

WHO-AIMS

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN MOROCCO



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*A report of the assessment of the mental health system in Morocco using the
World Health Organization - Assessment Instrument for
Mental Health Systems (WHO-AIMS).*

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**Ministry of Health
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Please refer to WHO-AIMS (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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The WHO-AIMS project is coordinated by Shekhar Saxena.

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 Morocco. 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 Morocco to develop information-based mental health plans with clear baseline 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.

Morocco's mental health policy was last revised in 2002 and the last revision of the mental health plan was in 2004. The last piece of mental health legislation was enacted in 1959 and a national human rights review body exists. Concerning social insurance schemes, only severe mental disorders are covered. In Morocco, there are 74 outpatient mental health facilities of which 5% are for children and adolescents only. There are no day treatment facilities available. Moreover, there are 15 community-based psychiatric inpatient units and 9 mental hospitals in Morocco. Four percent of the training for both medical doctors and nurses is devoted to mental health. Primary care doctors are allowed to prescribe psychotropic medications but nurses are not.

The total number of human resources working in mental health facilities or private practice is 1,464 (4.9 per 100,000 population). The breakdown according to profession is as follows: 306 psychiatrists (1.02 per 100,000 population), 209 other medical doctors, not specializing in psychiatry (0.70 per 100,000 population), 648 nurses (2.17 per 100,000 population), 50 psychologists (0.17 per 100,000 population), three social workers (0.01 per 100,000 population), 10 occupational therapists (0.01 per 100,000 population), and 238 other health and mental health workers including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors (0.80 per 100,000 population).

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. There are no legislative provisions for persons with mental disorders concerning employment, housing, or financial support. Nevertheless, there are formal collaborations with many departments/agencies to improve mental health. In terms of research, there are very few publications from Morocco each year on mental health.

Morocco remains strongly challenged by social development issues such as access to basic education and quality primary health care, elimination of illiteracy, reduction of poverty and social inequality, and increasing training and employment. In order to further the recommendations of the WHO Commission on Macroeconomics and Health, a recent World Bank report on social protection in Morocco has suggested an increase of public health care expenditures. The report suggests that these expenditures emphasize the following: rural programmes, financing and hospital reform, health sensitizing

initiatives and intersectoral partnerships (Country Cooperation Strategy for WHO and Morocco 2004–2007).

Introduction

Morocco covers an area of 710,850 sq. km and is located in north-west Africa, between the Mediterranean Sea, the Atlantic Ocean and the Sahara Desert. It shares its borders with Algeria to the east and Mauritania to the south.

Morocco is a constitutional monarchy. The official religion is Islam and the main languages spoken in the country are Arabic and French. The largest ethnic groups are Arab and Berber, neither of which represents a minority. The largest religious group is Muslim. In addition, there are a small number of other cultural/ethnic groups, mainly Europeans, and non-Muslim religious groups.

According to World Bank 2004 criteria, Morocco is a lower middle income country. The health budget as a percentage of government expenditure is 5.1%. The per capita total expenditure on health is US \$199, and the per capita government expenditure on health is US \$78 (WHO, 2004).

Administratively, the country is divided into regions which are subdivided into Provinces (rural and small cities) and Wilayas which are subdivided in prefectures (urban milieu). In total, there are 16 large regions and 68 provinces and prefectures. The regions currently have autonomous management (local governments).

The population of Morocco is 29,891,708, including 51,435 of foreigners (RGPH, see references below). The ratio of men to women is one to one (UNO, 2004). The average population density is 38.4 per sq. km. The population of Morocco is very young; 32.3% are under 15 years old, 41.9% are under 20 years old, and 8.0% are above 60 years of age (RGPH, 2004). The mean rate of population growth since 1994 is 1.4% (RGPH, 2004). The rate of urbanization, which developed considerably over the past two decades, is 55.1% (2004). The estimated number of people living in rural areas is 13,428,074 (RGPH, 2004).

The literacy rate is 63.3% for men and 38.3% for women (UNESCO/MoH, 2004). The life expectancy at birth is 68.8 years for males and 72.8 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 61 years for females (WHO, 2004). The infant mortality rate decreased by more than 50% from 94 per 1,000 live births in 1982 to 37 per 1,000 live births in 1998. The maternal mortality rate is 22.8 per 10,000 live births and the under 5 mortality rate is estimated at 46 per 1,000 live births.

Health System Infrastructure:

The national health system is organized in three main sectors:

1. *The public sector including the Royal Armed Forces Health Service and the Ministry of Public Health.*

The public sector aims to implement health prevention, promotion, and treatment and rehabilitation through four networks. The primary health care network consists of: (1) the rural dispensary, (2) the community health centre, (3) the local hospital, and (4) the urban health centre. The hospital network comprises general hospitals and specialized hospitals and is organized on three intervention levels: (1) public health polyclinics and provincial hospitals, (2) regional hospitals, and (3) academic hospitals. The rehabilitation network is in development in Morocco and presently consists of projects implemented by both government and non-governmental organizations.

2. *Private sector (profit-making):* composed of private clinics (Cabinets) and private hospitals.
3. *Private, non-profit sector* represented by national fund of social security institutions and mutual fund institutions.

Presently there are 72 general hospitals and 34 specialized hospitals, with a total of 25,715 beds. There are 2,510 primary health care institutions (1,863 in rural areas and 648 in urban areas), corresponding to one establishment per 1,109 inhabitants (2004 statistics).

MENTAL HEALTH

Introduction of modern psychiatry

The first psychiatric institutions in Morocco were built in 1920. Berrechid Hospital, a large asylum-type structure with 2,000-bed capacity (near Casablanca) was the first to be operational, followed by Til Mellil Psychiatric Hospital (in the Casablanca region). Regional psychiatric hospitals, with smaller capacity (80 to 100 beds), were then established in Marrakech, Oujda, Fès, Tangiers, Tétouan and Meknès. Since the 1960s, a number of inpatient units for mental health have been created and integrated into general hospitals (10 to 30 beds). From the 1980's, ambulatory psychiatry services (outpatients units) in the public and private sectors have been developed.

Legislative measures

The principal law is the *Dahir* of 1959 which addresses the prevention of mental illnesses and protection of the patients. This is the latest mental health legislation. Though it is old, its articles are well formulated and were examined by WHO experts in 1998. Further reviews will be done in the future. The main aim of the legislation is to guarantee that the prime mission of mental institutions is treating the patients while protecting their rights and their property during their period of illness. This law also achieved the following: created the Central Service for Mental Health and Degenerative Diseases and the Mental Health Committee, organized mental institutions and other psychiatric services, specified

different manners of patient admission and discharge, and outlined the modalities of protection of patients and their personal property.

In addition, the 1974 “Circulaire” (Ministerial recommendations document), introduced regionalization and “deinstitutionalization”. This was the start of a strategic policy to reduce number of beds in psychiatric hospitals, to create smaller units with fewer beds (20-40 beds) and to integrate mental health into general hospitals.

Mental health and degenerative diseases service

The Central Mental Health was created in 1959. This office became “operational” in 1988, because of insufficient human resources in the years prior. Currently, this office is named Mental Health and Degenerative Diseases Service and has the following responsibilities:

- Developing plans and programmes for the prevention and treatment of mental illnesses as well as the protection of the mentally ill
- Supervising medical care institutions (public and private), health centres and psychiatric institutions
- Coordinating different sectors involved in mental health care and with national and international nongovernmental organizations
- Overseeing continuing education of health professionals
- Furthering the goal of mental health
- Participating in the fight against drug addiction in coordination with other sectors.

Mental health care facilities

Psychiatric institutions are in four main sectors: public health, academic, military and private. NGOs who developed these institutions are largely responsible for their ongoing operation.

Data was collected in 2005, and is based on the year 2004.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Morocco's mental health policy was last revised in 2002 and includes the following components: (1) developing community mental health services, (2) downsizing large mental hospitals, (3) developing a mental health component in primary health care (4) Human resources (5) advocacy and promotion, (6) human rights protection of patients, (7) equity of access across different groups, (8) financing, and (9) quality improvement. An essential medicines list is present in the country.

The last revision of the mental health plan was in 2004 and contains the same components as the mental health policy but also includes reforming mental hospitals to provide more comprehensive care. In addition, a budget, timeframe, and specific goals are identified. The last piece of mental health legislation was enacted in 1959, which focused on: a) competency, capacity, and guardianship issues for people with mental illness; b) voluntary and involuntary treatment; c) law enforcement and other legal issues for people with mental illness; d) mechanisms to oversee involuntary admission and treatment practices; and e) mechanisms to implement the provisions of mental health legislation. The last version of a disaster/emergency plan for mental health was in 2003.

Financing of mental health services

The proportion of health care expenditures by the government health department directed towards mental health is 4%. About half (49%) of mental health expenditures is for mental hospitals. In terms of affordability of mental health services, 30% of the population has free access to essential psychotropic medicines. For those who have to pay for their medicines out of pocket, the cost of antipsychotic medication is 1.35 dollars per day, and the cost of antidepressant medication is 1.8 dollars per day, both costing roughly 2% of the daily minimum wage. Only severe mental disorders are covered in social insurance schemes.

Human rights policies

A national human rights review body exists which has the authority to oversee inspections in mental health facilities, review involuntary admission and discharge procedures, review complaints about investigation processes and impose sanctions on facilities that persistently violate patients' rights. All mental hospitals, community-based psychiatric inpatient units and community residential facilities benefit from at least one yearly review/inspection of human rights protection of patients. In terms of training, 11% of mental hospital staff and 7% of inpatient psychiatric units staff have had at least one day training, meeting, or other type of working session on human rights in the year of assessment.

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 is also involved in service planning, management/coordination, and monitoring and quality assessment of mental health services. Mental health services are organized in terms of catchment/service areas.

Mental health outpatient facilities

There are 74 outpatient mental health facilities in Morocco, of which 5% are for children and adolescents only. These facilities treat 150,458 users (503 per 100,000 population). Of all users of mental health outpatient facilities, 46% are female. The users treated in outpatient facilities are primarily diagnosed with schizophrenia (39%) and mood/affective disorders (26%). The average number of contacts for users treated through outpatient facilities is 1.73. None of outpatient facilities provide follow-up care in the community or mobile mental health teams. In terms of available treatments, the percentage of patients in outpatient facilities last year received one or more psychosocial interventions is unknown. All outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a near-by pharmacy all year long.

Day treatment facilities

While there are no official day treatment facilities in Morocco, there are a number of NGO-run day centres for youth aged 17 and younger with mental retardation and their families. They function as day care facilities, providing treatment and activities for the children. In addition, these facilities provide social support to the families and parents.

Community-based psychiatric inpatient units

There are 15 community-based psychiatric inpatient units available in the country for a total of 754 beds (2.52 per 100,000 population). There are no beds in community-based psychiatric inpatient units reserved for children and adolescents only. An estimated 19% of the 7,703 admitted patients are female. The diagnoses of admissions to community-based psychiatric inpatient units were primarily from the following two diagnostic groups: schizophrenia (70%) and mood/affective disorders (12%). All community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility all year long.

Community residential facilities

There are no community residential facilities available in the country.

Mental hospitals

There are 9 mental hospitals in the country and a total of 1147 beds (3.84 per 100,000 population). All of these facilities are organizationally integrated with mental health outpatient facilities. There are no beds in mental hospitals reserved for children and adolescents only. The number of beds has decreased by 11% in the last five years. These facilities treat 9523 users (31.86 per 100,000). Eighteen percent of patients are female. The patients admitted in mental hospitals are primarily diagnosed with schizophrenia (70%) and affective disorders (12%). Two percent of patients spend more than 10 years in mental hospitals, whereas 70% spend less than one year. Patients average an estimated 26 days per hospitalization. Few patients (less than 20%) in mental hospitals received one or more psychosocial interventions in the past year. All mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility.

Other Residential Facilities

There are two residential facilities with a total of 10 beds, specifically for people with substance abuse (including alcohol) problems, mainly from detoxification inpatient facilities.

There are an additional 16 residential facilities that are not formally mental health facilities but where, nevertheless, the majority of the people residing in these facilities have diagnosable mental disorders (e.g. mental retardation, substance abuse, dementia, epilepsy, psychosis). These facilities are specifically social residencies managed by the social ministry department. Residents in these facilities benefit from regularly scheduled medical visits by physicians from the health sector..

Human rights and equity

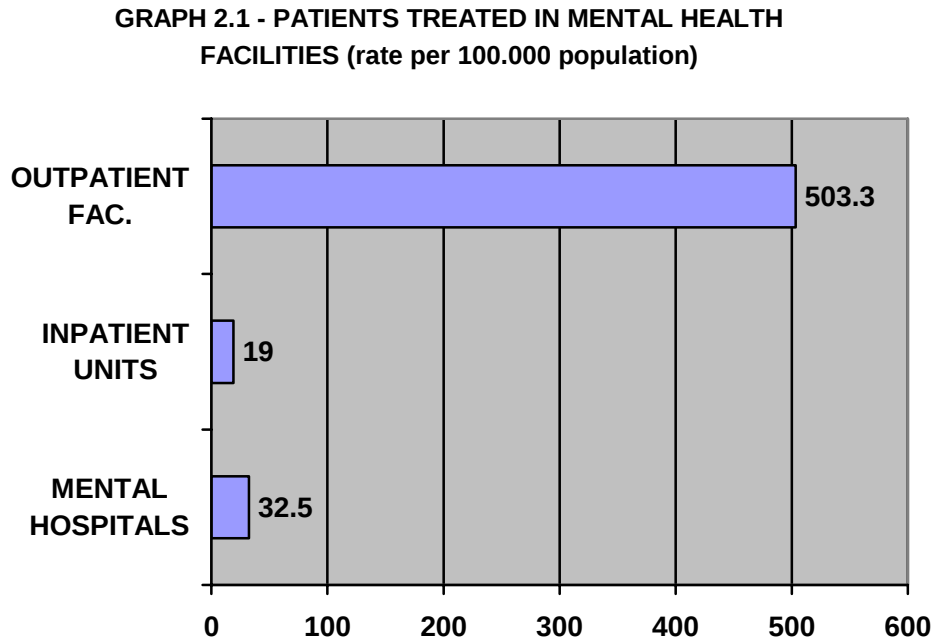
Over 20% of patients were physically restrained or secluded within the last year in both community-based psychiatric inpatient units and in mental hospitals. An estimated 70% of the total admissions to mental hospitals or to community-based inpatient care facilities are involuntary (typically conducted by police, family members, etc.).

18 patients in the community-based inpatient units and 23 patients in the mental hospitals were charged for committing crimes and subsequently judged irresponsible for reason of mental illness in the past year. Following inpatient treatment, these patients will undergo obligatory outpatient care as well. Only the physician can decide the time of discharge and, in case of disagreement between the physician and authorities, the case is assessed by the national commission of mental health (per Dahir 1959).

The proportion of psychiatry beds located in or near the largest city is 9.23 times greater than in the whole country. Inequity of access to mental health services exists for rural users and for a few Berberous groups as well, primarily because of language barriers.

Summary Graphs

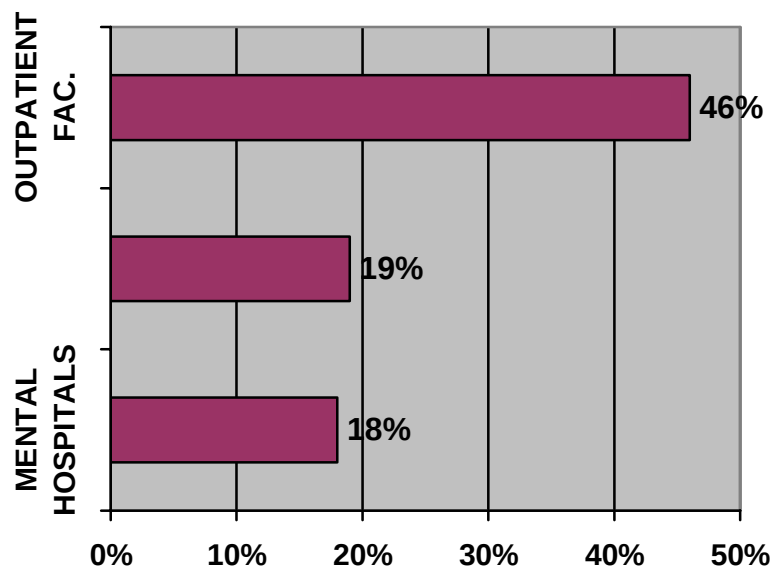
The majority of the users are treated in outpatient facilities (Graph 2.1).



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

Female users do not reach 50% of the population in all mental health facilities in the country. The proportion of female users is the highest in outpatient facilities (Graph 2.2).

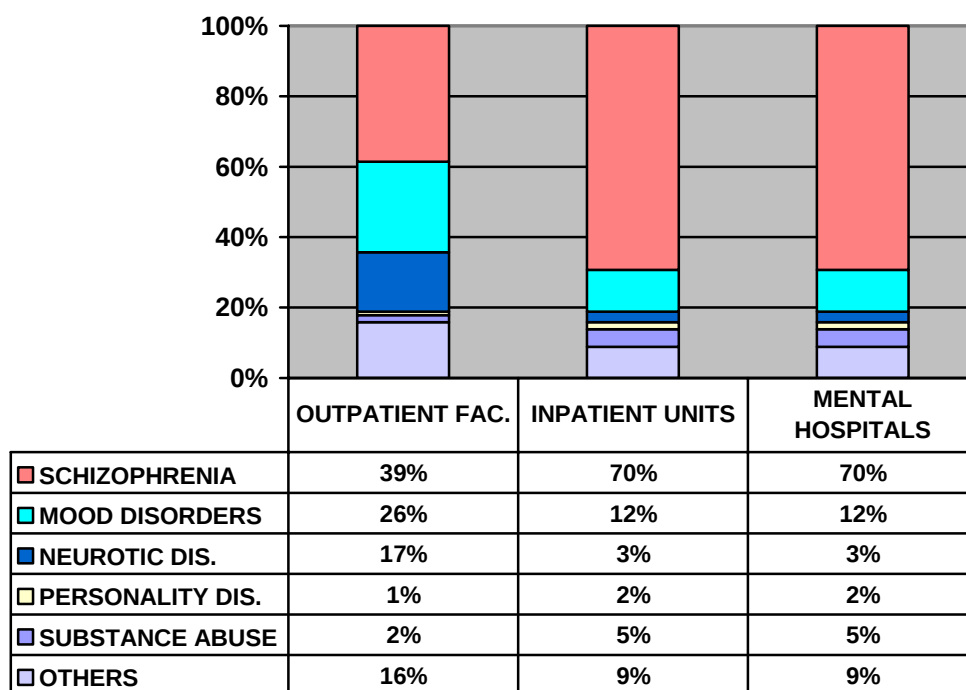
**GRAPH 2.2 - PERCENTAGES OF FEMALE USERS
TREATED IN MENTAL HEALTH FACILITIES**



Note: In this graph the percentage of female admissions in inpatient units is used as proxy of the percentage of women treated in the units

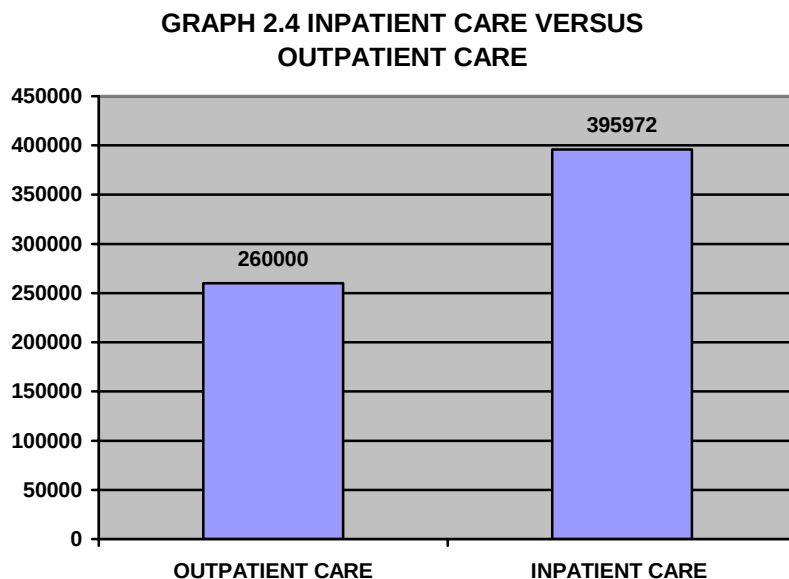
The distribution of diagnoses is similar between mental hospitals and inpatient units, but different in outpatient facilities. Schizophrenia is the more common diagnosis across all facilities followed by mood disorders (Graph 2.3).

GRAPH 2.3 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



Note: In this graph the percentage of admissions in inpatient units by diagnosis is used as proxy of the percentage of users admitted in the units

The ratio between outpatient care contacts and days spent in all the inpatient facilities (mental hospitals and general hospital inpatient units) is an indicator of extent of community care: in this country the ratio is 1:1.5 (Graph 2.4).



Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

Four percent of training for medical doctors and nurses is devoted to mental health. In terms of refresher training, 31% of primary health care doctors have received at least two days of refresher training in mental health, while there is no refresher training for primary health care nurses.

Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. Assessment or treatment protocols for key mental health conditions are available in a majority of the physician-based PHC clinics and in less than 20% of the non-physician based PHC clinics. The majority of full time primary health care providers in both physician and non-physician based primary health care clinics make at least one referral per month to a mental health professional. In the last year, fewer than 20% of primary health care doctors interacted with a mental health professional on a monthly basis.

Prescription in primary health care

Neither primary care nurses nor non-doctor/non-nurse primary health care workers are allowed to prescribe psychotropic medications. However, primary health care doctors are allowed to prescribe without restriction. In practice, mental health specialized nurses can prescribe psychotropic medications in cases of emergency. A majority of the physician-

based PHC clinics (between 51-80%) as well as the non-physician based clinics have at least one psychotropic medication of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic). They are available either in the facility or at a nearby pharmacy all year long.

Domain 4: Human Resources

Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice is 1,464 (4.9 per 100,000 population). The breakdown according to profession is as follows: 306 psychiatrists (1.02 per 100,000 population), 209 other medical doctors, not specializing in psychiatry (0.70 per 100,000 population), 648 nurses (2.17 per 100,000 population), 50 psychologists (0.17 per 100,000 population), three social workers (0.01 per 100,000 population), 10 occupational therapists (0.01 per 100,000 population), and 238 other health and mental health workers including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors (0.80 per 100,000 population).

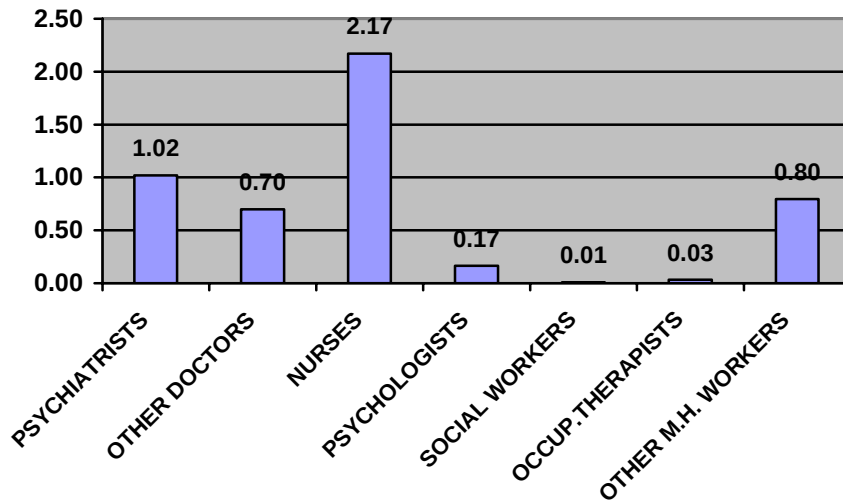
38% of Morocco's psychiatrists work only for government administered mental health facilities. A majority of the psychiatrists, 57%, are working only in or for mental health NGOs, for-profit mental health facilities or private practice. An estimated 5% of Morocco's psychiatrists work for both government administered mental health facilities and either a mental health NGO, for-profit mental health facility or private practice. An overwhelming majority (92%) of psychologists, social workers, nurses and occupational therapists work only in government administered mental health facilities.

Among those psychiatrists working only for government administered mental health facilities, 38 work in mental health outpatient facilities, 30 in community-based psychiatric inpatient units and 49 in mental hospitals. 206 medical doctors, not specialized in mental health, work in mental hospitals and only 3 in community-based psychiatric inpatient units. There are no medical doctors not specialized in mental health working in outpatient facilities. There are 76 nurses working in mental health outpatient facilities, 153 in community-based psychiatric inpatient units and 396 in mental hospitals. As for other mental health professionals, there are 35 psychologists, social workers, occupational therapists and other health or mental health workers working for mental health outpatient facilities, 138 in community-based psychiatric inpatient units, and 94 in mental hospitals.

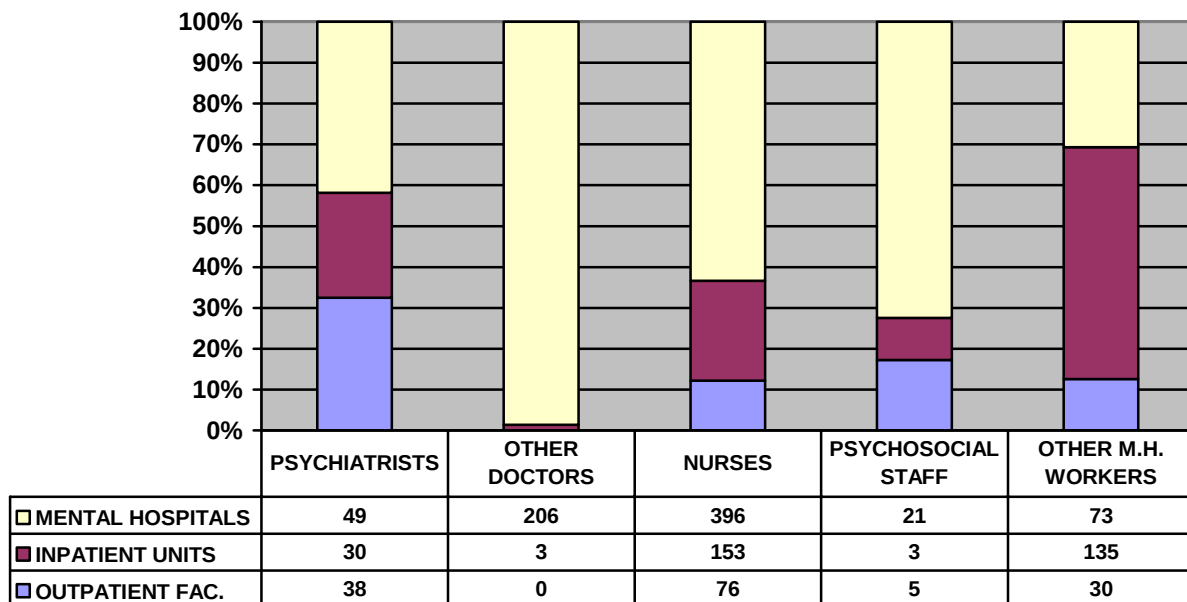
In terms of staffing in mental health facilities, there 0.04 psychiatrists per bed in both the community-based psychiatric inpatient units and mental hospitals. There are 0.20 nurses per bed working in the community-based inpatient units, in comparison to 0.35 per bed in mental hospitals. Finally, there are 0.02 psychosocial staff (e.g. psychologists, social workers and occupational therapists) per bed in mental hospitals and there are no psychosocial staff working in community-based inpatient units.

With respect to the distribution of human resources between urban and rural areas in Morocco, the density of psychiatrists working in mental health facilities per capita in urban areas is 1.37 times greater than the density for the whole country. The density of mental health nurses per capita in urban areas, however, is less than (0.72) the density for the whole country.

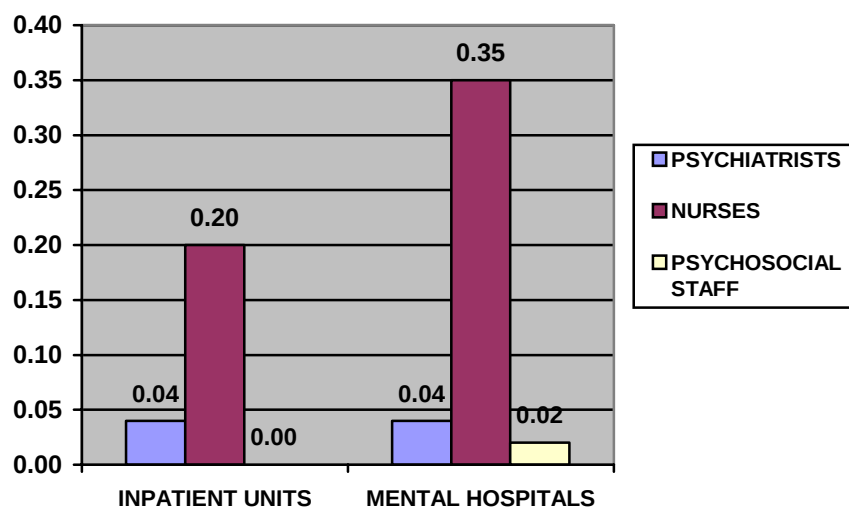
GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



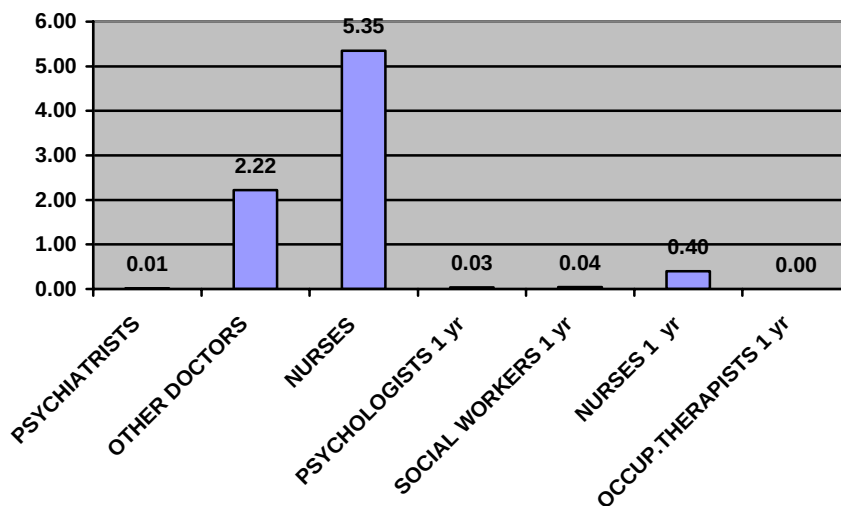
GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS



Training professionals in mental health

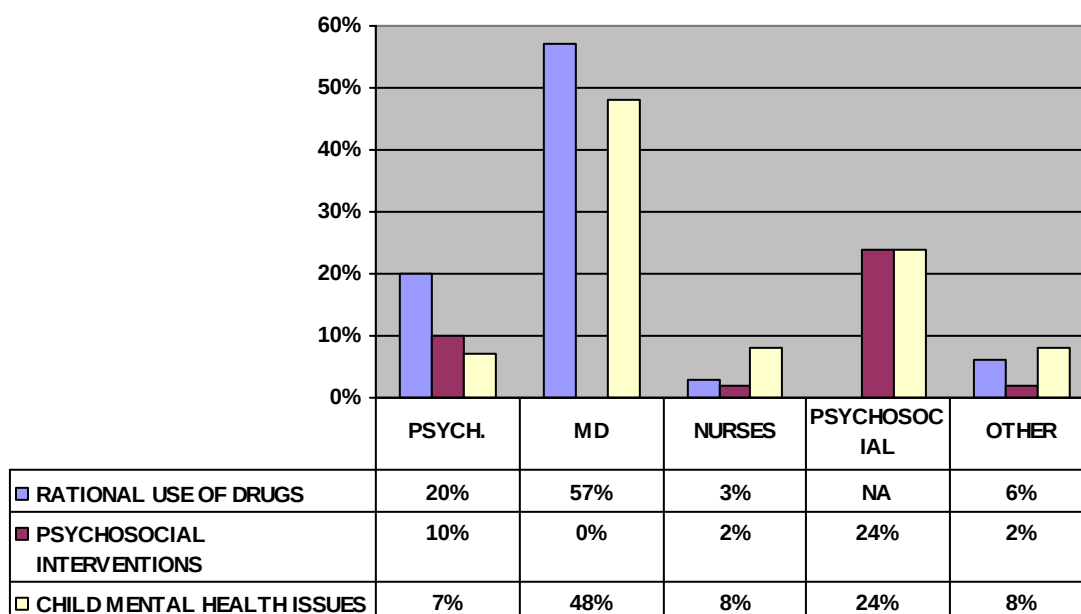
The number of professionals graduated last year in academic and educational institutions is as follows: 663 medical doctors (2.22 per 100,000 population), 1,600 nurses (5.35 per 100,000 population), four psychiatrists (0.013 per 100,000 population), 10 psychologists with at least 1 year training in mental health care (0.03 per 100,000 population), 120 nurses with at least one year training in mental health care (0.40 per 100,000 population), and 12 social workers with at least one year training in mental health care (0.04 per 100,000 population). Few (<20%) psychiatrists emigrate from the country within five years of the completion of their training. .

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



Twenty percent of psychiatrists in Morocco have received at least two days of refresher training on the rational use of psychotropic drugs in the last year. A majority of doctors not specialized in psychiatry, however working in or for mental health facilities had also received at least two days of refresher training on the rational use of psychotropic medication. Finally, only 3% of nurses and 6% of other mental health workers have received such training in the last year. Ten percent of psychiatrists have received at least two days of refresher training on psychosocial (non-biological) interventions in the last year, in comparison to 24% of all psychologists, social workers and occupational therapists and 2% of nurses and other health or mental health workers.

GRAPH 4.5 - 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 staff=psychologists, social workers, and occupational therapists. Other=other health and mental health workers

Consumer and family associations

There is very limited information about consumer and family associations in Morocco. While there is no interaction between mental health facilities and consumer associations, a few (less than 20%) mental health facilities have had interaction with family associations in the last year.

Domain 5: Public Education and Links with Other Sectors

Public education and awareness campaigns on mental health

There are coordinating bodies that coordinate and oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, professional associations and international agencies have all participated in promoting public education and awareness campaigns in the last five years. The participating agencies have targeted the following groups: the general population, children, adolescents, women, trauma survivors and other vulnerable or minority groups. In addition, public

education and awareness campaigns have targeted the following professional groups: health care providers, teachers, social services staff, leaders and politicians, and other groups linked to the health sector.

Legislative and financial provisions for persons with mental disorders

There are legislative provisions with respect to protection from discrimination (dismissal, lower wages) solely on account of mental disorder; however the legislation is not enforced. There are no legislative provisions for the following: (1) legal obligations for employers to hire a certain percentage of employees that are disabled, (2) priority in state housing and in subsidized housing schemes for people with severe mental disorders and (3) protection from discrimination in allocation of housing for people with severe mental disorders.

Links with other sectors

There are formal collaborations with the departments/agencies responsible for: HIV/AIDS, child and adolescent health, reproductive health, substance abuse, child protection, education, criminal justice, welfare and others. In terms of support for child and adolescent health, 1% of primary and secondary schools have either a part-time or full-time mental health professional. Fewer than 20% of primary and secondary schools engage in school-based activities to promote mental health and to prevent mental disorders.

Regarding mental health activities in the criminal justice system, the percentage of persons with psychosis is less than 2%. The majority of prisons (between 51-80%) have at least one prisoner per month in treatment contact with a mental health professional. While no police officers have participated in educational activities on mental health in the last five years, less than 20% of judges and lawyers have participated in such activities. In terms of financial support for users, no mental health facilities have access to programs outside the mental health facility that provide outside employment for people with severe mental disorders.

A policy of welfare cards for the disabled has existed since 2002. In order for patients to receive welfare cards, physicians in all specialities must specify the percent disability for each case. Then all cases are viewed by a national committee for approval of benefits. The welfare card reduces or waives the cost of some welfare services, (such, in public transports, and for several department services). This service is different and in addition to pensions. The current number of welfare card holders is unknown because of unavailable data.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists, and includes the number of beds, inpatient admissions, involuntary admissions, length of stay, numbers of patients who are physically restrained and

secluded, and patient diagnoses. The government health department routinely receives these data from all mental hospitals; community based psychiatric inpatient units, and mental health outpatient facilities. Based on the data, a report was published without comments on the data.

In terms of research, there are few publications from Morocco each year on mental health. As identified on PubMed, a total of 733 health publications were produced on the country in the last five years, among which only 9 publications were on the subject of mental health. Nonetheless, a majority of the psychiatrists working in mental health services in Morocco have been involved in mental health research as an investigator or co-investigator in the last five years. Whereas, it is estimated that approximately 51-80% of nurses working in mental health services and some (21-50%) psychologists and social workers in mental health services have participated in mental health research as an investigator or co-investigator in the last five years.

In the last five years, mental health research in Morocco has focused on the following topics: epidemiological studies in community and clinical samples, non-epidemiological clinical/questionnaires assessments of mental disorders, biology and genetics, services research, policy, programmes, financing/economics, psychosocial interventions/psychotherapeutic interventions and pharmacological, surgical, and electroconvulsive interventions.

Next Steps in Planning Mental Health Action

This study using the World Health Organization Assessment Instrument for Mental Health Systems builds on the foundation of the WHO Country Cooperation Strategy (CCH) developed with national partners in Morocco for 2004-2007. This study also enhances the sustainability of WHO-Morocco and its efforts to develop primary health care and strengthen the prevention of public health problems.

The next steps in Morocco's mental health system planning will aim to achieve the following objectives:

- Develop the necessary instruments for health policy planning and orientation
- Support decentralization of the health system while aiming to enhance effectiveness, quality and equity
- Strengthen technical partnerships to more effectively address priority programmes, primarily those aimed at targeting the needs of the community.

I. The following activities will be implemented according to the National Program for Mental Health and as part of the 2007-2008 WHO-EMRO cooperation strategy:

- Developing a five-year plan for mental health programmes for children and adolescents
- Conducting a national survey of child psychiatry
- Reviewing current mental health legislation
- Evaluating the programme of integration of mental health with primary health care

II. In an effort to revise the strategic policy for the fight against drug abuse, Morocco has conducted both a national survey of mental health and drug abuse and a rapid assessment of HIV/AIDS risk related to injection drug use. Findings from these assessments led to the development of a five-year National Action Plan for Harm Reduction (2006-2010). This plan is a component of the National Strategic AIDS Plan for 2007-2010, administered by the National Narcotics Commission.

Dissemination and planning workshop

A Dissemination and Planning Workshop is currently scheduled in near future.

The objectives of this workshop are as follows:

- 1) To discuss the results of the Assessment Instrument for Mental Health Systems (WHO-AIMS) with national and international stakeholders in order to develop an action plan for improving Morocco's mental health system
- 2) To disseminate the results of the National survey on mental disorders, conducted in partnership with the WHO (2003-2005) as well as the WHO-AIMS report.

In addition to the Ministry of Health, representatives from international NGOs and health institutions, primarily from France, Belgium and Holland will be invited to participate. The workshop will also invite representatives from government ministries active in the mental health sector, in addition to relevant local scientific and social organizations working in the area of social welfare.

Participants of the workshop will devise a formal appeal to strengthen the mental health sector while, at the same time, aim to improve cooperation among government sectors. The appeal will describe Morocco's objectives for the improvement of the mental health system, including a detailed outline of the government's role. A press conference with principal government stakeholders, such as members of parliament, as well as members of the community, will be also scheduled.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Morocco. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change.

The results of the assessment illustrate positive areas of the mental health system as well as gaps that need to be studied and addressed.

The mental health sector is governed by a legislative framework, the Dahir n°1-58-295, which was established in April 30, 1959, to prevent mental illness and to ensure the proper treatment and protection of psychiatric patients. However, there are no legislative provisions concerning employment, housing, or financial support for persons suffering from mental disorders.

Morocco is undergoing the following reforms: decentralization, integration of mental health into primary health care, reduction of the number of beds in mental hospitals, and an increase in the services available to patients at the community level.

In addition, there is the need to develop alternative consumer facilities, mainly for patients with chronic disorders. There is also a lack of health care facilities for vulnerable populations such as children, teenagers, and psychoactive substance users.

Morocco is faced with many social development challenges, such as access to basic education and quality primary health care, reduction of illiteracy, poverty and social inequity. Within the health sector, Morocco is also struggling to increase training and employment as well as to change the population's perceptions of people living with mental disorders and disabilities.

As a first step, Morocco is planning a national conference on mental health and drug abuse which will focus on advocacy and reducing stigma.