Dialogue Summary

Securing Access to Quality Mental Health Services in Primary Healthcare in Lebanon

K2P Policy Dialogue convenes key policymakers and stakeholders to capture contextual information, tacit knowledge, views and experiences including potential options to address high priority issues. K2P Policy Dialogues are informed by a pre-circulated K2P Policy Brief or Briefing Note to allow for focused discussion among policymakers and stakeholders.

Dialogue Summary

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Securing Access to Quality Mental Health Services in Primary Health Care in Lebanon

Knowledge to Policy Center K2P

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Dialogue
The policy dialogue about Securing Access to Quality Mental Health Services in Primary Health Care in Lebanon was held on 24 April 2014 at the Gefinor Rotana Hotel, Beirut, Lebanon. The policy dialogue was facilitated by Dr. Fadi El-Jardali, director of the K2P Center.

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Deliberations

Deliberation about the problem

Dialogue participants discussed both the overall framing of the problem as the limited access of a large proportion of individuals suffering from mental health problems and their families to mental health care services in primary health care (PHC) settings in Lebanon, and the underlying factors of the problem that had been described in the policy brief.

Participants agreed that there is a problem in the lack of trained healthcare professionals at PHC centers to recognize mental health conditions and provide basic mental health services.

However, a number of participants argued strongly that the issue is not only the limited access (i.e, *supply* of services) but also limited *demand* for services, relating to people's lack of awareness or knowledge about their mental health conditions. Participants argued that it is a matter of people's perception of their mental health problems as severe problems requiring professional care. One participant explained that out of those individuals who recognize that they have mental health problems, the majority believe that they are able to take care of the problem themselves or prefer to wait for it to "go away by itself". Another participant argued that the problem is not only of limited access to care, but rather access to good quality care.

Dialogue participants brought up a number of issues to be addressed:

1. The need to address people's perception towards PHC itself; to understand how people view PHC to be able to design campaigns that encourage them to seek it
2. The need to define what is meant by PHC settings, which segment of the PHC network is being addressed in the brief, and what the characteristics are of the target population who usually seeks PHC – we learned from participants' knowledge that around 1 million Lebanese people are regularly visiting PHC centers.
3. The need to define what exact mental health care services would be offered in primary care (whether psycho-

Background to the Policy Dialogue

The Policy dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action.

Key features of the dialogue were:

1) Addressing an issue currently being faced in Lebanon;
2) Focus on different underlying factors of the problem;
3) Focus on three elements of an approach for addressing the policy issue;
4) Informed by a pre-circulated K2P policy brief that synthesized both global and local research evidence about the problem, elements and key implementation considerations;
5) Informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach for addressing it;
6) Brought together many parties who would be involved in or affected by future decisions related to the issue;
7) Ensured fair representation among policymakers, stakeholders, and researchers;
8) Engaged a facilitator to assist with the deliberations;
9) Allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) Did not aim for consensus. Participants' views and experiences and the tacit knowledge they brought to the issues at hand formed key input to the dialogue. The dialogue was designed to spark insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary.

education, screening, support groups, promotion and prevention activities, etc.)

4. The importance of better defining "individuals" in the problem section to bring out the uniqueness of various populations- some solutions that work for adults may not work for young people.
5. The need to engage nurses in the follow-up actions pursuant to this dialogue, as they represent a primary stakeholder in PHC

Dialogue participants pointed out that the newly established Mental Health Program at the Ministry of Public Health (MOPH) will work on building up evidence concerning the usage of primary care mental health services and studying the help- seeking behavior of people with mental health problems in Lebanon. Existing studies show that people generally seek General Physicians (GPs) for their mental health problems. More in-depth studies might be needed. It was also noted that over the past few years, the MOPH has been engaging in partnerships with international NGOs to train GPs on basic mental health services, but retaining the trained GPs was a major barrier that led the MOPH to revise its integration approach. In addition, it was noted that the MOPH is trying to implement case management at the PHC level, and the main issue being faced is how to fund it and what kind of reimbursement mechanism to be used.

Participants agreed with the underlying factors pertaining to the issues of service delivery and governance. On the issue of financing, it was noted that PHC centers are already facing financial difficulties. The MOPH provides drugs to the PHC centers with which it contracts and allows them to collect nominal fees and carry out their own fundraising. In the contractual agreement, it is stated that these centers must provide the minimum package of health services required by the MOPH. However, the financial barrier has become a major issue and this "in-kind" arrangement is no longer sufficient, so the MOPH is currently designing a new and more sustainable financing arrangement for the PHC centers.

This section of the dialogue was wrapped up by participants reframing the problem as the limited knowledge of people suffering from mental health problems and their families about mental illness, as well as their limited access to mental health care services in primary health care (PHC) settings in Lebanon.

Deliberations about elements of a Policy approach for addressing the problem

Dialogue participants discussed three elements of a policy approach that had been examined in the policy brief.

Element 1› Integrate mental health into primary care service provision by developing an essential health services package to be a guaranteed minimum. Integration of mental health into PHC can happen through collaborative care, which aims to develop closer working relationships between PHC and specialist health care professionals.

During the deliberation about element one, dialogue participants:

1. agreed with the need for a minimum service package;
2. confirmed that task-shifting is a promising model but not enough on its own;
3. recommended scaling up for the most prevalent mental health conditions in Lebanon and using guidelines and protocols needed to standardize mental health practice in the context of PHC; and
4. acknowledged the issue of shortage of mental health professionals and the challenge of poor retention.

Participants agreed that there is a need to train all health practitioners to have the same level of basic understanding and communication skills in their approach to mental health cases.

On choosing between the different models of collaborative care (task-shifting, case management, liaison psychiatry), participants noted that one model, such as task-shifting which is important but insufficient, would not be enough and that a combination of different models will most probably be needed in the context of Lebanon.

One participant confirmed that the use of metric tools (such as screening scales) is suitable for the GP's approach to care; "the goal is not to turn the GP into a psychiatrist", noted another participant. Brief consultations of up to 6 minutes are appropriate in the context of PHC.

While participants acknowledged the value of task-shifting for nurses and other personnel in integration efforts, they noted the importance of

tapping into existing resources such as university medical residents and master level trainees. This could be one solution to address the shortage of mental health workforce. In addition, one participant noted the importance of task-shifting to the patient himself, not only the non-specialist healthcare professional, in the sense that patients should take responsibility for their own care, in other words, practicing a more "patient-centered approach" to care.

Several dialogue participants raised the question of which mental health conditions should be included in the package of essential services. Evidence-based packages exist for the six major mental, neurological and substance abuse disorders, and are recommended by the World Health Organization (WHO) Mental Health Gap Action Programme (mhGAP). These disorders are attention deficit hyperactivity disorders, epilepsy, depression, schizophrenia, alcohol use disorders and dementia. The step-by-step recommendations of the WHO mhGAP on the use of specific treatments in PHC for each of these disorders can be accessed via http://www.who.int/mental_health/mhGAP/en/.WHO . However, these conditions may have to be revised depending on the most prevalent mental health conditions in Lebanon. An adaptation workshop that will take place in June 2014 will aim at agreeing on the disorders to train on.

Other issues raised by participants that need to be addressed include:

1. How to include screening for highly prevalent mental health conditions in other national programs, such as the Non-Communicable Disease (NCD) program or Breast Cancer program
2. The need to work on providing incentives for health professionals in PHC centers to screen for mental health
3. The importance of understanding the quality of doctors who are moving out of the PHC network- in other words, are we retaining the "poorest kind of doctors"? If so, a bigger focus on training nurses is needed.
4. The issue of patient fidelity; patient may not open up easily or quickly with a new unfamiliar GP
5. Telepsychiatry as one component of a collaborative approach, because it is currently underused and could be a resource to leverage upon
6. The essentiality of teamwork; whereby participants, whereby social workers, psychologists and nurses need to work

collaboratively, and each team member must accept and respect that the other will do his job

Participants raised a potential harm of this element, which is that integrating screening, as part of a horizontal program, could possibly induce over diagnosing.

An important note acknowledged by some participants is that evidence shows that integration will not reduce psychiatrists' work, but rather change the nature of their work to start focusing on more complex and severe cases.

A number of participants suggested using a stepped-care model as a viable solution to address the challenges posed. A stepped care recovery model seeks to treat service users at the lowest appropriate service tier in the first instance, only 'stepping up' to intensive/specialist services as clinically required. The level of professional input is augmented gradually, until satisfactory health status is achieved. This offers clinical and financial advantages that can benefit service users and payers as well.

Element 2› Expand coverage of mental health services in the PHC setting, as well as coverage for specialist services for patients referred by PHC centres, through reimbursement by third party payers according to a capitation payment system. Under capitation, payment is made based on the number of patients to whom care is provided.

During the deliberation about this element, it was noted that the MOPH, as part of its effort to redesign a new financial arrangement for primary care, is currently considering some form of capitation as a model of financing for PHC services in general, not only for mental health services. Also, a mapping of NGOs working on mental health at the community level has been done; psychologists and psychiatrics are contracting with NGOs and being paid by them. In addition, the Mental Health Program at the MOPH will study the help-seeking behavior of individuals to understand what is happening at the PHC level.

Issues raised by the dialogue participants include:

1. The need to take the patient's perspective into consideration regarding capitation
2. The need for non-financial incentives for providers, which could be in a non-material form such as the prestige that comes from being part of a national and international initiative (MOPH, Accreditation Canada), or in a material form such as the MOPH helping providers secure their Continuing Medical Education (CME) through the Order of Physicians. Another non-financial

incentive highlighted was research opportunities for academicians.

3. The need to engaged community stakeholders in the catchment area of the PHC center, who could themselves become part of the financing mechanism for the center's mental health services

It was also noted that there are lessons to be learnt from the MOPH's successful experience with integrating dental care into PHC.

Element 3› Recognize parity between mental health and physical health by developing and implementing appropriate legislations. This includes issuing the draft law submitted by the Lebanese Psychological Association for the licensing of psychologists, as well as the proposed Mental Health Act of 2008 for the protection of psychiatric patients' rights.

In this section, participants discussed the current status of the Mental Health Act; it is still pending due to the idleness of the parliament and shortage of quorum. It is yet to be reviewed by the parliamentary committee. The Act focuses on the following areas:

1. Protection of the patient
2. How to control the work of the psychiatrist
3. Involuntary hospital admissions
4. Freedom of the patient to select the kind of treatment within the hospital, and to get a second medical opinion
5. Role of the government in treatment and follow up after discharge
6. ECT and security procedures

Participants realized that there might be an opportunity to lobby for and push forward this Act through patient advocacy initiatives.

Deliberations about Implementation Considerations

Participants deliberated about the implementation considerations mentioned in the brief, and brought up additional points worth considering:

1. There is lack of incentive for other doctors (neurologists, cardiologists, etc.) to refer patients to mental health professionals.
2. The lack of a system of referral is a problem; this was a problem of access faced by WHO when collaborating with MOPH in crisis times to provide MH services, calling for the need to address access at the continuum of care, not only point of contact.
3. A main challenge encountered by participants who were involved in previous mhGAP trainings is the continuity of the psychiatrist's availability at the PHC center to follow up on the cases being seen.
4. It will be very challenging to attract psychologists to work at PHC centers for a $1000 monthly salary; there is a need to come up with incentives to attract nurses.
5. Participants' experience in Out Patient Departments (OPD) revealed the issue of facing psychosocial problems in patients who present to the OPD, which will be challenging to tackle in PHC because its management is less straight-forward than clearly defined mental health conditions.

Next Steps

Deliberation about Next Steps

Some dialogue participants emphasized that the MOPH should take the leadership role through its Mental Health Program in the implementation of the following steps:

1. Decide on the mental health conditions to be included in the minimum package. An adaptation workshop that will take place in June 2014 will aim at agreeing on the disorders to train on.
2. Initiate the training, with the help of WHO funds.
3. Coordinate with the available services in the catchment areas of the PHC center including secondary care, to leverage on existing resources and establish feasible referral systems.
4. Collaborate with academic and research institutions for the research needs of the Mental Health Program, including understanding help-seeking behavior of people with mental health problems, and exploring people's perception and attitudes towards Primary Care in Lebanon.

Other concerned groups expressed their willingness to take on the following actions:

1. Involve professional bodies and academic institutions to increase the percentage of medical students who go into psychiatry.
2. Launch more synergy among psychologists through calling for a meeting gathering Chairs of Psychology Departments in the country especially those already working in NGOs.
3. Design and launch a patient advocacy initiative/campaign to raise awareness among the general public which will support the MOPH in its Mental Health Program.

Finally, all dialogue participants agreed that securing access to quality mental health services in primary care in Lebanon is very well needed. They pointed out that this policy dialogue meeting was an important opportunity for a large and diverse group to deliberate about the problem and elements. They emphasized the need to move forward to the next steps. Many of the deliberations will inform the work of the Mental Health Program of the MOPH that is to be launched on May 8, 2014.

Knowledge to Policy Center draws on an unparalleled breadth of synthesized evidence and context-specific knowledge to impact policy agendas and action. K2P does not restrict itself to research evidence but draws on and integrates multiple types and levels of knowledge to inform policy including grey literature, opinions and expertise of stakeholders.

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