	The implementation of a community based approach can face difficulties in this community as this approach	NC

	they do not feel their voice, or their family members' voice is heard by professionals when they decide any kind of intervention	the sense of privacy among service users as they do not feel comfortable to share the same place with primary care patients			was created in communities where they were used to the principle of family doctors. This is not supported by our culture	
3: SU 3	The time the mental health professionals provide to users to listen to their complaints is very short. This short time does not lead to effective communica-tion	NC	Service users and family members keep the treatment from mental illness as a secret because they are concerned about the community response to this and the discrimination they will receive by the community	Service users tend to avoid going to the community mental health centers and send one of their family members to collect the medication for them because of the stigma. Moreover, service users avoid receiving mental health workers at their homes because of the stigma	NC	NC

4: Carer 5	NC	NC	The community discrimination led some service users to withdraw from essential life activities.	NC	NC	NC
5: Carer 11	Mental health professionals do not dedicate enough time to communicate with users and their family members	NC	NC	Community-based activities may not be appropriate for our community because of the stigma	The community based approach would not be suitable for Gaza because Gaza has a more eastern culture and this approach was developed in a more western culture	The siege imposed in Gaza affects the availability of psychotropic medicines and therefore negatively affects the recovery of service users
6: SU7	When the service users see the mental health professionals they do not get a chance to talk to them because they are always in a hurry and service users do not feel that	Mental health facilities should not be integrated with other primary care facilities as this affects the privacy of service users	The community in Gaza plays a negative role in users' recovery	Service users would prefer going to the community centre rather than receiving mental health workers at their homes because this is less stigmatised. The participation in community-based activities would be possible	NC	Improving the political situation would help to improve the wellbeing of service users

	mental health professionals listen to them			if the identity of the service users would not be disclosed because nobody will stigmatise him/her in this case		
7: Carer 14	NC	Service users do not feel privacy in the community centers. The therapy room is always full with different workers and more than one service user	NC	Stigma is widely common among all layers of the community in Gaza. Regardless of age, sex and educational level	NC	NC
8: Carer 10	NC	NC	The community in Gaza has a negative attitude toward service users. This adds more pressure on service users and complicates their lives	NC	NC	NC

9: SU 6	The clinical practice cannot be improved until communication between mental health professionals and service users/family members is improved	NC	The community in Gaza verbally humiliate service users	Service users do not prefer to receive mental health workers at their homes because of the stigma	NC	NC
10: SU 10	Mental health professionals should be trained on effective communica-tion because the communica-tion methods they currently use are not useful	Mental health centers should not be integrated in primary care as this affects the privacy of service users	The community should show more understanding to mental health problems so service users can feel more supported	Service users do not prefer to receive mental health workers at their homes because of the stigma	NC	NC

11: SU 4	NC	Community centers do not have enough space to ensure the privacy of service users. More rooms should be added	NC	NC	NC	NC
12: SU 12	Improving communica-tion would help both service users and mental health professionals to better understand each other	NC	It is very important for service users to feel they are respected by the community in order to recover	NC	NC	NC

13: Carer 13	Mental health professionals do not talk with family members about the situation of the service user	NC	Employers do not support people with mental health problems to work with them, they always avoid recruiting people with mental health problems	NC	NC	NC
14: Carer 3	NC	NC	People in general avoid communicating with service users and neglect them	NC	NC	NC

15: Carer 1	Improving the doctor/patient relationship should be a priority for all policy makers	NC	The community in Gaza contributes to the development of mental illness by disrespecting people with mental health problems	Service users and family members feel embarrassed to participate in any community activity that will expose them to be identified by the community as they receive mental health services. Going to the centre is more protective to service users and their families as the chance of being identified by the community is less	NC	NC

17: SU 1	Service users value the effective communica-tion with mental health professionals as important as the medication they receive. The good communication is not practised by mental health professionals. Improving communication should be a top priority for policy makers to improve the mental health care	NC	NC	Service users do not prefer to receive mental health workers at their homes because of the stigma. The community in Gaza labeled all people receiving mental health care. This would affect the service user and also his/her family members	NC	The ongoing conflict affects the development of mental health services as policy makers prioritise responding to crisis more than developing the services

17: SU 8	Mental health professionals do not pay efforts to listen to users	The privacy is not maintained in the community mental health centers. The therapy rooms do not ensure privacy as it is always crowded and not closed	Employers in Gaza do not involve service users in any training or job opportunities	NC	NC	NC
18: Carer 4	In order to improve the clinical services service users should be able to communicate their needs with mental health professionals	NC	NC	NC	NC	NC

19: Carer 12	NC	NC	Service users are not supported to show their strengths because of the community discrimination	Stigma prevents many families seeking mental health care when their siblings develop mental health problems. They prefer traditional healers and religious healers	NC	NC
20: SU 5	NC	NC	NC	Service users avoid participating in community based activities because of the stigma	NC	NC
21: Carer 2	NC	NC	NC	Any participation in community based activities that would expose the service user or carer to identification as a person who receives mental health services would be avoided because of the stigma	NC	NC

22: Carer 8	NC	NC	The community in Gaza shows a lack of understanding to mental health issues	NC	The culture in Gaza does not support community based activities for mental health intervention	NC
23: Carer 6	NC	NC	NC	The stigma attached to mental illness can be stronger if the patient is a female more than a male	NC	NC

*NC: Not Coded

B. Charting of qualitative analysis for mental health professionals and policy makers- theme 4. Role of Crisis

Participant	4.1 Positive	4.2 Negative	4.3 Role of donors	4.4 Sustainability	4.5 Duplication	4.6 Waste of resources	4.7 Impact on professionals
1: Policy Maker 3	Crisis can increase the possibility for donors to support mental health projects	The conflict affects the existing mental health system negatively because it contributes to the duplication of services between the existing mental health workers and other mental health professionals coming from abroad to help. Additionally, the conflict creates a matrix of services that is neither integrated nor coordinated between different service providers	NC	There are many organisations and professionals who came to Gaza after the war to provide mental health interventions. Most of those organisations/professionals left shortly after the crisis. This added more pressure on the public sector as they were requested to sustain those activities	The mental health professionals and organisations come from outside to provide post emergency intervention after any crisis and causes duplication of services	NC	NC

Participant	4.1 Positive	4.2 Negative	4.3 Role of donors	4.4 Sustainability	4.5 Duplication	4.6 Waste of resources	4.7 Impact on professionals
2: Policy maker 1	NC	The conflict has a negative impact because efforts to develop the system are not coordinated between different service providers	International donors contribute to hindering the development of the mental health system by enforcing a lack of transparency and coordination	NC	NC	NC	NC
3: Policy maker 2	NC	The psychosocial short term projects have a negative impact because they distort the integrity of psychosocial and mental health interventions by mixing professional services with welfare services, and that impacts the quality of the services	NC	NC	Many organisations tend to provide the same services to the same affected population at the same time, while other victims who need mental health intervention do not receive it	Many NGOs used the financial resources they have to distribute welfare assistance. Mixing welfare assistance with psychosocial services helped to attract victims to seek psychosocial services. This would cause wasting of scarce mental	NC

Participant	4.1 Positive	4.2 Negative	4.3 Role of donors	4.4 Sustainability	4.5 Duplication	4.6 Waste of resources	4.7 Impact on professionals
						health resources to the welfare assistance and also would distort the value of the psychosocial care	
4: Policy maker 4	NC	The excessive number of NGOs providing mental health services without proper training or without enough trained mental health workers has a negative impact on the development of the system	The donors prefer short term programmes as this does not commit them to long term funding	The short term funding mechanism led many NGOs not to consider the sustainability of their programmes as they know that those activities will stop when the funding stops. Therefore, sustainability of services is not a priority for NGOs, the priority is to obtain funding	The support provided to the NGO sector creates a parallel, not qualified, mental health providers that duplicate the same services provided by the public sector	The money spent on emergency response programmes can be better used to create a well-equipped mental health system. If we can roughly calculate the amount of money that has been spent on mental health programmes in the last 20 years, this money can establish an advanced mental health system in Gaza that could be a model for all mental health services in the	The conflict and the restriction of movement in Gaza decreases the chance for professional contact with the knowledge and practice of mental health outside Gaza. This affects the policy makers' capacity to adhere to evidence-based knowledge and practice

Participant	4.1 Positive	4.2 Negative	4.3 Role of donors	4.4 Sustainability	4.5 Duplication	4.6 Waste of resources	4.7 Impact on professionals
						whole area"	
5: MH worker 6	NC	The conflict creates a sort of competition between NGOs to secure more funds. This affects the quality of mental health services provided	NC	NC	The duplication occurs in the crisis intervention time because NGOs rush to the field to show high capacity which helps them to receive funds from emergency donors	NC	NC

Participant	4.1 Positive	4.2 Negative	4.3 Role of donors	4.4 Sustainability	4.5 Duplication	4.6 Waste of resources	4.7 Impact on professionals
6: MH worker 10	NC	The resources are provided only to NGOs with no investment in the public sector	NC	Most of the affected population stop receiving care after a short period of the crisis because most NGOs tend to leave because of funding issues	NC	The unbalanced allocation of resources to NGOs can affect the normal development of the national mental health system by decreasing the chances of external support to the national system	NC

Participant	4.1 Positive	4.2 Negative	4.3 Role of donors	4.4 Sustainability	4.5 Duplication	4.6 Waste of resources	4.7 Impact on professionals
7: MH worker 3	NC	The allocation of resources to NGOs to provide emergency response programmes contributed to making the poor public sector, which provides more traditional mental health services, even poorer	NC	When NGOs provide other activities, such as training, they do not plan to sustain this training by follow up and supervision in the long term	NC	The allocation of the donors' money to NGOs affects the development of the national system and wastes the money in providing unsustainable programmes	NC
8: MH worker 7	Many affected victims receive services from NGOs after the crisis and this improves the accessibility to mental health services	The support given to NGOs makes them more equipped and more attractive to service users; this might affect the community confidence in the public services	NC	NC	NC	NC	NC

Participant	4.1 Positive	4.2 Negative	4.3 Role of donors	4.4 Sustainability	4.5 Duplication	4.6 Waste of resources	4.7 Impact on professionals
9: MH worker 1	Many training activities are organised through short term programmes. This increases the chance for providing more training to mental health workers	NC	International donors contribute to blocking the chances for coordination between the NGO and the public sector by enforcing a no-contact policy on the organisations they support so they are not allowed to coordinate or collaborate with the governmental organisations	The short term interventions never lead to the sustainable development of the mental health system in the long term. The short term interventions focus on here and now, while longer term developments focus on more comprehensive development of different aspects of the system	Duplication in provided services is one of the main barriers toward mental health services development. The duplication of providing services is always seen in focusing on one geographical area while other areas do not receive the same attention from mental health organisations	NC	NC

Participant	4.1 Positive	4.2 Negative	4.3 Role of donors	4.4 Sustainability	4.5 Duplication	4.6 Waste of resources	4.7 Impact on professionals
10: MH worker 13	The conflict and increase in emergency response programmes improved the community awareness to mental health interventions	The conflict makes the community more helpless and this impacts their belief in mental health intervention	NC	NC	NC	NGOs can sometimes misuse the funds provided to them. Most of this money is being spent on prioritised needs, such as irrelevant training activities	The conflict affects the mental health professionals themselves as they are exposed to the same violence
11: MH worker 14	NC	The conflict contributed to creating many organisations without proper qualifications to provide emergency mental health intervention	The mental health service providers should take part of this responsibility as they do not communicate their needs effectively with donors at the beginning and then they take what donors propose to them	NGOs are not concerned about the longer term development of the mental health services as they focus on providing short term intervention	The emergency funding mechanism contributed to the creation of many new mental health organisations, which are not well equipped with well-trained mental health professionals. Those organisations tend to rush to the field to provide post emergency services without prior	NC	NC

Participant	4.1 Positive	4.2 Negative	4.3 Role of donors	4.4 Sustainability	4.5 Duplication	4.6 Waste of resources	4.7 Impact on professionals
					coordination. This causes duplication in services provided to the same affected population		
12: MH worker 15	NC	The short term programs never contribute to the development of the mental health system	Funding psychosocial and mental health activities in Gaza depends on the donors' agenda and priorities and not on the real needs of the affected population or the needs of developing the mental health services in general	NC	The duplication of services caused by NGOs after any high scale crisis proved that post emergency programmes contributes to hindering the development of the mental health system	NC	NC

*NC: Not Coded

Appendix Eleven: Priority Areas for Training

Communication skills

Interviewing skills

Communication skills

Inter-sectoral coordination with other NGOs and key players

Assessment

Undertaking psychometric tests

Mental health assessment

Diagnosis and case formulation

Mental state examination

Disaster management

Crisis intervention

Psychiatric emergency

Knowledge and understanding

Mental illnesses, psychopathology of mental illness and intervention modalities

Terminology

Contemporary community mental health

Treatment modalities (intervention)

Psychotherapeutic approaches

Recovery approach

Cognitive behavioral therapy

Child mental health intervention

Family intervention

Supervision in mental health

Case management

EMDR

Prolong exposure technique

Managing difficult behaviours

Intervention with drug abuse problems

Mental health rehabilitation

Occupational therapy

Early detection of mental health disorders

Emotional regulation

Psychosocial support

Geriatric mental health

Personality disorders

Body and mind medicine

Group therapy

Play therapy

Problem solving

Holistic approach

Psychopharmacology

Community education

Practise safely and ethically

Ethics for mental health practice

Professional growth

Role of social worker in the community mental health centre

Managing burn out among employees

Training of trainers

Development strategies in mental health

Quality improvement in mental health

Multidisciplinary teamwork

Management

Evidence-based practices

Appendix Twelve: Barriers to Training

Administrative barriers

Administrative barriers

Shortage of staff

Social workers are the less to be targeted by training activities

Lack of stimulation on the professional growth

Lack of coordination between the administration and the directors of clinical placements

Workload

Lack of follow up among policy makers

Training activities are not adequately supported by the administration

Lack of equal opportunities for all staff to participate in training activities

Lack of coordination with NGOs

Logistic barriers

Clinical placements are not appropriate for the practical training

Insufficient training tools and logistics

The cost of postgraduate training is high

Blockade on Gaza and travel difficulties

Absence of clear job description for mental health workers

The system is not supportive

Universities are not interested in mental health training

Technical barriers

Using English as the language for training

Using difficult terminology in training

The specialty of trainers are not always matching the objectives of training

Insufficient qualified trainers

Many topics are not targeted by training course

Lack of references in Arabic

Insufficient practical training compared with theoretical training

Trainees' feedbacks are not considered

The training activities are not based on proper training needs assessment

Absence of proper evaluation for training activities

Time management

Socio-cultural barriers

Cultural barriers related to the community awareness on mental health issues

Political situation in Gaza

Lack of commitment by trainees