

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN LEBANON
2010**



**World Health
Organization**



MINISTRY OF PUBLIC HEALTH

**MINISTRY OF HEALTH
LEBANON**

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

2010



**Ministry of Health
Lebanon**

(WHO, Lebanon)

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WHO Department of Mental Health and Substance Abuse (MSD)

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The project in Lebanon was implemented by WHO-AIMS Lebanon Team : Antoine Saad, Ola Ataya, and Maria Khalife.

The preparation of this study was done with the collaboration of the Ministry of public Health (Dr. Walid Ammar and Racha Hamra) and IMC (International Medical Corps).

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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.

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The WHO-AIMS team at WHO Headquarters includes: Benedetto Saraceno, Shekhar Saxena, Tom Barrett, Antonio Lora, Mark van Ommeren, Jodi Morris, Grazia Motturi. Additional assistance has been provided by Ryan McBain.

The WHO-AIMS project is coordinated by Shekhar Saxena.

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 goal of collecting this information is to improve the Mental Health System and to provide a baseline for monitoring change. This will enable Lebanon to develop information-based Mental Health Plans with clear baseline information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in Mental Health promotion, prevention, care and rehabilitation.

Lebanon is a small Eastern Mediterranean country with a geographical area of 10452 sq/ km and a population around 4,350,000, including 500,000 refugees from different nationalities, most being Palestinians. The country belongs to the upper-middle income group with a diversity of 18 religions.

The mental health system benefits from different acts and legislations in different areas of mental health, namely:

- 1) Lebanese Act no 72-9/9/1983 Welfare Act and Protection and Treatment of Mentally Ill Patients.
- 2) Lebanese Act no 673-16/3/1998 Narcotic Drugs and Psychotropic Substances and Precursors.
- 3) Lebanese Act no 220-29/5/2000 Rights of Mentally Handicapped in Lebanon
- 4) Lebanese Act no 574-11/2/2004 Patients Rights and Informed Consent

Despite the presence of the above Acts, Lebanon is still not capable of enforcing and implementing human rights and protective laws for the mentally ill.

The budget for Mental Health constitutes 5% of the general health budget, mainly devoted to cover long stay inpatient cost in private mental hospitals whereas outpatient community based services are the responsibility of the private sector with no budget except for those providing certain psychotropic medicines for free. However, expenditures on mental health are still far below the needs.

In terms of availability of mental health facilities, the system still suffers from an imbalance with a crucial lack of community-based services such as residential or day treatment facilities. The mental health services should be organized in terms of catchment/ service areas because the MOH should be responsible for the provision of care to the population of every region in the country.

The essential list of psychotropic drugs is regularly updated and includes anti psychotics, antidepressants, anxiolytics, mood stabilizers and antiepileptics. Only doctors are allowed to prescribe without restrictions. There is no interaction with traditional healers/ practitioners who are not legally recognized.

The country also suffers from a shortage of mental health professionals (psychiatric nurses and psychiatrists).

Little research is carried out by personal initiative, therefore the need for national technical committee for mental health providing advice to the government on mental health policy legislation and service planning is necessary.

Mental Health action plan. Critical next steps in reforming the mental health system include:

- Prevention and promotion of mental health (Mental Health Awareness campaign)
- Creating a Mental Health department within the MOH general healthcare system
- Development of mental health national policy
- Developing a mental health information system
- Strengthening community-based facilities mainly public mental health outpatient facilities to provide availability of services in the 6 Lebanese districts
- Integration of mental health in community-based primary healthcare settings in order to move from Mental hospitals to community-based services.
- Mental health training for pre/post-graduate healthcare providers on emotional & psychosocial health in different health & educational institutions.
- Implementation of mental health activities in prisons (psychosocial rehabilitation programs for detainees)
- Creation of public substance abuse disorder (SUD)s treatment centers in/outpatient (detoxification, OST)
- Mapping primary health care center for referral and networking
- Behavioral Science rotation in medical schools should be mandatory and not elective
- Updating The Mental Health Act
- Creation of a national intelligence multidisciplinary committee with key people and experts in the fields of mental health, public relations, marketing, advertising, media, management, journalism, research etc. to study the needs, prioritize action steps, using logistics and setting a plan of execution while spreading awareness and educating etc..

Introduction

Lebanon is situated at the Eastern end of the Mediterranean sea with a geographical area of 10,452 sq km and a total population of 4,055,000 million (WHO 2005). From east to west it averages 50 km and is about 225 km from north to south. Two mountain ranges run parallel to each other down the length of the country: the Mount Lebanon and the Anti-Lebanon ranges. Between the two ranges lies the fertile plain of the Bekaa Valley, through which the Orontes (Assi) and Litani rivers flow. The climate is Mediterranean with mild to cool, wet winters and hot, dry summers.

The main languages used in the country are Arabic, English, and French. Ethnic background is an important factor in Lebanon. The country encompasses a great mix of cultural, religious, and ethnic groups which have been building up for more than 6,000 years. Although most of the population is today considered Arab, in the sense that Arabic is the national language, the ethnic self designations vary. Lebanese are overall genetically similar to the Phoenicians, and the Canaanites, as well as other modern Levantine populations, such as Syrians, Palestinians, and Jordanians. The question of ethnic identity has come to revolve more around aspects of cultural self-identification more than descent. Religious affiliation has also become a substitute in some respects for ethnic affiliation.

The present Lebanese constitution officially acknowledges 18 religious groups. Religious groups include Alawite, Armenian Catholic, Armenian Orthodox, Assyrian, Chaldean Catholic, Copts, Druze, Evangelical Christian, Greek catholic, Greek orthodox, Isma'ili, Jewish, Maronite, Roman Catholic, Sunni, Shi'a, Syriac Catholic, Syriac Orthodox. The small ethnic minority population includes Lebanese Armenians, Assyrians, Jews, Kurds, and Persians.

The country is an upper-middle income group country based on World Bank 2009 criteria. 28% percent of the population is under the age of 15 and 9% of the population are over the age of 60 (WHO 2005). 15% percent of the population is rural. The life expectancy at birth is 67.6 for males and 72 for females (WHO 2005). The healthy life expectancy at birth is 59 for males and 62 for females (WHO 2005). The literacy rate for men is 92.1% and the 80.3% for women (Unesco /MOH 2004).

The proportion of the health budget to GDP is 12.2%. The total per capita expenditure in health equals \$673 and the per capita government expenditure is \$189 (WHO 2004). Government expenditures on mental health are 5% of the total health budget.

There are 3 mental hospitals and 5 psychiatric units within general hospitals. There are a total of 43 psychiatric beds per 10,000 population (figure includes both psychiatric beds in general hospitals and mental hospitals). Two psychiatrists per 100,000 populations can be found. Lebanon depends mainly on the private sector for the provision of the health services. The Ministry of Health has contracts with the private sector in order for the needy patients to receive free treatment. There are no disability benefits for persons with mental disorders and no disability funding for mental health (Mental Health Atlas 2005).

This study was carried out by Antoine Saad of the Department of MOH, Lebanon. Technical support was provided by WHO's Mental Health Evidence and Research Team in Geneva.

The preparation of this study would not have been possible without the collaboration of the Ministry of Health and IMC. We are grateful for the support to Ola Ataya – Maria Khalife. The study was funded by WHO- Lebanon.

The development of this study has also benefited from the collaboration with: IDRAAC. Data were collected in 2008 and is based on the year 2004-2005.

Policy and Legislative Framework

Policy, plans, and legislation

There is no mental health policy or plan present in the country. However, an essential medicines list is present in the country and includes at least one medicine in the following categories:

- | |
|------------------------|
| 1. Antipsychotics |
| 2. Anxiolytics |
| 3. Antidepressants |
| 4. Mood stabilizers |
| 5. Antiepileptic drugs |

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

The last piece of mental health legislation ACT #72 was enacted in Sept/9/1983 which focused on the Welfare Act and protection and treatment of mentally ill patients.

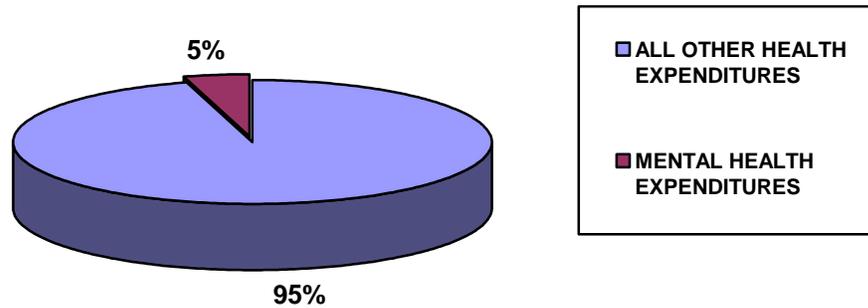
A review of a proposed project of mental health act is currently in process.

Financing of mental health services

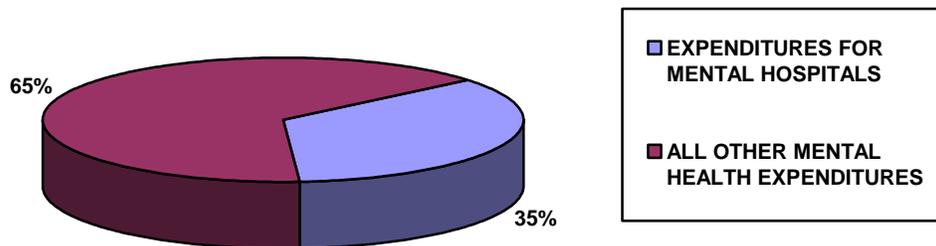
Five percent of health care expenditures by the government health department are directed towards mental health. Of all the expenditures spent on mental health, 54% of them are directed towards mental hospitals.

In terms of affordability of mental health services, 25% of the population has free access to essential psychotropic medicines. For those that have to pay for their medicines out of pocket, the cost of antipsychotic medication is 0.20 dollars per day, and the cost of antidepressant medication is 0.60 dollars per day. Severe mental disorders are covered in social insurance schemes.

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



Human rights policies

A national human rights review body doesn't exist; therefore there is no authority to oversee inspections in mental health facilities and to impose sanctions on those facilities that persistently violate patients' rights. An exception is the presence of Act #574 11/2/2004 on patients' rights and informed consent.

The review/inspection of human rights protection of patients in the mental hospitals in the country as well as for the community-based psychiatric inpatient units and community residential facilities are not performed given that there is no inspecting body.

Currently, there is no legislation in this matter and a call of action is desperately needed in this regard to enforce human rights inspection in all mental health facilities.

In terms of training, 67% of mental hospitals staff and none of inpatient psychiatric units staff have had at least one day training, meeting, or other type of working session on human rights in the last year.

Mental Health Services

Organization of mental health services

A Mental Health Authority does not exist in Lebanon. In addition, the service planning and monitoring and quality assessment of mental health services is lacking. Mental health services are not organized in terms of catchment/service areas.

Mental health outpatient facilities

There are 10 outpatient mental health facilities available in Lebanon, of which 30% are for children and adolescents only. Of all users treated in mental health outpatient facilities, the percentage of female and children or adolescents is unknown. No data is available for users treated in outpatient facilities when it comes to their primary diagnoses. Data on the average number of contacts per user is not available.

Forty percents of outpatient facilities provide follow-up care in the community, while 30% have mobile mental health teams. In terms of available treatments, no data are present about the percentage of patients in outpatient facilities who received one or more psychosocial interventions in the last year. The percent of outpatient facilities which have at least one psychotropic medicine of each therapeutic class is unknown (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

Day treatment facilities

There are no day treatment facilities available in the country.

Community-based psychiatric inpatient units

There are 5 community-based psychiatric inpatient units available in the country for a total of 1.175 beds per 100,000 populations. None of the beds in community-based psychiatric inpatient units are reserved for children and adolescents. Thirty four percent of patients are female and the percentage of children or adolescents is unknown. The diagnoses of admissions to community-based psychiatric inpatient units were primarily from the following diagnostic groups: mental and behavioural disorders due to psychoactive substance use (F10-F19) (36%), affective disorders (F30-F39) (29%), and psychotic disorders (F20-F29) (20%). On average patients spend 8.46 days in community-based psychiatric inpatient units per discharge. Some patients (21-50%) in community-based psychiatric inpatient units received one or more psychosocial interventions in the past year, while 100% of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility.

Community residential facilities

There are 7 community residential facilities available in the country. There are no data available; thus the number of patients treated per 100,000 populations and the number of beds reserved for children and adolescents are unknown. Data on the percentage of female and children/adolescents patients as well as the number of days spent in community residential facilities are not available.

Mental hospitals

There are 3 mental hospitals available in the country for a total of 42 beds per 100,000 populations. 33% of these facilities are organizationally integrated with mental health outpatient facilities. Five (5%) of these beds in mental hospitals are reserved for children and adolescents only. The number of beds has decreased by 2% in the last five years. These facilities treat 419 users per 100,000. Thirty Eight percent of patients are female and 2% are children or adolescents. The patients admitted in mental hospitals belong primarily to the following two diagnostic groups: schizophrenia, schizotypal & delusional disorders (F20-F29) (47%) and mood disorders (F30-F39) (12%). On average patients spend 279 days in mental hospitals. 19% of patients spend less than 1 year, 14% of patients spend 1-4 years in mental hospitals, 17% spend 5-10 years, and 49% of patients spend more than 10 years in mental hospitals. Some patients (21-50%) in mental hospitals received one or more psychosocial interventions in the past year. 100% of mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility.

Forensic and other residential facilities

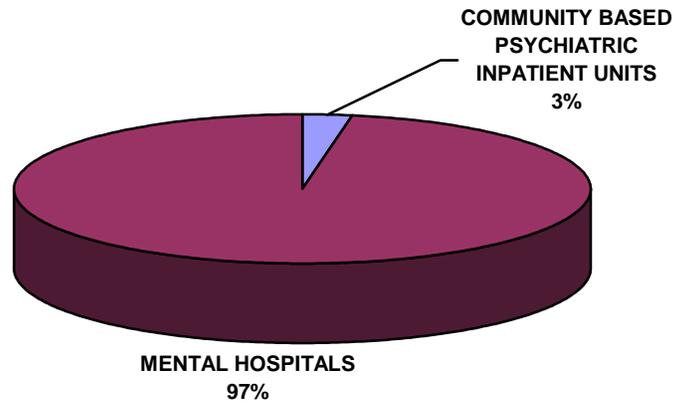
In addition to beds in mental health facilities, there are no beds for persons with mental disorders in forensic inpatient units and an unidentified number of beds in other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. Due to the absence of forensic facilities and units, no data about users or length of stay are available.

Human rights and equity

Five percent of all admissions to community-based inpatient psychiatric units and 15% of all admissions to mental hospitals are involuntary. Between 2-5% of patients were restrained or secluded within the last year in community-based psychiatric inpatient units, in comparison to 6-10% in mental hospitals. 100% of the psychiatric beds in the country are located in or near the largest city. Such a distribution prevents access for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

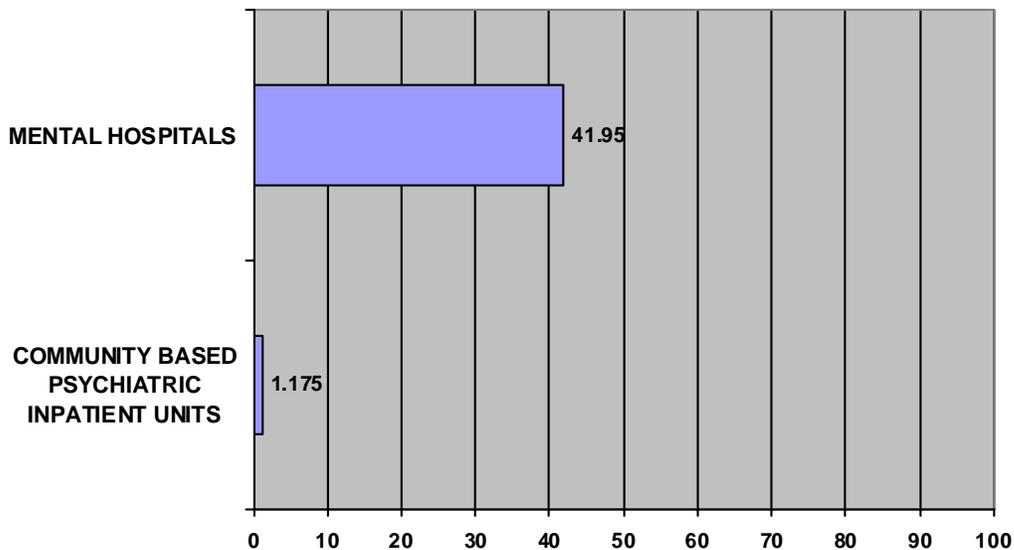
Summary Charts

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

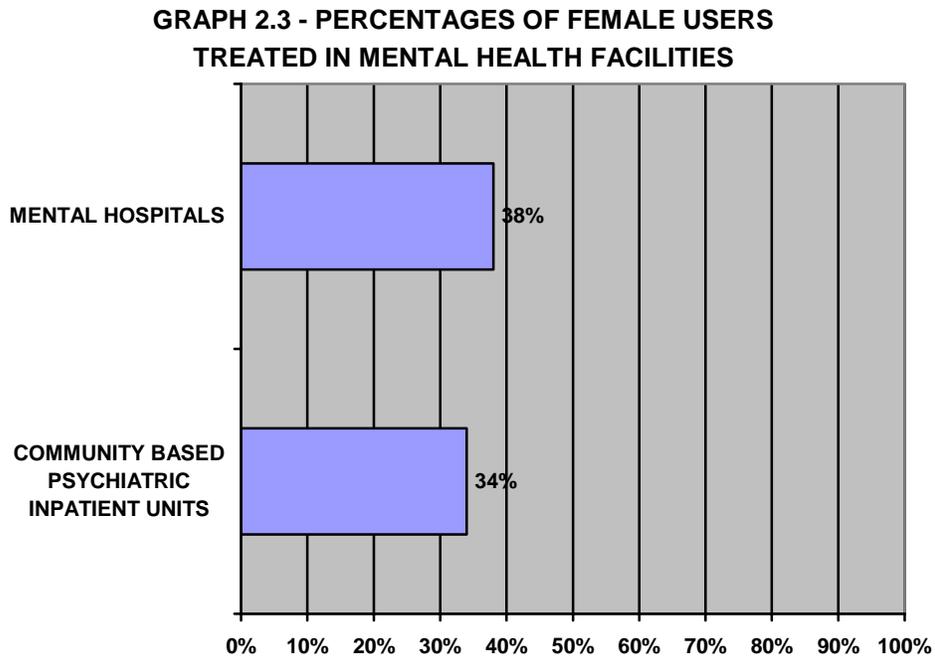


The majority of beds in the country are provided by mental hospitals, followed by community-based psychiatric inpatient units. There are no beds in terms of community residential facilities nor for forensic units.

GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)

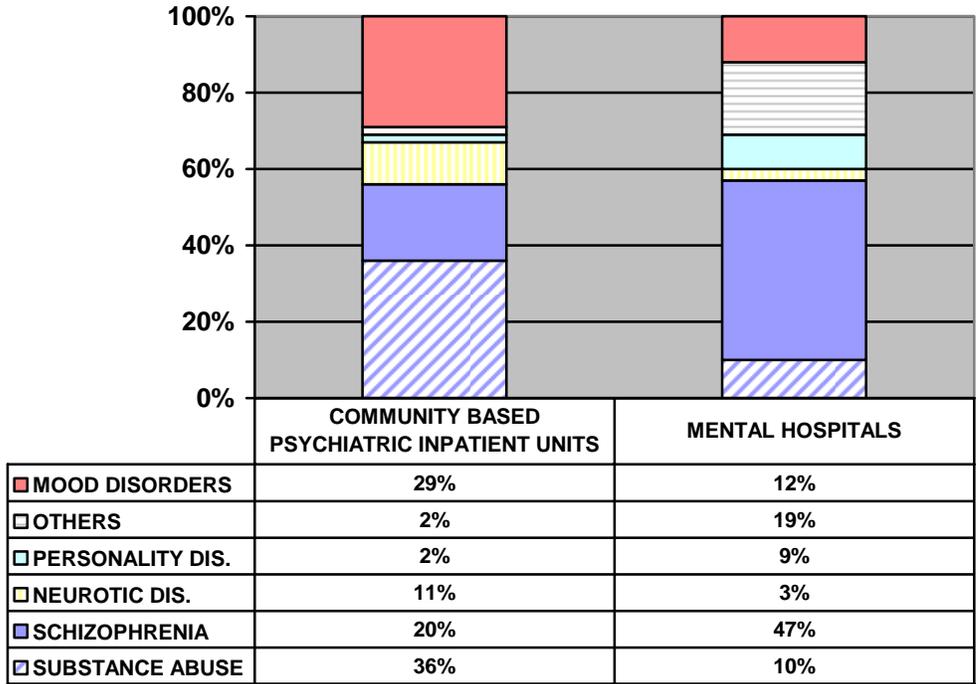


The majority of the users are treated in mental hospitals.



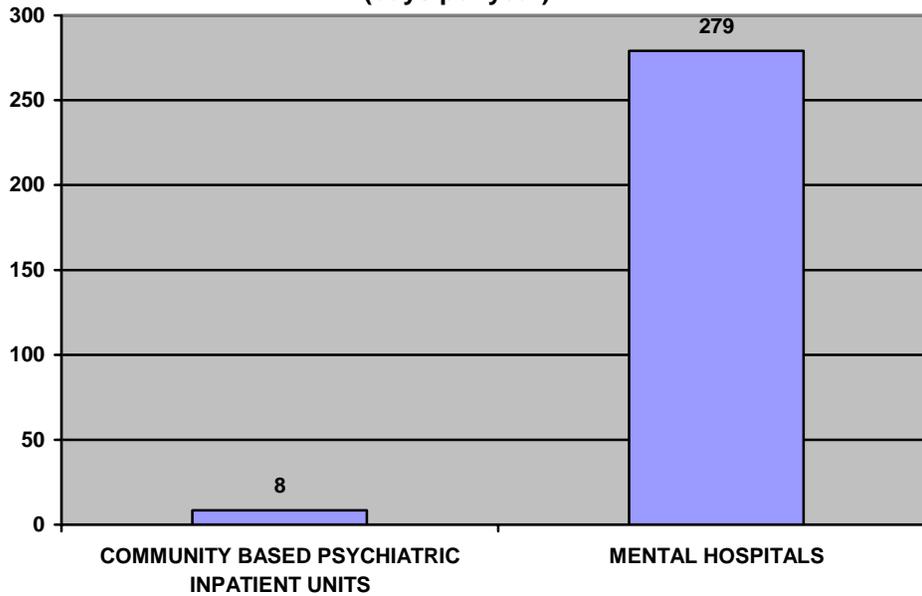
Female users make up less than 50% of the population in all mental health facilities in the country.

GRAPH 2.4 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



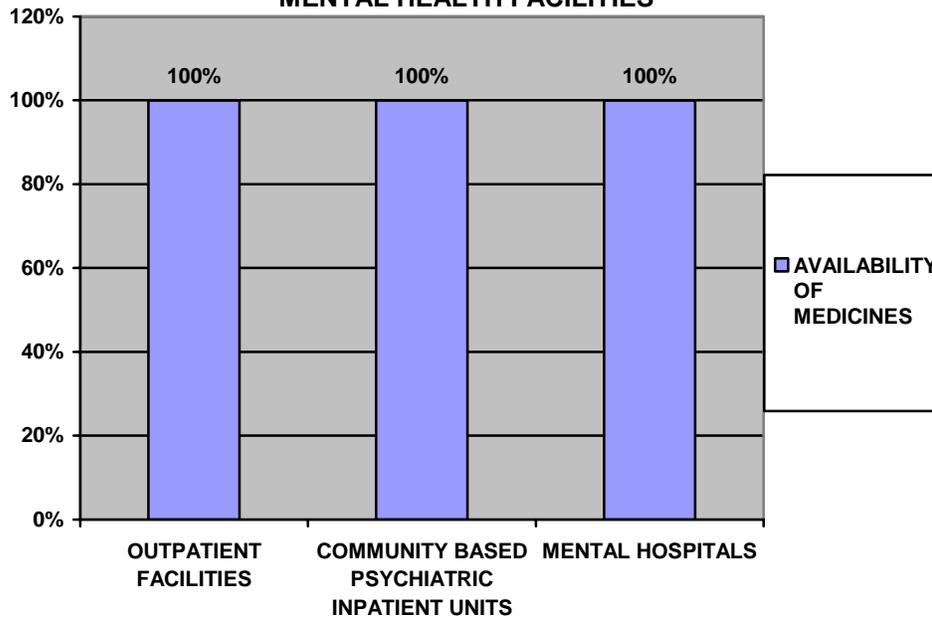
The distribution of diagnoses varies across facilities: in outpatients facilities no data is available, within community based inpatient units substance abuse and mood disorders are most common, and in mental hospitals schizophrenia and "other" diagnoses are most frequent.

**GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES
(days per year)**



The longest length of stay for users is in mental hospitals, followed by community-based psychiatric inpatient units. No data is available for community residential facilities.

GRAPH 2.7 - AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



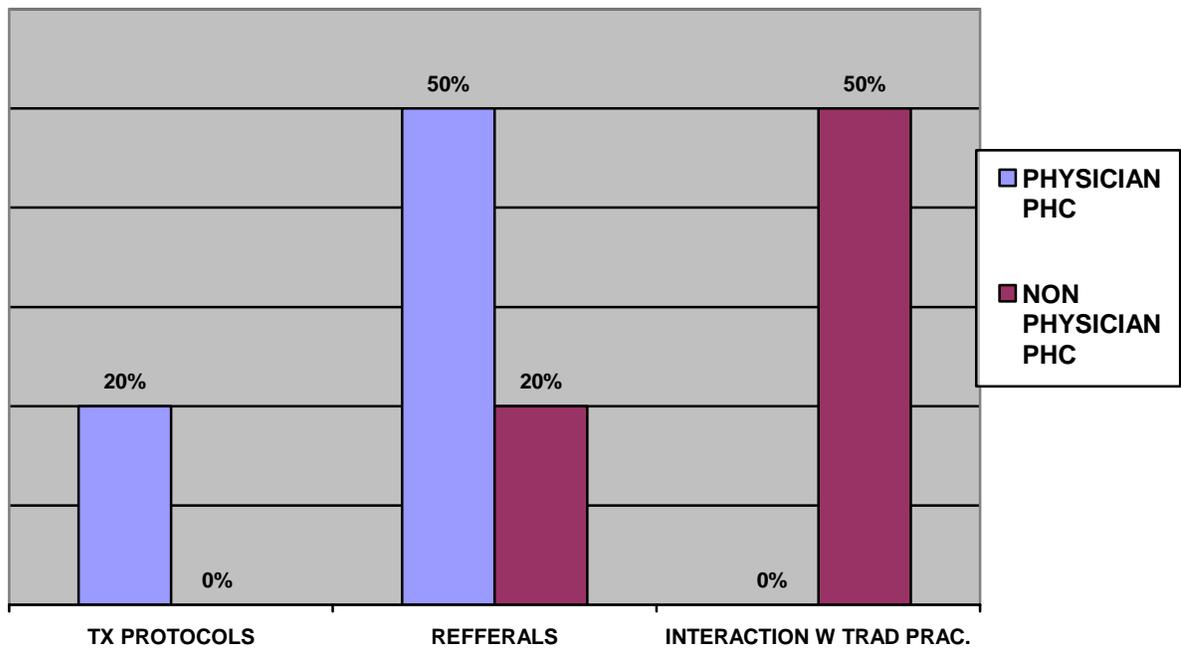
Psychotropic drugs are most widely available in mental hospitals, inpatient units, as well as in outpatient mental health facilities.

Mental Health in Primary Health Care

One percent of the training for medical doctors and nurses devoted to mental health. 6% of training in mental health is done for non-doctor/non-nurse primary health care workers. In terms of refresher training, 5% of primary health care doctors have received at least two days of refresher training in mental health, while the percentage of nurses and non-doctor/non-nurse primary health care workers who have received such training is unknown.

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. In terms of physician-based primary health care clinics, a few (between 1-20%) have assessment and treatment protocols for key mental health conditions, whereas the percentage for the non-physician-based clinics for primary health care is unidentifiable. Some of physician-based primary health care clinics (between 21% - 50%) make on average at least one referral to a mental health professional. Most of these clinics, however, make more than one referral per month. A few non-physician based primary health care clinics (between 1- 20%) make a referral to a higher level of care (e.g., mental health professional or physician-based primary health clinic). In terms of professional interaction between primary health care staff and other care providers, a few primary care doctors (between 1-20%) have interacted with a mental health professional at least once in the last year. None of physician-based PHC facilities (0%) have had interaction 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 - COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE



Prescription in primary health care

Non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications, as well as primary care nurses. In contrast, primary health care doctors are allowed to prescribe without restriction. As for availability of psychotropic medicines, all or almost all physician-based PHC clinics (between 80-100%) have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a nearby pharmacy all year long, in comparison to (0%) in non-physician based primary health care.

Human Resources

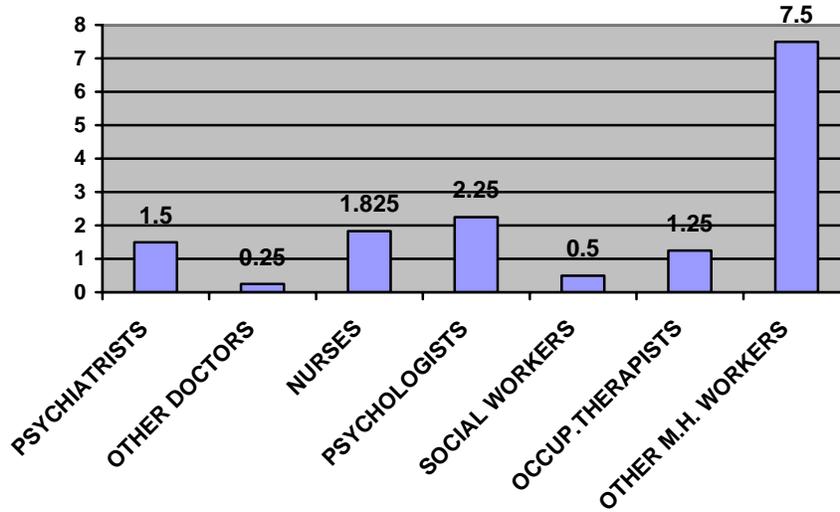
Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 population is 15.075. The breakdown according to profession is as follows: 1.5 psychiatrists; 0.25 other medical doctors (not specialized in psychiatry); 1.825 nurses; 2.25 psychologists; 0.5 social workers; 1.25 occupational therapists; and 7.5 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.

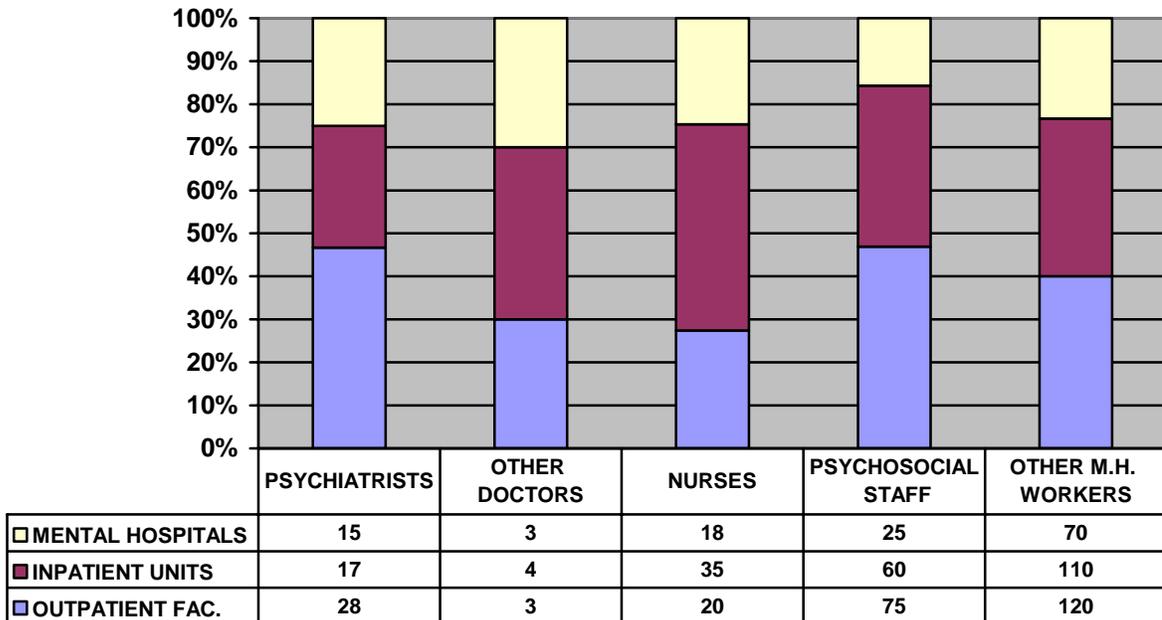
The majority of psychiatrists work in private practice and for profit mental health facilities, while two thirds of the psychosocial staff (psychologists, social workers, nurses and occupational therapists) work for government administered mental health facilities.

Regarding the workplace, 28 psychiatrists work in outpatient facilities, 17 in community-based psychiatric inpatient units and 15 in mental hospitals. Three medical doctors, not specialized in mental health, work in outpatient facilities, 4 in community-based psychiatric inpatient units and 3 in mental hospitals. As for nurses, 20 work in outpatient facilities, 35 in community-based psychiatric inpatient units and 18 in mental hospitals. Seventy five psychosocial staff (psychologists, social workers and occupational therapists) works in outpatient facilities, 60 in community-based psychiatric inpatient units and 25 in mental hospitals. With regards to other health or mental health workers, 120 work in outpatient facilities, 110 in community-based psychiatric inpatient units and 70 in mental hospitals. In terms of staffing in mental health facilities, there are 0.64 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.01 psychiatrists per bed in mental hospitals. As for nurses, there are 0.74 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.01 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 3.62 for community-based psychiatric inpatient units, and 0.05 per bed in mental hospitals.

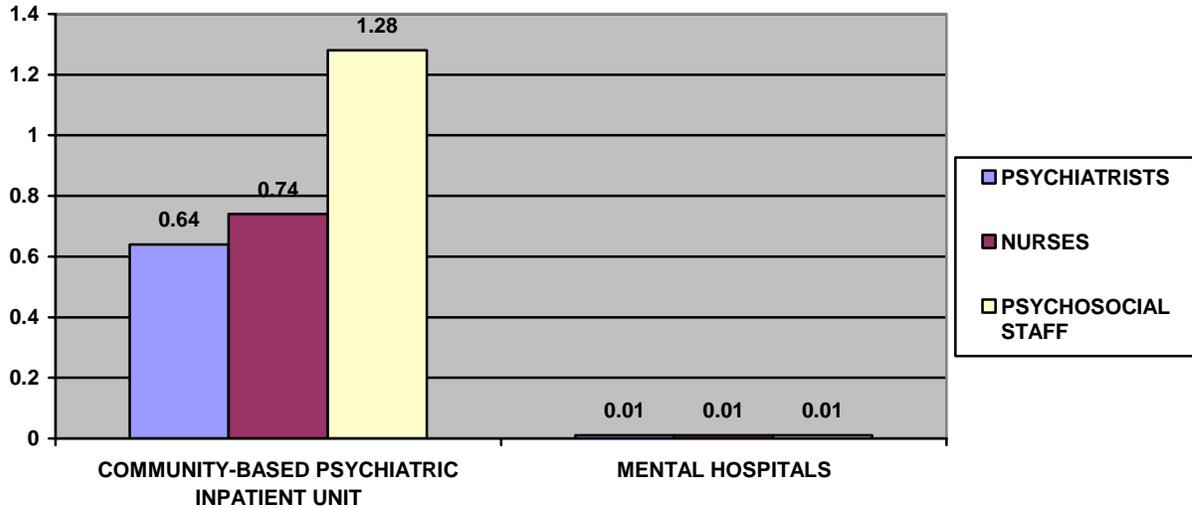
GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



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



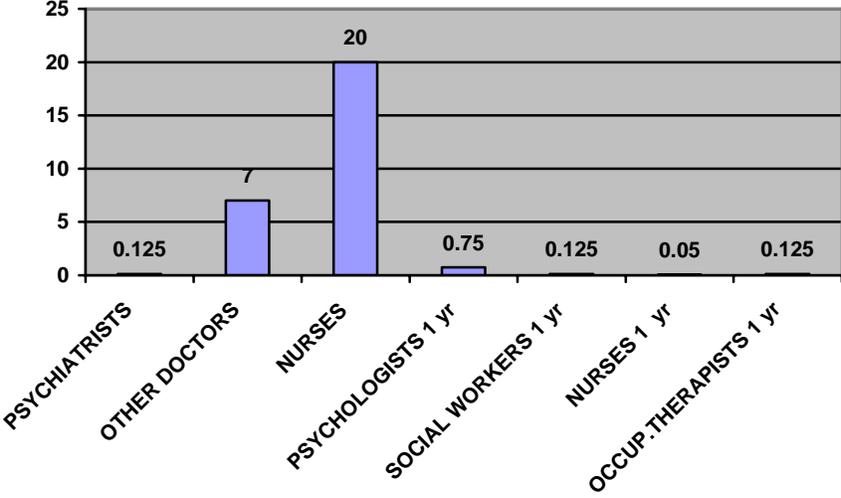
GRAPH 4.3 - AVERAGE NUMBER OF STAFF PER BED



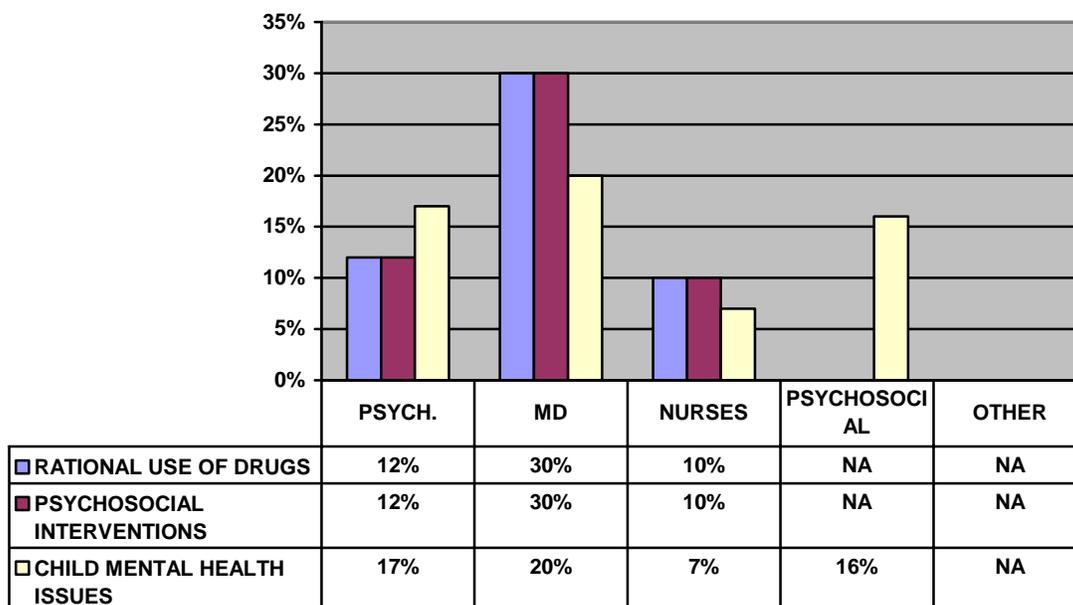
Training professionals in mental health

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 0.125 psychiatrists; 0.175 other medical doctors (not specialized in psychiatry); 0.5 nurses; 0.75 psychologists; 0.125 social workers; 0.125 occupational therapists per 100,000 population, and unknown number of 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). Between 1 and 20 % of psychiatrists immigrate to other countries within five of the completion of their training.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



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



Consumer and family associations

There are 5 users/consumers that are members of consumer associations and 4 family members that are members of family associations. The government provides support for consumer associations, and for family associations. Both consumer and family associations were not involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years.

While there is no interaction between mental health facilities and consumer associations, a few mental health facilities have had interaction with family associations. In addition to consumer and family associations, there are 70 NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups.

Public education and links with other sectors

Public education and awareness campaigns on mental health

There is no coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, and professional organizations have

all promoted public education and awareness campaigns in a limited manner in the last five years. These campaigns have targeted the following groups: The general population, children, women, and trauma survivors. In addition, there have been public education and awareness campaigns targeting professional groups including teachers and healthcare providers, social services staff, complimentary/ alternative/ traditional sector.

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 who are disabled, and (2) provisions concerning protection from discrimination (dismissal, lower wages) solely on the account of a mental disorder. Both of these provisions are not enforced. In addition, the following legal provision does not exist - provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders. At the present time, there is no legislative or financial support for discrimination in housing.

Links with other sectors

In addition to legislative and financial support, there are formal collaborations between the government department responsible for mental health and the departments/agencies responsible for: HIV/ AIDS, reproductive health, child and adolescent health and elderly. In terms of support for child and adolescent health, 1% of primary and secondary schools have either a part-time or full-time mental health professional, and a few schools (between 1-20%) have school-based activities to promote mental health and prevent mental disorders. Regarding mental health activities in the criminal justice system, the percentage of persons with mental retardation is about 6-10%. The corresponding percentage for psychosis is about 6-10%. Few prisons (between 1-20%) have at least one prisoner per month in treatment contact with a mental health professional. As for training, few police officers (between 1-20%) and few judges and lawyers (1-20%) have participated in educational activities on mental health in the last five years. In terms of financial support for users, none of the mental health facilities have access to programs 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 for a mental disability is not available.

Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. This list includes the number of beds, admissions, involuntary admissions, length of stay, and patient diagnoses. The government health department have not received enough data from mental hospitals, community-based psychiatric inpatient units, and mental health outpatient facilities. Therefore no report was produced on the data transmitted to the government health department. In terms of research, 5% of all health publications in the country were on mental health. This research focused on the following topics: epidemiological studies in community samples, non epidemiological clinical/ questionnaires assessment of mental health disorders, services research, and psychosocial, psychotherapeutic, pharmacological, surgical, and electroconvulsive interventions.

TYPE OF INFORMATION COMPILED	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FACILITIES
N° of beds	67%	100%	NA
N° inpatient admissions/users treated in outpatient facilities	67%	100%	NA
N° of days spent/user contacts in outpatient facilities.	67%	100%	NA
N° of involuntary admissions	33%	60%	NA
N° of users restrained	33%	20%	NA
Diagnoses	67%	100%	NA

Conclusions

Mental illness is a worldwide problem with implications at the individual and national levels. In the light of expected increases in mental illness and its burden worldwide, WHO has set forth recommendations to combat this public health concern. Through the current assessment and surveillance of available services in Lebanon, it is apparent that mental health services are inadequate and are not given the attention they require.

Treating mental illness in Lebanon, like everywhere in the world, is cost-effective.

As for research, it is absolutely needed to fill in those gaps and to advance the delivery of quality health care at the lowest possible cost. The goals of any mental health service ought to include prevention of mental illness, increasing awareness of the public towards these issues, providing services in the community in a way easily accessible to those most at need and treatment by qualified mental health professionals.

In order to implement the changes needed, the following components are necessary: greater funding and budgeting, manpower, mental health department within MoPH, accessible programmes to populations at risk, community-based mental health services, affordable and accessible psychosocial service and medication availability, cost-effectiveness studies and analysis in delivering the standard of care, and a sustainable mental health system and policy protected by the passing of legislation.

Since 1975, WHO has repeatedly made recommendations to integrate mental health services into primary care settings. More than 30 years later, these recommendations continue to be proposed. While complete fulfillment of the 10 WHO recommendations will require extensive funding and expertise, certain cost-effective measures in the treatment of mental illness in Lebanon can be initiated, and when adopted, are expected to lead to a healthier and more productive society. Indeed, certain steps can be undertaken without delay to ensure the promotion of mental health to the forefront of the national agenda.

No Health without Mental Health

Lebanon is a small country which has suffered from various wars and political conflicts throughout its history. Consequently a considerable number of Lebanese people have been exposed to war-related traumatic events at some point in their lives. Many display symptoms of mental disorders - mainly anxiety and mood disorder as per the latest local study. Unfortunately, the number of individuals with mental disorders not receiving a treatment is considerably high - 9 out of 10. Moreover, more than 90% of MH services are provided by the private sector & therefore paid out-of-pocket by service users.

Mental health is an important factor for any society to move forward, prosper and live in peace. Lebanon has a pool of psychiatrists, clinical psychologists, social workers, psychiatric nurses, mental health counselors as well as many other professionals (OT, speech therapist). Therefore, what is needed is funds to implement the right action plan to allow mental health system service delivery to be available, accessible and affordable in all areas of the country through public community-based outpatient services.

Mental illness ought to be de-stigmatized through different kinds of awareness campaigns in order to move from an isolated hospital-based approach to an integrated community-based model.