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Groupe Pompidou
Pompidou Group

SITUATIONAL NEEDS ASSESSMENT 2009

Filling the Gap: Meeting the Needs for Treatment of Substance Users and Treatment Centers

AJEM

سعادة السماء
Bonheur du Ciel

Énacle

الشبيبة لمكافحة المخدرات
jCD

جمعية العناية الصحية
SDC

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MEDNET-POMPIDOU GROUP

The overall objective of MedNET is to promote co-operation, exchanges and two-way transfer of knowledge between countries of the southern rim of the Mediterranean and Pompidou Group European states (North-South and South-North exchanges), as well as between countries of the Mediterranean themselves (South-South exchanges).

The objective is to improve the quality of drug policy implementation in all participating countries, with an emphasis on greater awareness of the cultural factors influencing intervention policies.

The setting up and development of the network:

The Pompidou Group first turned its attention to the Mediterranean region in 1999, when it held a conference in Malta on "co-operation in the Mediterranean region on drug use".

The first project in the region was the school survey of alcohol and other drug consumption (the MedSPAD survey: Mediterranean School Survey Project on Alcohol and Other Drugs). School surveys were conducted in the cities of Algiers and Rabat in 2005, followed by national surveys in Lebanon and Morocco in 2009.

In 2006, a feasibility study carried out at the initiative of France and the Netherlands culminated in the setting up of the Mediterranean network of co-operation on drugs and addiction (MedNET) and in the Pompidou Group's commitment to coordinate and manage the network. The network was initially set up for a period of one year (2006-2007), after which it was assessed. Its flexibility was commended, and the network has subsequently continued its activities, coordinated by the Pompidou Group.

Subsequently, MedNET activities have expanded steadily and promote effective and appropriate responses, through exchanges of good practice and regional co-operation, to drug use and the ensuing problems in the fields of prevention, treatment and law enforcement.

The first high-level MedNET Conference took place in Strasbourg on 1 December 2009. Its aim was to offer decision-makers in charge of drug issues in Mediterranean countries a forum for discussion and to bring them together for the first time. The Conference was attended by 30 participants from nine countries: Algeria, France, Italy, Jordan, the Lebanon, Malta, Morocco, Portugal and Tunisia, and by representatives of the European Union, the EMCDDA, UNODC and the Mentor Foundation. Egypt had to call off at the last moment but gave its approval to the Declaration of Commitment.

Algeria, Egypt, Morocco, Lebanon and Tunisia participated as observers in the Pompidou Group's ministerial conference in 2010.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome	الايدز
DAC	Drug Addiction Committee	لجنة الإدمان
DEBs	Drug Enforcement Bureaus	مكاتب مكافحة المخدرات
ER	Emergency room	غرفة الطوارئ
FSWs	Female sex workers	عاملات الجنس
GPs	General Practitioners	أطباء صحة عامة
HIV	Human Immunodeficiency Virus	فير وس نقص المناعة البشرية
IDUs	Injecting Drug Users	الأشخاص الذين يتعاطون المخدرات بواسطة الحقن
ISF	Internal Security Forces	قوى الأمن الداخلي
MEHE	Ministry of Education and Higher Education	وزارة التربية والتعليم العالي
MOJ	Ministry of Justice	وزارة العدل
MOPH	Ministry of Public Health	وزارة الصحة العامة
MOSA	Ministry of Social Affairs	وزارة الشؤون الإجتماعية

MSM	Men who have sex with men	الرجال الذين يمارسون الجنس مع الرجال
NGOs	Non-governmental Organizations	المنظمات غير الحكومية
OST	Opioid substitution treatment	علاج بدائل الأفيونات
SES	Socioeconomic status	الوضع الإجتماعي والإقتصادي
UNODC	United Nations Office on Drugs and Crime	مكتب الأمم المتحدة المعني بالمخدرات والجريمة
VCT	Voluntary Counseling and Testing	خدمة المشورة والفحص الطوعي

DEFINITIONS

CLASSIFICATION OF SUBSTANCES

Cannabis-type: hashish and marijuana.

Opioids: heroin, opium, and other opioids (for example, morphine, fentanyl, and buprenorphine).

Cocaine: powder (salt) cocaine, crack cocaine and other forms of cocaine.

Amphetamine-type: amphetamine, methamphetamine and ecstasy-type amphetamines.

Sedatives and tranquilizers: legally manufactured barbiturates and benzodiazepines.

Hallucinogens: lysergic acid diethylamide (LSD) and other hallucinogens.

Solvents and inhalants: a range of volatile substances such as gasoline/petrol, adhesives, aerosol products (for example, paint sprays, air fresheners, analgesic sprays), anesthetics (such as nitrous oxide), cleaning agents, solvents, and room odorizers (for example, amyl nitrite, butyl nitrite).

Other drugs: any illicit substances that do not fall within the above categories, such as gamma-hydroxybutyrate and anabolic-androgenic steroids.

TYPES OF ORGANIZATIONS

Faith-based: organizations that are religious in nature. Treatment services are based on spiritual or religious values. May or may not include the 12-steps recovery process.

Treatment community: residential center (live-in facility providing therapy for substance use).

Outpatient: health facility devoted to the care of patients with substance dependence and who do not reside at the clinic.

Inpatient short stay: center where the patients who are being treated reside for a limited amount of time, usually no more than 30 days.

Drop-in: ran by social services, a charity or an institute where people attend on an informal basis, to get advice or information, to meet others and to benefit from some services the center offers.

Intensive outpatient: health facility devoted to the care of patients with substance dependence and who do not reside at the clinic. Its outpatient programs typically last 6 to 8 hours a day.

Community treatment: the provision of routine treatment and support services in a variety of community settings to substance users and those with substance dependence. These include clinic based services, outpatient services, domiciliary and other visiting services, and consultation and liaison services to general practitioners, primary health care and private sector providers.

TYPES OF SERVICES

Case identification: diagnosis of substance dependence.

Comprehensive assessment: case identification including diagnosis of all and any psychological disorders as well as psychosocial and environmental factors relevant to the patient's substance issues.

Case management: regular follow up on all problem areas making sure that patients are receiving treatment to solve these problems. Case management involves assessment of need, care planning, implementation, and regular review.

Drop-in services: informal support that may include the dissemination of advice, information, and provisions without previous arrangements and commitment. People "drop in" and may stay for a short or long amount of time at the center or institution. They leave whenever they please.

Withdrawal management/supervised detoxification (home/facility): treatment intended to remove the physiological effects of the addictive substances.

Brief intervention: intervention that takes little time, ranging 2 to 60 minutes. It typically consists of counseling and education on substance use, with usually no more than 3-5 sessions.

Medication for addictions: medication prescribed for the treatment of addiction such as opioid substitution treatment (e.g. Methadone, Buprenorphine), opioid antagonists (e.g. Naltrexone) or aversion substances (e.g. Disulfiram).

Medication for medical condition: medication prescribed for medical conditions such as for rheumatoid arthritis (e.g.Ibuprofen), protease inhibitors for AIDS/HIV (e.g. Amprenavir), or insulin for Diabetes (e.g. insulin inhalation).

Psychiatric medication: licensed psychoactive substance taken to exert an effect on the mental state and used to treat mental disorders. Such medications include antipsychotics (e.g. Chlorpromazine), antidepressants (e.g. Citalopram) and anxiolytics (e.g. Clonazepam).

Medical support: assessment and treatment of medical conditions concurrent with substance dependence.

Group therapy sessions for addictions: psychotherapy or counseling in which a small group of individuals meet with a psychologist, psychiatrist, social worker, or other healthcare professionals and discuss addiction-related issues.

Educational group for addictions: Specific type of group therapy that focused on educating patients about their addiction and ways of coping. This type of group presents structured, group-specific content, often taught using videotapes, audiocassette, or lectures. Psychoeducational groups provide information designed to have a direct application to clients' lives to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf, such as entering a treatment program.

Individual therapy for addictions: psychotherapy or personal counseling with a psychotherapist or counselor to resolve issues related to addictions.

Individual therapy for mental health: psychotherapy or personal counseling with a psychotherapist to resolve issues related to mental health.

Group sessions for mental health: psychotherapy or counseling in which a small group of individuals meet with a psychologist, psychiatrist, social worker, or other healthcare professionals and discuss issues relevant to their mental health.

Day/evening treatment: programs that provide supervised, structured, full-day daytime activities which may include individual and group counseling, 12-step meetings, social and recreational activities, educational and vocational services, a program for family members, relapse prevention services and a continuing care program for individuals who have problems related to substance abuse, who need treatment that is more intensive than an outpatient program but do not require 24-hour hospital care and are currently substance and/or alcohol free. Most participants attend day treatment programs eight hours per day Monday through Friday with part-day sessions on the weekends though some programs are available as little as five hours per day or as long as 12 hours per day.

Outpatient treatment: The patient visits a doctor's office, a clinic, a hospital or other facility for treatment as opposed to residing within a center or hospital. Outpatient therapy is a level of care with the least amount of restriction. The therapy can be individual or group, structured or not.

Short-term inpatient treatment: Short-term residential programs, often referred to as chemical dependency units involve a 3- to 6-week inpatient treatment phase followed by extended outpatient therapy or participation in 12-step self-help groups, such as Narcotics Anonymous or Cocaine Anonymous.

Long-term inpatient treatment: long-term inpatient treatment or residential long-term treatment or therapeutic communities is defined as a rehabilitation program which lasts more than 30 days, usually several months or up to a year.

Supportive housing or sober housing: combination of housing and services intended as a cost-effective way to help people live more stable, productive lives. Supportive housing works well for those who face the most complex challenges--individuals and families confronted with homelessness and who also have very low incomes and/or serious, persistent issues that may include substance abuse, mental illness, HIV/AIDS, or other serious challenges to a successful life. Supportive Housing can be coupled with such social services as job training, life skills training, alcohol and substance abuse programs and case management to populations in need of assistance. Supportive housing is intended to be a successful solution that helps people recover and succeed while reducing the overall cost of care. Sober housing is self-run as there are no psychologists, counselors, or any health care professionals present to administer services or care to substance users.

Family support: program whose primary goals involve promoting the well being, functioning, healthy development, and/or economy of the family.

Legal support: assistance or consultancy by a legal advisor such as a lawyer on law-related substance issues.

Aftercare support or vocational assistance: the patient is followed-up on medically and psychologically after having attended a treatment program. This program's primary goals are following up on recovery and social reintegration. As part of its various interventions, aftercare support may include vocational assistance, where the counselor will assist an applicant gain access to an employment agency to help locate a job. Counselors may provide support (supported employment programs) if applicants need support to keep a job. This support may include job coaching, which includes working with the person in the workplace until the

person is comfortable with the work. The counselors also act as resources if a job does not work out by assessing what happened and counseling the person on how to improve performance or change habits that were not perceived favorably in the workplace.

Wellness-related activities: engagement in yoga, meditation, art therapy, recreation development or any other activity aiming at improving physical and mental well-being.

Outreach: approach for contacting drug users in their local neighborhoods and providing them with education, advice (risk reduction counseling), testing and counseling and the means (skills and/or products such as needles, syringes, bleach, condoms, sexually transmitted infections treatment) to change their risk behaviors related to injecting drug use and sex.

PROPER TREATMENT

Proper treatment is defined as the services matching the patients' needs or having an adequate supply of services and therefore having a satisfactory coverage.

HARM REDUCTION

Harm Reduction refers to policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption (International Harm Reduction Association, 2010). Harm reduction services for substance use include needle and syringe programs, opioid substitution treatment, Human Immunodeficiency Virus (HIV) testing and counseling, antiretroviral therapy, prevention and treatment of sexually transmitted infections, condom programs for injecting drug users and their sexual partners, vaccination diagnosis and treatment of viral hepatitis as well as prevention diagnosis and treatment of tuberculosis.

SYSTEM OF REFERRAL

A system of referral will include an organized coordination between two institutions involving a standard procedure and documentation.

CHAPTER I

EXECUTIVE SUMMARY

1 AIMS OF STUDY

(1) Determine the needs for treatment of individuals with substance dependence in all areas of Lebanon through the evaluation of substance users' characteristics, their experience in initiation, maintaining, and completing treatment, and legal factors affecting their treatment.

(2) Determine the needs of individuals, centers, or institutions dealing with substance users in all areas of Lebanon through the assessment of services provided and stated priorities for improvement of their work.

(3) Synthesize recommendations made by all parties involved in the field of substance dependence in an effort to plan future nationwide treatment and prevention strategies.

2 KEY FINDINGS

As estimated by non-governmental organizations (NGOs) and physicians in hospitals (psychiatry and emergency departments), most substance users in 2009 were between 18 and 34 years of age, and those seeking treatment at private practices were 18 to 24 years old. There was an overwhelming majority of men and Lebanese substance users across all samples. However, a higher proportion of females was encountered by emergency room (ER) doctors and private psychiatrists. Moreover, most health professionals reported

that around half of substance users were employed with a higher proportion of working individuals seen by the ER sample. A good number of patients (37-62%) belonged to a low socioeconomic status (SES), but in general, substance users come from all socio-economic backgrounds.

Substance users interviewed were generally males and Lebanese. The majority was between the age of 18 and 34 years old, however, half of substance users at NGOs were 18-24 and half of those accessed through outreach were 25-34 years old. As for their educational level, most substance users in both samples have not attained a university level; they were either in a technical school or a regular one. Among substance users at NGOs, a relatively equal number of individuals were either employed or unemployed, whereas the majority of substance users accessed through outreach were employed. The majority of all substance users interviewed reported earning an income of $2,000-$12,000 per year.

With respect to clinical characteristics, health practitioners and substance users reported the age of onset for any substance to range between 15 and 17 years, and the age of onset for the substance of choice to be between 16 and 19 years, with an average of 4 years of use before coming into treatment for the first time. Across all samples, the substances consumed the most were cannabis, heroin, and then cocaine. They were also the substances the most seized at arrests involving drug use accusations. However, different substances were found in different settings: alcohol was highly ranked among ER physicians; sedatives and tranquilizers (e.g. benzodiazepines) were also seen as common by psychiatrists, general practitioners (GPs), ER doctors, and half of substance users seeking treatment at NGOs. Furthermore, individuals who were less than 18 years old used cannabis the most, as evidenced by high rankings of cannabis by health professionals (NGOs, psychiatrists in hospitals and in private practice) and by both samples of substance users. Substance users between the age of 18 and 24 mainly used cannabis and opioids, along with, to a lesser extent, cocaine as well as sedatives and tranquilizers. Those aged 25 to 34 years old used cannabis, opioids, and cocaine, while those aged 35 years or more mainly used opioids and cannabis if they were seeking treatment, and cannabis and cocaine if they were accessed through outreach. Most substance users use more than one substance.

Treatment centers in Lebanon include NGOs and hospitals, which usually treat patients with substance dependence via their psychiatry departments. There are 11 NGOs and 15 hospitals specialized in the treatment of substance dependence and nearly all treatment centers (hospitals and NGOs) interviewed are geographically located in the governorates of Beirut and Mount Lebanon.

Overall, the majority of NGOs interviewed had a good number of available services (e.g., case identification, comprehensive assessment, case management, withdrawal management, brief intervention, individual therapy for addictions, group therapy for addictions, family support, legal support, aftercare support and wellness related activities). Still, half of the NGOs wished to be more focused on the family, legal, and aftercare support level. All NGOs, with the exception of one, lacked short-term inpatient treatment and outreach activities. Each of these types of services is located in either Beirut or Mount Lebanon, highlighting the need to develop more services covering all areas in Lebanon. Specifically, short-term inpatient treatment was seen as a priority for 5 NGOs. The mean duration of treatment at all NGOs interviewed was 317 days.

Hospitals also had a big range of services available: the most common were case identification, management, comprehensive assessment, withdrawal management, medications (psychiatric and for medical conditions), medical support, individual therapy for addictions, short-term inpatient treatment (which NGOs lacked), and family support. Services lacking were supportive housing, legal support, outreach activities, and group therapy sessions for mental health. Most psychiatrists assessing their needs stated they wished to add some of these services, namely supportive housing and legal support. Psychiatrists also desired intensive outpatient treatment, a specific type of outpatient service where patients spend 6-8 hours a day in the clinic. Also, most psychiatrists who evaluated their department's priorities believed a substance use hotline was lacking. The treatment duration at hospitals was around 10 days.

Factors related to the initiation, maintenance, and completions of treatment were investigated. In 2009, 774 substance users presented for treatment at the NGOs interviewed, but only 321 (42%) received treatment. Both samples of substance users interviewed reported the lack of vacancies and presence of waiting lists as significant reasons for the lack of treatment initiation, while substance users seeking treatment at NGOs emphasized their willingness to stop on their own when they had sought treatment in the past. Both NGO representatives and in-hospital psychiatrists emphasized the unwillingness of substance users to

stop using substances and the willingness to stop using independently as main factors for not initiating or completing treatment. Other factors agreed upon that impact treatment completion were treatment cost, treatment duration, and types of services provided by existing treatment centers. Factors such as family involvement, distance to reach the center, and centers' hours of service were not commonly mentioned.

Reasons for denying access to treatment at NGOs were patients' needs not fitting the services available at the center, and patient's psychiatric co-morbidity. It is also worth mentioning that 2 NGOs out of 5 denied treatment to substance users in 2009 based on their sexual orientation or the presence of infections such as hepatitis B, C or Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS). In 2009, NGOs had to refuse treatment to around 24 substance users.

Regarding accessibility of services, psychiatry departments at hospitals could accommodate more individuals than NGOs (on average 200 patients), but were more expensive, costing an average of 234 USD per day as opposed to 100 USD per month at NGOs. Cost of treatment at hospitals was a reason to refuse admission of patients at hospitals as confirmed by all psychiatrists.

Criteria of assessment of coverage consisted of gender, religion, nationality, and substances. Overall, services were available to individuals of all religions, nationalities, and using all types of substances used in both NGOs specialized in the treatment of substance dependence and hospitals. However, only 2 out of 8 NGOs extended their services to women, while all hospitals did.

All health professionals agree that substance users visiting their centers were usually referred by their personal environment, meaning they approached the center or clinic on their own or with the support of their family or loved ones. Few individuals reported that the referral process among health professionals was structured, and if existing, was satisfactory. In many cases, such as for ER physicians and GPs, there was no referral system.

The arrest and detention process was investigated. The Internal Security Forces (ISF), have arrested a total of 2,228 individuals for drug use, while 653 were arrested for other drug-related accusations in the year of 2009. Drug Enforcement Bureaus (DEBs) were not affiliated with any specialized medical facilities examining and/or treating drug users in case of an emergency.

Moreover, substance users seeking treatment at NGOs reported a higher rate of lawsuits (past and present) and incarceration than substance users accessed through outreach, but even so, in the latter sample almost a third of individuals had experienced a lawsuit and incarceration in the past. Substance users were generally incarcerated more than once and for an average period of 2 months.

After prosecution, around 40% of the judges claimed to have never issued a primary or final verdict requiring the drug addict to commit to a treatment facility with only 4% declaring to always issuing such a verdict. 20 judges had information regarding private or public centers or clinics that provide psychological or physical treatment for addiction, as well as their contact information. Among those who had information, 30% have actually contacted the centers. Of those contacting the centers, none of the judges described the level of cooperation provided as very good. The lack of cooperation between judges and centers was principally caused by the non-activation of the Drug Addiction Committee (DAC) and the lack of a free governmental center.

3 KEY RECOMMENDATIONS

The situational assessment generated many findings which formed the basis of recommendations made by the Skoun team to improve the work of those involved in the field and meet substance users' needs.

Role of the Lebanese Ministries

All Ministries

- Most Ministries are involved in the various facets of substance use and dependence (health, social/occupational, legal, and educational). Thus, the government as a whole should prioritize the issue of substance use and dependence.
- The NCD, which is composed of different Ministers, should be activated at the earliest time possible (as designated by the Lebanese Law on Drugs).

- If the NCD cannot be operational, a joint committee made of NGOs, hospitals, and others involved in the field and directed by a member of the government should be formed. The committee will carry an inter-ministerial mission, assuming the role of the NCD. Each member of the interim joint committee should represent a Ministry and put forth its respective services.
- The DAC [which assesses whether individuals (arrested or self-admitted) are dependent to substances and refer them to treatment] must become operational.

The Ministry of Public Health (MOPH)

- A mental health department which includes a unit for the treatment of substance dependence should be created.
- The Ministry should establish treatment centers providing detoxification in the governorates of North Lebanon, South Lebanon, Nabatieh, and Beqaa.
- The Ministry should affiliate with treatment centers focusing on the psychological aspects of dependence in the governorates of North Lebanon, South Lebanon, Nabatieh, and Beqaa.
- To increase access to treatment, the Ministry should allot funds to the treatment of substance dependence destined to existing treatment centers (other than the three it is affiliated with). Funding will allow:
- A reduction or elimination of treatment costs
- An increase in the capacity of health facilities
- An addition or expansion of services
- The recruitment of capable and committed employees

The Ministry of Social Affairs (MOSA)

- The MOSA should establish a national strategy covering universal, selective, and indicated prevention to achieve effective interventions for the community as a whole.

- The MOSA should also design a clear strategy for pre and post-treatment interventions.
- The MOSA should allot a budget for social affairs related to substance dependence as part of the contribution provided to all affiliated social services centers. Funding will allow all MOSA centers to:
- Receive trainings on social aspects of substance use and dependence
- Raise awareness in an efficient and consistent manner in their areas
- Conduct prevention activities in their areas
- Provide resourceful aftercare support, including social reintegration or vocational assistance
- Provide family support to families of substance users

The Ministry of Education and Higher Education (MEHE)

- The MEHE should make preventive education a priority in middle and secondary schools, and create drug and health education interventions in universities. Integrated evidence-based prevention programs in public and private schools' curriculum are recommended.

The Ministry of Justice (MOJ)

- The MOJ must integrate trainings on substance use and dependence in the judicial curriculum. The MOJ These trainings could take the form of lectures, workshops, or round tables, and can be coordinated with those specialized in the field of addiction such as NGOs, psychiatrists, or other experts.
- Since the DAC is not currently active, referral of arrested drug users to treatment can occur if the MOJ recruits experts, individuals trained to diagnose substance dependence, refer the drug user to the appropriate center, and follow-up with the case.

Role in Research

- Ministries' involvement in research is key and the government should attend to the need for a nationally coordinated approach to data collection.
- The MOPH should design, organize and regulate a drug and treatment-monitoring system, which provides valuable information on the extent and characteristics of drug use as well as on measures taken to deal with the phenomenon. This information can be collected with limited financial effort within the framework of treatment services, as data on treated persons are readily available and are already collected for treatment purposes.
- The MOSA and MEHE should direct and conduct national research on prevention by evaluating the effectiveness of current or potential interventions after having defined the target population.
- The MOJ should issue an official analysis of the data collected on cases of drug use until this day to identify future research focal points and direct representatives of the legal system to conduct ongoing research on legal factors of drug use. Also, research should be undertaken testing the effectiveness of arresting and prosecuting drug users in efforts of drug control.
- Ministries should create a computerized comprehensive research archive which goal is to provide ready access to substance use research data.

Substance Use Prevention and Awareness

General directions

- Effective awareness and prevention programs must be conducted. Therefore it is important that they be prepared carefully and based on research.
- Prevention and awareness programs should be designed to address individuals, families, schools/universities, and the community.
- Prevention and awareness programs should be tailored to the characteristics and needs of the target population.

- Programs should be implemented regularly, not on a one-time basis and the effectiveness must be continually tested.

Specific directions

- Data show that the age of onset of substance use is around 16-19 years old. It is important to set up awareness and prevention programs for this age range.
- Males reported an earlier age of onset of use, thus programs tailored to men should address socio-cultural norms impacting their substance use.
- Even though the percentage of females using substances was low, it appears that a higher proportion of women visit clinics and ER rooms when necessary. Awareness should be raised among female substance users concentrating on the reasons for not visiting treatment centers.
- Particular substances (the most commonly used) should be given emphasis: cannabis, opioids, cocaine, sedatives and tranquilizers, and alcohol. Specifically, correcting misconceptions on cannabis and alcohol is important. Chronic cannabis use can lead to dependence, and even though it is a legal substance, alcohol abuse can have detrimental effects (many substance-related emergencies and involve alcohol-related accidents).

Treatment-related awareness

- Misperceptions on substance use should be addressed so that those who suffer from an addiction perceive their condition to be an issue and initiate treatment. It is important for education, outreach and harm reduction services to be provided to substance users.
- Programs tailored to families can help them recognize a substance-related problem, teach them skills to address it with family members and support their loved ones. The existence of such programs is necessary since substance users are generally referred to treatment by their families or loved ones, if they do not come on their own.

- Dissemination of information on existing treatment centers, types of centers, services provided, and treatment costs as well as information on how to access these centers is vital as many users are not aware of available services in the country.
- It is also important for substance users to be aware that they can present themselves to the MOPH and receive treatment free of charge, when the Ministry's budget allows.

Substance Use Health Care Services

Treatment centers

- Considering the centralization of treatment centers to Beirut and Mount Lebanon, centers in North Lebanon, South Lebanon, Nabatieh, and Beqaa should be instituted.
- Existing treatment centers should increase their capacity to better meet the demand for treatment. If this is not possible, additional centers should be established.

Treatment services

- Treatment centers should provide different modalities of treatment in order to cover all possible existing treatment approaches in order for patients with substance dependence to find the services matching their needs.
- Both quantitative and qualitative data generated a large number of services needed. It is important to make available some of the services that are mostly needed:
  1. Opioid substitution treatment (OST) and other harm-reduction interventions
  2. Short-term inpatient treatment centers
  3. Outpatient centers and intensive outpatient clinics
  4. Drop-in centers
  5. Hotline services

6. Day/evening treatment
7. Supportive housing
8. Aftercare support (providing vocational assistance, social reintegration programs) is as important as treatment since it can affect relapse and post-treatment functioning and should be integrated as part of all treatment programs.

- Substance dependence and treatment of this disorder impact the family dynamics. Treatment centers should provide family support in a regular and structured manner and cover all past and potential issues encountered by family members.
- Outreach to those who do not seek treatment is vital to bring them into treatment. Specifically, providing outreach with home-visits can help families to refer their loved one to treatment.

Referrals to treatment

- In the absence of the DAC to refer substance users to treatment, treatment centers specialized in the treatment of substance dependence should design a system of referral with an established protocol (documentation, follow-up). The system should be practical and accessible to all those treating substance users but also all those who encounter substance users (ER doctors, GPs, NGOs working in the mental health field, social services centers, and others).

Substance Use Legal and Judicial System

Implementation of the Lebanese Law on Dugs

- As per the Lebanese Law on Drugs, drug users should be given the choice between treatment and incarceration.
- A free government center should be established as per the Law to refer drug users to treatment.
- A clear distinction should be made between the convictions of substance users and dealers. The sentences of the detainees for drug use accusations need to be reduced and their rights protected, while dealers, smugglers, and other traffickers should face tighter regulations or a stricter sentence.

- DEBs should affiliate with a treatment center in each area which could provide health care services (free of charge) in case of overdose, withdrawal symptoms or any other related emergencies. If this is not possible, each DEB should coordinate with a physician and a social worker making regular visits to police stations.

Revision of the Lebanese Law on Drugs

- In the absence of the DAC, the Law should be amended to allow for the creation of a structured referral system among healthcare and judicial systems. The system should reflect a joint vision of both parties and include documentation and assignment of experts working at the Hall of Justice and assisting judges in handling drug use cases. Experts should be individuals specialized in drug use, such as psychiatrists, social workers or psychologists and their role includes assessment, referral to a treatment center matching the user's needs, and follow-up of the case.
- Arrested drug users should be appointed a lawyer if they cannot afford legal fees.
- Criminal records of drug users should be expunged after corroboration of completion of treatment and adherence to a treatment program.

CHAPTER II

PROJECT BACKGROUND

There is a general acceptance by national stakeholders that over the last 15 years substance use has been a steadily growing phenomenon. NGOs dedicated to services for substance users have increased in number and size. The Law on Drugs was revised in 1998 as such: decriminalizing drug addiction, outlining the role of the Drug Addiction Committee, encouraging the Ministry of Public Health to create a national treatment facility, as well as laying the outline for diversionary justice measures. This law was the first action towards bringing addiction into the realm of a social and health problem. However, dealing with substance dependence through treatment instead of punishment is still one of the most critical issues in Lebanon.

Skoun, Lebanese Addictions Center, in 2008 launched its "For a Greater Respect for the Rights of Drug Addicts" project examining why the Law on Drugs is still, to a great extent, not applied, working with the police force and judicial system to sensitize them on the nature of addiction and effectiveness of treatment versus incarceration. Following this, work has begun with many judges and NGOs representatives to create a referral system from the courts to service providers to pilot and evaluate the effectiveness of court referrals and mandated treatment.

With the support of MedNET-Pompidou Group and in partnership with dedicated NGOs - AJEM, JCD, SIDC, Nusroto Cénacle du fils de l'Homme, Bonheur du Ciel- Skoun also initiated its lobbying work in 2010 through its "Filling the Gap: Meeting the Needs for Treatment and Treatment Centers in Lebanon" project whose overall objective is two-fold:

- ✓ Skoun hosted a learning tour to France organized by the French Embassy in Lebanon in coordination with Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie (MILDT). Lebanese judges, representatives from the judicial police, NGOs representatives and lawyers visited French officials and toured state legal and health facilities to gain firsthand

knowledge of the French model. The objective of the tour was to observe and learn from a successful existing system regarding addiction as a healthcare issue, in terms of the various legal resources that can be taken as well as possible treatment modalities. This served to inform Lebanese representatives on how to adapt a referral system within the Lebanese country context.

- ✓ Skoun hosted round tables with judges, lawyers, doctors, NGOs representatives and substance users for the creation of a proposal for suggested amendments and changes to the existing Law on Drugs. The amendment suggestions will serve to allow for the increased understanding that addiction is a mainstream healthcare issue and that different facilities and services need to be in place in order to address the needs of substance users.

These initiatives will contribute to the field of addiction by helping prevention practitioners, public and private institutions as well as clinical experts working with substance users create and design targeted interventions, programs and services to protect the rights of substance users and address the issue of substance use and abuse among the community at large.

INTRODUCTION AND AIMS

Substance use, including drugs and alcohol, has been a growing public health concern worldwide (Degenhardt et al., 2008; Hibell et al., 2003; Saeed & Richard, 2010; Todd, Safi, & Strathdee, 2005; United Nations Office on Drugs and Crime [UNODC], 2010). Globally, UNODC estimated between 3.5% and 5.7% individuals (16 – 64 years old) to have used any illegal drug at least once in the year of 2008. Moreover, a study in the same year was conducted showing a high prevalence of alcohol use, globally (Degenhardt et al., 2008).

Cannabis, the most widely produced and consumed type of substance worldwide, is responsible for ill health consequences in many countries (UNODC, 2010). On a global scope, high rates of cannabis use were observed, with 4.6% of cannabis use in Lebanon

(Degenhardt et al., 2008). Amphetamines were reported as the second most frequently used type of drug, with cocaine and opioids ranking third (UNODC, 2010). Use of amphetamines is a new global phenomenon. For many countries, its use and availability is rapidly rising. Amphetamines are perceived to be safe by young people posing serious threats to their health. Cocaine use represents a major health problem. In the US, around 18% of those who used cocaine at least once during the past year developed cocaine dependence. On a global scope, this drug causes tens of thousands of deaths yearly (UNODC, 2010). Opioids rank as the most severe drug problems worldwide, particularly in Asia and Europe. Their use may results in severe dependence and is frequently associated with HIV/AIDS (among injecting drug users), and hepatitis B and C. It is also associated with high rates of mortality; among the millions of opioids users worldwide, 10 thousands die yearly (UNODC, 2010). Those who inject drugs are the most problematic drug users, whereby morbidity and mortality rate associated with drug use involving needle injections is a global public health issue. The main detrimental issue is the spread of HIV among injecting drug users (IDUs), mainly caused by sharing injecting equipment, and a multiplier effect through sexual transmission to the wider population (UNODC, 2010).

With these medical, psychological, social, and legal implications, treatment of substance users is an impending priority. Worldwide, different treatment services may be encountered at treatment centers. Such services include, short-term inpatient treatment, long-term inpatient residential treatment or therapeutic community, outpatient treatment, and prison based programs. These treatment centers may adopt different philosophies, harm reduction, abstinence based, faith based, etc. They may as well take on different treatment modalities: maintenance medication, group therapy/support, family therapy/support, individual psychotherapy and counseling, social and legal support, low-threshold interventions, etc.

In the Arab region, little to no epidemiological studies have been conducted to describe treatment services, and examine substance users' profile, as well as their needs and those of treatment centers. Most of the studies in Lebanon have been conducted on university students (Karam et al., 2000; Karam, Maalouf, & Ghandour, 2004; Nassar, Melkian, & Der-Karabetian, 1973; Shediac-Rizkallah, Afifi-Soweid, Farhat, & Yeretzian, 2001) and school students (Groupe Pompidou & Université Saint Joseph, 2009) to measure the prevalence of substance use as well as risk factors. Other studies have focused on the negative consequences of using substances in Lebanon (El Fawal, 1999; Karam et al., 2004). Common problems include health and social setbacks, law-related issues (e.g., arrests and imprisonments), motor accidents, violent behaviors, financial problems, drug overdoses, and divorce. A national

representative study (L.E.B.A.N.O.N) conducted in 2006 by Karam and colleagues presents findings related to substance abuse related disorders. Among those who had one or more mental disorder (including substance abuse), only 10.9% had received treatment. In the Arab world, studies related to treatment in the mental health sector revealed a pressing need to develop treatment services for substance users in Lebanon (Okasha & Karam, 1998).

However, studies evaluating treatment and health services are lacking as most studies conducted focused on prevalence and related factors. Specific information is therefore essential to assess the needs of substance users in terms of treatment as well as those of treatment centers. The most recent needs assessment study by IDRAAC dates back to 2003 (Karam, Ghandour, Maalouf, & Yamout, 2003). Data was collected among high school students, university students, substance users in treatment centers (rehabilitation facilities and hospitals), individuals with substance-related arrests (drug possession/use/facilitation), prisoners with substance-related offenses, and substance users not actively seeking treatment and not arrested (outreach sample). Throughout this needs assessment, recommendations from the different interviewed parties were collected and presented to the Lebanese government to enhance the work in the field of addiction and fulfill the needs of substance users. The RSA Lebanon study has generated recommendations that covered four main themes; namely, the role of the Lebanese ministries, substance use prevention and awareness, substance use health care services, and substance use legal and judicial system.

Recommendations were made to several concerned ministries as this problem is intricately linked to health (physical and mental) and social domains. The Ministry of Public Health (MOPH) for instance was recommended to monitor substance use problems through the employment of full-time substance use specialists and the setting up of an interim committee that follows up on the implementation of the recommendations. On the other hand, the Ministry of Education and Higher Education (MEHE) should collaborate with the institutions and activists who could provide prevention strategies and methods. Needless to say, the Ministry of Social Affairs (MOSA) was recommended to take on its role in spreading the awareness on the issue of substance use and design and implement the appropriate prevention programs.

In the domain of substance use prevention and awareness, it has been proposed that awareness programs should be well-planned, well-tailored, and comprehensive in targeting the risk factors, harmfulness, and prevention of drug use. It is essential to target high

school and university students at school through the integration of substance use awareness in school curriculums, and in different settings. Families and school administrators should be provided with prevention strategies as well and be aware of the research available on substance use in schools. Substance users should be made aware of the availability of treatment programs through treatment centers promoting their programs. Finally, the need for field assessments and research that both serve as an identification and monitoring tool is essential for the evidence-based design of appropriate prevention and awareness efforts.

When it comes to substance use health care services, the RSA authors have recommended that available treatment centers be properly categorized, and that the treatment procedure be evaluated for its quality and effectiveness. Moreover, more treatment centers with expanded approaches to treatment should be built up and developed, primary health care services should be capable of delivering substance abuse-related services, relapse and aftercare for treated substance users should be available, and unified databases and registries should be put forth to improve the information system pertaining to substance use.

The RSA has also called out for the revision of the Lebanese Law on Drugs to become clearer as to the differentiation of the different forms of substance use and the substances being used. It was vitally recommended that the National Council on Drugs and the DAC be activated, alternatives to conviction and punishment be developed, the cooperation between the judicial system and the ministries be initiated and the control of illicit substances be strengthened.

Since 2003, no needs assessment, specifically evaluating treatment services, has been conducted in Lebanon. Hence, there is a need for a more up-to-date evaluation on the situation and the recommendations of concerned responsible groups in the field of dependence (substance users and treatment centers) to build future treatment and prevention strategies. We thus consider the needs assessment of substance users and treatment centers study conducted by Skoun Lebanese Addictions Center to be a monitoring tool that checked whether the various recommendations set forth in 2002 were translated into action plans by the various stakeholders concerned, as well as in evaluating the progress being made towards achieving the aforementioned recommendations. This research study will:

(1) Determine the needs for treatment of individuals with substance dependence in all areas of Lebanon through:

- Identification of the demographic and clinical characteristics of substance users seeking treatment at various health facilities and those not seeking treatment;
- Assessment of demands of substance users for treatment and factors related to the initiation, maintenance, and completion of treatment;
- Identification of legal factors and their impact on treatment among substance users.

(2) Determine the needs of individuals, centers, or institutions dealing with substance users in all areas of Lebanon through:

- Assessment of existing treatment services based on the evaluation of availability, accessibility, and coverage;
- Assessment of demands of health professionals specialized in the treatment of substance dependence or centers encountering substance users.

(3) Synthesize recommendations made by all parties involved in the field of substance dependence in an effort to plan future nationwide treatment and prevention strategies.

CHAPTER III

METHODOLOGY

A *Needs Assessment* descriptive research study was conducted in Lebanon in 2010 where both primary and secondary data were collected, through different data collection techniques. Devising the methodology of the study was done by Skoun team members throughout meetings aiming to respond to the research objectives set for the study. The HIV/AIDS department of the World Health Organization was also consulted with attempts to integrate their assessment framework, the Rapid Assessment and Response Technical-Guide (TG-RAR) into Skoun's needs assessment methodology. The Technical Guide to Rapid Assessment and Response (TG-RAR) provides a detailed introduction into all aspects of planning and implementing rapid situation assessments. The TG-RAR is generic in nature, describes how to assess a broad range of public health issues and is aimed at learning about populations and situations where little is known (WHO, 2003). Contact was also made on a consultant-basis with experts in the field of addiction, such as a psychiatrist, an epidemiologist, a prevention officer, a statistician, a clinical psychologist, and a lawyer.

PRIMARY DATA COLLECTION

The primary data collection involved a cross-sectional study conducted among several samples. Populations which were targeted consisted of: NGOs specialized in the treatment of substance dependence; hospitals comprising psychiatrists, ER doctors, and GPs; clinics where psychiatrists treat substance users; substance users either seeking treatment at NGOs and those not actively seeking treatment and not arrested at the time of the interview; the legal system, involving DEBs and judges handling drug use cases;

stakeholders (Lebanese Ministries of Public Health, Social Affairs, and Justice); and other service providers: social services centers affiliated to the MOSA and NGOs not specialized in the treatment of substance dependence. Data of NGOs and one hospital specialized in substance dependence were also aggregated. Substance users provided data for the year 2010, while all other data were compiled for the year of 2009. Data collection spanned the 6 governorates of Lebanon: Beirut, Mount Lebanon, North, South, Beqaa, and Nabatieh.

Common Methodological Considerations

1. Instrument, Development and Description

The assessment tool used in interviewing health facilities, substance users, and NGOs encountering substance users is a questionnaire developed by Skoun's researcher, modeling the Global Assessment Programme (GAP) of Drug Abuse Toolkit by the United Nations (UNODC, 2003). Questions related to need in areas of Lebanon and factors relevant to initiation, maintenance and completion of treatment were incorporated as to target the assessment of country-specific needs. The final versions of the questionnaire differ depending on each sample, but they generally include 8 sections: 1) the treatment center's profile (type of institution, team constitution, sources of funding); 2) demographic characteristics of substance users visiting the center or interviewed (age, gender, SES, and nationality); 3) clinical characteristics (type of substances used, age of onset of substance use, substance-related health status); 4) needs of substance users (lack of treatment or proper treatment in areas of Lebanon and factors related to the initiation, maintenance, or completion of treatment); 5) needs of the center (accessibility, availability, and coverage of treatment services; priorities for improvement of the center); 6) referrals (to and from other centers and individuals); 7) law-related issues (communication with police and judges, coordination between judicial and healthcare systems); 8) recommendations made to the Lebanese government to improve the work of all those working in the addiction field. The questions are closed-ended, including yes/no, multiple-choice, and scaled (i.e. Likert) questions and the remaining are open-ended targeting qualitative data.

Several meetings were held by the team throughout the development of the questionnaires to ensure their relevance to the objectives, comprehensiveness, and to confirm face and content validity. All questionnaires were translated to Arabic by a professional translator, and were reviewed by the team to check for and reconcile any discrepancies in the meaning of the questions. Fieldworkers were trained by the researcher through a comprehensive review of each questionnaire and mock interviews. The length of administration of the questionnaires ranged between 15 and 60 minutes.

2. Ethical Considerations

As the interviews were face-to-face with all interviewees, the administration of the questionnaire was not anonymous. However, confidentiality was preserved mentioning to the interviewees that data collected would be shared solely by the research team and that identifiers (names of interviewees, institutions, and addresses, if collected) would be removed upon data checking and would not appear in the report. When accessing files, permission was obtained from the bodies responsible, either the Institutional Review Board of the hospital or the head of the psychiatry department.

Even though names were not reported, given the nature of the study methodology, confidentiality could not be promised to DEB directors and Ministry representatives. In fact, the only way to report the results is to distinguish among the DEB located in different areas, and mention which Ministry had given specific data. When possible and if not invalidating the results, it was not mentioned which DEB head had reported specific data. The interviewees were made aware of these considerations.

3. Data Processing

Simultaneous to data collection, data was entered using the Statistical Package for the Social Sciences (SPSS) software by each fieldworker after the interview and were reviewed by another fieldworker, with the exception of recommendations which were

entered onto a Microsoft Word Document and organized by themes (legal, community, and health facilities). Data were cleaned on SPSS, reviewing for any logical inconsistencies and checking for wild codes.

Some variables were modified to account for the responses provided. Most interviewees working in health facilities did not provide the specific number of individuals referred from and to the treatment center, so the coding of the variables was changed to account for the ranking of individuals/institutions referring or being referred to.

With respect to data reported, respondents are sometimes asked to estimate a percentage, and in that case the average percentage is presented. Overall, an average of responses was reported when the number of missing values was low. When the number of missing responses was more than half, we have reported each response. The indicator of average used was the median considered the small number of participants (an extreme value would not distort the median as it does to the mean). When the median and mean were equal, the mean was not reported.

Specific Methodological Considerations

Health Facilities

1. Non-Governmental organizations (NGOs) specialized in the treatment of substance dependence

1.1. Design and sampling

All NGOs treating substance users in Lebanon were targeted. Treatment of substance dependence was defined as providing any treatment service, ranging from exclusive withdrawal management/detoxification to comprehensive care. A list of all NGOs was compiled based on knowledge of the NGOs' work and regular contact through various previous projects as well as common conferences and meetings attended by Skoun and the NGOs. These NGOs receive cases of substance use, abuse or dependence, and treat them through various modalities. The following treatment approaches describe NGOs in Lebanon at the time of recruitment:

therapeutic community (N=5), of which 3 are faith-based; outpatient (N=2), of which one is also a drop-in center; drop-in (N=1); community treatment (N=1); and community treatment, drop-in and intensive outpatient programs for prisoners and former prisoners (N=1). It was not possible to gather information on the eleventh NGO. With respect to participation in the study, one exclusion criterion applied if the NGO was not functional or open in 2009.

As NGOs represent the main treatment centers in Lebanon, and involvement was deemed crucial to the study, all those who agreed to participate were offered a partnership with Skoun. The terms of partnership relevant to Skoun's responsibilities were the following: design of the study, definition of aims, development of questionnaires relevant to each population interviewed, and data collection (through fieldwork), aggregation, entry, analysis, as well as report writing. Partners, in return, were expected to: share data, knowledge, and recommendations on the topic of substance users and their needs for treatment as well as the needs of treatment centers through filling the questionnaire designed for NGOs; interview substance users who visit their treatment facility for the first time during the entire time elapsing between July 30th, 2010, and October 29th,2010 (refer to section 4). 5 NGOs agreed to partner with Skoun. It is worth mentioning, however, that data collection, entry, and analysis was performed only by Skoun team members and that in order to avoid any resulting bias, partner NGOs did not have access to the data collected.

1.2. Data collection

Out of 11, 9 NGOs (82%) agreed to participate (Table 1.2, p. 40). Two NGOs refused to participate because the study required a time investment that was beyond their capabilities and not within their direct priorities. One is an inpatient residential center providing guidance and information, follow-up with respect to health, psychological and social aspects, legal follow-up, social reintegration and career orientation, family support and financial support for treatment of substance users. The NGO includes 96 beds (60 for men, 36 for women) and 50 employees. Generally, the duration of the residential program is 15-18 months, after which patients are followed-up for 15 months in an outpatient setting. The second NGO refusing to take part in the study is a community based organization which provides a shelter for boys who are juveniles delinquent and/or from a low SES, and provides them with the vocational training to enable them to acquire the technical certificates to ensure a brilliant future. It also helps supporting their families and increasing their living standards. Besides professional and family support, the NGO also offers social and psychological

services such as social reintegration and individual therapy for mental health, including addictions. The NGO director confirmed that a considerably large percentage of juvenile delinquents visit their 6 centers, located in the governorates of Beirut, Mount Lebanon, North Lebanon, and South Lebanon, are substance users. NGOs directors were gathered for a meeting explaining the study objectives and given a folder containing all the necessary documents (study objectives, methodology, and two questionnaires pertinent to them (NGO and substance user questionnaires). By the end of the meeting, the heads of each institution gave their input; comments elicited were recorded and taken into consideration by the research team for any issues related to scheduling, the instrument, and interaction with the substance users visiting the NGO. NGO directors were then contacted by fieldworkers to set up a meeting during which they would interview the director or the person deemed to provide the most accurate data. Interviewees were NGO directors, psychiatrists, social workers, assistants to the director or researchers. One NGO director interviewed was not able to provide us with any data and the NGO was therefore excluded from all analyses. The final sample is 8.

TABLE 1.2 *NUMBER OF INDIVIDUALS AND INSTITUTIONS PARTICIPATING, 2010*

	Retrieved data(primary data)	Retrieved data(secondary data)	Approached for primary data	Response rate (%)	Existing	Representativeness (%)
NGOs specialized in the treatment of substance users	8	2	11	73	11	73
NGOs encountering substance users	8	1	8	100	12[1]	67

[1]The number of NGOs that encounter substance users reported here are those that we know of.

Private practice psychiatrists		9	0	13	69	13	69
HOSPITALS[2]	In-hospital psychiatrists	13[3]	1 HOSPITAL	27	48	27[4]	48
	Emergency room (ER)doctors	7[5]		11	64	11[6]	64
	General Practitioners (GPs)	8[7]		14	57	14[8]	57
Drug Enforcement Bureaus (DEBs)		4	1 DEB (on behalf of all DEBs)	4	100	4	100

[2]Psychiatrists, ER doctors, and GPs were interviewed in each hospital treating substance users.

[3]13 Psychiatrists working in 10 hospitals were interviewed.

[4]The 27 existing psychiatrists worked in 14 different hospitals.

[5]7 ER doctors working in 7 hospitals were interviewed.

[6]The existing ER doctors worked in 11 hospitals. Each ER doctor represents his/her emergency medicine department.

[7]8 GPs working in 8 hospitals were interviewed.

[8]The existing GPs worked in 14 different hospitals. Each GP represents his/her family medicine department.

Judges	34	0	42	81	42[9]	81
Representative of MOPH	1	0	1	100	1	100
Representative of MOJ	1	0	1	100	1	100
Representative of MOSA	1	0	1	100	1	100
Social services affiliated with MOSA	41	0	41	100	95	43
Substance users seeking treatment at NGOs	75	0	75	100	Unavailable	Unavailable
Substance users accessed via outreach	319	0	319	100	Unavailable	Unavailable

2. Hospitals

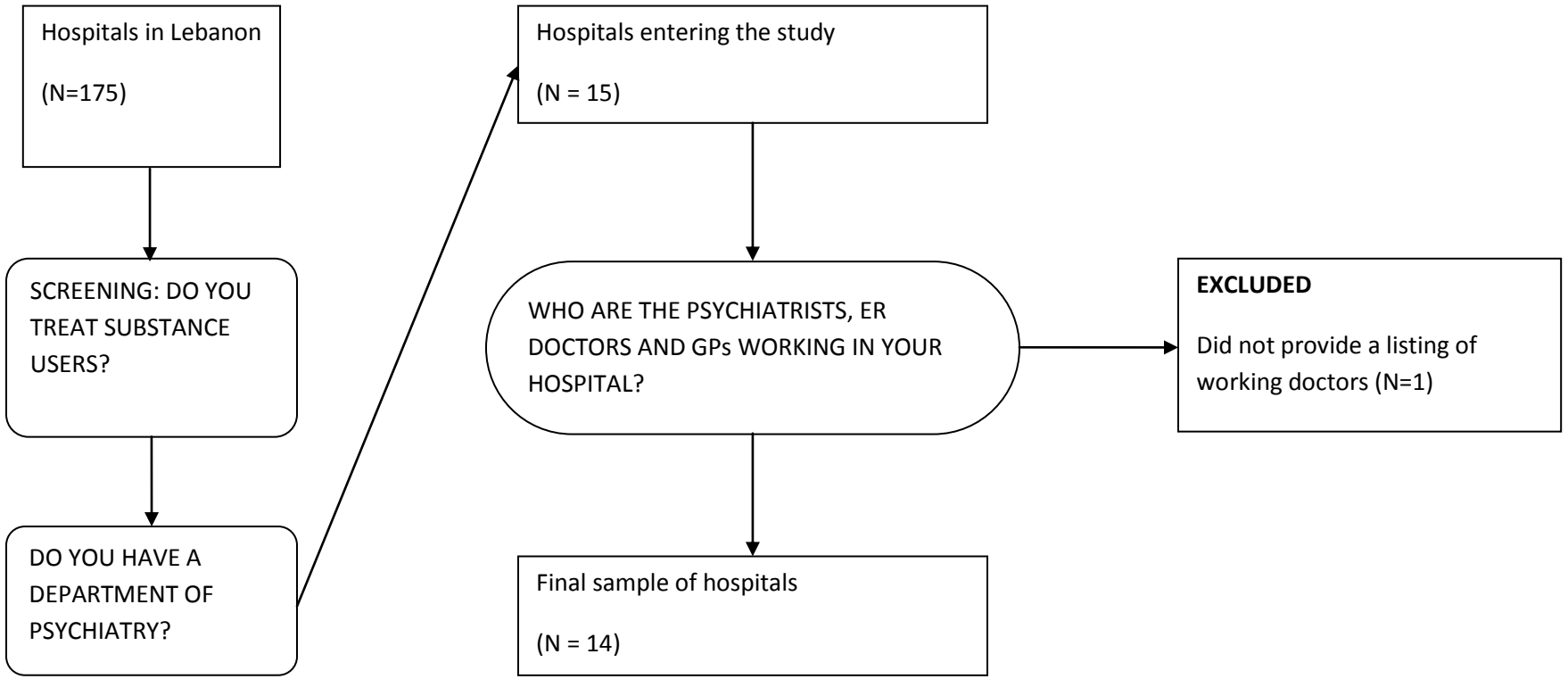
Hospitals treating substance users were considered to be well-informed on the issue of addiction and therefore able to provide us with accurate data. Hospitals handling substance use cases were considered to provide treatment if they had, in the inpatient unit of the psychiatry department, at least one psychiatrist reporting to treat patients with substance dependence.

Moreover, as part of one of the needs assessment objectives, we aimed to identify trends of substance use and services available to substance users in hospitals, and doing so through the interviews of diverse doctors was deemed important as substance users may not solely visit hospitals through the psychiatry department. Indeed, choosing different doctors with a probability of encountering

[9] This number refers to all the judges handling drug-related accusations.

substance users was essential in drawing a comprehensive picture of the substance use context in hospitals. We have therefore interviewed psychiatrists, ER doctors, and GPs in hospitals treating substance users. A listing of 146 hospitals was obtained from the Syndicate of Hospitals in Lebanon, which draws together nearly all private sector hospitals of Lebanon. We also acquired an inventory of all 29 governmental (public) hospitals of Lebanon through the Lebanese MOPH. Hospitals were screened and the final sample is 14 (Figure 2).

FIGURE 2 *SCREENING OF HOSPITALS SPECIALIZED IN SUBSTANCE DEPENDENCE, 2010*



2.1. In-hospital psychiatrists

2.1.1. Design and sampling

In-hospital psychiatrists are those working in the inpatient unit of the psychiatry department of hospitals welcoming substance users. Two exclusion criteria were defined: 1- not having worked in the inpatient unit of the psychiatry department of the hospital for the majority of the year 2009; 2- psychiatry sub-specialty of the physician is one other than substance-related disorders and there is only occasional involvement in the field of addiction, namely the treatment of substance dependence. 4 out of 31 in-hospital psychiatrists were excluded: 2 had not handled any psychiatric case in 2009, 1 was a child psychiatrist and 1 was a geriatric psychiatrist.

2.1.2. Data collection and processing

Data collection

27 in-hospital psychiatrists were contacted. When possible, we aimed to interview more than 1 psychiatrist from the same hospital in order to validate our data by comparison of the answers provided (contradictory answers of colleagues are reported in the results section of the report).Psychiatrists were sent a fax to the corresponding hospital or other workplace, otherwise an e-mail, including a cover letter written by Skoun's director explaining the study and its objectives as well as the questionnaire addressed to this population. After confirming reception of the documents, a meeting was scheduled by the fieldworkers who administered the questionnaire in the hospitals. 13 psychiatrists working in 10 different hospitals agreed to participate (Table 1.2, p. 40). The main reasons for refusal were not having the time to participate, not being able to share data, little or no interest in participating in the study, the length of the questionnaire, and not willing to cooperate with Skoun. Among those who participated, two psychiatrists, coming from different hospitals, did not have all the data available but wanted to compile it. Therefore, Skoun team delegated a fieldworker to access files at the psychiatry departments and to gather all data which would address the questions.

Data processing

Some psychiatrists were not able to estimate the percentage of substance classes used but gave ranks; we therefore converted corresponding variables to allow for a ranking system.

2.2. Emergency room (ER) doctors

2.2.1 Design and sampling

We aimed to interview 1 ER doctor per treating hospital and who had worked continuously in the emergency medicine department in 2009. Out of the 15 hospitals treating substance users, 11 had an emergency medicine department with working ER doctors. We had wished to interview ER doctors and GPs of hospitals not specialized in the treatment of substance users, but time constraints did not allow us to do so.

2.2.2 Instrument development and description

The questionnaire designed for ER physicians was modeled on the questionnaires described previously but was reduced, asking for concise information which could be gathered by the ER physician during the brief stay of the patient in the ER. It contained 7 sections. The segment asking about the needs of the hospital in terms of treatment was omitted as it was considered that the department of psychiatry was specialized in the treatment of substance dependence and therefore able to assess their needs. One question which was not in the questionnaire of NGOs and psychiatrists specialized in the treatment of substance dependence but was asked to ER physicians (and GPs) was: “do you routinely screen for drug use?”.

2.2.3. Data collection

The same procedure as above was followed to contact the 11 ER physicians. 7 doctors were interviewed while 4 refused to do so with the main reason being the inability to provide any data (Table 1.2, p. 40).

2.3. General practitioners (GPs)

2.3.1. Design and sampling

One GP per treating hospital was selected. 14 hospitals had at least a working GP while 1 did not. When given the choice between multiple GPs, it was mentioned to the nurse or operator that we wished to interview a GP having contact with substance users.

2.3.2. Instrument development and description

Similarly to the one designed for ER doctors, the questionnaire to be administered to GPs targeted routine substance use screening. Furthermore, two questions regarding the prescription of medications for substance dependence were added.

2.3.3. Data collection

Among the 14 GPs contacted, 8 were interviewed (Table 1.2, p. 40). The remaining GPs were not reached, refused because they could not contribute some of their time to the study, or declined participation because they could not share any data.

3. Private practice Psychiatrists

3.1. Design and sampling

A list of all psychiatrists in Lebanon was provided by the President of the Lebanese Psychiatric Society at the time of the study. Psychiatrists not working in the field of substance use, out of the country, not working in 2009, or affiliated with hospitals were excluded. If psychiatrists having a private practice spent most of their time working in a hospital, they were redirected to the sample of in-hospital psychiatrists. The number of private psychiatrists to interview was 13.

3.2. Data collection

9 of the psychiatrists agreed to participate (Table 1.2, p. 40). The rest avoided contact, refused because of a lack of time or because they were not interested in taking part in the study.

Substance Users

4. Substance users at non-governmental organizations (NGOs)

4.1. Design and sampling

We aimed to interview substance users seeking treatment at NGOs specialized in the treatment of substance dependence. Accordingly, consecutive admissions and outpatient visits of substance users at partner NGOs were monitored over a 3 months period. NGOs forming a partnership with Skoun committed to interview substance users seeking treatment during a time frame of 3 months in 2010 (refer to section 1.1). One of these 5 NGOs did not involve its patients because it is a prison treatment center and has a differing patient population; a separate study including only prisoners was conducted, which results will be released at a later time[10]. Still, one additional NGO agreed to participate in this survey. Thus, 6 NGOs (including Skoun) elected a representative to interview substance users on their first visit to their center. Three NGOs are located in Beirut, 2 in Mount Lebanon, and 1 in Beqaa and the interviewers identified by NGO directors were team members usually making the first contact with the substance user: psychologists, social workers, administrative assistants, fieldworkers, or educators.

[10] For further information on the data of prisoners please contact Ms Karen Estefane at caren@skoun.org.

4.2. Instrument development and questionnaire

The questionnaire developed was adapted so that answers provided by NGOs could be compared to those provided by substance users seeking treatment at these NGOs. Questions were therefore modified to directly highlight the substance user's characteristics and experience at treatment centers. Additional questions included knowledge of the Law on Drugs and legal history and status (lawsuits and previous incarceration). Questions related to past treatment targeted the last time the interviewee had sought and/or received treatment.

4.3. Training of interviewers

Each interviewer was trained by the researcher through a question-by-question review of the instrument. The training also entailed ethical considerations related to the interview (impartiality during administration of the questionnaire, promising confidentiality to the interviewee, stating that participation is voluntary and discontinuation is possible any time) and means of preventing the occurrence of interviewing the same individual twice across all NGOs.

4.4. Data collection and processing

Data collection

Data collection began on July 30th, 2010 following the training and was completed on October 29th, 2010. The completed questionnaires were submitted to Skoun 2 weeks after the start of data collection and screened. Any remark or comment regarding data recording was communicated to the interviewers for future reference. The total number of substance users interviewed in all NGOs was 75.

Data processing

No modifications were made to the responses given apart from the question on interaction with the team during visit or admission at the treatment center: a yes/no coding replaced the earlier response requiring that substance users state the

number of team members communicating with them. This change was made because during screening of the questionnaires, it was evident that each patient interacted with only one member of one or more types of professionals.

5. Substance users accessed through outreach work

5.1. Design and sampling

Soins Infirmiers et Développement Communautaire (SIDC), a Lebanese NGO which are involved in outreach to vulnerable groups, including substance users, coordinated this endeavor. Considering the resources available to the study, the elected timeline for data collection was 2 months. The director identified a team of two outreach workers, both former substance users working at SIDC, who were familiar with various areas of Lebanon. Recruitment was done through snowball sampling, where existing study subjects recruit other subjects from among their acquaintances. This sampling technique is often used in hidden populations which are difficult to access.

5.2. Instrument development and description

The development of the questionnaire was designed modeling the one addressed to substance users seeking treatment, with the same number of sections. Questions on current type of treatment, interaction with staff, treatment payment, financial support from MOPH were all raised in the past tense to refer to the last time the interviewee sought treatment, since he or she was not actively seeking treatment at the time of the interview. Factors related to past treatment were emphasized by adding more questions in order to fully understand reasons for not seeking treatment, when applicable. The questionnaire draft was reviewed by the director of SIDC and the two interviewers which provided comments considered in preparing the final version of the questionnaire, such as adding a question on the effects of the penal record.

5.3. Training of interviewers

Two members of the research team at Skoun trained the outreach workers to administer the questionnaire. The training session was similar to the ones conducted for interviewers at NGOs (section 4.3).

5.4. Data collection and processing

Data collection

Data collection started on September 22nd, 2010, and ended on November 22nd, 2010. The outreach workers presented the questionnaires to the Skoun team every 2 weeks, which were screened. Any observation on data collection made by the research team was communicated to the interviewers. This occurred to clarify the way a question was asked or recording responses in a specific way. Due to political unrest, substance users in few governorates were difficult to reach, yet 73 substance users were interviewed in those areas. The total sample of substance users accessed through outreach is 319.

Data processing

For the same reason stated above in the sample of users seeking treatment (refer to section 4.4), a yes/no coding was used to determine whether the interviewee had interacted with a specific team member at any treatment center. All other data were processed following the variables created based on each question of the instrument.

Legal System

The two populations chosen to represent the legal system in the needs assessment were DEBs and judges.

6. Drug enforcement bureaus (DEBs)

6.1. Design and sampling

The Central Bureau for Drug Enforcement in Lebanon is the drug enforcement branch of the Bureau for Criminal Investigation of the Judicial Police Unit which itself is a branch of the general directorate of the ISF. The Central DEB's jurisdiction extends over all the Lebanese territory, whereas its actual coverage is limited to the directorate of Beirut and Mount Lebanon. The Central DEB is associated with three different branches – regional offices – to cover the remaining areas. These regional offices are located in; (1) Tripoli, North Lebanon (2) Zahle, Beqaa and (3) Saida, South Lebanon. All four branches were selected in retrieving primary data.

6.2. Instrument development and description

The questionnaire was developed by Skoun's researcher and its legal advisor to the project, combining closed and open-ended questions on: 1) cases of arrest for drug use and drug-related accusations; 2) procedure of detention and arrest of the drug user; 3) referrals to treatment centers (NGOs or hospitals); 4) collection and centralization of data; 5) drug-related death cases; 6) recommendations made to the government to improve the DEB's work in the field of addiction. Alcohol was not included in the questionnaire as it is not subject to punishment by the law.

6.3. Data collection and processing

Data collection

After receiving an official approval from the Director General of the ISF, the heads of the DEBs of the Beirut (Central Bureau), North, South, and Beqaa governorates were contacted and interviewed (Table 1.2, p. 40).

Data processing

Questions were developed to distinguish between the 6 governorates. Indeed, most analyses of the study involve coding by area of Lebanon so as to map needs of substance users and treatment centers. However, due to the geographical distribution of the DEBs present in only 4 governorates, data on Nabatieh was included as part of the South Lebanon data, and data for Mount Lebanon was not reported with the exception of the number of arrest cases in this governorate, which were provided by the Central DEB. The Central DEB also did not collect the number of arrest cases by drug classes in Beirut. Moreover, number of arrest cases of drug users and other-drug related accusations (such as cultivation and facilitation) were based on accurate data for all governorates, but not for Beirut and Mount Lebanon. In fact, these figures were estimated by the Central Bureau. In addition, there was a discrepancy in the number of arrest cases in the Beqaa which were provided differently by the Central and the Beqaa DEBs. This was reported in the results section. Finally, we were not able to collect the number of cases with accusations of drug use and other crimes in all governorates of Lebanon. All other data relevant to the questionnaire were gathered.

7. Judges

7.1. Design and sampling

Judges who were the most influential on the ground regarding substance use were chosen through non-probability purposive sampling. This sampling strategy was chosen to quickly maximize our understanding of substance use. Out of the 504 judges working in Lebanon, we have selected 42 judges representing all judges handling drug-related cases (Table 1.2, p. 40).

7.2. Instrument development and description

The questionnaire was developed by the study's legal advisor, and is a combination of closed ended and open-ended questions, allowing for assessing legal notions and applications and their subsequent elaboration. Sections of the questionnaire were: 1)

jurisdiction in drug use cases; 2) judges' knowledge in substance use; 3) experts on substance use; 4) lawyers and rights of the defense; 5) treatment measures; 6) recommendations made to the government to improve the judges' work in the field of addiction.

7.3. Data collection

The list of judges was provided by our legal advisor and was utilized to contact them upon official approval of the Director General of the Ministry of Justice (MOJ). Out of the 42 judges, 35 participated (Table 1.2, p. 40). Responses of one judge were excluded from all analyses because he withdrew from the interview as he had not handled a case of drug use in a long time and believed that the answers provided would be inaccurate. Also, we were not able to reach 2 judges. The other 4 judges refused to participate: two did not feel they would be of value to the study since they did not see many drug use cases, one had no interest in participating in the study, and another scheduled an interview but did not attend. The final sample of judges is 34.

Stakeholders

8. Ministry of Public Health (MOPH)

8.1. Design and sampling

We aimed to interview one representative of the MOPH who was involved in the field of addiction and therefore able to provide us with the data requested.

8.2. Instrument development and description

The questionnaire addressed to the MOPH representative was developed by Skoun's researcher with the objective of evaluating the role and involvement of MOPH in the matter of substance use, abuse or dependence in Lebanon. The questionnaire included 6 sections: 1) role of MOPH with respect to addiction and interaction with the substance user seeking treatment; 2) funding of

treatment centers; 3) cases of substance use supported by MOPH; 4) data on substance users' health status (drug-related conditions); 5) data on substance-related deaths; 6) recommendations to improve the conditions of substance users in Lebanon. The questionnaire was translated to Arabic and reviewed before administration.

8.3. Data collection

An official letter written by Skoun's director was sent to the Minister of the MOPH stating the objectives of the study and advocating the importance of the Ministry's collaboration to the study. Once approval was granted, the President of the Drug Department at MOPH was contacted. One fieldworker met with the latter who returned the questionnaire a few days later after having collected the data necessary from different departments. Since an interview did not take place, the questionnaire was carefully screened and re-written onto a Word document in the form of the final report, and contact was made in case of ambiguous responses.

9. Ministry of Justice (MOJ)

9.1. Design and sampling

The MOJ is the governmental agency overseeing the building, maintenance and administration of courts, supervising public prosecutions, directing corrections and the prison system, and proposing legislation affecting civil or criminal law or procedure. We aimed to investigate its role with respect to the Law on Drugs by interviewing one representative of the MOJ.

9.2. Instrument development and description

The questionnaire was developed by the study's legal advisor and all questions were open-ended and targeted the following themes: 1) implementation of the Law on Drugs; 2) training of judges on the Law on Drugs; 3) coordination with the prosecution; 4) coordination with international parties; 5) recommendations to improve the condition of substance users in Lebanon.

9.3. Data collection

An official letter written by Skoun's director was sent to the MOJ asking for approval of interviewing a representative and explaining the purpose of the study. After authorization of the MOJ, the legal advisor and project coordinator, both involved in advocacy and substance-related legal issues, interviewed a member of the MOJ, the President of the Addiction Committee.

10. Ministry of Social Affairs (MOSA)

10.1. Design and sampling

The MOSA was deemed as important as the other ministries to be interviewed as it is also implicated in the field of addiction, even if not directly involved in treatment. In the same way as the other Ministries, one representative was targeted.

10.2. Instrument development and description

The questionnaire was developed by Skoun's researcher. Since the MOSA is mainly involved in social issues related to addiction, the following categories were set: 1) role of MOSA with respect to addiction and interaction with the substance user seeking treatment; 2) funding of affiliated social services centers and treatment centers; 3) coordination with MOPH; 4) data related to substance use; 5) recommendations to improve the conditions of substance users in Lebanon.

10.3. Data collection

An official letter directed to the Minister of Social Affairs was sent. Following the MOSA's approval, the questionnaire was sent to a social worker with experience in addiction, who reviewed the questions, collected the data, and discussed the remaining questions with her colleague, the advisor of MOSA, before returning the questionnaire.

Other Service Providers

11. Non-Governmental organizations (NGOs) encountering substance users

11.1. Design and sampling

NGOs working in the mental health field were selected as they may encounter substance users though they are not known as treatment centers for substance dependence. Two exclusion criteria were adopted, (1) NGOs not working in 2009, and (2) those not welcoming any case of substance use. Given the timeline set for the study methodology, 8 NGOs were randomly selected from a total of 12 NGOs that the team knew of. The populations of interest of these NGOs are children in the Palestinian camps and other areas in Lebanon, underprivileged populations, battered women and sex workers, lesbian, gay, bisexual, transgender individuals, and mental health patients. One NGO is specialized in substance use but not in the treatment of substance dependence and offer services revolving around prevention, referral, aftercare support, vocational assistance, family support, legal support, outreach activities and drop-in services. Substance users visited these NGOs with or without the intention of seeking help for their substance use, abuse, or dependence. Nevertheless, these NGOs were targeted in the aim of assessing what services they could provide to substance users, if existing, and to appraise the number and characteristics of substance users who visited them.

11.2. Instrument development and description

The same questionnaire as the one administered to NGOs treating substance users was used, removing questions that are not applicable. Moreover, instead of asking about percentages of patients visiting the NGO, we have asked about the percentage of substance users NGOs had seen in 2009. Furthermore, in order to get a comprehensive understanding of these NGOs' involvement in substance use, we added two questions: "do you routinely screen for substance use?" and "what types of services can you provide substance users with besides those mentioned previously?".

11.3. Data collection

Fieldworkers sent either a fax or an e-mail to the potential interviewees with an official letter from Skoun's director explaining the project and its purpose and highlighting the importance of the NGO's contribution. Interviewees were then called to verify that the fax or e-mail was delivered and to enquire on their participation. Following the agreement of all 8 NGOs to take part in the study, a meeting was scheduled whereby data was collected (Table 1.2., p. 40).

12. Social services centers affiliated with the Ministry of Social Affairs (MOSA)

12.1. Design and sampling

-Social services centers affiliated with the MOSA are located in all areas of Lebanon and observations resulting from a close cooperation between some MOSA centers and Skoun, put in evidence the need of many substance users for treatment. We therefore decided to interview these centers to determine the number of cases seen and their role with respect to substance user's treatment. Following official approval by the MOSA to contact these centers, a list of all 95 social services centers present in Lebanon was obtained from one of the centers. Random stratified sampling by area was used to select 41 MOSA centers (Table 1.2, p 40). This type of sampling was used because we wanted to access centers in all areas of Lebanon and wished that the number of centers would be proportionate to the number of centers present in each governorate.

12.2. Instrument development and description

The questionnaire was developed by Skoun's researcher after having met with one of the MOSA center's director who provided the main categories to target during the interview, and some specific questions. The questionnaire included questions divided into the following sections: 1) cases of substance use; 2) assessment of services (services provided by MOSA and available services in the area); 3) referrals to treatment; 4) coordination with stakeholders; 5) sources of funding; 6) recommendations made to other

governmental bodies to improve the centers' work in the field of addiction. It was semi-structured in nature with some questions being closed-ended.

12.3. Data collection

After receiving approval from the MOSA, the social services centers were sent a fax with the official letter and the questionnaire, if requested, before the interview. One interview to a center located in the Beqaa was difficult to schedule and therefore the fieldworker administered the questionnaire over the phone. All MOSA centers agreed to participate in the study.

SECONDARY DATA COLLECTION

Collecting data by others working in the field of substance use was deemed valuable as it could shed light on trends of substance use, number of substance users receiving treatment throughout the years, substance-related infections, or any factors related to the condition of substance users. Thus, throughout the study, we have asked for the cooperation of all those having collected data related to substance use. Different type of data was collected as each institution records data specific to its function. We were able to access data from 5 different sources: Psychiatric Hospital of the Cross, Soins Infirmiers et Développement Communautaire (SIDC), Hép Attitude Positive, the DEBs, and Skoun.

Psychiatric Hospital of the Cross

The Psychiatric Hospital of the Cross is a large non-governmental hospital specialized in the treatment of mental health, including substance dependence, located in Mount Lebanon. It provides short and long-term psychiatric treatment. Data retrieved from the

hospital was the number and demographic characteristics of substance users admitted for treatment from 2003 to 2008, divided into alcohol dependent and drug dependent individuals.

Soins Infirmiers et Développement Communautaire (SIDC)

SoinsInfirmiers et Développement Communautaire (SIDC) is an NGO which works in several areas to raise awareness and improve community development in order to uncover and reduce health problems. It works through various programs: home based nursing care, diabetes, health education, AIDS, and drug abuse programs. SIDC's services target vulnerable groups but also the population as a whole. By means of the drug abuse program, SIDC provides treatment to substance users visiting the center. Moreover, team members perform outreach work to substance users who do not demand treatment, drug prevention, and introduce harm reduction strategies for IDUs. The NGO also collaborates with local and regional NGOs to change or implement articles of the law which might hinder the treatment of substance users, namely articles of the Law on Drugs. SIDC provided us with data which revolved around outreach work and community development that targeted HIV/AIDS prevention for populations at risk in year 2009. It was collected through outreach work and mobile units interventions on three main populations: IDUs, female sex workers (FSWs), and men who have sex with men (MSM). Mobile units also accessed individuals from the general population. Data was collected on: the number and characteristics of IDU, FSWs, and MSM accessed, the percentage of those using drugs, knowledge of sexually transmitted infections, use of condom, and knowledge of health services.[11] We selected the data relevant to substance users and their needs.

[11]For more information related to these activities, please contact SIDC at info@sidc-lebanon.org.

Hép Attitude Positive

Hép attitude positive is an NGO which aims to generate aid and assistance to people infected with hepatitis B and C, to be carried out in Lebanon and the Middle East. Hép attitude positive offers treatment services for these infections. We contacted the director of the NGO asking for their help in providing us with any substance-related data.

Drug Enforcement Bureaus (DEBs)

The DEBs participated by allowing us to collect primary data but also sent the team secondary data with their annual statistical report which covers: 1) types and quantities of drugs and psychotropic substances seized in Lebanon; 2) number of individuals arrested with various drug-related accusations and related demographic characteristics during various years in Lebanon; 3) number of individuals arrested by different types of drugs in Lebanon; 4) landscape destroyed involving cultivation of substances in Lebanon. We have selected all data related to drug use for 2009 and previous years.

Skoun

Skoun, Lebanese Addictions Center, is an NGO specialized in the treatment of substance dependence. The center also offers prevention activities and is involved in advocacy to demand and support that the rights of substance users be respected. Additionally, Skoun collects data on its patient population at multiple times during the treatment process: at intake; at 3-, 6-, and 12-months outcome; and at termination of treatment. This allows Skoun to identify who the population is, what services are beneficial

to the patients, and how many succeed or relapse. Skoun is in the process of analyzing the outcome data thus to this date, only descriptive intake data is available[12]. Intake data for 2009 is shown in this report.

[12]For more information on data collection at Skoun, please contact caren@skoun.org.

CHAPTER IV

STUDY FINDINGS

RESULTS OF PRIMARY DATA ANALYSIS

Health Facilities

1. Non-governmental organizations (NGOs) specialized in the treatment of substance users

Overall, 8 NGOs specialized in the treatment of substance users were interviewed, whereby 4 were located in Mount Lebanon (NGO1, NGO3, NGO4 and NGO6), 3 in Beirut (NGO2, NGO7, NGO8) and 1 in the Beqaa governorate (NGO5).

One of the NGOs located in Mount Lebanon, is specifically located within a prison. It aims at treating prisoners only, with their choice as to whether they want to initiate treatment or not.

1.1. Cases of substance dependence

A total of 774 cases of substance dependence to any illegal drug and/or alcohol approached 7 of these NGOs in the year of 2009.

1.2 Demographic characteristics of patients with substance dependence

Most substance users visiting NGOs in 2009 were between 18 and 34 years of age, with the majority being males and Lebanese. Moreover, a relatively good number of substance users were of low SES and unemployed (Table 1.2.1).

TABLE 1.2.1 *PREVALENCE OF SUBSTANCE DEPENDENCE BY DEMOGRAPHICS, 2009*

	Substance dependence			
	N	**Median (%)***	**Mean (%)**	**(minimum – maximum)**
Age (years)				
< 18	8	6	14	(0-70)
18 – 24	8	36	38	(25-62)
25 – 34	8	35	36	(0-71)
≥ 35	8	13	12	(0-26)
Gender				
Males	8	100	98	(85-100)
Females	8	0	3	(0-15)
Nationality				
Lebanese	8	98	97	(90-100)
Non-Lebanese	8	3	3	(0-10)
Socioeconomic status				

Low	8	62	66	(31-100)
Middle	8	23	23	(0-44)
High	8	10	11	(0-25)
Employment status				
Employed	8	49	44	(0-100)
Unemployed	8	52	56	(0-100)

**Interviewees were asked to estimate the percentage of their patients belonging to a specific age group and SES, and the percentage of those being males/females, Lebanese/non Lebanese, employed/unemployed. An average of percentages reported was computed.*

1.3 Clinical characteristics of patients with substance dependence

Age of onset of substance use

Half of the NGOs reported an average age of onset of substance use of 15 years or lower, ranging from 10 to 17 [mean = 14]. As for the age of onset relative to the substance of choice, it was reported to be 16 years or lower [minimum-maximum: 15-19; mean = 17]. Moreover, once an individual has initiated use, the duration of use for the substance of choice before seeking treatment was 4 years, 3 being the minimum and 10 the maximum [mean = 5].

Changing trend of prevalence in substance use

Overall, the prevalence of cannabis, opioids, amphetamine-types, sedatives and tranquilizers, and alcohol was reported to have increased over a 1 to 2-year period (2007/2008-2009). Cocaine was thought to have increased by half of the interviewees while the rest believed its prevalence of use did not change considerably. No NGO claimed an increase in the use of solvents and inhalants;

quite a good number reported no significant change. As for other types of substances, none of the NGOs claimed a decrease; rather the majority believes that the prevalence of use has remained the same (Table 1.3.1).

TABLE 1.3.1 *NUMBER OF NGOS REPORTING ON THE TREND OF PREVALENCE IN SUBSTANCE USE BY SUBSTANCE CLASSIFICATION FROM 2007/2008 TO 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Large decrease	0	0	0	0	0	1 (17)	0	0	0
Some decrease	0	1 (17)	0	1 (17)	1 (17)	1 (17)	2 (40)	0	0
No significant change	1 (17)	0	3 (50)	1 (17)	1 (17)	3 (50)	3 (60)	0	4 (80)
Some increase	3 (50)	3 (50)	3 (50)	1 (17)	3 (50)	0	0	3 (50)	1 (20)
Large increase	2 (33)	2 (33)	0	3 (50)	1 (17)	1 (17)	0	3 (50)	0

Patients' primary choice of substance

Overall, opioids, followed by cannabis, were rated by NGOs as the substances mostly used by those seeking treatment in 2009. Cocaine was considered the third ranked substance to be used. Other substance classifications were considered of lower ranking (Table 1.3.2).

TABLE 1.3.2 *NUMBER OF NGOS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	1	3	0	0	0	0	0	0	0
Rank 2	1	1	0	1	0	0	0	1	0
Rank 3	1	0	3	0	0	0	0	0	0
Rank 4	0	0	1	1	1	1	0	0	0
Rank 5	1	0	0	2	1	0	0	1	0
Rank 6	0	0	0	0	1	2	2	0	1
Rank 7	0	0	0	0	0	0	1	0	0
Rank 8	0	0	0	0	0	0	0	1	0
Rank 9	0	0	0	0	0	0	0	0	1

Cannabis was considered as the substance most frequently used by substance users aged less than 18 years. Subsequently, opioids were ranked second with amphetamine-types ranking third (Table 1.3.3).

TABLE 1.3.3 *NUMBER OF NGOS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, < 18 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	5	1	0	0	0	0	0	0	0
Rank 2	0	3	0	0	2	0	0	1	0
Rank 3	0	1	1	2	1	0	0	0	1
Rank 4	0	0	1	1	1	0	0	2	0
Rank 5	0	1	1	0	2	0	0	0	0
Rank 6	0	0	0	0	0	2	0	0	0
Rank 7	0	0	0	0	0	0	2	1	0
Rank 8	0	0	0	0	0	0	0	1	1

For those aged between 18 and 24 years, opioids and cannabis were considered the substances in the upper ranking. Cocaine and, sedatives and tranquilizers, were ranked third and fourth respectively (Table 1.3.4).

TABLE 1.3.4 *NUMBER OF NGOS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, 18 TO 24 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	2	4	0	0	0	0	0	0	0
Rank 2	3	2	1	0	0	0	0	0	0
Rank 3	1	0	4	0	0	0	0	1	0
Rank 4	0	0	0	2	4	0	0	0	0
Rank 5	0	0	1	0	2	0	0	2	0
Rank 6	0	0	0	1	0	1	0	1	0
Rank 7	0	0	0	0	0	1	0	0	0
Rank 8	0	0	0	0	0	0	1	0	0
Rank 9	0	0	0	0	0	0	0	0	1

Opioids were considered to be the mostly used substance, as well as cannabis, for those aged 25 to 34 years old. Other substance classifications in the lower rankings included cocaine and alcohol (Table 1.3.5).

TABLE 1.3.5 *NUMBER OF NGOS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, 25 TO 34 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	2	3	1	0	0	0	0	0	0
Rank 2	2	3	0	0	1	0	0	0	0
Rank 3	0	0	2	1	1	0	0	2	0
Rank 4	1	0	0	0	1	1	0	2	0
Rank 5	0	0	1	0	1	0	0	1	0
Rank 6	0	0	0	1	0	0	0	0	0
Rank 7	0	0	0	0	0	1	0	0	0
Rank 8	0	0	0	0	0	0	1	0	0
Rank 9	0	0	0	0	0	0	0	0	1

Among the highest age group, opioids and cocaine were reported to be the substances mainly used. Additionally, cannabis was ranked fourth (Table 1.3.6).

TABLE 1.3.6 *NUMBER OF NGOS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, ≥ 35 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	1	2	2	0	0	0	0	0	0
Rank 2	1	1	2	0	0	0	0	1	0
Rank 3	1	1	0	0	1	0	0	1	0
Rank 4	2	0	0	0	1	0	0	1	0
Rank 5	0	1	0	0	0	1	0	0	0
Rank 6	0	0	0	0	0	0	0	0	0
Rank 7	0	0	0	0	0	0	0	0	0
Rank 8	0	0	0	0	0	0	0	0	0
Rank 9	0	0	0	0	0	0	0	0	0

Poly-substance use

Half of NGOs reported 90% of their patients, or lower, to have used at least two psychoactive substances simultaneously [minimum-maximum: 23-100; mean=80%]. Most common substance combinations included (1) cannabis and opioids; (2) opioids and, sedatives and tranquilizers; (3) cocaine and opioids. On a positive note, all interviewed NGOs provided treatment for poly-substance users.

Substance users' health status

Among the 3 NGOs who responded, half estimated 0% of their patients [minimum-maximum: 0-3; mean = 1%] to be infected with Hepatitis B. As for Hepatitis C, half reported that 6% of their patients, or lower, were infected with the virus [mean = 8%], ranging from 4 to 15% as reported by 5 NGOs. No cases of HIV positive were encountered, as reported by 3 NGOs.

When asked about the trend of prevalence of infections compared to the past 1 to 2 years, 3 NGOs claimed no significant change; another 3 claimed a slight increase whereas only 1 estimated a large increase.

1.4 Assessment of treatment services

Availability of treatment services

Overall, the majority of NGOs interviewed had a good number of available services (e.g., case identification, comprehensive assessment, case management, withdrawal management, brief intervention, group therapy for addictions, individual therapy for addictions, family support, legal support, and wellness related activities). These services, however, were not available for males and females in most NGOs, but were provided to those of all nationalities, religions and using all types of substances (Table 1.4.2).

TABLE 1.4.2 *NUMBER OF NGOS WITH AVAILABLE TREATMENT SERVICES AND THEIR COVERAGE, 2009*

Types of services	N	Availability	Coverage**							
			M and F	M only	All R	1 R only	All N	L only	All types of S	Specific S only
Case identification*	8	8	2	6	6	2	7	1	7	1
Comprehensive assessment*	7	7	2	5	6	1	7	0	7	0
Case management*	7	7	2	5	6	1	7	0	7	0
Information, guidance and advice*	7	7	2	5	6	1	7	0	7	0
Drop-in*	7	2	1	1	2	0	2	0	2	0
Withdrawal management/supervised detoxification (home/facility)*	7	6	2	4	6	0	6	0	6	0
Brief intervention*	7	7	2	5	6	1	7	0	7	0
Medications for addiction*	5	4	2	2	4	0	4	0	1	3

Medications for medical conditions*	5	5	2	3	4	1	5	0	5	0
Psychiatric medications*	5	3	2	1	3	0	3	0	3	0
Medical support*	5	5	2	3	4	1	5	0	5	0
Group therapy sessions for addiction*	6	6	2	4	5	1	6	0	6	0
Educational group sessions for addiction*	6	5	1	4	4	1	5	0	5	0
Individual therapy sessions for addiction*	7	7	3	4	6	1	7	0	7	0
Individual therapy for mental health*	6	5	1	4	4	1	5	0	5	0
Group therapy sessions for mental health*	4	3	0	3	2	1	3	0	3	0
Day/evening treatment*	5	4	1	3	3	1	4	0	4	0
Outpatient treatment*	5	4	2	2	4	0	4	0	4	0
Short-term inpatient treatment	5	1	1	0	1	0	1	0	1	0
Long-term inpatient	6	5	1	4	4	1	5	0	5	0

treatment*										
Supportive housing*	4	2	0	2	2	0	2	0	2	0
Family support*	7	7	3	4	6	1	7	0	7	0
Legal support*	6	6	2	4	5	1	6	0	6	0
Aftercare support or vocational assistance (job placement program)*	7	6	1	5	5	1	6	0	6	0
Wellness related activities (e.g., yoga, meditation, art therapy, recreation development)*	6	6	1	5	5	1	6	0	6	0
Outreach	7	1	1	0	1	0	1	0	1	0

**One NGO extends its services to prisoners or ex-prisoners.*
***M = Males; F = Females; R = Religion; N = Nationality; L = Lebanese; S = Substance*

Accessibility of treatment services

In general, 3 NGOs had a 24-hour service, with 3 NGOs opening for 8, 11 and 14 hours per day. Also, of the 6 NGOs responding, half could accommodate 36 patients or less for treatment per year [mean = 52], ranging from a capacity of 22 to 120 patients. Overall, a total of 314 patients could be accommodated by these NGOs. Moreover, NGO1 and NGO7 reported the majority of their patients traveling less than 15 km to reach the treatment center (100% and 70%, respectively), with the case not being true for NGO4. The average treatment cost per month for patients was 100 USD [minimum-maximum: 0-1100; mean=303 USD].

Duration of treatment

Half of the NGOs reported a usual duration for treatment to last for 318 days or less [mean = 280] with NGOs' responses ranging from 5 to 480 days. NGO 6, located in Mount Lebanon, reported a 5-day treatment duration consisting of withdrawal management only.

Availability of human resources

Half of the NGOs' clinical teams were, at the most, composed of, 1 psychiatrist [minimum-maximum: 0-2], 1 GP [minimum-maximum: 0-2], 2 psychologists [minimum-maximum: 1-7; mean = 3], 2 counselors [minimum-maximum: 0-6], 1 nurse [minimum-maximum: 0-2], 1 social worker [minimum-maximum: 0-4; mean = 2] and 3 other members in the clinical team [minimum-maximum: 1-5].

The non-clinical team of half of NGOs was composed of, 2 prevention officers [minimum-maximum: 0-5], 1 development officer [minimum-maximum: 0-3], 15 volunteers [minimum-maximum: 2-200; mean = 39], 1 religious figure [minimum-maximum: 0-6; mean = 2], 2 lawyers [minimum-maximum: 1-2], 3 administrators [minimum-maximum:1-5], 1 accountant [minimum-maximum: 1-2], 2 other non-clinical team members [minimum-maximum:1-3], and no researcher [minimum-maximum:0 – 4; mean = 1].

To note, one NGO had 23 volunteers whom worked as employees and had different specializations.

Required resources/services

The need for more human resources was ranked highest, followed by bigger space also ranking first. Moreover, the need for an effective communication with other treatment centers was generally ranked third. Other needed services were viewed of lower ranking (Table 1.4.3).

Those believing that additional treatment interventions or the expansion of existing services would help improve the treatment center, identified the specific type of treatment intervention needed. Short-term inpatient treatment was seen as the priority for 5 NGOs. Also, 4 NGOs believed in the need to focus on family, legal and aftercare support. Other types of services (e.g., drop-in,

day/evening treatment, outpatient treatment, long-term inpatient treatment, supportive housing, drug user hotline, outreach services, intensive outpatient treatment services and wellness-related activities) were recommended by fewer NGOs.

TABLE 1.4.3 *NUMBER OF NGOS REPORTING ON THE RANK OF REQUIRED RESOURCES, 2009*

	Increase space	Increase human resources	Increase the effectiveness of communication with other treatment centers	Increase the effectiveness of communication with judges	Increase governmental support	Add/expand services
Rank 1	3	4	0	0	2	1
Rank 2	2	3	1	1	2	0
Rank 3	1	0	4	1	0	1
Rank 4	1	1	2	1	1	1
Rank 5	0	0	0	2	2	2
Rank 6	0	0	0	2	0	1

When asked about clinical team members they wish to add, counselors and nurses were suggested by 4 NGOs. However, only 2 NGOs reported on the need to add psychiatrists, GPs, psychologists, social workers, and others (e.g., special educators).

As for the non-clinical team members, 4 NGOs required researchers and administrators to be added, with only 3 wanting to add accountants. Fewer NGOs felt they needed prevention officers, development officers, religious figures, volunteers, lawyers, and others such as sociologists.

Availability of treatment services in Lebanon

Availability of proper treatment/treatment was seen by 7 NGOs to be present in Mount Lebanon. Moreover, Beirut was also seen to include such treatment by 5 NGOs. On the other hand, the majority believed that North and South of Lebanon are in need of proper treatment/treatment (6 and 5 NGOs respectively). Responses on availability of Beqaa and Nabatieh's treatment services were mixed, 4 believed such services to be lacking, while 3 did not believe so (NGO3 did not report on an answer for this question).

1.5 Factors related to initiation, maintenance, and completion of treatment

Changing trend of prevalence in treatment

Mixed responses were obtained regarding the estimated trend of prevalence of people seeking treatment in 2009 compared to 2007/2008. About 38% estimated either a large increase or no significant change. On the other hand, 13% indicated a slight decrease or a slight increase.

Demand for treatment

Overall, half of NGOs reported 115 of their patients (or lower) to have presented for treatment at the interviewed NGOs, ranging from 25 to 245 [mean = 110]. NGO1 located in Mount Lebanon has had the greatest number of patients enrolling in the treatment program. As indicated in the table below, a substantial number of patients have presented for treatment but have not received it, with the exception of NGO5. NGO8 located in Beirut has treated the greatest number of individuals (Table 1.5.1). Among all NGOs, 48 patients or lower [mean = 45] have received treatment in the year of 2009.

TABLE 1.5.1 *NUMBER OF PEOPLE RECEIVING TREATMENT AND PRESENTING FOR TREATMENT BY NGOS, 2009*

	Number of people who have presented for treatment	Number of people who have received treatment
	N	N (%)
NGO1	245	45 (18)
NGO2	122	48 (39)
NGO4	77	32 (42)
NGO5	50	50 (100)
NGO6	25	6 (24)
NGO7	115	64 (56)
NGO8	140	76 (54)

Numbers refer to new admissions in 2009 and do not include patients who have already received treatment in previous years.
NGO3 did not report on any number.

Reasons for not receiving or discontinuing treatment after first consultation

Respondents generally agreed that substance users' unwillingness to stop using any type of substance was a reason for not continuing treatment after first consultation. Other reasons were mostly disagreed upon (Table 1.5.2).

TABLE 1.5.2 *NGOS' LEVEL OF AGREEMENT REGARDING REASONS FOR SUBSTANCE USERS NOT RECEIVING OR DISCONTINUING TREATMENT AFTER FIRST CONSULTATION, 2009*

	Distance to reach the center	Cost of treatment	No vacancies	Waiting list	Next appointment too far from first date of visit	Services not suitable to patients' needs	Willing to stop using substances on their own	Not willing to stop using substances
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	4 (67)	5 (83)	2 (33)	3 (50)	5 (83)	1 (17)	0	0
Disagree	0	1 (17)	1 (17)	0	1 (17)	2 (33)	1 (14)	1 (14)
Neutral/Mixed	1 (17)	0	1 (17)	1 (17)	0	2 (33)	3 (43)	1 (14)
Agree	1 (17)	0	1 (17)	0	0	0	1 (14)	3 (43)
Strongly agree	0	0	1 (17)	2 (33)	0	1 (17)	2 (29)	2 (29)

Reasons for not completing treatment

In the year of 2009, the NGOs reported 28% of their patients to have dropped out of their treatment program [minimum-maximum: 1-75; mean = 29%]. Possible reasons for not completing treatment were many, of which some were agreed and disagreed upon. Reasons mostly agreed to have an effect on not completing the treatment were (1) lack or loss of commitment to treatment, (2) lack of governmental support, and (3) treatment duration (Table 1.5.3).Other reasons, such as the absence of OST, or the stigma that

follows a drug user in society, were viewed to be potential reasons for non compliance to treatment. Moreover, cost of treatment leading to drop out was disagreed upon by all the respondents.

TABLE 1.5.3 *NGOS' LEVEL OF AGREEMENT REGARDING REASONS FOR NOT COMPLETING TREATMENT, 2009*

	Distance to reach the center	Cost of treatment	Lack of governmental support	Family involvement	Duration of treatment	Services not suitable to patients' needs	Lack or loss of commitment to treatment
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	3 (50)	3 (50)	1 (17)	1 (17)	1 (14)	1 (17)	0
Disagree	1 (17)	3 (50)	0	1 (17)	0	3 (50)	1 (14)
Neutral/Mixed	1 (17)	0	2 (33)	2 (33)	3 (43)	1 (17)	2 (29)
Agree	1 (17)	0	3 (50)	2 (33)	3 (43)	1 (17)	4 (57)
Strongly agree	0	0	0	0	0	0	0

On average, readmission rate was 9% or less [minimum-maximum: 1-20], as estimated by half of the 6 NGOs responding. All of those interviewed readmit patients who had dropped out of treatment.

Reasons for denying access to treatment

Half of NGOs denied access to treatment to 24 people or less, [minimum-maximum: 4-85; mean = 31]. Possible reasons for refusal mainly included services available at the center not fitting the patients' needs, and patient's psychiatric co-morbidity. Two NGOs did not admit individuals to their treatment program because of the presence of infections, such as hepatitis B, C, or HIV, and because of their sexual orientation (Table 1.5.4).

TABLE 1.5.4 *NGOS' LEVEL OF AGREEMENT REGARDING REASONS FOR DENYING ACCESS TO TREATMENT, 2009*

	Services not suitable to the patients' needs	No vacancies	Individuals could not afford treatment	Individuals had an infection	Individuals had a disability	Individuals' psychiatric co-morbidity	Individuals' sexual orientation
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	0	3 (50)	3 (60)	3 (60)	3 (60)	0	3 (60)
Disagree	1 (20)	0	1 (20)	0	0	1 (25)	0
Neutral/Mixed	2 (40)	1 (17)	0	0	1 (20)	1 (25)	0
Agree	0	1 (17)	1 (20)	0	0	2 (50)	0
Strongly agree	2 (40)	1 (17)	0	2 (40)	1 (20)	0	2 (40)

1.6 Referrals

Referral sources

Sources of referral ranked by most NGOs included, personal environment ranking highest, and social services ranking fourth (Table 1.6.1).

TABLE 1.6.1 *NUMBER OF NGOS REPORTING ON THE RANK OF REFERRAL SITES, 2009*

	Personal environment	Hospitals	Other NGOs	Private practice psychiatrists or psychologists	Law representatives	Social services centers
Rank 1	5	1	0	0	0	1
Rank 2	1	1	2	0	2	2
Rank 3	0	0	2	1	2	0
Rank 4	0	0	0	1	1	3
Rank 5	0	0	1	2	1	0
Rank 6	1	2	0	0	0	0

Referral sites

When asked where NGOs referred those that they could not treat, 4 ranked another NGO as first; hospitals were ranked second. Private practice psychiatrists or psychologists were not given a specific rank.

Referral system among health professionals

Six NGOs (NGO1, NGO4-NGO8) stated having a referral system in place with other treatment facilities, while NGO2 and NGO3 did not have such a system. Among those with a referral system, 33% viewed it to be of poor quality, 17% of average quality and 50% of good quality.

1.7 Legal situation of patients with substance dependence

Coordination with Internal Security Forces (ISF) and the judicial system

7 NGOs did not communicate any information to the police regarding patients (mandated or non-mandated but with legal issues), whereby 1 NGO did not respond. Among those not communicating information to the police, none felt legally obliged to do so.

Only 2 NGOs (NGO4 and NGO5) reported having an established system of coordination between the treatment center and the legal system (police, prosecution, courts) to accommodate mandated individuals. They explained that their system consisted of cooperation and coordination between NGOs, police, prosecution and the judges.

Half of the NGOs reported having a good relationship with the judicial system, with 2 claiming a very good one. Only NGO8 admitted to have a poor relationship, and NGO6 reported not having one in the first place.

When a judge would refer a patient to an NGO for treatment, his/her cooperation was claimed to be good by 4 NGOs, whereas 3 reported it to be poor. When a patient under trial is being sent to treatment, collaboration with the NGO was generally reported to be good by 4 NGOs. However, only NGO8 viewed it to be of very poor quality, with 2 describing the relationship to be neutral.

There was no actual follow-up on patients by the judges or prosecutors, as indicated by 5 NGOs. Only 1 NGO, however, reported a follow-up. On their end, when it came to communicating mandated individuals' admissions with the judges or prosecutors, 4 NGOs reported doing so, while 3 did not. Furthermore, the majority of NGOs (6 out of 7 respondents) did not notify the judges or prosecutors when a patient had dropped out of treatment. Moreover, 5 NGOs had standardized forms that are used to update the judges on the patient's treatment status, while 3 did not.

All NGOs reported having a legal advisor or someone who can follow up on legal issues with patient.

Effect of incarceration on treatment

3 NGOs reported incarceration to negatively affect the initiation and maintenance of treatment, with 1 NGO reporting to have a large negative effect. On the other hand, 2 NGOs believed incarceration to have no influence on the treatment, whereby only 1 NGO believing in a positive influence.

1.8 Sources of funding

Each NGO interviewed received funding from various sources. Funds directed to most NGOs were mainly coming from private donations and other types of sources for treatment. Local foundations, however, had only donated funds to 1 NGO (Table 1.8.1).

TABLE 1.8.1 *PERCENTAGE OF TOTAL FUNDING AS REPORTED BY EACH NGO, 2009*

	NGO1	NGO2	NGO3	NGO4	NGO6	NGO7	NGO8
	%	%	%	%	%	%	%
Private donations	3	90	60	10	0	64	10
Local foundations	0	0	0	10	0	0	0
International foundations	90	0	0	10	0	0	30
International donor agencies	0	0	0	10	0	12	30
Public donations	0	0	0	0	100	4	0
Other sources	7	10	40	60	0	20	30

More than one source of funding could be reported.
NGO5 did not respond to this question.

Moreover, none of the NGOs interviewed were funded by MOPH for treatment, but two were funded to provide VCT for HIV to those visiting the center as part of the National AIDS Control Program (NACP) implemented by the Ministry. Moreover, 3 NGOs indicated receiving donations from MOSA, with NGO7 (located in Beirut) specifying that the budget received was allotted for prevention. The remaining NGOs obtaining funding from the MOSA did not detail the allocation of the funding.

Two NGOs indicated that part of their annual revenues was generated from treatment of substance users, 20% and 15% respectively. 3 other NGOs stated that 0% of their annual revenues came from treatment, as treatment at these NGOs were free of

charge. The remaining 3 NGOs did not respond regarding this matter. In addition, the NGOs' yearly cost to treat 1 patient was, on average, 2,460 USD including rental fees, salaries, and office expenses [minimum-maximum: 516-9600; mean=5474 USD]

Only 10% of patients coming to NGO1 paid for treatment from their own money or through a family member or loved ones, whereas 60% attending NGO7 paid via these means. However, in NGOs 2, 5, and 6, none of the patients paid for treatment.

In 4 NGOs, the percentage of patients who were not able to afford treatment ranged from 10% to 95%. 2 NGOs stated that all patients were able to afford treatment, and 2 did not respond. All NGOs (except NGO4) were able to provide free treatment for individuals coming in for substance dependence. Among those, half of NGOs reported that 24 patients or less [mean =47] could be accommodated for free per year, ranging from 7 to 120. Number of patients being accommodated for free depended on the funding and donations received yearly.

1.9 Sources of information

3 NGOs based their responses on general observations, 2 on collected data and 3 on both collected data and general observations.

2. In-hospital psychiatrists

A total of 13 psychiatrists involved in treating individuals with substance dependence were interviewed. These psychiatrists worked in 10 different hospitals, of which 6 were located in Beirut and 4 in Mount Lebanon.

2.1 Cases of substance dependence

A total of 225 cases of substance dependence were encountered in 2009. Half of the psychiatrists reported that 30 patients at most [minimum-maximum: 8-81; mean = 45] with a primary diagnosis of substance dependence were treated in the inpatient unit in Beirut and Mount Lebanon. Moreover, half of the psychiatrists reported 9 patients [minimum-maximum: 2-30; mean = 12] to be admitted to a hospital with a secondary diagnosis of substance dependence. 5 out of 10 hospitals had an outpatient unit, but only one respondent, located in Mount Lebanon, reported 10 cases of substance dependence admitted in this unit. In all, 22% of psychiatric patients at most were diagnosed with substance dependence [minimum-maximum: 3-60; mean = 25%], whereby the hospital located in Mount Lebanon reported the highest proportion of substance dependent patients.

2.2 Demographic characteristics of patients with substance dependence

Patients of all age groups were encountered at the psychiatry departments with the greater part aged between 18 and 34 years. The majority of respondents were males and Lebanese, as generally assumed by the psychiatrists interviewed. Moreover, around half were of low SES, and slightly more than half were unemployed (Table 2.2.1).

TABLE 2.2.1 *PREVALENCE OF SUBSTANCE DEPENDENCE BY DEMOGRAPHICS, 2009*

Substance dependence	**N**	**Median (%)***	**Mean (%)**	**(minimum – maximum)**
Age (years)				
< 18	8	2	6	(0-20)
18 – 24	8	29	31	(13-50)
25 – 34	8	42	42	(20-75)
≥ 35	8	18	21	(6-51)
Gender				
Males	10	82	82	(65-100)
Females	10	19	18	(0-35)
Nationality				
Lebanese	8	90	90	(70-100)
Non-Lebanese	8	10	10	(0-30)
Socioeconomic status				

Low	8	45	52	(0-95)
Middle	8	30	25	(0-40)
High	8	20	23	(0-50)
Employment status				
Employed	6	48	43	(10-70)
Unemployed	6	53	57	(30-90)

**Interviewees were asked to estimate the percentage of their patients belonging to a specific age group and SES, and the percentage of those being males/females, Lebanese/non Lebanese, employed/unemployed. An average of percentages reported was computed.*

2.3 Clinical characteristics of patients with substance dependence

Age of onset of substance use

Half of the in-hospital psychiatrists estimated the age of onset for any type of substance to be 16 years or less [mean =17] and ranging from 14 to 22 years. As for the age of onset for the substance of choice, it was estimated to be 18 years or less [mean = 19] and ranging between 18 and 22 years. The average duration of using the substance of choice before coming to treatment for the first time was estimated by psychiatrists to be 3 years [minimum-maximum: 1-5].

Changing trend of prevalence in substance use

Most of the psychiatrists reported no significant change in the use of hallucinogens, solvents and inhalants and other types of substances in 2009 as compared to 2007/2008. Opioids use was presumed to have increased by the majority (Table 2.3.1).

TABLE 2.3.1 *NUMBER OF PSYCHIATRISTS REPORTING ON THE TREND OF PREVALENCE IN SUBSTANCE USE BY SUBSTANCE CLASSIFICATION FROM 2007/2008 TO 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Large decrease	0	0	0	1 (11)	0	0	1 (10)	0	0
Some decrease	0	0	0	1 (11)	0	0	0	0	0
No significant change	5 (50)	3 (27)	6 (55)	4 (44)	3 (38)	7 (70)	8 (80)	5 (50)	8 (89)
Some increase	3 (30)	1 (9)	3 (27)	1 (11)	3 (38)	2 (20)	1 (10)	4 (40)	1 (11)
Large increase	2 (20)	7 (64)	2 (18)	2 (22)	2 (25)	1 (10)	0	1 (10)	0

Patients' primary choice of substance

Based on patients visiting the interviewed psychiatrists, opioids were given the highest rank for the patients' primary choice of substance. Following that, alcohol was ranked third, with cocaine and hallucinogens ranking fourth. Sedatives and tranquilizers were high in the rankings (Table 2.3.2).

TABLE 2.3.2 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	2	7	0	0	2	0	0	2	0
Rank 2	2	1	1	1	3	0	0	2	1
Rank 3	2	2	3	0	2	0	0	6	0
Rank 4	0	1	4	3	2	4	3	1	1
Rank 5	3	0	2	2	0	1	1	0	1
Rank 6	0	0	0	1	0	0	2	0	1
Rank 7	0	0	0	1	0	2	0	0	1
Rank 8	0	0	0	0	0	1	2	0	0
Rank 9	0	0	0	0	0	0	0	0	1

Based on the different substance classifications, cannabis was ranked first by most psychiatrists for those who are less than 18 years of age. Opioids, sedatives and tranquilizers were ranked second. Alcohol was ranked second and fourth (Table 2.3.3).

TABLE 2.3.3 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, < 18 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	6	0	0	0	0	0	1	0	0
Rank 2	0	4	2	1	4	1	1	2	2
Rank 3	0	2	0	2	1	0	0	1	0
Rank 4	0	1	1	2	0	0	0	2	0
Rank 5	0	0	1	1	0	2	1	0	0
Rank 6	0	0	1	0	0	1	0	1	1
Rank 7	0	0	0	0	2	1	0	0	0
Rank 8	0	0	0	0	0	0	3	0	0
Rank 9	0	0	0	0	0	0	0	0	3

When classifying according to most frequent usage among those between 18 and 24 years of age, opioids and cannabis were ranked first. Cocaine was ranked third and fourth, and alcohol was ranked second and fourth. Moreover, solvents and inhalants as well as other substances were ranked fourth (Table 2.3.4).

TABLE 2.3.4 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, 18 TO 24 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	4	4	0	0	1	0	0	0	0
Rank 2	2	3	1	0	0	0	0	2	1
Rank 3	1	1	2	0	2	0	0	1	0
Rank 4	0	0	2	3	2	2	4	3	4
Rank 5	0	0	1	2	0	1	2	1	0
Rank 6	0	0	0	0	1	1	0	0	0
Rank 7	0	0	0	0	1	1	0	0	0
Rank 8	0	0	0	0	0	0	1	0	1
Rank 9	0	0	0	0	0	0	1	0	1

For patients between 25 and 34 years of age, psychiatrists ranked substances in the following order: opioids, cannabis, sedatives and tranquilizers, cocaine, then solvents and inhalants (Table 2.3.5).

TABLE 2.3.5 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, 25 TO 34 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	2	5	1	0	0	0	0	1	0
Rank 2	3	0	1	0	1	0	0	2	0
Rank 3	1	2	1	1	2	0	0	1	0
Rank 4	1	0	2	0	2	1	0	1	0
Rank 5	0	0	1	2	1	2	3	2	3
Rank 6	0	0	0	2	0	0	0	0	0
Rank 7	0	0	0	0	0	2	0	0	0
Rank 8	0	0	0	0	0	0	1	0	1
Rank 9	0	0	0	0	0	0	1	0	1

Among the highest age group, opioids were ranked first by psychiatrists, with cocaine ranking third. Alcohol was equally ranked first, second, and third. Cannabis and other substance classifications were given a fifth rank (Table 2.3.6).

TABLE 2.3.6 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENT'S PRIMARY CHOICE OF SUBSTANCE, ≥ 35 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	1	3	0	0	1	0	0	2	0
Rank 2	2	1	1	0	2	0	0	2	0
Rank 3	0	2	4	0	0	0	0	2	0
Rank 4	0	1	2	1	1	1	0	0	0
Rank 5	3	0	0	2	2	1	1	0	3
Rank 6	0	0	0	3	0	2	2	0	0
Rank 7	0	0	0	0	0	2	1	0	0
Rank 8	0	0	0	0	0	0	2	1	0
Rank 9	0	0	0	0	0	0	0	0	3

Poly-substance use

Individuals using one or more substances were entitled to receive treatment by all psychiatrists interviewed. Moreover, half of psychiatrists reported that 80% of their patients at most [minimum-maximum: 20-100; mean =73%] were poly-drug users. Psychiatrists assumed the following most common substance combinations: (1) heroin and, sedatives and tranquilizers; (2) heroin and cocaine; (3) heroin and cannabis; (4) cocaine and alcohol.

Substance users' health status

Half of psychiatrists reported that, at most, 5% of patients had hepatitis B, another 10% had hepatitis C and only 3% were substance users infected with HIV[minimum – maximum:0-20, 1-30, 0-10; mean =7%, 11%, 3% respectively].

A majority of psychiatrists (80%) viewed no significant change in the prevalence of hepatitis B and C, and HIV among substance users in 2009 compared to 2007/2008. Only 20% believed there might have been an increase.

2.4 Assessment of treatment services

Availability of treatment services

The majority of psychiatrists reported the availability of most treatment services except for the following: group therapy sessions for addictions, day/evening treatment, long term inpatient treatment, supportive housing, legal support, vocational assistance, after-care support, wellness-related activities and outreach. Of those having treatment services, all had an equal coverage of males and females, all nationalities, religions and types of substances. The one hospital that treats patients dependent to specific substances only is located in Beirut (Table 2.4.1).

TABLE 2.4.1 *NUMBER OF HOSPITALS WITH AVAILABLE TREATMENT SERVICES AND THEIR COVERAGE, 2009*

Types of services	**N**	**Availability**	**Coverage****							
			M and F	**M only**	**All R**	**1 R only**	**All N**	**L only**	**All types of S**	**Specific S only**
Case identification	9	8	8	0	8	0	8	0	7	1
Comprehensive assessment	9	8	8	0	8	0	8	0	7	1
Case management	9	8	8	0	8	0	8	0	7	1
Drop-in	9	5	5	0	5	0	5	0	4	1
Withdrawal management/supervised detoxification (home/facility)	9	8	8	0	8	0	8	0	7	1
Brief intervention	9	7	7	0	7	0	7	0	6	1
Medications for addiction*	9	6	6	0	6	0	6	0	5	1
Medications for medical conditions	9	8	8	0	8	0	8	0	7	1
Psychiatric medications	9	8	8	0	8	0	8	0	7	1
Medical support	9	8	8	0	8	0	8	0	7	1
Group therapy sessions for addiction	9	4	4	0	4	0	4	0	3	1

Educational group sessions for addiction	9	6	6	0	6	0	6	0	5	1
Individual therapy sessions for addiction	9	8	8	0	8	0	8	0	7	1
Individual therapy for mental health	9	7	7	0	7	0	7	0	7	0
Group therapy sessions for mental health	9	3	3	0	3	0	3	0	3	0
Day/evening treatment	9	4	4	0	4	0	4	0	3	1
Outpatient treatment*	9	5	5	0	5	0	5	0	4	1
Short-term inpatient treatment	9	8	8	0	8	0	8	0	7	1
Long-term inpatient treatment	9	4	4	0	4	0	4	0	3	1
Supportive housing*	9	0	0	0	0	0	0	0	0	0
Family support	9	8	8	0	8	0	8	0	7	1
Legal support*	9	1	1	0	1	0	1	0	1	0
Aftercare support or vocational assistance (job placement program)	9	4	4	0	4	0	4	0	3	1
Wellness related activities (e.g., yoga, meditation, art therapy, recreation development)	9	3	3	0	3	0	3	0	3	0

Outreach	9	2	2	0	2	0	2	0	2	0

**2 psychiatrists from the same hospital reported contradictory answers regarding availability and coverage, so this hospital was not included for the corresponding types of interventions.*

***M = Males; F = Females; R = Religion; N = Nationality; L = Lebanese; S = Substance*

A vast majority of psychiatrists (89%) reported presence of internal protocols and procedures for treatment of substance users, while only 11% claimed not having such structure, this case being in Beirut.

Accessibility of treatment services

Half of psychiatrists reported that around half of their patients or less needed to travel less than 15km [at least 20 minutes without traffic] to reach the treatment center (minimum-maximum: 20-60; mean = 46%). 7 hospitals were reported to have a 24-hour of service while only 1 had an 8-hour a day of service. The remaining respondents did not give out an answer. 7 psychiatrists working in 6 hospitals reported 12 beds [minimum-maximum: 5-18] or less to be available in the inpatient unit. 2 psychiatrists, however, coming from the same hospital, provided different answers (one reported having 12 beds and the other 18). Moreover, it was reported that a hospital could accommodate 200 patients for treatment [minimum-maximum: 52-450; mean = 230 patients] per year. Half of psychiatrists reported that treatment services provided would cost 243 USD or less per patient per day, ranging from 60 USD to 500 USD [mean= 263 USD].

Duration of treatment

Half of psychiatrists reported a duration for inpatients' stay for substance dependence to be 10 days or less [mean = 11] with a range of 4 to 25 days.

Availability of human resources

Half of the psychiatrists reported that 7 nurses or less were present in the clinical team[minimum – maximum: 0-150; mean=19] Moreover, the team constituted, at most, of 3 psychiatrists[minimum – maximum: 1-5], 2 psychologists [minimum – maximum:0-8;

mean = 3], 1GP [minimum – maximum:0-6; mean = 2], 1 social worker [minimum – maximum: 0-5] and 1 administrator [minimum – maximum:0-3]. There seemed to be nearly no prevention officers [minimum – maximum: 0-0], counselors [minimum – maximum: 0-1], development officers [minimum – maximum: 0-1], researchers [minimum – maximum: 0-2], volunteers [minimum – maximum: 0-0], religious figures [minimum – maximum: 0-2], lawyers [minimum – maximum:0-1], administrators [minimum – maximum: 0-3; mean = 1] and accountants [minimum – maximum: 0-1].

Required resources/services

Adding human resources to treatment centers for improvement was seen as a priority by a good number of psychiatrists, followed by making communication with other treatment centers more effective as well as increasing governmental support. Moreover, increasing effective communication with the judges referring individuals for treatment was ranked second and fourth (Table 2.5.3).

TABLE 2.5.3 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF REQUIRED RESOURCES, 2009*

	Increase space	Increase human resources	Increase the effectiveness of communication with other treatment centers	Increase effectiveness the of communication with judges	Increase governmental support	Add/expand services
Rank 1	2	5	1	1	3	2
Rank 2	2	3	4	3	3	2
Rank 3	2	0	2	1	0	1
Rank 4	1	0	0	3	1	2
Rank 5	2	1	1	1	1	1
Rank 6	0	0	1	0	1	1

Considering required human resources, 5 of 8 psychiatrists agreed that increasing the number of social workers would help improve the institution. However, the majority (75%) did not agree that more prevention officers, volunteers and lawyers would be needed. Again, 63% disagreed on the benefit of adding researchers and development officers to the institution. Moreover, few psychiatrists believed that the hospital needed more psychiatrists, GPs, psychologists, counselors, nurses, other clinical team members, religious figures, administrators, accountants or other non-clinical team members.

Different interventions were suggested to expand existing services or add new interventions. 4 of 5 psychiatrists proposed adding supportive housing, substance user hotline, intensive outpatient treatment and legal support.

Moreover, only 3 of 6 recommended adding long term inpatient treatment, family support, aftercare support, wellness-related activities and outreach activities to improve the available services. On the other hand, adding outpatient treatment, short-term inpatient, and day/evening treatments were viewed by 7 of 8 psychiatrists not to have an effect towards progress.

All psychiatrists agreed that harm reduction services were lacking, of which 38% strongly agree and 63% agree. Exactly half of psychiatrists also agreed that psychotherapy/counseling programs for substance dependence were absent, with 38% strongly agreeing and only 13% being neutral (no agreement or disagreement). Regarding withdrawal and detoxification services, 56% of psychiatrists agreed or strongly agreed that such services were lacking, while about 33% disagreed (of which 11% strongly disagreed), and 11% with no standing.

Availability of treatment services in Lebanon

Beirut and Mount Lebanon were the only area where 64% claimed that proper treatment is available. On the other hand, the majority of psychiatrists reported lack of treatment in Beqaa followed by North and South Lebanon (82%, 67%, and 64% respectively). Slightly more than half believed that Nabatieh also lacked treatment.

2.5 Factors related to initiation, maintenance, and completion of treatment

Changing trend of prevalence in treatment

More than half of psychiatrists (55%) reported an increase (slight/large), in the number of patients seeking treatment in 2009 compared to the previous one or two years.

Reasons for not completing treatment

Of the patients registered in the detoxification treatment, half of psychiatrists reported a drop out rate of 50% or less [minimum – maximum: 0-90; mean=44%]. Possible factors affecting dropout rates were investigated; loss of commitment to treatment, family involvement, and lack of support by the government was agreed upon by a good number of psychiatrists (Table 2.5.1).

TABLE 2.5.1 *PSYCHIATRISTS' LEVEL OF AGREEMENT REGARDING FACTORS AFFECTING COMPLIANCE TO TREATMENT, 2009*

	Distance to reach the center	Cost of treatment	Lack of governmental support	Family involvement	Duration of treatment	Services not suitable to patients' needs	Lack or loss of commitment to treatment
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	4 (33)	2 (17)	0	0	1 (8)	2 (17)	0
Disagree	5 (42)	1 (8)	0	1 (8)	4 (33)	4 (33)	0
Neutral/Mixed	0	1 (8)	3 (30)	2 (17)	3 (25)	1 (8)	1 (8)
Agree	3 (25)	4 (33)	5 (50)	7 (58)	3 (25)	3 (25)	7 (58)
Strongly agree	0	4 (33)	2 (20)	2 (17)	1 (8)	2 (17)	4 (33)

All psychiatrists claimed that the hospitals they are working in readmit patients who had dropped out of treatment. Moreover, half of psychiatrists reported 20% of substance users or less to have been readmitted in 2009 [minimum-maximum: 5-60].

Reasons for denying access to treatment

Half of psychiatrists reported that 3 patients or less [minimum – maximum: 0-20; mean=5] had to denied access to treatment. The main reason of refusal agreed upon by psychiatrists was the fact that the substance user could not afford treatment. 2 reasons, however, were not agreed upon at all, sexual orientation and psychiatrist co-morbidity of the substance user. There were mixed opinions among psychiatrists interviewed, about whether other reasons played a role in treatment refusal (Table 2.5.2).

TABLE 2.5.2 *PSYCHIATRISTS' LEVEL OF AGREEMENT REGARDING REASONS FOR DENYING ACCESS TO TREATMENT, 2009*

	Services not suitable to patients' needs	No vacancies	Individuals could not afford treatment	Individuals had an infection	Individuals had a disability	Individuals' psychiatric co-morbidity	Individuals' sexual orientation
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	0	1 (11)	0	2 (22)	4 (44)	2 (22)	3 (33)
Disagree	4 (44)	3 (33)	3 (30)	5 (56)	4 (44)	5 (56)	6 (67)
Neutral/Mixed	2 (22)	1 (11)	1 (10)	0	0	2 (22)	0
Agree	1 (11)	2 (22)	4 (40)	2 (22)	1 (11)	0	0
Strongly agree	2 (22)	2 (22)	2 (20)	0	0	0	0

2.6 Referrals

Referral sources

As reported by psychiatrists, being referred by a personal environment was ranked highest, followed by private practice psychiatrists/psychologists, and another hospital. Other referral sites were not highly ranked by the majority (Table 2.6.1).

TABLE 2.6.1 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF REFERRAL SITES, 2009*

	Personal environment	Other hospitals	NGOs	Private practice psychiatrists or psychologists	Law representatives	Social services centers
Rank 1	8	0	0	0	0	1
Rank 2	1	2	4	5	3	2
Rank 3	0	4	3	3	2	3
Rank 4	0	3	0	1	2	0
Rank 5	0	0	1	0	2	0
Rank 6	0	0	0	0	0	2

Referral sites

NGOs were ranked the highest by psychiatrists when they were asked where they referred patients for treatment if need be. Hospitals and private practitioners (psychiatrists and psychologists) were both ranked second.

Referral system among health professionals

Half of the psychiatrists reported having a system of referral with treatment facilities in place. Among those, half rated their referral as good, and the other half as mediocre.

2.7 Legal situation of patients with substance dependence

Coordination with Internal Security Forces (ISF) and judicial system

Almost all of the psychiatrists did not communicate any information to the ISF regarding patients whether the latter were mandated or non-mandated but with legal issues (92%). 91% of psychiatrists did not feel obligated to share patients' information.

2.8 Substance-related deaths

9 in-hospital psychiatrists reported no fatality from overdose, HIV, or other substance-related deaths while 1 claimed that 5 encountered patients died from overdose. This hospital is located in the Beirut governorate.

2.9 Sources of funding

Only 3 out of 10 hospitals received funding from MOPH. One of these hospitals specifically received funding for the treatment of substance dependence, while the two others did for the treatment of psychiatric disorders in general. Psychiatrists at these hospitals reported the possibility for a person suffering from substance dependence to get treated at their hospital at the expense of the MOPH; around 85-90% of the treatment cost is covered. However, the number of inpatient beds which cost is covered per year was not detailed.

Moreover, rate of treatment per year considering rental fees, salaries, and medication expenses was reported by 3 psychiatrists to be 1,000 USD, 5,000 USD and 30,000 USD per patient.

2.10 Source of information

3 of the physicians interviewed gave responses based on data collected, while 4 based their replies on general observations.

3. Emergency room (ER) doctors

7 ER doctors were interviewed in 7 different hospitals. 5 hospitals were located in Beirut and 2 in Mount Lebanon.

3.1 Cases of substance use

A total of 972 individuals were admitted to the ambulatory department of the ER physicians interviewed because of a substance-related condition (overdose, poisoning, and withdrawal symptoms); 2 ERs were located in Mount Lebanon and 5 in Beirut. The range of substance use cases was 12 to 400, with half of ER doctors reporting a number of 118 users or less [mean = 162](Table 3.1.1).

602 patients were admitted for a condition not related to substance use but were diagnosed with substance dependence in the ER, as reported by 4 ER doctors. However, 600 of these cases were reported by one ER, located in Beirut (Table 3.1.1).

TABLE 3.1.1 *NUMBER OF SUBSTANCE DEPENDENCE CASES AT ADMISSIONS OF RELATED AND UNRELATED CONDITIONS BY HOSPITAL, 2009*

	Substance *related* condition	Substance *unrelated* condition
	N	N
Hospital 1	400	600
Hospital 2	25	0
Hospital 3	35	2
Hospital 4		
Hospital 5	12	
Hospital 6	200	0
Hospital 7	700	

Shaded area cells indicate missing data.

3.2 Demographic characteristics of substance users

Substance use cases encountered at the ER were more likely to be males, and between 18 and 24 years of age. Moreover, cases were reported to be more prevalent among those of Lebanese nationality, employed and of low SES (Table 3.2.1).

TABLE 3.2.1 *PREVALENCE OF SUBSTANCE USE BY DEMOGRAPHICS, 2009*

Substance use	**N**	**Median (%)***	**Mean (%)**	**(minimum – maximum)**
Age (years)				
< 18	6	15	20	(2-50)
18 – 24	6	45	47	(25-80)
25 – 34	6	23	24	(10-50)
≥ 35	6	8	10	(3-20)
Gender				
Males	7	70	73	(50-90)
Females	7	30	27	(10-50)
Nationality				
Lebanese	7	90	84	(60-100)
Non-Lebanese	7	10	16	(0-40)
Socioeconomic status				

Low	5	25	46	(10-90)
Middle	5	10	21	(0-60)
High	5	30	33	(0-75)
Employment status				
Employed	4	65	65	(50-80)
Unemployed	4	35	35	(20-60)

**Interviewees were asked to estimate the percentage of their patients belonging to a specific age group and SES, and the percentage of those being males/females, Lebanese/non Lebanese, employed/unemployed. An average of percentages reported was computed.*

3.3 Clinical characteristics of substance users

Changing trend of prevalence in substance use

When comparing the trend of substance-related admissions to the ER in 2009 to the previous 1-2 years, 2 ER doctors indicated that there has been some increase in the cases of substance use encountered, whereas 2 highlighted no significant change and only 1, located in Beirut, noted a large increase. The 2 remaining doctors did not respond.

Patients' primary choice of substance

When classified based on most frequent usage, alcohol was ranked highest. Among the other substance classifications, sedatives and tranquilizers were ranked second and third. Furthermore, cocaine was ranked fourth and fifth, followed by amphetamine-types ranking sixth. Other types of substances were given lower rankings (Table 3.3.1).

TABLE 3.3.1 *NUMBER OF ER DOCTORS REPORTING ON THE RANK OF PATIENTS' PRIMARY CHOICE OF SUBSTANCE, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	1	0	0	0	1	0	0	5	0
Rank 2	2	2	0	0	3	0	0	0	0
Rank 3	2	1	0	0	3	0	0	1	0
Rank 4	0	1	3	2	0	0	0	1	0
Rank 5	0	2	3	1	0	0	0	0	1
Rank 6	1	1	1	3	0	1	0	0	0
Rank 7	0	0	0	1	0	3	1	0	2
Rank 8	1	0	0	0	0	3	3	0	0
Rank 9	0	0	0	0	0	0	3	0	4

3.4 Assessment of treatment services

Availability of treatment services

Respondents listed a number of interventions available to substance users visiting the ER, all consisting of emergency procedures. They involve gastric lavage and the intake of medications (e.g., Naloxone) to counter the effects of opiate overdose. Other ER doctors listed hydration, intubation and respiratory distress interventions (e.g., cardiopulmonary resuscitation).

Services provided by the ER doctors did not include routine screening for substance use, with the exception of one, located in the Beirut governorate.

Accessibility of treatment services

Half of ER doctors reported 65% of their patients or less travelling less than 15 kilometers [less than 20 minutes without traffic], and 35% or less travelling at least 15 kilometers to reach the hospital[minimum-maximum: 10-100, 0-90;means = 63% and 37%, respectively]. Hospitals where most patients travelled less than 15 kilometers to reach the ER department were located in Beirut.

Availability of treatment services in Lebanon

When asked about the services provided by other health professionals in the field of addiction, most ER doctors reported a lack of proper treatment/treatment in Beqaa (N=6), Nabatieh (N=6), and North of Lebanon (N=5). Doctors also reported a lack, but to a lesser extent, in South Lebanon (N=4). However, no lack of treatment or proper treatment was reported in Beirut and Mount Lebanon by most doctors.

3.5 Factors related to initiation and maintenance of treatment

Cost of treatment

5 out of the 7 ER physicians interviewed believed that cost of treatment was an extremely important factor in the initiation and maintenance of treatment. The remaining doctors viewed this factor to be of less significance.

3.6 Referrals

Referral sites

ER physicians primarily referred substance users to another department within the same hospital. Subsequently, physicians reported to refer their patients to private practice psychiatrists or psychologists. Referral to another hospital was ranked third, followed by a substance treatment center or an NGO ranking fourth (Table 3.6.1).

TABLE 3.6.1 *NUMBER OF ER DOCTORS REPORTING ON THE RANK OF REFERRAL SITES, 2009*

	Another department within the same hospital	Other hospitals	NGOs	Private practice psychiatrists or psychologists
Rank 1	3	0	1	1
Rank 2	1	2	1	3
Rank 3	0	3	1	1
Rank 4	1	0	2	0

Referral system among health professionals

Of the ER doctors, one reported having a referral system with other treatment centers whereas the others claimed not to have this system in place. The one doctor who used a referral system rated it as a good one.

3.7 Legal situation of substance users

Coordination with Internal Security Forces (ISF)

When asked whether information related to patients was communicated with the ISF, 3 respondents reported sharing information about their patients and felt they had to abide by the law. On the other hand, 4 claimed not sharing information with the ISF and did not feel legally obligated to do so.

3.8 Substance-related deaths

In 2009, the interviewees reported the incidence of 6 overdose cases, with an average of 1 case per ER department, as reported by 6 doctors. Moreover, only one death case resulting from substance withdrawal was encountered, as reported by 5 doctors. Only one ER doctor reported on other substance-related deaths (e.g., death resulting from a car accident under the influence of drugs), with 10 fatalities occurring in one hospital. All of these reported cases occurred in hospitals located in Beirut.

3.9 Sources of information

4 ER physicians based their responses on general observations, while only 3 doctors used data collected to support their answers.

4. General practitioners (GPs)

Eight GPs were interviewed in 8 different hospitals treating substance users. 4 were located in Beirut and 4 in Mount Lebanon.

4.1 Cases of substance dependence

Half of GPs estimated 4% of their patients or less treated in 2009 to have substance dependence to any illegal drug and/or alcohol, [minimum-maximum: 1-20%; mean=6%]. Only 1 GP assumed a higher percentage of substance dependence (20%), this case being in Mount Lebanon. The other's responses varied between 1-8%. The number of cases of substance dependence ranged between 3 and 36 per year, with an average of 19 cases per GP.

Among the treated patients, half of GPs assumed that 1% or less came for a substance-related medical condition [minimum-maximum:1-5%; mean = 2%], which include 6 patients or less [minimum-maximum: 0-36; mean = 15].

4.2 Clinical characteristics of patients with substance dependence

Changing trend of prevalence in substance use

From the years 2007/2008 to 2009, 5 GPs estimated a slight increase in the prevalence of substance use, 3 being from Beirut and 2 from Mount Lebanon. On the other hand, 2 GPs practicing their profession in Mount Lebanon indicated a large decrease and only 1 GP from a hospital located in Beirut assumed no significant change.

Patients' primary choice of substance

When categorizing based on most frequent usage, none of the substance classifications were exclusively ranked first. Cannabis was ranked first and third, and opioids, sedatives and tranquilizers were ranked first and fourth. Alcohol was merely ranked second, while cocaine was ranked second and third. Hallucinogens and other substance classifications were ranked seventh and ninth respectively (Table 4.2.1).

TABLE 4.2.1 *NUMBER OF GPS REPORTING ON THE RANK OF PATIENTS' PRIMARY CHOICE OF SUBSTANCE, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	2	2	0	0	2	0	0	1	0
Rank 2	1	1	2	0	1	0	0	2	0
Rank 3	2	1	2	0	1	1	0	0	0
Rank 4	1	2	0	0	2	0	0	1	0
Rank 5	0	0	1	1	0	0	1	1	0
Rank 6	0	0	0	1	1	0	0	1	1
Rank 7	0	0	0	1	0	2	1	0	0
Rank 8	0	0	0	1	0	2	1	0	0
Rank 9	0	0	0	0	0	0	1	0	3

4.3 Assessment of treatment services

Availability of treatment services

Routine screening for substance use was reported by 4 GPs, while 4 claimed not to do such assessment. Most GPs (7 out of 8) do not prescribe medications for addiction. The only one practitioner prescribing medications is from Mount Lebanon.

Availability of treatment services in Lebanon

Beirut is the only governorate with available treatment for substance users, as reported by all the GPs interviewed. On the contrary, South of Lebanon and Nabatieh were reported to lack proper treatment or lack of treatment at all. As for the North and Beqaa, 6 considered that treatment is lacking or not proper with only one GP believing otherwise. Moreover, Mount Lebanon was viewed by 6 GPs to include treatment, with 2 considering that area to have insufficient treatment.

4.4 Factors related to the initiation and maintenance of treatment

Cost of treatment

Cost of treatment of substance users in hospitals was reported as a strongly important factor for the initiation and maintenance of treatment in Lebanon by 6 GPs. The remaining 2 GPs viewed this factor to be moderately important.

4.5 Referrals

Referral sites

With respect to ranking of referral systems, a drug treatment center or an NGO was given the highest rank. Private practice psychiatrists or psychologists were ranked first and second, whereas referral to another department within the same hospital was ranked first and third (Table 4.5.1).

TABLE 4.5.1 *NUMBER OF GPS REPORTING ON THE RANK OF PLACES PATIENTS ARE BEING REFERRED TO, 2009*

	Another department within the same hospital	Other hospitals	NGOs	Private practice psychiatrists or psychologists
Rank 1	2	0	4	3
Rank 2	1	1	0	3
Rank 3	3	2	0	2
Rank 4	0	1	2	0

Referral system among health professionals

Only 2 GPs claimed to have a system of referral, of which one found it to be of poor quality, and the other one of mediocre quality. Among other GPs, 5 claimed not to have a referral system in place with other treatment facilities. Still, however, these GPs claimed to refer their patients to several treatment centers.

4.6 Legal situation of patients with substance dependence

Coordination with Internal Security Forces (ISF)

2 of the GPs claimed to communicate some information to the ISF about substance users visiting them, whereas 6 did not. However, all of the GPs did not feel legally committed to do. Among those who reported information, one claimed to do so when the parents

required it, while the second GP contacted the police when the substance user did not want to get treated or was becoming a danger to himself/herself and/or others.

4.7 Sources of information

Overall, the information presented above was based on general observations as reported by 2 GPs' responses given, with others not responding to this question.

5. Private practice Psychiatrists

9 psychiatrists in private practices were interviewed of which all were located in Beirut to the exception of one in the Mount Lebanon governorate.

5.1 Cases of substance dependence

Half of the private practice psychiatrists reported 10% of patients or less to have substance dependence to any illegal drug and/or alcohol among all individuals coming to their clinic [minimum-maximum: 5% - 80%]. Psychiatrists saw, in 2009, 38 cases of substance dependence or less, ranging from 3 to 80 cases [mean = 35], with the least cases seen in the clinic located in Mount Lebanon.

5.2 Demographic characteristics of patients with substance dependence

Substance dependence was reported to be more prevalent among patients who were young adults (18 to 24 years old), males, and of Lebanese origin. Moreover, slightly higher proportions of patients were unemployed and more than half were of middle and high SES (Table 5.2.1).

TABLE 5.2.1 *PREVALENCE OF SUBSTANCE DEPENDENCE BY DEMOGRAPHICS, 2009*

Substance dependence				
	N	**Median (%)***	**Mean (%)**	**(minimum – maximum)**
Age (years)				
< 18	7	20	14	(2-20)
18 – 24	7	70	56	(10-95)
25 – 34	7	15	17	(2-30)
≥ 35	7	5	13	(0-55)
Gender				
Males	9	75	74	(30-100)
Females	9	25	26	(0-70)
Nationality				

Lebanese	9	90	88	(75-100)
Non-Lebanese	9	10	12	(0-25)
Socioeconomic status				
Low	8	37	41	(20-75)
Middle	8	32	32	(0-60)
High	8	25	27	(0-75)
Employment status				
Employed	9	50	44	(10-90)
Unemployed	9	50	56	(10-100)

**Interviewees were asked to estimate the percentage of their patients belonging to a specific age group and SES, and the percentage of those being males/females, Lebanese/non Lebanese, employed/unemployed. An average of percentages reported was computed.*

5.3 Clinical characteristics of patients with substance dependence

Age of onset of substance use

Half of private practice psychiatrists reported the age of onset of any type of substance to be 16 years of age or less [minimum-maximum: 15-18], whereby age of onset for the substance of choice was 18 years old or less [minimum-maximum: 15-20]. Moreover, the mean duration of using the substance of choice was reported to be 3 years at most before coming to treatment for the first time [minimum-maximum: 2-5].

Changing trend of prevalence in substance use

Prevalence of any illegal substance and/or alcohol was estimated by many (44 – 67%) psychiatrists to have remained the same from 2007/2008 to 2009. Use of solvents was perceived by 1 psychiatrist to have slightly decreased over a 1-2 year period. A small number of psychiatrists, however, considered an increased prevalence for cocaine (33%), amphetamines-types (11%), sedatives (22%), hallucinogens (11%), alcohol (22%) and any other type of drugs (22%). Cannabis and opioids, on the other hand, were reported by an equal number of psychiatrists to have either decreased or increased.

Patients' primary choice of substance

Among the cases of substance use encountered by psychiatrists, opioids were ranked first and therefore the substance of choice used by the private practitioner's patients. Cocaine was ranked second, and cannabis was ranked second and third. Sedatives and tranquilizers were ranked first and second, and alcohol was in the first four rankings. Both amphetamine-types and hallucinogens were ranked fourth (Table 5.3.1).

TABLE 5.3.1 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENTS' PRIMARY CHOICE OF SUBSTANCE, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine - types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	0	3	1	1	2	0	0	2	0
Rank 2	5	0	3	0	0	1	0	1	0
Rank 3	2	2	1	1	2	1	1	1	0
Rank 4	0	2	1	3	1	3	2	1	1
Rank 5	0	0	1	1	1	0	2	0	2
Rank 6	0	0	0	1	0	0	0	1	0
Rank 7	0	0	0	0	0	2	0	0	0
Rank 8	0	0	0	0	0	0	2	0	0
Rank 9	0	0	0	0	0	0	0	0	2

Of the different types of substance classifications, cannabis was ranked highest among young patients (< 18 years old). In addition, sedatives and tranquilizers were ranked first, whereas opioids were ranked third. Alcohol was ranked first and third. Still, amphetamine-types and other types of substances were ranked fifth (Table 5.3.2).

TABLE 5.3.2 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENTS' PRIMARY CHOICE OF SUBSTANCE, < 18 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	4	0	0	0	2	0	0	3	0
Rank 2	3	1	1	0	1	1	0	1	0
Rank 3	0	3	0	1	1	0	0	2	0
Rank 4	0	1	1	1	1	1	1	0	0
Rank 5	0	0	1	2	0	1	1	1	2
Rank 6	0	0	0	1	0	0	1	0	0
Rank 7	0	0	1	0	0	0	1	0	0
Rank 8	0	0	0	0	0	1	0	0	1
Rank 9	0	0	0	0	0	0	0	0	1

Among the higher age group (18 – 24 years old), alcohol was ranked first by the psychiatrists as a primary drug of choice, with cannabis ranking second. Moreover, amphetamine-types, sedatives and tranquilizers, and hallucinogens were ranked fourth (Table 5.3.3).

TABLE 5.3.3 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENTS' PRIMARY CHOICE OF SUBSTANCE, 18 TO 24 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	2	1	1	1	1	0	0	3	0
Rank 2	3	1	2	0	0	0	0	2	0
Rank 3	0	2	0	1	2	1	0	1	0
Rank 4	1	1	0	2	3	2	1	0	0
Rank 5	0	1	1	2	0	2	2	0	2
Rank 6	0	0	0	0	0	0	1	1	0
Rank 7	1	0	1	0	0	0	1	0	1
Rank 8	0	0	0	0	0	1	0	0	0
Rank 9	0	0	0	0	0	0	0	0	1

Psychiatrists observed cannabis and alcohol to be the number one type of substance classification used among those whose age was between 25 and 34 years, with opioids ranking second. Cocaine, amphetamine-types, sedatives and tranquilizers, solvents and inhalants were subsequently ranked from 3 till 6 (Table 5.3.4).

TABLE 5.3.4 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENTS' PRIMARY CHOICE OF SUBSTANCES, 25 TO 34 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	3	1	0	0	1	0	0	3	0
Rank 2	2	2	1	0	1	0	0	1	0
Rank 3	1	1	3	0	0	0	0	1	0
Rank 4	0	2	1	3	1	2	2	1	1
Rank 5	0	0	0	1	2	1	0	0	1
Rank 6	0	0	0	0	0	0	2	0	0
Rank 7	1	0	1	0	0	0	0	0	1
Rank 8	0	0	0	0	0	1	0	0	0
Rank 9	0	0	0	0	0	0	0	0	1

Amid those aged 35 years or older, alcohol and sedatives and tranquilizers were ranked first by two psychiatrists. Cannabis was ranked second and opioids were ranked third. Additionally, amphetamine-types and other types of substances were ranked fifth (Table 5.3.5).

TABLE 5.3.5 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF PATIENTS' PRIMARY CHOICE OF SUBSTANCE, ≥ 35 YEARS OLD, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	1	0	0	0	2	0	0	2	0
Rank 2	2	1	1	0	0	0	0	1	0
Rank 3	0	2	0	0	1	0	0	1	0
Rank 4	0	1	1	1	1	1	1	0	0
Rank 5	1	0	1	2	0	1	1	0	2
Rank 6	0	0	0	1	0	0	1	0	0
Rank 7	0	0	1	0	0	0	0	0	0
Rank 8	0	0	0	0	0	1	0	0	0
Rank 9	0	0	0	0	0	0	0	0	1

Injection of substances

Half of the psychiatrists reported 20% of patients or less visiting their clinics to have used opioids via injection [minimum-maximum: 7-95, mean=32%], whereas none of substance users had injected cocaine [minimum-maximum: 0-10%; mean = 2%], amphetamine-types [minimum-maximum: 0-5%; mean = 1%] or other substances [minimum-maximum: 0-5%; mean = 1%]. Nearly all interviewed psychiatrists estimated a constant trend in substance injection from 2007/2008 to 2009.

Poly-substance use

Half of psychiatrists claimed that 68% of patients or less visiting their clinics were poly-substance users [minimum-maximum: 2-90; mean = 57%]. Adding to that, all reported providing poly-substance related treatment. Substance users mainly combined (1) cannabis (e.g., hashish) and opioids (e.g., heroin, morphine); (2) cocaine and alcohol.

5.4 Assessment of treatment services

Availability of treatment services

Psychiatrists in private practice reported providing outpatient services. The most common of these were diagnosis, pharmacological treatment (mostly medications for mental health), and psychotherapy. A few psychiatrists mentioned the availability, in their practice, of support, emergency care, spiritual therapy, follow-up, and referral for treatment elsewhere.

Accessibility of treatment services

Half of psychiatrists reported the following percentages: 50% of patients or less travelling <15 km [less than 20 minutes without traffic] to reach their psychiatrist's clinic and 50% or less travelling at least 15 km [at least 20 minutes without traffic] [minimum-maximum: 20-70 and 30-80; mean = 48% and 53%, respectively].

Availability of treatment services in Lebanon

Geographically, North Lebanon, South Lebanon, Beqaa and Nabatieh were reported by most psychiatrists to lack treatment or proper treatment (88%, 100%, 88%, and 75% respectively).

Most psychiatrists agreed that 2 types of interventions are lacking in Lebanon: harm reduction services (89%), and counseling programs for substance dependence (75%). On the other hand, withdrawal management was not reported to be lacking by half of the psychiatrists, with only a third believing that it was essential to have.

Only 2 types of services were believed to be present, short and long-term inpatient treatment. Yet, a good number of psychiatrists agreed that drop in services, day/evening treatment, wellness related activities and outreach activities are lacking in Lebanon or present but lacking in number. With regards to other types of services listed, psychiatrists agreed that such services are indeed lacking (Table 5.4.1).

TABLE 5.4.1 *PSYCHIATRISTS' LEVEL OF AGREEMENT REGARDING AVAILABILITY OF TREATMENT SERVICES IN LEBANON, 2009*

	Lack of drop in services	Lack of day/evening treatment	Lack of outpatient treatment	Lack of short-term inpatient treatment	Lack of long-term inpatient treatment	Lack of supportive housing	Lack of substance user hotline
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	0	1 (11)	0	1 (11)	1 (11)	1 (13)	1 (13)
Disagree	1 (11)	0	3 (33)	4 (45)	3 (34)	0	0
Neutral/Mixed	1 (11)	0	0	1 (11)	1 (11)	1 (13)	0
Agree	7 (78)	7 (88)	4 (45)	2 (22)	2 (22)	5 (63)	6 (75)
Strongly agree	0	0	2 (22)	1 (11)	2 (22)	1 (13)	1 (13)

	Lack of intensive outpatient treatment	Lack of family support	Lack of legal support	Lack of aftercare support or vocational assistance	Lack of wellness related activities	Lack of outreach activities
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	0	0	0	0	0	0
Disagree	1 (13)	2 (25)	1 (13)	0	0	0
Neutral/Mixed	0	1 (13)	1 (13)	1 (13)	1 (13)	1 (11)
Agree	6 (75)	4 (50)	4 (50)	6 (75)	7 (88)	8 (89)
Strongly agree	1 (13)	1 (13)	2 (25)	1 (13)	0	0

5.5 Factors related to initiation, maintenance and completion of treatment

Changing trend of prevalence in treatment

Compared to 2007/2008, 56% of psychiatrists reported a slight or large increase in the numbers of patients seeking treatment with 44% considering no significant change.

Reasons for not receiving or discontinuing treatment after first consultation

Examining possible reasons for patients not receiving or discontinuing treatment after first consultation in 2009, most psychiatrists agreed that (1) substance users not willing to quit substance use, (2) patients wanting to stop using substance independently, and (3) cost of treatment, were influential factors (Table 5.5.1).

TABLE 5.5.1 *PSYCHIATRISTS' LEVEL OF AGREEMENT REGARDING REASONS FOR NOT RECEIVING OR DISCONTINUING TREATMENT AFTER FIRST CONSULTATION, 2009*

	Distance to reach the center	Cost of treatment	No vacancies	Waiting list	Next appointment too far from first date of visit	Services not suitable to the patient's needs	Willing to stop using substances on their own	Not willing to stop using substances
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	1 (13)	0	2 (25)	2 (33)	1 (13)	0	1 (13)	0
Disagree	4 (50)	2 (25)	4 (50)	3 (50)	3 (38)	4 (50)	0	0
Neutral/Mixed	0	0	1 (13)	0	1 (13)	0	1 (13)	1 (13)
Agree	2 (25)	4 (50)	1 (13)	1 (17)	3 (38)	2 (25)	4 (50)	6 (75)
Strongly agree	1 (13)	2 (25)	0	0	0	2 (25)	2 (25)	1 (13)

Reasons for not completing treatment

It was estimated by half of the sample that 40% of patients or less have dropped out of treatment, ranging from 30% to 85% [mean= 49%]. In the attempt to understanding the main reason to why patients enrolled in treatment did not comply with treatment, several factors were presumed. The majority of psychiatrists agreed that (1) treatment cost, (2) duration, (3) lack or loss of commitment to treatment, were the most important reasons for dropping out of treatment. The other factors in treatment drop-out were also agreed upon by a good number of psychiatrists (Table 5.5.2).

TABLE 5.5.2 *PSYCHIATRISTS' LEVEL OF AGREEMENT REGARDING FACTORS AFFECTING COMPLIANCE TO TREATMENT, 2009*

	Distance to reach the center	Cost of treatment	Lack of governmental support	Family involvement	Duration of treatment	Services not suitable to patients' needs	Lack or loss of commitment to treatment
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	1 (11)	0	0	1 (11)	0	1 (11)	0
Disagree	1 (11)	0	2 (22)	1 (11)	1 (11)	0	0
Neutral/Mixed	1 (11)	1 (11)	1 (11)	1 (11)	1 (11)	2 (22)	2 (22)
Agree	5 (56)	7 (78)	4 (44)	4 (44)	6 (67)	5 (56)	6 (67)
Strongly agree	1 (11)	1 (11)	2 (22)	2 (22)	1 (11)	1 (11)	1 (11)

Psychiatrists could report on more than one factor

Psychiatrists also cited other potential factors that may be associated with treatment compliance, (1) pressure from family members to seek treatment (2) government's strict rules regarding substance use so patients become reluctant to initiate or even maintain treatment, (3) possibility of affecting their professional status and self image if they sought treatment, and (4) lack of knowledge in the substance use field.

5.6 Referrals

Referral sources

Patients being referred by their personal environment ranked highest followed by private practice psychiatrists/psychologists. Other referral sources were also high ranks, but by fewer psychiatrists (Table 5.6.1).

TABLE 5.6.1 *NUMBER OF PSYCHIATRISTS REPORTING ON THE RANK OF REFERRAL SITES, 2009*

	Personal environment	Hospitals	NGOs	Private practice psychiatrists or psychologists	Law representatives	Social services centers
Rank 1	8	0	0	1	0	0
Rank 2	1	4	3	6	4	4
Rank 3	0	2	2	1	0	2
Rank 4	0	3	2	1	4	2
Rank 5	0	0	2	0	0	1
Rank 6	0	0	0	0	1	0

Referral sites

When private psychiatrists had to refer patients, they usually contacted a hospital or another private practitioner (psychiatrist or psychologist). Interviewees ranked NGOs second as institutions where they referred patients to.

Referral system among health professionals

Slightly more than half of psychiatrists reported having a system of referral with other treatment facilities (56%). Among those who reported the presence of a system of referral in place, 3 of 4 described it as mediocre, while only 1 believed it to be of good quality.

5.7 Legal situation of patients with substance dependence

Coordination with Internal Security Forces (ISF)

Practically none of the psychiatrists communicated information to ISF, or any information about patients with legal issues (whether mandated or not). Only 1 psychiatrist reported sharing information about 2 patients. Also, none of the psychiatrists felt legally obliged to communicate information about their patients.

Effect of incarceration on treatment

About three-quarters of psychiatrists felt that incarceration negatively affected the initiation and maintenance of treatment of substance users, while 2 (22%) felt that being imprisoned would be beneficial. Moreover, most psychiatrists stated that having a penal record strongly influenced getting accepted to a university or being employed. Among those, three quarters felt it had a strong effect, while the rest believed it had a weak one.

5.8 Sources of information

All of the psychiatrists provided information based on general observations.

Substance users

6. Substance users at non-governmental organizations (NGOs)

75 substance users were interviewed upon consecutive admissions at 6 NGOs specialized in the treatment of substance dependence.

6.1 Demographic characteristics of patients with substance dependence

Substance users aged between 18 and 24 mainly constituted the study sample, with the majority being males and of Lebanese nationality. A relatively equal number of individuals were either employed or unemployed and a good number were not pursuing any form of education. The majority did not attend university or does not hold a university degree. Moreover, those with a yearly income ranged from $2,000-$12,000 were the bulk (Table 6.1.1).

TABLE 6.1.1 *DEMOGRAPHIC CHARACTERISTICS OF INDIVIDUALS WITH SUBSTANCE DEPENDENCE, 2010*

	N (%)
Age (years)	
< 18	4 (5)
18 – 24	39 (52)
25 – 34	20 (27)
≥ 35	12 (16)
Gender	
Male	73 (97)
Female	2 (3)
Nationality	
Lebanese	70 (93)
Dual citizenship (Lebanese and other)	2 (3)
Non-Lebanese	3 (4)
Educational level	
Illiterate	3 (4)

Elementary	8 (11)
Intermediate	23 (32)
Secondary	12 (16)
Technical school	14 (19)
University (no degree)	9 (12)
BA	4 (6)
Professional status	
Student	5 (7)
Employed	35 (47)
Student and employed	3(4)
None	31 (42)
Yearly income ($)	
2000-6000	19 (41)
6001-12000	17 (37)
12001-18000	6 (13)
18001-24000	2 (4)

24001-36000	0 (0)
36001-60000	2 (4)
>60001	0 (0)

6.2 Clinical characteristics of patients with substance dependence

Age of onset of substance use

Half of the substance users seen at NGOs reported initiating substance use at the age of 16 or less, ranging from 10 to 38 years [mean = 17 years of age]. As for using the substance of choice for which treatment is being sought for, the age of onset reported by half of the sample was 18 years at most [minimum-maximum: 12-38 years; mean: 20 years]. Once engaged in substance use, the duration of use, specifically for the substance of choice, before coming to treatment, was reported to be 1460 days or less [4 years], varying between 120 and 12,775 days [35 years] [mean = 2026 days (6 years)].

Among half of the males, the average age of onset of use for any substance was 16 years old or less [minimum-maximum: 10-38 years; mean = 17]. Half of the substance users males reported an age of onset for the substance of choice to be 18 years old or less [minimum-maximum: 12-38 years; mean = 19 years]. Onset of use for any substance among half of the females was 15 years old or less [minimum-maximum: 14-15 years], earlier than for males. However, females initiated use of the substance of choice at the age of 25 years old or less [minimum-maximum: 22-27 years], later in life as compared to males. Nevertheless, these numbers refer to responses given by only two females in this sample.

Patients' primary choice of substance

Among other substance classifications, opioids were ranked highest as the substance of preference. Relatively, a good number presented cannabis, and sedatives and tranquilizers with a high rank. Cocaine was given a rank of three (Table 6.2.1).

TABLE 6.2.1 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	26	32	8	3	13	2	0	1	0
Rank 2	26	11	9	8	14	5	0	2	0
Rank 3	10	11	18	3	10	2	1	6	0
Rank 4	2	8	12	7	4	2	0	6	0
Rank 5	3	3	3	4	2	3	0	4	0
Rank 6	0	1	1	2	3	4	2	5	1
Rank 7	0	0	0	1	0	2	0	1	3
Rank 8	0	0	0	0	0	0	0	0	2
Rank 9	0	0	0	0	0	0	1	0	1

For those aged less than 18 years old, no specific substance was given the highest rank by a majority. Still, cannabis as well as sedatives and tranquilizers were ranked highest (Table 6.2.2).

TABLE 6.2.2 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, <18 YEARS OLD, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Alcohol
Rank 1	2	0	0	0	2	0	0
Rank 2	2	1	1	0	0	0	0
Rank 3	0	2	1	0	0	0	0
Rank 4	0	0	0	1	1	0	0
Rank 5	0	0	0	0	0	0	1
Rank 6	0	0	0	0	1	0	0
Rank 7	0	0	0	0	0	1	0
Rank 8	0	0	0	0	0	0	0

Alcohol and other types of substances were not ranked by this age group

For those between 18 and 24 years of age, opioids and cannabis were ranked first by the majority of substance users. Sedatives and tranquilizers were ranked second, and cocaine ranked third (Table 6.2.3).

TABLE 6.2.3 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, 18 TO 24 YEARS OLD, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	18	19	4	3	5	1	0	0	0
Rank 2	8	5	5	5	9	3	0	0	0
Rank 3	5	3	7	3	7	1	1	2	0
Rank 4	1	5	7	5	1	2	0	1	0
Rank 5	1	3	2	1	0	2	0	3	0
Rank 6	0	1	0	0	1	2	1	4	1
Rank 7	0	0	0	1	0	0	0	2	2
Rank 8	0	0	0	0	0	0	0	0	0

For the older age group (25-34 years old), opioids were ranked first, and cannabis was ranked second. Sedatives and tranquilizers were also high in the rankings (Table 6.2.4).

TABLE 6.2.4 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, 25 TO 34 YEARS OLD, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	3	9	2	0	4	1	0	0	0
Rank 2	10	3	2	2	5	1	0	1	0
Rank 3	3	4	5	0	2	1	0	2	0
Rank 4	1	1	5	1	2	0	0	2	0
Rank 5	1	0	1	3	1	1	0	2	0
Rank 6	0	0	1	2	1	2	1	0	0
Rank 7	0	0	0	0	0	1	0	3	1
Rank 8	0	0	0	0	0	0	0	1	2

For the oldest age group (≥35 years old), opioids were ranked highest, followed by cannabis and cocaine, ranking second and third, respectively (Table 6.2.5).

TABLE 6.2.5 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, ≥ 35 YEARS OLD, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Alcohol
Rank 1	3	4	2	0	2	0	1
Rank 2	6	2	1	1	0	1	1
Rank 3	2	2	5	0	1	0	2
Rank 4	0	2	0	0	0	0	3
Rank 5	1	0	0	0	1	0	0
Rank 6	0	0	0	0	0	0	0
Rank 7	0	0	0	0	0	0	0
Rank 8	0	0	0	0	0	0	0

Alcohol and other types of substances were not ranked by this age group

Injection of substances

An average of 6 in 10 patients attending NGOs for treatment of substance dependence was using any illegal substance by means of injection, while the rest claimed otherwise.

Poly-substance use

70% of substance users regularly used more than one substance type simultaneously. Among this particular group, around 30% reported combining 2 to 3 different classes of substances while 9% were collectively using 4 to 5 substances. Most common combinations of substances used simultaneously included, (1) opioids and cocaine; (2) cannabis, opioids, and sedatives/tranquilizers; (3) cannabis, opioids, and cocaine.

Substance users' health status

Among the substance users, around 6% reported being infected with Hepatitis B or C, with 10% not knowledgeable of their status. Moreover, none of the substance users reported being HIV carriers, but 9% were not certain for their status. Among those being positively infected with any type of virus, 3 have sought treatment (2 for hepatitis C, 1 for hepatitis B), and 4 did not (2 for hepatitis C, 1 for hepatitis B, and 1 for hepatitis B and C).

6.3 Factors related to initiation, maintenance, and completion of treatment

Demand for treatment

Substance users seeking treatment were asked what type of treatment they were seeking. The various answers were divided into services and types of centers. Almost a quarter (N=18) desired individual psychotherapy, for mental health and/or addiction. 21 % expressed their need for any type of help to treat their substance addiction. 10 % felt that a combination of individual psychotherapy for mental health and/or addiction and medical treatment were most suited to their needs. Moreover, 8% wanted inpatient or

day/evening treatment (N=6). The rest wished for Opioid Substitution Treatment (OST) (N=5), withdrawal management (from home or a facility) (N=5), medical support (N=3), spiritual therapy (N=2), group therapy for mental health including addiction (N=2), family support (N=1), outpatient treatment (N=1), and alternative treatment such as acupuncture or meditation (N=1). 3 did not know what type of treatment they were seeking.

Of those seeking treatment, nearly 4 in 10 are doing so currently for the first time.

Interaction with human resources

Substance users presented to treatment were most likely to interact with social workers, psychologists, psychiatrists, and nurses (44%, 44%, 24%, and 22% respectively). On the other hand, GPs, and counselors (3% and 6% respectively) were least likely to initiate contact with the potential patients. Yet, the majority (63%) of substance users reported interaction with other staff members (e.g., educators, receptionists, religious figures).

Means of payment for treatment services

When asked about means of payment for treatment, the majority relied on their parents to cover their treatment expenses (74%). Others were self-supported (18%), or were supported by the treatment center itself (11%), other sources non identified (4%), MOPH (3%), and a friend (3%). Only around 12% have requested help from the MOPH. However, almost all substance users interviewed (97%) did not believe that the MOPH would cover the expenses of their treatment for substance dependence.

Past demand for treatment

Those who are not seeking treatment for the first time have either done so once (28%), or more than once (31%) in the past. The majority of those who did so had received treatment (91%). Among those who have formerly received treatment, between 20% and 23% received at least one of the following services, (1) withdrawal management or supervised detoxification (home or facility) (N=9), (2) individual therapy for mental health, including addiction (N=9), (3) long-term inpatient treatment (N=8), (4) faith-based treatment (N=8). Treatment services received by a lower proportion of substance users (3% to 10%) included: (1) medication for

addiction (N=4), (2) psychiatric medication (N=4), (3) group therapy sessions for addictions (N=3), (4) outpatient treatment (N=1), (5) medical support (N=1) or (6) educational group for addictions (N=1). Other types of services (e.g., drop-in services, day/evening treatment, short-term inpatient treatment, supportive housing or sober house, family support, legal support and aftercare) were received by none of the substance users. In general, around 26% of those receiving treatment have received more than one type of services.

Those who had not received treatment (9%) reported it was mainly because they discontinued it (N=3) or there was no vacancy at the treatment center where they presented themselves.

Reasons for not seeking treatment

The majority of substance users reported not seeking treatment in the past primarily because they did not perceive addiction to be a problem, they were willing to stop using substances on their own, they were afraid of being reported, or they were not willing to stop using substances(Table 6.3.1). 4 substance users provided other responses (e.g., lack of awareness of available substance treatment centers).

TABLE 6.3.1 *SUBSTANCE USERS' LEVEL OF AGREEMENT REGARDING REASONS FOR NOT SEEKING TREATMENT IN THE PAST, 2010*

	Distance to reach the center	Cost of treatment	Fear of being reported	Existing services not suitable to the individual's needs	Willing to stop substances on his/her own	Addiction was not perceived as a problem	Not willing to stop using substances
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	7 (50)	5 (31)	2 (11)	4 (33)	2 (9)	2 (9)	1 (5)
Disagree	5 (36)	5 (31)	2 (11)	4 (33)	2 (9)	0 (0)	1 (5)
Neutral/Mixed	0 (0)	1 (6)	0	2 (17)	0 (0)	1 (4)	3 (14)
Agree	0 (0)	3 (19)	6 (32)	1 (8)	8 (36)	8 (35)	7 (33)
Strongly agree	2 (14)	2 (13)	9 (47)	1 (8)	10 (46)	12 (52)	9 (43)

Reasons for not receiving or discontinuing treatment after first consultation

Substance users generally agreed on a few reasons for not receiving treatment or for having discontinued treatment after the first consultation. These being, substance users wanted to stop using substances on their own, their names had to be put on waiting list, and no available vacancies. Other reasons were mainly disagreed upon (distance to reach the center, cost of treatment, services not suitable with patients' needs, hours of services do not fit patients' schedule, both males and females are not admitted, no treatment provided for all nationalities, no available treatment for all types of substances). A decision was not reached with the remaining 2 reasons (Table 6.3.2).

TABLE 6.3.2 *SUBSTANCE USERS' LEVEL OF AGREEMENT REGARDING REASONS FOR NOT RECEIVING TREATMENT, OR DISCONTINUING TREATMENT AFTER FIRST CONSULTATION, 2010*

	Distance to reach the center	Cost of treatment	No vacancies	Name on waiting list	Next appointment too far from first date of visit	Services not suitable to the individual's needs	Center hours do not fit individual' schedule
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	8 (40)	6 (30)	5 (25)	4 (20)	5 (25)	4 (20)	6 (30)
Disagree	10 (50)	11 (55)	2 (10)	1 (5)	6 (30)	8 (40)	8 (40)
Neutral/Mixed	1 (5)	1 (5)	1 (5)	2 (10)	0	1 (5)	0
Agree	0	1 (5)	10 (50)	10 (50)	6 (30)	4 (20)	4 (20)
Strongly agree	1 (5)	1 (5)	2 (10)	3 (15)	3 (15)	3 (15)	2 (10)

TABLE 6.3.2 *SUBSTANCE USERS' LEVEL OF AGREEMENT REGARDING REASONS FOR NOT RECEIVING TREATMENT, OR DISCONTINUING TREATMENT AFTER FIRST CONSULTATION, 2010, CONTINUED*

	Center does not admit from both sexes	Center does not admit from all nationalities	Center does not admit people who have a dependence to all types of substances	Wanted to stop using substances on his/her own	Not willing to stop using substances
	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	9 (45)	9 (47)	8 (42)	3 (15)	5 (25)
Disagree	10 (50)	8 (42)	7 (37)	3 (15)	5 (25)
Neutral/Mixed	1 (5)	1 (5)	0	0	0
Agree	0	1 (5)	3 (16)	8 (40)	6 (30)
Strongly agree	0	0	1 (5)	6 (30)	4 (20)

Reasons for not completing treatment

Only 29 % who have previously started with a treatment service have actually completed the treatment. Among those not fulfilling all the treatment services (71%), the majority of substance users reported failing to do so because of the duration of treatment. A good number viewed several factors as not being influential (e.g., distance needed to reach the treatment center, cost of treatment, lack of support on the part of the government, family involvement). 2 reasons, however, were agreed and disagreed upon by an equal number of substance users, these being (1) center's services do not fit patients' needs, and (2) loss of commitment to treatment or relapse (Table 6.3.3). 11 respondents provided further reasons such as (1) *Inter-personal interactions* where most of

the respondents mentioned that arguments' arising with other clients as well as client-staff arguments were the reasons they did not complete the treatment and (2) *Psychological factors related to substance use* which were not addressed properly, and (3) *the onset of the Lebanese 2006 War* which impacted structural and functional aspects of the centers.

TABLE 6.3.3 *SUBSTANCE USERS' LEVEL OF AGREEMENT REGARDING FACTORS AFFECTING COMPLETION OF TREATMENT, 2010*

	Distance to reach the center	Cost of treatment	Lack of governmental support	Family involvement	Duration of treatment	Services not suitable to the patient's needs	Lack or loss of commitment to treatment
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	12 (57)	9 (43)	8 (38)	6 (30)	2 (8)	7 (28)	6 (29)
Disagree	6 (29)	7 (33)	8 (38)	11 (55)	4 (16)	6 (24)	4 (19)
Neutral/Mixed	1 (5)	1 (5)	1 (5)	0 (0)	0 (0)	0	1 (5)
Agree	1 (5)	3 (14)	2 (10)	2 (10)	10 (40)	6 (24)	8 (38)
Strongly agree	1 (5)	1 (5)	2 (10)	1 (5)	9 (36)	6 (24)	2 (10)

Reasons for returning to treatment center

Among those who have sought treatment previously, 28% returned to the same treatment center while 72% chose to seek treatment at a different center at the time of the interview. Those revisiting the same treatment center reported doing so mainly because they are more familiar with the treatment center, comfortable with rules and regulations and consider the staff to be friendly and caring. Those going to a new treatment center did so for the following reasons:

(1) *Opting for a different treatment program,* which comprised most of the responses. Reasons include, the perception that the new program may be more promising or the old one was not a successful one or they simply felt more comfortable with the regulations of the new center.

(2) *Inter-personal interactions*, where arguments and disagreements with other clients (in case of inpatient treatment centers) or the staff or administration of the previous center made the respondent choose a different center for treatment.

6.4 Referrals

Referral sources and coordination between heath and judicial systems

67% of substance users presented themselves to the center with the help of their own personal environment (e.g., friends, family, and self), while 22% were referred by social services centers or other referral systems (e.g., employer, school, university, and religious figures). Moreover, 8% were sent by a psychologist or a psychiatrist, 7% by another treatment center or an NGO, 5% by a law representative and 1% by a hospital.

Among the 4 substance users who were referred by a law representative, all reported being referred by a judge following their conviction. However, 2 reported that a public officer chose the treatment center while the other 2 were given the freedom to choose. Through the course of treatment until completion, 2 substance users reported no follow-up on behalf of the law representative that they were referred from, while 1 reported being regularly followed-up.

When given the opportunity to comment on the cooperation between judicial and healthcare systems, 60 % felt the system was unsatisfactory with the most common comment being that there was no real coordination. Some called the referral system a failure and referred to those concerned as “careless”. Others valued the law giving the choice to receive treatment or resume prosecution, but knew it was not being applied. The rest did not know anything about the cooperation between treatment centers and judges (N=11). Only one individual referred to the coordination as good. Moreover, one person questioned the system and law as a whole, stating that substance users should not only be referred to treatment to avoid prosecution but should truly want to get better.

6.5 Legal situation of patients with substance dependence

Knowledge about the law

The current law penalizes substance users as stated by 38% of the sample, while only 6% reported not having any information regarding the existing law. Yet, 56% thought prosecution would stop if the person was treated: a quarter of all respondents did not know if this law was applied by the judicial system; 16 % were convinced that judges applied the law, while 15 % were certain of the opposite.

Legal status

Around half of the sample had a substance-related lawsuit in the past, of which 57 % still had a pending lawsuit. Moreover, 61% have been previously imprisoned because of a substance-related issue. Half of those imprisoned reported an average frequency of occurrence of 3 times (minimum = 1; max = 30; mean = 4) and a duration of stay of 49 days (minimum = 1; maximum = 3650; mean = 233).

Effect of incarceration on treatment

Among those who were incarcerated, 71% reported that they had been negatively affected by their incarceration in relation to initiating, maintaining and completing treatment. On the other hand, 17% reported such an experience to have no effect while 12% reported that it had a positive consequence.

Information communicated to public officers

Personal information was disclosed to a public officer, reported 28% of substance users at NGOs. Among those, 9 reported their confidentiality to be exposed by a family member, 7 by a law representative (e.g., police officers, prosecutors and judges), and 1 by a treatment center/NGO or by private psychiatrist/psychologist and none by social services centers.

Confidentiality at the treatment center

17% of those having sought treatment in the past believed that their confidentiality was not respected at the treatment center. Among those, only 1 respondent claimed that he/she felt that confidentiality violation affected the initiation, maintenance, and completion of treatment.

Of the total sample, 27% reported not believing that the Lebanese law protected their confidentiality within treatment centers.

7. Substance users accessed through outreach work[13]

7.1 Demographic characteristics of substance users

A total of 319 substance users were interviewed at various locations. More than half of the interviews took place on the streets, and about a third took place in a private setting. The remaining interviews were reported to have taken place in entertainment centers (e.g., amusement centers, pool rooms), political parties' centers, along a coast (e.g., harbor, beach), restaurants/snacks/cafes, hair salons, drop-in centers, and hotels. Around half of the interviews took place in Mount Lebanon, with the rest of interviews taking place in other governorates. To underline, most of the interviews in Beirut and Mount Lebanon took place on the streets. Interviews in the North, Beqaa, the South and Nabatieh happened mostly in private settings (Table 7.1.1).

[13] Also referred to in this report as outreach users.

TABLE 7.1.1 *PLACE OF INTERVIEW TAKING PLACE BY GOVERNORATE, 2010*

Area / Place of interview		Beirut	Mount Lebanon	North	Beqaa	South	Nabatieh
		N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Total	319	60 (19)	154 (48)	32 (10)	34 (11)	25 (8)	14 (4)
Private setting	94 (29)	7 (12)	28 (18)	11 (34)	20 (59)	17 (68)	11 (79)
Night club	23 (7)	0	10 (6)	8 (25)	6 (18)	0	0
Street	167 (53)	50 (83)	96 (62)	7 (22)	6 (18)	5 (20)	3 (21)
Other*	35 (11)	3 (5)	21 (14)	6 (19)	2 (6)	3 (12)	0

**Other places of interview include centers of entertainment (amusement centers and pool rooms), political parties' centers, along a coast (harbor, beach), restaurants/snacks/cafes, hair salons, drop-in centers, and hotels.*

Substance users interviewed were generally males, aged between 25 and 34 years old. Moreover, most were Lebanese. As for their educational level, most have not attended a university level; they were either in a technical school or a regular one. A high percentage of this outreach population was employed, with a good number earning from $2,000-$6,000 on a yearly basis. (Table 7.1.2).

TABLE 7.1.2 *DEMOGRAPHIC CHARACTERISTICS OF SUBSTANCE USERS, 2010*

	N (%)
Age (years)	
< 18	14 (4)
18 – 24	82 (26)
25 – 34	163 (51)
≥ 35	60 (19)
Gender	
Male	286 (92)
Female	25 (8)
Nationality	
Lebanese	310 (97)
Lebanese, not registered	1 (0.3)
Dual citizenship (Lebanese and other)	1 (0.3)
Non-Lebanese	6 (2)
Educational level	

Illiterate	12 (4)
Elementary	27 (8)
Intermediate	60 (19)
Secondary	123 (39)
Technical school	59 (19)
University (no degree)	17 (5)
BA	15 (5)
Higher education or work	4 (1)
Professional status	
Student	5 (2)
Employed	260 (82)
Student and employed	7 (2)
Neither student nor employed	47 (14)
Yearly income ($)*	
2000-6000	176 (60)
6001-12000	67 (23)

12001-18000	17 (6)
18001-24000	22 (8)
24001-36000	7 (2)
36001-60000	2 (1)
>60001	3 (1)

**With respect to this sample, the numbers and percentages for yearly income are slightly different than the ones published in the Summary Report of this study, in March 2011.*

7.2 Clinical characteristics of substance users

Age of onset of substance use

Half of the substance users accessed through outreach work reported an age of onset for using any substance to be 17 years old or less, ranging from 10 to 27 years old [mean = 18 years]. As for the age of onset for any substance, it was reported to be, at most, 17 years old [minimum-maximum: 10-27; mean = 18] among males and 20 years old [minimum-maximum: 14-25] among females.

On the other hand, when it came to the substance of choice the individual was dependent on, the age reported was 19 years old or less [minimum-maximum: 10-30 years]. As for both genders, males had an age of onset at 19 years old or less [minimum-maximum: 10-30], and females at 20 [minimum-maximum: 16-25; mean = 21] years old or less.

Individuals' primary choice of substance

Substance users accessed through outreach mostly considered cannabis the main substance to be used as a primary choice. Moreover, cannabis, cocaine and opioids have been reported to be the substances most frequently used by the majority, ranking

first to third. Alcohol was mostly ranked first and fifth. Sedatives and tranquilizers ranked fourth (Table 7.2.1). Both males and females tended to rank cannabis as the highest substance of choice. Moreover, a good number of males reported using cocaine as the second choice, followed by sedatives and tranquilizers ranking fourth. Few females, however, reported on the rank of substances other than cannabis-types as their primary choice.

TABLE 7.2.1 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol
Rank 1	241	96	58	13	29	22	2	66
Rank 2	29	16	121	0	1	0	0	2
Rank 3	34	65	28	2	7	1	0	23
Rank 4	0	0	3	10	70	0	0	15
Rank 5	0	0	0	4	3	0	0	50
Rank 6	0	0	0	1	0	1	0	5
Rank 7	0	0	0	0	0	0	0	1

Other substances were not given any ranking

For those aged less than 18 years old, the substance primarily used by substance users was cannabis. Cocaine, on the other hand, was ranked second (Table 7.2.2).

TABLE 7.2.2 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, < 18 YEARS OLD, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Alcohol
Rank 1	13	3	2	2	3	4	3
Rank 2	0	1	5	1	0	0	0
Rank 3	1	1	0	0	0	0	2
Rank 4	0	0	0	0	1	0	1
Rank 5	0	0	0	0	0	0	1

Solvents and inhalants, and other types of substances were not given any ranking

For those between 18 and 24 years old, cannabis was ranked highest by the majority, with opioids and alcohol ranked first by a fewer number of substance users. Moreover, cocaine was ranked second, and sedatives and tranquilizers ranked fourth (Table 7.2.3).

TABLE 7.2.3 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, 18 TO 24 YEARS OLD, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Alcohol
Rank 1	67	17	6	2	3	4	12
Rank 2	9	7	27	0	0	0	0
Rank 3	3	13	13	3	3	0	9
Rank 4	0	0	0	1	13	0	8
Rank 5	0	0	0	0	1	0	8
Rank 6	0	0	0	0	0	0	2

Solvents/inhalants and other types of substances were not given any ranking

For the higher age group, the substance most frequently used was cannabis. Other types of substance were also ranked highest by a lower number of substance users and these included, opioids, cocaine, alcohol and, sedatives and tranquilizers (Table 7.2.4).

TABLE 7.2.4 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, 25 TO 34 YEARS OLD, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Alcohol
Rank 1	122	55	38	9	20	13	36
Rank 2	19	7	52	1	1	0	2
Rank 3	15	31	15	6	4	1	8
Rank 4	0	0	3	3	35	0	4
Rank 5	0	0	0	1	2	0	25
Rank 6	0	0	0	0	0	1	3
Rank 7	0	0	0	0	0	0	1

Solvents/inhalants and other types of substances were not given any ranking

For the highest age group, cannabis was ranked highest, so were opioids and alcohol. Cocaine was ranked second, and sedatives and tranquilizers were ranked fourth (Table 7.2.5).

TABLE 7.2.5 *NUMBER OF SUBSTANCE USERS REPORTING ON THE RANK OF THEIR PRIMARY CHOICE OF SUBSTANCE, ≥ 35 YEARS OLD, 2010*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Alcohol
Rank 1	39	21	12	0	3	1	15
Rank 2	1	1	37	0	0	0	0
Rank 3	15	20	0	1	0	0	4
Rank 4	0	0	0	0	21	0	2
Rank 5	0	0	0	0	0	0	16

Solvents and inhalants, and other types of substances were not given any ranking

Injection of substances

Around 3 in 10 substance users interviewed reported injecting substances upon use.

Poly-substance use

Overall, 262 poly-substance users (87%) were within the study sample of which 237 were males and 21 were females.

Most common combinations of types of substances involved, (1) cannabis, opioids (e.g., heroin), and cocaine; (2) cannabis, cocaine, opioids (e.g., heroin), sedatives/tranquilizers, and alcohol; (3) cannabis, cocaine, opioids (e.g., heroin), and sedatives/tranquilizers.

Substance users' health status

The majority of substance users did not have Hepatitis B or C (96% and 89% respectively). 3% reported having Hepatitis B and 9% having Hepatitis C, with 2% not aware of their status. As for the HIV, none reported being infected, however 3% did not know their status. Among those infected, 43 % have received treatment for one or more of the health conditions they had. 50% of those having hepatitis B received treatment for this health condition, and 38% of those diagnosed with hepatitis C received treatment for it. Among those receiving treatment, a specialized doctor was reported to have treated 15 substance users, only 1 reported treating him/herself, and only 1 reported being treated by an NGO.

When asked about reasons for not receiving treatment, 10 reported that doctors were not able to treat them due to their health status with the concurrent use of any type of substance. Others did not care to receive treatment (N=3), or could not afford it (N=5).

7.3 Factors related to initiation, maintenance, and completion of treatment

Reasons for not seeking treatment

Around 78% were not seeking treatment at the time of the interview, while 22% reported doing so. Of those not seeking treatment, reasons for not doing so were examined, and mainly included (1) cost of treatment, (2) substance users were not willing to stop use, (3) substance users were willing to stop use independently, and (4) substance use was not perceived a problem (Table 7.3.1). Other

reasons were also reported. Some claimed not being able to leave their job. Other have tried to quit the use of substances previously and have sought treatment, but failed. Also some reported doubt towards treatment, particularly in Lebanon.

TABLE 7.3.1 *SUBSTANCE USERS' LEVEL OF AGREEMENT REGARDING REASONS FOR NOT SEEKING TREATMENT AT THE TIME OF THE INTERVIEW, 2010*

	Distance to reach the center	Cost of treatment	Fear of being reported	Services not suitable to the patient's needs	Willing to stop using substances on his/her own	Substance use was not perceived as a problem	Not willing to stop using substances
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	1 (8)	1(1)	1 (10)	1 (7)	1 (3)	1 (4)	1 (1)
Disagree	1 (8)	1(1)	1 (10)	1 (7)	1 (3)	2 (8)	1 (1)
Neutral/Mixed	5 (31)	5 (6)	5 (40)	5 (29)	6 (13)	4 (17)	5 (5)
Agree	0	0	0	0	1 (3)	2 (8)	3 (4)
Strongly agree	7 (54)	73 (91)	4 (40)	8 (57)	31 (80)	15 (63)	69 (89)

Furthermore, most individuals interviewed had not sought treatment previously in their lives (N=226, 72%). Reasons for not doing so were investigated. The largest proportion agreed on few factors influencing them on not seeking treatment in the past: unwillingness to stop using substances, cost of treatment, substance use not perceived as a problem and willingness to stop using substance independently (Table 7.3.2).

TABLE 7.3.2 *SUBSTANCE USERS' LEVEL OF AGREEMENT REGARDING REASONS FOR NOT SEEKING TREATMENT IN THE PAST, 2010*

	Distance to reach the center	Cost of treatment	Fear of being reported	Services not suitable to the patient's needs	Willing to stop using substances on his/her own	Substance use was not perceived as a problem	Not willing to stop using substances
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	1 (6)	1(1)	1 (10)	1 (8)	0	1 (2)	1 (1)
Disagree	1 (6)	1(1)	1 (10)	1 (8)	1 (4)	1 (2)	2 (2)
Neutral/Mixed	7 (44)	7 (9)	4 (40)	7 (54)	5 (19)	7 (16)	5 (6)
Agree	3 (19)	3 (4)	0	2 (15)	3 (11)	5 (11)	4 (5)
Strongly agree	4 (25)	65 (84)	4 (40)	2 (15)	18 (67)	30 (68)	74 (86)

Past demand for treatment

87 substance users (28%) had ever sought treatment in the past, whether once (11%), or twice and more (17%). Of those who sought treatment, approximately the same proportions have received and have not received treatment (45% and 55% respectively).

Of those seeking treatment in the past, 40 % had wanted inpatient treatment (N=36). 20 % wished for outpatient treatment (N=18), and 18% desired any type of treatment (N=16). The rest sought OST (N=8), follow-up (N=4), inpatient treatment and withdrawal

management (N=2), individual psychotherapy (N=2). One person was seeking any treatment from home and 2 individuals did not know what type of treatment they were seeking.

72% of substance users initiating treatment in the past had received treatment at inpatient treatment centers (N=28). The rest (between 3% and 10%) received the following types of treatment services: withdrawal management in a hospital (N=4), outpatient treatment (N=3), individual psychotherapy for addictions (N=3), faith-based treatment (N=1), OST (N=1) and aftercare support (N=1). Three individuals (8%) had received more than one type of service formerly.

Interaction with human resources

When presenting for treatment in the past, most of the individuals interacted with psychiatrists (73%) and psychologists (55%), and a small percentage with social workers (15%). Nearly none reported interacting with nurses, GPs and counselors. Around 16% reported interacting with a diversity of other NGO staff (e.g., friends, fieldworkers, religious figures and center directors).

Reasons for not receiving or discontinuing treatment after first consultation

As reported by table 7.3.4, many reasons were agreed upon by substance users, as to why they had not continued treatment after their first consultation. These reasons being, (1) no vacancies at the centers, (2) their names were put on the waiting list, (3) cost of treatment, (4) distance to reach the center, (5) next appointment was too far from the first one, (6) the center does not admit people who developed dependence to all types of substance, and (7) centers do not accept patients with certain health conditions.

TABLE 7.3.4 *SUBSTANCE USERS' LEVEL OF AGREEMENT REGARDING REASONS FOR NOT CONTINUING TREATMENT AFTER FIRST CONSULTATION, 2010*

	Distance to reach the center	Cost of treatment	No vacancies	Name on waiting list	Next appointment too far from first date of visit	Services not suitable to the patient's needs	Center hours do not fit the individual's schedule
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	0	0	0	0	0	0	0
Disagree	2 (17)	3(11)	3 (10)	3 (11)	3 (18)	3 (43)	2 (100)
Neutral/Mixed	0	0	0	0	0	0	0
Agree	0	0	0	0	0	0	0
Strongly Agree	10 (83)	24 (89)	26 (90)	25 (89)	14 (82)	4 (57)	0

TABLE 7.3.4 *SUBSTANCE USERS' LEVEL OF AGREEMENT REGARDING REASONS FOR NOT CONTINUING TREATMENT AFTER FIRST CONSULTATION, 2010, CONTINUED*

	Center does not admit from both sexes	Center does not admit from all nationalities	Center does not admit people who have a dependence to all types of substances	Willing to stop using substances on his/her own	Not willing to stop using substances
	N (%)	N (%)	N (%)	N (%)	N (%)
Strongly disagree	0	0	0	0	0
Disagree	2 (100)	2 (100)	2 (33)	2 (67)	2 (100)
Neutral/Mixed	0	0	0	0	0
Agree	0	0	0	0	0
Strongly Agree	0	0	4 (67)	1 (33)	0

Reasons for not completing treatment

Among substance users that received treatment in the past, a vast majority reported not completing it (92%). Numbers of respondents were low when investigating reasons for non-completion, but the factor the mostly agreed upon was that services were not suitable to patients' needs (N=17). Duration of treatment (N=13) and the distance to reach the center (N=9) were also factors thought to affect compliance to treatment. Only a few respondents agreed with the other reasons mentioned, such as the family involvement, government's lack of follow up, or lack/loss of commitment to treatment. A few substance users further explained that

other factors not listed presented an impediment to treatment completion. These included difficulty of coping with treatment or an inability to receive substitution treatment on a regular basis.

Reasons for returning to treatment center

Among those who sought treatment more than once, the majority reported visiting another center (83%), while the remaining proportion visited the same treatment center.

Among the 47 who went to another center, 30% and 24% did so mainly for lack of vacancy at the former center, and because they are looking for a cheaper center, respectively. Moreover, 15% reported that the other center they went to was more affordable and only 9% were looking for change. In addition, some reported switching centers in the hope of finding substitution treatment.

Among the 10 who went to the same center, 40% claimed not knowing any other treatment center, or one that offers substitution treatment service. Also, 20% visited the same center out of habit; 10% to be with their friends and 10% because they were familiar with the people at the center.

Cost of treatment

The majority agreed that cost of treatment for substance use was an obstacle to seeking treatment. This majority mainly had a low income, ranging from $2,000-$12,000.

Of the respondents, very few claimed paying for treatment on their own (36%), through their friends (14%), or through the MOPH (3%). However, it was reported by the majority (69%) that parents paid for their treatment. Moreover, a third reported seeking help from the MOPH (33%), but practically all respondents (96%) did not believe that the MOPH would cover the costs related to their treatment.

7.4 Referrals

Referral sources and coordination between heath and judicial systems

About half of respondents reported being referred to treatment in the past by a private psychologist or psychiatrist, and about a third by a fieldworker (30%). In addition, very few reported being referred by social services center (16%), by another treatment center (11%), by hospital (9%), or by their personal environment, such as self, family, or friends (7%). None of the respondents reported being referred to treatment by law representatives (e.g., police officers, prosecutors and judges).

Among the 260 who elaborated on the coordination between the judicial and healthcare systems, many (N=145) substance users felt that the referral system was inexistent or a failure, basing their answer on past experiences. In general, interviewees felt that the current structure with respect to health care and justice did not help in any way. They reported the need to bribe (monetary incentive) officials and felt that people with connections and of higher SES were treated with more leniencies. The rest did not know of any cooperation between the judicial and healthcare treatment facilities (N=115).

7.5 Legal situation of substance users

Knowledge about the law

When asked about their knowledge on the Law on Drugs, most of the interviewees believed that the law penalizes substance users (71%). Moreover, around 20% knew that prosecution would stop if individuals were treated; however none of the interviewees believed that judges normally abide by this law. Of those who knew that prosecution could be suspended if one committed to treatment, most were certain that the judicial system played no part in enforcing the law, and 4 % were not sure. Around 9% of the interviewees were not aware of this law.

Legal status

31% of interviewees claimed to have had a lawsuit against them in the past. 77 % of those reported still having pending lawsuits against them.

Additionally, around 33% reported being previously imprisoned because of substance use. Half of the substance users reported being incarcerated twice (minimum = 1; maximum = 10; mean = 3) and for an average duration of 60 days (minimum = 1; maximum = 1080; mean = 93).

Among those who had been incarcerated, 41% of the respondents reported staying in prison for 30 days or less. Around 20% reported staying 31 to 60 days, and about a tenth stayed between 61 and 90 days (12%). More than a quarter had stayed for more than 90 days (26%).

Effects of incarceration and penal record

Drug users who have been previously incarcerated reported prison to have negatively affected the initiation and maintenance of treatment (92%).

Moreover, the majority (94%) reported that a previous penal record strongly affected their acceptance to a university or employment. Some mentioned that this record acted as a barrier when it came to job opportunities, and those who could became self-employed. It also ruined their reputation, their future and inhibited them from obtaining a health insurance and a driving license. Some noted that this record leads some of them to re-using substances (vicious cycle). Females, in particular, reported being strongly influenced by the penal record. Certain individuals claimed the need to bribe big amounts of money ($5,000) to DEBs in order not to have a criminal record. The rest felt that it had no influence.

Information communicated to public officers

Around 30 % of substance users (N=89) interviewed reported that their information had been disclosed to a public officer by their family (46%), a law representative (25%), and private practitioners (8%). None of the respondents stated that NGOs or social services

centers had communicated information about them to the law representatives. Still, 14 mentioned being denunciated by detectives. The remaining respondents did not know the source, or preferred not to mention it.

The majority of substance users believed that the Lebanese law respects patients' confidentiality (88%).

Confidentiality at the treatment center

Those having sought treatment in the past mainly reported believing that confidentiality between them and anyone in the treatment center was respected (93%). Among the very few that believed confidentiality was not respected, most felt that this had an effect on treatment outcome (75%) and only 25% felt it had no effect.

Legal system

8. Drug enforcement bureaus (DEBs)

The Central DEB head in Beirut and his three colleagues in the affiliated DEB branches of the North, Beqaa, and South governorates were interviewed.

DEBs reported that their role is to wage the War on Drugs. They control drug trafficking within Lebanese borders and gather data related to drugs in the country. They may also carry out prevention and guidance.

8.1 Arrest cases in 2009

Number of drug-related cases

The number of arrest cases for drug use only *and* drug use with other drug-related accusations was highest in Mount Lebanon. In all, and based on accurate data, Lebanon has arrested a total of 2,228 cases of drug use and 2,881 of drug use and other drug-related indictments in the year of 2009 (Table 8.1.1).

TABLE 8.1.1 *NUMBER OF ARREST CASES OF DRUG USE, OTHER RELATED ACCUSATIONS, AND DRUG USE WITH OTHER DRUG-RELATED ACCUSATIONS, 2009*

	Drug use only	Other drug-related accusations**	Drug use and other drug-related accusations
	N	N	N
Beirut	*267*	*73*	*340*
Mount Lebanon*	*1162*	*319*	*1481*
North	210	52	262
South	314	84	398
Beqaa	275	125	400
Lebanon	2228	653	2881

**This is the only information obtained regarding Mount Lebanon.*

***Other drug-related accusations include cultivation, manufacturing, transportation, smuggling, facilitation, dealing, financing, and other criminal accusations; Italicized numbers were estimated by the Central Bureau.*

Two DEB directors provided additional information regarding drug users stating that the majority aggregate where there is supply and demand. It was supposed that most arrests for drug use take place in Baalbeck (Beqaa governorate), Hermel (Beqaa governorate), and the Southern Suburb of Beirut (Mount Lebanon governorate) as traffickers are situated in these areas. Drug users were also arrested in the areas of Kaslik (Mount Lebanon governorate), Fanar (Mount Lebanon governorate), Aynata (Nabatieh governorate), and Arez (North governorate), and the dealers are arrested in Deir El Ahmar (Beqaa governorate).

Re-arrest rates in 2009 were of 50% in the South governorate, 10% in the Beqaa governorate. These include drug users who were arrested twice or more in the same governorates. The re-arrest rates were 50% as reported by the Central Bureau. We do not know if this figure applies to, Beirut, Beirut and Mount Lebanon (which data processed by the Central Bureau), or all governorates combined.

Even though the number of arrests for cannabis use was elevated in the North, South, and Beqaa governorates, it was especially high in South. Arrests for cocaine use were prevalent in the Beqaa, while arrests involving sedatives and tranquilizers were reported in majority in the North (Table 8.1.2).

TABLE 8.1.2 *NUMBER OF ARREST CASES BY DRUG CLASSES, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers*	Hallucinogens	Solvents and inhalants	Other**
North	59	25	4		118		4	0
South	227	38	9		13		0	27
Beqaa***	76	45	73		14		0	49

**Amphetamines, sedatives and tranquilizers, and hallucinogens are all classified as "pills" by the DEBs and therefore represent one category of drugs.*

***"Other" refers to other types of drugs as well as various types of drugs encountered altogether during arrest of a poly-drug user.*

The Central Bureau was unable to report the number of arrest cases by drug classes for Beirut or Beirut/Mount Lebanon combined.

****As per this table, the number of arrest cases by drug classes is 257 in the Beqaa while the number of arrest cases for the Beqaa region is 275, as reported differently by the Beqaa and Central DEBs, respectively. As attested by DEB directors, the Central Bureau may have processed arrest cases of 2008 in 2009, which may explain the discrepancy in the numbers.*

Arrest conditions

As estimated by the DEB directors, there were no cases of arrest upon denunciation by treatment centers after admitting the drug user to treatment or if the drug user had stopped treatment. Moreover, there were a good number of arrested cases in a public place and upon denunciations by an arrested drug user or by a police source (Table 8.1.3).

TABLE 8.1.3 *ESTIMATE OF THE PERCENTAGE OF ARREST CONDITIONS, 2009*

	Arrested in a public place	Arrested upon denunciation from another arrested drug user	Arrested upon denunciation from a police source	Arrested upon denunciation from a treatment center where the drug user had stopped treatment	Arrested upon denunciation from a treatment center after the drug user was admitted to treatment	Arrested upon a source related to the drug user	Arrested upon investigation for other crimes	Arrested during other circumstances
Beirut	30	30	10	0	0	2	8	0
North	45	35	10	0	0	5	3	2
South	80	20	40	0	0	2	5	0
Beqaa	30	30	10	0	0	2	8	0

Drug users may have been arrested in 2 different circumstances or more.

N = 4 for all cases.

8.2 Detention

Duration

As reported by the four DEB directors, the maximum period of arrest for a drug user in a police station is 48 hours, renewable once to a total maximum period of 96 hours as decreed by the law. They have reported that, in 2009, the average detention period of drug users in police stations in Lebanon was 48 hours. However, in some cases, arrest period may extend to 4 days.

Testing

4 DEB directors ran urine tests to detect the presence of different types of drugs: cocaine, cannabis-types, amphetamine-types, benzhexol, and opiates (e.g. heroin, morphine, codeine).

Urine tests were requested except in the case of a confession of drug use. Other types of tests (i.e., hair, blood, saliva and sweat), however, were not administered. The urine tests are performed at the Bureaus, making it a standardized procedure as police officers are trained on test administration.

Most, if not all, tests take place at the Bureaus. Most tests are taken at no cost to the detainee. If taken at the Bureau, the DEB or the general directorates of the ISF pay the fee. However, individuals may take the test in a laboratory if testing equipment is not available at the DEBs. Testing at the laboratory usually costs 16.66 USD, but if the detainee cannot afford the urine test bill, the DEB directors ask the laboratory to waive the fee.

Health assistance

DEBs were not affiliated with any specialized medical facilities examining and/or treating drug users in case of an emergency.

When asked about handling overdose and withdrawal symptom cases, 2 of the DEB directors reported taking the arrested drug users to a hospital. These directors were from Beirut and South governorates. One DEB director from the North reported administering anxiolytics[14] or sleeping pills after the consent of a specialized authority (e.g., a psychiatrist). The fourth DEB director, from the Beqaa governorate, reported sending drug users to a treatment center after completing appropriate procedures and after obtaining the General Prosecutor's approval. There is neither an official standard procedure nor a common treatment modality decreed by a governmental entity in case of overdose or withdrawal symptoms. The obstacle to that is, as stated by one of the DEB directors, the lack of treatment centers affiliated with the government and the lack of a unified treatment system.

[14] A type of drug used to treat anxiety.

8.3 Drug-related knowledge

2 DEBs in the North and Beqaa stated that the police station personnel in their Bureaus does not receive relevant and updated training sessions on dealing with drug users. The North DEB mentioned that officers have attended conferences and sessions related to drug use in general only, and not treatment, focusing on considering drug users as patients and not criminals. The other 2 DEBs interviewed, one being from Beirut and the other from the South, reported attending a few training sessions whereby their last two sessions were held by European organizations. The sessions consisted of drug-related knowledge, such as trafficking, prevention of drug use, and various topics such as: the recent techniques of investigation (exp: electronic tracking of the dealers in their cars); the importance to call the parents of the drug users during the investigation to inform them that the drug user has been arrested, the importance of asking the parents to come and see their children; the importance of consulting a doctor before starting the investigation with the drug users; treatment of drug users inside the prison based on the Jordanian experience; substitution treatment.

The police representatives reported the ability to recognize the difference between dependent and recreational drug users, which is based on their personal experience. Among those, the North DEB explained a certain dependency related to each type of drug; heroin typically has a physical dependency, while cocaine and cannabis are often used for recreational purposes. All interviewees claimed to address specific questions to drug users in the attempt of revealing their addiction history. However, none of the DEB directors acted on this distinction simply because such a differentiation does not exist in the implementation of the Law on Drugs.

8.4 Treatment measures

There is a clear law concerning the arrest process irrespective of the drug user's intention. This law does not differentiate between an addict and a non-addict. Also, the same procedures apply when it comes to "arrest", irrespective to how the drug user was arrested (e.g., by the police, denunciated by their families, or those turning themselves in). The interviewees asserted that there is a slight difference in the way drug users are treated. Those that attempt to escape or resist the arrest are more likely to be treated

with “force”; handcuffs are used for the drug user to be taken to the Bureau. However, less “force” is needed when they turn themselves in. In addition, the DEB director of the South governorate reported that university students are seen as less threatening than others and may be treated with careful consideration. It was also reported that more consideration is given to drug users as opposed to drug dealers during arrest.

As far as treatment is concerned, three out of the four interviewees, namely DEB of the Beirut, Beqaa, and South governorates, do not consider treatment as an aspect in decision-making during the arrest and detention processes. Throughout interviews, all DEB directors have confirmed inquiring about current treatment of the drug user or even referring some drug addiction cases to treatment centers. If the drug user commits to treatment during the detention and arrest process, the liberty of choice of treatment facility or modality is usually left to the drug user. But the DEB heads do not consider this procedure standard. Indeed, all reported that it is the judicial system that is held responsible if the drug user is enrolled in or intending to commit to a treatment program. They claimed that the DEB’s role in handling cases which involve drug dependence treatment is limited to following up with the treatment center treating the drug user, verifying the enrollment in treatment and notifying the concerned parties of the judicial system.

8.5 Referrals

None of the parties interviewed have a system of referral with treatment facilities, whether hospitals or NGOs. Moreover, they do not maintain regular contact with the hospitals and treatment centers offering physical or psychological treatment to drug users, whether free of charge or not. One reason may be the lack of treatment facilities in specific areas in Lebanon. One DEB director elaborated on this matter stating that there were no treatment centers in many areas of Lebanon, such as the North, and that some drug users resort to traveling to the Kingdom of Saudi Arabia or Jordan to get help.

8.6 Data monitoring system

Files on each person arrested for drug use are retained by the 4 Bureaus. These include information such as name, gender, birth date, area of residence, phone number, picture, employment status, types of drugs used, and number of arrests which are recorded on an identification form (Appendix 2). Data are entered on computers.

The central DEB gathers information collected at all other Bureaus, which send the identification form. However, the interviewees asserted that data among the Bureaus located in Beqaa, North and South Lebanon, are not usually shared, unless specific information is needed. This applies to cases in which the location of the arrest and the birth governorate of the drug user are not the same.

All DEB directors reported that their data recording system allows them to see who has been rearrested in their police stations, while only 1 of 4 directors (Central Bureau) reported that this system allowed to count re-arrests in other police stations or Bureaus. The remaining 3 DEBs not located in Beirut usually learn about re-arrests in other governorates by calling the Central Bureau. One director from the North Lebanon DEB also emphasized the difficulty to compute re-arrest rates in his Bureau or affiliated police stations due to a primitive computer data system.

At all Bureaus, the data recording system is not set in a way to follow up on the drug users' status, regardless of whether he/she started treatment to avoid prosecution, is prosecuted/, sentenced, or acquitted.

In any case, data collected at all Bureaus is never disposed of.

8.7 Substance-related deaths

In 2009, there were 2 fatal overdoses in Beirut, 2 in Beqaa, 1 in South and none in North police stations subsequent to the arrest. No other drug-related deaths were reported by the DEBs. These include deaths caused by AIDS, or deaths linked to other factors (e.g., car accidents under the influence of drugs).

Fatal overdoses, according to the DEB directors, are inaccurate, since not all deaths are identified as drug-related, because of social factors and stigma. Also, many fatalities might have occurred while the individual was under the influence of drugs: for instance, a car accident with the driver being under the influence of drugs; in this case, the death is reported as "automobile accident" and it leads to underreporting in number of drug-related deaths.

8.8. Sources of information

Three DEB directors based their responses on data collected while one used both data and general observations based on experience to provide us with answers.

9. Judges

9.1 Jurisdiction in cases of drug use

Overall, 34 judges were interviewed, with the majority from Mount Lebanon and Beirut. Approximately, more than half of the judges reported handling 50 drug use cases or more in the year of 2009. Moreover, those handling numerous drug use cases mostly came from Mount Lebanon, Beirut and Beqaa (Table 9.1.1).

TABLE 9.1.1 *NUMBER OF DRUG USE CASES HANDLED BY THE JUDGES BY JUDGES' EMPLOYMENT LOCATION, 2009*

Area			Mount Lebanon	Beirut	Beqaa	North Lebanon	Nabatieh	South Lebanon
		N (%)	12 (35)	10 (29)	5 (15)	4 (12)	2 (6)	1 (3)
Number of drug use cases	0	2 (6)	1	0	0	0	1	0
	1 to 9	4 (12)	0	3	1	0	0	0
	10 to 24	6 (17)	4	1	0	0	0	1
	25 to 50	4 (12)	1	1	0	1	1	0
	> 50	18 (53)	6	4	4	3	0	1

9.2 Drug use related knowledge

A relatively good number of judges, mostly from Beirut and Mount Lebanon, reported being knowledgeable about the different types of drugs and their effects (Table 9.2.1). Most judges claimed to primarily know such information from personal knowledge, with slightly less than half stating that their source of knowledge was lectures initiated by foreign associations. These judges mostly came from Mount Lebanon. Smaller proportions cited lectures initiated by MOJ and Lebanese Civil Society Associations (e.g., NGOs) (Table 9.2.2). Interestingly, 60% of those who claimed to have good/very good knowledge on either the different types of substances

or their effects have indicated to primarily obtain this information from a lecture either initiated by the MOJ, or by Lebanese civil society associations, or by foreign associations.

TABLE 9.2.1 *DESCRIPTION OF KNOWLEDGE ON DRUG USE, 2010*

	Knowledge on	
	Different types of drugs	**Effect of the different types of drugs**
	N (%)	**N (%)**
Very poor	0 (0)	2 (6)
Poor	2 (6)	2 (6)
Neutral	4 (12)	6 (18)
Good	17 (50)	14 (41)
Very good	11 (32)	10 (29)

TABLE 9.2.2 *SOURCE OF KNOWLEDGE BY JUDGES' EMPLOYMENT LOCATION, 2010*

Source of knowledge \ Area		Mount Lebanon	Beirut	Beqaa	North Lebanon	Nabatieh	South Lebanon
	N (%)	**12 (35)**	**10 (29)**	**5 (15)**	**4 (12)**	**2 (6)**	**1 (3)**
Personal knowledge	30 (88)	11	7	4	4	2	2
Lectures initiated by - MOJ and the Judicial Studies Institute	10 (29)	2	2	4	1	0	1
Lectures initiated by - Lebanese civil society associations (NGOs)	10 (31)	1	3	2	3	0	1
Lectures initiated by - Foreign associations or NGOS	15 (44)	6	3	1	1	2	2

Judges could report on more than one source of knowledge

9.3 Experts on drug use

A large number of judges reported the absence of a list of drug-related experts that are able to assist them on drug use cases (88%), of which the majority came from Mount Lebanon and Beirut (31% and 24%, respectively). Among the remaining judges, 3 reported having a list of less than 5 experts, and only one reported having a list of more than 10 experts on the matter. Of those reporting to

have a list of drug use related experts, one judge claimed that these experts were not under oath while the two others did not respond, and the judge having a list of 10 experts claimed that they were under oath. The fee, which might be demanded by the expert to confirm drug users' commitment to treatment and eventual recovery, was on average 278 USD ranging from 30 to 667 USD per case. However, only 44 % of judges have responded to this question. Judges stated that they would recruit experts who were assigned by external parties (e.g., Ministry or Office for Juvenile Protection). If not, they would recruit based on the experts' qualifications (including having a medical degree and expertise), dependability, and ethical considerations. Others also specified professional consideration, dedication, and their ability to communicate with patients. About two thirds of the judges interviewed believed they would not be able to assign an expert on the expense of public treasury (65%), of which most came from Beirut and Mount Lebanon (35% of the respondents for both). The remaining judges believing they could generally were from Beirut, Mount Lebanon and North Lebanon (33%, 22%, and 22%, respectively).

9.4 Lawyers and rights of the defense

Approximately half of the judges stated occasional representation of the defendants by a lawyer in drug-related issues, as well as commitment to treatment by the defendants. Few were the judges who believed that defendants were represented by lawyers most of or all the time, and an even fewer number reckoned that defendants regularly or always committed to treatment. Also, about a third of judges believed that lawyers hardly ever or at times plead the defendants' innocence on the basis of them having committed to treatment (Table 9.4.1). 57% of the interviewed judges did not recall cases where the defendants presented a certificate of completed recovery for addiction, whereas a quarter felt they did in many cases, with the rest supposing this rarely happening.

TABLE 9.4.1 *DESCRIPTION OF LAWYERS AND RIGHTS OF THE DEFENSE, 2010*

	Does a lawyer in drug-related issues represent the defendants?		Do the defendants commit to treatment?		How much do lawyers plead the defendants' innocence on the basis of them having committed to treatment?	
	N	%	N	%	N	%
Rarely	6	18	8	33	10	32
Sometimes	18	55	12	50	10	32
Mostly	8	24	3	13	7	23
Always	1	3	1	4	4	13

9.5 Treatment measures

Around 40% of the judges claimed to have never issued a primary or final verdict requiring the drug addict to commit to a treatment facility with only 4% declaring to always issuing such a verdict. Those claiming to have never issued primarily came from Mount Lebanon (36%). Other responses varied between rarely, sometimes and mostly (14%, 21%, 11% respectively). 20 judges had information regarding private or public centers or clinics that provide psychological or physical treatment for addiction, as well as their contact information. These judges were instituted in Mount Lebanon, Beirut and Beqaa (26%, 21%, 21%, respectively). When asked to indicate the name of these centers, most judges identified the same 2 NGOs while the other centers (NGOs or hospitals) were known by a minority or not recalled at all. Among those having the information, 30% have actually contacted the centers. Of those contacting the centers, 3 judges reported a poor or not satisfactory level of the cooperation provided by these centers, with

only 2 judges being pleased with the level of cooperation. None of the judges described the level of cooperation provided as very good.

Some enlightening information was gathered providing us with the means to assume that the lack of cooperation between judges and centers was principally caused by the low number of existing treatment centers, the high cost of treatment or the absence of centers assigned by the law. According to the judges, such centers should help Lebanese but also Palestinians, as it was stated that drug use is particularly a problem among this population. Another predominant reason was the lack of a system in place to facilitate this cooperation, with one judge highlighting the importance of this issue in the Beqaa governorate. This system should be implemented by the DAC, which, according to judges, should be put to work and be the link between substance users and the judges. Interviewees also identified the need for a list of all treatment centers to facilitate the cooperation and referral process. Some explained the non-satisfactory cooperation as due to lack of judges' authority on centers, as, in the absence of the DAC, the cooperation would then depend on the willingness of treatment centers to work with the judicial system.

Judges were asked who held the decision of choosing the treatment center when they required drug users to commit to treatment: for many, the treatment center was designated upon jurisdiction law (45%). A lower proportion reported that an expert working with the judge assigned the drug user to the treatment facility (27%) or the decision was left to the defendant (27%).

Measures to follow up with patients

The majority of judges have taken measures to ensure that the patient has stopped drug use (86%). Of those ensuing procedures, a large proportion reported requiring the patient to certify his abstinence by showing laboratory analysis results, followed by showing a report from the treatment center or a medical report. Very few assign an expert to document that the patient has stopped drug use (Table 9.5.1). Moreover, those taking measures are mainly acting in Beirut and Mount Lebanon (36%, 28%, respectively).

TABLE 9.5.1 *FOLLOW-UP MEASURES WITH PATIENTS AMONG THOSE WHO TAKE MEASURES TO ENSURE THAT THE PATIENT HAS STOPPED DRUG USE, 2010*

	Assigning an expert		Requiring the patients to certify their abstinence by showing					
			A report from the treatment centers		A medical report		Laboratory analysis results	
	N	%	N	%	N	%	N	%
No	22	88	8	32	10	40	7	28
Yes	3	12	17	68	15	60	18	72

Among 4 judges not taking any measures to ensure that the patient had stopped drug use, the following reasons were shared: these measures do not have an influence on verdicts, there is an absence of drug treatment facilities designated by the law, and a lack of clear methods to ensure the effectiveness of the available treatment facilities. One of the judges did not answer this question.

The largest proportion of judges reported trusting the reports issued by the treatment centers very much (45%), and more than a third reported having an average trust in them (35%). Very few trusted them poorly (17%) and only one reported not trusting them at all (4%). Those who reported having good trust mainly came from Beirut, North Lebanon and Mount Lebanon.

Practically none of the judges interviewed reported having a system of referral with other treatment facilities in place (97%), of which 33% came from Mount Lebanon and 27% from Beirut. The only judge who had a referral system in place rated it as good and came from Mount Lebanon.

9.6 Sources of information

All 34 judges claimed that their responses were based on general observations as opposed to data they had collected, with around a quarter of the judges (N=8) indicating that they made use of both data and observations when responding to the questionnaire administered.

Stakeholders

10. Ministry of Public Health (MOPH)

The President of the Drug Department at the MOPH was interviewed.

10.1 Function of the MOPH with respect to substance use

Role

The MOPH's main role is (1) to establish one or more treatment centers for detoxification of substance use, and (2) to affiliate with existing centers dealing with the psychological aspect of dependence. Two detoxification centers are currently being launched in Beirut and Mount Lebanon.

Referral process

If a substance user seeking treatment visits MOPH, he/she is referred to a treatment center affiliated with the Ministry (e.g., hospitals, dispensaries, NGOs). A patient is admitted to a particular treatment center depending on the availability and type of

treatment needed. The procedure takes place through the administrative section of the treatment center, after which the patient is diagnosed. Upon diagnosis, the doctor provides the patient with a medical report, which allows the patient to receive treatment at any center affiliated with the Ministry. If needed, the patient is afterward referred to a center with a different program, also affiliated with the Ministry.

10.2 MOPH's financial role

The MOPH funds treatment centers working in the field of substance use if they are legalized institutions and if there is enough money for contribution. In the year of 2009, the MOPH financially supported 3 treatment centers, of which 2 are hospitals (located in Beirut and Mount Lebanon) and 1 is an NGO (located in Mount Lebanon). These centers receive, on average, a contribution of 254,452 USD per year.

No specific number of individuals with substance use is entitled to receive direct free treatment from the MOPH. Based on the yearly monetary contributions, hospitals and NGOs are responsible for spending the money based on their respective costs and the substance users' needs. Moreover, treatment centers covered by the Ministry do not have criteria that exclude individuals with substance dependence from receiving treatment.

10.3 Cases of substance dependence

In 2008, 676 individuals with substance dependence have received free treatment covered by MOPH. A year later, this number rose by 31% (886 receiving treatment in 2009).

10.4 Trend of prevalence in treatment

When asked about the trend in the numbers of substance users receiving treatment in 2009 compared to 2007/2008, a large increase was reported. Cost was seen as an obstacle that played an essential role in the initiation, maintenance, and completion of treatment.

10.5 Substance users' health status

The MOPH does not have national data regarding the health profile of substance users in Lebanon. However, the Ministry representatives gather some information on substance users encountered through the centers working in the drug field. Based on data collected in 2009, 1-2 % of drug users were diagnosed with hepatitis B, 25-30% with hepatitis C, and 13% with HIV/AIDS. According to the MOPH representative, there has been a large increase in the prevalence of infections among substance injectors in 2009 compared to the previous one or two years.

10.6 Substance use related deaths

In 2009, the total number of substance-related deaths reported was 2, consisting of fatal heroin overdoses. Deaths from substance-related hepatitis C and other substance-related deaths, such as deaths resulting from a car accident while under the influence of substances amounted to 0. Moreover, compared to 2007/2008, a large decrease was estimated in the number of substance-related deaths.

11. Ministry of Justice (MOJ)

The President of the Addiction committee, also a judge, was interviewed.

11.1 Implementation of the Law on Drugs

The Law #673 (Appendix 1) of the Law on Drugs issued on March 16, 1998 stating that individuals with drug dependence should be treated as patients in need of treatment and not as criminals, is currently not being implemented. According to the Ministry, the main reason for the lack of law execution is the non-activation of the DAC. The DAC's role consists of referring the drug user to a treatment center and to supervise his/her treatment. In the event that the drug user stops the treatment, the Committee will inform the prosecution in order to restart his/her trial. In the event that the drug user recovers, the Committee will issue an attestation confirming the recovery and then the case against the drug user will be dropped. Yet, the establishment and activation of this Committee is being currently examined by the Ministry on 2 fronts, (1) establishment of a registry that supports the committee in performing its duties (e.g., reception of applications, file creation and management, writing minutes during hearings), and (2) compensations allocated to the committee's members by issuing an implementation decree. It was further highlighted that the main difficulty in implementing this law resides in the absence of affiliated treatment centers. On the other hand, the Ministry is counting on the committee's experience to initially define the needs, gaps and deficiencies in terms of treatment.

11.2 Training of judges on the Law on Drugs

Judges doing their internship do not receive any training sessions that acquaint them with techniques in dealing with drugs users. Moreover, it was reported that no training sessions were given to judges in 2009.

11.3 Coordination with the prosecution

The Ministry representative reported not giving any general instructions to public prosecution departments on the implementation of particular laws, such as the use of stringent or lax measures during prosecution, in light of the penal policy. She also added not having any intention of issuing similar instructions to public prosecution departments on the matter of dealing with drug users. The interviewee added that doing so is highly improbable.

11.4 Coordination with international parties

The MOJ official reported dealing with the French government on the implementation of the law on drugs, and in particular on the offense of substance use.

12. Ministry of Social Affairs (MOSA)

Data was collected on MOSA through the advisor of the Ministry and a social worker in the specialized social welfare department.

12.1 Function of the MOSA with respect to substance use

Role

MOSA's role mainly consists of (1) prevention, and (2) social reintegration. Substance use prevention (including awareness) mainly occurs prior to substance use, whereas social reintegration takes place during the recovery period. The body responsible for decision-making regarding social affairs related to substance use is the directorate of social affairs in the social welfare department.

The Ministry offers most of its activities and services through its affiliation with 95 social services centers all over Lebanon. These centers are the bodies responsible for the implementation of MOSA's social policies (including drug-related social policies). Coordination between MOSA and its social services centers takes place through the social welfare unit of the MOSA, which is responsible for the centers. The social services centers report to the unit.

As a primary role, social services centers mainly provide prevention of substance use to substance users visiting their centers. However, there is no unified prevention program in these centers: each center takes an individual initiative, whether related to prevention or other interventions, after receiving approval of the representatives of the unit of social welfare. The choice of the interventions depends on the needs assessed in the center's areas.

Referral process

If a substance user seeking treatment is to visit MOSA or one of its social services centers, he/she is then referred to a treatment center affiliated with MOSA. The center is chosen based on the substance user's social and psychological status as well as the severity of substance use. The social welfare department of MOSA, which specializes in addiction, is responsible for referring substance users to the appropriate centers.

12.2 MOSA's financial role

There is no specific budget allotted to social services centers from MOSA for substance related issues. However, a contract between the two parties is renewed yearly taking into consideration the Ministry's budget.

MOSA also provides financial contributions to any health facility that provides prevention and social reintegration with respect to substance use, when its budget permits. These centers need to be (1) legally instituted, need to have (2) technical equipment and an administrative team with specific conditions listed in the MOSA's care system terms of agreement, and (3) need to receive "deviant" individuals or at risk for deviance [deviant individuals are defined by MOSA as having one or more problems that make them unable to lead a normal life and be integrated in the society]. Their behavior will expose society to many problems which will inhibit its development. Deviant individuals are sex workers, homeless individuals, victims of physical or psychological abuse, single mothers and their children, orphans, and individuals who are substance dependent]. Once these 3 conditions are met, these centers then become affiliated with MOSA.

In 2009, 4 health facilities centers, namely NGOs, have been affiliated with MOSA and have received a financial contribution for social affairs related to substance use. 3 of these NGOs are located in Mount Lebanon, and one is located in Beqaa.

12.3 Coordination with MOPH

With respect to treatment of substance users, MOSA coordinates with MOPH indirectly through the social services centers and treatment centers affiliated with MOSA and working in the field of addiction.

12.4 Drug use related data

MOSA does not collect national data regarding the social profile of substance users in Lebanon.

Other Service Providers

13. Non-governmental organizations (NGOs) encountering substance users

Overall, 8 NGOs were interviewed. All are in Beirut except one, located in the South of Lebanon.

13.1 Cases of substance use

Half of the NGOs encountered 11 cases of substance use or less in the year of 2009, ranging from 1 to 35 cases [mean = 15]. Overall, a total of 118 substance users visited these NGOs in 2009.

13.2 Demographic characteristics of substance users

Most substance users coming to these NGOs were between the age of 18 and 34, to the exception of one NGO whereby individuals encountered were less than 18 years old. More males were encountered than females, the case not holding true for NGO5. Moreover, 2 NGOs reported mostly coming across Lebanese individuals, with another 2 encountering non-Lebanese (mostly being Palestinians and Syrians). As reported by only 2 NGOs, substance users in majority were of a low SES, and 2 NGOs not reporting on any percentage confirmed this qualitatively. One NGO reported that most substance users were employed whereas another claimed the majority to be unemployed, with only one encountering an equal proportion of employed and unemployed substance users (Table 13.2.1).

TABLE 13.2.1 *PREVALENCE OF SUBSTANCE USE BY DEMOGRAPHICS, 2009*

	Substance use **Estimated %**				
	NGO2	**NGO3**	**NGO4**	**NGO5**	**NGO6**
Age (years)					
< 18	100	10			0
18 – 24	0	10			90
25 – 34	0	70			10
≥ 35	0	10			0
Gender					
Males	90	99		0	60
Females	10	1		100	40
Nationality					
Lebanese	0	90	10	70	
Non-Lebanese	100	10	90	30	
Socioeconomic status					

Low	80			95	
Middle	20			5	
High	0			0	
Employment status					
Employed	50	65		10	
Unemployed	50	35		90	

Shaded areas indicate missing data; NGO1, NGO7 and NGO8 had missing data on all demographics

13.3 Clinical characteristics of substance users

Age of onset of substance use

Half of the NGOs (with 6 responding) estimated the age of onset of substance use to be 14 years old or less, ranging from 13 to 16 years. Moreover, only 3 NGOs reported on the age of onset for the substance of choice, of which half reported an age of 18 years old or less minimum-maximum: 13-23 years]. Individuals using their most desired substance were assumed by 2 NGOs to have used it for 5 years before seeking treatment.

Changing trend of prevalence in substance use

Only 2 NGOs shared their estimation on the trend of prevalence of substance use. One supposed no change from 2007/2008 to 2009, whereas the other assumed the change in prevalence to depend on the type of substances. Accordingly, the use of cannabis, sedatives, alcohol, were estimated to have largely increased, and the use of cocaine and amphetamine-types to have slightly

increased. To the contrary, the use of opioids and solvents were presumed to have slightly decreased, and hallucinogen use had largely decreased.

Individuals' primary choice of substance

When categorizing based on most common usage, cannabis was ranked highest by 2 NGOs, with amphetamine-types, sedatives/tranquilizers, hallucinogens and alcohol also ranking first by one NGO (Table 13.3.1).

TABLE 13.3.1 *NUMBER OF NGOS REPORTING ON THE RANK OF INDIVIDUALS' PRIMARY CHOICE OF SUBSTANCE, 2009*

	Cannabis	Opioids	Cocaine	Amphetamine-types	Sedatives and tranquilizers	Hallucinogens	Solvents and inhalants	Alcohol	Other substances
Rank 1	2	0	0	1	1	1	0	1	0
Rank 2	1	1	1	1	0	0	0	0	0
Rank 3	0	0	1	0	1	1	0	0	0
Rank 4	0	0	1	0	0	1	0	1	0
Rank 5	0	0	0	1	0	0	0	1	0
Rank 6	0	0	0	0	0	0	0	0	0

As for most frequently used substances by age groups, only one NGO responded. Among those aged 34 years or younger, the primary substance of choice was estimated to be cannabis. As for the older age group, alcohol was seen as the preferred substance.

Poly-substance use

Prevalence of poly-substance use was estimated to be 10 by one NGO and 80% by another. Common combinations of substances included (1) cannabis and opioids; (2) amphetamine and amphetamine-types (e.g., speed and ecstasy); (3) cannabis (hashish), sedatives and alcohol; (4) alcohol with other types of substances.

13.4 Assessment of services

Availability of services

All NGOs provided referrals of cases of substance use to treatment centers, whether NGOs or hospitals specialized in substance dependence. Services offered to substance users included identifying and managing cases of substance use as well as providing housing or a place to retreat. Family, aftercare and legal support were also reported to be available as well as wellness-related activities in part of these NGOs (Table 13.4.1). One of four NGOs reported routine screening for substance use.

TABLE 13.4.1 *NUMBER OF NGOS HAVING AVAILABLE SERVICES, 2009*

Service	N	Availability
Case identification	2	2
Comprehensive assessment	2	2
Case management	2	2
Drop-in	2	2

Withdrawal management	1	0
Brief intervention	1	0
Medication for addictions	2	0
Medication for mental condition	2	0
Psychiatric medication	1	0
Medical support	1	1
Group therapy sessions for addictions	2	0
Educational group for addictions	2	0
Individual therapy for addictions	2	2
Individual therapy for mental health	2	1
Group sessions for mental health	2	0
Day/evening treatment	2	0
Outpatient treatment	2	0
Short-term inpatient treatment	2	0
Long-term inpatient treatment	2	0
Supportive housing	2	2

Family support	3	3
Legal support	2	2
Aftercare support or vocational assistance	2	2
Wellness related activities	2	2
Outreach	2	1
Referral	8	8

Coverage of services

Most NGOs provided full coverage of available services for males and females, all religions, all nationalities and different types of substances, with the exception of 1 NGO that welcomes females only.

Accessibility of services

2 NGOs were open 8 hours daily, and one NGO extended its services to 6 hours per day. All NGOs referred patients to treatment for substance dependence at no cost. One NGO provided all of its services (such as family support) to substance users at no cost.

Team distribution

The most common member of the clinical team among the NGOs interviewed was social workers. The distribution of other clinical and non-clinical team members varied depending on the field of work of the NGO.

Only one NGO wished to add a GP to the clinical team members.

Availability of treatment services in Lebanon

Interviewees were asked about the lack of proper treatment or lack of treatment at all per geographical region in Lebanon. 2 NGOs agreed that such treatments were lacking in the South, Beqaa and Nabatieh. Mixed responses were given for other areas.

13.5 Factors related to initiation, maintenance, and completion of treatment

NGO representatives were asked about factors affecting compliance among those enrolled in treatment in general and not necessarily at their center. All the factors listed in the table below were agreed upon by all respondents to influence compliance to treatment and dropout rates among enrolled patients except for the distance travelled to the center (Table 13.5.1).

TABLE 13.5.1 *NGO'S LEVEL OF AGREEMENT REGARDING FACTORS AFFECTING COMPLIANCE TO TREATMENT, 2009*

	Distance to reach the center	Cost of treatment	Lack of governmental support	Family involvement	Duration of treatment	Services not suitable to the patients' needs	Loss of commitment to treatment
Strongly disagree	0	0	0	0	0	0	0
Disagree	2	0	0	0	0	0	0
Neutral/Mixed	0	0	0	0	1	1	0
Agree	1	1	2	4	1	1	2
Strongly Agree	1	3	0	0	0	1	0

13.6 Referrals

Referral sources

4 NGOs reported that substance users visiting them were mainly referred by their personal environment (e.g., self, family, and friends). One of these NGOs reported substance users also being referred by private practice psychiatrists or psychologists. None of the NGOs reported having referrals from other NGOs or substance treatment centers, hospitals, law representatives (e.g., judges, prosecutors, police officers), social services or any other referral sources (e.g., employers, schools/universities, religious figures). It is

worth mentioning that substance users may not have been referred for substance related services (e.g., mental health treatment, social services).

Referral sites

3 NGOs primarily referred substance users for treatment to other NGOs, one NGO referred to a hospital, with none referring to private clinics of psychiatrists/psychologists.

Referral system among health professionals

4 NGOs reported having a system of referral in place with other treatment facilities (e.g., NGOs and hospitals). Among these, 3 rated the referral system as good, whereas 1 considered it to be poor.

13.7 Legal situation of individuals with substance use

Coordination with Internal Security Forces (ISF)

Most of the NGOs (N=7) have not communicated information to the ISF regarding substance users in 2009. All respondents (3 out of the 7 NGO representatives) indicated that they did not feel legally obligated to do so.

3 of the NGOs had a legal advisor to support the NGO staff in issues pertaining to the law.

Effect of incarceration

According to 2 NGOs, having a penal record strongly affects entry into a university or employment. Other interviewees did not respond as they felt they did not have sufficient knowledge on substance-related legal issues.

13.8 Sources of funding

All except one of the 8 NGOs interviewed reported being funded by private donors. Other sources of funding were local foundations, international foundations, and international donor agencies as reported by 3, 4, and 5 NGOs respectively. Only one NGO receives public donations, namely local support by the government.

Funding from the MOPH was only provided for one of the NGOs interviewed to offer VCT for HIV. Also, 6 NGOs do not receive funding from MOSA, while one does. The budget allotted for social affairs of this NGO was distributed for three projects in 2009: 1) the rehabilitation of female prisoners (psychological and legal follow-up); 2) the operations of a prevention center located in Beirut which targets under-privileged girls aged 10 to 18 years old and aims at strengthening their academic performance and providing them with family support; 3) psychological and family follow-up in the center welcoming victims of sexual abuse or sex workers. The Ministry provides an amount of money by person and for a specific amount of people for each of the centers.

The majority of these NGOs do not generate revenues from treatment of mental illnesses.

One NGO reported that 40 % of its mental health patients could not afford treatment at all in 2009. However, mental health patients (including substance users) and other beneficiaries do not pay for the services provided by most of the NGOs interviewed.

13.9 Sources of information

7 out of 8 of the NGOs gave us information based on general observation and one based on data.

14. Social services centers affiliated with the Ministry of Social Affairs (MOSA)

14.1 Overview of the centers

Overall, 41 individuals from the centers were interviewed, of which 34 were responsible for the center itself, 6 were social workers and only 1 was a doctor. They worked in centers located in different regions in Lebanon: around 22% practiced their profession in the centers located in North Lebanon or Nabatieh, 17% in Mount Lebanon or Beqaa, 12% in South Lebanon and 10% in Beirut. Moreover, half of the social services estimated, at most, 183 thousand USD to have been contributed to these centers, ranging from 2 to 400 thousand USD per year [mean = 160 thousand USD].

14.2 Cases of substance use

In 2009, a total of 156 patients have visited the 41 services' centers affiliated with the MOSA. The centers encountered an average of 4 substance users. This ranged between 0 and 60 substance cases per center. The highest number was reported by centers located in Beirut, as well as a center in Nabatieh (Table 14.2.1).

TABLE 14.2.1 AVERAGE NUMBER OF SUBSTANCE USERS BY AREA OF CENTERS, 2009

	N	Average number
Beirut	4	12
Mount	7	1
North	9	1
South	5	2
Beqaa	6	0
Nabatieh	9	9

14.3 Assessment of treatment services within or surrounding the center

Availability of treatment services for substance users

The majority (93%) of the centers reported not providing treatment to substance users.

When asked about the types of services that these centers offered, the most common answers were providing patients with referrals to treatment centers (61%), awareness sessions (49%), particularly in schools. A minority offered health services (such as medical consultations, counseling and a follow-up with families of the substance users).

Availability of treatment centers in the area

More than three quarters of the centers visited (78%) did not have NGOs, hospitals or psychiatrists to treat substance users in their area. These responses were provided by the centers located in Nabatieh, Beqaa, South and North of Lebanon. Among those that did not face that problem, the majority was located in Mount Lebanon (44%) and Beirut (33%).

On a positive note, about half of the centers claimed that it would make an extensive difference to have a substance treatment center in their area to meet substance users' needs. These centers were mainly located in Nabatieh and North of Lebanon.

14.4 Referrals

Referrals to specialized parties

7 social services centers (17%) had referred individuals with substance dependence to treatment in 2009. Half of the centers reported referring 4 patients or less [minimum-maximum: 2-20; mean = 10] to a hospital, an NGO or private practitioners, with one center referring 60 patients to a hospital. Among those who provided referrals, most (86%) reported following up on substance users after referring them to treatment.

Referral process

The way referral takes place was assessed. The majority (90%) of the centers reported directly contacting the health facilities via phone calls. In addition, a small proportion (10%) of centers referred substance users through sending files (of the substance users) to the health facilities. One of the centers reported contacting MOSA to locate a treatment center.

Referral system among health professionals

When asked whether centers had a system of referral in place with other treatment facilities, the majority (90%) reported not having such system in place.

14.5 Coordination with Stakeholders

Coordination with the Ministry of Social Affairs (MOSA)

Most centers directly coordinated with MOSA. Going through the hierarchy, they filed official reports or work plans and awaited approval from higher officials. Some reported coordinating through phone calls or by arranging meetings with the Minister.

Coordination with the Ministry of Public Health (MOPH)

The majority of centers (81%) reported lack of coordination with MOPH. 3 of the centers interviewed interact with the Ministry regarding substance users by filling forms reporting the number of cases of substance use encountered. 2 centers reported providing medications to substance users through local dispensaries affiliated with MOPH or MOPH itself. However, it was reported in one center that coordination takes place by referring substance users to MOPH for treatment, at its expense when possible.

14.6 Sources of funding

It was reported by all 41 centers that no contributions was given by MOSA for social affairs (prevention, social reintegration) in the area of substance use.

Recommendations made by all interviewees

Recommendations targeted to the improvement of their involvement in the field of addiction were made by all interviewees and revolved around three main levels: legal, community, and health services.

The endnotes in this section refer to the interviewees having raised the recommendations listed:

[1] Recommended by NGOs

[2] Recommended by in-hospital psychiatrists

[3] Recommended by ER doctors

[4] Recommended by GPs

[5] Recommended by private practice psychiatrists

[6] Recommended by substance users seeking treatment at NGOs

[7] Recommended by substance users accessed through outreach

[8] Recommended by DEBs

[9] Recommended by judges

[10] Recommended by MOPH

[11] Recommended by MOJ

[12] Recommended by MOSA

[13] Recommended by NGOs encountering substance users

[14] Recommended by social services' centers affiliated with MOSA

1. Legal level

1.1. Law implementation

1.1.1. Respecting the Charter of Human Rights is a must[1].

1.1.2. There should be a full implementation of the Law # 673 (Appendix 1). All those involved in the field should adopt the philosophy of decriminalizing addiction by accepting the need for treatment of substance dependent individuals, and articles of the law that ensure unbiased medical treatment for substance users by treating them as patients rather than criminals should be enforced. Arrested substance users should be given the choice between treatment and incarceration instead of being sent directly to prosecution[1,2,3,4,5,6,7,13,14], except in cases where drug use is the main reason for committing criminal acts[9].

1.1.3. In virtue of articles 124-140 of law #673, the establishment of a Lebanese DAC is decreed. This committee is not active yet but should be operational because it is responsible for referring drug users to treatment centers free of charge through the MOPH[8]. Also, the DAC must consider providing counseling and assistance in the substance dependence field[9].

1.1.4. The National Council for Drugs (NCD), as dictated by article 205 of the law (Appendix 1), should be activated[10]. NCD, composed of different ministers (including the Ministers of Public Health, Justice, and of Social Affairs) and an assigned secretary general, has a major role in fighting the War on Drugs, setting up national action plans and policies, offering treatment and prevention activities, coordinating between different parties concerned with the matter of substances and substance use, and distributing budgets allotted for the matter of drugs among the ministries as well as contributions given to non-governmental bodies eligible to receive funding.

1.1.5. Article 182 of law #673 (Appendix 1) should be enforced[8].

1.1.6. The legal system should distinguish between substance users and dealers[1,13]. The sentences of the detainees for drug use accusations need to be reduced and their rights protected[9], with a focus on arrests of traffickers. Tighter regulations/stricter sentences for drug trafficking including cultivation, control on imported drugs and drug distribution2 as well as dealing should be made[4,5,6,7,8,9,14].

1.1.7. Supervision of nightclubs as well as refugees' camps with regards to potential drug use, dealing, and other drug-related actions should take place[8].

1.1.8. The prohibition of the sale of alcohol and cigarettes to those under the age of 18 must be monitored closely[8]. Also, existing rules and regulations regarding the use of illegal drugs should be enforced3.

1.2. Law amendment

1.2.1. An alternative to the DAC (that has not been activated since 1998) should be created by developing a system of referral between the healthcare and judicial systems working in the addiction field[13]. It was recommended that the system be standardized with a clear work plan, an assignment of experts (e.g. psychologists, psychiatrists, social workers) working in the Hall of Justice and assisting judges, documentation, a comprehensive guide of treatment centers, and follow-up[1,6,9,13].

1.2.2. Criminal records related to drug use accusations inhibit the possibility of engaging in a productive life after completion of treatment[6,7]. Records of substance users should be cleared[1,5,9].

1.2.3. It is imperative to reconsider some articles of the Law on Drugs governing the role of the Public Prosecution. These include the potential measures that could be taken by the Public Prosecution as alternatives to the punishment, the presence of physicians affiliated with the Public Prosecution or House of Justice, and the communication and coordination between the prosecution and the treatment facilities[1].

1.2.4. The law should also promote and influence referrals among health services providers, namely NGOs and hospitals through networking based on a clear work plan, documentation, and the creation of a comprehensive guide listing existing services[1].

1.2.5. Specialized laboratories affiliated with the government should be established to verify the detainee's drug use status[9]. Physicians should coordinate regularly with the ISF to monitor cases of substance dependence[5], and social workers should be present at police stations[14].

1.2.6. Substance abuse and dependence prison programs should be created for the large numbers of incarcerated drug users. Also, a separate unit for substance users should be established in prisons[1]. This section should include the basic resources guaranteeing the preservation of prisoners' rights[6]. Specialized doctors should also be available in prison to treat substance users and provide them with appropriate medication[4]. Furthermore, the prisons' security regulations should be adapted to cater to the ongoing treatment of substance users serving their sentence[1].

1.2.7. The law 212 of MOSA, not part of the Law on Drugs (Appendix 1), should be amended to further involve the MOSA in the field of addiction[12,14].

1.2.8. Standards should be set in defining drug dealing; for instance, facilitation should be distinguished from dealing[13].

1.2.9. It is imperative that the amount of drugs legally possessed by any individual be standardized across countries[9].

1.2.10. The Law should be amended so that more forceful measures are taken by the legal system with respect to alcohol abuse[5].

1.3. Ministries' involvement

1.3.1. The government should have an active role in the addiction field. Every Ministry, depending on its area of expertise, should further put forth services in the community (e.g. MOPH for treatment, MOSA for prevention campaigns)[14]. The government

should prioritize the issue of substance dependence and thus offer maximum care to substance users seeking treatment[5,6]. A mental health department, including substance dependence, within the MOPH, should be established[10].

1.3.2. Resources originating from the MOPH are essential. These include additional funds allotted to treatment centers[13], particularly NGOs, which will allow treatment centers to increase their capacity, to reduce their treatment costs, and be located in all governorates of Lebanon[1,2,3,4,7,8,9,10,12,14].

1.3.3. Treatment centers for substance dependence should be governmental or under the direct supervision and guardianship of governmental parties, such as MOPH, MEHE, MOSA, MOJ or NGOs officially recognized by the government [9,11]. MOPH should also evaluate treatment outcomes of various facilities[1].

1.3.4. MOPH should legalize opiates substitution treatment and design a system to ensure its implementation, which must be put in place to ensure the effective, professional, sustainable, and ethical implementation of substitution treatment[1,2,4,5,14].

1.3.5. Pharmacies should be monitored by MOPH and made aware not to dispense psychoactive medications without a doctor's prescription, as they could lead to abuse or dependence[1,9].

1.3.6. The MOPH should include substance dependence treatment costs within the social security[4].

1.3.7. The government should aim at treating equally individuals with substance dependence of different SES[7].

1.3.8. Prevention can have a stronger impact if supported by the Ministries. MEHE was encouraged to emphasize prevention in schools and integrate prevention into the school curriculum. Also, it is important that MEHE increases its funding for prevention and awareness and directs research-based prevention[14]. MOSA should establish a national strategy covering universal, selective, and indicated prevention to achieve effective interventions for the community as a whole[1].

1.3.9. The MOSA should also design a clear strategy for pre and post-treatment interventions[14].

1.3.10. The referral system between the MOSA and treatment centers should be improved by an agreement between the two parties. Ministries should put in place a procedure and documentations to make the referral process more systematic. As part of this, a guide that includes the contact information of all treatment centers should be made available to all MOSA centers to facilitate the referral of substance users to appropriate centers without going through a third party. MOSA should provide funds for these initiatives[14].

1.3.11. The government should provide employment to substance users[7].

1.3.12. Promoting the prohibition of drug use through the media (T.V. programs, advertisements...) is key[8].

1.3.13. There should be coordination among all ministries (Public Health, Social Affairs, Justice, Education and Higher Education, Youth and Sports) to address matters related to substance use/dependence[9,12]. An inter-ministerial mission should be designed to better control government-based endeavors in terms of substance use and dependence control[1].

1.3.14. Proper coordination between MOSA and MOPH should take place to treat substance users in public hospitals and to create a reception bureau for MOSA in these public hospitals[12]. MOSA and MOPH should initiate prevention initiatives in collaboration with specialized centers to conduct prevention campaigns in the community[14].

1.3.15. A joint committee of all those involved in the field of addiction should be established at the legal level[7], with the creation of a work protocol by MOPH applicable to all treatment centers. The protocol should be based upon clear principles and should represent a joint vision between all parties involved. This requires a working mechanism including both human and financial resources[14].

1.3.16. A network between NGOs and government officials to follow-up on cases of substance use and relevant issues should be established[5].

1.3.17. Ministries' involvement in research is key. The need for a nationally coordinated approach to data collection was highlighted by the suggestion of creating a drug information system. The system must collect comprehensive, detailed and in-depth data.

It should provide effective early warning of new trends in illicit drug markets, and constitute an important component of the overall approach to the monitoring of drug use and its associated harms[1,5].

1.3.18. Government-supported trainings should be presented to judges[9] and MOSA centers' staff to increase their capacities in the field of drug use and addiction. Training of judges, specifically, should revolve around substance dependence, treatment modalities, and effectiveness of treatment versus incarceration and must be made part of their curriculum by the MOJ[1]. Prevention officers in social services centers should be trained to learn and use their skills in prevention, follow-up and social reintegration with substance users[14].

2. Community level

2.1. All parties interviewed deemed awareness crucial2. Awareness should be raised in many settings and through many mediums: it was suggested to occur in the community[1,7,13,14], schools/universities[4,5,7,9,14], families[6,9,14], and via the media (television, radio, and internet)[4,9,14]. Many communicators wished and/or were advised to be involved: prevention officers at NGOs, at MOSA social services centers, social workers, GPs, psychiatrists, and even judges and police officers. Topics suggested were the types and effects of substances, the symptoms and consequences of substance dependence, and changing misconceptions about substances[4,9,14].

2.2. Prevention must be conducted at many levels (community, school, family)[8]. It should be aimed at reducing risk factors leading to substance use[4,7]. These risks include unemployment, family issues and dropping out of school[9]. It is also important to empower recipients to resist the temptations of drug use[9]. The presence of a psychologist for students is essential in every school to help students solve personal and familial problems and avoid risky behaviors[14]. Many also advocated alternative activities for youths such as after-school programs[1]. Moreover, promotion of education and positive values should be emphasized[4].

2.3. Social services centers affiliated with the MOSA should have a more extensive role in preventing substance use[13].

2.4. It is important to introduce the concept of evidence-based prevention that can help prevention practitioners use the results of effective and culturally sensitive prevention research to address drug abuse among children and adolescents in communities across the country[1].

2.5. Experts in the field should carry out ongoing research on substance use and dependence[1,9,14].

2.6. It is important to fight the stigma surrounding substance use[1,6]. Job opportunities for substance users should be made available[6].

2.7. Families should provide supervision and support to drug users, and they should work on helping them rather than humiliating them[9,14].

2.8. There should be more monitoring in schools and universities for substance users and dealers. School and university staff should also be aware of the issue to monitor students' behaviors[14].

3. Health facilities level

3.1. Treatment centers

3.1.1. It is essential to increase the number, and capacity of treatment facilities, as well as funds directed to treatment centers[1,2,3,5,6,7,8,9,13.]

3.1.2. Information regarding treatment centers' occupancy status should be made public[9].

3.1.3. Treatment centers should provide different and all modalities of treatment1[,6,7], and be adequately equipped2.

3.1.4. Treatment centers in all governorates of Lebanon should be instituted[1,5,13,14]. Establishing public treatment centers in the North governorate was deemed especially important[8].

3.1.5. Services for substance users should be decentralized, increasing the availability and accessibility to treatment centers[1].

3.1.6. In rural areas, there should be treatment centers, both public and private, working in parallel with social services centers[14].

3.1.7. Treatment centers (NGOs and hospitals) should be free of charge to those accessing their services including the cost of medications[2,4,7,9]. If this is not possible, facilities should provide affordable services[5,6].

3.1.8. Health facilities should be qualified to meet the needs of substance users especially those going through withdrawal symptoms[7], and doctor-patient confidentiality should be emphasized3,[7]. All improvements with respect to treatment of substance dependence should involve human resources knowledgeable about substance use and able to help individuals with substance dependence[5].

3.1.9. Public hospitals should have specialized professionals and clinics which treat substance users and a system of coordination should be established between MOPH and these public hospitals[14].

3.1.10. A system of referral should be developed with an established protocol among treatment centers, both NGOs and hospitals3. The system should be sustainable, practical, and accessible2,[13]. NGOs should cooperate together and create a synergic strategy in order to cover and offer all modalities of treatment, unifying them and benefiting substance users within the local framework of available services[1].

3.1.11. There should be an efficient long-term hospitalization system including detoxification and rehabilitation programs2.

3.1.12. There should be a psychiatry unit in the ERs of all hospitals so that immediate interaction with the substance user is made upon his/her arrival. In any case, ER doctors, nurses and other ER staff should be trained to handle all substance-related cases from intoxication to withdrawal symptoms in ERs3,[4].

3.1.13. More GPs need to be trained to work with substance users and courses on awareness of substance use, abuse, and dependence as well as suicidal ideations should be integrated into the university curriculum of physicians[4].

3.1.14. Free walk-in clinics for treatment of substance use/dependence are essential[5].

3.1.15. Dispensaries for mental health, including substance dependence, should be made available especially in the Beqaa[14].

3.1.16. Social services centers need to undergo extensive training to be able to deal with substance users and accommodate their needs[14].

3.1.17. A section within MOSA centers for substance dependence should be put in place. Two options were suggested: doctors working at the MOSA centers can ensure follow-up on drug use cases and referral of substance users to appropriate treatment centers, or a system within social services centers can be designed where doctors from different treatment centers specialized in addiction ensure routine visits to the social service centers to handle drug use cases. The availability of the doctor and a psychologist would create an incentive for treatment as it would motivate the patient and would allow eradicating the stigma surrounding those who consult psychologists and psychiatrists especially in the Nabatieh, North and Beqaa governorates[14].

3.1.18. NGOs should base their treatment services and any other types of interventions on evidence-based facts[1].

3.1.19. Specific interventions should be made available for juvenile delinquents facing addiction problems[14].

3.1.20. Treatment of substance dependence should be covered by private insurance[3].

3.2. Treatment services

3.2.1. Medications are a major part of the treatment process. Thus, opiates substitution treatment, which play an essential role in handing withdrawals, preventing relapse, and decreasing viral infections should be made available[1,2,6,7,14].

3.2.2. There should be a hotline for substance use/dependence within hospitals3 and NGOs to provide substance users with immediate assistance[4,5].

3.2.3. To improve the family environment of the drug addicts, we should provide outreach programs including house visits2 and family support[6].

3.2.4. A case management system to provide appropriate referrals must be devised[3].

3.2.5. It is important to work on increasing the number and capacity of outpatient treatment centers in order to guarantee cost-effective services to as many substance users as possible[1].

3.2.6. Harm reduction services, essential for disease prevention, overdose prevention, and better legal and social protection of drug users, should be made available[5]. Medications preventing overdose must be used[7].

3.2.7. Treatment centers providing psychological therapy for mental health and addiction, faith-based therapy, and hospitalization are needed[6].

3.2.8. There is a need for aftercare programs to allow for post-treatment follow-up[13], namely centers able to help users in securing employment and housing[5].

3.2.9. The importance of 28-day treatment programs, and Alcoholics Anonymous/Narcotics Anonymous programs was stated[5].

3.2.10. Substance users should benefit from recreational activities[7].

RESULTS OF SECONDARY DATA ANALYSIS

Psychiatric Hospital of the Cross

The Psychiatric Hospital of the Cross has received an average of 302 substance users from 2003 to 2008, most of which were males. Around half were between the ages of 20 and 29 years old and had attained complementary education. 64% to 71% were single, and the rest were mostly married. Approximately a quarter of patients used alcohol as the substance of choice (Table 1).

TABLE 1 *NUMBER AND DEMOGRAPHIC CHARACTERISTICS OF PATIENTS, 2003-2008*

	2003	2004	2005	2006	2007	2008
Number of drug users	235	320	317	294	330	316
Gender						
Male	216	280	285	246	289	290
Female	19	40	32	48	41	26
Age						
Less than 20	17	12	23	18	23	28
20-24	69	108	111	80	93	64
25-29	27	38	63	73	57	88

30-34	23	33	27	27	44	27
35-39	28	25	18	21	27	26
40-44	24	32	20	16	34	22
45 and above	47	72	55	59	52	61
Education						
Illiterate	5	1	7	0	4	1
Primary education	58	67	71	55	58	44
Complementary education	107	179	169	153	151	162
Secondary education	30	35	51	38	52	54
Technical education	0	0	0	0	0	0
University education	35	38	19	48	65	55
University degree	0	0	0	0	0	0
Civil status						
Single	160	201	225	202	211	207
Married	65	95	79	78	101	96
Divorced	4	21	10	11	6	8
Separated	3	2	1	2	7	4

Widowed	3	1	2	1	5	1
Main substance used						
Drugs	168	237	257	211	230	239
Alcohol	67	83	60	83	100	77

Soins Infirmiers et Développement Communautaire (SIDC)

1. Data collected through outreach

1.1. Number of participants

Injecting drug users (IDUs), men who have sex with men (MSM), and female sex workers (FSW) were accessed via outreach (Table 1.1).

TABLE 1.1 *NUMBER OF INTERVIEWEES PER CATEGORY, 2009*

Intravenous drug users (IDUS) (N)	1701
Men who have sex with men (MSM) (N)	764
Female sex workers (FSWs) (N)	1382

1.2. Injecting drug users (IDUs)

Around 60% of IDUs interviewed were located in Beirut and Mount Lebanon (Table 1.2.1). Most were males and Lebanese. A good number was between the ages of 21 and 30 and single. As for their educational level, a third did not know how to write or read, and the majority had not attained a university level (Table 1.2.2).

TABLE 1.2.1 *NUMBER OF IDUS INTERVIEWED BY GOVERNORATE, 2009*

	Beirut	Mount Lebanon	North Lebanon	South Lebanon	Bekaa	No answer
N (%)	499(29.3)	568(33.4)	247(14.5)	311(18.3)	67(3.9)	9(0.5)

TABLE 1.2.2 *NUMBER OF IDUS BY DEMOGRAPHIC CHARACTERISTICS, 2009*

Age	Less than 20	21-30	31-40	41-50	Older than 51	No answer
N (%)	158(9)	1065(63)	333(20)	63(40)	19(1)	63(4)

Gender	Male	Female	No answer
N (%)	1480(87)	68(4)	153(9)

Civil status	Single	Married	Widow	Live with partner	Divorced/Separated	No answer
N (%)	1126(66)	306(18)	17(1)	87(5)	133(8)	32(2)

Nationality	Lebanese	Non Lebanese	No nationality	No answer
N (%)	1458(86)	184(11)	1(0)	58(3)

Educational level	Illiterate	Knows how to read and write	Elementary	Secondary	Technical school	University	No answer
N (%)	160(9)	566(33)	294(17)	475(28)	77(5)	85(5)	44(3)

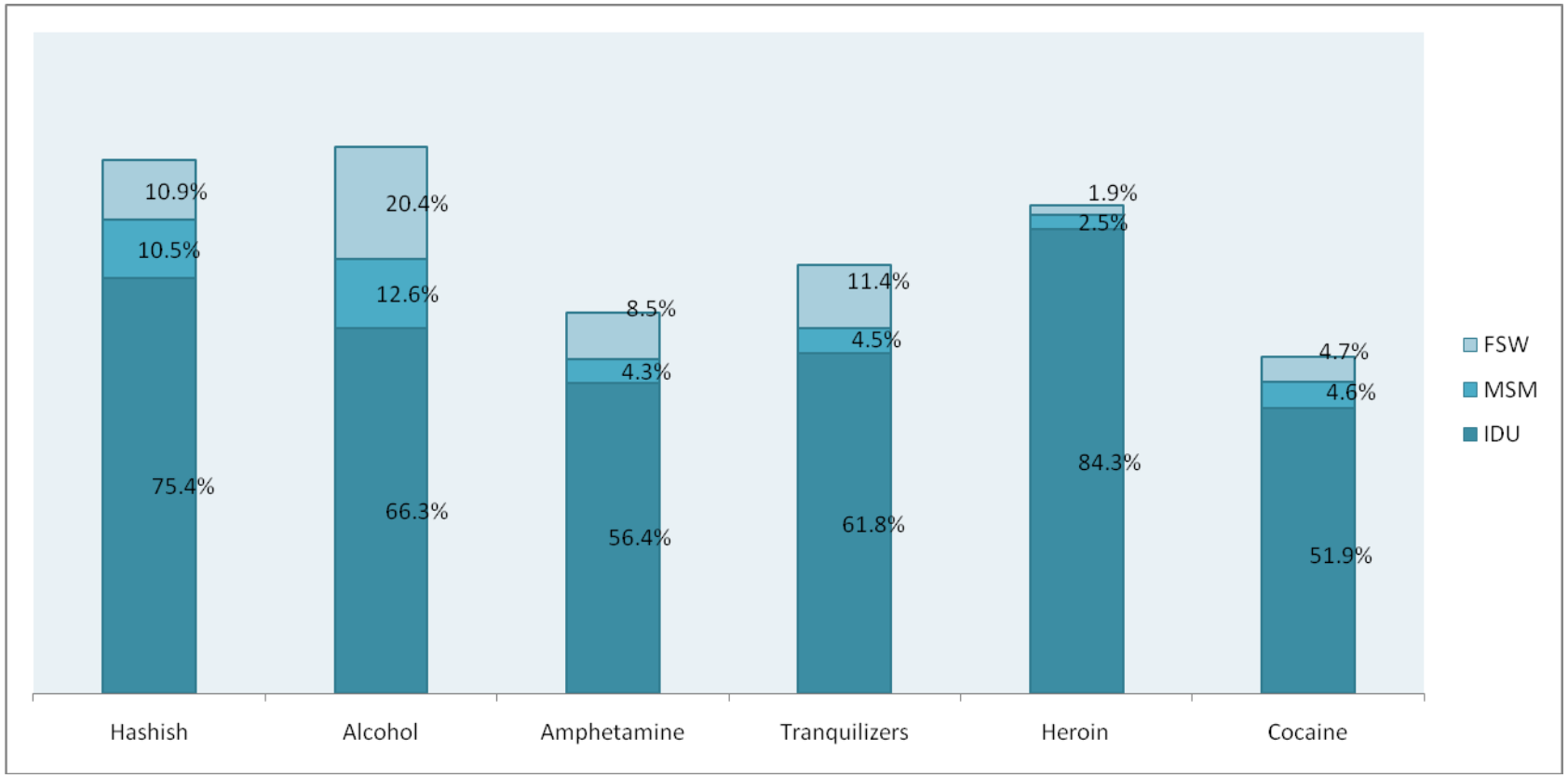
1.3. Drug use

When asked whether they were using substances at the time of the interview, 21% and 27% of MSM and FSWs, respectively reported they did.

Evidently, IDUs used substances to a larger extent compared to MSM and FSWs. The majority used heroin and cannabis (hashish), but all showed widespread use of substances. The percentages in Figure 1.3.1 add up to more than 100% which suggests that poly-substance use is common among this sample.

Among FSWs and MSM, the substances used the most were alcohol (20% and 13%, respectively) and cannabis (11%). Additionally, FSWs' substance trend shows the use of tranquilizers (11%) (Figure 1.3.1).

FIGURE 1.3.1 *DRUG USE BY TYPE OF DRUG, 2009*



The most common method of using substances was, for both MSM and FSWs, drinking and smoking. FSWs also reported using substances by swallowing (Table 1.3.1).

TABLE 1.3.1 *METHOD OF DRUG USE AMONG MSM AND FSWS USING DRUGS, 2009*

	Smell	Smoke	Inhale	Swallow	Drink	Inject
MSM N (%)*	41(5)	76(10)	15(2)	40(5)	91(12)	18(2)
FSWs N (%)	65(5)	145(11)	23(2)	146(11)	243(18)	15(1)

Individuals could report on the use of more than one method to consume substances.

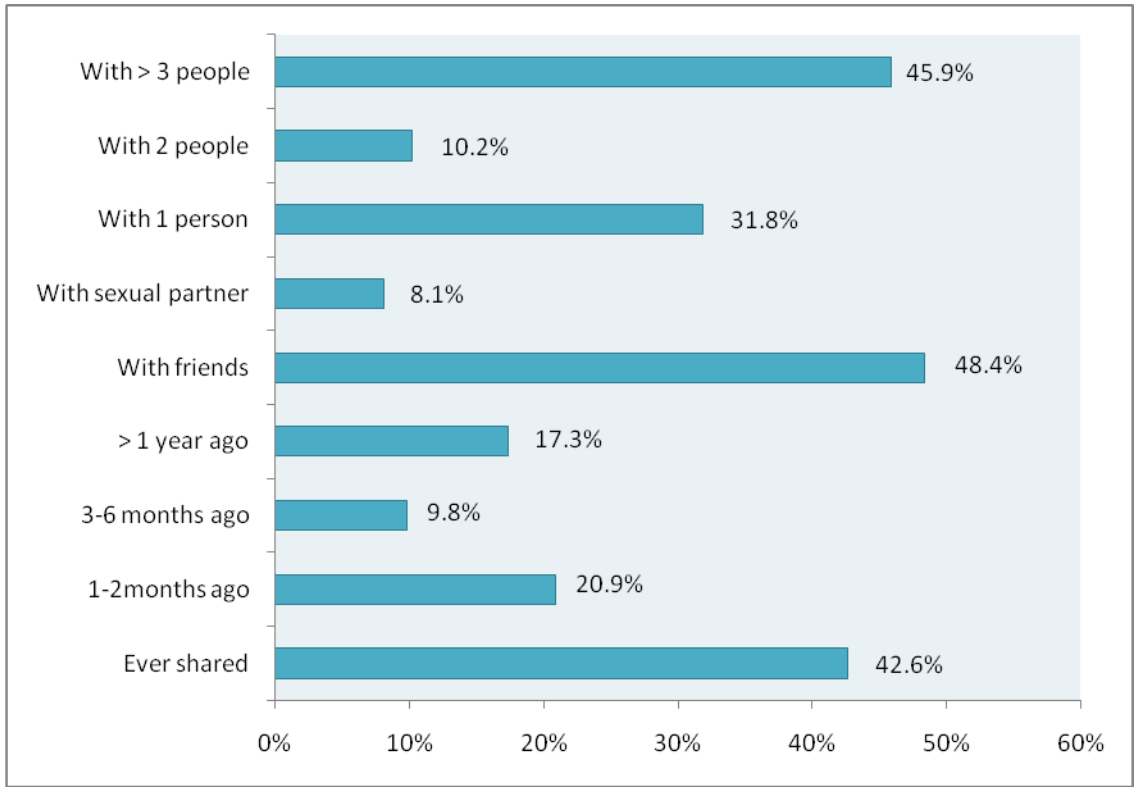
**Percentages were calculated by SIDC based on dividing the number of those using substances with each method by the total number of participants in the sample.*

Most IDUs reported using new sterilized needles when injecting (Table 1.3.2). However, the majority of IDUs does share needles. Around 43% had ever shared needles in the past and almost half had reported doing so with more than 3 people and with friends (Figure 1.3.2).

TABLE 1.3.2 *USE OF NEEDLES BY IDUS, 2009*

	Sharing needles with close person	Using the same needle many times	Using new sterilized needles
N (%)	204(12)	240(14.1)	1577(92.7)

FIGURE 1.3.2 *PATTERN OF NEEDLES SHARING BY IDUS, 2009*



1.4. Human Immunodeficiency Virus (HIV) testing

Most FSWs had not been previously tested for the presence of HIV, followed by MSM, and a little more than half of IDUs (Table 1.4).

TABLE 1.4 *PREVIOUS HIV TESTING, 2009*

	Yes	No
IDUs N (%)	747(44)	949(56)
MSM N (%)	267(35)	495(65)
FSWs N (%)	243(18)	1129(82)

Also, 66% to 75% of the interviewees had received information about HIV and sexually transmitted infections (STI). Hepatitis B and C were the most common STIs diagnosed among IDUs with a percentage of 4.2% for both in this sample. These infections were not as common for MSM and FSWs (0.5% and 1.4%, respectively).

1.5. Health services

More interviewees stated that they did not know about existing health services compared to those who were aware of their availability. They also felt that they would not benefit from these services (Tables 1.5.1 and 1.5.2).

TABLE 1.5.1 *KNOWLEDGE ABOUT HEALTH SERVICES, 2009*

	Yes	No
IDUs N (%)*	696(41)	961(57)
MSM N (%)	257(34)	496(65)
FSWs N (%)	198(14)	1176(85)

**Percentages were computed including missing values.*

TABLE 1.5.2 *PERCEPTION OF BENEFITING FROM SERVICES, 2009*

	Yes	No
IDUs N (%)*	255(15)	1398(82)
MSM N (%)	89(12)	657(86)
FSWs N (%)	44(3)	1309(95)

**Percentages were computed including missing values.*

If they requested any type of service, less than half of IDUs sought financial help, and 22% demanded medical services.

2. Data collected through peer awareness using mobile units

Similar data to the one shown here has been collected via mobile units. Results concur with the preceding and will not be shown here[15]. However, one finding is noteworthy: all individuals in the three groups (IDU, MSM, FSWs) tested negative for HIV; MSM and FSWs tested negative for hepatitis B, and all the FSWs tested negative for hepatitis C. MSM who tested for hepatitis C (N=14) all tested negative to the exception of one. Among the IDUs who were tested for hepatitis B (N=171) and C (N=202), 1 and 18 individuals tested positive for the respective infections (1 case was neither negative nor positive and labeled as "unspecified").

Hép Attitude Positive

The total number of individuals who presented at Hép attitude positive in 2009 was 40.

Based on the NGO's data, 75% of those with hepatitis B or C were substance users, thus 30 substance users visited the center. Overall, they were between 25 and 40 years old, generally not holding a school nor university degree, and belonging to a low socio-economic status.

[15] For further information related to this study, please contact SIDC at info@sidc-lebanon.org.

Drug Enforcement Bureaus

1. Types of drugs seized

TABLE 1 *QUANTITIES OF DRUGS SEIZED BY TYPE, 2009*

Type of drug seized	Quantities	
	Kilograms	Grams
Hashish	4092	561
Cocaine	16	203
Heroin	68	885
Marijuana	0	748
Unknown Powder	4	102
Cocaine mixed with heroin	0	839
Hashish plants	50005	690
Opium	20	19
Hashish seeds	3630	197

Type of drug seized	Quantities (N)
Cigarettes containing hashish	50
Narcotics	7813 pills
Captagon	1536033 pills
Benzhexol	1632 pills
Ecstasy	17312 pills
Lysergic acid diethylamide(LSD)	7 sheets; each containing 25 stamps
Syringe filled with unknown narcotics	371; each with a 3ml capacity
Syringes filled with various stimulants	1225; each with a 2ml capacity
Acetone	5 bottles; each with a 400 ml capacity

Amphetamine powder	0	1400

Ether	18 bottles; each with a 183 ml capacity
Cemo	134 bottles; each with a 100ml capacity

2. Number of cases by drug-related accusation and by area

In 2009, the ISF has arrested 2881 individuals involved in 1791 cases of drug use, dealing, facilitating, and other drug-related offenses (Tables 2.1. and 2.3). Most of these arrests were made within the country (Table 2.2).

TABLE 2.1 *NUMBER OF CASES SEIZED BY TYPE OF ACCUSATION, 2009*

Classification of the cases of arrests									
Cultivation	Manufacturing	Financing	Smuggling	Transporter	Dealing	Facilitating	Drug use	Other classification	Total
13	7	0	46	8	411	370	908	28	1791

TABLE 2.2 *NUMBER OF CASES SEIZED BY AREA, 2009*

Areas of arrests					
Land	Sea	Airport	Within the country	Unknown	Total
2	1	14	1774	0	1791

TABLE 2.3 *NUMBER OF INDIVIDUALS ARRESTED BY TYPE OF ACCUSATION, 2009*

Classification of accused individuals									
Farmer	Manufacturer	Financier	Smuggler	Transporter	Dealer	Facilitator	Drug user	Other classification	Total
2	5	0	60	10	127	420	2228	29	2881

3. Demographic characteristics of arrested drug users

Most drug users arrested in 2009 were between the ages of 18 and 35 (81%). However, in the earlier years of 2005 and 2006, the percentage of drug users in this age range was merely 41-55% as a larger percentage of older drug users was arrested. In 2009, males were overwhelmingly more arrested than females, and the majority of the arrested were employed at the time of the arrest (Table 3).

TABLE 3 *NUMBER OF DRUG USERS ARRESTED BY AGE, GENDER, NATIONALITY, AND WORK STATUS, 2005-2009*

Year	2005	2006	2007	2008	2009	2009 percentages (%)
Age						
Less than 18 years old	109	95	30	30	79	4
Between 18 and 25 years old	532	411	594	298	1002	45
Between 26 and 35 years old	295	180	620	1032	791	36
36 years old and above	571	764	404	268	356	16
Gender						
Male	1427	1385	1589	1561	2122	95
Female	80	65	59	67	106	5
Work status						

Unemployed			54	64	84	4
Employed			1462	1448	1977	89
Student			132	116	167	8
Total number of arrests						
	1507	1450	1648	1628	2228	100

Shaded areas indicate missing data.

4. Types of drugs used by arrested users

The substance that drug users were most arrested for was cannabis, for both males and females. It is followed by heroin and cocaine, although 6 times more females were arrested for the use of cocaine than for the use of heroin (Table 4).

TABLE 4 *NUMBER OF ARRESTED DRUG USERS BY GENDER AND DRUG, 2009*

M = male ; F = female

Cannabis (hashish)		Opium		Heroin		Cocaine		Marijuana and related drugs		Captagon		Various types of narcotic pills		Cemo and related drugs		Different types of unknown drugs		Total	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1120	49	0	0	404	7	377	44	3	0	2	0	139	2	14	0	63	4	2122	106

Skoun

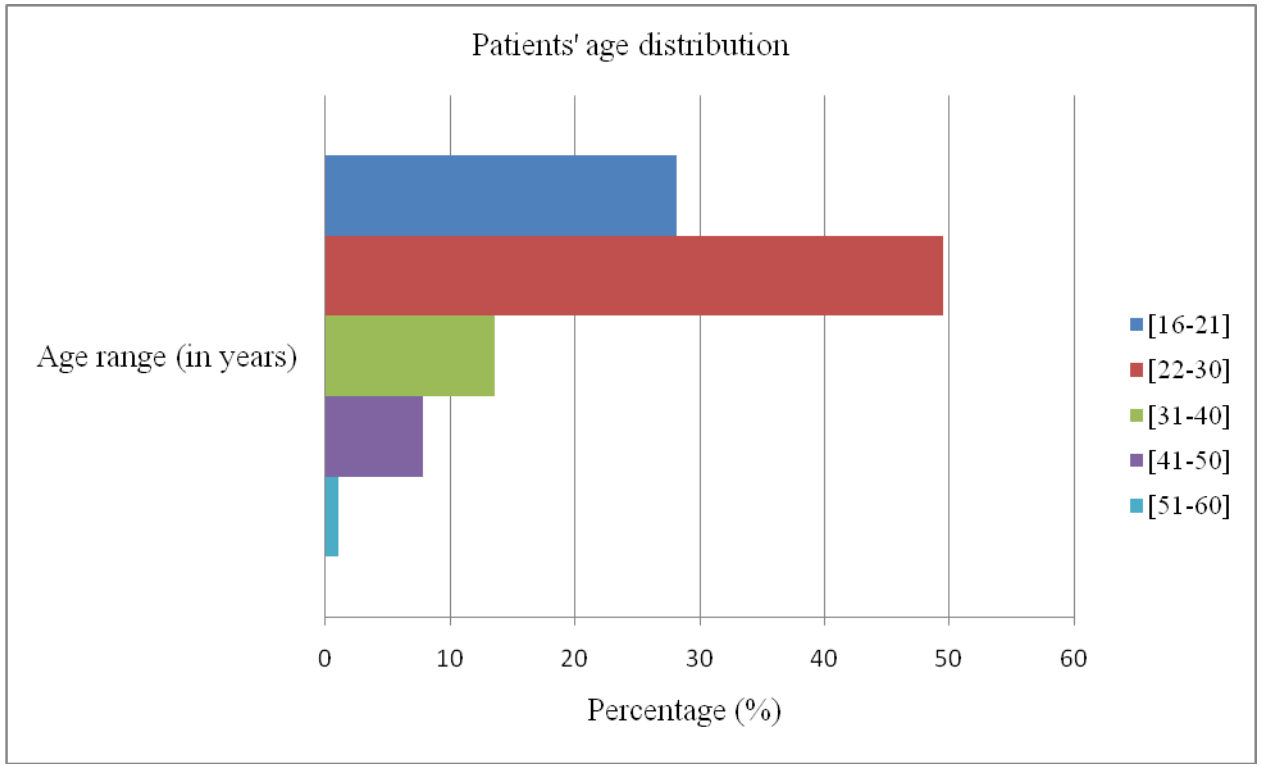
Skoun has received 115 individuals seeking treatment in the year 2009.

1. Demographic characteristics of Skoun patients

108 patients were male, while 7 were female, with a man to woman ratio of 15 to 1.

The mean age of Skoun's patients in 2009 was 26.59 years old (min = 16; max = 51). The majority of substance users were under the age of 30, and half of the patients belonged to the 22-30 age range (Figure 1).

FIGURE 1 *AGE DISTRIBUTION OF PATIENTS, 2009*

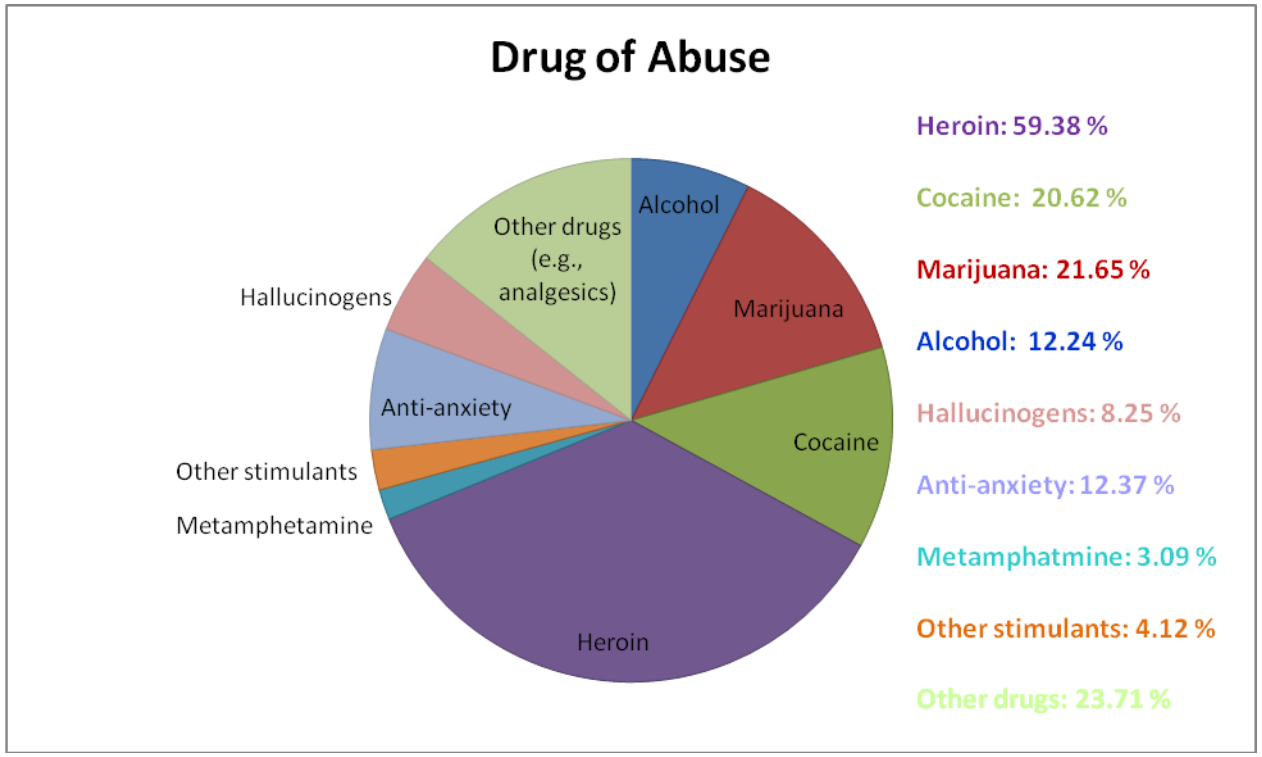


The average years of formal education among the patients was 12 years (N=115), and 81.25% of Skoun's patients earned less than 1,500,000 LL per month in the year 2009, whether it was income or an allowance (N=96).

2. Clinical characteristics of Skoun's patients

In 2009, a large percentage of Skoun's patients used heroin as their substance of choice. Other types of drugs (e.g. benzhexol), marijuana, and cocaine, follow, and are used by a little less than a quarter of substance users visiting the center. Other substances such as alcohol and anti-anxiety medications, are used to a smaller extent (N = 115) (Figure 2).

FIGURE 2 *PERCENTAGE OF PATIENTS BY TYPE OF SUBSTANCE USED, 2009*



Patients could report on more than one drug of abuse

With respect to injection, 42% had ever injected drugs, of which half were regularly injecting around the time of the interview while the other half used to inject but had stopped doing so (N=97).

3. Legal status of Skoun's patients

Patients were asked during intake if their substance use resulted in any legal consequence such as a lawsuit, incarceration, or other: 39% had faced a legal consequence for their use (N=96).

CHAPTER V

DISCUSSION OF FINDINGS

In the realm of understanding the current substance use situation in Lebanon, various parties involved in the addiction field were interviewed and many were representative of their respective populations (Table 1.2, Chapter III.). Data from a few remaining samples (e.g. substance users, social services centers affiliated with MOSA) should be interpreted with caution, as responses are limited to those interviewed who may not be representative of the general populations.

Still, this study allows us to identify trends of substance use, assess treatment services, legal implications of substance use and gather expert opinion on work in the addiction field in Lebanon. Being the most recent situational assessment conducted in the country (the last one was published in 2003), it provides new insights into the realm of substance use.

1. Demographic characteristics of Substance Users

The majority of substance users were between 18 and 24 years old. This was the case across all parties interviewed except for substance users accessed through outreach and those visiting in-hospital psychiatrists, who were in general 25 to 34 years old. The use of substances by younger people has a critical effect on their cognitive, physical, emotional and social state at an early stage in life. This highlights the need of planning, disseminating and enforcing an awareness and prevention strategy in schools and universities throughout the country, and among youth not enrolled in schools or universities.

Differences in gender were stable across samples as males were overwhelmingly more present than females. Two samples encountering females more than the other parties were psychiatrists in private practice and ER doctors (and, to a lesser extent, in-hospital psychiatrists). This suggests that females who may be seeking treatment prefer to do so within the confines of a private

practice, and visit the ER for emergent substance-related crises. Questions are asked as to whether females are less likely to use substances or less likely to seek treatment, because of socio-cultural norms and stigma. In any case, female substance users are also a minority of individuals arrested by the ISF for using drugs. It is important to note, however, that the number of arrested females in 2009 (N=106) has increased by 63 % since 2006. However, the total number of arrested users increased, and it would be interesting to investigate whether there is a real increase in the use of drugs among both males and females, or simply that the ISF are putting more efforts into arrests.

SES is relevant in defining the 'if' and 'how' substance users seek treatment. Indeed, data suggest that substance users from a higher SES are more likely to seek treatment. Also, interviewees working in diverse settings report different proportions of substance users belonging to a low, middle, and high SES. For instance, it appears that substance users encountered by NGOs being of low SES constitute the majority of patients, but are less prevalent in ERs. These findings highlight the fact that substance users come from all socio-economic backgrounds.

On one hand, as per health professionals' estimations, only half of substance users were employed; this was confirmed by substance users seeking treatment at NGOs whereby half are employed. On the other hand, 89 % of drug users arrested by the ISF were employed and the outreach sample, in majority, held a job. This difference may reflect the impairment in important social, occupational, and recreational activities that is characteristic of substance dependence diagnosis. Individuals seeking treatment, a clinical sample, may have lost their job or have difficulty finding one. Nevertheless, it appears that overall, at least half of substance users, if not more, hold a job and arresting them not only leads to an occupational impairment but also impedes their access to care.

2. Clinical characteristics of substance users

2.1. Age of onset of substance use

The average age of onset of use for any substance, calculated across samples, was 16 years old. The age of onset for the substance of choice was around 19 years old. The mean duration of use for the substance of choice before coming into treatment for the first

time was 4 years. Responses provided by interviewees were consistently similar (e.g. the range of the mean duration of use was 1 year). As a result, these figures appear to be close to the reality of the situation in the country and highlight the importance of awareness and interventions done to conduct substance users to seek treatment the earliest possible.

Regarding age of onset by gender, in both samples of substance users, males started using any substance, including the substance of choice, earlier than females. In understanding this result one must reflect on the social and cultural norms and values imposed differently on men and women in Lebanon. One possibility is that men usually have less parental constraints than females and thus might be offered more opportunities to start substance use at an earlier stage.

2.2. General trends of substance use

Opioids, cocaine, and to a lesser extent cannabis, were the types of substances ranked highest, in terms of substance use, by NGOs treating substance users and psychiatrists, both in hospitals and in private practice as well as by substance users seeking treatment. These substances were also the most arrested for by the ISF in terms of use. Also, users accessed through outreach showed that individuals using these substances do not necessarily seek treatment given that the majority of outreach users were not seeking treatment and were still using cannabis, cocaine, and opioids. Other common substances include sedatives and tranquilizers, amphetamine-types and hallucinogens.

Alcohol is highly ranked among ER physicians as they welcome a high number of alcohol-related conditions. Alcohol was also ranked first as the substance of choice by 20% of the outreach sample. These individuals were not actively seeking treatment and may resort to ER visits for various substance-related emergencies (accidents, violence, overdose…) and not more intensive and specialized treatment when in need. This can be explained by the fact that alcohol is not an illegal substance and therefore doctors in the ER do not report such cases to the ISF. Hence, individuals visiting the ER for alcohol-related issues may be less fearful than those using other substances. This identifies a need to focus on alcohol consumption in both aspects of prevention and treatment.

A few ER doctors provided further information by admitting that sometimes, when they receive substance users who has used any type of substance other then alcohol, they report the substance admitted for as alcohol. They do not want to legally abide to a law

they perceive as unconvincing to them and unfair to substance users. Cases of use of other substances may therefore have been underreported, and that of alcohol overreported. This does not compromise the finding that many individuals do go through alcohol-related emergencies, such as injuries, loss of consciousness, withdrawal symptoms (e.g. vomiting, hallucinations), or poisoning (e.g. mental confusion, seizures, hypothermia)

2.3. Specific trends of substance use

Cannabis-type

Health facilities and other service providers did rank cannabis (hashish, marijuana) as one of the main substances of choice used by patients, as did outreach substance users. Cannabis use is therefore recognized by a majority of those using and those working with users. However, even though it was used by the majority of substance users interviewed, cannabis use was generally ranked first by only a little more than a third of substance users at NGOs. Based on this data, if treatment is sought by a cannabis user, it may occur because of additional substances used (poly-substance use). Indeed, although they report using cannabis it is not usually the primary drug they are seeking treatment for. Also, it appears that cannabis users do not judge treatment for this type of substance use essential. They do not consider their cannabis use to be problematic. Through interviews with outreach workers, qualitative statements such as “smoking hashish is not a problem” and “just because I smoke hashish, does not mean that I am addicted” confirm this point. Contrary to the perceptions of individuals using hashish or marijuana, cannabis use can lead to dependence (Anthony, 2006; Ashton, 2001).

Opioids

The majority of substance users at NGOs used opioids, and 43 % ranked it as first among types of substances used. Moreover, its use was ranked first by 10 professionals specialized in the treatment of substance dependence from both the NGO and psychiatrists samples. It was also ranked first, second, and third by 4 out of 6 GPs. GPs may have recognized more opioids users because they provide alleviation of withdrawal from opioids, which is apparent when an opioid user visits a physician. Thus, GPs screening for the use of other substances which symptoms may not be as visible during a routine medical visit will further meet the needs of

substance users. In contrast, only 30% of outreach users used opioids as a substance of choice while heroin was the substance ranking highest among those seeking treatment at NGOs. The direct consequence of this observation is that the addictive nature of opioids and the social, psychological and physical toll it takes lends itself to high rates of people seeking help for heroin use. Furthermore, both NGOs and in-hospitals psychiatrists reported an increase in the prevalence of opioid use in 2009 as compared to 2007/2008, confirming the widespread use of opioids and substantiating the need for treatment services targeted to this specific class of substances.

Cocaine

68 % of substance users at NGOs and 66% of outreach users reported using cocaine, but a proportion of 11 % of treatment seekers and 18 % of outreach users ranked it first in terms of use. Still, cocaine use was highly ranked across all samples, according to substance users themselves and the ISF. Because cocaine is used widely but not necessarily the substance of choice of users, it would be interesting to investigate, in the future, the factors related to cocaine use (percentage of individuals using cocaine in combination with other substance, accessibility of the substance with respect to cost, and so forth).

Amphetamine-types

Amphetamine types were not as commonly encountered as previously listed substances among health professionals. However, substance users report using amphetamines which could mean that the use of this substance is irregular. Amphetamine-use was more widespread among substance users at NGOs (37%) than by the outreach sample (9%), and although the use of amphetamine-types is contained, the percentage of its use as a first substance of choice was identical across the two samples and equaled 4%. Furthermore, NGOs appraised that the use of amphetamine-types has increased in 2009 as compared to 2007/2008. This figure, albeit small, draws attention to the fact that use of all types of substances, including amphetamine-types, needs to be monitored. It is therefore important not to categorize them only as “recreational drugs” which do not utterly impact users’ lives.

Sedatives and tranquilizers

Sedatives and tranquilizers were regularly encountered and reported by health facilities, and ranked first, second, and third, in particular in hospitals and private practices. Ranking sedatives and tranquilizers as second and third may mean that they may be

combined with other substances, which often leads to critical health consequences, such as when sedatives or tranquilizers are ingested with alcohol (which was ranked first by most ER doctors).

Yet, they had lower rankings at NGOs specializing in the treatment of substance users. This means that individuals approach private settings more frequently than NGOs in the case of sedatives and tranquilizers. This difference in estimated patient characteristics may be due to several factors. First of these factors is the perception of substance users. Dependence to this category of substances is perceived by users to be the result of misuse of legal therapeutic agents. Therefore visiting doctors, whether psychiatrists, GPs, and ER physicians, seems more appropriate than NGOs, which in their eyes are centers specialized in the treatment of illicit drugs (e.g. heroin, cocaine). The second factor relates to the variety of reasons sedatives and tranquilizers are used. Indeed, suicides, whether attempted by substance users or not, is commonly attempted through an overdose of sedatives and tranquillizers (The Committee on Public Health, 1964; Tournier, Grolleau, Cougnard, Verdoux, & Molimard, 2009). This explains the high ranking of this type of substances in ER doctors.

GPs may also observe the use of sedatives and tranquilizers when they encounter users asking for prescriptions of this type of substance. A proportion of the Lebanese population obtains these medications through pharmacies without proper prescriptions and uses them regularly without necessarily seeking treatment (Naja, Pelissolo, Haddad, Baddoura, & Baddoura, 2000), as is the case of 9% of substance users accessed through outreach, who claim that sedatives and tranquilizers were their substance of choice (and 35% of outreach users ingested sedatives/tranquilizers regularly). This highlights the need for proper control of prescription drugs and caution in using them, as 17% of substance users visiting NGOs for treatment did so because of dependence to sedatives and tranquilizers. NGOs encountering substance users without treating them also ranked sedatives and tranquilizers as first and second, which confirms their extensive use among users.

Lastly, both NGOs specialized in the treatment of substance dependence and in-hospitals psychiatrists observed an increase in the use of sedatives and tranquilizers from 2007/2008 to 2009.

Hallucinogens

Hallucinogens were ranked fourth by psychiatrists, both in hospitals and private practice, and sixth by NGOs. They were ranked last or before last by ER physicians and GPs. Hence, hallucinogens are not that commonly seen in health facilities, which corroborates

evidence that hallucinogens are typically used as recreational drugs and do not commonly lead to dependence. In fact, studies have discussed the fact that no consensus has been reached on whether substances like hallucinogens have addictive properties (Lüscher & Ungless, 2006). 7 % of outreach users have ranked hallucinogens as their substance of choice but considering the nature of this sample, substance dependence could not be diagnosed. Also, only 2 individuals seeking treatment at NGOs for their use of this type of substance, of which one was using many other classes of substances, such as opioids and cocaine. In this case, hallucinogens are one among many substances used by a poly-substance user.

Furthermore, a quarter of substance users at NGOs use hallucinogens, whether ranked first or not, as opposed to 8% of outreach users, which may reflect the clinical characteristics of treatment seekers for substance dependence: they generally explore the use of more than one type of substance (and may or may not combine them), which significantly affects their biological and psychological systems. In any case, in-hospitals psychiatrists have reported no significant change in the prevalence of hallucinogens use among substance users.

Solvents and inhalants

Solvents and inhalants were not in the first ranks of any sample, including those of substance users (only 2 outreach users and 4 substance users at NGOs have reported their use of solvents and inhalants). However, psychiatrists in hospitals and private practice ranked solvents and inhalants fourth. Hence, this type of substance is not commonly used, but when it is overly used or subject to dependence, individuals will consult psychiatrists. In any case, NGOs and in-hospital psychiatrists have reported no significant change in the prevalence of solvents and inhalants in the year 2009 compared to 2007/2008.

Alcohol

As discussed above, alcohol use ranking was highest among ER physicians. It was also used by half of substance users accessed through outreach and a third of treatment seekers. Surprisingly, it was not ranked by most NGOs specialized in the treatment of substance dependence or encountering substance users, even if all reported an increase in the prevalence of alcohol use in 2009 compared to 2007/2008. It may be that alcohol users typically do not visit NGOs specialized in the treatment of substance dependence, which they consider to be solely “drug treatment centers”.

Alcohol was seen by other health professionals (psychiatrists, GPs), above all psychiatrists in hospitals. This could be related to the aforementioned reason that NGOs are drug treatment centers, to the process of detoxification, central to the treatment of alcohol abuse and dependence, and to the consultation of physicians to treat alcohol related health conditions, such as cirrhosis, alcoholic hepatitis, and alcoholic cardiomyopathy.

Other substances

Any illicit substances that do not fall within the above categories were used by 7 out of 75 substance users at NGOs, and by none of the substance users accessed through outreach. However, this number may be underreported as substance users mentioned, on many occasions, their use of benzhexol, an antiparkinsonian agent which can be used for recreational purposes, when recalling poly-substance combinations used. Also, substances classified in the "other" category were seen in patients with substance dependence at hospitals and private practices. However, both NGOs and in-hospital psychiatrists have reported no significant change in the prevalence of use of these substances. Nevertheless, even if around half of ER physicians and GPs ranked them last, mention of other substances point to the fact that unidentified trends of substances may be emerging. This is worth further investigation.

2.4. Trend of substances by age

Substance users aged 18 years old or less and 18-24

Cannabis has been ranked number one substance used by adolescent and young adults in agreement across health care providers and samples of substance users. Opioids were generally recognized as second in terms of adolescent use. Yet, this finding was contradicted by the outreach sample that ranked cocaine as second. The prevalence of cannabis and cocaine rather than opioids within the population accessed through outreach may be explained by the fact that this is a non-clinical sample compared to the clinical one who use opioids, which leads to severe dependency resulting in seeking health care facilities, as mentioned previously.

The only sample that does not confirm those findings are psychiatrists in private practices who ranked alcohol first. This may mean that youth resort to private practices when faced with alcohol-related issues rather than to other health care facilities. These individuals may not be aware of the severity of their abuse or dependence to alcohol, since it is a licit substance and usually commonly used by the Lebanese population belonging to this age group (Karam et al., 2004) and will visit clinics as opposed to NGOs or hospitals specialized in the treatment of substance dependence. This observation is supported by the fact that the rate of poly-substance use of patients at private practices is not as high as in other samples (57%). Indeed, individuals between the ages of 18 and 24 years (which constitute a majority of private practices psychiatrists' patients) may therefore use alcohol only without regularly combining it with any other substances, a behavior which usually worsens the prognosis and leads to visiting specialized drug treatment centers. Such findings highlight the need for more awareness on the dangers of alcohol abuse and dependency risks, particularly among the "at-risk" university student population.

Substance users between the ages of 25 and 34 years old

The use of substances for the 25 to 34 age group clusters around the three substances ranked the highest: cannabis, opioids, and cocaine. This is explained by the fact that this age group constitutes the majority of both substance users' samples of the study. Opioids and cannabis were ranked first and second by all interviewees, except private psychiatrists who ranked opioids as second. This reflects once again the nature of this type of substance, as individuals dependent to opioids may seek treatment at specialized centers such as NGOs or psychiatry department of hospitals. This is evidenced by the fact that 85 % of treatment seekers at NGOs use opioids, as opposed to only 57% of outreach users not seeking treatment. It is important to remember that outreach users ranked opioids third after cocaine.

Substance users aged 35 years old or more

The substances of choice for substance users aged 35 and above are opioids, followed by cannabis, cocaine and alcohol, according to treatment centers and the sample of substance users seeking treatment. As for outreach users, the ranking came as follows: cannabis, cocaine, and opioids. The findings for that age group indicate that the general trend has not changed. The only sample not giving a high ranking to cocaine was psychiatrists in private practices, who ranked alcohol and sedatives/tranquilizers as first. Again, doctors in private clinics see a different population of adults seeking treatment than NGOs and in-hospital psychiatrists, as

this has been shown for previous age groups. This confirms the dissimilar perceptions towards the different substances in the eyes of the Lebanese population. Visits to treatment centers for detoxification, rehabilitation, or other type of intensive treatment are seen as specific to opioids. On the other hand, alcohol and sedatives/tranquilizers dependence, as they are commonly used by the Lebanese population, are not considered reason for treatment.

2.5. Trend of substances by area

Trends of substances by area were assessed among substance users accessed via outreach. Cannabis was ranked first in all areas. Opioids were also ranked first in all areas to the exception of Beirut (ranked third in Beirut). Other substances ranked first in some areas: cocaine in North Lebanon, Nabatieh and Beqaa; alcohol in North and South Lebanon. Cocaine was also ranked second in governorates of Beirut, Mount Lebanon, South Lebanon, and Beqaa. Finally, sedatives and tranquilizers ranked fourth in Beirut, Mount Lebanon and Beqaa but were rarely ranked in other areas. However, as seen in the data provided by the DEBs, the highest number of arrests for pills (defined by the DEBs as including amphetamine-types, sedatives/tranquilizers, and hallucinogens) occurred in North Lebanon. Based on this data, we can conclude that substance users in the North use more amphetamine-types and hallucinogens than in other areas of Lebanon. Still, some discrepancies appear: the number of arrests for cocaine in the North, for instance, was only 4, while many substance users living in this governorate have ranked cocaine first and second. This may reflect the emphasis of the DEBs on arrest for specific types of substance in some governorates, a trend of use which is just about emerging, or still, that these substance users are a hidden population and therefore at-risk (this is typically the case of those who can only be accessed via outreach).

2.6. Poly-substance use

In both samples of substance users, the majority of individuals were poly-substance users, with the highest rate seen among outreach users, 87%. Most of these substance users used cannabis and their combination of substances always involved cannabis: cannabis, opioids, and cocaine; cannabis, opioids, cocaine, sedatives/tranquilizers, and alcohol; and cannabis, opioids, cocaine, and

sedatives and tranquilizers. Health professionals also estimated rates of poly-substance use in this descending order: NGOs (80%), in-hospitals psychiatrists (73%), and private practice psychiatrists (57%), with the common combinations among these samples being cannabis and opioids. Psychiatrists in private practices may have estimated the lowest rate of poly-substance use because they may not screen for different types of substances used the same way that hospitals and NGOs do and for the reason that poly-substance users require a more implicated treatment at NGOs and hospitals.

2.7. Substance users' health status

Substance use is an important risk factor in developing hepatitis B, C, or HIV which are transmitted through injection. In fact, secondary data have shown that hepatitis B and C were the most commonly diagnosed sexually transmitted infections among IDUs (4.2%), which were not the case for other groups, such as men who have sex with men (0.5%). Injection is a risky behavior that must be targeted, especially that the MOPH indicated a large increase in the prevalence of infections among IDUs in 2009 compared to 2007-2008.

Hepatitis C was the most prevalent health condition as estimated by MOPH, all health professionals and calculated in samples of substances users, followed by hepatitis B, and then HIV.

The rate of hepatitis C reported by MOPH was higher than that estimated by health professionals. It is possible that treatment centers did not screen for hepatitis C and refused to treat those infected with the virus. Furthermore, the rate provided by MOPH may be more prone to generalization to the substance user population in Lebanon as, most likely, more centers report infection cases to the Ministry than those included in our study, increasing the sample size. However, caution should be taken when interpreting the rate of 28% reported by MOPH because double-counting may be at hand if centers have not assigned unique identifiers to substance use cases. Nevertheless, in one center specialized in the treatment of hepatitis C, the majority of individuals (N=30) visiting the center were substance users. We therefore have to be reminded of the intimate association between substance use and hepatitis C, and put an emphasis on the implementation of measures decreasing the spread of this infection, such as systematic screening, education, and harm reduction interventions.

The highest rate of hepatitis B was seen in hospitals, which are ultimately specialized in the treatment of this viral liver infection. Nevertheless, the range of rates of hepatitis B reported was not very large, and it seems the prevalence of this virus among substance users is low (figures range between 1 and 7%). The same conclusion applies to HIV/AIDS: in-hospital psychiatrists estimated a prevalence o 3 %, but NGOs, substance users at NGOs, and outreach users all reported a null rate of HIV.

It is worth mentioning that only 2 NGOs out of the 8 interviewed perform VCT for HIV. Moreover, the rate reported by NGOs is probably biased because VCT is not administered to all patients but only to those who volunteer.

To measure the occurrence of HIV/AIDS in the Lebanese substance user population, testing should be more extensive across all NGOs in areas of Lebanon. This initiative could be coordinated by MOPH, which has gathered data through centers providing VCT but has not, up until now, gathered national data on the health profile of substance users. Nevertheless, data are gathered by the Ministry through centers providing VCT. This is of particular importance since 4 NGOs out of 7 judged the rate of hepatitis B, C, and HIV/AIDS to have increased in 2009 as compared to 2007/2008.

Furthermore, 2 to 10 % of substance users interviewed, both seeking and not seeking treatment, were not aware of their health status with respect to the presence of Hepatitis B, C, or HIV. Secondary data collected by SIDC substantiates an active endeavor: even among vulnerable groups such as female sex workers, men who have sex with men, and IDUs, 56 to 82 % had not been tested for HIV. This is considerable and coupled with the aforementioned, highlight the need for effective awareness strategies regarding these infections as well as further and consistent testing by all health facilities to positively influence prognosis of substance dependence and reduce the spread of infections.

3. Substance use cases

3.1. Figures of substance use cases in 2009 and 2010

Seeking healthcare, 774 substance users approached 7 participating NGOs and 225 visited in-hospitals psychiatrists interviewed seeking treatment for substance dependence in 2009. Some of the larger health facilities specialized in substance use refused to participate in the study, which may have lead to an underestimation of number of substance use cases.

Moreover, based on those interviewed in 2010, substance users not actively seeking treatment, outreach sample, were far more present in number than those seeking treatment (319 vs. 75). It appears that many substance users are not in treatment which highlights the need to investigate factors related to the initiation, maintenance, and completion of treatment (these will be discussed in section 5).

Furthermore, 972 substance users visited ERs for a substance-related condition (overdose, poisoning, and withdrawal symptoms). This high number signifies that a good number of substance users visit the ER when their situation requires urgent medical attention. This highlights the importance of emergency interventions targeted to substance-related conditions and of ER staff (doctors and nurses) interacting with substance users.

The number of drug users arrested by the ISF increase: in 2009, 2228 individuals were arrested based on accusations of drug use only. Arrests of substance users have risen by 54 % since 2006, and numbers apply across all governorates of Lebanon. Also, an estimated 1175 substance use cases were processed by judges in 2009. This shows a much larger number of drug users coming into contact with the law as opposed to access to care.

3.2. Trends in the prevalence of substance use cases

NGOs and psychiatrists were asked about the prevalence of use of specific substances (section 2.3). The remaining interviewees, ER doctors and GPs, who may not have extensive exposure to substance use cases, were asked to generally describe the trend of the

prevalence of substance use cases in 2009 compared to the one or two previous years. Most of these physicians agree that there is a slight increase in the use of any substances from 2007/2008 to 2009. Even so, an increase, albeit small, denotes the need for an increase in prevention activities and expansion of treatment services.

Nevertheless, with respect to services, data show that users are more likely seek treatment in 2009 compared to 2007/2008 as more than half of health care professionals reported an increase in the prevalence of substance users seeking their services.

4. Treatment services in Lebanon

4.1. Geographical distribution of treatment centers

All treatment centers participating in the study, whether NGOs or hospitals, were located in Beirut and Mount Lebanon, to the exception of one NGO located in the Beqaa governorate[16].

Treatment services are therefore localized in the two governorates of Beirut and Mount Lebanon, with more NGOs in Mount Lebanon than in Beirut, and hospitals distributed almost equally across the two governorates. As seen across samples, a high number of cases of substance use is seen in these areas, and having treatment services is favorable. Only a minority of interviewees believed that the areas of Beirut and Mount Lebanon did not include proper treatment to substance users.

[16] Two NGOs specialized in the treatment of substance dependence, one with two centers located in Mount Lebanon and the other owning 6 centers in Beirut, Mount Lebanon, North, and South Lebanon were not interviewed. However, the latter only provides services to juveniles between the ages of 12 and 18 years old. Moreover, 5 hospitals treating substance users which were not interviewed were located in Mount Lebanon (N=2), Beirut (N=2), and South (N=1).

What stems out of this picture is the fact that, only one treatment center is present in each of the Beqaa and South governorates, and no health facility has been identified in North Lebanon and Nabatieh. Also, the only NGO working with prisoners is located in Mount Lebanon, which highlights the need of having NGOs in prisons located in other areas of Lebanon, namely in Tripoli (North Lebanon), Zahle (Beqaa), Joub Jannine (Beqaa), and smaller prisons such as those in Barbar Al-Khazen (Beirut), Tyr (South), and Amioun (North).

Service providers not treating substance users, such as the NGOs and MOSA centers interviewed, have seen a numerous number of cases in Beqaa, North, South, and Nabatieh, with the highest number of cases (60) seen by a MOSA center in Nabatieh. Most MOSA centers in Beqaa, North, South and Nabatieh reported not having an NGO, hospitals, or psychiatrists in their areas to treat individuals with substance dependence. Social services centers in North Lebanon and Nabatieh claimed that it would make an extensive difference to have health facilities for substance use in their areas. Treatment services therefore need to be established in all areas of Lebanon. The MOPH has reported that it will fund treatment of substance dependence in two governmental hospitals in which comprehensive detoxifications services are currently being launched; however these are located in Beirut and Mount Lebanon. The Ministry could take the initiative of supporting similar hospitals in other areas of the country in the future.

Health professionals confirmed this evaluation by agreeing on the fact that proper treatment does exist only in the governorates of Beirut and Mount Lebanon (Table 4.1).

TABLE 4.1 *LEBANESE GOVERNORATES LACKING IN TREATMENT OR PROPER TREATMENT AS OBSERVED BY HEALTH PROFESSIONALS, 2010*

	Beirut	Mount Lebanon	North	South Lebanon	Nabatieh	Beqaa
NGOs specialized			√	√		
In-hospital psychiatrists						√
ER physicians			√		√	√
GPs			√	√	√	√
Private psychiatrists			√	√	√	√

Even if varied, these responses certainly point to the fact that additional treatment centers in all areas of Lebanon excluding Beirut and Mount Lebanon will benefit the substance use population. A question left to answer is how to assess proper treatment. Throughout the interviews, proper treatment was defined as *services matching the patients' needs or having an adequate supply of services and therefore having a satisfactory coverage*. However, interviewees' individual definitions of "matching needs" or "adequate supply of services" and personal opinions of services existing incorporates a bias in the responses given. This sheds light on the need for accreditation of treatment centers with respect to quality of care in the substance use field. Only when basic standards are set will we be able to assess treatment services.

4.2. Availability of treatment services and human resources

Most NGOs interviewed had a large number of services and can therefore be considered comprehensive substance treatment services. Most NGOs were able to provide case identification, comprehensive assessment, case management, information, guidance, advice, withdrawal management, brief intervention, individual and group therapy for addictions, family support, legal support, aftercare support, and wellness-related activities. Still, half of the NGOs wished to be more focused on the family, legal, and aftercare support level.

All NGOs, with the exception of one, lacked short-term inpatient treatment and outreach activities. Each of these types of services is located in either Beirut or Mount Lebanon, highlighting the need to develop more services covering all areas in Lebanon. Specifically, short-term inpatient treatment was seen as a priority for 5 NGOs, thus establishing short-term inpatient centers or short-term inpatient services as part of existing clinics should be considered in the strategic plan of the MOPH, centers affiliated to the MOPH and existing treatment centers.

Moreover, although NGO team members were usually very diverse, including clinical and non-clinical members with specific qualifications, NGOs emphasized the need for human resources, showing that recruiting additional members is important, if not necessary. Counselors, nurses, researchers and administrators were the most in demand, and some required accountants. One of the NGOs interviewed entirely relied on volunteers which may limit the impact that this NGO could have on the treatment of its patients. Employing an even larger diversity of staff will meet the needs of patients. Counselors will improve case management and the clinical aspects of treatment, along with nurses allowing regular toxicology screening and proper medical support. Researchers will collect data on each NGO patient population which will serve as a pillar for evidence-based prevention and treatment, and administrators will organize further the structure and function of the NGO. Funding should be made available to NGOs for them to employ a trained and consistent workforce. The MOPH could delegate a representative visiting each center and assessing specific human resources needs in light of the aforementioned proper treatment, before providing financial support or human resources.

Hospitals also had a big range of services available: the most common were case identification, management, comprehensive assessment, withdrawal management, medications (psychiatric and for medical conditions), medical support, individual therapy for addictions, short-term inpatient treatment (which NGOs lacked), and family support. Services lacking were supportive housing, legal

support, outreach activities, and group therapy sessions for mental health. Most psychiatrists assessing their needs stated they wished to add some of these services, namely supportive housing and legal support. Psychiatrists also desired intensive outpatient treatment (or day programs), a specific type of outpatient service where patients spend 6-8 hours a day in the clinic. Also, most psychiatrists who evaluated their department's priorities believed a substance use hotline was lacking.

Psychiatry departments had a diverse team of clinical members, similar to NGOs, but which were present in larger numbers. However, hospitals rarely had non-clinical team members, such as prevention or development officers. Still, psychiatrists interviewed agreed that outreach activities were lacking in Lebanon, thus adding prevention officers or outreach workers to their staff may be beneficial in getting more people in treatment.

Additionally, private psychiatrists believed that drop in services, day/evening treatment, and wellness related activities, harm reduction services, and counseling for substance dependence were lacking in Lebanon.

Many centers offer a wide range of services to substance users. However, the variety of needs brought up by these interviewees show that many services are still needed in most areas of the country. Therefore, greater efforts should be made to fill gaps by prioritizing the services reported to be needed by most (e.g., legal support). To be able to do so, each treatment center should be classified by the government. Indeed, there is, yet, no proper terminology for treatment centers (detoxification center, rehabilitation center, outpatient clinic, and so forth). Classification of centers will allow the effective structuring of services and the possibility of identifying the most important services needed by the center.

4.3. Coverage of treatment services

Some NGOs interviewed provided their services to males only, and some to those belonging to a specific religion. Based on our data, the proportion of females seeing treatment is much higher in private settings (19% in psychiatry departments, 30% in ERs, and 25% in clinics) than at NGOs (0%). This highlights the fact that women are demanding treatment, though not approaching or accessing NGOs and coverage could play a role. It would be valuable to assess the demand of female substance users in Lebanon, particularly in areas outside of Beirut, where no NGO can admit them for treatment.

This limitation in coverage was not the case of hospitals. Nearly all hospitals interviewed provided their services to both males and females, to those of different nationalities, of different religions, and using different types of substances.

4.4 Accessibility

Only a minority of NGOs had a 24 hour service. As suggested by many interviewees, creating a 24 hour hotline for substance dependence would increase accessibility to services and prevent problematic behaviors such as drug dealing, lapsing/relapsing or overdosing.

With respect to capacity, 6 NGOs can accommodate a total of 314 patients. The 2 others did not provide their capacity limit, but taken as a whole this number does not measure up to the high demand for treatment in 2009. One of NGO's priorities for improvement is to increase their space, which confirms that the capacity of the center is a major obstacle in accessibility to services. We also suggest to NGOs to expand their outpatient services. Indeed, based on our findings, the NGO accommodating the highest number of patients per year (N=120) was an outpatient clinic.

However, NGOs were accessible with respect to cost, and many reported supporting part or all of the treatment of their patients whenever it was possible.

As for hospitals, most had a 24 hour service and could accommodate an average of 200 patients per year, with an inpatient unit of 12 beds. But half of patients visiting the psychiatry departments had to drive at least 20 minutes to reach the hospitals. It can be argued that since these hospitals provide an inpatient stay, the accessibility in location is not vital. Still, increasing the number of hospitals in areas where there are no centers could help in reaching out to those coming from a low SES background or those who have no guidance in their area. It is also important to raise awareness on the presence of the already existing hospitals and to disseminate information on how to contact them and access them through campaigns, television/radio ads, or educational sessions.

Still, hospitals are not accessible in terms of cost, with services provided to substance users costing an average of 243 USD per day. Two options follow for the less fortunate ones: visit an NGO or receive financial support from a governmental body to be treated in the most suitable center matching one's needs. As per the Law on Drugs, the MOPH should refer individuals with substance to dependence to a treatment center affiliated with the Ministry and cover treatment costs. Efforts should be made to implement this law and therefore the Ministry should affiliate with more treatment centers, preferably in all areas of the country.

4.5 Other services provided by those encountering substance users

Other service providers which are not necessarily specialized in the treatment of substance dependence are ER doctors, GPs, and NGOs involved in the mental health field. Most ER physicians and NGOs as well as half of the GPs routinely screened for substance use. However, their services revolve around emergency-related interventions, medical services, referrals, and case management. To be able to perform these services at their optimum worth, evaluating the presence of a substance problem is necessary. For instance, a GP may prescribe a different type of medications knowing that it may affect symptoms or withdrawal of a substance regularly used by the patient. Also, NGOs would be able to provide referrals to an appropriate center which would target substance dependence in a specialized fashion.

Nevertheless, NGOs encountering substance users and MOSA centers also provide career orientation, family and legal support when possible, which is a strength as these services are reported to be lacking by those specialized in the treatment of substance users.

5. Factors related to the initiation, maintenance, and treatment of substance dependence

5.1. Demand for treatment

At most NGOs specialized in substance dependence, a substantial number of patients have presented for treatment in 2009 but have not initiated it or completed it. Among 774 substance users wishing to enroll in a treatment program, only 321 (42%) were able to access services provided at each of the NGOs interviewed. This finding is similar to a study conducted by Karam et al. (2006); comparing Lebanon to other countries, although the prevalence of disorders, including substance dependence, in Lebanon and West Europe is the same, the number of individuals not receiving treatment was considerably higher in Lebanon than in West Europe. This suggests the pressing need to identify factors related to the initiation of treatment, which may reflect personal factors of the treatment seeker, and/or increase the accessibility, whether in location, cost, hours of service, or capacity as well as service availability of all centers existing in Lebanon.

5.2. Perception of substance use

Most substance users, whether seeking treatment at NGOs or accessed through outreach, had not sought treatment in the past, were not seeking treatment at the time of the interview (for outreach substance users), had discontinued treatment after the first consultation, or had not completed treatment because they were not willing to stop the use of substances or because they wished to stop on their own. They have also claimed that they had not sought or were not seeking treatment since they had not perceived addiction to be a problem. Most NGOs and psychiatrists confirm these points; psychiatrists noted an additional factor: high treatment cost. This factor, however, applies only to some settings as some NGOs provide treatment free of charge. All this points to the nature of drug use and addiction, and highlights the need for harm reduction interventions for these drug using populations.

Nevertheless, it is important to mention that a much smaller number of NGOs and of both groups of substance users agreed with the fact that treatment was not completed because of lack or loss of commitment to treatment. Thus, it seems that this factor does not carry a lot of weight after treatment is initiated and other issues related to maintenance of treatment must therefore be addressed. Duration of treatment is a factor which many substance users agreed was an obstacle in completing treatment.

5.3. Duration of treatment

Duration of treatment is a factor that affects NGOs and not hospitals (which provide withdrawal management and related services for an average duration of only 10 days). Both samples of substance users listed the duration of treatment (estimated at around 317 days by NGOs) as a powerful factor in treatment drop-out. In fact, 70 % of those at NGOs and 92 % of those accessed via outreach had not completed treatment in the past. Some mentioned that they could not stay long without a job and needed to support themselves or their families. Giving that the majority of substance users recognized the duration of treatment as a main factor hindering completion of treatment, practitioners, NGO directors, and others involved should consider outpatient services or short-term inpatient services to address this need.

5.4. Cost of treatment

The high cost of treatment was considered to be an influential factor by ER doctors, GPs, and substance users accessed through outreach in initiating, maintaining and completing treatment. The cost of treatment was not mentioned by those seeking treatment at NGOs. Sixty percent (60%) of the latter group had sought treatment in the past as opposed to only 27 % of the street sample. This possibly allowed them to discover inexpensive treatment opportunities and not consider the cost as a factor in their decision-making. Still, the majority of outreach users interviewed earned less than 12000 USD annually. All treatment services, including withdrawal management, should be made affordable to all those who wish to access them.

Most substance users interviewed depended on their family, loved ones, or the treatment centers to finance the cost of their treatment, rather than depending on one's self. An overwhelming majority believed that if they asked MOPH to fund their treatment, the Ministry would not be able to help. Substance users need to be made aware of the fact that the Ministry has covered the treatment costs of 1562 substance users in 2008-2009, as reported by the MOPH representative. However, only 3 treatment centers are affiliated with MOPH in Lebanon, so patients must pay to initiate and maintain treatment at many other facilities.

Half of NGOs and most psychiatrists (both in hospitals and clinics) highlight the importance of cost in their respective centers by agreeing that the government's support and follow-up is an influential factor in the completion of treatment. The lowest drop-out rate was seen at NGOs (28%), which may be explained, among other reasons, by the lower cost of treatment than that seen at hospitals (reporting an average dropout rate of 50%) or clinics, whereby most fees are paid by the hour to the individual psychiatrist. Cost is therefore an essential factor and can be reduced by the MOPH further funding existing treatment centers, individual substance users, or create a free governmental treatment center. Any of these alternatives will reduce the demand for treatment and lower drop-out rates.

5.5. Treatment center's capacity

When asked why they had discontinued treatment after the first consultation, or were not able to receive treatment they had sought, both samples of substance users agreed that there were no vacancies at the time and they were put on a waiting list. These two factors reflect the limited capacity of treatment centers in Lebanon and are intricately linked to funding. These factors point towards increasing space and human resources at existing centers or establishing additional centers.

5.6. Treatment services

When substance users accessed through outreach were asked why they had not completed a treatment program in the past, most agreed that the services at the center had not matched their needs. Also, the majority of all substance users who had sought treatment more than once in the past had returned to a different center, and many had done so because the services they had received previously had not matched their needs. It is therefore important that a referral system between NGOs is put in place. Also, patients should enter a treatment program with the full understanding of what it entails (services available, alternative options in other centers, and intensity and duration of treatment) so that they can make an informed decision when committing to treatment. In addition, after initiation of treatment, an assessment of the outcome of treatment may allow the members of the

center to check that progress is being made, to reassess, and to take appropriate measures. We would be able to decrease the rate of drop-outs, and respond to patients' needs.

5.7. Refusals

NGOs denied access to treatment to an average of 24 substance users in the year 2009; the main reason being their needs not matching the services provided by the NGOs along with their co-morbidity with other mental illnesses. The first reason is an advantage to the patient who will be referred to a center accommodating his needs. The second reason may be limiting in our country where the number of institutions treating substance users with mental health conditions is minor. Moreover, two NGOs could not provide treatment to substance users because they had substance-related infections such as hepatitis C or HIV. Efforts should therefore target recruitment of staff able to deal with individuals having a difficult health status as this population is one of the most vulnerable. Lastly, two NGOs refused to treat substance users because of their sexual orientation. Reasons for these specific exclusion criteria are unknown. However, irrespective of their nature, it is important that these reasons do not translate into active discrimination that might interfere with the provision of treatment to those who need it.

5.8. Other factors

As reported by health professionals and substance users, distance to reach the center, schedule of the center, fear of being reported or coverage of the center (gender, religion, nationality, substance) were a few factors not seen to affect treatment. Stigma, though not assessed, was declared by some as impeding the initiation of treatment. Protecting self-image and maintaining a certain status is important to many substance users. Reducing societal stigma is therefore essential and will increase commitment to treatment. Many substance users also reported negative interactions with the staff or other patients (e.g. arguments) that constituted a factor in treatment drop-out. It is worth investigating whether these are occasional encounters or a group dynamic present in some treatment programs.

6. Referrals

All health professionals agreed that substance users visiting their centers were usually referred by their personal environment, meaning they approached the center or clinic on their own or with the support of their family or loved ones. Substance users seeking treatment at NGOs confirm this. The importance of awareness in the community, and support to families, is highlighted again through this finding.

As seen previously, more than half of MOSA centers provide referrals for treatment to substance users. The social services centers usually contact treatment centers directly, and sometimes send patient files to the parties concerned. Most importantly, most of those who have referred substance users in 2009 have followed-up after referral. Almost a quarter of substance users seeking treatment were referred by these centers, which puts in evidence the successful referral process they set in place. Still, most centers do not refer on a regular basis, and 90 % of the MOSA centers reported not having a system of referral with treatment centers, highlighting the need to work on designing a proper system of referral between the two parties in the future.

Substance users accessed through outreach are usually those not seeking treatment and therefore, will only be referred to treatment centers if they visit physicians. Indeed, 50 % of this sample reported being referred to treatment in the past by private practitioners. What is interesting is that almost a third were referred by outreach workers, a corroboration that outreach activities are valuable, if not necessary, in bringing the "hidden" population of substance users to health care services. As discussed previously, only one NGO conducts outreach in Lebanon. Adding outreach activities to their already existing services can help other NGOs and hospitals to treat further substance users not actively seeking treatment.

Half of the NGOs not specialized in the treatment of substance dependence had a proper system of referral in place, and most NGOs specialized in the addiction field had a referral system in place with other treatment centers, but only half believed it was good. Half of the psychiatrists, both in hospitals or private practice, reported having a referral system but 50 to 75 % of the psychiatrists felt it was mediocre. It appears that a proper system of referral is not consistently present among all those involved in the field, and it is not generally rated as satisfactory. This constitutes a problem for substance users who may not be directed towards appropriate treatment centers. In some cases, as for most ER doctors and GPs, there was no system of referral at all. This may be the case because these doctors do not have time to refer, do not know about treatment centers and services offered, or

may not consider it as part of their function. In any case, we could attempt to resolve this inadequacy by stressing the importance of referrals among physicians, providing a comprehensive guide listing all treatment centers in Lebanon , encouraging follow-up via documentation, setting up a Web page with all centers and respective services and advertising it. This initiative is applicable not only to ER doctors and GPs but also to all those involved in the field and is supported by most NGOs' responses claiming that having an effective communication with other treatment centers is one of their priorities. These endeavors can be part of a national standardized strategy for referrals, such as one designed by the NCD. The Council is currently not operational and thus, until its activation, a referral system could be established by a joint committee of those involved in the field.

7. Legal implications of substance use

7.1. Arrest, detention, and the role of the DEBs

In nearly all governorates, the most common source of denunciation for drug users was another drug user but on no account, treatment centers. NGOs or hospitals were estimated by the DEBs not to have denunciated drug users, whether the patients had just started treatment or had left the center. This was confirmed by interviews conducted with health professionals whereby all NGOs and most psychiatrists, both in-hospital and private, had not communicated any information to the police in 2009. However, 17% of substance users seeking treatment at NGOs felt that confidentiality was violated at the center where they had sought treatment in the past. Also, half of ER doctors had shared information on drug users visiting them. These doctors, contrary to the other health professionals, were required by the law to report cases of overdose. Two GPs also had referred drug users to DEBs: one believed the individual might hurt himself/herself or others, and one did so upon request from the parents. This is an issue contributing further to the criminalization of drug users.

According to the DEB directors, there is no distinction in the process of arresting and detaining drug users and drug dealers. There is a lack of legislation and, as a result, a lack of a set procedure to distinguish between drug users and drug dealers. However, DEB directors reported being more lenient towards users.

The condition of drug users may be negatively affected by the duration of detention in the police stations. The arrest period may frequently extend to or beyond the legally allowed 72 hours, and no specialized facility exists inside or affiliated to the stations or DEBs nor are there any health services within the police stations. All directors also reported not having a system of referral or even keeping contact with any treatment center. In case of an emergency, such as withdrawal symptoms, drug users are generally referred to a treatment center, after documentation and approval from the authorities. This process could be avoided by having health professionals working with the DEBs. This is especially important given that the DEBs directors reported not having received consistent training sessions on providing medical support to substance dependent individuals. One director mentioned that treatment centers in all of Lebanon, but mostly in rural areas, were lacking, which confirms the inequitable distribution of treatment services discussed previously.

Most DEB directors did not consider treatment as an important aspect in decision-making during arrest and detention. They did contact the families and treatment center where the arrested user was enrolled, but this procedure was not standard. They clearly stated that judges are those responsible for the outcome of each substance use case.

7.2. The role of judges in substance use

Results show that judges had different levels of familiarity in the field. Therefore, consistent training regarding drug use and addiction will serve all parties concerned. The judges who reported having a good or very good knowledge on the different types of drugs and their effects were the ones who had received trainings from the MOJ or NGOs, both national and international. However, the MOJ declared that it had not provided any training to judges in 2009 and that intern judges, in general, do not undergo training to deal with substance use cases. An inexpensive suggestion would be monthly presentations made by a member of a Lebanese NGO working in the field, (e.g. social worker, clinical psychologist, psychiatrist). In any case, collaboration with experts in the field seems to be more effective than personal initiatives and may help guide verdicts made by the judges handling drug use cases.

An interesting finding is that defendants are not always represented by lawyers. In fact, judges reckon that, in only 1 % of cases, defendants are always assigned lawyers with the majority of the judges' answers being "sometimes" or "rarely". This is probably

due to the fact that defendants may not always afford legal fees. Lack of legal representation is a factor hindering access to fair treatment under and the implementation of the law stipulating drug users' right to access to care. Efforts to provide legal aid need to be initiated.

Furthermore, only a minority of judges declared that defendants committed to treatment and that lawyers pleaded the user's innocence on the basis of them having committed to treatment. As reported by judges, not offering the option of treatment as an alternative to prosecution is related to the non-activation of the DAC (which role involves referring drug users to treatment centers) and the lack of a free governmental center. As a consequence, 40% of judges interviewed claimed to have never issued a primary or final verdict requiring the drug user to commit to treatment, which automatically leads to incarceration.

7.3. The impact of incarceration on treatment

A direct consequence of incarceration is the permanent penal record which strongly affects university enrollment or securing employment as substantiated by most substance users accessed via outreach. The presence of a penal record was a real obstruction: they could not secure employment easily and therefore had to become self-employed if they could; they could neither get health insurance nor a driving license. The penal record also has psychological consequences whereby many reported feeling shame that would not wane shortly since records are never cleared. Socially, they felt their reputation was ruined. These occupational, psychological and social consequences can affect the initiation, maintenance, or completion of treatment.

Still, incarceration in itself can ruin the possibility of accessing treatment. More than a third of substance users interviewed had a drug-related lawsuit against them in the past, and more than half (and the majority, for those accessed via outreach) still had pending lawsuits, showing the high prevalence of legal issues among those using drugs. Also, a large percentage (33 % of outreach users, 61% of those seeking treatment) had been incarcerated in the past, generally more than once. This is confirmed by the elevated re-arrest rates of 50% reported by the South and Central DEB directors whereby half of those arrested were, at some point in time, re-arrested. Addiction can be a persistent illness which may involve relapses; arresting and incarcerating potential patients repeatedly might not be the route to individual, familial, and collective accomplishment. In fact, the majority of all interviewees

(NGOs, psychiatrists, and substance users) agreed that incarceration had a negative impact on treatment. Then, it is worth re-visiting the factors impeding court-mandated treatment.

7.4. Court-mandated treatment

None of the substance users accessed through outreach were referred to treatment by a law representative, while 7 of those seeking treatment at NGOs were referred by a judge. They gave mixed responses on the person deciding on the center (themselves or the judge) and as to whether law representatives had followed-up after initiation or completion of treatment. NGOs were also asked about their relationship with judges: some had no relationship, and others rated it as either poor, good, or very good. Specific questions were asked about the cooperation of the judges when referring a patient for treatment and when a patient under trial had started treatment in 2009. Again, mixed responses from NGOs were provided. Moreover, when asked about current treatment centers they had information about, most judges recalled the same two NGOs and only a minority named other treatment centers. Among the 20 who had information on treatment centers, only 6 had contacted these centers of which half were unsatisfied with the level of cooperation. Some judges required a list of all treatment centers at the time of the interview. Mixed answers in the reports of drug users seeking treatment at NGOs, NGOs, and judges highlight the lack of a consistently applied, structured, and comprehensive referral system between judges and NGOs.

Most NGOs reported that judges or prosecutors had not followed-up on patients they had referred. However, on their end, only some NGOs had contacted judges upon admission to treatment of mandated patients, and most had not notified them if or when a patient dropped out of the program. Thus, it appears that there is a clear need for a structured collaboration between service providers and courts.

We still have to appreciate the impact that the lack of the referral system, and therefore of a dependable court-mandated treatment alternative has on the treatment initiation and completion of drug users. This is put in evidence by the elaboration provided by both samples of substance users in the study, whereby most had experienced or felt the system was unsuccessful, while the rest assumed that there was no system. Among 394 substance users interviewed, one rated the cooperation between

healthcare and judicial systems as good, which shows that there is no structured and standardized system of referral between the judicial system and health facilities.

Factors hindering court-mandated treatment were listed by judges and stated previously (high cost of treatment, lack of vacancy at centers, the absence of free treatment centers assigned by the law, the DAC not being operational). Some judges also mentioned their lack of authority on treatment centers as no law supported their direct affiliation with centers. All of these issues can be resolved if and when the DAC becomes operational since one of its main functions is to refer the drug users to treatment and provide them with services free of charge through a governmental treatment center.

Until the DAC's activation, a proper referral system should be implemented to protect the rights of drug users. The Law on Drugs can be revised to include experts, professionals specialized in the field of addiction that can assess substance dependence, motivate the substance user to be admitted to a center, choose the most suitable treatment program for the user, and follow-up until completion of treatment. Experts will be under oath and assisting judges with drug-related cases. Currently, most judges do not have a list of experts and two-third of the judges interviewed did not believe they could assign an expert at the expense of the public treasury. They usually tested for substance use by requiring a report from treatment centers, a medical report, or laboratory analysis results, but these were not done by all judges. If experts are assigned, they will be able to do this work reliably and be the main point of contact with treatment centers on the part of judges as well as report to them. Among the judges interviewed, most reported trusting reports issued by treatment centers, which facilitates the cooperation among centers and judges.

Nevertheless, experts will not replace the DAC which still has to be activated. Indeed, the representative of the MOJ interviewed confirmed that the main reason of the non-implementation of the Law on Drugs is the lack of an activated DAC. On a positive note, the MOJ is currently working on making the DAC operational by establishing a staff to support the DAC in its functions, and setting allocations for compensation of the DAC members. One issue left to unravel is the designation of centers affiliated with the government, which is necessary, according to the MOJ official, to refer patients to.

8. Role of Ministries in the substance use field

Among the Ministries interviewed, those most involved in the treatment of substance dependence were MOPH and MOJ. The MOPH's role is to establish one or more treatment centers for detoxification of addiction and to affiliate with existing centers. It provides funding to these centers as well. These activities, according to the current Law on Drugs (article 200 and 201) should be implemented via the National Council on Drugs, which includes members from various Ministries. The NCD is not currently active. The MOJ's role, with respect to the addiction field, is to currently implement the Law on Drugs through its various bodies, namely prosecutors and judges through the DAC. The activation of both the NCD and DAC will greatly impact the treatment of substance users as they affect funding of treatment centers, vacancy of existing centers, proper referral of those dependent on substances, treatment plans, prevention strategies, and national action plans and policies toward substance use, abuse, and dependence.

9. Funding in the matter of substance use

9.1 Funding of non-governmental organizations (NGOs)

In 2009, none of the NGOs specialized in the treatment of substance dependence received funding from one source, with the exception of one who had received 100 % of its financial support from public donations, namely municipality money. However, the main service provided by this NGO is a 5-day treatment detoxification program.

Funds directed to most NGOs were mainly coming from private donations and other unidentified sources, but not many funds originated from foundations (local or international) and international donor agencies. This, coupled to the fact that when foundations did offer funding to NGOs, international sources were more common and considerable than local ones, makes NGOs budgets unsteady. Moreover, none of the NGOs had the same funding distribution, representing an individual effort of each NGO to strive for funding. Sources of funding of NGOs encountering substance users (working in mental health, social or other services, and so forth) were similar in nature and numbers.

Most NGOs interviewed did not generate revenues from treatment in 2009, to the exception of 2 NGOs specialized in treatment of substance dependence, which had 20% and 15% of their revenues generated from treatment.

It is worth mentioning, however, that one of these NGOs was no longer charging patients for all services offered to them in 2010, which is a great improvement considering 60% of its patient population used to pay on their own or by way of their personal environment for treatment in 2009. In general, 5 NGOS charged patients for treatment services and 3 did not. When possible, depending on yearly donations, NGOs could provide free treatment to patients, which is of great help to many, but unreliable since donations vary yearly. Funding particulars do shed light on a major concern of NGOs in Lebanon: they may have no choice but to decrease the accessibility of their services by either taking in patients who can afford treatment, or decreasing the number of substance users admitted free of charge so as to limit their expenses.

9.2. Funding by MOPH

Among the interviewees, none of the NGOs specialized in the treatment of substance dependence and 3 hospitals were funded by MOPH for treatment in 2009. However, as mentioned previously, additional funds by MOPH can greatly improve treatment maintenance. In fact, in-hospital psychiatrists considered governmental support as a priority for improvement in the treatment of substance dependence.

Some of the other NGOs and hospitals not interviewed may receive funding from MOPH, as indicated by MOPH. The Ministry is affiliated to one NGO and 2 hospitals (of which one participated in the study) which are funded for the treatment of substance dependence. As discussed above, NGOs' need for financial support from MOPH is impending, and even if half were given the same contribution at these centers (an average of 138 thousand USD per year), accessibility in terms of cost/patient and capacity would be greatly improved to match demands for treatment of substance dependence. The remaining issue is whether contribution by MOPH is possible, as the MOPH representative reported that funding is provided based on available financial resources. On a positive note, the number of patients treated at the expense of MOPH has risen by 31% from 2008 to 2009.

9.3. Funding by MOSA

3 NGOs specialized in the treatment of substance dependence were being funded by MOSA, and one specified that the budget was allocated to prevention and social reintegration. As for NGOs encountering substance users, only 1 received funding from MOSA. Since both of these types of NGOs are involved with mental health patients, including substance users, funding for interventions done before and after treatment is essential and could improve the condition of substance users (or other vulnerable populations) visiting these NGOs. It is important that MOSA supports such interventions by funding and coordinating them, since, according to MOSA representatives, the Ministry's role involves prevention and social reintegration. The Ministry representative estimated MOSA's funding all over Lebanon in 2009 and reported that 4 did receive funding (3 located in Mount Lebanon and one in Beqaa). This distribution of funds is localized to two areas, similarly to that of treatment centers in Lebanon. So, allocation of funds should be done on the national level resulting in a greater impact of prevention and social reintegration in Lebanon

None of the in-hospital psychiatrists reported receiving funding from MOSA, but prevention and social reintegration do not generally fall within the scope of services provided by hospitals treating patients with substance dependence.

Social services centers affiliated with MOSA receive from the Ministry around 160,000 USD per year for matters related to social affairs, but no specific budget with respect to substance dependence was allotted by with respect to substance dependence (as reported by both the Ministry and the centers). Knowing that MOSA centers see an average of 4 substance users per center, prevention and social reintegration in terms of substance use could really influence not only substance users visiting social services centers, but also other individuals whom the centers have access to in their town. As reported by most MOSA centers, awareness and referrals are already made on an informal basis. Funding by MOSA would allow them to provide their services in a more standardized, resourceful, and capable manner. Moreover, since MOSA centers are located in all regions of Lebanon, their activities have the potential of improving the substance use situation nationwide.

DISCUSSION OF RECOMMENDATIONS PROPOSED BY THE STUDY SAMPLES

Recommendations made by the interviewees support the findings discussed in the previous section. Those which will be discussed below are the most significant recommendations and those proposed by the majority of the interviewees.

1. Legal Level

The implementation of the Law on Drugs with respect to court-mandated treatment was recommended by nearly all parties interviewed. Results show, indeed, that the law is not being implemented consistently because of a lack of a working mechanism, namely the non-activation of the DAC and the lack of free, governmental treatment centers. Therefore, recommendations revolving around the two latter points are fundamental to the referral of arrested drug users to treatment. Considering the negative impact of incarceration demonstrated by the quantitative data, activating the DAC and establishing governmental centers is a priority.

Given that these endeavors were not carried out since the last amendment of the Law on Drugs in 1998, alternatives should be considered. These include creating a system of referral between judicial and healthcare systems, both of which were recommended by the interviewees and supporting existing treatment centers.

The system of referral between judges and treatment centers can be structured and standardized by the assignment of experts to cases of drug use. Experts would be specialized in the addiction field and would assist judges in processing cases, from assessment of substance dependence to placement in a treatment center and follow-up. The concept of having experts was introduced to judges in our questionnaire and two thirds of judges did not believe that they could assign an expert at the expense of the public treasury. Lobbying the MOJ to recruit experts will allow the creation of a referral system and its execution until the DAC is activated.

Focus should be given to existing treatment centers working in the addiction field. Funding of MOPH to existing treatment centers can allow free cost of treatment for substance dependence, capacity increase of facilities, expansion of services and human resources, which will reduce the demand for treatment. All of the aforementioned points were recommended by the interviewees.

Most NGOs interviewed were accessible in terms of cost, however, with the support of the MOPH, hospitals will guarantee reasonable treatment costs and NGOs will be able to offer their services to those not able to afford any cost. In fact, cost was deemed to be an important factor in the initiation, maintenance and completion of treatment of substance dependence. NGOs will also benefit from the increase in capacity that they consider an impending priority. Indeed, based on our data, the main reasons why substance users discontinued treatment was the lack of vacancy or their name being put on a waiting list.

Other recommendations were made to highlight the importance of the MOPH's involvement in the substance dependence field. A mental health department should be established within the Ministry, it should evaluate outcomes of treatment programs. These recommendations are supported by our findings that accreditation criteria should be set so as to define and monitor proper treatment in our country. The NCD is the group responsible for initiating this undertaking, but it is currently non-operational. It was suggested that the NCD be activated.

The NCD, if active, can also work on establishing a drug information system, which was recommended by many in the field and recognized by Skoun while leading the present study. A nationally coordinated database will open the doors to many initiated such as research-based prevention activated, evidence-based treatment, and the establishment of interventions needed at different points in time. NGOs, who wished to add more researchers to their teams, could be focal points for data collection.

In any case, and because of the non-activation of the NCD, there should be a joint committee of all those involved in the field, namely specialized NGOs and hospitals, MOPH, MOSA, MOJ, and MEHE to instigate proposals and follow-up on them.

2. Community Level

At the community level, the most significant recommendations emphasized awareness and prevention and concur with findings of quantitative data. Raising awareness and conducting prevention activities are essential in educating the community with accurate information related to substances and substance dependence as well as preventing risky behaviors. The majority of substance users were young and therefore targeting the population of school and university students is important. Also, most substance users are referred to treatment by their personal environment. Thus, raising awareness among families may promote the initiation of

treatment of those who need it, especially if coupled to the provision of information on existing treatment centers. With respect to prevention, many recommended the reduction of risk factors such as family issues or unemployment. These are valuable, and prevention activities can vary depending on the characteristics of the target population. Prevention and awareness will also help to reduce societal stigma. Fighting the current stigma on drug users was recommended by many to be a priority as it hindered the initiation of treatment, as reported by interviewed substance users.

3. Health services

As discussed previously, treatment centers should be present in all areas of Lebanon, which was confirmed by the majority of interviewees. Many also suggested that doctor-patient or psychotherapist-patient confidentiality be respected, which was not always the case. Data show that some ER physicians, GPs, and psychiatrists, whether required by the law or not, disclosed confidential information on their patients to the ISF. This evidently has an effect on the maintenance and completion of treatment.

Centers specialized in addiction generally provided treatment to individual using any substance. Many recommended the use of OST to meet the needs of opioid users with respect to treatment. After legalization and licensing in Lebanon, OST should be implemented in the centers receiving the most opioids users, if not all centers. This endeavor is supported by many psychiatrists recommending harm reduction approaches. Within this framework of services, outreach was suggested by parties interviewed. Outreach activities could not only help in teaching skills or testing for infection but also in providing guidance to the appropriate treatment centers. Around 30 % of substance users accessed through outreach had been referred to treatment, in the past, by a fieldworker during outreach. Interviewees elaborated further by stating that outreach should include home visits with families. This can increase awareness within the family and draw out the support of family members in referring their loved one to treatment. Investing time and resources in outreach home visits shows promise since, as mentioned previously, individuals are mostly referred to treatment by their personal environment.

Moreover, many interviewers supported the establishment of a hotline for substance dependence. This would allow patients or individuals in high risk situations to access a minimum of services which are now unavailable after working hours, thereby increasing accessibility to services.

Interviewees also suggested the addition or expansion of most services (e.g. outpatient services, psychotherapy for mental health and addictions, faith-based therapy, withdrawal management, family support aftercare support) services, reiterating their recommendation that centers should cover all modalities of treatment. Since it is not possible for each center to provide all modalities, it was recommended that centers cooperate together and create a synergic strategy covering all types of services. In this sense, the communication among treatment centers and health professionals in general is crucial and many highlighted the importance of a coordination or referral system with a protocol followed by all. This cooperation could be planned by the joint committee mentioned above.

LIMITATIONS

General limitations

1. Study Instrument

Due to time constraints, the questionnaire was not pilot-tested. However, consultations with partner NGOs and key experts in the fields of epidemiology, psychology, psychiatry and the law were done to validate the questions asked.

2. Self-Reported Data

Recall bias may have been encountered whereby the interviewees were unable to recall past events, specifically quantitative questions related to estimating percentages, age of onset, duration of use, and so forth.

Specific limitations

1. Health Facilities, Legal System, Stakeholders, and Other Service Providers

1.1. Sample size

Two main treatment centers specialized in the treatment of substance dependence did not participate in the study. Since the samples of NGOs and hospitals (psychiatrists, ER doctors, and GPs) are small, having them in the study would have maximized the sample sizes and improved the accuracy of the data collected (e.g. services availability, accessibility, and coverage). Yet, response rates are favorable with data clearly highlighting the substance use situation in the country (Table 1.2, Chapter III).

The smallest response rate was that among in-hospital psychiatrists (48%). However, these psychiatrists worked in 10 hospitals of 15 available, and therefore psychiatry departments represented 67% of those targeted. Data collected at psychiatry departments thus ensures an adequate understanding of substance use and related factors in this setting,

Moreover, in order to abide to the time and budget framed by the study, ER doctors and GPs were interviewed only if working in hospitals specialized in the treatment of substance dependents, as we prioritized such establishments. Yet, the selection limited the sample size. Future studies should aim at interviewing those working in hospitals not specialized in substance use. This endeavor would most likely give us a different perspective on the whole situation, namely in identifying service available for substance users, estimating the average number of substance users visiting ERs and family medicine departments at these hospitals, as well as comparing data collected to those of specialized hospitals.

1.2. Available data

It proved to be difficult to network with some of the interviewed parties and organizations as data was not regularly collected, nor was it stored electronically and – in few cases – access to the data was not granted.

In the cases where no data was being regularly collected – such as with some NGOs and hospital physicians – there was a lot of missing responses. This was accounted for by the use of ranking and estimates of the data variables collected from these sources rather than real counts. Accordingly, results interpreted may reflect personal standing.

In the case where the data was collected but not electronically present – such as with some NGOs, hospitals, and private practitioners, it was difficult to obtain information during the interview. Therefore, when possible, a fieldworker or other team member accessed files on site and entered the data needed for the assessment.

Because of the two factors aforementioned, we experienced many cases of missing data. It is worth mentioning that missing data did not always occur because of data not being collected or compiled. Some interviewees were not able to provide an answer (e.g.

more than half of the judges could not estimate an average fee of a hired expert, most probably because they had claimed the absence of such experts in assisting them).

Moreover, permission was not granted to access data from all sources. This applied to primary and secondary data collection as the team faced resistance from many parties contacted. The team attempted to establish local partnerships and communicate the importance of the needs assessment as possible. Some remained hesitant, but several successful partnerships with fellow organizations working with substance users were made, which allowed for more data to be collected.

1.3. Reliable data

Even though data was screened and cleaned, some inconsistencies in the data collected were observed (e.g., discrepancy in the number of arrest cases in the Beqaa governorate was observed between those reported by the central DEB and the Beqaa). When possible, contact was re-initiated with the concerned parties for clarification or justification. Data which were not in agreement were reported as is in the results section.

2. Substance Users

2.1. Sample size

As a result of the lack of recent research studies, estimate on the prevalence of substance users is not available. So, the research team was unable to calculate a representative sample size of substance users in Lebanon, or at least identify if the sample size obtained in our study is representative. Also, due to time constraints, only substance users encountered at NGOs and on the street were interviewed; those in hospitals and other possible sources were not targeted.

2.2. Reliable data

The snowball sampling used to access substance users via outreach can produce numerous biases. To address this limitation and increase accuracy of the data collected, we have interviewed as many participants as possible and two different outreach workers having different contacts in diverse areas of Lebanon were recruited.

Furthermore, due to the interview's nature (face-to-face interview), some substance users may have provided favorable answers by succumbing to the social desirability effect or by fear of being reported despite the interviewer clearly highlighting confidentiality.

CHAPTER VI

KEY RECOMMENDATIONS

The situational assessment generated many findings which formed the basis of recommendations made by the Skoun team to improve the work of those involved in the field and meet substance users' needs. Recommendations center on legal, community, and health services themes.

It is worth mentioning that most recommendations are similar to the ones produced by the RSA (Karam et al., 2003), and to allow for a comparison of the two documents, recommendations will be organized in a similar manner with four themes:

1. Role of the Lebanese Ministries
2. Substance use prevention and awareness
3. Substance use health care services
4. Substance use legal and judicial system

Role of the Lebanese Ministries

All Ministries

- Most Ministries are involved in the various facets of substance use and dependence (health, social/occupational, legal, and educational). Thus, the government as a whole should prioritize the issue of substance use and dependence.

- The NCD, which is composed of different Ministers, should be activated at the earliest time possible (as designated by the Lebanese Law on Drugs).
- If the NCD cannot be operational, a joint committee made of NGOs, hospitals, and others involved in the field and directed by a member of the government should be formed. The committee will carry an inter-ministerial mission, assuming the role of the NCD. Each member of the interim joint committee should represent a Ministry and put forth its respective services.
- The DAC [which assesses whether individuals (arrested or self-admitted) are dependent to substances and refer them to treatment] must become operational.

The Ministry of Public Health (MOPH)

- A mental health department which includes a unit for the treatment of substance dependence should be created.
- The Ministry should establish treatment centers providing detoxification in the governorates of North Lebanon, South Lebanon, Nabatieh, and Beqaa.
- The Ministry should affiliate with treatment centers focusing on the psychological aspects of dependence in the governorates of North Lebanon, South Lebanon, Nabatieh, and Beqaa.
- To increase access to treatment, the Ministry should allot funds to the treatment of substance dependence destined to existing treatment centers (other than the three it is affiliated with). Funding will allow:
    1. A reduction or elimination of treatment costs
    2. An increase in the capacity of health facilities
    3. An addition or expansion of services

4. The recruitment of capable and committed employees

- The MOPH should classify treatment centers by type with a clear terminology so that professionals and beneficiaries can recognize the differences in the types of services provided by the centers (e.g. many NGOs and hospitals reported providing detoxification or withdrawal management but it is implemented differently in both settings).
- In the absence of the NCD, the MOPH should assess the quality of existing treatment centers by setting up accreditation criteria and evaluate them on a regular basis. Proper treatment should be defined.
- The MOPH should delegate a representative visiting each center and assessing specific needs in light of the aforementioned proper treatment, before providing financial support or human resources based on priorities of the budget allowances.
- The MOPH should legalize OST and design a system to ensure its implementation, which must be put in place to ensure the effective, professional, sustainable, and ethical implementation of the substitution treatment.
- The MOPH should monitor closely the dispensing of prescription medications by pharmacies and remind pharmacists of the specific medications which cannot be distributed without a prescription.

The Ministry of Social Affairs (MOSA)

- The MOSA should establish a national strategy covering universal, selective, and indicated prevention to achieve effective interventions for the community as a whole.
- The MOSA should also design a clear strategy for pre and post-treatment interventions.
- The MOSA should allot a budget for social affairs related to substance dependence as part of the contribution provided to all affiliated social services centers. Funding will allow all MOSA centers to:
- Receive trainings on social aspects of substance use and dependence

- Raise awareness in an efficient and consistent manner in their areas
- Conduct prevention activities in their areas
- Provide resourceful aftercare support, including social reintegration or vocational assistance
- Provide family support to families of substance users
- If funding to all centers is not possible, the budget allotted should cover a geographical spread so that the centers' services are provided in each district of Lebanon.
- The MOSA should design and support a referral system between social services centers and treatment centers including a procedure, a comprehensive list of services available in all areas of the country, and the proper documentation for referral and follow-up.

The Ministry of Education and Higher Education (MEHE)

- The MEHE should make preventive education a priority in middle and secondary schools, and create drug and health education interventions in universities. Integrated evidence-based prevention programs in public and private schools' curriculum are recommended.

The Ministry of Justice (MOJ)

- The MOJ must integrate trainings on substance use and dependence in the judicial curriculum. These trainings could take the form of lectures, workshops, or round tables, and can be coordinated with those specialized in the field of addiction such as NGOs, psychiatrists, or other experts.

- Since the DAC is not currently active, referral of arrested drug users to treatment can occur if the MOJ recruits experts, individuals trained to diagnose substance dependence, refer the drug user to the appropriate center, and follow-up with the case.

Role in Research

- Ministries' involvement in research is key and the government should attend to the need for a nationally coordinated approach to data collection.
- The MOPH should design, organize and regulate a drug and treatment-monitoring system, which provides valuable information on the extent and characteristics of drug use as well as on measures taken to deal with the phenomenon. This information can be collected with limited financial effort within the framework of treatment services, as data on treated persons are readily available and are already collected for treatment purposes.
- The MOSA and MEHE should direct and conduct national research on prevention by evaluating the effectiveness of current or potential interventions after having defined the target population.
- The MOJ should issue an official analysis of the data collected on cases of drug use until this day to identify future research focal points and direct representatives of the legal system to conduct ongoing research on legal factors of drug use.
- Ministries should create a computerized comprehensive research archive which goal is to provide ready access to substance use research data.

Substance Use Prevention and Awareness

General Directions

- Effective awareness and prevention programs must be conducted. Therefore it is important that they be prepared carefully and based on research.
- Prevention and awareness programs should be designed to address individuals, families, schools/universities, and the community.
- Prevention and awareness programs should be tailored to the characteristics and needs of the target population.
- Programs should be implemented regularly, not on a one-time basis and the effectiveness must be continually tested.
- Programs should be implemented in many settings (integration of programs into school curriculums, after-school youth programs, programs as part of community activities).
- To reach a wider audience, many prevention and awareness activities can be carried out through the media (television, radio, and internet).
- Substance use and dependence carries stigma in the Lebanese population. It is therefore important that all professionals to be involved in raising awareness and not only those specialized in the treatment of substance dependence: ER doctors, GPs, DEBs, judges, MOSA social services centers, and NGOs working in the mental health field.

Specific Directions

- Data show that the age of onset of substance use is around 16-19 years old. It is important to set up awareness and prevention programs for this age range.

- Males reported an earlier age of onset of use, thus programs tailored to men should address socio-cultural norms impacting their substance use.

- Even though the percentage of females using substances was low, it appears that a higher proportion of women visit clinics and ER rooms when necessary. Awareness should be raised among female substance users concentrating on the reasons for not visiting treatment centers.

- Particular substances (the most commonly used) should be given emphasis: cannabis, opioids, cocaine, sedatives and tranquilizers, and alcohol. Specifically, correcting misconceptions on cannabis and alcohol is important. Chronic cannabis use can lead to dependence, and even though it is a legal substance, alcohol abuse can have detrimental effects (many substance-related emergencies and involve alcohol-related accidents).

- Programs must address poly-substance use, given the high rates found in our data.

- Programs must be directed towards school/university teachers and counselors as the point of contact for students at risk or those using drugs.

Treatment-Related Awareness

- Misperceptions on substance use should be addressed so that those who suffer from an addiction perceive their condition to be an issue and initiate treatment. It is important that education, outreach and harm reduction services are made available to substance users.

- Programs tailored to families can help them recognize a substance-related problem, teach them skills to address it with family members and support their loved one. The existence of such programs is necessary since substance users are generally referred to treatment by their families or loved ones, if they do not come on their own.

- Dissemination of information on existing treatment centers, types of centers, services provided, and treatment costs as well as information on how to access these centers is vital as many users are not aware of available services in the country.
- It is also important for substance users to be aware that they can present themselves to the MOPH and receive treatment free of charge, when the Ministry's budget allows.

Research

- It is important to introduce the concept of evidence-based prevention that can help prevention practitioners use the results of effective and culturally sensitive prevention research to address substance use, abuse and dependence among children and adolescents in communities across the country. All prevention officers or practitioners in the substance use field should be regularly involved in research rather than base their interventions on mere observations. This would include an ongoing research on the profile of substance users, risk and protective factors of use, and the impact of prevention endeavors, which would impact the evaluation of the officers' work.

Substance Use Health Care Services

Treatment centers

- Considering the centralization of treatment centers to Beirut and Mount Lebanon, centers in North Lebanon, South Lebanon, Nabatieh, and Beqaa should be instituted.
- Existing treatment centers should increase their capacity to better meet the demand for treatment. If this is not possible, additional centers should be established.

- NGOs admitting females to treatment should be established, and they should ideally be located outside the governorate of Beirut, since, in our study, the two participating NGOS were located in the capital. It is preferable that such centers be inpatient since the two NGOs welcoming females in Lebanon are outpatient.

- It is important that patients know, at intake, what they can expect in terms of services available, alternative options in other centers, intensity, cost, and duration of treatment, so that they can make an informed decision when committing to treatment.

- After initiation of treatment, an assessment of the outcome of treatment may allow the members of the center to check that progress is being made, to reassess the situation if the patient is not improving, and to take appropriate measures, keeping in mind that treatment should be flexible to match patients' needs.

Treatment services

- Treatment centers should provide different modalities of treatment in order to cover all possible existing treatment approaches in order for patients with substance dependence to find the services matching their needs.

- Both quantitative and qualitative data generated a large number of services needed. It is important to make available some of the services that are mostly needed:

    1. OST and other harm-reduction interventions
    2. Short-term inpatient treatment centers
    3. Outpatient centers and intensive outpatient clinics
    4. Drop-in centers
    5. Hotline services

6. Day/evening treatment
7. Supportive housing

- Aftercare support (providing vocational assistance, social reintegration programs) is as important as treatment since it can affect relapse and post-treatment functioning and should be integrated as part of all treatment programs.
- Substance dependence and treatment of this disorder impact the family dynamics. Treatment centers should provide family support in a regular and structured manner and cover all past and potential issues encountered by family members.
- Outreach to those who do not seek treatment is vital to bring them into treatment. Specifically, providing outreach with home-visits can help families to refer their loved one to treatment.

Referrals to treatment

- In the absence of the DAC to refer substance users to treatment, treatment centers specialized in the treatment of substance dependence should design a system of referral with an established protocol (documentation, follow-up). The system should be practical and accessible to all those treating substance users but also all those who encounter substance users (ER doctors, GPs, NGOs working in the mental health field, social services centers, and others).
- In addition, providing a comprehensive guide of treatment centers available in the country to those not specialized in the field will improve referrals to treatment.

Other services impacting treatment

- It is necessary that ER physicians, GPs, NGOs working in the mental health field, social services centers, and any professional who may encounter substance users routinely screen for the presence of substance use among those visiting them.

- ER doctors and ER nurses should be trained in substance-related interventions.
- Given the effects and dangers of opioids use, it is essential that all those encountering opioids users refer them to treatment at the earliest time possible.
- A larger number of centers should provide free VCT.
- Confidentiality with patients should not be breached unless specifically required by the Law.

Research

- Treatment centers should collect data on their patient population to monitor characteristics of their patient population (demographic, clinical, social, and legal), drug use trends to shed light on the substance use situation. Data should also be collected on treatment outcomes which can help centers tailor their services to the needs of their patients.
- Research studies should be conducted in order to evaluate the effectiveness of various approaches.
- Epidemiological studies should be conducted at the national level, possibly through the cooperation of many specialized professionals, to assess the prevalence of substance use, substance use trends, substance-related infections, and factors related to use.
- A drug and treatment-monitoring system should be implemented which consists of ongoing collection of data to monitor the extent and characteristics of substance use as well as the services offered by treatment centers. This will allow the addition, expansion, or modification of services to be based on evidence and not only general observations.

Substance use legal and judicial system

Implementation of the Lebanese Law on Dugs

- As per the Lebanese Law on Drugs, a drug user should be given the choice between treatment and incarceration.
- A free government center should be established as per the Law to refer drug users to treatment.
- A clear distinction should be made between the convictions of substance users and dealers. The sentences of the detainees for drug use accusations need to be reduced and their rights protected, while dealers, smugglers, and other traffickers should face tighter regulations or a stricter sentence.
- In the absence of a governmental treatment center, DEBs should affiliate with an existing treatment center in each area which could provide health care services (free of charge) in case of overdose, withdrawal symptoms or any other related emergencies. If this is not possible, each DEB should coordinate with a physician and a social worker making regular visits to police stations.

Revision of the Lebanese Law on Drugs

- In the absence of the DAC, the Law should be amended to allow for the creation of a structured referral system among healthcare and judicial systems. The system should reflect a joint vision of both parties and include documentation and assignment of experts working at the Hall of Justice and assisting judges in handling drug use cases. Experts should be individuals specialized in drug use, such as psychiatrists, social workers or psychologists and their role includes assessment, referral to a treatment center matching the user's needs, and follow-up of the case.
- Arrested drug users should be appointed a lawyer if they cannot afford legal fees.

- Criminal records of drug users should be expunged after corroboration of completion of treatment and adherence to a treatment program.

Prisons

- Substance abuse prison programs should be established, including the basic resources guaranteeing the preservation of human rights.
- There should be more specialized NGOs working with drug users in prisons.

Research

- Representatives of the legal system should analyze the data collected on detainees and prisoners to measure the frequency and duration of pretrial detention and incarceration in order to examine the impact of criminalization on treatment initiation, maintenance, and completion.
- Research should be undertaken testing the effectiveness of arresting and prosecuting drug users in efforts of drug control.

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APPENDICES

APPENDIX 1

LAWS INVOLVING THE USE OF SUBSTANCES

Law 673

قانون رقم 673
1998 صادر في 16 آذار
يتعلق بالمخدرات والمؤثرات العقلية والسلائف

المادة 13 - حظر النباتات والمواد والمستحضرات المدرجة في الجدول الاول وجميع الاموال المتعلقة بها
تحظر النباتات وبذور النباتات والمواد والمستحضرات المدرجة في الجدول الاول ويحظر انتاجها وصنعها واستخراجها وتحضيرها وتحويلها وشراؤها وحيازتها واحرازها وتسلمها واقتناؤها وتملكها واستخدامها وصرفها وعرضها ونقلها وتسليمها وطرحها للبيع وبيعها وتوزيعها بالجملة او بالتجزئة وتبادلها والتنازل عنها مجانا او بعوض والتوسط والسمسرة بشأنها وارسالها وشحنها واستيرادها وتصديرها والاتجار بها مهما كان نوعه وبصورة عامة كل عمل او اجراء مهما كان نوعه يتعلق بها
وتحظر ايضا جميع الافعال المذكورة اعلاه اذا تعلقت بالمعدات او الادوات او سائر المواد مع علم الفاعل بانها ستستخدم او ستجري الاستعانة بها في انتاج او صنع او استخراج وتحضير او تحويل مواد ومستحضرات الجدول الاول

المادة 124 - احكام جزائية مطبقة على النباتات والمواد
تطبق احكام هذا الجزء على جميع النباتات والمواد الموضوع تحت المراقبة ويميز بين:
- المواد الشديدة الخطورة الممثلة بنباتات ومواد الجدولين الاول والثاني

- المواد الخطرة الممثلة بنباتات ومواد الجدول الثالث
- السلائف الممثلة بمواد الجدول الرابع

* المادة 182 - مراحل العلاج من التعاطي والادمان

يشمل العلاج الكامل من التعاطي والادمان على المخدرات المراحل الثلاث الآتية
مرحلة ازالة التسمم الادماني والارتهان الجسماني لعادة التعاطي وتتم في مصحات متخصصة معتمدة من وزارة الصحة العامة وتخضع لنظام المستشفيات ويكون المرضى فيها تحت حراسة القوى العامة
مرحلة العلاج والتخلص من الارتهان النفساني لعادة التعاطي وتتم في عيادات نفسية اجتماعية معتمدة من وزارة الصحة العامة
مرحلة تكميلية ترمي الى مساعدة المدمن على العودة الى الحياة الطبيعية واعادة تأهيله للاندماج في المجتمع وتتم في مؤسسات رعاية او لدى اشخاص طبيعيين معتمدين من وزارة الشؤون الاجتماعية

* المادة 183 - مطالبة المدمن اخضاعه للعلاج الجسماني والنفساني

لكل مدمن على المخدرات قبل اجراء أي ملاحقة ضده ان يتقدم تلقائيا امام لجنة مكافحة الادمان على المخدرات المنصوص عليها في المادة199 من هذا القانون طالبا اخضاعه لتدابير العلاج الجسماني والنفساني من مرضى التعاطي ويوقع تعهدا بذلك حيث يكون له الحق في هذه الحالة باخفاء هويته الا لاشخاص ملزمين بسر المهنة وعدم ملاحقته اذا تابع العلاج واستمر فيه حتى استحصاله على شهادة تثبت شفاءه التام من التسمم الادماني والاعتياد الجسماني وتخلصه من الارتهان النفساني لعادة التعاطي

* المادة 184 - ادارة المصح والمساعدة الاجتماعية

تحيل لجنة مكافحة الادمان المدمن على احد المصحات المخصصة حيث يوضع تحت المراقبة لمدة شهر يخضع فيه للفحوصات اللازمة وتكلف اللجنة مساعدة اجتماعية في وزارة الشؤون الاجتماعية لاجراء تحقيق ودراسة عن حياة المدمن الشخصية والعائلية والمهنية والاجتماعية

.وفي نهاية الشهر تقدم كل من ادارة المصح والمساعدة الاجتماعية تقريرا عن حالة المدمن الى لجنة مكافحة الادمان للبت بأمره

* المادة 199 - تأليف لجنة الادمان

تتالف لجنة الادمان على المخدرات بقرار من وزير العدل 2 من
قاض من الدرجة الحادية عشرة وما فوق رئيسا
ممثل عن وزارة الشؤون الاجتماعية
طبيب من وزارة الصحة العامة
ممثل عن المديرية المركزية لمكافحة المخدرات
شخص من المهتمين بشؤون المخدرات في المؤسسات الخاصة
اعضاء تقترحهم الادارات المختصة

* المادة 200 - إنشاء مصح لمعالجة المدمنين
تنشىء وزارة الصحة العامة مصحا او اكثر لمعالجة المدمنين على المخدرات من التسمم الادماني

* المادة 204 - منح اسرة المدمن اعانة شهرية

اذا تبين للجنة الادمان ان وجود المدمن في المصح يترك اسرته بغير موارد مالية، تقترح على وزير الشؤون الاجتماعية منح هذه الاسرة بقرار منه اعانة شهرية مناسبة ضمن الاعتمادات المرصدة لهذه الغاية

* المادة - 205 تأليف المجلس الوطني لشؤون المخدرات

ينشأ مجلس وطني لشؤون المخدرات يتألف على الشكل الآتي:

- رئيس مجلس الوزراء - رئيسا
- نائب رئيس مجلس الوزراء - نائبا للرئيس
- وزير العدل
- وزير الداخلية
- وزير الصحة العامة
- وزير الزراعة
- وزير المالية
- وزيرالتربية الوطنية والشباب والرياضة
- وزير الشؤون الاجتماعية
- وزير الخارجية - اعضاء
- امين عام المجلس - مقررا

ويمكن ان يدعى الى اجتماعاته وزراء آخرون حسبما تدعو الحاجة
كما يدعى الى اجتماعاته رئيس مصلحة الصيدلة ورئيس دائرة المخدرات في وزارة الصحة العامة والمدير المركزي لمكافحة المخدرات ونقيبي الاطباء ونقيب الصيادلة في لبنان وممثل عن المؤسسات الوطنية المعترف بها في حقل مكافحة المخدرات

* المادة 240 - حماية الاشخاص الآتين الى لبنان للادلاء بأقوالهم
لا تجوز ملاحقة الشاهد او الخبير او أي شخص آخر سواء اكان مطلق السراح او محبوسا يوافق على المجيء الى لبنان للادلاء بأقواله اثناء اجراءات معينة او للمعاونة في تحقيق او في ملاحقات جنائية او في اجراء قضائي. كما لا يجوز حبسه او معاقبته او تقييد حريته الشخصية باي قيد داخل لبنان

بسبب افعال ايجابية او سلبية او ادانات سابقة على حضوره. وتزول هذه الحصانة اذا بقي الشخص المعين داخل لبنان او عاد اليه بارادته لدى انقضاء مهلة مدتها خمسة عشر يوما متتالية بعد ابلاغه رسميا بأن وجوده لم يعد مطلوبا من السلطات اللبنانية
واذا كان الشخص المعنى محبوسا في الخارج فانه يستبقى في الحبس داخل لبنان ويتم اقتياده تحت الحراسة الى الدولة التي طلب منها بمجرد ان يصبح وجوده داخل لبنان غير ضروري

Law 212

قانون رقم 212
صادر في 2 نيسان1993
احداث وزارة الشؤون الاجتماعية

بموجب معدل:
18/5/1994 القانون رقم 327 تاريخ

المادة الاولى
تحدث وزارة تسمى "وزارة الشؤون الاجتماعية"، وتعدل تسمية وزارة الصحة والشؤون الاجتماعيةبحيث تصبح "وزارة الصحة العامة"

المادة 2
تتولى وزارة الشؤون الاجتماعية :
وضع خطة إنماء اجتماعي للبلاد ومراقبة تطبيقها
تنفيذ المشاريع الاجتماعية التي تتولاها الدولة بمفردها
تقديم المساعدات للمشاريع الاجتماعية القائمة والمساهمة في تحقيق مشاريع اجتماعية جديدة، وذلك وفقا للمبادىء والأنظمة التي تضعها الوزارة.
رعاية شؤون المعوقين والاهتمام بشؤون المؤسسات المعنية بالمعوقين

معالجة النتائج الاجتماعية للحرب بما فيها الرعاية الاجتماعية لذوي الضحايا والجرحى والمعوقين
رعاية شؤون الأيتام والاهتمام بشؤون دور الأيتام
الاهتمام بشؤون الأسرة
الاهتمام بشؤون الأحداث المنحرفين والمساجين وبالنشاطات الحرفية خاصة الريفية منها والعمل على تنميتها
رصد التحركات السكانية وأسبابها وتنظيم جهود الدولة والتنسيق مع القطاع الاهلي في هذا المضمار
الاهتمام بالحالات الطارئة التي تستوجب الإسعاف الاجتماعي والإغاثة
وضع برامج التأهيل والتدريب الاجتماعي والاشراف على تنفيذها
اقتراح منح المؤسسات الاجتماعية والجمعيات الخيرية صفة المنفعة العامة والسهر على التزامها بها
المشاركة في تنظيم حملات مكافحة الإدمان على جميع المستويات
تقديم الرعاية الاجتماعية لأسر شهداء الاعتداءات الاسرائيلية والمعتقلين في سجون العدو

وتراقب الوزارة المؤسسات الاجتماعية التي تقوم بخدمات اجتماعية ولا تتوخى الربح ومنها دور العجزة وذوي العاهات، ودور الأيتام والفئات المحتاجة، والمراكز الصحية الاجتماعية وسائر المؤسسات المماثلة التي ترعاها الطوائف والجمعيات الخيرية والهيئات المعترف بها والأفراد الذين يعملون في الحقل الاجتماعي

المادة 3

ألغي نص المادة 3 بموجب المادة الاولى من القانون رقم 327 تاريخ 1994/5/18 واستعيض عنه بالنص التالي:

تتألف وزارة الشؤون الاجتماعية من :

المعدل لهذا القانون والمنشور في عدد الجريدة الرسمية رقم 27 تاريخ 26/5/1994

-المديرية العامة للشؤون الاجتماعية التي تضم المديريات والمصالح الآتية:
-مصلحة الديوان
-مصلحة التخطيط والبحوث
-مصلحة المحاسبة

-مصلحة الخدمات الانمائية
-مديرية الخدمات الاجتماعية وتضم
-مصلحة شؤون المعوقين
-مصلحة الرعاية الاجتماعية
-مصلحة الجمعيات والهيئات الأهلية
-مصلحة الشؤون الأسرية
-مديرية التنمية الاجتماعية وتضم
-مصلحة التنمية الاجتماعية
-مصلحة الحرف والصناعات اليدوية.

المادة 4

أ - تنشأ مؤسسة عامة تدعى "الصندوق المركزي للشؤون الاجتماعية" غايته تمويل مشاريع اجتماعية كليا أو جزئيا، ويتمتع هذا الصندوق بالشخصية المعنوية والاستقلال المالي
لا يخضع الصندوق لأحكام المرسوم رقم 4517 (النظام العام للمؤسسات العامة). ويخضع لرقابة مجلس الخدمة المدنية ولرقابة التفتيش المركزي ولرقابة ديوان المحاسبة المؤخرة
يمارس وزير الشؤون الاجتماعية سلطة الوصاية على الصندوق

ب - تتكون موارد الصندوق من:
-ما يلحظ في الموازنة العامة
-المساعدات والهبات التي يقدمها أشخاص معنويون أو طبيعيون لبنانيون وغير لبنانيين ومنظمات أهلية لبنانية وغير لبنانية، محلية ودولية، لإنفاقها في الغايات التي أنشىء الصندوق من أجلها
-أي مواد أخرى

ج - تتولى ادارة الصندوق هيئة مؤلفة من ثلاثة أشخاص، يكون أحدهم رئيسا ومدير عام الشؤون الاجتماعية عضوا حكما

د - تحدد بمراسيم تتخذ في مجلس الوزراء أنظمة الصندوق بما فيها النظام الداخلي والنظام المالي وشروط تعيين هيئة ادارة الصندوق ومهامها ومخصصات كل من رئيس وعضوي الهيئة، وكذلك شروط تعيين المستخدمين والاجراء والمتعاقدين وملاكات وسلم الرتب والرواتب

المادة 5

تفصل المديرية العامة للشؤون الاجتماعية عن وزارة الصحة والشؤون الاجتماعية وتلحق بوزارة الشؤون الاجتماعيةبأجهزتها وملاكاتها كافة وينقل الموظفون والمؤقتون والمتعاقدون والأجراء وسائر العاملين فيها الى ملاك وزارة الشؤون الاجتماعية دونما حاجة لأي نص آخر ودون أن يؤدي ذلك الى أي تعديل في أوضاعهم الوظيفية ولا سيما لجهة الرتبة والراتب وحقهم في التدرج

ألغي نص البند 2 من المادة 5 بموجب المادة 2 من القانون رقم 327 تاريخ 1994/5/18 واستعيض عنه بالنص التالي:

يستمر تطبيق جميع النصوص المعمول بها بتاريخ نفاذ هذا القانون في المديرية العامة للشؤون الاجتماعية وتبقى سارية المفعول الانظمة المعتمدة بالنسبة للمراكز الصحية الاجتماعية ومراكز الخدمات الشاملة المنبثقة مباشرة عن وزارة الشؤون الاجتماعية بما فيها المركز الصحي الاجتماعي النموذجي ومركز التدريب الاجتماعي والمركز النموذجي للمعوقين والمشاريع المشتركة مع الهيئات الاهلية والدولية وبيت المحترف اللبناني، وفق نفس الأصول المالية المعتمدة حاليا وتنظم هذه الاصول بموجب قرار يصدر عن وزير الشؤون الاجتماعية وتعدل بالطريقة نفسها.

ويستعاض عن عبارتي "وزارة الصحة والشؤون الاجتماعية" و "وزير الصحة والشؤون الاجتماعية" أينما وردتا في هذه النصوص بعبارتي" وزارة الشؤون الاجتماعية" و "وزير الشؤون الاجتماعية"

المادة 6

تنقل الى وزارة الشؤون الاجتماعية الاعتمادات المرصدة في الموازنة العامة للمديرية العامة للشؤون الاجتماعية والاعتمادات العائدة للمهام المنوطة بهذه الوزارة

المادة 7

تحدد دقائق تطبيق أحكام هذا القانون بمراسيم تتخذ في مجلس الوزراء بناء على اقتراح وزير الشؤون الاجتماعية

المادة 8
تلغى جميع النصوص التي تخالف أحكام هذا القانون أو لا تتفق مع مضمونه

المادة 9
يعمل بهذا القانون فور نشره في الجريدة الرسمية

بيروت في 2 نيسان سنة 1993
الامضاء: الياس الهراوي

APPENDIX 2

DEB RECORDING SHEET

IDENTITY	NAME														
	TITLE														
	SURNAME														
	FATHER														
	MOTHER														
Date of Birth			Place of Birth				ID number				ID place		Phone number		
/ /															
Sex			Nationality				Identity document								
Male	Female		Lebanese	Arab	Foreigner	Country	ID	Birth certificate	Passport				Other documentation		
									Type		Number				
Occupation	Educational level		Family situation												
			Single	Married	Divorced	Widowed	Separated	Other situation							
Living area:															
Type of offence	Dealing	Smuggling	Promoting	Manufacturing	Cultivation	Drug use	Transfer	Financing	Other offences						

	Other drugs										
			Have been arrested before								
			Treatment organization								
			Result of the test								
	Narcotics medication		Current method of use	Other method							
	Speed			Injection							
	Ecstasy			Freebase							
	Captagone			Inhaling							
	LSD			Nargileh							
	Cocaine			Cigarette							
	Opium		Use for the first time	Partners							
	Heroin			Place							
	hashish oil			Method							
	Marijuana			Age							
	Cannabis			Type of drug							
	Type of drug used		Method of use			Notes					

Skoun, 2010, Situational Needs Assessment. Filling the Gap: Meeting the Needs for Treatment of Substance Users and Treatment Centers.