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ESSAY

The Limitations of Deinstitutionalization: The Case of the Israeli-Occupied Palestinian West Bank

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ABSTRACT
This essay examines the concept and limitations of deinstitutionalization as a principle and practice derived from Western paradigms, and how it has been problematically implemented in non-Western settings, including the Israeli-occupied West Bank. It begins by reviewing the international literature on deinstitutionalization of people with mental health illnesses/disabilities. It then examines the Palestinian experience with deinstitutionalization in the West Bank with an eye to its many limitations, in order to propose alternatives to successfully relocate people with mental health disabilities from hospitals to their communities, and to ensure for them a dignified life. The essay ends with an emphasis on this need in the Israeli-occupied Palestinian territories given the ongoing daily reality of Israeli military occupation and apartheid, which have had dire effects on Palestinians' mental health.

KEYWORDS
occupied Palestinian territories; West Bank; Gaza Strip; mental health disability; institutionalization; community care; deinstitutionalization of mental health services

A Historical Perspective

The deinstitutionalization movement did not begin in Europe until the middle of the twentieth century.[1] Prior to that, mental illness[2] was largely treated as a family matter, with confinement of mentally ill persons a rare exception.[3] However, beginning in the nineteenth and through the first half of the twentieth centuries, people with mental illnesses were generally regarded as violent and were thus segregated in large-scale residential care institutions located "at the edge of society."[4] European scientific and medical communities at the time were also focused on curing mental health disabilities, using different treatments and therapies in order to eliminate them.

This began to change in the 1960s, following growing criticism of residential care facilities, which critics argued bred stigmatization.[5] Reports also revealed that medical professionals in psychiatric facilities subjected residents to abusive treatments and poor living conditions,[6] amounting to human rights violations.[7] Interestingly, the nascent deinstitutionalization movement primarily focused on those with mental health illnesses with scarce attention to other types of disabilities. At the same time, proponents of deinstitutionalization believed that new antipsychotic medications would offer a cure.[8] That is, the advent of pharmacotherapy and the introduction of psychotropic medications[9] were thought to have the capacity to cure people from mental illness,[10] or to effectively control symptoms, thus allowing them to reintegrate into society.

Deinstitutionalization was also reported to be linked to the rise of neoliberal ideas.[11] Different Western governments began adopting social and economic policies oriented toward reducing public spending on services and support,[12] including psychiatric care. This was largely motivated by resource constraints and fiscal crises that drove governments to advocate for the less costly alternative of "community care."[13] The rise of market-based approaches to the provision of health services was thus intended to structure welfare provisions so as to reduce expenditures;[14] this meant replacing the idea of entitlement to the provision of services limiting access to state-subsidized healthcare to extreme cases. Yet, the deinstitutionalization paradigm shifted the notion of cure to that of care,[15] promoting the integration of people with mental illness into society whenever possible. This is how the social model of disability challenged medical and pathological views of disability in the 1970s in the UK, Scandinavia, the US, and elsewhere.

This new notion had considerable consequences. For instance, "insanity" became a social problem, with new sociopolitical ideas about disability emerging to counter medicalized approaches, leading to the deinstitutionalization of thousands in nursing homes and hospitals.[16] Mental health institutions became part of a "bygone age," replaced by the provision of care as a communal responsibility.[17] Thus, policies of "resettlement" from hospitals to communities were introduced to supposedly allow those with mental illnesses more personalized care as part of the community, rather than be removed from it.[18] The shift to community care extended beyond Europe and the US, with different countries following suit, including India,[19] South Africa,[20] Brazil,[21] Uzbekistan,[22] and the Israeli-occupied Palestinian territories (the West Bank and Gaza)—albeit with varying degrees of success.

Following a review of the problems of the Western approach to deinstitutionalization, this essay examines the Palestinian experience of deinstitutionalization in the Israeli-occupied West Bank, which was influenced by Western ideologies and funded by the World Health Organization (WHO),[23] the EU,[24] and other international aid and humanitarian organizations.[25] The discussion highlights the problems and limitations of applying this approach to the Palestinian setting, and what needs to be done in order to successfully implement community care for persons with mental disabilities living under Israeli military occupation and apartheid.

Indeed, the case of the West Bank shows that, while the concept of deinstitutionalization has merit, and despite donor-funded programs and initiatives, its implementation is generally problematic and counterproductive. As a case in point, and due to the lack of specialized personnel in so-called resource-poor countries, the WHO produced the Mental Health Gap Action Programme (mhGAP) in 2008, a generalized intervention guide meant to support governments in assessing and managing mental, neurological, and substance-use disorders in the community by nonspecialized primary healthcare (PHC) personnel.[26] Western donors thus did not consider the implementation of deinstitutionalization and community care with an eye to the specific and diverse needs and necessities of different social contexts, including the Israeli-occupied Palestinian territories. As this essay shows, deinstitutionalization in the West Bank has translated into verticalized programming and the dishing out of psychotropic medications at the PHC level, leaving people with mental health disabilities and their families to endure the consequences of the lack of effective support for life outside the hospital and in the community.

The Universal Limitations of Deinstitutionalization

While many countries underwent deinstitutionalization as part of the growing trend in the mid-twentieth century, there was no systematic examination of the effectiveness of community care in the various societies where it was implemented. That is, the idea that it is better to treat people with mental health conditions closer to their families was not examined before deinstitutionalizing, nor was there planning for alternative facilities and services, or for remedying the inadequacies of mental healthcare provision in general.[27] In fact, the Western approach to deinstitutionalization problematically assumed that those with mental illness had sympathetic families with organized and supportive households, and that deinstitutionalized persons would not cause hardship to their families. For example, patients in the US with mental illness were discharged from hospitals into urban communities unable to meet their minimal needs, leading to some being admitted to penal and correctional facilities, and others becoming homeless.[28] These erroneous assumptions of the deinstitutionalization movement were gradually exposed. A 1999 Norwegian study demonstrated that psychiatric problems remained frequent among discharged patients, with a significant increase in behavioral problems in spite of total deinstitutionalization and improved living conditions. In fact, the study concluded that most mental health problems among those discharged were not solved by reorganization or deinstitutionalization, that they had low social contact outside their families, and that they took up minimal activities other than watching television and listening to the radio.[29] Other studies reported barriers to the successful integration of people with mental illnesses and to the scale up of pilot deinstitutionalization projects to cover other communities; this was due to several reasons, including communities rejecting the deinstitutionalization model, inadequate patient follow-up by clinicians, and lack of critical resources.[30] Furthermore, a 2001 report found that some societies considered community care as a failure due to the increase in the number of deinstitutionalized patients living on the streets; they rejected the closure of mental institutions and assumed people with mental disability to be violent.[31]

A series of other studies also concluded that deinstitutionalization did not account for class differences. In other words, they demonstrated how the community-based approach benefitted the middle class with less severe illnesses, leaving lower-income people and those with severe mental illnesses with inadequate services and difficulties integrating into the community.[32] Indeed, the rhetoric of deinstitutionalization and community care concealed the reality that those with serious mental illness were, in fact, abandoned.[33] Importantly, the literature does not sufficiently raise the issue of the association of homelessness with poverty, and not only among those with mental illnesses, nor the fact that addressing homelessness can bring about major improvements in communal living for those with and without mental illnesses. Likewise, the literature does not address the problem that women tend to disproportionately bear the brunt of caring for deinstitutionalized persons at home.

Thus, the deinstitutionalization paradigm has suffered—and continues to suffer—from many problems, impeding the effective transition of those with mental illness to community care. Another major problem was the failure to establish alternatives to mental health facilities before institutional closure. Community care was simply thought to be enough to successfully reintegrate deinstitutionalized persons. Yet, among the various essentials needed for successful community care before total institutional closure is ensuring housing and daycare facilities for those who are sent back to their communities,[34] and whose families need assistance in

taking care of them. In fact, long-term housing facilities are required for those who need ongoing residence, and this should take the form of small group homes integrated in the community instead of large institutions.[35] Furthermore, community support workers must be trained and supervised,[36] as must doctors, nurses, social workers, and teachers[37] at the PHC level. All this requires necessary resources, not easily found in times of financial austerity and especially under Israeli military occupation.[38]

To be sure, the notion of institutionalization is complex, and is not about simply reducing hospitalization or the number of psychiatric beds.[39] It must be coupled with improvements in the quality of care in hospitals while simultaneously increasing access to quality care services in community settings, both for those with mental illnesses and their families. Addressing employment and housing among people with mental illnesses is crucial in this regard; otherwise, it risks contributing to their re-institutionalization, known as the revolving door syndrome.[40] There is also the necessity of destigmatizing mental illness in many communities.[41] If such preconditions are not met, community care risks turning into selective and verticalized programming of medication distribution. In fact, this has already occurred in different communities,[42] prompting some to call for building better state-run hospitals given that deinstitutionalization has failed.[43] These are only some of the limitations of the deinstitutionalization process that have largely gone unaddressed, including in the Israeli-occupied West Bank.

Deinstitutionalization in the West Bank

Arab societies, including Palestine, have historically been described as being tolerant of those with mental illnesses relative to their Western counterparts, with a long tradition of caring for them in hospitals and within the community.[44] That is, scholars have shown that unless violent, at which point confined to the home, people with mental illnesses were generally not excluded from public spaces in Arab societies.[45] While this is arguably a romanticized description that does not take into consideration the burden on families, especially women, in caring for those with mental illnesses at home, it is nevertheless a contrast to the historical condemnation and exclusion of those with mental illness in Western societies.[46] However, this changed with the advent of European colonialism in the Middle East and North Africa in the nineteenth and early twentieth centuries, and in Palestine specifically, with the establishment of the British Mandate in 1922. Indeed, the British colonial administration immediately opened a governmental hospital for the mentally ill in Bethlehem in 1922.[47] Modeled after the British system, the new hospital was to admit what British authorities called "lunatics," thus introducing coercive European psychiatric policies and practices, including confinement, to Palestine, as was happening in other societies colonized by European powers.[48] The establishment of the psychiatric hospital in Bethlehem may have been patterned after the psychiatric Bedlam Hospital in London, which was founded in 1247 and known at the time as the Priory of St. Mary of Bethlehem.[49] This suggestion, however, requires further investigation.

The policy of confinement continued during the period of Jordanian annexation of the West Bank between 1950 and 1967, following the dismemberment of Palestine and the exile of more than 700,000 Indigenous Palestinians as a result of the 1948 Nakba.[50] This policy also continued upon Israel's occupation of the West Bank and Gaza Strip in 1967.[51] While Israel implemented mental health reforms during the 1980s to deliver comprehensive mental health services at the community level within Israel proper,[52] it did not extend these services to the

occupied Palestinian territories (oPt), despite the fact that, as a military occupier, it is responsible under international law for the health of those under its rule. Palestinians in the West Bank and the Gaza Strip have thus received limited psychiatric outpatient services under Israeli military occupation.

The need for mental healthcare in the oPt became particularly evident after the second intifada of 2000, which lasted over four years. Reports indicate that there was an increase in affective disorders and neuroses among Palestinians in the West Bank and Gaza Strip during this period, which reflected the deterioration in the quality of life as a result of ongoing exposure to severe Israeli military aggression and targeted killings.[53] The WHO conducted an initial assessment in 2001,[54] the results of which led to a joint Franco-Italian strategic plan to deinstitutionalize mental health services in the West Bank and Gaza Strip, and to house those with mental illness in community. As in 1922, psychiatric policies produced in the West were thus imposed on the Palestinians, marking the arrival of the deinstitutionalization paradigm into a society devastated by ongoing Israeli military occupation and in the midst of an uprising against it.

Between 2002 and 2003, the Franco-Italian humanitarian initiative formulated a mental health policy for the West Bank and Gaza Strip,[55] and by 2004, with the financial and technical support of international donors, the Palestinian Ministry of Health signed an agreement with WHO and other international donors to reorganize mental health services in the West Bank and Gaza Strip. In line with Western approaches, the plan aimed to deinstitutionalize mental health services in the oPt, redistribute mental health resources, and provide a comprehensive local mental health service system based on the establishment of community mental health teams and centers, acute inpatient beds, daycare services, specialized services for children, and specialized care for the elderly. In the West Bank alone, ten community mental health centers were subsequently established, staffed by mental health teams.[56]

But the inconsistent and highly politicized nature of international aid to the oPt has taken its toll on the Palestinian health sector, including mental health. Following a scarcity in funds beginning in 2006, which deprioritized community mental health and training mental health professionals,[57] the EU and WHO introduced a three-year program in 2007 to move the community mental health scheme forward in the oPt. In the West Bank, the 2007 plan entailed moving away from inpatient hospital services and toward the establishment of community mental health centers in every city.[58] As a result, the Bethlehem Psychiatric Hospital began to be downsized—from 280 to roughly 180 beds by 2010.[59] Meanwhile, WHO signed another three-year agreement with the EU to continue its financial and technical support in the oPt. It was expected that by 2015, mental healthcare would have been integrated into PHC, programs against stigma and discrimination would have been established, and mental health professionals trained, monitored, and evaluated. By 2013, there were thirteen community mental health centers operating in the West Bank.[60] However, community mental health services continued to face interruptions in the flow of funds; the staff were generally overworked and overloaded with patients; and there was a shortage of medications. To make matters worse, the staff had limited opportunities for continuing education.

As of the middle of 2023, the Bethlehem Psychiatric Hospital in the West Bank contains 180 beds. However, forty of them are apparently not in operation because of a reported lack of trained medical staff. In addition, the hospital suffers from ineffective service provision, especially the needed coordination with community mental health centers. This is because

the hospital is managed by the director of all hospitals at the Palestinian Ministry of Health, while the community mental health centers are managed by the director of the mental health unit at the Ministry of Health, making effective coordination of policies, plans, interventions, and especially supervision of staff, a problem. This is due to serious coordination and communication difficulties between and within Palestinian Authority (PA) institutions.

Moreover, as of the middle of 2023, fourteen community mental health centers are in operation in the West Bank, according to officials in the Palestinian Ministry of Health.[61] These provide patients with psychiatric care and medications, the main strands of community mental healthcare in operation in these clinics. In addition to doctors and nurses, there are two staff members trained at the general and nonspecialized bachelor's degree level—one in social work and another in psychology—who provide basic counseling services to patients, but they, too, lack the financial and technical support needed for effective patient management. Furthermore, there are no resources available for professional development or continuing education, nor for proper supervision of staff. Other essential programs are not available but needed for effective and sustainable community care, such as rehabilitation and occupational therapy services, combatting stigma in the community, addressing poverty, education, and employment, and dealing with the housing crisis. Accordingly, despite efforts by the Palestinian Ministry of Health to develop its mental health strategy,[62] there are significant obstacles—mostly but not solely financial—that would prevent the implementation of this and many other strategies.[63]

In addition to the Bethlehem Psychiatric Hospital and the community mental health centers, there are smaller-level institutions that deal with the needs of the elderly and people with disabilities. An unofficial report published by a Palestinian media outlet indicates that there are thirty-one institutions in the West Bank that primarily care for the elderly.[64] Distressingly, these institutions reportedly also provide shelter for the homeless, including youth with physical disabilities, children with mental disabilities, Alzheimer's patients, orphaned children, among others. Of those facilities, thirteen are shelters housing people day and night, and the rest provide daycare services, home services, and counseling services. Otherwise, not much is known about these institutions, which calls for urgent further investigation.

In addition, ninety-six local and seventeen international institutions in the West Bank[65] report that they provide a range of support services for people with disabilities, with many offering psychosocial mental health services that sometimes turn into band-aid solutions, failing to adequately address the profound mental health problems Palestinians face on a daily basis as a result of Israel's apartheid military occupation. Fundamentally, a political cause of trauma and mental illness requires a political resolution. Indeed, Palestinians need justice, freedom, and self-determination instead of therapies. Be that as it may, most of these institutions provide daycare services as opposed to overnight housing for people with disabilities. We do not know much about these institutions, whether their programs are continuous or come and go with the vagaries of international aid and the priorities of donor governments and organizations. Likewise, very little is known about institutions primarily caring for the elderly, reiterating the need for a systematic investigation into all institutions providing mental health services to people with disabilities in order to properly map the mental health landscape in the West Bank and Gaza Strip.

Undeniably, the story of deinstitutionalization in the oPt is complex, multifaceted, and entangled with the involvement of various international institutions assisting a weak PA accused of corruption, cronyism, and mismanagement; it is even described as toothless.[66]

Indeed, PA operations are highly constrained by Israeli occupation forces who dominate every aspect of Palestinians' lives, including access to land, water, and other essential resources, in addition to continually exposing them to military violence and trauma.[67] All these factors, including unreliable funding that generally dictates what should be done in the oPt without due regard to context and culture, make it difficult to implement sustainable mental health programs, despite the efforts of international organizations and other local initiatives. And since the turn to deinstitutionalization has been primarily influenced by Western knowledge production, so, too, have the approaches, financial aid, and technical support of international groups in the oPt.

This, in itself, may not be a problem if all the other requirements for effective and sustainable implementation are met after donor aid ends. In reality, however, the reduction in international financial support of deinstitutionalization of mental health services in the West Bank and Gaza Strip has negatively affected community-based mental health programs. Indeed, what was designed to support the establishment of community-based mental health programs in the oPt, with the support of the EU, the WHO, and the French and Italian governments, has ended up a program of medication distribution at the community level in the West Bank.

Conclusion

Mental health services and programs in the West Bank are under-resourced, under-researched, and underfunded, even disheveled, with the involvement of too many international groups implementing problematic Western paradigms which often have limited effectiveness in the Palestinian context of ongoing Israeli settler colonization, military occupation, and apartheid. This essay thus highlights the importance of a systematic investigation to first determine what is being done, by whom, how, and for whom; and second, to understand the problems and limitations of the deinstitutionalization model in order to ensure that its implementation is compatible with what is needed.

This essay also raises questions as to what role, if any, the PA can play in providing for and protecting people with mental health illnesses in the West Bank. It further raises the question of the type of social contract Palestinians and the PA can negotiate to delineate rights and responsibilities, and where people with mental illness and other disabilities should fall within such a framework. Without effective long-term resource provision to ensure that the different aspects of community-based care programs are implemented effectively and continuously, they run the risk of creating more adverse conditions for Palestinians with disabilities, especially mental health disabilities. And this is precisely why it is critical to carry out an investigation[68] into the field with an eye to understanding the needs and priorities of local communities first and foremost.

Finally, as this essay has shown, the Western concept that people with mental illness should live in the community[69] has ultimately not worked in the Israeli-occupied West Bank, just as it has not worked in "free" and prosperous cities in the United States. When the initiative in the West Bank was supported financially and otherwise by international donors, it showed promise despite the limits of its Western foundations, with daycare facilities and other programs established to assist people with mental illness and their families. However, under oppressive Israeli military occupation, Palestinians' access to this critical financial support is interrupted and unreliable. Indeed, once financial support dried up, the deinstitutionalization

program in the West Bank quickly turned into one of medication provision with little programmatic support. Likewise, there were no longer resources for the professional development and continuing education of trained staff, nor for the adequate supervision of staff. Importantly, this is due first and foremost to the structural deficits imposed daily on Palestinian society by Israel's military occupation and apartheid policies. That is, before any deinstitutionalization paradigm, Western or otherwise, can be implemented in the oPt, and before they can begin to properly address their mental health, Palestinians first need freedom, sovereignty, and self-determination.

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Rita Giacaman is professor of public health at the Institute of Community and Public Health, which she founded in 1978 at Birzeit University, in the Israeli-occupied West Bank. As a researcher and practitioner, Giacaman played an important role in the development of the Palestinian primary healthcare model, in the establishment of the first women's health program, and in building the Palestinian community-based disability rehabilitation network. Her ongoing work entails the development of measures to assess context-appropriate psychosocial health programs to generate capacity to endure and resist ongoing war-like conditions, especially among youth.

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