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Comparative Study of the Forms of Care Centers for Individuals in the Four Continents with Those in Morocco

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Abstract: In Morocco, the rate of people affected by psychological and mental disorders is increasing every year, especially in the school environment. This negatively affects the development of the country and the promotion of the population as well as their profitability in society, which is explained by the scarcity of existing care centers for individuals in Morocco. This work aims to summarize the literature regarding help centers for children, adolescents, and other people, suffering from psychological disorders. We carried out a comparative study that constitutes a very fruitful approach consisting of a comparison between the forms of care centers in Africa, such as Morocco, Europe, such as France, America, such as Canada, and the United States through the comparisons of the general criteria between each quoted country. The results showed that the Anglophone model is the most successful and can be taken as a model to follow in the Moroccan context. Based on the results of this scientific study, it is clear that it is necessary to introduce the criteria used by the American model: the age category and the multidisciplinary team because they represent the pillars of the most successful healthcare center. In conclusion, the proper management of healthcare centers requires the interference of all existing models while taking advantage of the advantages and limitations of each experience.

Keywords: care, mental health, psychological disorders, management, leadership.

四大洲與摩洛哥個人照料中心形式比較研究

摘要：在摩洛哥，受心理和精神障礙影響的人數每年都在增加，尤其是在學校環境中。這對國家的發展和人口的提升以及他們在社會中的盈利能力產生了負面影響，這可以用摩洛哥現有的個人護理中心稀缺來解釋。這項工作旨在總結有關兒童、青少年和其他患有心理障礙的人的幫助中心的文獻。我們進行了一項比較研究，這是一種非常富有成效的方法，包括對非洲（例如摩洛哥）、歐洲（例如法國）、美國（例如加拿大）和美國的護理中心形式進行比較 每個引用國家之間的一般標準。結果表明，英語模式是最成功的，可以作為摩洛哥語境中可效仿的模式。根據這項科學研究的結果，很明顯有必要引入美國模式使用的標準：年齡類別和多學科團隊，因為它們代表了最成功的醫療中心的支柱。總之，醫療保健中心的正確

管理需要對所有現有模型進行干預，同時利用每種經驗的優勢和局限性。

关键词：護理，心理健康，心理障礙，管理，領導。

1. Introduction

Around the world, psychological and mental disorders affect many people. In 2019, one in eight people in the world or 970 million people had a mental disorder, with anxiety and depressive disorders being the most common [1].

In Morocco, 48.9% of the population over the age of 15 has or already has symptoms of a mental disorder, according to a national survey conducted by the Council of Economic, Social and Environmental Affairs [2].

According to [1], psychiatric disorders are characterized by clinically significant alterations in a person's cognitive state, emotion regulation, or behavior usually accompanied by a sense of pain or disability. It affects the mental health of children, adolescents, and others. The latter, broader term includes psychiatric disorders, psychosocial disorders, and other psychiatric disorders associated with significant feelings of stress, functional impairment, or risk of self-harm. This has a negative impact on the academic performance of learners in particular and on the social integration of individuals in general.

The causes of academic difficulties are multiple and often intertwined: Socio-cultural (disadvantaged environment) and/or Medical: Specific learning disabilities include dyslexia, illiteracy, and dyscalculia, which may be linked to each other or to other cognitive functions, notably attention deficit hyperactivity disorder, apraxia, aphasia, emotional disorder, or mental disorder [3].

In psychiatry, some authors tend to affirm that there are real epistemological turning points or even paradigm shifts in the process of building collaborative research [2]. In particular, it highlights the contribution of phenomenological approaches to the understanding and cultivation of psychic experiences, previously considered a handicap [2].

In educational settings, youth with behavioral problems disrupt the educational relationships that educational professionals seek to establish [4]. Certainly, therapeutic education improves treatment adherence and quality of life for individuals [5], and addresses patients' need to know and understand the why and how of their disease, and their treatment [6].

In most global health systems, the medico-social care of people with disabilities, especially those with severe neurological impairment (hemiplegia, paraplegia, etc.), mainly includes hospital, physical medicine, and rehabilitation (PMR) services [7, 8].

Through these services, patients receive re-education and rehabilitation to prepare them to return to their previous lives with as much independence as possible. These services offer a multidisciplinary range of medical and paramedical care (physical therapy, occupational therapy, psychotherapy, social support, speech therapy, equipment...) [7].

In this sense, our interest in this research work is based on the High Instructions communicated by His Majesty King Mohammed VI, President of the Mohammed V Foundation for Solidarity, concerning the realization of large-scale projects and medico-social structures that fall under two important programs of the Foundation in the fields of health and disability: the Mohammed V Foundation for Solidarity Proximity Medical Centers (CMP) and the network of the Mohammed VI National Center for the Disabled [9, 2].

Indeed, the Global Action Plan for Mental Health 2013–2030, will be the basis for this comparative study to achieve an efficient management of centers for the care of psychological disorders. Given the WHO's recognition of the essential role that mental health plays in achieving the goal of health for all.

This work emphasizes strengthening leadership, governance and information systems, the evidence base and research in the field of mental health. Additionally, the provision of comprehensive, integrated, and responsive mental health and social support services in a community setting, and finally, the implementation of the Promotion and Prevention Strategies in the same field.

2. Materials and Methods

We conducted a bibliographic search by consulting the following databases: [Google Scholar], [CrossRef], [PubMed], [Springer Open], [American Psychological Association (APA Psych-net)], [WHO], [UNESCO], using the following French terms translated into English: care center, psychological disorders, rate of care, re-education and educational rehabilitation, learning disabilities, mental health. These keywords were combined with the following terms: care center, psychological disorders, care rates, educational rehabilitation, learning disabilities, and mental health. Then, we chose as a method to adopt in this comparative study the qualitative method with an inductive approach, which, "consists in approaching concretely the subject of interest and letting the facts propose the important variables, the laws, and, eventually, the unifying theories" [10], also called empiric-inductive approach, is a working method that starts from facts, real and observable raw data, to go

toward their explanation.

Below is a diagram of the inductive method (Fig. 1).

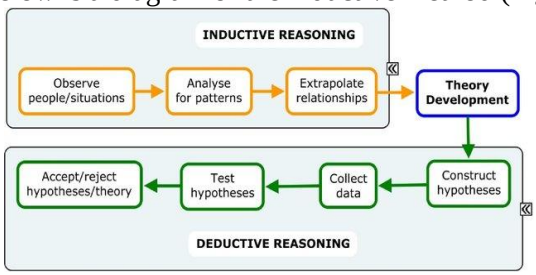

Fig. 1 Empirical inductive approach [48]

It is a method that fits perfectly with our study orientation, and in this sense, we will follow the following axes:

Table 1 Axes of the study

Organizational axis	Descriptive axis	Explanatory axis
Analyze resources to exclude or include	Describe the choice of comparison criteria	Explain the study procedure

2.1. Organizational Axis

To select our resources, inclusion/exclusion criteria were developed:

The first criterion is the date of the resource: if it is > 1994, the resource is included; if it is < 1994, the resource is excluded; the specificity of this criterion is to work with new references with a topical aspect. Now, the second criterion is the type of resource, we focus only on the articles, then the third criterion is the genre of the article, in this sense, if it approaches and treats specifically the subject of the study we include it, if it is general, we exclude it. Finally, another criterion was chosen is the country or contained approached by the resource, if it approaches a country that are the subject of our study, we include the resource, otherwise we exclude it.

The diagram below represents the procedure we have adopted for our study (Fig. 2).

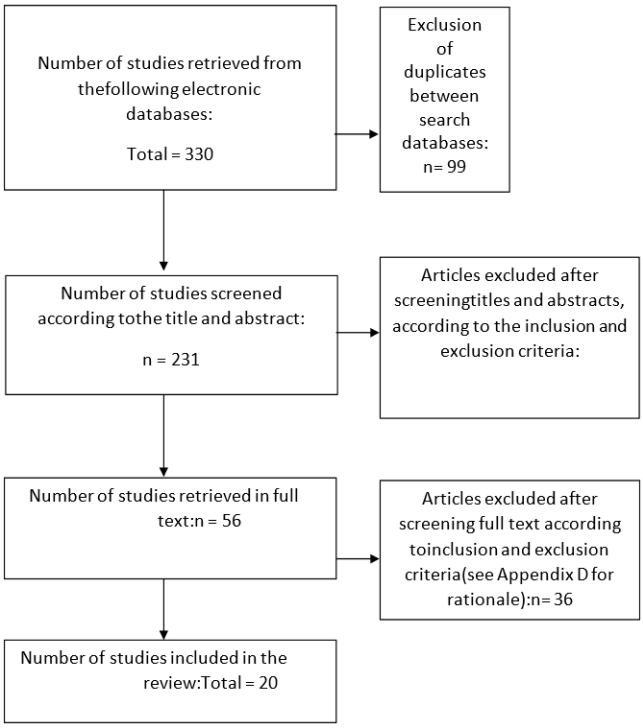

Fig. 2 Inclusion, non-exclusion, and study exit criteria

Below is a summary Table 2 of the resources taken:

Table 2 Inclusion and exclusion resources (Developed by the authors)

Resources	Type	Sources	Date	Results
Prevalence and Treatment of Mental Disorders	Article	[11]	2005	Two limitations of the study need to be noted. First, severity was assessed indirectly between 1990 and 1992 with the use of imputation, and second, the adequacy of treatment was not assessed. Both the strong relationship of imputed values to direct measures of severity in the NCS-R and the use of the multiple-imputation method to adjust for the increase in error variance when testing for significance tend to minimize concern concerning the first limitation. The second limitation is of more concern because research has shown that many patients with a mental disorder receive inadequate treatment. We were unable to study the adequacy.
Evidence-based psychological treatments for mental disorders: Modifiable barriers to access and possible solutions.	Article	[12]	2015	The principle domains during the period ahead include (1) helping patients identify good providers of EBPTs, (2) training many more providers to be able to deliver EBPTs, and (3) convincing governments to devote more resources to EBPTs.
The cost of mental disorders in France. European Neuropsychopharmacology,	Article	[13]	2013	We propose that the four components of cost (healthcare, social services, lost output and quality of life) be considered, to the best of data available in the country. Identifying knowledge gaps can also contribute to research on the economics of mental disorders.
Services for People with	Review	[14]	1997	People with mental retardation and health needs continue to challenge

Mental Retardation and Psychiatric Disorders: US-UK Comparative Overview.	Article			the service systems in both countries [49]. Current UK policy initiatives such as Care in the Community [50] have provided opportunities for improving services for people with mental retardation and mental health needs.
The prevalence of mental disorders and mental health service use in Japan.	Review Article	[15]	2019	This review has clarified that the prevalence of CMD in Japan has been relatively stable in the past decade. The 12-month prevalence of mental health service use has increased about 1.2 times to 1.6 times in the past 10–15 years according to the results of the WMHJ1, WMHJ2, CSLC, and the Patient Survey. Thus, it is very likely that the rise in mental health service use contributes to the increase in the number of patients. Whether the prevalence of depression has actually increased requires further study. Regarding cross-national comparison, the prevalence rate of CMD in Japan is not so different from that in China, but it is much lower compared to rates in the USA and Europe. The 12-month prevalence of mental health service use was still lower in Japan compared the prevalence rates in other high-income countries.
Overview of the Saudi National Mental Health Survey.	Article	[16]	2020	Finally, we hope that the findings from this survey will both increase health promotion and reduce the stigma associated with mental health problems in the KSA and elsewhere in the Arab world.
Prevalence, symptom patterns, and comorbidity of anxiety and depressive disorders in primary care in Qatar.	Article	[17]	2012	The study findings revealed that depression was more prevalent in the Qatari population than anxiety disorders. This study underscores the urgent need for improving the provision of mental health care in the primary healthcare services in the State of Qatar.

2.2. Descriptive Axis

2.2.1. Choice of Criteria

After a long navigation and research to discover the forms of center of care, we concluded that a center of this type it is composed of a multidisciplinary team that work in different services for very precise missions to welcome patients of different ages affected by different psychological disorders. The choice of the following criteria has considered the gathering of different disorders in patients worldwide to end up with a multidisciplinary psycho-educational medical center that meets the needs of all age categories.

Below is the diagram of the steps we followed and the table that explains each criterion of our study (Fig. 3).

Fig. 3 Procedures in chronological order [51]

Table 3 Criteria for the comparative study

Criterion	Definitions
The multidisciplinary team	In a medico-social environment, such as a structure that welcomes adolescents with disabilities, presenting an intellectual disability with or without associated disorders.
The missions	In the legal vocabulary, a "mission" is a charge with which a person is invested to fulfill a representation function or to conduct material or legal acts that his principal requires him to accomplish in an interest and with the means that the latter must provide. A mission is the movement of an employee of the structure at the request or with the authorization of the latter and for professional reasons.
The services	Derived from the Latin terms *servitĭum* (state of slavery, servitude, domesticity) and *servire* (to be enslaved), the word "service" refers to the action of serving (to be at the service/at the disposal of someone, ready to do what may be useful to them or what they ask).
Age Category Welcomes	Noun phrase (Anthropology) A group of people who share the same age, and the social rules that follow from it.
Disorders	Disturbance in the accomplishment of a physical or psychic function, which can be manifested at the level of an apparatus, an organ, and a tissue: Respiratory disorders. Personality disorders. 4. Alteration of the relations between people; the state of agitation, disarray: This threw the family into turmoil.

Continuation of Table 3	
Rate of coverage	The term is also used more specifically in the field of medicine and refers to providing care to a patient.

2.2.2. Choice of Countries

The choice of the countries that are the object of our comparative study was based on the fact that the countries mentioned have care centers that contain general criteria; below are the chosen countries: European (France & England), American (USA & Canada), Asian (Japan), Gulf countries: Qatar and Saudi Arabia, African (Morocco).

2.3. Explanatory Axis

In this step, we worked on the elaboration of the table that includes the collected results of the study. It presents the comparison criteria for each country in a detailed way. The table will be a fruitful tool to make an efficient comparison in this review.

Therefore, we proceeded to the use of data collected by content analysis [18], and more specifically to the thematic analysis that allows the highlighting of social representations or judgments of the authors from an examination of some constituent elements of the literature [19]: knowledge of the different existing centers and research on the percentage of the rates of care in the different countries chosen previously given the relevance of the studies conducted in them.

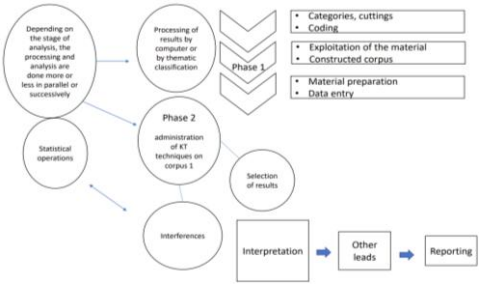

Fig. 4 Content analysis procedure (Developed by Seca J.-M., University of Lorraine, 2020/2021)

Table 3 contains five criteria for comparison:

– *Criterion 1:* The multidisciplinary team, this criterion will help us have a clear idea of the team that is needed in a center to be a care center that meets the health standards.

– *Criterion 2:* Missions and services, this criterion aims to list the different missions and services of an efficient care center.

– *Criterion 3:* The age category received, this criterion is chosen to specify the ages with more psychological and mental disorders.

– *Criterion 4:* Addresses the different disorders/difficulties taken care of each center, which clarifies for us the center that touches several disciplines

– *Criterion 5:* Presents the rate of care in each country, this last criterion considered as the most solid and which will give us a clear idea on the quality of the centers in each country, something that will specify us the strongest and most powerful reference model to follow in Morocco in order to pilot and manage the centers in an effective and efficient way immediately.

3. Results

Three hundred and thirty observations were collected and only twenty were selected for our comparative study, as shown in Table 4. All of them are exploitable for the appreciation has models that deal with the form of care center in the four continents: Europe, America, Africa, Asia, and the Gulf countries:

Table 4 The comparative study of care centers in the world

Country	Multidisciplinary team	Tasks/Services	The age category welcomes	Difficulties/disorders	Support Rate	Classification
France [20]	They are composed of psychiatrists, psychologists, and psychiatric nurses [21]	Integrated into the pre-hospital emergency medical services (SAMU) of each French province [22, 24]	General population	Anxiety, depression, burn out, and the high proportion of post-traumatic stress disorder [23]	18.4%	7
Canada [25]	Physicians, psychiatrists, psychologists, nurses, and other mental healthcare providers	Mental health and addiction services are provided by professionals and include medication and psychotherapeutic support [26]	Children and young people	Troubles, emotionless depression, anxiety, and substance abuse disorders, to severe conditions such as psychoses	20%	6
Japan [15]	Psychiatrists, psychologists, and other mental health professionals in any	Medical services Specialized psychiatry General medicine Non-medical (personal services such as religious services,	10–15 years old	Mood,anxiety, and substance-related disorders	27.8%	5

	setting, general practitioners or nurses, or counselors in non-psychiatric settings	social services)				
America [27]	Mental health professionals (such as psychiatrists and psychologists) [28]	Psychiatric Services: Psychiatric services, other psychiatric services, general health services, individualized services, and complementary and alternative medicine services [11]	18 to 54 years old [12]	Anxiety disorders, mood disorders, and substance-abuse disorders that were before [14]	49.9%	1
Saudi Arabia [16, 48]	Psychiatrists Other professionals Psychiatric nurses Psychologists Social workers Other psychiatrists	Services for individuals with mental health disorders or addiction (chemical and behavioral) Mental Health Services: Depression treatment, sleep disorders, obsessive-compulsive disorder, anxiety treatment, relationship difficulties, eating disorder treatment, stress treatment, panic attack treatment, anger management treatment, adolescent mental health support, and mood disorder treatment	15 to 75 years old	Depression, anxiety, somatization, or panic disorders	28.5%	4
England [29]	The department has hired occupational therapists, psychological assistants, and therapeutic assistants to conduct patient treatment sessions [30]	Primary Care Specialist, mental health specialist, social support services, physical health specialist, Teacher, teaching assistant [31]	Children and young people [32]	Emotional disorder, behavioral problems, and hyperactivity disorder Autism spectrum disorders, eating disorders and other less common disorders, predictors of mental disorders, some conditions and happiness, professional services, informal support and education, behavior, lifestyle, identity, and preschool children [14]	41%	2
Morocco [33]	Psychiatrists, Psychologists, Speech therapists, psychomotor therapists, social workers, medical secretaries [34, 35]	Medical rehabilitation service [36]	All age groups [37]	The center specializes in patients with physical disabilities requiring rehabilitation [38]	12.3 %	8
Qatar [39]	5 consultants psychiatrists, Non-consultant physician, psychologist, three therapists, occupational therapist, of them, social worker	The psychiatry department is the main provider of mental health services for the entire population of Qatar. It works with three others psychiatric services, those of the school health system, the armed forces, and the police force [40]	18–65 years old	Depressive disorders any anxiety disorder Mood disorders followed by separation anxiety and personality disorders	34%	3

Each of these models explains the shape of the center with its different components, and it is difficult to generalize the performance of one model or another. It will be necessary to establish the criteria to compare them, just as the evaluative or preventive approaches that will be recommended will differ.

Let's start with the first criterion, which is the multidisciplinarity of the team. We note that the centers in the United States are made up of a very different team from those in other countries, as shown in the table.

The United States has a successful strength in terms

of multidisciplinarity, which explains its permanent success, which pushes forward the success of the management of the medical-psychological-pedagogical centers in the whole country. Multidisciplinarity constitutes an important criterion reflecting subcriteria, and its presence facilitates the management of other specialties in the short and long term, something that this country has well understood and has implemented it

It turns out that the multidisciplinary team in the U.S. is composed of physicians, psychiatrists, psychologists, nurses, and other mental health providers (i.e., psychiatrists and psychologists), whereas the centers in Japan include psychiatrists, psychologists, other mental health professionals in any setting, a general practitioner or nurse or counselor in a non-mental health setting. Additionally, the center in France contains psychiatrists, psychologists, and nurses specialized in psychiatry. As for Qatar and Saudi Arabia, the centers are composed of psychiatrists, other medical specialists, mental health nurses, psychologists, social workers, and other mental health worker; for Morocco, the multidisciplinary team is as follows: Psychiatrist, Psychologists, Speech therapists, psychometricians, social workers, and medical secretaries and for the centers in England are composed of primary care professional mental health specialist, social care services, physical health specialist, teacher educational support worker.

The second criterion is services and missions, an important criterion reflecting the level of care and importance that the country gives to patients.

We note that there are various missions and services from one country to another, as highlighted in the table. The US centers' missions/services are multiple: psychiatric services, other mental health services, general medical services, human services, and complementary and alternative medicine services. Compared to Japan, the services/missions are: medical service, mental health, general medicine; non-medical care (human services, such as religious, social service providers, etc.).

Japan, on the other hand, pays attention to the diversity of missions and services, which has a positive but moderate influence on its support rate of 27.8%, while the other criteria in the table above are to be compared.

However, the services in France are integrated into the pre-hospital emergency medical services (SAMU) of each French province. The Department of Psychiatry is the primary provider of mental health services for the entire population of Qatar. It works with three other psychiatric services, those of the school health system, the armed forces, and the police. This demonstrates the interest approved by this country at the expense of health services for all social strata. Such remarkable benevolence highlights the citizens regardless of their age or profession.

Moreover, the age of the patients is different, which implies that the centers should consider the reception of the patients.

Our 3rd criterion is indeed the age of the patients. We can distinguish that the people who consult these centers have different ages, which pushes us to be interested in any category of the received ages.

First, we notice that France and Qatar have a countless capacity of reception presented by the general population of reception. This is a strong point for these two countries and encourages citizens to take care of their mental and psychological health from an early age. Canada and England welcome children and young people, then for the United States, they are more interested in the age group between 18 and 54 years old, Saudi Arabia welcomes between 15 and 75 years old, then Japan welcomes the 10–15 years old and finally Morocco is interested in all age groups.

Each of these age groups has patients with different psychological disorders/difficulties, which are the subject of the 4th criterion of our comparison.

This criterion is also essential for the medical-psychological-pedagogical centers.

We note that there is a common point between the difficulties treated in the centers of each country studied, which are anxiety and depression, which confirm the statistics provided by the WHO in 2019, as highlighted in our introduction. One in eight people in the world, that is to say, 970 million people, had a mental disorder, with anxiety and depressive disorders being the most frequent.

Certainly, the disorders treated in the United States are numerous, ranging from depression, anxiety and emotional disorders related to substance abuse, to serious conditions such as psychosis anxiety, mood and substance abuse disorders; the delay in treatment can explain this, as mentioned in the paragraph of the age criterion, the United States accommodates an age range that varies between 18 years and 54 years. Some disorders require early treatment at an early age, and any delay may negatively influence the recovery rate.

Regarding Japan, it has substance use disorders including the following disorders/difficulties managed in England emotional disorders, behavioral disorders, hyperactivity disorders, autism spectrum disorders, eating disorders and other less common disorders predictors of mental disorders Multiple conditions and well-being professional services, informal support and education Behavior, lifestyles and identities preschool children, except that this country treats with care all known disorders in its patients, this is explained through the Age category welcomes. The centers in Japan receive people between 10 and 15 years old, an age that is so important for early treatment that they do not even must expand the age range to 30, 50, or even more.

Additionally, in Saudi Arabia and Qatar, various disorders were found, including depressive disorders, anxiety disorders, and mood disorders followed by separation anxiety, personality disorders, depressive, anxiety, somatization, and panic disorders. The disorders observed in France are anxiety, depression, burn out, and a high proportion of post-traumatic disorders.

In Morocco, the disorders treated are physical handicaps requiring rehabilitation, which highlights a purely sanitary and why not psychological follow-up to follow the mental health of the patient, an equally important point, which the country must make more effort.

To take a reference model, another criterion has been set up, which shows the rate of care in each country. Using this criterion, we ranked the countries according to the qualitative performance of the centers.

We can observe various percentages of the care rate. First, there is no doubt that the United States manages its care in a successful way; the rate that it represents equal to 49.9% explain this, this percentage is also remarkable, which makes the difference from other countries.

As for England, it is 41% – a rate that is also remarkable and reveals the greatness of the country concerning its patients.

However, Canada has a 20% rate of care, a percentage that is somewhat average, but still this country has strong points in other criteria without forgetting that it is the 6th in classification, as shown in the table of comparison above.

Japan, the country with the most care for its patients from the age of 10, has a rate of 27.8%, a percentage that is respectable and that tends to develop in the coming days.

However, 28.5% as the rate of care for Saudi Arabia, and 34% for Qatar, on their side these two countries are in the average standards of percentages of care compared to other countries treated. Each of Saudi Arabia and Qatar made efforts for treating their citizens affected by depressive disorders, anxiety disorders, mood disorders, personality disorders, depressive, anxiety, somatization, and panic disorders.

In fact, France and Morocco have the lowest percentages in terms of care rates, 18.4% for the French country and 12% for the Moroccan country, such low percentages that require the good management of the medical-psychological centers and the patients received. It is necessary to emphasize the human body treated and to welcome it whatever its age or its treatment.

4. Discussion

The comparative study aims to clarify and shed lights on the quality of the centers of the countries and to deduce the strongest and most powerful reference model to be followed in Morocco in order to pilot and manage the centers in an effective and efficient way and at the same time to conduct the improvement of the procedure of care of the people affected by psychological disorders and especially of learning in the children and teenagers to improve their profitability and productivity in society .

It turns out that the relationship between the intensity of the reaction of the disorders and the adaptation of the individual to the situation, and therefore his level of performance, is not linear. At first, the level of the disorder and performance grow together, and then, as the disorder continues to increase, performance falls.

In terms of efficiency and individual balance, it is obvious to each individual to consult a care center and that is clearly our purpose of the study.

The results obtained show that despite the general criteria between the countries, and even more so the variety of these results, it is remarkable that the American country occupies the first place with the highest rate of care. The United Kingdom, on the other hand, comes in a close second with an equally high rate.

The appropriate choice of management policies ensures the good management of the centers, which positively influences the rate of care. Morocco has always favored educational and health reforms. It ensures the development and efficiency of these two pillar areas, which constitute the basis of society in the short and long term, by using existing means.

Based on the results of this scientific study, the following criteria should be introduced: the age category and the multidisciplinary team because they are the pillars of the most successful care center.

According to this comparative study, we can say that the American model and precisely the United States is the most successful model with a higher rate of care represented by 49.9%, an important percentage compared with the other countries treated in this study France: 18.4%, Canada: 20%, Japan: 27.8%, Saudi Arabia: 28.5%, England: 41%, Qatar: 34%, and Morocco: 12%.

It remains to be deduced that the American model followed by that of England are the ideal models to which a less strong country can refer in terms of managing and taking care of people having psychological disorders and especially learning disorders in children and adolescents in Morocco.

Financing in complex health systems, limited training mechanisms, and geopolitical/political issues, supportive health policies, strong education initiatives, continuous quality improvement, and outcome measurements across programs will provide evidence-based support to expand integrative care and ensure its sustainability [41].

Finally, a good management of care centers requires

the interference of all existing models while taking advantage of the advantages and limits of each experience.

Among the limitations of our study is the absence of documentation and the near existence of resources in the area of our study, especially from a current perspective. We did not receive any feedback from most people we contacted who were responsible for the care centers in the world. Despite the differences and progress in implementing integrative medicine models internationally, there are common challenges.

5. Conclusion

The problem of screening and prevention of psychological and mental disorders in society, particularly in schools, is therefore fundamental and requires the involvement of all professionals in the field who receive parents, children, and adolescents after childbirth [42].

The importance of interdependence between organizations and stakeholders requires a formalization of professional relationships whose challenge goes far beyond the simple delegation of tasks. This formalization of new mechanisms of professional cooperation cannot constitute a new obstacle to the global response to users' needs, but to help demonstrate, through innovation, the importance of the work-based approach to mental health [43].

The results showed that the Anglophone model is the most successful and can be taken as a model to follow in the Moroccan context.

Beyond structural reforms, it is a question of building a renewed vision of the graduation of care and services at the elbow of which new professionals can take shape. Consideration of the various actors – doctors, nurses, psychologists, medical auxiliaries, users, and families prefigures the need to review the professions that emerged from the Mental Health Plan [20].

In the perspective for the World Health Organization, here is the challenge that all countries will have to take up in the years to come: the integration of mental health in public health and psychiatric care in primary health care integrated from early age [44].

Mental health and psychiatry in Morocco are common in the academic, public, private, and military sectors. Despite considerable progress in the last twenty years, Morocco still has no more than 350 psychiatrists (thirty years ago there were less than ten) in addition to some 60 clinical psychologists, about 400 psychiatric nurses, and social workers [45, 46].

In conclusion, the Anglophone model manages the mass in terms of multidisciplinarity, the age category, the multidisciplinarity of the team within the medico-psychopedagogical centers. This implies that the good and efficient management of these centers in Morocco requires the interference of the success criteria of the American model to have Moroccan medico-psychopedagogical centers containing a multidisciplinary team that treats the different mental, psychological, and physical disorders for all age categories to minimize the rate of people affected by these disorders and to make the general interest triumph.

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