

Mental Health System in Egypt

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INTRODUCTION

The WHO requested from the general secretariat of mental health of Egypt to share in the WHO-AIMS project. This project aimed to collect information on the mental health system of Egypt using the World Health Organization System (WHO-AIMS). The project was supported by the WHO Country Office in Egypt, the regional office for the Eastern Mediterranean (EMRO), Cairo; the WHO head quarters as well the WHO-AIMS team. It took time and effort to accomplish this task. For that reason, we judged that it is mandatory to provide the whole document for our colleagues to get benefit of it. We thank the editors of the Egyptian Journal of Psychiatry for hosting the document. I have to thank also my colleagues who assisted me in the production:

- Dr. Sawsan Mourad, Training coordinator in the general secretariat of the mental health
- Professor Zeinab Lotfy, Dean of Nursing Faculty, Ain Shams University
- Dr Ahmed Youssef, Director of mental health in the MOHP
- Dr Ahmed Heshmat, Head of the Finish Project for Upgrading Mental health services in Egypt.

Finally, it is worthful to mention that the document is available at the following website:

http://www.wlio.mt/mental_health/evidence/WHO-AIMS/en/index.htm/

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The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system of Egypt.

The project in Egypt was implemented by the WHO-AIMS country team composed by: Mohamed Ghanem, Professor of Psychiatry, Ain Shams University and previous general secretary of mental health of Egypt; Sawsan Mourad, Training coordinator in the general secretariat of mental health; Zeinab Lotfi, Dean of Nursing Faculty, Ain Shams University; Ahmed Youssef, Director of mental health in the Ministry of Health and Ahmed Heshmat, Head of the Finnish project for

upgrading mental health services in Egypt. The project was supported by WR Z.S. Hallaj (a.i.), the WHO Representative, WHO Country Office Egypt.

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The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to WHO-AIMS (WHO, 2005) for full information on the development of WHO-AIMS at the following website. <http://www.who.int/mentalhealth/evidence/WHO-AIMS/en/index.html>. The project received financial assistance and/or seconded personnel from: The National Institute of Mental Health (NIMH) (under the National Institutes of Health) and the Center for Mental Health Services (under the Substance Abuse and Mental Health Services Administration [SAMHSA]) of the United States; The Health Authority of Regione Lombardia, Italy; The Ministry of Public Health of Belgium and The Institute of Neurosciences Mental Health and Addiction, Canadian Institutes of Health Research.

The WHO-AIMS team at WHO Headquarters includes: Benedetto Saraceno, Shekhar Saxena, Tom Barrett, Antonio Lora, Mark van Ommeren, Jodi Morris, Anna Maria Berrino and Grazia Motturi. Additional assistance has been provided by Danielle Barnett, Alexandra Isaksson, and Zainab Jabur.

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EXECUTIVE SUMMARY

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Egypt. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Egypt to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

A mental health policy and plan, as well as mental health legislation exist in Egypt. An emergency and disaster plan for mental health are currently being developed. In 2004, 2% of the governmental health expenditure was directed towards mental health. The majority of mental health funding is directed towards mental hospitals (59%). All mental disorders and all mental health problems of clinical concern are covered in social insurance schemes. At least 80% of the population has free access to essential psychotropic medicines. A national human rights review body exists. A national mental health authority exists which provides advice to the government on mental health policies and legislation.

There are 62 outpatient mental health facilities available in the country, of which 2 are for children and adolescents only. In 2004, these facilities treated 254 users per 100,000 general population. Female users make up over 50% of the population in all mental health facilities in the country. The proportion of female users is highest in outpatient facilities and mental hospitals and lowest in inpatients units.

The majority of beds in the country are provided by mental hospitals (9.12 beds per 100,000 population), followed by forensic units (1.04, beds per 100,000 population), and community-based inpatient psychiatric units (0.94 beds per 100,000 population). No beds in mental hospitals are reserved for children and adolescents only. There has been an increase in the

number of mental hospital beds in the last 5 years. The density of psychiatric beds in or around the largest city is 3.17 times greater than the density of beds in the entire country.

The distribution of diagnoses varies across facilities: in outpatient facilities mood disorders are most common whereas in inpatient facilities and mental hospitals schizophrenia has the highest prevalence. Psychotropic drugs are most widely available in mental hospitals, followed by outpatient units, and then inpatient mental health facilities. Most of mental health facilities are present in or near large cities. In order to promote equity of access to mental health services, Egypt is encouraging the development of community-based psychiatric units and outpatient facilities in each catchments area throughout the country.

Five percent of the training for medical doctors is devoted to mental health, in comparison to 10% of the training for nurses. In terms of refresher training, 5% of primary health care doctors have received at least two days of refresher training in mental health, while 1% of nurses and 6% of non-doctor/non-nurse primary health care workers have received such training. In terms of physician-based primary health care clinics, less than 20% have assessment and treatment protocols for key mental health conditions available. None of the physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category available in the facility or in a near-by pharmacy. However, at least one psychotropic medicine of each therapeutic category is available in mental hospitals or in a near-by pharmacy.

The total number of human resources working in mental health facilities per 100,000 populations is 4.98. There are 1.44 psychiatrists and 0.11 psychologists per 100,000 populations. In terms of staffing in mental health facilities, there are 0.17 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.07 psychiatrists per bed in mental hospitals. The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 1.6 times greater than the density of psychiatrists in the entire country. The density of nurses is 3 times greater in the largest city than the entire country.

In Egypt, there are no consumer or family associations of persons with mental disorders. There is a coordinating body, the General Secretariat of Mental Health, to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations, and international agencies have promoted public education and awareness campaigns in the last five years. While 97% of primary and secondary schools have either a part-time or full-time health professional, only about 1% of these professionals are trained in mental health.

Because of a new policy regarding mental health of school children, psychologists and social workers are being trained in mental health promotion and prevention programs. Regarding mental health activities in the criminal justice system, no prisons have at least one prisoner per month in treatment contact with a mental health professional. In terms of financial support for users, less than 20% of mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, 33% of people who receive social welfare benefits do so for a mental disability.

A formally defined list of individual data items that ought to be collected by all mental health facilities exists; however, the extent and completeness of the data collection is variable among mental health facilities (e.g. 100% of outpatient facilities collected data on the number of user contacts, while only 24% of outpatient facilities collected data on diagnoses). Of all health related research, 4% is conducted on mental health.

WHO-AIMS REPORT FOR EGYPT Introduction:

Egypt is located on the northeast corner of the African continent. It is bordered by Libya to the west, Sudan to the south, the Red Sea to the east, and the Mediterranean Sea to the north. The total area of the country covers approximately one million square kilometers. However, much of the land is desert and only 6% of Egyptian's area is inhabited. The main language used in country is Arabic - religious groups include Muslims and Catholics.

The population size in 2004 was 69.330 million of which 57.5% live in rural areas; 24.2% is less than 15 years of age, 61.7% is 15-64 years of age; and 4.1% is above 64 years of age. The life expectancy at birth for males is 66 years and 70 years for females. The healthy life expectancy at birth (2002) males is 57.8 and 60.2 for females. Literacy rate is 55.6% (WHO, 2004). Total health expenditure as percent of GDP (2003) is 5.8; per capita expenditure on health is US\$ 235. The number of primary health care physicians is 10.5 per 100,000 general population. These physicians work in 4,524 physician based primary health care units.

The budget of health system represents 3.4% of annual total budget, of which 2% is provided to mental health sector. This is insufficient for mental health services for managing and preventing mental disorders. There are two systems in the Egyptian Ministry of Health and Population MOHP which manage mental health. The first one is the general secretariat of mental health that manages the five major mental hospitals (Abbaseya, Khanka, Maamoura, Heliopolis, Helwan). The second is the general administrative for mental health in MOHP, which manages the other 10 mental hospitals, outpatient clinics all over the country and psychiatric departments in general hospitals. The second system is under the control of local authorities of each governorate.

There is a disproportionate distribution of mental health facilities and services between urban and rural areas, as they are more prevalent in urban areas (especially in large cities) than in rural areas. They are deficient in areas such as Sinai, Matrouh, Hurghada, and New Waadi. In addition, there is a deficiency of community and preventive mental health services all over the country. There are no residential facilities or users and family associations for people with mental disorders. Still, we need a lot of resources from governmental organizations and NGO's to properly support mentally ill people and their families.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Egypt's mental health policy was last revised in 2003 and includes the following components:

1. organization of services, developing community mental health services, reforming mental hospitals to provide more comprehensive care and developing a mental health component in primary health care;
2. human resources;
3. involvement of users and families;
4. advocacy and promotion;
5. human rights protection of users;
6. equity of access to mental health services across different groups;
7. financing;
8. quality improvement; and
9. a monitoring system. In addition, a list of essential medicines is present.

These medicines include:

1. antipsychotics,
2. anxiolytics,
3. antidepressants,
4. mood stabilizers,
5. antiepileptic drugs.

The last revision of the mental health plan was in 2003. This plan contains the following components,

1. Organization of services: developing community mental health services, reforming mental hospitals to provide more comprehensive care and developing a mental health component in primary health care,
2. Human resources,
3. Involvement of users and families,
4. Advocacy and promotion,
5. Human rights protection of users,
6. Equity of access to mental health services across different groups,
7. Financing,
8. Quality improvement, and
9. Monitoring system. In addition, budget, timeframe and specific goals are mentioned in the last mental health plan. Many of the goals identified in the last mental health plan have been reached within the last calendar year. There is no emergency/disaster

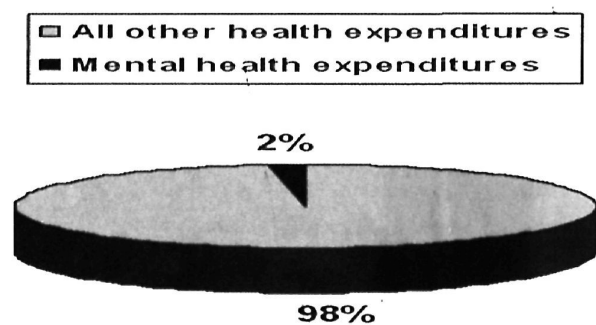
preparedness plan for mental health, but one is being developed.

The last piece of mental health legislation was enacted in 1944, which focused on:

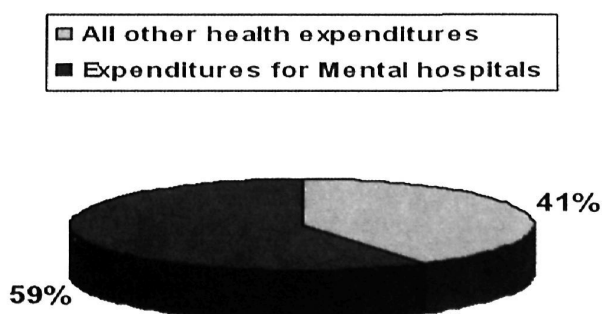
1. access to mental health care including access to the least restrictive care;
2. competency, capacity, and guardianship issues for people with mental illness;
3. voluntary and involuntary treatment;
4. law enforcement and other judicial system issues for people with mental illness;
5. mechanisms to oversee involuntary admission and treatment practices; and
6. mechanisms to implement the provisions of mental health legislation. Several meetings were held with experts, users, and family members to consider updating the legislation.

Financing of mental health services

Two percent of health care expenditures by the government health department are devoted to mental health (Graph 1.1). Of all the expenditures spent on mental health, 59% are devoted to mental hospitals (Graph 1.2).



Graph 1.1: Health Expenditure towards Mental Health



Graph 1.2: Health Expenditure towards Mental Hospitals

At least eighty percent of the population has free access to essential psychotropic medicines. For those that pay out of pocket, the cost of antipsychotic medication is 3% of the one day minimum wage in the local currency. The cost of antidepressant medication is 5% of the daily minimum wage. All mental disorders and all

mental health problems of clinical concern are covered in social insurance schemes.

Mental health finance is insufficient to cover the costs of mental health services. NGOs and community leaders share in the support and the improvement of mental health services. Resources from international organizations like WHO and from other countries also help to support the mental health system in Egypt.

Human rights policies

A national human rights review body exists, which has the authority to:

1. oversee regular inspections in mental health facilities;
2. review involuntary admission and discharge procedures;
3. review complaints investigation processes;
4. impose sanctions (e.g. withdraw accreditation, impose penalties, or close facilities that persistently violate human rights). Seven percent of mental hospitals had at least one review/inspection of human rights protection of patients in 2004. Thirty three percent of mental hospitals have had at least one day training on human rights protection of patients in the last two years. To address this issue, quality control teams have been developed in mental hospitals to provide continuous training on these issues..

Domain 2: Mental Health Services

Organization of mental health services

A national mental health authority exists which provides advice to the government on mental health policies and legislation. The mental health authority also is involved in (a) service planning, (b) service management and co-ordination, (c) monitoring and quality assessment of mental health services. Mental health services are organized in terms of catchment areas. There are no mental health facilities in some areas. However, residents in those areas that are not covered by basic mental health services have access to services in adjoining regions.

Mental health outpatient facilities

There are 62 outpatient mental health facilities available in the country, of which 2 are for children and adolescents only. In 2004, these facilities treated 176,133 users (254 users per 100,000 general population). Of all users treated in mental health outpatient facilities, 34% are female and 12% are children or adolescents. A database that includes diagnosis is currently being developed but it was not yet able to provide information for this report. To estimate the diagnoses of users treated in outpatient facilities we examined a sample (1800 cases; 10% of the total) of patients attending the outpatient clinic of Abbasya hospital and other community-based psychiatric inpatient units. The users treated in outpatient facilities are primarily diagnosed

with neurotic stress disorders (30%), schizophrenia and other psychotic disorders (25%). The average number of contacts per user is 5.4.

One outpatient facility provides follow-up care in the community, and one has a mental health mobile team. In terms of available interventions, the majority (51-80%) of users have received one or more psychosocial interventions in the past year. Eighty four percent of mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or in a near-by pharmacy all year round.

Day treatment facilities

There are two day treatment facilities in the country, none of which treat children and adolescents only. These facilities treat 5,917 users (8.5 per 100,000 general population). Of all users treated in day treatment facilities, 25% are female. On average, users spend 37.46 days in day treatment facilities. Day treatment is provided in two mental hospitals and will be implemented in other mental hospitals later. In 2005, one mental hospital started a day treatment program for children.

Community-based psychiatric inpatient units

There are 27 community-based psychiatric inpatient units available in the country for a total of 646 beds (0.94 beds per 100,000 population). Forty percent of admissions to community-based psychiatric inpatient units are female. No beds are available for children and adolescents. The diagnoses of admissions to community-based psychiatric inpatient were primarily from the following two diagnostic categories: neurotic disorders (19%) and schizophrenia (34%). These figures are estimations of diagnoses based upon a representative sample (720 cases; 10%) of cases treated in psychiatric inpatients units.

On average, patients spend 44 days per admission. The majority (51 - 80%) patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year. Eighty one percent of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community residential facilities

In Egypt, there are no community residential facilities for patients with mental disorders. The possible reasons for this include stigma related to mental illness, lack of trained working personnel and lack of funding.

Mental hospitals

There are 1.5 mental hospitals in the country with a total of 6,324 beds (9.12 beds per 100,000 population). AH

of these hospitals are organizationally integrated with mental health outpatient facilities. No beds in mental hospitals are reserved for children and adolescents only. The number of beds has increased by 25% in the last five years. The number of patients in mental hospitals in the year of assessment was 23,047, 40% of which were women. The patients admitted to mental hospitals are mainly diagnosed under two diagnostic categories: Schizophrenia and other psychotic disorders (73%) and mood (affective) disorders (11%). These figures are estimated based upon a sample (1134 cases; 25%) of patients treated at Abbassia hospital, which is fairly representative of mental hospitals in Egypt.

The average number of days spent in mental hospitals is 66.82. The majority (51-80%) of patients in mental hospitals received one or more psychosocial interventions in the last year. One hundred percent of mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Accurate data regarding the length of stay of patients in mental hospitals is difficult to estimate due to a large patient population and high turnover of patients. A database for all mental hospitals to track this type of data is being developed.

Forensic and other residential facilities

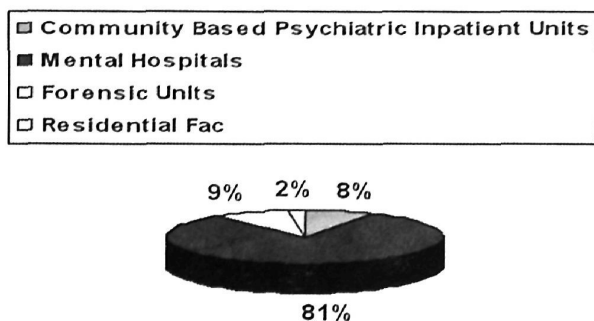
In addition to beds in mental health facilities, there are also 725 beds for persons with mental disorders in forensic inpatient units and 115 beds in other residential facilities e.g. detoxification inpatient facilities. In forensic inpatient units, 14% of patients spend less than one year, 31% of patients spend 1-4 years, 21% of patients spend 5-10 years, and 26% of patients spend more than 10 years.

Human rights and equity

One hundred percent of all admissions to community-based inpatient psychiatric units and 100% of all admissions to mental hospitals are involuntary. Because of lack of beds in mental hospitals, our priority is for psychotic patients and emergencies so patients with neurosis and other conditions are treated in outpatient facilities. The density of psychiatric beds in or around the largest city is 3.17 times greater than the density of beds in the entire country. Such a distribution of beds limits access for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

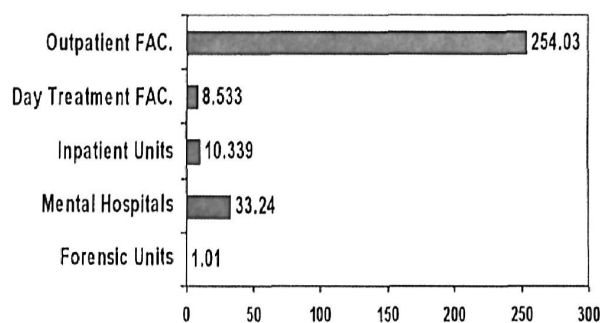
Summary Charts

The majority of beds in the country are provided by mental hospitals, followed by forensic units and community based inpatient psychiatric units inside the mental health system (Graph 2.1).



Graph 2.1: Beds in Mental Health Facilities and Other Residential Facilities

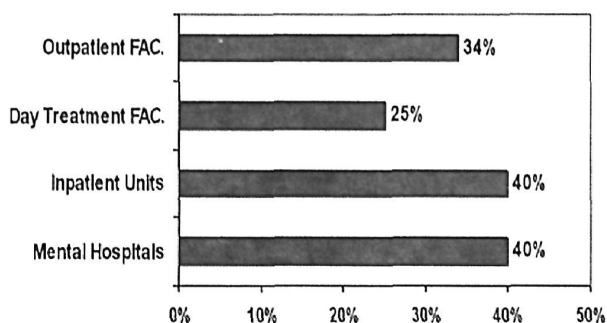
The majority of users are treated in outpatient facilities and in mental hospitals while the rate of users treated in inpatient units and day treatment facilities is lower (Graph 2.2).



Graph 2.2: Patients Treated in Mental Health Facilities (rate per 100,000 population)

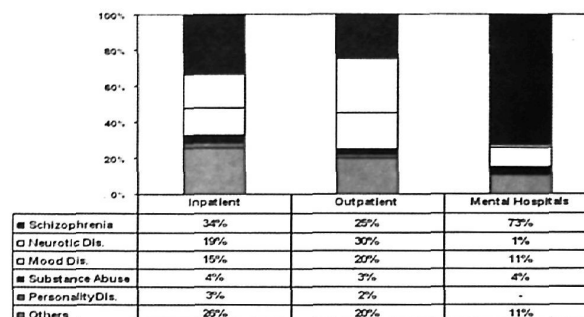
Note: In this graph the rate of admissions in inpatient units is used as proxy of the rate of users admitted in the units.

Female users make up less than 50% of the population in all mental health facilities in the country. The proportion of female users is highest in outpatient facilities and mental hospitals and lowest in inpatients units (Graph 2.3).



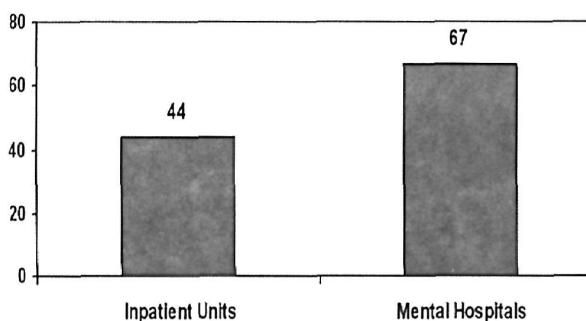
Graph 2.3: Percentages of Females Users Treated in Mental Health Facilities

Note: In this graph the percentage of female users' admissions in inpatient units is used as proxy of the percentage of women admitted in the units.



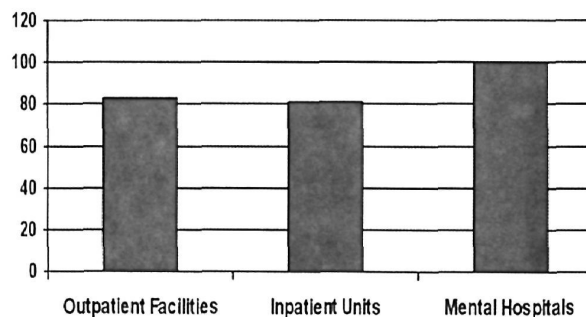
Graph 2.4: Patients Treated in Mental Health Facilities by Diagnosis
Note: In Graphs 2.4, 2.5, and 2.7, the percentage of admissions in inpatient units is used as proxy of the percentage of users in the units. These data are estimations based upon representative samples taken from the patient populations of these facilities.

The length of stay for users in mental hospitals is longer than in community based units (Graph 2.5).



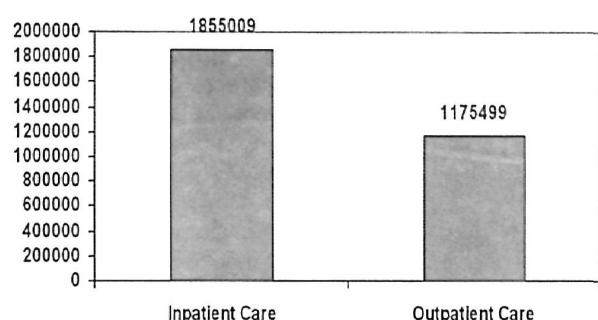
Graph 2.5: Length of Stay in Inpatient Facilities (days per year)

Psychotropic drugs are mostly widely available in mental hospitals, followed by outpatient units, and then inpatient mental health facilities (Graph 2.6).



Graph 2.6: Availability of Psychotropic Drugs in Mental Health Facilities

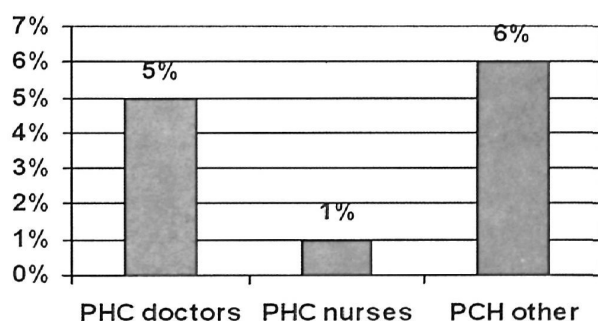
The ratio between days spent in all the inpatient facilities (mental hospitals and general hospital units) and outpatient/day care contacts is an indicator of extent of hospital care: in this country the ratio is 1, 6:1 (Graph 2.7).



Graph 2.7: Inpatient Care versus Outpatient Care

Domain 3: Mental Health in Primary Health Care Training in mental health care for primary care staff

Five percent of undergraduate training for medical doctors is devoted to mental health, in comparison to 10% of training for nurses. In terms of refresher training, 5% of primary health care doctors have received at least two days of refresher training in mental health, while 1% of nurses and 6% of non-doctor/non-nurse primary health care workers have received such training (Graph 3.1). Six-week workshops for training primary health care nurses and doctors were conducted between July 2004 and September 2005 in the following cities: Cairo, Charbia, Sharkia, Dakahlia, Kalyoubia, Kafr el Sheikh, Port Said, Menoufia, Suez, and Ismalilia. A total of approximately 516 doctors and 656 nurses participated in the training workshops. There will be an expansion of training of primary health care (PHC) staff in mental health as such a component was included in basic benefit package of PHC services.



Graph 3.1: % of Primary Care Professionals with at Least 2 Days of Refresher Training In Mental Health in the Last Year

Mental health in primary health care

All PHC clinics are physician based. In terms of physician-based primary health care clinics, a few (less than 20%) have assessment and treatment protocols for key mental health conditions available. A few (less than 20%) of physician-based primary health care doctors make on average at least one referral per month to a mental health professional. In terms of professional interaction between primary health care staff and other care providers, a few (less than 20%) primary care doctors have interacted with a mental health professional at least once a month in

the last year. None of physician-based PHC facilities and mental health facilities has had interaction with a complimentary/alternative/traditional practitioner.

The patients, especially from rural areas, often go to traditional and religions healers before or after seeking medical advice from the health system. This trend is difficult to study especially with regards to patients who use the health system in parallel with traditional ways.

Prescription in primary health care

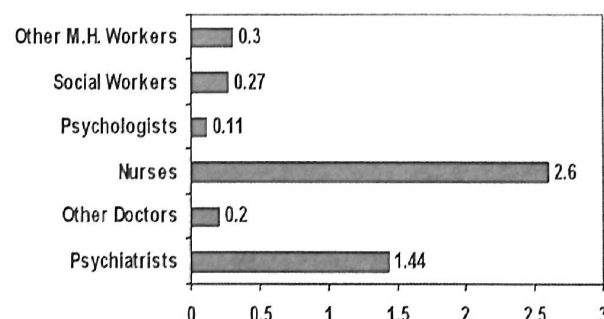
Primary health care (PHC) doctors are allowed to prescribe psychotropic medicines but with restrictions. PHC nurses and non-doctor/non-nurse PHC workers are not allowed to prescribe psychotropic medications in any circumstance.

PHC doctors are allowed to prescribe imipramine for management of depression and anxiety and chlorpromazine in case of emergencies. Only with additional specialized training in mental health are they allowed to prescribe more psychotropic medication. None of the physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

Domain 4: Human Resources

Number of human resources in mental health care

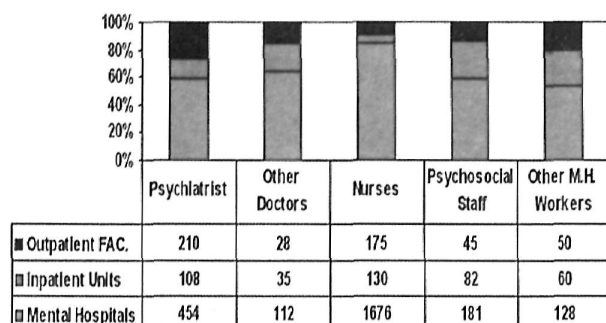
The total number of human resources working in mental health facilities per 100,000 population is 4.98. The breakdown according to profession is as follows: 1000 psychiatrists (1.44 per 100,000 population), 147 other medical doctors, not specialized in psychiatry (0.2 per 100,000), 1,806 nurses (2.6 per 100,000), 75 psychologists (0.11 per 100,000), 188 social workers (0.27 per 100,000), and 238 other health or mental health workers (0.3 per 100,000), including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors (Graph 4.1).



Graph 4.1: Human Resources In Mental Health (rate per 100,000 population)

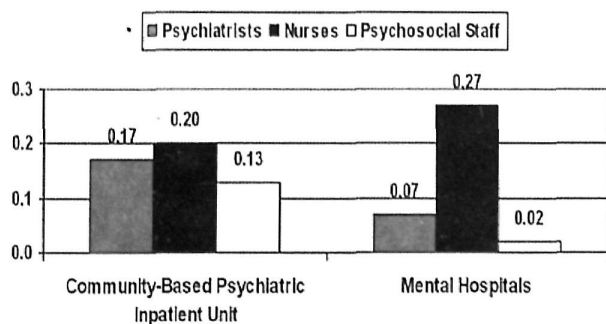
Regarding the workplace, 210 psychiatrists work in outpatient facilities, 108 in community-based psychiatric inpatient units and 454 in mental hospitals.

As for other medical doctors not specialized in mental health, 28 work in outpatient facilities, 35 work in community-based psychiatric inpatient units and 112 in mental hospitals. As for nurses, 175 work in outpatient facilities, 130 in community-based psychiatric inpatient units and 1,676 in mental hospitals. Forty five psychosocial staff (psychologists, social workers and occupational therapists) work in outpatient facilities, 82 in community-based psychiatric inpatient units and 181 in mental hospitals. Finally, for other health or mental health workers, 50 work in outpatient facilities, 60 work in community-based psychiatric inpatient units and 128 work in mental hospitals (Graph 4.2).



Graph 4.2: Staff Working In Mental Health Facilities (percentage in the graph, number in the table)

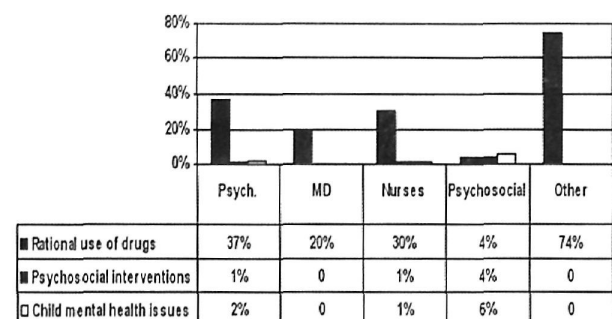
In terms of staffing in mental health facilities, there are 0.17 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.07 psychiatrists per bed in mental hospitals. As for nurses, there are 0.2 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.27 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists) 0.03 per bed in mental hospitals and 0.13 per bed in community-based psychiatric inpatient units. The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 1.6 times greater than the density of psychiatrists in the entire country. The density of nurses is three times greater in the largest city than the entire country.



Graph 4.3: Average Number of Staff Per Bed

Training professionals in mental healthThe number of professionals graduated last year in academic and

educational institutions is unknown. The proportions of mental health staff that attended refresher training on the rational use of drugs is as follows: 37% of psychiatrists, 15% of other medical doctors, 28% of nurses, 40% of other health and mental health workers. Only 1% of psychiatrists, 1% of nurses and 4% of psychologists, social workers and occupational therapists had refresher training on psychosocial interventions. Finally, 2% of psychiatrists, 1% of nurses and 6% of psychologists, social workers and occupational therapists had refresher training on child and adolescent mental health issues in the last year.



Graph 4.4: Percentage of Mental Health Staff with Two Days of Refresher Training in the Past Year

Psych = psychiatrists; MD = other medical doctors not specialized in psychiatry; psychosocial= psychologists, social workers, and occupational therapists; Other= other health and mental health workersConsumer and family associationsNo consumer and family associations of persons with mental disorders exist in Egypt.

Domain 5: Public education and links with other sectors

Public education and awareness campaigns on mental health

There is a coordinating body, the General Secretariat of Mental Health, to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations, and international agencies have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the general population, children, adolescents and women. In addition, there have been public education and awareness campaigns targeting professional groups including health care providers, teachers, social services staff, and leaders and politicians.

Legislative and financial provisions for persons with mental disorders

At the present time, there is no legislative or financial support for the following: legal obligations for employers to hire a certain percent of employees that are disabled; protection from discrimination (dismissal, lower wages) solely on account of mental disorder; priority in state housing and in subsidized housing schemes for people with severe mental disorders; or protection from discrimination in allocation of housing for people with severe mental disorders.

Links with other sectors

In addition to legislative and financial support, there are formal collaborations between the government department responsible for mental health and the departments/agencies responsible for primary health care/community health, HIV/AIDS, reproductive health, elderly health, child/adolescent health, substance abuse, child protection, education, welfare, and criminal justice.

In terms of support for child and adolescent health, 97% of primary and secondary schools have either a part-time or full-time health professional; about 1% of these professionals are trained in mental health. Few (less than 20%) have school-based activities to promote mental health and to prevent mental disorders. It is a new policy to involve mental health professional in our schools (psychologists and social workers), so a pilot study trains them in mental health promotion and prevention programs. This training will be expanded to cover all professional services to support and prevent mental disorders for children and adolescents. Regarding mental health activities in the criminal justice system, no prisons have at least one prisoner per month in treatment contact with a mental health professional. As for training, a few (less than 20%) police officers participated in educational activities on mental health in the last five years. No judges and lawyers have participated in educational activities on mental health in the last five years.

In terms of financial support for users, a few (less than 20%) mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, 33% of people who receive social welfare benefits do so for a mental disability.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. The extent of data collection is variable among mental health facilities (Table 6.1).

Table 6.1: Percentage of mental health facilities collecting and compiling data by type of information

	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
Nº of beds	100%	100%	NA
Nº inpatient admissions/ users treated in outpatient fac.	100%	100%	0%
Nº of days spent/user contacts in outpatient fac.	100%	100%	100%
Nº of involuntary admissions	100%	74%	NA
Nº of users 1 restrained	33%	0	NA
Diagnoses	33%	19%	24%

The government health department received data from 100% mental hospitals, 100% community based psychiatric inpatient units, and 100% mental health outpatient facilities. Based on this data a report was published which included comments on the data.

In terms of research, 4% of all health publications in the country were on mental health. The research focused on epidemiological studies in community samples, epidemiological studies in clinical samples, policy, programmes and financing/economics.

Strengths and weaknesses of the mental health system in Egypt

An updated mental health policy and a mental health plan are present in Egypt. However, mental health legislation is quite old and needs to be updated. For the promotion of human rights protection, inspection bodies started to work efficiently with one mental hospital. Only 2% of the governmental health expenditure was directed towards mental health. Fifty-nine (59%) of the budget for mental health was devoted to mental hospitals.

The network of mental health facilities is incomplete. Until now, mental hospitals are the facilities that provide the majority of mental health services in the country. Most of mental health facilities are present in or near large cities. Such a distribution of facilities limits access for rural users. In order to promote equity of access to mental health services, Egypt is encouraging the development of community-based psychiatric units and outpatient facilities in each catchments area throughout the country.

Essential psychotropic medicines are available in all mental health facilities, but they are not available in primary health care facilities. In primary health care, mental health issues were included recently and training of primary health care providers on mental health has been initiated. Also, the referral system to mental health professionals in primary health care is not well established.

No consumer or family associations are present in Egypt. Also, there is lack of formal links between the mental health sector and other related sectors such as NGOs. A mental health information database is currently being developed for all mental health facilities in Egypt.

Steps for strengthening the mental health system in Egypt

Short-term:

1. Enlarging the training role of multidisciplinary teams in all mental health facilities and primary health care units.
2. Involving psychologists and primary health care teams in schools in order to develop programme

for mental health promotion and to Support the patients' families. A target in the next 2 years is to improve the quality of life of our youth.

Long term:

1. Updating mental health legislation.
2. Strengthening community based facilities and services
3. Encouraging the contribution of NGO's in promotion of mental health issues and development of prevention programmes.
4. Continuous training of primary health care staff on mental health.
5. Increasing linkages between the mental health system and other key sectors which support and promote mental health (e.g. social welfare and ministry of education).
6. Expanding rehabilitation programmes.
7. Encouraging/support research in the field of mental health.
8. Developing anti-stigma programmes at the national level.

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