

Cruz, M. E., Cruz, I., Preux, P.-M., *et al* (1995) Headache and neurocysticercosis in Ecuador, South America. *Headache*, **35**, 93–97.

Gulbinat, W., Manderscheid, R., Baingana, F., *et al* (2004) The International Consortium on Mental Health Policy and Services: objectives, design and project implementation. *International Review of Psychiatry*, **16**, 5–17.

Jenkins, R. (ed.) (2004) International project on mental health policy and services. Phase 1: Instruments and country profiles. *International Review of Psychiatry*, **16**(1–2).

Jenkins, R., Gulbinat, W., Manderscheid, R., *et al* (2004) The Mental Health Country Profile: background, design and use of a systematic method of appraisal. The International Consortium on Mental Health

Policy and Services: objectives, design and project implementation. *International Review of Psychiatry*, **16**, 31–47.

Schilder, K., Tomov, T., Mladenova, M., *et al* (2004) The appropriate and use of focus group methodology across international mental health communities. The International Consortium on Mental Health Policy and Services: objectives, design and project implementation. *International Review of Psychiatry*, **16**, 24–30.

Townsend, C., Whiteford, H., Baingana, F., *et al* (2004) The Mental Health Policy Template: domains and elements for mental health policy formulation. The International Consortium on Mental Health Policy and Services: objectives, design and project implementation. *International Review of Psychiatry*, **16**, 18–23.

ORIGINAL PAPER

First-episode psychosis: factors associated with delayed access to care in a rural Egyptian setting

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Over the past few decades there has been a growing interest in first-episode psychosis (FEP), help-seeking behaviour and pathways to care. Treating psychotic disorders in their earliest stages has become a key focus for research and clinical care (Yung & McGorry, 2007). FEP studies show that the average time between onset of symptoms and first effective treatment is often 1 year or more (McGlashan, 1987). This long duration of untreated psychosis (DUP) is undesirable. Early treatment helps minimise the risk of the serious consequences of untreated psychosis, in terms of changes in mental state and behaviour (Larsen *et al*, 1998; Wyatt *et al*, 1998) and can reduce suffering (Ho *et al*, 2003). Some early results suggested that an 'early intervention in psychosis' (EIP) service is more cost-effective than generic services (Mihalopoulos *et al*, 1999).

Most FEP studies have been conducted in high-income countries. The study reported here addressed the question of delayed access to care for an FEP in a rural Egyptian setting.

Method

The study was approved by Al-Azhar University research and ethics committee. Consent was taken from patients and their families before they took part in the study.

All patients with an FEP (meeting ICD-10 criteria) presenting consecutively to the psychiatric department at Mansoura General Hospital (MGH) between January and June 2004 were interviewed. Patients and relevant others (family or friends) were interviewed either separately or together at first contact or after improvement of the acute stage.

The interview protocol consisted of a semi-structured, user-friendly interview which included seven main sections that required only the ticking of various options. In every section there was an additional space under '(Other)' to allow more flexibility and to allow the inclusion of any additional

information. The seven sections were: patient's details; mode of referral; referred to out-patient or in-patient department; DUP; family history of mental illness; diagnosis and treatment; and causes for delayed contact with the psychiatric service.

The study was carried out in Mansoura city, the capital of Eldakahlia province; it is surrounded by a large rural area which includes about 15 towns. The population of Eldakahlia is about 8 million, some 2 million of whom live in Mansoura. In Egypt, primary care is still underdeveloped. Therefore, access to secondary care is mainly not through primary care. Individuals who need specialist care are likely to present to the specialist clinic (state or private) based on their own perception of the nature of the problem or as advised by family or a friend. Two main medical centres cover healthcare in Eldakahlia: Mansoura University Hospital (MUH) and MGH. Each has a psychiatric department. The smaller hospitals (called central hospitals, of which there is one in each town or big village) have no psychiatric department. Therefore, the mental health service in Egypt is essentially hospital based, and there is no well developed community mental health service.

The psychiatric department at MGH has a catchment of about 1 million. It contains an eight-bed ward and an out-patient clinic attended by about 100 patients per day. The medical staff includes two senior house officers, eight specialists and two consultant psychiatrists, and the nursing and non-medical staff comprises eight psychiatric nurses, a psychologist and one social worker.

Results

Of the 43 patients referred to the study, 40 agreed to take part (2 refused admission and decided to seek treatment privately and 1 refused to take part in the study). Out of the 40 patients, 22 needed admission (6 under section and 16 informal) and 18 were treated as out-patients.

The diagnostic categories of the cases were: schizophrenia, 14; affective disorder, 15 (9 depression with psychotic symptoms, 5 manic episode and 1 mixed affective state); postpartum disorders, 5; and others, 6 (1 persistent delusional disorder and 5 mental and behavioural disorders due to cannabis and amphetamine misuse).

Table 1 shows the age of the participants and the classification of their geographical areas of residence, by gender.

On average, these patients undergoing their FEP had their first contact with psychiatric services about 7 months after onset: within 11 months for schizophrenia and within 3 months for affective disorders. In this respect there was no significant difference between males and females.

The main factors associated with delayed access to care were classified as cultural factors (36%), which included jinn/spirit (16%), a preference for traditional healers (10%) and female gender (10%) (Table 2).

The family was the main source of referral (18 of the 40 cases) followed by friends (8) and general practitioners (8). Five patients were referred by specialists, and the remaining patient by a sheikh.

Discussion

Interest in both FEP and DUP has increased greatly over the past few decades. This interest has influenced service models and development mostly in high-income countries; comparatively little has been achieved in low- and middle-income countries. Although it is logical to assume that intervention in the early stage of any illness is beneficial, evidence from economic evaluations is still limited (McCrone & Knapp, 2007). Such economic evidence is especially important for low- and middle-income countries.

In this study, DUP averaged 7 months for all types of FEP and 11 months in schizophrenia. This is shorter than that found in Western countries. Beiser *et al* (1993) found that

average DUP for schizophrenia was more than 1 year. The shorter duration in our study may be due to sample size and a high proportion of mood disorder cases. It is also possible that not recognising the early stage of illness by the public (probably owing to lack of knowledge of early symptoms of psychosis) may cause a spurious shortening of DUP. In the present study, patients with affective disorder accessed psychiatric services earlier than individuals with schizophrenia. This agrees with the findings of Lincoln & McGorry (2000).

In high-income countries, DUP may be influenced by a combined effect of help-seeking behaviour, delayed referral from primary care and delay within the psychiatric service due to waiting lists. In a British study, Brunet *et al* (2007) highlighted the effect of barriers within specialist services as highly significant. In the present study, DUP was mainly influenced by help-seeking behaviour rather than delayed referral from primary care or delay within the specialist service; this was because of the very limited role of primary care in Egypt and the absence of waiting lists in the specialist service. Thus, patients and carers decided for themselves about when and which medical specialist to consult.

Cultural factors and lack of knowledge seem to play an important role in delaying access to care on the part of those with an FEP. Interestingly, believing that mental illness is due to possession with jinn/spirits was the second most important factor identified (after lack of knowledge). A preference for seeing traditional healers (rather than healthcare professionals) in rural Egypt is a complex area; financial, geographical, cultural and religious factors may contribute. Ignorance about mental illness and mental health services was found to be the single most important factor (28%) associated with delayed access to care. Thus, public education may help reduce DUP.

Family members indicated that female gender of the patient discouraged them from seeking help, owing to concern about the effect of stigma of mental illness on their daughter and family reputation in a rural community. In a public survey conducted in the United Arab Emirates, 38% of respondents believed that stigma is worse and 60% believed that the family suffers more if the patient is a female (El-Adl & Balhaj, 2008). This indicates that female gender may be considered as a risk factor for delayed access to care. Loebel *et al* (1992) found that male gender was associated with longer DUP. Our study found no significant difference between genders. This may be due to the small sample size or family reluctance to seek help for women (or a combination of both).

Stigma has a significant role (as expected) and will continue to do so until it is adequately addressed. An Egyptian study showed that a programme addressing school students' attitude towards individuals diagnosed with mental illness achieved a positive change (Fahmy *et al*, 2004). Thus, a large-scale anti-stigma programme is needed. Sadly, financial factors play a significant role in delayed access to care. Although every individual in Egypt is entitled to free healthcare and open access to the National Health Service, the reality may be different. The effect of mental illness on the patient and lack of insight seem to have less influence than other factors. In rural Egypt, it is culturally acceptable for the family rather than the individual him/herself to make the decision to seek help, and children, whatever their age, have to respect the wish of their elders. In one case the in-patient facility was considered to be inappropriate for admitting a teenager, who was treated as an out-patient.

Table 1 Gender, geographical area and age of participants

	Male (n = 16)	Female (n = 24)	Total (n = 40)
Geographical area			
Rural	11 (27.5%)	22 (55%)	33 (82.5%)
City	5 (12.5%)	2 (5%)	7 (17.5%)
Age (years)			
14–20	2 (5%)	6 (15%)	8 (20%)
21–30	8 (20%)	11 (27.5%)	19 (47.5%)
31–40	2 (5%)	4 (10%)	6 (15%)
41–50	3 (7.5%)	0 (0%)	3 (7.5%)
> 50	1 (2.5%)	3 (7.5%)	4 (10%)

Table 2 Factors associated with delayed access to care

	Percentage of sample
Cultural	36
<i>specific cultural reasons</i>	
female gender	28
jinn/spirit	44
traditional healing	28
Knowledge	28
Stigma	14
Financial	14
Effect of mental illness	7.4
Service	0.6

Family was the main source of referral (45% of cases), whereas general practitioners referred 20% of cases only, and so were shown to have a lesser role in the pathways to psychiatric care. This is contrary to the important role of primary care in high-income countries (Edwards & McGorry, 2002; Shiers & Lester, 2004).

The study results may not provide an accurate reflection of DUP. However, the factors found to be associated with delayed access to care are important and need to be carefully addressed to improve access to psychiatric care for those with an FEP. Larger, longer studies are needed.

Conclusion

The study results indicate that cultural factors, lack of knowledge about mental illness and services, stigma and financial factors probably influence help-seeking behaviour, which in turn may play a significant role in delayed access to care in rural Egypt. Programmes to improve public awareness of mental illness and the available services and to address stigma are needed. Further development of the healthcare system and service model in Egypt is likely to help.

References

- Beiser, M., Erickson, D., Fleming, J. A. E., et al (1993) Establishing the onset of psychotic illness. *American Journal of Psychiatry*, **150**, 1349–1354.
- Brunet, K., Birchwood, M., Lester, H., et al (2007) Delays in mental health services and duration of untreated psychosis. *Psychiatric Bulletin*, **31**, 408–410.

- Edwards, J. & McGorry, P. (2002) *Key Service Elements. Early Recognition and Assistance: Implementing Early Intervention in Psychosis. A Guide to Establishing Early Psychosis Services*. Martin Dunitz.
- El-Adl, M. & Balhaj, T. (2008) Stigma of mental illness (SMI): views of the public in an Arabic culture. *Arab Journal of Psychiatry*, **19**, 57–65.
- Fahmy, E., Michael V., Elsheikh, H., et al (2004) Knowledge, attitude and behaviour towards mental illness across secondary schools in Benha city. *Egyptian Journal of Psychiatry*, **23**, 30–37.
- Ho, B.-C., Alicata, D., Ward, J., et al (2003) Untreated initial psychosis: relation to cognitive deficits and brain morphology in first episode schizophrenia. *American Journal of Psychiatry*, **160**, 142–148.
- Larsen, T. K., Johannsen, J. O. & Opjordsmoen, S. (1998) First episode schizophrenia with long duration of untreated psychosis. *British Journal of Psychiatry*, **172** (suppl. 33), s45–s52.
- Lincoln, C. & McGorry, P. (2000) Pathways to care in early psychosis: clinical and consumer perspectives. In *The Recognition and Management of Early Psychosis. A Preventive Approach* (eds P. McGorry & H. Jackson), pp. 51–79. Cambridge University Press.
- Loebel, A. D., Lieberman, J. A., Alvir, J. M. J., et al (1992) Duration of psychosis and outcome in first episode schizophrenia. *American Journal of Psychiatry*, **149**, 1183–1188.
- McCrone, P. & Knapp, M. (2007) Economic evaluation of early intervention services. *British Journal of Psychiatry*, **191** (suppl. 51), s19–s22.
- McGlashan, T. H. (1987) Recovery style from mental illness and long-term outcome. *Journal of Nervous and Mental Disease*, **175**, 681–685.
- Mihalopoulos, C., McGorry, P. D. & Carter, R. C. (1999) Is phase-specific, community oriented treatment of early psychosis an economically viable method of improving outcome? *Acta Psychiatrica Scandinavica*, **100**, 47–55.
- Shiers, D. & Lester, H. (2004) Early intervention for first episode psychosis needs greater involvement of primary care professionals for its success. *BMJ*, **328**, 1451–1452.
- Wyatt, R. J., Damiani, M. & Henter, I. D. (1998) First episode schizophrenia. *British Journal of Psychiatry*, **172** (suppl. 33), s77–s83.
- Yung, A. & McGorry, P. (2007) Prediction of psychosis: setting the stage. *British Journal of Psychiatry*, **191** (suppl. 1), s1–s8.

ORIGINAL PAPER

Bagh regrows – earthquake survivors as catalysts of community and personal reconstruction

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In our age of frequent natural disasters in this increasingly interdependent world, there is a pressing need to understand better the processes of societal adjustment. The Kashmir earthquake of 8 October 2005 brought human suffering on a massive scale. High rates of psychiatric morbidity have been reported (Niaz et al, 2006; see also <http://emdrpakistan.com>). Whereas the relevance of the application of Western, secularised, psychological treatment models to this group is outside the scope of this paper, survivors have faced catastrophe and destruction of both their internal and external realities.

More can be learnt about how some survivors who are in crisis achieve the transition to active helpers. Points for

consideration are the many studies that document the psychiatric and psychological impact of disasters on survivor populations (Van Griensven et al, 2006), as well as the significant risks that accrue to emergency and rescue personnel mobilised to respond to major incidents (Cetin et al, 2005; Hagh-Shenas et al, 2005).

A special opportunity to investigate early subjective accounts of how such developments can occur arose at a local competence and resource re-building initiative for survivors in December 2005 organised by the Qatar Red Crescent Society's Psychological Support Programme in Bagh (Urdu for 'garden'), the disaster-struck capital of Bagh District, Pakistan-Administered Kashmir.