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Mental health legislation in Lebanon: Nonconformity to international standards and clinical dilemmas in psychiatric practice

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1. Introduction

Mental health legislation represents an important means of protecting the rights of persons with mental disabilities by preventing human rights violations and discrimination and by legally reinforcing the objectives of a mental health policy. The last decade has seen significant changes in the laws relating to psychiatric practice all over the world, especially with the implementation of the Convention for the Rights of People with Disabilities (CRPD). In this paper, we review the existing legislation in Lebanon concerning the following areas in mental health: treatment and legal protection of persons with mental disabilities, criminal laws in relation to offenders with mental disorders, and laws regulating incapacity. We will discuss these texts in comparison with international recommendations and standards on the rights of persons with disabilities, showing the recurrent contradiction between them. Throughout our article, we will address the clinical dilemmas that Lebanese psychiatrists encounter in practice, in the absence of a clear legislation that can orient their decisions and protect their patients from abuse.

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**ABSTRACT**

Mental health legislation represents an important mean of protecting the rights of persons with mental disabilities by preventing human rights violations and discrimination and by legally reinforcing the objectives of a mental health policy. The last decade has seen significant changes in the laws relating to psychiatric practice all over the world, especially with the implementation of the Convention for the Rights of People with Disabilities (CRPD). In this paper, we review the existing legislation in Lebanon concerning the following areas in mental health: treatment and legal protection of persons with mental disabilities, criminal laws in relation to offenders with mental disorders, and laws regulating incapacity. We will discuss these texts in comparison with international recommendations and standards on the rights of persons with disabilities, showing the recurrent contradiction between them. Throughout our article, we will address the clinical dilemmas that Lebanese psychiatrists encounter in practice, in the absence of a clear legislation that can orient their decisions and protect their patients from abuse.

1. Introduction

Mental health legislation represents an important means of protecting the rights of persons with mental disabilities by preventing human rights violations and discrimination, promoting autonomy and liberty of the person, as well as access to mental health care and community integration (Rosenthal & Sundram, 2004). It also legally reinforces the objectives of a mental health policy, which is essential for integration of mental health into general health care settings and development of community based mental health services (Rosenthal & Sundram, 2004).

Mental health and human rights interact in many ways. Mental health policies and laws involve the exercise of government power and can thus promote or violate rights: autonomy, physical integrity, privacy, self-determination, legal capacity, liberty and security of the person. On the other hand, human rights violations affect mental health. Stigma, discrimination (alienation, marginalization, loss of dignity and self-worth) as well as restrictions on civil rights have detrimental effects on mental health. Although awareness and education have contributed to a better understanding of mental health and illness, mental illness still carries a huge burden of stigma in most parts of the world, with common social representations including the fact that people with mental disabilities are assumed to be lazy, weak, considered violent and invoke fear (World Health Organization WHO, 2003).

A mental health legislation in line with the international guideline will contribute to a better protection of the human rights of persons with mental disorders. However in some countries, mental health legislation contains provisions that lead to the violation of human rights (WHO, 2003). In addition 25% of countries with nearly 31% of the world’s population do not have national mental health legislation (WHO, 2003).

It is thus important for a country to have a mental health legislation that incorporates international human right standards, like the CRPD (Convention on the Rights of persons with disabilities). The CRPD is a legally binding UN document for nations that have ratified it. It was adopted by the United Nations General Assembly in 2006 (United Nations (UN) General Assembly, 2007). It supersedes the Principles for Protection of Persons with Mental Illness (MI principles) (UN General Assembly, 1991) and the Declaration of Madrid by the World Psychiatric Association (WPA, 1996) both of which remain the reference as international recommendations that specifically address all aspects of the treatment of mental disabilities.

The purpose of the CRPD is to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity”. Persons with disabilities include those who have long-term mental impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (UN general assembly, 2007).

The health system in Lebanon is one of the few Arab countries that do not have to date a mental health policy (Okasha, Karam, & Okasha, 2003).
illness should never be made on the basis of professional or family conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person’s community” (UN General Assembly, 1991). This means that if one does not adhere to the norms or values of the society he or she lives in, it does not mean that he or she has a mental illness.

2.2. Legal protection and place of treatment

In the legislative decree mentioned above, it is emphasized that the “mentally ill” should be given a legal protection that covers him in the private and public health institutions. It implicitly implies that the protection of the “mentally ill” is based upon his isolation in institutions, as it states that his “liberation” from the hospital must be done under the condition of a previous agreement with an association or a civil society organization to take the person in charge, in case his family is unable to do so. This is in clear contradiction with international standards, that advocate for the protection of persons and their treatment without isolation and that promote community care and de-institutionalization. Thus, the treatment should be as close as possible to the community and not in confined institutions (UN General Assembly, 2007). This would imply increasing availability of services that are of adequate quality and improving access to health care. To this purpose, legislation should address financing mental health, and above all integration of mental health into general health care with access to psychosocial interventions and access to health insurance and to medications.

Furthermore, the government did not create the associations or the primary health care settings that are cited in the legislative decree. Based on the WHO report on mental health services in Lebanon (2010), these services are not organized in terms of catchment/service areas, and there is lack of primary health care settings and clearly inadequate mental health services (WHO, 2010). This means that the only possibility for full coverage available is hospitalization in psychiatric hospitals, which results in practice toward the institutionalization of psychiatric patients rather then their inclusion in the community.

2.3. Involuntary admission and treatment

A fundamental principle of medical care is that treatment of a patient should be with their consent. In the majority of cases doctors should treat their patients according to this principle and it applies for all medical specialties, including mental health disorders. For consent to be valid the patient must have capacity to make medical treatment decisions, the consent must be informed and must be freely given (UN General Assembly, 1982).

Mental disorders can sometimes affect person’s decision-making capacities and they may not always seek or accept treatment for their problems. Rarely, persons with mental disorders may pose a risk to themselves and others because of impaired decision-making abilities. However, mental health legislation should always encourage voluntary admission and treatment and allow involuntary admission only in exceptional circumstances that are constrained by appropriate procedures to protect the rights of persons with mental disorders who are being treated involuntarily (UN General Assembly, 2007; WHO, 2003). The circumstances in which involuntary admissions occur must be outlined and clearly specified. Examples of conditions that could justify involuntary admission and treatment are an acute psychotic episode during schizophrenia, or a manic episode, or a major depressive episode with psychotic features. It is also internationally recommended to obtain certification from two accredited professionals, with the second opinion being from outside the institution and independent from the first opinion, and the legislation should give patients who are admitted involuntarily the right of appeal against their admission to a review body. In case of emergency situations where there is an immediate and imminent danger, a mental health law should set out the procedure for these situations, with immediate involuntary admission, and clear
definitions about what constitutes an emergency with specification of the time period for emergency admissions (WHO, 1996, 2003).

All these dispositions recommended by the WHO in the Service Guidance for implementation of mental health legislation are clearly not mentioned in the legislative decree 72/1983. There is no mental health authority in Lebanon and involuntary admissions are not controlled by a review body and are not supervised by the law. The legislative decree gives a very broad definition of cases of involuntary admissions and does not clearly specify the conditions where a patient can be admitted involuntary. In cases where a patient is brought to the mental institution in an “unconscious” state by any person or “power representative”, it is possible to maintain the patient in the institution by order of the general attorney or department administrator (mouhafez) or kaemmakam or head of municipality, upon a medical report from a psychiatrist (only one) that proves the necessity of surveillance and immediate treatment for the patient. Another option is that the patient can be maintained involuntary by court decision. The law also states that the family of the patient can decide to maintain him or her in the institution upon the report of the psychiatrist.

The law also defines very broad cases of involuntary admissions to psychiatric hospitals based on the decision of only one psychiatrist. And as mentioned above, the decision to discharge the patient is based upon an availability of an association or civil organization to take him in charge. This clearly goes against the principle of de-institutionalization.

In practice, involuntary admissions of psychiatric patients are not regulated by any law, since the existing legislation is extremely vague concerning the criteria and conditions for involuntary hospitalizations and treatment. The patient is maintained involuntary solely upon the medical decision without any supervision from any kind of authority (head of municipality, general attorney or judge) which gives the possibility to a great deal of abuse, when there is no third party to protect the patient. Moreover, there is no control on the duration of the involuntary hospitalization, and patients can stay months in the psychiatric institution without any legal supervision.

However, psychiatrists often face true clinical dilemmas and are obliged to act on what they think is in the patient’s best interest, especially when there is a risk of harm to the patient or a third party. Furthermore, most of the budget allocated to mental health care is directed toward hospitalizations and medications, which make it difficult to invest in community-based mental health care centers, because of the lack of human and financial resources available. Thus, involuntary hospitalization is often seen by the family and the doctor as the only means to treat the patient who is deteriorating at home in the absence of available community health care centers. This results in many patients being hospitalized involuntary in psychiatric hospitals and deprivation of liberty being decided without any legal supervision, making the patient in a state of dependence toward the psychiatrist.

2.4. Cost of treatment, access to care and mental health institutions: contribution of the government to the treatment

The legislative decree 72/1983 states that the government must be responsible of the cost of treatment of the “mentally ill” in the mental institutions and in the community and of his reinsertion. It states that the government must pay the treatment only in the case where the proved inability of the patient and his family to do it. However, in the law 220/2000 concerning the rights of people with intellectual disability, the principle of a free treatment applies to all persons with mental disabilities independently of their financial capacities. Nevertheless this can lead to confusion between the definitions of “intellectually disabled” and “mentally disabled” which are two separate conditions, whereas the two have the right to access free treatment so it is important that this law also include the “mentally disabled”.

In order to provide this treatment, the legislative decree 72/1983 states that health care units depending on the ministry of health must be created in the different regions, as well as departments for mental health in the governmental hospitals and centers for reinsertion and follow-up. It also suggests the creation of two bodies to coordinate these associations, mainly administrative and of social assistance. Unfortunately, these health care centers, departments and associations have not been created yet (Saghiieh & Saghiieh, 2009). The Ministry of Health contracts three psychiatric institutions for provision of services, and provides free psychotropic medications for persons not covered by the Social Security, but does not cover psychiatric consultations outside the institutions. Thus, in the absence of the community centers stated by the legislative decree 72/1983, any person that has a mental condition in need of inpatient care has to go to these specific psychiatric hospitals that are highly stigmatized in Lebanon, or to expensive psychiatric units in private hospitals that are not covered by any health insurance. Local and international NGOs are thus an important service provider for persons with mental disabilities in Lebanon, in the absence of available public community mental health care centers. It is noteworthy that the Ministry of Health has been working with International Medical Corps on the integration of mental health into primary health care (Hijazi, Weissbecker, & Chammay, 2011) and is currently working in Collaboration with the World Health Organization on scaling up the integration of mental health into primary care.

2.5. Comparison with international standards and the CRPD relating to human rights

2.5.1. Respect of the right to informed consent

The legislative decree 72/1983 does not mention anything about the right of the patient to give his informed consent and to consult his medical file. The Lebanese Act 574/2004 insisted on the obtaining of previous consent from the patient—or from the person responsible of him in case the patient is in a state where he cannot express his will—before performing any medical act except in case of emergency or imminent danger. The doctor is bound by this law to be clear and honest and to respect the will of the patient to refuse the treatment upon his responsibility, after informing him of the consequences of his refusal. The question that arises is whether this law should apply to the patient with a “mental illness” as to any other kind of patient. The answer should be positive as there is no reason to discrimination by the law. However, the MI principles as well as laws in many countries specify exceptions to obtaining informed consent, and the decision should be obtained from an independent authority such as a court or tribunal, in the case where there is no legal responsible of the patient and when the person is unlikely to recover capacity (UN General Assembly, 1991). The procedures for these exceptions are not specified in the Lebanese Law.

Whereas the law 574/2004 has insisted on having informed written consent before any medical act or procedure, it did not specify the necessity of consent for some type of psychiatric treatments as in the case of electroconvulsive therapy (ECT) or psychosurgery. Furthermore, it does not specify restrictions on the use of compulsory prescription of medication beyond a certain period. In practice, there is no legal framework or standard procedures on how the ECT is conducted in Lebanon, leaving a big room for differences between institutions and between psychiatrists. This applies also to the informed consent to the ECT by the person or his or her family.

2.5.2. Respect of the rights of the patients and their dignity

The legislative decree 72/1983 did not mention the right of the “mentally ill” to have access to a personalized and holistic program that takes into account the psychosocial aspects, as well as the right to be protected from harm and from unnecessary treatment. It also does not specify the rights and conditions in the mental health facilities, pertaining to privacy, to freedom of communication with the exterior world (letters, phone calls, visits, etc.), to freedom of religion and belief, and to the right to refuse labor inside the facility. Moreover, according to
international standards, a patient in a mental health facility should be informed as soon as possible after admission of all his rights with an explanation of those rights and how to exercise them (UN General Assembly, 1991).

The legislative decree 72/1983 states that the rights of the “mentally ill” must not be violated because of the illness, that his or her rights remain equal to other civilians, that the person has the right to humane caring and compassion and to receiving the adequate medical treatment. On the other hand, it ignores other important rights that are often violated that are clearly stated in the CRPD, and that include the right to participate in political and public and cultural life and the right to education and work (UN General Assembly, 2007). Moreover, there is absolutely no mention about seclusion and physical restraint, which must not be used to cover deficiencies in the mental health unit. It also does not mention the right of the patient to designate a lawyer and to obtain a lawyer for free and to complain about care.

In the absence of clear statements about the rights and respect of dignity of persons with mental disorders, there is a permanent risk of power abuse in any institution. In our opinion, patients’ rights and dignity are violated in Lebanese psychiatric institutions, especially concerning the use of physical constraint, isolation from the external world for long periods of time, as well as unpaid labor in the institution that is put under the frame of “occupational therapy”. For this purpose, studies exploring these issues in Lebanese mental health institutions are warranted. There is also an urgent need to raise awareness among mental health professionals about the rights of persons with mental conditions and among these persons themselves that often are not informed about their rights.

2.5.3. Rights of family and caregivers and their duties.

The legislative decree 72/1983 gives the family the right to hospitalize the patient against his or her will if decided by a psychiatrist incapable of consent. It also gives them the right to refuse his hospitalization or his stay in the hospital or any act that can violate the integrity of the patient. The family also has the right to obtain information and to express their opinion about the treatment. It is understandable to give the family these rights based on the assumption that they are acting in the patient’s best interest, and to involve them in the care of the patient. Nonetheless, it is of the same importance to balance between their rights and the rights of the patient.

2.5.4. Oversight bodies

The legislative decree 72/1983 gives the “national committee of the disabled” the responsibility for looking to the complaints about care and hospitalization from the patient and his family. The committee should give its decision in a one-month period and it would be immediately applicable, unless contradicted by the minister of health. Furthermore, the legislative decree gives the minister the power to refuse the decision of the committee, whereas the patient should be able to rely on a judiciary independent body to protect his rights (Saghieh & Saghieh, 2009). And finally, the review cases of involuntary admissions and treatment are made upon a complaint from a patient or his family, without any review body created to monitor these conditions in hospitals spontaneously after every involuntary admission as it should be the case to prevent an unnecessary maintenance of the hospitalization (WHO, 2003).

The WHO report on Mental Health System in Lebanon also states that there is no authority to oversee inspections in mental health facilities and to impose sanctions on those facilities that can violate patient’s rights. The review and inspection of human rights protection of patients in the mental hospitals in the country as well as for the community-based psychiatric inpatient units are not performed given that there is no inspecting body. Currently, there is no legislation in this matter and a call of action is desperately needed in this regard to enforce human rights inspection in all mental health facilities.

3. Criminal laws in relation to mentally disordered offenders

In general, the criminal law in Lebanon considers the presence of a mental disorder an attenuating factor for the sanction (Lebanese Act 572 of the Penal Code). Additionally, it requires that the person be detained in a “security asylum” for purposes of treatment. If the offender has an “insanity of mind”, the sanction can be canceled and he is thus detained in a “security asylum”. The detention goes on until his remission is proven, by a decision from the court that judged him, without any specification by the law of the maximum duration of the detention and he could be under parole after his liberation.

If the offender has an “abnormality of mind”—a mental disorder not severe enough to deem them “insane” but of sufficient degree to substantially impair their ability to determine or control their actions—the sanction is attenuated. But if he is an “idiot” and is a danger to public safety, he is detained in a security asylum to get treatment for the duration of the sanction. If he stays a danger to public security after this period, he is maintained in a security asylum by a decision from court for a period of maximum five years if he is convicted of a crime, and two years if he is convicted of an offense. He can be liberated before this period by a medical report stating that he is no longer a danger to public security and he could also be subjected to a probationary period after his discharge.

This law can lead to a great deal of abuse, especially with a definition as vague as “public security”, and the absence of ways to appeal the decision of the detention prolongation. The World Health Organization states that in the case of non-responsibility of the detained because of a mental disorder, he can return to the society unless it is proven that he needs treatment (Saghieh & Saghieh, 2009). He also should have the right of appeal and review of the decision of detention, and the right to receive adequate treatment and to participate in the decisions related to his treatment. His detention in the center should not exceed the duration of his sanction unless his mental condition is not yet stabilized and the conditions of common involuntary admission would then be applied.

The law does not mention the situation of the person with a mental condition between the date of the arrest and the date of the conviction. The court should also evaluate the fitness to plead of the person, knowing that this capacity is measured by evaluating his ability to understand the nature and the aims of the procedures and the possible sanctions as well as his ability to interact with a lawyer. There should be a limited date for the psychiatric expertise, to be sure that the person is not detained without reason. If it is proven that there is no fitness to plead in court, it is possible to delay the procedures until he recovers his ability and in this case, he should be transferred to a mental health institution to be treated. However the current law in Lebanon concerning mentally disordered offenders does not include information or conditions related to fitness to plead or to stand trial. There is no specification on criminal responsibility of the mentally ill, only vague terms about “insanity of the mind”, “abnormality of mind”, and not clear conditions and situations where the mentally ill can or cannot be held responsible for his actions.

In summary, the law of offenders with mental disorders clearly needs to be reviewed in light of international standards.

4. Laws relating to incapable adults

Capacity is a legal concept meaning the ability to enter into valid contracts. It is gained on adulthood and is presumed to be present throughout the lifespan unless permanently or temporarily lost. A Mental Capacity Act should provide the legal framework guiding decision-making on behalf of those who lack capacity to make decisions for themselves. Guardianship aims at preventing situations where a person whose capacity is impaired might be exploited by a third party, or where a person might take a decision that he wouldn’t have in his capacity intact. The principles of a Mental Capacity Act should include the
presumption of capacity of the person unless the contrary is established, the acting in the best interests of the person, the choice of the least restrictive option to their basic rights and freedom, and the declaration of incapacity made after all practical steps were taken to allow autonomy without success (Rosenthal & Sundram, 2004).

The law regulating incapacity in Lebanon dates back to the era of the ottoman’s occupation and have not been reviewed nor modified in the civil code of obligations and contracts that was supposed to supersede “Ahkam al Majalla”, the civil code at the times of the ottomans. This ancient law uses terms such as: the idiot and the insane, to differentiate levels of incapacity, and state that the legal obligations and contracts that are done by a person who is proved to be “idiot or insane” can be annulled, and that if he is considered incapable, a guardian should take decisions on his or her behalf concerning the personal welfare and financial decisions. Furthermore, they are not considered to have civil responsibility of their actions, and the guardian is considered responsible of their actions. An in-depth analysis of the law regulating incapacity in Lebanon, including a critical view on ahkam el Majalla has already been evoked by El-Husseini (1997) confirming that these texts are in clear contradiction with international human rights law; they do not mention at any time the rights of the disabled to recognition as persons before the law. There can be a great misuse of these laws, when people are wrongly assumed to lack capacity. The law doesn’t specify that lack of capacity cannot be presumed based on a person’s age or appearance, on any aspect of his behavior, on any condition or disorder from which he suffers. Also, a person cannot be considered incapable merely because they make an unwise decision. Moreover, there is no mention of the process for assessing incapacity, the procedure for appointment of guardian, the definition of the areas for guardianship, the duration, roles and responsibilities, as well as the penalties for failure of guardian to carry out duties, and the process of appeal against appointment of guardian, as well as regular review of need for guardianship, as stated by international recommendations (WHO, 1996). It also does not specify that certain decisions can also not be made by one person on behalf of another, like agreeing to marriage, civil partnership or divorce, consent to a sexual relationship and casting a ballot in an election (Rosenthal & Sundram, 2004).

It is urgent that these texts be reviewed and modified on the light of international human rights law, notably the CRPD, that promotes a new system whereby people with mental disabilities retain legal capacity and are provided with support in making decisions. Supported decision-making is the process whereby a vulnerable person is enabled which can be applied in psychiatric practice, International Journal of Law and Psychiatry (2015), xxx–xxx).

5. Conclusion

Mental health legislation can provide a legal framework for addressing critical issues such as community integration of persons with mental disorders, the provision of high quality care, the improvement of access to care, the protection of civil rights and the protection and promotion of rights in other critical areas such as housing, education and employment (UN General Assembly, 2007). Mental health legislation is thus more than just care and treatment legislation that is narrowly limited to the provision of treatment in institution-based health services and must address all the other psycho-social issues.

The last decade has seen significant changes in the laws relating to psychiatric practice all over the world. The modification of the Mental Health Act in France that took effect in July 2011, incorporated the new concept of a “mental health care program” which can be applied outside the institution and in the least possible restrictive environment, with intensification of the supervision and oversight bodies to regulate involuntary admissions and treatment (French Law 2011/803). In Egypt, the Parliament adopted in 2009 a new law entitled the “Law for the care of mental patients” that integrates international recommendations and human rights standards in all aspects of mental health care including, among others, the specification of the sanctions for service providers who violate patient’s rights and an obligation among mental health institutions to notify the public prosecutor within 24 h of involuntarily admitting a patient (Jenkins, Heshmat, Loza, Siekkonen, & Sorour, 2010). This new law obliges the Minister of Health to issue implementing regulations and this mental health reform is particularly timely in Egypt, given the country’s ratification in 2008 of the CRPD. Further changes are likely over the decade to come, especially with the implementation of the CRPD and the increasing awareness about the role of a mental health law in protecting and promoting human rights in persons with mental disabilities.

Unfortunately, in Lebanon, this issue seems forgotten. Our research within the official legislative texts reveals one legislative decree that treats specifically the protection and treatment of persons with mental disorders. This decree does not set out criteria and procedures to be followed in case of involuntary admissions or treatment, and above all, lacks any mention of a regular legal supervision on involuntary admissions and treatment in psychiatric institutions. Furthermore, there is no applicability of this legislation since the community health care centers for follow-up and reinsertion stated by the decree have not been created by the government. Thus the only way to access mental health care in the public sector is through the psychiatric institutions, which clearly does not promote community integration.

Perhaps the most striking legislation still in use is the text relating to incapacity dating back to the period of the ottomans. It uses terms such as “the idiot” and “the insane” to designate people with mental disorders or intellectual disabilities. This text from the “Ahkam el Majalla” (the “civil code” of the ottomans) lacks all specification about the procedures to assess capacity, the measures that should be taken in order to prevent them from guardianship abuse, as well as the review for need to guardianship.

In summary, the legislation relating to mental health and incapacity in Lebanon needs to be reviewed and modified according to international human rights, notably the CRPD. More research is necessary to increase the awareness of mental health professionals about the necessity for a mental health law and its day-to-day clinical implications. It would be interesting to conduct studies among professionals to see their awareness of the situation and their knowledge of the basic rights of the persons with mental conditions and of international recommendations, mainly in the area of involuntary admissions and treatment. Indeed, an understanding of how the law works seldom happens through reading the text legislation; it develops through training and experience and discussion with colleagues. But for this to happen, a legislation integrating the principles of human rights needs to exist, as well as a mental health policy. It is noteworthy to mention that a draft for a national mental health policy has been submitted in 2011 to the Ministry of Health by one of the authors, El Chammaili, commissioned by the WHO. This draft was developed after a first round of collecting a few expert opinions and review on the existing literature. A discussion and a consensus are to follow once the Ministry of Health agrees on the first draft that includes the revision of the mental health legislations in Lebanon.

Another important step is the recent submission of a proposal for a Mental Health Act to the Parliament, in the context of a project commissioned by the European Union with the coordination of the Office of the Minister of State for Administrative Reform and Development (OMSAR). It would be important to review this proposal and see if it is in accordance to international recommendations and if it does truly protect the patient and promote his rights. However the authors were not able to have access to the text.

It is important to remember that the law cannot resolve all clinical dilemmas. However, having a clear legislation reference orientates the

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psychiatrist in the clinical decision and above all protects the person with a mental disorder from abuse and discrimination. Perhaps the first action would be to increase awareness and to lobby among mental health professionals and service users for a mental health law in line with the international conventions on human rights.

Conflict of interest

None.

References

Ahkam Al Majalla Chapter 9 – Al Hajr (Declaration of incapacity), 2015.
Loi française n° 2011–803 du 5 juillet 2011 relative aux droits et à la protection des personnes faisant l’objet de soins psychiatres et aux modalités de leur prise en charge (French Law 2011/803, July 2011, concerning the rights and the protection of persons under psychiatric care and the modalities of their treatment).