WHO-AIMS

WHO-AIMS Report on Mental Health System in Lebanon

World Health Organization
Regional Office for the Eastern Mediterranean

Republic of Lebanon
Ministry of Public Health

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM

IN LEBANON

A report of the assessment of the mental health system in Lebanon using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

(Beirut, Lebanon)

2015

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

(WHO, Country Office for Lebanon)
(WHO, Regional Office for the Eastern Mediterranean)
WHO Department of Mental Health and Substance Abuse (MSD)

This publication has been produced by the WHO, Lebanon in collaboration with WHO, Regional Office for the Eastern Mediterranean (EMRO) and WHO, Headquarters. At WHO Headquarters this work has been supported by the Evidence and Research Team of the Department of Mental Health and Substance Abuse, Cluster of Non-communicable Diseases and Mental Health.

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(ISBN)

Suggested citation: WHO-AIMS Report on Mental Health System in Lebanon, WHO and Ministry of Health, Beirut, Lebanon, 2015.

Acknowledgement

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system of Lebanon.

This project was completed with the support of Dr Walid Ammar, Director General of the Ministry of Public Health (MOPH) in Lebanon. It was implemented by the National Mental Health Programme (NMHP) within the MOPH, headed by Dr Rabih El Chammay. It was coordinated and technically supported by Dr Wissam Kheir, MOPH mental health technical coordinator and reviewed by Dr Ghada Abou Mrad, MOPH monitoring and evaluation coordinator.

The project was supported by WHO Lebanon Country Office team: Dr Gabriele Riedner, Dr Alissar Rady, and Ms Edwina Zoghbi.

The project was also supported by the WHO Regional Office team: Dr Khalid Saeed.

The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.
http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

The project received financial assistance and/or seconded personnel from: The National Institute of Mental Health (NIMH) (under the National Institutes of Health) and the Center for Mental Health Services (under the Substance Abuse and Mental Health Services Administration [SAMHSA]) of the United States; The Health Authority of Regione Lombardia, Italy; The Ministry of Public Health of Belgium and The Institute of Neurosciences Mental Health and Addiction, Canadian Institutes of Health Research.

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Acronyms

CAS	Central Administration of Statistics
GDP	Gross Domestic Product
GP	General Practitioner
mhGAP	mental health Gap Action Programme
MOPH	Ministry of Public Health
NGO	Non-Governmental Organization
NMHP	National Mental Health Programme
NSSF	National Social Security Fund
PHC	Primary Health Care
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestine
WHO	World Health Organization
WHO-AIMS	World Health Organization Assessment Instrument for Mental health Systems

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Executive summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Lebanon.

The last mental health legislation ACT #72, enacted in 1983, is currently under revision to address some main issues such as the access to the least restrictive care (community-based mental health care). Until recently, there was no mental health strategy in place. Following the establishment of the National Mental Health Programme in 2014, which is the main authority for mental health within the Ministry of Public Health, a five-year strategy was developed and addresses the organization of services (domain 2), human resources (domain 2), involvement of users and families (domain 2), advocacy and promotion (domain 3), human rights protection of users, equity of access to mental health services across different groups (domains 2 and 5), financing (domain 1), quality improvement, and monitoring (domain 4).

The standards of mental health services may be evaluated through several means, including human rights monitoring. In Lebanon, there is no authority to oversee the human rights of individuals with mental conditions and inspect mental health facilities. There are no external review/inspection of human rights protection of patients in community-based psychiatric units and mental hospitals.

There are 42 mental health outpatient facilities in Lebanon, which provide services to an estimated 75 users per 100,000 population. There are 28.52 beds per 100,000 population in Lebanon's five mental hospitals, which serve 47.41 patients per 100,000 population and have an occupancy rate of 97%. There are eight community-based psychiatric inpatient units available with a total of 1.5 beds per 100,000 population. The most commonly assigned diagnosis in mental hospitals is schizophrenia, while in outpatient facilities and psychiatric inpatient units it is mood disorders.

There is a lack of mental health training for primary health care workers and interactions between the primary care and mental health system are rare.

The total number of human resources working in public mental health facilities, NGOs, and private practice is 15.27 per 100,000 population. There are an estimated 1.26 psychiatrists, 0.87 other medical doctors (not specialized in psychiatry), 3.26 nurses, 3.42 psychologists, 1.38 social workers, and 1.06 occupational therapists, working in mental health per 100,000 population.

Introduction

Lebanon is situated at the Eastern end of the Mediterranean Sea with a geographical area of 10,452 km^2. It is bounded by the Syrian Arab Republic in both the north and east and by the occupied Palestinian territory in the south. It spans 80 km at its widest point and extends 217 km from north to south.

The climate in the country has a Mediterranean aspect varying across the landform belts. The mean temperature in Beirut is 27°C in summer and 14°C in winter with 900 mm of annual rainfall. Two mountain ranges run parallel to each other down the length of the country: the Mount Lebanon and the Anti-Lebanon. Between the two ranges lies the fertile plain of the Bekaa Valley, through which the Orontes (Assi) and Litani rivers flow.

Administratively, the country is divided into eight provinces or Mouhafaza; Beirut, Mount Lebanon, North/Tripoli, Halba, Bekaa, Baalbek/Hermel, South, and Nabatieh. Excluding Beirut, the provinces are further divided into 25 districts or Qazas, which are made up of several cadastral zones.

The country encompasses a large mix of cultural, nationality, and religious groups. The official language is Arabic and other main languages used in the country are French, English, and Armenian.

The total estimated population of Lebanon is around 5,643,634 (including Palestinians living in camps and displaced Syrians). The latest population census dates back to 1932. Therefore the calculation of the estimated population count is based on the living household survey 2007, accounting for death and birth as reported to MOPH[1], and adding Palestinians living in camps[2] and displaced Syrians[3]. It is important to note that the total resident population increased by more than 30% following the Syrian crisis, positioning Lebanon as the host of the highest number per capita of displaced Syrians[4]. This demographic change has impacted heavily on the country's economy, infrastructure, health care system, employment, environmental health, and basic services.

Lebanon is an upper-middle income country based on the World Bank 2014 criteria. Around 25% of the population is under 15 years of age and 9.6% are over the age of 60[5]. The life expectancy of women and men is 82 and 80 years, respectively[6]. More than 85% of the population lives in urban areas mostly concentrated in Beirut and Mount Lebanon[7].

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[1] Central Administration of Statistics (CAS). The national survey of households living conditions. 2007. (http://www.cas.gov.lb/index.php/all-publications-en#households-living-conditions-survey-2007, accessed 2 May 2015).
[2] UNRWA. Lebanon. 2015. (http://www.unrwa.org/where-we-work/lebanon, accessed 5 June 2015).
[3] UNHCR. Registered Syrian Refugees. 2015. (http://data.unhcr.org/syrianrefugees/country.php?id=122, accessed 6 July 2015).
[4] World Health Organization. Country Cooperation Strategy at a glance- Lebanon. 2014. (http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_lbn_en.pdf, accessed 6 June 2015).
[5] CAS. The national survey of households living conditions. 2007; UNRWA. Lebanon. 2015; UNHCR. Registered Syrian Refugees. 2015
[6] MOPH statistical bulletin. 2013 (www.moph.gov.lb)
[7] CAS. The national survey of households living conditions. 2007.

The Gross Domestic Product (GDP) growth has slowed considerably in the past few years. The total health expenditure share from GDP is estimated at 7.2%[8]. The out-of-pocket expenditure is estimated at 38% (2012)[9], down from 60% in 1998, and is still considered high. Table 1 summarizes main features for Lebanon.

Table 1 | Lebanon country profile

Features	Lebanon
Area	10452 Km^2
Population	5,643,634*
Poverty (% of Total population)	28.6%**
Population Growth (2012)	1.7**
Per Capita Spending on Health (USD) (2012)	751**
Infant Mortality Rate per 1000 Live Births (2009)	9**
Maternal Mortality Rate per 10000 live Births (2012)	18**
Life Expectancy at birth (years) (2012)	80***

**Syrians displaced according to UNHCR: 1,172,753; Palestinian refugees living in camps: 238,500; Lebanese Population: 4,232,381.*
*** MOPH statistical bulletin, 2012 (www.moph.gov.lb)*
**** WHO, Lebanon: WHO statistical profile, retrieved from http://www.who.int/gho/countries/lbn.pdf?ua=1 (8/2015)*

In terms of health coverage, around 52% of the population[1], excluding displaced Syrians and Palestinians living in camps (covered by UNHCR and UNRWA, respectively), are covered by different types of insurance schemes. As for the uncovered section of the population, which make up around 48% of the total population, the MOPH covers hospital stays and expensive medications through the programme of catastrophic illnesses. In terms of mental health coverage, the majority of private insurances do not cover any mental health care. All other schemes[10] cover psychiatric consultations, psychotropic medications, and in-patient care with inconsistencies in the comprehensiveness and the extent of coverage level across different financing schemes.

The main objective of this assessment tool is to collect the necessary data to describe and measure the available resources and the utilization of mental health services in order to determine a baseline to monitor changes and inform policies and plans for a comprehensive mental health system in Lebanon.

Methodology

The WHO-AIMS (version 2.2) is the tool used for this assessment. It comprises six domains that are interdependent, conceptually interlinked, and somewhat overlapping, each with several sections and each section with a variable number of items (covering the 10 *World Health Report 2001* recommendations through 28 facets and 156 items) (Appendix 1). All six domains need to be assessed to form a relatively complete picture of a mental health system.

[8] MOPH National Health Accounts, 2012 (www.moph.gov.lb)
[9] Idem
[10] Namely, National Social Security Fund (NSSF), Army and the Internal Security Forces, and Public Servants Cooperation.

Questionnaires were developed in English based on the WHO-AIMS version 2.2 with some specific questions added to collect information relevant to the Lebanese context (Appendix 2). All questionnaires included operational definitions to facilitate the understanding of the questions and the type of information being requested. The entities to which questionnaires were to be sent, were identified based on WHO-AIMS definitions.

The assessment took place between February 2015 and July 2015, and data retrieved is based on the year 2014 and collected from facility, district/regional, and national levels (Table 2). Questionnaires were sent to the various health facilities, institutions, organizations, universities, and ministries, by email, fax, and in person, along with a cover letter. Contact by phone, email, or through meetings was done to provide administrative follow up and technical support for the comprehension and completion of the questionnaires, and to validate the information provided. Entities were contacted more than once before considering them as not responding. All information obtained was entered and analysed using the "WHO-AIMS 2.2 Excel Data Entry Programme".

Table 2 | Levels of data collection

	Data collection at		
Establishments	**Facility level**	**District/regional level**	**National level**
Mental hospitals	4 (80%)	0 (0%)	1 (20%)
Community-based psychiatric inpatient units	7 (88%)	0 (0%)	1 (12%)
Mental health outpatient facilities	25 (60%)	0 (0%)	12 (29%)
Community residential facilities	6 (86%)	0 (0%)	0 (0%)
Mental health day treatment facilities	5 (60%)	0 (0%)	0 (0%)
Universities	10 (65%)	5 (35%)	0 (0%)

Table 3 summarizes the different types of establishments to which the survey was sent along with their respective response rates.

Table 3 | Number of surveys sent and response rates

Establishments	**Number of surveys sent**	**Response rate**
Mental hospitals	5	80%
Community-based psychiatric inpatient units	7	100%
Mental health outpatient facilities	42	60%
Community residential facilities	7	86%
Mental health day treatment facilities	5	60%
Ministries	5	80%
Non-Governmental Organizations	36	53%
Universities	15	100%
Overall response rate		**69%**

As can be seen in table 3, the overall response rate is 69%, mainly due to the relatively low response rates of NGOs, mental health day treatment facilities, and mental health outpatient facilities.

DOMAIN 1: POLICY AND LEGISLATIVE FRAMEWORK

Policy, plans, and legislation

A National Mental Health Programme was established in the MOPH in May 2014 with the objective of advancing mental health care in Lebanon and the vision that all people living in Lebanon will have the opportunity to enjoy the best possible mental health and wellbeing. The mental health and substance use –prevention, promotion, and treatment- strategy was launched in May 2015. 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 strategy encompasses 5 domains:

1. Domain 1: Leadership and governance
2. Domain 2: Reorientation and scaling up of mental health services
3. Domain 3: Promotion and prevention
4. Domain 4: Information, evidence and research
5. Domain 5: Vulnerable groups

Through the aforementioned domains, the strategy addresses the WHO-AIMS policy components, namely the organization of services (domain 2), human resources (domain 2), involvement of users and families (domain 2), advocacy and promotion (domain 3), human rights protection of users, equity of access to mental health services across different groups (domains 2 and 5), financing (domain 1), quality improvement, and monitoring (domain 4).

An essential drug list exists in the country and was revised in 2014; it includes at least one psychotropic medicine in the following categories:

1. Antipsychotics
2. Antidepressants
3. Mood stabilizers
4. Antiepileptic drugs

Anxiolytics are not included in the essential drug list, however they are widely available in the country.

There is no emergency/disaster preparedness plan for mental health.

The last mental health legislation ACT #72 was enacted in Sept/9/1983 and had the following components:

- Rights of mental health service consumers, family members, and other care givers.
- Competency, capacity, and guardianship issues for people with mental illness.
- Voluntary and involuntary treatment.
- Accreditation of professionals and facilities.
- Law enforcement and other judicial system issues for people with mental illness.
- Mechanisms to oversee involuntary admission and treatment practices.
- Mechanisms to implement the provisions of mental health legislation.

The law specifies the creation of a mental health body in charge of overseeing and implementing mental health policies in Lebanon, and monitoring mental health services and treatment practices in health facilities. Procedures and standardized documentation exist in some components of the mental health legislation.

This law is currently under revision to address some main issues such as the access to the least restrictive care (community-based mental health care), the standards and regulations for involuntary admissions, and the working modalities of the mental health body. In addition, the revised law addresses accrediting mental health facilities. 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.

Financing of mental health services

The budget discussed hereunder is retrieved from the MOPH National Health Account and the financial expenditure for mental health was accessed through the MOPH information system. It was not possible to access data related to mental health expenditures from other governmental entities such as the Ministries of Social Affairs, Interior and Municipalities, and Defence hence the decision not to account for their general health budget. The assumption is that if we have included all the budgets of other entities spent on health the percentage spent on mental health would be much less than the one in this report.

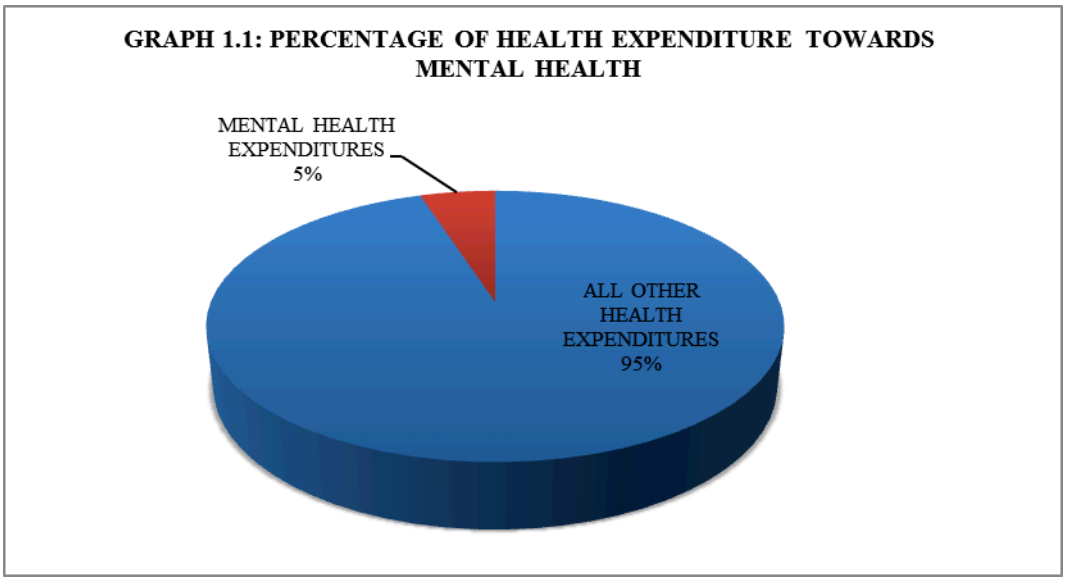
There is no specific/defined budget for mental health in the country. The mental health budget is incorporated within the MOPH budget, which does not dedicate a specific fixed amount for mental health services. It is estimated that 5% of the MOPH health care expenditures are directed towards mental health (Graph 1.1). Of all the expenditures spent on mental health, 54% are directed towards mental hospitals (Graph 1.2).

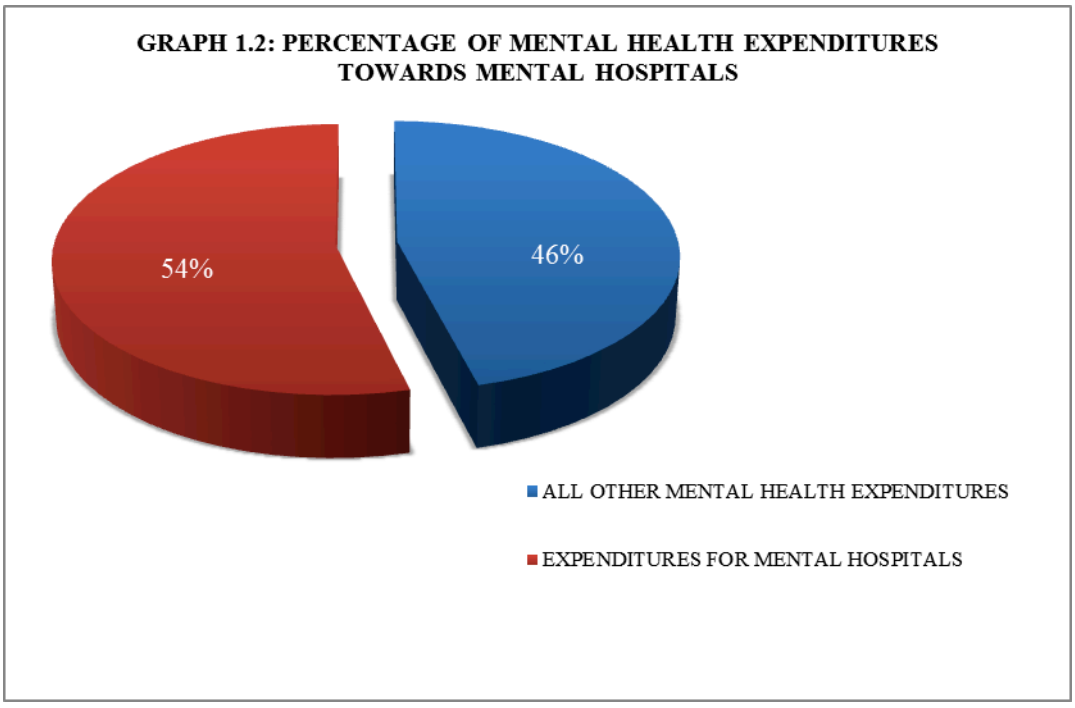
In terms of affordability of mental health services, 78% of the population[11] has free access to essential psychotropic medicines. For those who have to pay for their medicines out of pocket, the cost of antipsychotic and antidepressant medication is 0.13 dollars per day. One percent of the daily minimum wage is needed to pay for one day of antipsychotic medication by a user without any reimbursement, using the cheapest available drug, compared to two percent for antidepressant medication. All mental disorders are covered by social insurance schemes[12], however psychotherapeutic interventions are not covered.

It is to note that the situation is different for Palestinian refugees and displaced Syrians as they have separate budgets through UNRWA and UNHCR, respectively.

[11] This number accounts for: (1) all populations covered by health coverage schemes (except private insurances); (2) the most vulnerable uncovered Lebanese populations (which make up around 30% and are covered through the MOPH PHC network); and (3) the Palestinian refugees and displaced Syrians.

[12] Such as in the National Social Security Fund law, article #13





Human rights policies

Human rights organizations exist in Lebanon. However, there is currently no national - or regional - human rights review body in place. Although the aforementioned mental health decree law and its proposed revision specify the creation of a mental health body which has the authority to oversee the human rights of individuals with mental conditions, inspect mental health facilities, review involuntary admissions and discharge procedures, review complaints investigation processes, and impose sanctions on the facilities that

violate patients' rights, this body is not yet established and the modalities of its implementation and work are not yet in place.
There are no external review/inspection of human rights protection of patients in community-based psychiatric units and mental hospitals.
In terms of training, 40% of mental hospitals staff and 75% of inpatient psychiatric units staff have had at least one day training, meeting, or other type of working session on human rights in 2014.

DOMAIN 2: MENTAL HEALTH SERVICES

Organization of mental health services

The National Mental Health Programme in the MOPH is the main authority for mental health, involved in service planning as well as service management and coordination. Currently, the work towards the reorganization of services as per the WHO pyramid of optimal mix of services has been initiated. In addition, the mental health accreditation system has been reviewed and updated for community-based psychiatric inpatient units and is under review for mental hospitals and primary health care (PHC) centres. Mental health services are not organized per catchment area; however, the integration of mental health into primary care has been initiated, through the training of non-specialized staff in PHC centres on the detection, management and referral of mental health cases, in preparation for reorganization of mental health services per catchment area.

Mental health outpatient facilities[13]

There are 42 outpatient mental health facilities available in Lebanon, of which 10 (24%) are only for children and adolescents. In 2014, these facilities treated 4223 users (75 users per 100,000 population). Females and children and adolescents (17 years of age or younger) make up 58% and 34%, respectively, of all users treated in mental health outpatient facilities. Mood [affective] disorders (F30-F39)[14] make up 57% of primary diagnoses, followed by schizophrenia, schizotypal and delusional disorders (F20-F29) (29%) and neurotic, stress-related and somatoform disorders (F40F48) (5%). A further 7% were classed as having "other" diagnoses such as epilepsy or organic mental disorders and 1% of users treated had diagnosis of disorders of adult personality. In 2014, the average number of outpatient contacts[15] per user is 5.05. Twenty one percent of outpatient facilities provide routine follow-up care in the community; 3 facilities have mobile mental health teams.
In terms of available interventions, few users (between 1 and 20%) received one or more psychosocial interventions in mental health outpatient facilities in 2014. All mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-

[13] Defined as a facility that focuses on the management of mental disorders and the clinical and social problems related to it on an outpatient basis; ***includes:*** community mental health centres; mental health ambulatories; outpatient services for specific mental disorders or for specialized treatments; mental health outpatient departments in general hospitals; mental health policlinics; specialized NGO clinics that have mental health staff and provide mental health outpatient care; ***excludes:*** private practice; facilities that treat only people with alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis.
[14] Based on International Classification of Diseases (10th edition).
[15] Defined as an interaction involving a user and a staff member on outpatient basis.

psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or in a near-by pharmacy all year round.

Day treatment facilities[16]

There are 5 day-treatment facilities in Lebanon, of which 4 (80%) treat children and adolescents only. In 2014 these facilities treated 105 users (1.86 users per 100,000 population). Of all users treated, 41% are females and 85% are children or adolescents. Data from 3 out of 5 facilities shows that the average duration spent by users in these facilities is 57 days.

Community-based psychiatric inpatient units[17]

There are 8 community-based psychiatric inpatient units available in the country for a total of 85 beds (1.5 beds per 100,000 population). Forty eight percent of admissions to community-based psychiatric inpatient units are females and 7% are children or adolescents. Of all beds, none are reserved for children and adolescents exclusively, however, 92% can accommodate children and adolescents.

The diagnoses of admissions to community-based psychiatric inpatient units were primarily from the following diagnostic groups: mood [affective] disorders (F30-F39) (34%), neurotic, stress-related and somatoform disorders (F40F48) (25%), schizophrenia, schizotypal and delusional disorders (F20-F29) (21%), and mental and behavioural disorders due to psychoactive substance use (F10-F19) (14%). A further 4% were classed as having disorders of adult personality.

On average patients spend 7.33 days in community-based psychiatric inpatient units per discharge. Twelve percent of all admissions are involuntary.

Records of physical restraint and seclusion (confinement or isolation) indicate that approximately 6-10% of users were physically restrained or secluded in community-based psychiatric inpatient units in 2014.

A few users (1-20%) in community-based psychiatric inpatient units received one or more psychosocial interventions in 2014. All community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic,

[16] Defined as a facility that typically provides care for users during the day; the facilities are generally: (1) available to groups of users at the same time (rather than delivering services to individuals one at a time), (2) expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on users coming for appointments with staff and then leaving immediately after the appointment) and (3) involve attendances that last half or one full day.

- ***Includes:*** day centres; day care centres; sheltered workshops; club houses; drop-in centres; employment/rehabilitation workshops; social firms.
- ***Excludes:*** Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind; day treatment facilities for inpatients are excluded.

[17] Defined as a psychiatric unit that provides inpatient care for the management of mental disorders within a *community-based facility*; these units are usually located within general hospitals, they provide care to *users* with acute problems, and the period of stay is usually short (weeks to months).

- ***Includes:*** Both public and private non-profit and for-profit facilities; *community-based psychiatric inpatient units* for children and adolescents only; *community-based psychiatric inpatient units* for other specific groups (e.g. elderly).
- ***Excludes****: Mental hospitals*; *community residential facilities*; facilities that treat only people with alcohol and substance abuse disorder or mental retardation.

antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility all year long.

Community residential facilities[18]

The country counts 7 community residential facilities. The total number of beds is 95 (1.68 beds per 100,000 population) of which 16% are reserved solely for children and adolescents.
The number of users treated in community residential services in 2014 was 128 (2.26 per 100,000 population) with 32% of users being females and 12% children or adolescents. The average number of days spent in community residential services in 2014 was 206.71 days.

Mental hospitals[19]

There are 5 mental hospitals available in the country for a total of 1610 beds (28.52 beds per 100,000 population). The number of beds has increased by 1% in the last five years. Four percent of beds in mental hospitals are reserved for children and adolescents only. These facilities treated 2676 users (47.41 users per 100,000 population). Of all users treated in mental hospitals, 34% are females and 2% are 17 years or younger.
The diagnoses of admissions to mental hospitals were primarily from the following three diagnostic categories: schizophrenia, schizotypal & delusional disorders (F20-F29) (37%), mood [affective] disorders (F30-F39) (25%), and mental and behavioural disorders due to psychoactive substance use (F10-F19) (24%). A further 7% were classed as having "other" diagnoses such as epilepsy or organic mental disorders, 4% as having neurotic, stress-related and somatoform disorders (F40F48) and 3% of users treated had diagnosis of disorders of adult personality.
Data on involuntary admissions is not available (not provided by respondents).
On average patients spend 214 days in mental hospitals; 53% of patients spend less than 1 year, 24% of patients spend 1-4 years in mental hospitals, 7% spend 5-10 years, and 16% of patients spend more than 10 years in mental hospitals.
The occupancy rate of mental hospitals is 97%. Around 2-5% of users were physically restrained or secluded in mental hospitals in 2014.
Some patients (21-50%) in mental hospitals received one or more psychosocial interventions in 2014 and 80% of all mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer,

[18] Defined as a non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders; usually these facilities serve users with relatively stable mental disorders not requiring intensive medical interventions.

- ***Includes*:** Supervised housing; un-staffed group homes; group homes with some residential or visiting staff; hostels with day staff; hostels with day and night staff; hostels and homes with 24-hour nursing staff; halfway houses; therapeutic communities.
- ***Excludes*:** Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation; residential facilities in *mental hospitals*; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind (e.g. nursing homes and rest homes for elderly people, institutions treating mainly neurological disorders, or physical disability problems).

[19] 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.).

anxiolytic, and antiepileptic) available in the facility. Forty percent of mental hospitals (2 out of 5) are organizationally integrated with mental health outpatient facilities.
Based on additional questions added to the AIMS questionnaires (Appendix 2) and as reported by 3 mental hospitals, in 2014, the percentage of patients by type of payers was as follows:

- Out-of-pocket expenditures: 32%
- MOPH: 25%
- NSSF: 22%;
- Military funds: 14%;
- UNRWA: 7%.

In addition, the total number of deceased in 2014 as reported by 3 mental hospitals was 41.

Forensic facilities

The country counts 30 dedicated inpatient mental health beds for forensic patients (0.50 beds per 100,000 population). These patients are placed in a separate building, away from other inmates, to receive oral medication by non-specialized staff and return to the general prison upon stabilization. All these beds are in prison mental health treatment facilities. Data on users or length of stay is not available. Mental health in prison is being assessed in order to set a national strategy.

Other residential facilities[20]

Other residential services are as follows:

Facility	Number	Number of beds
Residential facilities specifically for people with substance abuse (including alcohol) problems (e.g. detoxification inpatient facilities)	5	90
Residential facilities specifically for people (of any age) with mental retardation	3	120
Residential facilities specifically for youth aged 17 years and younger with mental retardation	3	65
Residential facilities specifically for people with dementia	2	60
Residential facilities that formally are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders (e.g. mental retardation, substance abuse, dementia, epilepsy, psychosis)	2	15

[20] A residential facility that houses people with mental disorders but does not meet the definition for community residential facility or any other mental health facility defined for this instrument; **includes**: Residential facilities specifically for people with mental retardation, for people with substance abuse problems, or for people with dementia. Included are also residential facilities that formally are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders.

Human rights and equity

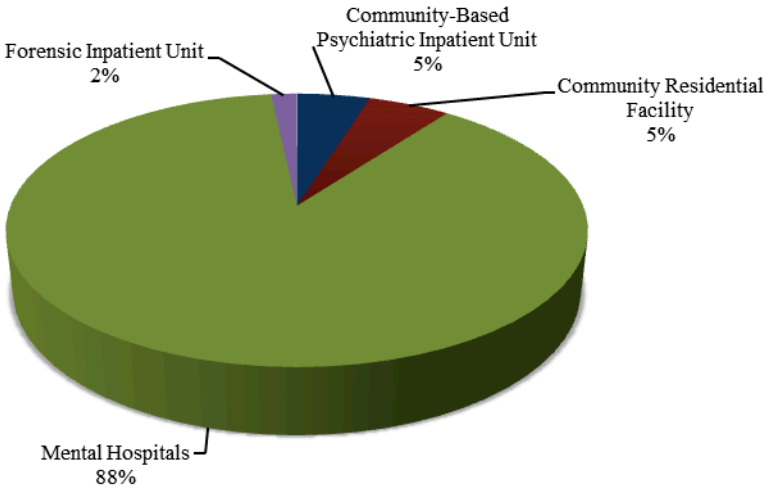
Twelve percent of all admissions to community-based psychiatric inpatient units are involuntary and data on involuntary admissions to mental hospitals is not available. It is to note that the practice of admitting a patient with mental condition to a psychiatric unit or mental hospital in Lebanon is conditioned to have an adult accompanying him/her and taking care of his/her admission and discharge. Between 6-10% of patients were restrained or secluded in 2014 in community-based psychiatric inpatient units, in comparison to 2-5% in mental hospitals. The ratio of number of psychiatry beds in or near the largest city to the total number of psychiatry beds in the country is 2.25. Such a distribution of beds prevents access to mental health services for rural users. None of the mental health outpatient facilities employ a specific strategy to ensure that linguistic minorities can access mental health services in a language in which they are fluent.

A substantial difference (greater than 50%) between government-administered and for-profit mental health care facilities is reported in terms of (1) the average duration of the waiting list for an initial non-emergency psychiatric outpatient appointment; (2) the average number of minutes of an outpatient consultation with a psychiatrist; and (3) the average number of beds per nurse in psychiatric inpatient facilities.

Summary charts

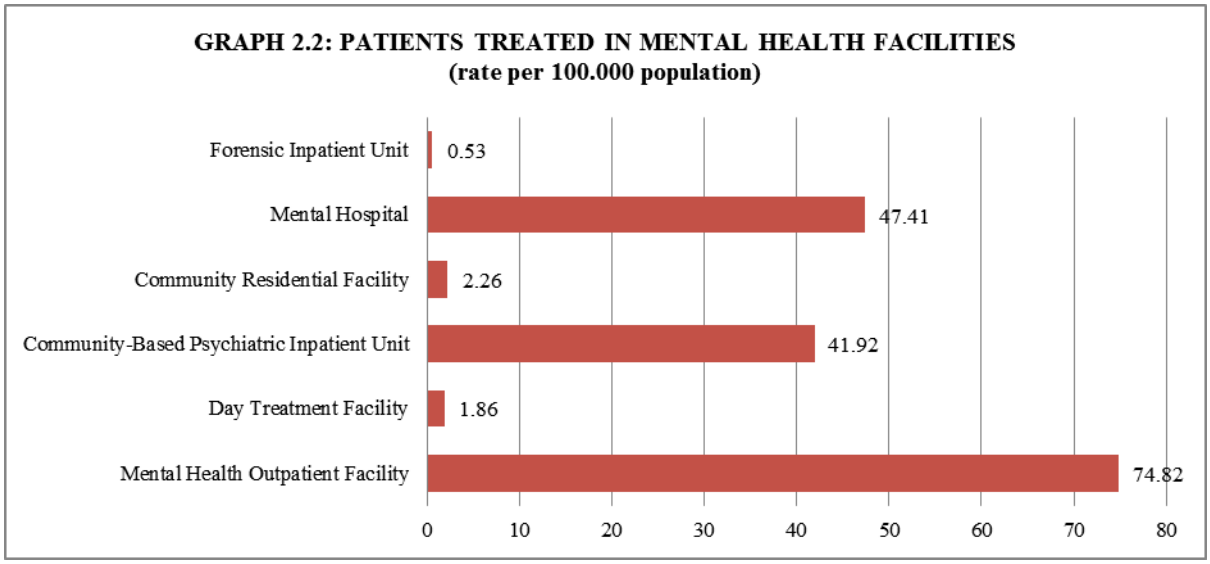
The following charts illustrate key differences in patients treated, users gender, diagnoses assigned and availability of psychotropic medicines across all mental health facilities in Lebanon.

GRAPH 2.1: BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES

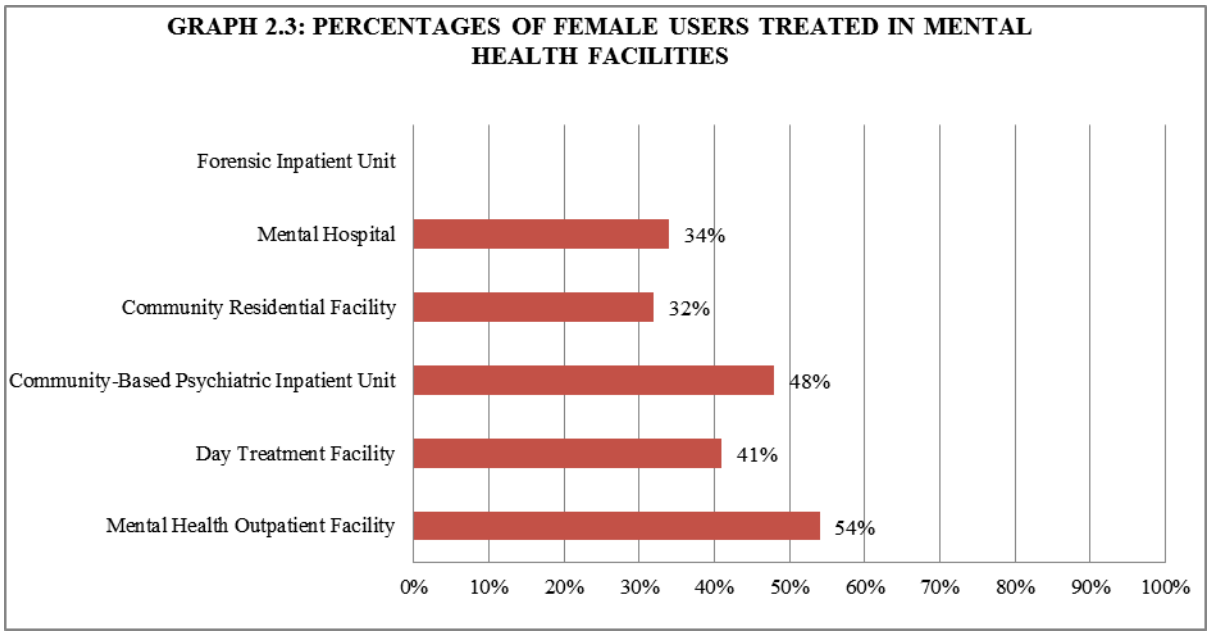


As shown in the graph 2.1, in the Lebanese mental health system, the majority of beds are

provided by mental hospitals, followed by community-based psychiatric inpatient units and community residential facilities.

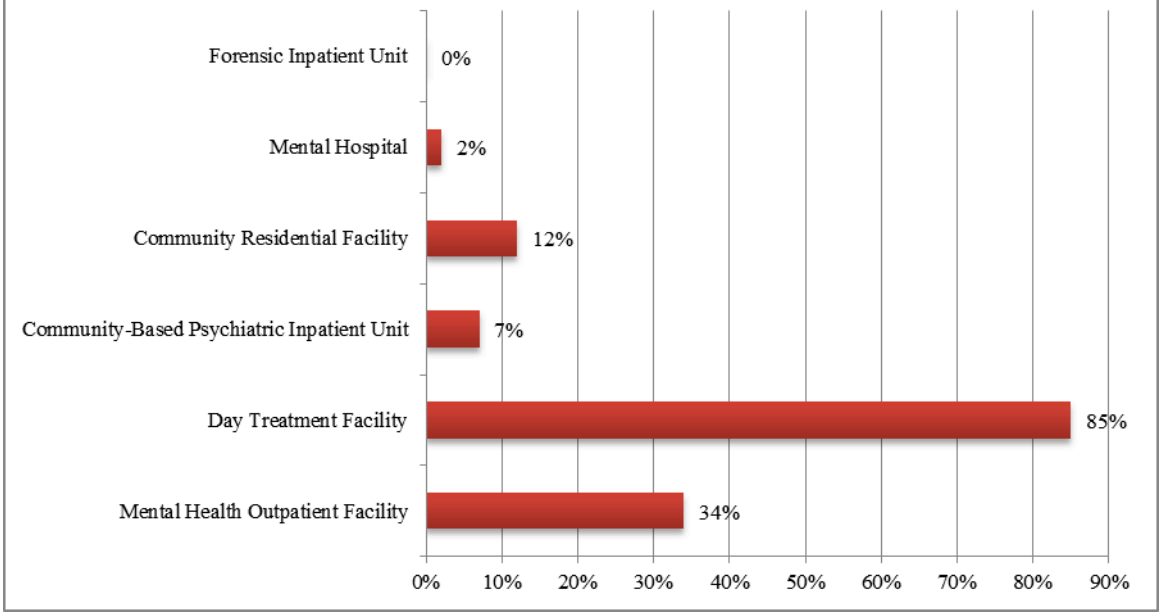


As illustrated in the graph 2.2, the majority of patients (92.12 per 100,000 population) are admitted for treatment and the remaining (76.68 per 100,000 population) are treated on outpatient basis.



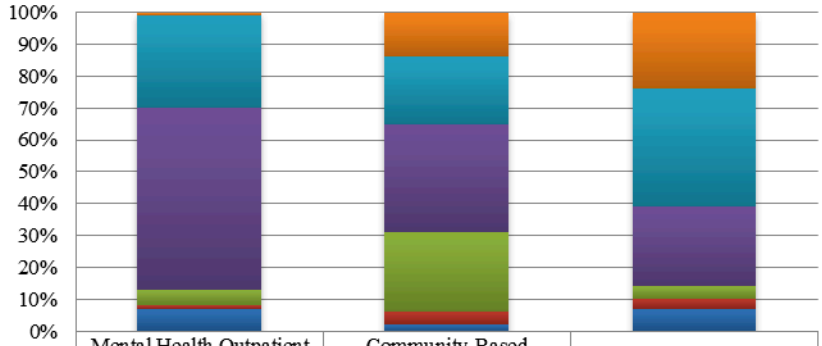
According to the graph 2.3, female users make up 54% of all patients treated in mental health outpatient facilities in Lebanon. Almost half (48%) of patients treated in community-based psychiatric inpatient units are females.

GRAPH 2.4: PERCENTAGES OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES



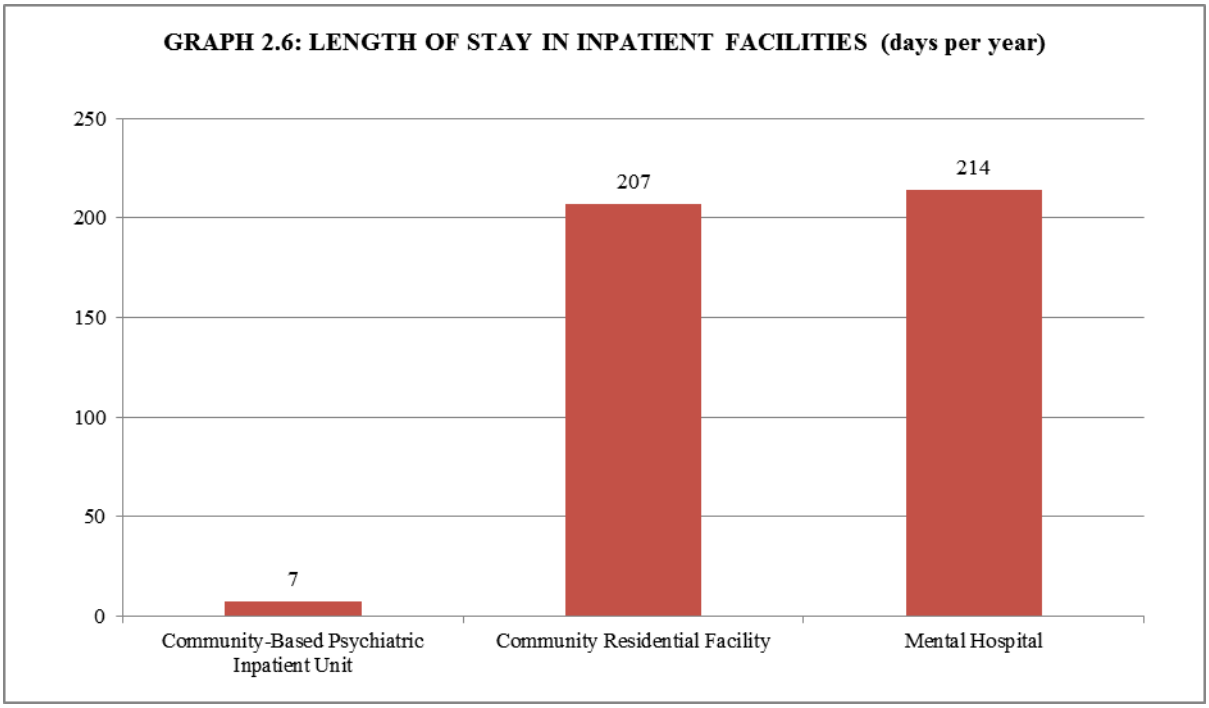
As shown in graph 2.4, children and adolescents make up 85% of all patients treated at day treatment facilities; this is due to the fact that 4 out of 5 day treatment facilities are exclusively for children and adolescents. Around 34% of users at outpatient facilities are children and adolescents.

GRAPH 2.5: PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS

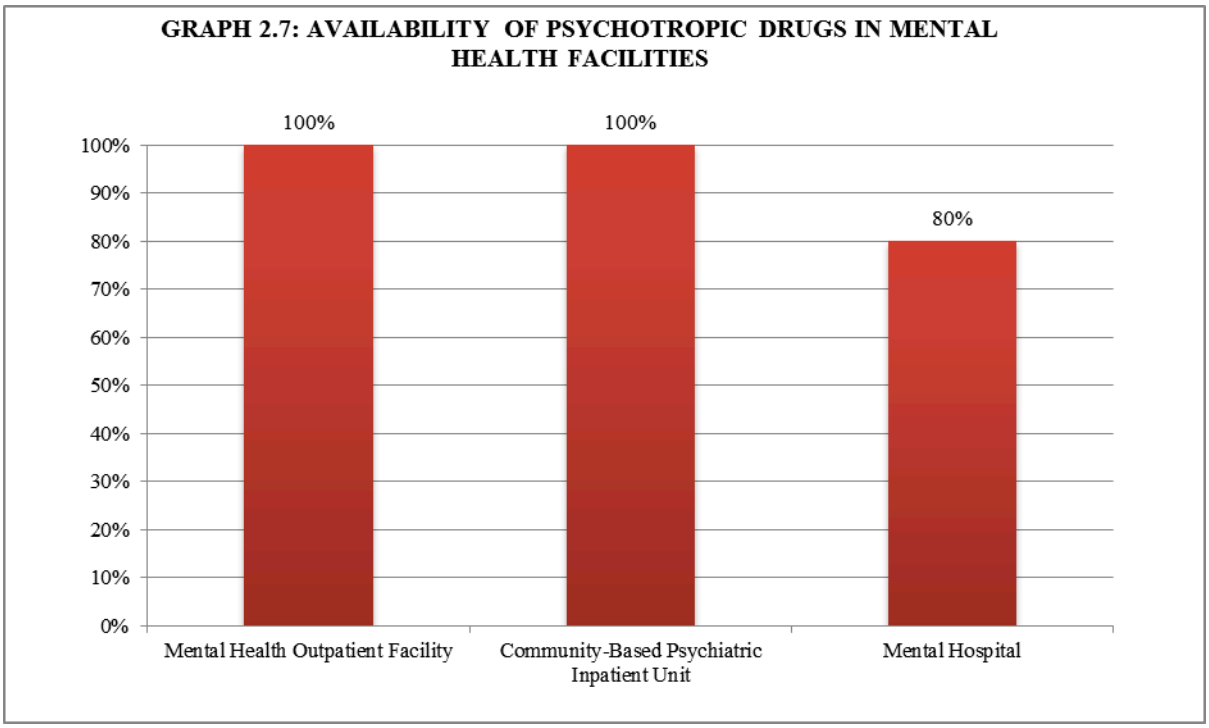


	Mental Health Outpatient Facility	Community-Based Psychiatric Inpatient Unit	Mental Hospital
Mental and behavioural disorders due to psychoactive substance use (F10-F19)	1%	14%	24%
Schizophrenia, schizotypal and delusional disorders (F20-F29)	29%	21%	37%
Mood [affective] disorders (F30-F39)	57%	34%	25%
Neurotic, stress-related and somatoform disorders (F40-F48)	5%	25%	4%
Disorders of adult personality and behaviour (F60-F69)	1%	4%	3%
Others	7%	2%	7%

Graph 2.5 shows the distribution of diagnoses across facilities: mood disorders are assigned to 57% of all patients treated at outpatient facilities, followed by schizophrenia, schizotypal and delusional disorders (29%). Mood disorders also account for the largest share of diagnoses at community based inpatient units (34%), followed by neurotic, stress-related and somatoform disorders (25%). In mental hospitals, schizophrenia schizotypal and delusional disorders are most frequent (37%).



Graph 2.6 shows that the longest average length of stay for users is in mental hospitals, followed by community residential facilities. The average length of stay in community-based psychiatric inpatient units is one week due to the short stay type of admission.



As per the graph 2.7, psychotropic drugs are widely available in mental health outpatient facilities, community-based psychiatric inpatient units, and mental hospitals; one of the mental hospitals suffered from shortages of psychotropic medications during the year 2014.

DOMAIN 3: MENTAL HEALTH IN PRIMARY HEALTH CARE

Training in mental health care for primary care staff

Out of the 920 centres (PHC centres and dispensaries) around 200 national PHC centres[21] were assessed in addition to 15 other PHC centres/dispensaries outside the MOPH network.

Only 3% of the training for medical doctors students is devoted to mental health, compared to 6% for nursing students.

In terms of refresher training, 13% of primary health care doctors have received at least two days of refresher training in mental health, while 29% of nurses and 28% of non-doctor/non-nurse primary health care workers have received such training (Graph 3.1).

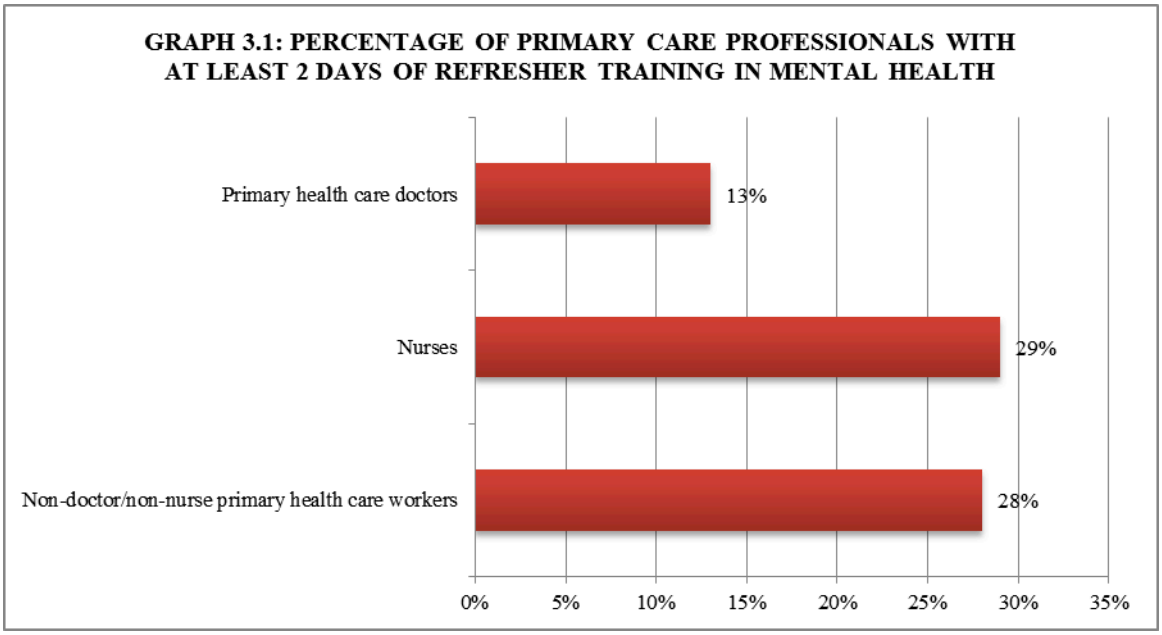
Primary health care clinics

The basic unit for primary health care delivery outside the private sector is either a dispensary or primary health care centre that are both physician-based and non-physician based [22].

[21] 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.

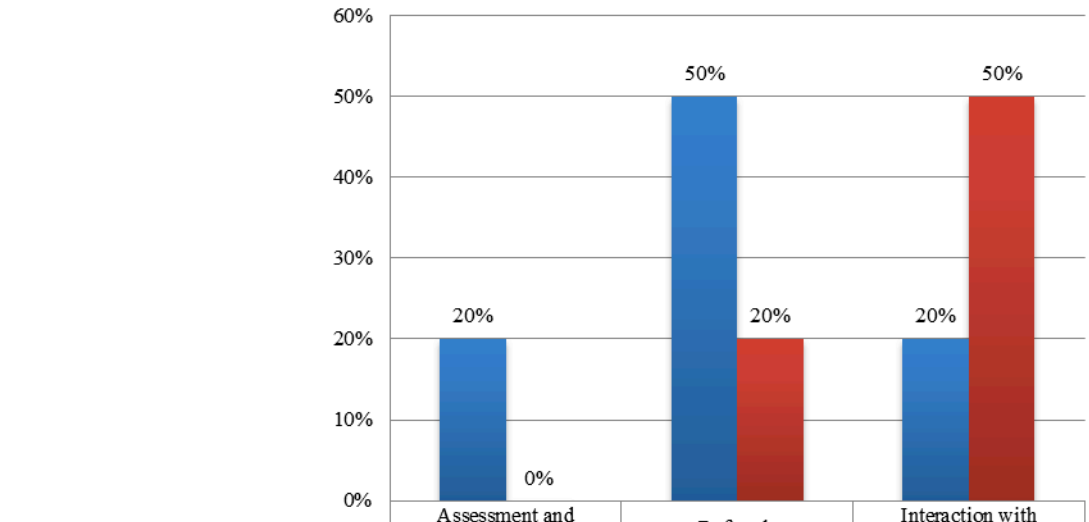
Data from the 215 PHC clinics assessed showed that a few physician-based clinics (1-20%) have assessment and treatment protocols for key mental health conditions compared to none of the non-physician based (Graph 3.2).
A few physician-based primary health care clinics (1-20%) make on average at least one referral per month to a mental health professional. Some non-physician based primary health care clinics (21-50%) make at least one referral per month to a higher level of care (e.g., mental health professional or physician-based primary health care clinic) (Graph 3.2). A few physician-based PHC clinics (1-20%) have had interactions with a complimentary/alternative/traditional practitioner, in comparison to some (21-50%) of the non-physician based clinics, and none of the mental health facilities (0%) (Graph 3.2).
In terms of professional interaction between primary health care staff and other care providers, a few primary care doctors (1-20%) have interacted with a mental health professional at least monthly in 2014.

GRAPH 3.1: PERCENTAGE OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH



[22] **Non-physician based primary health care clinic:** A *primary health care clinic* without a *primary health care doctor* as part of their regular staff.
Physician-based primary health care clinic: A *primary health care clinic* with *primary health care doctors as part of their regular staff.*

GRAPH 3.2: COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE



	Assessment and treatment protocols	Referrals	Interaction with traditional practitioners
Physician-based primary health care	20%	50%	20%
Non-physician-based primary health care	0%	20%	50%

Prescription in primary health care

Primary health care doctors are allowed to prescribe psychotropic medicines without restrictions. Nurses and non-doctor/non-nurse health care workers are not allowed to prescribe psychotropic medications in any circumstance.

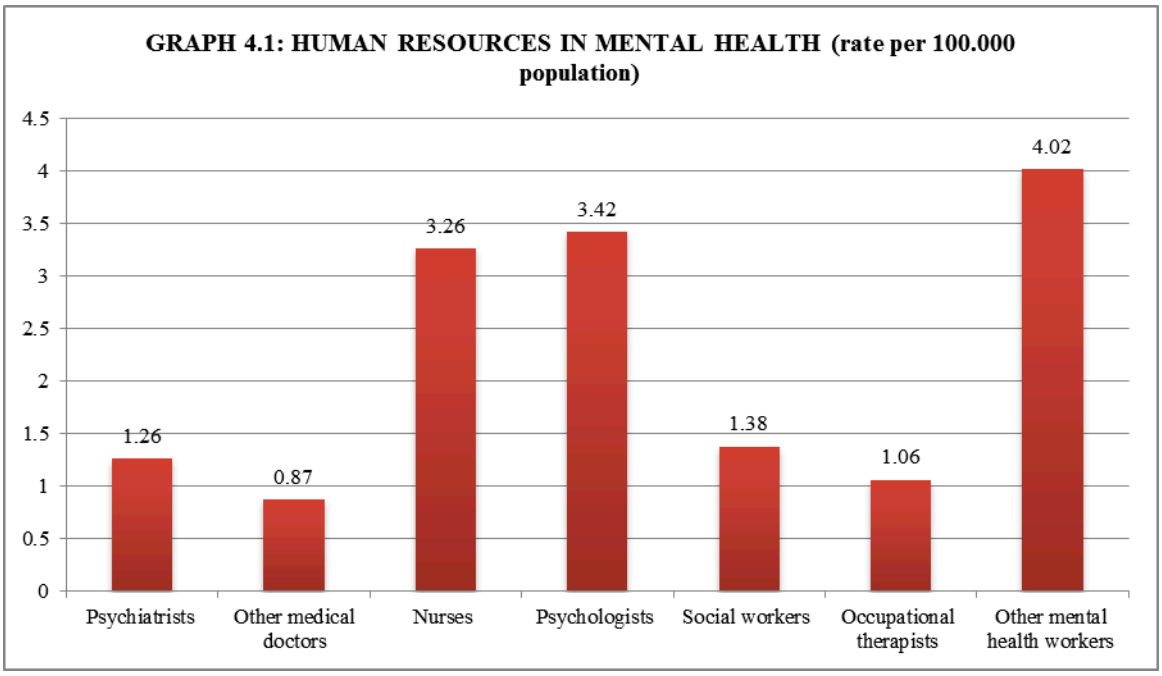
As for the availability of medicines to primary health care patients, almost all the physician-based and non-physician based primary health care clinics (81-100%) have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or in a nearby pharmacy all year long.

DOMAIN 4: HUMAN RESOURCES

Human resources in mental health

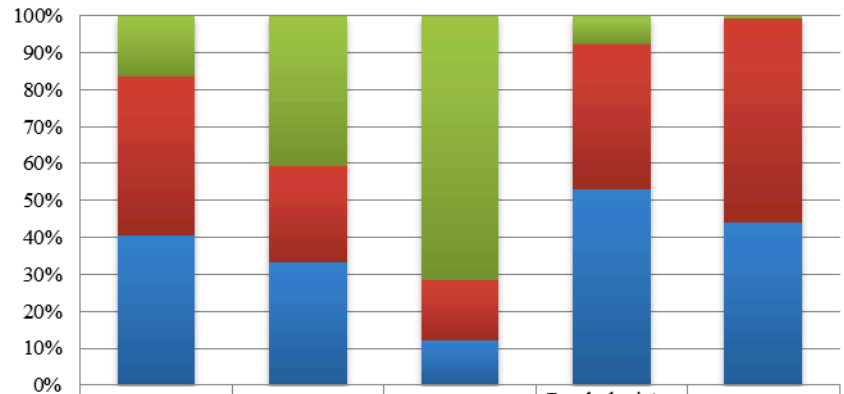
The total number of human resources working in public mental health facilities, NGOs, and private practice is 15.27 per 100,000 population. The breakdown according to profession is as follows: 1.26 psychiatrists; 0.87 other medical doctors (not specialized in psychiatry); 3.26 nurses; 3.42 psychologists; 1.38 social workers; 1.06 occupational therapists; and 4.02 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors) per 100,000 population (Graph 4.1). The majority of psychiatrists (92%) and psychologists, social workers, nurses, and occupational therapists (94%) work only in or for mental health NGOs, private practice, and for profit mental health facilities. Only 3% of psychologists, social

workers, nurses, and occupational therapists work solely in or for government administered mental health facilities.



Regarding the workplace, 32 psychiatrists work in outpatient facilities, 34 in community-based psychiatric inpatient units and 13 in mental hospitals. Nine medical doctors not specialized in mental health work in outpatient facilities, 7 in community-based psychiatric inpatient units and 11 in mental hospitals. As for nurses, 35 work in outpatient facilities, 47 in community-based psychiatric inpatient units and 206 in mental hospitals). As for psychologists, social workers, and occupational therapists, 82 work in outpatient facilities, 61 in community-based psychiatric inpatient units, and 12 in mental hospitals. With regards to other health or mental health workers, 92 work in outpatient facilities, 115 in community-based psychiatric inpatient units and only 2 in mental hospitals (Graph 4.2).

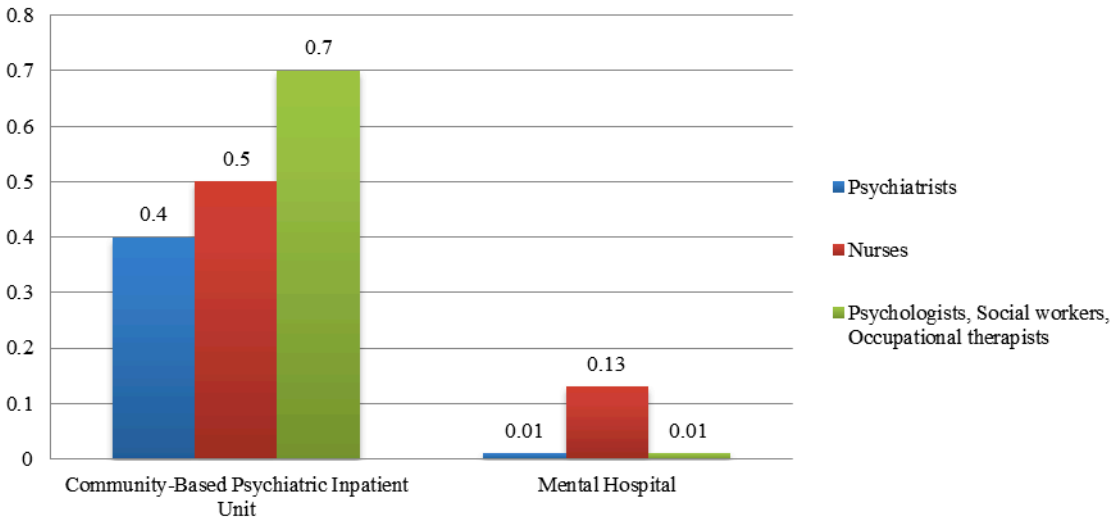
GRAPH 4.2: STAFF WORKING IN MENTAL HEALTH FACILITIES (percentage in the graph, number in the table)



	Psychiatrists	Other medical doctors	Nurses	Psychologists, Social workers, Occupational therapists	Other mental health workers
Mental Hospital	13	11	206	12	2
Community-Based Psychiatric Inpatient Unit	34	7	47	61	115
Mental Health Outpatient Facility	32	9	35	82	92

In terms of staffing in mental health facilities, there are 0.40 psychiatrists per bed in community-based psychiatric inpatient units, in comparison with 0.01 psychiatrists per bed in mental hospitals. As for nurses, there are 0.55 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.13 per bed in mental hospitals. As for psychologists, social workers, and occupational therapists, there are 0.72 per bed in community-based psychiatric inpatient units and 0.01 per bed in mental hospitals. Finally, for the other health or mental health workers, there are 1.35 per bed in community-based psychiatric inpatient units and practically none in mental hospitals (Graph 4.3).

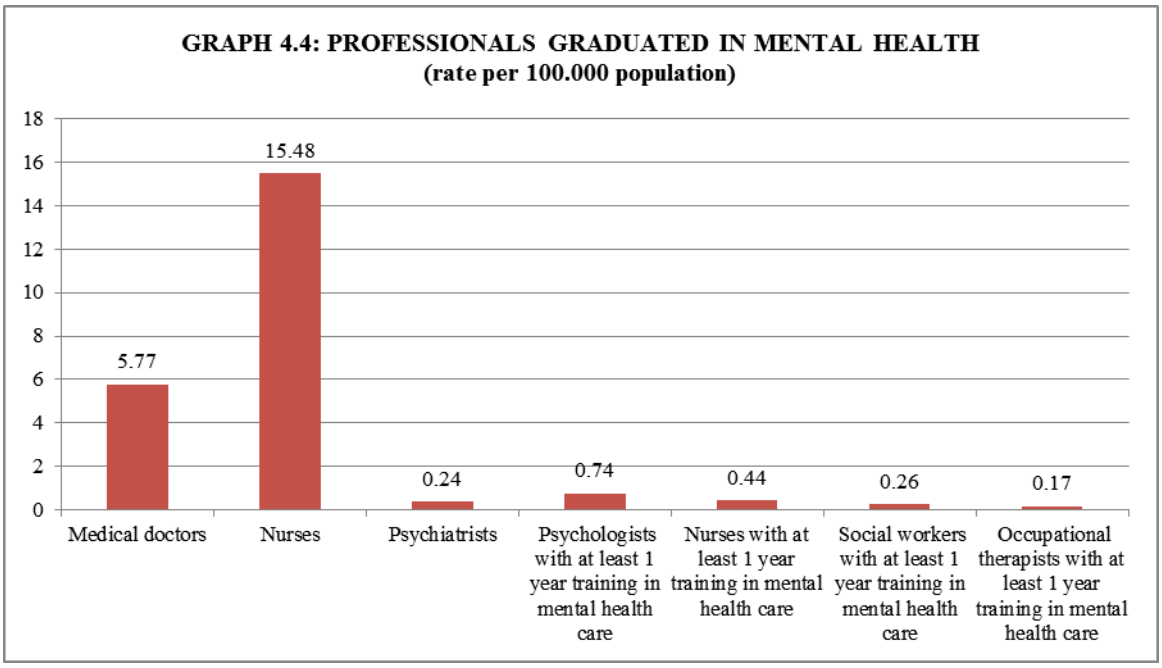
GRAPH 4.3: AVERAGE NUMBER OF STAFF PER BED



The ratio of psychiatrists working in mental health facilities that are based in or near the largest city to the rest of the country is 2.04 per 100,000 city population compared to 1.26 per 100,000 country population. As for nurses working in or near the largest city, the ratio is 2.19 per 100,000 city population compared to 3.26 per 100,000 country population.

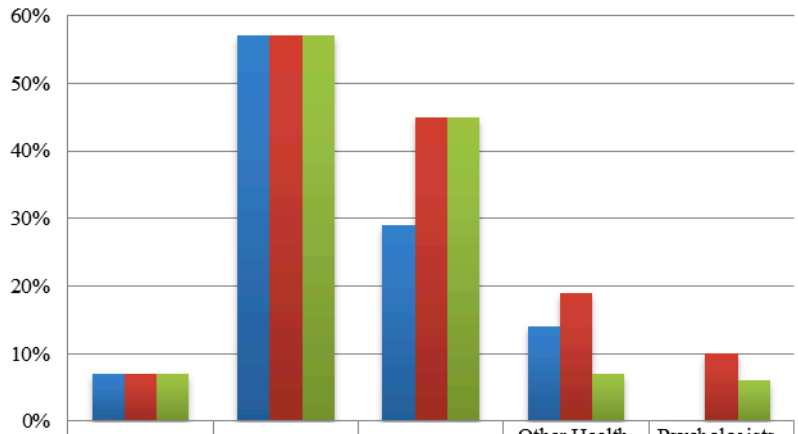
Training professionals in mental health

The number of professionals graduated in 2014 in academic and educational institutions per 100,000 population is as follows: 0.24 psychiatrists; 5.77 medical doctors (not specialized in psychiatry); 15.48 nurses; 0.44 nurses (with at least 1 year training in mental health care); 0.74 psychologists (with at least 1 year training in mental health care); 0.26 social workers (with at least 1 year training in mental health care); 0.17 occupational therapists (with at least 1 year training in mental health care) (Graph 4.4). A few psychiatrists (1-20%) immigrate to other countries within five years of the completion of their training.



In terms of refresher training for staff working in or for mental health facilities, 7% of psychiatrists and 57% of medical doctors (not specialized in psychiatry) received at least two days of refresher training on the rational use of psychotropic drugs, on psychosocial interventions, and on child and adolescent mental health issues. Also, 29% of nurses and 14% of other mental health workers received at least two days of refresher training on the rational use of psychotropic drugs. In addition, 45% of nurses, 10% of psychologists, and 19% of other mental health workers received at least two days of refresher training on psychosocial interventions. Six percent of psychologists, social workers and occupational therapists, 45% of nurses, and 7% of other health or mental health workers received at least 2 days refresher training for mental health staff on child and adolescent mental health issues.

GRAPH 4.5: PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



	Psychiatrists	Other medical doctors	Nurses	Other Health or Mental Health Workers	Psychologists, Social workers, Occupational therapists
Rational Use of Psychotropic Drugs	7%	57%	29%	14%	0
Psychosocial (non-biological) Interventions	7%	57%	45%	19%	10%
Child Mental Health Issues	7%	57%	45%	7%	6%

Consumer and family associations

There are 1 user/consumer associations and 2 family associations. The government provides economic support to user/consumer associations as well as family initiatives. The user/consumer association was involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years.

A few mental health facilities (1-20%) had interaction with user/consumer and family associations in 2014. There are 1 user/consumer association and 2 family associations involved in individual assistance activities such as counselling, housing, or support groups. In addition to consumer and family associations, there are 124 NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups and 20 NGOs involved in policies, legislation, or mental health advocacy.

DOMAIN 5: PUBLIC EDUCATION AND LINKS WITH OTHER SECTORS

Education and awareness campaigns

There is no coordinating body to oversee public education and awareness campaigns on mental health however the MOPH is providing technical support for actors conducting these campaigns. The entities that have promoted public education and awareness campaigns on mental health in the last five years include government agencies, NGOs, professional organizations, foundations, and international agencies. These campaigns targeted the following groups: the general population, children, adolescents, women, trauma survivors, and other vulnerable groups. In addition, there have been public

education and awareness campaigns targeting professional groups including health care providers, teachers, social services staff, and other professional groups linked to the health sectors.

Legislative and financial provisions for persons with mental disorders

The following legislative provisions exist to provide support for users: (1) provisions concerning a legal obligation for employers to hire a certain percentage of employees that are disabled (ACT# 220/2000, article 74); (2) provisions concerning protection from discrimination (conditions for job application) solely on account of mental disorder (ACT# 220/2000, article 69); (3) legislative or financial provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders (ACT# 220/2000, article 58). However, there are no legislative or financial provisions concerning protection from discrimination in allocation of housing for people with severe mental disorders. It is important to note that a legislative provision exists for financial compensation in case of unemployment for people with severe mental disorders (ACT# 200/2000, article 71).

Links with other sectors

In addition to legislative and financial support, there are formal collaborative programmes addressing the needs of people with mental health issues between the government departments responsible for mental health and the departments/agencies responsible for: primary health care/community health, child and adolescent health, child protection, substance use, education, and criminal justice.

In terms of financial support for users, none of the mental health facilities have access to programmes outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, the percentage of people who receive social welfare benefits because of disability due to mental disorder is not available (not reported).

In terms of support for child and adolescent health, 11% of primary and secondary schools have either a part-time or full-time mental health professional (e.g., psychologist, social worker, nurse specialized in mental health). A few primary and secondary schools (1-20%) have school-based activities to promote mental health and prevent mental disorders.

Regarding mental health in the criminal justice system, it is estimated that the percentage of persons with psychosis in prisons is less than 2%. The percentage of persons with mental retardation in prisons is unknown. Few prisons (1-20%) have at least one inmate per month in treatment contact with a mental health professional, either within the prison or outside in the community.

As for training activities, few police officers, judges, and lawyers (1-20%) have participated in educational activities on mental health in the last 5 years.

DOMAIN 6: MONITORING AND RESEARCH

Monitoring and research

The Lebanese MOPH maintains a formally defined list of individual data items that ought to be collected by all mental health facilities for patients covered or supported by the MOPH. This list includes admissions, length of stay, and patient diagnoses.

The government health department receives data from 100% of mental hospitals, 88% of community-based psychiatric inpatient units and 29% of the mental health outpatient facilities (Table 4). A statistical bulletin summarizing the received data transmitted to the government health department is periodically produced and published on the MOPH website.

Table 4 | Percent of mental health facilities collecting and compiling data by type of information for patients covered by the MOPH.

Type of information compiled	Mental hospitals	Community-based psychiatric inpatient units	Outpatient facilities
Number of beds	0%	0%	NA
Number of inpatient admissions/users treated in outpatient facilities	100%	88%	29%
Number of days spent/user contacts in outpatient facilities	100%	88%	29%
Number of involuntary admissions	0%	0%	NA
Number of users restrained	0%	0%	NA
Diagnoses	100%	88%	29%

NA: Not Applicable

An estimated 71% of all mental health outpatient facilities routinely collect and compile data on the number of users treated, the number of user contacts and diagnoses.

In terms of research, the proportion of indexed publications that are on mental health in the last five years is 28% out of all researched published in Lebanon (based on PUBMED), focused on the following topics:

- Epidemiological studies in community samples
- Epidemiological studies in clinical samples
- Non-epidemiological clinical/questionnaires assessments of mental disorders
- Services research
- Biology and genetics
- Policy, programmes, financing/economics
- Psychosocial interventions/psychotherapeutic interventions
- Pharmacological, surgical and electroconvulsive interventions

Professionals involved in mental health research are:

- Some (21-50%) psychiatrists working in mental health services
- Few (1-20%) nurses working in mental health services
- Few (1-20%) psychologists working in mental health services
- Few (1-20%) social workers working in mental health services

Challenges and opportunities

The use of the WHO-AIMS allows a comprehensive assessment of the mental health system in Lebanon and elucidates both the challenges and opportunities of the present system.
There is a mental health law in Lebanon (domain 1), with a proposed reviewed draft, however not all the components of the current law are implemented, namely the lack of human rights review body to oversee the human rights of individuals with mental conditions and inspect mental health facilities. Funding for mental health care remains low and mostly directed towards hospitalization. There is no emergency/disaster preparedness plan for mental health. A clear strength is the development of a mental health strategy for 2015-2020, which gained wide national consensus.

An inventory of mental health services (domain 2) in Lebanon shows that even though there are many outpatient clinics, the mental health system is quite hospital-based with an occupancy rate of 97%, thus increasing duration of waiting list. The care provided, both inpatient and outpatient, is mainly biological care (provision of psychotropic medication). Also, while a majority of individuals treated at mental health facilities are able to access psychotropic medicines, a continuous supply is not yet ensured for all the vulnerable population and only few persons are provided with psychosocial interventions. The cost of such interventions remains high and affordable to a limited population group. The distribution of psychiatric hospitals remains concentrated in the largest city thus preventing access to persons living in rural areas. As for forensic services, facilities are not adequately staffed and equipped.

An assessment of mental health in primary care (domain 3) suggests that there is little interaction between the primary care system and mental health professionals and primary care professionals receive little initial and refresher training on mental health topics.

Data on the number of human resources working in mental health in Lebanon (domain 4) indicate that there is a variety of professionals (e.g. psychiatrists, nurses, social workers) providing mental health services, with a higher concentration of nurses in mental hospitals compared to outpatient mental health facilities. The majority of mental health professionals work in private practice. Moreover, a few trained psychiatrists immigrate to other countries within five years of training. Lastly, there are many NGOs providing mental health services though not standardized, however, there is a lack of user and family associations in Lebanon.

Findings from domain 5 show that there are awareness campaigns on mental health

supporting different population groups (e.g. women, children, trauma survivors) and targeting a wide range of professionals (e.g. teachers, health care providers). However, there is no coordinating body systematically overseeing public mental health education and awareness campaigns. In addition, there is a mechanism for individuals to obtain social welfare benefits due to a mental disorder, however it is not well disseminated. Only few schools have activities promoting mental health and preventing mental disorders. There is a lack of mental health professionals visiting the prisons. Moreover, educational activities on mental health barely target police officers, judges, and lawyers.

Regarding monitoring and research (domain 6), findings illustrate that all mental hospitals and a larger majority of outpatient mental health facilities in Lebanon are collecting and transmitting essential mental health data for patients covered by the MOPH. Also, the percentage of professionals conducting mental health research is low. Shifting mental health services towards community-based will necessitate a thorough service-related research.

Next steps in strengthening the mental health system

Based on the domain summaries and a critical assessment of the challenges and opportunities, the following are possible next steps for the long-term improvement of Lebanon's mental health system:

Domain 1:

- Activate the mental health body mentioned in the decree law (Act# 72/1983) that is in charge of overseeing the human rights of persons with severe mental disorders and inspecting mental health facilities and develop a protocol for the routine review/inspection of mental health facilities and training plan for health professionals on the human rights protection of patients
- Enact the revised draft mental health law.
- Increase funding towards community mental health care.
- Develop an emergency/disaster preparedness plan for mental health.

Domain 2:

- Strengthen and expand community mental health care and work towards the integration individuals with severe and chronic mental illness into the community.
- Ensure continuous supply of essential psychotropic medication.
- Develop a strategy for mental health in prisons.
- Enhance the provision of quality psychosocial interventions, according to the bio-psychosocial model, for patients treated at both outpatient and inpatient mental health facilities.
- Improve access to mental health services for rural users.

Domain 3:

- Establish a referral system between all levels of care, enhance the interaction between the primary care system staff and mental health professionals.

- Complete the integration of mental health in primary care especially building the capacity of staff (GPs, primary care nurses and other health professionals) through the mental health Gap Action Programme (mhGAP).

Domain 4:

- Increase the number of mental health professionals working in community care, especially nurses.
- Standardize mental health services already provided by NGOs.
- Facilitate the creation of independent service users and family associations.

Domain 5:

- Facilitate the creation of a coordinating body systematically overseeing public education and awareness campaigns on mental health.
- Disseminate information for mental patients and their families on how to obtain social welfare benefits using the current law and ensure proper implementation mechanism.
- Increase school-based prevention and promotion mental health activities.
- Increase mental health professionals working inside prisons.
- Integrate mental health trainings for judges, lawyers and police officers in their curriculum and continuous education.
- Integrate and report on involuntary admissions data in the required mental health key indicators

Domain 6:

- Expand the number of facilities regularly reporting on the required mental health key indicators and monitor the quality of the data collected.
- Encourage/support research in the field of mental health for all mental health professionals, especially service-related research.

Appendix 1: Areas, sections, and number of items

Section		Description	Items
Domain 1: policy & legislative framework			
1.1	Mental health policy	Date and components included in mental health policy and essential medicines list	3
1.2	Mental health plan	Date, components included, and specification of strategies in the mental health plan	4
1.3	Mental health legislation	Date, components included, and implementation of *mental health legislation*	3
1.4	Monitoring human rights implementation	Monitoring and training on *human rights protection* in mental health services	5
1.5	Financing of mental health services	Expenditures and financial sources in mental health services	6
Domain 2: mental health services			
2.1	Organizational integration of mental health services	Organizational integration of mental health services across facilities	3
2.2	Mental health outpatient facilities	*Users* and services provided through *mental health outpatient facilities*	9
2.3	Day treatment facilities	*Users* and use of *mental health day treatment facilities*	6
2.4	Community-based psychiatric inpatient units	*Beds*, *patients*, and use of *community-based psychiatric inpatient units*	9
2.5	Community residential facilities	*Beds*/places, *users*, and use of *community residential facilities*	7
2.6	Mental hospitals	*Beds*, *patients*, and use of *mental hospitals*	12
2.7	Forensic inpatient units	*Beds* and *patients* in *forensic inpatient units*	3
2.8	Other residential facilities	Availability of *beds*/places in *other residential facilities* that provide care for people with mental disorders	2
2.9	Availability of psychosocial treatment in mental health facilities	Percentage of *users* who receive psychosocial treatments	3
2.10	Availability of essential psychotropic medicines	Effective availability of medicines at mental health facilities at all times	3
2.11	Equity of access to mental health services	Equity of access to mental health services across different population groups	6
Domain 3: mental health in primary health care			
3.1	Physician-based primary health care	Training of primary health care physicians in mental health, linkage with the mental health system, and psychotropic medicines in physician-based primary health care	7
3.2	Non-physician-based primary health care	Training of non-physician primary health care staff in mental health, linkage with the mental	9

		health system, and psychotropic medicines in non-physician based primary health care	
3.3	Interaction with complimentary/ alternative/ traditional practitioners	Interaction of primary health care and mental health facilities with complementary/ alternative/traditional practitioners	3
Domain 4: human resources			
4.1	Number of human resources	Number of staff working in or for mental health facilities	8
4.2	Training professionals in mental health	Aspects of training professionals in mental health	5
4.3	Consumer and family associations	Membership and support for *user*/*consumer* associations and family associations	4
4.4	Activities of consumer associations, family associations and other NGOs	Range of activities of *user/consumer* associations, family associations and other NGOs involved in mental health	8
Domain 5: public education & links with other sectors			
5.1	Public education and awareness campaigns on mental health	Specification of activities, methods and targeted populations in educational and awareness campaigns on mental health	4
5.2	Links with other sectors: formal collaboration	Formal collaboration in the form of laws, administration, and programmes with (other) health and non-health sectors aimed at improving mental health	5
5.3	Links with other sectors: activities	Extent of activities outside the mental health sector that address the needs of people with mental health issues	9
Domain 6: monitoring & research			
6.1	Monitoring mental health services	Routine collection and reporting of key data by mental health facilities	6
6.2	Mental health research	Extent and content of mental health research	3

Appendix 2: Additional questions added to the AIMS questionnaire

Domain 7: Cost information		
7.1	Number of admissions covered by out of pocket	
	Number of admissions covered by social security	
	Number of admissions covered by military funds	
	Number of admissions covered by other "the state employees cooperation"	
	Number of admissions covered by private insurance	
	Number of admissions covered by the ministry of health	
	Number of admissions covered by other third party payers *Please list all of them and specify number of admissions for each* …… …… …… …… ……	 …… …… …… ……
Domain 8: Death in mental hospitals		
8.1	What is the number of deceased people in 2014?	

The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Lebanon. This included the policy and legislative framework; mental health services; mental health in primary health care; human resources; public education and links with other sectors; and monitoring and research. The goal of collecting this information is to enable policy makers to develop information-based mental health plans with clear base-line information and targets. Also, it will help for comparison with other countries, especially those with similar backgrounds.

The network of mental health facilities in Lebanon consists of 42 mental health outpatient facilities, 8 community-based inpatient units, 7 community residential facilities, 5 day treatment facilities and 5 mental hospitals. The number of beds in mental hospitals is 28.52 per 100.000 general population. Only 5% of the governmental health expenditure is directed towards mental health, out of which, 54% are channelled to hospitalization. There are 15.27 human resources working in mental health per 100,000 general population.

Currently, there is a mental health strategy and an implementation plan is being developed. The legislation dates back to 1983. The main authority for mental health is the National Mental Health Programme in the Ministry of Public Health.
The results of this assessment point towards a need to reorient services to widespread community mental health care by increasing expenditure directed to primary care, enhancing staff capacities and setting a referral system. The activation of the mental health inspection body (referred to in the decree law) is also needed in order to improve human rights of mental health patients.

Findings from this assessment will serve as a baseline for future improvements of Lebanon's mental health system.