Mental Health and Psychosocial Support Services (MHPSS) for Syrian Refugees in Lebanon: Towards a Public Health Approach Beyond Diagnostic Categories

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Abstract

Following the massive influx to Lebanon of Syrians fleeing armed conflict, the UNHCR and various NGOs, in collaboration with the Ministry of Public Health (MoPH), are providing Mental Health and Psychosocial Support Services (MHPSS) for Syrian refugees. However little is known about the functioning of these services and their implications in terms of defining the experience of suffering of refugees. **Methods**: we conducted a study of MHPSS services based on a review of documents published by UNHCR, MoPH, and relevant NGOs, as well as the analysis of the discourse of health care professionals/policymakers. 60 semi-structured interviews were conducted with informants from various organizations. The questions focused on their experience with the services, the main challenges encountered and their perceptions of the Syrian refugees and their problems. The list of organizations was taken from a service mapping by the MoPh. **Findings**: MHPSS interventions in Lebanon endorse the Inter Agency Standing Committee Guidelines that prioritize community-based interventions. Yet, in practice they promote individual-focused, clinical and short-term interventions rather than long term ones. Health care professionals perceive Syrian refugees as lacking awareness on mental health disorders and needing education in this regard; but most of them lack knowledge about the Syrians' patterns of social strengths and weaknesses and their perceived needs in terms of mental health. **Conclusion**: Based on our findings, we reflect on the relevance of "evidence-based" interventions in this particular setting and suggest recommendations for sustainable and culturally sensitive mental health interventions.

Keywords: Syrian refugees, mental health, psychosocial support

Introduction

Since the beginning of the Syrian war, Lebanon has hosted more than one million Syrian displaced who have fled violence and armed conflict, according to the last official estimations of the United Nations High Commissioner for Refugees (UNHCR, 2017). In this context, the UNHCR, and various NGOs, in collaboration with the Lebanese Ministry of Public Health (MoPH), are providing Mental Health and Psychosocial Support Services (MHPSS) for Syrian refugees in Lebanon. Since humanitarian actors deal with refugees' suffering as a medical and psychological problem (Summerfield, 1999), few studies are dedicated to understand its social dimension. Hence little is known about how Syrian refugees perceive mental health services or more generally about the implications of these services in terms of defining and shaping their experience of suffering. A recent literature review led by the UNHCR aimed at informing on cultural specificities and idioms of distress of the Syrian community. However, the report ends by recommendations to improve screening of mental health disorders through the mental health Gap[91](MhGap), thus emphasizing the medical and diagnostic approach within MHPSS interventions (Hassan et al, 2015). Other studies on mental health among Syrian refugees are mostly epidemiologic studies and explore rates of psychiatric diagnosis, especially post-traumatic stress disorder (PTSD) and depression (Kazour, 2017; Karam, 2016; Naja, 2016). The various authors report a high prevalence of psychiatric disorders. These results should however be interpreted with caution as the diagnostic tools used in those studies are not validated in the Syrian context. Moreover, by emphasizing symptoms rather than the individual and collective experience of suffering, the struggle of refugees is reduced to a list of symptoms out of their context. Besides, in a recent special issue of the British Journal of Psychiatry, various authors insist on the importance of training fieldworkers on the psychiatric diagnosis by the MhGap, because of the increase of psychiatric disorders following war and displacement, with the underlying assumption that all refugees fall under the same psychological category. (Karam, 2016 ; AbouSaleh, 2016)

This tendency to medicalize the effects of war on communities by promoting an individual clinical approach rather than a public health community one has raised various critics among scholars. It was often

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[91] The Mental Health Gap is a tool elaborated by the World Health Organization (WHO), designed for primary health care professionals, to screen, diagnose and treat mental health conditions, according to *"evidence-based"* interventions (WHO, 2016), and promoted in low and middle-income countries. Critics of the MhGap have noted that it implies a universalizing process in the treatment of mental health conditions, without always taking into account the context in which those interventions are applied and implemented (Bemme, 2012)

criticized as being disempowering for refugees, giving them the sick role, while pathologizing ordinary human suffering and eradicating the socio-historical context in which this suffering takes place. (Mallki, 1996; Summerfield, 1999 ; Fassin et Retchaman, 2011). In an attempt to address these contradictory data and theories, the Inter Agency Standing Committee (IASC)[92] developed Guidelines for MHPSS services in war and crisis settings. Experts agreed that exposure to distress is a risk factor for social and mental health problems, but there was no agreement on the public health value of diagnosing and treating PTSD (IASC, 2007). They recommended that 1st line psychosocial interventions should be community-targeted: covering basic needs, providing safety, organizing social networks – religious, political, cultural – that re-establish systems of meaning and cohesion. These community-based interventions were viewed as a priority over specialized individual-focused interventions (psychotherapy and/or psychiatry consultations). The Guidelines coined the term "*mental health problems*" instead of "*disorders*" (IASC 2007), mitigating the assumption according to which refugees are considered as being systematically at risk of developing psychiatric disorders. In Lebanon, official published documents by UNHCR (2013) and MoPH (2015) on MHPSS services endorse the IASC guidelines but there is no data available on the services' functioning. In order to fill this gap, we have conducted an in-depth study of MHPSS services based on a review of key documents and the analysis of the discourse of health care professionals and policymakers.

Methodology

Data collection was gathered over the course of eight months (March-October 2016). All official publications on MHPSS services by UNHCR, MOPH, and relevant NGOs on the field were reviewed. We contacted NGOs providing specialized MHPSS services for Syrian refugees (psychiatry and psychotherapy consultations). The list of NGOs was taken from a service mapping published by the Ministry of Public Health (MoPh, 2015). All NGOs contacted (ten in total) accepted that we interview staff and/or mental health program coordinators. We did 60 semi-structured interviews with informants from different organizations, governmental and non governmental, local and international: program coordinators, at the regional and national level, service providers (psychologists, psychiatrists, social workers), representatives from UNHCR, Ministry of Social Affairs and

[92] The Inter-Agency Standing Committee (IASC) is the primary mechanism for inter-agency coordination of humanitarian assistance. It is a unique forum involving the key UN and non-UN humanitarian partners. The IASC was established in June 1992 in response to United Nations General Assembly Resolution 46/182 on the strengthening of humanitarian assistance.

Ministry of Public Health. The semi-structured interviews focused on their experience with the services, the main challenges encountered and their perceptions of the Syrian refugees and their problems. An approval was obtained from the ethics committee of Saint-Joseph University. A verbal consent was obtained from all participants; data was anonymous and confidential. The following findings are the result of the analysis of the informants' interviews as well as the analysis of key documents published on the subject (UNHCR, 2013; MoPH, 2015).

Findings

1) Organization of the MHPSS services: gaps between recommendations and practice

In response to the massive influx of Syrian refugees to Lebanon, the Lebanese Ministry of Public Health (MoPH), in partnership with the WHO and the United Nations Children's fund (UNICEF), established a Mental Health and Psychosocial Support task force (MHPSS-TF). Its aim is to "*coordinate the work of more than 62 mental health and psychosocial support staff actors working within the Syrian crisis response in Lebanon through a common annual action plan for all*." (Karam, 2016). Two recurrent aspects of the MHPSS-TF can be drawn from the discourse of key informants (professionals/policymakers): the emphasis on evidence-based interventions and the gap between IASC recommendations and MHPSS-TF goals and practices. The latter seem to be very oriented towards the medical aspect of suffering. As described by an MHPSS-TF representative:

" The MHPSS-TF aims at implementing cost-effective and evidence-based strategic mental health interventions, like integration of mental health care into primary health care using the WHO MhGap action program in primary care centers, training of trainers on Inter-Personal Therapy[93], with the aim of scaling it up to all professionals working in the humanitarian response, agreeing on a set of mental health and psychosocial indicators for all actors to report.

Q: Why did you choose IPT?

A: Actually, it could have been IPT or Trauma-Focused Cognitive Behavioral Therapy, because these interventions have proven to be effective in the refugee settings, but we chose IPT because we found it more convenient for refugees, it focuses more on daily life. Our aim is to promote

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[93] Interpersonal psychotherapy (IPT) is a brief, attachment-focused psychotherapy that centers on resolving interpersonal problems and symptomatic recovery. It is an empirically supported treatment that follows a highly structured and time-limited approach and is intended to be completed within 12–16 weeks. However, in the particular context of Syrian refugees, stressors are ongoing and chronic and short-term technical solutions might not apply to this context.

evidence-based interventions and randomized controlled trials have proven the efficiency of these interventions.
Q: How is IPT evidence-based in the Syrian context?
A: Not specifically in the Syrian context but there was a study of IPT in Uganda with refugees and it was validated and proven effective (Bolton, 2003)." [94]

The promotion of evidence-based interventions is emphasized as the main aspect of the MHPSS-TF. There seems to be an assumption that an intervention studied in Uganda can be transposed to the Syrian refugees context and be effective, as if all refugees had the same psychological condition. What is the meaning of evidence based medicine in this setting? By assuming that a certain model of therapy can generate a universally valid knowledge base, and retaining Western psychiatric categories as the basic framework for understanding human suffering, this type of interventions is questionable as it fails the "*fundamental test of scientific validity*" (Summerfield, 2008). As stated by Summerfield, validity is *" a concept meant to assess the nature of reality for the people being studied*". This very nature of reality of the people with whom we are intervening is bound up with local forms of knowledge systems that were not explored prior to implementing the evidence-based interventions. This might ultimately depoliticize the Syrian refugee subject, rendering him similar to all refugees, and eliminating social and political history as majors determinants of health and mental health. Moreover, IPT is designed to be a short-term intervention while the Syrian refugees crisis has become a chronic one, calling for long-term sustainable interventions.

Moreover, all program directors that we interviewed, as well as the head of the MHPSS TF, and the UNHCR representative, confirmed they followed the IASC model of interventions (2007), which is the one "*internationally recommended in the context of humanitarian crisis*"[95]. Yet, inconsistencies were noted between IASC recommendations on one hand, and the action plan of the MHPSS-TF on the other hand. According to the IASC pyramid, MHPSS services must be directed in priority to community and family interventions (level 1 and 2), before referral to individual psychosocial support (Level 3) or specialized consultations of psychiatry and psychotherapy (level 4). The different levels of the pyramid are as follow:

Level 1: Community-focused: basic needs, safety and security

Level 2: Community-focused: Strengthening community and family support

Level 3: Individual-focused: Non-specialized psychosocial support

[94] Interview with an MHPSS-TF representative, April 2016.
[95] Interview with an MHPSS-TF representative, April 2016.

Level 4: Individual-focused: Specialized or clinical services

However, the discourse of professionals and policy makers, as well as all the recommendations published by UNHCR and MoPH, emphasize the individual-focused levels, even more so the specialized level 4 (psychiatry/psychotherapy consultations) than the level 3, that includes non-specialized psychosocial support. The term "*psychosocial support*" remains vague and poorly defined by the various actors. It may include diverse and non-specific activities: child friendly spaces, awareness sessions, occupational activities. The level 3 includes more than 50 % of the total activities of MHPSS according to the MoPH mapping of services (MOPH 2015), while level 4 constitutes 10.3% and level 2, 34.2 %. There is no mention or information about Level 1, even though IASC guidelines recommend that levels 1 and 2 must be a priority. An evaluation of the MHPSS services in Lebanon by UNHCR in 2013 revealed that most of the needs noted were at level 1 and 2: Syrian Refugees are struggling to ensure adequate shelter, health services, food and education for their children (UNHCR, 2013). Most of them do not feel safe circulating, are isolated within the community and perceive the host community as rejecting. They also reported prostitution and domestic violence. Still, recommendations only targeted specialized interventions at level 4 (implicating a psychiatric diagnosis), which constitute less than 11% of the MHPSS services, and ignored the social needs found by the evaluation. The same omission was found in a document published by the MOPH (2015). Examples of these recommendations include training fieldworkers on the MhGap, homogenizing psychotherapeutic interventions of all NGOs by promoting IPT, and establishing a unified list for psychotropic medications.

Therefore the discourse of the MHPSS task force seems to be focused on the medical individual aspect even though it claims to be a community-based approach. There is no exploration available of the community's needs or on what knowledge systems the Syrian community resorts to in times of adversity, in order to build long-term sustainable community interventions. Instead, refugees are viewed as persons with "*lack of mental health literacy that need to be educated about the reality of psychiatric disorders*".[96]

2) Recruiting beneficiaries: Educating on mental health just enough to meet the target

The recruitment of beneficiaries by MHPSS services is done through various ways: they can be referred by the UNHCR at the level of registration: "*When a refugee comes to register, and we see that he/she is in distress, or that he/she is taking psychotropic medications, we will refer*

[96] Interview with an international NGO mental health coordinator, March 2016.

him/her to a UNHCR funded NGO providing MHPSS services"[97]. A sign of distress is therefore considered immediately as pertaining to MHPSS services. Sometimes the refugees hear about the services from other refugees. However the most frequent way of recruiting beneficiaries is through social workers or case managers of NGOs, while doing "*outreach visits or awareness sessions"*[98] at the Primary Health Care Centers of the Ministry of Social Affairs or the MoPH. At International Medical Corps (IMC), which is the main partner of the MoPH, all case managers are trained on the MhGap, to be able to "*detect symptoms that would necessitate an intervention*"[99]. After screening for symptoms, social workers refer Syrians to the psychologist or the psychiatrist for a diagnosis, which is the distinctive function of the specialist; the diagnosis is usually based on international diagnostic classification criteria. Detecting symptoms is one of their most important tasks; with time, social workers may get to know, maybe even more than the psychiatrist/psychotherapist, the refugee's life in its complexity, as they will often do home visit and support families on a daily basis. However symptoms remain the priority for categorization:

" We will explain to the person what is depression, what is PTSD, what is psychosis, how to detect and recognize them; most of the times they have the symptoms of depression but they don't know it is a depression. So we tell them that it is a disease like any others, that they should not be ashamed of it, that it can be treated and we explain to them what we can do."[100]

This social worker, as well as many other professionals, emphasized the lack of education of Syrian refugees on mental health disorders, and their need to be "*educated*" about it. The MhGap and awareness sessions will become tools to inform and educate: the production of psychiatric knowledge is done through a medical legitimization "*it is a disease like any other"* and a universalizing process "*it is one of the most frequent illnesses in the world*"[101]. As another social worker of IMC describes:

" In a way, we have to convince the refugees that they need the service. You should tell them that it will be helpful for them if they took some medications, that they should try, but sometimes you have to try hard before they accept, because they don't consider that this is a priority, they want a job, clothes, material aids, but we tell them we cannot help them materially but psychologically."[102]

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[97] Interview with a UNHCR staff, March 2017
[98] Interview with a social worker in an international NGO, August 2016
[99] Interview with an international NGO mental health coordinator, March 2016.
[100] Interview with a social worker in an international NGO, August 2016
[101] Ibid
[102] Interview with a social worker in an international NGO, July 2016

Even though the basic needs of beneficiaries are clearly recognized by social workers, the lack of education about mental health disorders is considered a priority over the expressed needs. Health care providers focus instead on letting the person "*know*" or "*recognize*" that he/she has a "*mental health disorder*" instead of addressing the social adversity that is causing the psychological distress. Policymakers and professionals also frequently evoke the concept of stigma surrounding mental health among refugees, as a result of their lack of knowledge in this area:

They (the refugees) often think the cause of a mystic delusion for example is a bad spirit or a possession. They don't know about psychosis. They will hide the person who has psychosis, they fear of being embarrassed, there is a lot of stigma around mental health that we should fight, explain that this is a disease, that there is nothing to be ashamed of, that the solution is not to go to a religious healer but to take a medication" [103]

The healer is immediately perceived as intervening against science and rational thinking. There is no attempt by professionals to understand what it means for the community to seek a healer, or how to collaborate with traditional healers and integrate them in the care plan as meaningful figures for some Syrians. Moreover, by creating a specific need among refugees, awareness sessions seek to catch patients and convince them of the services, yet only to a certain extent: indeed, there is a specific number of patients to reach each month, a target that is established by donors. All professionals mentioned the limits of funding and the constraint of the target: they have a pre-established number of consultations they should attain at the end of each month:

"Sometimes there is not enough patients but sometimes there is much more than the target number fixed but we cannot take everyone, because we work in an emergency context, these numbers are predetermined by donors and do not always reflect the needs. Sometimes we are obliged to refer to other NGOs. The target is fixed for psychologists and psychiatrists because the social workers can see as much as possible. Sometimes there is even a fluctuation in funding, and we are suddenly out of some medications for example" [104]

Politics of donors and funding of services are pre-established before the services are implemented, and without prior exploration of the people's needs or expectations: a certain number of patients is fixed every month for the psychiatrist and the psychotherapist, with a limited duration for treatment and follow-up (three to six months) as the services follow the logic of the "*emergency context*"*:*

[103] Interview with a psychiatrist working in an international NGO, May 2016

[104] Interview with a mental health program coordinator of an international NGO, March 2016.

"We work in an emergency context, so we cannot take everyone and we have a fixed duration for the follow-up, that is 3 to 6 months. We are currently promoting brief therapies like IPT or trauma focused therapy, as we want short-term outcomes, just to deal with the emergency before referring to a Primary Health Center"[105]

The concept of *"emergency context"* determines the type and nature of interventions: short-term interventions or therapies are favored over long-term ones. However, the Syrian refugee crisis has become protracted and has been evolving for more than six years now; considering it an emergency crisis rather than a chronic situation might overlook the actual needs of the Syrian community. Furthermore, awareness sessions create a need among Syrian refugees through recruiting beneficiaries and convincing them of the services. Yet, when services abruptly stop as the time allowed for "*emergency context*" has elapsed, refugees might experience a contradictory discourse by humanitarian actors that leaves them in a state of dependency and request. Besides, even though the "*emergency context*" notion is endorsed by main actors on the field (MoPH, MHPSS-TF, UNHCR), level 1 interventions of the pyramid (basic and security needs) - that should be prioritized in emergency contexts - are the least documented. Another problem frequently mentioned by professionals is the non sustainability of funding in terms of psychotropic medications: there can be an unpredictable and unexplained sudden shift in funding, leading to a shortage of medications, which may provoke serious relapses in patients that were previously stable (especially those suffering from psychosis). Therefore, priorities seem to be fixed by donors more so than by the persons concerned; they are considered as "*non informed or non educated about mental health*" [106]. Other implications of unsustainable funding in this "*emergency context*" include the limitations faced by psychiatrists when they want to request biological or radiological exams, if an organic disease is suspected. Most psychiatrists expressed that they feel restrained in their clinical activity. The number of consultations for psychiatrists and psychotherapists can vary from one month to another, depending on the target fixed by donors, creating instability of income for these specialists, which they cite as an inconvenience. For example, at International Medical Corps, psychiatrists are paid per consultation. By limiting the number of consultations, the psychiatrist's income is decreased, an inconvenience that is often brought up by our informants. On one hand, the humanitarian system is based on the "*economy of charity*"[107] with fluctuations in funding following the logic of

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[105] Interview with a mental health program coordinator in an international NGO, March 2016

[106] Interview with a psychiatrist working in a local NGO, July 2016

[107] Moghnie Lamia, Marraconi Filippo, 2016, unpublished paper

emergency context, while on the other hand it is a perceived source of employment for freshly graduated specialists seeking fixed incomes.

Conclusion

Our study shows that MHPSS services for Syrian refugees in Lebanon are mostly based on an individual clinical approach and promote brief short-term interventions, while considering the six-years ongoing Syrian crisis as a "*complex emergency*", and facing arbitrary shifts in aids. There does not seem to be a previous understanding of the community's perceived needs in terms of psychological wellbeing, mental illness, resources for surviving, patterns of social strengths and weaknesses. Without denying the importance of individual based interventions when indicated, experience from the field shows that most Syrian refugees do not suffer from underlying psychiatric disorders. Instead, their distress is related to their living conditions of poverty, isolation, and insecurity (UNHCR, 2013). Most of the interventions, however, address this distress as an individual disorder.

By focusing on individual diagnosis, resources are shifted away from the long-term rebuilding after war, the reinforcement of local capacities, and the restoration of basic rights and human security. Moreover, by dealing with the suffering of refugees as pertaining to the humanitarian and medical fields, MHPSS services may pathologize ordinary human suffering in reaction to horrifying events, and hinder important aspects like social history and political justice. This reveals the tendency of international donors to depoliticize collective and social suffering, as well as the Syrian refugee subject, rendering him an abstract entity that fits a bureaucratic category (being a refugee), and eliminating social history as a major determinant of mental health. Individual and political dimensions are thus confounded, and the political perspective erased.

Without denying the importance of individual-based interventions when indicated, we can stress the importance of separating the clinical response to mental illness from the public health response to distress caused by mass violations of human rights. These two aspects can only be conciliated within an approach integrating categories that make sense for individuals as members of a community, rather than isolated individuals. This requires changing entrenched perspectives of international agencies and donors with a parallel change in mental health services from short-term individual approaches to the development of sustainable long-term community mental health services, in combination with advocacy for political justice.

Moreover, addressing the "*lack of mental health knowledge among Syrian refugees*"[108] should be replaced by efforts to address the lack of knowledge of policymakers and professionals about the Syrian refugee context, systems of knowledge, idioms of distress and community resources, through more qualitative studies. Ultimately this will help design community-based interventions tailored to the Syrian refugee context. It will also unravel the sociopolitical determinants of health and mental health among Syrian refugees in Lebanon, through the theoretical framework of biolegitimacy, described by Didier Fassin (2009) as "*linking the matter of living (medical) and the meaning of politics (citizenship, in terms of social as well as civil rights)*".

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