Strategic Directions for Mental Health in Jordan: 2025-2030 Roadmap

Health Sectoral Committee

Higher Council for Science and Technology

Amman, Jordan

June 2024

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Abbreviations

WHO	World Health Organization
EMR	Eastern Mediterranean Region
PHC	primary health care
UNRWA	The United Nations Relief and Works Agency
UNHCR	United Nations High Commissioner for Refugees
mhGAP	Mental Health Gap Action Program
INGOs	International non-governmental organization
MOH	Ministry of Health
RMS	Royal Medical Services
NGOs	Non-Governmental Organization
NCMH	National Center for Mental Health
CMHCs	Community Mental Health Centers
IMC	International Medical Corps
MOSD	Ministry of Social Development
IERS	Interactive Electronic Information System
MHPSS	Mental Health Psychosocial Support
PWD	Persons with Disabilities Organizations.
NTC	National Technical Committee
MH	Mental Health
SU	Substance Use
IDP	Internally Displaced Person

Global Overview

Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

Determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one’s thoughts, emotions, behaviors and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports.

Depending on the local context, certain individuals and groups in society may be placed at a significantly higher risk of experiencing mental health problems. These vulnerable groups may include members of households living in poverty, people with chronic health conditions, infants and children exposed to maltreatment and neglect, adolescents first exposed to substance use, minority groups, indigenous populations, older people, people experiencing discrimination and human rights violations, prisoners, and people exposed to conflict, natural disasters or other humanitarian emergencies.

People with mental disorders experience disproportionately higher rates of disability and mortality. For example, persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended (such as cancers, cardiovascular diseases, diabetes) and suicide. Suicide is the second most common cause of death among young people worldwide.

Mental disorders often affect, and are affected by, other diseases such as cancer, cardiovascular disease and as such require common services and resource mobilization efforts. For example, there is evidence that depression predisposes people to myocardial infarction and diabetes, both of which conversely increase the likelihood of depression.

Many risk factors such as low socioeconomic status, alcohol use and stress are common to both mental disorders and other non-communicable diseases.

In 2019, across all ages, mental, neurological and substance use disorders together accounted for 10.1% of the global burden of diseases. Mental disorders accounted for 5.1%, neurological disorders accounted for 3.5%; while substance use conditions accounted for 1.5% (1).

In addition to the direct costs of treatment, mental health conditions come with a variety of indirect costs associated with reduced economic productivity, higher rates of unemployment and other economic impacts. Researchers from the World Economic Forum calculated that a broadly defined set of mental health conditions cost the world economy approximately US$ 2.5 trillion in 2010, combining lost economic productivity (US$ 1.7 trillion) and direct costs of care (US$ 0.8 trillion) This total cost was projected to rise to US$ 6 trillion by 2030. (2)

Governments around the world allocate just 2% of their health budgets to the treatment and prevention of mental health conditions. (2)

Because of stigmatization and discrimination, persons with mental disorders often have their human rights violated and many are denied economic, social and cultural rights, with restrictions on the rights to work and education, as well as reproductive rights and the right to the highest attainable standard of health. They are often denied civil and political rights such as the right to marry and found a family, the right to vote and to participate effectively and fully in public life, and the right to exercise their legal capacity on other issues affecting them, including their treatment and care. As such, persons with mental disorders often live in vulnerable situations and may be excluded and marginalized from society, and they are frequently subject to poverty. (3)

Close to 15% of the world's working population is estimated to experience a mental disorder at any given time, and around 8% of the world's young children (aged 5–9 years) and 14% of the world's adolescents (aged 10–19 years) live with a mental disorder. (1)

Mental disorders are common in all countries: they occur across all WHO Regions, ranging from 10.9% prevalence in the WHO African Region to 15.6% in the WHO Region of the Americas. They are somewhat more common in high-income countries. (1)

Globally, health systems have not yet adequately responded to the burden of mental disorders; as a consequence, the gap between the need for treatment and its provision is large.

Between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high-income countries is also high: between 35% and 50%. It is estimated that the annual spending on mental health globally is less than US$ 2 per person and less than US$ 0.25 per person in low-income countries. (1)

The number of specialized and general health workers dealing with mental health in low-income and middle-income countries is grossly insufficient. Almost half the world's population lives in countries where, on average, there is one psychiatrist to serve 200 000 or more people; other mental health care providers who are trained in the use of psychosocial interventions are even scarcer.

Only 36% of people living in low-income countries are covered by mental health legislation compared with 92% in high-income countries. (1)

The civil society movements for mental health in low-income and middle-income countries are not well developed. Organizations of people with mental disorders and psychosocial disabilities are present in only 49% of low-income countries compared with 83% of high-income countries; for family associations the respective figures are 39% and 80%. (1)

The availability of basic medicines for mental disorders in primary health care is notably low (in comparison to medicines available for infectious diseases and even other non-communicable diseases), and their use restricted because of the lack of qualified health workers with the appropriate authority to prescribe medications. In addition, the availability of non-pharmacological approaches and trained personnel to deliver these interventions is also lacking. Such factors act as important barriers to appropriate care for many persons with mental disorders.

Regional Overview

Findings for 2019 indicate that there has been progress towards the global targets of the Comprehensive Mental Health Action Plan in the Eastern Mediterranean Region. In 2013 and 2016, a smaller percentage of countries and territories in the Region than in the rest of the world had human rights-compliant mental health policies and plans, legislation, and promotion and prevention programmes, but by 2019 the percentage of countries/territories in the Region with these in place had grown to equal or exceed the percentage reported globally. The rate of suicide in the Region is just over half that reported globally, and the rate has reduced by 16% since 2013. The percentage of countries/territories in the Region reporting on a core set of mental health indicators has returned to more than 80%, after dipping in 2013. Baselines for service coverage have been established in some countries of the Region, though due to a lack of relevant data these are not known for the majority of countries.

Despite steady progress in the adoption of policies, plans and laws, as well as an improvement in the capacity to report regularly across years on a set of core mental health indicators, this regional review reveals massive inequalities between countries in terms of the availability and allocation of mental health resources – often, but not always, showing a pattern of the greatest levels of provision in Group 1 countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates) and the lowest levels in Group 3 countries (Afghanistan, Djibouti, Pakistan, Somalia, Sudan, Yemen). As for the rest of the world, the 2020 data also reveals significant gaps between the existence of policies, plans and laws regionally and their implementation and monitoring and the allocation of resources. Similar gaps are seen in the implementation of mental health services at the primary health care level. While guidelines for the integration of mental health into primary health care exist and have been adopted in most countries, with ongoing activities for training and supervision, the integration of interventions for service delivery, such as pharmacological and psychosocial interventions for mental health conditions, remains limited. The Mental health atlas 2020 shows significant limitations in the capacity of mental health information systems in some countries to report on specific indicators such as service utilization.

21 of the 22 countries and territories in the WHO Eastern Mediterranean Region (95%) at least partially completed the mental health atlas questionnaire. 24% of countries in the Region reported regular compilation of data specific to mental health covering at least the public sector. In addition, 62% of countries reported the compilation of mental health data as part of general health statistics only.14% of countries in the Region reported that no mental health data had been compiled and reported in the past two years. 599 articles on mental health were published from the Region in 2019. The percentage of research output on mental health relative to the total health research output was 5.6% in 2019. 81% of countries in the Region reported stand-alone policies/plans for mental health, and 71% reported stand-alone mental health laws. A further 5% of countries have mental health integrated into their general health policies or plans, and 10% have mental health integrated into disability laws. 59% of all countries in the Region, reported full alignment of their laws on mental health with international and regional human rights standards.

Regionally, 82% of public expenditure on mental health goes to mental hospitals. Nine countries, (41%) of all countries in the Region, reported that care and treatment of persons with severe mental health conditions were included in national health insurance or reimbursement schemes and in the insurance coverage of inpatient/outpatient mental health services. Regionally, the median number of

mental health workers was 8.0 per 100 000 population, with a large variation (from 1.3 mental health workers per 100 000 population in Group 3 countries to over 22 workers in Group 1 countries).

Five countries, (23%) of all countries in the Region, reported a functional integration of mental health into primary health care. Nineteen countries, (86%) of all countries in the Region, reported that guidelines for mental health integration into primary health care were available and adopted at the national level. Eighteen countries, (82%) of all countries in the Region, reported that training on the management of mental health conditions was delivered to health workers at the primary care level. Five countries, (23%) of all countries in the Region, reported that pharmacological interventions were available and were provided in more than 75% of their primary care centers.

The median number of mental health beds per 100 000 population ranged from below 2.5 beds in Group 3 countries to 9.6 beds in Group 1 countries. Significant disparities also exist for outpatient services and child and adolescent services. Mental health facilities for children and adolescents are sparsely available. In the 12 countries in the Region with child and adolescent inpatient facilities, the median number of facilities was 0.08 per 100 000 population. In the 16 countries with child and adolescent outpatient facilities, the median number of outpatient facilities was 0.12 per 100 000 population.

Sixteen countries, (73%) of all countries in the Region, have at least two functioning national, multisectoral mental health promotion and prevention programs. Of 65 functioning programs reported in the Region, 13 aimed to improve mental health awareness and/ or fight stigma, 11 were aimed at school-based mental health promotion, and 10 were MHPSS components of disaster preparedness/disaster risk reduction programs. The regional age-standardized suicide rate in 2019 was estimated to be 4.8 per 100 000 population, representing a 16% reduction in the rate of suicide since the 2013 baseline. (4)

Mental Health in Emergencies

The burden of mental disorders among conflict-affected populations is extremely high: WHO review of 129 studies in 39 countries showed that among people who have experienced war or other conflict in the previous 10 years, about one in five people (22%) had depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia. (5)

Most people affected by emergencies will experience distress (e.g. feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability or anger and/or aches and pains). This will for most people improve over time. However, the prevalence of common mental disorders such as depression and anxiety are expected to more than double in a humanitarian crisis.

There are various types of social and mental health problems in any large emergency:

Social problems:

- Pre-existing: e.g. poverty and discrimination of marginalized groups.
- Emergency-induced: e.g. family separation, lack of safety, loss of livelihoods, disrupted social networks, and low trust and resources.
- Humanitarian response-induced: e.g. overcrowding, lack of privacy, and undermining of community or traditional support.

Mental health problems:

- Pre-existing: e.g. mental disorders such as depression, schizophrenia or harmful use of alcohol.
- Emergency-induced: e.g. grief, acute stress reactions, harmful use of alcohol and drugs, depression and anxiety, including post-traumatic stress disorder.
- Humanitarian response-induced: e.g. anxiety due to a lack of information about food distribution or about how to obtain basic services.

According to WHO's review, the estimated prevalence of mental disorders among conflict- affected populations at any specific point in time is 13% for mild forms of depression, anxiety, and post-traumatic stress disorder and 4% for moderate forms of these disorders. The estimated prevalence for severe disorders (i.e. schizophrenia, bipolar disorder, severe depression, severe anxiety, and severe post-traumatic stress disorder) is 5 %. A review published in 2014 of the health information system from 90 refugee camps across 15 low- and middle-income countries found that 41% of health-care visits for mental, neurological and substance use disorders were for epilepsy/seizures, 23% for psychotic disorders, and 13% for moderate and severe forms of depression, anxiety or post-traumatic stress disorder. The global progress on mental health reform will happen more quickly if, during every crisis, efforts are initiated to convert the short-term increase in attention to mental health issues combined with a surge of aid, into momentum for long-term service development. Many countries have capitalized on emergency situations to build better mental health systems after crises. (5)

Mental Health Situation in Jordan

Two main assessments of mental health system and mental health services have been conducted in Jordan during the last 14 years, the first assessment was conducted in 2010 by the Higher Council for Science and Technology (HCST), Jordan, and the second assessment was carried out during January to March 2020 by the World Health Organization.

Main findings and recommendations of the HCST assessment (6):

- At that time a proper mental health policy and plan, as well as mental health legislation, do not officially exist in Jordan, but drafts have been compiled awaiting official endorsement by MOH.
- Less than 3% of governmental health expenditure was directed towards mental health and more than 90% of mental health funding was directed towards mental health hospitals.
- All mental health disorders and problems of clinical concern were covered by public health insurance schemes (civil and military insurances), and at least 80% of mentally ill patients had free access to essential psychotropic medicines.
- There were 64 outpatient mental health facilities in the country, only one of which serve children and adolescents.
- The majority of mental health beds in the country were in mental hospitals (8.2 beds per 100,000 population), followed by forensic units (0.01 bed per 100,000 population). But there were no beds in mental hospitals for children and adolescents and there was no increase in the number of hospital beds in the last 5 years and almost all psychiatric beds were in Amman.
- 6% of training programs in medical schools is devoted to mental health compared to 5% for nurses.
- Only 28% of primary health care (PHC) physicians received at least 2 days refresher training in mental health, while 5% of nurses and 6% of other PHC workers received such training.
- There were 1.2 psychiatrists and 6.9 psychologists per 100,000 population.
- Less than 6% of PHC clinics have available assessment and treatment protocols for common mental health conditions.
- About 40% of primary and secondary schools have a part-time or full-time health professional, only a small percentage were trained in mental health.
- About 50% of patients rated the care they received in hospital as excellent or very good, and 5% rated it as very poor.
- About 25% of service users reported that they always feel ashamed of their mental illness and 24% reported difficulties in reaching the source of care.
- About 90% of primary health care physicians reported that they believe they have a role in offering mental health services, and 83% of physicians reported they are willing to work to improve mental health services in Jordan, and only 22% of them reported that they have a protocol or guidelines to diagnose and treat mental health problems.

Recommendations:

1. Establishing comprehensive mental health legislation and plan of action that include a disaster preparedness mental health plan that protects and promotes the human rights of people with mental disorders, and facilitate the delivery of mental-health care.

2. Establishing mental health units within general hospitals in all sectors, community mental health facilities, and counseling units, in addition to establishment of child/adolescents' mental health facilities and services.
3. Increase and continue training primary health care staff on essential mental health care issues and expedite the integration of mental health services within the primary health care system.
4. Increase the number of human resources and psychosocial staff (e.g., social workers, psychologists, etc.).
5. Strengthening the link between the mental health system in Jordan with other sectors (Ministries of Education, Social Development, Public Works and Housing, etc.) through formal legislative frameworks.
6. Developing and enhancing public mental health awareness programs in collaboration with other sectors such as NGOs, Media, etc.
7. Improving the mental health information system and encouraging/supporting research in the field of mental health.

Findings of the assessment carried out by WHO and Ministry of Health during January to March 2020 (7):

The health system in Jordan is vulnerable and continues to face increasing demand associated with demographic and epidemiological issues. Due to its political and economic stability and relative proximity to countries in conflict, Jordan has a long history of receiving refugees. Jordan currently hosts more that 2 million Palestinian refugees registered with UNRWA, more than 1.3 million Syrian refugees, as well as 67,000 Iraqi refugees registered with UNHCR. These figures qualify Jordan as the second largest refugee host country at global level.

Jordan has several strengths and challenges to consider in its mental health care system. Mental health leaders are aware of the challenges the country faces and what the key next steps are to addressing these challenges, and there is increasing civil society activism around mental health and mental disorders and interest in the international community to support Jordan in mental health reform. However, there remain several challenges to improving mental health care in Jordan. Mental health governance needs to be restructured and enabled to steer the system and there is limited inter-sectoral coordination. There is limited budget for mental health. Medication availability for mental disorders is low at PHCs. Additionally, Jordan faces a shortage of mental health human resources and sub specialties and general lack of mental health data systems. A human resource plan for mental health has not been developed yet.

Mental health is mentioned 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). Additionally, Jordan has an endorsed National Mental Health and Substance Use Action Plan (2018-2021), which was launched in April 2018.

Jordan is currently operating under the National Mental Health Policy of 2011. This policy was reviewed in 2016, and considered relevant and reflective of the current context and mental health priorities in Jordan. The policy informed the development of the National Mental Health and Substance Use Action Plan (2018-2021).

The key Components of the Policy and Plan were:

- Integration of mental health at Primary Health Care level: The policy supports the integration of mental health into PHC aligned with the WHO technical package for the purpose of early detection and diagnosis and providing basic psychosocial interventions, pharmacological treatment, referral, and follow-up of mental health patients. The policy states that mental health services are to be provided in PHC settings by family doctors, trained general practitioners, and nurses.
- The Action Plan 2018-2021 includes a strategic intervention on the integration of mental health and substance use into primary health care through mental health GAP action program (mhGAP). It recommends implementing mhGAP P in 80 primary health care centers. Additionally, the plan recommends integrating mhGAP training in pre-service training (medical and nursing curricula).
- Strengthening mental health at secondary health care level: The policy supports the establishment of mental health acute admission units in general hospitals, as well as outpatient clinics and community mental health centers. Such services should be made available in all governorates. The Action Plan aimed to establish three additional inpatient units in MOH general hospitals and 9 community mental health centers, as well as outpatient clinics nationwide.
- Re-orienting the tertiary health care level: The policy advocates for reorienting care and establishment of acute inpatient wards in general hospitals. New admissions to tertiary care facilities will be gradually stopped and individual discharge plan for each patient will suggest alternative services including family care. Similarly, the Action Plan suggests the redistribution of resources (beds and specialists) from tertiary care facilities to acute inpatient wards in general hospitals.
- Legislation: 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 the 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. As for the Law on the Rights of Persons with Disabilities Act, its provisions cover persons with mental health conditions, since mental illness is included in the definition of disability. Based on Article 24 of the Law, mental health care in governmental health facilities is provided for free for all citizens.
- Implementation Status: While the Action Plan is being implemented, progress has been slow on some key areas. The MOH Disability and Mental Health Directorate has limited policy making authority and does not hold a budget. While mental health is being integrated at primary healthcare level, secondary facilities is not progressing at the same pace, with the establishment of community mental health centers mainly rely on INGOs. Multi-disciplinary bio-psychosocial models of care have not been implemented. Integration of mhGAP into pre-service curricula of medical and nursing students has not yet come to fruition. Additionally, resources are still concentrated at the tertiary level. Prevention and promotion activities has yet to be institutionalized in the public sector. Whereas a substance use strategy is in its final stages of development, the human resource plan for mental health has yet to be prepared.

<u>Governance of mental health in Jordan</u>:

Jordan's mental health system parallels the general health system and consists of the public sector including the Ministry of Health (MOH), Royal Medical Services (RMS), Jordan University Hospital, and King Abdullah University Hospital; the private sector; and the charitable sector (including national and international non-governmental organizations (NGOs mainly coordinated by UNHCR) as well as

UNRWA. These operate independently, with separate mechanisms for service delivery and financing. Within the MOH, responsibility for mental health sits with the Disability and Mental Health Directorate, which is situated under the MOH's Assistant to Secretary General for Primary Health Care. Additionally, a multi-sectorial National Technical Committee was established to advice the directorate. Meanwhile, the National Center for Mental Health (NCMH) is situated within the Health Directorates, under the Assistant to Secretary General for Technical Affairs and Health Directorates.

Mental Health Service Organization

Primary Health Care level:

Jordan's MOH operates a network of 383 Primary Health Care (PHC) centers, currently, 93 PHCs have integrated mental health in the services offered to beneficiaries, however, only 6 out of the 93 PHCs have a pharmacy, with only one anti-psychotic and one anti-depressant available. Additionally, UNRWA integrated mhGAP in its network of 22 PHCs serving Palestine refugees, and other NGOs provide mental health services in their clinics.

Secondary Health Care level:

Secondary care is provided by acute inpatient units, Community Mental Health Centers (CMHCs), and outpatient clinics.

Three acute inpatient units have been established in general hospitals as follows: 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). Additionally, an acute inpatient unit has been established in Zarqa Governmental Hospital, but no human resource has been allocated yet.

It should be highlighted that the acute inpatient units are only partially operating according to bio-psychosocial models of care due to the lack of psychologists and other providers.

Forty-eight MOH psychiatric outpatient clinics are operating nationwide (25 attached to hospitals and 23 not attached to hospitals), with an additional 5 clinics run by King Abdullah and Jordan University Hospitals (attached to hospitals), whereas RMS runs 16 clinics per week. The private sector has 44 outpatient clinics (not attached to hospitals), mainly concentrated in Amman. So far and according to the head of mental health specialty at MOH, there are no community mental health centers belonging to MOH or any governmental institution.

The INGO International Medical Corps (IMC) in collaboration with MOH, runs 12 community mental health centers (CMHCs) in urban areas implementing a case management model emphasizing biopsychosocial models of care.

Tertiary Health Care level:

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

Human Resources

There are an estimated 91 psychiatrists 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, 49 psychiatrists in the private sector (Private clinics: 44, Al Rasheed Hospital: (5).

Estimates of 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; the RMS mental health inpatient unit, the Jordan University Hospital, King Abdullah University Hospital, and Al Rashid Hospital (private sector).

Nurses and general practitioners receive pre-service training in mental health taught by psychiatrists and mental health nurses. Family doctors receive a three-month rotation in psychiatry.

Psychiatric Medications:

Essential antipsychotic, antidepressant, anxiolytic, mood-stabilizing, and antiepileptic medications are readily available at specialist mental health facilities in Jordan.

At basic PHC facilities run by general practitioners or family doctors, only one anti-psychotic (risperidone) and one anti-depressant (fluoxetine) are available, while comprehensive PHCs that include mental health specialists have, at least, all essential psychotropics in specialized units.

Health Information System:

Jordan's health information system does not track numbers of people screened or treated for mental disorder. However, the existing Interactive Electronic Information System (IERS) operating at PHC level will integrate a mental health module in the next biennium.

Sociocultural Factors:

Religious explanatory models and stigma impact many people's health-seeking behaviors. Many people seek out healing for physical and mental illness from religious healers. Mental illness is often seen as "God's fate or will", and thus leads to many people not seeking mental health services.

Non-Health Sector Activities:

Education**:** There is no formal screening for mental disorders in the Ministry of Education, however school-based counselors screen students to identify general counseling needs, which may include social or emotional issues. Counselors receive in-service training on various mental health conditions.

Justice: The Ministry of Social Development (MOSD) has a program that monitors and follows up on children and adolescents in the criminal justice system with the goal of reintegration. Also, has family protection units for families experiencing violence and has services for victims of human trafficking, which offers psychosocial and protective services.

Social Welfare: MOSD has programs to support citizens in need of services, including financial support, health insurance, and subsidized housing.

Child Welfare: MOSD has programs geared to target children's welfare including connecting children with mothers at the correctional facilities, foster homes when the need arises, subsidize housing, permits for children to visit their parents in correctional facilities, and financial aid.

Refugee services: Mental Health Psychosocial Support (MHPSS) Working Group coordinates several NGOs delivering services to refugees and vulnerable Jordanians, mainly in the governorates where the majority of Syrians reside. The Working Group focuses on offering psychosocial and mental health interventions at different levels of the Inter-Agency Standing Committee (IASC) pyramid. The Working Group is a subsector of both the protection and health sectors, and focuses on specialized services, comprehensive interventions, preventive strategies, and efficient referrals.

Advocacy: Civil society is increasingly more engaged in the rights of persons with mental health conditions. Our Step is the most relevant advocacy group, a service user's organization focusing its interventions in giving users a voice in policy making, raising awareness, providing peer support and counseling, and in supporting the integration of users in the community. Other advocacy groups include "I am a human right for rights for PWD".

Awareness-raising, Promotion, and Prevention:

A study on stigma of mental illness in Jordan conducted by Royal Medical Services in 2020 on 11940 patients to identify the reasons of delayed visit, cessation of visit, noncompliance, or delayed improvement revealed that 41% of these reasons were due to stigma. (8)

Awareness-raising, promotion, and prevention are not yet institutionalized in the public sector. These activities continue to rely on INGOs and NGOs organizing activities mainly in occasion of the World Mental Health Day (10 October). Local community initiatives include a number of innovative activities using Apps, and social media campaigns. Hareb (translates into fight) is a social media campaign which has been conducting a number of awareness raising sessions, using various media such as radio, TV and online platforms in addition to visiting schools and communities aiming to exchange knowledge and spread awareness.

Structure of the WHO Global Comprehensive Mental Health Action Plan 2013–2030 (9)

The vision of the plan:

- Mental health is valued, promoted and protected.
- Mental disorders are prevented.
- Persons affected by mental disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination.

The overall goal of the plan:

To promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

The objectives of the plan:

Objective 1**:** To strengthen effective leadership and governance for mental health.

Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

Objective 3: To implement strategies for mental health promotion and prevention.

Objective 4: To strengthen information systems, evidence and research for mental health.

Principles of the plan:

1. ***Universal health coverage***: Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental health disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery at the highest attainable standard of health.

2. ***Human rights***: Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

3. ***Evidence-based practice***: Mental health strategies and interventions for treatment, prevention and promotion should be based on scientific evidence and/or best practice, taking cultural considerations into account.

4. Life-course approach: Policies, plans and services for mental health need to take account of health and social needs at all stages of the life-course, including infancy, childhood, adolescence, adulthood and older age.

5. ***Multisector approach***: A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.

6. ***Empowerment of persons with mental disorders and psychosocial disabilities***: Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

Actions proposed by WHO for Member States to achieve the objectives:

Objective 1: To strengthen effective leadership and governance for mental health:

Proposed actions for Member States:

1. **Policy and law**: Develop, strengthen, keep up to date and implement national policies, strategies, programs, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.
2. **Resource planning:** Plan according to measured need and allocate a budget across all relevant sectors that is commensurate with identified human and other resources required to implement agreed upon evidence-based mental health plans and actions.
3. **Stakeholder collaboration**: Motivate and engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.
4. **Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations**. Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policies, laws and services.

Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings:

Proposed actions for Member States:

1. **Service reorganization and expanded coverage**: Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped care principles, as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient care, and outpatient care in general hospitals, primary care, comprehensive mental health centers, day care centers, support of people with mental disorders living with their families, and supported housing.
2. **Integrated and responsive care**: Integrate and coordinate holistic prevention, promotion, rehabilitation care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing, and education) through service user-driven treatment and recovery plans and, where appropriate, with the inputs of families and carers.
3. **Mental health in humanitarian emergencies** (including isolated, repeated or continuing conflict, violence and disasters). Work with national emergency committees and mental health

providers in order to include mental health and psychosocial support needs in emergency preparedness and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with mental disorders (pre-existing as well as emergency-induced) or psychosocial problems, including services for health and humanitarian workers, during and following emergencies, with due attention to the longer-term funding required to build or rebuild a community-based mental health system after the emergency.

4. **Resource planning**: Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally appropriate and human rights-oriented mental health and social care services, for children and adolescents, inter alia, by introducing mental health into undergraduate and graduate curricula; and through training and mentoring health workers in the field, particularly in non-specialized settings, in order to identify people with mental disorders and offer appropriate treatment and support as well as to refer people, as appropriate, to other levels of care.
5. **Address disparities**: Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.

Objective 3: To implement strategies for promotion and prevention in mental health.

Proposed actions for Member States:

1. **Mental health promotion and prevention**. Lead and coordinate a multisector strategy that combines universal and targeted interventions for promoting mental health and preventing mental disorders; for reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.
2. **Suicide prevention**. Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide.

Objective 4: To strengthen information systems, evidence and research for mental health.

Proposed actions for Member States:

1. **Information systems**: Integrate mental health information into the routine health information system, identify, collate, routinely report and use core mental health data disaggregated by sex and age (including data on completed and attempted suicides) in order to improve mental health service delivery, promotion and prevention strategies and to provide data for the Global Mental Health Observatory (as a part of WHO's Global Health Observatory).
2. **Evidence and research**: Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centers of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.

Structure of Jordan Mental Health and Substance Use Action Plan 2022-2026 (10)

The plan covers four strategic domains:

1. Governance
2. Health care
3. Promotion & prevention
4. Surveillance, monitoring & research

Governance interventions:

- Updating national mental health policy in line with international standards and human rights and improving the implementation of existing legislation for mental health.
- Strengthening the mandate and governance capacity of MOH Directorate for Disabilities and Mental Health.
- Enhancing management of mental health and psychosocial human resources (surveillance, recruitment, retention, redistribution) within Directorate and across MOH governance structures through the National Technical Committee (NTC).
- Strengthening inter-sectoral cooperation for mental health governance, with strengthening the role of MOH Directorate for Disabilities and Mental Health as an overarching coordination and governance body.
- Integration of mental health psychosocial support (MHPSS) in national emergency preparedness and response plans.
- Supporting the implementation of the health response component of the national strategy to combat narcotics and psychotropic substances.

Health care interventions:

- Enhancing retention and efficient redistribution of gender balanced mental health workforce.
- Primary care: Strengthening the integration of MH & SU within Primary Health Care.
- Secondary care level: Development of existing outpatient clinics in community based mental health centers (CMHCs); development of mental health (MH) inpatient services within general hospitals and implementation of the multidisciplinary biopsychosocial model.
- Tertiary care: Redistributing resources/ reorganizing long-stay mental hospitals (National Center for Mental Health NCMH, and Al Karama).
- Enhance availability and regulation of essential psychotropic medicines (identified within mhGAP – IG version 2.0) at each level of care, including Substance Use care (detoxification and opioid substitution treatment).
- Strengthening the capacity of MH &SU services for providing community-based support and care for refugees and IDPs.

Promotion & prevention interventions:

- Increasing MH&SU literacy, reducing stigma and discrimination.
- Implementing evidence-based promotion and prevention packages targeting the identified priorities.

Surveillance, Monitoring & Research Interventions:

- Establishing a quality system for the services provided and their regular monitoring.
- Regular monitoring of the MH&SU system using the national Integrated Electronic Reporting System (JIERS) and available tools.

Framework of the Strategic Plan of Mental Health in Jordan, 2025-2030

Strategic objective 1: Strengthening of governance and leadership of mental health.				
Targets	**Target description**	**Time Frame**	**Indicators**	**Means of Verification**
Target 1	Specific mental health legislation (law or bylaw) has been developed in line with the provisions of international standards and best practices. Or the current public health law has been amended by adding a special chapter on mental health.	2025-2026	Existence of a national mental health legislation that is being implemented and in line with international human rights instruments	Physically available new mental health legislation.
Target 2	Mental health and the rights of persons with mental disorders and psychosocial disabilities are mainstreamed into all sectoral policies, laws and strategies (for example, health, social affairs, education, justice and employment) including emergency preparedness and response, poverty reduction and development.	2025-2027	All sectoral policies, laws and strategies are amended to ensure respect and rights of persons with mental disorders and psychosocial disabilities.	Physically available all sectoral policies, laws and strategies
Target 3	The governance capacity and mandate of MOH Directorate for Disabilities and Mental Health have been strengthened and empowered.	2025	Empowered and well-functioning directorate.	Sufficient well-trained staff
Target 4	Mental health policy has been updated in line with the new legislation and the international standards of human rights.	2026	Existence of updated and endorsed mental health policy.	Physically available policy
Target 5	National Technical Committee (NTC) for mental health membership has been revised, ensuring representation of all relevant stakeholders	2025	Existence of a revised and functioning national technical committee (NTC) representing all relevant stakeholders.	Meetings of the committee on regular basis
Target 6	Inter-sectoral cooperation for mental health governance has been strengthened.	2025-2030	All relevant ministries and institutions implement their defined roles effectively	Existence of written documents that prove the implementation of activities related to the roles of ministries and institutions.
Target 7	Integration of Mental Health and Psychosocial Support (MHPSS) in national emergency preparedness and response plan.	2026	Mental health and psychosocial support (MHPSS) are integrated in national emergency preparedness and response plans	Existence of emergency preparedness and response plans that includes MHPSS.
Target 8	Doubling the annual budget allocated for mental health.	Starting from 2026	5% of the total governmental health expenditure is allocated for mental health care.	At least 5% of the total governmental expenditure on health is allocated for mental health care.

Target 9	Amending national legislations that encourage stigmatization, discrimination and human rights violations against people with mental disorders and psychosocial disabilities.	2026-2027	Local capacity and awareness have been built and raised among relevant stakeholder groups about mental health, law and human rights, including their responsibilities in relation to the implementation of policy, laws and regulations.	implemented legislations, and positive population awareness towards people with mental disorders positive.
Strategic objective 2: To provide comprehensive, integrated and responsive mental health and social care services.				
	Target description	**Time frame**	**Indicators**	**Means of verification**
Target 1	Mental health services are integrated in all primary health care comprehensive health centers.	2026-2027	1. All family physicians and general practitioners and at least two nurses or social workers working in comprehensive health centers are trained on conducting mental health GAP action program. 2. Community mental health centers are established and empowered in all governorates. 3. All comprehensive health care centers in the country provide basic mental and social care for most common mental health problems.	1. Number of comprehensive health centers with staff received the full package of training. 2.Number of these centers providing good quality mental health care. 3. Number of centers having continuous availability of essential medicines and number with stock out.
Target 2	Supporting the establishment and implementation of community mental health services run by NGOs, faith-based organizations and other community groups, which protect, respect and promote human rights and are subject to monitoring by government agencies.	2025-2030	Community mental health centers are established and empowered in all governorates.	Provision of services to local people with an outreach approach
Target 3	Tools or strategies for self-help and care for persons with mental disorders, including electronic and mobile technologies are developed.	2027	The tools /strategies for self-help and care for persons with	Number of people with mental health problems or their carers who use these technologies
Target 4	Mental health units are established in all MOH hospitals located in the centers of the governorates (at least 12 hospitals), 5 units in major RMS hospitals and another 5 units in major private hospitals, in addition to strengthening the two units currently available at university hospitals. In addition to the provision of outpatient mental health services in all governorates.	2025-2030	1.Hospitals have sufficient staff and functioning mental health units to provide inpatient and outpatient services. 2. Essential medicines included in the WHO Model List of Essential Medicines for treating common mental health disorders are continuously available and the	Audit of these hospitals and checking the continuous availability and functioning of these units.

			physicians are authorized to prescribe these medicines.	
Target 5	The units in general hospitals should allow several beds for children and adolescents.	2025-2030	The number of units in general hospitals that have beds for children and adolescent.	Check the available number of allocated beds.
Target 6	Mental health and social care are integrated into disease-specific programs and services, such as non-communicable diseases, maternal, reproductive health, child and adolescent health.	2026-2030	Programs that have Mental health and social care integrated	Through checking the plans and implementation activities of these programs.
Target 7	Develop capacity, and operational procedures for remote delivery of services (for example, telehealth) and use digital health solutions to support practitioners in providing care where feasible.	2027-2030	The capacity and operational procedures for remote delivery of services are established.	The system of remote delivery of services is implemented.
Target 8	Reorganization of the tertiary mental health care.	2027	1.The plan for gradual shift of financial resources and staff towards community-based care, general hospitals and primary health care has been developed. 2. A phased and budgeted plan is developed for scaling down and closing long-stay psychiatric institutions and replacing them with support for discharged residents to live in the community.	The plan for gradual shift of financial resources and staff is in place and implemented.

Strategic objective 3: To implement strategies for promotion and prevention in mental health.				
	Target description	**Time frame**	**Indicators**	**Means of verification**
Target 1	Increase public knowledge and understanding about mental health, how to stop discrimination and how to access services, through media awareness campaigns.	2025-2030	1. A well-organized awareness campaigns are designed and implemented targeting several groups including: the general population, mental healthcare providers, families of patients, mothers, service users and people with mental conditions, school-aged children and their educators, etc. through various platforms and modalities.	1.Number of awareness campaigns implemented.
Target 2	Universal and targeted school-based promotion and prevention activities are developed, including socioemotional life and skills programs, programs to counter bullying, violence, stigmatization and discrimination of persons with mental disorders and psychosocial disabilities.	2026	1.Drafting core messages aimed at different target groups, covering topics such as (but not limited to) signs & symptoms, risky behaviors, stigma, rights to confidentiality and privacy, rights to treatment and medicine prescription. 2. Specific awareness psy-education activities targeting family members of long-term service users in facilities under umbrella of (NCMH) are organized.	1. A guide targeting HC providers is in place. 2. A guide to available services for individuals is in place. 3. Specific awareness psy-education activities targeting family members of long-term service users are implemented. 4. Inclusion of service users' organizations is ensured in design and implementation of awareness activities.
Target 3	Policies and measures are developed by relevant ministries (for example, finance, labor and social welfare) for the protection of vulnerable populations during financial and economic crises.	2026-2030	Measures are implemented by relevant ministries for the protection of vulnerable populations during financial / economic crises.	Vulnerable populations are protected during financial and economic crises.
Target 4	Measures against discrimination in educational institutions and the workplaces are developed that promote full access to educational opportunities, work participation and return-to-work programs for people with mental disorders and psychosocial disabilities.	Starting from 2026	A guide targeting healthcare providers is developed, covering topics such as basic principles of psychosocial support for people with mental health and substance use conditions, existing services and referral pathways.	Discrimination in educational institutions and workplaces is disappearing.
Target 5	National multi-sectoral policies and measures are developed for the prevention of suicide, with special attention to groups identified as at increased risk.	2026-2027	1.multi-sectoral policies and measures are applied for the prevention of suicide.	The rate of suicide is decreasing.

			2. A guide to available services for individuals is developed: treatment facilities, mhGAP-trained centers, community-based services, substance-use related services, suicide prevention resources, child and adolescent services, etc. including locations, contact information, working hours, cost of services, service user rights…etc.	
Strategic objective 4: Strengthening information systems, evidence and research for mental health.				
	Target description	**Time frame**	**Indicators**	**Means of verification**
Target 1	Integration of mental health into the routine national health information system and within information systems of other relevant sectors.	2026-2030	Mental health is integrated into the national Electronic Reporting System (NIERS) and its available tools.	1. Detailed data collected from secondary and tertiary services in addition to routine data collected through the national health information system. 2. Regular data analysis and generation of regular reports
Target 2	The output of national research on mental health is improved and the academic collaboration is ensured on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation.	Starting from 2026	1. A funded national research agenda in the area of mental health, based on consultation with all stakeholders is developed 2. Cooperation between Academia, health and social services and other relevant settings in the field of mental health research has been strengthened. 3. Number of published articles on mental health research in the databases are increased. 4. Collaboration between national, and international research centers is strengthened.	By review of the annual published research articles on mental health in peer-reviewed and indexed journals conducted in the country.
Strategic objective 5: Development of human resources for mental health.				
	Target description	**Time frame**	**Indicators**	**Means of verification**

Target	Increasing the coverage of mental health multidisciplinary human resources.	Starting from 2026	1. The coverage rate of psychiatrists per 100,000 of population increased to at least 3. 2. Availability of multidisciplinary mental health team composed of at least two psychiatrists, one psychologist, three mental health nurses/ psychosocial workers in every mental health unit at general hospitals. 3. Availability of at least one mental health nurse/psychosocial worker in every comprehensive primary health care center. 4. Availability of a well-trained psychosocial worker in every governmental school.	1-Existence of a multidisciplinary mental health team working in every general hospital that have mental health unit, and at least one mental health nurse/psychosocial worker in every comprehensive primary health care center. 2-Existence of a formal mental health screening program for school students at ministry of education.

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