throughout the country. These clubs went on to form the Association for the Mentally Ill (AMI), in 2003. The AMI now receives funding from the Thai Health Promotion Foundation, the Health Systems Research Institute of Thailand and other agencies. The AMI has contributed to many activities related to mental health promotion and prevention, and to increasing awareness of mental health problems in Thailand.

Conclusions

Psychiatric services in Thailand, as in many low- and middle-income countries, still face shortages of mental health workers. Mental health problems are not well recognised by general practitioners. Patients' poor understanding of psychiatric disorders causes a delay in seeking help and frequently early discontinuation of drug treatment.

Many strategic plans have been initiated by the Thai Department of Mental Health, with the aim of increasing human resources and providing a better quality of care in both general and psychiatric hospitals. Destigmatisation campaigns have been run. We expect a brighter future for Thai psychiatric patients and their families within the next decade.

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COUNTRY PROFILE

Lebanon

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Lebanon is a western Asian country with an area of 10 452 km² and a population of around 4 million (excluding the 10 million Lebanese immigrants worldwide). It has approximately 60 psychiatrists, mostly concentrated in the capital, Beirut, although a trend for decentralisation is currently observed. The number of psychiatrists is steadily increasing as postgraduate training centres have been established during the past decade. There are, however, few sub-specialists, owing to a lack of adequate training programmes.

Training

Undergraduate training

Six schools of medicine offer medical undergraduate education. The 7-year curriculum includes courses on psychology, psychopathology, psychotherapies and general psychiatry. A typical example would be the undergraduate training programme at the American University of Beirut Medical School, where the Department of Psychiatry offers an undergraduate course to 'Med II' students and a clinical clerkship to 'Med III' students, as well as clinical electives to interns and residents. It also provides training and supervision for psychologists. The course covers:

- *Psychopathology*. A DSM–IV-based course introduces Med II students to normal and abnormal psychological mechanisms as well as the classification and pathophysiology of psychiatric illnesses.
- *Clinical clerkship in psychiatry*. Third-year medical students spend 1 month working on psychiatric cases and attending morning rounds on a psychiatric service. They are supervised by an attending psychiatrist. Students also attend the psychiatry clinic in the out-patient department, where they see new cases and prepare seminars.

The rotation also includes seminars on psychopathology, case presentation and discussions, interview techniques and basic psychotherapy, as well as psychopharmacology. Seminars are held daily and are supervised by the faculty members.

Postgraduate training

Psychiatrists go through a 4-year postgraduate training programme provided by two universities. This includes a 1-year rotation on medical wards (with a specific focus on neurology) as well as exposure to child, adult and geriatric psychiatry through in-patient psychiatric wards and out-patient facilities. One of these universities (Saint Joseph University, which, since the 1980s, has been affiliated to the Saint Anne Psychiatric University Centre in Paris, France) requires six research subjects, a university diploma in cognitive–behavioural therapy (CBT) and passing a neuropsychiatry examination in order to grant the specialty certificate; the other requires passing the Arab Board of Psychiatry examination (in its three parts).

Professional bodies and legislation

The Lebanese Psychiatry Association (LPA), founded in the mid-1980s, has a membership of 65 psychiatrists. It holds regular meetings, sponsors psychiatric seminars and closely follows – with the Lebanese Order of Physicians (LOP) – the drafting of legislation. In the absence of national programmes aimed at raising public awareness of psychiatry and mental health, the LPA works with the appropriate authorities to establish a new state strategy that incorporates psychiatry within the core of public health. Such efforts were rewarded in 2000, when, following a study on benzodiazepine use in the Lebanese population (after the war), which found a usage rate of 9.6% and a dependence rate of 50.2% among users (Naja *et al*, 2000), a state law was passed that prohibited selling these drugs without a medical prescription.

The mental health model in Lebanon

The mental health model in Lebanon has always combined the private and government sectors. Psychiatrists in private practice depend on private general hospitals to admit their patients, some of whom have these costs met by the public sector. Private insurance does not cover mental health, but the cover provided by public sector agencies does (e.g. that provided by social security, the armed forces and civil service unions). There are no governmental mental health institutions as such, and the public sector contracts for beds in private general hospitals.

There are two mental hospitals in Beirut: one that is run by the Order of the Cross, which has a capacity of around 1000 beds, including beds for acute, chronic, child and geriatric patients, as well as facilities for rehabilitation, drug misuse and day care; and the Islamic Mental Hospital, which has a similar capacity, layout and facilities. There is a third such institution in the south of the country – the Fanar Hospital, which is run by a private board. All three hospitals have a relatively high degree of stigmatisation and therefore cater mainly for psychiatric patients with a low degree of social integration.

Recently there has been a vast improvement in public general health services and therefore there is a campaign for a training programme for general practitioners, contracted by the government, in primary care mental health. With this in mind, steps were taken by the Ministry of Health to aid such a programme, taking into consideration the following:

- Research projects are to be funded by agencies and not by the Ministry of Health.
- The majority of health services (including mental health) are private and the government contracts with the private sector for services.
- All 60 or so psychiatrists are in private practice and the majority work with private institutions.
- The mental institutions (which are all private) carry the burden of maintaining a database, of quality assurance and consequently of conducting statistical and epidemiological surveys. They are funded to do so, however, through the Ministry of Health's contracts for in- and out-patient care, and so the data should be available to the Ministry.
- Non-governmental organisations are doing an adequate job in the south but should be further encouraged, since Ministry funds should be reserved for services needed in the whole country.
- Psychologists do not have a professional association, and there are no licensing laws for their practice.
- Awareness and anti-stigma programmes are available through international organisations. Already, anti-stigma programmes for schizophrenia and Alzheimer's disease are under way, with the support of two drug companies.
- Legislation is a very delicate issue as there is no updated Mental Health Act. So far, there have been no problems in consequence, but mental health should have a separate section or department at the Ministry, to handle all policies regarding mental health.
- As part of an ongoing evaluation of services provided by the Ministry, the cost-effectiveness of mental healthcare is being assessed.
- Mental health programmes proposed within the eastern Mediterranean region have been only partially implemented in some countries because of their 'over-ambitious' scope. All eastern Mediterranean countries have a centralised health delivery system except for Lebanon (as it is mostly in private hands). A mental health programme as such would be likely to have a similar fate; instead, improvements to services at different levels and at different times would be much more applicable and beneficial.

These considerations led to a strategy for a primary care mental health programme, with partial incorporation of mental health services into primary care, featuring education programmes in mental health for general practitioners, along the following lines:

- A part-time psychiatrist will be appointed to each primary care centre. The psychiatrist will be paid per weekly visit made. The object of such visits will be consultation on psychiatric patients presented by the general practitioners. Visits can be adjusted according to the needs of each centre. The visits will also feature a form of clinical seminar, where cases are discussed with the general practitioners.
- Psychiatrists will be appointed to the government general hospitals. Their role will be to provide a consultation–liaison service to the hospital and to provide in-patient psychiatric care (the number of beds allocated for the purpose will need to be five to ten or more, depending on the catchment areas of the hospital).
- Therapeutic teams will be created, comprising a psychiatrist, social worker and nurse, and psychologists can be available on demand.
- Ongoing monthly seminars will be given on various mental health topics relevant to general practice.

Psychogeriatric services

The age profile of the Lebanese population is shifting, as a higher proportion of its population reaches older ages. The existing services will not meet future needs. Although there are private homes that cater for the elderly, there are insufficient beds. A community-based system is needed, spearheaded by the Ministry of Health. This would be more cost-effective than the provision of in-patient beds for the elderly. This programme will be part of the primary care outpatient system, with the addition of a geriatrician and nurses

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to make domiciliary visits to monitor, and sometimes administer, home care, and also to help families to care for their elderly relatives. Greater public awareness and destigmatisation programmes will also be necessary. In-patient acute care will be in geriatric units in general hospitals. Such a system will minimise the back-log of admissions to homes for the elderly, which will be reserved for advanced cases.

Research and publications

In the absence of state financial support and because of the multiple wars that have devastated Lebanon, research work is still in its infancy. Nevertheless, some studies have, for example, found similar epidemiological characteristics in the Lebanese psychiatric population to those described in the literature for other countries. Other studies have examined the consequences of the war on psychiatric health, including post-traumatic stress disorder, benzodiazepine misuse and alcoholism. New publications have even appeared in the field of biological psychiatry.

Conclusion

Psychiatry in Lebanon is moving towards an increase in resources and capacities. The process of health sector reform will undoubtedly give psychiatry its place in the medical community.

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SPECIAL PAPER

Reform of the mental healthcare system in Greece, 1984–2006

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Greece joined the European Community in 1981 and, 3 years later, the Commission of the European Communities provided financial and technical assistance under EEC Regulation 815/84 for the modernisation of the Greek mental healthcare system, with an emphasis on decentralisation and the development of community-based services, as well as the deinstitutionalisation of long-stay patients and improvement of conditions in public mental hospitals.

Over the past 20 years, public sector psychiatry in Greece has shown notable progress in deinstitutionalisation and the development of rehabilitation services. The role of the large mental hospitals has gradually diminished. In the area of primary care, however, progress has been rather slow. Utilisation and training of primary care physicians have not been given the priority they deserve and much remains to be done in the areas of primary psychiatric prevention and sensitisation of the public to mental health issues, in spite of notable exceptions (e.g. the Athens Mental Health Promotion Project, 2003).

In the early 1980s, psychiatric care in Greece was largely based on nine overcrowded, inadequately staffed public mental hospitals, and on a number of private mental hospitals (Christodoulou, 1970; Madianos, 1983; Stefanis *et al*, 1986). Community-based mental health services were underdeveloped and there were no psychiatric units in general hospitals. Thus, mental health services could not meet the needs of the population (Madianos *et al*, 1993).

The urgent need to establish psychiatric units in general hospitals and to improve psychiatric education, as well as for more specialised training, full utilisation of other mental health professionals and revision of mental health legislation, had been stressed since at least 1970 (Christodoulou, 1970).

Reform

Reform of mental healthcare became imperative in 1983 within the context of planning for the new National Health System in Greece. Law 1397/83, especially article 21, provided the basis for the decentralisation of psychiatric services (Sarantidis *et al*, 1992; Madianos *et al*, 1999*a*).

The Greek government undertook revision of the psychiatric care system by developing a 5-year plan. As part of the response to a request from the Greek government for financial support, EEC Regulation 815/84, Programme B, was adopted in 1984 and provided a grant of 120 million ECU. The strategic objectives of the 5-year plan (1984–89) in fact extended beyond 1989, up to 1995, and emphasised decentralisation of mental health services and the development of community-based services, deinstitutionalisation of