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This paper begins with a historical perspective on mental health care from ancient Egypt to modern times. Current mental health services are described including epidemiological information, the structure of services, and methods of service delivery. Contrasts are made between urban and rural community care systems. The changing demographics of institutional care are analyzed in detail and future plans for psychiatric services are discussed. The recent development of comprehensive interdisciplinary model of service and the founding of a training center for this model is described.

Mental hospitals have been providing care and treatment for the mentally ill for the last two centuries. With improved physical methods of treatment and a liberal social climate, treatment of the mentally ill has shifted toward community based services. The provision of mental health services in psychiatric units in general hospitals also emerged as an alternative for treatment of the acutely mentally ill.

It has been envisaged, somewhat over-enthusiastically, that mental hospitals would be eventually phased out and replaced by community based psychiatric services with general hospitals as centers for short-term treatment. Although rapid return to the community is beneficial to many patients, rigid adherence to this policy is neither wise nor clinically effective.

History of Mental Health Services in Egypt

In Egypt three thousand years ago, Imhoteb, minister of King Zoser, the builder of the Sakkara pyramid, was a well known physician who treated mental patients in general hospitals. This fact was discovered in the "Sleeping Temple" in Sakkara, south of Cairo (Okasha, 1978; Ghaliongui, 1963).

The first mental hospital in the world was built in Baghdad, Iraq in 705. This was followed by hospitals in Cairo (800

AD), Damascus (1270 AD), and Allepo in Syria. At that time, mental patients were being burned, condemned and punished in Europe.

It is interesting to give a brief account of the 14th Century Kalawoun Hospital in Cairo. It had separate sections for surgery, ophthalmology, and medical and mental illnesses. Generous contributions by the wealthy of Cairo allowed a high standard of medical care and provided for patients during convalescence until they were gainfully occupied (Baashar, 1975). Two features are striking: the care of mental patients in a general hospital and the involvement of the community in the welfare of the patients, foreshadowed modern trends by six centuries.

In the beginning of the 19th century during the French occupation of Egypt, the director of medical services in the Egyptian Armed Forces, a French physician named Claude, approached the Egyptian ruler regarding the appalling state of mental patients in Cairo. At that time, all medical hospitals were under military auspices so mental patients in Cairo were transferred to a military hospital in the middle of the City (Al Azbakia). After a few years, they were transferred to an independent building not far away in Bolaque. In 1880, a great fire demolished one of the palaces of the prince except for a two-story building. This was painted yellow and became the first mental hospital in Cairo in the year 1883. It was called the Yellow Palace (El Saray El Safra). At that time it was situated in Abbassia a remote desert suburb of Cairo. Now it is in the middle of an expanded, overcrowded city and there are planes for the hospital's demolition. In 1912, another state mental hospital was built in Khanka. It occupied about 300 acres including a large plantation and was situated several kilometers north of Cairo. In 1967 a third mental hospital was established in Alexandria (Al Mamoura) and in 1979 another was founded in Helwan, a suburb south of Cairo.

Starting from 1949, outpatient facilities have been extended by central hospitals in almost all governorates of Egypt. There are thirteen medical schools in Egypt and each has a psychiatric unit with inpatient and outpatient psychiatric services. The largest mental hospital, Abbassia, is more than 100 years old and Khanka is about 80 years old. They are facing great difficulties regarding care, finances, treatment, and rehabilitation

while accommodating about 5,000 patients. The new policy of deinstitutionalization and provision of community care may reduce the number of hospitalized psychiatric patients but will not solve the problem (Okasha, 1988).

Community Mental Health

In spite of the rapid social changes in Egypt, the majority, especially in rural areas, belong to the extended family hierarchy. It is disgraceful and shameful to care for an elderly demented away from family surroundings. The parents of retarded or hyperkinetic children feel a primary responsibility towards their children rather than having them looked after in an institution.

In rural areas, community care is implemented naturally without the need of health caretakers. Egyptians have a special tolerance to mental disorders and have the ability to assimilates chronic mental patients even to a sacred degree. These patients and those with mild mental retardation or borderline intelligence are rehabilitated daily by cultivating and planting the countryside along with and under supervision of family members.

Community care in the form of extending health services to hostels, day centres, rehabilitation centres, health visitors is only available in big cities. A good example in applying community care is in the prevention of drug abuse. There has been an increase in the abuse of heroin and other narcotics since the early 1980s. Mass media orientation, legislative acts, antinarcotic squad seizure of traffickers, initiation of centres all over Egypt and deployment of social workers, religious people, and politicians to orientate the masses about the hazards of drug abuse, have triggered an interest in psychiatry and mental disorders.

A lot of epidemiological work has initiated a radical change in mental health policy and programs. Although community care started in the sixties, active participation of the community exploded with the increase of drug abuse among youth.

The priorities for community health care services in Egypt are not for mental health, but rather for bilharziasis (schistosomiasis), birth control, infectious diseases in children, and recently, smoking and illicit drug abuse. The programs which are available for community care in big cities take the form of

outpatient clinics, hostels for elderly, institutions for the mentally retarded, centres for drug abuse, school and university mental health.

The new national health program will focus on decentralization of mental health care and community care in different governorates. Emphasis is made on recruiting mental health teams, especially psychiatric nurses, psychiatric social workers, occupational therapists, and clinical psychologists.

Current Mental Health Services

The population of Egypt now is 56,000,000. There are about 100,000 doctors, one for each 560 citizens. There are about 500 psychiatrists which means one for each 200,000 citizens. There are about 7500 psychiatric beds, one bed for every 7000 citizens. The number of psychiatric beds in Egypt is less than 10% of the total hospital beds.

There are three mental hospitals in Cairo accommodating approximately 5600 patients, one in Alexandria, one in Dakahlia, one in Asyout. Psychiatric beds are also available in general and private hospitals.

Table 1

Number of Beds in Psychiatric Hospitals

Cairo	
Abbassia	2500
Khanka	2500
Helwan	600
Alexandria	
Mamoura	650
Dakahlia	
Harbit	50
Asyout	
In general hospitals	250
In private hospitals	800
TOTAL	7500

Egypt is divided into 24 governorates, 19 with psychiatric clinics and outpatient units and 5 with no psychiatric services, namely Matrouh, Red Sea, New Valley, and North and South Sinae.

In Egypt, there are about 250 clinical psychologists but hundreds of general psychologists are working in fields unrelated to the mental health services. There are many social workers practising in all psychiatric facilities, but unfortunately they are general social workers who have minimal graduate training in psychiatric social work. There was an attempt to educate psychiatric social workers at the Institute of Social Services in Cairo in 1960. It lasted only for two years due to a shortage of students.

There ar four High Institutes of Nursing equivalent to medical schools and they graduate highly qualified psychiatric nurses. Unfortunately, the majority leave the country to work in the petrodollar Arabian Gulf States with their incomparable salaries. The majority of nurses working in mental health facilities are general nurses with minimal psychiatric training. Nursing Schools graduate psychiatric nurses but in insufficient numbers to cover psychiatric services.

Traditional and religious healers play a major role in primary psychiatric care in Egypt. They deal with minor neurotic, psychosomatic, and transitory psychotic states using religious and group psychotherapies, suggestion, and devices such as emulets and incantations (Okasha, 1966). In one study (Okasha, 1968), it was estimated that 60% of outpatients at the university clinic in Cairo serving low socioeconomic classes have been to traditional healers before coming to the psychiatrist. The aftercare services in Egypt are still limited. This is due to the poor orientation of the masses to the need for follow-up care after initial improvement

Deinstitutionalization

Dehospitalization or deinstitutionalization can be achieved in several ways: (a) preventing or postponing admission to mental hospitals and referring to intensive nonresidential care or extramural hospitals (b); admitting to psychiatric wards in general hospitals; (c) shortening the hospital stay; (d) discharging long-stay patients to nonresidential care; and, (e) separating different

types of psychiatric units, i.e., units for mental retardation, dementia, addiction.

In order to evaluate the deinstitutionalization policy, the following questions are important to answer.

(a) Reducing the size of mental hospitals is often considered an important goal of deinstitutionalization. Have the size of hospitals been reduced in Egypt? If the number of inpatients is accepted as the indicator of the size of an institution, then indeed there is a slight decrease in the size for the largest mental hospitals in Egypt.

(b) Do mental hospitals show a reduction in inpatients and inpatient days? There has been a gradual decrease in the inpatient population of general mental hospitals accompanied by a decline in the annual inpatient days. We do not know which sections of the general mental hospitals were less utilized: the units for medium or long-stay patients, or the units for subspecialities such as psychogeriatrics and the mentally retarded patients. It seems that turnover occurs among those who stay less than one year.

(c) Has there been a decline in the length of stay of patients in mental hospitals? One possible explanation for the decrease in the annual number of inpatient days could be found in fewer admissions to and shorter stays in mental hospitals. Indeed the duration of treatment in mental hospitals has become shorter. About 30% of patients admitted to mental hospitals between 1980 and 1988 had been discharged within 6 to 12 months, a decrease from earlier decades. The trend in the 1980s was towards an increase in the percentage of stays from 1 to 5 years, but a decrease in long term hospitalization of more than 5 years (see Table 2).

d) Are psychiatric wards in general hospitals having an influence in reducing or preventing admission to mental hospitals? There are no signs that the psychiatric wards in general hospitals are helping to prevent more admissions to mental hospitals. Still the psychiatric wards in general hospitals do have a central function in the short-stay treatment of psychiatric patients.

Table 2

The Percentage of Inpatients According to Their Length of Stay in the Hospital from 1980 to 1988

Year	Less than 6 months	6–12 months	1–5 years	6–10 years	10–20 years	20 years
1980	23.9	5.9	30.8	12.5	14.3	12.6
1981	24.3	5.8	31.2	12.3	14.4	12.0
1982	24.1	6.9	30.9	12.4	14.2	11.5
1983	22.3	6.8	35.7	12.1	10.3	12.6
1984	22.8	7.1	32.0	11.6	14.1	12.4
1985	23.2	6.9	35.4	11.8	11.2	11.5
1986	22.7	6.5	36.1	11.7	11.6	11.4
1987	23.1	7.1	35.3	11.4	11.7	11.4
1988	23.5	6.7	36.0	11.0	11.4	11.3

The task of psychiatric wards in general hospitals and mental hospitals is to serve patients who are severely disturbed. Many patients and their families prefer to contact psychiatric wards of general hospitals for the clinical treatment of a first episode because of a shorter travelling distance and less stigmatization. There are some differences in the population of these two types of institutions. In general, patients in the psychiatric wards are young females with more years of schooling. There are also significant differences in respect to psychiatric diagnosis. The mental hospitals having 79% of their patients with a diagnosis in the schizophrenic spectrum, where as with the psychiatric wards 25% are diagnosed with schizophrenia. In the psychiatric wards 54% percent are affective disorders or anxiety disorders (see Table 3).

e) Is the expression "revolving door psychiatry" correct in view of admission and discharge rates? The characteristics of patients admitted to mental hospitals also have changed. There are more young, married and divorced patients with affective disorders, anxiety disorders, substance abuse, and personality disorders. There has been a change in the age distribution with an increase in the 20 to 40 years of age category and a decrease in the 45 to 64 years of age category. The proportion of the elderly patients admitted has remained relatively

constant. This reflects the admission and discharge policy of mental hospitals.

Table 3

Diagnosis by Type of Hospital

	State MH %	General MH %	Private MH%
Schizophrenic spectrum	79	25	43
Major affective disorders:			
Depression	5	28	17
Mania	4	13	12
Anorexia Nervosa	1	3	2
Anxiety disorders	—	13	—
Mental subnormality	2	—	—
Organic mental disorders	1	—	—
Substance abuse	7	3	12
Conversion dissociative disorders	1	6	4
Borderline personality disorders	—	2	2
Complication of psychotropics	—	3	2

Readmission figures document the results of admission and discharge of patients during symptomatic change. Patients are discharged with encapsulated delusions, cognitive deficits, and social handicaps. In different studies, it has been found that discharged schizophrenics have residual dysfunctions as follows: 15% delusions and hallucinations, 30% negative symptoms (adaptive behavioral or attitude problems), and 70% neurotic symptoms especially depression. Research also shows that 60% of chronic inpatients have cognitive impairment as measured by organicity batteries (Okasha, 1988). Following this line of argument, the admitted, long-stay schizophrenic patients of the 1950s have become the most evident "revolving door" patients of the 1980s.

f) Is the number of new and old long-stay patients decreasing? In the 1970s, many patients stayed continuously longer than two years in the hospital and 40% stayed more than ten years. Now the picture has changed. Many inpatients who were in the

hospitals for ten years or more have left. Also, some have died and many who were mentally retarded have been transferred to more suitable institutions.

The number of long-stay patients is constantly decreasing but this group still dominates the picture in the mental hospital days of stay. Many of the younger chronic patients have been released. At the end of 1980, about a third of the long-stay males and half of the long-stay females were 60 years or older. Previously these proportions were remarkably smaller.

Differences of long-stay and short-stay patients were studied at one of the largest mental hospitals in Cairo (Okasha, 1988). The study showed demographic and socioeconomic data distinguishing short-term and long-term patients (see Table 4). Married patients were found more often among those with short-term hospitalization (53%), than among those with long-stay hospitalizations (26%). Long-term patients were significantly less educated and younger on admission. They recorded a significantly higher prevalence of disturbed home atmosphere and family history of psychiatric disorder. They tended to be of low socioeconomic status and they were more likely to be unemployed. The vast majority of both groups were admitted involuntary but patients with short-term hospitalization showed a significantly higher rate of voluntary admission. Also they

Table 4

Psychodemographic Data

	Short Stay	Long Stay
Social Status	more married	more single
Employment	more employed	more unemployed
Education	more educated	more illiterate
Family atmosphere	more stable	more disturbed
Family history of psychiatric disorder	rare	more common
Voluntary admission	more frequent	less frequent
Previous admissions	frequent	rare
More visits/month	common	less frequent

had a significantly fewer number of previous psychiatric admissions.

The Okasha (1988) study also revealed differences in length of stay as affected by diagnosis (see Table 5). Patients of short-term hospitalization were more frequently diagnosed as paranoid (39%), disorganized (35%), and catatonic (12%). The patients with long-term hospitalization were labelled residual (29%) and undifferentiated subtypes (13%) according to DSM-III criteria.

Table 5

Diagnosis by Length of Stay

DSM-III	Short Stay	Long Stay
Disorganized	35	24
Catatonic	12	8
Paranoid	39	26
Undifferentiated	8	13
Residual	6	29
TOTAL	100	100

In a recent study comparing emergency and urgent admissions in state hospitals, general hospitals and private hospitals in Egypt, differences were found in the male/female distribution and also in the diagnostic pattern.

In all types of hospitals, schizophrenic spectrum showed the highest incidence. The major affective disorders and the anxiety disorders showed more admissions in the general hospitals, while substance abuse was evident in more of the private hospital admissions.

From these studies we can see that the necessity for the presence of mental hospitals is established. There is no doubt that a number of our patients will need a long-stay hospitalization. There are some characteristics in the psychodemographic data and in the subtypes and diagnostic categories of the psychiatric disorders that are associated with a prolonged stay in hospitals.

It would seem that this revolving door policy in psychiatry is not very successful because patients are discharged while they are still symptomatic so they drift onto the streets until they

commit some petty crime and then they are readmitted only to be discharged again onto the streets. We always speak about extramural services and community care but from my experience, whether in developed countries or developing ones, the community is not yet prepared to assimilate ex-mental patients or patients with residual symptoms.

It is well known that after an episode of schizophrenia, (sometimes an affective disorder) not less than 30% to 40% will be functioning at a lower level than prior to the episode. The more relapses they have, the more likelihood of handicap and incapacity. Thus, in more rapidly releasing patients form institutional care, we are putting a burden on families and the community services for people who are handicapped. We are asking the patients to resocialize themselves knowing that many of them have actual structural and morphological changes in their brains.

It is likely that mental hospitals will persist and will outlive their obituaries but with a lesser capacity and wider distribution throughout different parts of the country. They will accommodate patients because the community is unable to provide adequate services for them. They will be in need of not only medical treatment, but also rehabilitation and work therapy. This can be provided by psychiatric social workers, clinical psychologists and auxiliary psychiatric medical staff while short-term and emergency cases will require the experience of the medical profession, specifically the psychiatrists.

Future Trends

The future policy of psychiatric services in Egypt is to build medium-stay hospitals of 600 beds which will serve three neighboring governorates and short-stay hospitals of one hundred beds. At the time, there will be psychiatric wards in all general hospitals accommodating between 10 to 20 patients. The recommended ratio of psychiatry beds to medical beds is 1:10. The encouragement of intensive psychiatric outpatient treatment in all general hospitals is proposed. It is hoped that the era of deinstitutionalization and extramuralization will be put into perspective and we should be well aware of the burden the community is asked to tolerate.

The mental health program for the next ten years will provide a long-stay hospital of 150 to 200 beds in every governorate with outpatient day centre and short-stay beds for acute cases. It is envisaged that outpatient services should include an intensive role of the psychiatric social worker and the clinical psychologists, psychiatric health visitors and active participation of the psychiatric nurses.

The Egyptian program will focus on recruiting more personnel for the psychiatric team, namely, clinical psychologists, psychiatric social workers, occupational therapists, mental health visitors, and psychiatric nurses from the high institute of nursing and nursing schools. The training of these people is being given as much or more priority as is the training of psychiatrists.

In the summer of 1990 a model psychiatric centre, based on the psychiatric tearm concept, was opened at Ain Shams University as a prototype for other governorates in Egypt. The centre was initiated by charities and later financed by the government. It serves one hundred inpatients including sections for substance abuse, child psychiatry and geriatric psychiatry. The emphasis is outpatient services where one hundred patients can be examined daily. The involvement of psychiatric social workers, psychiatric nurses, and clinical psychologists with the psychiatrists in giving a comprehensive services to the patients will be an example for other centres. It has a liaisons with the high institute of nursing, nursing schools, faculties of social welfare, and psychology departments of universities to train their graduates in the multidisciplinary approach to psychiatric disorders. This centre emphasizes the fact that any psychiatric disorder is a psycho-socio-biological entity and unless the patient is approached in the history taking, aetiology and management with these three dimensions taken in consideration, the approach will be faulty.

The media coverage given to this model program has initiated a widespread tendency for pioneers to start projects or centres based mainly on charities. In developing countries, the state cannot afford by itself to finance mental health programs and give them the same priority as other health problems.

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