Policy Brief

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

K2P Policy Briefs bring together global research evidence, local evidence and context-specific knowledge to inform deliberations about health policies and programmes. It is prepared by synthesising and contextualizing the best available evidence about the problem and viable solutions through the involvement of content experts, policymakers and stakeholders.

Policy Brief

+ Included

Description of a health system problem

Viable options for addressing this problem

Strategies for implementing these options

× Not Included

Does not make **recommendations**

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K2P Policy Brief

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

Knowledge to Policy Center

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Key Messages

Key Messages

What's the problem?

The overall problem is 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.

What do we know about three elements of an approach to addressing the problem?

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.

- Compelling evidence from high-quality systematic reviews demonstrates the effectiveness and cost-effectiveness of collaborative care in PHC settings for the treatment of mental disorders.
- Issues that may stimulate deliberation include: which forms of collaborative care might be best suited for Lebanon's context (task shifting, case management, liaison psychiatry).

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.

- Only one high-quality systematic review specifically addressed this issue and concluded that there is not sufficient evidence yet to determine the best reimbursement system.
- Our search did retrieve other systematic reviews on reimbursement mechanisms for primary care in general that found several benefits for capitation over other systems: efficiency gains, higher levels of care, improving processes of care outcomes (drug-prescribing, referral and admissions), and provision of more preventive care.

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.

- Although no systematic reviews were identified about policies related to integration of mental health into PHC, numerous high-quality single studies found that enacting national mental health-related policies resulted in a decline in suicide and self-harm rates.

What implementation considerations need to be kept in mind?

The biggest barriers to implementation are likely at the professional and system levels:

- Psychiatrists have historically opposed integration efforts, GPs felt hesitant to deal with mental illness cases and PHC directors were resistant due to being overwhelmed with other programs being implemented.
- At the system level, differences in payment systems across different third party payers and the lack of reimbursement for collaborative care (case management, services provided by non-physicians), as well as the competing health priorities and limited financial resources are major barriers that need to be considered.

Executive Summary

Executive Summary

The Problem

The overall problem is 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. The current health system arrangements do not ensure equitable access to high quality mental health services.

Mental disorders are a leading direct cause of disease burden worldwide (Ferrari et al., 2013; Lin et al. 2008). An estimated one million out of four million Lebanese suffer from at least one mental disorder throughout their lives (Karam et al., 2008). Only a minority of those obtain treatment, and there are prolonged delays to seeking treatment ranging from six years for mood disorders to 28 years for anxiety disorders (Karam et al., 2008). Such delays are critical because early assessment and intervention can positively alter the natural progression of mental disorders into chronic and disabling conditions. The burden of mental disorders extends to other diseases as they worsen the outcome of co-occurring conditions such as cancer, heart disease and diabetes (WHO, 2011-a; Lin et al., 2008).

Mental health disorders are costly to national economies in terms of expenditure and loss of productivity (WHO, 2005-a). When present in caretakers, mental disorders impact children's health and development (WHO 2003; Dixon et al. 2006; Knapp et al. 2006). In Lebanon, the exposure to war-related trauma, internal conflicts, and political instability have increased the prevalence of some mental health disorders (Chahine & Chemali, 2009; Karam et al. 2006; Farhood & Dimassi, 2012).

The underlying factors of the problem stem from the health system arrangements in place. From the perspective of service delivery, currently, the only way to access mental health care in the public sector is through psychiatric institutions (Kerbage, El Chammay & Richa, 2013), which does not promote prevention or community integration. The integration of mental health into the PHC network is still weak (WHO, 2011-b; WHO & MOPH, 2010; Hijazi et al., 2011). PHC centres often lack essential psychotropic medications as well as assessment and treatment protocols necessary to provide frontline basic psychological and psychiatric interventions and a few of them regularly refer patients to specialized mental health care clinics when needed. In addition, evidence-based multidisciplinary treatment practices for mental health patients are rarely implemented. From a financing perspective, mental health services in Lebanon are poorly financed. Coverage of mental health services in Lebanon is extremely low as the primary source of financing for mental health

is out-of-pocket payment. There are disparities in the coverage of public funding mechanisms for mental health services, and private insurance and mutual funds do not explicitly cover these services. The dependence of the current system on out-of-pocket expenditure for mental health creates an access barrier for individuals with low incomes and who are at highest risk (WHO, 2003).

Elements of a policy approach to address the problem

Element 1› *Integrate mental health into primary care service provision by developing an essential health services package to be a guaranteed minimum*

The World Health Organization (WHO) strongly recommends the integration of mental health care into general PHC services, as the most viable way of ensuring that people have access to the mental health care they need (WHO et al., 2008). Essential health services to be delivered within PHC include early identification, treatment of common mental disorders, management of stable psychiatric patients, referral to other levels where required, attention to the mental health needs of people with physical health problems and mental health promotion and prevention (WHO et al., 2008).

Integration of mental health into PHC can happen through collaborative care, which aims to develop closer working relationships between PHC (family doctors or General Practitioners (GPs) and practice nurses) and specialist health care. There are different ways and models through which collaborative care can be implemented including task-shifting, case management, and liaison psychiatry (Kakuma et al., 2011; Reilly et al., 2013; Butler et al., 2008; Sterne, 2009; van der Feltz-Cornelis et al., 2010; Thota et al., 2012; Craven & Bland, 2006).

Compelling evidence has demonstrated the effectiveness and cost-effectiveness of PHC-led service systems for the treatment of mental disorders (WHO et al., 2008). Key findings from systematic reviews are presented in the table below.

Category of finding	Element 1
Benefits	12 systematic reviews, including 8 high-quality, 1 medium-quality, and 1 low-quality reviews[1], concluded that collaborative care is effective in improving mental health outcomes (Woltmann et al., 2012; Reilly et al., 2013; Smolders et al., 2008; Thota et al., 2012; Butler et al., 2008; Bower

[1] Quality of systematic reviews assessed using AMSTAR scale

Category of finding	Element 1
	et al., 2006; Bower & Rowland, 2006; Bower et al., 2011; Cape et al., 2010; Huibers et al., 2007; Boer et al., 2005; van der Feltz-Cornelis et al., 2010).
Potential harms	The identified systematic reviews did not report any harms.
Costs and/or cost-effectiveness in relation to the status quo	One medium-quality systematic review found that collaborative care models are effective at no net increase in overall health care treatment costs (Woltmann et al., 2012). Reductions in health care utilization were identified in three systematic reviews (Harkness & Bower, 2009; Chin et al., 2011; Reilly et al., 2013). According to WHO (2008), scaling up a full package of primary care-led mental health services for schizophrenia, bipolar disorder, depression and hazardous use of alcohol over a 10-year period would require a total additional investment of only US$3.2 to US$6.25 per capita in lower-middle income countries.
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	Two systematic reviews, including 1 of high-quality, concluded that it remains uncertain which specific models within collaborative care are more or less effective (Smolders et al., 2008; van Ginneken et al., 2013). Another systematic review indicated that further research is needed to determine whether collaborative care is effective for people with severe mental illness in terms of clinical outcomes and cost-effectiveness (Reilly et al., 2013).

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 (social insurance, private insurance, mutual funds, and public funds).*

Third party payers could begin reimbursing PHC centers according to a capitation payment system, whereby payment is made based on the number of patients to whom care is provided. As such, the insurer sets limitations to the number of sessions, to the amount covered annually, or to the number of days of hospital stay per enrolee.

Only one high-quality systematic review addressed payment mechanisms for mental health integrated into PHC, but it concluded that there is not yet sufficient evidence to determine which reimbursement system leads to better health outcomes or cost-effectiveness (Butler et al., 2008). Although

no other systematic reviews were identified specifically about reimbursement systems for mental health in primary care, our search did retrieve other systematic reviews on reimbursement mechanisms for primary care in general. Key findings are presented in the table below.

Category of finding	Element 2
Benefits	One systematic review found capitation in PHC effective in improving drug-prescribing process of care outcomes, referral and admissions outcomes and prescribing costs outcomes (Flodgren et al., 2011). One low-quality systematic review found that capitation is associated with higher levels of care, compared to salary payments; under capitation, doctors need to attract patients to their practice (Gosden et al., 1999). A systematic review on primary care dentists found that PHC dentists reimbursed under capitation tend to see their patients less frequently but give more preventive advice compared to FFS (Brocklehurst et al., 2013). Capitation for integrated mental health services is preferred to Fee-for-Service (FFS) system. FFS makes certain services more financially attractive than others. Thus, under FFS service provision may be driven by financial considerations rather than appropriateness to patients' needs (Fattore et al., 2000).
Potential harms	One systematic review found that compliance with a recommended number of primary care visits was lower under capitation compared to FFS systems (Gosden et al., 2000).
Costs and/or cost-effectiveness in relation to the status quo	One medium-quality systematic review found that capitation can lead to efficiency gains as well as reduction in provider-induced demand in developing countries compared to FFS (Robyn, 2012). Efficiency gains were confirmed in single studies in A+ ranking journal [2]publication (Catalano et al., 2000), and more service integration was observed: One B ranking journal study found that capitation encouraged community mental health care workers to increase utilization of testing in order to better match clients with appropriate services and avoid waste (Chou et al., 2005).
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the	Only one high-quality systematic review addressed payment mechanisms specifically for mental health integrated into PHC and it concluded that evidence was not sufficient to determine which reimbursement system leads to better health outcomes or cost-effectiveness (Butler et al., 2008).

[2] Journal rankings according to ISI Web of Knowledge

Category of finding	Element 2
approach element were pursued)	Three systematic reviews concluded that there is uncertainty about the impact of capitation systems and other financial incentive systems on health outcomes (Gosden et al., 2000; Flodgren et al., 2011; Akbari et al., 2005). There is conflicting evidence regarding the impact of capitation on referral from primary to secondary or tertiary care: One 'good systematic review with only minor limitations' found that PHC physician referrals to specialists decreased under capitation (Pantoja, 2008-a; Akbari et al., 2005; Davidson et al., 1992), while another review published in an A+ ranking journal found that more hospital referrals were made (Gosden et al., 2000).

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

Although no systematic reviews were identified about policies related to integration of mental health into PHC, the search identified compelling evidence from numerous single studies on enacting mental health legislation. One of the most important benefits identified by several high-quality studies was that enacting national mental health-related policies resulted in a decline in suicide and self-harm rates. Other findings are presented in the table below.

Category of finding	Element 3
Benefits	Numerous studies (3 from A+ ranking journals, 2 A ranking, and 2 C ranking) found that after passing national mental health-related policies, suicide and self-harm rates declined (Lang, 2013; Gunnell et al., 2012; Hoxey & Shah, 2000; Shah, 2007; Shah et al., 2001; Shah & Bhat, 2008; Wahlbeck et al., 2011). Five years following the implementation of the Irish Mental Health Act, a decrease in the rate of involuntary admission was witnessed, according to a study from an A ranking journal (Ramsay et al., 2013). Brazil witnessed a significant reduction in psychiatric beds in the decade following the enactment of laws that aimed at shifting mental health care from the hospital to the community, according to studies from A

Category of finding	Element 3
	and B ranking journals (Goncalves et al., 2012).
Potential harms	The literature did not report any harms.
Costs and/or cost-effectiveness in relation to the status quo	After the implementation of the 2001 mental health policy in Brazil, resources shifted towards community services, with a decrease of 39% in hospital expenditures and an increase of 404% in community-based expenditures (Goncalves et al., 2012). A study in a top ranking journal (A+) showed that the behavioural health insurance parity law in Oregon, U.S., improved insurance protection without substantial increase in total costs for the insurer. An increase in behavioural health spending of $25 would be equivalent to a 1% increase in total spending (McConnell et al., 2012).
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	One study, in a B ranking journal, found that mental health and substances abuse parity laws do little to improve access to mental health care services for children and adolescents (Barry & Busch, 2008).

Implementation considerations

Our literature synthesis has identified barriers to implementation at all levels of the health system: patient, professional, organizational and system levels. However, the biggest barriers appear at the professional and system levels. At the professional level, several studies reported psychiatrists' opposition to integration efforts, out of concern that visits to private psychiatrist clinics would be reduced, and concern that other professionals with little mental health training would not be competent enough to deal with psychiatric issues (Goldfracht et al., 2006; Sterne, 2009). PHC physicians and GPs were hesitant to deal with patients with mental distress due to stigma or lack of confidence in their ability to handle serious mental illness like schizophrenia, as well as their low expectations that enhanced care might really help patients (Rosendal et al., 2013; Sterne, 2009; Goldfracht et al., 2006). PHC directors were also resistant to integration efforts, due to preoccupation with other quality improvement programs being implemented (Goldfracht et al., 2006).

To manage cultural change, partnership formation between PHC professionals and mental health specialists can be helpful. To manage resistance to change, intensive internal marketing of the integration program to

managers and health care professionals was used in previous experiences; whereby the program was "framed" as a solution to the overuse of health care services by patients with undiagnosed or untreated mental illness (Goldfracht et al., 2006). Systematic reviews reported that clarifying the roles of different healthcare professionals involved in collaborative care was key for overcoming resistance to change (Nolan & Hewison, 2008).

At the system level, differences in payment systems across different third party payers may require sophisticated information and billing systems that may not be available in Lebanon (Ciapponi & Garcia Marti, 2009; Gosden et al., 2001). In addition, the lack of reimbursement for collaborative care, case management services, and services provided by non-physicians (example, nurses and psychologists) are main barriers.

Integrated care programs and insurance plans in other countries have undertaken a number of strategies to overcome these barriers, such as having plans credential providers, and creative employment and contract structures for care managers (Butler et al., 2008). A collaborative effort across the MOPH, other third party payers and the PHC network is also needed to clarify and coordinate reimbursement policies (Butler et al., 2008). There are competing health priorities, limited financial resources, and lack of ear-marked budgets for mental health, which is why it is vital to allocate resources to implement the program, and obtain additional funds from external sources (Goldfracht et al., 2006).

It is important to note that studies have found that the need for mental health specialists, particularly psychiatrists and neurologists, will continue even if task-shifting is implemented extensively. Existing evidence shows that the roles of these specialists can change, with clinical roles focused on complex psychiatric cases and diagnoses and less complex cases managed by trained non-specialist health workers (Kakuma et al., 2011; Sterne, 2009).

Content

K2P Policy Brief

The Problem

The overall problem is 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) setting in Lebanon. The current health system arrangements do not ensure equitable access to high quality mental health services.

Size of the Problem

Mental disorders are a leading direct cause of disease burden worldwide (Ferrari et al., 2013; Lin et al. 2008). An estimated one million out of four million Lebanese suffer from at least one mental disorder throughout their lives (Karam et al., 2008). More specifically, around 668,000 (16.7%) individuals suffer from anxiety disorders such as Post-Traumatic Stress Disorder (PTSD) and 504,000 (12.6%) suffer from mood disorders such as major depression (Karam et al., 2008). Only a minority of those obtain treatment and there are prolonged delays to seeking treatment ranging from six years for mood disorders to 28 years for anxiety disorders (Karam et al., 2008). Children with autism are first assessed at an average age of four years, whereas the first signs of autism appear around 12-30 months of age. Intellectual developmental disorders are also identified at a late stage (average of seven years) despite the fact that signs of these disorders are usually apparent before the age of 30 months (Dirani & Salamoun, 2013). Such delays are critical because early assessment and intervention can positively alter the natural progression of mental disorders into chronic and disabling conditions.

According to the Institute for Health Metrics and Evaluation Global Burden of Disease Study, the death rates due to self-harm in Lebanon were 2.14 per 100,000 and deaths due to mental/behavioral disorders were 1.72 per 100,000 as of 2010. Combined, these numbers indicate that 152 individuals in Lebanon die every year by suicide. These figures were estimated based on numbers from neighbouring countries and are considered an under-representation of the scope of the problem in Lebanon as cultural aspects limit the reporting of suicide cases (Institute for Health Metrics and Evaluation, 2013).

Background to Policy Brief

A K2P Policy Brief brings together global research evidence, local evidence and context-specific knowledge to inform deliberations about health policies and programs. It is prepared by synthesizing and contextualizing the best available evidence about the problem and viable solutions and options through the involvement of content experts, policymakers and stakeholders.

The preparation of the Policy Brief involved the following steps:

1) *Selecting a priority topic according to K2P criteria*
2) *Selecting a working team who deliberates to develop an outline for the policy brief and oversee the litmus testing phase.*
3) *Developing and refining the outline, particularly the framing of the problem and the viable options*
4) *Litmus testing by conducting one to one interviews with up to 15 selected policymakers and stakeholders to frame the problem and make sure all aspects are addressed.*
5) *Identifying, appraising and synthesizing relevant research evidence about the problem, options, and implementation considerations*
6) *Drafting the brief in such a way as to present concisely and in accessible language the global and local research evidence.*
7) *Undergoing merit review*
8) *Finalizing the Policy Brief based on the input of merit reviewers, translating into Arabic, validating translation, and disseminating through policy dialogues and other mechanisms.*

The burden of mental disorders extends to other diseases as they worsen the outcome of co-occurring conditions such as cancer, heart disease and diabetes (WHO, 2011-a; Lin et al., 2008). This is particularly alarming for Lebanon where cardiovascular diseases account for 45% of all deaths and cancers account for 19% (WHO, 2011-a). International studies found that mood and anxiety disorders occurred at higher rates in persons suffering from heart disease compared to those without heart disease. Persons with heart disease were 2.1 times more likely to have a mood disorder than persons without a heart disease, and 2.2 times more likely to have an anxiety disorder compared to those without heart disease (Ormel et al., 2007). Additionally, depression prevalence rates were found to be higher among persons with diabetes than among persons without diabetes. In Lebanon, 3.1% of persons with diabetes suffer from major depression, compared to only 1.7% of persons without diabetes (Lin et al., 2008).

Mental health disorders are costly to national economies in terms of expenditure and loss of productivity. Human and economic costs also fall on people with mental health disorders and their families, whose lives can be severely affected by unemployment for example (WHO, 2005-a). When present in caretakers, mental disorders impact children's health and development. Individuals suffering from some forms of severe mental illness may pose a risk of violence that impacts the safety of the general public (WHO 2003; Dixon et al. 2006; Knapp et al. 2006). As such, good mental health decreases costs of physical health care, increases productivity at the national level and reduces demands on the criminal justice system (WHO 2003; Dixon et al. 2006; Knapp et al. 2006).

In Lebanon, the exposure to war-related trauma, internal conflicts, and political instability contributed to the increased prevalence of some mental health disorders (Karam et al. 2006; Chahine & Chemali, 2009; Farhood & Dimassi, 2012). Indeed, significantly higher proportions of mood, anxiety and impulse-control disorders were found in Lebanese individuals exposed to war-related trauma, compared to non-exposure (Karam et al. 2006). Several studies have documented the high presence of mental disorders in Lebanese communities exposed to traumatic events. A recent study on a general population from South Lebanon, which was under military occupation for more than 20 years, revealed that the prevalence of PTSD reached 33.3% and depression reached 19.7% in some areas (Farhood & Dimassi, 2012). In another study, lifetime prevalence of major depression in four Lebanese communities exposed to the Lebanon wars (Kornet Shehwan, Ashrafieh, Ain Remmaneh and Bejjeh) reached 41.9% (Karam et al., 1998). Another study in the Greater Beirut area in the early 1990s found major depression in 33.3% and PTSD in 10.3% of children, one year after the end of the war (Chahine & Chemali, 2009).

Refugees are particularly vulnerable to mental health disorders. They were found to be 10 times more likely to have PTSD than the general population (Crumlish & O'Rourke, 2010). An assessment by the International Medical Corps of refugees at the Syrian/Lebanese border reported anxiety, feeling depressed, lethargy, eating and sleeping problems, anger and fatigue. Mothers reported changes in their children's behaviour, as well as an inability to show affection to their children. Another study revealed that up to 76% of children and up to 62% of adults in refugee camps suffer from PTSD. According to estimates of the Office of the United Nations High Commissioner for Refugees (UNHCR) (2014), by the end of 2014, the refugee population could reach 1.5 million in Lebanon. Therefore, there is a rising need for context specific mental health and psychosocial support interventions for refugees (Quosh, Eloul & Ajlani, 2013).

Underlying Factors

The underlying factors of the problem stem from the health system arrangements in place. Health system arrangements include governance, financing and delivery:

Governance

A draft for a national mental health and substance abuse strategy, previously prepared by Dr. Rabih El Chammay and commissioned by the World Health Organization (WHO) (Kerbage, El Chammay & Richa, 2013), has been put to action as of March 6th 2014, when the Ministry of Public Health (MOPH) announced the launching of the National Mental Health Programme. The integration of mental health and substance abuse at the level of PHC is the first of four key pillars of the programme, and it is the MOPH's imminent priority for the first two years of the programme:

- Pillar 1- Integration of Mental Health services within PHC (+ linkage with secondary level and referral to tertiary care)
- Pillar 2- Community mobilization
- Pillar 3- Access to advanced care
- Pillar 4- Rights of the vulnerable groups

This programme presents an opportunity to include mental health in the essential health package delivered at PHC centers (general medical care, pediatrics, dental and oral health, reproductive health, and cardiovascular medical care) (Ammar, 2009).

The only way to access mental health care in the public sector is through psychiatric institutions (Kerbage, El Chammay & Richa, 2013), which does not promote prevention or community integration. This is demonstrated

by the fact that the majority of beds in Lebanon are provided by the 3 mental hospitals available accounting for 42 beds per 100,000 population, followed by community-based psychiatric inpatient units[3] (5 units accounting for 1.175 beds per 100,000 population) (WHO & MOPH, 2010). The International Medical Corps (IMC) has partnered with the MOPH on a project to establish a mental health unit with the aim of collecting data from PHCs on certain indicators and generating lessons learned.

The existing legislation related to mental health, Lebanese Legislative Decree no. 72-9/9/1983 Welfare Act and Protection and Treatment of Mentally Ill Patients, is outdated and not enforced. The health system in Lebanon benefits from other isolated acts in different areas of mental health that are not integrated into a national mental health policy, these are the: Lebanese Act no 220-29/5/2000 Rights of Mentally Handicapped in Lebanon; Lebanese Act no 574-11/2/2004 Patients Rights and Informed Consent; and Lebanese Act no 673-16/3/1998 Narcotic Drugs and Psychotropic Substances and Precursors (WHO & MOPH, 2010; Kerbage, El Chammay & Richa, 2013). According to decree number 15206 issued in 1964, one of the conditions for the MOPH in Lebanon to contract with a private hospital is for the hospital to have a psychiatrist for every 120 beds (Saghieh & Saghieh, 2009); however this is not implemented.

In the past few years, several important attempts at strengthening governance of mental health have taken place. One step was the submission of a proposal for a Mental Health Act by the non- governmental organization IDRAAC to the Parliament. The proposal was submitted in the context of a project commissioned by the European Union with the coordination of the Office of the Minister of State for Administrative Reform and Development (OMSAR) (Kerbage, El Chammay & Richa, 2013). However, the draft has been pending approval since 2008 (Makki, 2013). Among its most important propositions, the Act sets codes of practice and procedures to guarantee the rights of patients admitted to mental hospitals voluntarily or involuntarily, as well as stresses the importance of confidentiality (CCNLE, 2008; Makki, 2013).

In addition, a draft law has been submitted to the Parliament by the Lebanese Psychological Association (LPA) for the regulation of psychologists' profession. The draft is currently being reviewed by the Committee of Justice.

Financing

Mental health services in Lebanon are poorly financed. Coverage of mental health services in Lebanon is very low as the primary source of

[3] Community-based psychiatric inpatient unit: A psychiatric unit, usually located within a general hospital, that provides inpatient care to users with acute problems. The length of stay is typically short (weeks to months) (WHO, 2005-b).

financing for mental health is out-of-pocket payment (WHO, 2011-b). There are disparities in the coverage of public funding mechanisms for mental health services, and private insurance and mutual funds explicitly do not cover them (Yehia, Saleh & Nahas, 2013). Diagnostic tests and imagery ordered by psychiatrists are not covered by insurers. The dependency of the current system on out-of-pocket expenditure for mental health creates a barrier to access for individuals with the lowest incomes and who are at the highest risks (WHO, 2003). The overall budget for PHC is small and the contractual arrangement the MOPH has with some of the PHC centers operated by NGOs involves in-kind contributions such as assistance in clinical and non-clinical training and also providing vaccines, essential drugs and medical and educational supplies (Ammar, 2009), but does not involve financial transactions. PHC centers are concerned that their limited financial resources act as a major barrier to providing high quality PHC services (Ammar, 2009). Article number 4 of the proposed Mental Health Act dictates the right for any mental health patient who is uninsured to be covered by the MOPH for hospitalization, and it also states that the MOPH will contract with specialized treatment and rehabilitation institutions to provide treatment for uninsured patients (CCNLE, 2008; Makki, 2013); this is yet to be implemented.

In addition, there are concerns about the efficiency of financial coverage for mental health in Lebanon. Examining data from the MOPH and General Security Forces (GSF), it is evident that over 70% of their spending goes to inpatient services (Yehia, Saleh & Nahas, 2013). This signals inefficiency, since evidence indicates that outpatient services can be more cost-effective than inpatient services. For example, in the case of alcohol dependence and substance abuse, treatment in outpatient settings costs $6,300 per abstinent case, compared to $15,600 in inpatient (Mojtabai & Zivin, 2003).

Delivery

In Lebanon, the gap in mental health treatment delivery is alarming. There is insufficient mental health service provision due to the limited availability of services in health care settings and shortage of mental health workforce. Less than 70 Lebanese psychiatrists serve over 4.5 million individuals with a median of three mental health professionals per 100,000 population. This is lower than the global rate of six mental health professionals per 100,000 population. Unofficial figures indicate that 68 out of these 70 psychiatrists are located in Beirut. People in rural areas have poorer and inequitable access to mental health services than in urban areas due to the geographical mal-distribution of services.

The integration of mental health into the PHC network is still weak (WHO, 2011-b; WHO & MOPH, 2010; Hijazi et al., 2011). Such weak integration

in an Arab country like Lebanon is alarming because so many patients who may be suffering from psychological problems may go unnoticed by doctors in primary care without the proper training, especially when patients present with 'somatization'. In the Arab world, somatization, whereby patients present to primary care facilities complaining of physically unexplained symptoms, is common. The prevalence rate of somatised mental disorders among primary care patients was found to be 12% in the UAE (El-Rufaie et al., 1999) and 19% in KSA (Becker et al., 2002).

In Lebanon, PHC centres often lack essential psychotropic medications as well as assessment and treatment protocols necessary to provide frontline basic psychological and psychiatric interventions and a few of them regularly refer patients to specialized mental health care clinics when needed. In addition, evidence-based multidisciplinary treatment practices for mental health patients are rarely implemented. The MOPH has previously worked on training general practitioners (GPs) on basic mental health services to be delivered within PHC centers across the country, but these efforts have not been successful so far as trained GPs would exit the system or not remain in the same center.

Although the number of psychiatrists is low, there is a significant number of psychologists and other mental health workers who can play an important role in the integration of mental health into primary care (given they are supported with the proper training and regulated as a profession). There are 101 psychologists registered in the LPA, with 70 out of those being clinical psychologists able to deliver psychotherapy. And according to the WHO-AIMS Report (2010), the ratio of mental-health provider per 100,000 population is as follows: 1.5 psychiatrists; 0.2 other medical doctors; 1.8 nurses; 2.2 psychologists; 0.5 social workers; 1.2 occupational therapists; and 7.5 other mental-health workers (Dirani & Salamoun, 2013; WHO & MOPH, 2010).

Another underlying factor that reduces the demand for mental health services in Lebanon is social stigma and lack of knowledge about mental health. People suffering from mental illness in Lebanon "do not know that they are sick or that what they are suffering from is a sickness", states one stakeholder (Yehia, Saleh & Nahas, 2013). Individuals are also often reluctant to seek mental health services due to fear of stigma (Hijazi et al., 2011; Chahine & Chemali, 2009). October 2013 has witnessed the first efforts towards raising awareness about mental health in Lebanon through two national mental health campaigns initiated by the private sector. However, there continues to be a dire need for psycho-education to all concerned parties, from medical staff at PHCs, patients and families to the community at large.

Elements of a policy approach to address the problem

Element 1

Integrate mental health into PHC service provision (assessment, diagnosis, treatment, and referral if needed), by developing an essential health services package to be a guaranteed minimum.

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 (social insurance, private insurance mutual funds, and public funds).

An appropriate payment mechanism is capitation; the insurer can put limitations to the number of sessions, to the amount covered annually per enrolee, or to the number of days of stay in case of hospitalization.

Element 3

Recognize parity between mental health and physical health by developing and implementing appropriate legislations, including the draft law submitted by the LPA for the licensing of psychologists, as well as the proposed Mental Health Act of 2008 for the protection of psychiatric patients' rights.

Elements

Policy Elements and Implementation Considerations

Element 1

Integrate mental health into PHC service provision (assessment, diagnosis, treatment, and referral if needed), by developing an essential health services package to be a guaranteed minimum

The WHO strongly recommends the integration of mental health care into general PHC services, as the most viable way of ensuring that people have access to the mental health care they need (WHO et al., 2008). Essential health services to be delivered within PHC include early identification, treatment of common mental disorders, management of stable psychiatric patients, referral to other levels where required, attention to the mental health needs of people with physical health problems and mental health promotion and prevention (WHO et al., 2008). Evidence-based packages exist for the six major mental, neurological and substance abuse disorders, and are recommended by the WHO Mental Health Gap Action Programme (mhGAP). These disorders are attention deficit hyperactivity disorders, epilepsy, depression, schizophrenia, alcohol use disorders and dementia (Patel & Thornicroft, 2009). 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/.

Compelling evidence demonstrated the effectiveness and cost-effectiveness of PHC-led service systems for the treatment of mental disorders (WHO et al., 2008). According to WHO (2008), scaling up a full package of PHC-led mental health services for schizophrenia, bipolar disorder, depression and hazardous use of alcohol over a 10-year period would require a total additional investment of only US$1.85 to US$2.6 per capita in low-income countries, and US$3.2 to US$6.25 per capita in lower-middle income countries.

Integration of mental health into PHC can happen through different models. Wagner's Collaborative Chronic Care Model (CCM) informs most integration models cited in the literature. Collaborative care aims to develop closer working relationships between PHC (family doctors or GPs and practice nurses) and specialist health care. There are different ways in which this can be achieved including task-shifting, case management, liaison psychiatry, which in turn makes collaborative care complex (Reilly et al., 2013; Craven & Bland, 2006).

Task-shifting is used to transfer the tasks of mental health specialists to existing or new non-specialist health care staff (Kakuma et al., 2011). Case management introduces the case manager as a new role in the primary care setting to assist in the management of patients with mental illness through structured and systematic delivery of interventions (Reilly et al.,

SUMMARY

Element 1
Integrate mental health into PHC service provision (assessment, diagnosis, treatment, and referral if needed), by developing an essential health services package to be a guaranteed minimum.

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 (social insurance, private insurance mutual funds, and public funds).
An appropriate payment mechanism is capitation; the insurer can put limitations to the number of sessions, to the amount covered annually per enrollee, or to the number of days of stay in case of hospitalization.

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

2013; Butler et al., 2008). In Liaison psychiatry, psychiatrists work collaboratively with PHC physicians for consultation and decision support in treating patients with mental health problems (Sterne, 2009; Reilly et al., 2013; van der Feltz-Cornelis et al., 2010; Thota et al., 2012). Key findings from systematic reviews are presented in the table below.

Table 1 **Key findings** from systematic reviews and single studies

Benefits	12 systematic reviews, including 8 high-quality, 1 medium-quality, and 1 low-quality reviews, found the following benefits of collaborative care on mental health into PHC (no matter what form it takes): Collaborative care models, regardless of the form they take, can improve mental and physical outcomes for individuals with mental disorders in primary care, and they provide a robust clinical and policy framework for care integration (Woltmann et al., 2012; Reilly et al., 2013; Smolders et al., 2008; Thota et al., 2012; van Ginneken et al., 2013) Collaborative care models were found to improve patients' satisfaction with care, which includes patients' perception of their access to services, quality of healthcare providers, communication with providers and administrative staff and success of treatment (Thota et al., 2012). Significant improvements in treatment response and remission rates were reported across different levels of integration in a consistent manner (Butler et al., 2008). Psychosocial interventions (brief cognitive behavioral therapy, problem-solving therapy and counselling) by trained mental health professionals in primary care yields better mental health outcomes than usual care by the GP in the short run. However, outcomes are not significantly different in the long run (Bower et al., 2006; Bower et al., 2011; Cape et al., 2010; Huibers et al., 2007). Non-specialist health workers have some promising benefits in improving mental health outcomes (van Ginneken et al., 2013). There is a significant effect for paraprofessionals in treatment programs for anxiety and depression compared to no treatment (Boer et al., 2005). Psychiatric consultation model for patients with somatoform disorders and depression in PHC is effective (van der Feltz-Cornelis et al., 2010).
Potential harms	Not addressed by any of the identified systematic reviews
Costs and/or cost-effectiveness in	5 systematic reviews, including 1 medium-quality review, reported the following results regarding costs and cost-effectiveness: Presence of mental health workers (counselors or

relation to the status quo	psychiatrists) on-site may reduce the number of visits to the doctors, referral to off-site mental health specialists and drug related costs. However, these reductions were small and not found consistently in all studies (Harkness & Bower, 2009; Chin et al., 2011) There were too few studies to draw any conclusions about the cost-effectiveness of using non-specialist health workers (van Ginneken et al., 2013). Collaborative care may be effective in reducing hospitalizations compared to usual care (Reilly et al., 2013). Collaborative chronic care models are effective at no net increase in overall health care treatment costs (Woltmann et al., 2012)
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	Uncertainty regarding the effectiveness of integration: Evidence from a medium-quality systematic review was insufficient to determine the benefits of screening in primary care populations (Connor et al., 2013). Current evidence does not answer the question of whether enhanced care delivered by front line PHC professionals has an effect on the outcome of patients with functional somatic symptoms (Rosendal et al., 2013). Uncertainty regarding reduction in health care costs: A low-quality systematic review found that although some types of health care utilization were reduced, there was no evidence that counselling reduced overall health care costs (Bower & Rowland, 2006). Uncertainty about which specific interventions within collaborative care are more or less effective: One review could not make conclusions about which specific interventions using non-specialist health workers are more effective due in sufficient evidence (van Ginneken et al., 2013) and a high-quality review reported that specific features of effective collaborative care were not clearly specified (Smolders et al., 2008). Further research is needed to determine whether collaborative care is effective for people with severe mental illness (Reilly et al., 2013).
Key elements of the approach if it was tried elsewhere	2 systematic reviews, 1 high-quality and 1 low-quality, reported the following elements of successful collaborative care to be taken into consideration: Supportive re-structuring/re-organization (Smolders et al., 2008; Craven et al., 2006): Service restructuring designed to support changes in practice patterns of primary health care providers is required.

	Location of primary care physicians and mental health specialists (Smolders et al., 2008; Craven & Bland, 2006): Collaborative practice is likely to be most developed when clinicians are co-located and most effective when the location is familiar and non-stigmatizing for patients. Provision of resources (Smolders et al., 2008): Need to offer fair and reasonable reimbursement for roles that had not existed before the integration, such as case management services and for telephone or in-person supervision by mental health professionals serving primary care providers. Enhanced patient education (Craven & Bland, 2006): Enhanced patient education was part of many studies with good outcomes. Consumer choice about treatment modality may be important in treatment engagement in collaborative care (for example, having the option to choose psychotherapy vs. medication). A medium-quality review identified six components for collaborative care models (Woltmann et al., 2012): patient self management support delivery system redesign use of clinical information systems provider decision support linkage to community resources health care organization support. A high-quality review stressed on Wagner's definition of the Collaborative Care Model which includes the following elements (Butler et al., 2008): practice re-design patient education enhanced expert system (providing education and decision support to clinicians) information system to track outcomes and provide feedback
Stakeholders' views and experiences	A major issue is that many GPs still feel that physical health problems are more their concern than mental health problems and view treatment of severe mental illness as the job of psychiatrists and other mental health professionals (Reilly et al., 2013).

Implementation Considerations

In identifying challenges that may be faced in pursuing the different elements, it is helpful to consider difficulties in relation to several

groups: patients, professionals, organizations and systems. A list of potential challenges and counterstrategies for implementing element 1 is provided in the table below.

It is important to note that studies have found that the need for mental health specialists, particularly psychiatrists and neurologists, will continue even if task-shifting is implemented extensively. Existing evidence shows that the roles of these specialists can change, with clinical roles focused on complex psychiatric cases and diagnoses and less complex cases managed by trained non-specialists health workers (Kakuma et al., 2011). Moreover, it was not shown that collaborative care reduces professional skills or de-professionalizes mental health work. On the contrary, there is a growing demand for more professional mental health support in the community, and psychiatric liaison offers a middle position between leaving all mental health cases in the hands of PHC physicians or referring all cases to specialists (Sterne, 2009).

Table 2 **Barriers and Counterstrategies**

Level	Barriers	Counterstrategies
Patient	Patients' reluctance to accept non-physical understandings of somatic symptoms (Rosendal et al., 2013).	
Professional	GPs' low expectations that enhanced care might help patients (Rosendal et al, 2013) PHC physicians' lack of confidence in their ability to handle individuals with serious illnesses such as schizophrenia or bipolar disorder (Sterne, 2009) PHC physicians' hesitation to deal with patients with mental distress related to the associated stigma (Goldfracht et al., 2006) Psychiatrists' opposition, due to feeling that integration would reduce visits to private psychiatric clinics and limit their income (Sterne, 2009) Psychiatrists' concern that doctors with little mental health training will be dealing with psychiatric	Intensive internal marketing of the integration program was used in previous experiences, in order to manage resistance to change from managers and health care professionals responsible for implementation. The program was "framed" as a solution to the overuse of health care services by patients with undiagnosed or untreated mental illness (Goldfracht et al., 2006). Building a cooperative process to involve all stakeholders in developing the integration program, in order to foster sense of ownership (Goldfracht et al., 2006). Allocating resources for implementing the program and

	issues (Sterne, 2009) PHC directors' resistance, because they may already be preoccupied with other quality improvement programs and fear they do not have time for new programs (Goldfracht et al., 2006)	obtaining additional funds from external sources was important for implementation of the programme (Goldfracht et al., 2006).
Organization	Heavy workload and time constraints (Rosendal et al., 2013; Goldfracht et al., 2006) Resistance to change, new staff and new roles, and balancing competing demands (Butler et al., 2008)	
System	Financial constraints (Butler et al., 2008) Reimbursement arrangements (Butler et al., 2008) Shortage of mental health facilities to which patients could be referred to, when needed (Goldfracht et al., 2006)	Integrated care programs and insurance plans undertook a number of strategies such as having plans credential providers and having creative employment and contract structures for care managers, but these strategies were limited in scope because any given practice is likely to treat patients from multiple insurance plans, so full integration is possible only if all plans are willing to participate (Butler et al., 2008).

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 (social insurance, private insurance, mutual funds, and public funds). An appropriate payment mechanism is capitation; the insurer can put limitations to the number of sessions, to the amount covered annually per enrollee, or to the number of days of hospital stay.

There are different payment systems which can work as financial incentives or disincentives affecting physicians' behaviour; these are: fee-for-

service (FFS) (payment is made for every item of care provided), fixed salary (lump sum payment for a set number of working hours or sessions), target payments and bonuses (payments for providing a pre-specified level or change in a specific behaviour or quality of care), and capitation (payments based on the number of patients) (Goden et al., 2000; Brocklehurst et al., 2013; Ciapponi & Garcia Marti, 2009; Gosden et al., 2001; Guiffrida et al., 1999; Flodgren et al., 2011).

In Lebanon, third party payers do not reimburse patients that utilize PHC services. Only hospital services are reimbursed. The current accreditation efforts by PHC centers in Lebanon present a great opportunity for third party payers to consider contracting with PHC centers to provide services, including mental health care, to patients enrolled in their plans (El-Jardali & Jaafar, 2012). Third party payers could begin reimbursing PHC centers according to a capitation payment system, whereby payment is made based on the number of patients to whom care is provided. A capitation formula has been used in other countries for reimbursing mental health services when mental health was added to the mandatory basket of services under the National Health Insurance plan (Gross et al., 2007).

Only one high-quality systematic review addressed payment mechanisms for mental health integrated into PHC, but it concluded that there is not yet sufficient evidence to determine which reimbursement system leads to better health outcomes or cost-effectiveness (Butler et al., 2008).

Although no other systematic reviews were identified specifically about reimbursement systems for mental health in primary care, our search did retrieve other systematic reviews on reimbursement mechanisms for primary care in general.

Capitation for integrated mental health services is preferred to FFS, because an FFS system makes certain services more financially attractive than others. Thus, service provision in a FFS system may be driven by financial considerations rather than appropriateness to patients' needs. It is also contradictory to have a fragmented funding system when the policy is calling for developing a strongly integrated system of mental health care (Fattore et al., 2000). This is critical in Lebanon because there are multiple funding entities (MOPH, NSSF, Military, the 3 Security Forces Funds, Mutual Funds, and Private Insurance Companies) which already present complexity in the system. Instead of each entity needing to establish pricing codes for different mental health services, a capitation system would simplify this process by having funders reimburse providers based on a maximum allowable amount per patient ("capita") on a yearly basis.

A roundtable discussion on mental health financing in Lebanon revealed psychiatrists' support of capitation as a reimbursement mechanism (Yehia, Saleh & Nahas, under review). They believe it is a viable method for

reimbursing mental health services as it simplifies the complexity that mental illness diagnosis poses on the process of pricing different services, especially in the case of co-morbid mental conditions (such as alcohol abuse and depression):

'Making a package with a maximum limit is better. And regarding alcoholism, many times you have a psychiatric comorbidity (…) meaning a patient would get admitted because he is depressed and is at the same time alcoholic, so you cannot constrain it. You can limit it better if you create a package with a cap.'

'The cap per person does not get used up quickly. The number of persons that end up being readmitted to the hospital within the same year is a minority, less than 10%. Ninety percent of people do not get admitted more than once a year to the hospital'.

Capitation is currently used for mental health coverage by Saint George Hospital and the Lebanese American University in their medical insurance plan for students, employees and faculty members (Yehia, Nahas & Saleh, under review).

Table 3 **Key findings** from systematic reviews and single studies

Benefits	All factors remaining the same, reducing the price of health services (by removing/decreasing user fees) tends to increase demand (Garcia Marti & Ciapponi, 2008; Lagaarde & Palmer, 2006; Lagarde & Palmer, 2011). Capitation is effective compared to salary payment, which was found ineffective (Flodgren et al., 2011). Primary care dentists under capitation tended to see their patients less frequently and carry out fewer fillings and extractions, but tended to give more preventive advice, compared to FFS (Brocklehurst et al., 2013). Salary payments were associated with lower levels of care compared to capitation and FFS (Gosden et al., 1999). Under capitation, in order to increase income, doctors need to attract patients to their practice, perhaps by offering more services as an indicator of higher quality. Capitation gives funders a level of control over expenditure compared to FFS (Ciapponi & Garcia Marti, 2009; Gosden et al., 2001). Results showed no adverse effect of capitation on PHC visits to office-based physicians. Capitation physician referrals to specialists decreased relative to all other groups studied, consistent with the theory that the financial incentives in capitation will lead PHC physicians to reduce referrals to specialists (Pantoja, 2008-a; Akbari et al., 2005; Davidson et al., 1992).
Potential harms	Compliance with a recommended number of PHC visits was lower in capitation compared to FFS (Gosden et al., 2000).

	More hospital referrals and repeat prescriptions were made under capitation compared to FFS (Gosden et al., 2000).
Costs and/or cost-effectiveness in relation to the status quo	Capitation can lead to efficiency gains and contribute to improved community-based health insurance performance in developing countries, while FFS may pose threats to the long-term financial viability of community-based health insurance schemes. Paying providers through capitation systems led to a reduction in provider-induced demand (Robyn, 2012). Efficiency gains were confirmed in single studies as well: In a U.S. study, it was found that a capitation model was more cost-effective for Medicaid patients with severe mental illness than FFS models (Grieve et al., 2008). In another U.S. study, capitation was found to reduce the costs of children and adolescents' mental health services compared to FFS. Providers also reduced costs by reducing inpatient treatment (Catalano et al., 2000). More service integration was observed and less complex service packages were provided under capitation compared to FFS. Capitation encouraged community mental health care workers to provide more efficient services; for example, there was increased utilization of testing in order to better match clients with appropriate services and avoid waste (Chou et al., 2005). A review on remuneration methods for PHC dentists concluded that there was insufficient information regarding the cost-effectiveness of the different methods (Brocklehurst et al., 2013).
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	Only one high-quality systematic review addressed payment mechanisms specifically for mental health integrated into PHC and it concluded that evidence was not sufficient to determine which reimbursement system leads to better health outcomes or cost-effectiveness (Butler et al., 2008). No evidence was found on patient health outcomes under capitation payments systems vs. salary (Gosden et al., 2000). No evidence was found that financial incentives can improve patient outcomes (Flodgren et al., 2011). There is uncertainty about the effect of financial interventions such as capitation on the appropriateness of referral from primary to secondary care (Pantoja, 2008-a; Akbari et al., 2005).
Key elements of the approach if it was tried elsewhere	Factors that need to be considered in assessing whether the intervention (financial incentive) effects are likely to be transferable to other settings include the availability of: Resources to finance the incentives beyond restructuring existing payment systems Routine data on quality of care (Pantoja, 2008-b; Petersen et al., 2006).

	Factors that should be considered in applying this evidence in low and middle-income countries include: the existence of a formal referral system and its ability to absorb additional referrals; the availability of resources to implement the intervention; the extent to which referrals are made by physicians or by other health workers The intensity of the intervention needed to change specific behaviours in different health workers. (Pantoja, 2008-a; Akbari et al., 2005) Factors that need to be considered to assess whether the intervention effects are likely to be transferable to other settings include: Availability of specialists Financial and administrative support (Flottorp, 2008; Gruen et al., 2003)
Stakeholders' views and experiences	No identified systematic reviews addressed stakeholders' views and experiences regarding capitation. Roundtable discussion found that psychiatrists believed capitation was a viable method for reimbursing mental health services as it simplifies the complexity that mental illness diagnosis poses on the process of pricing different services, especially in the case of co-morbid mental conditions.

Implementation Considerations

Key findings from systematic reviews on implementation considerations are presented in the table below. Additionally, it is worth noting that a single study reported that a strategy to control costs under capitation is to identify patients who incur more costs in the system and aim to change their patterns of care by matching their needs to the services provided (Chou et al., 2005).

Table 4 **Barriers and Counterstrategies**

Level	Barriers	Counterstrategies
Patient	None identified	Improving reimbursement of evidence-based practices, collaborative care, team approaches to providing care and reimbursement of case management services Increasing payment for professional services by non-physician practitioners
Professional	Third party payers are already overwhelmed by the workload they have regarding hospital reimbursement, and PHC reimbursement will require extra efforts from them (K2P Evidence Brief). PHC centers may charge different	

	rates for the same service, depending on the public sector fund that is expected to pay (K2P Evidence Brief).	Increasing reimbursement rates Improving incentives for screening and prevention
Organization	PHC practices often deal with various insurance plans, and inconsistent payment policies across plans make it hard for practices to undertake the necessary investments to implement integrated care (Butler et al., 2008).	Collaboration among the MOPH, other third party payers and the PHC network to clarify and coordinate reimbursement policies (Butler et al., 2008).
System	Differences in payment systems and infrastructure may require sophisticated information and billing systems that are not available in some settings (Ciapponi & Garcia Marti, 2009; Gosden et al., 2001). A high-quality systematic review provided the most comprehensive information to date on barriers and counterstrategies to implementation of integrated care associated with public reimbursement structures (Butler et al., 2008): Lack of reimbursement for collaborative care, case management services, and services provided by non-physicians (alternate practitioners). Low reimbursement rates of crucial mental health services Lack of reimbursement incentives for screening and providing preventive mental health services	

Element 3

Recognize parity between mental health and physical health by developing and implementing appropriate legislations, including the draft law submitted by the LPA for the licensing of psychologists, as well as the proposed Mental Health Act of 2008 for the protection of psychiatric patients' rights.

No systematic reviews were identified about policies related to mental health services; however, the search identified compelling evidence from numerous single studies on enacting mental health legislation. Findings are presented in the table below.

Table 5 **Key findings** from single studies as no systematic reviews were identified

Benefits	Numerous studies found that after passing national mental health-related policies, suicide and self-harm rates declined: A U.S. study found that when states enacted laws requiring insurance coverage to include mental health benefits on par with physical health, suicide rates decreased significantly by 5% (Lang, 2013). A study from England found that in the 5-year period following the enactment of a national mental health policy initiative for suicide prevention, self-harm admissions declined significantly after psychiatric hospital discharge (particularly by 14% in the first week after discharge), compared to the 5-year period prior to the enactment of the policy. One component of the policy required that people with severe mental illness be followed up in the community within 7 days of discharge (Gunnell et al., 2012). In England and Whales, the implementation of national policies for the improvement of mental health services was associated with a decline in elderly suicide rates (Hoxey & Shah, 2000; Shah, 2007; Shah et al., 2001). Another study confirmed a significant relationship between elderly suicide rates and improved mental health service provision (Shah & Bhat, 2008). A study examining mental health systems and deinstitutionalization movements in three countries (Denmark, Finland and Sweden) found that where national suicide prevention plans were implemented, the risk of suicide among people with mental disorders was reduced; in contrast to Sweden where the plan was poorly implemented and was associated with a lack of improvement in suicide risk (Wahlbeck

	et al., 2011). Five years following the implementation of the Irish Mental Health Act, the rate of involuntary admission decreased (Ramsay et al., 2013). In Israel, the decade following the enactment of a law for the rehabilitation of people with mental disabilities in the community witnessed a 4-fold increase in the number of persons receiving rehabilitation services in the community, an 8-fold increase in the government budget for mental health rehab services, and a 50% decrease in the number of psychiatric beds, accompanied with a significant reduction in the length of psychiatric hospital stays (Aviram et al., 2012). Ten years after the enactment of a federal law in Brazil that aimed at shifting mental health care from the hospital to the community, Brazil saw a reduction by 18,500 psychiatric beds and implementation of hundreds of community-based services (Goncalves et al., 2012).
Potential harms	The literature did not identify any potential harms.
Costs and/or cost-effectiveness in relation to the status quo	Mental health parity laws are helpful in reducing the financial burden on mental illness patients and their families without driving up healthcare costs for the insurer (Barry & Busch, 2008). For children suffering from mental illness, parity has resulted in a 25% reduction of the out-of-pocket share of treatment expenses (Barry et al., 2013). Community-based care is more cost-effective compared to hospitalization when it comes to mental illness (Goncalves et al., 2012; Beecham et al., 2004; Mansell et al., 2007). After the implementation of the 2001 mental health policy in Brazil, an analysis of mental health expenditures showed that resources shifted towards community services, with a decrease of 39% in hospital expenditures and an increase of 404% in community-based expenditures (Goncalves et al., 2012). A study on behavioural health insurance parity law in Oregon, U.S., found that parity can improve insurance protection without substantial increase in total costs for the insurer. An increase in behavioural health spending of $25 would be equivalent to a 1% increase in total spending (McConnell et al., 2012).
Uncertainty regarding benefits and potential harms *	There is uncertainty regarding the actual benefits of mental health and substances abuse parity laws on improving access to mental health care services for children and adolescents (Barry & Busch, 2008).
Key elements of the approach	Key elements that supported the issuance of Israel's law for the Rehabilitation of Persons with Mental Disabilities in the Community

if it was tried elsewhere	were (Aviram et al., 2012): Leadership and commitment of legislative members to champion the legislative process Coalition of interest groups Budget support from the Ministry of Finance
Stakeholders' views and experiences	A study in Ireland found that 94% of GPs support a general policy on shared care between specialized psychiatric services and PHC for patients who are stable on their treatment (Agyapong et al., 2012).
	*Monitoring and evaluation could be warranted if the approach element were pursued

Implementation Considerations

Experiences of other countries, including Ghana, Ireland, Australia and England demonstrate common barriers faced in the implementation of mental health policies, particularly those aimed at integrating mental health care into primary care. These barriers are also likely to be encountered in the implementation of mental health policies in Lebanon. Key barriers and counterstrategies are presented in the table below.

Table 6 **Barriers and Counterstrategies**

Level	Barriers	Counterstrategies
Patient	Lack of patients' confidence in PHC professionals' capacity to provide mental health care (Agyapong et al., 2012)	Training and capacity development Forming partnerships between PHC professionals and mental health specialists (Callaly & Fletcher, 2005; Fullet et al., 2011) Leadership from within the psychiatry profession is critical to drive cultural change (Callaly & Fletcher, 2005) Developing clear guidelines that define the role and function of different professions within the collaborative model (Fuller et al., 2011; Nolan & Hewison, 2008) Improving health budgets for PHC, including budgets for investing in technology
Professional	Cultural change within the general practice and mental health professions (Callaly & Fletcher, 2005) Lack of clarity about roles of different healthcare professionals in the integrated model (Nolan & Hewison, 2008)	
Organization	Development of technology to support integrated service provision (Callaly & Fletcher, 2005)	
System	Competing health priorities for the MOPH (Awenva et al., 2010)	

Lack of inter-sectoral and inter-ministerial collaboration and consultation (Awenva et al., 2010)	Establishing formal mental health policy guidelines to support policy implementation (Mbatia & Jenkins, 2010)
Lack of political commitment to mental health (Awenva et al., 2010)	Conducting wide consultation with stakeholders to secure buy-in and facilitate policy implementation
The MOPH's limited financial resources	Launching advocacy campaign involving service users, mental health professionals, researchers and NGOs to exert pressure to place mental health on the political agenda (Awenva et al., 2010)
The lack of ear-marked budgets for mental health care (Salvador-Carulla et al., 2010)	

Next Steps

Next Steps

The aim of this policy brief is to foster dialogue informed by the best available evidence. The intention is not to advocate specific policy elements or close off discussion. Further actions will flow from the deliberations that the policy brief is intended to inform. These may include:

- Deliberation amongst policymakers and stakeholders regarding the policy elements described in this policy brief.
- Refining elements, for example by incorporating components of elements, removing or modifying components.

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