Mental health in the Middle East

Measuring progress towards integrated, accessible and equitable mental health

Contents

About this report

Mental health in the Middle East - Measuring progress towards integrated, accessible and equitable mental health is an Economist Impact report sponsored by Janssen: Pharmaceutical Companies of Johnson & Johnson. As part of the research, Economist Impact developed a policy scorecard to illuminate the status and progress towards improving mental health integration in the Middle East and North Africa (MENA) region. This scorecard allowed us to explore government commitment and accountability, efforts to reduce stigma and advance awareness of mental health, and the accessibility and affordability of mental health services. We also explore the burden of mental illness in the MENA region and critical barriers to the access and provision of mental health care.

The research focuses on six countries in the MENA region: Egypt, Jordan, Kuwait, Oman, Qatar and Saudi Arabia, providing a representative and diverse sample in terms of population size and income groups in the region.

The research was supported by a pragmatic literature review, expert interviews and an advisory panel to assess the key enablers and barriers towards mental health integration in the region. A full description of the scorecard and our methodology is available in Appendix 1.

We would like to thank the following individuals who served as our expert panelists on the topic and provided key insights and guidance on the direction of our research (listed alphabetically):

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- **Dr Nasser Loza,** president of the World Federation for Mental Health (2021-23); director, Behman Psychiatric Hospital; and founder, Egyptian Society for the Rights of People with Mental Illness, Egypt

- **Dr Nicholas Scull,** psychologist and general manager, FAWSEC Medical, Kuwait

- **Susan Clelland,** director, National Mental Health Program, Ministry of Public Health, Qatar

Executive summary

Background

Although the prevalence rates of mental health conditions in the Middle East have remained relatively consistent over the past two decades, mental health conditions are increasing as a share of the total disease burden.[1] Collectively, the Middle East and North Africa (MENA) region forms the global hotspot for the proportion of mental health disorders as a share of the total disease burden. In Jordan, Oman, Kuwait and Qatar, the share of mental health conditions as a share of the total disease burden is over double the global average of 5%.[1] The burden of mental illness may be further exacerbated in the coming years by the risk factors associated with a young population and a high burden of non-communicable diseases.

Although mental health is receiving more interest from policymakers, and there are clear signs of progress across the region, a number of longstanding barriers remain, including:

1. **Insufficient human resources to meet mental health care needs**

   A lack of appropriately trained workers limits mental health care in the Middle East. The number of mental health professionals per capita has declined in recent years and is lower than global averages.[2,3] In high-income countries worldwide, the median number of mental health workers per 100,000 is 62.2; Kuwait,

Qatar, Oman and Saudi Arabia all have less than half this number.[2] The level of training and quality standards of mental health professionals, particularly psychologists, is also a worry in the region.

2. **An outdated institutional focus that isolates mental health patients from the community**

   The global shift from isolated long-term care facilities and specialist mental institutions to outpatient facilities, mental health wards in general hospitals and care that supports the integration of patients into the community has largely lagged behind in many countries in the Middle East. Even in countries where mental hospitals are largely short-stay facilities rather than ones for housing patients permanently, many individuals remain institutionalised.

3. **Widespread mental health illiteracy and stigma**

   A lack of mental health literacy and prevailing stigma constitute the biggest barriers to mental health care in the region. Poor mental health literacy and negative attitudes towards those with mental ill-health greatly impede help-seeking behaviour. Negative experiences with healthcare professionals and mental health services also serve as a barrier to continuing treatment.

Although these challenges prevail, there are signs of improvement. Mental health is gaining greater government attention with widespread efforts to strengthen mental health policy and workforce quality. Although still a major barrier, stigma has declined noticeably in the region, particularly towards those with mild to moderate mental health conditions such as depression or anxiety. The covid-19 pandemic has also been a catalyst for accelerated change and stigma reduction.

Measuring progress towards integrated, accessible and equitable mental health care

In order to examine methodically the strength of key assets on which our countries of interest can build effective mental health care provision, Economist Impact has created the MENA Mental Health Scorecard. It looks at how six MENA countries—Egypt, Jordan, Kuwait, Oman, Qatar and Saudi Arabia—are doing on each of 16 indicators, grouped into three broad domains:

- **Government commitment and accountability**, including the existence of relevant policies and legal protections for those living with mental illness, as well as the funding devoted to mental health care and the technology and research infrastructure in place.

- **Empowering individuals and communities**, including mental health promotion initiatives by governments and community groups, the role of the patient in healthcare planning, how mental health care specialists work with other care providers, and the treatment of vulnerable populations.

- **Accessibility of mental health services**, which looks at a range of factors related to how easily the general population and those at particular risk can receive care.

Rather than a way to reveal winners and losers, the MENA Mental Health Scorecard is meant to start discussions about existing strengths on which to build, and weaknesses that require attention.

Domain	Indicator	Total possible score	Egypt	Jordan	Kuwait	Qatar	Oman	Saudi Arabia
1. Government commitment and accountability	1.1 National strategy, policy or plan for mental health	3	0	3	1	3	1	2
	1.2 Protection of individuals with mental health conditions	1	0.5	0	1	1	0	0.5
	1.3 Suicide prevention	1	1	1	0	0	0	0
	1.4 Spending on mental health	1	0	0	0	0	0	0.5
	1.5 Data infrastructure	1	1	0	0	1	1	1
	1.6 Research output	1	0	1	0	0	0	1
Total Domain 1		8	2.5	5	2	5	2	5
2. Empowering individuals and communities	2.1 Awareness and education	1	1	0	1	1	0	1
	2.2 Community initiatives	2	2	2	2	2	2	2
	2.3 Incorporation of the patient voice	1	0	0	0	0	0	0
	2.4 Integration with other sectors	2	1	2	0	1	1	2
	2.5 Vulnerable populations	2	1	1	0	2	0	0
Total Domain 2		8	5	5	3	6	3	5
3. Accessibility of mental health services	3.1 Integration with primary care	2	0	0	0.5	2	0.5	1
	3.2 Affordability of mental health care	2	2	2	1.5	1	2	2
	3.3 Integration with comorbid conditions	1	1	0	0	1	0	1
	3.4 Mental health helpline	1	1	1	0.5	1	0.5	0.5
	3.5 Digital health	1	0.5	0.5	0.5	0.5	0.5	0.5
Total Domain 3		7	4.5	3.5	3	5.5	3.5	5
Domain 3 without affordability indicator*		5	2.5	1.5	1.5	4.5	1.5	3

*Indicator 3.2 measures the coverage of mental health services and essential psychiatric medications under the national basic insurance. Across a number of countries where these services are fully covered, access is often restricted due to limited service. provision and high demand.

Key findings

There is a need to strengthen the policy and legislative environment for mental health

Although all countries, with the exception of Egypt, have a mental health policy or plan, there is significant variance in how well policy translates into action. For example, Qatar's wide-ranging policy framework has led to meaningful improvement and a scale-up of mental health services, whereas Jordan's comprehensive policy environment has seen limited progress. Although mental health legislation exists in most countries, these laws are often not in line with international human rights standards, limiting the protection of those with mental health conditions.

Suicide prevention represents one of the biggest areas of weakness

None of the four Gulf Cooperation Council (GCC) states have a suicide prevention policy or plan, and suicide is still criminalised in many countries, reinforcing existing stigma and barriers to help-seeking. Although Jordan and Egypt reportedly do have a stand-alone strategy, policy or plan for suicide prevention, both countries made moves towards criminalising suicide in 2022. Every country in our study has a suicide prevention or mental health helpline—

some were introduced in response to the covid-19 pandemic and have remained owing to enduring demand. However, not all offer round-the-clock availability. A mental health emergency or crisis can occur at any hour and may require an immediate response—providing out-of-hours access to support services is essential.

Policies and laws need funding to aid their implementation, as well as good data to support their ongoing improvement and any required adjustments

Investment in mental health falls short across the region. All study countries spend less than the Lancet Commission's recommended proportion of their national healthcare budget on mental health, and only Saudi Arabia spends above the global average for its income group.[4,2] There is a need for improved collection of surveillance data and national research output to inform policy and the development of mental health services. Egypt, Qatar and Saudi Arabia have conducted extensive surveys, which have improved health officials' understanding of the mental illness burden. Although there has been a notable increase in mental health research output over the past two to three years, particularly in Saudi Arabia and Qatar, it is still relatively small by international standards.[2]

It is likely that improvements in mental health literacy and stigma stem in part from an increase in awareness and education efforts in the region

Government-led mental health campaigns have been introduced in Egypt, Kuwait, Qatar and Saudi Arabia, with the goal of increasing awareness and reducing stigma. A range of actors outside of the health sector, including education, workplaces, faith-based organisations and community groups, are playing an increasingly important role in mental health outreach and awareness activities. Ongoing research and evaluation is needed to ensure investment towards interventions that will deliver the greatest impact.

The voices of patients, service users and patient advocacy organisations are largely unheard in mental health policy and planning

Involving patients and service users in the design and delivery of mental health policy and planning can result in culturally responsive health systems that target the needs of the local population. Patient advocacy organisations, which play an integral role in raising awareness, reducing stigma and supporting people suffering from mental illness, also need to be supported and given a seat at the discussion table.

Commitment and collaboration between health and non-health actors is lacking in many countries

A multisectoral approach to policy formulation and implementation is essential to support societal integration of mental health services. Although civil society organisations in almost all study countries are active in mental health awareness initiatives and events, formal cooperation with the health sector is often missing. The National Centre for Mental Health Promotion in Saudi Arabia, whose board includes representatives from diverse government ministries, medical associations and charities, is a promising example of cross-sector collaboration.[5]

Mental health care must reach all population groups, including the most vulnerable

Refugees in Jordan and lower-income migrant workers in the four Gulf countries constitute a significant proportion of these countries' respective populations. All countries, with the expectation of Qatar, fail to recognise these groups in mental health policy and planning. Qatar has also taken meaningful steps to expand and adapt mental health services to its migrant worker population. Although mental health care is accessible to refugees in Egypt and Jordan, this is due mainly to the efforts of international development organisations.

Although mental health services are fully or partially covered under the basic national insurance in all countries, coverage doesn't necessarily translate into access

High demand and a shortage of mental health workers mean that despite well-intentioned generosity, access to public mental health services can be extremely limited and involve long wait times. Integrating mental health services into primary and community care provides the best and most cost-effective opportunity to cover entire populations, including those that are hardest to reach.

Progress towards mental health integration into primary care varies across the six countries

Qatar and Saudi Arabia, where integration is at the heart of national mental health strategies, have made significant progress. In contrast, there have been only moderate efforts in Oman and Kuwait and little advancement in Egypt and Jordan. Collaboration between mental health specialists and primary care physicians is limited, while access to medication and psychosocial services remains challenging across many countries. Managing comorbidity of mental health conditions and major NCDs requires integrating mental health services into other health service areas through referral pathways and collaborative care models. Mental health is included in the clinical guidelines for diabetes,

cancer and/or perinatal care in Egypt, Kuwait, Qatar and Saudi Arabia, indicating a recognition among these countries of the link between mental and physical health. However, evidence of these guidelines being used in practice is limited, and some countries lack the resources to support collaborative care.

As telehealth and digital tools become more mainstream, there is a need for integration within mental health policy and ongoing evaluation
Telemedicine and digital mental health solutions have proven beneficial in improving the reach and accessibility of mental health support services in the region, particularly during the pandemic; however, concerns remain regarding the evaluation of these technologies. Mental health mobile apps are beneficial in reducing stigma as they are one step removed from human interaction, but may do more harm than good if not adapted to the cultural context. Telehealth technology offers huge potential for reducing unmet mental health care needs, especially in remote areas. However, disparities in digital infrastructure and internet access in some countries will need to be addressed.

Key takeaways

- Although existing strategies and legislation are an essential start, officials in our scorecard countries need to enhance them to meet international best practice and human rights provisions.

- Suicide prevention needs urgent attention, including appropriate suicide prevention policies, the decriminalisation of suicide and expansion of mental health helplines to provide round the clock support.

- Essential supports for effective implementation of any mental health policy framework—sufficient budgets, data collection and relevant research output—need to be enhanced.

- Campaigns to improve mental health awareness and reduce stigma need to incorporate ongoing research and evaluation of what works best, from structure to messaging.

- Healthcare systems need to draw on wider expertise from patients, service users and patient advocacy groups in order to provide care to individuals who have extensive multisectoral needs.

- More effort is required to respond to the specific needs of vulnerable groups such as refugees and low-income migrant workers.

- Health officials need to prioritise and commit resources to integrating mental health care delivery with primary care and the management of common co-morbid conditions.

- Policymakers need to consider how best to integrate the use and evaluation of the growing number of digital tools into broader mental health strategies.

Country areas of focus

The results of the scorecard can be used to identify potential areas of focus for each country. Here we provide a high-level overview of progress towards integrated, accessible and equitable mental healthcare in each country and priority areas of focus, taking into consideration the stage of development and capacity of the health system in each country, as well as other socio-economic and contextual factors.

Note that we have not run any local workshops or in-depth country research; therefore, our findings should not be considered recommendations. We discuss the findings from the scorecard thematically in this white paper. Further details, including research methodology and indicator descriptions, can be found in the appendix.

Egypt scores poorly on government commitment and accountability, while there have been moderate efforts to increase mental health awareness and promotion efforts and accessibility of mental health services.

- **Strategy, policy and planning:** Egypt does not have a strategy, policy or plan for mental health. A standalone mental health strategy that is also aligned with the national health strategy or vision would provide direction and guide future progress on mental health.

- **Protection of individuals with mental health conditions:** Although Egypt has a mental health law, this legislation is not in line with human-rights covenants and has faced resistance from the psychiatric community owing to the use of involuntary treatment.

- **Affordability:** Although mental health services are reportedly covered under national basic health insurance, in practice access is restricted owing to limited services. As Egypt implements universal health coverage, it will be essential that mental health services are included in the covered interventions.

Jordan scores moderately across government commitment and empowerment of individuals and communities, and lower on the accessibility of mental health services. Although the country has mental health policies and plans, implementation remains an area for improvement.

- **Policy implementation:** Progress towards implementing the country's mental health plan has been slow. Allocating appropriate financial resources to mental health (currently, the government does not report spending on mental health) could help to support the development and integration of mental health services in primary and community care and capacity building.

- **Multi-sector collaboration:** Although civil society organisations and non-health sectors are actively involved in providing mental

health services, limited budget and influence in policymaking limit their reach. There is a need to strengthen co-operation with the health sector.

- **Integration with primary care:** Although the country's mental health policy calls for the delivery of services through primary care, mental health is provided through less than 10% of primary care facilities. Access to essential psychiatric medications is also very limited in primary care.

Kuwait scores low across all three domains; however, the score masks some notable areas of progress around integrating mental health into primary care and community-based initiatives to increase awareness and education of mental health.

- **Policy and planning:** Although Kuwait has a mental health policy, it falls short of the human-rights covenants to which the country is a party, and there is no long-term strategy to guide the direction of mental healthcare in the country.

- **Data collection and reporting:** Kuwait doesn't report spending on mental healthcare, nor does it systematically collect statistics on mental health. Comprehensive data on the burden of mental illness and spending on mental health would allow resources to be directed to where they are most needed.

- **Multi-sector collaboration:** Civil society organisations and community groups have been very active in mental health awareness and promotion efforts, which have been instrumental in progressing policy on mental health; however, formal co-operation from the health sector is lacking.

Oman scores moderately on the accessibility of mental health services and low on government commitment and accountability, and on empowering individuals and communities.

- **Government commitment:** Although Oman's Health Vision 2050 briefly mentions mental health, the country has no standalone

strategy, policy or plan to guide the future direction and development of mental health, nor does it currently have any legislation to protect the rights of those living with mental health conditions.

- **Multisector collaboration:** Civil society organisations and the private sector are active in leading mental health awareness and promotion initiatives in the country, with limited support or co-operation from the government.

- **Integration with primary and community care:** Although the integration of mental health into primary care has begun in Oman, progress is inconsistent across the country, and there is a need to increase access to essential psychiatric medications and psychosocial support services.

Qatar scores moderately well across all areas of the scorecard and has made significant progress across a number of areas, including policy, planning and legislation, research and resource allocation, integration of mental health services into primary care, and adapting mental health services for its migrant worker population.

- **Suicide prevention:** Although Qatar has a 24-hour helpline for mental health, the country has no standalone strategy or plan for suicide prevention and suicide is reportedly criminalised in the country, which could result in underreporting.

- **Incorporation of the patient voice:** Although the Qatar Mental Health Strategy includes plans for engaging patients in decision-making, there is currently no evidence of this happening in practice.

- **Digital health:** Although there is evidence of digital health and telepsychiatry services helping to support access to mental health care, implementing guidelines to support the use, integration and evaluation of telehealth and digital health tools will help to ensure that quality or privacy are not compromised as this technology evolves.

Saudi Arabia scores moderately well across all areas of the scorecard, with notable advancements in the allocation of funding and resources towards mental health and multisector coordination.

- **Protection of individuals with mental health conditions:** Although Saudi Arabia has a mental health law, which does promote patient rights and best practice care, the legislation fails to meet international standards, and there is no independent review body through which patients and their advocates can contest decisions.

- **Incorporation of the patient voice:** Although there is increased recognition that the patient voice and experience should be considered in health policy or planning, there is little evidence that the patient voice has been incorporated into policy, planning or service delivery for mental health.

- **Migrant workers:** Migrant workers, many of whom earn low incomes, account for over 38% of the population in Saudi Arabia. There is no mention of migrant workers in national mental health policies, nor is there evidence of specialised or adapted services for this population group.

Introduction: The burden of mental illness in the MENA region

The World Health Organisation (WHO) defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community."[6] Despite tweaked phrasing since 1950,[7] the WHO's core definition has remained the same—mental health is measured according to what individuals can do rather than being defined as an absence of disease.

Consideration of the burden from poor mental health needs to also focus on illness. The WHO definition's breadth complicates this task. Most serious diseases, for example, can create emotions that impede individuals from working "well" or realising their full abilities. Even when restricted to brain-related conditions, drawing a clear line around mental illness is complicated (see box 1). To examine the burden of mental illness, this report uses the prevalence of, and the disability-adjusted life years (DALYs) attributable to, conditions in the Global Burden of Disease (GBD) study's "mental disorders" category.[8] We also look at mortality from self-harm (suicides).

The real prevalence of mental illness in the MENA region remains poorly understood

Accurate diagnosis statistics are difficult to determine, as mental health is underreported and under-diagnosed owing to stigma and low levels of awareness.[1] Stigmatisation—discussed in detail later—reduces mental health help-seeking, which contributes to substantial underreporting of mental health symptoms, leaving an indeterminate number of cases undiagnosed.

The data presented in this section provide a rough picture of what is happening based on available data sources. Compared using age-standardised prevalence rates, which adjust estimated national health results to those that would exist if each country's population had identical age demographics, the burden of mental ill health in the six study countries is substantial, yet has been relatively stable over the past two decades. According to 2019 data, the prevalence of mental health conditions ranges between 13.6% in Qatar to 16.2% in Jordan.[1]

Although the prevalence of mental health conditions has remained relatively consistent over the past two decades, mental health conditions have increased significantly as a share of the total disease burden

This burden of mental health conditions seen in our study countries is not out of the ordinary. For high-income countries worldwide, a category into which Kuwait, Oman, Qatar and

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a DALYs are a measure of the overall burden of a condition, expressed as the number of years lost due to ill health, disability or early death.

Saudi Arabia fall, the average is 15%. Jordan and Egypt, with respective averages of 16.2% and 14.5%, are slightly higher than the average for their respective income groups. Although overall prevalence rates of mental health conditions appear on par or even slightly low compared with the global average in some countries, locally reported figures are often higher. A national survey of 22,000 families in Egypt by the country's Ministry of Health in 2018 indicated that 25% of Egyptians suffer from mental health issues.[9]

Figure 1: The burden of mental illness in the MENA region, 2019

	Prevalence of mental health conditions	Mental health conditions as a % of the total burden of disease	Prevalence of anxiety disorders	Prevalence of depression
Global	~15%	~5%	3.8%	3.4%
High-income	14.9%	6.7%	5.3%	4.0%
Upper middle income	12.5%	5.7%	4.2%	3.3%
Lower middle income	12.8%	4.3%	3.4%	3.7%
Egypt	14.6%	6.7%	4.8%	4.1%
Jordan	16.3%	10.2%	5.2%	4.4%
Kuwait	14.1%	12.2%	4.9%	4.4%
Oman	13.7%	10.4%	4.8%	4.1%
Qatar	13.6%	13.7%	4.5%	4.2%
Saudi Arabia	13.7%	8.9%	4.8%	4.4%

Source: IHME, Global Burden of Disease 2019 (sourced from ourworldindata.org).[1]

Figure 2: Share of the population with mental health conditions, 1990–2019
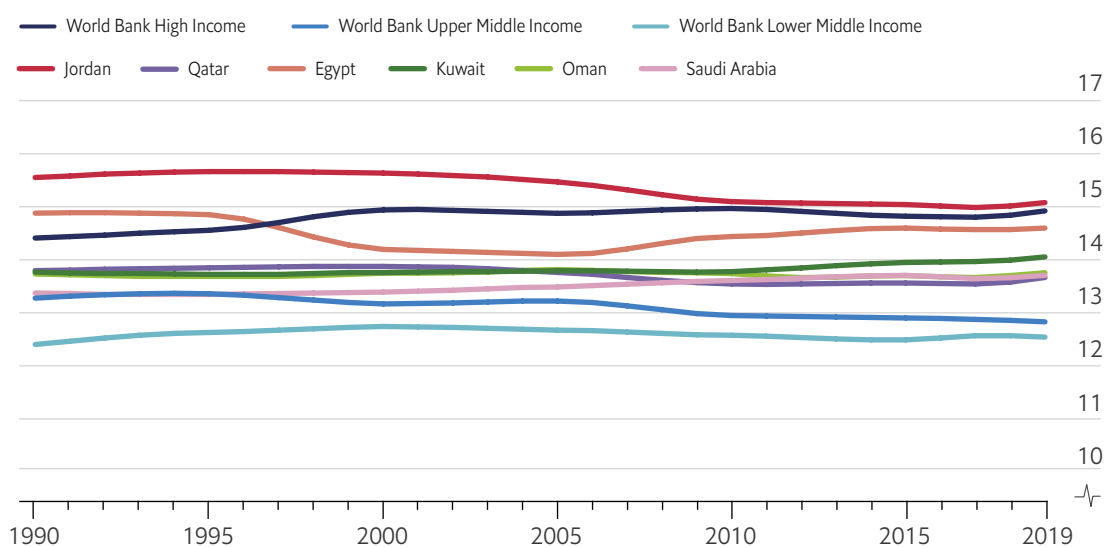
Source: IHME, Global Burden of Disease 2019 (sourced from ourworldindata.org).[1]
Note. IHME GBD data include depression, anxiety, bipolar, eating disorders and schizophrenia. Owing to the widespread under-diagnosis of mental illness, these estimates use a combination of sources, including medical and national records, epidemiological data, survey data, and meta-regression models.

Data from the study countries show that the prevalence of mental health conditions (figure 2) has remained relatively stable over the past two decades, increasing by just 0.38 percentage points (pp) in Saudi Arabia and 0.03 pp in Oman and decreasing by 0.29 pp in Egypt between 1990 and 2019. However, mental health conditions have increased significantly as a share of the total disease burden (figure 3), increasing by 3.38 pp in Egypt (from 3.17% in 1990 to 6.69% in 2019) and 5.42 pp in Oman (from 3.99% in 1990 to 10.41% in 2019).[1]

Much more rapid progress in preventing and treating other acute and chronic diseases means that the percentage of DALYs attributable to mental disorders has unambiguously risen in each of the study countries and, for all but Egypt, is now well above the average for high-income countries. In Jordan, Oman, Kuwait and Qatar, the share of mental health conditions as a share of the total disease burden was over double the global average of 5% in 2019—the percentage in Qatar was the highest, with mental health conditions making up 13.67% of its total disease burden (Figure 3). The accompanying map shows that the study countries collectively form the global hotspot for the proportion of mental health disorders as a share of total disease burden (Figure 4).

Figure 3: Mental health conditions as a share of total disease burden, 1990–2019
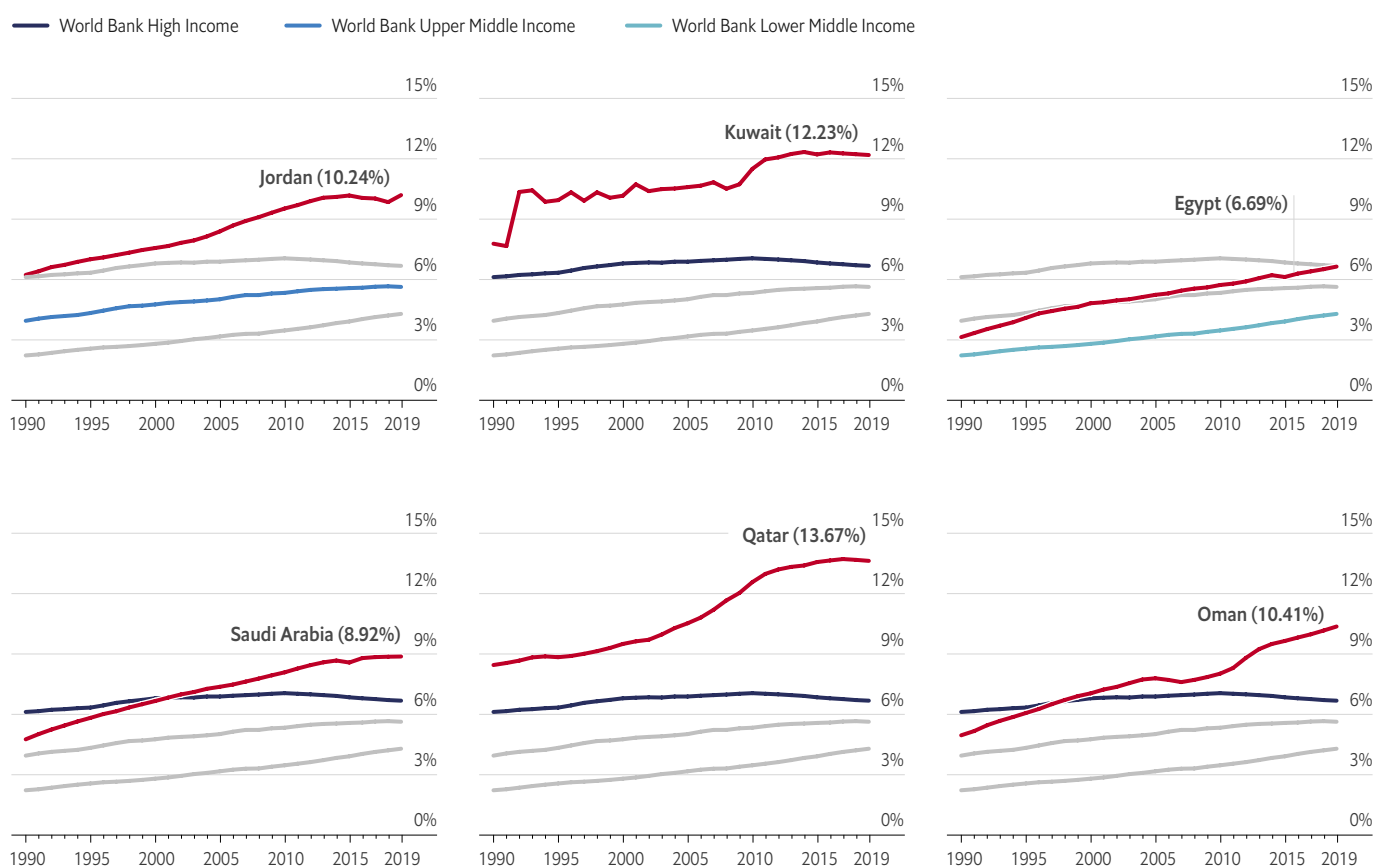
Source: IHME, Global Burden of Disease 2019 (sourced from ourworldindata.org).[1]
Note. Disease burden is measured in DALYs (disability-adjusted life years). DALYs measure total burden of disease, both from years of life lost and years lived with a disability.
One DALY equals one lost year of healthy life.

Figure 4: Global burden of mental health conditions as a share of total disease burden, 2019
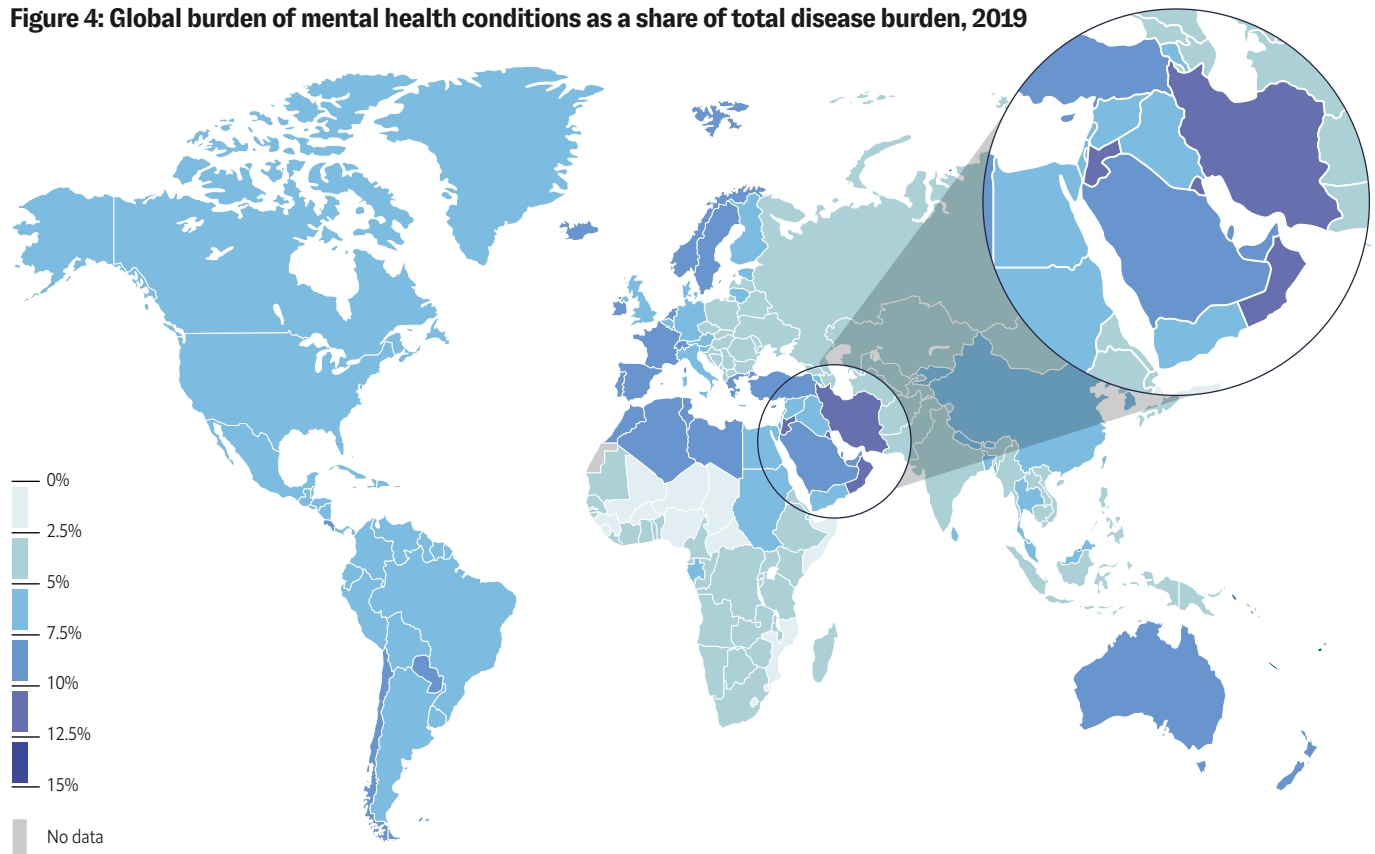
Source: IHME, Global Burden of Disease 2019 (sourced from ourworldindata.org).[1]
Note. Disease burden is measured in DALYs (disability-adjusted life years). DALYs measure total burden of disease, both from years of life lost and years lived with a disability. One DALY equals one lost year of healthy life.

The rate of suicide in the MENA region is lower than global averages - however this may be due to underreporting

A majority of suicides—although not included as an outcome of mental disorders by the GBD—arise from mental illness.[10] Suicide is also a risk factor for the region's large youth population: the WHO reports that suicide is the third leading cause of death globally in 15-19 year-olds.[11] Long-term data on mortality from suicide suggest little change in the region over the past two decades, with a decline in some countries. The rate of suicide also appears to be significantly lower in the MENA region compared with its global counterparts. For example, while the average rate of suicide was 10.8% in 2019

for high-income countries, the study countries under this category—Saudi Arabia, Qatar, Oman and Kuwait—all report less than half of this rate, ranging from 2.6% in Oman to 4.2% in Saudi Arabia. As discussed earlier, the comparatively lower mortality in the study countries may result from underreporting owing to stigma.[12] "There is underreporting of suicide, largely as a result of huge stigma," says Dr Nasser Loza, president of the World Federation for Mental Health (2021-23) and director of Behman Psychiatric Hospital in Cairo, Egypt. Furthermore, many countries in the MENA region do not have a suicide or self-harm registry system. These systems are essential for providing accurate data on self-harm and suicide and revealing trends over time.[13]

Figure 5: Annual suicides per 100,000 people, 1990-2019

— World Bank High Income   — World Bank Upper Middle Income   — World Bank Lower Middle Income
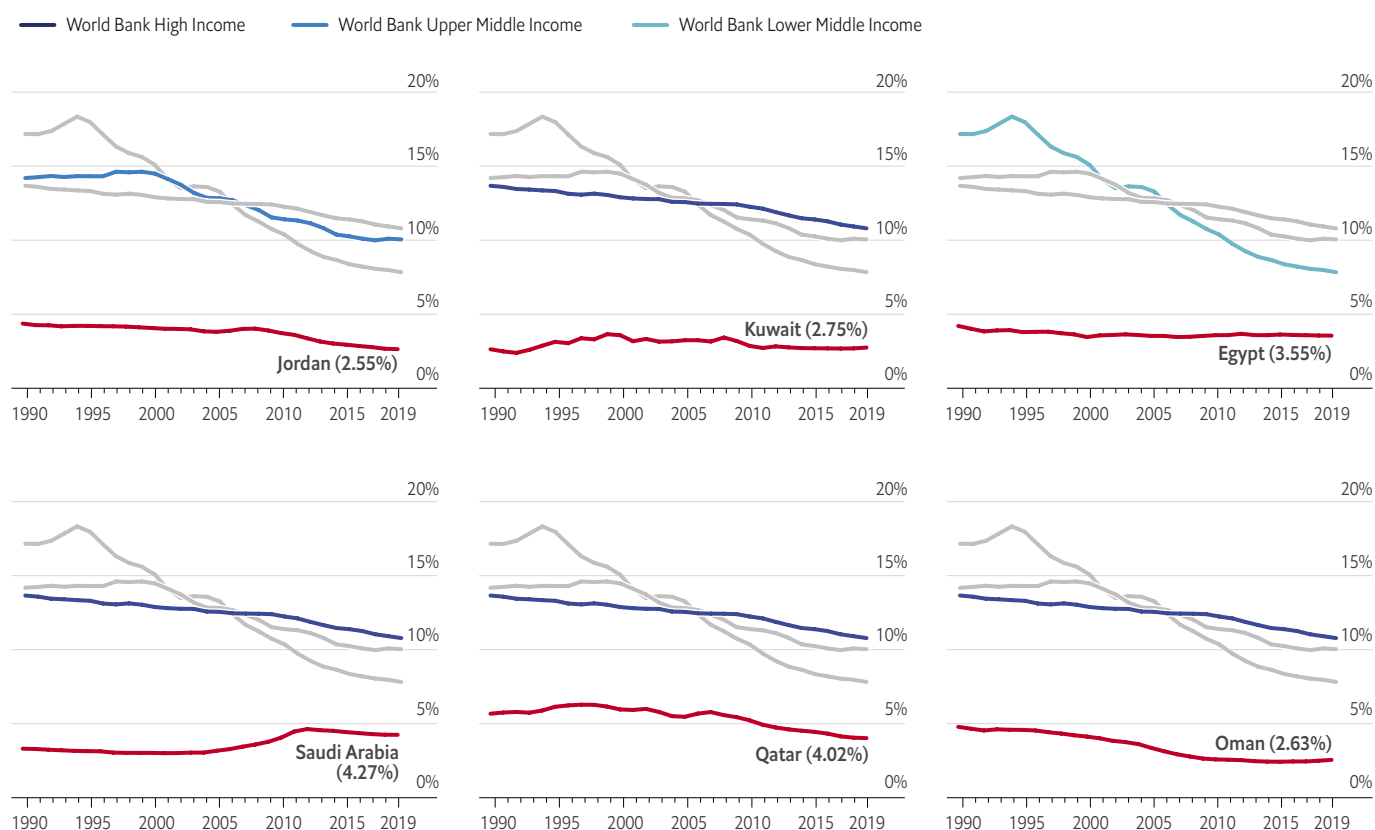
Source: IHME, Global Burden of Disease 2019 (sourced from ourworldindata.org).[12]

The burden of mental illness may be further exacerbated in the coming years by the risk factors associated with a young population and high burden of non-communicable diseases

Of the MENA region's population of 679m, 60% are under the age of 30.[14] Younger people are particularly vulnerable—according to the WHO, 50% of mental health problems start by age 14 and 75% start by age 24.[11] Mental health disorders account for 45% of the burden of disease in 10-24-year-olds globally, with depression and anxiety among the leading causes.[15] Substantial evidence exists that mental health conditions can be a precursor to, or consequence of, other major non-communicable diseases (NCDs), such as diabetes, cancer and cardiovascular disease.[16] According to a WHO study on the comorbidity between mental health disorders and major NCDs, depression is two to three times more common in those with diabetes

than those without.[16] The rate of diabetes is high across all study countries, particularly Egypt and Saudi Arabia, where the prevalence rate is over 20%.[17]

Beyond the significant human toll, the countries in this study pay an economic cost for those affected by mental illness. In 2022, PwC estimated that the annual cost of lost productivity from untreated mental illness in GCC states is US$3.5bn.[18] This figure leaves out treatment costs, and the countries included do not correspond to those in this study. Nevertheless, it does give an impressionistic idea of the economic implications of mental illness in the region.

Although the true burden of mental illness in the study countries remains poorly understood, one thing is clear: mental illness is now too big a part of the region's overall health burden to ignore.

BOX 1

Defining the boundaries of mental illness—the challenges of measuring the mental health burden

The true global disease burden of mental illness remains elusive. Mental illness covers a diverse range of mental, neurological and substance-use conditions caused or triggered by biological, psychological, social and environmental factors. The extent of the mental illness burden depends on what one includes in the calculation, and defining these boundaries is under increasing debate. Two data sets that attempt to capture this burden are the Institute of Health Metrics and Evaluation's Global Burden of Disease (GBD) and the Mental, Neurological, Substance Use Disorders and Suicide (MNSS; sometimes the second S is categorised as "self-harm") designation, both of which have their strengths and limitations.

Global Burden of Disease: The GBD "mental disorders" category includes schizophrenia, depression in its various forms (including bipolar disorder), anxiety, eating disorders, autism, ADHD and several other, lower-prevalence conditions.[19] The list is a traditional one, and reflects a distinction between ailments of the mind and of the body. The GBD is currently one of the only sources of global-level estimates across most countries on the prevalence and disease burden of mental health disorders. However, owing to the classification of what is included in the "mental disorders" category, the estimates may undercount the mental health–related burden. The GBD's "mental disorders" category also fails to capture mortality from suicide or self-harm—the very few deaths included in this GBD category arise mainly from eating disorders.

Mental, Neurological, Substance Use Disorders and Suicide: To capture the overall burden, in all its form, of mental and neurological diseases, researchers have created the MNSS category. This has the advantage of raising the profile of this accumulation of conditions. A recent comment in The Lancet calculated that MNSS as a category accounted for 13% of all DALYs worldwide, making it the second highest cause after cardiovascular disease. This compares with 4.9% of DALYs for mental disorders using existing GBD measures.[20] However, the scope of conditions that fall under MNSS can be too expansive. For example, it includes all DALYs from tension headaches, even those that might have causes unrelated to mental or neurological diseases.[21] On a practical note, the necessary calculations are not available for our study countries. Therefore, this study does not adopt MNSS data.

This study relies on the GBD figures for mental disorders, as well as the number of suicides, in discussing the mental health burden in our study countries. However, we recognise that these numbers represent a lower limit on the toll which these conditions exert. The true figure, and therefore the urgency of the need for a health system response, is likely to be much higher.

Barriers to an effective response: Long-term weaknesses in mental health care provision

Later sections in this report examine the very real differences between our countries of interest. For now, even while acknowledging bright spots of progress, an understanding of current mental health care provision across the region needs to consider the longer-term deficiencies that remain unaddressed. These include a scarcity of appropriately trained mental health professionals to meet mental health needs, an over reliance on outdated institutional practices, and prevailing stigma and low mental health literacy.

Of course, the problem in not unique to the region. "Mental health is always the last [healthcare] priority worldwide," says Dr Mohammad Alsuwaidan, a psychiatrist and founder of the MindWell clinic in Kuwait. Although examples of good practice exist—some

of which are discussed later in this study—they are far from common practice. Dr Michael Elnemais Fawzy, an Egyptian psychiatrist, observes of Egypt that "on an individual level, you will hear great stories" of isolated efforts, but these do not translate into systemic change.

Insufficient human resources to meet mental health care needs

A lack of appropriately trained workers limits mental health care in the Middle East. Data on the mental health workforce in the region illustrate a decline in the total number of healthcare professionals working in mental health per capita over the past six years.[2,3]

Looking at the international context, the figures from the MENA countries are comparatively low given income levels and the significant mental health burden. In high-income countries worldwide, the median number of mental health workers per 100,000 is 62.2; Kuwait, Qatar, Oman and Saudi Arabia all have less than half this number, with just 13 mental health workers per 100,000 population in Oman and 17.7 in Saudi Arabia. Jordan, with 4.13 mental health workers per 100,000, is also well below the average of 14.7 for upper-middle-income countries. Egypt has slightly more mental health workers compared with the average of 3.8 per 100,000 population for lower-middle-income counties; however, at 5.8 per 100,000, the proportion in

> ## "Mental health is always the last [healthcare] priority worldwide."
>
> Dr Mohammad Alsuwaidan, founder and clinical director of MindWell, Kuwait

Figure 6: Change in the mental health workforce per 100,000 population, 2014–20

	World Bank High Income		World Bank Upper Middle Income		World Bank Lower Middle Income		Egypt		Jordan		Kuwait		Qatar		Oman		Saudi Arabia	
	2014	2020	2014	2020	2014	2020	2014	2020	2014	2020	2014	2020	2014	2020	2014	2020	2014	2020
Total mental health workforce	52.3	62.2	15.9	14.7	3.2	3.8	7.3	5.83	7.8	4.13	34	18.75	16.3	25.28	15.8	13.07	16.5	17.7
Psychiatrists	6.6	8.6	1.2	1.7	0.4	0.4	0.68	0.84	0.51	1.04	3.3	2.35	2.95	2.22	2.32	1.65	2.13	3.41
Psychologists	2.7	10.7	1.4	1.6	0.2	0.3	0.12	0.86	0.27	0.11	2.1	1.35	1.98	1.62	0.38	0.96	1.38	3.25
Mental health nurses	31.9	29	7.1	5.1	2.5	1.3	3.1	3.9	4.72	2.97	19.23	18.75	8.82	18.18	12.71	9.91	10.49	2.54

Sources: WHO, Mental Health Atlas 2014, https://apps.who.int/iris/rest/bitstreams/803874/retrieve; Mental Health Atlas 2020, 2021, https://apps.who.int/iris/rest/bitstreams/1376861/retrieve.
Note. Where human resource density has risen, the 2020 figures have a green background. Declines are marked in amber.

Egypt is negligible by global standards. None of the high-income study countries come close to the median number of 8.6 psychiatrists per 100,000; there are just 2.13 per 100,000 in Saudi Arabia and 2.32 per 100,000 in Oman.[2]

Not visible in the data is another common worry in the region—the quality standards of these professionals. Susan Clelland, director of Qatar's National Mental Health Program reports that the country has an active mental health training programme for primary health care workers, including doctors and nurses. This helps to explain the rise in Qatari workforce figures. However, Dr Khalid Saeed, regional advisor for Mental Health and Substance Abuse at the WHO notes that most clinicians listed as mental health nurses elsewhere in the region "are general duty nurses" simply assigned to the role.

In certain countries, some psychologists may have even less relevant training. The most alarming example is Kuwait. The rise in mental health difficulties after the Iraqi invasion drove the government to give the Ministry of Commerce, not the Ministry of Health, responsibility for psychologists' qualifications. "Many untrained people received the same kind of license that a salon or a gym would have," says Dr Alsuwaidan. In Oman too, says Dr Alya Sultan, a clinical psychologist at Oman's Eunoia Clinic, many still practice psychology with only a bachelor's degree. "That gives you an idea about the standard of practice," she says. "It is something that really needs to be attended to."

According to Dr Nancy Baron, founder-director of Cairo's Psychosocial Services and Training Institute, public psychiatric clinics and hospitals in Egypt, which has among the fewest mental health workers per capita in our study, are "completely overcrowded" most days, those in the capital, Cairo, "overwhelmingly so." Oman's 13 healthcare workers per 100,000 in 2020 is just shy of the average number for our six countries.[22] "[The current workforce] is not a sufficient workforce. Public patients face a huge waiting list and even private ones face substantial delays," says Dr Mirza, adding that wait times are among of the most frequent complaints he hears from patients. In Saudi Arabia the slightly higher mental health workforce density does not eliminate such problems. A 2022 survey of mental health outpatients reported high levels of frustration due to wait times for emergency care and the inability to schedule an appointment.[23] In Kuwait too, reports Dr Nicholas Scull, general manager of FAWSEC Medical, "there's a shortage of mental health providers and even private psychiatric care involves "a wait of over a year.""

Even for fully qualified professionals operating to peak capacity is a challenge when they have so few colleagues. "Many [mental health professionals] are experiencing burnout, says Dr Mirza. "Everybody needs an urgent appointment or seven-day follow-up. There is only so much a person can do with limited resources." Ultimately, the test of whether the workforce is sufficiently large or skilled comes not down to international comparisons and formal certification, but to whether it meets the needs of those who seek help. Here, comprehensive data are lacking, but impressions from experts suggest that the current supply is far from sufficient.

Outdated institutional focus which isolates mental health patients from the community

Decades ago, a global shift began away from isolation of those living with mental illness in long-term care facilities, usually with little in the way of active treatment. Best practice became oriented around health and social care arrangements that favour the integration of patients into the community.[24] The aim has been to replace large, specialist mental institutions with community centres, outpatient facilities and mental health wards in general hospitals. In much of the world— especially in high-income countries—this deinstitutionalisation process is largely complete. In several of our study countries, though, it lags behind.

Jordan and Saudi Arabia appear to have made particularly little progress. In the former, as of 2020 49% of patients in mental hospitals stay for more than five years and a further 17% for between one and five years.[25] In 2017 Saudi Arabia's director general of mental health reported that, of the then 4,000 beds available in mental hospitals, 1,000 were blocked by patients who could not leave as their families would not accept them back.[26] Presumably, others had long-term stays for different reasons. Dr Haifa Al Gahtani, a consultant psychiatrist in Saudi Arabia and executive director at the Renewal and Reward Centre, reports that institutionalisation remains common, with patients "segregated in specialist institutions a lot of the time in very hidden, deserted places outside of the city."

Even in countries where mental hospitals are largely short-stay facilities rather than designed to house patients permanently, a worryingly large number of individuals remain institutionalised. In Egypt, for example, only 10% of those admitted to mental hospitals stay for more than one year— close to the global average.[27] However, experts we spoke to for this research suggest that this figure may only reflect recent admissions and that long-term stays in mental health institutions remain an issue. Similarly, in Kuwait, where officially only 8% stay for longer than a year, the problem is also visible.[28] Dr Alsuwaidan estimates that at the Gulf's largest facility, the Kuwait Centre for Mental Health, half of the roughly 1,000 beds are occupied by long-term cases.

"In most Middle Eastern countries the prominent model of [mental health] service delivery is through big hospitals, often in large cities away from the community."

Dr Khalid Saeed, regional advisor, mental health and substance abuse, Regional Office for the Eastern Mediterranean, World Health Organisation

When the choice is putting vulnerable people on the street or keeping them in hospital, the latter is the only humane option. The problem is the lack of other choices. Effective deinstitutionalisation requires facilities to support those living with mental illness in the community. Here, many of our study countries fall short. In Egypt, for example, 19 mental hospitals provide inpatient and outpatient facilities, but only two general hospitals have mental health wards and just one non-hospital mental health outpatient facility exists.[27] In Jordan, the number of mental health beds in general hospitals is less than 5% of that in mental institutions.[25] In Kuwait, says Dr Alsuwaidan, "the whole idea of assisted living or hospice care for chronic mental health cases doesn't exist."

"The whole idea of assisted living or hospice care for chronic mental health cases doesn't exist."

Dr Mohammad Alsuwaidan, founder and clinical director of MindWell, Kuwait

BOX 2

Defining mental health literacy and stigma

The first definition of **mental health literacy**, from 1997, is still applicable: "Knowledge and beliefs about mental disorders which aid their recognition, management or prevention." This includes how to find information, engage in self-help and seek interventions.[28] A large body of evidence supports the positive association between adverse health outcomes and low mental health literacy. A low level of mental health literacy may also hinder public acceptance of evidence-based mental health care. Much of the stigma and misunderstanding about mental health disorders can be attributed to a lack of mental health literacy.[29]

"**Stigma**" describes a broad and complex web of attitudes. Major, overlapping, categories include self-stigma (an individual's beliefs that having a given condition makes one a lesser person); personal stigma (an individual's beliefs that others with a given condition are lesser people); and public stigma (common attitudes within a society that those with a condition are lesser people).[30] Stigma is a well-documented barrier to help-seeking behaviour and is a global issue that reaches all geographies and cultures—globally 80-90% of people with mental health disorders report experiencing stigma and discrimination.[31]

Nor does such hospital-centricity result simply from reliance on existing infrastructure rather than spending on new facilities. Dr Mirza notes that, in Oman, the mental hospital in the capital, Muscat, is a modern facility opened in the past decade. Unfortunately, it is too small to meet the needs of the population and only a handful of beds in general hospital wards exist anywhere in the country. He adds that "safeguarding social services are almost non-existent."

In short, the most common situation in our study countries is that too few clinicians are trying to deliver mental health care using hospital-focused structures that no longer reflect global best practice.

Bitter fruits of the same tree: mental health illiteracy and stigma

Stigma, according to Dr Aseel Omran Alsabbrie, a consultant family physician in Kuwait, is "one of the biggest barriers" to provision of mental health care in the region, words which almost every expert interviewed for this study echo. Although somewhat distinct, mental health illiteracy and stigma against those affected are certainly interlinked (box 2). Their joint presence and impact is also not unique to the region nor permanently embedded in the culture of our study countries. That said, both problems continue to interact to form a major barrier to better mental health care provision in the region.

Mental health literacy data in the study countries is sparse and often outdated. The data that do exist collectively point to low levels of awareness.[33] Just 52% of respondents to a 2017 survey of the general Saudi population had heard of bipolar disorder and, of these, only around half thought that medication could help.[34] More recently, and more worrying, a study of Egyptian undergraduate medical students found compelling evidence of low depression and suicide literacy.[35]

If not addressed, poor mental health literacy will greatly impede help-seeking behaviour. "A lot of

> ## "Communities [in the Middle East region] are rarely educated about warning signs for mental illness, or the physiological and environmental factors that can contribute to it."
>
> Dr Arokiasamy Perianayagam, professor, policy department, Social & Economic Survey Research Institute (SESRI), Qatar University

people don't know what to do once they realise they have [a mental health] condition," says Dr Alsuwaidan. Dr Alsabbrie agrees that even those who realise that they have a problem lack "confidence in, or knowledge about, the service and what is available." We see similar challenges in data from Saudi Arabia: a 2018 survey found that 87% of respondents did not know about psychiatric services available in the country.[36]

Like illiteracy, stigma reduces ones willingness to seek help. Dr Elnemais Fawzy explains that part of the issue is self-stigma: "People believe internally that they are 'mad,' there is no solution to their problem, and they will stay 'mad.'" Public stigma also makes looking for medical help seem dangerous. Dr Alsuwaidan notes that today's concerns for many in the region "have always been there: Will people find out about this? If someone does, will I be able to get married? Will I be able to get a job or be fired from my job? Will this go on my record?" Dr Abdullah Dukhail AlKhathami, a consultant family physician in Saudi Arabia and vice-chair of the Wonca Working Party on Mental Health, says that "when a mental health problem is discovered in the primary care setting, many patients refuse to be referred to the psychiatric hospital." However, Dr AlKhathami notes that mental health problems are seldom identified in primary care, which he believes is largely related to gaps in undergraduate and postgraduate training for medical doctors. Dr Al Abdulla explains that, "due to close knit communities and the public stigma, some patients are reluctant to seek mental health support for fear of their

condition becoming known in the community.", she adds that "efforts to provide a greater range of mental health services within a primary care setting and improve public awareness, have resulted in significant progress in this area with more people accessing mental health support in recent years."

Negative experiences with healthcare professionals or mental health services also serve as a barrier to continuing treatment

Lack of mental health literacy and stigma towards those with mental illness besets not just the general population but those working in health systems. Lack of trust in the healthcare system is also reflected in the Saudi National Mental Health Survey (SNMHS), a community-based epidemiological survey in a nationally representative sample of respondents aged 15-65. Among those with a perceived need and not seeking help, 9% believed that mental healthcare would be ineffective. The figures are more striking among the small number of people who dropped out of care. Of these, 29% gave stigma as a reason, but 46% said that their choice arose from a negative experience of the treatment provider.[37] A study on mental health help-seeking among Omani adolescents found that fear of stigma matters greatly, although belief or disbelief in whether the treatment would do any good is nearly as important.[38] Dr Scull reports from a study conducted by his organisation in Kuwait that people willing to fight through stigma to see a psychologist are unlikely to return if they get bad healthcare from an unqualified professional.

Understanding cultural nuances and perceptions of mental health—including how they can be both a barrier and an enabler to help-seeking—is important

In the Middle East beliefs about the origins and nature of mental illness are heavily influenced by religious teachings, cultural stereotypes and family tradition.[39] A combination of longstanding popular perceptions and particular interpretations of Islam can create challenges for the provision of modern mental health services. A 2017 survey in Saudi Arabia, found that only 49% believed that drugs could be an effective treatment for bipolar disease, yet over half thought that prayer could.[34]

Misconceptions can reduce help-seeking. As Dr Alya Sultan points out, people who attribute their suffering to the evil eye or some other external cause are less likely to think that mental health professionals can help. A 2018 study looking at attitudes toward mental illness among the Arab population suggested that many Arabs prefer seeking support from faith healers or

referring to God as a first approach to treating mental illness.[39]

Integrating mental health awareness with religion can help mitigate these misconceptions. Dr Naif Al-Mutawa, professor of clinical psychology at Kuwait University, recalls going to a worship service in Saudi Arabia a few years ago where he knew that the sermon would discuss mental health issues. He was sceptical about what would be said, but heard "an amazing sermon that surrounded mental health in a really good way. [The speaker's] and my solutions may differ, but the information was very valuable."

Changing cultural beliefs around mental health will take time in the Middle East, as elsewhere, but it will succeed faster where health systems visibly demonstrate good outcomes. "If you cannot convince the community that you are providing a good service, stigma will continue," says Dr AbdulHameed Al-Habeeb, consultant psychiatrist at the Saudi Ministry of Health's National Center for Mental Health Promotion. "And when we talk about stigma actually sometimes it's not stigma but that we are not available. If we're not there to help our patients when they need it, they will look for other sources of help."

Are winds of change beginning to blow?

Although an insufficient workforce, outdated institutional arrangements, widespread mental health illiteracy and stigma remain significant and longstanding challenges in the MENA region, there are clear signs of improvement across the countries in this study.

Mental health is gaining greater government attention with widespread efforts to strengthen mental health policy and workforce quality

Globally, mental health has emerged as a public health priority with increased recognition that good mental health is essential to the functioning, wellbeing and performance of

individuals, communities, society and the economy. Every country in this study now has a mental health policy, albeit of varying quality and not all up to date. However, even imperfect policies can represent progress. Kuwait, as discussed in a later section, has one of the least comprehensive mental health policy frameworks. Consistent with this situation, political support for work on mental health is "still weak", says Dr Alsabbrie. "We don't have the complete support financially," she adds. "But it is better than in 2011. Now we have support for the medication and training, and complete support for making guidelines."

Mental health workforce oversight has also improved in several of the states in our study. As noted above, regulation for psychology professionals has tightened in several countries. Dr Al Gahtani, who has worked as an examiner with the Saudi Board of Psychiatry over the past decade, says that "the standard of training [in Saud Arabia] has risen greatly."

While stigma prevails, there is a notable decline, particularly among the younger generation

Almost every expert that we interviewed reports that, while still a major problem, stigma has declined noticeably in their countries. For example, Dr Alsuwaidan says of Kuwait that

awareness and acceptance of mental health "has improved drastically over the last ten years, especially in younger people".

"The younger population [in Oman] shows more interest in mental health awareness campaigns," adds Dr Hamed Al Sinawi, senior consultant psychiatrist in the Department of Behavioural Medicine at Sultan Qaboos University Hospital and chairman of the Oman Alzheimer's Society. Dr Al Gahtani has seen signs of the same kind of change in Saudi Arabia. Men who two decades ago might have come to her clinic with heads covered and in dark glasses now no longer take such steps to hide their identities. Nevertheless, many in the older generation remain sceptical, she adds. The decline in stigma is also not seen across all mental health conditions. While greater sympathy now exists for those with depression or anxiety, says Dr Al Gahtani, "if you have schizophrenia people will stay away from you."

The covid-19 pandemic provides an opportunity to gain momentum and normalise mental health

The covid-19 pandemic disrupted the pattern of slow change to the mental health landscape. As in much of the rest of the world, worry about the disease and disruption arising from lockdowns and other control measures greatly heightened levels of stress across populations in our study countries.

"Although much has been done, there is still a long way to go. There is a need for more public education to contain the negative attitudes and to focus on the global concept of mental health as part of general health, like any other ailment."

Dr Samir Abu Moghli, former president, Jordanian Psychological Association

The resultant increase in the incidence and burden of mental illness was impossible to ignore. Mental health emerged as a national priority across many of the countries in the study. Four created psychiatric or psychosocial helplines to help people cope with the burden.[40] Others went further: most covid isolation units in Egypt, for example, had a psychiatrist attached to it, says Dr Baron.

However, the most important, lasting impact of the pandemic on mental health is likely to be changed attitudes. As Dr Yasmin Altwaijri, senior scientist and head of epidemiology at King Faisal Specialist Hospital and Research Center in Saudi Arabia, explains, almost "everybody was suffering from anxiety, lack of sleep and depression, or all of those. So, the dialogue surrounding mental health and the stigma really improved." Experts from other countries paint a similar picture. Dr Al Abdulla reports that Qatar specifically rolled out a mental health awareness campaign during the pandemic, "The 'Are you OK' campaign changed the conversation around mental health and made it more okay to talk about, helping to create an environment where mental health is talked about as openly as physical health." she says. In data from the Qatar National Mental Health Attitudes and Awareness Survey 2020, we are seeing such signs of improved awareness, with 77% of adults surveyed reporting moderate to high awareness of mental health in 2020, compared with 52% in 2018.[41]

Kuwait saw a similar increase in understanding some years earlier. Dr Al-Mutawa recalls that, after the first Iraq War, the authorities "did a very good job educating the population about PTSD, psychosocial issues, etcetera. All of a sudden, it became socially acceptable to reach out for help, even if your problem predated the invasion."

This improvement in reduction of stigma, while undeniably positive, brings challenges as well. In particular, both Dr Scull and Dr Mirza say that reduction of stigma has led to increased immediate demand for overstretched mental health services in Kuwait and Oman respectively. Yet Dr Al-Mutawa and Dr Mirza report that it is also likely that changed attitudes are behind a higher number of people being interested in becoming mental health professionals in the two countries. This could ease the workforce challenge, but only if training facilities and health service positions are created.

These short- and longer-term developments all give hope of accelerated progress in meeting the still-pressing mental health service needs in the study countries. The rest of this study considers several key areas that will shape the extent to which countries succeed—or fall short—in carrying out this transformation.

Insights from the MENA Mental Health Scorecard

Introduction to the scorecard

In order to examine methodically the strength of key assets on which our countries of interest can build effective mental healthcare provision, Economist Impact has created the MENA Mental Health Scorecard. It looks at how six MENA countries—Egypt, Jordan, Kuwait, Oman, Qatar and Saudi Arabia—are doing on each of 16 indicators grouped into three broad domains.

The domains and indicators were developed based on a pragmatic literature review to identify key enablers and barriers to mental healthcare provision in the region. An expert panel discussion provided insight and direction to help shape the development of the framework for the scorecard, in addition to further secondary research and interviews with mental health experts across the six study countries.

The three domain areas are:

- *Government commitment and accountability*, including the existence of relevant policies and legal protections for those living with mental illness, as well as the funding devoted to mental healthcare and the technology and research infrastructure in place.

- *Empowering individuals and communities*, including mental health promotion initiatives by governments and community groups, the role of the patient in healthcare planning, how mental healthcare specialists work with other care providers, and the treatment of vulnerable populations.

- *Accessibility of mental health services*, which looks at a range of matters related to how easily the general population and those at particular risk can receive care.

Table: Country selection according to income group classification

High income	Upper middle income	Lower middle income
Kuwait	Jordan	Egypt
Qatar		
Oman		
Saudi Arabia		

Source: World Bank country classifications by income level: 2021-22. [42]

Table: Towards Mental Health Integration in the MENA region: Domain weighting

Domain	Scoring range	Low	Medium	High
1. Government commitment and accountability	0-8	0-3	4-7	8
2. Empowering individuals and communities	0-8	0-3	4-7	8
3. Accessibility of mental health services	0-10	0-3	4-6	7

Domain	Egypt	Jordan	Kuwait	Qatar	Oman	Saudi Arabia
1. Government commitment and accountability	2.5	5	2	5	2	5
2. Empowering individuals and communities	5	5	3	6	3	5
3. Accessibility of mental health services	4.5	3.5	3	5.5	3.5	5

Our data are inevitably constrained to measuring how well health systems are doing at present. This said, the scorecard's underlying assumption is that countries that are already making progress today are likely to lead into the future.

The scorecard is not an index that provides overall national scores, or even domain ones. Instead, the only meaningful comparisons between countries are for results on the same indicator. More generally, this scorecard, rather than a way to reveal winners and losers, is meant to start discussions about existing strengths on which to build, and weaknesses that require attention. (For full details of the methodology and scoring criteria please refer to the appendix)

Insights from the scorecard—the big picture

The above chart reveals the domain results of the scorecard. As it shows, the values are sorted into groupings of high, medium, and low scores with distinct colouring used to enable easier identification. As noted above, the scorecard does not calculate an overall score; however, several clear findings emerge from taking the scorecard as a whole.

The scores reveal that broadly speaking, the six countries covered fall into three tiers: Qatar and

Saudi Arabia consistently score near the top across the three domains, Egypt and Jordan have more mixed results, and Kuwait and Oman tend to trail in each area of the scorecard.

Population size and density do not seem to have a significant effect on mental health care provision in our study countries

Total population could have an effect, as the higher the number of people the larger—and presumably more complex—the health system. Qatar, which is doing well, has the smallest total population of the six scorecard countries, but the next smallest are Kuwait and Oman, which have lower scores across a number of areas. Similarly, Egypt and Saudi Arabia are the most populous but fall into different tiers in the scorecard results.

Population density, or lack thereof, is definitely a challenge in some states. Health systems in low-density countries commonly need to wrestle with such problematic capital-periphery, and broader urban-rural, divides. These problems, though, do not seem to affect our scorecard outcomes. Although Oman has the lowest density of the six countries, relatively high-scoring Saudi Arabia's is nearly the same. Similarly, little difference on this metric exists between Kuwait and Qatar.

Table: Total population and population per square kilometre, 2022

Total population (millions), 2022		Population per square kilometre, 2022	
Egypt	103.90	Kuwait	239.58
Saudi Arabia	34.90	Qatar	232.62
Jordan	11.28	Jordan	127.10
Oman	4.58	Egypt	111.50
Kuwait	4.47	Saudi Arabia	16.94
Qatar	2.68	Oman	14.79

Source: UN Population Division, World Population Prospects 2022. [43]

Figure 7: Estimated GDP per capita (US$), 2022

Qatar

82,438

Kuwait

41,414

Saudi Arabia

28,794

Oman

23,540

Jordan

4,274

Egypt

3,525
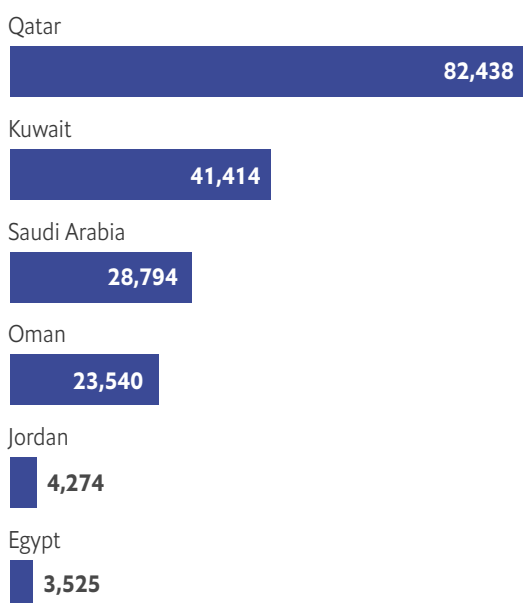
Source: IMF Data Mapper. [44]

Wealth: The money available in a state—as measured in GDP per capita—also does not seem closely related to our scores. While Qatar is significantly wealthier than other countries, Kuwait has a higher GDP than Saudi Arabia. Moreover, both Kuwait and Oman are far ahead of Jordan and Egypt, which do noticeably better on the scorecard.

Healthcare spending: Two final data sets together suggest that the key factor behind differences in our scores is the collective choices made by health system policymakers and officials. All six countries have universal health coverage (UHC) in some form, although it is still being rolled out in Egypt. Especially in the wealthier states, though, per capita public health spending—either through direct government funding or via compulsory schemes—does not map onto our scorecard results. Here, Kuwait spends the most on healthcare and Oman is well ahead of both Jordan and Egypt.

Such spending has created health systems that have, overall, substantial strengths. The 2019 Global Burden of Disease study created a UHC Index of Effective Coverage for a wide range of health services and determined the results for each of the world's countries and territories.[45] On this measure, the study countries do reasonably well, with Kuwait and Qatar scoring at a similar level to the US, and Oman, Jordan, and Saudi Arabia scoring similarly to states in eastern Europe. Presumably, as universal health coverage is established in Egypt, it too will see improvements.

The data indicate that, for the health system as a whole, two of the top three performing countries—Kuwait and Oman—are those with the poorest overall outcomes in our scorecard.

Table: Healthcare spending and Universal Health Coverage (UHC), 2019

Government schemes and compulsory contributory health care financing (current US$ per capita), 2019		GBD UHC Index of Effective Coverage, 2019	
Kuwait	1,529	Kuwait	82
Qatar	1,315	Qatar	80
Saudi Arabia*	1,105	Oman	71
Oman	540	Jordan	70
Jordan	174	Saudi Arabia	64
Egypt	43	Egypt	55

Source: GBD 2019 Universal Health Coverage Collaborators. [44]; WHO, Global Health Expenditure Database. [45]
*Saudi Arabia figure for 2018

Moreover, Kuwait puts the most funding per capita into healthcare overall. This suggests that what shapes performance on mental healthcare is not differences in disease burden, resources or health expertise, but policy choices on how much to spend where. The nature of those choices to date has often not been conducive to mental health services.

Dr Saeed believes that the current focus on UHC potentially provides a more receptive environment to bring mental health in from the cold. Few UHC systems cover everything.

Instead, among the key decisions in building one up over time is deciding what to include. If, says Dr Saeed, "mental health can be made part of the UHC basic service package, it could mean sustainable financing and human resources available within the system across all levels, from tertiary care to primary healthcare, and across the promotion, prevention, treatment and rehabilitation continuum of mental health." Unless and until countries do include mental health in basic UHC packages, broader mental health care improvements will be slow.

A closer look at the domains

4.1. Government commitment and accountability: isolated policies with too little focus on implementation

Domain	Indicator	Total possible score	Egypt	Jordan	Kuwait	Qatar	Oman	Saudi Arabia
1. Government commitment and accountability	1.1 National strategy, policy or plan for mental health	3	0	3	1	3	1	2
	1.2 Protection of individuals with mental health conditions	1	0.5	0	1	1	0	0.5
	1.3 Suicide prevention	1	1	1	0	0	0	0
	1.4 Spending on mental health	1	0	0	0	0	0	0.5
	1.5 Data infrastructure	1	1	0	0	1	1	1
	1.6 Research output	1	0	1	0	0	0	1
Total Domain 1		8	2.5	5	2	5	2	5

Generally weak policy and legal structures

On our policy and legal instruments indicators (1.1-1.3) no country gets full marks. Most have some kind of strategy or policy, although not Egypt—the country's most recent identifiable strategy is nearly seven years old.[27] Oman receives 1 point because its *Health Vision 2050* briefly mentions integrating mental healthcare into primary care. In general, the strategy treats mental health almost like an afterthought, as an aspect of non-communicable disease.[47,48]

Kuwait also scores only 1 point. The country has recently enacted a mental health policy, but by its own assessment this falls well short of the human rights covenants to which the country is a party.[28] "Kuwait doesn't really have a well-articulated plan and there is no larger, country-wide discussion about what the strategy should be," says Dr Scull.

Qatar and Jordan both score full marks, indicating the inclusion of mental health in general health policy as well as specific mental health plans and strategies in line with human rights covenants.[25,49-53] Saudi Arabia scores 2

"There is an ongoing need to make sure that policies and laws are aligned with the international best standards and national commitments."

Dr Khalid Saeed, regional advisor, mental health and substance abuse, Regional Office for the Eastern Mediterranean, World Health Organisation

points out of the maximum 3: its officials gave their plan's compliance with human rights commitments 4 (out of 5) points.[54] Although the specific reasons are not given, the problem may reflect a lack of a patient voice in the formulation of policy, a situation that certainly existed until around 2015, says Dr Al Gahtani, and for which no evidence of change since exists.[55]

Nor does existence of a plan ensure that significant change is taking place. A WHO situation assessment conducted in 2020 found that Jordan's progress toward implementing its plan was slow in key areas, including a lack of community mental health centres, a continuing concentration of resources in mental hospitals and little relevant content in medical training.[52] Of the six scorecard countries, Qatar's wide-ranging policy framework, which covers every major area of mental health, is the most promising. In Dr Al Abdulla's words, Qatar has done "a really good job developing strategy and putting in a lot of resources."

Although mental health legislation exists in most countries, laws are often not in line with international human rights standards, limiting the protection of those with mental health conditions

In addition to government strategy, the scorecard measures how well formal legislation covers mental healthcare provision and the rights of patients. Such laws are an essential foundation for mental health systems, but neither Oman nor Jordan have evidence of such legislation.[22,25] In Oman one is being discussed, says Dr Mirza, but he cannot estimate when it might be ready, given the amount of work involved and the low priority that policymakers give to the field. Jordan does formally protect those living with mental illness from involuntary hospitalisation under its Rights of Persons with Disabilities Act. However, the substantive meaning of the guarantee is in doubt: no formal body is tasked with enforcing those rights, nor does any legislation protect against discrimination.[52]

Egypt gets only a half point. It has had a Mental Health Act since 2009 that regulates the field and protects those under treatment. Unfortunately, the country regressed in 2020 despite protests within the country and from the psychiatric community worldwide. Amendments to the Act now allow use of involuntary electro-convulsive therapy (ECT) – an irreversible treatment – with only vaguely defined restrictions.[56]

Saudi Arabia also falls short. Its 2016 mental health law does promote best practice in care and patient rights in many areas and was a substantial improvement on the previously-existing legal framework. Nevertheless, as one review noted, the legislation fails to meet international standards regarding patient, capacity and there is no independent review body through which patients and their advocates can contest decisions.[57]

Kuwait, despite weaknesses in overarching policy, enacted a Mental Health Law in 2019 that

covers both the right of patients to treatment and their rights within the system.[28] Dr Scull calls the legislation "a great start and great for psychiatry", but adds that it does not cover the entire breadth of mental healthcare. The other country getting full points, Qatar, has gone further than the other study countries. Its 2016 Mental Health Law, consciously drafted to be consistent with WHO best practice, provides comprehensive patient protections and rules on the kind of care to which patients have a right. The challenge now is full implementation, which remains ongoing.[58]

Suicide prevention represents one of the biggest areas of weakness

None of the four Gulf States have a relevant standalone strategy, policy or plan for suicide prevention. In Qatar, attempted suicide attracts criminal liabilities, while in Kuwait psychiatric assessment in an institution is mandatory. Suicide was a crime in Oman until 2017, but a major revision to the penal code in 2018 quietly dropped this provision.[59,60] In Saudi Arabia, the matter is unclear because the country has no penal code; the first one was still being drafted in 2022.[61]

According to the *WHO Mental Health Atlas 2020*, Egypt and Jordan both have some form of standalone suicide prevention strategy or plan.[25,27] If the *Atlas* is accurate, though, other evidence of prevention efforts are hard to find. Indeed, in 2022 a letter from several Egyptian experts appeared in *Lancet Psychiatry* encouraging their government to adopt a national suicide prevention strategy for the first time.[62] Similarly, a 2020 WHO assessment of Jordan's mental health situation found no suicide policy or plan.[52] Worse still, in 2022 both countries saw moves to criminalise suicide, with legislation passing in Jordan but apparently stalled or dropped in Egypt.[63]

The meaning of regional legislation on suicide for mental health can easily be misunderstood.

In some cases, it is more of a statement than a reality: nobody has been charged in Qatar in over five years under its law and no clear examples of prosecution can be found in press reports from Saudi Arabia.[64] Although attempted suicide in many of these countries attracts a fine, for several mandatory treatment is the result. In Kuwait, the Correctional Institutions Law requires officials from the Ministry of the Interior to take the individual to a mental health facility for evaluation, rather than to prison.[65] Egypt's draft law had similar provisions. Finally, suicide per se is not always the target. Jordan's law bans only public suicide and seems targeted at suicide bombers and those killing themselves as extreme acts of political protest.[66]

These laws are more a symptom of a problem than the disease. Even before Jordan's new law was enacted, government data on suicide attempts was released in crime statistics rather than healthcare ones.[67] Oman, which does not criminalise suicide, saw its first suicide awareness campaign in September 2022. Although a milestone, says Dr Mirza, in many ways "it backfired" with strong public opposition, including even from some medical personnel. "In theory, at least, [laws against suicide] reflect the priorities and the culture of the community," says Nasser Loza, president of the World Federation for Mental Health. The pressing need is to change those attitudes.

The major damage that these laws create, then, is not the long-term incarceration of those who attempt suicide, but re-enforcement of existing stigma and creation of barriers between those who need help and the healthcare personnel best able to provide it. Even where possibly well-intentioned, using judicial officials to force people into institutional care, though perhaps better than simple incarceration, is far inferior to voluntary treatment. It is no surprise that, at a global level, such laws seem to slow progress on suicide prevention.[64]

Funding, data and research: an insufficient support framework

Funding and good data are needed to facilitate implementation, ongoing improvement and necessary adjustments to policy and laws. The majority of countries score 1 out of 3 on our relevant indicators (1.4-1.6); however, Saudi Arabia, which has made notable advancements in the allocation of spending towards mental health and research focused on mental health, performs better.

Spending on mental health is far from sufficient to meet the current treatment gap

Appropriate financial resources are an obvious requirement. "Funding may be the most important thing," says Dr Mirza. "Without it, you can't recruit; you can't expand services; you can't get new medications. It all eventually boils down to funding." The lack of money in the system is accordingly the biggest problem for Oman, he adds. His country is not unique: the majority of study countries get zero in our scorecard on funding; Saudi Arabia is the exception.

How much, though, is enough? The ideal goal – used for our scoring – comes from the Lancet Commission on Global Mental Health and Sustainable Development. It recommended in 2018 that low- and middle-income states

"should increase their mental health allocation to at least 5% and high-income countries to at least 10% of the total health budget."[4] No country in our study comes even close. However, these figures are admittedly aspirational. Only a handful of OECD states achieved them in 2018.[68] Indeed, the *Mental Health Atlas 2020* reports that the median mental health spending as a proportion of total government domestic health expenditure came to 3.8% for high-income states, 1.6% for upper-middle-income ones, and 1.1% in lower-middle-income countries.[2] Given the global treatment gap, especially in low-income countries, this level of spending is clearly insufficient.[69]

Jordan and Kuwait do not release figures related to mental health spending. This is not unusual. "Very few countries in the Arab world even designate mental health expenditure as part of their overall health budget," says Dr Perianayagam. It is likely that whatever is spent is a very small amount. In Jordan's case, the Disability and Mental Health Directorate within the Ministry of Health is responsible for mental health but has no formal budget.[52] Furthermore, estimating mental health expenditure in any country is complex owing to the range of potential funding sources, diverse sets of service providers (specialist mental health services, general health services and social care services) and the variety of services provided.[2]

Countries that do provide data report low spending. Egypt's per capita spending figure in 2019 was equivalent to 1% of total health expenditure.[27] This figure is similar to those of other study countries but more stark given the country's much lower overall health budget. In absolute terms, spending on mental health was the equivalent of about US$0.42 per capita. As the country increases healthcare budgets with the roll out of universal health coverage, it will be essential that mental health services are included in the covered interventions.

Among our wealthier states, absolute spending may be higher, but the proportional amount remains small, at 1.8% of healthcare spending in Oman and 1.3% in Qatar.[22,49] The latter number may seem low compared with the policy ambition that the country claims, but is more than double the 0.6% it reported for 2016, showing substantial growth.[70] On spending, Saudi Arabia is substantially ahead of others, and even surpasses the global median, devoting 4% of its total government healthcare spending to mental health in 2019.[54] Nevertheless, even it will need more to meet its needs in this field.

Building a solid evidence base through national mental health surveys and research is essential to support policy development and implementation

Another essential foundation for effective strategy is information. Some countries do little to illuminate the extent and nature of this challenge. Kuwait and Jordan do not compile specific mental health statistics, and any information that they have comes from general health system data. Hence they score zero on the relevant indicator. Oman gets a point because it gathers and provides data on specific psychiatric case levels within the health system, although the wider field of mental health is not covered.[71]

Egypt, Qatar and Saudi Arabia, meanwhile, have conducted extensive surveys to improve health officials' understanding of the mental illness burden. In 2018, Egypt's Ministry of Health conducted a random survey of 22,000 families to assess the prevalence of mental illness.[72] Qatar used two surveys to create an index of mental health attitudes and awareness, in order to allow it to tailor initiatives to specific parts of the population. It is also carrying out a needs assessment in conjunction with the World Mental Health Survey.[73] The Saudi National Mental Health Survey, formally known as the Saudi National Health and Stress Survey, drew on a representative sample of 4,000 households across the country and involved completion of an extensive questionnaire covering a wide range of issues related to mental health. It not only allows national officials to understand their domestic situation but, because the survey instrument is being used in 35 different countries in conjunction with the World Mental Health Survey Initiative, it will also allow international comparisons. Initial results were published in 2021 with more detailed results due to follow.[74] "We have such a rich data set, we can spend many years just doing analysis," says Dr Altwaijri, a principal investigator on the project.

Improving national research output is essential to supporting effective mental health services that are appropriate for the local culture and context

All healthcare mixes learning from global sources with understanding the needs and attributes of individual populations. Mental health is no exception. Even individual interventions need to be structured around what will help within the

"Unless your policies are guided by evidence it's very difficult to make the case that mental health needs to be a priority."

Dr Khalid Saeed, regional advisor, mental health and substance abuse, Regional Office for the Eastern Mediterranean, World Health Organisation

"Too often clinicians take interventions and measures from research done in the West, thinking that one size fits all. But that doesn't work."

Dr Samya Ahmad Al Abdulla, senior consultant of family medicine and executive director of operations at Primary Health Care Corporation, Qatar

local context, says Dr Al Gahtani "You cannot just impose things and say this works. You need research to develop common language simplifying therapeutic concepts for mental health professionals and patients," adding that we also need "to identify which interventions are effective for which condition while keeping in mind cultural beliefs and norms."

Local research is essential to supporting effective local mental health services. With this in mind, the scorecard looks at the proportion of national health research devoted to mental health appearing in high-quality scientific journals in 2019 and compares it to the percentage in states of the same income level.[2] By this metric, Jordan exceeded the level of output of its income group and accordingly scores a point—although on its own this outcome gives an incomplete impression. The 31 papers originating from Jordan in 2019 appears large relative to a low number of academic publications overall. Also, many Jordanian studies understandably examine

the mental health issues of Syrian refugees. This might reflect a lack of development in research infrastructure insofar as such publications can readily attract international funding rather than relying on domestic sources.

On the other hand, Saudi Arabia had the highest total academic output related to mental health in 2019—43 papers. This appears small proportionally because overall output in life sciences in 2019 was more than 4.5 times that of Qatar and over 36 times that of Jordan, the second and third most prolific countries in our study.[75] Moreover, since 2020, substantial output from the Saudi National Mental Health Survey has either sparked, or coincided with, an apparent rise in other publications, such as those on stigma and mental health patient satisfaction described earlier in this section.[74] In practice, Saudi Arabia has the most extensive domestic body of research on mental illness in the scorecard. That said, compared with other healthcare fields it remains relatively small by international standards.

Key findings

Government commitment and accountability

1. There is a need to strengthen the policy environment and match intention with action
Although all countries, with the exception of Egypt, have a mental health policy or plan, in some counties these fail to meet international human rights covenants. There is also significant variance in how well policy translates into action. For instance, Qatar's wide-ranging policy framework has translated into meaningful improvement and a scale-up of mental health services while Jordan's comprehensive policy environment has seen limited progress. Dedicated funding, targets and wider multisector support are needed to support successful implementation of existing mental health policies and plans.

2. Mental health legislation needs to be expanded with robust safeguards and oversight to protect people living with mental health conditions
Mental health legislation has been introduced and recently updated in many countries, with the exception of Oman and Jordan, where there is no evidence of such legislation. However, many laws still do not meet international human rights and accountability standards. Mental health legislation should also protect people with mental health conditions from discrimination and support the right to live independently and be included in the community.[76]

3. Prioritising suicide prevention as part of the national health and public policy agenda is an urgent need
None of the four Gulf States have a standalone strategy, policy, or plan for suicide prevention. Although Jordan and Egypt reportedly do have such a strategy, policy or plan, both countries made moves towards criminalising suicide in 2022. National suicide prevention strategies and policies are an important indicator of government commitment to tackling suicide, while providing leadership and guidance on evidence-based suicide prevention interventions.[77]

4. Dedicated financial resources are required to implement policies and laws and scale access to mental health services
Investment in mental health falls short across the region. All study countries spent less than the Lancet Commission on Global Mental Health and Sustainable Development's recommended proportion of national healthcare budgets on mental health in 2018, and only Saudi Arabia spends above the global average for its income group.

5. Timely and accurate population health data is needed to understand the burden of mental health at a local level
The demographics, culture and socioeconomic influences of the Middle East region—and those of the individual study countries—are unique, and there is a need for improved collection of surveillance data to understand these factors at national and local levels. Egypt, Qatar and Saudi Arabia have conducted extensive surveys, which have improved health officials' understanding of the mental illness burden. The availability of timely and relevant information on the current prevalence and trends of mental health disorders in the region will also support the allocation of appropriate services and funding.

6. High-quality local research can inform policy and development of mental health programmes
Research output is disproportionately low across the region—Arab countries account for over 5.5% of the global population yet produce just 1% of the global output of peer-reviewed publications in mental health research.[78] Furthermore, existing studies are often limited to well-defined populations or cohorts such as university students, patients with diabetes, postpartum females and local communities, which makes their results less generalisable to the population.[79] The voices of those with mental health issues and using mental health services are usually not represented in the literature.[80]

4.2. Empowering individuals and communities

Domain	Indicator	Total possible score	Egypt	Jordan	Kuwait	Qatar	Oman	Saudi Arabia
2. Empowering individuals and communities	2.1 Awareness and education	1	1	0	1	1	0	1
	2.2 Community initiatives	2	2	2	2	2	2	2
	2.3 Incorporation of the patient voice	1	0	0	0	0	0	0
	2.4 Integration with other sectors	2	1	2	0	1	1	2
	2.5 Vulnerable populations	2	1	1	0	2	0	0
Total Domain 2		8	5	5	3	6	3	5

Widespread mental health literacy efforts

Improvements on mental health literacy and stigma likely stem in part from an increase in awareness and education efforts in the region. These may be predominantly government initiatives (measured in indicator 2.1) or efforts involving community actors (indicator 2.2). Of the three possible points in these two indicators, every country scores at least two, and four of the six get full marks.

Government-led mental health campaigns have been introduced in Egypt, Kuwait, Qatar and Saudi Arabia with the goal of increasing awareness and reducing stigma

Mental health campaigns, promotion and awareness efforts take on a wide range of forms. Currently, at the government level, Qatar's "Are you OK?" and Kuwait's "Now I Understand", begun in 2020 and 2022 respectively, are high-profile, longer-term programmes intended to increase awareness as a whole.[81,82] This approach allows standardised messaging across health, social media, social welfare and workplace efforts says Susan Clelland. The impact of these efforts are visible in the Qatar National Mental Health Attitudes and Awareness Survey 2020, with 56% of respondents recalling recent communications on mental health and well-being in the country, compared to just 20% in 2020. These results also translate positively to improved mental health literacy, with 56% reporting increased knowledge of where to seek mental health services and support, up from 46% in 2018.[41]

Saudi Arabia, on the other hand, established the National Centre for Mental Health Promotion in 2019, which is tasked with "proposing and adopting awareness programmes in line with emerging social changes." Rather than focus on a headline campaign, it has adopted a range of initiatives, including publications, apps, a call centre to provide information on mental health and its treatment, a mental health first aid programme for health professionals and the community, and projects aimed to help religious leaders and companies to both understand mental illness and support those affected.[5]

Egypt has launched a number of national campaigns in recent years, including "Time to Know About Mental Health" and "Our Mental Health is a Priority", the latter of which is focused on women.[27] These efforts, though, have not gained media traction. The absence of a high-profile headline programme is not a sign of indifference. Dr Baron sees "a lot of effort made in Egypt, like everywhere else in the world,

> ## "Mental health education should be started at an early stage in the schools and maybe even before that."

Dr Ahmed Bawaneh, country director, International Medical Corps, Jordan

to try to deal with stigma," adding, for example, that popular soap operas even include relevant story lines.

A range of actors outside of the health sector, including education, workplaces, faith-based organisations and community groups, are playing an increasingly important role in mental health outreach and awareness activities

Although Jordan and Oman score zero on the government programmes indicator, they still show some level of activity. During the covid-19 pandemic, Jordan's National Centre for Mental Health used social and traditional media to spread relevant health messages.[83] Oman's Ministry of Health used social media in a similar way during that period.[84] In 2021 it also was a partner in the launch of "Pause Breathe Choose", a national programme aimed to support the mental health of healthcare workers, although the ambition is eventually to reach the whole population. The Oman government's limited role is consistent with Dr Sultan's experience. Most campaigns, she says, come from "individuals, private clinics or people gathering to create them." For example, "the newly formed, Psychology of Youth volunteering team and the "Not Alone" awareness campaign led by Whispers of Serenity Clinic both engage in outreach and awareness raising activities."

Oman is not unusual in the extent of its non-governmental activity. Across our six study countries, mental health awareness raising

efforts have been launched in recent years by a vast number of actors, including private and public health workers, educators, patient and family mental health support groups, businesses ranging from banks to cosmetics producers—both for their own employees and society at large, journalists, NGOs, activists, artists from various fields, and leaders of faith-based organisations. If anything, the volume is increasing, especially in the light of the experience of the covid-19 pandemic. "Large companies contact mental health professions to ask "'can you participate in our public awareness campaign?'" says Dr Alsuwaidan. "That's something that we never used to see, even five years ago." Although civil society in the Middle East faces constraints in some fields, in this area it is vibrant—so much so that every scorecard country gets full points for the range of actors trying to increase awareness.

The only question is the extent to which these public and private efforts are effective. Most of our interviewees are in agreement with Dr Alsabbrie, who believes that the changes in thinking and public discussion that such efforts have accomplished are collectively "a big achievement over the last ten years." Qatar has "concrete evidence" that its efforts have had a positive effect, says Susan Clelland, and Saudi Arabia's National Centre for Mental Health Promotion says that it does monitor "national indicators in the field of mental health promotion."[5] Nevertheless, even globally, "evidence for media campaigns is relatively limited", says Dr Saeed.

Creating care for patients but not with patients

Integration of the patient voice into healthcare service design and delivery has become the norm, or at least the goal, in most of Europe, North America and Australasia. The need exists in mental healthcare at least as much as any other field.

Relevant patient organisations, which distil and communicate their members' views, also exist across the scorecard countries—some focused on specific mental illnesses and others with a more general focus. Various civil society organisations, including some dedicated to mental health, played an instrumental role in pushing for and helping to draft Kuwait's first mental health law in 2019.[85]

However, these associations have not obtained any role or input into decisions on mental healthcare provision in the country. Nor have affected individuals. Dr Alsabbrie reports "no advocacy or patient's point of view in [Kuwait's] policymaking," and the country is no exception—every scorecard country scores zero on our patient voice indicator (2.3). As Dr Elnemais Fawzy says of Egypt, "there is nothing called integration of patient views inside mental healthcare policy and planning."

In Saudi Arabia, the Patient Bill of Rights and Responsibilities, published by the Ministry of Health, expresses a belief in "empowering and involving [patients] in decisions that support and improve the services provided" and states that mental health patients should be involved in the treatment plan "by any means possible".[55] However, it is unclear if patient involvement extends to input into policy or service design.

A multisector approach to policy formulation and implementation is essential to support true societal integration of mental health

The absence of patient involvement is consistent with low involvement by actors beyond the Ministry of Health in the design of mental healthcare. Given the wide range of social and employment needs for those living with mental illness, a multi-faceted approach is necessary. In practice, it is also rare in the study countries. Several countries that do score points are rewarded for intent rather than the situation on the ground.

Although Oman's government reported that it was interested in providing mental health support in schools and worked with UNICEF on a programme that trained a limited number of counsellors, the extent of these efforts appears limited.[86] Similarly, Egypt's score of 1

"**The contribution of the end-user is crucial.** We assume, as the care provider, that we know what's best for our patients. Maybe what we think has some accuracy to it. However, we don't know."

Dr Haifa Al Gahtani, founder and chief executive officer of Renewal and Reward Mental Health Center, Saudi Arabia

point comes from a single initiative of uncertain duration, the "Our Mental Health is a Priority" campaign. This had no formal health sector role, but did include trained psychiatrists among those helping.[87] In Kuwait, civil society organisations host relevant events in academic organisations, but without formal co-operation from the health sector.[88]

Jordan's score of 2 points also does not necessarily reflect extensive co-operation. Although a WHO Situational Assessment reported that a multi-sectoral National Technical Committee was established to advise the Disability and Mental Health Directorate, given that this directorate has no budget or policymaking power, it is unclear whether the technical committee's advice has led to any substantive result.[52] Jordan certainly has non-healthcare departments providing services to those with mental health issues: the justice department, for example, offers psychosocial help to victims of human trafficking.[52] In general, though, explains Ahmed Bawaneh, country director for the International Medical Corps in Jordan, the roll out of mental health policy is "focused far too closely on the clinical interventions (specialised) rather than involving a whole-of-government approach." Other potential actors, he adds, are "not active players, most of the time."

In Qatar, there are several examples of cross-sector collaboration to support policy development and service development. Susan Clelland, director of the National Mental Health Program at the Ministry of Public Health, reports that there are now active mental health programmes in schools, universities, prisons and workplaces, as well as collaboration with the Supreme Committee for Delivery and Legacy, the body responsible for the delivery of the 2022 FIFA World Cup, which included training for staff and services for migrant workers.

In Saudi Arabia, The National Centre for Mental Health Promotion co-ordinates the efforts

of various health, educational and research bodies in the field, and its board includes representatives from diverse government ministries as well as medical associations and charities. Its mandate also includes promotion of mental health at universities and in workplaces.[5] As this example shows, true integration requires conscious policy: it does not happen by accident.

Limited Protection for the Vulnerable

Indicator 2.5 looks at how well mental health policies and services address vulnerable sub-populations. For each country, we addressed a specific group of substantial size. In Jordan and Egypt, we look at the refugee community. Jordan had over 700,000 refugees at the end of 2021, not counting the more than 2m long-term Palestinian residents and refugees. Egypt's figure is significantly lower at 280,000, and while representing less than 1% of the population is still an important population cohort.[89]

Common elements of the refugee experience—conflict; flight; distance from home and, in many cases, family; the nature of the communities in which they are temporarily settled—collectively present a wide range of stresses. This creates distinct mental health needs.

While mental health care is provided to refugees, this mainly happens through international development organisations

Both Egypt and Jordan score 1 out of a possible 2 points. Neither covers mental health for refugees in its policies, but some tailored mental health services do exist for members of this population in each country. However, this provision largely reflects the efforts of the international community more than that of the countries themselves. In Jordan, the government's major contribution is to lead a Working Group to co-ordinate NGO efforts to provide mental health services to refugees and vulnerable Jordanians in areas with high refugee concentrations.[52] Indeed,

Mental health services adapted to the specific needs of migrant workers—a significant population across the Gulf countries—are virtually non-existent with the exception of Qatar

Our Gulf scorecard countries host only a few hundred refugees each rather than hundreds of thousands.[89] Instead, foreign migrant labourers constitute the largest potentially vulnerable population group. Such individuals make up between 29% (Oman) and 79% (Qatar) of the total population.[91-94] Although some foreigners are high-paid professionals working for major corporations, most are low-wage workers. These workers have special mental health needs arising from social and cultural dislocation and separation from family. Moreover, just as the native populations of our scorecard countries need mental health services with an understanding of the nuances of their culture, so do people from abroad. Too often, even where services are accessible, they are unable to address the specific needs of migrants.[95,96]

Kuwait, Oman and Saudi Arabia do not make specific mention of migrant labourers in their policies, nor do specialised services seem to exist. Qatar, though, is a welcome exception. Its National Mental Health Strategy for Qatar and National Health Strategy 2018-2022 both recognise the need to provide mental health services for lower-skilled migrant workers.[53] As part of the latter strategy the health system has created a specific mental health service—including inpatient hospital facilities and the integration of mental health into primary care—in the Doha Industrial Area. This zone is exclusively populated by manual migrant workers. The public company responsible for the hospital has also recruited a culturally competent workforce that speaks the same mother tongue as many of the migrants. Although the service continues to evolve, it sets the stage for a much-needed focus on the mental health of lower skilled migrants in the wider Gulf region.[97]

the country is so reliant on outside humanitarian organisations that Dr Bawaneh fears that, should they ever leave, various elements of the country's mental health services would be "almost not sustainable."

While refugees are able to access outpatient mental health care in Egypt's public hospital system, these facilities are overcrowded and—despite years of discussion with the government—inpatient care is "just not easily accessible", says Dr Baron. In practice, the UN High Commissioner for Refugees (UNHCR) has set up and funded an almost parallel system for refugees who "need therapy, inpatient care, counselling or have more complicated cases." The international community's involvement in refugee mental health in these countries is not surprising. "You won't find a programme in the world in today's times that does refugee care that does not include psychosocial and mental health care," says Dr Baron. "Though never enough, there are resources and money available."

Governments should seek ways to use this activity to strengthen domestic infrastructure as well, rather than acting as a passive host. UNHCR is trying simultaneously to help its clients and to build up Egypt's mental health system. It has agreed to pay for six new outpatient clinics, 100 new inpatient beds and electronic equipment for two existing hospitals. All of these facilities will be available to both refugees and Egyptians.[90]

Key findings

Empowering individuals and communities

1. Mental health awareness and promotion initiatives are having a positive impact on stigma reduction; however, ongoing evaluation is needed

Governments in Egypt, Kuwait, Qatar and Saudi Arabia have stepped up mental health awareness and promotion efforts, and actors from non-health sectors, civil society and community groups are active in mental health awareness-raising efforts in all six study countries. Ongoing research and evaluation should support promotion and prevention activities to ensure investment towards interventions that will deliver the greatest impact. Public awareness and health promotion initiatives should also seek to leverage the region's strong family and community values and educate families—as well as community and religious leaders, who are often the front line of support.[30]

2. Embracing a whole-of-government approach to mental health is critical for providing comprehensive people-centred mental health care

Although civil society organisations in almost all six study countries are active in mental health awareness initiatives and events, formal co-operation with the health sector is often missing. Collaboration between health and non-health sectors is essential. Identifying national champions and formulating dedicated cross-sectoral teams responsible for mental health policy activity and stakeholder engagement can support sustained co-ordination and joint action on mental health.[98]

3. Involving patients and service users in the design and delivery of mental health policy and planning can create culturally responsive and locally adapted mental health services

Although patient advocacy associations for mental health exist across the countries in this study, their voice in mental health policy and planning is largely ignored, as are the voices of mental health patients and service users. Applying co-design methods to involve patients and service users in the design and delivery of mental health policy and planning can result in culturally responsive health systems that target the needs of the local population.[99] Encouraging and supporting patient advocacy organisations—which play an integral role in raising awareness, reducing stigma and supporting people suffering from mental illness—and ensuring that they have a seat at the table regarding decision-making is also important.

4. Mental health services need to reach and respond to the needs of vulnerable populations

All countries, with the expectation of Qatar, fail to recognise these groups in mental health policy and planning. Qatar has also taken meaningful steps to expand and adapt mental health services to its migrant worker population. Policymakers must proactively identify and provide support to members of groups that may be particularly vulnerable to mental health disorders and have difficulty accessing services. Promotion and prevention efforts should target these individuals in their communities, and services may need to be adapted to accommodate different languages and cultural backgrounds.

4.3. Accessibility of mental health services

Domain	Indicator	Total possible score	Egypt	Jordan	Kuwait	Qatar	Oman	Saudi Arabia
3. Accessibility of mental health services	3.1 Integration with primary care	2	0	0	0	2	0	1
	3.2 Affordability of mental health care	2	2	2	1.5	1	2	2
	3.3 Integration with comorbid conditions	1	1	0	0	1	0	1
	3.4 Mental health helpline	1	1	1	0.5	1	0.5	1
	3.5 Digital health	1	0.5	0.5	0.5	0.5	0.5	0.5
Total Domain 3		7	4.5	3.5	3	5.5	3.5	5
Domain 3 without affordability indicator*		5	2.5	1.5	1.5	4.5	1.5	3

*Indicator 3.2 measures the coverage of mental health services and essential psychiatric medications under the national basic insurance. Across a number of countries where these services are fully covered, access is often restricted due to limited service.

A very affordable lack of care?

Although mental health care is fully or partially covered at the point of service in all countries, in practice these services are not always accessible

The scorecard's final domain measures how well people can obtain mental health care. The affordability indicator (3.2) provides apparent good news. Four scorecard countries get full marks, indicating full state insurance coverage for care and medications. Kuwait falls slightly short because of restricted pharmaceutical coverage.[28] Qatar receives just 1 out of 2 points because of co-payments currently charged for care for expatriates.[49] The new Healthcare Services Law that the country is rolling out may address that issue. It requires all employers to obtain health cover from an approved insurer for all expat workers and their families. Chronic illnesses are a mandatory part of basic coverage, but what precisely is paid for remains unclear.[100]

However, this formal generosity has limited actual meaning because too little care exists no matter who is ostensibly willing to pay. In Egypt, for example, overcrowding means that even patients willing to wait long enough "get a short period of time with the doctor, with basically no time for therapy, as a general rule," says Dr Baron. Those with serious conditions typically simply get a prescription. The costs are very low, she adds, but the problem is overcrowding.

In Oman, says Dr Mirza, access to free public healthcare entails such huge waiting lists that patients opt for private care. "A lot of people can't afford [private care]," he adds, especially for long-term treatment, but they lack other viable options. Even in relatively well-provisioned Qatar, problems exist with access to psychologists within the public health system. "Appointments are very far between," says Dr Al Abdulla. "Imagine seeing a psychologist every six weeks—what kind of therapy is that? But the private world, it's expensive."

Nor is private insurance necessarily an option for those who can afford it. In Dr Alsuwaidan's experience in Kuwait, the vast majority of policies do not pay for mental health care. In short, state coverage of mental health costs is laudable, but to make it meaningful will require functioning service provision.

Integration into primary care

The most worrying result from our scorecard from this domain is that, outside of the affordability indicator, only Qatar and Saudi Arabia score more than half of all possible points on other aspects of accessibility.

The difficulties begin in the two indicators measuring mental healthcare integration—with primary care (indicator 3.1) and management of frequent co-morbid conditions, such as NCDs (indicator 3.3). Weaknesses here are consistent with the continuing extensive reliance on large, specialist mental health institutions discussed earlier.

Significant progress on the integration of mental health into primary care is visible in Qatar and Saudi Arabia. However, in other countries prevailing stigma, bureaucracy and lack of co-ordination stifle integration

It is difficult to overestimate the utility of integrating mental health into primary care. Such integration can overcome some of the biggest barriers to consultation and treatment in the region. Dr Alsuwaidan notes, for example, that stigma is far less likely to arise "if I can go to my family doctor, who's not called a psychiatrist or a psychologist," but who may be able to treat a mild or moderate condition. "Treatment provided through primary clinics rather than in specialist hospitals greatly reduces stress on patients," agrees Dr AlKhathami.

Another benefit of primary care is that, in many scorecard countries, it is readily accessible—definitely more so than mental health specialist care. In Oman, "luckily primary care is quite good," says Dr Mirza. "All family medicine doctors have six months training in psychiatry. They can pick up mild conditions and offer some medications." For those who need referrals, however, the waiting list is long.

Despite the obvious benefits, achieving integration faces various barriers. Experts in the region involved in promoting care at this level give a few examples: in Kuwait, Dr Alsabbrie reports, stigma among primary care clinicians toward treating mental health conditions has been an unexpected difficulty; in Egypt, Dr Elnemais Fawzy recalls, efforts to integrate care were undermined by bureaucratic infighting between officials responsible for primary care and for mental health.

These, and the general difficulties always present for healthcare innovation, help to explain the low scores on primary care integration. For this indicator, we used self-assessment data from the *Mental Health Atlas 2020*, which asked respondents about the existence of five important elements of such integration.[2] The five elements include: the availability and adoption of guidelines for mental health integration into primary health; availability of pharmacological and psychological interventions for mental health conditions at the primary

> ## "Treatment provided through primary clinics rather than in specialist hospitals greatly reduces stress on patients."
>
> Dr Abdullah Dukhail AlKhathami, director, Primary Mental Health Care Programme, Ministry of Health, Saudi Arabia

care level; training provided to health workers at primary care level on the management of mental health conditions; and the involvement of mental health specialists in the training and supervision of primary care professionals. The *Atlas* considers a score of 4 or 5 points (out of 5) indicative of functional integration. Our scorecard, accordingly, gives 1 point for a score of 4 in the *Atlas*, and 2 for a score of 5.

On our scorecard, Egypt and Jordan score 0, indicating a lack of functional integration. While Kuwait and Oman score 0.5 for notable, yet inconsistent, progress in this area. This result obscures a range of effort. In Egypt, "there is nothing you can call integration at all: no system, no screening, and nothing after discharge [from a hospital]," says Dr Elnemais Fawzy. Jordan does slightly better. Its mental health policies call for service delivery through primary care. However, a UN Situational Assessment reports that, while the country has over 1,000 primary care facilities of various kinds, just 83 or 93 of these—the report is inconsistent—provide integrated mental healthcare. This represents fewer than one per 100,000 population. Moreover, only six of these centres have a pharmacy that can deliver relevant medication, which is in turn restricted to just two drugs.[52] Dr Samir Abu Moghli, former president of the Jordanian Psychological Association notes that while integration of mental health into the primary care system "has started in some governorates under the auspices of Ministry of Health, psychotherapy is still in an infant stage." The majority of services in this area are provided through the private sector, limiting accessibility for low-income people, says Dr Abu Moghli.

Kuwait and Oman appear to be doing better. Dr Alsabbrie is head of the former's mental health program in primary care. She says that, despite very slow progress over the past decade, "a big improvement [has occurred] in integration of mental health in primary care clinics." Now, roughly half of clinics have some services, guidelines have been published and key performance indicators are being tracked.

On the other hand, says Dr Alsuwaidan, "formal referral mechanisms still do not exist." Meanwhile in Oman, integration of these services is increasing into primary care, although progress in different regions is very uneven, says Dr Sultan. Nevertheless, both states still fall short for fully functional integration. In practice, little evidence exists in either country that mental healthcare at the primary level goes beyond psychiatric treatment supplemented by medication. Although, as Dr Al Sinawi explains, "access to medication is still a problem, due to lack of funding and also a perception that psychotropic medicines are addictive." Only Oman appears to encourage talk therapy at this level in its guidelines, but in practice "it's more about the medical model," says Dr Sultan.

Saudi Arabia and Qatar, the countries that score full marks on this indicator, have pursued integration actively. To improve early detection of mental health conditions in primary care, the Saudi Ministry of Health introduced the 5-Step Patient Interview to screen, diagnose and treat mild to moderate mental health conditions in primary care settings. The approach, which has shown to be comparable to an expert interview by a psychiatrist, helps to identify high-risk patients with mental health conditions that often remain undiagnosed while also alleviating "doctor shopping" among dissatisfied patients and family members.[101] The "evidence-based, very sensitive, very specific, and high reliable approach" makes identifying high-risk patients easier for primary care physicians, says Dr AlKhathami, one of the early champions of the programme. "A patient will never come and say, "I am sad", especially here in our area, the Middle East. But he will come and say, "I have uncontrolled diabetes", or "I have a headache or lower back pain"." The approach favours non-pharmacological treatment, such as sleep hygiene, exercise and stress reduction, as a starting point for managing mild-moderate depression and anxiety, with pharmacological treatment initiated if the patient is unresponsive or deteriorates. According to Dr AlKhathami, collaboration remains a real barrier to implementation: "Psychiatrists often don't think that family doctors or primary healthcare doctors can diagnose or manage depression on their side."

In Qatar, provision of mental healthcare in the community is at the core of the country's National Mental Health Strategy 2013-2018 and of the follow-on National Mental Health and Wellbeing Strategic Framework 2019-2022.[102] This includes specialist community clinics, but also a major role for primary medicine. A long-term pilot project, beginning in 2014, involved three primary care centres, with a focus on treatment of mild to moderate anxiety and depression. The initiative had to address a wide range of issues, including training, continuing education, practice guidelines, supply of psychotropic medication, information gathering and sharing, and co-ordination between primary and specialist care.[103] The pilot's success led to the programme's roll out to all primary healthcare facilities in the country.[104]

BOX 3

Integration in low resource settings - Mental Health Gap Action Programme (mhGAP)

The Mental Health Gap Action Programme (mhGAP), an ongoing World Health Organisation (WHO) programme, recognises the urgent need to scale up mental health services in the Middle East region.[105] The programme's framework identifies high-impact, cost-effective, affordable and feasible strategic actions to support the expansion of services for mental health in low-resource settings—although the programme has also been adopted by high income countries including Saudi Arabia. A focus on the programme includes building mental health system capacity through training non-specialists in mental health detection, treatment and management.[106]
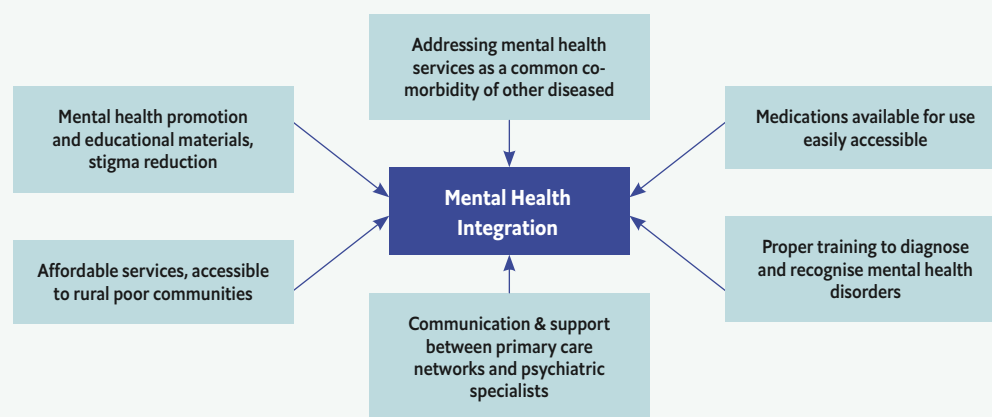
Adapted from concepts of World Health Organization Mental Health Gap Action Programme, 2013.

In Jordan, the mhGAP has been implemented across five psychiatric hospitals, three psychiatric inpatient units and 103 primary healthcare facilities to improve integration. As of 2022, nearly 200 primary healthcare providers had been trained in the mhGAP programme to identify and manage care for people with mental health conditions.[52]

A systematic review of the mhGAP notes the ongoing need for supervision, training and task-sharing, broader stakeholder support, and long-term commitment as barriers to sustainable implementation.[107] The WHO also stresses that multisector commitment and joint stakeholder responsibility of government, health professionals, civil society and communities, and support from the international community, as essential to scaling up the programme.[105]

The interconnectedness of mental and physical health problems is recognised in Egypt, Qatar and Saudi Arabia, with mental health included in the guidelines for common comorbid conditions such as diabetes and cancer care

On the surface, integration of mental healthcare into management of common co-morbidities seems to be more extensive than for primary care. Egypt, Kuwait, Qatar and Saudi Arabia each gain a point here. We look at whether a country has included mental health issues within the clinical guidelines for one or more of diabetes, cancer or perinatal care. On the ground, what is in the guidelines does not always match the reality. In Egypt, says Dr Elnemais Fawzy, no real integration exists between NCDs and mental health care. Similarly, Dr AlKhathami says of Saudi Arabia that whatever the NCD guidelines might say, "clinicians treating these conditions often do not consider mental health in their work."

The situation is better in Kuwait, says Dr Alsabbrie. Guidelines for the treatment of common chronic diseases require checks for anxiety and depression once or twice a year, while "the primary mental health clinic has to monitor patients' weight, their blood pressure, their HbA1c," she says. "We are involved in each other's work in order not to miss chronic diseases with the mental health [issues], and mental health [issues] with chronic diseases."

Qatar has been active in this area as well. Not only does it score a point for its guidelines, Susan Clelland reports that the health system has integrated mental health services across various areas, including rheumatology, communicable disease, cancer care and research, urology, and heart health. This has involved relevant training for specialists in these areas and inclusion of mental health professionals, predominantly psychologists, on the relevant teams. The effort is recent, she adds, so evaluation has not yet occurred.

The concept of healthy aging and mental health, which includes components of physical health and mental health, will become more important for integration, as we expect to see an increase in the elderly population in the region over the next decade.[108] Dr Al Sinawi, a consultant psychiatrist who specialises in older adults, suggests "yearly check-ups that include screening for depression and cognitive impairment for people aged over 60 in primary care."

Experimenting with new technology but making insufficient use of the old

This domain's final two indicators look at how countries are using information and communication technology to provide help for those living with mental illness.

While not new, mental health helplines have only recently been adopted by many of the study countries

Mental health and suicide helplines are effective in supporting the mental health of service users, providing emotional and social support and preventing suicide and self-harm. The history of suicide prevention hotlines goes back at least 70 years, when an English vicar founded the Samaritans.[109] Since then, the idea has been used for various forms of mental health (and other) emergency care. Every country in our scorecard has a suicide prevention or mental health counselling helpline, in most cases initially set up to help with the stresses of isolation during covid-19 lockdowns. While relatively new to some countries, the benefits have been far reaching. Those running Qatar's mental health helpline, for example, say that it had 46,000 calls in its first two years.[110] It is "very accessible and easy," says Dr Al Abdulla. "They have people who speak different languages and provide almost immediate plans for people."

Qatar scores full points as their national mental health helpline is now available 24/7. Saudi Arabia scores half a point. The NCMH 'psychological counseling call center' is operational six hours a day; however, the

Ministry of Health's 937 call centre is available 24/7 and can provide support and referral services for mental health.[111] Kuwait and Oman get half a point because none of their services are open around the clock. For example, the helpline in Oman—which is run by a private clinic—can be reached four hours a day.[84] In Kuwait help is available eight hours per day[112] This is simply insufficient when a mental health crisis can occur any time. Nor are these phone lines necessarily well-known to those in need. A 2022 study found that only 18% of the adult population and just 34% of those with a history of mental illness were aware of the existence of Saudi Arabia's National Centre for Health Promotion's Psychological Consultation Centre helpline, which has been available since 2013.[5]

Egypt and Jordan also get full points. Egypt has two government helplines, one for psychosocial help and the other where social workers can, if appropriate, refer the caller to a mental health clinician.[111,113] Although ostensibly created by the Ministry of Health, the Jordanian Association of Psychiatrists, and the International Medical Corps (IMC), it is almost certainly largely an NGO initiative. The listed number is the IMC's 24-hour duty phone.[83]

Telemedicine and digital mental health solutions have proven beneficial in improving the reach and accessibility of mental health support services in the region, particularly during the pandemic; however, concerns remain regarding the evaluation of these technologies

A more recent arrival than helplines has been the increased use of tele-consultations and apps, again accelerated as a means to address covid-related restrictions on movement. These tools help to overcome a number of barriers to care, such as reducing patient travel and allowing clinicians to use their time more efficiently. This type of interaction also has important attractions in societies where stigma remains an issue. "It makes [consultations] more private," says Dr Alsabbrie. "No one can judge [patients]."

That said, developing best practice for telehealth remains very much a work in progress. Even the

desire for privacy that drives interest in its use can impede its effectiveness. "We're having some challenges with engagement," says Dr Al Abdulla of a study that she is conducting. "Women don't want to turn on their cameras because they're at home without their headscarves." Moreover, new technology cannot overcome certain deep-seated problems. Dr Elnemais Fawzy says that a WHO trial in Egypt of telehealth in psychiatry failed because of poor training for those involved, weak organisation and a lack of the patient voice in design. The consensus among the experts interviewed for this study is that it is worth seeing how telehealth can be used, but it still requires full evaluation.

Apps, as one step removed from human interaction, give rise to other concerns. Dr Gahtani says that, although they are becoming popular in some countries, like all mental health advice provision they need to take account of the specific cultural context of these countries or they will not work. "US or European apps of however high a quality might end up doing more harm than good."

Projects in the region to develop local apps and digital tools certainly abound. In 2022, for example, Egypt launched a digital mental health and addiction service that combined education, counselling, and psycho-social support.[114] Kuwait provided treatment to over 60,000 users during the covid-19 pandemic through its Corona Care platform.[88] Saudi Arabia's Qareboon app allows users to request confidential text or audio counselling.[115] Qatar opened a telepsychiatry service in March 2020.[115] In Jordan, the Relax app—another collaborative project of the IMC and the country's health ministry—now provides information on mental health and available services, and provides the option of anonymous telephone calls.[116]

However, no country gains full marks on this indicator, because none have integrated the use, or even examination, of digital tools into their mental health strategies or policies. Given the still unproven nature of the technology, an overarching approach that includes evaluation is crucial to making the most of their potential while avoiding pitfalls.

Key findings

Accessibility of mental health services

1. Scaling low threshold and cost-effective mental health services is necessary to ensure that coverage translates to access

Although mental health services are fully or partially covered under the basic national insurance in all countries, coverage doesn't necessarily translate into access. High demand and a shortage of mental health workers result in long wait times for public services. Integrating mental health services into primary and community care provides the best and most cost-effective opportunity to cover entire populations, including those hardest to reach. Health authorities should also explore ways of scaling up access to affordable psychological therapies to support those with mild to moderate mental health conditions before their mental health needs escalate.

2. Integrating mental health services into primary care is the most cost-effective means of expanding access

Progress towards mental health integration into primary care varies across the six study countries, ranging from significant progress in Qatar and Saudi Arabia, where integration is at the heart of national mental health strategies, to moderate steps in Oman and Kuwait and little advancement in Egypt and Jordan. Integration of mental health services into general healthcare improves the availability, quality, acceptability and accessibility of mental healthcare, while reducing costs and stigma faced by service users. Training and capacity building of primary care physicians to recognise and provide support for common mental disorders will be essential. Integration models should also support the delivery of psychotherapy through training primary care workers. Essential psychiatric medications should be prescribed and dispensed through primary care to reduce pressure on the limited number of psychiatrists in the region.

3. Referral pathways and collaborative care models need strengthening to address the comorbidity between mental health and other priority health services

Mental health is included in the clinical guidelines for diabetes, cancer and/or perinatal care in Egypt, Kuwait, Qatar and Saudi Arabia, indicating a recognition among these countries of the link between mental and physical health. However, evidence of these guidelines in practice is limited, and in some countries resources are not provided to support collaborative care. Managing comorbidity of mental health conditions and major NCDs requires integrating mental health services into other health service areas through referral pathways and collaborative care models.

4. Mental health helplines need to be expanded to ensure that there is support for a mental health crisis at any hour

Every country in our study has a suicide prevention or mental health helpline, some of which were introduced in response to the covid-19 pandemic and have remained owing to demand. However, Oman and Kuwait do not offer round-the-clock availability. As a mental health emergency or crisis can occur at any hour and may require an immediate response, providing out-of-hours access to support services is essential. Building awareness that these services exist and how to access them is also important, as is including other options for contact such as messaging or web chat.

5. As telehealth and digital tools become more mainstream, there is a need for integration within mental health policy and ongoing evaluation

There is evidence of the use of telemedicine and digital mental health solutions across all of the countries in this study, many of which were embraced out of necessity during the pandemic to maintain and expand access to mental health services. Telehealth technology offers huge potential for reducing unmet need for mental health care, especially in remote areas. However, disparities in digital infrastructure and internet access in some countries will need to be addressed—according to World Bank statistics, the percentage of the population using the internet ranges from 66% in Jordan and 72% in Egypt to 100% of the population in Qatar, 99% in Kuwait, 98% in Saudi Arabia and 95% in Oman.[117] Implementing guidelines for evaluation is also essential to ensure that quality or privacy are not compromised. Some countries, including the UK and Germany, have introduced certification systems for mental health-orientated mobile apps and digital solutions to establish a baseline for areas such as clinical safety, security and proof of benefit.[118,119]

Moving forward: Key takeaways for accelerating progress

The burden of mental illness in our scorecard countries is comparable to that of high-income ones worldwide. The size of this toll per capita has been steady. Progress in other areas of healthcare, though, has made mental illness steadily more prevalent among the overall needs that health systems must address; high-income countries globally have seen no such increase. As a result, our six study countries are now the global hotspot for the proportion of mental disorders within total health burden. Health authorities and policymakers cannot continue to focus elsewhere to the detriment of mental health.

Insufficient workforce and other resources for mental health, the organisation of care around institutional arrangements designed as much to isolate patients as treat them, along with high levels of mental health illiteracy and stigma—even within health systems—combine to limit the quantity and quality of care. Such issues have existed in much of the world. Nevertheless, in recent decades most developed countries have seen substantial improvements. Until recently, this shift was happening at a much slower pace in the MENA region.

There are clear signs of progress across the region. Policymakers have given the issue more attention, and stigma, especially among the young, seems to be in decline—a silver lining of the covid-19 pandemic is that there is awareness, understanding and sympathy for those experiencing at least milder forms of mental illness, notably anxiety and depression.

This study has used a scorecard to delve into the complexities of how our countries are doing in the provision of mental healthcare. It has revealed the following:

1. Mental health strategies and laws have become increasingly common in the region. Nevertheless, most still fall short of international best practice, including on human rights provisions. Moreover, although all of our countries have a mental health strategy or a law, half do not have both. As a result, only Qatar scores full points on our two policy indicators. Existing strategies and legislation are an essential start, but officials need to enhance them.

2. Suicide prevention programmes remain a particular weakness across the board. None of the study countries have a visible suicide prevention programme. Worse still, outside of Oman, they have either criminalised suicide or recently debated doing so. Although elements of these laws and their enforcement reflect benign or humane intent, they inevitably impede effective assistance to those needing help.

3. In our scorecard countries, essential supports for effective implementation of any mental health policy framework—sufficient budgets, data collection and relevant research output—are still generally missing. In particular, none of the six countries spends the recommended amount on mental healthcare, and only Saudi Arabia does better than the global average for its income group.

4. Campaigns to improve mental health awareness and reduce stigma are common in the region. In every country, various civil society actors conduct such efforts and, in most, governments have their own campaigns and programmes. Still missing, though, is any published, detailed study of what works best in campaigns—from structure to messaging.

5. The patient voice is largely unheard across the six countries. Patient groups do exist, but they have no role in the design of mental health care delivery. Moreover, government actors outside of the health system also too rarely play a role in mental health policies. Healthcare systems must draw on wider expertise in order to provide care to individuals who have extensive multi-sectoral needs.

6. The mental health of those from vulnerable groups in society—with refugees used as a proxy in Egypt and Jordan, and migrant workers in the Gulf countries—in general receives insufficient attention from domestic health systems. The care that refugees receive comes largely from international bodies, either directly or through NGOs that they support. Nor do most states show much effort in meeting the specific needs of migrant workers. Qatar provides a good counter-example of what such care might look like.

7. All countries formally cover the large majority of mental healthcare costs. Though laudable, the frequent lack of functioning service provision means that this apparent generosity contributes far less to real accessibility than it might on the surface.

8. Healthcare officials in many of our countries recognise the likely benefits of integrating mental healthcare delivery with primary care and the management of common co-morbid conditions. However, according to their own self-assessment, of our six countries, only the health systems of Saudi Arabia and Qatar have functional integration with primary care, and only Kuwait and Qatar link up mental health and NCD management in practice.

9. Those involved in mental healthcare see the possible benefits of digital technology in patient education and interaction. Health systems are right to pursue such opportunities, but also need to improve on the availability of mental health helplines - currently Kuwait and Oman do not offer 24-hour support. Meanwhile, policymakers need to consider how best to integrate the use and evaluation of a growing number of digital tools into broader mental health strategies.

Overall, the progress made in recent years is promising. Civil society and government have been campaigning against mental health illiteracy and stigma; governments have begun to draft relevant policies; examples of best practice are starting to appear in different areas of mental healthcare provision; and, in theory, health systems stand ready to pay patient treatment costs. Stakeholders across the field of mental health now need to build on them to provide the care which the region needs.

Appendix

The research for this programme consisted of a pragmatic literature review, expert interviews and an expert advisory panel to assess the key enablers and barriers to mental health integration in the MENA region. The research focuses on six countries: Egypt, Saudi Arabia, Oman, Qatar, Jordan and Kuwait, providing a representative sample and diversity in terms of population size and income groups across the region

Literature review methods

The rapid evidence review followed a pragmatic methodology, designed to identify key papers and concepts to inform the key themes and development of the MENA Mental Health Scorecard. The literature search used the following structured search approaches:

- Bibliographic database search in MEDLINE and Embase

- Grey literature searches to identify relevant reports not published in scientific journals and therefore not included in bibliographic databases

- Supplementary search techniques such as internet search using advanced Google search techniques, citation tracking and checking the references in relevant publications

The database search was carried out in May 2022 and was limited to English and Arabic language reports published in the past five years. The search identified 907 articles. After a first sift, we selected 373 potentially relevant studies and grey literature reports published between 2016 and 2022. These studies were reviewed and clustered by theme. We note that the review is neither systematic nor comprehensive in scope—such a review would take many months to complete. Rather, we included selected systematic reviews and recent literature and survey results on mental health in the MENA region with a focus on barriers to access and considerations for integration. The review also included insights from global best practice.

The Expert Advisory Panel meeting was conducted on July 5th 2022 to discuss the burden of mental ill-health in the MENA region, gaps and challenges across the patient journey, and key thematic and domain areas for the development of the scorecard.

Scorecard Methodology

Based on the themes identified in the literature review, a draft scorecard framework was developed for discussion with the Expert Panel. The framework was refined in response to the Expert Panel's feedback and additional desktop research, data analysis and expert interviews.

The scorecard framework for the assessment of countries' integration and accessibility of mental health services focuses on three key areas or domains and 16 indicators:

The domains are:

- *Government commitment and accountability*, including the existence of relevant policies and legal protections for those living with mental illness, as well as the funding devoted to mental healthcare and the technology and research infrastructure in place. (*six indicators*)

- *Empowering individuals and communities*, including mental health promotion initiatives by governments and community groups, the role of the patient in healthcare planning, how mental healthcare specialists work with other care providers and the treatment of vulnerable populations. (*five indicators*)

- *Accessibility of mental health services*, looking at a range of matters related to how easily the general population and those at particular risk can receive care. (*five indicators*)

The table below provides information about the aim of each indicator as well as the scoring criteria. The indicators are of various types. Some are binary, recognising the existence or not of a specific and beneficial societal, government or health system effort, asset, or attribute relevant to mental illness prevention or treatment. An example is indicator 2.1, which awards a point for the existence of any programme or campaign to improve mental health awareness or mental health literacy. Other metrics are more complex qualitative assessments. For example, indicator 1.1 on national policies gives scores from 0-3 points, depending on the existence, extent and content of existing plans and strategies. Others are quantitative, such as the proportion of the health budget devoted to mental health.

Scorecard Limitations

Interpretation of the MENA Mental Health Scorecard's results requires two important caveats. First, such an exercise is constrained by the availability of internationally comparable data. Lack of detailed information proved to be a particular challenge for the scorecard, making some important areas impossible to include, such as continuity of care and the extent of psychosocial support within the community. Just as importantly, what we do measure often relates to the existence of a law, policy, plan or service, not the extent or quality of implementation—let alone the use of monitoring to improve performance over time. In short, the scorecard looks at basic elements of a response to the challenge of mental health that every one of the covered countries should have. Thus, in an ideal world, the norm would be very high scores. Anything else should be seen as a need for substantial change.

Second, a benchmarking exercise like the MENA Mental Health Scorecard is impressionistic rather than precise. The scores are a rough indicator of how countries are doing. Moreover, although all of the indicators are important for assessing mental health support for those affected by mental illness within countries, we have tried to judge their relative importance. The need for all of the areas measured by our indicators to create a mutually supportive and integrated response would make such ranking difficult and, ultimately, meaningless. Good policies are essential, for example, but so are money and input from patient voices.

As a result, this is not an index that provides overall national scores, or even domain ones. Instead, the only meaningful comparisons between countries are for results on the same indicator. More generally, rather than a way to reveal winners and losers, the MENA Mental Health Scorecard is meant to start discussions about existing strengths on which to build, and weaknesses that require attention.

Towards Mental Health Integration in the MENA region: Domain weighting

Domain	Scoring range	Low	Medium	High
1. Government commitment and accountability	0-8	0-3	4-7	8
2. Empowering individuals and communities	0-8	0-3	4-7	8
3. Accessibility of mental health services	0-10	0-3	4-6	7

Domain	Indicator	Aim
1. Government commitment and accountability	1.1 National strategy, policy or plan for mental health	To assess government commitment to mental health
	1.2 Protection of individuals with mental health conditions	To assess whether the rights and dignity of mental health patients are protected
	1.3 Suicide prevention	To assess government commitment to suicide awareness and prevention
	1.4 Spending on mental health	To assess government commitment of financial resources to mental health
	1.5 Data infrastructure	To assess the availability of data on mental health and monitoring of mental health
	1.6 Research output	To assess mental health research output compared to total health research output in the country
2. Empowering individuals and communities	2.1 Awareness and education	To assess the presence of mental health promotion or prevention programmes or campaigns to improve mental health awareness and mental health literacy
	2.2 Community initiatives	To assess the presence of mental health awareness and education initiatives outside of the health sector in schools, workplaces, and community and/or faith-based organisations
	2.3 Incorporation of the patient voice	To assess if the voice of the patient or service user is considered in mental health policy, planning or service design
	2.4 Integration with other sectors	To assess if there is collaboration between health and non-health sectors in mental health, policy, planning and delivery
	2.5 Vulnerable populations	To assess if vulnerable populations (e.g. low-income workers and refugees) are considered in mental health policy and planning and assess if services are tailored to this population

Domain	Indicator	Aim
3. Accessibility of mental health services	3.1 Integration with primary care	To assess whether mental health services are accessible through primary care
	3.2 Affordability of mental health care	To assess the status of coverage and reimbursement for mental health conditions
	3.3 Integration with comorbid conditions	To assess if mental health is integrated into care pathways for common comorbid diseases such as chronic diseases, diabetes, cancer care and perinatal care
	3.4 Mental health helpline	To assess the availability of crisis services for mental health
	3.5 Digital health	To assess if mental health services can be assessed virtually through telehealth or technology-based solutions

Country scoring

Domain	Indicator	Scoring criteria	Egypt	Jordan	Kuwait	Qatar	Oman	Saudi Arabia
1. Government commitment and accountability	a. Is mental health included in the national strategy, policy or plan for health? (Published within the past five years) b. Does the country have a national strategy, policy or plan for mental health? (Published within the past five years) c. Is the strategy, policy or plan fully in line with human rights covenants (self-rated as per WHO Mental Health Atlas 2020)?	If Yes for a = +1 b = +1 c = +1	0	3	1	3	1	2
	a. Does the country have a standalone law for mental health? b. Is the mental health law fully in line with human rights covenants (self-rated as per WHO Mental Health Atlas 2020)?	If Yes for a = 0.5 b = 0.5	0.5	0	1	1	0	0.5
	Does the country have a strategy, policy or plan for suicide prevention?	Yes=1 No=0	1	1	0	0	0	0

Domain	Indicator	Scoring criteria	Egypt	Jordan	Kuwait	Qatar	Oman	Saudi Arabia
1. Government commitment and accountability (cont.)	How much of total healthcare spending is allocated to mental health? Scoring based on Lancet Commission's recommendation that low- and middle-income countries should spend at least 5% of their health budgets on mental health and high-income countries at least 10%. *The Lancet. United for global mental health. (Internet) The Lancet Commission on Global Mental Health – 1 year on. 2020. Available from: https://unitedgmh.org/lancet-commission-global-mental-health-1-year*	Above 5% of total healthcare spending = 1 Below 5% of total healthcare spending = 0 No data reported = 0	0	0	0	0	0	0.5[b]
	Is information on mental health collected at a national level e.g. through a national mental health survey or health information system?	Yes = 1 No = 0	1	0	0	1	1	1
	Is the proportion of national health research focused on mental health equal or higher than the average global output for the country's income group? Scoring based on output from the WHO Mental Health Atlas, 2020.	Higher or equal = 1 Lower = 0 Lower-middle income: = or <3.9% (Egypt) Upper-middle income: = or <5.2% (Jordan) High income: = or <8% (Kuwait, Qatar, Oman, Saudi Arabia)	0	1	0	0	0	1[c]

[b] Although Saudi Arabia does not meet the 10% allocation under the Lancet Recommendation, mental health accounts for 4% of the country's total healthcare spending. The country spends more than the average of other World Bank high-income countries of 3.8%, which is why Saudi Arabia has been given 0.5 points.
[c] According to the Mental Health Atlas 2020, the percentage of mental health research output in total research output within Saudi Arabia is 3.91%, lower than the average for the high-income group of 8%. However, the country performs significantly better than other countries in the scorecard, with evidence of research output being considered in policy formulation. For this reason, Saudi Arabia has been given 1 point.

Domain	Indicator	Scoring criteria	Egypt	Jordan	Kuwait	Qatar	Oman	Saudi Arabia
2. Empowering individuals and communities	Is there a national programme or campaign to support mental health promotion or prevention?	Yes=1 No=0	1	0	1	1	0	1
	Is there evidence of mental health awareness initiatives conducted by one or more of the following: schools, workplaces, faith-based or community organisations?	Yes for 1 of the following; schools, workplaces, faith-based or community organisation= 1 Yes for 2 or more of the following; schools, workplaces, faith-based or community organisation= 2	2	2	2	2	2	2
	Is there evidence of patient/service user/ patient organisation involvement in mental health policy, planning or service delivery?	Yes = 1 No = 0	0	0	0	0	0	0
	a. Are non-health sectors included in the national mental health strategy, policy or plan? b. Is there evidence of collaboration on mental health initiatives such as awareness and promotion activities among health and non-health sectors?	If Yes for a = +1 b = +1	1	2	0	1	1	2
	a. Are vulnerable populations addressed in national mental health policy and plans? b. Is there evidence of mental health services tailored to the needs of vulnerable populations?	If Yes for a = +1 b = +1	1	1	0	2	0	0

Domain	Indicator	Scoring criteria	Egypt	Jordan	Kuwait	Qatar	Oman	Saudi Arabia
3. Accessibility of mental health services	Is integration of mental health into primary care considered functional (self-rated as per WHO Mental Health Atlas 2020—scoring of 4 or higher out of 5 = functional)?[d]	Country scores 5 out of 5 on functionality of mental health integration into primary care = 2 Country scores 4 out of 5 on functionality of mental health integration into primary care = 1 Country scores 3 out of 5 or lower on functionality of mental health integration into primary care = 0	0	0	0.5	2	0.5	1
	a. Are mental health services covered under the national basic insurance? a.1. fully covered a.2. partially covered b. Are essential psychiatric medications covered under national basic insurance? b.1. fully covered b.2. partially covered	If Yes for a.1 = 1 a.2 = 0.5 If Yes for b.1 = 1 b.2 = 0.5	2	2	1.5	1	2	2
	Is there evidence of integration or co-ordination of mental health services in the guidelines or treatment pathways for one or more of the following: diabetes, cancer, perinatal care?	Yes = 1 No = 0	1	0	0	1	0	1
	a. Does the country have a dedicated mental health or suicide prevention hotline or helpline? b. Is the mental health or suicide prevention hotline or helpline operational 24 hours a day?	If Yes for a = 0.5 b = 0.5	1	1	0.5	1	0.5	0.5
	a.Is digital health or telehealth included in national mental health policy or plans? b. Is there evidence of telehealth or technology-based solutions provided through the national health service to support access to mental health services?	If Yes for a = 0.5 b = 0.5	0.5	0.5	0.5	0.5	0.5	0.5

[d] In the WHO Mental Health Atlas 2020, integration of mental health in primary care is evaluated through a self-rated 5-point checklist: 1) guidelines for mental health integration into primary health care are available and adopted at the national level; 2) pharmacological interventions for mental health conditions are available and provided at the primary care level; 3) psychosocial interventions for mental health conditions are available and provided at the primary care level; 4) health workers at primary care level receive training on the management of mental health conditions; 5) mental health specialists are involved in the training and supervision of primary care professionals. A score of 4 or higher is considered functional integration.

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