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Mental Health in Palestine: Country Report

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الصحة النفسية في فلسطين

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Abstract

Individuals living in Palestine face obstacles in daily living and in the access of mental health services that are unique to the Palestinian context. Social and political disruptions, starting with large-scale displacement of the indigenous Palestinian population during the 1948 Nakba and continuing with the occupation, have brought the population under considerable psychosocial stress. Such disruptions have fragmented the delivery of mental healthcare and are the distal cause of numerous barriers to care. Palestinian mental health professionals and partnering colleagues ought to work towards an integrated system of care in which patients are seen as core members of interdisciplinary mental health teams, in which mental healthcare is integrated with the rest of medical care, in which Palestinian mental health professionals and institutions form mutually enriching long-term partnerships with international colleagues and institutions, and in which mental healthcare is integrated into a broader agenda of public health, human rights, and social liberation.

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Introduction

Meeting the need for mental health care for the population in Palestine is an ongoing struggle. The overall population of Palestine is 4.4 million,[1] divided between the non-contiguous areas of the West Bank (2.3 million[2]), Gaza (1.8 million[3]), and East Jerusalem (270,000[4]) within the occupied Palestinian territory. A central event in Palestinian history is the 1948 Nakba, the Arabic word for Catastrophe, during which hundreds of thousands of Palestinians were uprooted from their homes and became refugees in Gaza, the West Bank, and surrounding countries. From 1948 until 1967, Egypt administered Gaza and Jordan administered the West Bank. Since 1967, the Israeli occupation has had a crushing impact on life in Palestine through imposing poverty, unemployment, pervasive violence, trauma, and imprisonment, the restriction of resources (such as water, building materials, and electricity), and intermittent restrictions of movement.[4] Consequently, the unemployment level is 20% and 31%[5] in the West Bank and Gaza respectively; the median family size in the West Bank is 5.4 with an average income per adult being 9 USD/day;[6] in Gaza the average size is 6, with an average income per adult being 5 USD/day. Such social inequality likely places Palestinians at greater risk of mental disorders.[7] Israeli state policies have generally worked to undermine any moves towards political, economic, or health sector independence and self-sufficiency on the part of Palestinians.[8] In addition to global effects on Palestinian wellbeing, the economic, political, military, and social situation imposes notable stresses both chronic and acute, which have bearing on undermining the mental health of the population.

A focus on only one aspect of the Palestinian reality offers some insight into its mental health challenges. Approximately 40% of the men in the Occupied Palestinian territory have been detained by Israel, often for indeterminate periods for no specific charges and often suffering mistreatment or outright torture while detained.[9]

Epidemiology

It is within this challenging political and economic context that we find little in the way of epidemiological data on mental illness in Palestine. In this regard, the World Health Organization (WHO) claims that for mental health data in Palestine "No reliable national data exists."[10] In the absence of reliable epidemiologic data, it is reasonable to assume that most common mental disorders occur at roughly the same rate in Palestine as they do globally, and indeed the WHO estimates that 5%–10% of the population in the occupied Palestinian territory may currently suffer some form of common mental disorder"[10]. Certain disorders such as alcoholism and anorexia are far less common in Palestine than in many places due to cultural attitudes that vary from those in the West. Injection drug use in Palestine is uncommon, but a growing concern.[11]

The limited data that does exist are prone to inaccuracies: this is a consequence of a political climate that incentivizes the leveraging of 'research' for ideological agenda(s), as noted by the UK based psychiatrist Derek Summerfield.[12] For example, a 2007 study of 229 adolescents in Gaza found that 69% had signs of post-traumatic stress disorder (PTSD), 95% experienced anxiety and 40% exhibited symptoms of depression.[13] Similarly a study conducted after Operation Cast Lead, in 2010, found that only 1.3% of children did not show any signs of PTSD.[14] Juxtaposed to data from these sorts of studies, our clinical experience in Gaza has shown that patients diagnosed with PTSD often meet full criteria for depression or a common anxiety disorder but do not meet full PTSD criteria. This observation also has been acknowledged by the well-respected Gaza based psychiatrist Dr Eyad El Sarraj.[15] Likewise, claims that 40% of the Palestinian population is depressed are suspect:[16] In our clinical experience we have observed that many Palestinians experiencing social distress will articulate it through high scores on self-reports on depression questionnaires but in fact have no impairment in functioning and do not meet DSM criteria for depression.

If the rates of most mental disorders in Palestine are similar to global rates, this would mean that there are roughly 40,000 Palestinians with schizophrenia and roughly 400,000 who will experience one or more major depressive episodes at some point in their lifetime. The WHO estimates that only 4,500 patients reach services yearly;[10] however, we believe the number is much more than that.

Systems of care

It is readily apparent that the Palestinian mental healthcare system cannot presently meet the needs of the population. Nonetheless, as is the case with epidemiology, we lack reliable system-wide data on the system of care. What is known: There is one governmental psychiatric hospital in Bethlehem with roughly 80 acute care and 20 long-term care beds and there is one governmental psychiatric hospital in Gaza with roughly 20 male and 20 female beds.[17] Both the Gaza and West Bank governments run community mental health systems, which, according to the WHO statistics, treat a subset of the 4,500 patients who receive treatment yearly.[10] There are also a few non-governmental organizations, which run mental health or counseling centers in the West Bank and Gaza. A small number of psychiatrists do provide private sector medication management and psychotherapy. While published data counts 20 Palestinian psychiatrists in the West Bank and Gaza combined,[18] we believe that there are now roughly 20 psychiatrists in the West Bank and 10 in Gaza. There are only a few doctoral level psychologists. There are hundreds of bachelors and masters level psychologists and social workers; however, programs providing this level of training lack substantial clinical exposure. It is likely that management of many mental health problems is provided by general practitioners and neurologists; however, there are no formalized systems through which general practitioners can refer or receive consultation on patients with complicated psychiatric presentations. It is again worth noting that the provision of healthcare has been undermined by the occupation and the political situation that Palestinians face.

Barriers to care

Given the shortages in health care personnel and absence of formalized referral systems, patients face numerous barriers to care. One major barrier is awareness. Insofar as many Palestinians are not aware of mental health issues and how they present, behaviors associated with depression and other common illnesses are often not understood to be psychiatric problems. For example in one survey of mothers in Gaza, only 19.6% perceived suicidal behavior as a manifestation of mental health problems.[19] Patients may be labeled pejoratively, viewed as lazy or perhaps crazy, but there is not a widespread understanding that they suffer from a treatable medical condition. Even if mental illness is recognized as such, stigma may prevent or delay patients from presenting;[20] both internalized stigma, through which patients devalue themselves, and family concerns about social standing or marriage prospects for other siblings often lead families to avoid mental health services. Finally, physical access to services can represent an insurmountable barrier.

Today, care in Palestine is divided up into three separate regions: the West Bank, Gaza, and East Jerusalem. Although Gaza is only 50km from the West Bank and East Jerusalem is physically contiguous with the West Bank, restrictions on freedom of movement substantially limit patients from receiving care outside of their own area of residence. Even within the West Bank, the areas controlled by the Palestinian Authority are segregated from each other in a Bantustan-like formation,[21] leading to intermittent difficulties for patients from one part of the West Bank accessing services in another part of the West Bank. The cost of treatment and of medications and the inconsistent availability of medications on the WHO essential medicines list present additional access issues.

Recommendations

Improvements in the Palestinian system of mental healthcare will best be achieved through vertical and horizontal integration of mental health services and the flattening of hierarchies.

- Efficient and effective care provision requires multidisciplinary teams. To expand the reach of the limited number of Palestinian psychiatrists, mental health centers should empower a non-physician professional team member, such as a psychologist or social worker, to be the primary clinical point of contact for patients. The therapist also interfaces with collateral contacts including the patient's family for assessment and treatment planning purposes, facilitates case management and other needed non-medical services, and calls on the psychiatrist as needed. While the psychiatrist remains responsible for the care overall, she is not central to every aspect of care; indeed, she is only called on to do those things that psychiatrists can do. It is worth noting that the patient and patient's family should also be thought of as team members, especially given that the traditional family structure in Palestine remains strong. Efforts to educate the patient and family pay of in increased patient adherence.[22,23] One of us, a psychiatrist, serves as medical director of a community mental health center in Ramallah, Palestine and administrates the center in accordance with this principle. In our experience it is highly efficient and well received by Palestinian patients.
- Mental healthcare must also be integrated into general medical care - expanding primary care providers' capacity to screen for and treat common mental disorders and to refer patients with complicated presentations to specialists. Such work, along with awareness raising and anti-stigma campaigns, will reduce many barriers to care. Such efforts are already underway through a joint Palestinian/WHO venture using the WHO mental health gap framework. One of us, a psychiatrist, has been involved in this work at the advisory level and has personally trained more than 250 primary care clinicians in 2011 in the basics of mental health diagnosis and treatment. While we lack system-level data, our clinical experience indicates that this training[24] has markedly increased referrals from primary care providers. Additionally, the newest research tells us that the best medical outcomes are associated with integrated treatment plans for medical and mental disorders: for example, the unified treatment of heart disease and depression. Public health initiatives can and should be developed that integrate diagnosis and treatment for both mental health and general medical disorders at the point of service delivery.
- International partnerships to expand Palestinian mental health sector human resources and research capacity are also advisable. Numerous cooperative endeavors are currently underway including continuing mental health education and the provision of psychiatry residency and fellowship training,[25] a multi-institution research collaboration on neuroscience[26] an ongoing 4+ year relationship between British Cognitive Behavioral Therapy trainers and Palestinian clinicians to disseminate CBT within Palestine, and an ongoing partnership which three of us are affiliated, which facilitates medical education-related training, research, and writing partnerships between Palestinians and internationals. Such efforts should also advance the implementation of electronic medical records that will facilitate the collection of much needed epidemiologic, quality improvement, and outcomes data. International partnerships have the potential to advance research breadth and depth, and they must prioritize research that is salient to Palestinian policy makers and front line clinicians.[27]
- Finally, the Palestinian mental healthcare system and its international partners must place public health and human rights, including the right to self-determination, as a cornerstone of the mental health agenda. Current research indicates that for common mental disorders, genes and environmental factors in isolation from each other have little predictive power.[28] Instead, it is the interaction of genes with environmental risk factors, including stressors related to war, occupation, unemployment, and economic deprivation, which predict mental illness. Thus psychiatrists should focus on prevention by strengthening human rights for women and children as vulnerable groups, by protecting patient rights thorough legislation such as mental health acts, and by addressing upstream risk factors like family violence,

community violence, and ethnic/military violence. Psychiatrists must be on the forefront of integrating the world of biomedicine with social realities, demonstrating how efforts to improve mental health must include a human rights and social liberation agenda. And psychiatrists must also speak candidly that without political and economic independence, Palestinian policy planners will be constrained in implementing needed system improvements.

Conclusion

Efforts to build and sustain healthcare systems are challenging worldwide: in Palestine those challenges are compounded by an occupation and related social, political, and economic disruptions which intrude on almost every aspect Palestinian life. Consequent fragmentation of the mental health system and associated barriers to care prevent many patients from seeking needed treatment. To address this situation, the system needs to move toward vertical and horizontal integration of services. The patients and their families should be seen as core members of interdisciplinary, nonhierarchical mental health teams; mental healthcare should be integrated into the rest of medical care and public health, with an emphasis on prevention; and partnerships between Palestinians and internationals should support cooperation on medical education, research, and service delivery endeavors. In Palestine in particular, where social, political, and economic injustice are such potent factors in society-wide and individual patient wellbeing, psychiatrists must promote an understanding that mental health is intricately tied to human rights and social liberation.

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الملخص

يواجه الأشخاص الذين يعيشون في فلسطين عقبات في حياتهم اليومية وفي الوصول إلى الخدمات النفسية ذات طبيعة خاصة للفلسطينيين. الاضطرابات الاجتماعية والسياسية، بدءا من نزوح السكان الفلسطينيين الأصليين على نطاق واسع خلال نكبة عام 1948 والمستمر مع الاحتلال، وضعت السكان تحت الضغط النفسي والاجتماعي الكبير. لقد ادت مثل هذه الإضطرابات الى تعطيل ايصال الخدمات النفسية كما أنها كانت سببا رئيسيا في ايجاد الحواجز للوصول إلى الرعاية. يجب على المهنيين العاملين في مجال الصحة النفسية وعلى مشاركيهم العمل للوصول إلى نظام متكامل للرعاية يكون فيه المرضى اعضاء اساسيين ضمن فريق العناية النفسية متعدد التخصصات، بحيث تكون الرعاية النفسية متكاملة مع بقية الرعاية الطبية، وبحيث يكون بين المهنيين في الصحة النفسية الفلسطينية ومؤسسات الرعاية النفسية شراكة غنية طويلة الأمد مع زملائهم في العالم ومع المؤسسات العالمية. وبذلك تصبح الرعاية النفسية مندمجة مع اجندة واسعة تشمل الصحة العامة وحقوق الإنسان والتحرر الإجتماعي.

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