Community Mental Health Services in Egypt

Организация амбулаторной психиатрической службы в Египте

Short communication

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ABSTRACT

As far back as the 14th Century, Egypt had already developed mental health care in a community-based sense in Kalaoon Hospital in Cairo, 600 years before similar institutions were founded across the globe.

By 2001, an Egyptian-Finnish bilateral comprehensive reform program was incorporated. A few years later, in 2007, the Minister of Health and Population initiated a proper appraisal of the mental health services in Egypt, which was aimed at achieving better integration and coordination in the mental health sector, as well as supervision and training on the national, governmental, and primary care levels.

By 2009, the Mental Health Act of 2009 (Law 71) brought basic conceptual changes to the care of people with a mental illness in Egyptian institutions, replacing the outdated 1944 law that had been used in Egypt for decades. However, despite all of the important steps Egypt is taking to move toward more integrated mental health services, more effort and resources are still needed to fight against stigma and to develop a comprehensive multidisciplinary approach that is approachable and effective to all those who need it.

АННОТАЦИЯ

Уже в 14-м веке в Египте существовала развитая служба психиатрической помощи, организованная по территориальному принципу, в больнице Калаун в Каире, то есть за 600 лет до создания подобных учреждений по всему миру.

К 2001 году была внедрена египетско-финская двусторонняя программа современного реформирования. Несколькими годами позже, в 2007 году, министр социальной политики и здравоохранения инициировал комплексную оценку служб психиатрической помощи в Египте. Данная акция была направлена на достижение более высокого уровня интеграции и координации в секторе психического здоровья, а также включала обучающую деятельность и контроль качества на национальном, правительственном уровне и в условиях первичного звена медицинской помощи.

Утвержденный в 2009 году Акт о психическом здоровье (Закон 71) внес основные концептуальные изменения в оказание медицинской помощи лицам с психическими заболеваниями в лечебных учреждениях Египта. Данный акт заменил закон от 1944 года, который действовал в Египте на протяжении нескольких десятилетий. Несмотря на все эти важные шаги, Египет продолжает двигаться в направлении более тесной интеграции служб психиатрической помощи. В стране по-прежнему сохраняется необходимость в привлечении большего количества ресурсов и усилий для борьбы со стигматизацией лиц с психическими расстройствами, а также для создания комплексного мультидисциплинарного подхода, который может быть применим в отношении всех нуждающихся в помощи.

Keywords: *Egypt; mental health; community services*

Ключевые слова: *Египет; психическое здоровье; службы помощи по месту жительства*

BACKGROUND

In Egypt, the concept and management of mental health in are presented from the Pharaonic era. Papyri from the Pharaonic period show that they described mental disorders though theories of causation which were mystical in nature, yet were treated on a somatic basis [1]. In the 14th century, 600 years before similar institutions were founded in Europe, the first psychiatric unit was established, in Kalaoon Hospital in Cairo [2, 3]. It had sections for surgery, ophthalmology, and medical and mental illnesses. Astonishingly, the care of mentally ill patients appears to have been community based, probably for the first time in history [4]. However, the building of asylums away from residential areas, to separate those with mental illnesses from their communities, only began in the late 19th century [5]. At the beginning of the British protectorate in Egypt, the modern practice of asylum care was introduced, to the extent that the Department of Mental Health at the Medical School of Cairo University was closed in 1880 and psychiatrists were directed towards the newly built asylums, where training for their profession was more vocational in nature than academic [6]. In 1944, mental health legalization was introduced in Egypt, after agreement from the Egyptian parliament, in advance of the majority of Arab and African countries [7]. The law formed the basis of hospital practice of psychiatry for about 30 years. Not so astonishingly, by the 1980s, psychiatric hospitals were detaining numerous patients who were not suffering from psychotic disorders but rather had addictions or behavioral disorders (largely because of loopholes in the relevant legislation); in fact, the involuntary detention of patients on moral grounds became common practice [8].

Egypt is the most populous nation in the Arab world; its population is equivalent to 1.25% of the total world population. The nation is administratively divided into 26 governorates (regions) and Luxor City, and 203 districts. The four Urban Governorates (Cairo, Alexandria, Port Said, and Suez) have no rural population [9]. With its rapid increase in population, and economic, political, and military challenges in its modern history, economic growth has been significantly affected, and hence the country's medical and mental services have accordingly suffered.

Until 2000, there was an alarming treatment gap in mental health services, as evident in the huge discrepancy between the number of people who needed therapy and those who actually received it. The total number of hospital beds for a population of over 75 million was 6156 (including the 680 forensic psychiatric patients at Khanka, 95 forensic beds at Abbassia, and 13 forensic beds at Ma'amoura). This was an average of less than 1 bed per 12,000 of the population across the country as a whole, compared with a WHO recommendation of 5–8 beds per 10,000 population [10]. Mental hospitals were mostly based in Cairo and Alexandria, with not enough attention being given to integration into primary care, and hence inadequate prevention, early detection, or prompt management. With this concentration of mental health services and staff in hospitals in the three largest cities, there was hugely insufficient decentralization across the country to all governorates, districts, and communities [11]. Moreover, in real practice, when the national hospitals are excluded from the calculation, since it is not good practice to use them to admit people a long way away from their communities, the number of beds per population is probably even lower in most governorates [12].

An appraisal of the situation took place in 2001 after studying all the necessary data and conducting site visits and workshops, resulting in a six-year reform program (Egymen) 2002–2007. This was initiated by Egyptian- Finnish bilateral aid, and then continued by the Ministry of Health and Population (MOHP) from 2007-present, with sustained technical support from the WHO Collaborating Centre (WHOCC), Institute of Psychiatry, the WHO Eastern Mediterranean Regional Office (EMRO) and WHO Geneva. The project was able to put into place a reform program which has been sustained beyond the end of the funding with considerable focus on appropriate treatment at the primary care level, strengthening of the referral system, interministerial and intersectoral liaison, rehabilitation, and media work to mobilize community engagement [11].

In May 2009, the Mental Health Act of 2009 Law 71 [8] brought basic conceptual changes to the care of people with a mental illness in Egyptian institutions. This, like its predecessor, focused on the rights of those with a mental illness, independent second opinions from psychiatrists, and patients' right to consent to treatment. The real change in the environment of mental hospitals followed the policy of opening the gates to visitors, the press, and international professional organizations such as the Royal College of Psychiatrists, the Arab Board of Psychiatry, the Institute of Psychiatry in London, and the World Federation for Mental Health, all of whom offered to support the work. Training workshops were conducted throughout Egypt

for psychiatrists about use of the new mental health act, which included providing educational material about the various sections of the law and practical training on how to apply these sections in different clinical scenarios [6]. In 2011, the Code of Practice of the Mental Health Act was redrafted (Ministerial Decree, Number 210) The new Code allowed the compulsory use of psychotropic medication to facilitate bringing people to hospital from their private homes without prior permission from the district attorney. Involuntary electroconvulsive therapy (ECT) without second opinion for up to three initial sessions also became legitimate. In addition, the role of patients' rights committees was diminished. This is because the new law provided additional guarantees for the rights of mental health patients by providing adequate protection to patients against ill-treatment and exploitation [6].

THE ORGANIZATION OF MENTAL HEALTH CARE

Mental health services in Egypt are provided through more than one system. First, the main provider is the General Secretariat of Mental Health (GSMHT), which is a part of the Ministry of Health (MOH), managing 18 hospitals and centers in 14 governorates. Second, there are mental health departments in the general hospitals, which are administratively under the supervision of the MOH. The General Administrative section of the Ministry of Health (MOH) supervises private mental hospitals, non-governmental organizations (NGOs), and outpatient clinics countrywide. In addition to these, there are psychiatric departments in the medical schools of public universities [13], which are under the supervision of the Ministry of High Education, and also some psychiatric departments in military hospitals, under the supervision of the Ministry of Interior and Ministry of Defense [14]. Unfortunately, there was a lack of systematic linkages between the Ministry of Health and other departments within the MOHP (recently split into the Ministry of Health and the Ministry of Population), and other key ministries and key agencies, until the mid-2000s [11]. According to the latest report, the GSMHAT now has 18 hospitals and centers providing mental health and addiction treatment services in 13 governorates (out of 27) with about 5237 beds and 22 outpatients clinics [15].

Mental Health Services in Primary Care

Egypt has a relatively well-developed primary care system made up of two tiers, the first of which is the family health unit (FHU), and the second, the family health center (FHC).

Each family health unit comprises doctors, nurses, social workers, and health educators, and each family health center has a similar core team of doctors, nurses, social workers, and health educators. In addition to this core team, there are some specialists based in family health centers (e.g., pediatricians). The current role of the family health center health team is largely to take referrals from family health units, to see direct consultations, and to make referrals to the district level. The difference between FHUs and FHCs in terms of mental health provision is that in FHUs primary care physicians assess patients and, if necessary, refer them to the FHC. FHCs have a psychiatrist visiting two days a week from the local mental hospital to run outpatient clinics within the FHC, and to liaise with GPs over difficult cases [11].

Ideally, they would also take responsibility of overseeing the catchment area population and the FHUs within the catchment area, but this is not yet a specified part of their role. As regards the integration of mental health services within primary care services, this is run under the General Secretariat of Mental Health and Addiction Treatment (GSMHAT), which is a governmental body dedicated to the provision of mental health services and drug dependence treatment and rehabilitation. Its scope includes inpatient psychiatric hospitals, outpatient mental health care centers and primary health care services. GSMHAT supervises the 18 governmental mental health hospitals in Egypt. In addition, GSMHAT works as the main educational body in the area of mental health and addiction treatment. It does not only provide training to its own employees but extends it to all other service providers.

The total number of primary care units in Egypt (2017) was 5391, distributed across all cities according to population density in each city. Human resources per unit consist of a family physician, an internal medicine specialist, a surgery specialist, and six nurses and social workers. The actual number of physicians assigned in primary care units was 9022, whereas the target number which should have been assigned was 16,000 [15].

Day Centers

There has been a development of addiction day care centers in four GSMHATs (El Matar hospital-Abbassia hospital, El-Maamoura hospital and El Khanka hospital) To join this program, the client is required to complete the rehabilitation phase inside the hospital or achieve

physical and psychological stability outside the hospital. The program includes psychiatric education, improving life skills for high-risk situations, motivation, CBT, family therapy, family consultation, and relapse prevention techniques [15].

Specialized Services
Addiction
15 out of 18 GSMHAT hospitals provide a service for addiction treatment (outpatient, inpatient, and day care units) with a total number of 563 beds. The majority of inpatient services for addiction treatment are provided by Abbassia Hospital, which is a large centralized mental health hospital [15].

Forensic Psychiatry
Forensic psychiatry is mainly implemented in the Al Khanka and Al Abbassia hospitals, consisting of ten wards. The operating power of units by 2016 was 594–613 beds, with occupancy rates range from 90% to 100% [15].

Child Psychiatry
Forty percent of the Egyptian population are under the age of 18 [9] and 15–20% of them need mental health services; unfortunately, only 5% of these individuals receive them. Child and adolescent mental health services are provided by the public health sector (40%) and the public sector (60%), which comprise pediatricians (50%), general psychiatrists (20%), non-professionals (20%), child and adolescent psychiatrists (7%), and primary care physicians (3%). Meanwhile, educational services are provided by national governmental schools (70%), private sector schools (20%), and public sector schools (5%) [16].

According to the Pathway to Child and Adolescent Mental Health Services among Patients in Urban Settings in Egypt, in about 67% of mental health cases the first contact is either with a pediatrician or a psychiatrist, while 5% of cases seek traditional healers. Most patients are referred to the clinic by relatives (30%) followed by pediatricians (21%), schoolteachers (12%), and traditional healers (5%) [17].

Human Resources
The total figure for human resources working as mental health providers in mental health facilities is 3,836: 2790 nurses, 117 psychologists, and 224 social workers, according to the latest report by Noby [15]. The total

number of psychiatrists registered in Egypt is around 1100 (Egyptian Psychiatrists' Association, personal communication, 2018), 889 of whom work within GSMHAT facilities.

Over the years outlined in this paper, the psychiatry component of the undergraduate curriculum has been improved, as well as the structure, content, and delivery of the postgraduate psychiatry training, and salaries have been doubled for trainees working in psychiatry at the MOH.

DISCUSSION
Over the past two decades, Egypt has been moving forward in a steady steps, aiming to improve mental health services. The Egyptian program, together with the development of the Mental Health Act (Act No. 71 of 2009), has led to a major shift in the development of mental health services in Egypt. This change has been manifest in the increase in investments in mental health services, and the organization of various awareness-raising campaigns for mental disorders, and national programs to combat the stigma of mental illness and to prevent discrimination against people suffering from mental health conditions. The 2009 mental health legislation and its code of practice provided not only a legislative process but also an opportunity to fight against stigma and increase public awareness, and to secure the rights of the patients [13].

This is also in parallel with considerable efforts in education and training, where, as previously mentioned, both undergraduate and postgraduate education and training in psychiatry are much advanced, alongside a significant increase in trainee salaries. Trainees are now encouraged to start their postgraduate training early, and are given protected training and learning time. They are encouraged to take the Egyptian Fellowship Degree in Psychiatry. The Ministry of Health is establishing a recognized training program in all districts; an appraisal system for trainees has been piloted, which is planned to be generalized to all trainees, and it is also planning to establish a CPD system for all psychiatrists, including trainees [11].

Nevertheless, there are still many gaps that prevent the complete fulfilment of the Egyptian government's legal obligations with respect to mental healthcare. One of the main gaps can be seen in its structure itself, as the National Mental Health Counsel, which

is the monitoring body, is chaired by the Minster of Health himself, who should in fact be monitored by the council. Mental hospitals are often based in urban areas. Their numbers are insufficient in areas such as Sinai, Matrouh, Hurghada, and New Waadi. Therefore, those who live in rural areas and seek to gain access to mental health care are burdened by travel and lodging expenses, in addition to time and travel effort. Similarly, forensic psychiatric services are centralized (at Khanka, Abbassia, and Ma'amoura). The patients, especially those from rural areas, often go to traditional healers before or after seeking medical advice from the health system. Outpatient services are hospital-based, so the same issues (travel, expenses, effort and use of traditional healers) also apply to these services [13].

Another problem is that there is still a lack of systems for outreach to people with severe mental illness living at home, for home-based rehabilitation, and for intermediate services at governorate or district level. There are no community rehabilitation centers, day care centers, or halfway houses across the country, apart from those linked to the national hospitals of Abbassia, Heliopolis, and Khanka. When patients are discharged from hospital, there is a problem with them being unable to continue to access medicines. However, the mental health services in the Aswan governorate are conducting useful outreach, enabling hospital admissions to be greatly reduced, as is a pilot outreach project at Abbassia hospital [11].

Meanwhile, action needs to be taken to address the insufficient child and adolescent mental health services. Services need to be included in the country's mental health agenda. The state has an obligation to provide specialized care for children and young people in light of the overwhelming data that suggests 50 percent or more of adult mental disorders begin before the age of 14 [18], and that children and adolescents with untreated mental disorders become an economic and social burden to society [19]. Legislative and policy reform also needs to be accompanied by training, awareness-raising campaigns, and research, for which adequate financial resources also need to be allocated. Yet, unfortunately, economic restrictions affect our ability to document and evaluate the existing resources and outcomes, and prohibits overseas electives in child and adolescent mental health or becoming affiliated with international recommendations and standards, hence, affecting the uniformity of our practice [20].

Another very important problem is the lack of adequately trained mental health nurses and social workers. Nurses need to be oriented to psychosocial skills, rehabilitation, and issues of patient welfare, including risk assessment and humane management of violence. There is no occupational therapy training program either, and other professionals lack an OT orientation. There are psychologists, but it is unclear how many are in the health sector and what roles they are playing [11].

There are no systematic mechanisms for delivery of CPD for mental and neurological health for other relevant public sector workers, including teachers, police, and prison staff. Traditional and religious healers are common, and people regularly consult them either before or during consultation with official services.

CONCLUSION

A national appraisal of the current situation, including the deficiencies, needs to be implemented to gain a full understanding of the gaps in the system. The lack of human resources implemented in highly qualified psychiatrists, social workers, mental health nurses, and occupational therapists need to be addressed. Adequate financial resources are needed for better documentation and appraisal of the current situation, and for improvements in training and application of guidelines to be in line with the appropriate international standards.

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