Executive Summary

Evidence from the behavioural sciences is increasingly used to inform and improve policy around the world across many domains. These behavioural insights can be used for a number of purposes, such as improving communication to the public, encouraging healthier behaviour, and increasing the uptake of social services that improve life outcomes. However, not all evidence can be equally applied to any policy; the strength of the evidence and suitability for the situation at hand should be assessed case by case and ideally more evidence within the new context should be established. This report presents an approach to incorporating behavioural insights into policy using a number of examples while leveraging original work on mental health, trust, and decision-making in Lebanon. The aim is not to present a specific recipe or set of recommendations, but to share general concepts and examples for consideration in establishing a behavioural policy framework.

This report complements our workshop on evidence-based policy and provides basic information to participants in advance.

This publication is funded through the UK Research and Innovation GCRF Research for Health in Conflict (R4HCMENA); developing capability, partnerships and research in the Middle and North Africa ES/P010962/1.

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Introduction

What are behavioural insights?
The success of a policy largely depends on the assumptions it is built on. This includes tailoring a policy to the environment where it is applied as well as anticipating how the target population will react to it. While policies for decades relied on economic models assuming that people think rationally and want to maximize their outcomes, research from behavioural and decision sciences has shown that decisions are dependent on a number of internal motivators and external factors. Accounting for such factors based on reliable evidence can therefore improve policy outcomes and acceptance.

What are the advantages of behavioural insights?
Behavioural policy is typically implemented through small changes in the environment (see next page) with positive effects and without coercion (‘nudging’). For example, having found that surgeons are often under stress and can forget minor but crucial checks, the WHO developed a checklist that was associated with an error reduction from 23% to 6%\(^1\). Instead of assuming that people will behave in a fully rational and error-free way, by incorporating behavioural insights, we can account for actual behaviour.

Why build on behavioural insights in Lebanon?
For this report, we will predominantly focus on the interplay of behaviour and health: The behaviours and habits of non-clinical populations may increase or decrease the risk of subsequent health problems. This includes habits relating to diet, exercise, smoking, driving, and more. At the point of service delivery, doctors make decisions relating to diagnoses and treatment, patients make decisions with regards to when to seek aid, whether to keep appointments, whether to follow the doctor’s prescriptions, etc. Therefore, behavioural science can be used to inform proactive interventions, designed to increase the overall health of the population and reduce pressure on healthcare providers as well as set up interventions that makes the service delivery itself more efficient and effective. This report aims to provide guidance on translating behavioural and mental health research into policy, building on a practice previously successful in Lebanon\(^2\).
Common behavioural interventions

Choice architecture

We face numerous decisions every day. Some of these decisions may be conscious and deliberate (such as buying a car), while others are less thought out, such as selecting a beverage for lunch, or deciding on which side of the road to walk. Choice architecture is a way of designing the environment in which decisions are made in a way that the more beneficial option is more likely to be chosen. As a result, we ideally make more directly beneficial decisions – for ourselves or for society – without giving away our freedom of choice. Two common ways to do this are nudges and boosts.

Nudges

Nudges are low-cost, easy-to-implement interventions that alter the environment of a decision in a way that highlights a more beneficial option\(^3\).

If the goal was to have people eat healthier, one example of a nudge would be placing healthy food options more visibly or salient. This preserves a person’s free choice of meal, but still increases the number of people who choose healthy nutrition.

Boosts

Boosts aim to foster a decision-makers competence or build new competence regarding the choice at hand, often by encouraging a more informed, deliberate process\(^4\).

Boosts can involve simple tools such as calculators for determining budget allocations or interactive apps from grocery stores that help consumers estimate health value of their choices as they shop.
Consider what influences decisions

In classic economic models, humans are assumed to always act rationally and gain-oriented – that is, choosing to their highest benefit. This is often the case in decisions with certainty, where the outcome is clear: we would prefer $120 over $100 if given the choice. When it comes to decisions under risk, humans do not always choose the option with the highest potential value – this is because gains and losses are not perceived equally. In other words: the prospect of losing $100 often appears more dangerous than the prospect of winning $100 seems appealing. This is not only limited to decisions regarding money.

Based on an individual’s reference point, they may make different decisions, which is why framing a message or situation is important to consider: telling a patient that 90% of people survive an operation is much more comforting than being told that there is a 10% chance to die.

Communicating effectively

Not only the reference point is important when communicating with the public: People engage with information more if it is salient and simple. One large-scale study showed that letters simplifying their content, or using short bullet points receive more responses, than a standard text.

Simply not being aware of available public services is a crucial structural barrier to the uptake of healthcare services. Evidence suggests large differences in education between the Lebanese population and refugees, and also the generally low healthcare service uptake of Syrian refugees:

These findings alone may not give clear indications for policy but indicate that further testing of simplifying messages may reveal how uptake could be increased through small changes in communication.
Only 6% of Lebanese adolescents affected by mental disorders report to have sought help\textsuperscript{10}. Social stigma is a common barrier for people all over the world to access mental health services\textsuperscript{11}. Behavioural insights can be used to support people in their choice to seek help. One example of engaging people affected by a stigma-heavy disorder is the successful use of financial incentives for HIV testing in Malawi. Participants collected test results more often when given a small financial incentive\textsuperscript{12}.

### Reducing mental health stigma

Mental health literacy has been identified as one of the crucial aspects in reducing barriers to mental healthcare\textsuperscript{11}. While reducing stigma on a wider level is a complex and complicated task, it can be achieved through education, as well as through contact with stigmatized groups\textsuperscript{13,14}.

**Education**

Replacing stereotypes with facts

**Contact**

Interacting with members of stigmatized groups

Face-to-face contact has larger impact than by video.

Adapted from Bojanić et al. (2016)
Providing patients an active role in their treatment

**Trust** plays a large role in the decision to start treatment and choosing a physician or provider.

Lebanese and refugees report very low trust towards others but put much higher trust in family members\(^8\), which may also explain some successes of former Syrian healthcare workers in refugee camps\(^{15}\). More and more patients prefer to make active decisions in their own healthcare\(^{16}\). Evidence also indicates that patient involvement is often related to an increase in trust into the healthcare system\(^{17}\).

**Potential benefits of involving patients in decision-making**

- **10%** Higher completion rates\(^ {18}\)
- **17%** Higher life satisfaction\(^ {18}\)
- **58%** Chance to show higher improvement\(^ {19}\)
Despite knowing about many health outcomes, people often neglect simple beneficial behaviours such as taking their medication as scheduled or showing up to healthcare appointments.

Brief text-message **reminder messages** can improve various kinds of health behaviours, such as medicine adherence\(^20\) or support smokers in quitting\(^21\).

**E-Mental Health interventions**

The use of digital applications in mental healthcare remove the barrier of requiring patients to be physically present at a care facility or provider. This has been particularly helpful since the start of the COVID-19 pandemic\(^22\). However, clear ethical guidelines are still missing.

Preliminary results exist regarding one WHO guided **E-Mental health intervention in Lebanon**\(^23\). The intervention is a brief self-help programme with minimal guidance.

While the intervention shows potential effects on depression and anxiety, the study also found that it needs to be better tailored to younger people and singles, made more motivating, and easier to use.

- **High satisfaction as well as positive attitudes towards apps among refugees and immigrants**\(^22\)
- **Symptoms improve in...**
  - Anxiety
  - Depression
  - Post-Traumatic Stress Disorder

However...

- **Poor implementation and reporting of ethical standards so far**
Behavioral insights and mental health in Lebanon

Exploring traits of the population

When using evidence to inform policy, it is always crucial to remember that populations often differ from another. It is reasonable to assume that refugees—who have left their homes and are more likely to have recently gone through other traumatic events—feel and behave differently from the average population of the host country. If the goal is to develop inclusive policies, a first step could be to capture and compare levels of well-being.

Well-being in Lebanese nationals and refugees

Researchers tried to find out how strongly refugee well-being may differ from local populations. Surprisingly, there were no significant differences in any dimension in a sample of over 600 people in Lebanon.8

Can policy be derived from these findings alone?

Will refugees with low or high well-being behave like Lebanese with low or high mental health?
The role of mental health in risk-taking: Example from Lebanon

Lebanese

No differences in risk-taking on average

While both are in a very different situation, researchers found that refugees in Lebanon make about the same amount of risky financial decisions as the general population. Both groups take more risk when choices involve losses.

Does mental health play a role in decision-making?

If well-being is...

Data shows...

Poor to moderate

Lebanese and Refugees make similar decisions

High

Refugees make more risky choices

How could we encourage more risky decisions, when they are beneficial, especially in those with poor mental health?

What are the reasons for poor/good mental health?

Which other factors need to be taken into account?

Where are risky choices beneficial or suboptimal?

When do we need other measures of risk?

Findings reported on this and the previous page are based on research by the authors, currently under review.
Developing policies using scientific evidence

A process model generating and incorporating evidence into policy

What is the issue?
- Define target **population & outcome** for improvement
- Can be **proactive** to create opportunity, **prevent** unwanted situation, or **treatment** for persisting issue

How useful is the available evidence?
- **Quality**, **accuracy**, and **objectivity** of evidence
- **Credibility**: Is there a clear argument for the use of methods and conclusions drawn?
- **Practicality**: Is the evidence accessible and interventions feasible to implement?

Is the evidence valid in context?
- **Relevance**: Can it be generalised?
- Is evidence appropriate for this population & context?

Conduct research in context
- Clarify and operationalise research goals
- Adapt methods to context
- Identify factors that distinguish the situation at hand from those previous research has been conducted in

Intervention
- **Scaling**: Moving from controlled projects to wider implementation
- **Phasing**: Breaking down implementation in stages
- **Sensing**: Evaluating the practice

This process is based on information compiled in Ruggeri et al. (2019)
References


