

# Integration of Mental Health and Psychosocial Support in Primary Health Care

for Children, Adolescents, Pregnant Women and New Mothers  
in the Middle East and North Africa Region

JORDAN





# **Integration of Mental Health and Psychosocial Support in Primary Health Care**

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Jordan Country Report 2023

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## Acronyms and abbreviations

<b>DALY</b>	disability-adjusted life years
<b>EMRO</b>	Eastern Mediterranean Regional Office (WHO)
<b>GBD</b>	global burden of disease
<b>GSHS</b>	Global School Health Survey
<b>IASC</b>	Inter-Agency Standing Committee
<b>IMC</b>	International Medical Corps
<b>JICA</b>	Japan International Cooperation Agency
<b>JWU</b>	Jordanian Women's Union
<b>MENA</b>	Middle East and North Africa Region
<b>MENARO</b>	UNICEF Middle East and North Africa Regional Office (UNICEF)
<b>mhGAP</b>	Mental Health Gap Action Programme (WHO)
<b>MHPSS</b>	mental health and psychosocial support
<b>MOE</b>	Ministry of Education
<b>MOH</b>	Ministry of Health
<b>MIT</b>	Ministry of Information Technology
<b>MOSD</b>	Ministry of Social Development
<b>NCFA</b>	National Council for Family Affairs
<b>NCMH</b>	National Centre for Mental Health
<b>NGO</b>	non-governmental organization
<b>PFA-C</b>	psychological first aid for children
<b>PHC</b>	primary health care
<b>PHCC</b>	primary health care centre
<b>PPD</b>	postpartum depression
<b>PTSD</b>	post-traumatic stress disorder
<b>RHAS</b>	Royal Health Awareness Society
<b>RMS</b>	Royal Medical Services
<b>SRH</b>	sexual and reproductive health
<b>THP</b>	Thinking Healthy Programme
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	United Nations High Commissioner for Refugees (UNHCR)
<b>UNICEF</b>	United Nations Children's Fund
<b>UNRWA</b>	United Nations Relief and Works Agency for Palestine Refugees in the Near East
<b>WHO</b>	World Health Organization

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# Executive summary

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Mental health is becoming a priority for most health care systems around the world and was particularly accelerated during the unprecedented COVID-19 pandemic. Recently, mental disorders have been found to affect about 1 in 7 children and adolescents worldwide, with 50 per cent of disorders arising before the age of 14 years.<sup>1</sup> In Jordan and in many other countries, efforts to manage mental health conditions are reactive rather than proactive, focusing mainly on treatment rather than prevention and promotion. Globally, children, adolescents, and pregnant and new mothers are at higher risk and more vulnerable to psychological distress that may not meet diagnostic criteria for mental disorders but that may affect their health and well-being. For children and adolescents, psychological distress may result in poor mental health, causing further problems in their biopsychosocial health and learning that might not be addressed. The poor mental health of pregnant women and new mothers contributes to complications that may impact their infants and increase the risk of further problems and disorders.

Worldwide mental health research conducted in educational settings involving school-aged children and adolescents focuses mainly on early and late adolescence. Despite the significant need of support for these age groups, the dearth of knowledge, proposed interventions and research are observed in humanitarian settings. In Jordan, mental health for children and adolescents, and maternal health services are not prioritized. Mental health services in Jordan are not well defined or understood in primary mental health care. Children, adolescents, and women during pregnancy and the postpartum period are receiving the attention of health care professionals and policymakers; however, such attention is emphasizing a biological-oriented care model to meet physical needs rather than the bio-psycho-social care model to meet the mental health and psychosocial support (MHPSS) needs.

Integrating children, adolescent and maternal mental health care requires strengthening care delivery systems and system changes to facilitate such integration. This involves bringing mental health services close to people who need it and enhancing the capacity of primary health care professionals in mental health. Providing mental health services in primary health care settings integrates both delivery systems and referral of people with mental health needs to more specialized services. Delivery systems include prevention, promotion, identification, diagnosis and treatment. This integration utilizes a holistic MHPSS approach to emphasize the promotion of well-being, prevention of mental health problems, and ensures quality and accessible primary mental health care for those with mental health conditions, along with referrals for conditions that cannot be addressed at the primary health care level.

To support the need to strengthen MHPSS services for children, adolescents, and pregnant and new mothers in Jordan, UNICEF MENARO, in collaboration with WHO EMRO, initiated a regional implementation research effort to explore how MHPSS can be most effectively implemented in primary care settings. The regional research effort, which included a secondary literature review, in-depth analysis and critical stakeholder consultations, contributed to a deeper understanding of MHPSS needs, the available services, and critical gaps across the promotion, prevention, care and treatment within primary health care, as well as emphasizing MHPSS linkages to the social welfare, child protection and education sectors. The information gathered through this effort provided specific recommendations to establish the foundation and support the integration and delivery of MHPSS for children, adolescents, and pregnant women and new mothers at the primary health care level.

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<sup>1</sup> United Nations Children's Fund (2019). *UNICEF: 1 in 7 adolescents suffers mental disorders*. Deutsche Welle. <https://www.dw.com/en/unicef-1-in-7-young-people-suffering-from-mental-disorders/a-59407188>



In general, the literature review showed that the mental health of children and adolescents has attracted the attention of researchers in the past few decades.<sup>2</sup> Several studies attempted to address mental health problems that are serious and affect children's and adolescents' well-being. In Jordan, mental disorders are estimated to be the leading cause of poor health among children and adolescents aged 10–19 years, accounting for almost a quarter of this age group's total disease burden, measured in (DALYs). Nearly 1 in 6 (16.3 per cent) of adolescents were estimated to be living with a mental disorder in 2019, with depression and anxiety being the leading causes. Studies showed that 11–17 per cent of school-attending adolescents and adolescents in juvenile correction agencies are affected by suicidality related to depression.<sup>3, 4</sup> Unfortunately, we lack information on the prevalence of suicidality among children and adolescents in Jordan. Stigma and fear of being labelled as mentally ill contributed to poor engagement in, adherence to, and use of mental health services among adolescents in Jordan.<sup>5</sup>

Severe mental health disorders are often not detected among children and adolescents, as well as other underdiagnosed and underreported less severe conditions that contribute to poor mental health of children and adolescents. Fibromyalgia, alexithymia, social anxiety, ineffective coping, risk behaviours and bullying were associated with mental health problems among children and adolescents.<sup>6, 7</sup> Among women, postpartum depression (PPD) is one of the most common mood-related disorders associated with childbearing and disproportionately affects women in lower-middle-income countries. In Jordan, PPD affects approximately 22 per cent of women.<sup>8</sup> A recent study reported 50 per cent of 1,107 women screened experienced postpartum depression,<sup>9</sup> which was among the highest when compared to studies in other countries in the region. In another previous study, 25 per cent of screened postpartum women (total of 315) suffered from moderate to severe depression, and 50 per cent of the sample had mild depression.<sup>10</sup>

The Jordanian efforts to improve and promote mental health have focused mainly on adults and improving services coverage in the country. Although efforts have resulted in improving mental health services through increasing points of service for mental health, there are still gaps that need to be filled, such as lack of validated screening tools for mental health for children and adolescents at schools and primary care centres; lack of management protocols for children, adolescents and pregnant/new mothers; limited attention to prevention and promotion; and a focus on specialized services rather than integration through primary health care (PHC). Furthermore, Jordan lacks legislation and policies that specifically support mental health care for children, adolescents and pregnant women/new mothers. Mental health is addressed in the three main health policies for the country: the Ministry of Health National Strategic Health Plan (2018–2022), the Health Sector Reform (2018–2022), and the National Strategy for Health Sector in Jordan (2016–2020).<sup>11</sup> Additionally, Jordan has endorsed a National Mental Health and Substance Use Action Plan (2022–2026).<sup>12</sup> The country is currently operating under the 2011 National Mental Health Policy. This policy was reviewed in 2016 and is considered relevant and reflective of Jordan's current context and mental health priorities. The policy informed the development of the National Mental Health and Substance Use Action Plan (2018–2021).<sup>13</sup>

<sup>2</sup> Institute for Health Metrics and Evaluation (2019). *Global Burden of Disease Study*.

<sup>3</sup> Najdawi, Z. R., et al (2022). *Depressive symptoms among students pursuing the general secondary education certificate examination (Tawjihi): A national study*. International Journal of Mental Health, 1-18.

<sup>4</sup> Qaddoura, N., et al. (2022). *Psychosocial determinants of adolescent suicide: A national survey*. Archives of Psychiatric Nursing, 40, 15-24.

<sup>5</sup> Dardas, L. A., et al. (2019). *Depression in Arab adolescents: A qualitative study*. Journal of psychosocial nursing and mental health services, 57(10), 34-43.

<sup>6</sup> Hamdan-Mansour, A. M., et al. (2022). Psychological Predictors of Fibromyalgia among High School Students. *Journal of Psychosocial Nursing and Mental Health Services*, 1-7.

<sup>7</sup> Halasa, S., et al. (2020). *Post-traumatic stress and social anxiety among children of Syrian refugees in Jordan*. International Journal of Mental Health and Addiction, 18(6), 1611-1619.

<sup>8</sup> Borgen Project (2022). *Tackling postpartum depression in Jordan*. <https://borgenproject.org/postpartum-depression-in-jordan/>

<sup>9</sup> Mohammad, K.I., et al. (2021). *Informative title: Effects of social support, parenting stress and self-efficacy on postpartum depression among adolescent mothers in Jordan*. Journal of Clinical Nursing, 30(23-24), 3456-3465.

<sup>10</sup> Safadi, R.R., et al. (2016). *Demographic, maternal, and infant health correlates of post-partum depression in Jordan*. Nursing & health sciences, 18(3), 306-313.

<sup>11</sup> World Health Organization (2020). *Jordan WHO Special Initiative for Mental Health Situational Assessment*. WHO Jordan.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

Stakeholders identified several obstacles and gaps related to integrating the mental health of children, adolescents, pregnant women and new mothers into primary care services.

**Regarding policies and legislation**, the stakeholders noted that currently they are limited in providing a comprehensive strategy for child and adolescent mental health and well-being, and lack the roles and mechanisms needed to strengthen linkages with other key sectors such as child protection and education. There is no mental health act or similar legislation, nor specific legal considerations or protection for children, adolescents or mothers who are engaged in the mental health system.

**Regarding the availability of financial resources and budget** for mental health services, the stakeholders stated that there is a lack of information related to financial resources and how the allocated budget per programme or project related to mental health is managed. The lack of funds to support an interns' programme in the field of medical specialization for psychiatry has contributed to a reluctance to seek this specialization.

**Insufficient numbers of trained providers**, particularly with training on child and adolescent mental health, was noted as another challenge. Although mental health and specialization in the field of MHPSS has recently improved and attracted Jordanians to establish new specializations at the master's level, such as psychiatric nursing and clinical psychology, stakeholders asserted that lack of specialized mental health services and the shortage of MHPSS staff are still significant gaps to integrated mental health at the primary care level, particularly in the government sector, which is the largest health care provider in Jordan. Due to more competitive (higher) salaries, most mental health personnel prefer to work in the private sector.

As stated by stakeholders, mental health illiteracy and stigma among the general population could be why the focus is placed on adults' mental health while the mental health of children, adolescents and pregnant women/new mothers is almost ignored. It was observed that most of the service packages in primary mental health services lack sensitivity to gender and specific developmental needs such as childhood and puberty. Service packages and clinical protocols focus on physiological and developmental conditions. Primary health care settings lack human resources and specialized personnel in mental health, not only at primary health care centres (PHCCs), but also at schools. Stakeholders reported a lack of specialization within the field of paediatric psychiatry and maternal mental health, and lack of training for general physicians on mental health leading to unqualified personnel conducting and providing primary mental health care in primary care settings. In addition, lack of data related to mental health such as the prevalence and incidence of mental disorders, lack of suicide surveillance systems, and lack of mental health indicators were noted by stakeholders as challenges.

Although there are obstacles and gaps related to the mental health of children, adolescents, and pregnant women/new mothers at primary care centres, stakeholders were able to make practical recommendations to improve and promote the integration of mental health into primary care settings. Some key recommendations for addressing child and adolescent mental health that stakeholders across different sectors have include:

- Developing a national plan for child and adolescent mental health
- Increasing financial resources
- Strengthening training (pre- and in-service)
- Coordinating programmes to address mental health stigma and literacy
- Improving systems to promote quality of care (accreditation, standardized tools, evaluation)
- Integrating of MHPSS into child protection and education settings





# 1. Introduction

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Mental health services in Jordan are not well recognized by those who may need them, and Jordanians are not aware of most of the services available. Many residents of Jordan lack general knowledge about mental health conditions,<sup>14</sup> and seeking mental health care is still stigmatized among Jordanians and refugees in Jordan. In addition, the country has a shortage of specialized mental health care personnel and psychiatric professionals, along with poor utilization of the mental health services that do exist and limited access to those services.<sup>15</sup>

According to the World Health Organization (WHO), mental health is one of the main components of health and wellness status and requires integration with other health components, including physical, psychological, social and spiritual health.<sup>16</sup> Therefore, promoting mental health and wellness positively impacts general health and increases economic productivity and social engagement. Primary health care (PHC) is essential for promoting mental health and for helping to prevent, detect and respond to mental health conditions and disorders, and is well positioned to support treatment and rehabilitation.

Mental health and psychosocial support (MHPSS) are receiving attention from national and international organizations in Jordan. However, similar to other countries in the Middle East and North Africa (MENA) region, the mental health of children and adolescents aged 0–18 years is one of the most neglected health issues. Before COVID-19, WHO estimated that 10 to 20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by age 14.<sup>17</sup> In the MENA region, it is estimated that around one in six adolescents (about 15 per cent) aged 10–19 years is living with a mental disorder. Suicide is the fourth leading cause of death of 15–19-year-olds.<sup>18</sup> One child/adolescent aged 10–19 years ends their life every 11 minutes.<sup>19</sup> According to UNICEF and the Gallup Global Survey, one out of five young people aged 15–24 years reported feeling depressed and having little interest in doing things.<sup>20</sup> Many more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorders but that significantly impacts their health, development and well-being.

Mental health is a core component of health for women, particularly before, during and after childbirth. Reports have indicated that mental disorders such as depression and anxiety are experienced during the perinatal period, with higher rates found in low-and-middle-income countries.<sup>21</sup> Other studies emphasize the high susceptibility of pregnant women to emotional instability and daily stress.<sup>22</sup> Such conditions may cause harmful physical and mental consequences for pregnant women and their foetuses, as well as for infants later on,<sup>23</sup> and be direct threats to pregnancy and to mothers' health, causing problems such as those related to breastfeeding and coping with psychologically related factors in the after birth.

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<sup>14</sup> Bawadi, H., et al. (2022). *Barriers to the use of mental health services by Syrian refugees in Jordan: A qualitative study*. Eastern Mediterranean Health Journal, 28(3), 197-203.

<sup>15</sup> Rayan, A., & Jaradat, A. (2016). *Stigma of mental illness and attitudes toward psychological help-seeking in Jordanian university students*. Research in Psychology and Behavioral Sciences, 4(1), 7-14.

<sup>16</sup> World Health Organization (2022). *Mental health in Jordan*. retrieved on July 15, 2022 from: <http://www.emro.who.int/jor/jordan-news/mental-health-in-jordan.html>

<sup>17</sup> Kessler R.C., et al. (2007). *Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative*. World Psychiatry, 6(3): 168-76.

<sup>18</sup> United Nations Children's Fund (2021). *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*. New York: UNICEF, 2021.

<sup>19</sup> Ibid.

<sup>20</sup> Ibid.

<sup>21</sup> Abdoli, A., et al. (2020). *The COVID-19 pandemic, psychological stress during pregnancy, and risk of neurodevelopmental disorders in offspring: a neglected consequence*. Journal of Psychosomatic Obstetrics & Gynecology, 41(3), 247-248.

<sup>22</sup> Stein, A., et al. (2014). Effects of perinatal mental disorders on the fetus and child. *Lancet* 384, 1800–1819. [https://doi.org/10.1016/S0140-6736\(14\)61277-0](https://doi.org/10.1016/S0140-6736(14)61277-0).

<sup>23</sup> Gemmill, A., et al. (2019). *Association of preterm births among US latina women with the 2016 presidential election*. JAMA Netw. Open 2. <https://doi.org/10.1001/jamanetworkopen.2019.7084> e197084-e197084.





Mental health care and primary health care delivery systems have evolved to operate differently, with distinct priorities placed on each. Primary health care, which aims at essential health care delivery, is provided close to where people live and work and requires active participation. WHO defines primary health care as *“a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people’s needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment.”*<sup>24</sup>

For mental disorders, historically, the focus has been on institution-based, specialized treatment. However, there has been a significant shift globally and in Jordan towards primary and community-based services that are more person-centred, emphasizing recovery and rehabilitation, and including interventions to prevent poor mental health and promote psychosocial well-being. Advances in treating mental disorders and increased recognition of the body-mind connection, which addresses the impact of mental health on physical health, has encouraged the integration of MHPSS services in primary health care, providing access to more people.<sup>25</sup>

Enhancing mental health care within primary care has several benefits. A WHO mental health report states that supporting mental health in primary health care would contribute to effectively managing mental health at the community-level, where services are likely to be more accessible and acceptable. At the primary health care level, care can also be more individualized, with a greater capacity to address psychosocial well-being, providing linkages with other forms of support to address risk factors and social determinants of mental health, and making mental health care less stigmatizing.

Such connection and integration have been suggested for children, adolescents and women during pregnancy and after birth. Integrating child, adolescent and maternal mental health care into primary health care requires strengthening both care delivery systems and systems to facilitate such integration. This involves bringing mental health services closer to people and enhancing the capacity of health care professionals in mental health service provision. Providing mental health services in primary health care settings integrates delivery system principles and activities involving prevention, promotion, diagnosis and treatment, along with referral for people with mental health needs that require more specialized services. Delivery of mental health services in primary care settings enhances early detection and prevention of mental health problems. In addition, integration of these services into primary health care is expected to reduce the effect of stigma associated with mental health-seeking behaviours.

<sup>24</sup> World Health Organization (2021). Primary health care. Retrieved on July 15, 2022 from <https://www.who.int/news-room/fact-sheets/detail/primary-health-care>

<sup>25</sup> Burnett-Zeigler, I., et al. (2016). Mind-body approaches to treating mental health symptoms among disadvantaged populations: A comprehensive review. *The Journal of Alternative and Complementary Medicine*, 22(2), 115-124.



## 2. Aims, objectives and approach

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The aim of this study is to understand how MHPSS for children, adolescents and pregnant/postpartum women can be effectively integrated and delivered through primary health care in Jordan.

Specific **objectives** are to:

1. Identify the current and potential roles and responsibilities for primary health care in delivering MHPSS for children, adolescents and pregnant/postpartum women.
2. Explore current challenges and opportunities to strengthen the delivery of MHPSS through primary health care.
3. Identify the support and capacity-building steps required for the implementation of MHPSS through primary health care by adopting a systems-strengthening lens.
4. Explore linkages between primary health care and other key sectors (including child protection and education) needed to support MHPSS.

### 2.1 Expected outcomes

The expected outcomes of the **study** are to inform the development of country-specific and regional recommendations defining how MHPSS could be integrated through primary health care, including which services, platforms and considerations are needed to support effective implementation. These recommendations will be targeted and presented to the government, non-government organizations (NGOs) including service-delivery agencies, United Nations agencies, youth-focused organizations and donors in the region. These stakeholders include national and regional-level policymakers and implementers, with UNICEF and WHO supporting ongoing efforts to translate the study findings and recommendations into policy and programming. While the focus will initially be on stakeholders within Jordan and other focal countries, the recommendations will also be disseminated more widely to other countries in the MENA region through UNICEF and the regional Technical Advisory Group.

### 2.2 Methodology

The first step was a desk review to assess the current situation of MHPSS in primary health care settings. The research then used qualitative methods within an exploratory study design. The qualitative methods included collecting participants' perspectives and opinions on barriers and opportunities regarding the integration MHPSS into primary health care targeting children, adolescents, pregnant women and new mothers. To gather qualitative data, meetings and interviews were undertaken.

#### Desk review

In Jordan, the desk review supplemented the regional overview of mental health needs and national mental health policies. The review explored in greater depth the extent to which MHPSS is integrated into primary health care policies, plans and programmes (including maternal health and child health), and linkages with different sectors (including education and child protection). The desk review also covered of peer-reviewed and grey literature to explore existing approaches, barriers and enablers to the integration of MHPSS for children and adolescents, and maternal mental health in primary health care.

The desk review aimed to:

1. Review and synthesize available peer-reviewed and grey literature, describing mental health needs, barriers and enablers to accessing mental health services at the primary health care or community level for children's adolescents' and maternal mental health.
2. Review and synthesize available national policies on mental health, child and adolescent health, maternal and child health, child protection and education to identify what MHPSS services exist or have been recommended to be delivered through primary health care and existing linkages between key sectors.
3. Review and synthesize peer-reviewed and grey literature of current MHPSS programmes delivered through primary health care to describe approaches and gaps.

To address the gaps and limitations of the national-level survey data and modelled data, peer-reviewed articles and grey literature reports were searched and reviewed to describe in more detail the mental health needs and barriers to accessing mental health care – particularly for underserved or higher-risk populations. Peer-reviewed articles published from January 2017 onwards were sought from Medline (OvidSP), Cinhal (Ebsco Host), Embase (OvidSP), PubMed, Scopus and PsycINFO. Preliminary descriptive studies (qualitative and quantitative), and review articles (systematic reviews, meta-analyses, scoping reviews, and narrative reviews) were used in this review. Studies were included if they were conducted in Jordan and were focused on children and/or adolescents aged 0-18 years or on maternal mental health and described one or more of the following: mental health outcomes, risks and determinants of mental health and/or psychosocial well-being, and/or barriers and enablers to accessing quality mental health services.

Titles and abstracts were screened for eligibility, and data from relevant full-text articles, a total of 25 peer-reviewed articles, were extracted to identify major topic areas, the type of study, targeted populations, settings and findings. These findings were synthesized to describe Jordan's key needs, risks, determinants, and barriers and enablers. In addition, grey literature (including United Nations agency and non-government reports), a total of 29 documents that describe mental health needs, barriers and enablers was found through general internet searches using Google Scholar and targeted searches of regional United Nations agency, government and non-government websites.

### Review of national mental health-related policies and legislation

National-level government policies, plans, strategies and legislation related to mental health and primary health care were identified and reviewed. These included:

- Mental-health-specific policies, plans, strategies and legislation:
  - o Mental health act or similar legislation
  - o National mental health policy/plan/strategy
  - o Mental health implementation/operational/action plan
  - o Children, adolescents and/or youth mental health policy plan/strategy
  - o Maternal mental health plan/strategy
- Primary-health-care-related policies, plans and/or strategies that focus on:
  - o Primary health care
  - o Child health and/or development
  - o Adolescent health and/or development
  - o Maternal and child health
  - o Maternal health/reproductive health
  - o Nutrition
  - o Humanitarian/refugee health
- Non-health sector policies, plans, strategies and legislation:
  - o School-health, school counselling, school health promotion, or school mental health policies
  - o Child protection policy/plans/legislation, including detention; and juvenile policy/plans/legislation

Mental-health-specific policies and legislation were mapped to identify the following:

- Specific policy objectives, actions and indicators for children and adolescents aged 0-18 years and for maternal mental health
- MHPSS to be delivered or integrated through primary health care mapped against the Inter-Agency Standing Committee (IASC) MHPSS intervention pyramid
- System requirements to support delivery of MHPSS through primary health care (e.g., policy actions around the training of providers)
- Documented linkages with education and child protection/social welfare sectors
- Primary-health-care-related policies and plans were reviewed to identify the extent to which MHPSS are integrated, and non-health sector policies were reviewed to identify objectives or actions concerning MHPSS and linkages with primary health care.

### Review of existing programmes to integrate or deliver MHPSS through primary health care

Published, unpublished or non-indexed reports (total of 14) describing or evaluating programmes to integrate or deliver MHPSS through primary health care (including maternal mental health or maternal and child health) were also sought through journal databases listed above and through general internet searches using Google Scholar and targeted searches of regional United Nations agency, government, and non-government websites. This helped identify current approaches, challenges, gaps and lessons learned:

- Current types of MHPSS provided and to which populations
- Primary-care mental health workforce
- Linkages with secondary and tertiary care mental health workforce and services
- Linkages with other sectors (such as education and child protection)
- Gaps in service delivery
- Challenges and lessons learned for integrating MHPSS in primary health care.

### Country-level stakeholder meetings

In-person group meetings were conducted in Jordan, facilitated by the country research leads IMC, Burnet Institute and UNICEF, to present an overview of the key findings and co-develop detailed recommendations for government, non-government and United Nations agencies. The meetings were attended by high-level representatives from the government, NGOs, professional associations, United Nations agencies and youth organizations.

### Description of participating stakeholders

The total number of participants was 24 stakeholders representing the targeted sectors: health, child protection, education, and policy and legislative. Eight participants were male, and 16 were females, with ages ranging from 20 to 59 years, with a mean age of 39.9 years (SD=10.5). Of the participants, 17 were currently working at a governmental agency, 3 were working at NGOs (national or international), 1 was with a youth-based organization, and 3 were working at United Nations agencies.

Their specialties varied: four identified themselves as working in child protection, youth-based and/or MHPSS specialized professionals, five worked in education as counsellors, nine were health professionals at different managerial and service levels, and six were specialists in women's health. All reported that they were or are currently involved in providing MHPSS. The main areas in which the stakeholders worked is as follows:

- Mental health and psychosocial support services
- Counselling and school mental health
- Maternal mental health and maternal health with a focus on postpartum depression
- Child protection/family protection services
- Managing mental health programmes

- Providing primary MHPSS services for people with disabilities
- Tutor of primary psychological care services
- Providing MHPSS to families and the Juvenile and Family Protection Department
- Providing counselling services to patients.

### Stakeholders meeting

The meeting helped present a regional overview of the integration of MHPSS in primary health care in collaboration with the social welfare, child protection and education sectors. This workshop addressed the following main objectives:

1. Identify the fundamental concepts of MHPSS, primary mental health care, and mental health aspects related to children, adolescents, and pregnant women/new mothers.
2. Address the key elements of integrating MHPSS in primary health care (based on the desk review).
3. Map the existing mechanisms, including challenges, around the implementation of MHPSS for children, adolescents, pregnant women/new mothers in primary health care.
4. Identify linkages that currently exist with child protection, social welfare and education.
5. Identify and map the different key stakeholders engaged in delivering MHPSS.
6. Provide input around required actions needed at the facility level and community level, and key system strengthening considerations (policy, governance, service delivery, accessibility, workforce, financial resources, participation, and data and information needs) and how these can be implemented within each country setting.

The meeting was considered an opportunity to present the study to stakeholders and agencies engaged in mental health care in Jordan. It included presentations on project phases and desk review outcomes by the IMC team. Governmental, non-governmental, United Nations, academic and private sector agencies were invited to the meeting and one of the objectives was to enhance partnerships to build a coalition toward improving the project outcomes. The meeting presented the role of each of the collaborators.

There were six round table discussions with specific purposes and assignments. Participants selected the round table discussion that best matched their area of experience and their agencies' concerns, which included children, adolescents, pregnant women and new mothers. Each discussion group was asked to focus on the following:

1. Challenges/barriers around the implementation of MHPSS in primary health care.
2. The linkages that currently exist among child protection, social welfare and education.
3. The identification and mapping the different key stakeholders engaged in delivering MHPSS in primary health care.

### Key informant interviews

The qualitative research method explored in-depth how MHPSS for children, adolescents and pregnant/postpartum women can be more effectively integrated into primary health care, including existing approaches, barriers, enablers, systems-strengthening requirements, and linkages with other sectors.

Key informants included representatives from the health, protection and education sectors; policymakers and programmers; primary health care, protection/social welfare and protection service providers; United Nations agency representatives; youth representatives from youth-focused and youth-led organizations engaged in mental health or adolescent health (aged 18 years and over); and government and non-government (national and international) organization representatives involved with health, education and child protection/social welfare.

**Inclusion criteria:** Current role/responsibility includes policy, management, or delivery of MHPSS and/or policy, design, or implementation of child and adolescent health programmes in a participating country, must be age 18 years or older, and have the ability to provide voluntary informed consent.

**Exclusion criteria:** Children or adolescents aged younger than the age 18 years.

Participants were recruited from a diverse range of stakeholders, and every effort was made to ensure a balance of genders and ethnic groups where possible. Due to the limited scope, timeframe and resources available for the project, interviews were conducted in the main urban centre in Jordan. Key informants with experience working in diverse settings, including rural and remote areas and conflict-affected settings, were recruited and interviewed face-to-face. A total of 24 interviews were conducted.

The researchers met, in person, individually, with each potential participant who expressed interest in the study to explain in detail the objectives, procedures, risks and benefits, as well as to provide a written participant information sheet and emphasize that participation is voluntary.

The research team developed a semi-structured interview guide based on a review of published and grey literature related to MHPSS and available WHO and UNICEF tools and frameworks. The interview guide was also informed by previous research led by the Burnet Institute exploring MHPSS for children and adolescents in East Asia and the Pacific. The final questions in the interview guide were refined with the local Technical Advisory Group (TAG) and followed the desk-based review in each country.

The main topics the interviews explored were:

- What MHPSS services are already being provided through primary health care, and how are these delivered (through which types of services/facilities, by which types of providers, and for which populations).
- What additional services could be provided (including preventive and promotion services), and how these services might be delivered.
- What linkages and referral mechanisms exist with secondary- and tertiary-level mental health care, and how could they be strengthened.
- What existing linkages/referral mechanisms exist with other sectors (child protection, education), and how could they be strengthened.
- What challenges and enablers impact the implementation of MHPSS through primary health care and through which mechanisms:
  - o Policies/legislative
  - o Coordination/governance
  - o Tools, standards of care, protocols
  - o Workforce (roles of different cadres, training/supervision/support needs)
  - o Service delivery (integration into existing services vs. standalone child and adolescent mental health services)
  - o Budget and financing
  - o Community participation
  - o Data and information.

The analysis of the key informant interviews was conducted utilizing the rapid, directed content analysis approach of the Consolidated Framework for Implementation Research.

## 2.3 Ethics review

The study protocol, consent form, data collection tools, and other materials used were approved by the Alfred Hospital Ethics Committee in Australia, University of Jordan, and Jordanian Ministry of Health. Due to the relatively low risk of the study (i.e., interviews with high-level stakeholders about policy and implementation issues, no personal or sensitive information being sought, and minimal risk of harm associated with participation), it was agreed that overarching ethics approval from Australia with letters of approval from a recognized authority in each country was appropriate. Confidentiality, risks and benefits from participation were also addressed.





# 3. Conceptual and policy frameworks

## 3.1 Definitions

### What is psychosocial well-being?

The term 'psychosocial' refers to the dynamic relationship between a person's psychological and social dimensions. The psychological dimension includes internal demands, emotions, thought processes, feelings, and reactions. The social dimension includes relationships, family and community networks, social values, and cultural practices. Psychosocial support refers to the actions that address both the psychological and social needs of individuals, families and communities.<sup>26</sup> This corresponds with the WHO definition of health, *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*<sup>27</sup> While psychosocial well-being emphasizes both psychological and social states, the physical and other domains suggested by WHO are integrated into the practical meaning of psychosocial well-being.

### What is mental health and psychosocial support?

The comprehensive and holistic nature of the term 'psychosocial' allows for proposing a multidimensional perspective of what psychosocial support is. IASC defines 'mental health and psychosocial support' as *"any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder."*<sup>28</sup> Some theorists indicate that MHPSS includes mental health counselling, education, spiritual support, group support, and many other such services.<sup>29</sup> These services are usually provided by mental health professionals such as psychologists, social workers, specialized nurses, counsellors, and/or others. Aspects of MHPSS can also be provided by trained (but non-specialist) nurses, doctors, teachers, early childhood development workers, peers and community members. These types of services can take place in various settings, such as homes, schools, clubs, clinics and community-based settings. Such services require professionals to use their accumulated knowledge and experience in their fields of specialty, allowing for an interdisciplinary application approach. It also requires collecting information from different resources such as family members, co-workers, educators, relatives and others. For those exposed to traumatic experiences, a specific type of intervention is needed. Therefore, MHPSS might refer to exploring the inner world and relationships of individuals and their environments.<sup>30</sup> MHPSS helps individuals and communities heal their psychological wounds and rebuild social structures after an emergency or a critical event. It can also help change people into active survivors rather than passive victims.<sup>31</sup>

This project uses WHO and UNICEF definitions of mental health and psychosocial well-being (see **Box 1**), emphasizing mental health as a positive state rather than the presence of mental disorder (or absence of mental health).

<sup>26</sup> International Federation of Red Cross and Red Crescent Societies (2009). Psychosocial interventions. A Handbook. International Federation of Red Cross and Red Crescent Societies. 2009. [http://pscentre.org/wp-content/uploads/PSI-Handbook\\_EN\\_July10.pdf](http://pscentre.org/wp-content/uploads/PSI-Handbook_EN_July10.pdf)

<sup>27</sup> World Health Organization. (2006). A state of complete physical mental and social wellbeing and not merely the absence of disease or infirmity. Constitution of the World Health Organization Basic Documents.

<sup>28</sup> World Health Organization (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. 2007.

<sup>29</sup> Ibid.

<sup>30</sup> Warwick, I., Neville, R., & Smith, K. (2006). My life in Huddersfield: Supporting young asylum seekers and refugees to record their experiences of living in Huddersfield. Social work education, 25(2), 129-137.

<sup>31</sup> UNICEF, Definition of psychosocial supports. Retrieved 2 April 2019. [https://www.unicef.org/tokyo/jp/Definition\\_of\\_psychosocial\\_supports.pdf](https://www.unicef.org/tokyo/jp/Definition_of_psychosocial_supports.pdf)

## What is maternal mental health?

Maternal mental health refers to mental health problems and disorders that occur during the perinatal period. This includes all mental health problems during the prenatal period (when women are pregnant) and the postpartum period (the first year after the baby is born). Several mental disorders might be observed during these periods, including but not limited to, depression; anxiety disorders, which include generalized anxiety disorder, panic disorder, obsessive-compulsive disorder and birth-related post-traumatic stress disorder (PTSD); bipolar disorder; and postpartum psychosis.<sup>32</sup> In literature, the terms prenatal and maternal concepts are used interchangeably, where 'peri' is Latin for 'around', and 'natal' is Latin for 'birth'. Therefore, perinatal mental health refers to women's mental health during pregnancy and the first years after birth. The significant importance of this period is that one in five women (20 per cent of women) experience perinatal mental health problems during pregnancy or within the early postnatal years, 70 per cent are concealing complaints, and suicide is the leading cause of direct maternal death within a year of having a baby.<sup>33</sup>

## Child and adolescent mental health: Defining age ranges and mental health characteristics

The onset and end of adolescence depends on the purpose of studies and the nature of the phenomenon being studied. For example, some authors differentiate between early adolescence (ages 10–15 years) and late adolescence (ages 15–19 years),<sup>34</sup> while others define adolescence in three phases: early (ages 11–14 years), middle (ages 15–17 years), and late (ages 18–20 years).<sup>35</sup> WHO defines 'adolescents' as people aged 10–19 years and 'youth' as those aged 15–24 years. The terms 'young people' and 'adolescents and young adults' are increasingly used to refer to 10–24-year-olds, commonly differentiated into three five-year age bands of early adolescence (ages 10–14 years), late adolescence (ages 15–19 years), and young adults (ages 20–24 years). In general, the term childhood includes adolescence and refers to a period of life from day one until reaching the age of 18 years.

It has been reported that most mental disorders start in childhood and adolescence, where adolescence is a crucial period for developing social and emotional habits essential for mental well-being.<sup>36</sup> Children and adolescents might adopt healthy sleep patterns; exercise regularly; develop coping, problem-solving and interpersonal skills; and learn to manage emotions. However, a lack of appropriate protective and supportive environments in the family, at school and in the wider community might cause harmful mental effects on children and adolescents, precipitating the development of mental health problems that might also exacerbate mental disorders. International reports showed that one in seven 10–19-year-olds experiences a mental disorder. Suicide is the fourth leading cause of death among 15–19-year-olds, and depression, anxiety and behavioural disorders are among the leading causes of illness and disability among adolescents.<sup>37</sup>

Similarly, mental health and psychosocial support (MHPSS) is not limited to services and support for children, adolescents and mothers with mental health conditions. In keeping with UNICEF's Multisectoral Operational Framework and other key global frameworks, MHPSS strongly focuses on actions needed to prevent poor mental health by addressing risk factors or enhancing protective factors and necessary actions to promote psychosocial well-being.

<sup>32</sup> California Task Force on the Status of Maternal Mental Health Care (2017). A report from the California Task Force on the Status of Maternal Mental Health Care. Retrieved on July 15, 2022 from: <https://www.2020mom.org/ca-task-force-recommendations>

<sup>33</sup> Maternal Health Alliance (2022). Perinatal mental health. Retrieved on July 15, 2022 from <https://maternalmentalhealthalliance.org/about/perinatal-mental-health/>

<sup>34</sup> Cobb, N. J. (1998). Adolescence: Continuity, change and diversity (3rd ed). Mountain View, CA: Mayfield Publishing Company.

<sup>35</sup> Crockett, L. J., & Petersen, A.C. (1993). Adolescent development: Health risks and opportunities for health promotion. In A. C. S.G. Millstein, Petersen, & E.O. Nightingale (Ed.), Promoting the health of adolescents: new direction for the twenty-first century (pp. 13–37). New York: Oxford University Press.

<sup>36</sup> Berasategi Santxo, N., Idoiaga Mondragon, N., Ozamiz-Etxebarria, N., & Dosil-Santamaria, M. (2021). Wellbeing of Adolescents in De-Escalation Situation: Physical, Emotional, Social, and Academic Impact. *Frontiers in Psychology*, 12, 646027.

<sup>37</sup> World Health Organization (2020). WHO Global Health Estimates 2000–2019. Retrieved on July, 15, 2020 from: <https://www.who.int/data/global-health-estimates>





### Box 1: Definitions

**Mental health and psychosocial well-being** are a positive state in which children and adolescents are able to cope with emotions and normal stresses, have the capacity to build relationships and social skills, are able to learn, and have a positive sense of self and identity.

**Mental health condition** is a broad term that encompasses the continuum of mild psychological distress through to mental disorders, that may be temporary or chronic, fluctuating or progressive. During childhood and adolescence, common mental health conditions include difficulties with behaviour, learning or socialization; worry, anxiety, unhappiness or loneliness; and disorders such as depression, anxiety, conduct disorder, psychosis, bipolar disorder, eating disorders, substance use disorders, attention deficit/hyperactivity disorder, intellectual disability, autism, and post-traumatic stress disorder.

**Mental health and psychosocial support (MHPSS) refers to any support, service, or action that aims to protect or promote psychosocial well-being or prevent or treat mental disorders.**

Adapted from UNICEF State of the World's Children 2021

## 3.2 Responsive care, prevention and mental health promotion

Global and regional frameworks, guidelines, plans and other guidance documents outline key actions to support the mental health and psychosocial well-being of children, adolescents and caregivers broadly related to **responsive care, prevention and mental health promotion**. This includes key actions to prevent poor mental health by addressing risks and protective factors through the health sector, in addition to responsive clinical care and managing those with mental health conditions.

Many actions for MHPSS can be effectively delivered through primary health care – either as stand-alone mental health programmes or integrated into other service-delivery platforms (such as maternal and child health care, nutrition programmes, and physical health services). MHPSS actions include:

### Responsive care for those with mental health conditions:

- Identification, screening, assessment and diagnosis of mental health conditions, including self-harm or suicidal behaviour.
- Psychological first aid and emergency care for acute mental disorders or suicidal behaviours.
- Provision of care and management (including psychosocial interventions and pharmacological interventions, where required).
- Multi-disciplinary/collaborative care models to provide person-centred care and support that promotes recovery and rehabilitation.
- Robust referral mechanisms for specialized mental health services and support.
- Robust referral mechanisms with other sectors (social welfare, child protection, justice, education) to ensure timely assessment and care through health services, and for health services to refer individuals and families for other kinds of support.
- Identification and care for parents'/caregivers' mental health (including maternal mental health).

### Prevention of poor mental health by addressing risk and protective factors:

- Delivery, referral to, and/or support for positive parenting programmes (universal, and targeted for families at risk and for families with children living with poor mental health conditions).
- Identification, screening, psychosocial interventions and referral for substance use.
- Identification, screening, psychosocial interventions and referral for exposure to or witnessing violence, including family violence, intimate partner violence, sexual violence, maltreatment, neglect and peer victimization. This also involves the integration of MHPSS into services for survivors of violence and strengthened linkages with child protection.
- Support to programmes that build social and emotional learning and interpersonal skills including integration into early childhood development programmes, and delivery or referral of psychosocial interventions and other kinds of support to build social and emotional learning and skills for those at risk of poor mental health. This includes for pregnant adolescents and adolescent caregivers; those living with HIV, chronic illness or disability; and those affected by conflict or disaster.
- Support and linkages with schools and other settings to create safe and enabling learning environments, including school health services, teacher well-being, referral mechanisms, and support for education staff capacity in mental health and behavioural management.

### Mental health promotion:

- Support stigma-reduction campaigns and consider stigma in the design and delivery of mental health services (including efforts to reduce stigma and discrimination in health settings).
- Develop raising awareness and supporting programmes to improve community mental health literacy.
- Create opportunities and mechanisms that enable and encourage the participation of children, adolescents and their families in the design, planning, delivery and evaluation of MHPSS, including adolescent-responsive health services.
- Linkages, collaboration and coordination with other sectors (including social welfare/social protection) to address social determinants of mental health and well-being.

The 2022 WHO World Mental Health Report defines key priorities for primary health care, including actions to:

- Strengthen the capacity of general health providers to identify, assess and manage common mental health conditions.
- Embed mental health providers in primary health care services.
- Establish collaborative care models.
- Integrate mental health into disease-specific services (e.g., HIV).
- Integrate mental health into population-specific services (e.g., perinatal care, reproductive health care and adolescent health programmes).

# 4. Current situation for children, adolescents, pregnant women and new mothers

## 4.1 Mental health outcomes

The nationally representative and comparable primary data describing the prevalence of mental health conditions for this age group are limited. However, modelled estimates from the Global Burden of Disease 2019 estimated that one in six (16.3 per cent) of adolescents in Jordan aged 10–19 years lived with a mental disorder in 2019. Anxiety and depressive disorders are the most common mental disorders among 15–19-year-olds, while anxiety, conduct disorder and developmental disorders predominate in childhood and early adolescence.<sup>38, 39</sup> The prevalence of anxiety and depression is higher among girls than boys across all age groups, while boys have higher rates of conduct disorder and developmental disorders.

Limited primary data is available describing national-level estimates of mental disorders among children and adolescents. The Global School Health Survey (GSHS) in Jordan showed that 18.4 per cent of students aged 13–15 years could not sleep at night due to being worried either most of the time or always during the previous 12 months (an indicator of anxiety). Rates were almost double among girls compared with boys.<sup>40</sup>

The impact of mental disorders and intentional self-harm on health can be estimated using disability-adjusted life years (DALYs), which measure the total disease burden in terms of years of healthy life lost due to disability (illness) or premature mortality. In Jordan, mental disorders are the leading cause of poor health during adolescence (measured in DALYs), accounting for almost a quarter (23 per cent) of the total disease burden among 10–19-year-olds. During early childhood, neurodevelopmental disorders predominate. From age 10–19 years, there is a significant increase in the burden of poor mental health due to anxiety and depressive disorders. While girls experience a higher burden of poor mental health overall compared with boys due to excess depression and anxiety, boys have a higher burden of poor health due to conduct disorder that emerges from later childhood into early adolescence.<sup>41</sup>

Suicide is closely related to poor mental health. Available data from GSHS conducted between 2007 and 2016 revealed that, in Jordan, 17.4 per cent and 15.5 per cent of 13–15-year-old students had seriously considered suicide in the 12 months preceding the survey. Rates of suicidal ideation and attempt were similar between girls and boys, though girls had slightly higher rates. The national-level age-disaggregated data describing suicide mortality for adolescents in Jordan is minimal. Adjusting for missing data (e.g., deaths not reported) or misclassification of cause of death, the GBD 2019 estimated that there are almost 1,800 deaths annually due to suicide among 10–19-year-olds in the MENA region, with suicide being the fifth leading cause of death of 15–19-year-olds in Jordan. Just over half of suicide deaths among young adolescents aged 10–14 years are among girls. However, in older adolescents, boys account for almost two thirds of all suicide deaths. Boys have a substantially higher mortality rate than girls in Jordan: males had a 1.2 per cent rate compared to females at 0.5 per cent. Although the rate of death due to suicide is less in Jordan compared to other countries in the MENA region, the ratio of boys to girls seems higher than many other countries.

<sup>38</sup> James, S.L. et al. (2018). *Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017*. The Lancet, 392(10159), 1789–1858.

<sup>39</sup> World Health Organization (2021). *Mental Health Atlas 2020*. Geneva: WHO.

<sup>40</sup> James, S.L. et al. (2018). *Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017*. The Lancet, 392(10159), 1789–1858.

<sup>41</sup> Ibid.

The literature review showed that the health of children and adolescents attracted the attention of researchers in the past few decades. Several studies attempted to address mental health problems that are serious and affect the well-being of children and adolescents. Studies that explore suicidal tendencies among school adolescents and adolescents at juvenile correction agencies show that 11–17 per cent of them are suicidal, and that suicidal ideation is related to depression.<sup>42, 43</sup> In Jordan, there is a lack sufficient information about the suicide of children and adolescents in Jordan and a lack of a national suicide surveillance system to record, report and follow up on suicide risk and incidence.

It has also been reported that there are gender differences if depression symptoms are reported or observed, willingness to seek mental health care, ability to communicate symptoms, and expectations of care.<sup>44</sup> Stigma and fear of being labelled as mentally ill contributed to poor engagement in, adherence to, and use of mental health services among adolescents in Jordan.<sup>45</sup> Furthermore, stigma scores were associated with an increased likelihood of seeking help from a school counsellor or a family member, even among those with moderate to severe depression.<sup>46</sup> Unfortunately, no study has been found in Jordan addressing primary mental health care for children and adolescents. The studies indirectly signified the role of primary health care providers. However, investigating the effect of and role of primary health care providers in addressing mental health problems and lowering risks to mental disorders or problems have not been addressed in Jordan.

## 4.2 Risks and determinants of children's and adolescents' mental health

The 2021 UNICEF State of the World's Children report defines three spheres of influence shaping children's and adolescents' mental health and well-being. These are;

- **'world of the child'**: individual assets, parents, caregivers and families
- **'world around the child'**: safety, security and healthy attachment in school, communities and online
- **'world at large'**: social determinants including poverty, disaster, conflict, discrimination, migration.<sup>47</sup>

Childhood and adolescence are times of rapid change in social context and roles, and the timing and nature of exposure to the environment and immediate social context can powerfully shape mental health and well-being. These risks and protective factors are cumulative across the life course and are often clustered – those who experience multiple adverse childhood experiences (abuse, neglect, violence, or dysfunction within families, peers, or the community) have the highest risk of poor mental health.<sup>48</sup>

National-level data in Jordan describing attachment and the quality of caregiving are limited. Data from UNICEF's Multiple Indicator Cluster Surveys (MICS) report that most children under the age of five are adequately supervised at home.<sup>49</sup> Most children under the age of five receive early stimulation from household members to promote early learning and school readiness. UNICEF data/MICS 2000–2020 showed that Jordan has the highest rate of adult engagement with their children's early stimulation and responsive care (91 per cent and 92 per cent for females and males, respectively). On the other hand, rates for children with inadequate supervision were 16 per cent and 14 per cent for females and males, respectively<sup>50</sup> (see **Figure 1**).

<sup>42</sup> Najdawi, Z.R. et al. (2022). Depressive symptoms among students pursuing the general secondary education certificate examination (Tawjihi): A national study. *International Journal of Mental Health*, 1-18.

<sup>43</sup> Qaddoura, N. et al. (2022). Psychosocial determinants of adolescent suicide: A national survey. *Archives of Psychiatric Nursing*, 40, 15-24.

<sup>44</sup> Ibid.

<sup>45</sup> Dardas, L.A. et al. (2019). Depression in Arab adolescents: A qualitative study. *Journal of psychosocial nursing and mental health services*, 57(10), 34-43.

<sup>46</sup> Ibid.

<sup>47</sup> United Nations Children's Fund (2021). *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*. New York: UNICEF, 2021.

<sup>48</sup> Ibid.

<sup>49</sup> UNICEF. Mental Health and Psychosocial Wellbeing: Technical note.

<sup>50</sup> Ibid.



Relationships with parents and caregivers are essential for adolescents' mental health and well-being. However, national data and studies exploring the quality of parenting and attachment during adolescence are very limited. GSHS revealed that, in Jordan, around 43 per cent of 13–15-year-olds report that their parents or guardians either mostly or always knew what they were doing with their free time. The percentage of 13–15-year-olds who reported that their parents never or rarely knew what they were doing was 34.9 per cent (Jordan).<sup>51</sup> Slightly lower rates of 13–15-year-olds reported that their parents understood their problems or worries (males reported 36 per cent and females 31 per cent).

Similarly, those who reported that their parents never or rarely understood their problems amounted to 43.4 per cent in Jordan, similar to girls and boys. Regarding aggression and violence, 84.1 per cent of males and 74.5 per cent of females aged 1–14 years have experienced any form of violent discipline (psychological aggression and/or physical punishment) at home in the past month. Moreover, it has been reported that 9.7 per cent of females aged 20–24 years were married by age 18, and 5.0 per cent commenced childbearing by age 18.<sup>52</sup> In Jordan, similar to other countries in the MENA region, there is very limited data on the mental health needs of children and adolescents with chronic illness and disability, though they may experience a higher burden of poor mental health (and/or exposure to risks such as violence, abuse and neglect).

Children and adolescents living in alternative care, including residential care, are also at increased risk of poor mental health and exposure to risk factors, such as violence. Accurate data on the number of children living in alternative care are limited. Nonetheless, UNICEF estimated that in 2016 there were around 212,000 children aged 0–17 years in the MENA region living in residential care, and another 52,000 in foster care.<sup>53</sup> In Jordan, for children in alternative care, UNICEF and the Jordanian Government (MOSD 2019) estimated that around 21 in 100,000 children were in residential care.<sup>54</sup> There are very limited data describing mental health needs or risks for these children, and considerable variation in living environments and conditions. However, research in many settings has indicated that institutional care can profoundly impact social, emotional and interpersonal development and increase risks for exposure to violence, abuse and poor mental health.

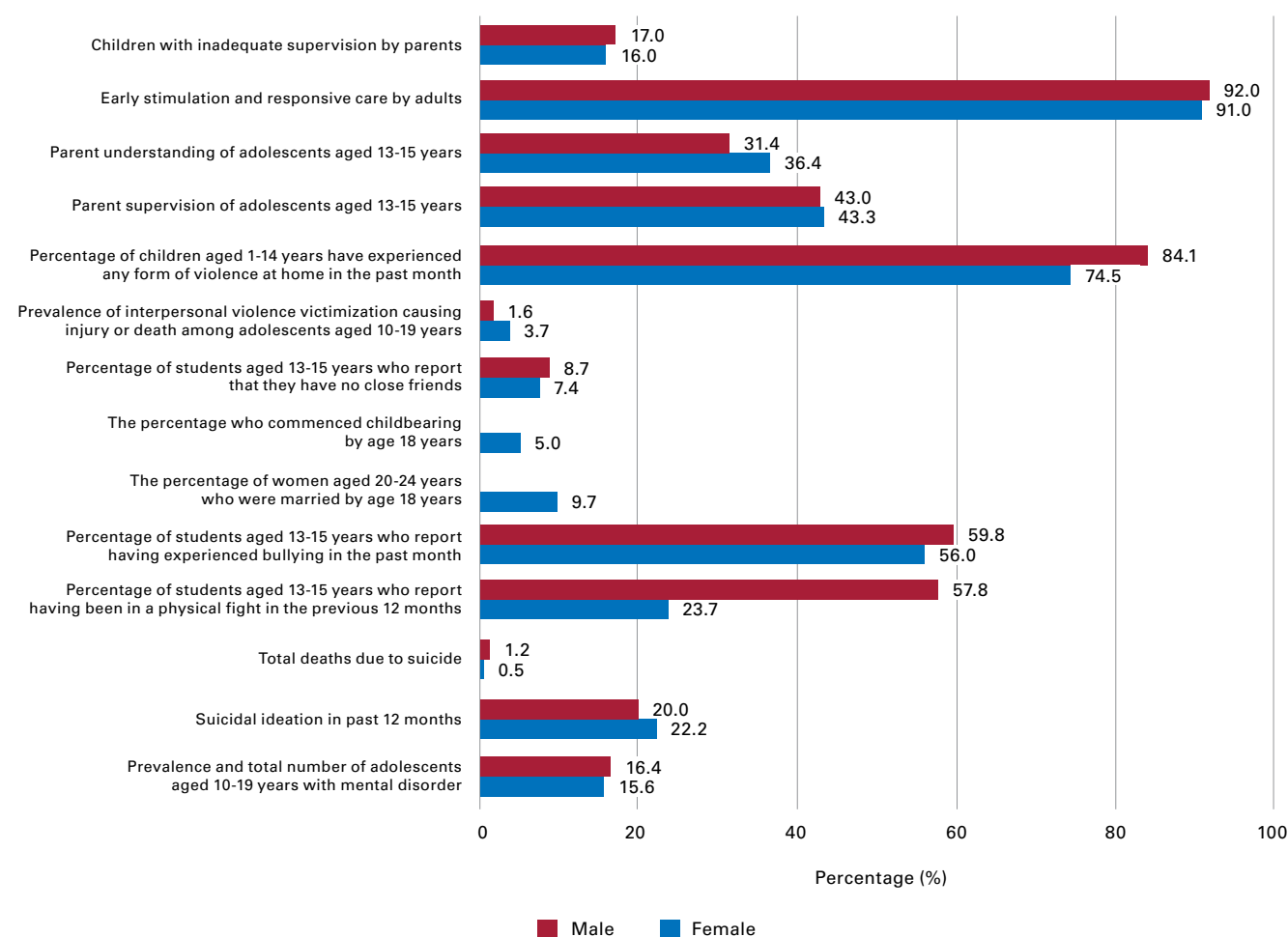
<sup>51</sup> James, S.L. et al. (2018). *Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017*. *The Lancet*, 392(10159), 1789–1858.

<sup>52</sup> Ibid.

<sup>53</sup> Petrowski N, Cappa C, Gross P. Estimating the number of children in formal alternative care: Challenges and results. *Child Abuse & Neglect* 2017; 70: 388–98.

<sup>54</sup> UNICEF (2023). Children in Alternative care. <https://data.unicef.org/topic/child-protection/children-alternative-care/>



**Figure 1: Prevalence of key risk factors of children and adolescents**

Source: GBD 2019

### 4.3 Maternal mental health

It is estimated that almost one in six women in low-income and middle-income countries experience common perinatal mental health disorders (including depression and anxiety) during pregnancy and one in five during the postpartum period.<sup>55</sup> Many more experience symptoms of psychological distress, loneliness, isolation and self-harm, with suicide estimated to account for 20 per cent of maternal deaths, globally, in the year after childbirth.<sup>56</sup> Risk factors for perinatal mental health conditions include being young (including adolescent mothers) and/or unmarried, experiencing intimate partner violence, lacking partner or family emotional support, and being socioeconomic disadvantaged. Previous history of mental health conditions also increases the risk for perinatal mental disorders.<sup>57</sup> Higher rates of poor maternal mental health have also been reported among migrant women, particularly refugees and asylum seekers.<sup>58, 59</sup> Poor maternal mental health can profoundly impact the physical health of infants and children, caregiving (attachment, responsive care), and the cognitive development and mental health of children and adolescents.<sup>60</sup>

<sup>55</sup> Fisher J, Cabral de Mello M, Patel V, et al. Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. *Bull World Health Organ* 2012; 90(2): 139G-49G.

<sup>56</sup> Lindahl V, Pearson JL, Colpe L. Prevalence of suicidality during pregnancy and the postpartum. *Arch Womens Ment Health* 2005; 8(2): 77-87.

<sup>57</sup> Fisher J, Cabral de Mello M, Patel V, et al. Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. *Bull World Health Organ* 2012; 90(2): 139G-49G.

<sup>58</sup> Yoneda K, Hababeh M, Kitamura A, Seita A, Kamiya Y. Prevalence and characteristics of Palestine refugee mothers at risk of postpartum depression in Amman, Jordan: a cross-sectional study. *Lancet* 2021; 398 Suppl 1: S28.

<sup>59</sup> Anderson FM, Hatch SL, Comacchio C, Howard LM. Prevalence and risk of mental disorders in the perinatal period among migrant women: a systematic review and meta-analysis. *Archives of women's mental health* 2017; 20(3): 449-62.

<sup>60</sup> McNab SE, Dryer SL, Fitzgerald L, et al. The silent burden: a landscape analysis of common perinatal mental disorders in low- and middle-income countries. *BMC Pregnancy and Childbirth* 2022; 22(1): 342.

For the MENA region, there are currently no comparable national-level indicators or data describing mental health outcomes of women during pregnancy or in 12 months following birth. A recent global systematic review of postpartum depression among healthy women found the highest prevalence among women in the Middle East (26 per cent compared with 12 per cent, globally).<sup>61</sup> A systematic review published in 2021 of postpartum depression in the MENA region reported a similar prevalence of 27 per cent, with socioeconomic disadvantage, low educational attainment, pregnancy-related complications, inadequate social support from family, and unplanned pregnancy among key risk factors.<sup>62</sup> A similar 2021 review of postpartum depression, including studies from 13 countries in the region, reported a prevalence of 40 per cent in Jordan.<sup>63</sup> Women affected by conflict, including those who are forcibly displaced, are at increased risk of perinatal mental disorders, including post-traumatic stress.

## Maternal mental health needs, risks and determinants

According to World Bank data, Jordan ranks 14 of 21 in the MENA region for life expectancy and 12 of 21 for infant mortality.<sup>64</sup> Maternal mortality is at 29.8 per 100,00 live births. Antenatal care coverage is at 98 per cent.<sup>65</sup> A potential risk is lack of partner support during pregnancy, and nearly one quarter of ever-married women aged 15–49 years in Jordan report being a survivor of intimate partner violence.<sup>66</sup> A 2021 report published by the Jordanian Women's Union (JWU) indicated that, for the past 20 years, an average of 1,500 women annually report abuse; during the past two years, 2,727 cases have been reported. In 2019, it was estimated that 45.5 per cent of the abuse case were reported compared to 54.6 in 2020, as documented by the JWU hotline service centre.<sup>67</sup> The report also indicated that husbands are still the most reported abusers (70 per cent), and that the most abused women are aged 23–47 years (87 per cent), which is the reproductive age for women. The reports lack information about maternal-related issues, such as women's pregnancy and postpartum status.

Literature shows that maternal mental health has been largely unaddressed in most mental health studies, with the exception of postpartum depression (PPD). PPD is one of the most common mood-related disorders associated with childbearing and disproportionately affects women in lower- and middle-income countries. In Jordan, postpartum depression affects approximately **22 per cent of women**.<sup>68</sup> A 2021 study reports that postpartum depression among Jordanian women was among the highest in compared to other countries in the region, as of the 1,107 women screened in Jordan for postpartum depression, 50 per cent were affected.<sup>69</sup> In a study from 2016, 25 per cent of screened post-partum women (total of 315) suffered from moderate to severe depression, and 50 per cent of the sample had mild depression.<sup>70</sup> The researchers found that none of the most significant demographic characteristics, such as age, income, education and employment, were directly associated with PPD, which suggests that the effect of sociodemographic factors might contribute to women's willingness to access and utilize mental health care services. However, a 2013 study among Arab Jordanian military nurses showed that income, problems during pregnancy and mode of birth were the strongest predictors of PPD, indicating the importance of maternal mental health care during pregnancy and postpartum period.<sup>71</sup>

<sup>61</sup> Shorey S, Chee CYI, Ng ED, Chan YH, Tam WWS, Chong YS. Prevalence and incidence of postpartum depression among healthy mothers: A systematic review and meta-analysis. *J Psychiatr Res* 2018; 104: 235–48.

<sup>62</sup> Alshikh Ahmad H, Alkhatib A, Luo J. Prevalence and risk factors of postpartum depression in the Middle East: a systematic review and meta-analysis. *BMC Pregnancy Childbirth* 2021; 21(1): 542.

<sup>63</sup> Wang Z, Liu J, Shuai H, et al. Mapping global prevalence of depression among postpartum women. *Translational Psychiatry* 2021; 11(1): 543.

<sup>64</sup> World Bank. World Bank Country and Lending Groups. The World Bank <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lendinggroups> (2016)

<sup>65</sup> Department of Statistics (DOS) and ICF. Jordan Population and Family and Health Survey 2017–18. (2019).

<sup>66</sup> Ibid.

<sup>67</sup> Jordanian Women's Union (2021). Annual counselling report for 2019–2021. Amman. Jordan. 2021.

<sup>68</sup> Borgen Project. (2022). Tackling postpartum depression in Jordan (2022). <https://borgenproject.org/postpartum-depression-in-jordan/>

<sup>69</sup> Mohammad, K.I., et al. (2021). *Informative title: Effects of social support, parenting stress and self-efficacy on postpartum depression among adolescent mothers in Jordan*. *Journal of Clinical Nursing*. 30(23–24), 3456–3465.

<sup>70</sup> Safadi, R.R., et al. (2016). *Demographic, maternal, and infant health correlates of post-partum depression in Jordan*. *Nursing & health sciences*, 18(3), 306–313.

<sup>71</sup> Yehia, D., et al. (2013). *Prevalence and predictors of postpartum depression among Arabic Muslim Jordanian women serving in the military*. *J. Perinat. Neonat. Nursing* 2013; 27: 25–33.





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Studies have reported that PPD diagnosis has increased during the last few years. The studies estimate that PPD increased from 25–27 per cent to almost 50 per cent of post-partum women. A rapid assessment in March 2022 by IMC Jordan on sexual and reproductive health (SRH) addressed the maternal mental health services in the Azraq Camp for Syrian refugees. This assessment indicated that 29.1 per cent of SRH service users displayed negative emotional states, including symptoms of depression, anxiety and acute distress. The report highlighted that the main barriers to seeking mental health services among females receiving SRH services are personal and community stigma, low mental health literacy, lack of social support, lack of integrated MHPSS services within SRH services, and limited to no awareness of available services.

None of the existing inpatient or outpatient mental health/psychiatric facilities are specifically for maternal mental health. According to the WHO Mental Health Atlas (2020), there are 23 community mental health units providing mental health care across Jordan that are run in collaboration with IMC as part of primary health care centres directed by MOH. However, maternal mental health has not been specifically identified as one of the programmes or services offered, though it is provided. Currently, there are no specific maternal mental health care plans proposed.

In Jordan, there is one school-based mental health programme. It is led by WHO and implemented by the Royal Health Awareness Society, in coordination with MOH and the Ministry of Education (MOE). The programme focuses on mental-health-awareness campaigns, and social and emotional early childhood development, as well as addressing student mental health problems, promotion and prevention along with capacity building for teachers and counsellors. Parental mental health programmes were not addressed in any programmes.<sup>72</sup>

According to a 2022 WHO Newsletter, in Jordan, 496 health care professionals were trained on MHPSS services, 47 organizations were engaged in training, 350,000 people were reached through mental health awareness campaigns, 12 capacity-building initiatives were launched, 9 facilities were supported through procurement, 2 facilities were renovated, and 58 schools were trained on mental health promotion and prevention. In addition, 56 primary health care providers from across Jordan were trained through the *Mental Health Gap Action Programme Intervention Guide* (mhGAP-IG).<sup>73</sup>

<sup>72</sup> World Health Organization (2020). *Mental Health Atlas 2020*. Amman, Jordan.

<sup>73</sup> World Health Organization (2022). *Newsletter: Strengthening the mental health system, improve access and services for vulnerable Jordanians and refugees – Second Phase* September.



# 5. Current responses

## 5.1 National mental health policies, legislation and plans

Jordan is currently operating under the 2011 National Mental Health Policy. This policy was reviewed in 2016 and is considered relevant and reflective of Jordan's current context and mental health priorities. In addition, Jordan has endorsed the National Mental Health and Substance Use Action Plan (2022–2026), which was informed by the National Mental Health Policy.<sup>74</sup>

There is no dedicated mental health legislation in Jordan. However, mental health provisions are included in two laws: the Public Health Law (No. 47, Chapter 4, 2008), and Law on the Rights of Persons with Disabilities Act (No. 20, 2017). Within the Public Health Law, No 47, there are provisions for managing patients who require treatment against their will. In the Law on the Rights of Persons with Disabilities, the provisions cover persons with mental health conditions, since mental illness is included in the definition of disability. A proposed criminalization of suicide recently suggested by the government has jeopardized reducing the stigma of mental illness and raised many questions about measures that need to be adopted by the public authorities to combat mental illness stigma and enhance mental well-being.

**Table 1: Components and equity of mental health policies and plans**

		Policy	Plan
<b>Components</b>	Maternal	Addressed	Addressed
	Child/adolescent	Addressed	Addressed
	HIV	Not addressed	Not addressed
	Alcohol/substance use	Not addressed	Addressed
	Epilepsy	Not addressed	Not addressed
	Dementia	Not addressed	Addressed
	Promotion/prevention	Addressed	--
	Suicide	Not addressed	n/s
<b>Equity</b>	Gender	Not addressed	Not addressed
	Age/life course	Partially addressed	Partially addressed
	Rural/urban	Partially addressed	Partially addressed
	Socio-economic status	Addressed	Not addressed
	Vulnerable population	Not addressed	Not addressed

Addressed
  Not addressed
  Partially addressed

n/s Not specified
  -- Not assessed

Adopted from World Health Organization (2020). Jordan WHO Special Initiative for Mental Health Situational Assessment.

<sup>74</sup> World Health Organization (2020). Jordan WHO Special Initiative for Mental Health Situational Assessment. WHO Jordan.

## 5.2 Overview of the mental health care system

According to WHO, Jordan has been identified as a country in need of intense support for strengthening the mental health care system. In 2008, Jordan was chosen from six countries suggested as the first country to implement the WHO Mental Health Action Programme (mhGAP). The first National Mental Health Policy and Action Plan was developed by a National Steering Committee, which represented a large number of stakeholders. In the organization of mental health services, the focus has shifted from purely hospital-based care to community-based services, using the bio-psychosocial model of health. This encompasses a multidisciplinary approach to address biological, psychological and social influences, requiring a specialized mental health team. One of the main components for integrating MHPSS into primary health care is to implement mhGAP training.<sup>75</sup>

Jordan's mental health system, which is in parallel to the general health system, consists of the public sector including the Ministry of Health (MOH), Royal Medical Services (RMS), Jordan University Hospital, King Abdullah University Hospital, the private sector and the charitable sector (national and international NGOs as well as UNRWA for Palestinian refugees). These agencies, institutions and hospitals operate independently, with separate service delivery and financing mechanisms. Within the MOH, responsibility for mental health is with the Disability and Mental Health Directorate, which is under the MOH Assistant to the Secretary General for Primary Health Care.

### Primary mental health care

Currently, 93 health care centres (out of the 112 comprehensive health care centres, 375 primary health care centres and 190 peripheral health centres) have integrated mental health in the services offered and have staff trained through mhGAP. However, only 6 out of the 93 have a pharmacy, which has only one type of anti-psychotic and one type of anti-depressant available. Out of the primary health care centres, there are 19 community mental health clinics run by IMC and MOH. UNRWA reports that they have integrated mhGAP in their network of 22 primary health care centres serving Palestinian refugees, and some NGOs provide mental health services in their clinics.

### Secondary mental health care services

Secondary care is provided by acute inpatient units, community mental health centres and outpatient clinics. Three acute inpatient units have been established in general hospitals: MOH Ma'an Governmental Hospital in the south (15 beds), Jordan University Hospital in Amman (12 beds), and King Abdullah University Hospital in the north (12 beds). However, Ma'an and King Abdullah only have a ward for males and females, respectively. For children under the age of 16, there are no allocated units or beds in the MOH facilities. However, the university-affiliated hospitals, army-affiliated RMS, and private hospitals can hospitalize them.

### Tertiary mental health care services

The MOH National Centre for Mental Health (NCMH) operates three mental hospitals, including the NCMH itself (205 beds), Al-Karama Hospital (150 beds), and the National Centre (47 beds). A forensic facility (140 beds) has been built and is currently awaiting the allocation of human resources. Furthermore, the RMS operates a highly specialized standalone acute inpatient unit (38 beds), and the private sector has one private psychiatric hospital (Al Rasheed Hospital, 120 beds).

<sup>75</sup> World Health Organization (2022). *Mental health in Jordan*. Retrieved on 6 July 2022 from <http://www.emro.who.int/jor/jordan-news/mental-health-in-jordan.html>

## 5.3 Health care and the MHPSS workforce

The workforce in Jordan has over 200 doctors, 220 nurses and 130 pharmacists per 100,000 population.<sup>76</sup> An estimated 91 psychiatrists are practicing in the country (just under 1 per 100,000 population) and 13 psychiatric nurses (0.13 per 100,000). The psychiatrists are distributed as follows: 42 psychiatrists in the public system (MOH: 22, RMS: 13, King Abdullah University Hospital, Jordan University Hospital and other universities: 7), and 49 psychiatrists in the private sector (private clinics: 44, Al Rasheed Hospital: 5). Estimates on the numbers of neurologists, psychologists and mental health social workers are unavailable. Additional mental health human resources include an estimated 93 psychiatric residents, and 1,140 NGO-based workers providing mental health and psychosocial support services. Training facilities for psychiatric residents include the MOH NCMH, RMS mental health inpatient unit, Jordan University Hospital, King Abdullah University Hospital and Al Rashid Hospital (private sector).<sup>77</sup>

### Mental health workforce at the primary care level



As mentioned, the available information about mental health care services for inpatient and outpatient mental health/psychiatric units indicate that there are 5 mental health hospitals, 3 psychiatric hospital inpatients units, 1 forensic unit, 83 community-based non-hospital mental health facilities, 2 alcohol/drug addiction facilities, and no child, adolescent or maternal mental health or psychiatric units (for inpatients or outpatients).<sup>78, 79</sup> No information is available about the number of mental health workers in the field child and adolescent mental health or maternal mental health. There are six outpatient facilities providing mental health services for all ages, while none of the inpatient facilities is specifically for maternal mental health.<sup>80</sup> There are 23 community-based mental health facilities (0.23 per 100,000 of the population). The WHO Mental Health

Atlas-2020<sup>81</sup> reported that there is only one school-based mental health programme, while maternal and parental mental health programmes do not exist.

Available IMC data regarding the workforce covering mental services at primary care facilities and community mental health care centres (primarily provided by MOH, IMC and UNRWA) show they provide services to all age groups including children, adolescents and women (including pregnant and postpartum). Information regarding the workforce at the other agencies needs to be organized, as no information is available about the exact numbers given the high turnover and service changes during the past few years.

<sup>76</sup> World Health Organization (2020). *Jordan WHO Special Initiative for Mental Health Situational Assessment*. WHO Jordan.

<sup>77</sup> Ibid.

<sup>78</sup> Ibid.

<sup>79</sup> World Health Organization (2020). *Mental Health Atlas*. Amman, Jordan.

<sup>80</sup> Ibid.

<sup>81</sup> Ibid.

## 5.4 Responsive care for mental health conditions

The provision and management of mental health care are led by the Directorate of Mental Health and Disabilities at MOH. Within the directorate, activities related to mental health and psychosocial support services include those directed to inpatient and outpatient beneficiaries. The directorate coordinates with national and international agencies from different sectors to facilitate access to and utilization of mental health services. Coordination with other directorates, such the Directorate of School Health and the Maternal and Child Health Directorate, is one of the approaches used by the MOH to enhance the utilization of and access to mental health services. Within the Directorate of Mental Health and Disabilities, the roles and responsibilities include developing standards of mental health care services, formulating national policies, participating in reforming mental health service plans, and training and capacity building of specialized and non-specialized mental health workers. In the case of children's, adolescents' and maternal mental health, the directorate limited its responsibilities by enhancing MHPSS services at primary care centres by training specialized and non-specialized mental health workers to assess the psychological well-being of children, adolescents and mothers, as needed. However, effective MHPSS services are challenged by several factors, including the shortage of staff at primary care centres, lack of specialized mental health workers and mental health illiteracy among users of services.

For the past two decades, the Jordanian Government has directed significant resources to address mental health needs and improve access and use of mental health services nationwide. The reform plan includes establishing eight outpatient psychiatric care units and mhGAP training for health care providers at primary care centres, in collaboration with the WHO, IMC and other MHPSS stakeholders. However, child, adolescent and maternal mental health have received little specific attention, and health services often lack sensitivity to their needs.

### Screening and early identification of mental health needs



Screening for mental health problems and early detection of mental illness at schools and primary care directed to children, adolescents, pregnant women and new mothers are critical issues that are receiving little attention from governmental and non-governmental health agencies. Screening is not well-addressed through health, school, social welfare and child protection systems. Within the health sector, there is a lack of mental health screening tools related to children, adolescents, pregnant women and new mothers, and this has been identified as a key gap in Jordan's national health system. In addition, the lack of mental health professionals at primary care centres has been identified as a key gap in providing children, adolescents, pregnant women and new mothers with mental health care.

School counsellors primarily evaluate children and adolescents for mental health problems, and parents are informed if there is a need to follow up on their children's mental health needs. The Royal Health Awareness Society (RHAS) highlighted that, although the school mental health programme was implemented, there is still a need to improve the referral process between the school and health sectors to ensure safe referral and access to services. Detection and screening for mental health problems among school children and adolescents are conducted individually by school counsellors. There is also no specific tool that is used or adopted to evaluate mental health of children and adolescents other than school counsellors' and teachers' knowledge regarding the warning signs and symptoms for children. In this regard, the school counsellors intervene primarily upon request from teachers or children rather than systematically working on screening and detecting mental health problems among children and adolescents.

At comprehensive and primary health care facilities in Jordan, health workers and case managers are directing their services and care to adults with mental health problems. The shortage of children and adolescent mental health specialists, such as paediatric psychiatrists or child psychologists, is a key gap in MHPSS services provided at primary care centres. This issue also applies to pregnant women and new mothers who are not routinely screened for mental health conditions. The mhGAP training at 93 primary care centres enabled midwives to incorporate questions related to postpartum depression and anxiety into their assessment for pregnant women and new mothers. However, the follow-up and referral mechanisms are still unclear and depend on women's approval for undertaking care with a specialized mental health care professional.

## Referral pathways

Referral pathways for responsive care in Jordan take place between and within systems, including NGOs and national and international institutions. Although formal referral systems exist in governmental agencies, informal referral is still observed across other governmental and non-governmental institutions. These mechanisms and protocols are informal rather than based on standardized referral protocols and processes, and rely mainly on agencies' internal protocols or signed collaboration agreements with other governmental and non-governmental agencies.

Within the **health sector**, child, adolescent and maternal health specialists are not available. Those who seek treatment at primary care centres for mental and psychological conditions are being evaluated by non-specialized personnel or primary care providers who generally refer them to specialists within the primary care level or to secondary or tertiary facilities if needed. The limited number of trained or competent health professionals to manage children's and adolescents' mental health or behavioural problems at primary care centres indicates that children, adolescents, pregnant women and new mothers with mental health problems are either overlooked or superficially assessed and referred to highly specialized services for evaluation. This may cause delays in seeking help and treatment, particularly for those who lack specialized services within their geographical area or have economic difficulties related to travel costs and paying for specialized services.

Within primary care centres, there is no clear referral procedure or protocol for children and adolescents with mental health needs. The informal protocol indicates that there is a primary care provider who suggests referring the case to a mental health specialist. However, there is a clear policy to manage care for those who are referred to a mental health and psychosocial specialist within the system. The mental health policy guidelines, the commonly known standard operating procedures for inpatient units and outpatient clinics, indicate that referral is transferring an individual from one clinician to another clinician or specialist; or from one setting or service to another resource, either for consultation or care that the referring source is not prepared or qualified to provide. In addition, the policy indicates that by drawing on the evaluation, a decision is made whether to refer the client to an inpatient psychiatric unit or continue treatment at the outpatient clinic, taking into account the severity or stability of the disorder.<sup>82</sup> Such guidance on how to manage patients between the levels of care from primary to tertiary exists in the governmental health care system.

Other agencies limit their MHPSS services at the primary care level and informally refer those who need to be seen by a mental health specialist to a governmental primary care centre or advise them to seek a mental health specialist in the private sector. As mentioned, this is likely to result in a delay in seeking treatment due to bureaucratic processes in the referral system at governmental health centres, lack of specialist mental health professionals at primary care centres, and/or due to economic barriers, such as transportation costs and long distances, to centres that provide mental health services. However, similar standard referral protocols and mechanisms are not as well developed for other sectors in Jordan, and even where guidance exists, bottlenecks and administrative barriers contribute to a reliance on less formal mechanisms.

<sup>82</sup> Jordanian Nursing Council (2021). *Standard Operating Procedures for Inpatients Units and Outpatients Clinic: Mental Health Policy Guidelines*. Amman, Jordan.



In **school settings**, stakeholders reported that students identified by school counsellors or teachers are initially seen and evaluated by the school counsellor, who is responsible for alerting parents/carers and encouraging them to seek mental health care for students that need help. A major challenge is overcoming parents' lack of awareness and stigma regarding mental health. In addition, there is no clear system for formal referrals between schools and the health care system. This may cause a delay or lack of follow-up care for children or adolescents with mental health problems.

Children and adolescents who have severe forms of mental health problems, based on teachers' reports, will be evaluated by the school counsellor and their parents will be accordingly informed about the critical situation for their child, encouraging them to seek specialized mental health services. Based on stakeholders' reports, most school counsellors lack the knowledge, experience and capacity to manage students' mental health problems and are overwhelmed with multiple roles and assignments, as only one counsellor is available for each school of all grades.

The limited availability of guidance counsellors in schools means that the responsibility for addressing students' mental health issues may fall on teachers who may have received less training to carry out this role. Schools have no clear protocol for referral or management of mental health conditions. The lack of sustainable MHPSS training for school counsellors and not including teachers in such training are critical gaps in referral and management of mental health problems at schools. The role of school nurses in physical and nutritional care is another gap to be addressed, and roles the Ministry of Education and Ministry of Health are limited to environmental and physical health care for students, as MHPSS services or activities are not included in their objectives or responsibilities. The Ministry of Social Development is responsible for kindergarten licensing and accreditation, which is mainly concerned with environmental health requirements at kindergartens and nurseries, not for MHPSS service requirements.

Given their close relationships with communities and officers from government sectors, **NGOs** also play an essential role in the referral system. This includes early identification of at-risk children or families, and facilitating referrals or linkages to services. According to stakeholders' reports, cases that require follow-up or evaluation by specialized mental health professionals are referred to another specialized NGOs or governmental agencies based on their knowledge and personal connections. Stakeholders noted that NGOs have more flexible work hours and operations, enabling them to respond more quickly to acute needs in the community outside of official working hours. However, the lack of feedback or follow-up reports was also noted by stakeholders. Therefore, no further information is communicated back to the referring NGO from once they refer the case to other agencies, leading to interrupted health care processes.

Across **all sectors**, stakeholders indicated administratively complex and time-consuming referral processes, inadequate tools and protocols, reliance on informal referral networks, and a lack of available services and specialists to take referrals. Moreover, within the health sector, the lack of trained providers in primary-level facilities leads to over-referral to tertiary-level centres, where providers are concentrated. This results in long delays between referral and care, and often requires families to travel considerable distances to access services. Similar challenges are common in other sectors, including over-reliance on residential care and institutional facilities, impacting referrals within sectors and referrals to health services. Without effective referrals and access to care, screening alone is reported to stigmatize children and families.

## Management of mental health conditions and continuing care

Clinical management of mental health conditions is primarily provided through the **health sector**. In Jordan, as mentioned, 93 primary health care facilities (out of the 112 comprehensive health centres, 375, primary health centres, and 190 peripheral health centres) have integrated mental health into the services offered to beneficiaries through mhGAP. However, only six out of the 93 have a pharmacy, with only one type of anti-psychotic and one anti-depressant available. Additionally, UNRWA integrated mhGAP into its network of 22 primary health centres serving Palestine refugees, and other NGOs provide mental health services in their clinics.

At the secondary care level, mental health care is provided by acute inpatient units, community mental health centres and outpatient clinics. Three acute inpatient units have been established in general hospitals as follows: MOH Ma'an Governmental Hospital in the south (15 beds), Jordan University Hospital in Amman (12 beds), and King Abdullah University Hospital in the north (12 beds). However, Ma'an and King Abdullah only have a ward for males and females, respectively. At the tertiary care level, mental health care is provided by MOH-NCMH, which operates three mental hospitals, including the NCMH itself (205 beds), Al-Karama Hospital (150 beds), and the National Centre for Addiction Rehabilitation (47 beds). A forensic facility (140 beds) has been built and is currently awaiting allocation of human resources.

The Royal Medical Services, the military sector of health care services in Jordan, operates a highly specialized standalone acute inpatient unit (38 beds), whereas the private sector has one private psychiatric hospital: Al Rasheed Hospital (120 beds).<sup>83</sup>

Jordan has over 200 doctors, 220 nurses, and 130 pharmacists per 100,000 population. An estimated 91 psychiatrists are practicing in the country, or just under one per 100,000 population, and 13 psychiatric nurses (0.13 per 100,000). The psychiatrists are distributed as follows: 42 psychiatrists in the public system (MOH: 22, RMS: 13, King Abdullah University Hospital, Jordan University Hospital, and other universities: 7), and 49 psychiatrists in the private sector (Private clinics: 44, Al Rasheed Hospital: 5). Estimates on numbers of neurologists, psychologists, and mental health social workers are unavailable. Additional mental health human resources include an estimated 93 psychiatric residents 27 and 1,140 NGO-based workers providing mental health and psychosocial support services. Training facilities for psychiatric residents include the MOH NCMH; the RMS Mental Health Inpatient Unit, the Jordan University Hospital, King Abdullah University Hospital, and Al Rashid Hospital (private sector).<sup>84</sup>

As aforementioned, the information available about mental health in Jordan and given per inpatients and outpatients mental health/psychiatric units indicates that there are five mental health hospitals, three psychiatric hospital inpatients units, one forensic unit, 83 community-based non-hospital mental health facility, two alcohol/drug addiction facilities, and no child/adolescent and maternal mental health or psychiatric units (inpatients or outpatients).<sup>85, 86</sup> Additionally, no child and adolescent mental health/psychiatric facility and no data are available about mental health workers for child/adolescents' mental health or maternal mental health. As previously mentioned, six outpatient facilities are specifically for children and adolescent mental health, while none of the inpatient facilities is specifically for maternal mental health.<sup>87</sup> Besides the information about International Medical Corps regarding staff covering mental services at primary care and community mental health care centres (primarily provided by MOH, IMC, and UNRWA), please see page 31. All these services are provided to all age groups, including children, adolescents, adults, and women (pregnant and postpartum). Information regarding the workforce at the other agencies and MOH need to be organized as no information is available about the exact numbers due to high turnover and service changes during the past few years.

According to IMC, the primary barriers to seeking mental health care were feelings of helplessness, lack of financial means, unawareness and poor recognition of mental health problems, cost of treatment, lack of privacy, and stigma.<sup>88</sup> MHPSS services were found and concentrated in mainly three governorates: Amman (19.5 per cent), Irbid (17.6 per cent), and Ma'raq (16.5 per cent), followed by the central governorate of Zarqa at 14.2 per cent. Service users have identified that access to MHPSS services can be improved by providing affordable mental health care, medications, and transportation. For children and adolescents, in particular, mental health services are limited at primary care centres. There are only seven units that are managed by the MOH and 18 units managed by IMC across the country, providing holistic MHPSS service packages.

<sup>83</sup> World Health Organization (2020). *Jordan WHO Special Initiative for Mental Health Situational Assessment*. WHO Jordan.

<sup>84</sup> Ibid.

<sup>85</sup> Ibid.

<sup>86</sup> World Health Organization (2020). *Mental Health Atlas*. Amman, Jordan.

<sup>87</sup> Ibid.

<sup>88</sup> International Medical Corp (2019). *Utilization of Mental Health and Psychosocial Support Services among Syrian Refugees and Jordanians*. Amman, Jordan. <https://reliefweb.int/report/jordan/utilization-mental-health-and-psychosocial-support-services-among-syrian-refugees-and>

These units primarily provide mental health care to adults. Moreover, the inpatient psychiatric services (hospitalization services) provided by the MOH do not include those below the age of 18 years. However, it can only accept 16 years and above on an exceptional informal basis. Usually, children and adolescents who need hospitalization services will use available private or university-affiliated hospitals. This is a main barrier to MHPSS services provided to children and adolescents in Jordan. Nevertheless, evidence showed that the private sector and NGOs are contributing to mental health services for children and adolescents; however, most of these services are related to awareness and general medical and psychosocial support services. For example, primary health care services directed to children and adolescents focus on general medicine, periodical examination, dentistry, vaccinations, health education for students, health care and awareness services for pregnant women, family care and follow-up during pregnancy, childbirth, and proper nutrition for mothers, infants and children.<sup>89</sup>

Jordan suffers from a shortage of mental health care services at primary care centres. Accessing and utilizing challenges to maternal mental health care services are almost the same to other populations, including lack of financial means, limited mental health literacy, expensive treatment costs, privacy and confidentiality concerns, and stigma and social discrimination for individuals with mental health conditions.<sup>90</sup>

Other challenges include the lack of awareness about mental disorders and services' provision, availability, accessibility and affordability of mental health services.<sup>91</sup> However, PPD (the most severe mental health problem that pregnant and postpartum women face) is underreported/non-detected, and maternal mental health counselling and intervention are almost neglected. One of the most predominant risk factors for PPD among Jordanian mothers is the lack of social support due to stigma. According to stakeholders, postpartum depression is receiving significant attention among reproductive health care specialists and midwives trained through the mhGAP to assess for mental and psychological problems of pregnant and new mothers. However, few midwives are trained on mhGAP, and reproductive health services are limited to comprehensive health centres where few of these centres integrated mhGAP into their care provision (93 out of 487 health care centres across the country).<sup>92</sup> According to Dr. Malak Alouri, Director of Mental Health and Disabilities at MOH, postpartum depression is receiving a great level of attention among reproductive health care specialists. Nevertheless, mental health needs are not limited to PPD, and MHPSS is severely needed for children, adolescents and pregnant and postpartum women at the primary care level.

In school settings, mental health services are only provided by school counsellors. Stakeholders reported that school counsellors are overwhelmed and only focus on general counselling for those who seek counselling or have been referred by their teachers. Stakeholders also indicated that school counsellors are not adequately competent to manage severe mental health problems of students at school. Lack of sustainable training and capacity building of school counsellors, lack of resources at schools, lack of motivation, and high turnover rate have also been reported by stakeholders as core gaps related to the appropriate management of students' mental health problems. School nurses and general physicians are only available in some private schools, and their role is limited to general physical complaints and emergency health care management.



<sup>89</sup> Caritas Jordan (2020). *Primary health care services*. <https://www.caritasjordan.org.jo/primary-health-care>

<sup>90</sup> International Medical Corp (2019). *Utilization of Mental Health and Psychosocial Support Services among Syrian Refugees and Jordanians*. Amman, Jordan. <https://reliefweb.int/report/jordan/utilization-mental-health-and-psychosocial-support-services-among-syrian-refugees-and>

<sup>91</sup> Bawadi, H., et al. (2022). *Barriers to the use of mental health services by Syrian refugees in Jordan: A qualitative study*. Eastern Mediterranean Health Journal, 28(3), 197-203.

<sup>92</sup> Caritas Jordan (2020). *Primary health care services*. <https://www.caritasjordan.org.jo/primary-health-care>





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In Jordan, the Community-Based Mental Health and Psychosocial Support for Children including Child Refugee Populations is a training programme conducted by the Japan International Cooperation Agency (JICA). The aim of the programme is to develop and disseminate psychological first aid for children (PFA-C) in close collaboration with the MOH and Ministry of Education. The PFA-C training package was adapted to the current Jordanian situation, and training sessions were conducted for government officials of the central ministries and regional directorates of health and education, as well as for teachers, counsellors and medical personnel who come into contact with children in the community. A total of 640 participants have completed at least one day of PFA-C training.

Furthermore, to address research gaps in mental health for children and adolescents, especially in vulnerable communities, a large-scale, school-based cross-sectional mental health survey was launched in Jordan by EMPHNET in collaboration JICA, MOH, MOE, and UNRWA. The target population in this survey includes Jordanian children and adolescents aged between ages 8–18 years, and including Syrian and Palestinian refugees from public, private and UNRWA schools in all governorates of Jordan, including schools in Zaatari Camp. Data from this research is expected to generate estimates on the prevalence of mental disorders and describe mental health-seeking behaviours and barriers among the target population. The findings of this study will help inform decision makers in the country on preventive and therapeutic services for school children and adolescents.<sup>93</sup>

To sustain and build the capacity of specialized and non-specialized mental health workers, United Nations agencies, such as UNHCR through IMC, have conducted several training workshops for staff and professionals to integrate MHPSS into their practices. Their focus was mainly on refugees and those referred for mental health care involving the most vulnerable host-community population. In addition, IMC and WHO have conducted a series of mhGAP trainings to strengthen mental health literacy and build the capacity of health care professionals, with a focus on the MOH staff to provide mental health services at the PHC level.

Of the current programmes, one is the Thinking Healthy Programme (THP), which is a psychosocial intervention for perinatal depression designed to be delivered through community health workers. THP is now part of the WHO mhGAP series for global dissemination and is recommended as a first-line low-intensity psychosocial intervention for perinatal depression. WHO intends to enhance mhGAP with THP, which will make it the first to address the perinatal phase. In collaboration with WHO, MOH now includes mhGAP in the elective fourth year training for the family medicine intern programme. This includes THP, enabling family doctors to address all mental health-related problems not only among children and adolescents, but also among pregnant and new mothers in their routine care.

<sup>93</sup> Eastern Mediterranean Public Health Network (2022). *Large-scale Mental Health Survey Targets Children and Adolescents in Jordan*. Amman, Jordan.

## 5.5 Preventive mental health care

Preventive mental health care is intervening to *prevent* poor mental health problems by addressing risk factors and/or enhancing protective factors.<sup>94</sup> The School Health Directorate at MOE and the School Health Directorate at MOH are the two main directorates responsible for school health. Mental health has been emphasized through counsellors' responsibilities. However, other national institutions, such as the National Council for Family Affairs (NCFA), have also contributed to school mental health by focusing on issues related to domestic violence and other protection concerns. The aim is to improve mechanisms for the detection and reporting of child abuse at Jordanian schools. According to NCFA, under-reporting of child abuse and domestic violence is still a challenge to understanding children's mental health issues.<sup>95</sup> The National School Health Strategy 2018–2022<sup>96</sup> stressed eight major objectives to be achieved, focusing on general physical and environmental health at school.

The strategy did emphasize that one of the core components of school health is mental health and psychosocial support. The MOH is responsible for emphasizing physical and environmental health at school, while mental health and psychosocial support are not tasked to MOH. Jordan's National Strategy on Reproductive and Sexual Health 2020–2030 has tried to address violence against women and indicated a significant increase in violence rates against women in the past few years. However, none of the plans, strategies, aims, or objectives indicate supporting the screening and detection of mental health problems related to domestic violence or mental health problems during pregnancy and post-delivery.<sup>97</sup>

The Jordan River Foundation (JRF) has produced a Child Safety Programme to combat all forms of violence against women and children, mainly domestic violence. The Child Safety Programme is directed towards helping end all forms of violence and abuse through child protection interventions, rehabilitation services, prevention programmes, and parenting training.

According to the Jordanian Ministry of Social Development (MOSD), the average number of juveniles detained and sentenced was 270 in 2020. In this year, Jordan witnessed a 31 per cent rise in juvenile suicide rates. Article 2 of the Juvenile Law in Jordan states, "An Office for Behaviour Monitoring (Pro-bation) shall be established at every court provided that one of its employees shall be specialized in psychology or sociology." Article 10 (a) of the Juvenile Law supported the role of psychologists and social workers at juvenile houses. Social workers and psychologists are entrusted with a number of psychological and social responsibilities. Psychologists' main roles are to determine adolescents' psychological problems, be involved in adolescents' rehabilitation programmes or specialized psychological treatment and follow up any special psychological treatment programmes. Such roles depend on the capacity of psychologists who will be responsible for all five juvenile houses in Jordan, which receive an average of 3,000 adolescents per year.<sup>98</sup> Stakeholders have indicated that psychologists and counsellors at juvenile houses lack capacity-building courses, lack support for follow-up care, and are overwhelmed with responsibilities due to the high number of adolescents at the houses compared to the number of psychologists per house, which is usually one per house if any at all.

Although substance use and mental disorders have been investigated adequately in research in Jordan, all inpatient mental health settings are designated for adults only. Stakeholders reported that children and adolescents with mental disorders are referred to the private sector and hospitals, and admitted to general wards under hidden diagnoses other than mental disorders. In addition, there is a lack of specialized mental health professionals in child and adolescent mental health. In Jordan, some activities and initiatives have targeted substance use and mental health of children and adolescents. For example, the "No to Drugs" and "Yes to Life" initiatives have been announced by RHAS and the Antinarcotic Department of the General Public Security to empower parents of children between the ages of 12–14 years with basic information about drug addiction and prevention in Jordan. RHAS has also produced another campaign called "My Hand in Your Hand" to combat drug use amongst youth and prevent drug addiction.

<sup>94</sup> Miles, J., et al. (2010). *A public health approach to children's mental health: A conceptual framework*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

<sup>95</sup> National Council for Family Affairs (2020). *Annual Report*. <https://ncfa.org.jo/uploads/2022/10/a6ac58c0-fc1f-634bb8f462d0.pdf>

<sup>96</sup> Jordanian Ministry of Health (2022). *National strategy for school health 2018-2022*. Amman, Jordan.

<sup>97</sup> Higher Population Council (2020). *Jordan's National Strategy Reproductive and Sexual Health 2020 – 2030*. Amman, Jordan.

<sup>98</sup> Ministry of Social Development (2022). Amman Jordan. [www.mosd.gov.jo](http://www.mosd.gov.jo)

## 5.6 Promotion of mental health and well-being



Promotion is defined as intervening to optimize positive mental health by addressing social determinants of mental health and psychosocial support. For the PHC sector, this includes addressing mental-health-related stigma and discrimination, improving awareness and mental health literacy, and strengthening linkages with other sectors to address social determinants (poverty reduction and safe housing). There are limited interventions and programmes to promote the mental health of children, adolescents, pregnant women and new mothers in Jordan. School counsellors work independently and informally at schools to assess and advise students with mental health problems and/or at high risk of mental disorders. As mentioned, their role is limited to alerting parents and informing them about their children's mental health needs and the urgency of seeking specialized mental health care. School

counsellors are not able to follow up on or mandate such urgent needs and treatment. They lack the capacity for specialized mental health services but can help undertake mental health literacy events at schools for the community if there is support from other stakeholders and resources.

RHAS conducted the Schools Mental Health Programme to support mental health community awareness initiatives targeting vulnerable Jordanians and refugees. It helped international non-governmental organizations (INGOs) implement community mobilization campaigns (e.g., World Mental Health Day, etc.) and launch a complimentary social media campaign. RHAS also supported INGOs implement the WHO Regional School Mental Health Package in collaboration with MOE, and build the capacity of 25 beneficiaries of the Our Step Association.<sup>99</sup>

The IMC has also conducted several campaigns and activities to increase awareness and combat mental health illiteracy. For example, the "See Us in Our Eyes", "One Life Matters", and "Let us Save Lives Campaign". These campaigns aimed to combat stigma against mental illness and encourage those in need to seek mental health services. The campaigns focused on serious mental health issues, including anti-suicide interventions. Other activities were directed to child protection, emphasizing the importance of child protection against domestic violence. Activities included the "Violence against children Campaign".

The stakeholder interviews and meetings related to mental health and primary care in Jordan involved participants across the health, education and child protection sectors. They identified adopting and developing mental health programmes as priorities, and indicated the importance of enhancing and supporting funding to programmes, plans and initiatives that focus on mental health needs for children, adolescents, and pregnant and postpartum women at the primary care level. Despite the efforts of the MOH in implementing several plans to train specialized and non-specialized mental health care professionals at the primary care level, these plans and training programmes have not specifically addressed mental health care of children, adolescents, and pregnant and postpartum women in primary care settings. Thus, there is a need to integrate mental health action plans within child protection programmes, reproductive health care units, family protection centres, and community mental health centres. Such programmes must be sustained and supported over the long term with a multi-year plan and adopted as part of the institutional strategy for staff development. For example, it is necessary to have mental health courses as part of the student curriculum and programmes that help school counsellors develop their psychological counselling skills.

<sup>99</sup> Royal Health Awareness Society (2021). *School Mental Health Program*. Amman, Jordan.







# 6. Challenges and recommendations to strengthen integration

## 6.1 Legislation, policy, strategy and leadership

### Challenges



This section addresses political commitment, leadership, governance and the policy framework. Jordan has developed a supportive policy framework to ensure the mental health and well-being of children, adolescents and families. The National Mental Health Policy (2011–2021) includes specific objectives to develop quality child and adolescent mental health services at the PHC level, focusing on preventing, screening and responding to developmental disorders and mental health needs. Maternal mental health has also received much attention, specifically on addressing postpartum depression. The Mental Health National Policy also articulates actions to be delivered at PHC and community levels, using the mhGAP to support integration. This includes actions for early detection, basic psychological interventions, pharmacological treatments, referral systems and mobile teams for emergency care. The policy also addresses some key aspects of prevention and promotion, including supporting positive parenting and linkages with schools to support children and families. These are essential foundations for strengthening the integration of MHPSS at the PHC level.

However, according to stakeholders, current policies and plans are limited in providing a comprehensive strategy for child and adolescent mental health and well-being, and gaps include the roles and mechanisms needed to strengthen linkages with other key sectors, such as child protection and education. There is currently no mental health act or similar legislation, nor specific legal considerations or protections for children, adolescents, or mothers engaged in the mental health system. Clear legislative or policy guidance on parental consent for adolescents is lacking. Stakeholders noted a need for both legislation and national policies that specifically address the needs of children, adolescents, and mothers, with particular attention to ensuring collaboration from all key sectors and implementing agencies.

There is a need for a comprehensive and unified strategy that clearly outlines MHPSS to be provided through PHC for care, prevention, and promotion, aligning mental health policy with the national insurance plan, clear roles for other sectors (such as school-based mental health), and an enhanced role for PHC in providing outreach and community-based services. Stakeholders also identified a need for national, standardized guidance for providing MHPSS for children, adolescents, and mothers at PHC, including a practice guide for specialist and non-specialist providers. In addition, stakeholders acknowledged that there are still issues with leadership and care delivery at various levels of health care services in Jordan.

## Examples of stakeholders' responses

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•• We have mental health act, but it is not activated, and we need to make this applied to all levels from kindergarten to school and universities. ••

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•• The government needs to create a national health identification number (ID). All citizens need to receive their health care based on their ID and it has to be connected across all health care centres and settings. So, if someone has a problem, the ID will enable access to health information for this person. ••

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•• We need an umbrella to lead and incorporate all primary care MHPSS to improve coordination. ••

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•• We need a national strategy to integrate mental health into primary care. ••

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•• We are not aware how to make a referral to specialized and advanced care. Each organization or agency had its own policy. ••

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•• The governmental and public agencies need to adopt a national plan and decision-makers should be aware that mental health is affecting all families. ••

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## Recommendations

### A more robust national mechanism for coordination and planning

Currently, mental health units within the PHC Directorate at MOH provide central governance and oversight for implementing the national policy. The National Committee, including representatives from MOE and MOSD, also provides an essential multisectoral structure for supporting national-level governance and planning. However, stakeholders described the need for a multisectoral governance structure at the national level (led by MOH-PHC and mental health directorates) with a specific focus on children and adolescents to improve coordination and collaboration, and develop national plans and strategies, supported by a multisectoral advisory board with expertise in child and adolescent mental health and well-being. The limited coordination across all partners and agencies was noted as a key challenge, particularly at the implementation and administrative levels. This contributes to inconsistent integration of services at the PHC level, and service delivery gaps among public services, NGO-supported facilities and private providers.

A national platform or national coordinating mechanism was recommended to include all relevant agencies not only to improve collaboration but also to ensure alignment and compliance with the national policy and guidelines.

### Update national mental health policies and legislation

The stakeholders highlighted a need to update national mental health policies and legislation considering the mental health needs of children, adolescents, pregnant and new mothers. Such an effort must be at the national level where all related governmental and non-governmental agencies are collaborating to make such an update within two to five years. As Jordan's leading and largest provider of health care services, MOH can lead such efforts. Moreover, stakeholders acknowledged the need to create consistent mental health care plans across all comprehensive health care centres in Jordan.

Recommendations included activating the roles and responsibilities of the national mental health steering committee; establishing a national guide for mental health care services, information, monitoring and evaluation; and developing and updating the existed policies, regulations, legislations and protocols of mental health care at primary care centres to integrate mental health care of children, adolescents, pregnant and new mothers.

### Enhance and support increased political commitment for MHPSS through PHC

Although stakeholders showed a high level of awareness about the challenges to integrating primary mental health into primary care, they identified numerous recommendations that would enhance and support increased political commitment for MHPSS through PHC. Most of the recommendations were at the national level and were comprehensive to include health, education, and child protection sectors.

The recommendations mainly addressed the need to revisit policies and procedures used to manage and provide mental health care services at the national level, including those related to child and family mental health care at PHC centres. These include recommendations for a national platform for mental health, creating a national mental health registry, prioritizing the national plan for training and employment of mental health professionals, creating a national guide to MHPSS, adopting a clear national protocol of referrals across the sectors and within the sectors to facilitate follow-up care and access to individuals' mental health information.

**Table 2: Recommendations for legislation, policy, strategy and leadership**

Purpose	Leading agency (ies)	Next steps	Time frame
Update national mental health policies and legislation considering mental health needs of children, adolescents, pregnant women and new mothers	MOH, NCFA, and the National Mental Health Steering Committee	MOH to take the lead in the coordination with the Mental Health Steering Committee to conduct a workshop to review and revise current mental health policies and legislation, as well as endorse the updated ones	Medium to long term
Create consistent mental health care plans across all comprehensive health care centres in Jordan	MOH, with the support of the National Mental Health Steering Committee and mental health technical agency	MOH, with the support of the National Mental Health Steering Committee and mental health technical agency to draft and consider one mental health care model and approach to be applied across PHC services	Medium to long term
Activate the roles and responsibilities of the National Mental Health Steering Committee	MOH	MOH to draft terms of reference (TOR) and pay more advocacy and governance for the National Mental Health Steering Committee	Medium to long term
Establish a national guide for mental health care services, information, monitoring and evaluation	MOH with UN agencies, USAID, and IMC	Develop a plan and materials for developing knowledge and skills to be used as a practice guide by PHC providers to address the mental health needs of children, adolescents, pregnant women and new mothers	Medium to long term

Purpose	Leading agency (ies)	Next steps	Time frame
Integrate mental health care services as one standard of care of the accreditation process and protocols of health care centres and agencies provided by HCHC	MOH and HCAC	MOH with HCAC to develop standardized monitoring indicators for PHCCs to include mental health integration and services to ensure efficient and effective services	Medium to long term
Update national mental health policies in collaboration with all related national and international agencies	MOH, UN agencies, HCD, and MHPSS actors	Intersectoral collaboration to review current national mental health policies	Medium to long term
Create mental health care plans that are sensitive to mental health needs of children (developmental disorders)	MOH and UN agencies (including WHO) and mental health expert agencies like IMC	Develop a plan and material for knowledge and skills transfer for PHC providers to address developmental delays and disorders among children	Short term
Create a national strategy for primary mental health care	MOH	MOH to draft TOR and pay more advocacy and governance for the National Mental Health Steering Committee	Medium to long term
Activate mental health laws and policies	MOH	MOH to draft TOR and pay more advocacy and governance for the mental health policy applications	Medium to long term
Create a national platform for primary mental health	MOH and HCD, MHPSS actors	Intersectoral collaboration to propose a national primary mental health care plan	Medium to long term
Create a national registry for mental health services	MOH and Hakim	MOH to draft TOR and pay more advocacy and governance for the national mental health registry	Medium to long term
Integrate primary mental health and MHPSS into education systems for health and social science specialties	MOH, MOE, HHC and health associations	MOH, with MOHE, HHC and health associations to develop a curriculum review committee to integrate primary mental health for children, adolescents, pregnant women and new mothers into their curricula	Short term



## 6.2 Budget and financing

Financial support is a significant issue and was discussed in all stakeholders' discussions and interviews. This topic covers three main areas: financial resources, sources of budget, and budget management. Stakeholders identified challenges related to financial support, and lack of information related to financial resources and allocated budgets per programme or project related to mental health was the main concern. Stakeholders could not define nor identify how financial resources are managed at all levels.

Nevertheless, they realized that one of the main challenges is the lack of funds available to support intern programmes in psychiatry, which leads to reluctance to seek specialization in this field. Moreover, stakeholders have noted that the available funds are not managed appropriately, as important sectors and settings lack the needed funds. For example, they noted that schools and primary mental health care for children, adolescents, and women are not receiving the appropriate funding for training programmes, employment, resources and awareness programmes in the community. Such a challenge assumes that funds are directed to certain programmes and services prioritized over primary mental health care services.

Although stakeholders were able to report on financial and budgeting challenges, they could not make recommendations on how to improve the use of financial resources available to them or their agencies. Financial and budgeting issues are managed by higher levels of management rather than middle or lower levels. Participating stakeholders emphasized their lack of knowledge about the actual budget allocated for programmes and services, and could not justify how their agencies or institutions used the available resources.

### Examples of stakeholders' responses

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“ At schools, we do not have the budget to manage and organize training or awareness programmes for mothers and students.”

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“ We do not know how much money they allocate for mental health services and training.”

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“ We are not aware about the budget and how they allocate budget for needed services.”

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### Purchasing and payment systems

In relation to purchasing and payment systems, stakeholders could not identify the real challenges due to the lack of information available to them and the absence of communication with higher management levels that take the responsibility to make decisions. This could also be related to the inability of stakeholders to identify the economic and financial problems and the real reasons behind people not seeking mental health services despite these being free of charge for Jordanians. One explanation could be attributed to the fact that refugees and residents with invalid documents in Jordan do have to pay for MOH services. For example, stakeholders working in education as counsellors and school nurses provide mental health services as part of their job description but some students or families may not be aware of these, or be aware that workers in United Nations agencies or NGOs are free of charge for clients. These example of mental health services and specialized mental health services are provided by the public authorities free of charge even though mental health services by public facilities are limited, so there is no inclusion under other types of health insurance.

Stakeholders addressed the cost and financial issues related to seeking mental health services in the private sector, and the huge difference between the public and private sectors in terms of the cost of mental health services, making it unaffordable to the majority of residents in Jordan. Stakeholders also emphasized the high cost of mental health treatment (pharmacological and non-pharmacological treatments), lack of a national health insurance plan, and non-motivating work environment (underpayment, turnover, non-motivated school counsellors, among other issues) as main challenges.

Of significant note is that stakeholders have explicitly declared their awareness of the unfair financial and non-financial compensation for mental health workers and those specialized in mental health. Unequal wages between public and private sectors have been noted by stakeholders, contributing to the tendency toward accepting posts and positions in the private sector and avoiding the public health sector. They have recommended that mental health professionals be fairly compensated for their efforts, and their wages be improved, based on the workload of those in mental health services, especially school counsellors. Others recommended offering specialized and non-specialized primary mental health professionals training programmes, workshops and certified programmes as one means of compensation instead of financial compensation. Some stakeholders identified the differences among the specialized personnel based on their job descriptions or titles.



**Table 3: Recommendations related to budgeting and finance**

Purpose	Leading agency (ies)	Next steps	Time frame
Improve remuneration and financial incentives for mental health professionals	MOH, MHPSS stakeholders	MOH to take the lead to create a system of compensation and career development for mental health professionals in the public sector	Medium to long term
Prioritize hiring more mental health professionals at MOH	Government (MOH)	More advocacy efforts to give priority to mental health professional recruitment	Medium term
Create a National Health Insurance Coverage Plan for mental health	Government and Jordan Insurance Federation (JIF)	Allocate funds and support insurance schema so that private insurance covers mental health services that MOH does not provide.	Medium term
Improve wages considering the efforts and workload of those working in mental health services, especially school counsellors	MOH, MOE, MHPSS actors	MOE to take the lead to re-establish a wage scale for mental health professionals	Medium to long term

## Examples of responses on the cost of mental health care

•• People are afraid to seek mental health due to fears related to the cost of psychiatric treatment, which is high, as they know. ••

•• Seeking psychiatric care is extremely expensive.  
I, myself, sought counselling for my son and paid 50 JD for one session.  
People may not be able to afford such expensive service. ••

•• People are avoiding mental health services because they think it is costly.  
They are not capable of managing that cost. ••

•• Mental health services are considered costly,  
and it is not all available for free. People cannot afford it. ••

•• Most of the medications are very expensive even for those who are financially capable. At a few institutions, we have the first generation only, which are the drugs that mainly cause some unpleasant side effects such as increasing weight. ••

•• Health insurance is needed as people cannot seek mental health services that cost a lot.  
Health insurance is a real problem. ••

•• Counsellors are underpaid, and they are concerned about their poor economic status.  
How come they are able to provide mental health services for problems that are originally caused by economic constraints that they are themselves suffering from? ••

•• Specialized mental health providers are receiving very low pay compared to what they may receive when they work outside Jordan or in the private sector. ••

•• We know that salaries are a problem and cannot be easily managed.  
But there are other options such as compensating with training courses, workshops and certification programmes. ••



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## 6.3 Service delivery

Service delivery for MHPSS within primary care settings was one of the most interrelated topics that participants discussed, and included the model of care for integration through PHC services or potentially a standalone mental health system at the primary-care level, and delivery through other sectors, accessibility, linkages and referral mechanisms.

Stakeholders identified the lack of specialized mental health services as one of the main challenges in the country at the PHC level. Challenges include a lack of MHPSS personnel, shortage of MHPSS services, fragmented mental health services, and lack of coordination regarding the resources and approaches used in providing mental health services. Notably, stakeholders have addressed that most mental health personnel prefer to work in the private sector due to the more competitive salaries compared to the government. Mental health illiteracy and stigma were considered as additional challenges.

Improving specialist care and specialized professionals will improve service delivery at the PHC level. This could take various forms, such as increasing capacity, increasing the workforce, increasing training opportunities, and better allocating and distributing services to areas where mental health professionals are needed.

Another significant challenge the stakeholders addressed was the lack of sensitivity of primary mental health services to adolescent developmental issues and gender is. The lack of gender-sensitive mental health services was addressed in various forms, such as unequal attention to mental health needs, non-gender-oriented services, lack of school programmes focusing on gender-related issues, and lack of puberty-related MHPSS problems. For example, puberty and sexual development issues and the variations in needs for males and females are poorly addressed. In addition to this, adolescent pregnancy and child marriage are not incorporated into services.

One of the main issues raised by stakeholders that was based on observation was reliance on responsiveness rather than guidance and prevention. Stakeholders expressed concern about being late or delayed in providing appropriate care due to the lack of a national strategic planning for mental health, particularly in schools and primary care settings. It has been noticed that the health care sector, especially within mental health units, are not working systematically and on long-term plans. They wait until the issues arise and then react to try to find a solution that may or may not be effective or efficient. This can be seen in referrals and coordination of care. Mental health professionals or care providers in schools and primary care settings who refer students or women at reproductive health clinics noted that they suffer due to the lack of well-established referral systems for follow-up and feedback mechanisms. When referring someone to specialized mental health services, they get an initial response accepting the case, and then no more information is received. The connection is interrupted. They have no access to information systems to follow up, and those who manage the referred cases do not write follow-up care reports that they can access. Most importantly, the interruption of communication leaves the primary care practitioner unaware of the case progression even if the individual returns to school or to the outpatient clinic.

### Community role in PHC

Engagement with communities and other stakeholders was discussed in terms of the participation of children, adolescents and families, and feedback, monitoring, and evaluation. The stakeholders identified personal and community stigma as the most significant challenge to providing and integrating mental health into primary care for children, adolescents and new mothers. Stigma results in various barriers, including avoiding seeking mental health services, lack of family awareness, lack of sense of the importance of mental health services, lack of awareness about the availability of mental health services, and lack of awareness about mental health conditions and disorders. Among stakeholders, this stigma may contribute to the recommendations that mainly focus on enhancing the role of school counsellors and family medicine practitioners in preventing and promoting mental health. It is assumed that stakeholders found that enhancing the positive role of school and family will combat stigma against mental health conditions and enhance awareness toward the need to seek mental health care and psychological counselling.



Moreover, stakeholders have reported that unclear family roles, lack of family involvement, and inactive school roles were among the challenges that need to be addressed while planning to integrate mental health into primary care settings. Another point to be addressed is the unequal mental health services provided in which some groups of people have been identified as disadvantaged in terms of mental health services, such as those living in remote areas, refugees, pregnant women, new mothers, and individuals with physical disabilities. Refugees and pregnant and new mothers are often not provided with the required mental health services in primary care settings. This could be one significant challenge that has also been addressed in other categories that can be all integrated into one national plan.

The lack of a transparent referral system between various health care services and levels or within the same health care service is a significant challenge. According to stakeholders, most health care professionals use their connections to facilitate referrals and are not aware of the process and protocol that can be followed to facilitate referrals when necessary. In addition, children, adolescents, pregnant and new mothers referred to mental health professionals are not mandated nor motivated to seek consultation and mental health services if the cost and/or distance to specialized mental health services makes it inaccessible, and/or if they fear the stigma of going to specialized mental health care services.

The challenges related to guidelines and standards of care, accreditation and certification, and monitoring were discussed in relation to quality of care and mental health care service delivery. Stakeholders were less informed about challenges and recommendations related to integrating mental health into the primary care for children, adolescents and new mothers than they were on more general mental health care issues. Two main challenges mentioned related to the national guidelines and policies for children with disabilities and unethical practices by the health care providers, based on the perception of services users who showed that health care providers had violated their rights and that they felt unprotected by the law. The legislation and policy section of this report has addressed these two issues in more detail. However, community stakeholders emphasized that lack of accreditation and quality monitoring are main issues that might contributed to the lack of integration of mental health of children, adolescents, pregnant and new mothers into primary care services. The standard proposed by the monitoring and accreditation agencies would enable health care providers to adhere to comprehensive health care services for all age groups in primary care settings.

It is necessary to develop national standards and tools to support providers in delivering high-quality, respectful and inclusive care to children and families. Enhancing and improving accountability and evaluating health care services provided at PHCCs are also necessary. For example, utilizing standards for evaluating health care service outcomes would motivate mental health professionals to create a follow-up care system and ensure its appropriate application. This would also support implementing ethical conduct related to mental health practices. Breach of confidentiality and lack of sensitive mental health care were noted as challenges that negatively impact the quality of care and delay the integration of mental health into primary care settings. Therefore, patients' rights and enforcing ethical conduct regarding mental health were a concern for stakeholders.

## Research and quality indicators

Stakeholders were able to identify the need for conducting research, such as quantitative research, to establish evidence-based practices and create references for decision-making by measuring the impact of the available mental health services on the quality of mental health care services provided to children, adolescents, pregnant/new mothers at primary care centres. Such studies would enable researchers and care providers in humanitarian sectors to better understand the workforce and training needs and identify target groups and relevant activities. The targeted settings should include health care centres, schools, and child protection centres, as well as involving private, public, and international sectors in Jordan. These research studies will inform policy- and decision-makers and help them to determine indicators related to the incidence and prevalence of mental conditions among children, adolescents, pregnant women/new mothers. Moreover, research outcomes will be used as a database for national and international agencies concerned with the mental health of children, adolescents, pregnant women/new mothers in primary care settings. Stakeholders have also emphasized the need to direct efforts toward coordination, monitoring and follow-up during treatment and use of preventive measures. Primary health care systems need to establish indicators for evaluating service quality. Policy- and decision-makers need to ensure that the list of indicators be addressed and reported periodically so that information is kept up to date.

## Examples of stakeholders' responses on service delivery

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"We need to have specialized personnel to help children and adolescents overcome their mental and psychological problems."

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"Psychological first aid is not available."

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"The pregnant mothers are not taken care of from a mental health perspective. There should be emphasis on children's and mothers' mental health perspectives and needs."

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"People do not accept referral to a mental health specialist. We had a girl who had psychological problems, and we tried to convince her family to seek mental health service. If the service user does not accept that, how can I help her?"

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"People are afraid to go to psychiatrists. They may go simply to a dentist, but to a psychiatrist, it is not possible. They are afraid to be called crazy."

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"Females are more likely to suffer from consequences of violence. For example, society will always punish them, and they will be victimized."

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"In general, females need to have more attention to their mental health needs during the puberty phase due to changes in hormones and body and appearance."

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"We are not working systematically and on long-term plans. We just wait until the problem happens, and then we make the intervention. This is not healthy."

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"There is no road map and clear coordination among the agencies on how they should refer their patients to avoid repeated services."

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"Students are not aware about the counsellors' actual role. They think it is only mental. No, we can integrate mental with physical. They are not aware about that, and we need to make it clear for them."

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"I need to know how these children, if referred to any agency, are being followed up."

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"We suffer from lack of follow-up. When we refer someone, they make their initial response, and then no more information is received. We do not know, and they do not respond to our emails or calls. We have no way to find out what had happened to that referred person."

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"We have patients come from very far places because they do not want their relative to know about them. Nurses and other was telling that X person came to our unit. Neither nurses nor the other staff have the ethics of conduct. There are no kind of punishments for those who breach confidentiality".

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"We need to have more quantitative research like impact studies and create indicators for mental health in primary health care settings. This will help us to figure out where we are in the quality of care at the primary health care level."

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## Recommendations related to service delivery

Being oriented and sensitive to gender-related and cultural factors enabled the stakeholders to make recommendations to integrate mental health into the primary health care system. These recommendations are based on proposing alternative solutions to challenges they raised about care provision. It has been suggested to integrate MHPSS as part of routine care in primary care settings, and to include screening and early detection of mental health conditions and risks at school and SRH outpatient units to provide specialized maternal mental health services, suicide prevention programmes and counselling and support for self-harm. It is recommended to have a well-placed and structured preventative approach rather than a responsive interventional crisis management model. This recommendation has been supported with suggestions to hire more specialized personnel, such as paediatric psychiatrists, and capacity building for mental and primary health care staff, specialized and non-specialized.

A long list of recommendations has been proposed to improve responsive care that includes improving the coordination between governmental agencies through a unified platform by the Ministry of Information Technology (MIT), developing standardized national mental health training online/in-person for specialized and non-specialized mental health personnel, developing training guidelines that can be used in primary care settings by health professionals, have an updated online map showing services point for mental health care utilizing a unified national platform, developing a clear and practical online national referral system across sectors, and prioritizing hiring more mental health professionals at MOH. As the leading ministry, MOH can coordinate with all local and international partners and those concerned with mental health in primary care settings. Plans can be made on a short-, medium-, and long-term basis according to priority and available resources. This would require multisectoral integration to facilitate access to mental health services in primary care settings, and overcome barriers related to the referral system by creating a national protocol for inter- and intra-sectorial referral of mental health services.



**Table 4: Recommendations related to service delivery**

Purpose	Leading agency(ies)	Next step	Time frame
<b>Responsive care</b>			
Improve the coordination between government agencies through a unified platform by the MIT	Government (MOH, MOSD, MOE, MIT) and non-governmental agencies (United Nations and developmental actors)	Through a unified national platform for mental health networks, referrals and training plans	Short term
Updated online map that shows services points for mental health care services utilizing a unified national platform	Government (MOH, MOSD, MOE, IT) and non-government agencies (community-based organizations (CBOs), NGOs, INGOs)	Through a unified national platform for mental health networks, referrals and training plans	Short term
Provide MHPSS services to children at pre-school age to enable screening	MOH and MOE	Pre-requisite mental health screening like the vaccination card	Short
Develop a clear and practical online national referral system across sectors	Governmental (MOH, MOSD, MOE, MIT) and non-governmental agencies (CBOs, NGOs, INGOs)	Through a unified national platform for mental health networks, referrals and training plans	Medium term
<b>Prevention</b>			
Develop training guidelines in relation to MHPSS sensitizing gender differences, issues and protection concerns	MOH, FPD, MOSD, and other concerned agencies (United Nations agencies, INGOs, NGOs)	<ul style="list-style-type: none"> <li>• Develop consistent primary mental health training guides for all agencies in Jordan</li> <li>• Improve intersectoral communication and coordination</li> <li>• Propose that specialized mental health professionals volunteer to train other health workers</li> </ul>	Medium term
Integrate MHPSS into existing services and programmes, such as violence. And develop guidelines and protocols for the identification and management of mental health conditions and risk factors	Government (MOH, MOSD, MOE, FPD) and non-governmental (IMC, United Nations agencies, development donors, and MHPSS/protection actors)	<ul style="list-style-type: none"> <li>• MoH lead, coordinate, and supervise capacity-building training focusing on primary and secondary care prevention levels</li> </ul>	Medium to long term



Purpose	Leading agency(ies)	Next step	Time frame
Enhance linkages between governmental and non-governmental agencies in terms of training and volunteering in crisis management	Government (MOH, MOSD, National Centre for Security and Crises Management (NCSCM)) and NGOs (UN agencies, development donors)	<ul style="list-style-type: none"> <li>Engage government focal points in co-chairing the health, protection and education sectors</li> <li>With the support of United Nations and donors, and in coordination with NCSCM, conduct a capacity-building plan for volunteers to be first responders in crises</li> </ul>	Short to medium term
Enhance outreach of primary mental health care services to remote and disadvantaged areas, focusing on MHPSS services and children and adolescent mental health	Government and NGOs	<ul style="list-style-type: none"> <li>MOH to develop guidelines for primary mental health care outreach services</li> <li>MOH to provide supervision over outreach services</li> <li>United Nations and MHPSS actors to coordinate the outreach work with MOH and MOSD</li> </ul>	Medium term
Enhance screening and early detection of mental health needs and risks at schools and primary care settings	MOH and MOE, with support from international agencies	<ul style="list-style-type: none"> <li>MOH (school health and mental health directorates) to support MOE (counselling department) in providing a capacity-building plan with trainers to address the most common mental health conditions and management skills</li> <li>MOE and counsellors to include mental health indicators to assess and screen children with alarming signs and symptoms</li> <li>MOE, counsellors and health committees trained to provide psychosocial well-being activities for children at schools</li> </ul>	Medium term

Purpose	Leading agency(ies)	Next step	Time frame
<b>Promotion</b>			
Combat stigma against mental health treatment and conditions among children and adolescents by focusing on schools	MOH, MOE, and MIT	<ul style="list-style-type: none"> <li>Media (TV, movies, social media)</li> <li>Mental health platforms</li> <li>Electronic mental health resources</li> </ul>	Medium term
Develop community-based and outreach approaches to improve mental health literacy, service access and utilization	MOH, United Nations agencies and mental health actors	<ul style="list-style-type: none"> <li>Provide monetary compensation for transportation to improve access and utilization</li> <li>MOH, with the support of United Nations agencies, donors and mental health technical agencies, to support capacity-building training and outreach approaches by developing capacities of health committees and CBOs</li> </ul>	Short to medium term
Activate national mental health teamwork through the National Steering Committee under one well recognized national umbrella	MOH and NCFA	Supervise, develop and update national plans, strategies, and policies	Medium term
Integrate youth agencies into national policy bodies and committees to enhance their role and representation	MOSD, United Nations agencies, MoH, MOE and MHPSS actors	Engage youth-based organizations and youths on youth-related needs and concerns to be addressed in policies and implementation activities	Medium term
Enforce patients' rights	MOSD, United Nations agencies, MoH, MOE, and MHPSS actors	Supervise, develop and update national plans, strategies and policies to ensure that patients' rights and ethics are amended and/or incorporated into the review of policies and legislations.	Medium term
Conduct quantitative research and create MH indicators	MOH, WHO, UNICEF, USAID, and HACC	Conduct quantitative research and create indicators and databases for mental health for children, adolescents, pregnant women/new mothers at the PHC level	Medium term

## 6.4 Workforce

In Jordan, there are an estimated 91 psychiatrists practicing in the country, or just under 1 per 100,000 population, and 13 psychiatric nurses (0.85 per 100,000). The psychiatrists are distributed as follows: 42 psychiatrists in the public system (MOH: 22, RMS: 13, King Abdullah University Hospital, Jordan University Hospital, and other universities: 7), and 49 psychiatrists in the private sector (private clinics: 44, Al Rasheed Hospital: 5). Estimates on the numbers of neurologists, psychologists and mental health social workers are unavailable. Additional mental health human resources include an estimated 93 psychiatric residents and 1,140 NGO-based workers providing mental health and psychosocial support services. Training facilities for psychiatric residents include MOH NCMH; the RMS Mental Health Inpatient Unit, the Jordan University Hospital, King Abdullah University Hospital, and Al Rashid Hospital (private sector).<sup>100</sup>



There are five mental health hospitals, three psychiatric hospital inpatient units, one forensic unit, 83 community-based non-hospital mental health facilities, two alcohol/drug addiction facilities, and no child/adolescent and maternal mental health or psychiatric units (inpatients or outpatients).<sup>101, 102</sup> It was highlighted that no mental health facilities are considered as child and adolescent mental health/psychiatric facilities, and the available information about mental health workers in child/adolescents' mental health or maternal mental health is insufficient. Only a limited number of up to six outpatient facilities could include all age categories without focusing on age category.<sup>103</sup> There are 23 community-based mental health facilities (0.23 per 100,000 of population). The WHO Mental Health Atlas – 2020<sup>104</sup> reported that there is only one school-based mental health programme, while maternal and parental mental health programmes do not exist.

IMC's available data regarding staff covering mental services at primary care and community mental health care centres (primarily provided by MOH, IMC and UNRWA) indicated that there are 11 psychiatrists (one is a child psychiatrist), 13 clinical psychologists, 35 mental health counsellors (case managers), 13 mental health pharmacists, 6 mental health nurses, 2 MHPSS officers, and 13 MHPSS focal points (case managers). Those specialized individuals provide services to all age groups, including children, adolescents, adults, and women (pregnant and postpartum). Information regarding the workforce at the other agencies and MOH need to be organized, as no information is available about the exact numbers due to high turnover and service changes during the past few years due to the outbreak of COVID-19.

<sup>100</sup> World Health Organization (2020). *Jordan WHO Special Initiative for Mental Health Situational Assessment*. WHO Jordan.

<sup>101</sup> Ibid.

<sup>102</sup> World Health Organization (2020). *Mental Health Atlas*. Amman, Jordan

<sup>103</sup> Ibid.

<sup>104</sup> Ibid.

The discussions and interviews with stakeholders revealed that they could elaborate and reflect extensively on challenges related to the workforce and specialization in psychiatric and mental health services as it matters more than their actual roles and describes their real-life experiences within the various working settings and sectors. Stakeholders showed a high level of awareness and understanding of the real challenges interfering with integrating mental health in primary care settings. The category included several subcategories: integration of MHPSS into existing roles/cadres, competencies, training, supervision, remuneration and job aids. Several challenges were identified that could explicitly show that primary health care settings suffer from lack of human resources and specialized personnel in the mental health field, not merely at the primary care level.

The most reported challenges by stakeholders were the lack of mental health professionals at PHCCs, lack of specialized mental health personnel at schools, lack of specialization within the specialties within mental health (such as paediatric psychiatry and maternal mental health), lack of trained general physicians on mental health, and having unqualified personnel conduct and provide primary mental health care within the primary care settings. Such issues, which are related to availability of mental health professionals within and across all levels of mental health, have contributed to the burden placed on health care professionals and might force health care professionals in primary care settings to ignore mental health care needs in primary care settings. Stakeholders identified the lack of a specialized mental health workforce as a critical challenge that influences the quality of care provided and limits mental health service coverage. For example, having only one paediatric psychiatrist is noted, indicating the poor mental health services provided to children and adolescents. Not having any specialized maternal mental health professionals is another challenge that influences maternal mental health services.

The education and child protection sectors also suffer from shortages of staff and qualified mental health professionals. Stakeholders stated that one challenge is the unclear role of school counsellors. Focusing on physical health at schools limits the responsibilities of School Health Directorates at MOE, and MOH's responsibilities for public and environmental health ignore mental health. It was noted that mental health assessment and screening for mental health problems are not integrated at primary care centres, schools and child protection centres. Due to staff shortages, the job description of school counsellors is not well activated. There was only one school counsellor for each school, and most of them reported being trained a long time ago and not being up to date on the most recent knowledge and skills related to mental health interventions and psychological counselling for children and adolescents.

In addition, shortages of MHPSS services in primary health care settings and staff specialized in MHPSS at in private health care, school and child protection settings were noted as significant challenges for integrating mental health. In terms of limited specialized services and unequal distribution of MHPSS professionals across the available primary care centres, overlapping and unclear roles of MHPSS personnel and specialized mental health professionals was reported. This indicates that stakeholders are aware of the magnitude of the problem related to the shortage of staff and resources.

Challenges were also reported in the unavailability of the mental health workforce, whether specialized mental health professionals or non-specialized, hindering the ability of the health care system and health care professionals to integrate primary mental health for all age groups. This may contribute to ignoring the mental health of children, adolescents and pregnant and new mothers at all levels. Stakeholders have stressed that mental health is also a major challenge at the secondary and tertiary levels, and mental health professionals are lacking at all levels. In particular, paediatric mental health specialists are lacking along with those who can provide mental health assistance and consultation to pregnant and new mothers.

One significant cultural issue regarding the workforce was that most health care workers at the primary care centres in regions outside of the main cities belong to the same community. Therefore, individuals and service users know each other very well. This may hinder service users from expressing their needs for mental health counselling and make health care professionals avoid offering mental health services out of fear of stigma and lack of confidentiality. Such conflict related to family relations would contribute to avoiding seeking mental health and not offering mental health services in most PHCCs in rural and remote areas, even with the presence and availability of mental health professionals in those centres. If they need mental health services, people may need to travel long distances to get the services when they have the financial capability to afford the cost of travelling and mental health services.



## Examples of stakeholders' responses on the workforce

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•• We lack human resources allocated to mental health and primary mental health care services. ••

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•• Most schools have counsellors, but their role is inactive. ••

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•• There is a specific time to finish your workload. ••

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•• We have clear work overload, especially nurses.  
But in time they lose their power to continue because of work overload. ••

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•• We do not have specialized personnel in the field of children's psychology. ••

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•• Family problems should be managed by specialized family counsellors.  
We do not have such specialty. ••

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•• We need to have specialized individuals in the field of MHPSS to be able to provide the services and make the appropriate referrals after screening and detection. ••

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•• We are limiting our specialized services in terms of medication and diagnosis.  
But counselling, psychosocial support and interventions are not available at the centres.  
It is limited at the national centre for mental health to some extent. ••

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•• I guess primary mental health should be given a priority,  
and it is not available in most of our primary health care centres. ••

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•• As midwives, we do not know, and we lack knowledge about psychological well-being.  
All we know is the little information that we have personally gained over time. ••

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•• People are coming to you hesitantly and not sure that she wants to get the service. ••

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Although challenges related to the workforce were the most difficult to stakeholders, they managed to identify areas where improvement and integration of primary mental health could be feasible. Stakeholders recommended having a national sustainable MHPSS training plan and specialized MHPSS personnel in various fields such as child and family protection, paediatric care, school mental health, adolescent care, and maternal and reproductive health care. Moreover, stakeholders showed they knew the missing mental health services in primary care settings. They also noted that there is a need to have more MHPSS services that can be provided by non-specialized mental health services based on well-established training programmes, such as psychological first aid, lay counselling, and early detection and assessment of mental health. They emphasized the role of family medicine and midwives in enhancing maternal and child mental health care at primary care centres. The shortage of staff and resources and the need for training might have contributed to re-directing the stakeholders from addressing their personal needs at the centres as care providers and managers. They minimally addressed self and staff care, the importance of inter-sectorial coordination, and the influence of publishing their success stories.

**Table 5: Recommendations related to the workforce**

Purpose	Leading agency (ies)	Next steps	Time frame
Establish units for MHPSS within health care centres to enhance mental health literacy and combat stigma among the general population and community	MOH, in collaboration with national and international agencies	In collaboration with funds and support from national and international agencies to set a national mental health coverage plan	Short to medium term
National training plan on MHPSS for specialized and non-specialized health workers based on providers' needs, focusing on enhancement of their competencies and responding to requirements of their roles	MOH, MOSD, NCFA, MOE, and MHPSS actors	Develop a national mental training plan across sectors	Short term
Train health professionals on providing comprehensive and effective mental health care	MOH and United Nations agencies (including WHO) and mental health expert agencies like IMC	Develop plan and material for knowledge and skills transfer for PHC providers	Short to medium term
Support specialization and psychiatric intern programmes	MOH, Jordan Medical Council (JMC), with the support of the National Mental Health Steering Committee and mental health technical agencies	MOH and JMC, with the support of the National Mental Health Steering Committee to support and fund psychiatric intern programmes	Medium to long term
Offer specialized and non-specialized primary mental health professionals training programmes, workshops and certified programmes as one means of compensation instead of financial compensation.	MOH and MHPSS actors	MOH to take the lead in creating a national plan of training as a compensatory mechanism and incentive system for mental health professionals	Short to medium term
Empower school counsellors and activate their roles at schools	MOH and MOE	Training and support by adopting MOH policies and protocols	Short term
Develop training guidelines that can be used in primary care settings by health professionals	Governmental (MOH) and non-governmental agencies (IMC, United Nations agencies, MHPSS Steering Committee)	MOH to take the lead in developing guidelines for a multidisciplinary team used by the PHC service providers to ensure efficient services	Medium term

Purpose	Leading agency (ies)	Next steps	Time frame
Develop standardized national mental health training online/in-person for specialized and non-specialized mental health personnel	Led by governmental (MOH, MOSD) and non-governmental agencies (IMC, United Nations agencies, MHPSS Steering Committee)	MOH, in collaboration with MOSD, MOE, and MHPSS actors, to develop standardized training for frontline workers online/ in-person.	Medium term
Improve training for early childhood educators to strengthen social and emotional learning	MOH and MOSD	Provide context-based training for counsellors according to children's age categories	Short to medium term
Match specialization at universities with needs for mental health services	MOH, Higher Education Council, and Bureau of Employees	Curriculum development	Long term
Hire more specialized mental health professionals, such as psychiatric nurses, and psychologists	MOH, BOE and national professional agencies	Develop a plan for embayment and re-allocation of mental health professionals within the primary and secondary levels of care	Short to medium term
Prioritize a national plan for the training and employment of mental health professionals	MOH, the National Mental Health Steering Committee and employment agencies	MOH with HCAC to develop standardized capacity-building indicators for PHCs to include mental health integration and services to ensure efficient and effective services	Medium to long term
Self-care and staff care	MOH and MHPSS actors	Develop a national mental health training plan across sectors related to self and staff care	Medium term
Establish inter-sectorial counselling exchange agreements	MOH, MOSD, NCFA, MOE and MHPSS actors	Activate the agreements between MOH and the competent authorities to activate the secondment system and the exchange of experiences and cadres	Short to medium term







## 7. Final recommendations and conclusions

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Primary mental health care is becoming an essential requirement worldwide. This study indicated that stakeholders who are care providers, counsellors, managers and teachers from national and international agencies, governmental and non-governmental agencies, child protection and United Nations agencies are aware of the need to integrate mental health in the primary care of children, adolescents and new mothers. The aim of the study was to investigate how mental health can be integrated into primary care in Jordan. The desk review, the brainstorming meeting with stakeholders and experts in the mental and primary care field in Jordan, and the interviews with significant stakeholders provided and validated the imminent need for such integration and suggested how such integration can be achieved. The study participants and stakeholders were able to diagnose the current situation and recommend ways to improve mental health practices and integrate mental health into primary care.

School counsellors and personnel were aware of their needs and the barriers and challenges related to the integration of mental health. Health care providers were aware of the need to provide maternal mental health and child and adolescent mental health care as part of primary care services in Jordan. Respondents indicated the need for sustainable training, funded programmes and improving working conditions for primary health care workers through financial and non-financial compensatory mechanisms. Personnel at NGOs and United Nations agencies emphasized the need for national umbrella for laws, regulation, legislation, referral, data management, policies, training, and mental health accessibility and coverage. There was consensus among all stakeholders across their managerial level on almost all these issues. Therefore, they were able to propose recommendations to enable the integration of mental health into primary health care of children, adolescents and new mothers.

The proposed recommendations can be summarized as follows:

- **Develop a national mental health plan for MHPSS.** This requires national efforts across all levels of management in collaboration with national and international organizations and agencies to create a national guide for MHPSS services, a national strategy for the integration and implementation of mental health in the primary care level of services, employment and allocation of resources and services, creating a national platform for mental health services, activating mental health law and policies, developing MHPSS practice guide and national mental health registry, and establishing a national umbrella for MHPSS services and specialized services.
- **Develop essential and advanced sustainable MHPSS training programmes.** This would enhance the capacity of MHPSS personnel's knowledge and skills and allow non-MHPSS professionals to acquire the skills and knowledge that enable them to participate in mental health prevention and promotion while providing care for their clients in primary care settings. Training non-MHPSS personnel, such as gynaecologists, midwives, general nurses, paediatricians, paediatric nurses, schoolteachers, and school nurses, can enhance and increase mental health coverage and support prevention programmes through screening and early detection of mental health problems and support making appropriate and timely referrals. The topics that non-MHPSS personnel across social welfare and protection, education and other sectors can be trained on include developmental problems, maternal mental health, protection concerns, violence, abuse, bullying, children and adolescents' behavioural misconduct, substance-abuse-related disorders, anxiety, postpartum depression, traumatic childhood experiences, and traumatic life events. This could be part of developing a sense of shared responsibility for MHPSS between families and society that will help provide parents and mothers with the essential knowledge and skills needed to create a happy family.

- **Addressing stigma surrounding mental health conditions and seeking behaviour.** This is a cornerstone issue that must be addressed and mainstreamed. Combatting stigma should be addressed at the national level and across all levels and sectors of care and management, utilizing all possible means of communication and media. The main purposes are to correct misconceptions about mental health and illness, enhance mental health literacy, improve access to mental health care and services, increase public awareness of primary mental health services, increase public awareness regarding available mental health services, correct false and stigmatized information related to mental health and illness through formal and social media, and create a free national platform for mental health education, consultation and guidance. Moreover, efforts have been exerted to incorporate concepts of mental health and illness into the social welfare and protection sectors, and school and university curricula. Various forms of awareness efforts, such as pamphlets, posters, conferences, seminars, TV programmes and short films, can be employed in schools, universities, health care centres and local and national events, be they cultural, social or educational.
- **Include non-specialized health care services providers,** such as midwives, general nurses, gynaecologists, paediatricians and teachers, in MHPSS training. This requires extending training programmes, such as mhGAP and other similar MHPSS training courses, to include non-specialized mental health services. This will significantly enhance and promote primary mental health provision across all sectors and expand mental health services provided in areas where specialized mental health specialists might not be available. In addition, the low-intensity package of MHPSS services can be introduced through non-specialized personnel. Early detection, screening, prevention and promotion of mental well-being will be achievable through non-specialized trained personnel. Furthermore, this strategic step will be economical and save time and effort for service users.
- **Accreditation and certified programmes and services.** The need for monitoring and evaluating mental health services and the willingness to integrate mental health at the primary care level for children, adolescents and new mothers requires all programmes and mental health services to be accredited by a national trustee system of governmental and non-governmental MHPSS agencies. This will enable MHPSS specialized and non-specialized personnel to be oriented to the essential and valid programmes of training and services that their agencies can adopt to enhance the integration of mental health at the primary care level. It also requires a high level of inter-sectorial coordination and collaboration. The monitoring and evaluation of provided mental health services for improvement of mental health services and ensuring that ethical and legal consideration of mental health practices are applied. This ensures the intended benefits and avoid harm to those using mental health care services.
- **Multisectoral integration strategy and implementation.** The stakeholders have addressed the urgent need to develop a multisectoral integration strategy that promotes primary mental health care for children, adolescents, and new mothers. The integration may take different forms, guiding agencies on how to provide the foundation for effective response and help efficiently meet the holistic needs of children, adolescents, and new mothers. They could create an "Integrated Response Framework" that promotes primary mental health care and provides comprehensive MHPSS services for all beneficiaries, including children, adolescents, and new mothers.
- **Social welfare and child protection.** It was clear that most stakeholders could identify the need for a national well-established child protection working agenda. There are many facets to this issue which includes both children with mental health conditions who need protection and children of adults with mental health problems who need protection. Some parents with a mental illness need additional support to care for their children from family, friends and health professionals, and some parents with mental health conditions may worry about losing the care of their children, and especially need support and care from specialized MHPSS personnel. People with mental health conditions who have other family responsibilities may have concerns about their capacity when they are not well, including remaining employed or spending time as caregivers.

On the other hand, children and adolescents with mental health problems need more attention at home and at school. A child protection system may keep children from being deprived of required early detection, prevention and intervention for their mental health conditions, and well as continued promotion of mental health well-being. The child welfare system typically receives and investigates reports of possible child abuse and neglect, and provides services to families that need assistance in the safety and care of their children. This may include finding safe homes, and arranging for reunification or adoption. The child welfare and protection system can enhance community responsibility, mainly through professionals, such as teachers, child-care workers, health professionals, those working with adults with on improving parenting skills, MHPSS workers, and specialized and non-specialized mental health care professionals in primary care settings and schools. It is also an essential responsibility for staff and others involved in sports clubs, community activities, youth clubs, religious/faith organizations, and other organizations catering to children and adolescents.

- **Financial support for mental health access and utilization.** For many, financial barriers are impediments to receiving needed MHPSS services. Stakeholders' responses often cited concerns about the cost of care, lack of health insurance coverage, transportation costs to services units, cost of reaching specialized services, lack of services in remote areas and lack of access to services close to living areas as reasons for those in need not receiving mental health care. Overcoming these financial barriers calls for creating national health insurance plans for all Jordan residents. It has been reported that health insurance is a key factor in enabling better access to and use of mental health care services. In addition, the cost of medication and availability of mental health services with equal distribution of MHPSS services and personnel would also enable better use of and access to mental health services for children, adolescents and new mothers.

International evidence suggests that charging patients for MHPSS services results in services being distributed according to the ability to pay, resulting in inequitable access to care, which is damaging to society as a whole. Private health insurance poses three main problems for mental health service users:

1. exclusion of mental health benefits,
2. limited access to those without employment, and
3. refusal to insure pre-existing conditions.

A national plan for health insurance that includes mental health services can offer protection to those with mental health problems. However, the quality and distribution of publicly financed MHPSS services make access difficult in practice, particularly for people in rural or remote communities, and refugees.

- **Conduct quantitative studies that measure the impact of the availability and quality of mental health services** provided to children, adolescents, pregnant and new mothers at primary care centres. The targeted settings should include health care centres, schools and child protection centres, and cover all sectors in Jordan; private, public and international. Therefore, researchers need funding and support from local and international agencies to address multiple factors including the impact of current services, determinants to services, willingness to use services, prevalence and incidence of mental illness, usability and accessibility of services, service coverage, and the availability of specialized and non-specialized primary mental health services.
- **Establish mental health care indicators for primary mental health care services** provided to children, adolescents, pregnant women and new mothers at primary care centres. This effort should include indicators for monitoring and follow-up during treatment, coordinated care, continuity of care and use of preventive measures. Primary health care systems need to establish indicators to evaluate service quality. Policy and decision-makers need to realize that the list of indicators must be reported on and addressed periodically to determine how to plan for needs and improvements to mental health resources, mental health promotion and prevention, mental health risks, mental health literacy, positive mental health awareness, self-harm and suicidality reduction, and utilization of mental health care services, quality of care, costs, the burden of disease and mortality, and sociodemographic variables and impacts on public mental health.

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