INTERNATIONAL CONSULTANCY ON "MID-TERM EVALUATION OF THE LEBANON NATIONAL MENTAL HEALTH STRATEGY FOR THE MOPH NATIONAL MENTAL HEALTH PROGRAMME"

JOINT REPORT OF PROF. JOSÉ CALDAS DE ALMEIDA AND PROF. BENEDETTO SARACENO

This report includes the following deliverables:

- Build consensus with stakeholders (MOPH-NMHP and WHO) on the expected outcomes and the methodology of the mid-term evaluation
- Review the available relevant key documents including the strategy, its theory of change, implementation plan, and monitoring and evaluation plan, as well as stakeholder mapping and analysis, projects reports, standard operating procedures, progress reports, memorandums of understanding with partners, official MOPH statements, communications and press releases, publications and other relevant documents.
- Review the organizational structure, team composition and organization of NMHP
- Identify gaps and recommend opportunities for strengthening the capacity and optimizing the organization of the NMHP
- Discuss with internal and external key stakeholders to explore perceptions of and expectations toward the NMHP and the national mental health strategy implementation.
- Provide recommendations for improving the implementation of the national mental health strategy towards reform of mental health in Lebanon.
- Validate and reach a consensus on recommendations and priority areas.
- Prepare the final version of the evaluation report.

22 June 2018

Mid-term evaluation Report of the National Mental Health Strategy for the Lebanon MOPH National Mental Health Programme

1. Introduction

A Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon for the period of 2015-2020 (the first national mental health strategy in this country) was launched in 2015, following a consultative and participatory process which included all key stakeholders in the country.

The National Mental Health Strategy was created to ensure the implementation of the National Mental Health Programme (NMHP) that had been created in 2014 within the Ministry of Public Health (MOPH) with the support of the World Health Organization (WHO), UNICEF, and International Medical Corps (IMC), with the aim of reforming mental health care in Lebanon and providing services beyond medical treatment at the community level, in line with Human Rights and the latest evidence for best practices.

The Strategy represented a key development in the process of mental health care reform that has been taking place in Lebanon in the last few years. Since its origin, several efforts were made, including, among others, a mental health strategy draft written jointly by the ministry of Public Health and WHO in 2011, and a programme supported by WHO and the MOPH to train primary care professionals using the mh-GAP tools.

It should be noted that the problems associated to the Syrian crisis response had a strong impact and a decisive role in this process, as they clearly showed that only with a good coordination of all involved entities it would be possible to ensure an effective Mental Health & Psychosocial Support (MHPSS) response to the Syrian refugees, as well as good quality mental health care to the Lebanese population.

In fact, one major recommendation of a report of the UN Refugee Agency (UNHCR) in December 2013 was to create mental health and psychosocial coordination mechanisms between the actors involved in the Syrian Crisis response. In January 2014, following this recommendation, a Mental Health and Psychosocial Taskforce (MHPSS TF) was created with the aim of coordinating and harmonizing the MHPSS response; and in May 2014 the ministry launched the first national mental health program for mental health, in partnership with WHO, UNICEF and IMC.

When this process was started the mental health system in Lebanon suffered from several important limitations:

- There was no mental health policy and the mental health legislation was outdated and had innumerous gaps.
- There was a chronic under funding and the large majority of funds were allocated to hospital-based care.
- The majority of insurances did not cover mental health care.
- Psychiatric hospital-based acute mental health care, provided by private services, had long waiting lists, and long-term care was mostly provided by large institutions.
- Outpatient care was mainly provided in the private sector with high cost, affordable to a limited population group.
- Continuous supply of psychotropic medication was not ensured for all the vulnerable population.
- Mental health integration in primary healthcare was limited.
- There were very high stigma and low levels of public awareness about mental health. Misconceptions about treatments contributed to discrimination in service delivery, low treatment seeking and service utilization.
- Human resources were concentrated in private practice and relying on non-specialized staff not equipped to provide mental health care.
- The mental health information system had very serious limitations, making difficult strategic planning.
- Despite the existence of some research groups doing good research, there was a lack of epidemiological and services research.

The implementation of this Strategy by the NMHP and partners has been carried out since then under the coordination of a team led by Dr. Rabih El Chammay. Although integrated in the MOPH, the NMHP has been financed until now by external funds.

In 2018, the National Mental Health Programme considered necessary to engage in a mid-term evaluation of the national mental health strategy 2015-2020 with the objective of identifying gaps and opportunities for updating/prioritizing strategic targets and objectives and identify avenues for sustainability planning.

With the support of WHO (WCO Lebanon), the authors of the present Report (JM Caldas de Almeida and B Saraceno) were recruited as independent external international consultants to conduct an independent mid-term evaluation of the implementation of the "Mental Health and Substance Use Strategy for Lebanon 2015-2020".

The main purpose of the consultancy was to provide recommendations to improve quality, effectiveness, and efficiency in achieving the desired outcomes towards mental health reform.

In this Report, we present the results of this evaluation, which was carried out on 21 May- 18 June 2018.

We want to express our gratitude to Dr. Gabrielle Riedner, WHO Representative, Dr Alissar Rady, WHO Responsible Officer, and Ms. Edwina Zoghbi, WHO Public Health Officer, for all the support they gave us in all stages of the mid-term evaluation of the National Mental Health Strategy in Lebanon.
We also thank the Team of the NMHP for having created the conditions for a comprehensive assessment of the various components of the National Mental Health Strategy and for having provided the support we needed to visit all the services and departments that were considered relevant for a broad view of the mental health system in the country.
Special thanks are due to Dr. Rabih Al Chammay, the Leader of the NMHP, for the continued availability shown during all process and for his commitment to make possible an independent and comprehensive evaluation of the National Mental Health Strategy.
A final word to thank all the stakeholders we contacted for their willingness to share with us their experiences and all the information that was relevant for our work in this evaluation.

2. Objectives of the evaluation

In accordance with the TOR, the objectives of the evaluation were:

- To assess the level of the implementation of the strategy and the progress towards the achievement of the expected results
- To assess the efficiency and effectiveness of the implementation through examining conducive factors as well as challenges that need to be addressed.
- To provide recommendations for the effective and efficient implementation and monitoring of the remaining part of the strategy towards mental health reform.

3. Methods

A review of the available relevant key documents related with the national strategy development and implementation was made. The documents reviewed included, among others, the Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon, progress reports, memorandums of understanding with partners, official Ministry of Public Health (MOPH) statements, communications and press releases, publications and other relevant documents.

Visits to inpatient and outpatient mental health services, primary health care services and services for drug addictions were made by one of us (JMCdA), to better understand how they are organized and to assess the quality of the care they provide.

We also discussed with internal and external key stakeholders the mental health situation in Lebanon and explored their perceptions of and expectations toward the NMHP and the national mental health strategy implementation (services visited and stakeholders contacted are included in Annexes 1 and 2).

Throughout the mission in Beirut daily briefings took place with WHO officers and with the NMHP team.

4. The National Mental Health Strategy

As the National Mental Health Strategy is the main focus of this evaluation, we carried out a critical analysis of the strategy, oriented to respond to the following questions:

- How was the strategy developed?
- How was the strategy structured and which is the content of its final version?
- Are the priorities defined for each domain aligned with the main problems of the mental health system in Lebanon? and
- Are they supported by the available evidence?

Our comments on the above issues are the following:

4.1. Development process

The National Mental Health Strategy was the result of a long and iterative process that included the participation of a large number of stakeholders. This process was initiated with a revision of a draft for a national strategy jointly written by WHO and MOPH in 2011. This draft was revised in line with the regional framework for mental health before being shared with around 20 local and international experts for review. Feedback was compiled and the comments were integrated into a third draft. A national meeting was held to specifically discuss the strategic objectives for identified vulnerable groups such as survivors of SGBV, LGBT community, domestic workers, survivors of torture, and families of missing persons, resulting in a fourth draft.

All these steps show that the elaboration of the strategy was developed through a participated and iterative process, that involved all the relevant stakeholders. This approach made possible the development of a large consensus on the need of a national strategy and contributed to give the different stakeholders a sense of ownership in relation to the final strategy.

All the actors that we have met during our mission in Beirut expressed their support to the idea of implementing a national strategy, and unanimously referred their appreciation for the possibilities they had to participate in this process.

4.2. Structure and content

The National Mental Health Strategy was built in accordance with the WHO framework on mental health and taking into consideration the human rights approach promoted by

international treaties, covenants and conventions in this field. In fact, the vision, the mission and the values and guiding principles of the Strategy are in line with the principles and recommendations of WHO on mental health policy and services, and the domains of action of the strategy include the four main objectives of the WHO Mental Health Action Plan 2013-2020 - leadership and governance, reorientation of services towards community care, promotion and prevention, information system and research.

A fifth domain – vulnerable groups- has been added given the special importance that the response to the needs of refugees and other vulnerable groups will continue to have in Lebanon in the near future. The purpose of adding this domain, therefore, was to ensure that everyone was included in the strategy and that the specific needs of specially vulnerable groups are taken into consideration.

4.3. Priorities

Priorities were defined for each domain, in accordance with the assessment that was made about the main problems and challenges found in Lebanon mental health system.

Domain Leadership and Governance.

The establishment of a governance structure in the MOPH with adequate staffing and sustainable financing was considered the first priority. Although the transition from the current situation to a full integration in MOPH may represent a challenge in terms of financing, human resources and administrative flexibility, we agree this is a very important measure that should be fully implemented in the near future. The experience of other countries show that, to successfully implement a mental health reform with the complexity the Lebanon reform already has nowadays, the existence of an entity well positioned in the organogram of the ministry, with a robust technical capacity and a budget proportional to the needs of the population, is absolutely needed. We consider that it is of utmost importance to ensure that the new mental health governance structure at the MOPH will have the same core competencies that already exist in the current NHMP Team and that an appropriate institutional continuity will be guaranteed.

We also agree that the revision of the governmental budgetary allocations for mental health and the integration of defined priority conditions in governmental and non-governmental insurance schemes are also relevant priorities.

The reform of the mental health system implies significant changes in the allocation of resources and specific incentives will be needed to promote new services. On the other hand, given the insufficiencies of the existing insurance schemes, some changes will be also needed in this area.

The revision of legislation is also an obvious priority, given the gaps and the insufficiencies of the existing legislation, and knowing the importance an updated law has in order to ensure protection and promotion of human rights of persons with mental disorders, quality of care and community-based service development.

The emphasis on the participation of persons with mental disorders and their families in mental health policy and services is rightly included among the priorities: it is now recommended by international organizations and requires a special attention in Lebanon, given the weakness of users and family associations in the country.

Domain Provision of services

The main priority of the strategy is to "improve availability and distribution of mental healthcare through developing evidence-based services at all levels of healthcare in line with the WHO service organization pyramid".

We consider this an excellent strategic decision. The WHO "pyramid of services" provides an optimal mix of services required by people with mental disorders (Funk *et al*. 2004). The model is based on the premise that no single service can meet all mental health needs. In fact, without any one of these service levels, and referrals up and down the pyramid, the "system" breaks down and the other parts are unable to function effectively and efficiently.

The inclusion of a Piloting guided self-help e-mental health services as a priority in the first level of the pyramid seems a good way of strengthening self-help in case of specific mental health conditions such as anxiety, and it may also contribute to the dissemination of the use of new technologies in mental health care in Lebanon.

The decision of considering the integration of mental health in primary health care as the main priority in the first level of formal care, is supported by all the available evidence. In fact, as stated by Funk and others, "the integration of mental health care into primary health services is a critical component of comprehensive mental health care. Essential services at this level include early identification of mental disorders, management of stable psychiatric patients, referral to other levels where required as well as promotional and prevention activities. Depending on who carries out first level health care in a particular country, activities and interventions may be carried out by general practitioners, nurses or other staff that provide assessment, treatment and referral services" (Funk *et al*., 2004).

The integration of mental health in primary health care has proved to be a complex process in most countries (Silva M & Caldas de Almeida JM (2014). The most common barriers found in other countries are the following:

- No national policies for MH in PHC
- No national policies for training and supervision of PHC workers
- Different financing mechanisms between PHC & specialists
- Health workers stigma & discrimination towards people with mental disorders
- Allowing only psychiatrists to prescribe psychotropic drugs

Addressing these common barriers implies choosing one of four possible models of mental health care in primary care according to the importance of the primary care professionals in the management of mental health problems and the degree to which the model focuses on improving their skills and confidence (Bower & Gilbody, 2005).

1. Training primary care staff— This involves the provision of knowledge and skills concerning mental health care to primary care professionals. It might involve improving prescribing or providing skills in psychological therapy. Training can involve widespread dissemination of information and guidelines or more intensive practice based education seminars.
2. Consultation-liaison—This is a variant of the training model but involves mental health specialists entering into an ongoing educational relationship with primary care professionals, to support them in caring for individual patients. Referral to specialist care is needed in a small proportion of cases.
3. Collaborative care—Collaborative care can involve aspects of both training and consultation-liaison but also includes the addition of case managers who work with patients and liaise with primary care professionals and specialists in order to improve quality of care. Often based on the principles of chronic disease management, this model may also involve screening, education of patients, changes in practice routines, and developments in information technology.
4. Replacement/referral—In this model the primary responsibility for the management of the presenting problem is passed to the specialist for the duration of treatment.

All these approaches, with the exception of the last one, imply some basic core competencies for Primary Health Care staff:

- Assessment and diagnosis: simplified but reliable GHQ, ICD 10phc, AUDIT, ASSIST, mhGAP
- Listening and Support
- Treatment using psychotropic medication and psychological basic support
- Referral
- Community Intervention

If these core strategies and principles are adopted and adapted to the local context of the country in which mental health is integrated in primary care, mental health services at this level greatly increases physical accessibility, as first level general health care is usually relatively close to where people live. In addition, the person can be treated as a whole person who may have co-morbid physical and mental health problems. Seeking and receiving treatments part of a general health care is also often less stigmatizing for an individual, especially where having a mental disorder is regarded as shameful. Services are therefore more acceptable to users than having to be treated in a psychiatric facility. From a clinical perspective, it has been found that most common mental disorders can be treated at primary care level. In situations where there are

few trained mental health practitioners, an integrated approach substantially increases the chances of being treated for mental disorders. Integration of mental health into primary health care requires careful training and supervision of staff. Staff need to be equipped with knowledge and skills that enable them to provide mental health care through training provided as part of initial health worker training as well as ongoing in-service training. Finally, the integration of mental health into primary care improves identification and treatment rates for priority mental disorders and promotes access and holistic care for comorbid physical and mental health problems (WHO, 2009).

Even in countries where primary health care services are weak, this can be achieved if primary care workers are provided with training followed by sufficient support and supervision by secondary-level services.

As we will describe in the next section, dedicated to implementation, specific strategies were adopted in Lebanon in order to address the above-mentioned barriers and challenges associated to the integration of mental health in primary health care.

In relation to training of professionals, the idea of using the WHO Mental Health Gap Action Programme (mh-GAP) as a key tool in the integration of mental health in primary care in Lebanon was a good decision. The mh-GAP provides resources to support the provision of front-line services for a range of priority conditions to be delivered through primary health care and other non-specialist settings (WHO, 2010) and the fact that there was already some work done in Lebanon in the use of this instrument facilitated a lot its implementation.

A priority goal of the strategy is the reorientation of services towards a cost-effective community-based model, in line with Human Rights and the latest evidence for best practices.

To attain this goal the strategy prioritize the development of specialized community-based multidisciplinary mental health teams and the opening of psychiatric wards in public general hospitals. The key role of these two priorities – which form the specialized level of the WHO pyramid of mental health care that follows the primary care level – is today largely supported by scientific evidence.

In fact, there is sufficient evidence proving that Community Mental Health Teams:

a) Increase user's satisfaction, quality of life and increase met needs (Thornicroft & Tansella, 2003)
b) Improve adherence to treatment and identify and treat more often and earlier relapses (Conway, 1994; Killaspy, 2007).
c) Improve continuity of care (Sytema *et al.,* 1997*).*

In addition, accessibility to mental health care of people with longer-term mental disorders is much better with community-based services than with the traditional psychiatric hospitals (Thornicroft & Tansella, 2003).

In synthesis, Community Mental Health Care is a model of service able to:

i) providing treatment and care to severely mentally ill persons;
ii) providing or coordinate psychosocial rehabilitation interventions;

iii) supporting users and their family including at home;

iv) coordinating referral and back referral mechanisms with the Primary Health Care level;

v) training and supervising Primary Health Care level professionals;

vi) coordinating in-patient activities provided by formal psychiatric services or by teams in general hospitals.

The development of mental health services in General Hospital settings has also proved to be another critical element of the organization of services, for several reasons: "Given the nature of mental disorders, for a number of people some hospitalization at some time (or times) during acute phases of their condition will be necessary. As with integrated primary mental health care, mental health care in general hospitals is more accessible and acceptable than in dedicated psychiatric hospitals. In any country, especially low and middle income countries, there are likely to be only a few dedicated psychiatric hospitals and these are usually situated in urban areas – albeit often someway out of town. These hospitals are very often not geographically or financially accessible to patients or families wishing to visit them. There is also often high stigma associated with these facilities which are often the butt of highly discriminatory jokes or references. While clearly the issues of stigma needs to be directly dealt with, until such time as stigma around mental disorder and particularly psychiatric hospitals does change, most people prefer to get treatment in a general hospital. Any co-morbid conditions can also more easily be treated and special investigations can be conducted" (Saraceno et al. 2009).

According to the Strategy, the above-mentioned priorities in the provision of services - piloting guided self-help e-mental health services, integration of mental health into primary health care using the WHO mental health Gap Action Programme adapted for Lebanon, development of community-based multidisciplinary mental health teams, and creation of psychiatric units in general hospitals - are complemented by two other important priorities that are already being implemented: scaling-up evidence-based psychotherapies and training Emergency Room staff on management of psychiatric emergencies. Both respond to significant problems in Lebanon. Before the reform there was a significant lack of capacity in the provision of psychological interventions and the WHO training programme on Inter-Personal Therapy (IPT) offered an excellent opportunity to scale up an empirically validated treatment for a variety of psychiatric disorders, including affective, anxiety and eating disorders. On its turn, training the staff of the emergency rooms is an effective way of improving the management of psychiatric emergencies.

We would also like to underline the relevance and appropriateness of a number of other strategic priorities that were also established across all the levels of the WHO pyramid:

- ensuring competent and responsive human resources for service delivery at all levels through revision of university curricula and through tailored capacity-building;
- building a referral system linking all levels of care;
- developing accreditation standards;
- building an e-HIS with quality and outcome indicators at all levels of care;

- establishing a national mechanism to assess the human rights protection of persons in facilities providing mental health services according to quality rights standards; and
- ensuring equitable provision and rational prescription of appropriate medication (through rationalisation and harmonization of medication list based on quality, safety, efficacy and cost-effectiveness, and development of guidelines of rational prescription and capacity-building).

Overall, these priorities cover in a comprehensive way most of the important challenges and insufficiencies of the mental health system in Lebanon before the reform.

In terms of provision of care, however, there is one issue that, in our opinion, was insufficiently addressed in the Strategy: integrated care and social inclusion of people with severe and long-term mental disorders.

It is important to note that several important steps were already planned in this respect. On one hand, the establishment of a national mechanism to assess the human rights protection of persons in facilities providing mental health services according to quality rights standards was planned. On the other hand, the inclusion in the strategy of an objective related with the development "of eligibility criteria for persons in long-stay psychiatric hospitals to be reintegrated in the community, based on international guidelines and national assessments", was also a very important step. Finally, the scaling-up of community-based mental health services, which is currently under implementation, to ensure that the services base is available before the full shift is operated, is undoubtedely another key step in this process.

However, specific strategies to improve quality of care in psychiatric institutions and to promote integrated recovery-oriented responses in the community based on a rehabilitation perspective are, in our opinion, needed. The improvement of quality of care in institutions is a very complex process that implies profound changes in the functioning of the institutions, the rehabilitation of patients a their participation in the daily life of the institution. All experiences in this area across the world show that the implementation of these changes require training of professionals, reorganization of services and promotion of new activities and programmes. The promotion of integrated recovery-oriented responses in the community based on a rehabilitation perspective, on its turn, require the development of a network of psychosocial rehabilitation facilities and programmes (mainly in the residential, occupational en vocational training areas).

Domain Promotion and prevention.

The established priorities are aligned with the available evidence. The importance attributed to the implementation of a media and communication strategy, which includes an annual national mental health awareness campaign, dissemination of information about mental health and mental health care, and building the capacity of media professionals on responsible reporting and portrayal of mental health, is justified by the importance of stigma and lack of mental health literacy in Lebanon.

Prioritizing evidence-based mental health prevention and promotion in schools, national maternal and child health programmes, and implementing an evidence-based framework for prevention and monitoring of suicide, seem a reasonable choice given the existing evidence.

Domain Information, Evidence and Research

Establishing an operational mental health information system, developing a monitoring and evaluation system and promoting implementation and outcome evaluation research are three indispensable actions required to attain the main objective of the Strategy in this field: building the necessary systems and mechanisms to obtain reliable and timely information on mental health determinants, status and system performance to inform mental health planning and service development.

Domain Vulnerable groups.

The Strategy gives, as expected, a very special attention to Palestinian refugees and Syrian displaced populations. It also includes children, elderly, persons with disabilities, persons receiving palliative care, persons in prison, survivors of sexual and gender-based violence, survivors of torture, families of missing persons during the war, foreign domestic workers, and the LGBT community, groups that undoubtedly experience significant mental health problems and deserve to be taken into consideration in a national mental health strategy.

In conclusion, a priority goal of the National Strategy strategy is the reorientation of services towards a cost-effective community-based model. In line with the Strategy, seven cost-effective and evidence-based strategic interventions were planned to increase universal accessibility to high-quality preventive and curative mental health services. These interventions include:

- Integration of mental health into primary health care using the WHO mh-GAP Programme adapted for Lebanon
- Development of community-based multidisciplinary mental health teams
- Evidence-based psychotherapies (Inter-personal Psychotherapy) training
- Piloting guided self-help e-mental health services
- Development of an inter-sectoral referral system for crisis management
- Rolling-out Psychological First Aid training
- Regular monitoring of mental health facilities to ensure protection of human, child and women's rights of persons with mental disorders using the WHO Quality rights toolkit.

In addition, to coordinate the MHPSS response to the Syrian crisis, the MOPH established and is currently chairing jointly with WHO and UNICEF, the Mental Health and Psychosocial Support Task Force (MHPSS TF).

4.4 What is missing

Overall, the Strategy is well structured and aligned with the recommendations from WHO and other international organizations. The defined priorities respond to the main insufficiencies of the mental health system before the reform and address most of the challenges associated with the improvement of mental health care in the country.

However, as previously mentioned, there is one exception. Although reorientation of services and development of community-based services are frequently mentioned in the Strategy, the consultants do not recognize in the Strategy sufficient specific strategic measures oriented toward reorienting the model of care predominantly used in the existing institutions and ensuring a progressive shift from institutional-based care to community-based, rehabilitation oriented services for people with severe mental disorders.

We know today that deinstitutionalization is a complex process that takes time and has to be well planned, in accordance with the specificities of each country. It is also a process that requires clear political support. For these reasons, psychiatric hospitals have been neglected in many countries.

There are, however, solid arguments to include the reform of mental hospitals and their replacement with community services, among the priorities of mental health services reform in low and middle-income countries. "Psychiatric institutions have a history of serious human rights violations, poor clinical outcomes and inadequate rehabilitation programmes. They are also costly and consume a disproportionate proportion of mental health expenditure. The WHO have thus recommended replacing these institutions with a network of services in the community and, for the majority, care in general hospitals where hospitalization is warranted" (Saraceno et al., 2009, cit.).

As described by Killaspy and others "the last fifty years have seen one of the greatest international social movements of all time - the closure of large institutions and the development of community based services for people with mental health problems. Although many factors have been suggested as fuelling this process, one major driver was a change in society's attitude towards people with mental illness, away from exclusion and marginalisation towards inclusion and participation. In many low and middle-income countries (LMIC), mental health care provision remains limited to a small number of large, overcrowded institutions that are under resourced and inefficient…..Human rights organisations have played a major role in driving the process of deinstitutionalisation globally, calling attention to violations of patients' human rights and clarifying the ethical and values based arguments for community based mental health care" (Killaspy et al, 2018). There is enough evidence showing that people with severe chronic mental disabilities should be not cared for in large, traditional psychiatric hospitals. Even if the most solid evidence (for example, the TAPS study in London by Leff, 1997) only refers to the benefits of deinstitutionalisation for people already institutionalised and not to those never institutionalised, the reasons for move away from large traditional psychiatric hospital are rather compelling. First of all, as Thornicroft and Tansella say (Thornicroft and Tansella, 2003): "When deinstitutionalization is carefully carried out, for those who have previously received long-term in-patient care for many years, then the

outcomes are more favourable for most people who are discharged to community care" (Tansella, 1986; Thornicroft & Bebbington, 1989; Shepherd & Murray, 2001).

In addition, the risks of human rights violations are much higher in large traditional psychiatric hospitals than in alternative types of community residential care: "Mental Hospitals in developing and developed countries have a history of serious human rights violations. During the past two decades this has led to either their closure or their comprehensive reform. In spite of the improvements made, a serious human rights concern still surround the remaining long-stay mental hospitals in developed and developing countries (WHO, 2003).

It should be noted that, despite all the difficulties associated to the implementation of this process, encouraging developments took place in low and middle income countries in different parts of the world – e.g., Brazil, Chile and Panama, in Latin America; Sri Lanka, Vietnam and India, in Asia; and Mozambique and South Africa, in Africa.

There are reasons to believe that the momentum created by the mental health reform in Lebanon may represent a great opportunity to include more ambitious objectives in this area, taking advantage of the lessons learned in other parts of the world.

The assessment of the human rights protection of persons in facilities providing mental health services, the development of eligibility criteria for persons in long-stay psychiatric hospitals to be reintegrated in the community, and the scaling-up of community-based mental health services, which is currently under implementation, to ensure that the services base is available before the full shift is operated, are of course important measures to reorient the model of care predominantly used in the existing institutions and to ensure a progressive shift from institutional-based care to community-based, rehabilitation oriented services for people with severe mental disorders.

However, this is only a part of the deinstitutionalization process, which will have to be inserted in a comprehensive strategy including measures to change work methods in the institutions, prepare patients who will be deinstitutionalized, realocate finantial and human resources from institutions to the community, develop psychosocial rehabilitation, etc. For all these reasons, we consider that a more active and comprehensive approach should be taken regarding deinstitutionalization.

5. Implementation

In this part of the report the consultants will analyze the progress made in the implementation of the Strategy in each of its domains. We will focus our discussion on the achievements, barriers and facilitating factors that were found through the implementation process.

Leadership and Governance

The first priority in this domain was the establishment of a governance structure in the MOPH with adequate staffing and sustainable financing. A very significant progress was made

in relation to this key goal of the Strategy. First of all, most of the stakeholders we met agree that this integration is needed. As the responsible of one NGO said "if they are not able to ensure an institutional basis there is always the risk of disappearing, because without that basis they don´t have an identity and they cannot have sustained financing". Most importantly, the creation of this structure is now explicitly supported by the key decision makers in the MOPH and is most welcomed by the leaders of important departments of this ministry.

This progress was possible because mental health is now recognized as an important public health priority. The challenges raised by the immigration of almost one million refugees had a very important role in the perception of the importance of mental health. As one important stakeholder said "before the refugees from Syria came mental health was not considered a priority. Now the situation is completely different, mental health is mainstreaming and more and more considered an important issue".

The work developed by the NMHP Team also significantly contributed to this new perception. Having contacted, during our mission, with a large number of actors from various areas – Government, NGO´s, International organizations, health services, health professionals, representatives of the academia and of people with mental health problems - we could see that the NMHP Team has gained the respect of all sectors, and its vision, technical and scientific capacity and motivation are highly valued. This is the merit of the Team and of course of its leadership.

The way the NMHP was organized and structured also had a major influence in this process. For this reason, we think it deserves a brief analysis. In accordance to its organogram, the Head of the Programme responds to the MOPH Director General. This position in the organogram made possible an easy access to the highest levels of decision in the Ministry, which is always a factor of great importance in the implementation of reforms that have the complexity of a mental health reform. Under the Head of the Programme, and reporting directly to him, there is an Operation Manager, who provides the operational support that is needed to the daily work of the different areas and follows-up all projects. The Coordinators of the 5 thematic areas of technical work - Mental Health Legislation and Human Rights, Policy &Advocacy, Prevention & Promotion, Service development, Service Quality improvement - and the MHPSS Unit (each one with a Coordinator) are under the Operation Manager and report directly to her. The Coordinators are assisted by a support branch, which consists of Public Health Officers that support them in different projects. The Head of the Programme counts also with the support of a Joint Planning Committee, which includes coordinators of the different thematic areas of work and the operations manager.

This seems a reasonable organizational structure for a Programme that has the mission and the objectives of the NMHP, and is not fully integrated in the Ministry (and therefore cannot count with the full support of the technical and administrative machine of the Ministry). The areas of technical work largely coincide with the areas usually found in mental health units of ministries of health that are engaged in the implementation of a mental health reform. It would be possible to merge some of these areas under the same coordination, what would facilitate the joint planning, but this is something that depends very much from the specific national context and the available human resources.

The Team is composed of professionals from different disciplines and backgrounds, many of them with a public health training and perspective, which is one of the positive things we could notice in our interactions with the Team. The evolution of the reform – and the full integration of the Programme in the Ministry- will certainly require some adaptations and the strengthening of some competences. One that seems easy to anticipate is in the area of rehabilitation and transformation of psychiatric institutions, an area that we will comment in other parts of the Report.

Regarding the organization of the Programme, the number of standard operational procedures, forms, instructions of work and policies, covering all kinds of topics, that were developed by the Programme, is a good indicator of the attention dedicated to organizational issues. Other aspects that we noticed in this area include the detail of the Terms of Reference for all the members of the Team and the quality of the progress reports.

The involvement of a large range of stakeholders and the establishment of many partnerships were also major achievements in the implementation of the Strategy. Thanks to this involvement, MOU´s have been stablished or are under finalization with:

- Ministries (Education, Justice)
- Local NGOs working in mental health or substance use (Abaad, Sanad, Embrace, EDMR Lebanon Association, SIDC, Skoun, Overcome, Association Francophone pour les Malades Mentaux, Lebanese Institute for Social Care and Vocational Training, Nudge Lebanon, MEEDA Lebanon)
- International NGOs (Caritas, Médecins du Monde, International Medical Corps)
- Local universities (University Saint Joseph)
- International Universities (Columbia University, World Learning)
- UN agencies (WHO, UNICEF)
- Professional asscosciations (Syndicate of Social Workers)

The NMHP was also able to create synergies with many other initiatives, to mobilize funds from various sources, and to establish collaborative projects with multiple institutions and agencies.

The recognition of the need of a mental health strategy and of building a consensus on its priorities was also a significant achievement. A special reference should be made to the capacity of the NMHP to mobilize financial resources, both at the national and the international levels, and to establish a fruitful collaboration with WHO and other international organizations. In this respect, the institutional support provided by UNICEF to the NMHP deserves a special reference, given the determinant role it had for the establishment and the implementation of the Programme.

The revision of legislation to ensure protection and promotion of human rights of persons with mental disorders, quality of care and community-based service development, and to set standards for mental health care provision was another key priority whose implementation is in an advanced stage of implementation. A draft of the new law was produced with the collaboration of relevant stakeholders and the NMHP is currently working with the parliamentary committees to finalize and pass this law.

Significant progress was also made in the revision of governmental budgetary allocations for mental health and in the integration of defined priority conditions in governmental and non-governmental insurance schemes.

In order to ensure the implementation of a comprehensive national response to substance use, the NMHP is coordinating the "Inter-ministerial Substance Use Response Strategy for Lebanon 2016-2021" launched jointly in December 2016 by the ministries of Public Health, Social Affairs, Interior and Municipalities, Justice and Education.

This strategy, created as a response for substance use including alcohol, drugs and tobacco, through a participatory process involving all relevant stakeholders, has the following goals: 1) Increased availability of high quality age and gender sensitive prevention, treatment, rehabilitation, social re-integration and harm reduction services and 2) Increased accessibility to these services, 3) Increased protection of human rights of persons with substance use disorders, and 4) Increased efficiency and effectiveness of supply reduction activities.

To attain these goals, the strategy includes six domains of action: 1- Leadership and governance 2-Health and social welfare sectors response 3- Supply reduction 4- Monitoring and surveillance 5- International cooperation 6-Vulnerable groups. It should be noted that the goals and domains of action of this strategy are in line with the WHO Regional Framework for Strengthening Public Health Response to Substance Use and with the framework of the international drug conventions.

Other important achievements include:

- Aligning mental health and psychosocial support actors in Lebanon with the national Strategy
- Mainstreaming Mental Health in other national strategies such as: MOPH Health Strategy, Government strategy for Prevention of Violent Extremism.

Therefore, we consider that in the leadership and governance domain most of the objectives were successfully attained. The establishment of a governance structure in the MOPH seems the best way of overcoming the ambiguities and shortcomings of the current model. If confirmed, it will be a great advance in the mental health reform in Lebanon, but at the same time it will certainly create new challenges.

Reorientation and development of services

Significant progresses were made towards the achievement of the main expected results in this domain.

In the first levels of the WHO pyramid, the pilot project on an electronic guided self-help intervention, promoted with the support of WHO and the d´Harcourt Foundation, was an interesting way of promoting self-help with the support of innovative electronic tools. Several other initiatives – e.g, national awareness campaigns on mental health, newsletters and other publications on mental health issues - also contributed to enhance mental health literacy in the population and to strengthen the involvement of different agencies in Mental health promotion.

Most of the objectives in relation to the integration of mental health in primary care were also attained. In the MOPH network of Primary Care Health Centers (PCHCs), 75 centres were trained with the mh-GAP until now, and a total of 336 people were trained in 2016-17 on mh-GAP related modules.

During our mission, we could visit two Centers in Beirut and discuss with professionals from Centers located in other parts of the country how their mental health work is organized.

The Makhzoumi Primary Health Care Center in Beirut is a service with excellent facilities, with mental health care activities well organized and adequately integrated in other health programmes. The staff include professionals trained with mh-GAP and in IPT as well as a psychiatrist. The Primary Health Care Center located in the Rafic Hariri University Hospital campus has also excellent facilities and offers unique conditions for collaboration with specialized care, given its proximity to both the Community Mental Health Center and the Psychiatric Inpatient Unit.

The professionals of the other PHCCs with whom we met had received mh-GAP training and some had training in IPT. The way mental health care was organized in these Centers varied from Center to Center, but all offered some kind of stepped care, including screening, counselling or psychotherapy and prescription of medication. It should be noted that all of them said that referral to more specialized care is frequently a problem, given the difficulties of finding a timely response from specialist services.

In relation to the first specialized level of care, two multidisciplinary community mental health centres, responsible for providing integrated care to complex and severe cases that are referred from the PHCCs, were created so far - one is in Beirut and the other in Bekaa. The first one, established in the Rafic Hariri University Hospital, is located in one of the buildings that integrate the campus of this general hospital, next to a Primary Health Care Center. The access is easy and its proximity with both the PHCC and a new inpatient psychiatric unit that is being created in the same hospital facilitates the coordination with these two other levels of care. In our visit to this community mental health center we found a multidisciplinary team, including case managers, psychologists, nurses and psychiatrists, very committed in the development of an innovative integrated model of care based in the community.

It should be noted that the integration of mental health packages in the Emergency Primary Healthcare Restoration Project covered by the World Bank creates excellent conditions for the expansion and sustainability of the measures already taken to promote integrated mental health care in Lebanon. In fact, according to this project, four priority evidence-based mental health packages were developed in line with the WHO mh-GAP and national guidelines (on depression, psychosis, developmental disorders and substance use and alcohol disorders), and each package includes different mental health clinical activities that will be conducted first at the Primary HealthCare Center with integrated mental health services (PHCC) and then as needed at the Community Mental Health Center (CMHC), with the possibility of referring back stable cases to PHCC.

The mental health system in Lebanon had no public psychiatric units in General Hospitals, relying exclusively on contracts established with psychiatric units in private hospitals. In accordance with the objectives of the Strategy, a new public inpatient psychiatric unit was opened at the Rafic Hariri University Hospital. The space is large, with good conditions for the hospitalization of acute patients, and special attention is being given to the training of the members of its team.

It should be noted that these three facilities of the Rafic Hariri Hospital can be used as a training center for the professionals that will be involved in the development of new mental health services in the country. This campus, in fact, has unique conditions to train professionals in integrated community-based, recovery oriented, mental health care.

Several initiatives to ensure competent and responsive human resources for service delivery at all levels deserve a special reference:

- A new training course to develop the capacity of emergency room staff of public and private hospitals on managing psychiatric emergencies, an initiative that certainly can be a good contribution to improve the quality of crisis interventions and to promote a more adequate referral of these cases to other levels of care.
- A programme to build local capacity in an evidence-based psychotherapy approach (IPT), which was essential to prepare the primary care services to manage common mental disorders
- Training for the management of persons in crisis, including persons at risk of suicide, conducted by the NMHP to around 60 case managers in different NGOs
- Training workshops on Psychological First Aid (PFA) for PHC centres
- A revision of university curricula related to mental health.

In May 2015, the Ministry of Public Health developed standards for Primary Care, in collaboration with Accreditation Canada, as well as standards for integrated mental health services and for community mental health centers. The measures taken to develop accreditation standards for mental health facilities can have an important role in the improvement of quality of care in inpatient units as well as in the coordination of these units with community based services. Given the importance of private services participation in the mental health systems, the accreditation of services can be an effective way of ensuring good quality of care and proper coordination of care across the system.

The same can be said about the initiatives that were promoted by the NMHP in areas such as building a referral system linking all levels of care, developing an e-HIS with quality and outcome indicators at all levels of care, establishing a national mechanism to assess the human rights protection of persons in facilities providing mental health services according to quality rights standards, and ensuring equitable provision and rational prescription of appropriate medication (through rationalisation and harmonization of medication list based on quality, safety, efficacy and cost-effectiveness, and development of guidelines of rational prescription and capacity-building).

Regarding the improvement of the mental health information system, mental health modules (namely for depression, psychosis, developmental disorders and substance use) were developed to be integrated in the health information system of the PHCCs, and key indicators for a national mental health registry were also developed with the software specifications. During our stay in Beirut, we had the opportunity to meet with the persons responsible for the development of the mental health information system and we could see how advanced this project is and how promising is the new system.

We also met with people responsible for the adaptation to Lebanon of the Quality Rights tools and for conducting the first assessments of services carried out with these tools. Based on this experience it will be now possible to monitor the quality and protection of human rights in mental health facilities.

This monitoring is specially needed in the existing psychiatric hospitals. We had the opportunity to visit hospitals in Lebanon and despite the important contributions these institutions have made and still make to mental health care of people with severe mental disorders, the truth is that, like in many other countries, psychiatric hospitals in Lebanon are structured in a way that makes it impossible to ensure the standards of care that are today universally accepted, and that we find there many human rights problems that require urgent and radical changes. Assessment of human rights is an important strategy to start the required changes, but this is only a first step, that will have to be followed by many other activities integrated in a comprehensive reform of care for people with severe mental disorders.

As mentioned before, this is, in our opinion, the main weakness of the Strategy. We are aware that this is a very complex part of the reform, and that various strategies will have to be implemented in a timely manner in order to overcome the barriers that inevitably will come up in this process. In the recommendations chapter of this Report we will address this relevant issue and will make some suggestions on actions that could be initiated in a near future.

We could not conclude this part of the report without a brief reference to the implementation of the substance use response strategy, coordinated by the NMHP. In Beirut, we had the opportunity to discuss this strategy with the NMHP Team, to talk with leaders of NGO´s working in the field, and to visit a centre for substance use prevention, harm reduction and treatment that is part of the comprehensive mental health and substance use programme launched in the Rafic Hariri University Hospital. Through these contacts, we could see the advances that are being made, namely in areas such as updating legislation, developing interventions in prisons, coordination between mental health services and services for people with substance abuse problems, and the creation of the National Observatory on Drugs and Drug Additions in the MOPH.

Promotion, prevention

The experience in promotion and prevention before the reform in Lebanon was scarce. Several steps were taken to change this situation. National awareness campaigns on mental health were launched, an early childhood development strategy with the ministries of social affairs and education was initiated, and discussions started with the Ministry of Education on the development of a mental health promotion and prevention plan for schools.

The Ministry of Education is very interested in strengthening collaboration with the NMHP. A representative of the Ministry communicated us their concerns with violence and mental health among children, with suicide attempts in adolescents and with mental health problems among professors. In her opinion, “policies and documents are not enough…we need to have experts saying what is necessary to do and start actions immediately…we also want to see the development centers of MOSA starting interventions in schools”. In conclusion, there is an

agreement about the need to start programmes in schools, with the collaboration of education, health and social affairs sectors, and a common action plan including the priorities that were agreed, is awaiting signature by the new Minister.

Information, research and evidence

The objectives defined for this domain were achieved. Thanks to a collaborative work developed with the MOPH department responsible for information, a group of mental health indicators were developed and their integration in the national health information system is in an advanced stage of implementation. We had the opportunity to see how the system works and our impression is that this new system will certainly be very useful to inform planning and service development.

Progress was also made in the development of a national psychiatric registry to identify trends in mental disorders diagnosis and help-seeking behavior, and a National Observatory on Drugs and Drug Addiction was recently established within the Ministry of Public Health in partnership with the Narcotics department, and the first annual report on the drug situation in Lebanon was also recently launched.

In the field of research, a series of studies are being conducted, in collaboration with WHO and universities from other countries, which include three Randomized Control Trials and one implementation research on mental health and psychosocial support (MHPSS) interventions. A continued collaboration was also established with the main national mental health research groups, which made possible the development of a consensus on how to develop a common strategy in this area.

We had meetings with the representatives of some of these groups, which have an impressive research capacity, and could confirm that they are very interested in working together with the NMHP in the development of studies that can produce new knowledge to support the improvement of mental health care in Lebanon.

Vulnerable groups

As expected, special attention has been dedicated to the mental health problems of refugees. In collaboration with UNRWA, measures were taken to improve the responses to Palestinian refugees, and the coordination of the MHPSS response to the Syrian Crisis has been conducted through a national task force that includes all actors in the field.

The NMHP is also working on implementing interventions to address the needs of persons from vulnerable groups such as children and adolescents, Survivors of sexual and gender-based violence, persons from the LGBT Community, Survivors of Torture, Families of disappeared persons during the war, older adults, and persons in prison.
The level of implementation is different in each of these groups. In relation to persons in the prisons there is already a psychiatrist providing services, and a specific sub-strategy for mental health and substance use in prisons is currently under development. For the LGBT

group a manual with best practices for mental health professionals working with the LGBT community was developed and around 100 professionals were trained in collaboration with Lebanese Medical Association for Sexual Health. For survivors of SGBV, the NMHP is working with ABAAD, a local NGO with large experience in the field, on developing a shelter with its accreditation criteria for women survivors of SGBV with mental health conditions. Finally, a work meeting was conducted with mental health professionals and International Committee of the Red Cross on ambiguous loss for families of missing persons during the war.

7. Strengths, weaknesses, opportunities, facilitating factors, barriers and challenges

In conclusion, we could summarize the implementation of the National Strategy by saying that the main strengths, weaknesses, facilitating factors, barriers, challenges and opportunities are the following:

Strengths

- Political commitment of the MOPH
- National Mental Health Programme (NMHP) leadership
- Technical capacity of NMHP Team
- Support from the MOSA (Ministry of Social Affairs)
- Involvement of stakeholders and existing partnerships
- Level of recognition of the need of a mental health strategy
- Consensus on priorities
- Strategy goals in line with main priorities and challenges
- Existing network of Primary Health Care services integrating mental health Care
- Support from WHO and the excellent cooperation established with the WHO Country Office, EMRO and HQ-Department of Mental Health and Substance Abuse
- The institutional support from UNICEF and other international organisations

Weaknesses

- Ambiguities of the current governance model
- NMHP dependence on international financing

Barriers

- High stigma associated to mental disorders
- Low level of trust on public services
- Fragmentation of mental health system and weakness of public services
- Mental health care for the SMI mostly centred on institutional approaches and with significant problems of accessibility, quality, respect of human rights, and continuity of care.

Facilitating factors

- Lebanon long experience of developing health based on partnerships involving various sectors and stakeholders
- International financial support associated to the refugees' crisis
- Know-how in health information systems and accreditation of services
- Public mental health research groups of good quality

Areas of major challenges and opportunities that need to be addressed

- Establishing a clear and efficient governance model of the NMHP
- Showing concrete results (with outcome indicators) in key areas of the NMHP, namely integration of mental health in primary care, coordination of health and social care, and programmes for refugees and other vulnerable groups (e.g. children)
- Developing a clear strategy focused on the problems related to mental health care for persons with severe mental disorders

8. Recommendations

We conclude this Report with ten key recommendations. The last one, because it is related to the level of mental health care that will represent, in our opinion, the most complex challenge in Lebanon in the near future, will be followed by some reflections and suggestions based on the evidence obtained in reforms conducted in other countries.

The 10 recommendations are the following:

1. Implement the institutionalization of the NMHP within the Ministry of Public Health, ensuring that the NMHP will:
    a. Occupy a position in the Ministry organogram that guarantees an easy access to the highest decision making levels
    b. Have a team with technical capacity in the areas that are key in mental health policy and planning
    c. Have a budget commensurate with the magnitude of mental health problems;
2. Refine the planification of the national strategy, estimating (if possible) a budget commensurate with the resources that are needed to attain the established objectives ;
3. Extend the integration of mental health care in primary care, and strengthen the development of collaborative care between PHC and specialized services already initiated (Please see comments and suggestions bellow);
4. Focus prevention activities in the areas in which a more robust evidence already exists (e.g. suicide, support to parenting, interventions in schools) and support the implementation of effective programmes in these areas;
5. Complement what is already being done in capacity building with:
    a. a programme designed to develop the capacities of the leaders of mental health teams
    b. a programme to train members of Community mental health centres in the development of integrated care for people with severe mental disorders, including case management;
6. Create an evidence base from which to advocate for increased funding from internal and external stakeholders for increased scale up of services. To do so, we suggest the use of the WHO OneHealth Tool, along with the mhGAP costing tool, to cost clinical interventions and to project the health benefits expected from their implementation (monetizing the benefits by estimating the economic gains) (Chisholm *et al.,* 2016);
7. Plan measures for the implementation of the new mental health law when it will be passed in the Parliament, including activities such as:
    a. Promoting a national debate on mental health and human rights
    b. Monitoring protection of human rights in mental health services;
8. Establish strategic synergies with the best existing groups in epidemiology and services research, in order to involve them in the reform and, if possible, create conditions to a project or two that can contribute to increase the knowledge on the needs for care, the barriers in delivery of care, etc.;
9. Transform the Rafic Hariri Hospital mental health facilities in a "Training Center on innovative integrated mental health care " to train professionals of different disciplines and to demonstrate the model that is being developed in Lebanon (at the national and international levels);

10. Put in place a specific strategy focused on providing integrated care to and social inclusion of persons suffering from severe mental disorders, including:
    a. Support to and monitoring of the community mental health centres included in the World Bank project
    b. Ensuring the full functioning of the inpatient unit located in the Rafic Hariri General Hospital and the creation of other units in general hospitals
    c. Establishing MOU´s with the 5 existing psychiatric hospitals that may facilitate the implementation of measures to improve quality of care and protect human rights in the existing psychiatric hospitals
    d. Creating financial incentives that may encourage private mental health services that currently provide hospital care to shift from hospital to community care and psychosocial rehabilitation (See comments and suggestions presented bellow).

Comments and suggestions on Recommendations 3 and 10

INTEGRATING MENTAL IN PRIMARY CARE

According to the World Health Organization (WHO & Wonca, 2008), and taking into consideration the available evidence (Silva & Caldas de Almeida, 2014), the success of a more integrated approach to care will depend on a number of factors. We suggest that a special attention will be dedicated to the following ones:

- Continued political commitment from the government to integrated mental health care is fundamental to success.
- Advocacy is required to change attitudes and behavior. Time and effort are required to sensitize national and local political leadership, health authorities, management, and primary care workers about the importance of mental health integration. Estimates of the prevalence of mental disorders, the burden they impose if left untreated, the human rights violations that often occur in psychiatric hospitals, and the existence of effective primary care-based treatments are often important arguments.
- Regarding training of primary care workers, available evidence show that collaborative or shared care models, in which joint consultations and interventions are held between primary care workers and mental health specialists, are an especially promising way of providing ongoing training and support. The training should include all categories of

health workers and other workers whose work touches on the mental health of the community, e.g. security officers and receptionists in health facilities.

- The Collaborative care model should be the ultimate goal to attain in the future. A Cochrane review of 79 RCTs involving over 24.000 patients provides the evidence base for the efficacy and effectiveness of Collaborative Care for the delivery of treatment to common mental disorders (Archer et al, 2012, Huffman et al, 2014).
- Primary care tasks must be limited and doable. Decisions about specific areas of responsibility must be taken after consultation with different stakeholders in the community, assessment of available human and financial resources, and careful consideration of the strengths and weaknesses of the current health system for addressing mental health. Functions of primary care workers may be expanded as practitioners gain skills and confidence.
- Specialist mental health professionals must be available to support primary care. Primary care staff has to be adequately supervised if integration is to succeed. This support can come from community mental health centres, secondary-level hospitals, or skilled practitioners working specifically within the primary care system. Mental health professionals should be regularly available to primary care staff to give advice on the management and treatment of people with mental disorders. Referral criteria should be clear, and information and communications systems should be available. The support from specialized mental health teams to primary care professional is an important challenge in Lebanon. However, if the new community mental health centres will be developed as planned, Lebanon will have good opportunities to meet this challenge.
- Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.
- Financial and human resources are needed. Although primary care for mental health is cost effective, financial resources are required to establish and maintain a service. In this respect, the project financed by the World Bank can be a decisive factor in the first phase, but it will be necessary to ensure the sustainability of this process.

PROVISION OF INTEGRATED CARE FOR PERSONS SUFFERING FROM SEVERE MENTAL DISORDERS

Providing community-based integrated care to persons suffering from severe mental disorders in countries where the treatment to this group of people is predominantly centered on traditional psychiatric institutions, and where the experience in psychosocial rehabilitation and recovery-oriented services is very scarce, represents a big challenge.

We hope that the conceptual reflections and the lessons learned from reforms developed in other countries that are described in the following lines may be helpful for the ongoing Mental Health National Strategy in Lebanon.

Most of the problems in this area result from the fact that severe mental disorders and related disabilities are long term conditions and require long term management, as well as a radical change of paradigm in mental health care. In fact, the psychosocial model has emerged as a

fundamental approach to be balanced with the biomedical model. This balance is especially evident when approaching long term mental health disabilities where psychotropic drugs and endless hospitalization have been proven as ineffective or even harmful.

As stated by the UN Special Rapporteur D. Puras: "The psychosocial model has emerged as an evidence-based response to the biomedical paradigm. It looks beyond (without excluding) biological factors, understanding psychological and social experiences as risk factors contributing to poor mental health and as positive contributors to well-being. That can include short-term and low-cost interventions that can be integrated into regular care. When used appropriately, such interventions can empower the disadvantaged, improve parenting and other competencies, target individuals in their context, improve the quality of relationships and promote self-esteem and dignity. For any mental health system to be compliant with the right to health, the biomedical and psychosocial models and interventions must be appropriately balanced, avoiding the arbitrary assumption that biomedical interventions are more effective (Puras, 2017) ."

It is important to note, however, that Psychosocial Rehabilitation should not be considered and organized as a separate service providing self-standing interventions, but it should be a regular component of all mental health services dealing with people suffering from long term mental disabilities. Psychosocial rehabilitation should be a component both of residential services (long term hospital care or, preferably, long term community based residential care), and of community mental health services (out-patient/ambulatory clinics or, preferably, community mental health teams and services).

In order to ensure psychosocial rehabilitation a mental health system should include several components – residential facilities, work and employment programmes, and community rehabilitation teams and recovery-oriented approach.

RESIDENTIAL CARE

Psychosocial rehabilitation may require an effective alternative type of long -stay residential care and that can be initiated when patients are still in long stay institutions and should be continued once patients are no longer in long stay institutions.

According to Thornicroft and Tansella (2003), "Three categories of such residential care can be identified:

i) 24 hours staffed residential care (high-staffed hostels, residential care homes or nursing homes);

ii) day staffed residential places (hostels or residential homes which are staffed during the day); and

iii) lower supported accommodation (minimally supported hostels or residential homes with visiting staff)".

In the words of Killaspy *et al.* (2018): "Housing-related support, or supported accommodation, operates as a component of the broader mental health 'care pathway' by providing focused, flexible support to service users with more complex needs that prevent

them living independently……Supported accommodation services aim to address service users' functional impairments by helping them to develop practical living skills, improve social functioning and promote recovery and independence". However, Psychosocial Rehabilitation has a scope much broader than just establishing human and inclusive residential care and it encompasses Work and Employment interventions and, more in general, a broad spectrum of socially including activities developed at community level by Community Rehabilitation Teams.

WORK AND EMPLOYMENT

Psychosocial Rehabilitation includes a fundamental dimension represented by providing work and employment opportunities which have been proved as a powerful and effective factor promoting inclusion and enjoyment of full citizenship.

There is a range of different forms of rehabilitation centered on occupation and work. While traditional forms of occupational therapy have shown rather poor potential of effective results in terms of social inclusion, other models are much more promising.

There are essentially two models:

- ✓ Social Work Cooperatives where several users are associated within the same working activity and are paid according to social cooperative market, which have been successfully developed in some European countries (e.g.: Italy, Spain);
- ✓ Employment support which emphasises placement in real market and competitive jobs supported from employment specialist. "In a synthesis of available RCT evidence, a recent Cochrane Review found that, compared to other vocational interventions, supported employment increases the length and tenure of competitive employment, and is associated with a shorter period to first employment, amongst people with mental illness….RCT evidence also indicates significant improvements in non-vocational outcomes, such as quality of life and occupational engagement in participants receiving IPS, when compared to those utilising traditional vocational rehabilitation services" (Killaspy *et al*., 2018).

COMMUNITY REHABILITATION TEAMS AND RECOVERY-ORIENTED APPROACH

Psychosocial rehabilitation should not be seen as a single intervention developed in a single ad hoc established place; indeed, this view represents a rather traditional and outmoded approach: in traditional asylums there were and still exist "special places" where patients were "entertained" using repetitive activities like drawing or practicing some simple manual activity. These interventions were not contributing at all to social inclusion or to the empowerment of users.

Modern Psychosocial Rehabilitation should offer multidisciplinary support to individuals with complex and enduring mental health problems and their carers. Evidence-based, psychosocial interventions should be preferably provided in the community, "focusing on

improving social, vocational and occupational outcomes, and aim to support individuals to achieve both personal recovery and increased independence" (Killaspy *et al*., p. 9, 2018).

This approach implies the availability of Community Rehabilitation Teams, as part of the Community Mental Health service approach, able to convey therapeutic optimism and to support individuals through supported accommodation pathway, work and employment opportunities, social inclusion and family support.

In this modern approach the Psychosocial Rehabilitation implies new professional skills and a clear and sustained involvement of users in all process of rehabilitation.

As stated by M. Slade and others (2014): "People personally affected by mental illness have become increasingly vocal in communicating what helps in moving beyond the role of "patient". Recovery has been defined as -a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles- and -a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness-. At its heart, personal recovery is a subjective experience".

Recovery represents a real paradigm shift which substantially modifies traditional ways of providing psychosocial rehabilitation because it put users's needs and wishes at its centre. Traditional models of clinical recovery, namely symptom remission, should be complemented by an emphasis on personal recovery. Recovery oriented practices mean helping individuals live a meaningful life in contrast to setting clinical goals dictated by professionals: "Shifting to practice that is built on equal partnership, hope-promoting and facilitating self-determination requires a transformation of services, practices and the paradigm within which they are delivered" (Slade *et al*, 2014).

It should be noted that outcomes of innovative Psychosocial Rehabilitation strategies and recovery-oriented approaches could be significantly improved and having much more relevant impact when personal health budgets are designed to promote self-determination. Personal Health Budgets "increase individual choice and control, by providing long-term mental health service users with a set amount of public money to be spent on personal health and social care needs…..A three-year evaluation of a PHB scheme in England found that, for individuals with mental health problems, overall costs decreased by 12% for those receiving PHBs, compared to an 8% increase for those receive standard care. Overall, the PHB group also reported higher levels of care-related quality of life and psychological wellbeing" (Killaspy *et al*., p.17, 2018.).

However, as noted in many WHO's documents (e.g.: Atlas, WHO-AIMS), many countries are faced with a scarcity of human resources for mental health care but this should not be a reason to keep traditional ways of conceiving and practicing Psychosocial Rehabilitation Services. On the contrary, efforts to develop a workforce able to deliver modern mental health and psychosocial rehabilitation can be undertaken going beyond the exclusive utilization of specialized mental health professionals. As stated by the UN Secretary General Special Rapporteur (Puras, 2017): "countries must undertake efforts to develop a workforce, including general practitioners and community health workers, as well as other professionals, such as teachers, social workers and other peer support and community workers with appropriate skills (including human rights education)"

Another question that is frequently formulated in the beginning of mental health services reforms is: What can be done to improve quality and human rights in outmoded psychiatric hospitals while it is not possible to promote a systematic process of deinstitutionalization?

This question is especially relevant because, as previously mentioned, psychiatric institutions have a history of serious human rights violations, poor clinical outcomes and inadequate rehabilitation programmes. They are also costly and consume a disproportionate proportion of mental health expenditure. On the other hand, there is enough evidence showing that people with severe chronic mental disabilities should be not cared for in large, traditional psychiatric hospitals. When deinstitutionalization is carried out carefully for those who previously received long-term inpatient care, the outcomes are more favourable for most patients who are discharged into community care (Caldas de Almeida & Killaspy, 2011).

It should be noted, however, that successful deinstitutionalization programmes involve investment in community-based services, development of human resources with an appropriate skill mix and parallel funding to manage the transition. The range and capacity of residential long-term care that will be needed in any particular area is dependent upon which other services are available or developed locally, and upon social and cultural factors, such as the amount of family care provided (Van Wijngaarden *et al, 2003*).

Therefore, improvement of quality of care in psychiatric hospitals and processes of deinstitutionalization should be encouraged, developed and monitored (WHO-Gulbenkian, 2014). The WHO Quality Rights Tool Kit is a useful resource to guide the process of examining the human rights situation in institutions and guiding collaborative reform (WHO, 2015).

While reducing the numbers of patients residing in long-stay facilities will release resources to pay for the development of community-based mental health services, it needs to be stressed that parallel dual funding will still be required during the period of reorganization.

WHAT CAN BE DONE WHEN IT´S NOT POSSIBLE TO PROMOTE AN IMMEDIATE PROCESS OF DE-INSTITUTIONALIZATION

Sometimes due to local circumstances it is not possible to promote an immediate process of de-institutionalization (e.g.: the existence of a private psychiatric hospital system, separate and independent from Ministry of Health direct control; when there is a severe shortage of funds for mental health community services development).

However, this rather common situation should not prevent health authorities, planners and mental health professionals to improve Psychiatric Hospital conditions and to put the bases for future process of deinstitutionalization.

This process may need a combination of moral persuasion and financial incentives because often Government has financial agreements with private hospitals. A careful negotiation may lead to a win-win solution where private hospitals may see an interest in joining hand with public sector in reducing the hegemonic role of psychiatric hospitals, reducing their size and improving infrastructure environmental conditions of users institutionalized.

The Model IDEA is based on the establishment of three different and simultaneous programmes and their constant assessment. The three programmes are associated to three "virtual" spaces of action within the psychiatric hospital: i) the exit door; ii) the entrance door; and iii) the inner space.

The acronym IDEA stands for the following:

- **I**ncreasing community care for those who can leave the psychiatric hospital
- **D**ecreasing admissions in psychiatric hospital
- **E**nhancing quality of care and rights of those who stay in psychiatric hospital
- **A**ssessing periodically the process

The first programme (**I**ncreasing community care for those who can leave the psychiatric hospital) works on the EXIT DOOR and puts its focus on a group of users who present clinical and social conditions (severity, symptoms, family support, existing community resources) allowing a relatively easy discharge from hospital. They often may represent at least the 30% of the hospital population. This group of users should be identified through a careful social and clinical assessment by an ad hoc created group of professionals (nurses, psychologists, psychiatrists and social workers) who will be in charge of identifying potential solutions within their own communities (family or independent protected facility accommodation) and negotiating the discharge with local communities, families, primary health care services and other specialist services if they exist.

The staff suitable for this first programme are those young professionals motivated and enthusiastic in working outside the hospital, looking for solutions, visiting communities and dealing with families.

The second programme (**D**ecreasing admissions in psychiatric hospital) works on the ENTRANCE DOOR and requires a limited group of senior staff identifying the catchment areas which could be potentially able to significantly decrease the admissions in psychiatric hospitals.

It must be noticed that too often Deinstitutionalization is seen exclusively as a process aiming at discharging patients from psychiatric hospitals while the significant and core factor promoting the progressive decreasing of the size of psychiatric hospitals is the reductions of admission more than the increase of discharges.

Paradoxically, if a psychiatric hospital would stop new admissions leaving untouched its existing population, it will disappear in twenty/twenty-five years by natural death of its population.

On the contrary, a psychiatric hospital even able to discharge a significant number of patients (let's say, 50%) but not stopping new admissions, will continue existing forever because the turnover of a new population of young chronic patients.

In other words, when health authorities find difficult discharging many chronic patients, a successful strategy is decreasing slowly but systematically new admissions.

The main objective of this programme will be establishing connections with the health and mental health services located in different catchment areas where the organization of care is relatively rich in terms of human and logistic resources.

These relatively "rich" areas could be the first ones to commit to a reduction of admissions in psychiatric hospital. The presence and availability of beds for acute psychiatric patients in General Hospital would be of course a fundamental factor facilitating the progressive decrease of psychiatric hospital admissions. In other words, catchment areas equipped with community mental health service or team plus the possibility to admit acute cases in general hospital will be in the best position to stop new admissions in old asylums.

To run this programme senior staff especially skilled in negotiating with the outside health and non-health sectors are needed. However, this small group of staff in charge of decreasing admissions in psychiatric hospital will need a clear, sustained and coordinated support from health authorities.

The third programme (**E**nhancing quality of care and rights of those who stay in psychiatric hospital) works on the INNER SPACE of the Hospital and requires a larger group of staff (essentially, nurses, occupational therapists and psychologists) able to significantly improve the living conditions of those patients who are not candidate to rapid discharge from hospital due to severity of disability, age or social abandonment.

This means significantly enhancing human rights protection and respect, improving a variety of elements like individual space, privacy and more in general humanizing the hospital facilities (toilets, sleeping rooms, living spaces).

In addition, meaningful activities of entertainment and periodic experiences of individual or group "going out" opportunities, should be systematically developed and implemented.

Often senior nurses are the most reluctant in accepting programmes of deinstitutionalization, but, on the contrary, they can be excellent in working towards the improvement of the everyday living-conditions of users.

If the staff could use some additional resources to implement these kinds of improvements, they can revamp their dormant enthusiasm and motivation: this important facilitating factors is obviously linked to ad hoc agreements between Government and private hospitals administrations.

Of course, the three Programmes (**I, D, E**) should be constantly assessed and evaluated (**A**ssessing periodically the process) by an independent group of people (mental health professionals, professionals from justice system, human rights advocates, family and users associations members) according to a set of pre-established indicators and criteria of quality (including the periodical application of WHO Quality Rights Instrument).

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