The integration of mental health into primary health care in Lebanon

Zeinab Hijazi, Inka Weissbecker & Rabih Chammay

In Lebanon, the International Medical Corps is working to address the multiple needs of Iraqi refugees, as well as the long term needs of the vulnerable host population, by integrating mental health services into primary health care (PHC). Over the past two years, 152 PHC providers (doctors, nurses and social workers) were trained in the identification, management and referral of people with mental health problems. The Ministry of Health has certified the completion of a training that includes: 12 theoretical training days, and a minimum of three on-the-job, supervised clinical sessions. Two formative evaluations were conducted to guide training implementation. Trainees completed pre/post tests, and clinical skills were evaluated during the on-the-job supervision sessions. Trainees showed an average of 12–25% improvement in knowledge, and 85% doctors and 91% nurses met minimum competency standards. Results from the evaluation were used to address challenges, including: strengthening referral mechanisms; promoting organisational change through clinic management; tailoring training for different groups of professionals; utilising a team approach to care, providing refresher training on topics such as medication management and planning longer term follow-up. The project provides important input towards integrating mental health into primary health, on the national policy level.

Keywords: integration, iraqi refugees, lebanon, mental health, primary health care

Introduction

Mental illness continues to be one of the most neglected and under-funded health problems, causing significant disease burden and vulnerability. Approximately 75% of individuals with mental health problems in many low income countries have no access to appropriate services (World Health Organization, 2008a). Integrating mental health into general health care is one of the most viable ways of closing the treatment gap for untreated mental illnesses (World Health Organization, 2008a; Lancet Global Mental Health Group, 2007). This integration can be achieved by training general healthcare workers in the identification, management (pharmacological and non-pharmacological), and appropriate referral of mental health cases, as outlined by recently released WHO Mental Health Gap Action Programme (mhGAP) guidelines (World Health Organization, 2010b). Such integrated services are more sustainable, less stigmatising and more accessible through reaching larger segments of the population (Inter-Agency Standing Committee, 2007). Integration is most successful when mental health is incorporated in health policy and legislative frameworks, accompanied by adequate resources (World Health Organization, 2008b). Efforts to integrate mental health into general healthcare are increasingly documented in several low resource countries (World Health Organization, 2010b). The International Medical Corps (IMC) has been conducting programmes supporting mental health integration into general health care in Sri Lanka, Sierra Leone, Chad, Iraq, Syria,

Haiti, and Jordan. This article describes the situation in Lebanon, which illustrates the challenges and opportunities in this line of work.

The Lebanon context

Background

Lebanon is an upper middle income country with a population of approximately 4350,000. This includes 500,000 refugees from different nationalities, of which 47,280 are from Iraq. Most others (around 400.000) are Palestinians served by UNRWA, the United Nations Relief and Works Agency for Palestine Refugees (UNHCR, 2010, World Health Organization, 2010a). IMC started to work in Lebanon after the war in 2006 that involved the Hezbollah paramilitary forces and the Israeli military. The conflict led to the deaths of over 1,400 people, most of whom were Lebanese, and displaced a further 1275,000 people. The political and security situation in Lebanon and the surrounding region remains unstable. There is no adequate legal framework that addresses the short or long term needs of refugees, who often work illegally, suffer exploitation, and are subject to detention and deportation (UNHCR, 2010). Survival remains a daily struggle given deteriorating health, plummeting income levels, poor, over crowded living conditions, and uncertain futures (Le Roch et al., 2010).

Mental health

Prevalence of Mental Health Problems

According to a 2006 national epidemiological survey in Lebanon, 17% of respondents met criteria for at least one mental disorder in the last 12 months (Karam et al., 2006). In another study, the lifetime rate of major depression in Beirut was reported to be 19%, and higher proportions of mental disorders were found in respondents exposed to multiple war-related distressing events (Weissman, Bland, & Canino, 1996). High levels of psychological distress were also reported among 50% of Iraqi refugees, and 34% of these had experienced extremely stressful events such as: witnessing the assassination of relatives and friends; kidnapping; torture; and rape (International Organization for Migration, 2008). Women were found to be taking up new responsibilities, while men saw their role and mandate being eroded. Terre des hommes-Lausanne (Tdh-L), who were providing psychosocial support and counselling to Iraqi refugees in Lebanon, found that of the 83 clients who sought psychosocial services, the majority suffered from emotional disorders (92.7%) followed by behavioural disorders (55.4%) and sleeping disorders (48.2%) (La Roch et al., 2010).

Mental health services

Lebanon primarily depends on the private sector for the provision of mental health services, which are free of charge for eligible low-income patients through the Ministry of Health (MOH). Specialised mental health services are available at three private mental hospitals, and five psychiatric units within general hospitals, which are located centrally around the capital, Beirut. There is a lack of community based mental health services, and services are not available in every catchment area (WHO, 2010b). Lebanon has relatively few mental health specialists, with an average of two psychiatrists per 100,000 of the population (WHO 2010b). The budget for mental health constitutes 5% of the general health budget, which is mainly allocated for long stay inpatient costs in mental hospitals. Whereas outpatient, community based services are the responsibility of the private sector, with no budget except those that provide selected

psychotropic medicines for free. Mental health care provided through primary health care (PHC) is typically restricted to prescription of medication through the doctor (and, in our opinion, seldom properly). Few clinics have social workers that are trained in mental health. Lebanon does not have a current mental health policy or plan, which has been cited as one of the main barriers to improving mental health services.

Individuals are often reluctant to visit mental health services due to fear of stigma. Data from the country suggests that only 10% of those with mental disorders seek care, mainly from general physicians at clinics, or polyclinics that are operated by private doctors, or charities, but not by mental health professionals (Karam et al., 2006; World Health Organization, 2010a). The data further suggests that of those who do receive services, 85% are treated in the general medical sector and the mental health care system, and the rest by religious or spiritual healers. One study found that Iraqi refugees are unlikely to seek out mental health services due to: stigmatisation of such services in their country; limited accessibility; and lack of community outreach (IOM, 2008). The expression of unspecific somatic complaints, instead of psychological problems, is common among both the host population and the refugees (IOM, 2008).

Integration of mental health into primary health care in Lebanon

Context

Since the ceasefire in the war between Israel and the Lebanese Hezbollah went into effect in August 2006, IMC has been working with local partners and governments to provide basic primary health care services, secondary and tertiary healthcare, and health education. Funding has focused on addressing multiple and complex needs of refugees and the host population in Jordan and Syria, which included mental health services, since 2007. Training PHC staff to integrate basic mental health care into their clinical and public health practice became a way of meeting refugee and host population needs, as detailed in the following steps.

Project coordination and collaboration

Government

At the end of the 2006 war, IMC recruited psychiatrists and psychologists as trainers from the Lebanese Institute for Development Research Advocacy and Applied Care (IDRAAC), and trained national primary health care staff of a local health NGO (AMEL Association). In 2007, ten PHC clinics across Lebanon were targeted in a pilot to inform discussions with the government on the possibilities of integrating mental health into PHC, at a national level. In 2008, IMC built on the piloted training, and held discussions with the MOH General Director, sharing the training programme framework and work plan. The MOH was supportive of the NGOs work as a result of past successful health programming, and offered their support in training MOH PHC staff in Lebanon's eight provinces[1]. The MOH has been subsequently involved in approving the training material, and has certified the training. IMC has continued to actively involve the MOH in an effort to take the first steps in informing a mental health plan in Lebanon.

Professional associations

In 2008, IMC, Lebanese psychiatrists and service providers formed an advisory board that collaborated on developing the mental health training programme. The board consisted of an MOH psychiatrist, the head of the Lebanese Psychiatric Society, a

psychiatrist consultant, and the IMC programme manager and two psychologists. The board's role ended in August 2009.

The Head of the Lebanese Psychiatric Society approved the training manual in October 2009, who also submitted the material to the Lebanese Order of Physicians (LOP). In February 2011, the LOP approved the provision of Continuing Medical Education (CME) credit to trainees (doctors registered with the LOP) who completed both the theoretical, and the on-the-job, training components. This was a lengthy process and was only completed at the onset of the third cycle of training. Trainees from the previous two cycles received training certificates, accredited and signed, by the Minister of Health.

Mental health PHC training design

Timeline The PHC training took place from February 2007 to August 2010, and included three training cycles, with twelve theoretical training days per cycle over three months (one day per week), and two formative evaluations (see Table 1).

Selection of PHC clinics

Cycle I trainees were selected by the AMEL Association. Cycle II and III trainees were recruited from seven NGO-supported general health clinics, and 18 clinics supported by MOH, the Ministry of Social Affairs (MOSA) or local NGOs. The MOH agreed with the selection of the clinics. These were located in five of the eight provinces with both a large proportion of Iraqi refugees, and a vulnerable host population.

Selection of PHC staff

General practitioners (GP) were selected through a formal recruitment process, approved by the government, using the following criteria; being a certified GP, having at least two years experience at the PHC level, and being willing to attend the required days of training. Doctors with specialties (e.g. gynaecology), who had also practiced as GPs, were also eligible. PHC doctors, who had participated in the training, nominated mid-level staff from their respective clinics for inclusion.

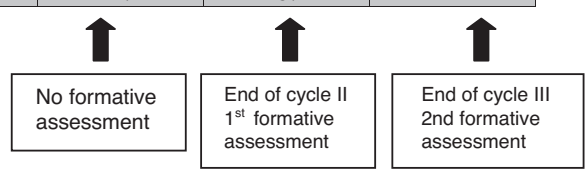
PHC training materials and content

The *Mental Health Training Manual* was drafted by Lebanese psychologists and reviewed by international mental health specialists from IMC, and the Lebanese Psychiatric Society (LPS). The manual was based on previous IMC material, *IASC Guidelines on Mental Health and Psychosocial Support in Emergencies* and '*Where There is No Psychiatrist*' by Vikram Patel (2003). Topics were selected based on the first formative evaluation, assessments of the most prevalent disorders seen at the PHC level (as indicated by trainees as part of their application form, and discussions with heads of clinics and the MOH) and periodic revisions throughout Cycle II. Trainees indicated that they were most interested in: depression; anxiety; medically unexplained complaints; and sleep problems. The topics included in the final manual are outlined in Table 2. Medication management was addressed as part of each relevant mental disorder and covered: prescriptions, dosages, and overall management for GPs; and basic pharmacology, duration of treatment, side effects, medication compliance and psycho education for mid-level staff.

More specialised topics were included for specific groups of trainees. Gynaecologists received training on: detecting domestic abuse; providing support and linking survivors of violence to services; post partum depression; and post partum psychosis. The training for paediatricians emphasised: behavioural disorders in children; maternal

Table 1. PHC Mental Health Training Overview

	February 2007-august 2007	September 2008-august 2009	September 2009-august 2010	
	Cycle I	Cycle II	Cycle III	Total
Total # of trained PHC workers	17	75	60	152
GPs	6	43	20	69
Paediatricians	2	18	7	27
Gynaecologists	4	6	3	13
Nurses	5	4	13	22
Social workers	0	4	15	19
Admin/head of clinic	0	0	2	2
Trainees completing 12 training days	NA*	100%	100%	NA
Trainees completing at least three on-the-job training supervised clinical sessions	90%	38 % mid level staff 50% doctors	100%	NA
Number of trainees completing pre/post test	NA**	74	56	130
Average pre test %	NA	63%	48%	NA
Average post test %	NA	75%	74%	NA
% Improvement	NA	12%	25%	NA



* Training in cycle I included four training days only
** Results not available

*Training in Cycle I included four training days only. **Results not available.

depression; monitoring a child (height/growth) taking methylphenidate for attention deficit hyperactivity disorder (ADHD); recognising signs of child abuse and neglect; and paying attention to school performance as a signal for exploration of other problems. The training was consistent with an adult learning perspective (Bryan et al., 2009), where trainees (and managers) were engaged in discussing the rationale of learning about mental health, and the challenges to be addressed. Trainings were tailored to trainees from different backgrounds, and encouraged active involvement in the learning process and to provide feedback. Educators not only served as the distributors of content, but also were involved as facilitators of learning, and assessors of competency. The theoretical training consisted of four training days in Cycle I, and 12 training days in Cycles II and III. The increase in training days (from 4 to 12) was the result of recommendations from the mental health team and the advisory board. The on-the-job (OTJ) supervision component consisted of at least three days, and started after 6–7 days of theoretical training. Each trainee was assigned a psychiatrist for technical

Table 2. PHC mental health training content

Day 1
- Pre test

Introduction to mental health
  - Concept of mental health and disorder
  - Communication skills and effective interaction
  - Misconceptions of the mentally ill
- Biology and the mind
  - Brain vs. mind
  - Motivational, emotional, and cognitive processes

Day 2
- Assessment of mental disorders
  - Types, symptoms, and etiology of mental disorders
- Psychiatric interview
  - Mental status examination
  - Writing case summaries

Day 3
- Mood disorders
  - Depressive disorders
  - Bipolar disorder
  - Etiology of mood disorders
  - Differential diagnosis
  - Managing mood disorders
  - Treatment and psychopharmacology

Day 4
- Anxiety disorders
  - Characteristics and etiology of the different types of anxiety disorders
  - Managing anxiety disorders
  - Treatment and psychopharmacology

Day 5
- Somatoform disorders
  - Different types of somatoform disorders
  - Etiology of somatoform disorders
  - Management and treatment
- Sleep disorders
- Sexual dysfunction disorders

Day 6
- Severe mental disorders
  - Psychosis
  - Schizophrenia
  - Brief acute psychosis
- Eating disorders
  - Anorexia nervosa
  - Bulimia nervosa

Day 7
- Child and adolescent mental health
  - Mental retardation and learning difficulties
  - Child abuse
  - Conduct disorder
  - Enuresis
  - Adolescence
- Elderly mental health
  - Dementia
  - Elderly abuse

Day 8
- Addiction and substance abuse
  - Process of addiction
  - Different classes of drugs
  - Management and treatment
- Midterm

Day 9
- Psychiatric emergencies
  - Epilepsy/seizures
  - Delusions and hallucinations
  - Suicide
  - Case management and referrals

Day 10
- Trauma
  - Loss and grief
  - Domestic violence

Day 11
- Treatment of mental disorders
  - Psychopharmacology
  - Medication management/case management
  - Counseling therapy
- Referral system

Day 12
- Closing subjects
- Relaxation techniques for managing stress
- Q&A discussions
- Post Test

consultations, who also observed while they saw patients.

Refresher training

Refresher training consisted of at least two theoretical training days, and at least one follow up OTJ training day for staff, from all cycles. The training was based on previous formative evaluations on training gaps and was tailored to staff specialisations: GPs reviewed how to use proper prescribing habits; paediatricians received in-depth sessions on child and adolescent mental health; gynaecologists received training on identifying, managing, and referring cases of abuse; while gastrointestinal doctors practiced identification and management of psychosomatic complaints. Mid-level staff was trained on psychosocial interventions including family supports. The refresher training was consistent with WHO Mental Health Gap Action Programme (mhGAP) guidelines.

Mental health PHC training assessments

First formative evaluation

The first evaluation, conducted by an external evaluator (from the American University of Beirut), took place after Cycle II, with the objective of standardising the training materials. Three (n = 6, n = 5 and n = 7) two-hour focus group discussions (FGD), including GPs and mid-level staff, were conducted by a facilitator and one note-taker with participants from Cycles I and II. Questions focused on the logistical aspects of the training, content, presentations and subjects, quality of trainers, and quality and feedback from the OTJ sessions. All participants were contacted by psychosocial field officers and asked whether they would be interested in taking part in the FGD on specific dates. The facilitator conducted in-depth interviews with the three main trainers (Technical Mental Health Advisor, Head of the Lebanese Psychiatric Society and MOH psychiatrist) to obtain feedback on the training.

Second formative evaluation

The second evaluation was carried out at the end of training Cycle III to obtain feedback on the training, and to inform the design of refresher training. Five two-hour FGDs were held by one facilitator (trainer) and one note-taker with participants from Cycles II and III (GPs n = 7 and n = 8; mid-level staff, n = 6; Paediatricians, n = 5; Gynaecologists, n = 2). Questions focused on general impressions of the training: appropriateness of topics; experience of trainers; ability to identify, diagnose and refer cases of mental illness; appropriateness of the OTJ trainings; and interest in refresher training.

Knowledge and competency measures

Mental health knowledge was assessed with a 50-item test developed by the project, which consisted of brief case studies, and multiple choice questions on diagnosis, management, and referral. The test was administered before, mid-term (22 items), and after the theoretical training. The goal of the mid-term was to determine knowledge gaps to be addressed while training was ongoing.

Clinical performance was measured by the psychiatric OTJ supervisor, using a Competency Checklist adapted from the *'mini-CEX for specialist training in psychiatry, Royal College of Psychiatrists' (* see Boxes 1 and 2 for a sample of the checklist administered to GPs. The checklist assesses the ability of the trainee to: establish rapport; demonstrate active listening; basic attending; the ability to communicate competence; make appropriate referrals; and write case reports. Each skill was graded using a 5-point scale ranging from 1 (demonstration of the task or usage of

Box 1: Ample questions from mental health knowledge pre/post tests

1. Samira is 14 years old, and for more than a week she has had decreased appetite, refused to go to school or partake in activities she once considered fun and enjoyable, and says she is tired all the time and mostly sighs and sulks. She is normally, by nature, very optimistic but has been heard talking about death and wondering what the purpose of life is all about. She avoids social events where she has to interact with friends or people. Her mother became worried when she received a call from Samira's principle telling her that Samira is on the verge of failing three of her courses. When talking to her about her grades, she said toher mother, 'who cares? Just leave me alone. We're all going to die in the end anyway.'

1.1. Samira's pattern of behavior indicates which of the following disorders?

a) Panic disorder
b) School refusal
c) Social phobia
d) Major depression disorder
e) Separation anxiety disorder

the skill was not completed as expected) to 5 (demonstration of task or usage of skill was excellent). Minimum competency standards of a 4-point average ('*Good*') were agreed by IMC's Mental Health Technical Advisor and the psychiatrist supervisors. The checklist was administered.

Mental health PHC training results

First formative evaluation

Qualitative results indicated that the training benefited the trainees by allowing them to: network and share experiences with colleagues; increased their awareness of mental health issues within their work and social environment; and improve their ability to listen to patients and identify mental health problems. Main recommendations included: separate groups for physicians and non-physicians; provide more time for case discussions and role-play; address rational use of medications in each topic session (including when to start, monitor and discontinue, medication); focus more on family support for mid-level staff; conduct refresher trainings on some topics (e.g. depression); recruit physicians and mid-level staff from the same clinics in order to facilitate joint and coordinated service provision; and start OTJ training during theoretical training.

Second formative evaluation

Participants reported that the training offered them an opportunity to network and engage in discussions with peers about using newly acquired skills, increased their communication and listening skills, heightened their tolerance for patients presenting with vague and/or persistent complaints, enhanced awareness of mental illness symptoms, and improved their ability to recognise somatisation and differentiate between organic and mental health problems. Quotes from trainees included: *'after the training, the way I dealt with patients changed, I started to listen to them more and I want to know about their history and what got them here'; "w, I can diagnose depression and assess matters. I pay attention to mental health symptoms, and some have come back to see me'.* Trainees also seemed to undergo a change in attitude towards mental illness, stating for example: *'I used to think that a fainting woman wanted only to have the attention of the doctor and that she was faking it, now I know that she is not'; 'after this training, I realised that I was depressed, I went and saw a psychiatrist*'; and '*I understand better what my teenage son is going through, we talk more*'.

Trainees reported being better able to identify common mental disorders, such as

Box 2: Mental health on-the-job training.Competency checklist and goal setting form

Doctor's name:

Place:

Supervisor's name:

Please use this scale to assess the practicum student's skills:

5 - Demonstration of this task *or* usage of this skill was: EXCEPTIONAL

4 - Demonstration of this task *or* usage of this skill was: GOOD

3 - Demonstration of this task *or* usage of this skill was: FAIR

2 - Demonstration of this task *or* usage of this skill was: POOR

1 - Demonstration of this task/task*or* usage of this skillwas: NOT COMPLETED as expected

Assessment / intake skills	Skill level	Comments
Taking appropriate history of patient's presenting complaints		
Taking appropriate psychiatric history		
Taking appropriate medical history		
Taking family history		
Taking occupational history		
Asking questions about patient's daily functioning		

Communication skills	Skill level	Comments
Demonstration of core conditions ofgenuineness, unconditional positiveregard, and empathy in the doctor-patient relationship		
Demonstration of active listening, basicattending, and ability to communicate competence		

Practice skills	yes	no	Comments
Makes correct diagnosis			
Takes appropriate decision re: medication &treatment			
If prescribing, gives correct advice & information about the drug			
Records data correctly			
Provide clear instructions & explanations for patient about his/her problem			
Includes psychosocial component in the treatment			

Goal	Comments
1	
2	
3	

depression and anxiety, although they remained less confident diagnosing more severe disorders, such as schizophrenia and bipolar disorder. Trainees also expressed reluctance to prescribe medication, were unsure about how to manage medications and where to refer and how to follow up. Trainees stated, for example; *'we benefited from assessing and analysing cases, but when it came to our practice, it was harder. I don't have the courage to prescribe medication.*' Nurses and social workers requested training on prevention. Trainees requested more OTJ sessions, and regular follow-up for at least one year following the training (consultation visits once a month), and that trainers remain points of reference for technical questions. Additional topics requested included stress management, preventing burnout, and communicating with angry or violent patients.

Knowledge and clinical competency

Results of the *mental health knowledge* test among trainees who completed the training (n = 96, Cycles II and III, see Table 1 for details) showed an average of 57% correct answers on the pre-test (n = 130 Cycles II and III), 81% on the mid-term (n = 30, PHC doctors from Cycle III only) and 74% on the final (n = 130 Cycles II and III). This corresponds to an 18% improvement in knowledge. It seemed that participants in Cycle III had somewhat lower pre test scores than other cycles, which may also be because this group encompassed PHC workers less familiar with mental health care, in more deprived areas, with Iraqi refugees. Mid-term results had shown that trainees had a good understanding of differential diagnosis, but had difficulties in identifying the correct medications for common mental disorders. Subsequent revision sessions addressed this gap, and knowledge was further increased on the post test.

Results regarding *clinical performance* indicated that doctor trainees achieved an average rating of 86% (n = 96 Cycles II and III), while 85% met minimum competency standards, with 60% meeting high competency standards using the Competency Checklist. Among mid-level staff, 92% (n = 33 Cycles II and III) met the minimum competency standards, with 38% (of the 92%) meeting high competency standards. Main difficulties reported by the supervisors included: patients not showing up; doctors not asking enough questions; pushing the trainer to intervene if mental health issues were communicated; over emphasising psychological components, while forgetting about the medical examination; short consultation time; no confidentiality or privacy; and leading questions asked by physicians.

Results of the knowledge pre/post test, and the OTJ training checklist, carried out at the end of Cycle III, indicated that while trainees' identification of mental disorders improved, they still had difficulty knowing when to refer patients, when to prescribe medications, and explaining the purpose behind the medication, and dosages, as well as managing follow-up cases and knowing when to discharge.

Discussion

Challenges and lessons learned

Between 2007 and 2010, IMC built on formative evaluations and lessons learned in designing a training programme of mental health integration that fit with existing resources, structures and systems, and proved to be a comprehensive and effective training. There are several challenges and lessons learned that emerged over the course of the project.

Prescribing habits

Formal evaluations and supervision reports from trainers suggested that a significant number of doctors continued to maintain their old prescribing habits, and showed resistance to prescribing antidepressants, while continuing to prescribe benzodiazepines. This problem was surprising, given that this topic was covered extensively during both the theoretical and OTJ training. In response, refresher training was focused on proper prescribing and medication management, and included case discussions from the GP's respective practices.

Team approach to care

Formative evaluations and experiences indicated that mental health at the PHC level needs to be provided through an all-inclusive trained team of medical professionals and social workers working together, with a need for long term follow up, support and supervision. This is particularly crucial in absence of a gatekeeper. Therefore, IMC developed an approach to tailor training to GPs, mid-level staff, social workers, and doctors from different specialities. Staff had also indicated a preference for separate groups (first formative evaluation) and this approach seemed to work well for meeting training needs and increasing comfort of staff to openly talk about challenges. The organization is also currently piloting the integration of case management teams attached to PHC clinics, by engaging three case management teams that include social workers, psychologists, and psychiatrists working with clinic staff, on managing patients in need of psychiatric, psychological and social support.

Ongoing supervision and support

A key finding from the formative evaluations was that trainees needed to be followed-up after the conclusion of training. Trainers and trainees reported that they created informal networks to ask for technical input on cases seen at the PHC level. IMC also organised refresher trainings for one year following the initial training. In addition, there are plans to strengthen communication and consultation among trained PHC staff and mental health specialists by strengthening referral networks, and setting up two supervision units, made up of a psychiatrist, psychologist and social worker or psychiatric nurse. The supervision units will be stationed within ministry clinics or local organisations, that can sustain the units following NGO-support, in 2 out of 4 regions in Lebanon, where partner clinics are situated, and almost no secondary mental health services are available.

Referral networks

The integration of mental health into PHC is reliant on a coordinated network of community services, including specialised mental health services. However, appropriate referral systems between primary, and secondary services were often absent, and many trainees indicated difficulties in determining where to refer. In response, IMC strengthened referral networks and mapped free and accessible mental health services within the five geographical areas of partner clinics, and produced a referral booklet that was shared with the MOH, NGO PHCs, and other service providers.

Organisational integration

Training clinical staff was insufficient if the head of the clinic did not promote the organisational integration of mental health into PHC services. Such organisational changes included proper assessments, management and follow-up, spending more time with patients, or allocating sessions or even a day, for mental health cases. Heads of clinics

face significant challenges, including shortage of staff, inadequate working conditions, and limited budget and resources. PHC trainees expressed that they want to be supported in lobbying for mental health integration. As a response, IMC organised a one-day orientation session for heads of clinics, focusing on the importance of integrating mental health, to determine roles of trained PHC workers, and to discuss their own role in supporting integration.

Data tracking and reporting

PHC clinics in Lebanon do not routinely track mental health patient data, such as diagnosis, medications, intervention management and referral. IMC developed an outpatient record form, but this was not regularly used. Tracking and reporting on mental health data is one aspect of mental health PHC integration that requires institutional agreement, and organisational change and commitment. As a result, IMC is planning to work with PHC heads to advocate for, and support, integration of mental health at all levels, including reporting.

Limitations

This project has had several limitations. The data collected was mostly qualitative, and evaluations were formative. Modifying the training continuously, based on feedback, may have also resulted in trainees with different knowledge and skill levels. However, the refresher training has been designed to address specific knowledge gaps. Furthermore, ensuring that evaluations and feedback were built into the project design made it possible to develop a mental health training programme closely tailored to trainee needs in Lebanon.

The overall objective of this project was increasing access to mental health services for vulnerable populations, including Iraqi refugees. It should be noted that we primarily analysed activities and results, rather than outcomes. This project also did not measure patient levels and organisational outcomes, which would have shown greater access to, and utilisation of, services. These included: changes in number of cases identified, managed, and referred at the PHC level; and the use of referral links and consultations (with trainers and providers of secondary mental health services). However, it should also be noted that this project had a longer term impact of leading to further funding of activities, opportunities for further evaluation, and impact on national policy. Furthermore, this article is describing a pilot process evaluation to guide programming, and IMC is currently planning to carry out a formal evaluation of its programme to evaluate patient levels and organisational outcomes.

Contributions to national policy and practice

From the start of the project, IMC has worked closely with governmental actors and other key stakeholders. In June 2010, a memorandum was drafted, with the collaboration of the LOP, with plans to take the first steps towards integrating mental health into the PHC on a national level. The memorandum delineates the responsibilities of LOP, such as: 1) provision of training space; 2) participation in reviewing and approving training material (in collaboration with IMC and the Lebanese Psychiatric Society), for the provision of CME credits; 3) facilitating provision of CME credits to trained PHC doctors; and 4) advocating for the establishment of a National Mental Health Policy to integrate mental health into the PHC. WHO and MOH have identified a consultant to carry out a national situation analysis on mental health, and produce a

strategy with a three year national mental health plan. The technical committee includes the local IMC mental health coordinator. Objectives of this strategy include establishing catchment areas for mental health services, GPs as gatekeepers, and a referral system between PHCs and secondary care. IMC has also been engaged in discussions with MOSA to review the national emergency plan currently pending approval at the ministry, and to include trained PHC workers within its first response framework. In this case, therefore, trained PHC staff would be able to provide first line mental healthcare during an emergency.

This project serves as one example of designing a mental health PHC integration curriculum and training, involving formative research, programme modifications, and close collaboration with the government and key stakeholders. Future activities will focus on providing continued refresher training, strengthening referral systems, and supporting integration of mental health at the PHC organisational level, with the goal of contributing to, and informing, national mental health practice and policy.

References

Bryan, R. L., Kreuter, M. W. & Brownson, R. C. (2009). Integrating adult learning principles into training for public health practice. *Health Promotion Practice, 10*, 557-563.

Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC.

International and International Organization for Migration (IOM) (2008). *Assessment on Psychosocial Needs of Iraqis Displaced in Jordan and Lebanon*. http://www.iom.int/jahia/webdav/shared/shared/mainsite/published_docs/brochures_and_info_sheets/report_psy_assessment.pdf.

Karam, E. G., Mneimneh, Z. N., Dimassi, H., Fayyad, J. A., Karam, A. N., Nasser, S. C., Chatterji, S. & Kessler, R. C. (2006). Prevalence and treatment of mental disorders in Lebanon: a national epidemiological survey. *Lancet, 367*, 1000-1006.

Lancet Global Mental Health Group (2007). Scale up services for mental disorders: a call for action. *Lancet, 370*, 1241-52.

Le Roch, K., Pons, E., Squire, J., Anthoine-Milhomme, J. & Colliou, Y. (2010). Two Psychosocial Assistance Approaches for Iraqi Urban Refugees in Jordan and Lebanon: Center-Based Services Compared to Community Outreach Services. *Journal of Muslim Mental Health, 5*, 99-119.

Patel, V. (2003). *Where there is no psychiatrist: A mental health care manual*. London, UK: Royal College of Psychiatrists.

United Nations High Commission for Refugees (UNHCR) (2010). *2010 UNHCR country operations profile – Lebanon*. UNHCR Planning Figures for Lebanon 2010/2011. Available at: http://www.unhcr.org/pages/49e486676.html Retrieved on 25 November 2010.

Weissman, M. N., Bland, R. C. & Canino, G. J. (1996). Cross-national epidemiology of major depression and bipolar disorder. *JAMA, 276*, 293-299.

World Health Organization (2008a). *Mental Health Gap Action Programme (mhGAP): Scaling up care for mental, neurological and substance use disorders*. WHO: Geneva.

World Health Organization/Wonca (2008b). *Integrating mental health into primary care* A global perspective Geneva: World Health Organization. World Health Organization. WHO-AIMS.

World Health Organization (2010). *Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP).* Geneva: World Health Organization.

[1] Akkar, Nabatiyeh, Baalbek, Beirut, Beqaa, Mount Lebanon, North Lebanon, South Lebanon.

Zeinab Hijazi, MA, is the Regional Mental Health Coordinator for International Medical Corps in the Middle East; she is finalising her International Masters in Mental Health Policy and Services. She supports country teams and provides guidance and oversight in the development and running of culturally appropriate mental health and psychosocial programmes.
email: zhijazi@InternationalMedicalCorps. org.
Inka Weissbecker, PhD, MPH, is the Global Mental Health and Psychosocial Advisor for International Medical Corps, she has a PhD in clinical psychology and an MPH in Global Health and Population studies. She provides technical support for programmes globally.
Rabih Chammay, MD Chammay is a psychiatrist. He teaches at the faculty of medicine at Saint Joseph University in Beirut and is currently the mental health Advisor for IMC in Lebanon, a regional consultant for the Rehabilitation and Research Center for Torture Victims (RCT) and a consultant for WHO, mainly in developing and delivering training from the Mental Health Gap Action Programme (mhGAP-IG) and in drafting a national mental health strategy for Lebanon.