Situational Needs Assessment 2009

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

Beirut-Lebanon

Draft report

Summary of comprehensive report

Karen Estefane, head of research, Skoun, Lebanese Addictions Center, March 2011

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I. 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.

II. Acronyms

DEB	Drug enforcement bureau
ER	Emergency room
GP	General practitioner
HIV	Human Immunodeficiency Virus
ISF	Internal security forces
MEHE	Ministry of Education and Higher Education
MOJ	Ministry of Justice
MOPH	Ministry of Public Health
MOSA	Ministry of Social Affairs
NGO	Non-governmental organization
RSA	Rapid Situational Assessment
SES	Socioeconomic status

III. Definitions

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 professional 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 professional 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.

IV. Study progress

The study is at its final phase with the final report currently being written. Results presented below comprise neither all of the findings nor a comprehensive discussion of the results. Indeed, this report was intended to summarize the major aspects relating to the needs of substance users and treatment centers. We hope that you read, in the short future, our all-inclusive final report upon publication. Please contact Karen Estefane at caren@skoun.org or Chantal Chedid at prevention@skoun.org to be provided with a copy.

V. Project background and introduction

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 Narcotics law 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 1998 law 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 advocacy 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 Narcotics Law. 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.

In the Arab region, little to no epidemiological studies have been conducted to examine substance users' profile and describe treatment services. Most of the studies in Lebanon have been conducted on university students (Karam et al., 2000; Karam, Maalouf & Ghandour, 2004; Nassar, Melikian, & Der-Karabetian., 1973; 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 by Karam and colleagues (2006) 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 the Institute for Development, Research, Advocacy and Applied Care (IDRAAC) dates back to 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 (street 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 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 MEHE should collaborate with the institutions and activists who could provide prevention strategies and methods. Needless to say, the 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 the promotion of treatment centers to their programs. Finally, the need for field assessments and research that both serve as an identification and a 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 develop, 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 is vitally recommended that the National Council on Drugs and the Drug Addiction Committee 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 (Karam, Ghandour, Maalouf, &Yamout, 2003).

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 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.

Thus, 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 through 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.

VI. Methodology

To meet the study's objectives, a cross sectional design was carried out between February 2010 and January 2011. The methodology entailed the collection of both primary and secondary data, through different data collection techniques. Specific parties interviewed were chosen to depict a comprehensive picture of the substance use situation in Lebanon.

The assessment tool is a questionnaire developed modeling the Global Assessment Programme (GAP) of Drug Abuse Toolkit by the United Nations (UN, 2002). Questions related to need in areas or Lebanon or factors relevant to incompletion of treatment were incorporated as to target country-specific needs. The final version of the questionnaire uses both quantitative and qualitative data and is organized into various sections, depending on the party targeted for interviewed. Common sections included: NGO or hospital's profile (type of institution, team constitution, sources of funding); demographic characteristics of substance users visiting the treatment facilities (age, gender, socioeconomic status, and nationality); substance use trends (type of substances, age of onset of substance use); treatment services (assessment of availability, accessibility, and coverage of treatment services; lack of treatment or proper treatment in areas of Lebanon, reasons for treatment non-initiation and drop-outs, reasons for refusing treatment to drug users, and factors related to the initiation, maintenance, or completion of treatment); law-related issues; recommendations to the government made by interviewees to improve their work in the field of addiction. The questionnaire was administered by fieldworkers after consent for participation was granted. Anonymity was not preserved since interviews consisted of face-to-face encounters. However, confidentiality was assured with interviewees knowing that identifiers would be removed and the data collected would only be shared by members of the research team.

Parties interviewed consisted of:

Health professionals:

- NGOs: N = 8 out of 11 specialized in the treatment of substance dependence.
- Hospitals: N= 10 out of 15 hospitals treating for substance dependence. Within hospitals, 3 types of doctors were interviewed:
    - Psychiatrists: N= 13 out of 29 working in psychiatry departments of hospitals participating in the study.
    - Emergency Room physicians: N = 8 out of 9 working in different emergency departments of participating hospitals.
    - General practitioners: N = 8 out of 10 working in different hospitals.
- Private practice psychiatrists: N = 9 out of 14 psychiatrists working as private practitioners.

Substance users:

- Substance users at NGOs: N = 75 presenting for treatment consecutively during a 3-month period at 6 NGOs specialized in the treatment of substance dependence.
- Substance users accessed through outreach: N = 319.

Legal system:

- Drug Enforcement Bureaus: N = 4 out of 4 branches endorsing the responsibilities of the Judicial Police Unit in all areas of Lebanon.
- Courts: N = 34 out of 42 judges handling substance use accusations selected through non-probability purposive sampling.

Stakeholders:

- Ministry of Public Health (1 representative).
- Ministry of Social Affairs (2 representatives).
- Ministry of Justice (1 representative).

Other service providers:

- NGOs not specialized in the treatment of substance users: N = 8 out of 14 NGOs identified in Lebanon.
- Social services centers affiliated with the Ministry of Social Affairs: N = 41 out of 41 selected through stratified random sampling with 95 centers existing in Lebanon.

VII. Results of the primary data

1. Main findings

Cases of substance dependence

Table 1 Cases of substance use as reported by parties interviewed, 2009

NGOs specialized in treatment	In-hospitals psychiatrists	ER doctors	Private practice psychiatrists	DEBs	Judges	NGOs not treating	Social services centers
774	225	972	213	2228	1175	118	156

Demographic characteristics of substance users

Most substance users visiting NGOs and hospitals (psychiatry and emergency departments) 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 ER doctors and private psychiatrists. Moreover, around half of substance users were employed with a higher percentage seen by the ER sample. In general, a good number of substance users (37-62%) belonged to a low SES, and a lower percentage was estimated by ER doctors (Table 2).

Table 2 Demographic characteristics of substance users as reported by health professionals, 2009

	NGOs			In-hospital psychiatrists			ER doctors			Private practice psychiatrists		
	N	Median (%)	(min – max)	N	Median (%)	(min – max)	N	Median (%)	(min – max)	N	Median (%)	(min – max)
Age (years)												
< 18	8	6	(0-70)	8	2	(0-20)	6	15	(2-50)	7	20	(2-20)
18 – 24	8	36	(25-62)	8	29	(13-50)	6	45	(25-80)	7	70	(10-95)
25 – 34	8	35	(0-71)	8	42	(20-75)	6	23	(10-50)	7	15	(2-30)
≥ 35	8	13	(0-26)	8	18	(6-51)	6	8	(3-20)	7	5	(0-55)
Gender												
Males	8	100*	(85-100)	10	82	(65-100)	7	70	(50-90)	9	75	(30-100)
Females	8	0	(0-15)	10	19	(0-35)	7	30	(10-50)	9	25	(0-70)
Nationality												
Lebanese	8	98	(90-100)	8	90	(70-100)	7	90	(60-100)	9	90	(75-100)
Non-Lebanese	8	3	(0-10)	8	10	(0-30)	7	10	(0-40)	9	10	(0-25)
Socioeconomic status												
Low	8	62	(31-100)	8	45	(0-95)	5	25	(10-90)	8	37	(20-75)
Middle	8	26	(8-44)	8	30	(0-40)	5	10	(0-60)	8	32	(0-60)
High	8	10	(2-25)	8	20	(0-50)	5	30	(0-75)	8	25	(0-75)
Employment status												
Employed	8	49	(0-100)	6	48	(10-70)	4	65	(50-80)	9	50	(10-90)
Unemployed	8	52	(0-100)	6	53	(30-90)	4	35	(20-60)	9	50	(10-100)

* Medians for gender were not adjusted to account only for NGOs seeing both men and women. In 2 NGOs admitting women for treatment, the median of the estimated percentage of women was 8% in 2009.

Substance users interviewed were generally males and Lebanese. The majority was between the ages 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 attended 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 (Table 3).

Table 3 Demographic characteristics of substance users, 2010

	Substance users at NGOs	**Substance users accessed through outreach**
	N (%)	N (%)
Age (years)		
< 18	4 (5%)	14 (4%)
18 – 24	39 (52%)	82 (26%)
25 – 34	20 (27%)	163 (51%)
≥ 35	12 (16%)	60 (19%)
Gender		
Male	73 (97%)	286 (92%)
Female	2 (3%)	25 (8%)
Nationality		
Lebanese	70 (93%)	308 (97%)
Dual citizenship (Lebanese and other)	2 (3%)	1 (0.3%)
Non-Lebanese	3 (4%)	5 (2%)

Table 3 Demographic characteristics of substance users, 2010, continued

	Substance users at NGOs	**Substance users accessed through outreach**
	N (%)	N (%)
Educational level		
Illiterate	3 (4%)	12 (4%)
Elementary	8 (11%)	27 (8%)
Intermediate	23 (32%)	60 (19%)
Secondary	12 (16%)	123 (39%)
Technical school	14 (19%)	59 (19%)
University (no degree)	9 (12%)	17 (5%)
BA	4 (6%)	15 (5%)
Higher education or work	0 (0%)	4(1%)
Professional status		
Student	5 (7%)	5 (2%)
Employed	35 (47%)	260 (82%)
Student and employed	3(4%)	7 (2%)
None	31 (42%)	47 (13%)
Yearly income ($)		
2000-6000	19 (41%)	177 (60%)
6001-12000	17 (37%)	64 (22%)
12001-18000	6 (13%)	19 (6%)
18001-24000	2 (4%)	0 (0%)
24001-36000	0 (0%)	22 (8%)
36001-60000	2 (4%)	7 (3%)
>60001	0 (0%)	2 (1%)

Substance use trends

Age of onset of substance use

Table 4 Age of onset of substance use reported by health professionals, 2009

	NGOs			In-hospital psychiatrists			Private practice psychiatrists		
	N	Median (%)	(min – max)	N	Median (%)	(min – max)	N	Median (%)	(min – max)
Age of onset for any substance (years)	8	15	(10-17)	11	16	(14-22)	6	16	(15-18)
Age of onset for the substance of choice (years)	8	16	(15-19)	7	18	(18-22)	7	18	(15-20)
Duration of use of the substance of choice before seeking treatment (years)	7	4	(3-10)	9	3	(1-5)	6	3	(2-5)

Table 5 Age of onset of substance use reported by substance users, 2010

	Substance users at NGOs			Substance users accessed through outreach		
	N	Median (%)	(min – max)	N	Median (%)	(min – max)
Age of onset for any substance (years)	74	16	(10-38)	317	17	(10-27)
Age of onset for the substance of choice (years)	72	18	(12-38)	316	19	(10-30)
Duration of use of the substance of choice before seeking treatment (years)	68	4	(1-35)	N/A	N/A	N/A

Substances used

- **Opioids** (e.g. heroin), and to a lesser extent **cannabis** (e.g. hashish), were the types of substances ranked highest by NGOs treating substance users and psychiatrists (in hospitals and in private practice). This was confirmed among the sample of substance users seeking treatment at NGOs. This trend seem accurate as, if substance users desire treatment for dependence to these substances, they will visit either an NGO specialized in the treatment of dependence, a psychiatry department of a hospital admitting them, or a private practice. However, when asked about cannabis use by their patient population in 2009, NGOs did not provide a consistent ranking, ranking a large variety of substances. On the other hand, many individuals using opioids and cannabis do not seek treatment for use of these substances, as evidenced by the majority of outreach users using cannabis, opioids. It is also worth mentioning that most substance users (N=241) accessed through outreach ranked cannabis first among all substances listed (N=304).

- **Cocaine** was consistently ranked high across all samples (health professionals and substance users), but mostly clustered in the second and third ranks.

- Cannabis, cocaine and opioids users were the most arrested for by the ISF.

- Sedatives and tranquilizers (e.g. benzodiazepines) were also seen as common by psychiatrists, GPs, ER doctors, and half of substance users seeking treatment at NGOs. These substances are, as a result, considerably used and sought treatment for.

- When **amphetamine-types** (e.g. methamphetamine) and **hallucinogens** (e.g. lysergic acid diethylamide) were assessed by interviewees, they consistently ranked fourth (in some samples, hallucinogens had a lower ranking than amphetamine-types), an indication that these substances were used occasionally or in combination with other substances to provide a desired effect. Indeed, these substances are known as recreational drugs.

- **Alcohol** was highly ranked among ER physicians. ER physicians may welcome a high number of alcohol-related conditions because alcohol is not subject to punishment by law and therefore doctors in the ER do not report such cases to the ISF. Hence individuals visiting the emergency department for alcohol-related issues may be less fearful than those using other substances. It also appears that many individuals do endure alcohol-related emergencies. Alcohol was also ranked first as the substance of choice by 20% of outreach users these individuals are not actively seeking treatment and may resort to ER visits and not more intensive and specialized treatment when in need of help.

- 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 ages of 18 and 24 mainly used cannabis and opioids, along with, to a lesser extent, cocaine as well as sedatives and tranquilizers. Those between the ages of 25 and 34 years old used cannabis, opioids, and cocaine, while those aged 35 years or mainly used opioids.

Injecting trends

An average of 6 in 10 patients visiting NGOs for treatment of substance dependence had used any illegal substance by means of injection (N= 73) , prior to treatment, while the rest claimed otherwise. This figure is more elevated than that seen among users accessed outreach, with 3 in 10 patients reporting injecting substances (N= 308).

Treatment services

Substance users presenting for and receiving treatment at NGOs

Overall, half of NGOs reported that 115 substance users (or lower) have presented for treatment, ranging from 25 to 245 [mean = 110]. As indicated in the table below, a substantial number of individuals have presented for treatment but have not received it or completed it, with the exception of one NGO (Table 6).

Table 6 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)
NGO3	77	32 (42)
NGO4	50	50 (100)
NGO5	25	6 (24)
NGO6	115	64 (56)
NGO7	140	76 (54)

Numbers refer to new admissions in 2009 and do not include patients who have already received treatment in previous years.

Availability of treatment services: services by area

Overall, 8 NGOs specialized in the treatment of substance users were interviewed, whereby 4 were located in Mount Lebanon, 3 in Beirut and 1 in the Beqaa governorate (Figure 1). One of the NGOs located in Mount Lebanon, was specifically located within a prison. It aims at treating prisoners only, with their choice as to whether they want to initiate treatment or not.

A total of 13 psychiatrists working in hospitals involved in treating individuals with substance dependence were interviewed. These psychiatrists came from 10 different hospitals, of which 6 were located in Beirut, 4 in Mount Lebanon (Figure 2).

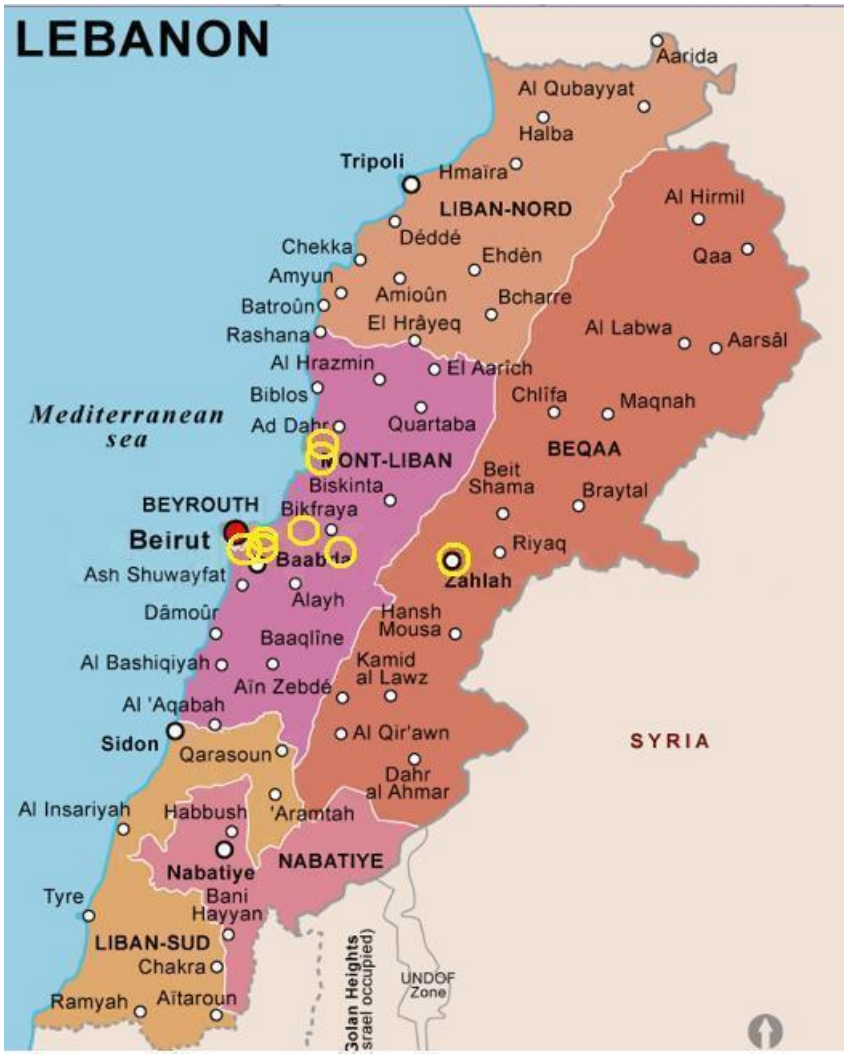

Figure 1 Distribution of NGOs specialized in the treatment of substance dependence in Lebanon

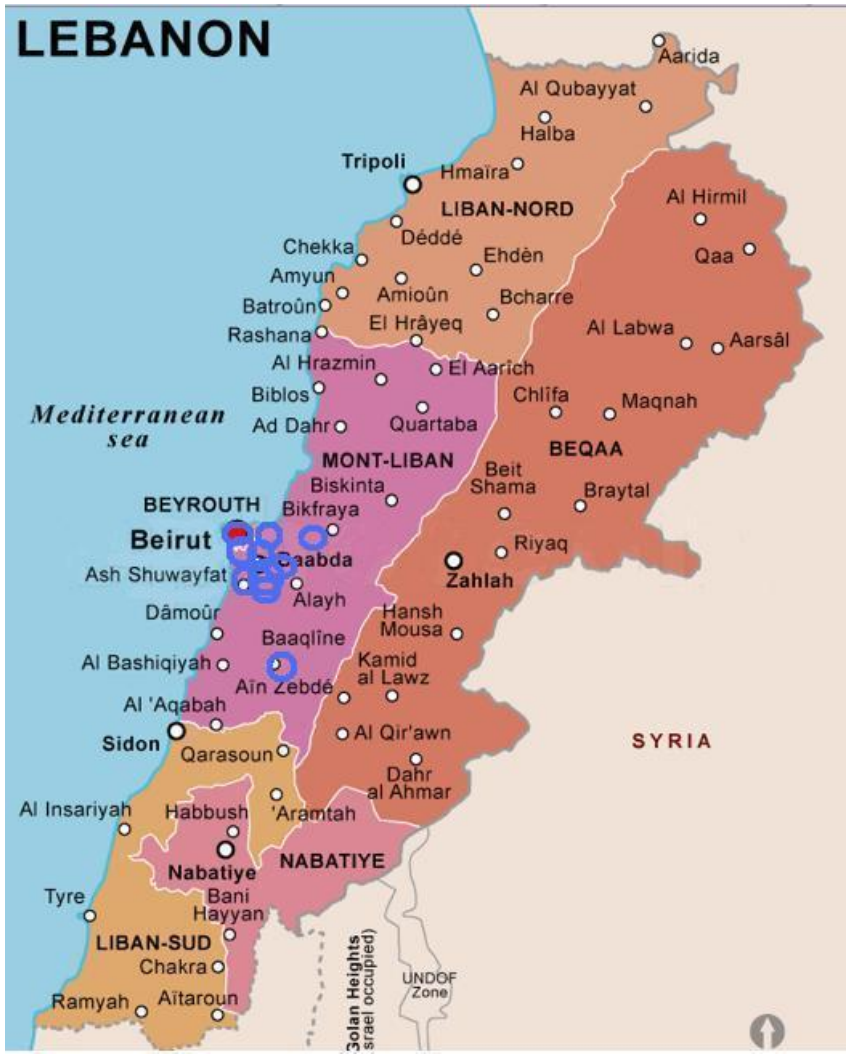

Figure 2 Distribution of hospitals specialized in the treatment of substance dependence in Lebanon

Availability of treatment services: services by health facility

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) (Table 7).

Table 7 Number of NGOs with available treatment services, 2009

Types of services	N	Availability
Case identification*	8	8
Comprehensive assessment*	7	7
Case management*	7	7
Information, guidance and advice*	7	7
Drop-in*	6	1
Withdrawal management/supervised detoxification (home/facility)*	7	6
Brief intervention*	7	7
Medications for addiction*	5	4
Medications for medical conditions*	5	5
Psychiatric medications*	5	5
Medical support*	5	5
Group therapy sessions for addiction*	6	6
Educational group sessions for addiction*	6	5
Individual therapy sessions for addiction*	7	7
Individual therapy for mental health*	6	5
Group sessions for mental health*	4	3
Day/evening treatment*	5	4
Outpatient treatment*	5	4

Table 7 Number of NGOs with available treatment services, 2009, continued

Types of services	N	Availability
Short-term inpatient treatment	5	1
Long-term inpatient treatment*	6	5
Supportive housing*	4	2
Family support*	7	7
Legal support*	6	6
Aftercare support or vocational assistance (job placement program)*	7	6
Wellness related activities (e.g., yoga, meditation, art therapy, recreation development)*	6	6
Outreach	7	1

* One NGO extends its services within the prison setting, including outpatient services to prisoners or ex-prisoners.

Psychiatry departments of participating hospitals also had a good number of available services, albeit less than those extended by NGOs specialized in treatment of substance dependence. Existing services evaluated included assessment (case identification, comprehensive assessment, case management), withdrawal management/supervised detoxification, medical interventions (psychiatric medications, medications for medical conditions), and individual therapy for addictions (Table 8).

Table 8 Number of hospital with available treatment services, 2009

Types of services	N	Availability
Case identification	9	8
Comprehensive assessment	9	8
Case management	9	8
Drop-in	9	6
Withdrawal management/supervised detoxification (home/facility)	9	8

Table 8 Number of hospital with available treatment services, 2009, continued

Types of services	N	Availability
Brief intervention	9	7
Medications for addiction*	9	6
Medications for medical conditions	9	8
Psychiatric medications	9	8
Medical support	9	8
Group therapy sessions for addiction	9	4
Educational group sessions for addiction	9	6
Individual therapy sessions for addiction	9	8
Individual therapy for mental health	9	7
Group sessions for mental health	9	3
Day/evening treatment	9	4
Outpatient treatment*	9	5
Short-term inpatient treatment	9	8
Long-term inpatient treatment	9	4
Supportive housing*	9	0
Family support*	9	8
Legal support*	9	1
Aftercare support or vocational assistance (job placement program)	9	4
Wellness related activities (e.g., yoga, meditation, art therapy, recreation development)	9	3
Outreach	9	2

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

Coverage of treatment services

Criteria of assessment of coverage consisted of gender, religion, nationality, and substances. Overall, services were available to all religions, nationalities, and for 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.

Accessibility of treatment services

In general, 3 NGOs had a 24-hour service, and 3 NGOs opened for 8, 11 and 14 hours per day. Most hospitals (N=8) were reported to have a 24-hour of service. The remaining respondents did not give out an answer.

With respect to location, 2 NGOs reported the majority of their patients traveling less than 15 km [20 minutes without traffic] to reach the treatment center (100% and 70%, respectively), with the case not being true for 1 NGO. Half of psychiatrists reported that around half of their patients or less needed to travel less than 15km to reach the treatment center (minimum-maximum: 20-60; mean = 46%).

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. In hospitals, it was reported that 200 patients could be accommodated for treatment [minimum-maximum: 52-450; mean = 230 patients]. Moreover, half of psychiatrists responding reported 12 beds [minimum-maximum: 5-18; mean = 12] or less to be available in the inpatient unit, as 7 psychiatrists responded from 6 different hospitals. 2 psychiatrists, however, coming from the same hospital, provided different answers (one reported having 12 beds and the other 18).

Half of the NGOs reported a usual duration for treatment to last for 317 days or less [mean = 280] with NGOs' responses ranging from 5 to 480 days. The NGO reporting a 5-day treatment duration[1] was located in Mount Lebanon. In contrast, 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.

The average treatment cost per month for patients was 120 USD [minimum-maximum: 100-1100; mean=340 USD] at NGOs interviewed, while 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].

[1] 5-day treatment duration consists of detoxification only

Factors related to treatment initiation, maintenance and completion

NGOs, psychiatrists, and substance users were asked about the reasons for substance users not receiving treatment or discontinuing treatment after presenting for treatment and the first consultation. Reasons investigated were the distance to reach the treatment center, the cost of treatment, the suitability of services to the substance user's needs, lack of vacancies, presence of a waiting list, the next appointment being too far from the data of the first visit, the substance user's willingness to stop using independently, and unwillingness to stop using. Substance users were also asked about further reasons related to accessibility (e.g. hours of service of the center) and coverage (e.g. nationalities). The reasons most agreed on by health professionals were the unwillingness of substance users to stop using substances and the willingness to stop using independently. Private practice psychiatrists also agreed with the cost of treating being a factor in discontinuation of treatment, which was confirmed by the substance users accessed through outreach. Both samples of substance users interviewed reported the lack of vacancies and waiting lists as significant reasons for the lack of treatment initiation, and substance users seeking treatment at NGOs emphasized their willingness to stop on their own.

Dropout rates and reasons for not completing treatment were also investigated interviewing substance users and those treating them. NGOs, in-hospital psychiatrists, and private practice psychiatrists estimated dropout rates ranging from 28 to 50 %, on average, but the rates calculated among substance users were higher (Table 9).

Table 9 Dropout rates estimated by health professionals and calculated among substance users, 2009-2010

NGOs specialized in treatment (N=7)	In-hospital psychiatrists (N=7)	Private practice psychiatrists (N=7)	Substance users at NGOs (N=33)	Substance users accessed through outreach (N= 37)
28% [mean = 29%] minimum-maximum: 1-75	50% [mean = 44 %] minimum-maximum: 0=90	40 % [mean = 49 %] minimum-maximum: 5-60	70% had not completed treatment when initiating it	92 % had not completed treatment when initiating it

Factors related to the non-completion of treatment enumerated were: the distance to reach the treatment center, the cost of treatment, the center's hours of service, the suitability of services to the substance user's needs, the duration of treatment, substance user's lack or loss of commitment to treatment, family involvement, and the government's lack of support. Factors deemed the most relevant to dropping out of treatment are listed in table 10.

Table 10 Reasons for non-completion of treatment endorsed by health professionals and substance users, 2009-2010

NGOs specialized in treatment	In-hospital psychiatrists	Private practice psychiatrists	Substance users at NGOs	Outreach substance users
Lack/loss of commitment to treatment (57%, N=7)	Lack/loss of commitment to treatment (91%,N=12)	Treatment cost (89%,N=9)	Treatment duration (76%, N= 25)	Services not suited to patients' needs (43%,N=25)
Lack of governmental support (50%, N=6)	Family involvement (75%,N=12)	Duration (78%,N=9)		Duration (76%,N=25)
Treatment duration (43%, N=7)	Lack of governmental support (70%,N=10)	Lack/loss of commitment to treatment (78%,N=9)		Distance (10%,N=21)

Half of NGOs denied access to treatment to 24 people or less, [minimum-maximum: 4-85; mean = 31]. Possible reasons for refusal mainly included patients' needs not fitting the services available at the center, and patient's psychiatric comorbidity. 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 HIV/AIDS.

Half of psychiatrists reported that 3 patients or less [minimum – maximum: 0-20; mean = 5] had to be refused for 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 comorbidity of the substance user. There were mixed opinions among psychiatrists interviewed, about whether other reasons, such as the lack of vacancies and presence of infections, played a role in denying access to psychiatric services.

Legal system

Drug enforcement bureaus: arrest and detention

Besides taking suitable measures with regards to cases of drug users involving treatment, DEBs reported that their role is to wage the War on Drugs. They control drug trafficking over Lebanese borders and gather data related to drugs in the country. They may also carry out prevention and guidance.

The number of arrest cases for drug use only *and* 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 653 other drug-related indictments in the year of 2009 (Table 11).

Table 11 Number of arrest cases of drug use and other drug-related accusations, 2009

	Drug use only	Other drug-related accusations[1]
	N	N
Beirut	*267*	*73*
Mount Lebanon	*1162*	*319*
North	210	52
South	314	84
Beqaa	275	125
Lebanon	2228	653

[1]Other drug-related accusations include cultivation, manufacturing, smuggling, commerce, financing, transportation, facilitation, and other criminal accusations.
Italicized numbers are estimated by the Central Bureau.

As estimated by the DEB directors, there were no cases of arrest by way of denunciation from treatment centers following the admission of the drug user to treatment or after the individual's discontinuation of treatment. Moreover, there were a good number of arrested cases in a public place and upon denunciations from an arrested drug user or from a public source (Table 12).

Table 12 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 public 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.

Legal status of substance users

Factors related to the law were investigated such as the presence of a lawsuit and incarceration. Substance users seeking treatment at NGOs reported such events as more common than substance users accessed through outreach, but even so, in the latter sample around 30% of individuals had experienced a lawsuit and incarceration in the past (Table 13).

Table 13 Reports of lawsuit and incarceration by substance users, 2010

	Lawsuit (past)	Pending lawsuit (present)	Incarceration	Frequency of incarceration (times)	Duration of incarceration (days)
Substance users at NGOs	54% (N=68)	44% (N=52)	61% (N=71)	Median:=3 Min-max: 1-30 Mean=4 (N=43)	Median=49 Min-max: 1-3650 Mean=232 (N=42)
Substance users accessed through outreach	31% (N=315)	76% (N=97)	33% (N=301)	Median=2 Min-max: 1-10 Mean=3 (N=97)	Median=60 Min-max: 1-1080 Mean=93 (N=95)

Treatment measures at the courts

The majority of judges interviewed were from Beirut and Mount Lebanon.

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. When asked to indicate the name of these centers, only 2 NGOs were mentioned by judges: one by all, and the second by most. These judges are instituted in Mount Lebanon, Beirut and Beqaa (26%, 21%, 21%, respectively). Among those who had 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 high cost of treatment or absence of free treatment in centers that would be assigned by the law. According to some judges, such centers should help Lebanese but also Palestinians, as it was stated that drug use is particularly a problem among this population. The importance of having more treatment centers was also highlighted. 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. Interviewees 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 the referrals would then depend on the willingness of treatment centers to cooperate with the judicial system. They also relate the lack of a coordinated system to the non-activation of the Drug Addiction Committee, which, as said by them, should be put to work and refer substance users in courts.

Stakeholders and sources of funding

Ministry of Public Health

None of the NGOs interviewed received funding for treatment of substance dependence by MOPH. 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 would be covered. However, the number of inpatient beds which cost will be covered per year was not detailed.

The President of the Drug Department at the Ministry of Public Health was interviewed. The MOPH's main role is (1) to establish one or more treatment centers for detoxification of substance use, and (2) to connect with existing centers dealing with the psychological aspect of dependence with two centers currently being launched in Beirut and Mount Lebanon.

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 254,451.48 USD per year.

No specific number of individuals with substance dependence is entitled to receive direct free treatment from the MOPH. Based on the yearly monetary contributions, hospitals and NGOs treating individuals with substance dependence 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 patients from receiving treatment. In 2008, 676 individuals with substance use have received free treatment from MOPH. A year later, this number rose by 31% (886 receiving treatment in 2009).

Ministry of Social Affairs

Two representatives of the MOSA were interviewed: the advisor of MOSA and a social worker from the specialized social welfare department. 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 happens 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 implement MOSA's social policies, including drug-related social policies.

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. When asked about funding by MOSA, half of the social services centers 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].

MOSA also provides financial contributions to any health facilities centers that provide 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 makes 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.

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

2. Main recommendations

Recommendations targeted to the improvement of their work in the field of addiction were made by all interviewees (NGOs specialized and not specialized in the treatment of substance users, in-hospital psychiatrists, ER doctors, GPs, private practice psychiatrists, substance users seeking treatment at NGOs and those accessed through outreach, judges, drug enforcement bureaus, MOPH, MOSA, MOJ, and social services centers affiliated with MOSA) and revolved around three main levels: legal, community, and health services.

Legal level

- There should be a **full law implementation**. Arrested substance users should be given the choice between treatment and incarceration instead of going directly to prosecution. Moreover, the legal system should distinguish between substance users and dealers, with tighter regulations for drug trafficking. Also, as part of the law implementation, the National Council for Drugs and the Drug Addiction Committee should be operational.
- **Amendment of the law** is imperative. Specifically, the Narcotics law can be modified at several levels and the law 212 of MOSA should be amended. The clearance of criminal records was also emphasized.

- The **government** should have **an active role** in the addiction field. It should prioritize the issue of substance dependence and thus offer maximum care to substance users seeking treatment. In this sense, **resources** originating from the government are essential. These include additional funds allotted to treatment centers; involvement of the government so that treatment centers be free of charge, increase their capacity, and be located in all governorates of Lebanon with medical, psychological, social, entertainment and career orientation services; and designing a clear strategy for pre and post-treatment interventions.
- Creation of a **referral system** between judicial and healthcare systems is a must. It was recommended that the system be standardized with assignment of experts working in the Hall of Justice and assisting judges, documentation, and follow-up.
- The law should also 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.
- 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. An inter-ministerial mission should be designed to better control government-based endeavors in terms of substance use and dependence control.
- As part of this, it was recommended that MOSA and MOPH work closely to treat substance users in public hospitals and create a reception bureau for MOSA in these hospitals.
- **A joint committee** of all those involved in the field of addiction should be established at the legal level, with the creation of a work protocol by MOPH applicable to all treatment centers. MOPH should also evaluate treatment outcomes of various facilities.
- **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. Moreover, there should be a national strategy covering universal, selective, and indicated prevention.
- It is essential that **pharmacies be monitored** with respect to prescription medications dispensed, especially when those could lead to abuse or dependence.
- MOPH should **legalize opiates substitution treatment** and design a system to ensure its implementation.
- MOPH's involvement in research is key. Indeed, creating a **national drug information system** would help to monitor substance use and dependence.
- Judges and prevention officers working in MOSA centers emphasized their need to broaden their knowledge on substance use by **government-supported trainings**.
- **Corruption and violation in the police system** should be controlled.
- **Fair treatment** of substance users was emphasized. Interrogation techniques by the ISF should be reconsidered.
- **Physicians** should coordinate regularly with the **ISF**, and **social workers** should be present at police stations.

- In **prisons**, there should be **a separate unit for substance users**. This section should include the basic resources as per the prisoners' rights.

Community level

- **Awareness** was deemed crucial by all parties interviews. Awareness should be conducted in many settings and through many mediums: it was suggested to occur in the community, universities, schools, families, and via the media. Many communicators wished and/or were advised to be involved: prevention officers at NGOs, at MOSA social services centers, social workers, and even judges and police officers.
- **Prevention** is a must: reducing risk factors leading to substance use, such as unemployment, family issues and dropping out of school was recommended. Many also advocated alternative activities for youths such as after-school programs.
- There ought to be **ongoing research** on substance use and dependence.
- It is important to **question and fight the stigma** surrounding substance users.

Health services level

- It is essential to increase the **number, capacity, and funds of treatment facilities**. These centers should provide **different modalities** of treatment.
- Treatment centers (NGOs) should be **free of charge** to those accessing their services.
- It is vital to have treatment centers in **all governorates** of Lebanon.
- A system to access **long-term hospitalization at no charge** should be planned.
- There is a need for **public hospitals with specialized professional** and **clinics** in charge of treatment of substance users.
- In **rural areas**, there should be **treatment centers**, both public and private, working in parallel with social services centers.
- **Free walk-in clinics** for treatment of substance use/dependence are essential.
- **Dispensaries** for mental health, including substance dependence, should be made available.
- **A section within MOSA** centers for substance dependence is important to have. Two options were suggested: doctors working at the 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.

- 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. Also, ER doctors and nurses should be trained to provide suitable care to substance users in ERs.
- A **case management system** to provide appropriate referrals must be devised.
- There should be a **hotline** for substance use/dependence within hospitals and treatment centers.
- There is a need for **aftercare programs**, namely centers able to help users in securing employment and housing. Others mentioned the importance of **28-day treatment programs**, and **Alcoholics Anonymous/Narcotics Anonymous programs**. Substance users could also benefit from **opiates substitution treatment** and **outreach programs** including house visits. **Recreational activities** were considered to improve the treatment of substance users.
- There should be a **structured referral system** between NGOs and hospitals.
- **Confidentiality and professionalism** (staff well-trained, specialized) among treatment centers are required.

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