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UTILIZATION OF MENTAL HEALTH SERVICES IN LEBANON: PATTERNS, BARRIERS AND UNMET NEEDS

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ABSTRACT

Introduction: Despite the availability and effectiveness of psychotropic medications, people living with mental disorders do not seek help or discontinue treatment. **Objectives**: To identify the rate of unmet needs, patterns and barriers to seeking care and their relationship to selected socio-demographic characteristics among people experienced mental disorders in the past 12 months. **Method**: A secondary data analysis based on Lebanese Evaluation for Burden of Ailment and need of Nation study (L.E.B.A.N.O.N). **Results**: Out of 1031 respondents, 322 (17.9%) were diagnosed with at least one mental disorder in the last year. Of whom, 281 participants did not seek treatment which indicated that unmet needs to seek care was more than 90%. Three types of barriers were assessed, namely: low perceived need, attitudinal and structural barriers. Participants with severe mental disorders were less likely to perceive low need for care compared to those with mild disorder (OR=0.15; CI: 0.02-0.93; P=0.04). **Conclusion**: The study recommended integration of mental health within the general medical care, training of family doctors and general practitioners on early detection and referral of mental problems and further research on mental health services utilization and unmet needs to seek care in order to keep monitoring any progress achieved in terms of rate of treatment and mental health literacy.

KEYWORDS: Utilization, Patterns, Barriers, Unmet Needs**,** Mental Health Services.

INTRODUCTION

Mental disorders are widespread, causing considerable morbidity and disability. Despite documented effectiveness of treatment, a high proportion of people do not receive care or drop out of treatment.[1] The proportion of people living with the mental disorders that used mental health services in the last 12 months was 2% in Nigeria and 18% in the United States.[2] Likewise, the prevalence of mental health services use in Canada was 9.5%.[3]

Like many other Arab countries, Lebanon does not have a national policy on mental health although the number of mental health professionals in Lebanon exceeded that of other Middle East countries. For example, there are 60 psychiatrists and 100 psychologists per 4 million population, and 274 general practitioners per 100000 populations.[4] On the other hand, the majority of psychiatrists work in private mental health centers. Meanwhile, 75% of other mental health professionals such as psychologists, social workers and nurses, work in public mental health facilities.[5]

Unmet need can be defined as the difference between the number of people with mental disorders and the number of people who seek care. Unmet needs can be resulted from many reasons. Of these, severity of the disease, lack of knowledge about the effectiveness of psychiatric treatment and social stigma which are in turn leading to underutilization of mental health services.[6] Attitudes and beliefs are also associated with use of services.[3] The magnitude of utilization of mental health services is a reflection of barriers that prevent people from seeking help. Therefore, assessing the levels of utilization and barriers to seeking care is an issue of great importance to the public health practice.[7] The interrelation of self-rated health, perceived need for health services, personal practices, the health care system and the physical environment can also lead to the utilization of health services.[8]

Unmet needs for mental health services are common in the developing countries.[2] Therefore, addressing unmet needs requires diligent research and efforts to capture all aspects of the problem and eventually improve accessibility and availability of services. The specific objectives of the current research are to assess patterns of utilization of mental health services (MHS) in the past 12 months specifically proportion that used MHS, identify barriers to seeking care for mental disorders and examine the relationship between barriers and selected socio-demographic characteristics, as well as severity of disorders and self-rated mental health.

METHODS

A secondary data analysis based on Lebanese Evaluation for Burden of Ailment and need of Nation study (L.E.B.A.N.O.N), which was a nationally representative study conducted in 2002-2003 to assess the burden of mental disorders and the utilization of mental health services. The current study was carried out at the Institute for Development, Research, Advocacy and Applied care (IDRAAC) in Beirut, Lebanon from June to December 2013. IDRAAC is a non-governmental and non-profit organization that was established by a group of Lebanese experts in the field of mental health in 1997 in response to the paucity of data on mental disorders in Lebanon and lack of assessment tools to assess the burden of these mental problems.

The main objective of this study was to assess the burden of mental disorders in Lebanon in terms of the prevalence, use of mental health services and exposure to war-related traumatic events. Interviews were done face-to-face in two phases. Phase I included a core diagnostic assessment of all respondents (n=2857). Phase II included an assessment of correlates of disorders. The Phase II interview was done for all Phase I respondents who met lifetime criteria for any mental disorder plus a probability sub-sample of other respondents (n=1031).

The CIDI (Composite International Diagnostic Interview), version 3.0 and DSM-IV (Diagnostic and Statistical Manual-version IV) were used to identify people with mental disorders in the past 12 months; specifically anxiety, mood, impulse, substance use and others. The CIDI is one of the epidemiological instruments used to screen and assess mental disorders. It is used within the World Mental Health Surveys Initiative and has been adopted by the World Health Organization (WHO). It is a structured interview that is designed to diagnose mental disorders in conjunction with the DSM-IV. All participants were asked about use of Mental Health Services (MHS). A list of treatment providers, including both traditional healers and medicine professionals, was presented. Follow-up questions were asked about most recent treatment. Reports of 12 month treatment were classified into three categories: mental-health specialist (psychiatrist, psychologist, and other mental-health professional), general medical (general medical doctor, nurse, other health professional not in a mental-health setting) and non-healthcare (religious or spiritual adviser, herbalists, fortuneteller, or counselor not in a mental-health setting). Unmet need was measured by the proportion who did not seek care when they have mental disorders.

Three types of barriers were assessed: low perceived need, attitudinal barriers and structural barriers. Out of those who had mental problems, respondents who reported no use of mental health services were asked whether there was a time in the past 12 months when they felt they might have needed to see a professional for problems with their emotions, nerves or mental health. Those who did not think they needed help or thought they needed help for less than 4 weeks were coded as '**low perceived need**'. Those with '**perceived need'** were then asked about attitudinal and structural barriers. The attitudinal barriers included patient's perceptions like wanting to handle the problem on his/her own; thinking that the problem would get better by itself, having old experiences with ineffective treatment and stigma. The Structural barriers included financial reasons, availability of services, transportation or difficulties of getting an appointment. Independent variables that may be associated with the barriers of interest were selected based on results of previous studies, and their availability in the L.E.B.A.N.O.N study. The Covariates were.

- **Age:** categorized as respondents were less than 50 years OR greater than 50 years old; based on the distribution of the original categories which were categorized into 4 categories; (18-34, 35-49, 50-64 and 65+).

- **Gender:** Male OR Female.

- **Education:** grouped into low educational level(no education, primary or some secondary) or high educational level (secondary , some university or university completed).

- **Income:** Low (low and low average) OR High (high and high average).

The family income divided by the number of family member to get the income per family member. The mean was taken as a cutoff point to categorize the income as follows:
Low if it was less than half of the mean
Low average if it was from half to the whole mean
High average if it was twice the mean
High if it was more than twice the mean.

- **Self-rated mental health**

Positive for participants rated their mental health as (excellent, very good and good) OR Negative for those rated their mental health as (medium and weak).

• **Severity of the 12-month mental disorder:** Severe OR Moderate OR Mild. Cases were classified by the original investigator as follows; severe if they were diagnosed with bipolar I disorder or substance dependence with suicide attempt in the last 12 months. Other cases classified as moderate if they have substance dependence without suicidal attempt. The remaining cases were classified as mild.

Statistical Analysis Software (SAS) and Special Package for Social Sciences (SPSS) Version 18 were used to analyze data. The next step was running univariate analyses to check on variability and decide on bracketing. Unadjusted logistic model was created to include all independent variables that are mentioned beforehand. Unadjusted and adjusted odds ratios of perceived low need and their 95% confidence intervals were calculated for each independent variable. All unadjusted odds ratios with a p value ≤ 0.2 were included in the final logistic model in which the significance level of 0.05 was considered.

Since questions on attitudinal barriers and structural barriers were applicable to only small number of participants (26 and 13 respondents), only frequency distribution table and bar chart on the distribution of the top three barriers presented.

RESULTS

Out of 1031 (427 males and 604 females) participants, 322 (101 males and 221 females) experienced at least one mental disorder in the last 12 month; specifically, they had anxiety (12.1%), mood (6.9%), impulse (1.7) disorder or substance abuse/dependence (1.3%). Descriptive data are shown in (Table-1).

Out of 322 participants who reported mental health problems in the last year, only 41 (9.3%) contacted any of these professionals which indicated that the unmet need to seek mental health care was about (90.7%), (Figure-1). On the other hand, considering the patterns of mental health services utilization in terms of any health professionals consulted; figure-2 presents proportions that contacted mental, general health professionals or non-health professionals (religious or spiritual leaders) as follows: 22%, 61% and 17% respectively.

As mentioned earlier, the number of participants who answered questions on attitudinal barriers and structural barriers were 26 and 13 respectively. The participants, who reported attitudinal barriers were mostly below 50 years, female, low income, negatively rated their mental health and had severe mental disorder (Table-2). On the other hand, the participants

who reported structural barriers were less than 50 years old, female, low educational level, low income, negatively self-rated their mental health and had severe mental illness (Table-3).

Table-4 presents unadjusted and adjusted odds ratios of low perceived need by selected socio-demographics [age, gender, education, income, self-rated mental health and need variable (severity of mental problem)]. At the univariate level, old age females who negatively rated their mental health and had severe mental problems were significantly related to low perceived need. In the multivariate model, only severity of mental disorder was significantly related to the low perceived need, whereas having a severe mental illness increase the odds of low perceived need by 0.15 times as compared to those with mild disorder (OR=0.15; 95% CI: 0.02-0.93; P=0.04).

Table. 1: Mental-disorder specific prevalence in the last 12 months.

12-month mental disorders							
		Anxiety	Mood	Impulse	substance	Any disorder	
Gender	**Total**	**N (%)**	**N (%)**	**N (%)**	**N (%)**	**Total**	**N (%)**
Male	427	44(4.71)	55(5.4)	18(1.8)	7(2.1)	419	101(11.4)
Female	604	154(19.4)	118(8.5)	18(1.8)	5(0.59)	598	221(24.3)
Total	1031	198(12.13)	173(6.9)	36(1.7)	12(1.34)	1017	322(17.9)

Table. 2: Frequencies and percentages of participants who reported attitudinal barriers in relation to selected covariates (n=26).

Variables	Attitudinal barrier	
	Total	**N (%)**
Age		
<50 years	208	24(11.5)
>50 years	73	2(2.7)
Gender		
Male	89	2(2.3)
Female	192	24(12.5)
Education		
Low	170	12(7.1)
High	111	14(12.6)
Income		
Low	163	17(10.4)
High	118	9(7.6)
Self-rated mental health		
Positive	161	12(7.5)
Negative	120	14(11.7)
Severity of mental disorder		
Severe	75	14(18.7)
Moderate	125	7(5.6)
Mild	81	5(6.2)

Table. 3: Frequencies and percentages of participants who reported structural barriers in relation to selected covariates (n=13).

Variables	Structural barrier	
	Total	N (%)
Age		
<50 years	208	12(5.8)
>50 years	73	1 (1.4)
Gender		
Male	89	1 (1.12)
Female	192	12(6.25)
Education		
Low	170	7(4.12)
High	111	6(5.4)
Income		
Low	163	8(4.9)
High	118	5(4.3)
Self-rated mental health		
Positive	161	5(3.1)
Negative	120	8(6.7)
Severity of mental disorder		
Severe	75	7(9.3)
Moderate	125	5(4.00)
Mild	81	1(1.23)

Table. 4: Frequencies, percentages, univariate and multivariate analysis of low perceived need to selected covariates.

			Simple logistic regression			Multiple logistic regression		
			Low perceived need			Low perceived need		
Variables	**Total**	**N(%)**	**OR**	**CI**	**P**	**OR**	**CI**	**P**
Age								
<50 years	**208**	**187(91.7)**	**1**			**1**		
>50 years	**73**	**69(96.41)**	**4.6**	**1.92-11.1**	**0.0006**	**2.18**	**0.76-6.26**	**0.15**
Gender								
Male	**89**	**85(94.9)**	**1**			**1**		
Female	**192**	**171(91.3)**	**0.23**	**0.09-0.61**	**0.003**	**0.5**	**0.17-1.47**	**0.21**
Education								
Low	**170**	**156(92.3)**	**1**					
High	**111**	**100(92.7)**	**0.96**	**0.41-2.25**	**0.93**			
Income								
Low	**163**	**148(94.01)**	**1**					
High	**118**	**108(90.5)**	**0.76**	**0.31-1.88**	**0.56**			
Self-rated mental health								
Positive	**161**	**152(94.3)**	**1**					
Negative	**120**	**104(88.14)**	**0.22**	**0.08-0.59**	**0.003**			
Severity of mental disorder								
severe	**75**	**61(79.6)**	**0.14**	**0.02-1.0**	**0.02**	**0.15**	**0.02-0.93**	**0.01**
Moderate	**125**	**117(95.1)**	**0.73**	**0.12-4.3**	**0.33**	**0.73**	**0.12-4.4**	**0.34**
Mild	**81**	**78(96.4)**	**1**		**0.05****	**1**		**0.04****
	****/P-value of the variable (severity of mental problem)**							

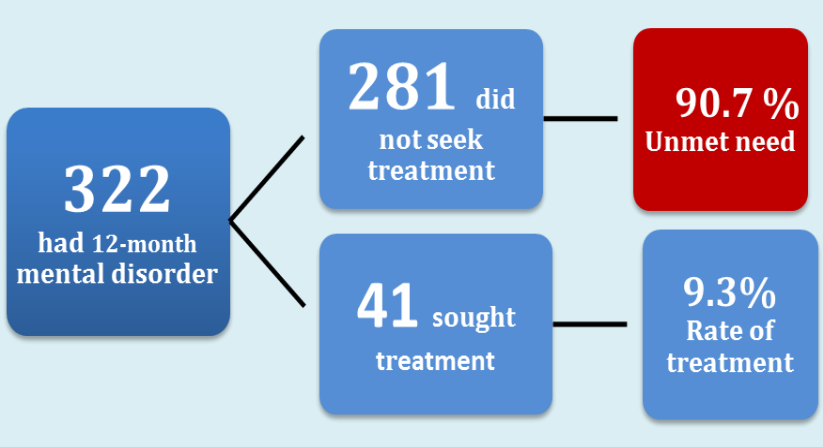

Figure. 1: Rates of treatment and unmet needs among the study population (n=322).

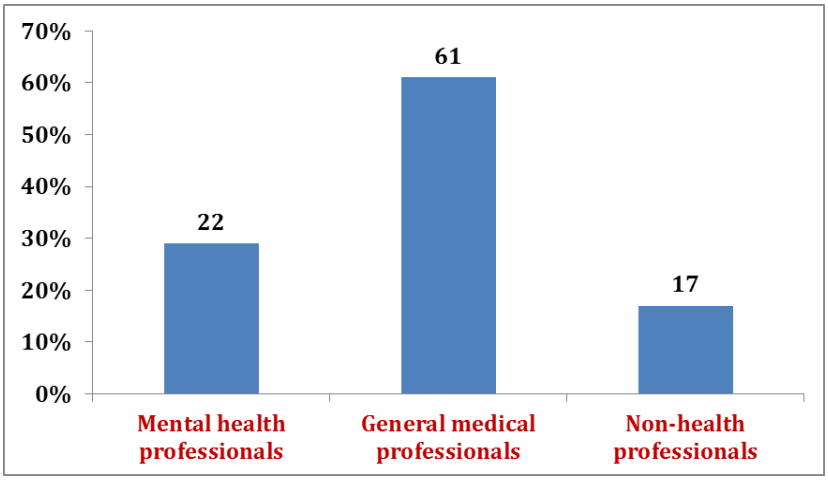

Figure. 2: Percentages of any health professionals contacted by the participants in the last 12 months.

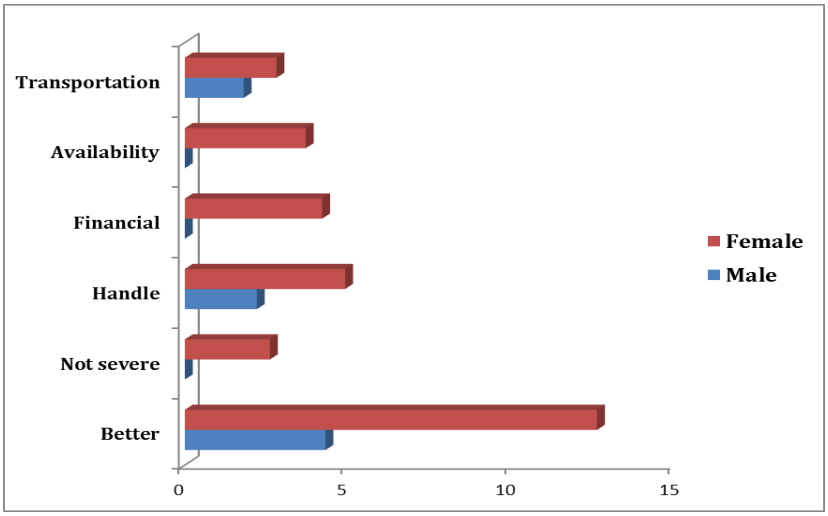

Figure. 3: Percentages of top three attitudinal and structural barriers reported by participants, by gender.

Barriers to mental health services utilization according to the CIDI questions

Handle: Respondents wanted to handle the problem on their own

Not severe: Respondents thought that the problem was not severe

Better: Respondents thought the problem would get better by its own

Financial: Respondents were worried about the cost of treatment

Availability: Respondents did not know where to go OR whom to visit

Transportation: Respondents had problems of transportation, child care or getting Appointment which in turn limited their access to treatment.

DISCUSSION

The current study showed that the rate of unmet needs to mental health services in Lebanon was 90.7% which can be attributed to the social stigmatization and lack of mental health literacy. Individuals who do not recognize need for health services; do not use them. As a result, only small proportion of people who need mental health services tend to use services which indicates that perceived need is a necessary factor, but not sufficient for seeking care. It was estimated that 3.1% of the adult population of the western European Union has unmet need for mental health services.[8] Also, Other national surveys in Australia, Europe and the United States revealed that 12% to 30% of the population had met criteria of a mental disorder in the past 12 months. These surveys indicated that 65% to 80% of people with a diagnosed mental disorder were not receiving any mental health help.[9] Moreover, Asian countries less frequently use treatment for mental illnesses. For example, Japan has a high rate of suicide worldwide, 75% of those who completed suicide did not take any psychiatric medications one year before the suicidal attempt.[6]

With regard to the patterns of mental health services utilization in terms of any health professionals consulted; the study revealed that proportions of people who contacted mental, general health professionals or non-health professionals (religious or spiritual leaders) as follows: 22%, 61% and 17% respectively. On the other hand, it is worthy to note that a national study in Lebanon found that 308 (17%) of respondents met the characteristics of at least one mental disorder in the last 12 months. Of whom, 47 (10.9%) participants sought health care. Out of which, the majority (85%) consulted the general practitioner and mental health care professionals.[10]

The current study found that the main factor for not seeking care was that the mental problem will be better by itself in the short run or it can be handled by their own as reported by most

people (24%) who are not seeking care for their mental disorders (Figure-3). Whereas, a survey was done in Canada in 2002 to identify the most common factors of not seeking care as reported by people with mental disorders; 72% of those not using the mental health services believed that the problem will be better by itself or it can be handled by their own.(3) In addition, the data collected in 24 countries from the World Health Organization (WHO) and the World Mental Health Initiative (WMHI), low perceived need and attitudinal barriers were the most common barriers for seeking mental health care. Also, attitudinal barriers were more important than structural barriers for starting and maintaining treatment. Of these attitudinal barriers, intent to handle the problem on one's own was the most reported by the participants.[1]

The main limitations of the current study are the CIDI; version 3.0 has not been validated yet in Lebanon. However, the Arabic version of CIDI was translated from the original English using five-step process, forward and backward translation, resolution, pilot testing and final revision.[10] Therefore, the lack of validation of the CIDI can be considered one of the limitations which in turn affect the reliability and validity of the study. Moreover, this study was basically a secondary data analysis; therefore, it was not feasible to include variables that might have a substantial effect on utilization of mental health services in Lebanon such as health insurance. Furthermore, the data was collected through face to face interview. As a result, the possibility of recall bias represents one of the limitations because data collection was based on self-reporting.

CONCLUSION

One of the most important lessons learned from this study was, mental health services in Lebanon are underutilized and there is a high rate (90.7%) of unmet needs to seek help. Moreover, the majority (61%) sought care at the general medical care facilities. Therefore, integration of mental health care within the general medical care will enhance early detection of mental illnesses. Besides, training of family doctors on early detection and referral of individuals with mental illnesses is of great importance and supports the integration of mental health services. Furthermore, severity of mental disorder was the only determinant of mental health services use. Hence, Further research on mental health services utilization and unmet needs to seek care in order to keep monitoring any progress achieved in terms of rate of treatment and mental health literacy.

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