REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

Mental Health
and Substance Use
Prevention, Promotion, and Treatment

Situation analysis and strategy for Lebanon
2015 - 2020

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and Substance Use
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تم انتاج هذا الكتيب بدعم من الاتحاد الأوروبي وتمت طباعته من قبل منظمة الصحة العالمية بالشراكة مع مفوضية الأمم المتحدة العليا لشؤون اللاجئين وذلك في إطار مشروع بإدارة وزارة الصحة العامة. إن وزارة الصحة العامة هي الجهة الوحيدة المسؤولة عن محتوى هذا الكتيب ولا يمكن اعتباره بأي حال من الأحوال على أنه يعكس وجهة نظر الاتحاد الأوروبي.

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FOREWORD
By His Excellency, the Minister of Public Health

The National Mental Health Programme (NMHP) at the Ministry of Public Health (MOPH) is launching a Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon.

I am pleased to share this document that constitutes an integral part of the National Health Strategy and will guide the ministry for the coming 6 years in meeting the needs of our communities in the area of mental health and substance use.

I am grateful to all the efforts and time put in preparation of this document. Many people have allocated time and resources to make valuable recommendations to the strategy. The NMHP and its partners have been leading this work. Local and international NGOs, UN agencies, ministries, mental health experts, and many others have been involved in the preparation and review of this document. I would like to express my particular appreciation to the programme director Dr Rabih Chammay for his commitment and professional work and to the Director General Dr Walid Ammar for his leadership. The result of this participatory endeavour is a well-informed national strategy owned and supported by all relevant actors.

Over the next 5 years, we will all combine our efforts in order to strengthen effective leadership and governance for mental health and provide comprehensive, integrated and responsive mental health and social care services in community-based settings. We will also develop and implement key promotion and prevention activities for mental health and substance use disorders and obtain evidence-based knowledge to inform mental health policy and service development through an operational Health Information System (HIS) and coordinated national research practice. Finally, we will strive to meet the needs of specific vulnerable groups with regards to mental health and substance use.

The main challenge now is to transform this strategy into a reality. This, in particular, will change the life of many people and will improve mental health in Lebanon.

Wael Abou Faour
Minister of Public Health

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Association Justice et Misericorde
Balsam
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Centre Libanais des Droits Humains
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Handicap International
HelpAge International
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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-retroviral treatment
DALYs	Disability-Adjusted Life-Years
DSM IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
FDW	Foreign Domestic Worker
GBD	Global Burden of Disease
GP	General Practitioner
GSHS	Global School Health Survey
HIS	Health Information System
HIV	Human Immunodeficiency Virus
ICD	International Classification of Disease
ICRC	International Committee of the Red Cross
IMC	International Medical Corps
INGO	International Non-Governmental Organization
LGBT	Lesbian Gay Bisexual and Transsexual
LPA	Lebanese Psychological Association
MEHE	Ministry of Education and Higher Education
mhGAP	mental health Gap Action Programme
mhGAP-IG	mental health Gap Action Programme- Intervention Guide
MHPSS	Mental Health and Psychosocial Support
MOPH	Ministry of Public Health
MOIM	Ministry of Interior and Municipalities
MOJ	Ministry of Justice
MOSA	Ministry of Social Affairs
NAP	National AIDS Program
NGO	Non-Governmental Organization
NMHP	National Mental Health Programme
NSSF	National Social Security Fund
OST	Opioid Substitution Treatment
PHC	Primary Health Care
PTSD	Post-Traumatic Stress Disorder
RSA	Rapid Situation Assessment
SDC	Social Development Centre
SGBV	Sexual and Gender Based Violence
UN	United Nations
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNODC	United Nations Office on Drugs and Crime
UNRWA	United Nations Relief and Works Agency for Palestine
WHO	World Health Organization
WHO-AIMS	World Health Organization Assessment Instrument for Mental health Systems
YLDs	Years Lived with Disability
YLLs	Years of Life Lost

EXECUTIVE SUMMARY

Stigma remains a main challenge facing mental health and substance use, cutting across all aspects of care and leading to discrimination, negatively impacting service development, delivery and utilization. Chronic under-funding and the inclination of funding towards curative hospital-based care have led to a scarcity of specialized human resources and services that are mostly based in the private sector. The public sector, while progressively regaining its leadership and regulatory role, is currently overstretched due to the increase in demography following the Syrian crisis. Consensus between the different actors, as well as political will, are the driving forces towards setting a national mental health and substance use strategy, to bridge the treatment gap, improve access to quality care, promote and protect human rights, and restore mental health through effective prevention, promotion, and treatment.

The MOPH vision is for all people living in Lebanon to have the opportunity to enjoy the best possible mental health and wellbeing. The strategy addresses mental and substance use disorders in a cost-effective, evidence-based and multidisciplinary approach with an emphasis on community involvement, continuum of care, human rights, and cultural relevance. The goals and domains of action of the strategy are in line with the WHO Global Action Plan for Mental Health (2013-2020). The strategy covers five domains; strengthening effective leadership and governance for mental health (domain 1); providing comprehensive, integrated and responsive mental health and social care services in community-based settings for all populations (domain 2) especially the needs of specific vulnerable groups (domain 5). Another domain covers implementing key promotion and prevention activities for mental health and substance use disorders (domain 3). Obtaining evidence-based knowledge to inform mental health policy and service development through an operational Health Information System and coordinated national research practice is another domain (domain 4). Strategic objectives are set under every domain of action. In addition, yearly targets are developed to ensure successful achievement of these objectives.

INTRODUCTION

The Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy highlights Lebanon's vision and objectives for the coming 6 years. This strategy supports evidence-based practice among professionals and provision of optimal services as well as changing peoples' attitudes towards mental health and substance use.

In May 2014, the MOPH launched the National Mental Health Programme with the support of 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 programme has been working on many fronts: integration of mental health into primary care, engaging universities and scientific societies, mapping of the mental health system in Lebanon, developing key documents for mental health, to name a few. In addition, the MOPH established and is currently chairing the Mental Health and Psychosocial Support (MHPSS) task force. Co-chaired by WHO and UNICEF, this task force includes around 40 organizations working on the Syrian Crisis response in Lebanon with the aim of harmonizing and mainstreaming MHPSS in all sectors and improving access to care.

One year after its launch, the NMHP is launching a Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon for the period of 2015-2020. This is in line with the MOPH policy to expand existing services provided since many years and that consisted of covering inpatient care in psychiatric hospitals and psychotropic medications for outpatients who do not benefit from any health coverage plan.

The current document is the result of a long series of hard work, effort, time, research, and expertise. In order to build on solid grounds, the NMHP activated the work on a draft for a national strategy jointly written by WHO and MOPH in 2011. The 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.

A final national consensus meeting in April 2015 adopted the final document that comprises all national priorities identified by the main actors before being launched in May 2015.

We are delighted to see the launching of this important document, that incorporates inputs from all actors in mental health and substance use in Lebanon, and that will guide the mental health reform in Lebanon for the next 6 years.

I would like to commend Dr Rabih Chammay for coordinating all these efforts and to thank each and every one who contributed to this document. We remain confident that the same collaboration that led to producing this strategy will continue in the future to ensure the implementation with the same commitment and enthusiasm.

Walid Ammar
Director General
Ministry of Public Health

N.B.
Terms written in bold in the strategy are defined in the "Glossary of terms" section at the end of the document.

I. Global overview

Mental and substance use disorders constitute one of the top public health concerns, as measured by prevalence, disability, burden of disease, and mortality. At any point in time, no less than 10% of the population has mental disorders as reported by the World Health Organization (WHO) from more than a decade ago *(1)*. According to the Global Burden of Disease (GBD) study[1] of 2010 *(2)*, mental and substance use disorders accounted for 183.9 million disability-adjusted life-years **(DALYs)** worldwide and comprised approximately 7.4% of the total disease burden. The global epidemiological transition over the past decades, and the shift from communicable to non-communicable diseases, translated to a further increase in the number of sufferers from mental and substance use disorders which now represent 4 of the 10 leading causes of disability worldwide *(1)*. Table 1 shows the breakdown of diseases within the mental disorders category as a percent of global **DALYs**.

Table 1. Percent of Global DALYs within the mental disorders category (2010) *(2)*

Disorder	Percent of Global DALYs within the mental disorders category (2010)
Major Depressive Disorder	34.12
Anxiety Disorders	14.49
Drug Use Disorders	10.80
Alcohol Use Disorders	9.53
Schizophrenia	8.10
Bipolar Disorder	6.95
Other mental disorders	16.03

In terms of mortality, mental and substance use disorders are strongly correlated with suicide, estimated to be around one million suicides annually *(3)*, with more than 75% of suicides occurring in low- and middle-income countries. This translates into one suicide death every 40 seconds. Subsequently, suicide ranks second leading cause of death among 15–29 years olds (for both genders) *(3)*.

Mental and substance use disorders are correlated with suboptimal access to appropriate care, low rates of treatment, poor adherence to treatment, and an increase in risky behaviours in addition to stigma and discrimination *(1)*. This is accentuated in low- and middle-income countries as 80% of the global disease burden due to mental and substance use disorders is found in these areas *(4)*. It is estimated that the treatment gap for mental and substance use disorders is 76.3–85.4% in less-developed countries *(5)*. This translates into around four out of five people in contexts of low- and middle-income countries who need mental health services and do not receive them.

Narrowing down the scope to the Eastern Mediterranean Region, mental and substance use disorders are quite common as **psychological distress** rates vary between 15.6% and 35.5%, with higher rates in countries under complex emergency situations *(6)*. The most frequent disorders in the Region are depression and anxiety. In terms of DALYs, mental and substance use disorders account for 12% of the DALYs lost in the Region. As for treatment gaps, based on the WHO-AIMS[1] project, an overall treatment gap of more than 90% is suggested for mental and substance use disorders.

Various risk factors increase the risk for mental and substance use disorders, namely poverty, conflict, displacement, gender-based violence, low education levels, and chronic physical health conditions *(1, 4, 7)*. In their turn, mental and substance use disorders worsen social and economic circumstances, leading to a vicious cycle of poverty and illness, exacerbated by stigma and discrimination. Due to the great impact they have on individuals' and communities' social and economic wellbeing, mental and substance use disorders were granted a United Nations General Assembly Special Session (UNGASS) in 2012 *(8)*, positioning them as a global development priority.

1 The WHO-AIMS is an Assessment Instrument for Mental health Systems. It is a tool for collecting essential information on the mental health system in order to strengthen and improve this system. By definition, the latter includes all organizations and resources focused on improving mental health. The report in the Eastern Mediterranean Region includes 14 countries in the Region that completed WHO-AIMS between 2005 and 2009.

II. The context of Lebanon

A. MENTAL DISORDERS IN LEBANON

Mental health has been an increasing public health concern. Latest evidence dating from 2008 shows that approximately 4.6% of the Lebanese population had experienced a severe mental disorder (including depression and anxiety) in the previous year before the study *(9)*. In addition, around 25.8% met the criteria for at least one of the mental disorders[2] and 10.5% experienced more than one disorder at some point in their lives. Depression was the most prevalent individual disorder (lifetime prevalence of 9.9%) *(9)*. Anxiety disorders were found in 16.7% of the population while mood disorders in 12.6%. As for suicide, 4.3% of the population experienced suicidal ideation and 2% attempted suicide *(10)*.

Very few individuals who experienced any type of mental disorder had ever received any professional treatment. For those who did seek professional treatment, a substantial delay ranging from 6 years to 28 years was noticed between the onset of the disorder and the beginning of professional treatment *(9)*, leading to increased burden on healthcare. Another big share of the population goes to religious healers or "spiritual advisers", and fortune tellers for treatment *(9)*. The high prevalence of mental disorders, the early age of onset and long delays in seeking treatment have exacerbated the burden of mental disorders. This is in addition to the sensitive and taboo nature of the topic which hinders proper reporting *(9)*.

Furthermore, individuals exposed to war-related events are at a higher risk for developing a mental disorder (3.1 times more likely to experience mood disorders and 2 times more for anxiety disorders) *(10)*. In fact, approximately 70% of the Lebanese population was exposed to one or more war events, including 60% of children ages 0–10 *(11)* and, up to 38% of the Lebanese population had been a war refugee/displaced. The effect of war exposures is cumulative and this is more evident in Lebanon where political unrests and armed conflicts are continuous *(12)*.

2 As classified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) which is one of the standard classifications of mental disorders used by mental health professionals. It consists of 3 key components; (1) the diagnostic classification, (2) the diagnostic criteria sets, and (3) the descriptive text.

B. SUBSTANCE USE DISORDERS IN LEBANON

Most of the studies conducted in Lebanon in relation to drug use since 2003 point towards a unanimity with regard to perceptions of increasing drug use, particularly amongst youth (15-24 years). Based on the Rapid Situation Assessment (RSA) (2003) that was done in diverse segments of the Lebanese population, it was shown that substance use is initiated as early as 9 years of age, and the mean age of first drunkenness was 15 to 17 years *(13, 14)*. Most substances that persons tend to experiment with are alcohol and nicotine, followed by cannabis (hashish/marijuana), the latter being the most commonly used illicit drug in both high school and university students *(14)*. Half of the treatment admissions were due to Heroin use. Around half of the persons using substance and who are seeking treatment or institutionalized also commonly inject drugs and high rates of needle sharing was perceived. As for treatment gap, only 2.1% of university students and 2.8% of high school students reported ever seeking professional help for substance use problems (excluding alcohol). The most common reason for not seeking treatment is unperceived need *(14)*.

C. VULNERABLE GROUPS IN LEBANON

Some groups are particularly vulnerable[3] and need more attention when it comes to mental health and substance use disorders as they are more susceptible to stigma or marginalization and are less likely to seek mental health/substance use services. In Lebanon, vulnerable groups include persons with disabilities, children and adolescents, older adults, persons receiving palliative care, persons in prisons, survivors of torture and their families, families of disappeared from armed conflicts and wars, persons living with HIV/AIDS, survivors of sexual and gender-based violence, Lesbian, Gay, Bisexual, and Transsexual (LGBT) community, foreign domestic workers, Palestinian refugees, and displaced populations. Table 2 provides demography of the main vulnerable groups residing in Lebanon.

3 We mean by vulnerable groups the groups that are at a higher risk to develop psychological distress or mental disorders due to their circumstances or sometimes increased stigma. This does not mean that persons in these vulnerable groups necessarily have mental disorders but we wanted to highlight the necessity of including them in the national strategy and, in some cases, cater for their specific needs.

Table 2. Persons residing in Lebanon

Persons residing in Lebanon	Number	Source
Residing in Lebanon, excluding displaced Syrians and Palestinians living in camps	4,232,381	Calculation based on the living household survey 2007, and accounting for death and birth as reported to MOPH *(15)*
• Elderly >65y (9.6%)	406,309	Calculation using the new estimate of residents of 2014 and the percentage as stated in the living household survey 2007 *(15)*
• Children <15y (24.6%)	1,041,166	Idem
• Adolescent and youth (15-24y) (19.5%)	825,315	Idem
• Persons living with disabilities (2%)	84,648	Calculation using the new estimate of residents of 2014 and the percentage as stated in the living household survey 2004 *(16)*
Palestinians living in camps	238,500 (out of 449,957 registered in Lebanon)	UNRWA *(17)*
Displaced Syrians	1,172,753	UNHCR *(18)*
Foreign domestic workers	>250,000	ILO *(19)*
Persons living with HIV/ AIDS	1,780 (cumulative)	NAP *(20)*
Persons in prison	~ 6,000 (snapshot) 11,958 (during 2014[4])	Ministry of Justice (MOJ) snapshot July 2015 (incarcerated; including arrested and convicted) *(21)*
Families of disappeared from armed conflicts and war	~ 3,500 registered names with ICRC >17,000 reported missing to police[5]	International Committee of the Red Cross report *(22)*

4 The cumulative number of persons in prisons during the year 2014 is 11,958. However, at any point in time, around half of them (~6,000) are found in prisons.

5 This number is reported to the police but without any investigation. Therefore it is considered to be inflated.

1- Persons with disabilities

This group includes mental and physical disabilities, at all age categories, and represents 2% of the persons residing in Lebanon. Living with a disability leads to a much lower chance of getting a job or an education *(23)*.

2- Children and adolescents

The Global School Health Survey (GSHS) data shows that around 15.2% of the students had serious suicidal ideations, 11.6% made a plan about how they would attempt suicide, and 13.8% actually attempted suicide one or more times in the last year before the initiation of the study *(24, 25)*. Recent data in Beirut (2012) shows that about 26.1% of adolescents aged 11 to 17 years were diagnosed with a psychiatric disorder *(26)*. Of those diagnosed with mental conditions, only 6% reported seeking professional help.

The GSHS-2011 results show that 5% of students aged 13-15 ever used drugs compared to 3.5% in 2005 *(24, 25)*. Alarmingly, among those who had ever used drugs, almost half of them did before the age of 10 years. As for alcohol use, around 28.5% of students had at least one alcoholic drink in the past 30 days *(25)* compared with 19.5% in 2005 *(24)*. Nearly 87% of students who had ever had a drink, had their first drink before the age of 14 years. Almost 17% of students have experienced adverse effects of alcohol use such as hang-over, feeling sick, getting into trouble, or missing school at least once in their lifetime *(25)*.

3- Older adults

The elderly (65 years and over) constituted 9.6% of the Lebanese population in 2007 *(15)* and are expected to reach 10.2% by 2025 *(27)*. Among this group, 9.3% suffer from a mood disorder and 3% had suicidal ideation *(28)*. In underprivileged neighbourhoods around Beirut, depression was reported among 1 in 4 respondents older than 60 *(29)*. In Beirut and Mount Lebanon, dementia was prevalent in 10.5% of a randomly selected sample of participants *(30)*. Also, dementia was reported in 60% of one nursing home residents. Among these patients, 49.2% had severe forms of dementia *(31)*.

4- Persons receiving palliative care

According to a qualitative study on Lebanese oncology patients receiving palliative care, major complaints were distress from being dependent and losing control of their own lives, as well as fearing pain and feeling worry for family members *(32)*.

5- Persons in prisons

With the current poor conditions in most Lebanese prisons, the physical and mental health of inmates is at stake. In Roumieh prison, around one third of the inmates are incarcerated on the grounds of drug-related crimes *(33)*. Around

65.1% of those inmates were diagnosed with lifetime substance dependence *(14)*. The majority of inmates never perceived the need to seek treatment whereby only a third of them ever sought treatment for substance use disorders (mainly heroin). According to the 2012 National Health Statistics, the most common chronic disease detected among inmates was depression *(34)*.

6- Survivors of torture and their families

The consequences of torture reach far beyond physical pain and may include symptoms such as intrusive thoughts or memories, severe anxiety, insomnia, nightmares, depression and memory lapses and in many cases Post-Traumatic Stress Disorder (PTSD) *(35)*. Research among 135 survivors of torture and arbitrary detention showed that the main needs arise from problems of a psychological nature, and this burden has prevented the survivors from reintegrating in society *(36)*.

7- Families of disappeared from armed conflicts and wars

Emotional distress is the main burden facing families of missing persons in addition to the difficulty of coping with uncertainty regarding the fate of these persons. Many have been missing for more than 40 years due to war and armed conflicts. Most of these persons' families suffer headaches, sleep problems, nervousness, excessive worry, general fatigue and unhappiness *(22)*.

8-Persons living with HIV/AIDS

The prevalence of mental disorders –mostly psychological distress, depression, and suicide- is significantly higher in persons living with HIV than in the general population, with a high concentration of cases among vulnerable, marginalized and stigmatized groups such as drug users and persons in prisons *(37)*. This is in addition to the loss of their family, social support, and friends. The situation for persons living with HIV/AIDS is also aggravated by the stigma faced and the minimal access to treatment *(37)*. In Lebanon, around 900 persons living with HIV are currently receiving free **anti-retroviral treatment (ARV)** (based on eligibility criteria), through the National AIDS Program (NAP) *(20)*. The latter are more prone to mental disorders associated with the ARV treatment which lowers their adherence to the medication. It is a vicious cycle of illness whereby, in its turn, mental illness lowers the likelihood of receiving ARV treatment *(37)*.

9- Survivors of sexual and gender-based violence (SGBV)

SGBV is violence that is directed against a person on the basis of gender and comprises rape, sexual abuse, domestic violence, naming but a few *(38)*. Survivors are at a higher risk of developing depression, post-traumatic stress disorder, and anxiety *(39)*. Sexual and other forms of gender-based violence are increasingly reported in situations of complex emergencies. Research conducted since the year 2000 shows that 35% of women presenting to health care centres in Lebanon were exposed to SGBV *(40)*.

10- Lesbian, Gay, Bisexual, and Transsexual (LGBT) community

The International Classification of Disease (ICD) (10th edition), among several classification systems, declassified homosexuality as a mental disorder *(41)*. In 2013, the Lebanese Psychiatric Society (LPS) and the Lebanese Psychological Association (LPA) stated that homosexuality is not a mental disorder and does not need to be treated *(42)*. However, the social stigma associated with homosexuality and mistreatment of the LGBT community remains, especially that the common interpretation of the Lebanese law associates this type of sexual orientation to a crime. As a coping mechanism, some members of this community resort to various forms of social avoidance or withdrawal while others describe substance use (mainly alcohol) as another way of coping *(43)*.

11- Foreign domestic workers (FDWs)

Many FDWs in Lebanon have been victims of harsh working conditions, long working hours, little or no pay, and in many situations verbal and even physical abuse, which has been affecting their physical and mental health. This is reflected in the fact that psychiatric admissions of female FDWs to psychiatric hospitals has increased in recent years *(44)*. Additionally, data from 2008 shows that close to one FDW commits suicide each week in Lebanon *(45)*.

12- Palestinian refugees

All 12 official Palestinian refugee camps in Lebanon are facing serious problems mostly due to on-going conflict and unrest and unfortunate living conditions characterized by overcrowding and inadequate basic infrastructure *(46)*. Among patients approaching medical care in Burj-Al-Barajni camp, depression affects almost one-third, 22% have anxiety, and 14% psychosis *(47)*.

13- Displaced populations

Up till July 2015, the number of registered displaced Syrians in Lebanon reached around 1,200,000 *(18)*. Around 300,000 displaced Syrians are estimated to be most vulnerable, 60% of them being women and children. Adding to past exposure to traumatic events related to war and conflict *(48)*, the majority of this population is currently experiencing various hardships related to displacement, impoverishment, loss of home/loved ones, and lack of access to basic services. Moreover, domestic violence has been increasing *(48)*. Since January 2014, a mental health and **psychosocial support** (MHPSS) task force, chaired by the MOPH and co-chaired by WHO and UNICEF, was established to coordinate the MHPSS interventions of the different actors caring for displaced Syrians.

D. SNAPSHOT OF THE MENTAL HEALTH AND SUBSTANCE USE SYSTEM IN LEBANON

The following section will provide a brief overview of the general health system in Lebanon and will discuss the mental health services: (a) **primary health care (PHC)**; and (b) **in-patient care**; substance use services; and human resources. This section will also provide an idea of the national mental health research, laws and legislation, financing, and the role of media.

1- Overview of the health system in Lebanon

The health system in Lebanon is highly fragmented, characterized by a dominant private sector, a very active NGO sector, and a public sector progressively regaining its leadership and regulatory role over the past two decades. Main features in the Lebanese health system are the public, the private, and the public-private mix.

A widespread network of services was developed as part of the **Primary Health Care** strategy that was revised in 2004. This strategy has established a link between the private sector and the public sector through the NGOs and the existing local bodies. Out of the 920 centres (PHC centres and dispensaries) managed either by MOPH, Ministry of Social Affairs (MOSA), municipalities or NGOs, around 200 PHC centres[6] are affiliated with the MOPH PHC network, providing various packages of ambulatory health services.

With a total of 172 private hospitals *(49)* offering around 10,200 beds *(50)*, there is an oversupply of private beds in comparison to a recovering public hospital sector accounting for 28 public hospitals *(51)* which offer about 1,700 beds *(50)*. The health system is also characterized by a surplus of medical doctors and a shortage in nurses and paramedical staff, with the following estimates; physicians: 320/100,000 population *(52)*; nurses: 307/100,000 population *(53)*. Most of the aforementioned staff do not receive proper training on mental health and **psychosocial interventions**. Accreditation system for both PHC centres and hospitals is in place.

With the advent of the Syrian crisis, the total resident population increased by more than 30% positioning Lebanon as the host of the highest number per capita of displaced Syrians *(54)*. This demographic change has impacted heavily on the country's economy, infrastructure, employment, environmental

6 The centres enrolled in the network are governed by a contractual agreement with the MOPH for provision of health services mainly: child health and vaccination, reproductive health, oral health; treatment for common diseases, early screening for non-communicable diseases, medication, health awareness, and environmental health. They also benefit from capacity building and support through the existing health programs. An additional 250 centres (outside the MOPH network) benefit from medication for chronic diseases subsidized by the MOPH.

health, and basic services. The World Bank estimated that during the 2012-2014 period, around 170,000 Lebanese are pushed into poverty (in addition to the 1.2 million currently living below the upper poverty line) *(54)*. These latter determinants of health have led to significant impacts on the health system, overstretched with increased utilization of the health services at PHC level and in-hospital by around 50% and 35%, respectively, in addition to an increase in demand on non-communicable diseases services (especially cardiovascular and mental health) *(55)*.

2- Mental health services

Similarly to the general health system, mental health services are predominantly provided by the private sector as well as mostly skewed to specialized outpatient and inpatient care. Strategic shifts are steered by the MOPH towards integration of mental health into **primary health care**.

a- Primary Health Care:

Mental health care is not integrated in most PHC centres and dispensaries. The level of integration varies among different entities, ranging from delivery of essential psychotropic medication to very few having consultations by a mental health specialist. In 2014, as part of the MOPH plan for integrating mental health into **primary health care**, PHC workers (GPs, nurses, and social workers) of 50 centres within the MOPH network have received training on assessing, identifying, managing and referring mental health cases using the mental health Gap Action Programme- Intervention Guide[7] (mhGAP-IG).

Provision of mental health services in outpatient care comprises mainly private clinics involving psychiatrists and psychologists. In a few cases, multiple mental health specialists will work in a multidisciplinary team to provide services mainly with children with learning difficulties.

b- In-patient care:

In Lebanon there are currently 8 psychiatric wards (in general hospitals) that provide **in-patient** mental health services. This translates into approximately 1.5 beds for mental health in general hospitals per 100,000 population *(56)*.

In addition, there are 5 active mental health hospitals in Lebanon with approximately 28.52 beds per 100,000 population *(56)*.

7 The mhGAP is an intervention guide for clinical decision-making for the priority mental health conditions namely depression, psychosis, epilepsy, developmental and behavioural disorders in children and adolescents, dementia, alcohol and drug use disorders, self-harm/suicide, stress, and other significant emotional or medically unexplained complaints. It was developed by WHO and launched in 2010 for low- and middle- income countries. The mhGAP training materials were adapted to local context.

3. Services for persons with substance use disorders

Several NGOs in Lebanon have been quite active in addressing issues related to substance use disorders through a variety of interventions such as prevention, rehabilitation, abstinence, and harm reduction. With regards to substance use prevention, multiple approaches are being implemented such as **life skills education**, **peer-to-peer education**, road shows, and general awareness campaigns. Few **detoxification** beds are available in public and private hospitals. As for **rehabilitation**, NGOs are offering this service in residential settings or in outpatient clinics, with limited capacity to receive beneficiaries. With regards to **harm reduction**, the services remain limited, varying from **Opioid Substitution Treatment (OST)**, impaired driving awareness campaigns, **drop-in centres**, needle and syringe exchange programs, and outreach and educational services to minimize risky behaviours.

4. Human resources

The figures below are estimates of the current number of the main specialized human resources working in mental health facilities or private practice *(56)*:

- 71 psychiatrists; 1.26 per 100,000 population
- 193 psychologists; 3.42 per 100,000 population

Main schools of **psychotherapy** training are mostly focused on long-term interventions with no national certification processes yet in place. **Psychoanalysis** remains the main school of **psychotherapy** training, with recent schools emerging such as cognitive and behavioural therapy, systemic, and psychosomatic interventions.

5. Research in mental health

Research regarding mental health in Lebanon in the last decade targeted mainly prevalence, treatment/medication side effects, diagnostic tools, various disease and their associated mental conditions in addition to ethics, perceptions/stigma and disease determinants, involving adults and children and adolescents. As for substance use, research focused mainly on alcohol addiction. Only few studies target mental health and substance use service research (including policy, plans, and programmes).

6. Legislations

The latest mental health decree law (ACT#72) *(57)*, enacted in 1983, focuses on the organization of the care, treatment, and rehabilitation of patients with mental conditions as well as protecting the rights of these patients and their families. It regulates guardianship issues for people with mental conditions and facilitates the access to in-hospital care for the most vulnerable groups. The law stipulates the creation of a mental health body, under the governance of the MOPH, to oversee and implement mental health policies in Lebanon, and monitor mental health services and treatment practices in health facilities.

This decree law is currently under revision to address some main issues such as the access to free **community-based** mental health care, the standards and regulations for involuntary admissions, and the working modalities of the mental health body, in addition to accrediting facilities and credentialing mental health professionals. It also adds legislation provision for facilitating the creation of patient associations, family associations, and support groups. In addition, it specifies accountability and criminal penalties for violations of the law.
A law was proposed by the LPA to regulate the profession of psychologists and another law was proposed by the syndicate of psychotherapists to regulate the profession of psychotherapists.

The substance use law (ACT#673) *(58)* enacted in 1998, and its amendments, are related to narcotic drugs, and **psychotropic medications** and their precursors. It focuses on supply reduction, penal provisions, and governance bodies and international cooperation for drug control. It classifies substance use as a crime with a sanction varying between 3 months and 3 years in addition to a fine (article 127). Lately, the judiciary system can refer an arrested person for substance use to a ministerial committee which has the authority to offer the person the option of rehabilitation instead of prison, especially if it is a first arrest for the crime at hand.

Although several decrees have been issued to restrict the sale of **anxiolytics and sedatives**, however, a few medications with potential for abuse are still easily accessed. In 2010, a ministerial decision allowed provision of **Buprenorphine** to individuals using heroin under strict supervision by a psychiatrist and close follow-up by a multidisciplinary mental health team.

Although the mental health decree law (ACT#72) *(57)* mentions protection of rights of patients with mental conditions in general, however, patients' rights are detailed in a separate law (ACT#574) *(59)* enacted in 2004. The latter specifies the right of the patient (or representative) to get medical information and directly access the medical file, to consent on the treatment act, to have respect of personal life and patient confidentiality.

7. Financing

Despite the different financial schemes in Lebanon (Table 3), around half of the population remains uncovered, excluding displaced Syrians and Palestinians living in camps (covered by UNHCR and UNRWA respectively). For this section of the population, the MOPH covers hospital stays and expensive medications through the programme of catastrophic illnesses and has recently engaged, through the Universal Health Coverage project, into a pre-paid set of services to be delivered to the most vulnerable Lebanese. Most schemes involve some cost sharing. Moreover, the burden of **out-of-pocket expenditure** remains

the largest source of health expenditure in Lebanon although the MOPH has succeeded in reducing the **out-of-pocket expenditures** from 60% in 1998 to 38% in 2012. In addition, health spending as a share of GDP has fallen from 12.4% to 7.2% *(34, 60)*.

Table 3. Distribution of actual labour force by insurance coverage type

Insurance coverage	Type of insurance or insurance institution	Percentage
	National Social Security Fund (NSSF)	26.7
	Private insurance	11.5
	Army and the Internal Security Forces	8.3
	Public Servants Cooperation	5.0
	Other type (municipality, etc.)	0.7
Total covered		**52.2**
Total not covered		**47.8**

Of the total MOPH health expenditures, only 5% is directed towards mental health, out of which around half (54%) is spent on **in-patient care** *(56)*.

As for mental health coverage, the majority of private insurances do not cover any care. All other schemes cover psychiatric consultations, **psychotropic medications**, and **in-patient care** with inconsistencies in the level of coverage across different financing schemes.

As for substance use, care is mainly covered through MOPH and MOSA.

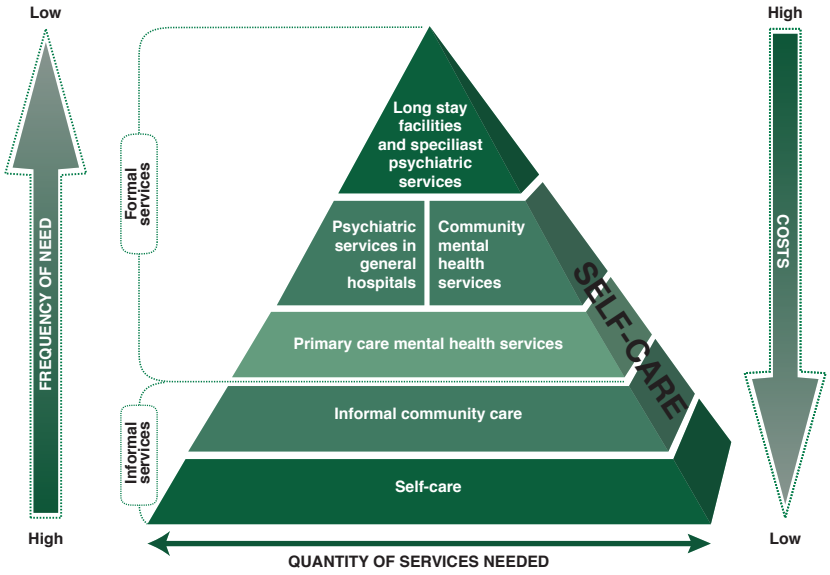
8. Media

By providing a platform for communicating evidence-based, health-related messages, media can play a key role in decreasing stigma and enhancing screening, prevention, and treatment of mental and substance use disorders. Up till now, the media in Lebanon are not using any specific strategy to approach mental health issues, although some journalists have expressed a high level of interest in becoming important sources of public information and in working towards decreasing the stigma. Some private entities initiated in the last few years limited campaigns on specific topics such as stigma, suicide and substance use. Television programmes also covered some issues related to specific aspects of mental health and substance use with different levels of sensitivity and accuracy and various contradictory effects.

E. MAIN OPPORTUNITIES AND CHALLENGES

Stigma remains a main challenge facing mental health and substance use, cutting across all aspects of care and leading to discrimination, with a huge impact on service development, delivery and utilization. Low levels of public awareness about mental and substance use disorders and their related treatments leads to not perceiving the need to seek adequate and professional care in addition to misconceptions about treatments. This is accentuated by the media channelling scattered information which is not always evidence-based. Adding to this, chronic under-funding and the inclination of funding towards curative hospital-based care and services have led to a scarcity of mental health human resources and services that are mainly available in the private sector, leading to limited access to care. Based on the WHO service organization pyramid (Figure 1), the levels of services in Lebanon are inverted, meaning that the tip of the pyramid –hospitalization and specialized care– takes the largest share of funding while the base of the pyramid –primary care and informal care– remains neglected. In addition, the availability of services for persons with mental and substance use disorders remains limited and mostly centralized, with no referral system in place to ensure continuum of care.

Figure 1. The WHO service organization pyramid[8] for an optimal mix of services for mental health *(61)*



8 In line with the WHO mental health service organization pyramid, mental health services start with self-care and informal care that are generally provided by one's self or one's network and peers, and are cross-cutting across all levels of care. Formal mental health care services should be offered through widespread PHC services and should be made easily accessible and affordable to the population. Specialized psychiatric care should remain at the tip of the pyramid.

Although many components of the current mental health and substance use laws are stated to protect patients and provide them with adequate care, and stipulations of several bodies to oversee the implementation of care are mentioned, however, the level of implementation of these components remains very low and the overseeing bodies are not fully in place. This is in addition to low levels of awareness of health professionals and the general population about these laws, which further hinders proper implementation (especially at the level of actors directly implementing the laws such as the judges, lawyers, and police officers). Some components of these laws need to be revisited especially the ones related to the criminalization of persons with substance use disorders, as the focus of interventions is **harm reduction**, rehabilitation, and reintegration into community rather than sanctioning.

Lack of research especially service (operational) research and service organization and effectiveness remains a major challenge to informing strategic planning, interventions, and policy change. Redirecting legislations, policies, financing, and services to sustainable cost-effective and human rights-oriented **community-based** quality care is grounded on proper research, surveillance, monitoring, and evaluation. The recent assessment of mental health system of services (WHO-AIMS) is a building block for priority actions in mental health care. The establishment of indicator-based health information system (HIS) will also serve as a ground for mental health surveillance and monitoring, and facilitate evaluation.

The increase of the population residing in Lebanon due to the Syrian crisis has led to overstretching the health system. Although it is considered a huge challenge, and showed the gap in health services especially mental health, it also created an opportunity to synergize efforts. In fact, the shortage of funding has pushed the humanitarian actors to harmonize approaches and build upon the existing health system and redirect interventions towards primary health care.

> "Emergency situations – in spite of the adversity and challenges they create – are openings to transform mental health care"
>
> *WHO, 2013 (62)*

This context created the momentum for collaboration between ministries, UN agencies, and international and local NGOs and for mobilization of resources towards developmental aspects. This momentum was also facilitated by a history of strategic cooperation between the MOPH and most mental health actors as well as the commitment of the MOPH to bridge the gap in mental health services and the establishment of the NMHP within the MOPH.

Consensus between the different actors, as well as political will, are the driving forces towards setting a national mental health and substance use strategy, to bridge the treatment gap, improve access to quality care, promote and protect human rights, and restore mental health through effective prevention, promotion, and treatment.

A- VISION

All people living in Lebanon will have the opportunity to enjoy the best possible mental health and wellbeing.

B- MISSION

To ensure the development of a sustainable mental health system that guarantees the provision of and universal accessibility to high quality mental health curative and preventive services through a cost-effective, evidence-based and **multidisciplinary approach**, with an emphasis on community involvement, continuum of care, human rights, and cultural relevance.

C- VALUES AND GUIDING PRINCIPLES

The NMHP employs a human rights based approach in all its activities including the National Mental Health Strategy, which is constructed around a set of values and guiding principles that stem from social, cultural, economic, civil, and political rights. Therefore, the programme strives to respect and promote the following values and principles that form the pillars of this strategy:

Autonomy

All services will respect and promote the independence and self-sufficiency of people with mental health needs and disabilities and their care givers, through openness and honesty in the provision of information, respect in individual interactions, empowerment and partnership in service planning and delivery.

Dignity

All people affected with mental health disorders and their families, and all people providing services, will receive equal access to opportunities, services and care practices that fit with their diverse needs associated with their health status but also with their gender, age, religion, sexual orientation, socio-economic status, legal status, geographic location, language, culture, or other personal characteristics.

Participation

Participation is a hallmark of a quality mental health system and a key mechanism for ensuring accountability. All stakeholders, including persons with mental health disorders, and their families, will participate as full citizens in the planning, legislation, development, delivery and evaluation of mental health services. Participation will be consensus-oriented, through the mediation of different views to reach a consensus on what is the best interest of the whole community.

Empowerment

All stakeholders will be empowered, through ensuring their rights to acceptable and accessible services, to autonomy and self-determination, to be recognized as a person before the law without discrimination and through the de-stigmatization of mental disorders and the guarantee of more inclusive and respectful services with user and provider/caregiver involvement. In particular, all users of mental health services will exercise an adequate level of control over events in their lives, by enjoying decision-making power, having access to adequate resources and information, and having a range of options to choose from.

Accountability and integrity

At all times and at all levels, a high level of accountability shall be maintained in the development and management of the national mental health system, to all those affected by the programme's decisions and actions, including the public and all institutional stakeholders, through the maintenance of transparency and the respect of the rule of law.

Quality

The whole mental health system will be geared towards quality. High quality mental health services, in line with clearly defined national and international standards, to all stakeholders, will be ensured at all levels through the use of evidence informed practices, the adoption of a responsive and regulatory approach, the development of qualified mental health professionals, and the maintenance of universal accessibility, comprehensiveness of services and continuity of care.

D- GOALS AND DOMAINS OF ACTION

The goals and domains of action of the Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon 2015-2020 are in line with the WHO Global Action Plan for Mental Health (2013-2020) and the proposed framework to scale up action on mental health in the Eastern Mediterranean Region.

The domains of action correspond to key performance areas where resources must be committed to achieve the set goals that address the identified critical issues to the strengthening of the mental health system in the country.

Strategic objectives are set under every domain of action as key measures of performance relative to critical success factors for the achievement of the set goals.

Domain	Goal
Domain 1 Leadership and governance	Strengthen effective leadership and governance for mental health.
Domain 2 Reorientation and scaling up of mental health services	Provide comprehensive, integrated and responsive mental health and social care services in **community-based** settings.
Domain 3 Promotion and prevention	Develop and implement key promotion and prevention strategies for mental health and substance use.
Domain 4 Information, evidence and research	Obtain evidence-based knowledge to inform mental health planning and service development through an operational Health Information System (HIS) and coordinated national research practice.
Domain 5 Vulnerable groups	Improve access to equitable evidence-based mental health services –preventive and curative– for all persons in the vulnerable groups living in Lebanon.

Domain 1

Leadership and governance

Goal:
Strengthen effective leadership and governance for mental health.

DOMAIN 1: LEADERSHIP AND GOVERNANCE

Goal: Strengthen effective leadership and governance for mental health.

1.1 GOVERNANCE OF MENTAL HEALTH

Interventions will focus on:
- Creating a sustainable mental health and substance use department within the MOPH that provides a multi-sectorial and coordinated approach to mental health policy, development, and planning.

This requires the establishment of a common governance structure. The MOPH is committed to create a National Mental Health and Substance Use Department to facilitate and monitor the implementation of the Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon. This department will work with other public entities, different ministries and government sectors such as; social affairs, housing, education, and employment/labour sectors; as well as community organizations, media (radio, television, newspaper) and partners in private and civil society - to oversee the development and governance of the policy, plans, and legislation.

Strategic objectives:

1.1.1 Establish a Mental Health and Substance Use unit or department at the MOPH, with adequate staffing and sustainable financial resources
1.1.2 Develop a child and gender sensitive Mental Health and **Psychosocial Support** Emergency Response Plan
1.1.3 Develop a National Substance Use Response Strategy

1.2 FINANCING

Interventions will focus on:
- Ensuring sufficient funds to attain the strategic goals for mental and substance use disorders stated in this document.

The MOPH, with the government and all involved ministries and partners, will carefully revise the current budget, reallocate resources and seek funds for ensuring the necessary budget to implement the mental health activities listed in this strategy. A clear funding strategy for the programme will be developed. Resources can also be mobilized from international donors and from the revision of the existing mental health budget.

Strategic objectives:

1.2.1 Revise MOPH budgetary allocations for mental health expenditures
1.2.2 Integrate defined priority mental health conditions in the basic health, social and child protection packages of the government and social/ private insurance reimbursement schemes

1.3 LEGISLATION AND HUMAN RIGHTS

Interventions will focus on:
- Enacting a mental health and substance use legislative framework in line with human rights and international conventions.

The MOPH, with the government and all involved ministries and partners, will review the mental health and substance use legislation. The new legislation will be a useful and effective tool to improve the situation of persons with mental and/or substance use disorders and ensure their protection against human rights violations, as well as the promotion of autonomy, liberty, and access to health care. The legislation will also tackle regulatory elements to ensure quality of care and service development, including setting standards for mental health care providers, registration and licensing procedures.

Strategic objectives:

1.3.1 Revise all existing laws and regulations related to mental health and substance use
1.3.2 Develop needed mental health and substance use related law proposals
1.3.3 Enact the MOPH revised mental health law for protection of persons with mental disorders

1.4 MEDIA, COMMUNICATION, AND ADVOCACY

Interventions will focus on:

- Increasing awareness levels on the NMHP, mental health literacy, and stigma and discrimination.
- Working with all mental health actors including persons with mental disorders and their families to advocate for their rights and improved services.

The NMHP will be in charge of developing a mental health communication strategy that will help generate positive media coverage, change attitudes, increase awareness, generate support and encourage financial contributions. It will also disseminate information about the NMHP activities. An advocacy strategy will also be developed that aims at fighting stigma and discrimination, empowering persons with mental disorders and their families, lobbying for better financial coverage for the care and treatment of mental disorders, and protecting the rights of people with mental disorders.

Strategic objectives:

1.4.1 Develop a media and communication strategy

1.4.2 Establish an inter-sectorial collaboration mechanism between all relevant ministries and actors to mainstream mental health in other sectors

1.4.3 Facilitate the creation of independent service users and families associations

1.4.4 Develop a child and gender sensitive advocacy strategy for mental and substance use disorders related stigma and discrimination

Domain 2

Reorientation and scaling up of mental health services

Goal:
Provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

DOMAIN 2: REORIENTATION AND SCALING UP OF MENTAL HEALTH SERVICES

Goal: Provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

2.1 ORGANIZATION OF SERVICES

Interventions will focus on:

- Reorienting services towards scaling-up integrated and community based mental health services for all persons living in Lebanon that are centred and adapted to people's needs through a **recovery-oriented approach**.

These services will be organized according to the WHO optimal mix of services pyramid. This model will improve accessibility, availability, affordability and quality for persons living in Lebanon through the provision of services in the community in the least restrictive way possible. These services will include having trained multidisciplinary teams to provide supervision for PHC centres, act as referral points for specialized care for persons with mental and substance use disorders. This entails coordination between all health providers; primarily the MOPH, MOSA, Ministry of Interior and Municipalities (MOIM), NGOs, and INGOs that provide and/or support the provision of PHC services. Coordination between the PHC and the secondary and tertiary levels of care is also needed.

Strategic objectives:

2.1.1 Integrate mental health into PHC centres and **Social Development Centres (SDCs)**[9] that are part of the MOPH network
2.1.2 Develop **community-based multidisciplinary mental health teams**
2.1.3 Contract with general hospitals for beds in **inpatient psychiatric wards**
2.1.4 Monitor regularly mental health facilities to ensure protection of human, child and women's rights of persons with mental disorders using **quality and rights standards** in line with international treaties, conventions signed/ratified by the Government of Lebanon in addition to the national constitution and laws in place
2.1.5 Develop a referral system linking all levels of care, including all organizations working for the vulnerable groups[10] identified in the strategy
2.1.6 Develop eligibility criteria for persons in **long-stay psychiatric hospitals** to be reintegrated in the community, based on international guidelines and national assessments
2.1.7 Adapt and pilot an e-mental health guided self-help programme for Lebanon

2.2 HUMAN RESOURCES

Interventions will focus on:

- Ensuring the adequate human resources for the delivery of mental health services at all levels and the implementation of the strategy components.

Human resources are a key element for the success of any mental health reform as mental health and substance use service provision relies heavily on the skills, knowledge, and motivation of the persons providing them. Inter-sectorial action on mental health and substance use requires the engagement and coordination of health and non-health professionals. Specific trainings tailored to the needs of health professionals will be developed. Non-healthcare professionals will also be trained on actions they can take to improve the mental health of the people they come in contact with. They will be engaged in roles and actions to promote mental health care taking into consideration the human rights approach.

9 SDCs that are affiliated to the MOPH network are PHC centres run by MOSA.

10 We mean by vulnerable groups the groups that are at a higher risk to develop **psychological distress** or mental disorders due to their circumstances or sometimes increased stigma. This does not mean that persons in these vulnerable groups necessarily have mental disorders but we wanted to highlight the necessity of including them in the national strategy and, in some cases, cater for their specific needs.

Strategic objectives:

2.2.1 Implement a capacity building plan tailored for specialized staff **(MHPSS in-service providers)** in line with the **multidisciplinary approac**h, in compliance with the **biopsychosocial** and **recovery models**, at all levels of care, in collaboration with relevant actors

2.2.2 Develop a capacity building proposal tailored for **non-specialized health and social welfare/protection care staff** at all levels of care in collaboration with all relevant actors (syndicates, orders, scientific societies, associations, etc.)

2.2.3 Develop a capacity building proposal tailored for non-health care staff (police, legal professions, religious leaders, teachers, community leaders, etc.) in collaboration with relevant ministries and actors

2.2.4 Revise the undergraduate mental health curricula for health and social welfare professionals and the postgraduate medical programmes towards a **multidisciplinary approach** in compliance with the **biopsychosocial** and **recovery models** in collaboration with academic institutions

2.3 PROCUREMENT AND DISTRIBUTION OF ESSENTIAL MEDICINES

Interventions will focus on:

- Ensuring sustainable procurement of agreed upon psychotropic medications from the national list for persons with mental disorders not covered by any health plan.

Provision of appropriate and effective medication is essential to ensure persons with mental disorders benefit from the opportunity to live active productive lives in the community. The most cost-effective drugs with minimal side effects will be procured and distributed to all health facilities in a way that maximizes benefit to those who need them in all geographical areas, using the MOPH network and securing a low abuse rate.

Strategic objectives:

2.3.1 Update periodically the **PHC essential psychotropic medications list**
2.3.2 Ensure the uninterrupted availability of **essential psychotropic medications in PHC** centres through regular assessments of the PHC centres' needed quantities
2.3.3 Revise the **MOPH list of psychotropic medications for prescriptions by specialists**
2.3.4 Develop guidelines for the rational prescription of **psychotropic medications**
2.3.5 Revise the **restricted prescription medications list of the MOPH**

2.4 QUALITY IMPROVEMENT

Interventions will focus on:
- Continuous improvement in the quality of services provided in line with evidence-based, cost-effective and culturally appropriate interventions.

Only high quality implementation and service provision will ensure that the vision of this strategy is achieved. This means that only evidence-based interventions are provided for mental health and substance use at all service levels. It also implies that the available resources are used in a cost-effective way, and that service providers remain accountable to those who use them. Accreditation criteria for psychiatric wards, PHC centre, community services and mental health hospitals will be reviewed and updated. **Clinical and service protocols** for priority conditions (mental health Gap Action Programme) will also be developed.

Strategic objectives:

2.4.1 Develop **accreditation standards** for mental health/substance use institutions/organizations taking into consideration the special needs of children, children with disabilities and other vulnerable groups
2.4.2 Develop a **code of ethics** for mental health/substance use service providers
2.4.3 Adopt a monitoring and evaluation system to ensure quality of mental health/substance use services

Domain 3

Promotion and prevention

Goal:
Develop and implement key promotion and prevention strategies for mental health and substance use.

DOMAIN 3: PROMOTION AND PREVENTION

Goal: Develop and implement key promotion and prevention strategies for mental health and substance use.

Promotion and prevention of mental health and substance use disorders is a key component of this strategy. Effective, evidence-based prevention programmes exist and can be tailored to the Lebanese context. In addition, the negative perception of persons with mental or substance use disorders can be a huge barrier to accessing services and can lead to discrimination and violation of human rights. Action will be taken to address this perception and to raise awareness about mental and substance use disorders, as well as their effective treatment.

Strategic objectives:

3.1.1 Establish an inter-ministerial mechanism (between MOSA, Ministry of Education and Higher Education (MEHE), MOIM, MOJ and MOPH to develop and implement a national evidence-based MHPSS promotion and prevention action plan

3.1.2 Integrate evidence-based mental health promotion and prevention into national protection programming in collaboration with the MOSA (social protection, child protection, Sexual and Gender based violence, minors in the judiciary system)

3.1.3 Integrate evidence-based mental health promotion and prevention into maternal and child health programmes

3.1.4 Integrate evidence-based mental health promotion and prevention into schools

3.1.5 Implement an evidence-based framework for prevention and monitoring of suicide

Domain 4

Information, evidence and research

Goal:
Obtain evidence-based knowledge to inform mental health planning and service development through an operational Health Information System (HIS) and coordinated national research practice.

DOMAIN 4: INFORMATION, EVIDENCE AND RESEARCH

Goal: Obtain evidence-based knowledge to inform mental health planning and service development through an operational Health Information System (HIS) and coordinated national research practice.

4.1 HEALTH INFORMATION SYSTEM

Interventions will focus on:
- Using data collected through a mental health HIS to inform service planning and delivery.

The HIS (currently being transformed into an electronic HIS) will include key mental health/substance use indicators. Patient record forms will be designed or modified in facilities where data will be collected. Data collection procedures will be standardized, and data on mental health and substance use will be collected, processed and analysed from all health facilities.

Strategic objectives:

4.1.1 Integrate a core set of mental health indicators within the national HIS at all levels: outpatient (dispensaries, PHC centres, and mental health clinics) and inpatient (psychiatric hospitals and psychiatric wards)

4.2 RESEARCH

Interventions will focus on:
- Ensuring a consensus around a national mental health research agenda and coordinating its research activities.

In addition to effective information systems, a high-quality mental health system also requires on-going research to improve understanding of mental health disorders and lead to effective interventions to reduce the impact of mental disorders. A national mental health research agenda will be developed to ensure that Lebanon commissions priority research programmes and is responsive to new research. In addition, on-going research will inform the development and enhancement of tailored mental health services and health promotion and prevention initiatives.

Strategic objectives:

4.2.1 Create a national committee for mental health research to advice and support the MOPH on mental health research and knowledge dissemination in line with the national mental health framework

4.2.2 Conduct regularly assessments of the mental health system using the WHO-AIMS tool

4.3 EVALUATION OF POLICIES AND SERVICES

Interventions will focus on:

- Evaluating the progress of the current plan and informing future planning activities.

Monitoring and evaluation are key processes in determining whether the goals set in the policy and plan are being realized and allow decision makers to make short and longer term service and policy related decisions and changes. A clear Monitoring and Evaluation framework will be developed and implemented to record progress and reorient future plans.

Strategic objectives:

4.3.1 Implement a Monitoring and Evaluation framework for the strategy

Domain 5

Vulnerable groups

Goal:
Improve access to equitable evidence-based mental health services –preventive and curative– for all persons in the vulnerable groups living in Lebanon.

DOMAIN 5: VULNERABLE GROUPS

Goal: Improve access to equitable evidence-based mental health services –preventive and curative– for all persons in the vulnerable groups living in Lebanon.

Interventions will focus on:

- Ensuring that vulnerable groups[11] living in Lebanon receive comprehensive and equitable mental health services.

Coordination will be promoted with various existing actors to develop structured programmes within different ministries aimed at improving the **psychosocial wellbeing** of the different vulnerable groups.

Strategic objectives:

5.1 Persons with disabilities *[Including mental and physical disabilities, and all age categories (children, adults and older adults)]*	**5.1.1**	Integrate MHPSS into the programmes of all relevant actors who work with persons with disabilities
5.2 Children and adolescents	**5.2.1**	Develop evidence-based guidelines for MHPSS services targeting children and adolescents
5.3 Older adults	**5.3.1**	Train General Practitioners, family physicians and relevant health care workers on screening, assessing and managing older adults with mental health conditions, in line with the human resources capacity building plans in the strategy
5.4 Persons receiving palliative care	**5.4.1**	Develop an evidence-based capacity building plan for MHPSS services for providers working in palliative care
5.5 Persons in prisons	**5.5.1**	Develop a strategy for mental health and substance use in prisons and detention centres in coordination with relevant ministries and actors

11 We mean by vulnerable groups the groups that are at a higher risk to develop psychological distress or mental disorders due to their circumstances and sometimes increased stigma. This does not mean that persons in these vulnerable groups necessarily have mental disorders but we wanted to highlight the necessity of including them in the national strategy and, in some cases, cater for their specific needs. For more details, refer to section II.C.

Strategic objectives:

5.6 Survivors of torture and their families	**5.6.1**	Train mental health providers working with survivors of torture on properly and timely assessing, documenting and managing the impact of torture on the mental health of the survivors and their families
5.7 Families of disappeared from armed conflicts and wars	**5.7.1**	Train mental health specialists working with families of the disappeared on relevant evidence-informed therapy techniques
	5.7.2	Create a national memorial for missing persons in coordination with all relevant actors
5.8 Persons living with HIV/AIDS	**5.8.1**	In collaboration with NAP, train HIV specialists and health workers on common mental and substance use disorders and effect of stigma on persons living with HIV/AIDS (detection, assessment and management)
5.9 SGBV survivors	**5.9.1**	Develop evidence-based capacity building plan for MHPSS services for providers working with SGBV survivors and their partners
	5.9.2	Integrate MHPSS into the programmes of all relevant actors who work with SGBV survivors and their partners
5.10 LGBT community	**5.10.1**	Adapt international standards for best practices for mental health care for LGBT community to the cultural context
	5.10.2	Develop capacities of mental health professionals on good practices for working with LGBT community in collaboration with relevant actors
5.11 Foreign domestic workers	**5.11.1**	Conduct a situation analysis to assess access of foreign domestic workers to MHPSS services
	5.11.2	Include the coverage of mental health services in the insurance schemes of foreign domestic workers
5.12 Palestinian refugees	**5.12.1**	Establish a leadership and governance mechanism for agencies working for mental health of Palestinian refugees supported by UNRWA in line with the MOPH structure
	5.12.2	Establish a sustainable referral system between actors in the field supported by UNRWA and the MOPH
5.13 Displaced populations	**5.13.1**	Develop an annual action plan for the MHPSS task force
	5.13.2	Monitor regularly the activities under the MHPSS task force action plan

Targets for successful achievement of strategic objectives

1.1.3	A National Substance Use Strategy is developed and launched
2.3.2	Quarterly assessments of the PHC centres' needed quantity of psychotropic medications are conducted through inspection visits and a systematic feedback mechanism from the centres
4.2.2	An assessment of the mental health system is conducted using the WHO-AIMS tool and repeated every five years
4.3.1	A Monitoring and Evaluation framework for the strategy is developed and implemented
5.13.1	An annual action plan for the MHPSS TF is developed
5.13.2	The MHPSS TF log-frame is updated every six months

2016

1.1.2 A child and gender sensitive MHPSS Emergency Response Plan is developed

1.2.1 A report of MOPH budgetary allocations revision with proposed recommendations is submitted

1.4.1 A media and communication strategy is developed

1.4.2 An inter-sectorial collaboration mechanism between all relevant actors and ministries is established to mainstream mental health in other sectors

1.4.3 An MOPH action plan for facilitation of the creation of independent service users and families associations is developed and implemented in coordination and through engagement of other key ministries

1.4.4 A child and gender sensitive advocacy strategy for mental and substance use disorders related stigma and discrimination is developed

2.1.3 At least two general hospitals that have **inpatient psychiatric** units are contracted by the MOPH

2.1.5 A referral system linking all levels of care, including all organizations working for the vulnerable groups identified in the strategy, is established and activated

2.3.3 The **MOPH list of psychotropic medications for prescriptions by specialists** is revised

2.3.5 The **restricted prescription medications list of the MOPH** is revised

2.4.2 A **code of ethics** for mental health/substance use service providers is developed

3.1.1 An inter-ministerial coordination mechanism (between MOSA, MEHE, MOIM, MOJ and MOPH) is in place to develop and implement a national evidence-based MHPSS promotion and prevention action plan

3.1.1 A national evidence-based, child and gender sensitive MHPSS promotion and prevention action plan is in place

4.2.1 A national committee for mental health research is created to inform the MOPH about service development research needs

4.2.1 A national mental health research agenda is adopted

5.1.1 MHPSS are integrated into the programmes of all relevant actors who work with persons with disabilities

5.5.1 A strategy for mental health and substance use in prisons and detention centres is developed in coordination with relevant ministries and actors

2017

1.1.1 A functional mental health and substance use unit or a department is established at the MOPH

1.3.1 All existing laws and regulations related to mental health and substance use are revised taking into account the cross-sectorial nature of MHPSS

1.3.3 The MOPH revised mental health law is passed and an implementation framework for the legislation is established and activated

2.1.4 A report of the WHO quality right toolkit for monitoring mental health facilities to ensure protection of human rights of persons with mental disorders is published every two years

2.2.1 A capacity building plan tailored for specialized staff is implemented

2.3.1 The **PHC essential psychotropic medications list** is updated and the update is repeated at least every three years

2.4.1 **Accreditation standards** for mental health/substance use institutions/organizations are developed taking into consideration needs of children, children with disabilities and other vulnerable groups

3.1.2 Evidence-based mental health promotion and prevention are integrated into national protection programming in collaboration with the MOSA

3.1.4 Evidence-based mental health promotion and prevention are integrated into schools

5.4.1 An evidence-based capacity building plan for MHPSS services for providers working in palliative care is developed

5.11.1 A situation analysis to assess access of foreign domestic workers to MHPSS services is conducted

2018

1.2.2	Defined priority mental health conditions are integrated in the basic health, social and child protection delivery packages of the government and social/private insurance reimbursement schemes
1.3.2	Needed mental health and substance use related law proposals are developed; these laws and their respective implementation decrees are child and gender sensitive
2.2.2	A capacity building proposal tailored for **non-specialized health and social welfare/protection staff** at all levels of care is developed
2.2.3	A capacity building proposal tailored for non-health care staff (police, legal professions, religious leaders, teachers, community leaders, etc.) is developed
2.3.4	Guidelines for the national prescription of psychotropic medications are developed
2.4.3	A monitoring and evaluation system to ensure quality of mental health/substance use services is adopted
3.1.3	Evidence-based mental health promotion and prevention are integrated into maternal and child health programmes
5.9.1	An evidence-based capacity-building plan for MHPSS services is developed for providers working with SGBV survivors and their partners
5.11.2	Coverage of mental health services is included in the insurance schemes of foreign domestic workers

2.1.7	An e-mental health guided self-help programme for Lebanon is adapted and piloted
3.1.5	An evidence-based framework for prevention and monitoring of suicide is developed and implemented
5.7.1	Mental health specialists working with families of the disappeared are trained on relevant evidence-informed therapy techniques
5.10.2	A capacity building plan on good practices for working with LGBT community for mental health professionals is developed in collaboration with relevant actors
5.12.1	Mental health is integrated into **primary health care** in all UNRWA clinics
5.12.1	UNRWA has an MHPSS strategy in line with the national strategy
5.12.1	UNRWA has a well-established MHPSS coordination mechanism in line with the national mental health strategy
5.12.2	A sustainable referral system between actors working with Palestinian Refugees is well established under the leadership of UNRWA and the support of MOPH

2.1.1	All PHC centres that are part of the MOPH network are trained and supervised on mhGAP-IG and other relevant trainings
2.1.1	All PHC centres that are part of the MOPH network have regular supply of psychotropic medicines
2.1.1	All MOSA **SDCs** that are part of the MOPH network are trained and supervised on mhGAP-IG and other relevant trainings
2.1.2	A multidisciplinary team that will be providing supervision for PHC centres and SDCs, acting as a referral point and providing care for persons with mental disorders is formed and assigned to three of the remote districts
2.1.6	Assessment of the eligibility of persons in **long-stay psychiatric hospitals** to be reintegrated in the community is conducted
2.1.6	Eligibility criteria for reintegration in the community of persons in **long-stay psychiatric hospitals** are established
2.2.4	The undergraduate mental health curricula for health and social welfare professionals and the postgraduate medical programmes are revised towards a **multidisciplinary approach** in compliance with the biopsychosocial and recovery models in collaboration with academic institutions
4.1.1	A core set of mental health indicators is integrated within the national health information system at all levels: outpatient (dispensaries, PHC centres and mental health clinics) and inpatient (psychiatric hospitals and psychiatric wards)
5.2.1	Evidence-based guidelines for MHPSS services targeting children and adolescents are disseminated to the relevant actors
5.3.1	General Practitioners, family physicians and relevant health care workers are trained on screening, assessing and managing older adults with mental health conditions, in line with the human resources capacity building plans in the strategy
5.6.1	Mental health providers working with survivors of torture are trained on properly and timely assessing, documenting and managing the impact of torture on the mental health of survivors and their families
5.7.2	A national memorial for missing persons is created
5.8.1	In collaboration with NAP, HIV specialists and health workers are trained on common mental health conditions/substance use and the effect of stigma on persons living with HIV/AIDS (detection, assessment and management)
5.9.2	MHPSS is integrated into the programmes of all relevant actors who work with SGBV survivors and their partners
5.10.1	Culturally-adapted standards for mental health care for the LGBT community are disseminated to the relevant actors

GLOSSARY OF TERMS

1. **Accreditation standards:** A set of guidelines and principles predetermined by a professional accrediting agency to which organizations must abide by to demonstrate credibility and dedication to ongoing compliance with the highest levels of quality.

2. **Anti-retroviral treatment:** Antiretroviral therapy (ART) is treatment of people infected with human immunodeficiency virus (HIV) using anti-HIV drugs. The standard treatment consists of a combination of at least three drugs (often called "highly active antiretroviral therapy" or HAART) that suppress HIV replication. Three drugs are used in order to reduce the likelihood of the virus developing resistance. ART has the potential both to reduce mortality and morbidity rates among HIV-infected people, and to improve their quality of life.

3. **Anxiolytics and sedatives:** A class of medication that decrease anxiety and nervousness and that can be prescribed by doctors for short periods of time. Some of these medications have the potential of creating an addiction if not taken in accordance with the doctor's prescription.

4. **Biopsychosocial model:** A model which recognizes the interaction of various biological, psychological and social factors in the development of mental health and substance use disorders and stipulates designing interventions addressing all three aspects.

5. **Buprenorphine:** Buprenorphine is a synthetic opioid that is being increasingly used for substitution therapy of opioid dependence.

6. **Clinical and service protocols:** Clinical and service protocols provide a locally agreed standard to which clinicians and organizations can work and against which they can be audited. Protocols allows health care providers to offer appropriate diagnostic treatment and care services to patients, variance reports to purchasers and quality training to clinical staff.

7. **Code of ethics:** A guide of principles and standards of conduct which are based on values and which define the essentials of honorable behavior to which practitioners of a profession are expected to conform to.

8. **Community-based (approach):** A multidisciplinary approach promoting service delivery at community level (i.e. close to where persons are living) in the least restrictive manner, ensuring the maintained inclusion of persons in their community.

9. **Community-based multidisciplinary mental health teams:** These teams provide a multidisciplinary secondary care service for people with mental health problems. The service is provided by health and social care workers offering treatment, care, information, advice and support for service users and their care givers.

10. **DALYS:** "Disability adjusted life years" (DALYs), is a way of quantifying the health gap between current and ideal health status. DALYs are a representation of the total number of years lost to illness, disability, or premature death within a given population. DALYs are calculated by adding the number of years of life lost (YLLs) to the number of years lived with disability (YLDs) for a certain disease or disorder.

11. **Detoxification:** Medically managing the symptoms resulting from suddenly stopping the regular use of alcohol and other addictive substances.

12. **Drop-in centre:** A place where people with substance use disorders may call or pass by for advice or assistance.

13. **Harm reduction:** The application of a set of public health principles aimed at preventing or reducing the negative consequences associated with drug use.

14. **In-patient care:** In-patient care refers to care for a patient who is formally admitted (or hospitalised) to an institution for treatment and/or care and who stays for a minimum of one night in the hospital or other institution providing in-patient care.

15. **Inpatient psychiatric wards:** Refers to a unit or a facility that delivers or supports stay-in care for the management and treatment of mental disorders.

16. **Life skills education:** A prevention intervention targeting children and youth through building their skills in areas such as problem-solving, conflict resolution, setting goals and communication to enable them to deal more effectively with the demands and challenges of everyday life, and to prevent psychological distress, mental disorders and risky behaviors such as substance use.

17. **Long-stay psychiatric hospitals:** Defined as a specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders; usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialization varies considerably: in some cases only long-stay custodial services are offered, in others specialized and short-term services are also available (rehabilitation services, specialist units for children and elderly, etc.)

18. **MHPSS in-service providers:** Mental Health and Psychosocial Support professionals actively engaged in the profession.

19. **MOPH list of psychotropic medications for prescriptions by specialists:** The list of psychotropic and neurological medications recommended by the Ministry of Public Health-National Mental Health Programme to be prescribed in the humanitarian setting especially at the specialized healthcare level and in the emergency rooms of private and public hospitals (MoPH). Lists are published on: *http://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program*

20. **Multidisciplinary approach:** An approach involving multiple disciplines or professional specializations with the aim of ensuring a holistic perspective on defining a problem and addressing it effectively.

21. **Non-specialized health and social welfare/protection care staff:** Non-specialized health care providers can include primary health care professionals like social workers, nurses and occupational therapists who might be involved in care of persons with mental disorders.

22. **Opioid:** A class of medication prescribed by physicians in order to relieve pain. This class of medication can be addictive if not taken as prescribed.

23. **Opioid Substitution Therapy:** A therapy which involves replacing an illegal opioid, with a prescribed medicine such as methadone or buprenorphine to be taken under medical supervision within the framework of a multidisciplinary.

24. **Out-of-pocket expenditure:** Share of financial expenditure on health paid by the patient or their family out of pocket.

25. **Peer-to-peer education programmes:** A form of skill-building whereby persons are trained to provide promotion and prevention activities to persons of the same age group, social group or who might share similar life experiences.

26. **PHC essential psychotropic medications list:** An essential revised drug list exists in the Lebanon. It includes at least one psychotropic medicine in the following categories:
    1. Antidepressants
    2. Antiepileptic drugs
    3. Antipsychotics

27. **Primary health care:** The essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination (Alma Ata definition).

28. **Psychoanalysis:** Psychoanalysis is a specialty in psychology that is distinguished from other specialties by its body of knowledge and its intensive treatment approaches. It aims at structural changes and modifications of a person's personality. Psychoanalysis promotes awareness of unconscious, maladaptive and habitually recurrent patterns of emotion and behavior, allowing previously unconscious aspects of the self to become integrated and promoting optimal functioning, healing and creative expression.

29. **Psychological distress:** Psychological distress is largely defined as a state of emotional suffering characterized by symptoms of depression (e.g., lost interest; sadness; hopelessness) and anxiety (e.g., restlessness; feeling tense). It can interfere with wellbeing and functioning.

30. **Psychosocial interventions:** Structured psychological or social interventions that can be used to address substance-related problems, among others. They can be used at different stages from prevention to treatment and social re-integration.

31. **Psychosocial support (Interventions/programs):** Interventions/ Programs which rely on a scale of care and support which influences both the individual and the social environment in which people live in. It ranges from care and support offered by caregivers, family members friends and community members on a daily basis but also extends to care and support offered by specialized psychological and social services.

32. **Psychosocial wellbeing:** It refers to a state of balance between the self, others and the environment, including the effective functioning of individuals and communities. Overall, mental health and psychosocial wellbeing encompasses various areas including emotion, behavior, thought, memory, physical aspects, learning capacity and ability to function.

33. **Psychotherapy:** Psychotherapy is a collaborative treatment based on the relationship between an individual and a psychologist. I/NGOs and governmental entities providing or supporting psychotherapy services have psychologists that apply evidence based procedures (CBT, IPT, psychodynamic therapy, schema-focused therapy etc.) to identify and change maladaptive thoughts and behaviour patterns, help people develop healthier and more effective habits, overcome mental health disorders etc. Examples of cases where people seek psychotherapy include anxiety, depression, self-harm/suicide, behavioural disorders, developmental disorders, psychosis, substance abuse and so forth.

34. **Psychotropic medications:** Psychotropic medications can be used as part of the treatment of mental disorders. Psychotropic medications comprise several categories such as anti-psychotics, anti-depressants, mood stabilizers and anti-epileptic medications.

35. **Quality and rights standards:** Standards to assess and improve quality and human rights in mental health and social care facilities aiming to give countries information on quality and human rights standards in facilities that must be respected, protected and fulfilled.

36. **Recovery model:** This model emphasizes the necessity of empowering people to take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.

37. **Recovery-oriented approach:** Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognize and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.

38. **Rehabilitation:** It is the processes of medical and psychosocial treatments aiming to support the person with substance use disorders to recover.

39. **Restricted medication list:** A list of medication with addictive potential that includes strict guidelines for their prescription and dispensing. This list is developed and regularly updated by the Ministry of Public Health of Lebanon.

40. **Social development centres:** The Social Development Centers (SDCs), according to Decree No. 5734 dated 09.29.1994 (organization of the Ministry of Social Affairs , identification of its staff and terms of appointment of some of its functions), are social projects emanating from the Ministry of Social Affairs, directly related to the department of development services. The provision of activities in the SDCs is coordinated with the various departments in the ministry. SDCs are considered to be the core for the identification, design and implementation of projects aiming at initiating and promoting social development in Lebanon at various levels.

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