Lebanese Republic
Ministry of Public Health
National Mental Health Programme

National Mental Health Strategy

For Lebanon (2024 - 2030)

Reforming the Mental Health System

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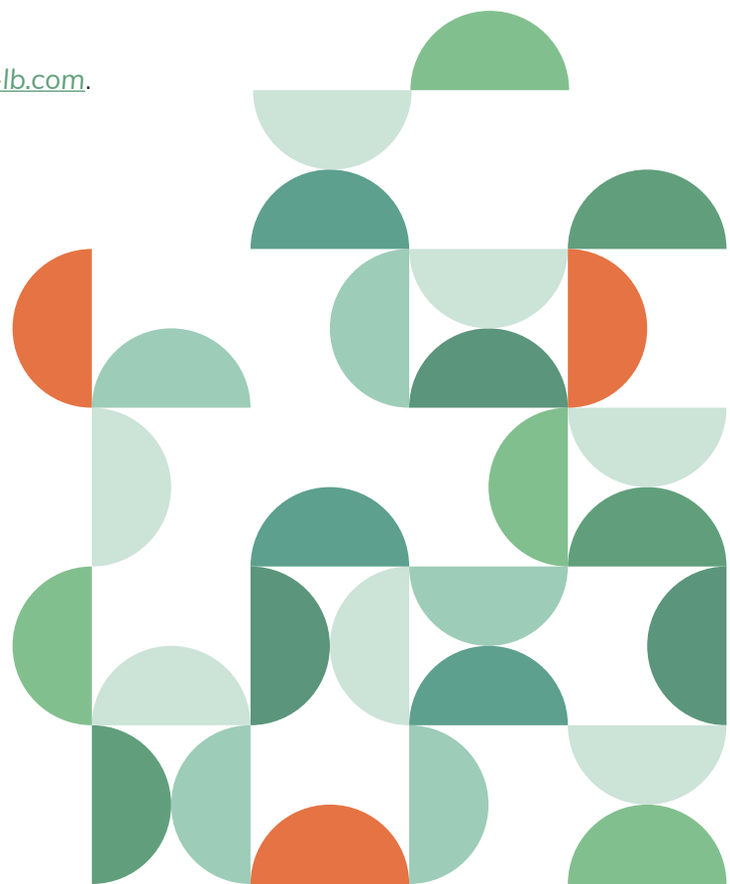
This document is available in Arabic.

Both English and Arabic documents are available at:
The National Mental Health Programme (moph.gov.lb)

Suggested citation:
Ministry of Public Health. 2024. National Mental Health Strategy for Lebanon (2024-2030)- Reforming the mental health system. Beirut: Lebanon.

For more information, please contact *mh.moph@nmhp-lb.com*.



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FOREWORD

It is with great pleasure and a profound sense of responsibility that I share the updated National Mental Health Strategy for Lebanon (2024-2030) developed by the National Mental Health Programme (NMHP) at the Ministry of Public Health (MOPH) in close collaboration with the World Health Organization.

As our nation faces unique challenges, the mental health of the population living in Lebanon remains a priority that requires our attention and commitment. The devastating events of the past few years, including the COVID-19 pandemic, the economic crisis, the Beirut Port explosion, and other upheavals, have taken their toll on the population's mental health and well-being and further strained the health system and worsened health indicators. Mental health is at the centre of our daily lives and an integral cornerstone within the National Health Strategy in Lebanon.

This updated National Mental Health Strategy reflects a collective effort and commitment of all relevant actors to strengthen the mental health system for all persons living in Lebanon. It has been developed through extensive consultations with ministries, UN agencies, local and international NGOs, mental health experts, civil society organizations, and individuals with lived experiences. I am grateful for their invaluable insights and expertise that have helped shape the strategy to align with our national priorities and to address the remaining gaps and challenges that still face the mental health system in Lebanon. I also wish to extend my gratitude to the NMHP team and to the programme director Dr Rabih El Chammay, for all their hard work to improve the mental health system in Lebanon, to the World Health Organization (WHO) Country Office for their continuous technical and strategic support, and to the Agence française de développement (AFD) for their financial support for the development of this strategy.

Over the coming seven years, we commit to strengthening effective leadership and governance structures, increasing equitable access to quality community-based mental health care, and increasing promotive and preventive evidence-based interventions for mental health. We also aim to prioritize research and the systematized collection of information for surveillance and monitoring of key mental health indicators to inform evidence-based policies and planning.

As we continue this journey to strengthen the mental health system in Lebanon, we recognize that mental health is not solely the responsibility of the MOPH but a collaborative endeavour that requires the active participation of all relevant stakeholders. And I believe that our collective dedication and commitment can ensure that the mental health of all people living in Lebanon becomes a reality.

Dr. Firass Abiad
Minister of Public Health

ACKNOWLEDGEMENTS[1]

Acknowledgement goes to all individuals and organizations who contributed and facilitated the process of developing and reviewing this strategy document, with special credit to those who had a key role in its drafting, editing, revision, and finalization. Special acknowledgement goes to the technical support received from the World Health Organization (WHO) Lebanon country office and the financial support provided by the Agence française de développement (AFD) for the development of this strategy.

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2 The draft strategy was sent for review to national stakeholders and experts. The persons who are acknowledged for their input are the ones who reviewed the draft and provided feedback.

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Rafic Hariri University Hospital, RHUH: Lama Souaiby
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WHO HQ: Ken Carswell
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Justice for Mental Health: Sasha Al Hajj Assaf, Thurayya Zreik
Kafa: Mira Merie
Lebanese Centre for Human Rights: Jeanine Dede, Julie Khoury, Nisrine Moufarrej, Rima Nassar, Stephanie Haddad

Lebanese Red Cross: Berna Beyrouthy
Medical Aid for Palestinians: Jacques Lahoud, Lana Kalawoun
Medair: Joewey-Ann Semaan
Menahra: Elie Aaraj
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Caritas Lebanon: Sami Chalhoub
Deutsche Gesellschaft für Internationale Zusammenarbeit, GIZ: Alena Mehlau, Philip Noun
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Professor Shekhar Saxena (*psychiatrist and international consultant*)

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Special acknowledgement goes to the 88 persons from the public who have shared their feedback on the strategy draft when posted publicly for review.

Persons who supported in facilitation[3] of the national consultation meeting:

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3 Group work facilitation, note-taking, administrative support, etc.

LIST OF FIGURES

LIST OF ABBREVIATIONS

CPI	Consumer Price Index
DALYs	Disability-Adjusted Life Years
EMDR	Eye Movement Desensitization and Reprocessing
ER	Emergency Room
FAO	Food and Agriculture Organization
GDP	Gross Domestic Product
GSF	General Security Forces
GPs	General Practitioners
HIS	Health Information System
IPT	Interpersonal Psychotherapy
LCRP	Lebanon Crisis Response Plan
MEHE	Ministry of Education and Higher Education
M&E	Monitoring and evaluation
mhGAP	Mental health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MOPH	Ministry of Public Health
MOSA	Ministry of Social Affairs
MSNA	Multi-sector needs assessment
NCDs	Noncommunicable Diseases
NGOs	Non-governmental organizations
NMHERM	National mental health emergency response mechanism
NMHP	National Mental Health Programme
PHC	Primary Health Care
PHENICS	Primary Health Care Network Information Communication System
PM+	Problem Management Plus
PRL	Palestinian refugees in Lebanon
PTSD	Post-Traumatic Stress Disorder
RCT	Randomized Control Trial
SGBV	Sexual and Gender-based Violence
UHC	Universal Health Coverage
UN	United Nations
UN ESCWA	United Nations Economic and Social Commission for West Asia
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
VASyR	Vulnerability Assessment of Syrian Refugees in Lebanon
WFP	World Food Programme
WHO	World Health Organization
WHO-AIMS	World Health Organization Assessment Instrument for Mental Health Systems

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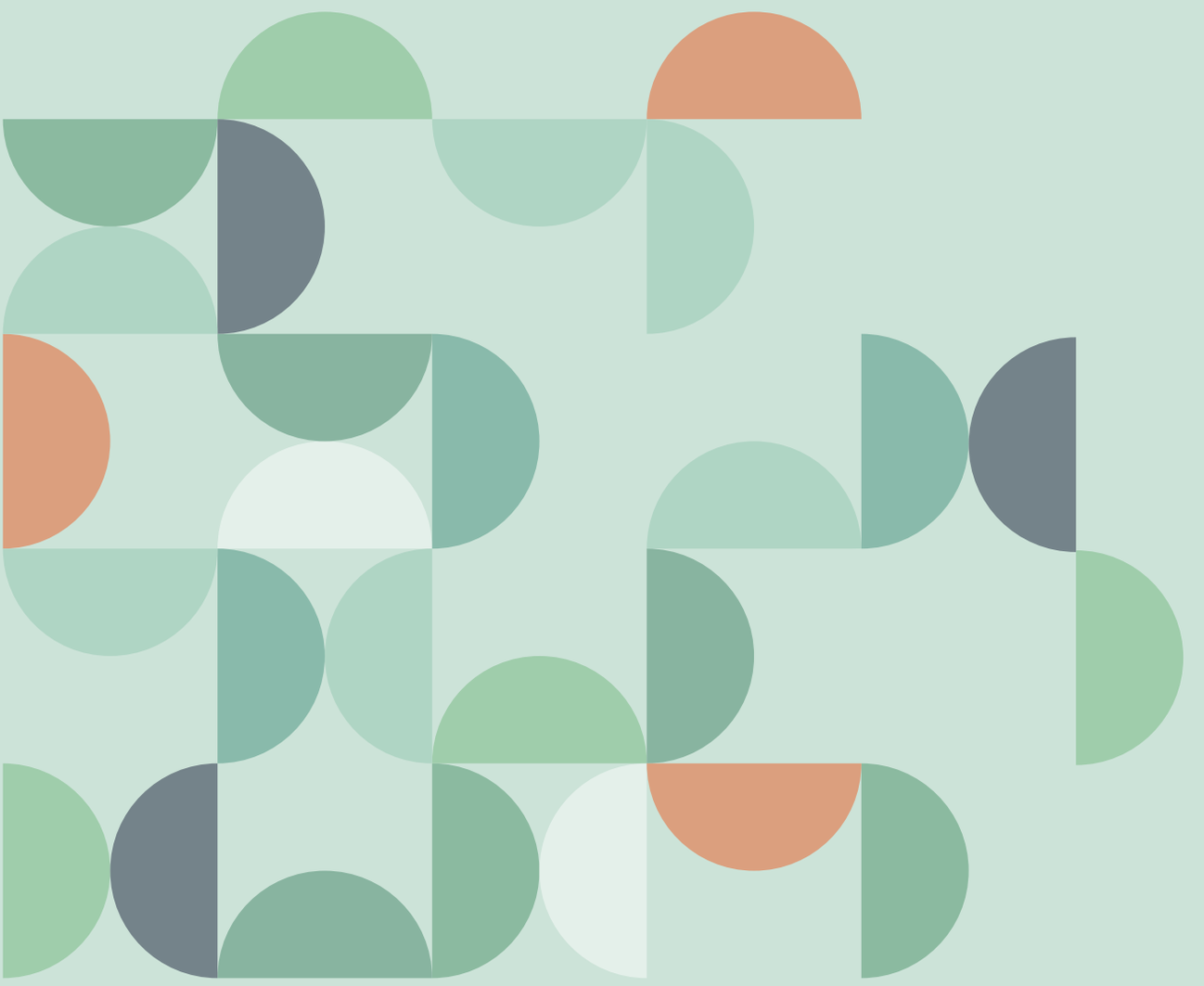


EXECUTIVE SUMMARY

There is a lot that can be done to promote and protect mental health for all populations and help people going through difficult times, and we all have a role to play. This strategy is a roadmap spanning over a 7-year period, to guide the Ministry of Public Health (MOPH) and all relevant stakeholders, to synergize efforts towards improving mental health in Lebanon. Especially in our country context, improving mental health also requires addressing the social, economic, and political factors, all of which are determinants that negatively impact mental health and hinder recovery.

The development of the strategy involved a comprehensive approach to address key questions. Firstly, an assessment of the country's mental health landscape was conducted, encompassing burden of diseases and needs, and the current system available to respond to these needs, as well as review of efforts done so far to identify areas of action that require sustainment or enhancement. Furthermore, consultations with local experts and stakeholders including persons with lived experience were conducted to inform the strategy's priorities. The strategy was also shaped by insights derived from international guidelines, including WHO guidelines and evidence-based recommendations. Special attention was given to selecting approaches that were contextually relevant and adaptable to the local context. Finally, the strategy was shared with the public for further input and refinement.

The strategy comprehensively addresses all building blocks of the mental health system to improve the overall mental health of individuals and prevent mental disorders, with a focus on the below key topics:

1. Ensure there is more awareness about mental health and less misconceptions, and that interventions that are proven to help in preventing mental ill health are increasingly adopted and implemented. This includes emphasizing the importance of addressing the political and socio-economic determinants of mental health.
2. Empower and equip individuals with the necessary resources, knowledge, skills, and support systems to protect their mental health and to access available services when needed.
3. Ensure that individuals with mental health conditions can access high-quality care as soon as they need it, regardless of their place of residence.
4. Support health care providers and all relevant professionals in doing their jobs, through evidence-based capacity-building as well as through supporting them in safeguarding their own mental health.
5. Limit and prevent harmful practices during the provision of mental health services that violate human rights and quality principles.
6. Bolster the availability of data and the implementation of helpful research to inform and reinforce efforts aimed at enhancing mental health across the country.
7. Establish the appropriate legal frameworks, policies, and funding mechanisms to support the strengthening of the mental health system.
8. Integrate the views, perspectives, and preferences of persons with lived experience in the design and development of services and related policies and practices.

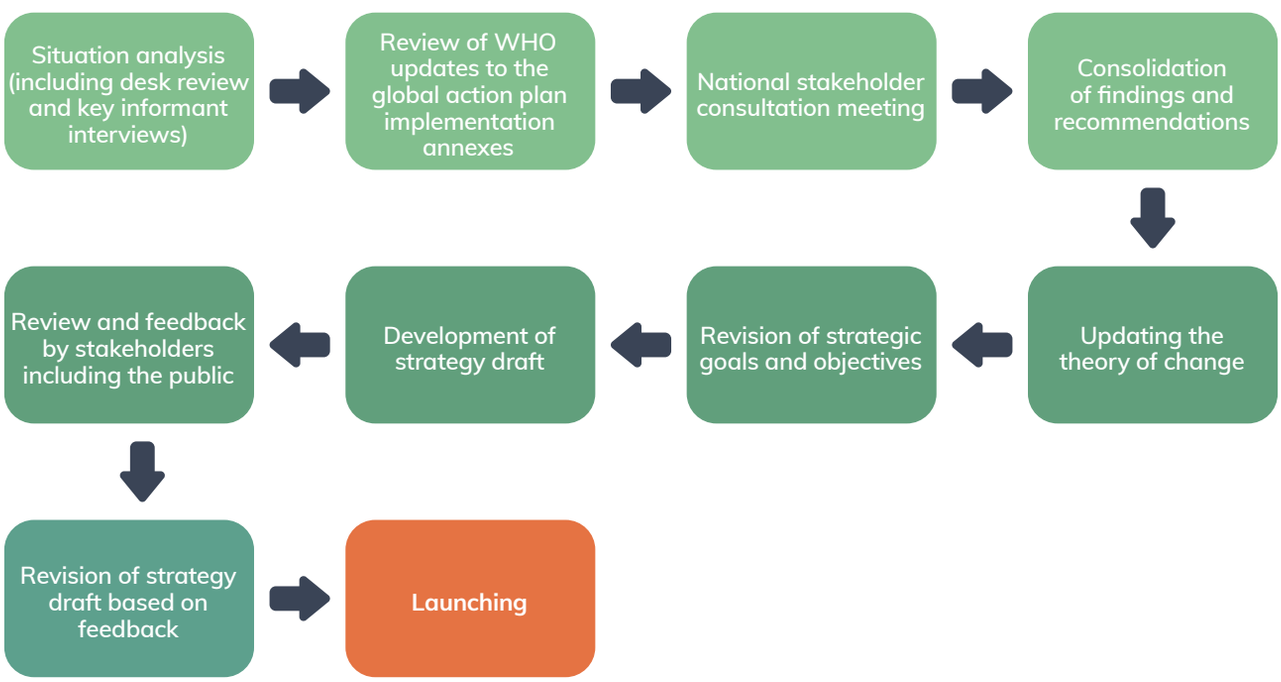
Each of these topics has specific actions planned to be implemented to make the needed improvements in the country.

STRATEGY DEVELOPMENT PROCESS

The first National Strategy for Mental Health in Lebanon was launched in 2015, following a participatory process with all stakeholders, in line with the *WHO Global Action Plan for Mental Health*. As the implementation period of the WHO Global Action Plan was extended till 2030, the National Mental Health Strategy's implementation timespan was extended till the same year. Ensuring adaptation to emerging needs since its launch was deemed nevertheless necessary, and as such, a revision process of the strategy was initiated to ensure needed updates are incorporated.

The revision process is outlined in figure 1 below.

Figure 1. *Development process of the National Mental Health Strategy 2024-2030*



The key principles upheld throughout the process included the below. Details on steps taken to maintain them are detailed in table 1.

- Maximizing the participation of all stakeholders
- Maintaining transparency
- Building on evidence and international guidelines and frameworks

Table 1. Steps taken to uphold the key principles for the strategy development process

Principle	Process steps
Maximizing the participation of all stakeholders	• Inviting key informants to participate in interviews as part of the situation analysis. • Inviting all stakeholders to participate in the national consultation meeting. • Sharing with all stakeholders, including the public, the draft strategy for review and input.
Maintaining transparency	• Presenting the full strategy development process to stakeholders. • Documenting how feedback of stakeholders was addressed and the rationale behind it.
Building on evidence and international guidelines and frameworks	• Reviewing the WHO comprehensive mental health action plan 2013-2030. • Reviewing recommendations in the WHO World Mental Health Report.

The development process started with an extensive desk review of reports, studies, and articles from international organizations. This review aimed to provide an overview of Lebanon's current crises and their impacts on the health care system, particularly the mental health system. Subsequently, key informant interviews were conducted to complement the desk review. Findings were consolidated into a comprehensive situational analysis of the country's mental health landscape. The achievements of the 2015-2020 National Mental Health Strategy were compiled and mapped, and remaining gaps, challenges, and opportunities were identified. To validate these findings and set priorities for the updated strategy, a national consultation meeting was held with focused discussions around the various domains of action. A total of 58 persons participated in this consultation exercise, representing 30 stakeholder entities across various sectors including ministries, international agencies, local and international non-governmental organizations (NGOs), academic institutions, professionals' associations, the local service user association, etc. Through these consultations, gaps were further articulated, and priorities were validated. The updating of the theory of change also supported the articulation of priorities.

Subsequently, the strategy draft was shared with stakeholders for review.

A total of **125 persons** provided valuable feedback.

Notably, **68%** of these respondents expressed having **lived experience with mental health**.

Among the respondents were representatives from professional orders and associations, ministries, representatives of the local service user association, researchers and academic professionals, persons working in mental health promotion, prevention or service provision in international and local NGOs, United Nations (UN) agencies, civil society organizations, and more.

This process ensured that the strategic goals and objectives of the updated strategy were well-informed, comprehensive, and tailored to the specific needs of Lebanon's mental health landscape.

SITUATION ANALYSIS

I. OVERALL SITUATION IN LEBANON: A COUNTRY GRAPPLING WITH MULTIPLE CRISES

A. Context

Lebanon has been struggling with compounded crises that have added a toll on people's mental health and put enormous strain on the country's already fragile health system (1-3).

According to the World Bank, Lebanon's economic crisis ranks among the **top 3 most severe economic collapses** globally since the mid-nineteenth century (1).

Lebanon's Gross Domestic Product (GDP) dropped by 36.35% from an estimated US$52 billion in 2019 to a projected US$18.08 billion in 2021, the **highest contraction** in a list of 193 countries (4, 5).

According to the United Nations Economic and Social Commission for West Asia (UN-ESCWA), around 4 million people are living in **multidimensional poverty**; the rate of the latter has almost doubled from 42% in 2019 to 82% of the total population in 2021 (6). The **unemployment** rate also almost doubled, having reached 29.6% in 2022 up from 11.4% in 2019 (7, 8). Around 91% of Lebanese and Palestinian refugee households interviewed in the 2022 multi-sector needs assessment (9), reported having **unmet needs** with 20% of them having extreme to very extreme needs; 16% for Lebanese, 27% for Palestinian refugees in Lebanon (PRL), and 9% for migrant households have extreme unmet needs. The 2023 multi-sector needs assessment showed that 92% of interviewed Lebanese households reported being unable to meet all their essential needs, with the top reported need being health care as reported by 64% of the interviewees (10).

Living conditions have been deteriorating; all Lebanese governorates have been experiencing electricity blackouts that sometimes exceeded 22 hours per day (2, 6, 11, 12), with wider inequities in electricity access, favouring those who can afford private diesel generators. This has put various essential services in crisis mode, including hospitals, most of which were forced to operate at only 50% capacity during that period (12, 13). The economic collapse, rise in unemployment and sharp increase in food prices have been pushing Lebanon into an **acute food insecurity crisis** (14). The Lebanon Vulnerability and Food Security Assessment conducted by WFP and the World Bank in 2021 revealed that 47% Lebanese and refugee households have challenges in accessing food and other basic needs (15), where refugees are at a particular risk of food insecurity (14). According to the World Bank, the Consumer Price Index (CPI) hit an all-time high record of 612.4 in 2021 which is almost five times the one recorded in 2019 (16). The dramatic effect that the economic crisis has had on the livelihoods of all people living in Lebanon and its associated deterioration of basic services and the limited country resources has been the primary factor for social tensions between the refugee and Lebanese communities. The Lebanon Crisis Response Plan (LCRP) 2023 report indicates that the main source of these inter-communal tensions is the competition over lower-skilled jobs and over essential goods and services. **Intra-communal tension** among the Lebanese communities have also been on the rise in recent years, with the main driver being the political instability and differences (17). This continued decline in the economy, heightened political instability, and ongoing worry regarding access to necessities, along with the limited capacity of security institutions,

resulted in the **deterioration of social safety and security** and increasing crime and consequently to additional distress for all communities in Lebanon.

Lebanon has been also weathering an unprecedented **health crisis** because of the COVID-19 pandemic that started in 2020 and the surge of the cholera outbreak in 2022. This is coupled with a political stagnation and **civil unrest**, a protracted **refugee crisis**, and a **humanitarian crisis** resulting from the devastating explosions that rocked the capital on 4 August 2020 (1, 2, 18, 19). The massive explosion, which ranked among the most powerful non-nuclear explosions ever recorded, killed more than 200 people, injured thousands, left around 300,000 people homeless and caused damages estimated at US$15 billion (20-23).

B. Impact of Lebanon's crises on the health system

The Lebanese health system, characterized by a dominant private sector and robust NGO sector, has been severely affected by the multiple compounded crises. The **currency devaluation** has been causing detrimental impacts on the health sector. The total health expenditure per capita (LBP 975,000) which was equivalent to US$ 650 is now equivalent to less than US$ 50. Health care institutions have become consumed with securing fuel and necessities, limiting hours of service provision, or closing wards in hospitals, in addition to other coping mechanisms. In addition, basic and life-saving medications have been in short supply with the restrictions in foreign currency, severely limiting the importation of vital medications and medical goods (2, 13, 24, 25).

Infrastructural barriers such as electricity cuts and internet connectivity have also hindered the public's access to remote health services (17, 26). The cost of health services and medications has been largely increasing given the severe inflation and currency depreciation, where a **1,123% increase in medication prices** was recorded between 2018 and 2022 (27). A study examining the affordability trends of psychiatric medications in Lebanon revealed a significant 7.47-fold increase in the percentage of mean monthly income allocated to purchasing these medications from 2019 to 2023 (28).

Furthermore, the health system is losing a critical mass of **human resources** needed for the provision of services, which will have a long-lasting impact as the country grapples with myriad crises (1).

Almost **40% of skilled medical doctors** and **30% of registered nurses** have already left the country either permanently or temporarily (13).

The flight of the human capital will not only reduce society's access to the services provided by these professions but will also exacerbate the collapse of the economy and impede its recovery (1, 6, 29).

II. BURDEN OF MENTAL DISORDERS IN LEBANON

A national prevalence study from 2006 estimated that approximately 1 in 4 people in Lebanon go through at least one mental disorder throughout their lives, with anxiety disorders and depression being the most prevalent (30). Today, after the cumulative calamities that Lebanon experienced in the recent years, these numbers have soared. Recent data published in 2025 revealed that 62.8% of a sample of 1,000 Lebanese individuals, who were screened by telephone, tested positive for either depression, anxiety, or PTSD. Among these, 47.8% were identified with probable depression, 45.3% with probable anxiety, 43.5% with probable PTSD, and 28.1% had all three disorders combined.[4]

4 Karam, E. G., El-Jamal, M., Osman, R., Toukan, S., Mouawad, G. I., & Al Barathie, J. (2025). The aftermath of multiple trauma on a nation: unraveling Lebanon's unique mental health struggle. Frontiers in Psychiatry, 15, 1444245. This reference was published after the launch of the strategy and has been included to provide additional context and updated information, but it is not listed in the main reference list as it was not available at the time of writing.

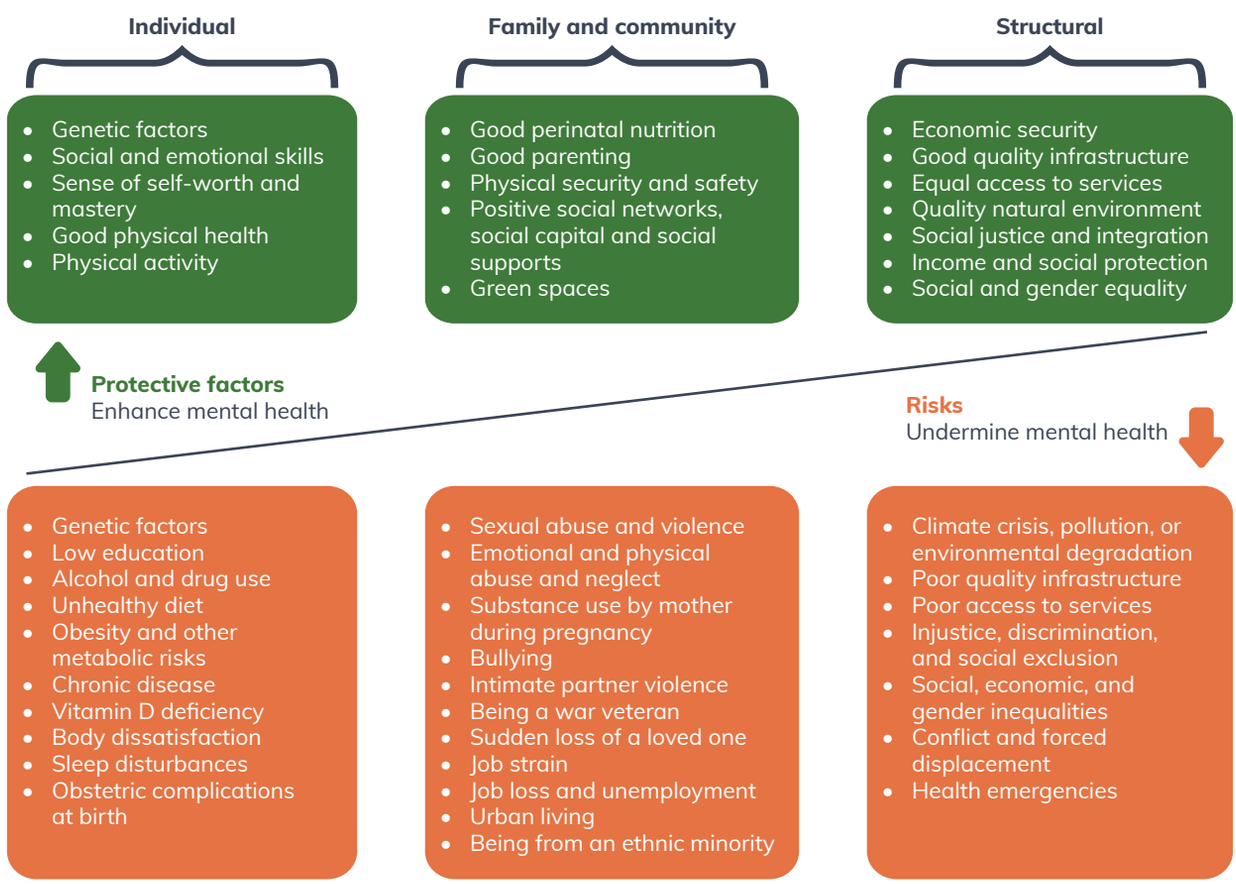
Suicide mortality rate in Lebanon is estimated at 2.8 per 100,000 population (*reported in 2019*) (31). On average, there is one suicide death every 2.1 days and one suicide attempt every 6 hours in Lebanon (32). However, these figures do not portray the true number of suicide cases due to under-reporting caused by the insufficient surveillance system and the stigma associated with suicide (33). It is important to note that data from countries that have been through financial crises points to an increase in the suicide rate in such context.

Some population groups are at increased vulnerability for mental health conditions. Lebanon's older population, comprising 10% of the total population, represents a vulnerable group that is susceptible to developing mental health conditions and facing stigmatization (34). A pilot study revealed that 9% of the older population in Lebanon suffer from dementia (35). Another national survey estimated that 10.6% of older adults have at least 1 mental health condition (36).

Incarcerated individuals are another vulnerable population both susceptible to the onset of mental health conditions and affected by the repercussions of unaddressed mental health issues. While research on this topic is limited in Lebanon, a study revealed that Lebanese prison inmates have a prevalence rate of 2% for bipolar disorders and 5.7% for primary psychotic disorders. Moreover, only a small fraction of these inmates receive prescriptions for psychotropic medications (37).

The burden of disease is also increasing with the multiple contextual factors amidst the compounded crises the country is facing and that are considerably impacting mental health by increasing risk factors and decreasing protective factors. In this context, the vulnerability of the whole population living in Lebanon to psychological distress and mental ill-health is increasing. This increasing vulnerability tops up vulnerabilities due to risk factors that were already present at the family, community, and structural level, such as those in figure 2.

Figure 2. *Examples of risk factors and protective factors impacting mental health. Reprinted from World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022. (38)*



In addition to that, only 9.8% of people with a lifetime mental disorder in Lebanon seek professional help due to a low perceived need for treatment among the majority (*as per data collected between 2002 and 2003 as part of the national prevalence study*) (39). Moreover, public awareness of the right to health care, including access to quality mental health care and knowledge on the available services remains limited (18, 39, 40). Among those who do seek treatment, substantial delays ranging from 6 to 28 years between the onset of disorders and onset of treatment are reported (30). Such delays are critical for individuals and their families and burdensome to the health system, because early assessment and intervention can prevent the progression of mental disorders into chronic and disabling conditions (41). Additionally, these delays in seeking treatment are widening in the context of the economic crisis and loss of livelihoods since people are postponing seeking non-urgent services to prioritize other more urgent needs (40).

The burden of mental disorders also extends to other diseases as it increases the morbidity of co-occurring noncommunicable diseases (*NCDs*) such as cancer, heart disease, and diabetes (42-44). This is particularly relevant for Lebanon where NCDs account for 91% of all deaths (45). Many local studies have demonstrated a direct correlation between worsened psychiatric distress and conditions such as depression, anxiety, suicidal ideation, and the presence of chronic diseases (46-49). Moreover, individuals living with HIV, who are already at risk of discrimination, stigmatization, and diminished quality of life, are at a two-to-four-fold greater risk of experiencing the development and exacerbation of mental health issues globally (50, 51). In Lebanon, a study conducted on 94 HIV patients revealed that more than 70% of them have at least one psychiatric disorder (52), with the most prevalent disorder being depression. The latter is consistent with global data.

Moreover, mental disorders have a significant impact on the national economy. In addition to the direct treatment costs and costs of long-term care, mental disorders are associated with indirect economic costs related to the person's and caregivers' work loss, lost employment opportunities, reduced performance, absenteeism, early retirement, disability and care seeking, and premature mortality (53, 54). A study examining employer attitudes in Lebanon towards hiring individuals with stable chronic mental illnesses found that such employees were perceived to have reduced efficiency and self-esteem, and were at higher risk of being laid off (55). Work losses and missed opportunities not only economically affect individuals and households, but also have societal costs through increased unemployment, loss of skilled labour, lost productivity and reduced tax revenue (56). International literature consistently indicates that poor mental health is closely linked to diminished productivity, manifested through absenteeism and presenteeism, resulting in significant economic losses for countries (57, 58). Global estimates show that the global economy loses US$ 1 trillion annually due to anxiety and depression alone (59).

A. Impact of the economic and political crises on the population's mental health

Lebanon has been struggling for decades with political challenges and ongoing unrest which affected the government's ability to adequately provide basic population needs (60, 61). This context amplifies the challenges in living conditions encountered daily in Lebanon, expanding them beyond individual struggles to encompass the entire community and broader systems. Additionally, the severe economic crisis, coupled with increased levels of crime, violence, and unsafety, have worsened the challenges faced by the public and exacerbated social inequalities. As a result, Lebanese communities have experienced a profound sense of collective suffering, disrespect, and insecurity, all of which have been having a severe toll on the population's mental health (62-64).

Moreover, the political and economic situation may have an effect on the surge of suicide cases. A total of 168 suicide deaths in 2023 have been recorded by the Internal Security Forces, representing a 21.7% rise in recorded cases from 2022 and a 46% rise from 2021. This rise can be attributed to either an increase in reporting of suicides or to a higher prevalence of suicides, but it is difficult to draw conclusions given the lack of a comprehensive monitoring system for suicide (65). The 2022 LCRP also highlights reports of escalation in suicidal ideation and instances of self-harm across Lebanon that may be associated with the country's severe economic crisis (17). Furthermore, self-reported psychological distress, including feelings of depression, fear, emotional exhaustion, anger, and hopelessness, has increased in Syrian and Palestinian refugee populations, as well as in the host community (40). Additionally, the multi-sector needs assessment (MSNA) report for 2022 shows that 45%, 50% and 21% of Lebanese, PRL, and migrant households reported having at least one adult member impacted psychologically or physically by the economic crisis. Of these percentages, 87%, 81% and 92%, respectively, did not seek health care services (66). While the percentage of Lebanese households reporting having members with unmet health care needs decreased to 26% (*out of the 28% that reported were in need to access health care*) in 2023, these percentages remain alarming (10).

Another critical phenomenon reported anecdotally by mental health service providers is the rise in substance use among both youth and adult populations residing in Lebanon, including both Lebanese and non-Lebanese individuals (40). However, nationwide statistics regarding this issue remain scarce. These findings are in line with international literature which shows that economic recessions are directly associated with a decline in the mental well-being of a population and elevated occurrences of common mental disorders, substance-related issues, and suicidal tendencies (62).

Lebanon's older population has also been facing dire conditions since the multifaceted and unparalleled crises began in 2019. The absence of essential social protection and pension schemes, alongside the financial crisis that devaluated individuals' life savings and limited familial financial support has exacerbated the poverty and vulnerability of this demographic group (67, 68). Additionally, the surge of emigration of family members has had profound impacts on the well-being of the physical and mental health of older persons (68). A study that examined the effects of the multiple crises on the living conditions, as well as the physical and mental health of 580 older individuals between the ages of 50 and 94, revealed escalating feelings of loneliness and social isolation along with elevated levels of depression, anxiety, and fear of death. Notably, 57% of respondents reported experiencing sadness and desperation, while 10% admitted to contemplating self-harm (69).

B. Impact of the history of conflict

Conflict and war impose extreme suffering and loss on human lives, which come conjointly with mental and psychological distress (70). Lebanon has a long history of wars, conflicts, assassinations, and political turmoil which may have contributed to the burden of mental illness in the Lebanese population (71-73). For example, a systematic review documenting Post-Traumatic Stress Disorder (*PTSD*) in adolescents over the course of conflicts that Lebanon witnessed showed that the prevalence rates slowly increased with time, where it ranged from 8.5% to 14.7% for the civil war, increased to 21.6% for the Grapes of Wrath War in different sample sizes, and reached a range of 15.4% to 35.0% for the 2006 July War (74). Moreover, intergenerational trauma is reported within both Lebanese and refugee communities, where the exposure of mothers to war-related events is directly linked to their risk of developing a mental disorder such as depression (75) and PTSD (76). Another study found a correlation between caregivers experiencing depression and anxiety symptoms and their children showing worse psychosocial outcomes and increased morbidity (77).

With the numerous conflict-affected countries today, WHO conducted a comprehensive systematic review in which it updated its estimates on the prevalence of mental disorders in populations impacted by conflict. This review concluded a prevalence of 22% for mental disorders like depression, anxiety, PTSD, bipolar disorder, and schizophrenia of various severities in conflict-affected populations, and estimated that at any point in time around 9% of this population suffers from moderate to severe mental disorders (78).

C. Impact of the Syrian humanitarian crisis

Displaced populations are particularly vulnerable to mental disorders as they are more likely to be exposed to trauma and ten times more likely to experience PTSD in comparison to the general population of their host country (70). The case of Lebanon is no different, where the world's largest Syrian refugee population of 1.3 million per capita in 2021 resides (79). Several studies targeting groups of Syrian refugees in Lebanon were conducted. In a non-random sample of 452 persons, a 27.2% point prevalence of PTSD was found (80, 81) and a 22% prevalence of moderate to severe depression in a sample of 3,255 displaced persons living in informal settlements across the country (82). While most studies targeting Syrian refugees in Lebanon focus on examining PTSD, as per WHO updated estimates, other mental disorders are also prevalent in conflict affected populations including refugees. Additionally, mental health conditions are not solely the result of traumatic war-related experiences, but also due to the displacement, challenging life conditions, violence, discrimination and the continuous fear of evictions and arrests that both Syrians displaced (40) and Palestinian refugees (83, 84) face in Lebanon. A rise in restrictive measures targeting displaced Syrians have been reported, as well as collective evictions and social tensions (17). Moreover, studies show that the main predictor of clinical symptoms of depression, anxiety, PTSD, and conduct disorders for Syrian refugee children living in informal settlements in Lebanon is socio-environmental living conditions (77). These dire circumstances make refugees significantly more vulnerable to mental health distress in response to any other stressors, like during the COVID-19 pandemic (19).

D. Impact of the COVID-19 pandemic

The emergence of the COVID-19 pandemic with the lockdowns and restrictions that followed played a main role in the surge of mental health conditions experienced globally and the exacerbation of pre-existing ones during this period. In just one year of the pandemic, the number of people living with anxiety disorder and major depression rose by 26% and 28%, respectively (38, 85). This rise was attributed to lifestyle changes, isolation, and fear of contracting the virus, and was exacerbated by the disruption of health services and the severe treatment gap for mental health conditions.

In Lebanon, an online cross-sectional survey assessing the impact of COVID-19 lockdown on the psychological well-being of 157 Lebanese individuals with no prior diagnosis of a mental disorder showed that 60% of the sample exhibited depressive symptoms and almost 75% exhibited mild to severe anxious symptoms (86). These rates are considerably higher than those observed in other countries during the pandemic suggesting that there may be factors accentuating the mental health burden associated with COVID-19 which are specific to the Lebanese context (86, 87). Other cross-sectional studies involving 386 and 4,397 individuals from the Lebanese general population respectively revealed a significant correlation among psychological stress, depression, anxiety, obsessive-compulsive traits, and insomnia, amidst the COVID-19 pandemic (88, 89).

Health care workers at the frontlines during the pandemic endured the highest levels of distress. A survey of 1,751 health care workers revealed that moderate to high-level of personal, work-related and client-related burnout was recorded in 86.3%, 79.2% and 83.3% of the responses, respectively

(90). Other studies addressing work fatigue and distress in Lebanese health care workers showed that moderate to high level of emotional, mental and physical work fatigue were reported in 66%, 64.8% and 65.1% of the cases, respectively (91) and a high risk of acute distress in almost 60% of frontliners (92). The burnout and fatigue detected in these studies were significantly associated with the long working hours, high threat perception, many night shifts and insufficient sleep, stressful life events, low pay and in some cases pre-existing mental health conditions.

E. Impact of the Beirut port explosion

A needs and perception survey conducted by the World Bank in August 2020, right after the Beirut port explosion, showed that around 3,400 Beirut residents identified mental health services as one of the most pressing needs (93). In another online cross-sectional population survey conducted two months following the explosion, around 80% of 2,078 individuals who were exposed to the explosion screened positive for depression and 37% met criteria for PTSD (94). Moreover, in a study assessing the prevalence of probable blast-related mental disorders, 64% of 801 children (*aged 8-17 years*) screened positive for anxiety, 52% screened positive for PTSD, and 33% screened positive for depression (95).

F. Impact of the increased protection concerns

Conflict, wars, and crises have always had a particular impact on children and adolescents' psychosocial development and well-being. National surveys indicated that 32.7% of children and adolescents in Lebanon suffered from mental disorders (96) and 11.5% experienced suicidal ideation (97). Amidst the multiple crises the country is facing, risk factors to children and adolescents' mental health are escalating. They are facing heightened daily stressors and the declining mental well-being of their caregivers, affecting their behaviour and relationships. Moreover, there is a direct increase in protection concerns, further exacerbating the challenges faced by children. The economic downfall has for instance exacerbated the issues of violence against children and women, gender-based violence, child exploitation and abuse (98, 99) and has deprived many children from educational opportunities (17). Indeed, school dropouts have been on the rise due to the increasing costs associated with schooling. A United Nations International Children's Emergency Fund (*UNICEF*) survey in 2023 showed that 26% of interviewed households had at least one child not enrolled in any type of learning (100), up from 18% in 2020 (64). For Syrian refugee families this figure is up at 52%. Furthermore, the economic crisis has led to the devaluation of the teachers' salaries resulting in teacher strikes requesting higher wages, disruption of the academic year, and decline in the quality of learning and teachers' performance (17). In contrast, child labour and marriages particularly in Syrian refugee families are on the rise as a means to alleviate financial burden (64), where 16% of Lebanese households and one in three Syrian refugee households are sending their children to work to supplement household income (100). These circumstances not only put children at an even higher risk of exploitation and abuse but also expose them to harmful coping strategies such as substance use and engaging in illegal activities (64). Another group with particular protection concerns in Lebanon are persons with disabilities who have consistently encountered social and legal obstacles, such as stigma, exclusion, limited awareness of their rights, and difficulties accessing their basic needs. And while the entire population has been severely affected by the financial crisis, this vulnerable group, which is estimated to account for 10 to 15% of the Lebanese population, silently grapples with even greater challenges, striving multiple times harder to make ends meet and access essential services (101, 102). National disability inclusion survey results in 2023 show that despite having greater needs to access health care, 90% of the respondents could not access health services and medications due to financial and non-financial barriers, 45% of the households had limited access to food (101) and 20% of households reported resorting to emergency level coping strategies (103). Moreover, physical, sensory, and intellectual impairments have been closely associated with higher prevalence of severe

distress, depression, anxiety, and other symptoms of mental disorders in persons with disabilities of different age groups (*44, 104-107*). However, despite this obvious need for mental health services, persons with disabilities rarely access these services (*103*). Consequently, persons with disabilities find themselves trapped in a relentless cycle where their concurrent health issues impede their educational and vocational engagement, as well as social integration (*108*). This cycle, compounded by Lebanon's economic challenges and inadequate social protection systems, further places a burden on their mental well-being and intensifies their experiences of discrimination, marginalization, and exclusion.

Women and children are another population group that find themselves at a higher risk of violence (*including domestic violence*), coercion, deprivation, exploitation, trafficking and abuse as inequalities deepen and vulnerabilities increase (*17, 109*). There has been a troubling increase in cases of sexual and gender-based violence (*SGBV*) including coerced prostitution, sexual assault, and extortion (*40*). Sexual exploitation has reportedly doubled during the first half of 2021 in comparison to 2020. Also, female- and child-headed households as well as persons with disabilities, refugees and older people are continuously at an immense risk of discrimination and abuse by their employers and landlords (*110*). All these conditions put SGBV survivors at an increased risk of psychological distress and developing mental health conditions (*17*).

III. KNOWLEDGE, ATTITUDES, AND BEHAVIOURS AROUND MENTAL HEALTH

Stigma and limited knowledge on mental health and well-being are main contributing factors to the alarming mental health treatment gap that exceeds 90% in Lebanon (*111*). The limited understanding and awareness of mental health, coupled with the prevalence of traditional beliefs, as well as some religious beliefs, fuel the stigma surrounding mental health, preventing help-seeking and access to mental health services (*112*). A study assessing the knowledge, attitude and behaviours towards mental disorders showed that 67.8% of the Lebanese population exhibit stigma toward mental illness, 61.9% had knowledge of mental illness, and 66.6% had more accepting behaviours, where better attitudes were associated with more knowledge (*113*). In a study in a rural area in Lebanon, the stigmatizing attitudes towards mental illness in host and refugee populations were associated with shame and fear, and referring to religious healers was perceived as more culturally acceptable than seeking help from mental health professionals (*114*). Other studies showed that stigma is quite prevalent even among educated youth (*115*), religious subgroups (*116*), and health care providers (*115*). In addition to self-stigma and community stigma, provider-based stigma and structural stigma are cross-cutting challenges that negatively impact service development and delivery across all levels of care (*117*). In addition to stigma, in a nationally representative study, it was found that 73% of the population had a low perceived need for treatment (*39*). All these factors impact mental health service provision and help-seeking behaviour.

Nevertheless, the UN indicated that the COVID-19 pandemic contributed globally to reducing the stigma associated with mental health concerns and made help-seeking for such issues more socially acceptable (*118*). In Lebanon, recent data showed that a significant 65% of the population prioritizes their mental well-being.[5] In addition, data from PHC shows an increase in the number of consultations during recent years, amounting to 32% from 2020 to 2021 (*119*) and to 44% from 2021 to 2022 (*120*). This trend may be driven by the rising demand for subsidized services due to the unaffordability in the private sector, as well as the growing need for mental health in primary health care services, and potentially reflecting increased awareness, knowledge and acceptance of mental health needs, as well as the increased efforts of to respond to these growing needs (*119, 121*).

5 Karam, E. G., El-Jamal, M., Osman, R., Toukan, S., Mouawad, G. I., & Al Barathie, J. (2025). The aftermath of multiple trauma on a nation: unraveling Lebanon's unique mental health struggle. Frontiers in Psychiatry, 15, 1444245. This reference was published after the launch of the strategy and has been included to provide additional context and updated information, but it is not listed in the main reference list as it was not available at the time of writing.

IV. MAIN ACHIEVEMENTS UNDER THE NATIONAL MENTAL HEALTH STRATEGY (2015-2020)

The National Mental Health Programme (*NMHP*) was launched in 2014 within the Ministry of Public Health (*MOPH*) as the governing entity for mental health with the role of leading the reform of the mental health system in the country. In 2015, the NMHP launched the first national strategy for mental health in Lebanon, covering the period of 2015-2020 (122). The strategy's vision that "All people living in Lebanon will have the opportunity to enjoy the best possible mental health and well-being" was set to be achieved through five domains of action: 1) Leadership and Governance, 2) Service Provision, 3) Promotion and Prevention, 4) Information, Research and Evidence, 5) Vulnerable Groups. The strategy is aligned with evidence-based frameworks and tools, including the WHO comprehensive mental health action plan 2013-2020 and the WHO World Mental Health Report; and was adapted to the local context with a system-building approach.

The NMHP and partners have been implementing the priority activities under the strategy. Highlights of some of the main achievements are presented below by domain of action of the strategy.

DOMAIN 1: LEADERSHIP AND GOVERNANCE

Efforts in this domain aimed to strengthen effective leadership and governance for mental health; to provide the basis for policy and regulation and oversee the development of the national mental health system.

At the level of governance, several steps were taken towards the establishment of a sustainable governing entity for mental health within the MOPH. Mental health policy has been mainstreamed in other national strategies and policies such as those for child protection, the protection of older adults, prevention of violent extremism, etc. A national strategy focused on substance use response was developed inter-ministerially for the first time. Additionally, in response to the multiple emergencies that occurred (*such as the COVID-19 pandemic and the Beirut Port explosion*), national inter-sectoral action plans for the Mental Health and Psychosocial Support (*MHPSS*) response were developed and implemented. Subsequently, and building on the learnings from the latter responses, the process for the development of a national emergency preparedness plan for MHPSS has been initiated to inform preparedness efforts for any type of emergency that may arise.

At the level of legislation, a new mental health draft bill[6] tackling the protection of persons with mental disorders, the scale-up of community-based mental health services, and the governance of the mental health system was developed and is currently awaiting transfer to the general assembly for voting. Efforts have been made to advocate for and support the revision process of existing legislation related to mental health and substance use such as the substance use legislation and article 232 of the penal code[7] to ensure their alignment with human rights and public health principles. Actions were also taken to support the passing and subsequent enforcement of the new law for the regulation of the psychology profession, in addition to supporting the passing of the law for establishing an Order of Psychologists and the election of the first executive board of the Order.

At the level of financing, the scale-up of community mental health services is a key pillar of the new mental health draft bill proposed. This will provide the legislative framework for the revision of the budgetary allocations for mental health service provision. Packages of care were developed and are

6 The draft bill tackles the protection of persons with mental disorders, the strengthening of governance for public mental health, and the scale-up of community-based mental health services.

7 The proposed amendment seeks to clarify that convicts with severe mental disorders sentenced by a jury would not be incarcerated until "cured", but rather until "recovered". This acknowledgment stems from the understanding that some mental health disorders like psychosis are incurable but manageable. So, the verdict "until cured" refers to a life sentence. Instead, the amendment emphasizes the importance of ensuring that individuals receive necessary treatment while serving their sentences.

being piloted at PHC level, defining care pathways for various mental disorders. These packages will facilitate the identification of services to be covered and are a step towards ensuring mental health care is part of Universal Health Coverage (*UHC*). A costing exercise and a cost-benefit analysis of community mental health services to be scaled-up were conducted to inform advocacy for effective financial coverage (*See Box 1*). In terms of coverage by private insurers, basic benefit packages have been drafted to be proposed to insurance companies.

Box 1. Costing exercise

A costing and cost-benefit analysis exercise was conducted in Lebanon with two objectives: 1) to cost mental health services with the purpose of informing planning and budgeting; and 2) to develop a comparison of costs and benefits of mental health interventions and services for policy and advocacy purposes.

The resulting investment case provides the economic rationale for investing in mental health, detailing the impact of scaling-up investment in mental health treatment and prevention in the long-run. It covers six disorders: anxiety disorders and PTSD, depression, psychosis, bipolar disorder, epilepsy, and alcohol use/dependence. The WHO OneHealth Tool (OHT) was used for this exercise, with adaptations.

The results of the investment case show that investing in mental health in Lebanon will generate benefits: ***health impact*** and ***economic gains*** (productivity restored).

The scale-up of all interventions would generate, ***143,252 Healthy Life-Years Lived*** (HLY), ***374,527 averted cases***, and ***1,751 avoided deaths*** over 20 years.

The productivity gains are estimated at ***USD 1.1 billion*** over 20 years.

The greatest impacts are observed for interventions targeting ***depression*** (17,808 HLY gained over 10 years) and ***anxiety disorders*** (5,803 HLY gained over 10 years) due to the number of people affected by these disorders.

The benefit to cost ratio compares the total costs and the benefits of investing in the interventions, for each disorder. When using the productivity gains and social value, all packages together have ***a global positive benefit-cost ratio of 4.2 over 20 years***.

DOMAIN 2: REORIENTATION AND SCALING UP OF MENTAL HEALTH SERVICES

The goal in this domain was to develop comprehensive, integrated[8], and responsive mental health and social care services in community-based settings. In line with WHO recommendations, effective, safe, quality, evidence-based interventions are being developed and scaled-up at each level of care.

At the self-help level, an e-mental health guided self-help programme (called "Step-By-Step") was developed based on a WHO face-to-face intervention (*PM+*) and was adapted and piloted in Lebanon. A randomized control trial (*RCT*)was further completed and proved the effectiveness of this intervention in the treatment of depression and anxiety disorders (*123, 124*). An implementation study was conducted and is awaiting publishing. The results will be used to inform the scale-up of this service nationally.

The NMHP has won, for the Step-By-Step programme, the ***2023 United Nations Task Force Award*** that recognizes outstanding work on NCDs and mental health, including capitalizing on technology and innovation.

At the primary and secondary levels of care, multiple actions have been implemented towards the integration of mental health into primary health care. General practitioners (*GPs*), nurses, and social workers and other primary health care centre staff from a pool of PHC centres that are part of the MOPH network were trained and supervised on integration of mental health into PHC using the WHO mental

8 As per the World Mental Health Report 2022 an integrated approach to care ensures mental and physical health conditions are considered, managed and monitored simultaneously. https://www.who.int/publications/i/item/9789240049338

health Gap Action Programme (*mhGAP*) intervention guide. Multiple supporting tools were developed (job aids for care providers, informational and educational material on various mental disorders, etc.). Mental health related standards were also integrated in the national accreditation standards for PHC centres. Multidisciplinary teams of mental health professionals providing specialized mental health care with a linkage to PHC were piloted. Building on this experience, a new model of care and national packages of mental health care were developed (see Box 2). The pilot versions of the packages for depression and anxiety disorders were finalized and capacity-building on these pilot versions has been ongoing since 2022 for a pool of 11 PHC centres across Lebanon. Multiple organizations have played a role in contributing to this work, from service provision to the piloting of the integration of the packages of care, to conducting outreach activities for orienting and improving the public's knowledge of the mental health services available at the PHC level, etc. The pilot will be critical in informing the scale-up of the packages of care. Moreover, packages of care for psychosis and substance use are currently under development (125).

Box 2. National packages of mental health care under pilot

The model of care under pilot for the development of interlinked community-based primary (non-specialized) and secondary (specialized) services is based on a stepped care community-based approach, that uses task shifting and gate keeping by general practitioners at PHC level, with defined referral pathways to specialists. The packages were developed in line with the WHO mental health Gap Action Programme (mhGAP) and were contextualized to fit the local system.

The model conceives the linkage of a pool of PHC centers in the same geographical area to a PHC that hosts specialized mental health professionals. At the primary health care level, detection, screening, assessment and diagnosis, management and follow-up are done with clearly defined roles for the GP and social worker, as well for the nurse, midwife, pediatrician or OBGYN for detection and screening. At the secondary level, complex or severe cases referred by the GP are managed. An important role of assessment and management of psychosocial stressors and care coordination is given to the social worker. The packages of care define in detail the specific acts to be done by each professional, including when to refer to whom. A mechanism of support, guidance on challenging cases, and continued capacity building on the field is included for non-specialists.

At the tertiary level, multiple actions were implemented to support the increase of the number and geographical coverage of inpatient beds. These efforts included revising the MOPH tariff for contracting general hospitals for mental health admission and contracting with facilities. Furthermore, the first inpatient unit in a public hospital was opened, with a second one under development. Additionally, support to open inpatient mental health units was provided in the form of technical guidance and capacity-building to multiple private hospitals across Lebanon willing to be contracted by the MOPH.

Furthermore, steps were taken in the direction of improving the quality and human rights protection in inpatient mental health care, as well as addressing human rights violations, particularly at the level of long-stay institutions. For example, multiple facilities were assessed using the WHO *QualityRights* toolkit by a pool of national assessors who were trained and overseen by the NMHP. Two residential psychiatric facilities were closed. The Minister of Public Health issued multiple decisions (*ex: No. 270/1 and 650/1*) concerning the quality of care and human rights in the field of mental health care, stipulating, among other things, the assessment of the condition of all residential facilities in line with the WHO *QualityRights* toolkit. The *QualityRights* standards and principles were also integrated in the national accreditation standards for hospitals.

At the level of responding to mental health emergencies, a national mental health emergency response mechanism was designed and successfully piloted in Beirut governorate in 2021. The pilot results

indicated the feasibility and effectiveness of this mechanism, providing valuable guidance for making necessary adjustments and expanding the model to other governorates as conceived. This mechanism was expanded to Tripoli. The mechanism includes mobile mental health teams that can attend to a person in a mental health emergency (including suicide attempts) who needs immediate support in a timely and effective manner at their location, as well as accompaniment in the Lebanese Red Cross or Civil Defesne ambulances in case hospitalization is needed. This mechanism is linked to the National Lifeline 1564, launched in 2017, which provides on-phone immediate emotional support, suicide risk assessment and de-escalation and which activates the mobile teams upon need. National training material for emergency room (*ER*) staff on managing mental health emergencies was also developed and capacity-building initiated for at least one to two ER staff in all hospitals in the country.

As **human resources** are a critical building block for service provision, capacity-building interventions were implemented targeting mental health, general health, and allied health professionals, as well as social care professionals and frontliners from various other sectors. The capacity-building interventions ranged from strengthening capacities for identification of mental health conditions and safe referral by non-specialists, and managing mental health emergencies, to building local capacity in evidence-based therapy approaches (*such as Interpersonal Psychotherapy (IPT)* and Eye Movement Desensitization and Reprocessing (*EMDR*)). Lebanon is the first country in the Region to have local mental health professionals trained on IPT as well as local trained trainers and supervisors. Additionally, a national guideline on maternal mental health was developed and capacity-building of health and social care professionals was initiated. Attending to persons in emergencies based on Psychological First Aid principles, as well as providing care in line with human rights and quality principles were also among the capacity-building areas. To build local capacity in developing mental health services, the first diploma in Lebanon and in the region on the development and organization of mental health services was launched with the first cohort graduating in 2022. The first edition of the diploma underwent evaluation, based on which the diploma was revised and a second edition is to be launched in 2024.

In terms of availability and accessibility to psychotropic medication when needed, the national list of psychotropic and neurologic medications for outpatient and ER settings was revised in a consultative process.[9] A guideline for the rational prescription of psychotropic medications was developed and orientation workshops were conducted for psychiatrists and neurologists. Capacity-building on the guideline was also integrated in relevant training for mental health professionals and GPs. The MOPH Director General issued Circular number 60 (*20/06/2018*)[10] urging all service providers to comply with the guideline and the national medication list. Furthermore, more efforts were put in place to increase availability and accessibility to psychotropic medications at PHC centres.

DOMAIN 3: PROMOTION AND PREVENTION

Efforts in this domain focused on developing and implementing evidence-based promotion and prevention strategies for mental health and substance use. Interventions such as national annual awareness campaigns on mental health and suicide were conducted by numerous actors to raise awareness about mental health and ill-heath and address misconceptions, as well as to promote mental health.

A Practical Guide for Media Professionals on the Coverage of Mental Health and Substance Use[11] was developed and media professionals participated in a series of training workshops on how to protect and promote their own mental health and on coverage of mental health, including suicide, based on the national guide.

9 The process took into consideration medications public health relevance, evidence of efficacy, as well as safety and comparative cost-effectiveness, in line with continuum of care.

10 *Circular No. 60, Issued 20/06/2018 Rational prescription of medication for priority mental and neurological conditions.*

11 *Practical guide for media professionals on the coverage of mental health and substance use*

In terms of suicide prevention, multiple interventions implemented in line with the strategy contributed to increased action on suicide prevention, including increasing availability and accessibility to mental health services, promotion of responsible media reporting of suicide, etc. A national hotline for emotional support and suicide prevention, the 1564 Lifeline, was launched in 2017. The Lifeline offers an anonymous telephone service by operators trained on the provision of emotional support, conducting suicide risk assessments, de-escalating suicidal crisis, and orienting to community mental health services. The Lifeline is receiving more than 1,000 calls every month on average and has been found to be effective at significantly decreasing subjective levels of distress among those calling for emotional distress and those with suicide-related behaviour (*126*). The Lifeline will be undergoing an external evaluation with the support of WHO to assess effectiveness, evaluate the operational model, and gather lessons learned to inform any needed action.

DOMAIN 4: INFORMATION, EVIDENCE, AND RESEARCH

Efforts in this domain focused towards building the necessary systems and mechanisms to obtain reliable and timely information on mental health determinants, service utilization and system performance, and towards implementing research projects, that can inform policy and service development for mental health.

In terms of information systems, mental health indicators are being defined for all levels of care and the possibilities of their integration within existing national health information systems (*HIS*) (such as the information systems for PHC or for hospitals) is under assessment. A core set of indicators on MHPSS service utilization was developed for humanitarian actors doing MHPSS programming to inform the identification of gaps and service planning. An online MHPSS service mapping platform (4Ws-Who is doing What, Where and until When) was developed in 2017 and updated in 2022. A national mental health registry for psychiatrists was developed and piloted, with the aim of identifying trends in mental disorders and treatments as well as help-seeking behaviour, for service users consulting a psychiatrist for the first time. A situation analysis on suicide monitoring and surveillance was initiated to inform the development of an action plan to strengthen it.

In terms of research, circulars[12] related to the regulation of research in the field of MHPSS and substance use were issued by the MOPH to ensure alignment with ethical principles and protection of vulnerable populations. Multiple research projects were completed or are in progress to inform service development and scale-up. RCTs were completed or under implementation on various MHPSS interventions. Implementation research studies on the scale-up of specific interventions within the national system are also being completed. Other research studies are focused on informing the strengthening of governance for mental health system reform, and include themes such as governance mechanisms, financing and service user participation.

DOMAIN 5: VULNERABLE GROUPS

Efforts in this domain focused on improving access to equitable evidence-based preventive and curative mental health services for all persons in the identified vulnerable groups living in Lebanon. Some examples are provided below:

- Annual action plans were developed for the MHPSS Task Force, the national coordination mechanism for the MHPSS response to the Syrian crisis, chaired by the MOPH and co-chaired by WHO and UNICEF. Key coordination functions were carried, as well as capacity-building and the development of tools and guidelines.

12 *Circular number 48 Dated 12 June 2017* and *Circular number 22 Dated 9/3/2018 related to the regulation of studies in the field of mental health and psychosocial support*.

- Mental health was integrated in the national standard operating procedures for response to SGBV that were developed under the Ministry of Social Affairs (MOSA) as well as in guidance notes for SGBV case management[13]. Capacity building was conducted for frontliners working in the SGBV sector on identification of mental disorders in survivors and safe referral.
- Multiple steps were completed in the development process of a national strategy for mental health in prisons (situation assessment, theory of change, strategy initial drafting, etc.). Inter-ministerial coordination was started to move towards an inter-ministerial strategy. In parallel, mental health consultations were being provided in Lebanon's largest central prison with support from WHO.
- Research studies were conducted to assess the needs and accessibility to mental health services for migrant workers. Multiple advocacy actions were conducted, including the development of an advocacy plan by a committee under the MHPSS Task Force to increase equitable accessibility to mental health services for foreign domestic workers.

V. NATIONAL MENTAL HEALTH STRATEGY (2015-2020) MID-TERM EVALUATION[14]

An external independent mid-term evaluation of the implementation of the National Mental Health Strategy was conducted at the end of 2018. The evaluation concluded that most objectives of the strategy set for the mid-term had been attained. Key recommendations were formulated (127), including: extending the integration of mental health care in PHC; strengthening the already initiated development of collaborative care between PHC and specialized services; focusing prevention activities in the areas in which more robust evidence already exists (e.g. suicide, support to parenting, certain interventions in schools) and supporting the implementation of effective programmes in these areas; and putting in place a specific strategy focused on providing integrated care to and social inclusion of persons with severe mental disorders.

VI. OPPORTUNITIES, GAPS, AND CHALLENGES

The mid-term evaluation of the 2015-2020 mental health strategy revealed several noteworthy accomplishments that were attained during the strategy's implementation. These achievements serve as a solid foundation upon which further successes can be built and opportunities capitalized on for the comprehensive enhancement of the mental health care system. Nevertheless, amidst these gains, significant gaps and persistent challenges continue to impede the system's advancement, including the complexity of the challenges within the context it operates in. The 2024-2030 strategy was designed with the approach of capitalizing on achievements and ongoing efforts, and tackling gaps where feasible, while focusing action where it is most needed.

A. At the level of leadership and governance

Having a functional mental health unit in the MOPH, with an allocated budget and responsibility for strategic planning is key to ensure the development and implementation of effective national policy and legal frameworks (38). The presence of the NMHP, and its leadership and efforts in engaging stakeholders and creating a collaborative governance model were described in key informant interviews as one of the main contributing factors to the mental health system developments in Lebanon in the

13 Such as the Gender-Based Violence Standard Operating Procedures.
14 Mid-term evaluation of the Lebanon National Mental Health Strategy.

past years. The passing of the new mental health draft bill in the parliament would allow the legislative institutionalization of the NMHP (128). Also, in terms of governance, the creation of the first service users' association is an opportunity to increase the effective participation of service users in the development and governance of the mental health system.

In terms of coordination, the MHPSS Task Force has been perceived as an effective mechanism for the coordination of the MHPSS humanitarian response to the several crises that the country has been facing (*e.g. Syrian crisis, Beirut Port explosion, etc.*) and creates opportunities for mainstreaming MHPSS in different sectors and synergizing the efforts of partners. Another identified strength of the TF is the role of the MOPH in chairing it which creates a bridge between organizations operating in MHPSS and the MOPH and promotes alignment with the National Mental Health Strategy. As such, addressing current barriers to its effective work will be key to strengthen this national coordination body.

In terms of policy development and advocacy, having a National Mental Health Strategy is essential in ensuring clarity of vision and direction of action towards where it is most needed in the most effective way possible. The development of the first national strategy for mental health in 2015 was described by stakeholders as one of the key policy developments that has shaped the mental health system and led the direction for the reform. The updated national strategy will be an opportunity to continue and strengthen the consolidation of efforts to achieve set objectives for the mental health system strengthening. The planned development of a sub-strategy focused on the mental health of children, adolescents, and youth, as well as an action plan for persons living with dementia will also support in ensuring actions to protect and promote the mental health of these vulnerable groups are as responsive and effective as possible. Furthermore, windows of opportunity remain critical to look out for to ensure mainstreaming of mental health in other sectors, as has been done so far. Additionally, the accumulated experiences of responding to emergencies such as the Syrians displaced humanitarian crisis, the COVID-19 pandemic, and the Beirut Port explosion, present an opportunity to build on the lessons learned and strengthen MHPSS emergency preparedness.

When it comes to legislative reform, on one hand, passing the mental health draft bill will be a key step to complete the work on addressing the legislative gaps in relation to regulation of involuntary hospitalization, governance and scale-up of community mental health services. Legislative reform for mental health, however, is highly dependent on the political situation in the country, like any other legislative action. On the other hand, implementing legislative reforms in other areas such as employment, social protection, poverty reduction, judicial systems, education, etc. is also critical to ensure the determinants of mental health are effectively addressed. This will require engagement and commitment in other sectors beyond health and in the wider government.

In terms of financing of mental health services, there are disparities in the coverage of public funding mechanisms [MOPH, National Social Security Fund (*NSSF*), Military and General Security Forces (*GSF*) or Cooperative for Civil Servants] (131). Most of the hospitalization covered by these funds occurs in psychiatric institutions rather than general hospitals (129). Also, according to data from the MOPH and the GSF, more than 70% of their spending on mental health goes to inpatient care (130, 131). As for private insurance schemes, they do not explicitly cover mental health treatment (54, 129). Consequently, the burden of financing mental health services falls on out-of-pocket expenditure. Indeed, outpatient mental health services are increasingly available at the PHC level as part of the efforts to increase the integration of mental health at this level of care. These services are for the most part subsidized by international organizations and provided free of charge or at minimal fee. As such, in terms of funding, in addition to the MOPH, the primary source of financial support for mental health services in Lebanon is external donor funding (111). While it has been relatively efficient in filling a significant gap, reliance on project-based donor funding for mental health hinders building programs that can help strengthen

the mental health system, affecting sustainability. This reality necessitates advocacy efforts for the development of benefit packages and the integration of priority mental health conditions into insurance schemes. The costing of the comprehensive set of community mental health services that are needed in the country that is currently being finalized by the NMHP and WHO, including basic packages for mental health care, presents an opportunity to inform advocacy efforts for effective investment and adequate budgetary allocation for mental health.

B. At the level of reorganization of mental health services

Ensuring the integration of mental health within basic packages of essential services and financial protection schemes will be critical to close the mental health care gap as emphasized by WHO (38). The national packages of care that were developed for priority mental health conditions, and that are currently being piloted, constitute an opportunity to move in this direction.

It is critical to build on the work done so far at this level to accelerate progress on the development of community-based mental health services, as increasing availability of services becomes a growing pressing need, especially in the context of the multiple crises adding stressors on the population. Indeed, anecdotal accounts of stakeholders point to a surge in public demand for mental health services at PHC centres and increased waiting lists. The focus is on developing a network of interrelated community-based services, in line with WHO's model network (*Figure* 3). This includes, as a priority for the health system, the scaling-up of primary (non-specialized) and secondary (specialized) mental health care services, optimizing referral pathways amongst them, as well as increasing both the number and geographical coverage of inpatient mental health care beds in general hospitals. The major challenge facing this priority action is the lack of financial resources, as well as the availability of competent/trained human resources for health and social care.

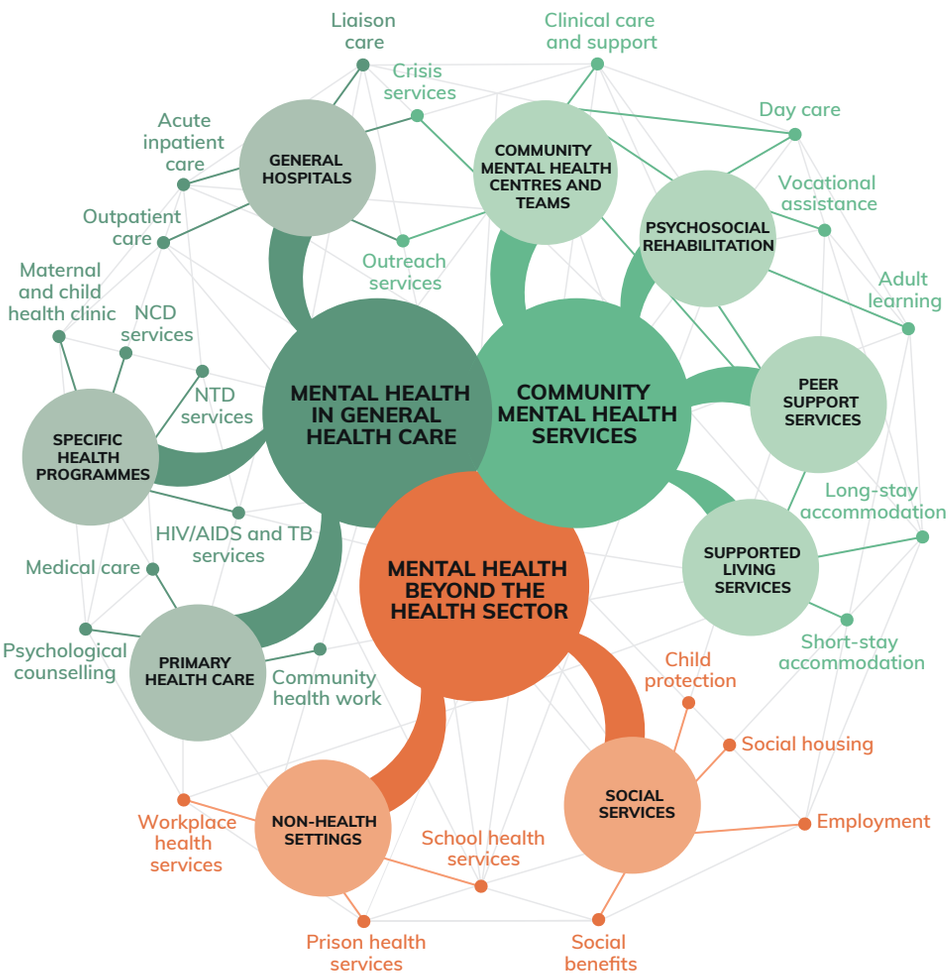


Figure 3. *WHO model network of community-based mental health services. Reprinted from World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO (38)*

Considering the economic crisis, the health system has been losing a critical mass of its workforce including psychiatrists and other mental health professionals due to the increasing migration and "brain drain". This severely impacts the provision, availability, and quality of mental health care services in Lebanon, including the scale-up of services. For instance, one of the reported challenges to open mental health wards in public general hospitals is the unavailability of human resources, that are specialized or trained in mental health and who are willing to work in the public sector. Indeed, the scarcity of psychiatrists and psychiatric nurses was already felt prior to the economic collapse which exacerbated it, and the retention rates of general health professionals who could be trained on mental health was also affected by the economic collapse (134). Nonetheless, discussions have begun between the key stakeholders in the country to set up a roadmap to address this challenge, including to increase the availability and retention of mental health professionals, and to scale-up the capacity of other health care professionals in mental health where relevant.

Increasing community-based mental health services will be one of the critical strategies to achieve the deinstitutionalization of mental health care. Other strategies include supporting long-stay residential institutions in shifting to community-based care and decreasing the number of inpatient beds in institutions. This process, as agreed amongst stakeholders, is a long and heavy one requiring system-related changes and the engagement of other than the health sector including establishing supported housing, providing work opportunities, etc. This is particularly challenging in the current country context. However, the closing of few long-stay residential facilities due to breaches of human rights as well as due to COVID-19 has created a momentum for accelerating deinstitutionalization.

Another obstacle limiting accessibility to mental health services are challenges linked to physical accessibility, either due to unavailability of services in certain areas, or due to increasing costs of transportation because of the economic crisis. There are multiple opportunities to address these gaps, including exploring the use of telehealth services as well as scaling-up "Step-By-Step", the national e-mental health guided self-help service that has proven to be effective in the treatment of depression and anxiety disorders.

Addressing challenges to sustaining or building other services as recommended in WHO's network model, such as crisis services or services in non-health settings like prisons is also needed. For instance, actions will be required to financially sustain the National Lifeline, as well as the national mental health emergency response mechanism.[15] When it comes to prisons, in 2022, the medical centre of the largest prison in the country was integrated in the national Primary Health Care network and ongoing projects are operating to strengthen its capacity. Ensuring uninterrupted access to psychotropic medications has its challenges, affected by several factors such as increased needs at PHC level, global issues affecting the medication supply chain, decrease in government funds for medication and reliance on external funds.

The recent establishment of the Lebanese Order of Psychologists and the presence of a national society for Psychiatrists within the Order of Physicians constitute important opportunities for collaboration to strengthen these professions, and to address the pre-existing gaps in qualified professionals, which are increasing with the current brain drain (132, 133). As such, it is important to build on the progress made at the level of building local capacity in evidence-based therapy approaches and moving towards exploring how these trainings can be made available pre-service, in addition to in-service. Building the capacity of non-specialized frontline workers is also increasingly important to ensure timely identification of mental health needs and linkage to appropriate services. Working with frontline agencies such as

15 The mechanism includes mobile mental health teams that can attend to a person in a mental health emergency (including suicide attempts) who needs immediate support in a timely and effective manner at their location, as well as accompaniment in the Lebanese Red Cross or Civil Defense ambulances in case hospitalization is needed. This mechanism is linked to the National Lifeline 1564 which provides on-phone immediate emotional support, suicide risk assessment and de-escalation and which activates the mobile teams upon need.

security forces who may be present on-site when legally mandated during response to suicide attempts or other emergencies to increase capacity for effective support is also needed.

Emergency situations are another unpredictable challenge that faces the health system, including the mental health system. For instance, the COVID-19 and cholera outbreaks have impacted indirectly the provision of mental health care. One of the challenges, for example, to opening inpatient mental health units in the current context is the prioritization by hospital management of communicable disease outbreaks such as COVID-19 and cholera. The risk of such contextual variables arising needs to be mitigated through emergency preparedness plans. These emergencies are also increasing stressors on human resources for health. Protecting the mental health of the human resources for health is a critical need as part of any effort to maintain resilience and strengthen the national health system.

C. At the level of scale-up of prevention and promotion

Prevention of mental ill-health and promotion of mental health starts with addressing the social and structural determinants of mental health. Action at this level would require whole-of-government and whole-of-society approaches[16] and engagement as most of the determinants lie outside the health sector. The continued contribution and leadership of the health sector is nevertheless needed through advocacy and through integrating promotion and prevention efforts within health services where possible.

Increasing awareness on mental health and tackling misconceptions and stigma remains key to promote mental health as well as help-seeking and to reduce stigma-related barriers to care. Mass media communication on mental health increased in the past years through the national yearly campaigns that were implemented in collaboration with partners. The use of social media in communication on mental health also increased, benefiting from the presence of various organizations and influencers tackling it, as well as awareness-raising interventions in the community. Stakeholders involved in service provision reported a rise of mental health care consultations and pointed out to an increased awareness in the population about mental health and to an increased realization of the impact of social and structural determinants on mental health. This may provide an opportunity for knowledge, attitude and behaviour change towards mental health.

A powerful platform that is important to capitalize on when it comes to promotion and prevention is the media. Engaging and partnering with media professionals is critical, as they constitute a key stakeholder that has an important role to play in promoting mental health. Expanding the work already initiated on building the capacities of media professionals in playing this role will be a priority. The motivation of many professionals and recognition of the importance of mental health among them is an opportunity. Nevertheless, given the complexity of the media world and the competing priorities and interests within this ecosystem, changing the systems through which media professionals operate to enable systemic changes that can ensure effective reporting and portrayal of mental health in the media remains a challenge to be addressed.

Schools constitute another important platform for promotion and prevention, as they constitute both a place of opportunity and risk for mental health. The implementation of key evidence-based interventions at that level, such as school-based social and emotional learning programmes at a national scale is one of the most effective strategies (38). In addition, tackling risk factors for mental health within the school environment, such as addressing bullying, would ensure a protective learning environment within the education sector. However, the design of any intervention will have to take into consideration the

16 A whole-of-government (WoG) approach to health is defined as: an approach in which all relevant stakeholders are engaged and "public service agencies work across portfolio boundaries to develop integrated policies and programmes towards the achievement of shared or complementary, interdependent goals." (extracted from "*Whole of government and whole of society approaches: call for further research to improve population health and health equity*")

current challenges facing the education sector because of the economic crisis, which can make the implementation and scale-up of interventions in schools challenging.

Beyond the school, protecting and promoting the mental health of children and adolescents start at home, and enabling good parenting is a core intervention. Parenting support goes beyond parental training, and interventions such as ensuring adequate paid maternity and paternity leaves, universally accessible quality day care, social protection (*including insurance and income assistance*), etc. are essential. Addressing these structural determinants is critical yet challenging as it is also beyond the scope of the health sector alone. Advocacy and implementation of feasible evidence-based interventions to build support systems for good parenting are both needed.

The workplace constitutes another important platform for protecting and promoting mental health (*38*). Multiple risk factors to mental health can play out in the workplace. Many are increasing in the current economic context in the country that is putting a strain on workplaces, such as the sharp reduction in wages due to the inflation and currency devaluation, the impact of increased stress on interpersonal relationships, etc. This makes interventions to protect and promote mental health in the workplace more important, but also more difficult to implement. The increasing awareness around mental health in the workplace globally, as well as locally based on anecdotal reports, is however an opportunity to start implementing actions in this direction.

D. At the level of mental health information systems and research

Integration of mental health related indicators and monitoring tools within the existing national HIS is critical to ensure information related to mental health conditions is collected along with information for other health conditions. As a result, the challenges that are hindering the development of a national HIS will also be faced when integrating mental health in this overarching system. The lack of unified patient ID, the limited interoperability between the different systems used, the non-standardization of indicators used by the different stakeholders, etc. are all examples of these challenges. Navigating these complexities will be challenging to address as the need for information remains critical to inform planning and policy development for mental health system strengthening. The availability of data is also important for surveillance, particularly for suicide. The absence of a national system to pool and analyze suicide-related data from the various authorities and stakeholders, the challenges in the death reporting system in general, as well as the stigma that often impacts the reporting of deaths by suicide by families and communities are among the factors that are limiting suicide surveillance.

Furthermore, when it comes to availability of information to inform policy development, there remains a need to set-up participatory mechanisms and tools to facilitate coordination of mental health research in the country to ensure tackling priority areas for the mental health system reform and ensure complementarity. The presence of local researchers and academic institutions and partnerships with global academic entities constitutes an opportunity if efforts are well concerted.

NATIONAL MENTAL HEALTH STRATEGY

2024-2030

NATIONAL MENTAL HEALTH STRATEGY 2024-2030

I. VISION

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

II. MISSION

To ensure the development of a sustainable mental health system that guarantees the provision of and universal accessibility to high quality, safe, integrated, people-centred mental health preventive, and curative services, with an emphasis on recovery, human rights and alignment with scientific evidence.

III. VALUES

Dignity and respect: Any intervention should be delivered taking into consideration that every person has the right to be treated with dignity and respect and the right to self-determination. Services should be equally accessible and cater to the varied needs related to an individual's health status, gender, age, disability, religion, sexual orientation, socio-economic status, legal status, geographic location, language, culture, and other personal attributes.

Participation and autonomy: Effective participation of stakeholders, including persons with lived experience, in the governance of the mental health system and in the design, planning and implementation of system-strengthening interventions should be sought. Mental health services should be planned and provided in partnership with the service users. Persons have the right to be in control of their recovery journeys and they should be supported to take personal responsibility for their own recovery journey to ensure that their unique goals, strengths, and needs are identified and acted upon.

Quality: Quality is to be prioritized for all system-strengthening interventions and across all levels of the mental health system, through building on evidence and best practices to ensure effectiveness, safety, people-centredness, timeliness, equity, integration, and efficiency.

Accountability and integrity: Accountability to the public, individuals with a mental health condition, and all institutional stakeholders impacted by the system's decisions and actions, should be promoted in line with international human rights conventions. Maintaining transparency, enhancing the provision of respectful and quality interventions, and upholding the rights of service users and their families are key pillars to uphold these values.

IV. THEORY OF CHANGE

The Theory of Change is available in *Annex III*.

V. KEY PRINCIPLES FOR DESIGN AND IMPLEMENTATION OF THE STRATEGY

Evidence-based practices: Any intervention planned and implemented in line with this strategy, and all services to be developed, should be founded on scientific evidence and best practices, while accounting for cultural considerations. This is essential to ensure they meet high-quality standards, prioritize safety, are delivered in a timely, efficient, and effective manner, and are respectful of individuals' various needs.

Human rights-based: Having a mental health condition should never be a reason to deprive any person of their human rights (*38*). The strategy is driven by the recognition that everyone has the right to mental health. As emphasized by WHO, this includes "the right to protection from mental health risks, the right to accessible and acceptable quality services, and the right to liberty, independence, and inclusion in the community". The strategy aligns with the international human rights conventions and agreements and is oriented to the protection and promotion of universal human rights (*38*). It seeks to promote the protection against human rights violations and discrimination, by advocating for "mental health for all" and ensuring equitable access to mental health interventions and services for all individuals in Lebanon.

Innovation and technology: Openness to innovative solutions, including digital technologies and an inter-operable health information system that enhances data exchange and sharing of knowledge, is one of the principles to be followed in the implementation of the strategy. As highlighted by the WHO Global strategy on digital health 2020-2025, digital technologies have a proven potential to enhance health outcomes (*134*). When used effectively and in line with evidence, they may facilitate data-driven decision-making, support digital therapeutics, promote person-centred care, contribute to increasing evidence-based knowledge, and support the capacity-building of professionals.

Life-course approach: This approach emphasizes and recognizes the dynamic relationship between the exposure to various impactful factors throughout one's life course and the subsequent positive or negative health -including mental health- outcomes, on the individuals and the population (*135*). As such, each person might be in a different place on the mental health continuum over the course of their lives in response to different and changing situations and factors at the individual, social and structural levels. In line with this approach, the strategy aims to promote and protect people's mental health at all ages. (*38*).

Person-centred care: This approach puts the person, rather than their disease, at the heart of the health care services, such that individuals receiving care are treated as partners in their own health and in designing the service. Through this approach, individuals are empowered, fostering a trusting relationship where they actively participate in their health care decisions. It also considers their life needs, goals, viewpoints, preferences, as well as those of their families and communities. This results in improved self-management for one's health and health conditions, continuity of health care, and ultimately, better health outcomes.

Meaningful engagement of persons with lived experience: This strategy promotes the public health policy and practice that lived experience is a significant type of expertise and a valuable form of evidence, along with the other conventional ones. As such, actively engaging persons with mental disorders and their families or caregivers in policy and intervention development and implementation through

transparent collaborative approaches is key to ensure ownership and partnerships in mental health. Lived experience can inform the planning and delivery of services, as well as inform policies that might impact other aspects of the persons' daily lives such that these policies and interventions are more effective and responsive to their needs.

Multi-sectoral collaboration: Stakeholders from all sectors -health and non-health, governmental and non-governmental- have a role to play when it comes to promoting and protecting mental health. Promoting 'mental health in all policies' is key to achieving effective action for promoting and protecting mental health. Partnerships are to be built and fostered between relevant public and private sector stakeholders to allow system-building in a holistic and effective manner, to promote effectiveness and sustainability of actions for the local system-strengthening.

System-strengthening: The strategy's long-term aim is building a sustainable resilient system. As such, system-building is the overarching key principle adopted for the development and implementation of the strategy. This includes implementing task sharing and shifting which fosters a shared accountability, optimizes resource utilization, and creates a more effective governance structure.

VI. DOMAINS OF ACTION AND GOALS

Domain of action I: Leadership and governance
Strengthen and sustain effective leadership and governance for mental health.

Domain of action II: Community-based mental health services
Increase availability of and accessibility to comprehensive, integrated, person-centred, and responsive mental health services in community-based settings and decrease institution-based services.

Domain of action III: Promotion and prevention
Increase protective and promotive factors for mental health at the individual, social and structural levels and decrease the impact of mental health risk factors.

Domain of action IV: Information, evidence, and research
Increase availability of evidence-based knowledge to inform policy development and implementation for mental health to support system strengthening and monitoring.

VII. STRATEGIC OBJECTIVES BY DOMAIN OF ACTION

Domain of action I: LEADERSHIP AND GOVERNANCE

GOAL: Strengthen and sustain effective leadership and governance for mental health.

STRATEGIC OBJECTIVES:

1.1 Governance mechanisms

1.1.1 Establish effective governance mechanisms and tools for the mental health system as per the mental health draft bill.[17]

1.1.2 Establish mechanisms for increasing the engagement with and meaningful participation of persons with lived experience in the governance of the mental health system.

1.1.3 Support capacity-building of persons with lived experience in advocacy for mental health system strengthening.

1.1.4 Strengthen the national MHPSS Task Force as the coordination body for all actors working in MHPSS in Lebanon.

1.2 Policy development and advocacy

1.2.1 Mainstream mental health policies in other sectors where relevant (e.g., social protection, education, labour, etc.) and promote inter-sectoral collaboration.

1.2.2 Implement effective advocacy activities to support the implementation of all strategic objectives of the National Mental Health Strategy and to address any arising issues related to mental health that require advocacy at the national level.

1.2.3 Develop and implement a national emergency preparedness plan for MHPSS and ensure its mainstreaming in other national emergency preparedness plans where relevant.

1.2.4 Strengthen the implementation of priority actions and advocacy for preventing and reducing the impact of harmful substance use, including advocacy for increased financing to support these actions.

1.2.5 Develop a national sub-strategy for the mental health of children, adolescents, and youth.

1.2.6 Develop a national action plan for the public health response to dementia.

1.2.7 Support the role of the relevant professional orders, syndicates and scientific bodies (such as the Lebanese Psychiatric Society and Order of Psychologists) in regulating, organizing, and advancing the professions related to mental health.

1.2.8 Advocate for the inclusion of disability related to mental health conditions within the classification of disability for health and social protection eligibility.

1.2.9 Develop national guidelines for disability-inclusive mental health preventive, promotive and treatment services, and interventions.

17 This new mental health draft bill was developed and is currently awaiting transfer to the general assembly for voting. It tackles the protection of persons with mental disorders, the scale-up of community-based mental health services, and the governance of the mental health system.

1.3 Financing

1.3.1 Conduct a comprehensive analysis of mental health expenditure in public funds in Lebanon to inform the reform of mental health financing.

1.3.2 Conduct a situation analysis on modalities to reorient governmental financial resources towards community-based mental health care.

1.3.3 Advocate for sufficient and sustainable financing for community-based mental health services[18] by the various third-party payers and coverage schemes for all people in Lebanon including those covering non-Lebanese nationalities, in line with the costing exercise of the community mental health services.

1.4 Legislation

1.4.1 Advocate for the adoption of the mental health draft bill and its implementation mechanisms.

1.4.2 Advocate for the adoption of a revised drug law that stipulates the decriminalization of illicit drug possession for personal use, in line with international treaties and public health principles.

1.4.3 Advocate for the amendment of article 232 of the Lebanese Penal Code[19] to ensure persons who commit a crime due to a severe mental disorder are not incarcerated indefinitely because of the current text in the law.

1.4.4 Propose amendments to the national legislation for a redefinition of fundamental legal concepts that pertain to human dignity and rights (such as legal capacity, protection of persons with lived experience, criminal liability, human dignity, mental disability, etc.), in line with international conventions and treaties.

Domain of action II: COMMUNITY-BASED MENTAL HEALTH SERVICES

GOAL: Increase availability of and accessibility to comprehensive, integrated, person-centred, and responsive mental health services in community-based settings and decrease institution-based services.

STRATEGIC OBJECTIVES:

2.1 Service re-orientation and development

2.1.1 Work towards ensuring the financial sustainability and scale-up of the "Step-By-Step"[20] e-mental health-guided self-help service for adults with depression and anxiety disorders.

2.1.2 Explore the adequacy of the "Step-By-Step" e-mental health guided self-help service for youth.

2.1.3 Develop integrated community-based inter-linked primary and secondary mental health services (specialized and non-specialized) in line with the national model of care,[21] within the PHC centres in the national MOPH network.

18 This includes primary (non-specialized) and secondary (specialized) mental health care services, as well as inpatient mental health care in general hospitals.
19 Lebanese Penal Code
20 Step-by-Step is a self-help intervention for individuals struggling with low mood and stress. It is confidential, free of charge, and available through a mobile application or website. Step-by-Step is run by the National Mental Health Programme and is currently being implemented as a free service for people residing in Lebanon.
21 See Box 2 in "Situation Analysis" section IV.

2.1.4 Pilot the linkage of schools to community mental health services.

2.1.5 Increase availability and geographical accessibility of inpatient mental health services in general public hospitals in line with the WHO *QualityRights* standards and national guidelines through supporting these hospitals in opening and operating inpatient mental health units[22].

2.1.6 Strengthen mental health emergency response capacity and liaison mental health care in general hospitals where new inpatient mental health units are established.

2.1.7 Work towards ensuring the financial sustainability of the National Lifeline 1564 for Emotional Support and Suicide Prevention.

2.1.8 Work towards the scale-up and financial sustainability of the piloted National Mental Health Emergency Response Mechanism[23] to support persons going through a mental health emergency.

2.1.9 Assess all facilities providing inpatient mental health care for quality and human rights protection in line with the WHO *QualityRights* standards and with international treaties and conventions signed or ratified by the Government of Lebanon in addition to the national constitution and laws in place and support them in developing improvement plans.

2.1.10 Support long-stay mental health facilities in the implementation of deinstitutionalization plans.[24]

2.1.11 Conduct a feasibility and acceptability study on alternative housing in the context of deinstitutionalization for persons with severe mental disorders.[25]

2.1.12 Integrate mental health services in health services in prisons where possible.

2.2 Availability of qualified human resources for mental health

2.2.1 Develop and implement a national plan to address the shortage in psychiatrists due to migration.

2.2.2 Develop and implement a national plan to increase the availability of psychiatric nurses especially in inpatient mental health care units.

2.2.3 Increase capacity of local mental health professionals on evidence-based therapy approaches (such as IPT, CBT, etc.) through in-service training and integration of training within relevant university curricula where possible.

2.2.4 Increase the knowledge and improve the skills and competencies of mental health, physical health and social care professionals on human rights and mental health.

2.2.5 Increase capacity of health and social care professionals on maternal mental health in line with the national guidelines for health care providers on maternal mental health[26] through in-service training and integration of training in relevant university curricula where possible.

2.2.6 Build the capacity of relevant non-specialized frontline workers operating in relevant sectors (such as those related to child protection and SGBV) on evidence-based mental health interventions to identify mental health conditions, and properly support and refer persons.

22 These units should be linked to mental health services at the primary and secondary levels of mental health care with clear referral pathways in line with the national model of care.

23 This mechanism includes mobile teams that support persons going through a mental health emergency at their location and ensure their accompaniment in the Lebanese Red Cross or Civil Defense ambulances in case hospitalization is needed based on the assessment of the person's situation.

24 These plans would be a guiding frame for long-stay facilities to deinstitutionalize mental health care at their facilities (through for example decreasing their caseloads and number of beds, supporting persons to reintegrate in the community, repurposing facilities and shifting resources towards developing community-based mental health services, etc.).

25 Shared residential complexes for persons with severe mental disorders and who have no community social support.

26 *Guidelines for health care providers on maternal mental health*

2.2.7 Build the knowledge and capacity of relevant internal security forces frontliners on mental health and on providing support to persons experiencing a mental health emergency or attempting suicide.

2.2.8 Build local capacity in mental health service development and organization through sustaining the locally established university diploma.[27]

2.3 Availability and rational prescription of psychotropic medications

2.3.1 Ensure the regular review of the national list of psychotropic and neurologic medications.[28]

2.3.2 Ensure continuous availability of and accessibility to psychotropic medications in line with the national list of psychotropic and neurologic medications.

2.3.3 Increase the capacity of psychiatrists practicing in Lebanon on the national guide for the rational prescription of medications for priority mental and neurological conditions for specialists in the public health system[29] through in-service training and integration of training into relevant university curricula.

Domain of action III: PROMOTION AND PREVENTION

GOAL: Increase protective and promotive factors for mental health at the individual, social and structural levels and decrease the impact of mental health risk factors.

STRATEGIC OBJECTIVES:

3.1 Influencing the determinants of mental health

3.1.1 Advocate for addressing the social and structural determinants of mental health[30].

3.2 Building individual capital for mental health

3.2.1 Implement evidence-based prevention interventions[31] to build needed life skills and to support good parenting.

3.2.2 Promote knowledge, behaviour and attitude changes related to mental health via national contextualized awareness-raising campaigns and other activities.

3.2.3 Increase public awareness about mental health services available and how to access them.

3.3 Supporting the creation of work environments that protect and promote mental health

3.3.1 Increase the number of workplaces[32] that sign and adopt the National Charter for Mental Health in the Workplace[33].

27 This diploma, run in 2022 for the first time, targets public health and health professionals (physicians, psychologists, social workers, nurses, etc.) and other professionals (program managers, directors of health facilities, etc.)

28 *National List of psychotropic and neurologic medications*

29 *Guide for the rational prescription of medications for priority mental and neurological conditions for specialists in the public health system*

30 See figure 2 in background for examples.

31 These interventions are to be defined in the national sub-strategy on children and adolescents, to be developed under the framework of this National Mental Health Strategy.

32 This includes any workplace operating in any sector (health care, education, industrial, services, humanitarian, etc.)

33 The charter, launched by the MOPH and WHO, lays out the key principles and actions that can be implemented by employers to protect, promote and support mental health in their workplace (link: *National Charter for Mental Health in the Workplace*)

3.3.2 Build the capacity of Human Resources managers and other relevant focal points in workplaces on mental health in the workplace.[34]

3.3.3 Build workers' mental health literacy and skills in stress management.[35]

3.4 Supporting the creation of enabling learning environments[36]

3.4.1 Advocate for and support the implementation of evidence-based interventions to create protective learning environments.[37]

3.5 Engaging and partnering with the media

3.5.1 Continue capacity-building of media[38] professionals on the national guidelines for reporting on and portrayal of mental health and substance use in the media through in-service training and through integration of training in relevant university curricula where possible.

3.5.2 Explore with the management of local media agencies the development of mental health sensitive editorial policies.

Domain of action IV: INFORMATION, EVIDENCE, AND RESEARCH

GOAL: Increase availability of evidence-based knowledge to inform policy development and implementation for mental health to support system strengthening and monitoring.

STRATEGIC OBJECTIVES:

4.1 Information systems

4.1.1 Integrate a core set of mental health indicators within the national existing HIS at all levels of care (outpatient and inpatient).

4.1.2 Develop a national system for suicide monitoring and surveillance.

4.1.3 Ensure regular availability of an updated mapping of MHPSS services and increase awareness of it for all relevant stakeholders.

4.1.4 Increase the development and publication of regular reports on the mental health burden and system situation - based on available and reported data from all relevant sources - that can inform planning and advocacy efforts and enhance transparency.

4.1.5 Integrate mental health in relevant needs assessments conducted on a national scale whenever possible (including multi-sectoral assessments conducted by United Nations agencies[39]).

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34 In line with the *WHO guidelines for mental health at work*, this training should aim to improve managers' knowledge, attitudes and behaviours for mental health and to enable them to know when and how to support team members who may require support related to mental health. It can also enable them to adjust job stressors in working conditions.

35 In line with the *WHO guidelines for mental health at work*, this training should aim to improve knowledge about mental health, reduce stigmatizing attitudes in trainees, and enable workers to appropriately support themselves or colleagues (e.g. through identifying the signs of emotional distress and taking appropriate action such as seeking or facilitating help).

36 Learning environments encompass settings where infants, children, and adolescents can receive nurturing care and support, such as their home, daycare centres, or schools.

37 As per the WHO World Mental Health Report 2022 recommendations, these interventions include improving school culture and safety, preschool education and enrichment programmes, anti-bullying programmes, anti-racism and anti-sexism programmes, peer support groups and mentoring programmes within schools, health literacy in mental health for teachers. Interventions to be advocated for with relevant stakeholders or implemented may be further specified in the national sub-strategy on children and adolescents, to be developed under the framework of this National Mental Health Strategy.

38 Traditional and new media

39 Examples include: the Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR), the Multi Sector Needs assessment (MSNA), etc.

4.2 Research prioritization, regulation and knowledge translation

4.2.1 Develop a national research agenda for mental health with the aim of promoting research that can inform policy making and service development, and of advocating for funding for national research.

4.2.2 Advocate for the uptake and implementation of the national mental health research agenda and the translation of research findings into policy actions and interventions.

4.2.3 Develop a national mental health research network to support coordination between local researchers.

4.2.4 Maintain an updated repository of mental health research conducted or under implementation in Lebanon.

4.2.5 Reinforce the implementation of MOPH Circular 22 issued on 9/3/2018 related to the regulation of research in MHPSS, including through developing national guidelines to ensure protection of vulnerable groups targeted in mental health research and orienting stakeholders on them.

VIII. IMPLEMENTATION CONSIDERATIONS AND BUDGET EXPLANATORY NOTES

The execution of the mental health strategy for Lebanon will be delineated through a comprehensive implementation action plan, outlining in detail the execution steps of each strategic objective, inputs needed, all stakeholders that need to be involved and timelines for action. The plan will remain dynamic and flexible. Such flexibility will allow for adjustments in response to changing circumstances, emerging priorities, and lessons learned from ongoing evaluation efforts, as well as allow embracing windows of opportunity, including in terms of funding.

Furthermore, an M&E framework will be developed and overseen by the Monitoring, Evaluation, Accountability, and Learning (*MEAL*) unit of the NMHP. This framework will scrutinize the implementation progress across the strategy's domains, elucidating achievements, barriers, and facilitating factors. Regular monitoring will entail the periodic measurement of key indicators throughout the strategy's duration, as well as the assessment of outcomes, and identification of areas for improvement throughout the implementation process.

Presently, there is no predetermined governmental funding allocated for the implementation of the strategy, given Lebanon's context and the lack of earmarked budget for mental health. Consequently, implementation of objectives that require resource allocation will hinge upon opportunity planning and leveraging available funding avenues where needed. This underscores the imperative for robust advocacy efforts to galvanize resources. To support the mobilization of needed financial resources for strategy implementation, a budget estimate will be developed. Actors active in mental health in Lebanon will continue to have an important role in ensuring convergence of resources available for mental health in the country towards where they are needed, as outlined in the Strategy.

Collaborative efforts were a success factor of the implementation of the first National Mental Health Strategy. Strengthening these efforts will be key for the implementation of this updated strategy, which constitutes a roadmap for all actors in mental health in the country. The NMHP, as steerer of the strategy, will continue to collaboratively engage with all relevant stakeholders for its implementation and to strengthen coordination between all actors to maximize complementarity of efforts and avoid duplications. All stakeholders have a role to play in fulfilling this latter aim. Efforts of mental health actors in ensuring that any action taken is coordinated to ensure its effective contribution to the objectives in the national strategy and its implementation plan will be key.

Annex I:
Suicide prevention in the mental health strategy (2024-2030)

This annex provides a mapping of the strategic objectives in the National Mental Health Strategy to the cross-cutting foundations and evidence-based interventions set in the WHO Live Life Framework for suicide prevention.[40]

Cross cutting-foundations from WHO Live Life Framework	Strategic objectives of the National Mental Health Strategy	Related domain of action in the National Mental Health Strategy
Situation analysis	The situation around suicide in Lebanon is covered in the situation analysis that informed the strategy development (see "Situation Analysis" section).	Not applicable
Multi-sectoral collaboration	Fostering multi-sectoral collaboration is a key set principle for the implementation of the strategy (see "*Key principles*" section).	Not applicable
Awareness raising and advocacy	3.1.1 Advocate for addressing the social and structural determinants of mental health. 1.2.1 Mainstream mental health policies in other sectors where relevant (e.g., social protection, education, labor, etc.) and promote inter-sectoral collaboration. 1.2.2 Implement effective advocacy activities to support the implementation of all strategic objectives of the National Mental Health Strategy and to address any arising issues related to mental health that require advocacy at the national level. 1.1.3 Support capacity-building of persons with lived experience in advocacy for mental health system strengthening. 2.1.7 Work towards ensuring the financial sustainability of the National Lifeline 1564 for Emotional Support and Suicide Prevention. 3.2.2 Promote knowledge, behaviour and attitude changes related to mental health via national contextualized awareness-raising campaigns and other activities. 3.2.3 Increase public awareness about mental health services available and how to access them.	Domain 1: Leadership and governance And Domain 3: Promotion and Prevention

40 *The Live Life Initative for Suicide Prevention*.

Capacity-building	2.1.3	Develop integrated community-based inter-linked primary and secondary mental health services (specialized and non-specialized) in line with the national model of care, within the PHC centres in the national MOPH network.	Domain 2: Community-based services And Domain 3: Promotion and Prevention
	2.1.6	Strengthen mental health emergency response capacity and liaison mental health care in general hospitals where new inpatient mental health units are established.	
	2.1.8	Work towards the scale-up and financial sustainability of the piloted National Mental Health Emergency Response Mechanism[41] to support persons going through a mental health emergency.	
	2.2.1	Develop and implement a national plan to address the shortage in psychiatrists due to migration.	
	2.2.3	Increase capacity of local mental health professionals on evidence-based therapy approaches (such as IPT, CBT, etc.) through in-service training and integration of training within relevant university curricula where possible.	
	2.2.4	Increase the knowledge and improve the skills and competencies of mental health, physical health and social care professionals on human rights and mental health.	
	2.2.5	Increase capacity of health and social care professionals on maternal mental health in line with the national guidelines for health care providers on maternal mental health[42] through in-service training and integration of training in relevant university curricula where possible.	
	2.2.6	Build the capacity of relevant non-specialized frontline workers operating in relevant sectors (such as those related to child protection and SGBV) on evidence-based mental health interventions to identify mental health conditions, and properly support and refer persons.	
	2.2.7	Build the knowledge and capacity of relevant internal security forces frontliners on mental health and on providing support to persons experiencing a mental health emergency or attempting suicide.	
	3.3.3	Build workers' mental health literacy and skills in stress management.[43]	
	3.5.1	Continue capacity-building of media professionals on the national guidelines for reporting on and portrayal of mental health and substance use in the media through in-service training and through integration of training in relevant university curricula where possible.	
	3.5.2	Explore with the management of local media agencies the development of mental health sensitive editorial policies.	

41 This mechanism includes mobile teams that support persons going through a mental health emergency at their location and ensure their accompaniment in the Lebanese Red Cross or Civil Defense ambulances in case hospitalization is needed based on the assessment of the person's situation.

42 *Guidelines for health care providers on maternal mental health*

43 In line with the WHO guidelines for mental health in the workplace, this training should aim to improve knowledge about mental health, reduce stigmatising attitudes in trainees, and enable workers to appropriately support themselves or colleagues (e.g. through identifying the signs of emotional distress and taking appropriate action such as seeking or facilitating help).

Financing	1.3.1 Conduct a comprehensive analysis of mental health expenditure in public funds in Lebanon to inform the reform of mental health financing. 1.3.2 Conduct a situation analysis on modalities to reorient governmental financial resources towards community-based mental health care. 1.3.3 Advocate for sufficient and sustainable financing for community-based mental health services by the various third-party payers and coverage schemes for all people in Lebanon including those covering non-Lebanese nationalities, in line with the costing exercise of the community mental health services.	Domain 1: Leadership and Governance
Surveillance, monitoring, and evaluation	4.1.2 Develop a national system for suicide monitoring and surveillance.	Domain 4: Information, evidence and research

Key effective evidence-based interventions from WHO Live Life Framework	**Strategic objectives of the National Mental Health Strategy**	**Related domain of action**
Limit Access to the means of suicide	No objective. Not applicable in the current Lebanese context.	
Interact with the media for responsible reporting of suicide	3.5.1 Continue capacity-building of media professionals on the national guidelines for reporting on and portrayal of mental health and substance use in the media through in-service training and through integration of training in relevant university curricula where possible. 3.5.2 Explore with the management of local media agencies the development of mental health sensitive editorial policies.	Domain 3: Promotion and prevention
Foster socio-emotional life skills in adolescents	3.2.1 Implement evidence-based prevention interventions[44] to build needed life skills and to support good parenting.	Domain 3: Promotion and prevention

44 These interventions are to be defined in the national sub-strategy on children and adolescents, to be developed under the framework of this National Mental Health Strategy.

Early identify, assess, manage and follow-up anyone who is affected by suicidal behaviours	2.1.1 Work towards ensuring the financial sustainability and scale-up of the "Step-By-Step" e-mental health guided self-help service for adults with depression and anxiety disorders. 2.1.3 Develop integrated community-based inter-linked primary and secondary mental health services (specialized and non-specialized) in line with the national model of care, within the PHC centres in the national MOPH network. 2.1.4 Pilot the linkage of schools to community mental health services. 2.1.5 Increase availability and geographical accessibility of inpatient mental health services in general public hospitals in line with the WHO *QualityRights* standards and national guidelines through supporting these hospitals in opening and operating inpatient mental health units.[45] 2.1.6 Strengthen mental health emergency response capacity and liaison mental health care in general hospitals where new inpatient mental health units are established. 2.1.7 Work towards ensuring the financial sustainability of the National Lifeline 1564 for Emotional Support and Suicide Prevention. 2.1.8 Work towards the scale-up and financial sustainability of the piloted National Mental Health Emergency Response Mechanism[46] to support persons going through a mental health emergency. 2.1.12 Integrate mental health services in health services in prisons where possible. 2.2.5 Increase capacity of health and social care professionals on maternal mental health in line with the national guidelines for health care providers on maternal mental health[47] through in-service training and integration of training in relevant university curricula where possible. 2.2.6 Build the capacity of relevant non-specialized frontline workers operating in relevant sectors (such as those related to child protection and SGBV) on evidence-based mental health interventions to identify mental health conditions, and properly support and refer persons. 2.2.7 Build the knowledge and capacity of relevant internal security forces frontliners on mental health and on providing support to persons experiencing a mental health emergency or attempting suicide.	Domain 2: Community-based services

45 These units should be linked to mental health services at the primary and secondary levels of mental health care with clear referral pathways in line with the national model of care.

46 This mechanism includes mobile teams that support persons going through a mental health emergency at their location and ensure their accompaniment in the Lebanese Red Cross or Civil Defense ambulances in case hospitalization is needed based on the assessment of the person's situation.

47 *Guidelines for health care providers on maternal mental health*

Annex II:
Glossary of main mental health terms

The below definitions are used in the Strategy, extracted from the World Mental Health Report:

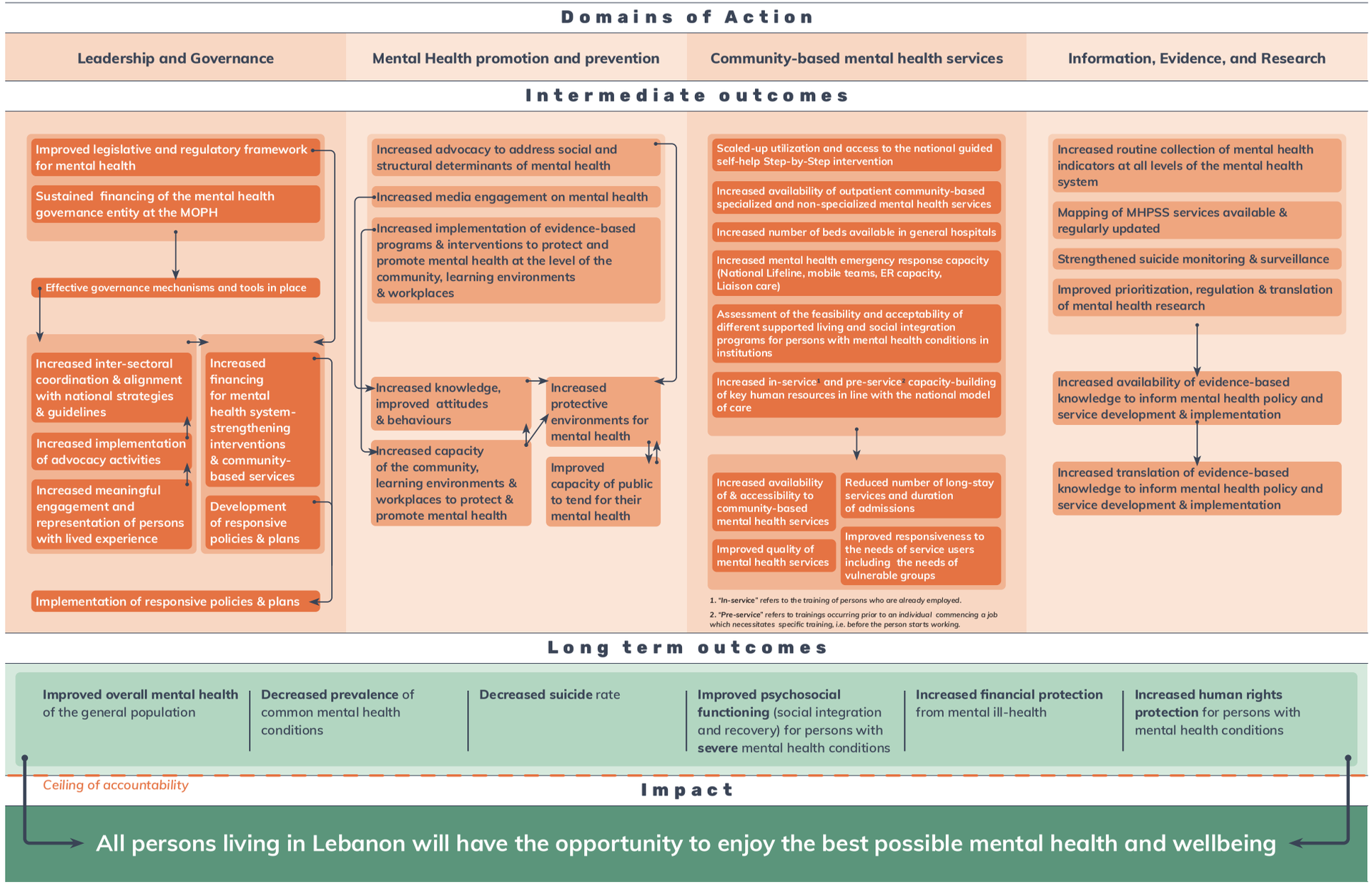
Mental health: A state of mental well-being that enables people to cope with the stresses of life, realize their abilities, to learn well and work well, and to contribute to their communities. Mental health is an integral component of health and well-being and is more than the absence of mental disorder.

Mental health conditions: A broad term covering mental disorders and psychosocial disabilities. It also covers other mental states associated with significant distress, impairment in functioning, or risk of self-harm. To bring together and speak to the widest group of stakeholders possible, this term is used throughout this report except when discussing data that rely on defined categories of mental disorder.

Mental disorder: As defined by the International Classification of Diseases 11th Revision (*ICD-11*), a mental disorder is a syndrome characterized by psychosocial disability. Disability that arises when someone with a long-term mental impairment interacts with various barriers that may hinder their full and effective participation in society on an equal basis with others. Examples of such barriers are discrimination, stigma and exclusion.

Psychosocial disability: Aligned with the Convention on the Rights of Persons with Disabilities, psychosocial disability is disability that arises when someone with a long-term mental impairment interacts with various barriers that may hinder their full and effective participation in society on an equal basis with others. Examples of such barriers are discrimination, stigma and exclusion.

Annex III: Theory Of Change map *for the mental health system reform in Lebanon*



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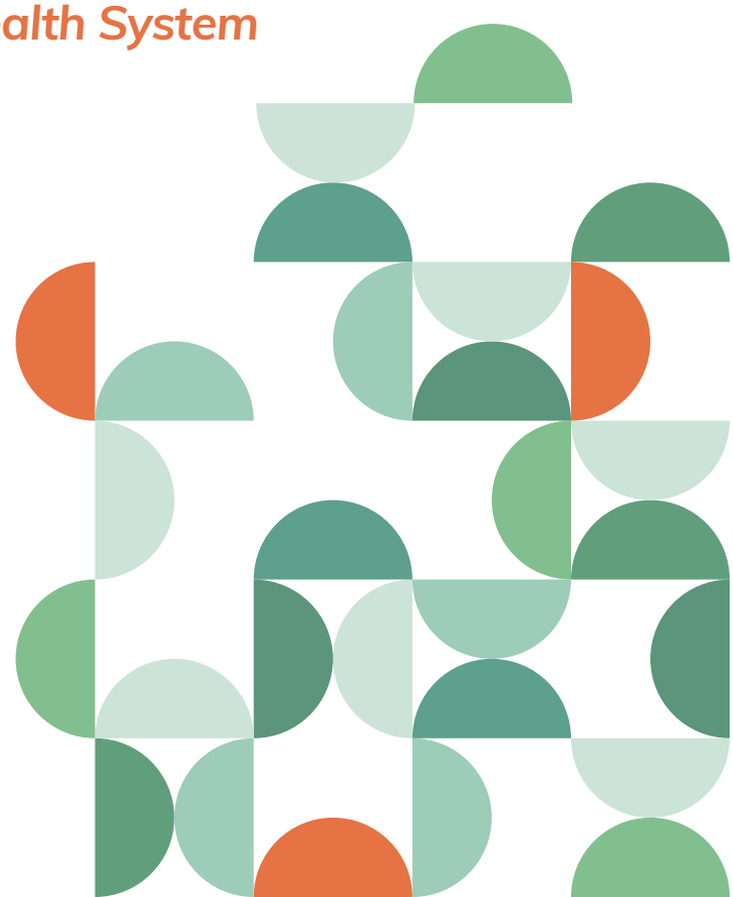
National Mental Health Strategy

For Lebanon (2024 - 2030)

Reforming the Mental Health System



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