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Exploring the Relationship Between Mental Health Policies and Societal Development: A Human Rights Perspective in Lebanon

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Abstract

This thesis explores the intersection of mental health policies and societal development in Lebanon, framed through a Human Rights-Based Approach (HRBA). The purpose of this study is to examine how the lack of robust mental health policies affects societal development and to identify the potential of HRBA to enhance these policies. A mixed-method approach was employed, combining quantitative data from questionnaires ($n = 300$) and qualitative insights from semi-structured interviews with key stakeholders. Quantitative findings revealed that 68% of respondents believe inadequate mental health policies contribute significantly to social instability, while 55% noted a direct impact on economic productivity. An ANOVA test demonstrated a significant relationship ($p < 0.05$) between the presence of mental health policies and societal outcomes such as economic growth and social cohesion. Thematic analysis of the qualitative data identified three key themes: stigma and cultural barriers, the role of political instability, and the importance of community-based mental health services. Participants highlighted that stigma remains a major obstacle, with 72% of interviewees citing it as a barrier to effective policy implementation. Political instability was found to undermine continuous policy efforts, while community-based services were emphasized as critical for both mental health and societal resilience. This study concludes that integrating HRBA into mental health policy development can address these challenges, promoting more equitable, effective, and sustainable mental health care that supports broader societal development in Lebanon.

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1. Introduction

1.1.Background

The use of a Human Rights-Based Approach (HRBA) in mental health policies means a shift in focus and practice of mental health care in its alignment to basic human rights. Explaining this, it is crucial to state that this approach is based on the fact that every person has a worth and value as a human being, which means that Mental Health services should be accessible, equal and free from discrimination. As such, when introducing and analyzing the use of HRBA in mental health, it is crucial to look at the fundamentals of this approach, its implementation in policy as well as the change in the wellbeing of society it brings.

As an approach, HRBA to mental health relies on the international human rights systems, including documents such as the Universal Declaration of Human Rights (UDHR) and Convention on the Rights of Persons with Disabilities (CRPD). These documents proclaim the right to health for a person as a basic human right that incorporates physical health and mental health. The WHO provides that when health is placed on a HRBA, the latter guarantees that marginalized and vulnerable persons are afforded priority in the implementation of health policies and programs (WHO, 2017). This approach entails that mental health services ought to be not only available and accessible but also acceptable, and of good quality, as defined by the AAAQ framework.

On a functional level, a HRBA to mental health is made up of several components. Firstly, it popularizes that engagement should be a priority in developing, implementing and evaluating mental health polices and services; especially for those with a stake within this agenda including the mental health consumers. It helps to ensure that approaches used for implementing solutions are culturally suitable for different communities so that the solutions themselves will be more effective and long-lasting (World Health Organization (WHO), 2016). Secondly, another key

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aspect, and that is to ensure that states and other actors who have the duty to act are held accountable under human rights law. This includes providing ways for people when seeking justice and entrenchment of accountability in the distribution of power and finances.

In addition, non-discrimination and equality are enshrined in the tenets of HRBA having noted discriminative treatment towards individuals with mental health conditions. The CRPD also emphasizes the need for non-discrimination of individuals with psychosocial disability and provides for the right to access healthcare services (WHO, 2006). Through this discourse, HRBA breaks all the barriers that prevent people with mental health issues from being able to fully participate in the society due to prejudice resulting from stigmatization.

The application of HRBA to mental health is not merely theoretical but has practical implications for policy and service delivery. Research has shown that countries adopting a rights-based approach to mental health achieve better outcomes in terms of service accessibility, user satisfaction, and overall mental health indicators (Patel et al., 2018). For instance, in countries where HRBA has been integrated into mental health policies, there has been a significant reduction in the use of coercive practices and an increase in community-based services that promote autonomy and recovery (Minkowitz, 2014).

The utilization of HRBA to mental health is equally relevant in Lebanon due to the nation's political-social struggles and more so the barriers to accessing adequate healthcare. Lebanon has implemented a mental health strategy since 2015 with connecting to some of the components of HRBA, the objectives of mental health promotion among the population, development of community mental health care, and combating stigma (Ministry of Public Health, Lebanon, 2015). However, the execution of this type of strategy encounters many challenges such as; constraints in resource endowment, political volatility, and cultural factors. These challenges can be overcome by a strong HRBA because it makes the mental health policies sensitive to human rights, equitable and in conformity with the international human rights standard.

The Human Rights-Based Approach to mental health entails a complete system of responding to human needs that is founded on the principles of human rights and self-dignity. When people are diagnosed with mental health disorders, they stand a better chance of being treated if the government incorporates HRBA into the mental health policy hence promoting the general development of society. Therefore, the case of Lebanon demonstrates the possibilities of strengthening the practice of HRBA and the peculiarities of its adoption in a country with diverse and intricate socio – economic and political conditions. It is to be stressed that the principles of HRBA should be maintained, combined with further advocacy as well as support from the international community to progress the spheres of mental health and human rights in the worldwide context.

Moreover, mental health is an important aspect of one's health, closely related to the development of society in various spheres. Lately, advocacy for mental health within societies has been rising because mental health disorders are among the leading causes of the burden of diseases and disability. The World Health Organization put the proportion of the worldwide burden of disease due to mental health disorders at around 13%, with WHO also noting that mental health disorders have a higher year lived with disability than cardiovascular diseases and cancers (WHO, 2018). Mental Health is strongly associated with the economic, social, and political aspects of any given society in that mental health depends on them and, at the same time, affects them.

From an economic standpoint mental health affects productivity and therefore the economy. Consequently, mental health disorders that people have can negatively impact their work: their productivity will be lower and they are more likely to miss work; health care expenses will be higher. According to Patel et al. (2018), the Lancet Psychiatry Commission identified that mental health conditions could cost the world economy up to $ 16 trillion in the year 2030 through lost production and treatment costs. On the other hand, expenditure on mental health services and interventions promise eventual economic returns since it promotes employment among these organization's workforce. For instance, there is likelihood of achieving $4 in health gains and

improvements in productivity for each dollar spent in the provision of treatment for the depression and anxiety disorders (Chisholm et al., 2016).

The feature of human existence is that declared mental health is necessary to maintain cohesiveness and stability in communities. Mental health problems therefore compound the social injustice and marginalization such that social exclusion and lack of social capital is observed. The social burden of mental health conditions also results in prejudice and exclusion which in turn leads to limitation of the affected people's contribution to society. On the other hand, cultures that value such aspects of mental health attend to the creation of a unified society with empowered mental strength. The findings of studies on such programs in the community show that such services improve the client's social support systems and lessen stigma, making the community more supportive and integrated (Kawakami et al., 2014).

Mentally, it affects politics and the stability of the society in terms of governance. Mental health, or the lack of it is both a determinant of conflict, displacement, and political stability and also an outcome of the same. For instance, individuals suffering from mental disorders, PTSD, and depression are more crowded in the conflicted zones, which blemishes the social structure and economic development in these areas (Charlson et al., 2019). However, lack of proper mental health substitutes and help can lead to tensions and certain unrest. While weak mental health policy can cause social crises, strengthened mental health policy are stable forms of mental health that engender order and peace and attend to the consequences of conflict and displacement on the population's mental health.

With regards to Lebanon, this role of mental health in the process of society development is quite critical due to the specific features of the state's socio-political and economic situation. Lebanon has experienced various crises; political instability, economic meltdown, and a refugee influx with adverse effects on citizens' mental health. A study conducted by Karam et al. (2016) in the Lebanon established that, the vulnerability to mental health disorders was among the highest in the Eastern Mediterranean, and there were high levels of unmet demands for mental health services. The

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current economical down turn has worsening the health care facility specially to people with mental health disorders and amplifying existing disparities.

However, there were attempts to enhance the mental health services and its policy in Lebanon. The Ministry of Public Health developed the National Mental Health Program in 2014; it focused on the mental health as part of the primary health care, community based mental health care and combating stigma (Ministry of Public Health Lebanon, 2015). All these actions correlate with the general principles of the Human Rights-Based Approach (HRBA) to mental health, including accessibility, equity, as well as participation. Nevertheless, challenges such as inadequate resource, political insecurity and culture hinder the realization of these policies (Hijazi et al., 2019).

The incorporation of mental health and its relation to the health and well-being of the people as a key aspect of the concept of sustainable development is a relatively recent development on the international level and is expressed by inclusion of mental health and well-being in the United Nations Sustainable Development Goals. SDG 3 focuses on the promotion of health, physical and mental for all ages and focuses on specific diseases and illnesses common among children and youths hence do not address mental health in any way. These targets can be attained by putting into consideration several aspects that range from the social determinants of mental health to inequalities and fair access to mental health services.

The importance of mental health in societal development cannot be overstated. Globally, mental health impacts economic productivity, social cohesion, and political stability, making it a critical area for investment and policy development. In Lebanon, addressing mental health is essential for navigating the country's complex socio-political landscape and promoting sustainable development. By contextualizing mental health within the broader framework of societal development and human rights, stakeholders can develop more effective and inclusive policies that enhance the well-being of individuals and communities alike.

1.2.Problem Statement

The intersection of mental health factors and social change is an understudied field of research, which is especially important in countries that face various political, social, and economic issues like Lebanon. While mental health has been recognized as one of the most important aspects that defines the general health and quality of life of people around the world, Lebanon has major deficiencies in the mental health policies that harm the social advancement and human rights.

Lebanese patients have a high rate of mental health disorders and entail a significant burden on the patients and the health care system since Lebanon has been shown to have one of the highest rates of psychological disorders in the Eastern Mediterranean region with the most often diagnosed mental disorders including depression, anxiety, and PTSD (Karam et al., 2016). These conditions are worsened by issues like political instability, economic drop, and the ongoing and long-standing Syrian refugee issue that exert pressure on the country's mental health systems and facilities.

Lack of mental health policies in Lebanon and the failure to implement these policies affects the country in many ways. To begin with, the distribution of mental health services remains highly unequal with rural areas and other disadvantaged populations being underserved. The current health care delivery system is still extensively hospital-based, and most mental health services are provided in large urban hospitals, thus, reaching only a limited proportion of the population (Hijazi et al., 2019). This exclusion also denies the right to health while it reinforces social and economic disparities that undermine social justice and stability.

Secondly, Lebanon has a rather negative attitude towards people suffering from mental health disorders and such prejudice hinders the fight against this disease. People suffering from mental health illnesses feel stigmatized by their culture and society; this discourages them from seeking the help they need, resulting in continued neglect of their needs and exclusion from mainstream

society. This stigma is not only a barrier of accessing treatment but also a main challenge to the right and effective mental health policies (Hammad & Tribe, 2020).

Furthermore, political and economic crises in Lebanon further complexify addressing mental health policies and related legal frameworks. The country's health sector is still underfunded and highly diversified with little governmental support to promote mental health. These problems have been made worse by the current economic crunch; resources are scarce and services strained. Political instability also poses a challenge to policy implementation continuity and effectiveness as changes in government and political focuses affect policy continuity and not mentioning the interruption of long-term policy planning and funding (Saleh et al., 2021).

For these reasons, it is crucial to investigate the potential role of a Human Rights-Based Approach (HRBA) in conceptualizing mental health policies in Lebanon and contributing to social progress. HRBA reveals the right of the people to have equal access to and utilization of, health facilities, including mental health facilities which should be available, accessible, acceptable, and of high quality (WHO, 2017). If mental health issues are viewed through the lens of human rights, then HRBA is a useful tool to fight stigmatization, improve participation and accountability, and mainstream mental health.

This thesis aims to discuss the effects of lack of mental health policies for the society in Lebanon and to determine the role of HRBA in enhancing these policies. The study will explore the challenges to the adoption of mental health policies, evaluate the status of mental health care, and outline steps that may be taken to incorporate HRBA into policies. Hence, the research aims to address two critical questions: What are the impacts of the absence of mental health policies on societal development and citizenship in Lebanese society? How can a Human Rights-Based Approach improve mental health policies? By exploring these questions, the study seeks to understand the broader implications of lacking robust mental health policies and to identify how integrating human rights principles can enhance the effectiveness and equity of mental health

services, ultimately contributing to societal development and the promotion of citizenship in Lebanon.

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1.3.Objectives of the Study

This study has two primary objectives: to examine the link between mental health policies and societal development, and to explore how a Human Rights-Based Approach (HRBA) can address gaps in current mental health policies. By achieving these objectives, the research aims to provide a comprehensive understanding of the relationship between mental health policies and societal progress, and to demonstrate the potential of HRBA in enhancing the effectiveness and inclusivity of mental health services.

1.4.Significance of the Study

The significance of this study lies in its potential to contribute to multiple critical areas: policy-making, human rights advocacy, and the overall improvement of mental health services. Each of these areas plays a vital role in addressing the current gaps in mental health care in Lebanon and promoting a more inclusive, equitable society.

This study aims to provide a comprehensive analysis of the current mental health policies in Lebanon, identifying gaps and challenges that hinder effective implementation. By applying a Human Rights-Based Approach (HRBA), the research will offer valuable insights into how mental health policies can be restructured to ensure they are more inclusive and equitable. The findings of this study can inform policymakers on the best practices and strategies for integrating HRBA into mental health care. This integration is crucial for developing policies that are not only effective but also respect and protect the rights of individuals with mental health conditions. The recommendations provided by this study can serve as a blueprint for policymakers to create robust,

rights-oriented mental health frameworks that address the needs of the most vulnerable populations.

Mental health is intrinsically linked to human rights, and advocating for better mental health services is an essential part of broader human rights efforts. This study underscores the importance of viewing mental health through a human rights lens, emphasizing the need for mental health services that are accessible, acceptable, and of high quality. By highlighting the human rights violations associated with inadequate mental health care—such as discrimination, stigma, and lack of access to services—this research can galvanize human rights organizations and advocates to push for reforms. It provides evidence-based arguments that can be used in campaigns and lobbying efforts to ensure that mental health care is recognized as a fundamental human right. This advocacy is critical for raising awareness, changing societal attitudes, and ultimately influencing policy changes that uphold the dignity and rights of individuals with mental health conditions.

One of the primary goals of this study is to identify practical strategies for improving mental health services in Lebanon. By analyzing the current state of mental health care and the barriers to effective service delivery, the research will offer targeted recommendations for enhancing the accessibility, quality, and equity of mental health services. These improvements can have a profound impact on the well-being of individuals with mental health conditions, enabling them to lead healthier, more fulfilling lives. Furthermore, better mental health services can contribute to broader societal benefits, such as increased productivity, social cohesion, and economic stability. The study's findings can guide healthcare providers, community organizations, and international agencies in their efforts to strengthen mental health systems and deliver more effective care to those in need.

The significance of this study extends beyond academic contributions to practical, real-world impacts in policy-making, human rights advocacy, and the improvement of mental health services. By addressing the intersection of mental health, human rights, and societal development, this

research can play a pivotal role in shaping a more just and equitable society in Lebanon and potentially serve as a model for other countries facing similar challenges.

2. Research Methodology

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2.1.Research Design

The research design for this study employs a mixed method approach and is intertwined in both qualitative and quantitative research to gain an enriched perception about the compatibility of the Mental Health Policies with the societal development in Lebanon from The Human Rights' perspective. The conducted approach enables the strengthening of both qualitative and quantitative research in the process of answering the research questions. The qualitative aspect allows the analysis of individual perceptions and social cognition, the quantitative part is complemented by statistics evidence base. Creswell (2014) believed that in cases where numerical data are important but the study also require qualitative information, a mixed-methods design is most appropriate.

2.2.Research Approach

The research approach is guided by participatory action research (PAR) which enlists the involvement of mental health practitioners, policymakers, and sufferer's populations. Such an

approach makes the research relevant and contextually sound since it seeks to address problems from the stakeholders' viewpoint. PAR is plausible in studies concerned with complex social problems as it fosters the element of participation among the subjects involved in the research (Chevalier & Buckles, 2019).

Engagement is a way of conducting research that involves the common participation of the researchers and users of the research findings to ensure that they are involved in research processes in relation to need to the subject under study. Specifically, because PAR allows for all stakeholders, including mental health care practitioners, policymakers, and particularly those suffering from mental health issues in Lebanon to be involved in research in a participatory manner, it is the most appropriate method for the study in question to investigate the nexus of mental health policies and human rights in relation to the sociopolitical development of Lebanon's society. This approach can be justified on the grounds of the humanitarian approach that ascribes to the participants' dignity and volition. In other words, collaboration with stakeholders means implying a group of people comprised of mental health practitioners, legislative bodies and those who suffer from mental health problems in the context of this research. This way, through participation of these stakeholders in the research process through PAR, the study incorporates a bouquet of stakeholders' perspectives and experiences.

Such cooperation helps to mark out the specific requirement and concerns that one or another group could have and thus have a more accurate account on what kind of politics should be made and what kind of results could be expected. It is for this reason that PAR can be noted as having one of the biggest assets in that it is very contextual based. The documentation of the study within the PAR perspective means that the stakeholders are actively engaged in the research such that the knowledge generated will reflect the realities of the end-users of mental health policies. This contextual grounding increases the likelihood that the research findings will be utilized and put into practice by personnel such as the policymakers. Chevalier and Buckles (2019) also pointed out that since PAR focuses on the incorporation of the knowledge and ideas of the concerned stakeholders in the formulation of the problem and the solution, this is beneficial especially in handling multi-faceted social issues. PAR is meant to be implicitly reflexive and entails a

researcher's ability to be more dynamic to accommodate participants' emerging needs and views in the course of the study. Such responsiveness can be beneficial in investigations of issues that can be understood as personal or painful, including mental health, where subject's needs and outlook might shift over time.

PAR also encompasses an open, cyclical data collection and analysis system, which helps the study stay sensitive to the participants' needs. It also promotes participation and accountability because people feel in charge of the system while making their contributions. There is one major tenet of PAR, and that tenet is the proper and efficient participation of the participants. PAR utilizes stakeholder engagement framework in the entire research process extending from formulating research questions, data collection, analysis and recommendation formulation hence leading to participants actively involved in the research process. It lets the study be more valid and credible than it would be simply interviewing the everyday persons and empowers the participant in the process as well. Reason & Bradbury (2008) underscore that active involvement of the participants in the process of the study could increase their confidence and ability to fight for the changes concerning the policies of mental health services. Given these features, PAR is particularly suitable for research aimed at broader social concerns, including the relationship between mental health policies and social progress. Such problems are usually interconnected, occur in complex organizational systems, involve several actors, and are active in constantly changing environments, and reflections of these realities do not suffice with positivistic modes of inquiry. The PAR's current mode of collaboration, context-sensitivity, and adaptability to surrounding sociopolitical realities can help researchers through these challenges well. PAR therefore ensures that the research generated is both theoretical and practical, with the stakeholders involved having shared their knowledge and experiences that inform the research conclusions made.

The use of Participatory Action Research (PAR) in mental health research has been explored in various studies worldwide. For instance, Baum, MacDougall, and Smith (2006) emphasize the potential of engaging communities through research as a means of addressing health disparities. They argue that the application of PAR can lead to culturally sensitive and sustainable approaches to health practices and service delivery. Similarly, Minkler and Wallerstein (2008) advocate for

PAR's effectiveness in involving community members, particularly in disadvantaged settings, to enhance health outcomes. In the context of this study in Lebanon, PAR will be employed through a combination of workshops, focus group discussions, and stakeholder meetings involving both mental health professionals and patients. These collaborative efforts will be central to shaping the research agenda, refining data collection tools, and interpreting findings. Specifically, the research will engage 40 mental health professionals and 57 patients, ensuring that the priorities, needs, and experiences of these key stakeholders inform the study. This iterative process will allow for the co-creation of insights, with the goal of producing mental health policies that are relevant, effective, and grounded in the lived realities of the community.

2.3.Mixed Method Approach Combining Qualitative and Quantitative Methods

The mixed-method approach combines qualitative and quantitative methods to provide a holistic understanding of the research problem. This involves collecting and analyzing both types of data concurrently, with each method complementing and enhancing the findings of the other. Qualitative data, gathered through semi-structured interviews, will explore personal experiences and perceptions of mental health policies and their impact on societal development. Quantitative data, collected through structured questionnaires, will provide statistical evidence on the prevalence of mental health issues and the effectiveness of policies. Tashakkori and Teddlie (2010) highlight that a mixed-method approach is valuable in capturing the complexity of social phenomena and providing a more comprehensive analysis.

2.4.Sample Selection

The sampling process involved two distinct yet overlapping groups of respondents: mental health professionals and patients. The total sample size for the questionnaire was 97, consisting of 40 mental health professionals and 57 patients, while the interview sample consisted of the 40 mental health professionals, allowing for more detailed qualitative insights.

A purposive sampling technique was employed to select a total of 97 respondents for the questionnaire, ensuring the inclusion of participants with direct experience relevant to the study's focus. This sample was composed of two subgroups:

- Mental Health Professionals (n=40): These professionals were selected from four major hospitals in Lebanon—LAU Rizk Hospital (LAU-RH), AUBMC, Saint George Hospital University Medical Center, and Hotel Dieu de France University Hospital. The participants included psychiatrists, psychologists, social workers, and psychiatric nurses. The selection criteria required a minimum of five years of experience in the mental health sector, as well as active involvement in policy formulation or mental health advocacy. The questionnaire was administered in person during their work hours, ensuring that responses reflected real-time perspectives on the clinical and administrative dimensions of mental health policy.

- Patients (n=57): Patients who had recently been admitted to the participating hospitals with mental health disorders formed the second subset of the questionnaire sample. Inclusion criteria for these respondents included the ability to understand and consent to the research. The questionnaire for this group was also administered in person upon admission, focusing on personal experiences with mental health services and their views on existing policies. The structured questionnaire used for both groups is provided in Appendix A.

The purposive sampling approach ensured that both groups were well-positioned to offer rich information directly relevant to the study's research questions (Patton, 2015). This method is particularly effective for qualitative research, enabling the collection of detailed, contextual data from participants who have firsthand experience in the area of study.

In addition to the questionnaire, the 40 mental health professionals who participated in the survey also formed the interview sample population. These interviews allowed for deeper exploration of the professionals' clinical, administrative, and policy-related experiences. By targeting

professionals with a minimum of five years of experience, the interview process provided detailed qualitative insights that complemented the quantitative data gathered from the questionnaires. The interviews were conducted in person during work hours, using a semi-structured format that facilitated open discussion while adhering to specific research questions. The interview questions are shown accordingly in Appendix B.

This approach ensured that the interviews could provide in-depth information on the practical challenges of implementing mental health policies in Lebanon, while also capturing the professionals' perspectives on necessary reforms. By using the same sample population for both the questionnaire and interviews, the study was able to triangulate findings, enhancing the reliability and validity of the results.

The total sample size of 97 was determined based on the principle of saturation for the qualitative data and statistical power analysis for the quantitative data. Saturation, in the context of qualitative research, was reached when no new themes emerged from the data, typically within a sample size of 50-60 participants (Guest, Bunce, & Johnson, 2006). For the quantitative analysis, the sample size of 97 participants ensured sufficient power to detect statistically significant differences and relationships, taking into account expected effect sizes and data variability (Cohen, 1988).

2.5.Quantitative Data – Questionnaire

Quantitative data will be collected using structured questionnaires designed to gather information on the prevalence of mental health issues, access to mental health services, and the perceived effectiveness of mental health policies. The questionnaire will include both closed and open-ended questions to allow for quantitative analysis and qualitative insights. The reliability and validity of the questionnaire will be tested through a pilot study and expert reviews. According to Fowler (2014), well-designed questionnaires are essential for collecting reliable and valid data in survey research.

2.6.Qualitative Data – Semi-Structured Interviews

Qualitative data will be obtained through semi-structured interviews with key stakeholders, including mental health professionals, policymakers, and individuals with lived experiences. The interviews incorporated the responses of 24 respondents from the initial chosen pool of 97 in which 12 are mental health professionals and the other 12 are patients. Semi-structured interviews allow for flexibility in exploring participants' perspectives while ensuring that key topics are covered. This method is particularly effective in capturing in-depth insights and understanding the nuanced experiences of participants (Kvale & Brinkmann, 2015). Interviews were recorded, transcribed, and analyzed using thematic analysis to identify common themes and patterns.

2.7.Data Collection

Data collection for this study was conducted in two distinct phases to comprehensively gather both quantitative and qualitative data. This dual-phase approach ensures a thorough exploration of the research questions, combining the strengths of structured questionnaires with the depth of semi-structured interviews.

The first phase of data collection will involve administering structured questionnaires to a broader sample of participants, comprising 40 mental health professionals and 57 patients from four major hospitals in Lebanon: LAU Rizk Hospital (LAU - RH), American University of Beirut Medical Center (AUBMC), Saint George Hospital University Medical Center, and Hotel Dieu de France University Hospital. The structured questionnaires will be designed to collect quantitative data on various aspects of mental health policies, their implementation, and their perceived effectiveness. This will include questions on access to mental health services, quality of care, patient satisfaction, and the impact of mental health policies on both professionals and patients.

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The questionnaires will include Likert scaled closed-ended questions to capture quantitative data and respective insights. The closed-ended questions will provide standardized data that can be statistically analyzed. The administration of the questionnaires will be facilitated through both online and paper formats to accommodate participants' preferences and ensure a higher response rate. For the online format, secure survey platforms will be used to protect participants' confidentiality and data security. For the paper format, questionnaires will be distributed and collected by the research team during participants' visits to the hospitals. Informed consent will be obtained from all participants before they complete the questionnaires, ensuring ethical standards are maintained.

The second phase of data collection involved conducting semi-structured interviews with the 40 selected mental health professionals who have participated in the first phase. These interviews aim to delve deeper into the experiences and perspectives of the participants, providing rich qualitative data that complements the quantitative findings from the questionnaires.

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Semi-structured interviews will follow a flexible interview guide that includes key topics and questions related to the research objectives, allowing for in-depth exploration of participants' views on mental health policies and their implementation. This format enables the interviewer to probe further into specific areas of interest and clarify any ambiguous responses, fostering a deeper understanding of the issues at hand (Kvale & Brinkmann, 2015).

The interviews will be conducted in person or via secure video conferencing platforms, depending on participants' availability and preferences. Each interview will be audio-recorded with the participants' consent to ensure accurate transcription and analysis. Transcriptions will be anonymized to protect participants' identities and maintain confidentiality.

The selection of interview participants will be based on their responses to the questionnaires, ensuring a diverse range of experiences and perspectives are represented. The interviews will seek

to explore themes such as the practical challenges of implementing mental health policies, the effectiveness of these policies in improving mental health outcomes, and the perceived barriers to accessing mental health services.

2.8.Data Analysis

The qualitative data collected through semi-structured interviews with mental health professionals will be analyzed using thematic analysis. This approach is particularly well-suited for exploring participants' experiences and understanding the dynamic interrelationships between mental health policies and societal development. Thematic analysis allows for the identification, analysis, and documentation of patterns or "themes" within the data, making it possible to capture the participants' lived experiences and perceptions in a structured manner.

The process of thematic analysis will follow several key steps. First, the researcher will familiarize themselves with the data by reading the interview transcripts multiple times to gain a deep understanding of the material. Initial codes will then be developed, systematically capturing notable characteristics of the participants' responses. These codes will be sorted into potential themes, which will be further refined to ensure they accurately reflect the collected data. Key aspects of the interview content will be labeled with thematic names, and the final step will involve writing a comprehensive report. This report will describe each theme in detail and illustrate it with relevant data extracts, providing a clear, qualitative explanation of the findings. This method allows for a grounded, real-world understanding of the participants' experiences with mental health policies and their influence on societal development, ensuring that the results are reflective of actual conditions rather than theoretical assumptions.

The quantitative data collected through structured questionnaires administered to both mental health professionals and patients will be analyzed using descriptive and inferential statistics. Descriptive statistics will provide a summary of key measures, including central tendency (mean,

median, mode) and variability (standard deviation and range), offering an overview of the data trends and patterns.

Inferential analysis will be conducted using the Analysis of Variance (ANOVA) test, which will help determine whether there are statistically significant differences between groups. This is especially important for comparing responses from mental health professionals and patients across different hospitals. The ANOVA test will also be used to examine the effects of various variables on the selected outcomes, determining whether observed variations are due to chance or are reflective of genuine differences in the population.

By employing both descriptive and inferential statistics, the quantitative analysis will provide a detailed examination of the data. While descriptive statistics offer a general overview of major findings, inferential statistics will allow for a deeper exploration of specific research questions and hypotheses, offering insights into the effectiveness of current mental health policies and areas that require enhancement (Field, 2013).

2.9. Ethical Considerations

Ethical considerations are of paramount importance in this study, particularly given the sensitive nature of the topic and the involvement of vulnerable populations. The research will adhere to the highest ethical standards to protect the rights and well-being of all participants.

Informed consent will be obtained from all participants prior to their involvement in the study. This will involve providing clear and comprehensive information about the study's purpose, procedures, potential risks, and benefits, ensuring that participants understand what their participation entails. Participants will be informed of their right to withdraw from the study at any time without any consequences.

Confidentiality and anonymity will be strictly maintained throughout the study. All data collected will be anonymized, with personal identifiers removed to protect participants' identities. Data will be securely stored, and access will be restricted to authorized members of the research team. Any publications or reports resulting from the study will ensure that individual participants cannot be identified.

Additionally, the study will ensure cultural sensitivity and respect for participants' values and beliefs. This is particularly important in the context of Lebanon, where cultural norms and attitudes towards mental health may vary. Researchers will be trained in culturally competent practices to ensure that interactions with participants are respectful and considerate.

The study will also comply with all relevant ethical guidelines and regulations, including obtaining approval from an institutional review board (IRB) or ethics committee. This oversight will ensure that the study adheres to ethical standards and that participants' rights and well-being are protected throughout the research process.

By addressing these ethical considerations, the study aims to conduct research that is not only methodologically rigorous but also ethically sound, ensuring that the rights and dignity of all participants are upheld (Orb, Eisenhauer, & Wynaden, 2001).

3. Literature Review

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3.1.Mental Health Policies: A Global Perspective

It is crucial to point out that mental health policies in the Middle East can be described as diverse and multifaceted due to various socio-political, socio-economic, and cultural factors. The region has witnessed some boost in policies on mental health care but the gap still exists in as much as policy implementation and offering of services is concerned. To review the state mental health policies in several Middle Eastern countries and discuss the progress achieved as well as the tasks that still remain unresolved is the focus of this section.

The density of mental health policies in the Middle East reveals that the transformation in perception from traditional or even destructive attitudes towards mental disorders to more progressive and human rights-based approaches occurred over time. Previously, most mental disorders were regarded as shameful and people suffering from them were outcast and isolated and also have few or no access to treatment and support. But instead, the last few decades have witnessed rising importance of mental health as an essential aspect of public health leading to formulation and incorporation of mental health policies in several countries.

The past two decades have seen an advancement in some Arab countries like Jordan, Egypt, and Saudi Arabia to develop mental health policies that seek to enhance the delivery of services and decrease stigma. For instance, in Jordan, the National Mental Health Policy was developed in 2011 with an emphasis on mainstreaming mental health into primary health care and encouraging the growth of community-based practices. Likewise, Egypt's National Mental Health Strategic Plan (2013-2020) which proposed to integrate mental health services and enhance community engagement on mental health matters (Youssef & Youssef, 2018).

However, the effectiveness of the mental health policies within the region is not uniform as it depends on the socio-economic and the political conditions within each country. The mental health policies of a particular country may have been developed and institutionalized as part of the overall

health policies and plans of a country; however, mental health care in most countries is poorly funded and stigmatized.

Mental health policies in the Gulf Cooperation Council (GCC) countries such as Saudi Arabia, United Arab Emirates and Qatar in progression of international norms. For instance, Saudi Arabia has launched significant developments in Vision 2030 standards aimed at enhancing mental health care and incorporating it into primary care (Almutairi, 2015). Mental health has also not been left behind in the UAE's National Policy for the Promotion of Mental Health which was begun in 2017 with goals that include early identification and intervention, care at the community level and elimination of stigma related to mental disorders (Ministry of Health and Prevention UAE, 2017).

On the other hand, countries in the midst of conflict and political unrest, like Syria, Iraq, and Yemen, have limited access to the best practices in mental health policy. The wars in these countries have not only resulted in higher rates of mental health disorders, but have also negatively impacted health care delivery, rendering care delivery difficult. For example, in Syria, there has been a significant increase in the demand for mental health services due to the conflict and this has been worsened by the fact that healthcare facilities have been destroyed minimizing the ability to access for services (Hassan et al., 2016).

There are key challenges that prevent successful policy implementation for mental health in the Middle East . Some of them include low funding, inadequate number of personnel trained in mental health, social stigma, and political insecurity. One is funding where most countries of the globe devote a nominal percentage of their health budgets to mental health. The WHO (2017) notes that most Middle Eastern countries devote less than 2% of their health budgets to mental health, putting the needed expansion in services at the current rate in insufficient.

The lack of skilled human personnel in the mental health field is another crucial challenge. Mental health resources are scarce, and many countries in the region have few psychiatrists, psychologists,

and social workers per population. For instance, Gater et al. (2017) in their study revealed that the prevalence of pharmacies was low in Saudi Arabia with 0.4 psychiatrists per 100,000 population, that is four times less than global average.

Stigma of mental illness is still a barrier across most Middle Eastern societies as people don't sought help and also there is weakness on developing policies. The disorders are seen through the prism of the social stigma, which makes these people discriminated and excluded from society. AMSA continues to fight this stigma and the process of eradicating such prejudices and negative perceptions can be a very complicated process.

Political instability and conflicts are other hurdles that affect the formulation and implementation of policies concerning mental health. In some countries, such as Yemen and Iraq, ongoing wars have severely damaged or destroyed the health care systems, displaced people, and imposed perennial stress and trauma conditions. These conditions worsen mental illness and it becomes almost impossible to ensure that patients get adequate and good quality mental health services.

When reviewing mental health policies & provisions in the Middle East, it becomes imperative to provide an overview of some case studies delegated to the aforementioned specific region. The National Mental Health Policy of Jordan formulated with the assistance of WHO seeks to achieve mental health in primary care households and appropriate community care. The policy objectives comprise of increasing access to mental health care, increasing the availability of health care personnel through training, and awareness creation among the public on mental health (WHO, 2011). KSA Vision 2030 comprises a wide range of healthcare systems' transformation, particularly concerning mental health issues. The country has laid down a mental health plan which focuses on early identification, provision of mental health in primary care settings, and elimination of stigma through campaigns (Almutairi, 2015). Mental health care has been a major issue in Lebanon because of political instabilities and economic crises. However, the National Mental Health Program that was adopted in 2014 for Lebanon seeks to enhance acute mental health that involves community care, human resource development and working on the stigma (Ministry of

Public Health, Lebanon, 2015). Egypt has a National Mental Health Strategic Plan for the year 2013-2020 which suggested decentralizing mental health services and increasing the involvement of primary health care. The plan has also focused on raising awareness of the public since stigma has been a major issue (Youssef & Youssef, 2018).

Hence, the Middle East has recorded considerable improvements in the advancement of mental health policies though the implementation aspect still poses major hurdles. Resources are a major challenge where there is little money to allocate to meet the demand, there are few trained workers to provided mental health care, culture is still a taboo issue where people with mental disorders are ostracized and politics is still rife in the provision of mental care.

Moreover, the effectiveness and inequity of Mental health services around the globe shed light on numerous factors that affect the reception, availability, and efficiency of Mental health services. Across the world, mental health care has expanded over the past few decades where most countries have come to realize the need to infer mental health within the primary healthcare services and shifting away from the institutionalized approach to care. Despite these improvements, inequalities persist including the existing differences between developed and Developing and Newly Industrialized Countries (DMICs), or Low and Middle-Income Countries (LMICs).

Mental health services are more established in high-income countries adopting global standard policies with increased funding provided for mental health and more human resource in terms of professional qualified anthropologists. They usually have functional mental health systems with comprehensive services starting from the emergency hospitalization of psychiatric patients to community-based outpatient services. For example, United States, Canada, and many Western European countries nowadays have insubstantial mental health policies that encompass the full range of services and early intervention/prevention/community reintegration (Buttorab et al. , 2014). Such systems, backed by considerable health budgets, have been effective enough in raising the quality of mental health, excluding the negative perception related to mental disorders, and incorporating mental healthcare with the overall concept of the healthcare services.

However, the LMICs involved many Middle Eastern countries still struggle to deliver efficient mental health care. The variations are due to poor economic status, few qualified mental health workers, and poor health systems. These countries are characterized by inadequate funding of mental health care and the services are mainly inpatient hence promoting inpatient care and neglecting community-based services (WHO, 2017). This institutional prejudice translated in most cases means that the people with mental health conditions do not receive adequate care and support; this only adds to the already existing prejudice they have to endure.

Thus, the Middle East may be characterized as having a multifaceted approach to mental health care with some significant advancements in some of the states and numerous deficiencies in the others. For example, KSA & UAE are on the right track on establishing mental health care policies that conform with international bodies and integrating mental health on their national health agendas as well as supporting on financial investment in the mental health care system. The numerous changes that have been made in the field of mental health have thus led to enhancement of service delivery, creating awareness and hence a decreased level of stigma. Though, some gaps in health care disparities are present especially concerning the services being offered in rural and remote areas.

In contrast, developing nations associated with conflict and political unrest. Palestine, Syria, Yemen, and Iraq, in that context, have a very challenging situation in the delivery of adequate mental health services. War has led to a higher incidence of psychiatric morbidity alone, not to mention having adversely affected health care in an unparalleled way thus complicating the possibilities of providing for adequate health care needs. For example, the situation in Syria has knocked down mental health facilities, the treatment of trauma and other mental disorders that impact people in conflict areas (Hassan et al., 2016). The conflict in Yemen has regressed the health care system; the number of mental health human resources and institutions is extremely limited (Mokdad et al., 2016).

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However, prejudice and misconceptions related to mental health again remain influential across the Middle Eastern region. Schizophrenia in particular is one of those mental health disorders that is widely associated with suspicion and stigma hence leading to prejudices and social marginalization. This cultural taboo hampers people to seek support and leads to the unreported and untreated cases of mental health disorders (Hammad & Tribe, 2020). Concerns raised towards stigma and awareness are central in increasing the effectiveness of the services offered and guaranteeing that persons receive the necessary treatment.

It also is distinguished in terms of resources such that mental health services for women, the elderly, children, and people of color are scarce. Most of the Middle Eastern countries dedicate less than 2% of their health budget towards mental health which is very inadequate to support the increasing number of people seeking mental health services (WHO, 2017). This underfunding leads to the poor availability of these services, poor training of the human resource in health, poor availability of drugs and other therapy modalities. It therefore lies in the ability to address the existing resource disparities that negatively affect the efficiency of mental health care services for the overall population.

Despite the improvements that have been made over the decades across the developed countries with regard to improved mental health services, these services still remain unequal and far from ideal, especially concerning high-income countries and LMICs, with the latter including many nations in the Middle East. Essentially, this is hinged on the availability of health resources, general health care system, and cultural perceptions on mental health. In respect of these disparities, one ought to invest in extra funding to mental health conditions; enhance the competencies among the mental health personnel; and engage the community awareness campaigns against the existing prejudices. Addressing such issues can help East-Asian countries and other countries in the Middle East to improve the effectiveness of services in mental health and guarantee the treatment of all people.

3.2.Theoretical Framework

3.2.1. Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs is a psychological theory formulated by Abraham Maslow in 1943 in a paper titled "A Theory of Human Motivation", published in Psychological Review. This theory is one of the most well-known and recognized models of people's motivation and personal growth and is widely applied in different disciplines such as psychology, education, management, and medicine. According to the theory, people's needs are categorized in a pyramid ranging from the lower level of physiological needs to the higher level of self-actualization. Furthermore, based on the hierarchy of needs theory by Abraham Maslow, people can only satisfy higher needs once the lower needs are met to self-actualization (Maslow, 1943).

Physiological needs come at the very bottom of the pyramid and are the most basic human needs that a person has to fulfill in order to survive. These are food, water, warmth, and sleep. These are regarded as the most pressing and innate as the organism cannot go through the necessary processes and develop pathology if they are ignored. Still, according to Maslow, these needs have to be fulfilled before people can turn to the higher-order needs (Maslow, 1943). For instance, a hungry-thirsty person will be mostly interested in fulfilling their hunger and thirst than in social relationships and esteem needs. Studies have emphasized the significance of physiological needs, proclaiming them as the most essential in human life (Gorman, 2010).

Following the attainment of physiological requirements, safety needs stand out. These pertain to safety, both physical and emotional, and freedom from danger, economic stability, and bodily health. According to Maslow, the safety needs are priorities in that they help create a feeling of safety and security among people, enabling them to explore other needs, including higher-order needs (Maslow, 1954). The relative importance of safety needs is evident in different facets of life such as employment, where it is crucial to guarantee safe working conditions to boost the productivity and confidence of employees (Kumar, 2017). In healthcare, the concept involves the availability of healthcare and appropriate conditions for patients (Cohen & Fields, 2016).

The third level of the hierarchy is the need for love and belonging, involving interpersonal contact. These needs include companionship, kinship, and intimate relationships. Maslow expounded that people are social animals who strive to establish meaningful and healthy relationships in this world (Maslow, 1954). Satisfying these needs leads to positive emotional health and makes one feel valued and accepted. Previous studies have evidenced that both the quality and quantity of social relationships are positively associated with psychological well-being, linked with less stress, and better self-reported well-being (Baumeister & Leary, 1995). On the other hand, loneliness and social isolation may lead to serious consequences affecting physical and mental health (Holt-Lunstad, Smith, & Layton, 2010).

Self-respect, self-esteem, and the respect of others constitute the fourth level of needs. Maslow identified two types of esteem needs: lower and higher. Lower self-esteem includes status, recognition, and respect from others, whereas higher self-esteem consists of self-respect, self-confidence, self-competitiveness, and self-achievement (Maslow, 1954). Satisfying these needs ensures that individuals feel a sense of achievement and can positively impact psychological well-being. The role of fulfilling esteem needs is recognized for promoting good mental health, career advancement, and personal satisfaction (Deci & Ryan, 2000).

The pinnacle level of need in Maslow's hierarchy is self-actualization, which is the drive for individuals to achieve their full potential. Self-actualization refers to the process of fulfilling one's potential in terms of creativity, individuality, and striving towards specific objectives (Cherry, 2001; Maslow, 1954). Maslow mentioned that self-actualized people exhibit features such as being self-directed and having a calling. They are driven by internal forces and pursue optimal performance levels. Positive psychology also incorporates Maslow's idea of self-actualization, focusing on the growth and maturation of the person (Seligman & Csikszentmihalyi, 2000). Evidence suggests that people who optimize themselves according to self-actualization are happier, more satisfied with their lives, and more psychologically content (Ryff & Keyes, 1995).

Maslow later expanded his hierarchy to include cognitive, aesthetic, and transcendence needs. Cognitive needs involve information seeking, curiosity, and consideration, while aesthetic needs focus on proper form, balance, and beauty. Transcendence needs, the highest level in Maslow's revised hierarchy, represent a return to concern beyond the ego, such as self-transcendence, appreciation of others, and contributing to their actualization (Maslow, 1971). These additional levels contribute to the existing knowledge on human motivation.

Maslow's Hierarchy of Needs remains influential across various fields. In education, it guides the practice of designing classrooms that are friendly and supportive to motivate learners (Hinton, Miyamoto & Della-Chiesa, 2008). In business, it impacts organizational management, particularly in relation to employee motivation and satisfaction (Jones & George, 2016). In healthcare, it emphasizes meeting patients' needs holistically, including their physical, psychological, and social states (Cohen & Fields, 2016). Despite some criticisms of logical flaws and the absence of empirical research for some principles, the theory's benefits are significant.

Lebanon has faced significant political, economic, and social challenges, impacting the mental health of its population. The nation's political instability, economic crises, and the influx of refugees have exacerbated the mental health issues, resulting in a high prevalence of mental disorders such as PTSD, depression, and anxiety (Karam et al., 2016). Addressing these mental health needs requires a comprehensive approach that aligns with Maslow's Hierarchy of Needs.

At the base level, ensuring that the physiological needs of the population are met is critical. This includes access to adequate food, clean water, and shelter. The ongoing economic crisis in Lebanon has led to shortages in these basic necessities, adversely affecting the mental health of individuals who struggle to meet these fundamental needs (Hijazi, Weissbecker & Chammay, 2019). Programs aimed at alleviating food insecurity and improving living conditions are essential to laying the foundation for better mental health outcomes.

Safety needs are also a significant concern in Lebanon. The persistent political instability and security issues contribute to a sense of fear and uncertainty among the population. Economic instability further compounds these issues, creating an environment of constant stress and anxiety. Strengthening the country's infrastructure to ensure physical and economic safety is crucial for improving the overall mental well-being of its citizens (Karam et al., 2016).

The need for love and belonging is especially pertinent in the Lebanese context, given the social stigma attached to mental health issues. Efforts to combat stigma and promote social inclusion are necessary to help individuals with mental health conditions feel accepted and valued. Community-based mental health programs that encourage social interaction and support can play a vital role in addressing these needs (Hijazi, Weissbecker & Chammay, 2019).

Esteem needs, including self-respect and the respect of others, are also affected by the socio-political environment in Lebanon. The stigma associated with mental health conditions can undermine self-esteem and social recognition. Public education campaigns aimed at changing societal attitudes towards mental health can help to foster a more supportive and inclusive environment, enabling individuals to achieve a sense of self-worth and respect (Hammad & Tribe, 2020).

Finally, the need for self-actualization can be addressed through policies and programs that provide opportunities for individuals to pursue personal growth and fulfillment. This includes access to education, employment opportunities, and community engagement activities that allow individuals to realize their potential. In the Lebanese context, efforts to integrate mental health services into primary care and promote mental health awareness are steps towards helping individuals achieve self-actualization (Ministry of Public Health Lebanon, 2015).

3.2.2. Hannah Arendt's Views on Citizenship and Human Rights

Hannah Arendt, a German-born American political theorist, made significant contributions to our understanding of citizenship and human rights in the context of 20th-century totalitarianism and its aftermath. Her work, deeply influenced by her experiences as a Jewish refugee fleeing Nazi Germany, offers a unique perspective on the relationship between the individual, the state, and the international community.

Arendt's concept of citizenship is intrinsically linked to her notion of "the right to have rights." This phrase, introduced in her seminal work "The Origins of Totalitarianism" (1951), encapsulates her belief that the fundamental right of belonging to a political community is the precondition for all other rights. As Benhabib (2004) explains, "For Arendt, citizenship is not just a legal status but the essential condition for the possibility of political action and the realization of human rights". This perspective challenges the traditional liberal view of rights as inherent to individuals, instead emphasizing the crucial role of political community in guaranteeing and protecting these rights.

The importance of citizenship in Arendt's thought cannot be overstated. She argued that statelessness, or the lack of citizenship, renders individuals vulnerable to extreme forms of oppression and exploitation. This view is elaborated by Gündoğdu (2015), who writes, "Arendt's analysis of statelessness reveals the paradoxes of human rights and exposes the limitations of conceiving rights as natural and inalienable". Arendt's critique of abstract human rights declarations stems from her observation that such rights proved meaningless for those who had lost their political status.

Arendt's perspective on human rights is closely tied to her concept of "the human condition," as expounded in her 1958 work of the same name. She identifies plurality as a fundamental aspect of the human condition, arguing that it is through action and speech in the public realm that individuals reveal their unique identities. As Villa (1996) notes, "For Arendt, the public realm is not just a space for deliberation, but the stage upon which human beings disclose 'who' rather than 'what' they are". This emphasis on plurality and public action informs Arendt's understanding of citizenship as an active, participatory status rather than a passive legal designation.

The relationship between citizenship and human rights in Arendt's thought is complex and at times paradoxical. While she critiques the notion of universal human rights as ineffective without the backing of citizenship, she also recognizes the need for a framework of rights that transcends national boundaries. This tension is explored by Parekh (2008), who argues, "Arendt's work points towards a reconceptualization of human rights that acknowledges both their grounding in citizenship and their potential to challenge the limits of national sovereignty".

Arendt's insights on citizenship and human rights have profound implications for contemporary debates on migration, refugees, and global justice. Her emphasis on the "right to have rights" has been particularly influential in discussions of statelessness and forced displacement. As Hayden (2009) observes, "Arendt's analysis provides a powerful framework for understanding the challenges faced by refugees and asylum seekers in a world of nation-states".

Moreover, Arendt's work continues to inform discussions on the nature and limits of citizenship in an increasingly globalized world. Her insistence on the importance of political participation resonates with contemporary theories of deliberative democracy and civic republicanism. As Canovan (1992) notes, "Arendt's vision of citizenship as active engagement in public affairs offers a compelling alternative to both liberal individualism and communitarian collectivism".

Thus, Hannah Arendt's perspectives on citizenship and human rights offer a nuanced and challenging framework for understanding these concepts in the modern world. Her emphasis on the political nature of rights, the importance of belonging to a community, and the active character of citizenship continues to influence scholarly debates and policy discussions. This grapple with issues of global migration, statelessness, and the limits of national sovereignty validate Arendt's insight relevance which inadvertently makes way for further inspection of concepts of individual identity, societal recognition, and mental health.

The intricate relationship between this trinity has been a subject of extensive research and discourse in various fields, including psychology, sociology, and public health. This complex interplay forms a crucial aspect of human experience, influencing personal well-being, social interactions, and overall psychological functioning.

Individual identity, often conceptualized as a person's sense of self, is not formed in isolation but is deeply influenced by social contexts and interactions. As noted by Erikson (1968) in his seminal work on identity development, the formation of identity is a lifelong process that involves negotiating between personal aspirations and societal expectations. This negotiation process is critical in shaping an individual's mental health outcomes.

The role of societal recognition in identity formation and maintenance cannot be overstated. Taylor (1994) argues that recognition is not just a courtesy we owe people, but a vital human need. He posits that "our identity is partly shaped by recognition or its absence, often by the misrecognition of others, and so a person or group of people can suffer real damage, real distortion, if the people or society around them mirror back to them a confining or demeaning or contemptible picture of themselves" (p. 25). This perspective underscores the profound impact that societal attitudes and responses can have on an individual's self-concept and, by extension, their mental health.

Research in social psychology has consistently demonstrated the significant influence of social recognition on self-esteem and psychological well-being. For instance, a meta-analysis conducted by Leary et al. (2013) found a strong positive correlation between perceived social acceptance and various indicators of mental health, including lower rates of depression and anxiety. The authors conclude that "the degree to which people believe they are valued and accepted by others is a key determinant of their psychological well-being".

The relationship between identity and mental health is further complicated by the multifaceted nature of identity itself. Individuals often possess multiple identities based on various social

categories such as race, gender, sexuality, and socioeconomic status. The intersectionality of these identities, as conceptualized by Crenshaw (1991), can lead to unique experiences of recognition or marginalization that significantly impact mental health outcomes. For example, a study by Seng et al. (2012) found that women with intersecting marginalized identities experienced higher rates of post-traumatic stress disorder, highlighting the cumulative effect of multiple forms of social non-recognition on mental health.

Moreover, the process of identity formation and the quest for societal recognition can be particularly challenging for individuals from marginalized or minority groups. Sue et al. (2007) introduced the concept of microaggressions – subtle, often unintentional forms of discrimination – which can have a detrimental effect on mental health. They argue that "the constant, continuing, cumulative experience of racial microaggressions can theoretically result in diminished mortality, augmented morbidity, and flattened confidence". This underscores the potential long-term mental health consequences of persistent societal non-recognition or misrecognition.

The impact of societal recognition on mental health is not limited to individual-level interactions but extends to broader societal structures and institutions. Marmot (2015) argues that the degree of control individuals has over their lives, which is often determined by their social position and the recognition they receive from society, is a key social determinant of health, including mental health. He states that "empowerment – having control over your life – is critical to health and well-being".

In the context of globalization and increasing cultural diversity, the interplay between identity, societal recognition, and mental health takes on new dimensions. Berry's (1997) acculturation model suggests that individuals' strategies for negotiating their cultural identities in multicultural contexts can significantly impact their psychological adaptation. The extent to which societies recognize and value cultural diversity can thus have profound implications for the mental health of immigrant and minority populations.

The rise of social media and digital technologies has introduced new complexities to the relationship between identity, societal recognition, and mental health. While these platforms offer new avenues for identity expression and social validation, they also present risks. A study by Vogel et al. (2014) found that greater Facebook use was associated with lower self-esteem, mediated by greater exposure to upward social comparisons. This highlights the double-edged nature of digital spaces in providing recognition and potentially impacting mental health.

Therapeutic approaches have increasingly recognized the importance of addressing issues of identity and societal recognition in promoting mental health. Narrative therapy, developed by White and Epston (1990), focuses on helping individuals reconstruct their identities through the retelling and reauthoring of their personal stories. This approach acknowledges the social construction of identity and aims to empower individuals to resist societal narratives that may be detrimental to their mental health.

Similarly, community psychology approaches emphasize the importance of social context in mental health interventions. Prilleltensky (2008) argues for a justice-oriented approach to well-being that recognizes the role of power dynamics and societal structures in shaping individual and collective mental health. He proposes that "well-being, psychosocial and otherwise, cannot be cultivated unless we pay attention to issues of power, oppression, and liberation" (p. 116).

The intricate connection between individual identity, societal recognition, and mental health represents a critical area of inquiry with significant implications for both theory and practice. As our understanding of these relationships continues to evolve, it becomes increasingly clear that efforts to promote mental health must consider the broader social contexts in which identities are formed, negotiated, and recognized. Future research in this field may benefit from interdisciplinary approaches that can capture the complexity of these interactions and inform more holistic strategies for promoting individual and collective well-being.

3.2.3. Correlation of Theories

The convergence of Maslow's Hierarchy of Needs and Hannah Arendt's perspectives on citizenship and human rights offers a multifaceted framework for understanding the relationship between mental health policies and societal development. This section explores how these theoretical constructs can be integrated to provide a comprehensive understanding of the human rights-based approach to mental health in Lebanon.

The convergence of Maslow's Hierarchy of Needs and Hannah Arendt's perspectives on citizenship and human rights offers a multifaceted framework for understanding the relationship between mental health policies and societal development. This section explores how these theoretical constructs can be integrated to provide a comprehensive understanding of the human rights-based approach to mental health in Lebanon.

Maslow's Hierarchy of Needs is foundational in understanding human motivation, emphasizing the sequential fulfillment of needs from basic physiological needs to higher-order needs like self-actualization. This theory underlines the necessity of meeting basic needs for physical and psychological well-being, which aligns closely with the principles of human rights. According to Maslow, unmet basic needs can lead to significant psychological distress and hinder the attainment of higher-level needs, such as self-esteem and self-actualization.

The Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) emphasize that all individuals are entitled to an adequate standard of living, including food, water, shelter, and health care. These rights directly correspond to Maslow's basic and safety needs. In the context of Lebanon, ensuring that these fundamental needs are met is crucial for the mental well-being of its citizens, particularly given the country's political and economic challenges.

Hannah Arendt's notion of "the right to have rights" underscores the importance of belonging to a political community as a precondition for the realization of other rights. Arendt argues that without citizenship, individuals are deprived of the fundamental right to participate in society, which can lead to severe marginalization and exclusion. This perspective is particularly relevant in the context of Lebanon, where political instability and economic crises have exacerbated the challenges faced by marginalized groups, including refugees and individuals with mental health conditions.

Arendt's emphasis on political participation and the public realm aligns with Maslow's higher-order needs of belonging, esteem, and self-actualization. For individuals to achieve psychological well-being, they must feel recognized and valued within their community. In Lebanon, the integration of a human rights-based approach to mental health policies can ensure that individuals are not only provided with the basic necessities but also afforded the opportunity to participate fully in society, thereby enhancing their sense of belonging and self-worth.

The interplay between individual identity, societal recognition, and mental health is a critical area of inquiry. According to Taylor (1994), societal recognition is essential for the development of a positive self-concept and psychological well-being. This idea is supported by Maslow's theory, which posits that the need for esteem and self-actualization can only be fulfilled when individuals are recognized and valued by their community.

In Lebanon, societal recognition of mental health issues and the individuals affected by them is paramount. Stigmatization and discrimination against individuals with mental health conditions can lead to social exclusion and hinder their ability to seek and receive appropriate care. By adopting a human rights-based approach, Lebanon can address these issues by promoting non-discrimination, ensuring equitable access to mental health services, and fostering an environment where individuals with mental health conditions are valued and included in the community.

Integrating Maslow's and Arendt's theories into mental health policy development in Lebanon offers several practical implications. Firstly, policies should focus on meeting the basic needs of all individuals, ensuring access to adequate food, water, shelter, and healthcare. This approach aligns with Maslow's emphasis on the importance of fulfilling basic physiological and safety needs as a foundation for psychological well-being.

Secondly, mental health policies should promote active citizenship and political participation. By creating opportunities for individuals to engage in the political and social life of their communities, Lebanon can help fulfill the higher-order needs of belonging and esteem, as articulated by Maslow, and the fundamental right to have rights, as emphasized by Arendt.

Lastly, addressing societal recognition and combating stigma are crucial for improving mental health outcomes. Policies should include public education campaigns to raise awareness about mental health issues, promote understanding and acceptance, and reduce stigma. This approach aligns with both Maslow's and Arendt's theories, emphasizing the importance of societal recognition for psychological well-being and the fulfillment of human rights.

The integration of Maslow's Hierarchy of Needs and Hannah Arendt's views on citizenship and human rights provides a robust framework for understanding the relationship between mental health policies and societal development in Lebanon.

3.3.Linkages Between Mental Health and Societal Development

3.3.1. Review of literature connecting mental health to economic, social, and political aspects of development

The level of mental health has implications on economic output and most particularly on the economic progress. Negative mental health leads to lower output and efficiency, shrinkage in work

attendance and a rise in the medical expenses. WHO states that depression and anxiety disorders lead to the global loss of $1 trillion in productivity every year (WHO 2017). Symptoms resulting from mental health disorders may limit one's capability to perform work duties hence dwindling their income level and economic status. It is especially a challenge in developing countries where social assistance may not be easily available to every citizen. For instance, Chisholm et al. (2016) sought to determine the return on investment for Depression- and anxiety-interventions worldwide and realized that each dollar invested on scaling up such treatment yields better health and productivity worth four dollars.

Lebanon marks the significant impact of its economic tribulations on subsequent citizen mental health problems. The instability of its economy amplifies the difficulties that people with mental health issues encounter in their daily lives. The latter is herein caused by high unemployment rates and lack of adequate healthcare services led to mental health issues which makes unemployment even more pronounced hence the cycle of death. Karam et al. (2016) noted those there was a major economic cost of mental health disorders in Lebanon, urging the need for integrated mental health policies, economic and health needs.

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This paper asserts that mental health and the state of people's mental health is crucial for the social fabric and strength of societies. Optimal mental health enhances daily functioning, responsibilities, and social interactions within the community. On the other hand, mental health disorders cause social exclusion, marginalization, and disconnection from social relationships. The culture of shame surrounding mental health issues also deters people from seeking treatment, and their symptoms may worsen as well as their social experiences (Corrigan and Watson 2002).

Regarding the Lebanese context, political and religious crises, sectarianism, and admissions of refugees have weakened social capital. The above risk factors predispose people to numerous mental health disorders such as PTSD and depression (Karam et al., 2016). The Lebanese Ministry

of Public Health in their (2015) health sector strategic plan has acknowledged the need to address mental health in order to promote social inclusion and has had some campaigns aimed at fighting stigma and ensuring that mental health care got integrated into the primary health care system. Despite these campaigns, cultural issues and stigma constitute major hurdles to such solutions (Hijazi, Weissbecker, & Chammay, 2019).

The socio-political climate is especially significant in determining the outlook, development, and the mental health situation within a society. Social unrest, violence, and poor political leadership raise mental health concerns and hamper mainstream mental health promotion. According to Charlson et al. (2019), there are correlations between mental health disorders, and areas found within conflict and political instabilities.

Like many Middle Eastern countries, Lebanon's political situation has also witnessed extremely long periods of unrest, and this has impacted the Lebanese people's mental well-being. The Syrian refugee crisis has added another layer to the problem as it puts more pressure on Lebanon that has scarce supplies of mental health first aid resources (Hassan et al., 2016). However, the following challenges have been observed in Malawi through inadequate mental health facilities: The National Mental Health Program was initiated in 2014/2015 aimed at addressing these challenges through the establishment of the community-based mental health services as well as the promotion of mental health. They added that political instability and unpredictable funding are some of the main issues that affect the effectiveness of such policies (Saleh et al., 2021).

This implies that all these spheres are linked hence making it challenging to address mental health challenges since they stem from various causes. Inability to find a job, reduced earnings, or being unpaid can result in social issues like increased criminal activity and Family breakdowns, which relate to the health of the mind. These challenges may be compounded by political instability since the resulting civil unrest destroys infrastructures and raises tension among people. These components play an aggregate role of proactively responding to mental health with this concept being best understood when a multi-factorial approach is adopted when addressing the same.

Such an approach is necessary in Lebanon, and the following are the reasons why. Poverty, unemployment, civil unrest, family breakdown, social isolation, political instability, and lack of access to healthcare also signify a hostile climate for the mentally ill in the country. These problems are necessary for any effective mental health policy agenda because mental health policies must guarantee citizens have what they need to respond to their mental health needs. Similarly, Patel et al., 2018 argue for the need to incorporate mental health into the larger development perspectives given the ever hinted potential social and economic returns on investment.

3.3.2. Discussion on mental health as a factor in economic productivity, social cohesion, and political stability

Mental health is a crucial determinant of economic productivity, significantly impacting labor markets and economic growth. Poor mental health conditions, such as depression and anxiety, are leading causes of disability worldwide, affecting individuals' ability to work and maintain consistent employment. The World Health Organization (WHO) estimates that depression and anxiety alone cost the global economy $1 trillion annually in lost productivity (WHO, 2017). This economic burden is due to absenteeism (missing work due to health issues) and presenteeism (being at work but underperforming due to health problems).

In Lebanon, the economic impact of mental health issues is exacerbated by the country's political and economic instability. High unemployment rates and economic uncertainty increase stress levels and contribute to mental health problems, creating a vicious cycle that hampers economic development. According to Karam et al. (2016), mental health disorders are prevalent in Lebanon, significantly burdening the healthcare system and the economy. Addressing mental health issues through comprehensive policies could improve workforce productivity and contribute to economic recovery and growth.

Mental health is deeply intertwined with social cohesion, influencing the stability and harmony of communities. Good mental health fosters positive social interactions, community engagement, and the development of supportive social networks. Conversely, mental health disorders can lead to social isolation, stigmatization, and the breakdown of social relationships, which can undermine community cohesion.

Social stigma associated with mental health conditions remains a significant barrier to social inclusion and support. Corrigan and Watson (2002) highlight that stigma can prevent individuals from seeking help, exacerbating their conditions and leading to further social withdrawal. This social exclusion can have profound effects on community dynamics, reducing social capital and weakening the social fabric.

In Lebanon, the social impact of mental health issues is compounded by cultural and social norms that stigmatize mental illness. This stigma often prevents individuals from accessing necessary care and support, leading to untreated mental health conditions that disrupt social cohesion. The Lebanese Ministry of Public Health (2015) has recognized the need to address mental health stigma and integrate mental health services into primary care to improve social cohesion. However, cultural barriers and limited resources continue to pose significant challenges to these efforts (Hijazi, Weissbecker, & Chammay, 2019).

The political environment significantly influences mental health, and in turn, mental health affects political stability. Political instability, conflict, and inadequate governance can exacerbate mental health issues, leading to increased rates of disorders such as PTSD, depression, and anxiety. These mental health issues can destabilize societies by reducing individuals' ability to participate in civic activities, weakening governance, and increasing social unrest.

Regions affected by conflict and political unrest often experience higher rates of mental health disorders. Charlson et al. (2019) found that mental disorders are prevalent in conflict settings, with

significant implications for political stability and societal resilience. In such environments, the trauma and stress associated with conflict can impair cognitive functioning, reduce social cohesion, and hinder economic productivity, creating a feedback loop that perpetuates instability.

Lebanon's political landscape, marked by prolonged instability and conflict, has profound effects on the mental health of its citizens. The influx of refugees, economic crises, and ongoing political tensions contribute to widespread mental health issues, which in turn affect the country's political stability. The National Mental Health Program launched in 2014 aims to address these challenges by developing community-based mental health services and promoting mental health awareness. However, consistent political instability and lack of funding remain significant barriers to the successful implementation of these policies (Saleh et al., 2021).

Addressing mental health comprehensively requires integrating mental health policies into broader economic, social, and political development agendas. Mental health should be recognized as a critical component of human capital, essential for sustainable development. Patel et al. (2018) emphasize that integrating mental health into development strategies can lead to substantial benefits, including improved health outcomes, enhanced productivity, and greater social and political stability.

3.4.Human Rights-Based Approach to Mental Health

3.4.1. Existing studies and evidence supporting HRBA in mental health during the 21st Century

A Human Rights-Based Approach (HRBA) to mental health emphasizes the integration of international human rights norms and standards into mental health policies and practices. This approach is grounded in the belief that mental health care is not merely a medical or social service

but a fundamental human right. HRBA aims to ensure that mental health policies promote equality, non-discrimination, participation, accountability, and transparency.

The World Health Organization (WHO) and various human rights organizations have advocated for the adoption of HRBA in mental health, arguing that it can lead to better health outcomes and greater respect for the rights of individuals with mental health conditions. According to the WHO (2017), HRBA to mental health involves making mental health services available, accessible, acceptable, and of good quality, aligned with the AAAQ framework. This approach ensures that mental health services are integrated into the broader health and social care systems, emphasizing the importance of non-discrimination and the right to health.

One of the most compelling pieces of evidence supporting HRBA in mental health comes from countries that have successfully implemented this approach. For instance, Patel et al. (2018) found that countries adopting HRBA to mental health policies saw significant improvements in service accessibility, user satisfaction, and overall mental health outcomes. These countries have shifted from a purely medical model of mental health care to one that incorporates social, economic, and cultural dimensions, ensuring a more holistic and inclusive approach to mental health.

In Australia, the implementation of HRBA in mental health policies has led to the development of comprehensive community-based mental health services. The National Mental Health Commission (2014) reported that integrating human rights principles into mental health care has resulted in reduced stigma, increased user participation, and better access to services. This approach has also promoted the deinstitutionalization of mental health care, emphasizing the importance of community-based support systems.

Another example is the United Kingdom, where the adoption of HRBA in mental health policies has been linked to significant policy reforms and improvements in service delivery. According to Minkowitz (2014), the UK's Mental Health Act was amended to incorporate human rights

principles, ensuring that individuals with mental health conditions have greater autonomy and protection against coercive practices. This legislative change has led to a reduction in the use of involuntary treatment and an increase in the availability of community-based services.

HRBA to mental health also promotes social inclusion and combats stigma and discrimination. By recognizing mental health as a human right, HRBA challenges the social and structural barriers that prevent individuals with mental health conditions from fully participating in society. Corrigan and Watson (2002) highlight that stigma and discrimination are significant obstacles to mental health care, often leading to social exclusion and marginalization. HRBA addresses these issues by promoting the rights of individuals with mental health conditions and ensuring their inclusion in all aspects of life.

In Lebanon, the National Mental Health Program, launched in 2014, incorporates elements of HRBA to address the mental health needs of its population. This program emphasizes the importance of non-discrimination, participation, and accountability in mental health care. Despite the challenges posed by political instability and limited resources, the program has made significant strides in improving mental health services and promoting social inclusion (Hijazi, Weissbecker, & Chammay, 2019).

International human rights instruments play a crucial role in supporting HRBA in mental health. The Convention on the Rights of Persons with Disabilities (CRPD) is a landmark treaty that outlines the rights of individuals with disabilities, including those with mental health conditions. The CRPD emphasizes the right to health, autonomy, and participation, and calls for the elimination of discrimination and coercive practices in mental health care (United Nations, 2006).

Research has shown that countries that ratify and implement the CRPD see significant improvements in their mental health policies and practices. For example, Gooding et al. (2017) found that the CRPD has led to legislative and policy changes in several countries, promoting

greater respect for the rights of individuals with mental health conditions and improving access to services. The CRPD's focus on non-discrimination, participation, and accountability aligns closely with the principles of HRBA, reinforcing the importance of human rights in mental health care.

While there is substantial evidence supporting HRBA in mental health, challenges remain in its implementation. These challenges include limited resources, lack of political will, and cultural barriers. For HRBA to be fully effective, it requires a commitment from governments, civil society, and international organizations to prioritize mental health as a human rights issue.

Future research should focus on developing and evaluating interventions that integrate HRBA into mental health care. This includes exploring innovative approaches to service delivery, enhancing the capacity of mental health professionals to incorporate human rights principles into their practice, and promoting greater participation of individuals with mental health conditions in policy-making processes.

3.4.2. Analysis of HRBA's impact on mental health policies and practices

The Human Rights-Based Approach (HRBA) to mental health has had a profound impact on the development and implementation of mental health policies and practices globally. This approach integrates the principles of international human rights law into mental health care, ensuring that policies are designed to protect and promote the rights of individuals with mental health conditions. The impact of HRBA on mental health policies and practices can be observed in several key areas, including policy development, service delivery, and the protection of human rights.

One of the most significant impacts of HRBA on mental health policies is the shift from a purely medical model to a more holistic approach that incorporates social, economic, and cultural dimensions. This shift recognizes that mental health is not just a medical issue but also a human

rights issue. Countries that have adopted HRBA in their mental health policies have developed more comprehensive and inclusive policies that address the broader determinants of mental health.

For instance, the United Kingdom's Mental Health Act was revised to include human rights principles, ensuring greater protection for individuals with mental health conditions. Minkowitz (2014) highlights that this legislative change has led to a reduction in the use of coercive practices and an increase in the availability of community-based services. Similarly, in Australia, the adoption of HRBA has resulted in the development of policies that prioritize non-discrimination, participation, and accountability in mental health care (National Mental Health Commission, 2014).

In Lebanon, the National Mental Health Program, launched in 2014, has incorporated HRBA principles to address the mental health needs of its population. This program emphasizes the importance of non-discrimination, participation, and accountability, and has led to the development of community-based mental health services (Hijazi, Weissbecker, & Chammay, 2019). The inclusion of HRBA in policy development ensures that mental health policies are aligned with international human rights standards, promoting greater equity and justice.

HRBA has also had a significant impact on the delivery of mental health services. By promoting the principles of availability, accessibility, acceptability, and quality (AAAQ), HRBA ensures that mental health services are designed to meet the needs of all individuals, particularly those who are most marginalized and vulnerable.

In practice, this means that mental health services are not only more widely available but also more accessible to those who need them. For example, the integration of mental health services into primary healthcare in Lebanon has made it easier for individuals to access care without facing stigma or discrimination (Hijazi, Weissbecker, & Chammay, 2019). Additionally, the focus on

acceptability ensures that mental health services are culturally appropriate and sensitive to the needs of diverse populations.

The emphasis on quality in HRBA has led to improvements in the standard of care provided to individuals with mental health conditions. This includes the training of mental health professionals in human rights principles and the development of guidelines and standards to ensure that services are provided in a manner that respects the dignity and autonomy of individuals (World Health Organization, 2017). In Australia, for instance, the implementation of HRBA has led to better training for mental health professionals and the development of policies that promote person-centered care (National Mental Health Commission, 2014).

HRBA has played a crucial role in protecting the human rights of individuals with mental health conditions. By embedding human rights principles into mental health policies and practices, HRBA ensures that individuals are protected from discrimination, coercion, and abuse.

The Convention on the Rights of Persons with Disabilities (CRPD) has been instrumental in promoting HRBA in mental health. The CRPD emphasizes the rights of individuals with disabilities, including those with mental health conditions, to live independently, participate fully in the community, and access the same opportunities as others (United Nations, 2006). Countries that have ratified the CRPD have made significant strides in protecting the rights of individuals with mental health conditions. For example, Gooding et al. (2017) found that the CRPD has led to legislative and policy changes in several countries, promoting greater respect for the rights of individuals with mental health conditions and improving access to services.

In the United Kingdom, the Mental Health Act amendments have enhanced the protection of human rights by reducing the use of involuntary treatment and promoting the autonomy of individuals with mental health conditions (Minkowitz, 2014). Similarly, in Lebanon, the National Mental Health Program has focused on protecting the rights of individuals with mental health

conditions by promoting non-discrimination and ensuring that services are provided in a manner that respects their dignity and autonomy (Hijazi, Weissbecker, & Chammay, 2019).

Despite the positive impact of HRBA on mental health policies and practices, several challenges and limitations remain. One of the main challenges is the lack of resources and funding for mental health services. Implementing HRBA requires significant investment in training, infrastructure, and service delivery, which can be difficult for countries with limited resources.

Another challenge is the need for political will and commitment to fully implement HRBA. In many countries, mental health remains a low priority, and there is often resistance to adopting new approaches that challenge existing practices. Cultural barriers and stigma also pose significant challenges to the implementation of HRBA, particularly in countries where mental health is not widely recognized or understood.

Furthermore, while HRBA emphasizes the importance of participation and accountability, ensuring meaningful participation of individuals with mental health conditions in policy-making and service delivery can be challenging. This requires a shift in attitudes and practices, as well as the development of mechanisms to facilitate participation and ensure that individuals' voices are heard and respected.

3.5.Structural Barriers

Structural barriers refer to the systemic issues that hinder the implementation of mental health policies. One of the most significant structural barriers is the lack of adequate funding and resources. Mental health services are often underfunded compared to other areas of healthcare. The World Health Organization (WHO, 2017) reports that mental health receives less than 2% of national health budgets in many countries. This underfunding results in a lack of infrastructure,

insufficient numbers of trained mental health professionals, and inadequate availability of essential medications and treatments.

In Lebanon, the economic crisis has further exacerbated the structural challenges facing the mental health system. Limited financial resources have led to shortages of medications and mental health professionals, making it difficult to provide comprehensive care (Karam et al., 2016). The National Mental Health Program, while ambitious, faces significant challenges in securing the necessary funding to implement its initiatives fully (Hijazi, Weissbecker, & Chammay, 2019).

Another structural barrier is the fragmented nature of mental health services. In many countries, mental health services are not integrated into the primary healthcare system, resulting in a lack of coordination and continuity of care. This fragmentation can lead to gaps in service provision and difficulties in accessing care. The WHO (2013) emphasizes the importance of integrating mental health services into primary healthcare to improve access and coordination of care.

3.6.Cultural Barriers

Cultural barriers refer to the societal attitudes, beliefs, and norms that can hinder the implementation of mental health policies. Stigma and discrimination against individuals with mental health conditions are pervasive cultural barriers that prevent people from seeking help and accessing services. Corrigan and Watson (2002) highlight that stigma can lead to social exclusion and a reluctance to seek treatment, which can exacerbate mental health conditions and delay recovery.

In Lebanon, cultural attitudes towards mental health are influenced by traditional beliefs and social norms. Mental health conditions are often viewed as a source of shame, leading to stigmatization and discrimination. This stigma can prevent individuals from seeking help and can also impact the

willingness of families and communities to support those with mental health conditions (Hammad & Tribe, 2020). Efforts to combat stigma and raise awareness about mental health are essential for overcoming these cultural barriers.

Cultural competence in mental health care is also a significant challenge. Mental health services must be culturally sensitive and responsive to the needs of diverse populations. This requires training mental health professionals to understand and respect cultural differences and to provide care that is culturally appropriate. In Lebanon, the National Mental Health Program has recognized the importance of cultural competence and has developed initiatives to train mental health professionals in culturally sensitive practices (Hijazi, Weissbecker, & Chammay, 2019).

3.7.Political Barriers

Political barriers refer to the challenges related to governance, policy-making, and political will that can hinder the implementation of mental health policies. One of the primary political barriers is the lack of political commitment and leadership. Mental health is often not prioritized in national health agendas, leading to inadequate policies and insufficient funding. The WHO (2018) emphasizes the importance of political leadership and commitment in addressing mental health challenges and developing effective policies.

In Lebanon, political instability and frequent changes in government have posed significant challenges to the implementation of mental health policies. The country's political landscape is characterized by sectarian divisions and frequent conflicts, which can disrupt policy continuity and hinder long-term planning (Saleh et al., 2021). The National Mental Health Program has faced difficulties in securing sustained political support and funding, impacting its ability to achieve its goals (Hijazi, Weissbecker, & Chammay, 2019).

Another political barrier is the lack of comprehensive mental health legislation and policy frameworks. Effective mental health policies require robust legal and policy frameworks that protect the rights of individuals with mental health conditions and ensure access to care. The Convention on the Rights of Persons with Disabilities (CRPD) provides a framework for developing such policies, emphasizing the importance of non-discrimination, participation, and accountability (United Nations, 2006). However, many countries, including Lebanon, still lack comprehensive mental health legislation that aligns with international human rights standards.

4. Results

4.1.Presentation of Results

The qualitative data comprises of questionnaires that include responses from 24 people; 12 of them are mental health professionals and 12 of them are patients. These responses relate to participants' use of mental health services, their views on policy efficiency, challenges to access services, adequacy of staff training, and suggestions for enhancement. Key observations include: It was found that both the groups had some positive as well as some neutral views. Experts said that for the most part, satisfaction with services is good; however, there are areas in which improvements can be made, such as policy inclusiveness, and the provision of resources. While health care consumers were somewhat more equivocal in their responses, some pointed to long waits and lack of equipment as major concerns. A frequently mentioned point was that policies exist, and yet they remain rigid, ineffective or often outdated. This sentiment was expressed by both groups who implied that there is a need for policy updates as well as improved implementation frameworks. The perceived barriers included; financial barriers, stigmatization, and cultural barriers were mentioned most often. These challenges were described by both professionals and patients as important barriers that limit people's ability to obtain mental health care. The employed staff appears to be generally well-trained and qualified, however there is an identified deficit of staff development and a high demand for further training and specialized training in crisis management. This was also a common sentiment among patients who complained that staff should be more considerate. Stigma still poses a problem and is seen amongst the two groups regarding discrimination in particular concerning the marginalized. This brings out the need to continually work towards eradicating culture prejudices and at the same time raising awareness on the mental

health issues within the hospital setting. The most frequently suggested measures were raising funds, providing service availability in the rural regions, and changing community awareness to minimize prejudice. In terms of the child care debates, both groups asserted that there should be more formal services for children in the community and more vigorous implementation of the child protection policies in place.

The quantitative data offers the participants' numerical responses concerning perceived aspects of mental health services and policies. These ratings grouped by the scope, regularity, quality, patient satisfaction, adherence to policies, fairness, and barriers to service, including fees and prejudice. It can be observed that some services are lacking while others are scarce with a typical example being the rural and urban divide. There is more to outreach and service expansion in rural regions and the participants rated accessibility and availability lower in rural regions. In general, the quality of care and satisfaction scores were moderate but with few more improved hospitals having better resources and more modern facilities. Nevertheless, there were sustained requests for better staff training and compliance with the policies in these aspects. Several respondents offered different ratings regarding the effectiveness and equity of policies in place suggesting that although there are policies, the issue is their enforcement. Equity ratings were also bad due to perceived inadequate service provision to those in the developing nations as well as in the Developing world. From the perceptual analysis of the hospitals, financial issues, perceived stigma, and cultural issues were consistently perceived to be important by the staff of the hospitals. These were presented as some of the main challenges that have to be overcome for better functioning of the mental health services.

Qualitative and quantitative data analysis paints a rather intricate picture of mental health service delivery in the surveyed hospitals. As much as there are areas of specialty like the general competence of mental health professionals, there are some challenges that are apparent. These are clear indications that mental health still has a long way to go before it can be effectively addressed across the Australasian region; where policies remain stale or are not implemented due to financial handicaps, cultural barriers are rife and the stigmatization of mental health still persists. These observations point to the need for identifying, promoting, and utilizing the Human Rights-Based

Approach (HRBA) for mental health. Based on the data, it can be concluded that incorporating the components of the HRBA into mental health policies might contribute to overcoming many of the challenges described by both mental health workers and patients. In addition, the demands for more money, training, and policy updates are vital areas that need to be analyzed in the thesis with more detail as such issues are crucial for the enhancement of mental health and the provision of services for everyone.

4.2.Quantitative Analysis

4.2.1. Descriptive Statistics

Mean values obtained over the columns of figures vary from 2. 79 to 3.18. The analysis of the responses of patients and treatment outcome can be deduced to range from somewhat neutral to slightly positive. Averaging the overall scores obtained for each statement, the survey yielded the highest mean (3. 18) in the aspects covered under Column 5, and the lowest mean (2. 79) in the aspects covered under Column 12. The standard error values for each of the independent variable groups varied from 0. 133 to 0. 158 are respectively small, this means that most of the sample means are near the true population means. These consistencies suggest that the sample size is adequate in the context of risk being generalizable toward the population sample.

The standard deviations across the columns, in turn, range from 1. 31 to 1. 56 responses which are moderate in terms of fluctuations. Again, the most variation is noted in the Column 6, and the least variation in the Column 7. Such a fluctuation intimates that though response is pegged on average responses, participants are spread widely in their experiences. Also, negative kurtosis means the distribution is less peaky than the normal distribution or in other words the data is spread out with less observations of the extremes. These values are near to zero, thus, the distribution of the data is relatively symmetric relative to the calculated mean.

The range for each column is always 4 showing that participants did employ all the measures to the greatest extent across this rating scale. These values are most frequently located in the center of the scale with the modes equal to 3 or 4. It is centered at 4 and this aids in substantiating the proposition that most of the responses are nearer to neutral to slightly positive.

The mean values across the columns are not very much distorted and are ranging from 2. 79 to 3.18. In general, respondents seem to have fair/staunch neutral or near positive perceptions on the measured facets. The low standard errors imply that the sample means approximate well the population means. A similar picture can be observed by comparing median values with the centrality that has been captured by the means, although the mode differs to some extent, demonstrating that there are some shifts as to the most popular responses.

The standard deviations show moderate spread of the data while the variances reflect higher variance in the columns such as Column 6 while lower variance in column 7 indicates more consistent respondent answers. Negative kurtosis indicates a lower peak or more platykurtic distribution, and the closer the skewness coefficients to zero, the more probably the distribution is mesokurtic. The observation of these values at 4 for each of the columns, minimum of 1 and the maximum of 5 has further given an indication that the respondents used all the rating scale appropriately.

4.2.2. ANOVA One Way Test

The between-group sum of squares SS at 19. 52 seems to be relatively low as compared to the within-group variation with SS at 3410. 93. This implies that even though the overall mean of the groups is significantly different, the variability in the means is not so much different from each other, that is, most of the variability in the scores are coming from within the different groups. The mean square between groups, (MS = 1. 148) also testifies that the variation across the different groups is virtually negligible. The means square with groups is lesser than the mean square

between groups, but the difference is not considerable, while the mean square within groups is much higher (MS = 1. 973). Thus, it indicates the fact that the variability in the responses of the individuals in each group is much more than the differences in the average of these groups.

From the above analysis, one can observe that F-statistic equal to 0. 5818 is less than the F crit equal to 1. 6287. With a calculated P-value of 0. 9076 the data is at variance to hypothesis test at the 95% confidence level. 05 hence supporting the analysis that we do not have enough evidence to see any difference in the mean of the two groups. This makes it possible to conclude that the observed differences in the arrows concerning the mean values of this variable are mere artifacts, which bear no systematic relation to any of the marks along the vertical axis, the group means cannot be said to be significantly different.

From the results of ANOVA, it was seen that the various groups' ratings are not significantly different. This means that the mental health services and policies are regarded in the same way no matter whether the person is a man or a woman, young or old, a worker or a student or a professional, or if there are some differences, they are not large enough to be measured. Thus, there is a slight tendency to have neutral or slightly positive perceptions; nevertheless, there should also be observed that the level of variability is different from one subject to another, according to standard deviations and variances. Such conclusions underscore the usability of pinpointed concerns like availability of the resources, policy revisions, and staff development for enhancing the ratings and obtaining the more unified experience of the users from all the segments.

4.3.Qualitative Analysis - Thematic Analysis

The thematic analysis followed a number of methodical phases to make sure they had exploited the qualitative data to the maximum. The intended outcome was to identify significant patterns and themes from the data that may also give understanding of participants' patient services and policy. The details of this analysis are shown in the below table following the six-phase process which comprises data familiarization followed by the production of themes.

First, there was a process of familiarization with the data, which was made up of answers from mental health service providers and consumers. At this stage, the data was read several times while trying to familiarize oneself with the content of the data. First of all, outlines of the main ideas, the presence of the same concepts and phrases, and the most distinct definitions were sketched out. Since this was an exploratory study, quantification of results was not possible, but this phase was very important in establishing a base for the later coding from which points of-interest could be advanced and searched in the later phases.

Subsequently, familiarization was done and the data was computationally disposed into discreet units as concepts or observations pertaining to a specific category. These segments were then given codes, which privileged the core meaning of what was being conveyed. For instance, statements qualified as 'Barriers to access' included 'long waiting times', 'lack of resources', while under 'Quality of Care' were statements like 'competent staff'. This process involved capturing of both the manifest as well as the latent content of the interviews. Inter-coder reliability for the coding was implemented hence inferring that no preconceived biases were engaged. This aided in the procedure that witnessed a single piece of data having the possibility to provide more than one code, if the data was relevant to two or more of the codes defined.

In this phase, all the obtained codes were screened and arranged into potential themes category. The relative emphasis was made on the interconnection between codes as well as on how such codes could be grouped together according to some broader categories that are usually characteristic of repeated patterns present in the analyzed data. For example, codes such as "financial costs" were assigned to the theme labeled "Barriers to access" and codes such as "policies that take long", "policies that are outdated" and "policies that needs to be modernized" were grouped into the theme labeled "Effectiveness of policies". This process was cyclical and continued until further relations between the codes became apparent.

The themes generated in the previous phase were checked in order to ensure that they captured the material of the interviews and that they are unique. Some themes were combined while others were disaggregated and if there was insufficient data to support a theme, then it was omitted. For example, the initial list of themes, such as the policies' effectiveness, was developed further to make a distinction between the 'Effectiveness of policies' and 'Recommendations for improvements,' so that each theme addressed a specific aspect of the participants' and clients' experiences. This phase also involved going back to the participants' responses to be sure that the identified themes were not imposed by the researchers.

The themes which were generated after the presentation and discussion of each subtheme were then defined and labelled. This included coming up with a precise definition for all the themes in that chapter. For instance, in the case of "Barriers to Access," the operationalisation involved a list of any impediment that could prevent a participant from accessing mental health services whether in terms of cost, geography or social structure. Secondary themes were also defined where it was deemed necessary to cover different aspects of a general theme. For instance, the following themes were expanded into sub-themes under "Quality of Care": "Competent Staff" and "Need for Crisis Training". Naming the themes seemed to be a critical process so that the final analysis could be understood by other people.

The last process of the data analysis process was the documentation of the results and the process of delivering the themes and the evidence that backed the themes. This made it easier to incorporate the views of the participants to the presentation of the different themes as the following selected quotes embraced the use of actual participants' quotes: The report not only described the themes but also explained how these themes were related, composed a logical flow that shed a light on some important findings about mental health services and policies across the states. The analysis of the thematic elements showed the following findings: the December 2021 paper would be that barriers such as financing and stigma influenced patients' access to services; there was a need for policies and professionals to be updated; and there was a challenge for more equal and accessible mental health services.

As illustrated from the under thematic analysis, there are critical issues that requires attention in an effort to enhance mental health services. The first was “Access Issues” which included issues to do with money, time, and prejudice which keep patients from getting appropriate treatment. The other major finding was the fact that participants were of the opinion that there is poor policies for improvement of quality of teaching and learning as most of the current policies are either outdated or implemented in a partial way. The theme of “Quality of Care” highlighted the need for continued training in the interventionists’ work, as participants later demanded more training, specifically, specialized trainings more for crises management. Last, the study found it shameful that there was limited access to services with rural status and other minorities having less access than those in wealthy urban areas implying that there is a need for policies that enhance access of mental health services for the underprivileged groups.

Commented [KE10]: All these tables are to be placed in Annexes

4.4.Discussion

The integration of qualitative and quantitative data provides a nuanced understanding of participants' experiences with mental health services and policies. The qualitative data highlighted several critical themes, including barriers to access, the effectiveness of policies, the quality of

care, equitability, and experiences of stigma. These themes were echoed in the quantitative findings, where descriptive statistics and ANOVA tests further supported the patterns observed in the qualitative responses.

For instance, the mean values in the quantitative data, ranging from 2.79 to 3.18, suggest a generally neutral to slightly positive perception of mental health services. This aligns with the qualitative findings, where many participants expressed satisfaction with the services but also pointed out areas for improvement. The relatively small standard errors in the quantitative data (ranging from 0.133 to 0.158) indicate that the responses were consistent across participants, mirroring the recurring themes of "Quality of Care" and "Effectiveness of Policies" identified in the qualitative analysis.

The ANOVA results, which showed no statistically significant differences between the groups, further support the idea that participants, regardless of their background, share similar perceptions of the mental health services. This lack of significant differences suggests that the issues raised, such as barriers to access and the need for policy updates, are pervasive across different demographics and are not isolated to specific groups. The qualitative theme of "Equitability and Accessibility" also supports this finding, with participants across various groups highlighting the need for more equitable access to services.

The findings from this study resonate with existing literature on mental health service delivery and policy. Previous research has consistently identified barriers to access as a significant challenge in mental health care. Participants frequently mentioned stigma, particularly among marginalized groups, as a key factor preventing them from seeking care, which aligns with the literature's emphasis on the need to address social and cultural factors in mental health care delivery.

Furthermore, the theme of "Effectiveness of Policies" reflects the ongoing debate in the literature about the adequacy of current mental health policies. As seen in studies by Thornicroft et al. (2010)

and Patel et al. (2018), there is a growing consensus that while policies exist, their implementation often falls short, particularly in terms of ensuring equitable access and addressing the needs of underserved populations. The qualitative data in this study revealed similar concerns, with participants calling for more flexible and modernized policies that can adapt to the changing landscape of mental health care.

The quantitative findings, particularly the lack of significant differences between groups in the ANOVA results, suggest that these policy challenges are widespread. This supports the argument made by WHO (2013) that mental health services often fail to reach the most vulnerable populations, not because of a lack of policies, but due to the ineffectiveness of their implementation. The alignment between the qualitative themes and the quantitative data in this study reinforces the need for a more robust and comprehensive approach to policy development and implementation.

From the integrated analysis, several deductions can be made. First, it is evident that while participants generally view mental health services in a neutral to positive light, significant challenges remain. The pervasive nature of barriers to access, as highlighted by both qualitative and quantitative data, suggests that these issues are deeply embedded in the system. Financial constraints, long waiting times, and stigma are not just isolated problems but are indicative of broader structural issues that need to be addressed.

Second, the consistent call for policy updates across different groups points to a gap between policy formulation and practical implementation. Participants expressed frustration with outdated policies and inconsistent application, despite Lebanon adopting a new mental health policy in 2015. This reflects ongoing challenges in the policy's implementation, which participants believe is still lacking in practice. This frustration aligns with the literature's critique of current mental health frameworks, highlighting that even recently formulated policies face hurdles in application. The findings suggest that policies need to be more dynamic and responsive to the needs of both patients and professionals, ensuring that implementation aligns with policy objectives.

Third, the theme of "Quality of Care" underscores the importance of ongoing professional development. While participants acknowledged the competence of mental health professionals, there was a clear demand for more specialized training, particularly in crisis management and empathy. This deduction is critical as it highlights the need for continuous investment in the training and support of mental health professionals to ensure they can meet the evolving needs of their patients.

Finally, the lack of significant differences between groups in the quantitative data suggests that the issues identified are systemic rather than localized to specific demographics. This finding implies that any interventions aimed at improving mental health services must be comprehensive and inclusive, addressing the needs of all groups rather than focusing on specific populations.

The findings from this study have several implications for mental health policy and practice. First, the pervasive barriers to access identified in both qualitative and quantitative data suggest that there is a need for a more equitable distribution of resources. Policymakers should prioritize reducing financial barriers and wait times, particularly in rural and underserved areas. This could involve increasing funding for mental health services, expanding community-based programs, and implementing targeted outreach initiatives to ensure that all individuals have access to the care they need.

Second, the call for policy updates and better implementation highlights the need for a more agile policy framework. Mental health policies should be regularly reviewed and updated to reflect the latest research and best practices. Additionally, efforts should be made to ensure that these policies are applied consistently across different settings, with mechanisms in place to monitor and evaluate their effectiveness.

Third, the emphasis on quality of care underscores the importance of continuous professional development. Mental health professionals should be provided with ongoing training opportunities to enhance their skills and knowledge, particularly in areas such as crisis management and culturally sensitive care. This could involve partnerships with academic institutions and professional organizations to offer specialized training programs and certifications.

Finally, the findings suggest that efforts to reduce stigma and discrimination must be prioritized. This could involve public awareness campaigns, education programs, and the inclusion of anti-stigma initiatives in mental health policies. By addressing the social and cultural factors that contribute to stigma, mental health services can become more accessible and supportive for all individuals.

Future research should focus on exploring the experiences of specific subgroups, such as individuals from marginalized communities or those with complex mental health needs. This would provide a more detailed understanding of the challenges faced by these populations and help develop targeted interventions that address their unique needs.

Policymakers and practitioners should collaborate to develop and implement more inclusive and flexible mental health policies. This could involve engaging with patients, professionals, and community stakeholders to co-create policies that are responsive to the needs of all individuals. Additionally, efforts should be made to ensure that these policies are adequately funded and supported by the necessary infrastructure.

Finally, there is a need for more research on the role of stigma in mental health care. While this study highlighted the impact of stigma on access to services, further research is needed to explore the underlying causes of stigma and develop effective strategies for reducing it. This could involve examining the intersection of stigma with other social determinants of health, such as race, gender, and socioeconomic status.

The integration of qualitative and quantitative data in this study has provided a comprehensive understanding of the challenges and opportunities in mental health service delivery. While there are areas of strength, such as the competence of mental health professionals, significant barriers to access and policy implementation remain. By addressing these issues through targeted interventions and policy updates, mental health services can become more equitable, effective, and supportive for all individuals. The findings from this study offer valuable insights for policymakers, practitioners, and researchers, and provide a foundation for future efforts to improve mental health care.

5. Comparative Analysis

5.1.Description of the criteria for selecting case studies

The process of choosing cases for this thesis was a careful one, based on criteria that sought to achieve relevance, comparisons and depth on this case. The first and foremost filter was the

geopolitical one because the focus was made on the countries with different types of socio-political systems and having mental health policies implemented at different levels of development and political stability. It was intended to gather as many accounts as possible, especially in the areas where numerous conflicts and other challenges, such as economical and societal ones, have taken place – these are the factors that can help to reveal the relationship between mental health policies and human rights.

The countries chosen for comparison are Lebanon, Iraq, and Palestine as these countries have long-suffering political instabilities affecting health and development. All these countries have faced some issues in putting into practice the mental health policies in their countries because of the factors like war, displacement, and economic hardships. These countries were selected for the comparative analysis in order to reveal the work of mental health policies in maintaining social stability and improvement in such countries' conditions in face of adversities.

The third important criterion was the feasibility, that is, the presence of data and documents on mental health policies and their functioning. The countries were chosen because they have been featured in numerous researches and publications as well as have received significant amount of international assistance in the form of developmental aid. Said this, it is possible to guarantee that the comparative analysis of the cases described can rely on well-documented experiences and give a rich and comprehensive picture of what has been achieved and what obstacles have been encountered at each site.

Finally, selectivity was also influenced by a desire to examines how cultural influences the mental health policies. The culturally and religiously diverse Middle Eastern setting therefore presents a chance to observe the effect of the cultural beliefs and practices on the formulation and application of mental health policies. The choices made for the case studies offer possibilities on how those cultural factors intervene with political and economic characteristics to form mental health results.

5.2. Explanation of the comparative analysis approach

The analytical approach used in this thesis is comparative analysis, where the selected case studies are compared and contrasted to find out similarities and differences as well as lessons that can be learnt from them. This approach is based on the qualitative research paradigm which focuses on the relationships between context and the outcomes of mental health policy. The structure of the analysis is in line with the themes derived from the literature review and thematic analysis such as accessing barriers, policy efficiency, cultural factors, and human rights.

The method of comparison starts with an analysis of the mental health policies in each of the countries under comparison and conforms to such aspects as development, implementation and results. This necessitates the analysis of published policies and research papers, governmental reports and journals and other international organizations to know why such policies are implemented and the difficulties faced when it was implemented. The comparison then shifts towards how each country has dealt with these concerns including stigma, resources for mental health, and how mental health has been incorporated into a country's overall healthcare system.

As a part of the comparative analysis, there is a necessity to consider the differences in how the socio-political systems of the countries contributed to the development of their mental health policies. For instance, in Lebanon, political unrest and economic challenges have significantly limited the enactment of mental health programs, and in Iraq, war and ongoing conflict define the focus and possibilities of mental health initiatives. In Palestine, occupation, and its sociopolitical consequences are crucial considerations when addressing mental health services. Thus, the aim of the comparison of these contexts is to explain the relationship between the political environment and the efficiency of mental health policies.

The second subtheme of the comparative analysis focuses on how human rights have been integrated into mental health policies. The analysis evaluates the level of compliance of each

country's policies and legislation in respects to international human rights standards, particularly those outlined in the Convention on the Rights of Persons with Disabilities (CRPD). This includes examining the manner in which policies respond to matters like non-discrimination, participation and service access for those with mental health disorders and how they safeguard their rights.

The comparative analysis makes use of the quantitative data gathered in the course of the research, including descriptive statistics, as well as results of the ANOVA analysis, to gauge the equality of outcomes of mental health policy across the groups and regions within each country. This aids in establishing benchmarks of fairness and effectiveness as well as providing programs where intercession was partial or complete.

Finally, the comparative analysis approach aims at enhancing understanding on the overall determinant of mental health policy performance in different settings. Thus, through the comparison between similarities and differences in the challenges and the corresponding solutions, the study seeks to provide suggestions that will be beneficial in policy formulation in Lebanon and other countries experiencing such challenges. My objective is to help expand knowledge about mental health policies' potential and optimal implementation, both within the context of relevant social changes and in terms of human rights and the welfare of people with mental disorders.

5.3.Case Studies

5.3.1. Case Study 1: Iraq

Several of Iraq's mental health policies have a history of conflict, politics, and economics, especially over the last few decades. During the 1990s, the healthcare system in Iraq deteriorated even further with the Gulf War and several years of sanctions took toll on mental health of citizens

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(Alhasnawi et al., 2009). Since the post-2003 period, there have been attempts to restore the required and long overdue health care framework, which entails mental health care as well. It is noteworthy that in Iraq, the Ministry of Health has developed the National Mental Health Strategy for 2013 – 2017 with the support of the WHO; the strategy grew out of an effort to integrate mental health into primary care and to address the stigmatization of mental illnesses. Yet, its practical application has not been very effective due to shortage of resources and constant conflicts affecting its security.

Iraq's social progress has been greatly affected by these scourges, including the emergence of ISIS and the concomitant waves of displacement that affected millions of people. These events have led to trauma, anxiety, and depression that are documented in the population (Al-Attar et al., 2020). This has been compounded by lack of social infrastructure such as infrastructures, high unemployment rates and poverty. Counselling and other mental health care services are understaffed and underfunded, which contributes to the formal mental health care gap experienced by clients. The existing societal environment in Iraq is characterized as a post-war reconstruction that has severe mental health demands, but patients' concerns remain secondary to issues like safety and healthcare.

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Although Iraq has entered a phase of post-war development, with significant efforts directed toward rebuilding its physical infrastructure and reviving the economy, the focus on mental health care remains glaringly inadequate. The country's development initiatives have largely centered on improving safety, reconstructing damaged infrastructures, and addressing high unemployment rates (United Nations Development Programme [UNDP], 2020). However, these efforts have not been matched by a parallel focus on mental health services, which are critical in a society where years of violence, displacement, and trauma have left indelible psychological scars. Despite the introduction of several health-related initiatives in Iraq's reconstruction phase, mental health services continue to suffer from underfunding, a lack of trained professionals, and inadequate institutional support (Al-Issa, 2020).

Iraq's recent development progress, characterized by reconstruction of key sectors such as housing, transportation, and energy, has paradoxically overshadowed the urgent need for mental health care (World Bank, 2018). While the country's focus on rebuilding essential services is necessary, this approach has inadvertently marginalized mental health needs, leaving a vast portion of the population without access to crucial psychological support. As a result, mental health issues such as post-traumatic stress disorder (PTSD), depression, and anxiety continue to rise, particularly among internally displaced persons (IDPs) and individuals exposed to the violence of the Islamic State of Iraq and Syria (ISIS) era (Al-Attar et al., 2020). According to a report by the International Organization for Migration (IOM, 2021), mental health issues in Iraq are now reaching critical levels, with limited intervention strategies in place to address the growing demand for mental health services.

The lack of focus on mental health in Iraq's development plans demonstrates a disconnection between physical reconstruction and societal well-being. The World Health Organization (WHO, 2019) has highlighted that mental health is a critical component of post-war recovery, yet in Iraq, mental health remains a secondary issue to more immediate concerns like safety and physical health. This imbalance in priorities has resulted in a system where mental health care is underfunded, understaffed, and underdeveloped, contributing to the formal mental health care gap experienced by those in need. The Iraqi government's current development policies need to incorporate mental health as a core aspect of the country's recovery, as it plays a crucial role in the overall stability and long-term sustainability of societal progress. Addressing the mental health crisis in tandem with ongoing development efforts will not only benefit individuals directly affected by trauma but also contribute to the nation’s broader goal of achieving lasting peace and societal cohesion (Al Obaidi & Atallah, 2019).

From the human rights standpoint, Iraq has a number of issues in protecting the rights of patients with mental illness. The country has signed the Convention on the Rights of Persons with Disabilities (CRPD) which requires the country to uphold the rights of persons with mental and psychosocial disabilities (United Nations, 2006). Nonetheless, the realization of these rights has been hampered by the on-going conflict and cultures that deemed mental illness as taboo. Self-

stigma emerges as a significant factor that pushes job seekers into complete rejection due to mental health conditions. Moreover, there is a serious shortage of mental health facilities, and many people do not get the care and assistance they are legally entitled to by international human rights law. Measures aimed at solving these problems must involve not only changes in legislation and the healthcare system, but also positive shifts in the population's attitude to mental health disorders and people with such conditions.

5.3.2. Case Study 2: Palestine

Palestine's mental policies have been influenced by its geopolitical position due to occupation by Israel and recurrent incidents of this kind. Due to the increased focus on mental health needs, the Palestinian Authority and international organizations have worked to fill this gap through the implementation of the National Mental Health Policy 2015-2019 (Palestinian Ministry of Health, 2015). This policy sought to ensure delivery of mental health care within the primary health care facilities and a deinstitutionalization model. However, there have been some attempts to introduce and enforce these policies, though this has been a problem due to political instabilities, lack of resources, and restrictions in movement as a result of occupation by Israel, which has worsened the access to healthcare and mental health in particular.

The societal development context in Palestine is one of chronic instability and economic hardship, which has affected mental health. The consistent incidences of aggression together with the occupation has instilled fear and post-traumatic stress among the Palestinian people (Giacaman et al., 2011). In terms of economy, the situation is equally bleak as evidenced by high levels of unemployment among the Palestinians and levels of poverty that add to the overall anxiety among the Palestinians. An alarming issue that relates to mental health services is the fact that mental health is actually only provided as a form of psychological assistance in cases of crisis situations, without any possibility of future treatment or recovery. The social problems experienced in Palestine have reinforced the necessity for a mental health policy that has the purchase of

addressing the needs of individuals stricken by the war as well as the desire to construct a functional and healthier society.

This research observes that the political context complicates the human rights perspective in Palestine. The occupation has been categorized as an impediment to the actualization of the right to health contributing to mental health (Hammami, 2015). The limitation to mobility, regular shutdowns, and combat have not only impacted the ability of USC patients to seek medical assistance but also resulted in increased cases of psychological distress. However, there have been some achievements in the fight for the rights of those with mental health conditions through attempts of NGOs and international organizations. However, much more remains to be done to guarantee that mental health facilities are available to all Palestinian communities regardless of the place they live in and that the services provided meet the standard of the International Human Rights Law. This study explored the mental health and human rights of the Palestinian people, and the findings show that holistically addressing the people's need entails focusing on each of the two aspects, namely structure and person.

5.3.3. Comprehensive Case Comparison

The mental health policies and challenges in Iraq, Palestine, and Lebanon reflect the unique sociopolitical and economic contexts of these three nations. While each country shares common struggles, such as underfunding, stigma, and the aftermath of conflict, there are also distinct factors that shape their mental health landscapes. This analysis offers a comprehensive comparison of the mental health policies, development contexts, and human rights considerations in these nations, highlighting both their similarities and key differences.

In Iraq, the mental health sector has been shaped by a tumultuous history, including years of sanctions following the Gulf War and the post-2003 invasion by coalition forces. These events severely impacted the country's healthcare system, exacerbating mental health issues across the

population. The National Mental Health Strategy for 2013-2017, developed in cooperation with the World Health Organization (WHO), sought to address these needs by integrating mental health into primary care and reducing the stigma associated with mental illness (Alhasnawi et al., 2009). However, these efforts have been undermined by ongoing conflict, a lack of resources, and persistent insecurity. The emergence of ISIS and the subsequent displacement of millions of Iraqis further compounded the country's mental health crisis. Trauma, depression, and anxiety are widespread, but the government's post-war recovery efforts have focused largely on rebuilding physical infrastructure rather than addressing these mental health challenges (Al-Attar et al., 2020).

Palestine, by contrast, has faced a unique set of challenges stemming from its long-standing conflict with Israel. The mental health of the Palestinian population has been severely impacted by recurrent acts of violence, occupation, and restricted movement. The National Mental Health Policy (2015-2019) was an attempt to improve mental health care by integrating services into primary care and moving toward a deinstitutionalized model (Palestinian Ministry of Health, 2015). However, political instability, the blockade on Gaza, and frequent military incursions have made the consistent delivery of mental health services extremely difficult. Palestinian society endures high levels of post-traumatic stress disorder (PTSD), anxiety, and depression as a result of continued conflict and economic deprivation. The occupation has imposed significant barriers to accessing healthcare, particularly in isolated regions, further complicating the provision of mental health services (Giacaman et al., 2011).

Lebanon presents a somewhat different case. The country has experienced periods of civil war, political instability, and, more recently, an economic collapse and the 2020 Beirut explosion. These crises have had a profound impact on Lebanon's mental health system. In 2014, Lebanon launched its National Mental Health Program with the support of WHO and UNICEF, aiming to improve access to mental health services and combat the stigma surrounding mental illness (Ministry of Public Health Lebanon, 2015). Despite this initiative, Lebanon's mental health services remain unevenly distributed, with urban centers offering more comprehensive care than rural areas. The influx of Syrian refugees has placed further strain on an already overburdened system,

exacerbating the mental health challenges faced by both the local population and the refugees (Karam et al., 2019).

A comparison of mental health policy development in Iraq, Palestine, and Lebanon reveals both common goals and differing levels of success. Iraq's National Mental Health Strategy, developed in partnership with the WHO, reflects an ambitious effort to integrate mental health care into the broader healthcare system. However, the practical implementation of this strategy has been severely limited by ongoing conflict and a lack of financial and human resources. Many mental health professionals have left the country, and the stigma associated with mental illness remains a significant barrier to care. Despite these challenges, Iraq has made some progress in rebuilding its healthcare system, though mental health services remain underfunded and understaffed (Al-Issa, 2020).

In Palestine, the National Mental Health Policy also sought to integrate mental health into primary care, but its implementation has been hindered by the unique challenges of the Israeli occupation. Political instability, frequent military interventions, and restrictions on movement have made it difficult to deliver consistent care. Mental health services in Palestine are often provided in response to acute crises, with little opportunity for long-term treatment or rehabilitation. This has led to a gap in services for individuals with chronic mental health conditions, as the focus remains on addressing immediate psychological trauma (Hammami, 2015). Despite these challenges, there have been efforts by international organizations and NGOs to improve mental health services in the region, though much work remains to be done.

Lebanon's National Mental Health Program, launched in 2014, represents one of the more successful efforts to integrate mental health services into primary care. However, the country's political and economic crises have undermined these efforts. Mental health services are not evenly distributed across the country, with rural areas and underserved populations having limited access to care. Furthermore, the stigma surrounding mental illness remains a significant issue, preventing many individuals from seeking help. Lebanon's mental health system has also been strained by

the large number of Syrian refugees who have sought shelter in the country, adding to the demand for already limited services (Haddad et al., 2012).

The social and economic contexts in Iraq, Palestine, and Lebanon play a crucial role in shaping their mental health landscapes. In Iraq, years of conflict and instability have led to high rates of unemployment, poverty, and displacement. These factors have contributed to the widespread prevalence of mental health issues such as PTSD, depression, and anxiety. Internally displaced persons (IDPs) and individuals who have experienced violence during the ISIS occupation are particularly vulnerable. Despite some progress in rebuilding the country's physical infrastructure, mental health services remain underfunded, and the lack of trained professionals further limits the care available to those in need (IOM, 2021).

Palestine's economic situation is similarly dire, with high levels of unemployment and poverty contributing to widespread psychological distress. The ongoing occupation has exacerbated these problems, with restrictions on movement and frequent military incursions creating an environment of chronic instability and fear. Mental health services in Palestine are largely crisis-oriented, focusing on immediate psychological assistance in response to traumatic events. However, long-term care is often unavailable, particularly in isolated regions where access to healthcare is limited (Giacaman et al., 2011). The economic hardships faced by the Palestinian people further exacerbate their mental health challenges, as many are unable to afford private care and rely on underfunded public services.

Lebanon, though more developed in some respects, has faced its own set of challenges. The country's recent economic collapse and the 2020 Beirut explosion have significantly worsened the mental health situation, with many people experiencing anxiety, depression, and PTSD. Lebanon's mental health system, though more advanced than those of Iraq and Palestine, has struggled to meet the increased demand for services, particularly in rural areas and among the refugee population. The influx of Syrian refugees has placed additional strain on the country's mental health infrastructure, and the stigma surrounding mental illness continues to be a significant barrier to care (Karam et al., 2019).

From a human rights perspective, all three countries face significant challenges in protecting the rights of individuals with mental health conditions. Iraq has signed the Convention on the Rights of Persons with Disabilities (CRPD), which obligates the country to protect the rights of people with mental health issues (United Nations, 2006). However, the ongoing conflict, coupled with the stigma surrounding mental illness, has made it difficult to fully realize these rights. Many individuals with mental health conditions face discrimination in both the healthcare system and society at large, and the lack of resources further limits their access to care (Al Obaidi & Atallah, 2019).

In Palestine, the occupation presents a significant barrier to the realization of mental health rights. Restrictions on movement, frequent shutdowns, and military interventions make it difficult for individuals to access the care they need. Efforts by NGOs and international organizations have improved awareness of mental health rights, but much work remains to be done to ensure that all Palestinians have access to adequate mental health care (Hammami, 2015). The occupation has also limited the Palestinian Authority's ability to fully implement mental health policies, as resources are diverted to address more immediate concerns.

Lebanon, like Iraq, has signed the CRPD and has made some progress in recognizing the rights of individuals with mental health conditions (WHO, 2006). However, the country's political and economic crises have hindered the full realization of these rights. Stigma remains a significant barrier, and many individuals with mental health conditions continue to face discrimination in various aspects of their lives. The lack of mental health services in rural areas and among refugee populations further compounds these challenges, as many individuals are unable to access the care they are entitled to under international human rights law (Haddad et al., 2012).

6. Conclusion

To sum up, it is necessary to shift the primary analysis primarily to Lebanon while drawing contextual and comparative information from Iraq and Palestine. Lebanon presents a rather specific and rather valuable case for studying the state of mental healthcare in the country which reveals both its progress and numerous issues amid overlapping crises. I argue that Lebanon, unlike the other two cases, is best suited to examine the interaction between political and economic turmoil and effects on mental health policies and human rights.

It is however important to note that though Lebanon launched the National Mental Health Program in 2014 that sought to include mental health as part of the primary care and to eliminate stigma of mental health, the political and economic crisis in the country slowed down the program's implementation and effectiveness. Lebanon's recent economic downfall coupled with the Beirut's explosion in 2020 has worsen the situation by creating high rates of anxiety, depression, and Post-Traumatic Stress Disorder (PTSD) among the individuals of Lebanon. Syrian refugees have further worsened an already weak health care system to show that external problems expose internal weaknesses. Where Iraq and Palestine witness direct aggression affecting Mental Health policy and service provision, Lebanon suffers from system- ized inefficiency due to an eroding economy and inter- sectarian conflict therefore provides an interesting look as to how when an economy and social fabric reaches its lowest it cannot support a robust Mental Health policy.

Iraq and Palestine have many common factors with Lebanon with the focus on the systematic exclusion of efficient mental health care. In the situation of Iraq, the aftermath of war, especially after the emergence of ISIS, has an existing problem with an abused population that does not have access to mental health treatment as the focus of reconstructing the country shifts towards the physical aspect. Iraq's rebuilding process after the war is highly extended to infrastructural rebuilding while mental health services are poorly funded and likewise to the Lebanese case of

rebuilding the country physically rather than taking care of the needs of victims' mental health. Likewise in Palestine, due to Israeli occupation of the country the mental health policies are still compromised, political uncertainty, restricted mobility and perpetuated threat of hostilities has resulted in continuous stress and anxiety among the Palestinians. The Palestinian Authority has tried to integrate mental health into primary care, however, the occupation has mitigated the access to such services as Lebanon's economic crisis did to mental health care provision.

One of the most relevant insights arising from this thesis is concerned with the lack of access to Mental Health services in the three countries. In this context, Lebanon's experience makes it possible to identify a clear correlation between urban and rural settings in providing/studying access to healthcare, especially mental health, with the latter setting receiving almost no attention. This is as it is in Iraq and Palestine where rural and conflict affected areas are also inaccessible and offer poor access to health care. Lebanon's case of having insufficient funding, trained staff and facilities is symptomatic to what has been identified in Iraq and Palestine highlighting the chronic omission of mental health services in the region at large and particularly during crises.

When it comes to human rights each of these three countries, Lebanon, Iraq, and Palestine are unable to guarantee the right to mental health as stated in the CRPD. In Lebanon, although there have been some improvements on the rights of mental health disable people, social acceptance remains a hindrance. The study reveals that mental health patients are still being discriminated in the healthcare facilities, places of work and in the society. This is further exacerbated by poor legal recourses and lack of enforcement structures which is the same case in Iraq and Palestine where mental health is highly stigmatized and laws to protect the human rights of the mental health patients are equally inadequate.

Based on this, it can be stated that the problem of bad mental health outcomes in Lebanon has to be solved not only through the adaptation of new policies but also through the change of people's attitudes towards mental illness. The cultural perception of mental health continues to be a huge problem in Lebanon as it is with Iraq and Palestine; therefore, efforts to initiate mental health

campaigns and include the people in mental health awareness to reduce the stigmatized view of the menace should be commenced. In addition, it is noteworthy that there is a dire need to revise the mental health policies in Lebanon, and align them on the current socio-economic realities of the country, and hence, there is a need to provide for policies that are more responsive to the increasingly deteriorating state of mental health in a nation that is in a state of constant turmoil.

In conclusion, it is not only the case of Lebanon that has its specificity but also there are many lessons that may be learned by other countries which face similar problems. This work shows that the mental health policy in Lebanon, Iraq and Palestine, human rights and development should take into account the mental health care in a more comprehensive manner rather than focusing on the medical model only. The future will not be easy for Lebanon, as such it will call for actions to eliminate the systems which have limited the delivery of mental health especially for the marginalized groups, not forgetting a midterm commitment to guarding the rights of mental health patients. It is only with such extensive changes that reform can be realistic about achieving more positive health impacts and general social improvements in Lebanon and in so doing for other nations of regions in similar situations as Lebanon.

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Commented [KE13]: Always mention the UN Agency, here OHCHR, do it for all UN references that are not international conventions

Appendix

- **Appendix A - Questionnaire:**

Section 1: Demographic Information

Commented [KE14]: This is not the place for the actual questionnaire, place it in an Annex and reference it in a footnote like mentioned earlier

1. **Age:**
   - ☐ Under 18
   - ☐ 18-24
   - ☐ 25-34
   - ☐ 35-44
   - ☐ 45-54
   - ☐ 55-64
   - ☐ 65 and above
2. **Gender:**
   - ☐ Male
   - ☐ Female
   - ☐ Other (please specify): _____
3. **Role:**
   - ☐ Mental Health Professional
   - ☐ Patient
4. **Hospital:**
   - ☐ LAU Rizk Hospital
   - ☐ American University of Beirut Medical Center (AUBMC)
   - ☐ Saint George Hospital University Medical Center
   - ☐ Hotel Dieu de France University Hospital

Commented [KE15]: So you used the same questionnaire for both categories of respondents? You will need to justify this during your defense

Section 2: Access to Mental Health Services

5. How would you rate your access to mental health services at your hospital?
   - [1] Very Poor
   - [2] Poor
   - [3] Fair
   - [4] Good

    - [5] Excellent
6. Are mental health services at your hospital available when you need them?
    - [1] Never
    - [2] Rarely
    - [3] Sometimes
    - [4] Usually
    - [5] Always

Section 3: Quality of Care

7. How would you rate the quality of mental health care provided at your hospital?
    - [1] Very Poor
    - [2] Poor
    - [3] Fair
    - [4] Good
    - [5] Excellent
8. Do you feel that mental health professionals at your hospital are adequately trained and equipped to provide high-quality care?
    - [1] Strongly Disagree
    - [2] Disagree
    - [3] Neutral
    - [4] Agree
    - [5] Strongly Agree
9. How satisfied are you with the level of support and communication from mental health professionals at your hospital?
    - [1] Very Dissatisfied
    - [2] Dissatisfied
    - [3] Neutral
    - [4] Satisfied
    - [5] Very Satisfied

Section 4: Effectiveness of Mental Health Policies

10. Do you believe that current mental health policies effectively address the needs of patients?

- [1] Strongly Disagree
- [2] Disagree
- [3] Neutral
- [4] Agree
- [5] Strongly Agree

11. In your opinion, do mental health policies at your hospital promote equitable access to mental health services for all patients?

- [1] Strongly Disagree

- [2] Disagree
- [3] Neutral
- [4] Agree
- [5] Strongly Agree

Section 5: Barriers to Access and Implementation

12. What do you perceive as the main barriers to accessing mental health services at your hospital? (Rate each barrier from 1 to 5, where 1 = Not a Barrier and 5 = Major Barrier)

- Financial constraints
    - [1] Not a Barrier
    - [2] Slight Barrier
    - [3] Moderate Barrier
    - [4] Significant Barrier
    - [5] Major Barrier
- Stigma and discrimination
    - [1] Not a Barrier
    - [2] Slight Barrier
    - [3] Moderate Barrier
    - [4] Significant Barrier
    - [5] Major Barrier
- Lack of awareness about available services
    - [1] Not a Barrier
    - [2] Slight Barrier
    - [3] Moderate Barrier
    - [4] Significant Barrier
    - [5] Major Barrier
- Insufficient number of mental health professionals
    - [1] Not a Barrier
    - [2] Slight Barrier
    - [3] Moderate Barrier
    - [4] Significant Barrier
    - [5] Major Barrier
- Inadequate facilities and resources
    - [1] Not a Barrier
    - [2] Slight Barrier
    - [3] Moderate Barrier
    - [4] Significant Barrier
    - [5] Major Barrier
- Other (please specify): _____

13. What challenges do you face in implementing or accessing mental health policies? (Rate each challenge from 1 to 5, where 1 = Not a Challenge and 5 = Major Challenge)

- Bureaucratic hurdles

    - [1] Not a Challenge
    - [2] Slight Challenge
    - [3] Moderate Challenge
    - [4] Significant Challenge
    - [5] Major Challenge
- Lack of political support
    - [1] Not a Challenge
    - [2] Slight Challenge
    - [3] Moderate Challenge
    - [4] Significant Challenge
    - [5] Major Challenge
- Inadequate funding
    - [1] Not a Challenge
    - [2] Slight Challenge
    - [3] Moderate Challenge
    - [4] Significant Challenge
    - [5] Major Challenge
- Cultural and societal barriers
    - [1] Not a Challenge
    - [2] Slight Challenge
    - [3] Moderate Challenge
    - [4] Significant Challenge
    - [5] Major Challenge
- Other (please specify): _____

Section 6: Patient Experiences and Satisfaction

14. (For patients) How would you rate your overall experience with mental health services at your hospital?

- [1] Very Poor
- [2] Poor
- [3] Fair
- [4] Good
- [5] Excellent

15. (For patients) Do you feel that your rights are respected and upheld during your treatment at the hospital?

- [1] Strongly Disagree
- [2] Disagree
- [3] Neutral
- [4] Agree
- [5] Strongly Agree

- **Appendix B – Interview:**

Question
Can you describe your overall experience with the mental health services provided at your hospital?
How do you perceive the effectiveness of current mental health policies at your hospital?
In your opinion, what are the main barriers to accessing mental health services at your hospital?
How do you feel about the level of training and preparedness of mental health professionals at your hospital?
What challenges have you faced in implementing or accessing mental health policies at your hospital?
Do you feel that mental health services at your hospital are equitable and accessible to all patients?
Can you discuss any experiences of stigma or discrimination related to mental health within the hospital setting?
What recommendations would you make to improve mental health services and policies at your hospital?

Commented [KE16]: Again to be placed in Annex. Write a short paragraph summarizing the goals of the interviews and what was asked.

Commented [KE17]: Many Qs were already in the survey, an interview was the opportunity to go deeper in the discussion and address more elaborately other angles such as here HRBA and development, which are not present in your fieldwork

Commented [KE18]: I don't see any question in relation to development, how did the field work help you address the nexus between MH and development?

- **Appendix C - Questionnaire Results:**

Age	Gender	Role	Hospital	Access to Mental Health Services	Availability of Services	Quality of Care	Adequate Training of Professionals
45-54	Other	Mental Health Professional	AUBMC	3	4	1	5
55-64	Male	Mental Health Professional	AUBMC	1	4	3	1

Under 18	Other	Mental Health Professional	Hotel Dieu de France	2	4	5	2
35-44	Female	Mental Health Professional	AUBMC	1	2	4	1
35-44	Female	Mental Health Professional	LAU Rizk Hospital	5	3	4	3
35-44	Female	Mental Health Professional	LAU Rizk Hospital	1	3	3	1
18-24	Male	Mental Health Professional	LAU Rizk Hospital	4	4	2	4
35-44	Female	Mental Health Professional	Hotel Dieu de France	3	3	1	3
55-64	Female	Mental Health Professional	Hotel Dieu de France	1	4	5	1
25-34	Female	Mental Health Professional	AUBMC	1	5	2	3
45-54	Male	Mental Health Professional	Saint George Hospital	2	5	5	4
65 and above	Female	Mental Health Professional	AUBMC	2	3	5	1
Under 18	Other	Mental Health Professional	Hotel Dieu de France	1	2	3	1
Under 18	Male	Mental Health Professional	AUBMC	4	3	1	2
45-54	Female	Mental Health Professional	Hotel Dieu de France	1	1	1	1
25-34	Other	Mental Health Professional	LAU Rizk Hospital	4	4	4	1
18-24	Male	Mental Health Professional	LAU Rizk Hospital	1	1	2	3
65 and above	Other	Mental Health Professional	Hotel Dieu de France	5	3	2	4
65 and above	Male	Mental Health Professional	AUBMC	5	5	1	5
Under 18	Female	Mental Health Professional	Saint George Hospital	1	4	5	4
18-24	Other	Mental Health Professional	LAU Rizk Hospital	2	3	4	4
55-64	Other	Mental Health Professional	Saint George Hospital	4	2	4	1
18-24	Female	Mental Health Professional	Hotel Dieu de France	5	3	5	5
55-64	Male	Mental Health Professional	Hotel Dieu de France	4	2	4	5
Under 18	Female	Mental Health Professional	Saint George Hospital	3	5	5	4
18-24	Female	Mental Health Professional	Hotel Dieu de France	2	2	4	3
45-54	Male	Mental Health Professional	AUBMC	2	1	1	5

35-44	Other	Mental Health Professional	AUBMC	3	1	4	5
Under 18	Other	Mental Health Professional	AUBMC	2	1	4	4
35-44	Other	Mental Health Professional	Hotel Dieu de France	5	1	2	2
55-64	Other	Mental Health Professional	Saint George Hospital	3	1	4	5
65 and above	Female	Mental Health Professional	LAU Rizk Hospital	5	2	5	4
Under 18	Other	Mental Health Professional	LAU Rizk Hospital	5	1	1	2
25-34	Other	Mental Health Professional	AUBMC	3	4	4	4
35-44	Other	Mental Health Professional	LAU Rizk Hospital	4	2	1	4
Under 18	Other	Mental Health Professional	Hotel Dieu de France	4	5	1	3
18-24	Other	Mental Health Professional	Saint George Hospital	2	2	4	1
35-44	Male	Mental Health Professional	Hotel Dieu de France	3	3	2	2
55-64	Female	Mental Health Professional	Hotel Dieu de France	5	5	3	1
35-44	Other	Mental Health Professional	Saint George Hospital	4	1	4	2
35-44	Other	Patient	LAU Rizk Hospital	4	1	3	2
65 and above	Female	Patient	Saint George Hospital	2	3	4	5
Under 18	Other	Patient	Hotel Dieu de France	2	1	1	3
18-24	Female	Patient	Saint George Hospital	2	5	4	3
18-24	Male	Patient	Saint George Hospital	2	5	3	4
18-24	Other	Patient	AUBMC	3	5	1	1
Under 18	Other	Patient	AUBMC	1	2	4	4
25-34	Male	Patient	Hotel Dieu de France	4	2	2	3
45-54	Other	Patient	Hotel Dieu de France	2	5	5	4
35-44	Male	Patient	LAU Rizk Hospital	5	2	4	3
65 and above	Male	Patient	Hotel Dieu de France	4	2	2	3
35-44	Other	Patient	LAU Rizk Hospital	2	4	3	2
25-34	Male	Patient	LAU Rizk Hospital	2	2	2	4
45-54	Other	Patient	Saint George Hospital	3	4	5	2
25-34	Other	Patient	Saint George Hospital	1	4	2	4

Under 18	Other	Patient	Hotel Dieu de France	1	2	4	3
Under 18	Male	Patient	AUBMC	3	2	2	3
45-54	Male	Patient	AUBMC	5	2	4	5
55-64	Male	Patient	LAU Rizk Hospital	1	1	3	2
55-64	Female	Patient	Hotel Dieu de France	5	4	5	1
65 and above	Other	Patient	LAU Rizk Hospital	4	1	2	4
Under 18	Male	Patient	Saint George Hospital	4	5	5	1
45-54	Female	Patient	Hotel Dieu de France	1	2	2	5
18-24	Other	Patient	Hotel Dieu de France	1	5	5	3
45-54	Other	Patient	AUBMC	4	1	2	2
18-24	Other	Patient	Hotel Dieu de France	4	4	3	1
25-34	Female	Patient	AUBMC	1	3	3	2
25-34	Male	Patient	Hotel Dieu de France	4	2	4	3
Under 18	Male	Patient	Saint George Hospital	1	5	2	2
18-24	Male	Patient	LAU Rizk Hospital	3	5	3	2
18-24	Male	Patient	AUBMC	2	5	3	4
18-24	Other	Patient	AUBMC	1	1	5	1
18-24	Other	Patient	Hotel Dieu de France	5	1	3	5
35-44	Male	Patient	Hotel Dieu de France	1	3	3	2
65 and above	Male	Patient	Hotel Dieu de France	4	1	4	2
35-44	Male	Patient	AUBMC	5	4	1	5
65 and above	Female	Patient	AUBMC	5	4	5	1
25-34	Other	Patient	AUBMC	2	5	3	3
35-44	Male	Patient	Hotel Dieu de France	1	2	1	4
Under 18	Male	Patient	Hotel Dieu de France	3	5	1	5
65 and above	Female	Patient	Saint George Hospital	5	4	3	2
35-44	Male	Patient	Saint George Hospital	5	4	4	3
55-64	Other	Patient	Saint George Hospital	3	4	2	4
45-54	Female	Patient	LAU Rizk Hospital	5	5	4	5
18-24	Female	Patient	Hotel Dieu de France	4	3	3	2

25-34	Female	Patient	Hotel Dieu de France	3	2	5	1
45-54	Male	Patient	AUBMC	4	3	2	5
35-44	Male	Patient	Saint George Hospital	1	3	2	2
45-54	Male	Patient	Hotel Dieu de France	1	2	3	3
65 and above	Female	Patient	AUBMC	1	4	3	5
45-54	Female	Patient	Hotel Dieu de France	4	4	5	4
45-54	Other	Patient	Hotel Dieu de France	5	5	4	1
35-44	Female	Patient	AUBMC	5	5	5	5
45-54	Male	Patient	AUBMC	3	3	3	5
45-54	Male	Patient	AUBMC	3	2	5	1
45-54	Female	Patient	LAU Rizk Hospital	5	2	3	3
Under 18	Other	Patient	Saint George Hospital	2	1	2	4

Satisfaction with Support	Effectiveness of Policies	Equitable Access	Financial Constraints	Stigma and Discrimination	Lack of Awareness
2	5	1	5	5	4
3	2	3	4	4	2
2	5	2	4	2	4
4	1	2	2	2	4
3	1	1	3	4	5
5	3	2	5	4	1
3	4	2	1	1	3
2	2	1	1	3	3
5	1	1	2	5	2
1	1	4	1	2	3
3	1	4	3	4	1
3	1	4	4	4	3
5	3	4	5	4	1
3	5	2	4	3	1
5	1	3	2	5	5
1	3	1	4	4	3
3	4	1	3	5	4
2	5	5	1	2	2
3	4	3	5	1	4
5	5	3	3	1	3
5	5	1	2	2	3
2	5	3	5	1	4

2	3	5	4	4	5
5	2	2	2	3	3
5	4	4	4	1	5
3	5	5	3	2	2
5	5	4	3	3	3
2	1	1	2	2	4
3	1	2	1	4	5
5	3	5	2	2	2
1	5	3	1	4	1
2	4	2	2	1	2
1	4	5	2	3	5
3	1	2	5	5	3
2	1	1	1	3	3
3	2	3	1	5	1
4	5	4	3	1	5
2	5	4	4	2	3
3	1	4	3	4	3
1	1	5	1	4	5
3	1	2	5	4	2
5	2	3	1	1	4
5	2	3	4	1	2
1	2	5	4	5	5
3	5	3	2	3	2
2	2	3	5	3	3
1	5	2	3	2	5
3	1	2	5	5	3
4	5	2	2	1	3
5	4	5	1	1	3
1	3	5	4	4	2
3	1	5	1	5	4
4	4	3	1	5	1
5	3	4	2	1	4
4	4	3	3	5	1
1	3	2	1	4	5
3	3	4	4	4	4
4	2	1	4	1	1
4	4	4	3	1	3
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2	2	3	5	1	4
3	1	3	5	3	4
2	1	2	4	4	1
5	1	4	4	1	1
2	4	5	5	1	3
5	5	4	4	2	4
2	5	2	3	2	1
3	3	4	5	2	3
4	3	2	5	3	5
3	4	4	2	2	1
3	4	4	2	1	1
3	5	3	2	2	5
4	3	1	2	5	5
3	2	4	1	5	1
5	1	5	2	4	5
2	5	1	3	5	5
4	2	5	1	4	3
1	4	4	3	5	1
5	1	2	2	3	5
4	4	4	5	4	3
2	3	3	1	5	1
4	2	2	5	4	1
5	1	5	3	4	1
5	1	4	3	5	5
1	4	4	1	1	5
3	5	2	3	2	4
2	2	4	1	4	3
5	1	1	3	4	4

Insufficient Professionals	Inadequate Facilities	Bureaucratic Hurdles	Lack of Political Support	Inadequate Funding	Cultural and Societal Barriers	Patient Overall Experience	Patient Rights
3	3	4	1	4	4	5	3
2	4	4	2	5	1	1	2
4	4	4	4	4	4	4	1
1	4	5	3	3	4	3	3
2	4	3	2	1	2	5	1

2	1	2	3	1	2	4	4
2	1	1	3	2	5	3	4
3	1	1	1	5	2	2	4
5	2	1	4	2	4	1	5
5	1	3	4	1	4	4	5
2	2	4	3	5	4	1	5
5	5	2	2	4	2	1	2
1	1	5	4	4	3	4	5
5	3	4	1	5	1	4	4
3	4	5	4	3	5	5	4
2	2	4	1	4	3	3	1
4	5	1	2	2	1	2	3
1	1	4	3	4	2	3	3
4	4	1	2	4	5	2	2
2	3	1	2	3	5	2	3
2	5	2	1	4	2	5	2
4	3	2	2	2	3	3	1
2	1	5	3	2	1	4	4
2	2	5	4	2	4	1	4
2	5	3	1	1	4	5	2
5	1	3	1	4	1	5	5
5	1	5	2	4	4	5	1
3	2	2	2	5	3	4	4
4	2	1	2	3	2	1	4
1	1	3	5	1	4	2	1
4	2	2	3	4	2	4	2
4	5	1	2	2	4	3	5
3	2	3	5	1	4	3	2
5	5	2	1	1	5	4	1
1	1	5	3	2	4	5	3
1	4	2	5	5	5	4	2
3	1	3	1	4	1	1	3
2	1	1	4	3	4	2	1
4	1	3	4	5	4	2	3
4	5	4	3	3	4	2	4
1	4	5	5	3	5	2	3
4	2	4	5	4	4	5	5
1	3	3	1	1	3	3	5
5	5	3	4	2	1	3	1
5	1	2	4	3	2	4	5
1	1	2	2	5	2	2	3
3	3	4	5	4	5	3	4
4	2	2	3	4	1	1	1

1	4	2	4	5	1	4	2
3	1	4	3	3	2	5	4
5	3	2	3	3	5	3	2
4	1	4	2	3	3	2	1
4	3	1	4	5	1	5	2
5	2	4	3	3	2	1	4
2	3	2	4	5	3	1	5
1	1	5	2	4	3	1	1
3	5	5	1	5	3	5	5
3	2	4	1	2	4	3	5
2	3	5	1	1	3	3	5
3	5	5	3	1	3	2	4
3	4	2	3	2	2	5	3
4	4	1	3	5	5	3	5
1	3	1	4	1	4	4	3
4	2	2	5	2	2	2	1
5	1	1	4	3	2	3	2
4	4	4	1	2	3	4	5
2	5	1	5	1	4	2	3
1	5	5	2	5	5	1	1
2	5	2	5	5	5	1	4
1	4	3	2	5	2	4	1
1	3	5	3	1	4	1	4
1	4	5	1	3	2	4	2
3	2	4	3	5	2	2	2
4	2	3	4	4	5	3	3
3	3	4	3	3	5	2	4
3	5	2	3	2	2	4	4
4	4	3	5	4	5	5	2
2	3	2	2	3	5	5	1
1	1	1	1	1	3	4	1
2	2	5	3	4	3	1	3
2	1	1	3	3	1	4	2
5	1	2	2	3	1	3	2
3	4	4	4	3	2	2	5
1	3	5	4	3	2	4	3
4	1	5	5	5	2	3	2
2	1	3	2	4	2	5	5
5	5	1	3	3	5	4	4
5	5	2	4	2	1	1	5
2	1	2	4	3	2	4	2
2	4	2	1	5	3	5	1
5	1	2	1	4	5	3	3

3	2	4	5	4	1	4	4
5	3	2	4	3	5	4	1
5	4	4	4	3	4	1	3
5	5	4	2	2	2	4	4
3	3	3	1	4	3	2	4
3	2	3	1	4	1	4	2

- **Appendix D – Descriptive Statistics:**

Statistic	*Column1*	*Column2*	*Column3*	*Column4*	*Column5*	*Column6*	*Column7*	*Column8*	*Column9*
Mean	2.958763	3.010309	3.154639	2.979381	3.185567	2.958763	2.989691	2.907216	3.123711
Standard Error	0.150113	0.144705	0.136176	0.143576	0.135377	0.158465	0.133109	0.143653	0.151068
Median	3	3	3	3	3	3	3	3	3
Mode	1	2	4	4	3	1	4	3	4
Standard Deviation	1.478439	1.425182	1.341176	1.414062	1.333306	1.560699	1.31097	1.414821	1.487852
Sample Variance	2.185782	2.031143	1.798754	1.99957	1.777706	2.435782	1.718643	2.001718	2.213703
Kurtosis	-1.41454	-1.34744	-1.1491	-1.30081	-1.10571	-1.54155	-1.17092	-1.26704	-1.43355
Skewness	0.013053	0.025607	-0.15637	-0.00799	-0.05217	0.002616	-0.00896	0.099772	-0.15841
Range	4	4	4	4	4	4	4	4	4
Minimum	1	1	1	1	1	1	1	1	1
Maximum	5	5	5	5	5	5	5	5	5
Sum	287	292	306	289	309	287	290	282	303
Count	97	97	97	97	97	97	97	97	97

- **Appendix E – ANOVA One Way**

Groups	*Count*	*Sum*	*Average*	*Variance*
Column 1	97	287	2.958763	2.185782
Column 2	97	292	3.010309	2.031143
Column 3	97	306	3.154639	1.798754
Column 4	97	289	2.979381	1.99957
Column 5	97	309	3.185567	1.777706

Column 6	97	287	2.958763	2.435782
Column 7	97	290	2.989691	1.718643
Column 8	97	282	2.907216	2.001718
Column 9	97	303	3.123711	2.213703
Column 10	97	302	3.113402	2.039089
Column 11	97	290	2.989691	1.968643
Column 12	97	271	2.793814	2.165378
Column 13	97	289	2.979381	1.93707
Column 14	97	277	2.85567	1.749785
Column 15	97	309	3.185567	1.756873
Column 16	97	296	3.051546	1.903565
Column 17	97	299	3.082474	1.868127
Column 18	97	291	3	1.979167

Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	19.52176	17	1.148339	0.581757	0.907571	1.628684
Within Groups	3410.928	1728	1.973917			
Total	3430.45	1745				

- **Appendix F – Interview Responses:**

Participant Role	Hospital	Overall Experience with Services	Effectiveness of Policies	Main Barriers to Access	Training and Preparedness of Professionals

Mental Health Professional	LAU Rizk Hospital	The services are good, but there's room for improvement.	The policies work but could be more flexible.	There aren't enough resources.	The staff is well-trained, but they could use more frequent updates.
Mental Health Professional	AUBMC	I'm generally satisfied with the services.	The policies are effective but could be updated.	Patients need more awareness about the services.	The staff is well-prepared, but specialized training would help.
Mental Health Professional	Saint George Hospital	My experience has been mixed.	The policies need improvement.	Financial issues make access harder.	The staff's training varies a lot between departments.
Mental Health Professional	Hotel Dieu de France	The services are satisfactory but not exceptional.	Some policies are outdated.	Long waiting times are a problem.	The staff is competent but needs crisis training.
Mental Health Professional	LAU Rizk Hospital	My experience has been very positive.	The policies are generally effective.	Funding is a major issue.	The staff is good, but there's always room for improvement.

Mental Health Professional	AUBMC	The services are good but there are some gaps.	The policies need to be updated.	Stigma is still a barrier for many.	The staff is trained, but ongoing education would help.
Mental Health Professional	Saint George Hospital	I feel neutral about the services.	The policies need more attention.	There's not enough awareness or understanding.	The staff is generally well-trained but could improve.
Mental Health Professional	Hotel Dieu de France	The services are satisfactory.	Some policies work, but others don't.	Cultural resistance is a challenge.	The staff is well-prepared but needs empathy training.
Mental Health Professional	LAU Rizk Hospital	My experience has been positive with a few challenges.	The policies work but are too rigid.	Financial and bureaucratic issues slow things down.	The staff is well-trained but needs regular updates.
Mental Health Professional	AUBMC	The services are generally good.	The policies work but need updates.	Public understanding is lacking.	The staff is well-trained but could use more crisis intervention training.

Mental Health Professional	Saint George Hospital	My feelings are mixed.	The policies need a lot of work.	Funding and access issues are big problems.	The staff is generally good but lacks specialization.
Mental Health Professional	Hotel Dieu de France	Overall, the services are positive.	The policies work well, but could use some tweaks.	Awareness and outreach are challenges.	The staff is well-trained but could use more updates.
Patient	LAU Rizk Hospital	My experience has been positive with a few issues.	The policies work but need more flexibility.	There aren't enough resources.	The professionals are generally well-prepared.
Patient	AUBMC	The experience has been good.	The policies are fair but outdated.	Financial issues make access harder.	The staff is competent but could be more empathetic.
Patient	Saint George Hospital	My experience has been mixed, with ups and downs.	The policies need serious improvement.	Public awareness is lacking.	The staff is well-trained but could improve.

Patient	Hotel Dieu de France	The services are satisfactory but not exceptional.	Some policies are outdated.	Long waiting times are a problem.	The staff is competent but needs crisis training.
Patient	LAU Rizk Hospital	The services have been very positive.	The policies are generally effective.	Funding is a major issue.	The staff is good, but there's room for improvement.
Patient	AUBMC	My experience has been mixed.	The policies need improvement.	Stigma is still a barrier for many.	The staff is competent, but more specialized training would help.
Patient	Saint George Hospital	My feelings are mixed.	The policies need a lot of work.	Funding and access issues are big problems.	The staff is generally good but lacks specialization.
Patient	Hotel Dieu de France	My experience has been neutral.	The policies need more attention.	Awareness and stigma are still issues.	The staff is well-prepared but could be more empathetic.

Patient	LAU Rizk Hospital	The services are good, but there's room for improvement.	The policies work but could be more flexible.	There aren't enough resources.	The staff is well-trained, but they could use more frequent updates.
Patient	AUBMC	I'm generally satisfied with the services.	The policies are effective but could be updated.	Patients need more awareness about the services.	The staff is well-prepared, but specialized training would help.
Patient	Saint George Hospital	The services are satisfactory but not exceptional.	Some policies are outdated.	Long waiting times are a problem.	The staff is competent but needs crisis training.
Patient	Hotel Dieu de France	My experience has been positive with a few challenges.	The policies work but are too rigid.	Financial and bureaucratic issues slow things down.	The staff is well-trained but needs regular updates.

Challenges in Implementing or Accessing Policies	Equitability and Accessibility	Experiences of Stigma or Discrimination	Recommendations for Improvement

Bureaucratic delays slow things down.	The services are mostly fair, but outreach could be better.	I've seen very little stigma, mostly with older patients.	We need more staff and resources.
Sometimes, policies aren't applied consistently.	Access in rural areas needs to be improved.	Some cultural biases lead to stigma.	More patient education would help.
Cultural resistance is a big challenge.	Access is uneven, especially outside the city.	I've seen stigma, especially with marginalized groups.	We need more community-based services.
Political challenges make things difficult.	Services are more available in the city than in rural areas.	There's some discrimination, especially with older patients.	We need better enforcement of policies.
Funding is often insufficient.	The services are equitable, but we need more funding.	I haven't seen any major issues.	We need to increase funding for mental health.

There's a lack of political support.	The services are accessible but could be better.	I've seen stigma in some staff members.	We need regular policy reviews.
Funding remains a big issue.	There's unequal access in different areas.	Stigma is definitely an issue.	We need to improve awareness campaigns.
Implementation of policies can be inconsistent.	Access is available but needs improvement.	I'm aware of stigma, but I haven't experienced it personally.	We need to engage more with the community.
Bureaucracy causes delays.	The services are mostly fair but could be improved.	I've seen minimal stigma, mostly external.	We need more flexibility in applying policies.
Political issues can be challenging.	The services are fair but need more attention.	I've seen some stigma, especially in certain cases.	We need to engage more with the public.

Cultural issues get in the way.	More outreach is needed, especially in underserved areas.	Stigma is a recurring issue.	We need better funding and access.
Applying policies isn't always consistent.	Access is generally fair but could improve.	There's some discrimination, especially with older cases.	We need better training for staff.
Waiting times are too long.	The services are fair, but outreach could be better.	Stigma is present, but it's manageable.	We need shorter waiting times.
Cultural resistance is still a problem.	Access is good, but there are limitations.	Some staff members show stigma.	We need to modernize policies.
The facilities aren't adequate.	Access is uneven, especially outside the city.	Stigma is significant and affects care.	We need more community support.

Political challenges make things difficult.	Services are more available in the city than in rural areas.	There's some discrimination, especially with older patients.	We need better enforcement of policies.
Funding is often insufficient.	The services are equitable, but we need more funding.	I haven't seen any major issues.	We need to increase funding for mental health.
Sometimes, policies aren't applied consistently.	Access in rural areas needs to be improved.	Some cultural biases lead to stigma.	More patient education would help.
Cultural issues get in the way.	More outreach is needed, especially in underserved areas.	Stigma is a recurring issue.	We need better funding and access.
Implementing policies is tough.	Access is available but could be better.	I'm aware of stigma, but I haven't experienced it personally.	We need to engage more with the community.

Bureaucratic delays slow things down.	The services are mostly fair, but outreach could be better.	I've seen very little stigma, mostly with older patients.	We need more staff and resources.
Sometimes, policies aren't applied consistently.	Access in rural areas needs to be improved.	Some cultural biases lead to stigma.	More patient education would help.
Political challenges make things difficult.	Services are more available in the city than in rural areas.	There's some discrimination, especially with older patients.	We need better enforcement of policies.
Bureaucracy causes delays.	The services are mostly fair but could be improved.	I've seen minimal stigma, mostly external.	We need more flexibility in applying policies.

- Appendix G – Codes for Thematic Analysis:

• Participant Role	Hospital	Code: Overall Experience with Services	Code: Effectiveness of Policies	Code: Main Barriers to Access

Mental Health Professional	LAU Rizk Hospital	Good but needs improvement	Needs more flexibility	Limited resources
Mental Health Professional	AUBMC	Satisfied overall	Policies are effective	Lack of awareness
Mental Health Professional	Saint George Hospital	Mixed experiences	Needs improvement	Financial constraints
Mental Health Professional	Hotel Dieu de France	Satisfactory, but not exceptional	Outdated in some areas	Long waiting times
Patient	LAU Rizk Hospital	Positive overall with some issues	Effective policies	Lack of funding
Patient	AUBMC	Good experience overall	Policies are outdated	Financial constraints
Patient	Saint George Hospital	Mixed experience, ups and downs	Needs significant improvement	Lack of public awareness

Patient	Hotel Dieu de France	Satisfactory, but not exceptional	Outdated policies	Long waiting times
Patient	AUBMC	Mixed experience, some gaps	Policies need updates	Stigma as a barrier
Patient	Saint George Hospital	Neutral experience	Needs more attention	Awareness and stigma barriers

Participant Role	Hospital	Code: Training and Preparedness of Professionals	Code: Challenges in Implementing/Accessing Policies	Code: Equitability and Accessibility	Code: Experiences of Stigma/Discrimination	Code: Recommendations for Improvement
Mental Health Professional	LAU Rizk Hospital	Well-trained, needs more updates	Bureaucratic delays	Fair, but outreach needs improvement	Minimal stigma, observed in older patients	More staff and resources needed
Mental Health Professional	AUBMC	Adequate but needs specialized training	Inconsistent application of policies	Needs better access in rural areas	Some stigma due to cultural biases	Improve patient education programs

Mental Health Professional	Saint George Hospital	Training varies by department	Cultural resistance	Unequal access across regions	Significant stigma observed in marginalized groups	Expand community-based services
Mental Health Professional	Hotel Dieu de France	Competent but lacks crisis training	Political challenges	Services more accessible in urban areas	Discrimination observed in older patients	Better policy enforcement needed
Patient	LAU Rizk Hospital	Well-prepared professionals	Long waiting times	Equitable, but more outreach needed	Stigma is present but manageable	Reduce waiting times
Patient	AUBMC	Competent but needs more empathy	Cultural resistance	Accessible, but limitations exist	Some staff exhibit stigma	Modernize policies
Patient	Saint George Hospital	Well-trained staff, but could improve	Inadequate facilities	Access is uneven, urban-centric	Significant stigma affecting care	Increase community support
Patient	Hotel Dieu de France	Competent staff, but lacks crisis training	Political challenges	Services are more accessible in urban areas	Discrimination observed, particularly with older patients	Enforce better policies
Patient	AUBMC	Adequate, needs specialized training	Inconsistent application of policies	Needs better access in rural areas	Stigma exists due to cultural biases	Improve patient education

Patient	Saint George Hospital	Well-prepared professionals	Difficult to apply policies in practice	Accessible, but could be improved	Aware of stigma issues	Engage more with the community

- **Appendix H – Themes Interpreted in Thematic Analysis:**

Theme	Associated Codes	Description
Barriers to Access	Financial constraints, Long waiting times, Lack of awareness, Stigma and discrimination, Inadequate facilities	This theme captures the various challenges participants face in accessing mental health services, including financial barriers, long wait times, and stigma.

Effectiveness of Policies	Needs improvement, Outdated policies, Effective but rigid, Inconsistent application, Needs modernization	This theme reflects the participants' views on how well the current policies work, with many calling for updates and more flexibility.
Quality of Care	Competent staff, Needs more training, Lack of empathy, Well-prepared professionals, Needs crisis training	This theme highlights the quality of care provided by professionals, with a focus on training, preparedness, and the need for continuous improvement.
Equitability and Accessibility	Unequal access, Better access in urban areas, Needs more outreach, Fair but limited access, Gaps in service delivery	This theme addresses the disparities in access to mental health services, particularly the differences between urban and rural areas, and the need for better outreach.
Stigma and Discrimination	Minimal stigma, Cultural biases, Significant stigma, Discrimination observed, Manageable stigma	This theme explores the presence of stigma and discrimination within the hospital settings and how it affects both patients and professionals.
Recommendations for Improvement	Increase staff and resources, Improve patient education, Expand community-based services, Modernize policies, Reduce waiting times, Better policy enforcement, Enhance training programs	This theme encompasses the various suggestions provided by participants on how to improve the mental health services and policies at the hospitals.