

NEEDS AND BARRIERS FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT AMONG SYRIAN REFUGEES IN LEBANON: PERSPECTIVES FOR FUTURE INTERVENTIONS



Acknowledgements

The report is the result of a cooperation between DIGNITY, DRC Lebanon, and supported by the American University of Beirut (AUB) Center for Civic Engagement and Community Service. The research study received prior official approval by the National Mental Health Programme (NMHP), Ministry of Public Health Lebanon.

This document covers development activities implemented with the financial assistance Danida. The views expressed herein should not be taken, in any way, to reflect the official opinion of the Danish Ministry of Foreign Affairs, and Danida is not responsible for any use that may be made of the information it contains.

This document covers humanitarian aid activities implemented with the financial assistance of the European Union. The views expressed herein should not be taken, in any way, to reflect the official opinion of the European Union, and the European Commission is not responsible for any use that may be made of the information it contains.

Authors

Ane Kirstine Viller Hansen (DIGNITY – Danish Institute Against Torture)
Rune Askgaard (DIGNITY – Danish Institute Against Torture)
Diam Abou-Diab (Danish Refugee Council – Lebanon)

Special thanks to:

Rabih El Chammay, MD Head of Programme
Nour Kik, Policy and Advocacy Coordinator of the National Mental Health Programme (NMHP), Ministry of Public Health – Lebanon for kind advise and support during the process.
Rabih Shibli and his team at the Center for Civic Engagement and Community Service
Maya Boulos, Protection Specialist, Danish Refugee Council
and Nete Sloth Hansen-Nord

Contents

List of tables and figures	5
Abbreviations	5
Executive summary	6
Introduction	6
Methodology	6
Results	7
Recommendations	7
Introduction	8
The Syrian crisis in Lebanon	8
The objectives of the study and future perspectives for planning	9
Methodology	10
Study design	10
Training interviewers	10
Ethical considerations – Referral of emergency cases	10
Measures	10
Data collection process	11
Data analysis	11
Quantitative and qualitative data analysis	11
Results	12
Respondents Characteristics	12
Basic needs	13
Exposure to traumatic events	13
Psychosocial symptoms and needs assessment	14
Distress levels	14
Self-rated health	14
Pain	15
Functionality	15
Correlations between pain, distress, functionality and self-rated health	17
Awareness, needs and use of MHPSS	17
Help-seeking behavior and coping with life stress	18
Barriers to accessing Mental Health and Psycho Social Support	20
Attitudes for future use and suggestions for MHPSS services	21
Limitations	25

List of tables and figures

Figure 1. Number of years as a refugee	12
Table 1. Demographic data	12
Table 2. Respondents' experience of violence	13
Figure 2. Exposure to traumatic events.	13
Figure 4. Self-rated health	14
Figure 3. Do you have a problem because you feel life stress or very distressed?	14
Table 3. Logistic regression for self-rated health	15
Figure 5. Physical pain during the last 4 weeks	15
Table 4. WHO Disability Assessment Schedule	15
Table 5. Binary logistic regression for functionality - WHODAS	16
Table 6. Correlations between mental health symptoms	17
Figure 6. Knowledge about psychosocial support programmes in the community	17
Figure 7. Percentage who needed assistance to deal with physical pain, life stress or distress	17
Figure 8. Providers of support for dealing with life stress or distress	18
Figure 9. Preferred assistance provider to deal to with physical pain, life stress or distress	18
Figure 10. Obstacles to seeking or accessing MHPSS	20
Figure 11. Percentage who would consider using psychosocial support programmes in the future	21
Figure 12. Suggestions for complementary services for people in need of MHPSS	21
Figure 13. Causal diagram including perceived barriers and suggested solutions	22

Abbreviations

AUB: American University of Beirut

AUB-CCECS: Center for Civic Engagement and Community Service at the American University of Beirut

DIGNITY: Danish Institute Against Torture

DRC: Danish Refugee Council

FGD: Focus Group Discussion

HPRT: Harvard Program in Refugee Trauma

MHPSS: Mental Health and Psychosocial Support

NGO: Non-Governmental Organisation

NMHP: National Mental Health Programme

SF-36: 36-Item Short Form Survey

WHO: World Health Organisation

PM: Protection Monitoring

PTSD: Post Traumatic Stress Disorder



Photo by: Eduardo Soteras Jali/DRC

“Everything is hard in Lebanon, and we live in an area very far from all the services.”

Executive summary

Introduction

Syrians in Lebanese refugee communities are subject to numerous stressors which can be caused by traumatic events in conflict situations or the daily life as a refugee: struggling to preserve basic living conditions and dealing with the uncertainty about the future are just a few of the everyday challenges for displaced Syrians. War-related traumatic experiences and daily stressors affect the long-term psychosocial wellbeing of refugees; social distress, cognitive problems, chronic pain and PTSD are typical documented reactions from prolonged stress situations. Mental health services are needed to lift the condition of displaced Syrians. With nearly one million Syrian refugees registered in Lebanon, the need for mental health and psychosocial support (MHPSS) is alarmingly high; however, options are scarce. Besides the lack of supply, challenges exist to accessing the available MHPSS services.

This report by DIGNITY and DRC examines existing obstacles to accessing MHPSS services, the gaps in supply and generates knowledge about the needs for services among the refugee population in Lebanon. Through a public health approach, the aim of the report is to make specific recommendations which can guide organisations in the field, when designing future MHPSS interventions.

Methodology

The study was conducted with a mixed methods research approach using qualitative and quantitative data. DRC completed 32 focus group discussions on psychosocial wellbeing involving 358 Syrian refugees across three Lebanese governorates: Bekaa, Akkar and Tripoli. The quantitative component consisted of a cross-sectional survey with a sample of 1082 respondents from the same refugee communities. The measures contain socio-demographic descriptions, an exploration of psychosocial symptoms based on items from validated scales, questions about exposure to traumatic events and awareness of psychosocial programs, help-seeking behavior and suggestions for future services. The data were collected in March 2018.

Results

This study provides evidence of a large gap between the need of MHPSS among Syrian refugees and provided services. Of the 1082 respondents in this study, 62% expressed that they needed assistance to deal with physical pain and distress. Almost 80% reported being in pain, of which 27% were in severe or very severe pain. Additionally, 55% suffer from distress and 56% rate their own health as fair or poor. Even among the 18-25-year-olds, the prevalence of reporting their overall health as fair was 30.7%. For functionality levels, 28.5% felt severely or extremely emotionally affected by their health problems, and more than 20% had serious difficulties in doing day-to-day work. On the other hand, the majority (72-74%) had no problems in maintaining friendships and participating in community activities.

Overall, this study shows that 32.5% of respondents have been exposed to one or multiple traumatic events. More specifically, 25.8% have lost a close family member, 8% have been exposed to violence and 7.9% have been arrested, detained or imprisoned.

Additionally, the findings showed that those who had lost a close family member, had a much higher risk of experiencing pain and distress, having functionality difficulties in their everyday life and a bad self-rated

health. Other factors influencing distress, pain, functionality and self-rated health were age, gender, exposure to violence and unmet basic needs.

The mental health symptoms assessed in this study were all positively correlated internally. There were strong positive correlations between pain, self-rated health and being emotionally affected by health problems. This establishes the fact that psychosocial challenges and pain occur simultaneously and reinforce each other. In addition, the qualitative findings revealed that insecure basic needs, such as food, shelter, security and employment played a key role in the experience of distress.

One out of three expressed that there were important barriers to access MHPSS. The top three barriers were transportation, expenses and lack of knowledge of service location. Overall, there was a high demand for MHPSS services, as 67% wanted to use such programs in the future. NGOs were the preferred assistance provider by 41% of the respondents and the majority (52.8%) preferred livelihood programs as complementary service for people in need of MHPSS. Other suggestions for complementary services were accompaniment to seek services (43.2%) and outdoor activities (38.6%).

Recommendations

- NGOs should provide MHPSS services with a focus on empowerment and self-reliance
- Introduce interventions focusing on pain mechanisms, coping strategies and physical resilience
- Implement livelihood programmes
- Increase service accessibility and outreach activities
- Provide support groups for people who have lost a close family member
- Highlight the importance of supervision and training
- Ensure high quality service provisions by applying relevant outcome measures and to further contribute to the evidence base for MHPSS
- Diversify MHPSS activities to different target groups, including men and women, and address the needs of elderly and individuals with disabilities

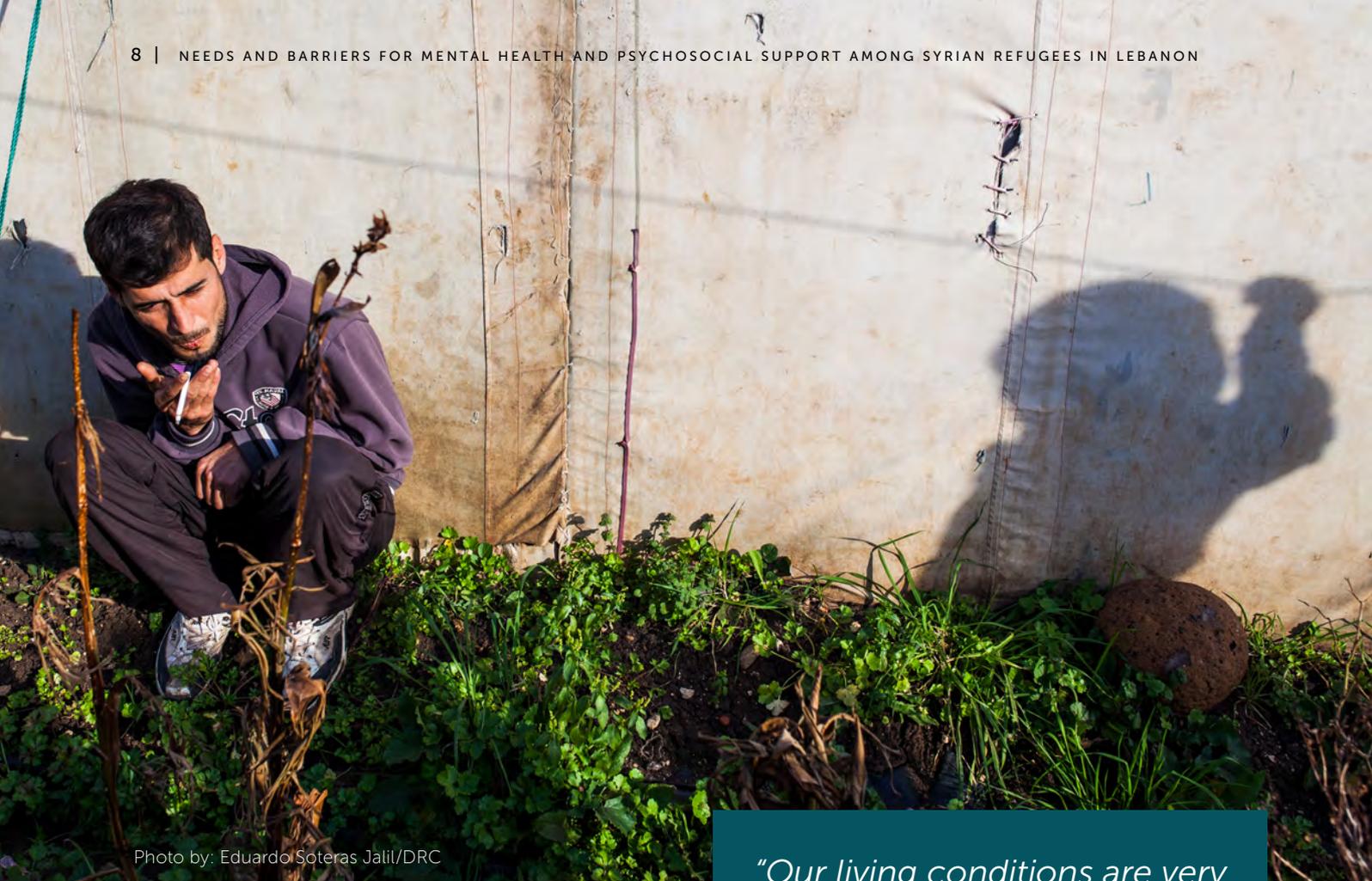


Photo by: Eduardo Soteras Jalil/DRC

"Our living conditions are very bad: No food, no life."

Introduction

The Syrian crisis in Lebanon

As of the 31st of March 2018, 991,165 Syrians were registered with UNHCR Lebanon: 52% females and 48% males with a total of 55% children below the age of 18.¹ Due to the overwhelming number of refugees, the Government of Lebanon is struggling to uphold basic human rights and services to these vulnerable populations. As a result, Syrian refugees continue to see their living conditions deteriorate, including in terms of mental health.² Following the Lebanese experience with Palestinian camps, and lack of full control over these camps, the Lebanese government is hesitant to establish official camps for Syrian refugees.³ As no formal shelter policy has been implemented, refugees are forced to live in communities, in Informal Tented Settlements and private apartments or rooms.

The negative consequences of the Syrian crisis on mental health and psychosocial wellbeing are profound; both due to traumatic events experienced during the war and to daily stressors of displacement. War-related experiences include bombing of civilians, torture, disappearances and sexual violence. Daily stressors of displacement include poverty, lack of basic needs and services, on-going risks of violence and exploitation, loss of family and community supports, loss of identity and uncertainty about the future.^{4,5} A high proportion of traumatic events in life may indicate a need for psychosocial support or therapy. Studies have shown that exposure to physical violence correlates with mental health disorders such as post-traumatic stress disorder (PTSD), depression and anxiety.⁶ Studies within Syrian refugee populations have shown that the loss or disappearance of a close family

- 1 UNHCR, *Situation Syria Regional Refugee Response*, <http://bit.ly/1jsBiUu> (Accessed May 15, 2018)
- 2 UNHCR, UNICEF & WFP, *Vulnerability Assessment of Syrian Refugees in Lebanon 2017*, 2017. <https://reliefweb.int/sites/reliefweb.int/files/resources/VASyR%202017.compressed.pdf> (Accessed May 15, 2018)
- 3 Janie Z. Shen, "Why Are There No Syrian Refugee Camps in Lebanon?" *Forced Migration Forum*, 22 June 2017, <https://bit.ly/2rvFWu2> (Accessed May 15, 2018).
- 4 Ghayda Hassan et al. *Culture, context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflict*, UNHCR, 2017, <http://www.unhcr.org/55f6b90f9.pdf> (Accessed May 15, 2018).
- 5 Ghayda Hassan et al. "Mental health and psychosocial wellbeing of Syrians affected by armed conflict," *Epidemiology and Psychiatric Sciences*, 25 no. 2, (2016) 129–141, Cambridge University Press
- 6 Wegner S. Ribeiro et al. "Exposure to violence and mental health problems in low and middle-income countries: a literature review," *Rev. Bras. Psiquiatr.* 31 (suppl. 2) 2009, 49–57.

member is correlated with high numbers of psychological distress outcomes.⁷ A systematic review on detainment of asylum seekers and refugees has shown that the mental health consequences can be detrimental in terms of PTSD, depression, anxiety and suicidal ideations, even when the imprisonment effect is isolated and a potential trauma history is taken into account.⁸

Syrian refugees in Lebanon are very likely to experience a wide range of mental health problems. Mental health consequences that may be found among Syrian refugees are psychological distress including emotional problems such as grief, fear, frustration and anxiety, besides cognitive problems including loss of control, helplessness and hopelessness. Furthermore, symptoms can be physical, such as fatigue, loss of appetite, pain, as well as social and behavioural aggression and interpersonal difficulties. All these consequences of distress are widely documented.⁹ A recent review based on data from 8,176 Syrian refugees showed that 42.97% suffered from PTSD, 40.85% had symptoms of major depression and finally the prevalence for anxiety disorder was 26.6%.¹⁰ A failure to treat distress can cause long-term chronic pain and may result in PTSD, if no treatment is received.¹¹ This might eventually determine the future well-being of numerous refugees across the globe. Considering the various sources of distress and the well-documented negative long-term consequences, there is an urgent need for preventive, evidence based Mental Health and Psychosocial Support (MHPSS) interventions targeting refugees and other vulnerable populations in Lebanon.

There are many obstacles for refugees to access MHPSS, including lack of knowledge about the services, cost and transportation issues,¹² as well as not being accepted at the facility.¹³ Other personal challenges include stigma around psychological distress, incomprehensive cultural sensitivity and feeling emotionally isolated.¹⁴

In order to address the mental health needs of refugees, as well as the host communities', the Ministry of Public Health launched a National Mental Health Programme (NMHP) in May 2015, to ensure the development of a sustainable mental health system that guarantees the provision and universal accessibility of high quality

mental health services.¹⁵ This national strategy for mental health 2015–2020 is in line with the World Health Organisation (WHO) Mental health action plan 2013–2020 focusing on developing community-based mental health services through evidence-based approaches and interventions. It is of high priority to the Lebanese government and mental health system to address this enormous challenge of responding to the needs of the refugee community and the host population as well as for the international community (NGOs) supporting the mental health system through comprehensive services for refugees.¹⁶

The MHPSS needs among the refugee community far exceed the amount of services offered, and despite many MHPSS services provided by state and non-state organisations, there is limited capacity within MHPSS service delivery in Lebanon.¹⁷ Furthermore, challenges exist to accessing the present MHPSS services. While donors and organisations acknowledge the growing focus on MHPSS by the Lebanese government, the gap between services and the growing needs in the MENA region persist, exacerbated by violent conflicts and poor living conditions in the region. This study is a result of a collaboration on knowledge generation between DIGNITY (Danish Institute Against Torture) and Danish Refugee Council (DRC).

The objectives of the study and future perspectives for planning

The overarching goal is to contribute to the improvement of mental health among refugees and Lebanese nationals through new knowledge on needs, help-seeking behavior, barriers to access MHPSS and perceptions of future mental health support. A public health approach to MHPSS was applied to provide a knowledge base to effectively address the huge challenges of mental health among Syrian refugees. This report provides organisations working within the MHPSS field with recommendations for designing and implementing focused outreach MHPSS interventions for refugees and Lebanese nationals in need of psychosocial support.

7 Man Cheung Chung et al. "The impact of trauma exposure characteristics. 2018

8 Katy Robjant, Rita Hassan & Cornelius Katona "Mental health implications of detaining asylum seekers: systematic review" *The British Journal of Psychiatry*, 2009, 194, 306-312.

9 Hassan et al. 2015. "Culture, context and the Mental Health and Psychosocial Wellbeing of Syrians," UNHCR

10 Emma PeConga & Marie Høgh Thøgersen, Post-traumatic stress disorder, depression and anxiety in Syrian refugees: A systematic review of prevalence rates, *European Journal of Public Health* (2018).

11 Timothy Sharp & Allison Harvey, "Chronic pain and posttraumatic stress disorder: mutual maintenance?" *Clin Psychol Rev.*, 21(6), (2001) 857-877.

12 Government of Lebanon & United Nations, *Lebanon Crisis Response Plan (2017- 2020)*, January 2017, https://reliefweb.int/sites/reliefweb.int/files/resources/2017_2020_LCRP_ENG-1.pdf (Accessed May 15, 2018).

13 UNHCR, UNICEF & WFP, *Vulnerability Assessment of Syrian Refugees in Lebanon 2017*

14 Hassan et al. "Mental health...", 2016

15 Ministry of Labour, Republic of Lebanon, *The National Mental Health Programme*, <https://bit.ly/2rg9Uq> (Accessed May 15, 2018).

16 World Health Organization, *WHO support to the humanitarian response in Lebanon: 2 years in review 2014-15*, http://www.who.int/migrants/publications/WHO_Lebanon_AnnualReport.pdf?ua=1 (Accessed May 15, 2018)

17 Government of Lebanon & United Nations, "Lebanon Crisis Response Plan..

Methodology

Study design

The study is based on quantitative and qualitative research methods. A cross-sectional study design was applied with a semi-random sample of 1,082 respondents from the refugee community in the Bekaa region, Akkar and Tripoli. These areas were chosen based on DRC's areas of operation, who was responsible for data collection and logistics. The survey questions were incorporated into the existing DRC Protection Monitoring (PM) tools carried out monthly to monitor and track protection trends among the Syrian refugee population. Selection criterion for respondents was 18 years of age and above. The interviewers consisted of the PM team composed of 12 field monitors and three PM officers. They all have in depth contextual knowledge of the target population and the areas of intervention. The qualitative data consists of 32 Focus Group Discussions (FGDs) on the subject of mental health conducted by DRC, involving a total of 358 Syrian refugees in Bekaa, Akkar and Tripoli.

Training interviewers

Prior to data collection, interviewers received training from the Center for Civic Engagement and Community Service at the American University of Beirut (AUB-CCECS), DRC and DIGNITY on the objectives of the study, the specific requirements for administering MHPSS related questionnaires, and the interview process regarding informed consent, relaying interview questions and identification of cases to refer to specialised services. The AUB-CCECS team has been trained by the Harvard Program in Refugee Trauma (HPRT) team to administer MHPSS surveys to vulnerable Syrian refugee children and adults living in informal tented settlements, and were chosen based on their solid experience.

Ethical considerations – Referral of emergency cases

All respondents were informed about the purpose and thematic content of the study and were notified of the sensitive nature of the questions and their right to withdraw at any time. Written informed consent was given. A referral system for potential emergency cases identified during interviews followed the interagency process already in place; individuals requiring psychosocial support were referred to DRC's case management services, where – after individual assessment – they could be referred to a mental health provider. If specialised psychological help was needed, the expert would refer the client to Restart Center for Rehabilitation of Victims of Violence and Torture, Lebanon.

Measures

The quantitative component of this assessment was based on a set of validated scales and well-tested variables, and was divided into five main sections. The first section consisted of a socio-demographic description of the population based on DRC's PM questionnaire. The second component sought to explore the concepts: 'self-rated health', 'functionality', 'pain' and 'distress'. Self-rated health and pain was retrieved from the Short Form Survey Instrument (SF-36). Several studies suggest that poor self-rated health is a strong predictor of mortality and morbidity.¹⁸ Pain was measured by a single item addressing the severity of physical pain in six answer categories. Functionality was assessed by a selection of items from the WHO's Disability Assessment Schedule (WHODAS).¹⁹ Questions measuring distress were retrieved from The Humanitarian Emergency Settings Perceived Needs Scale (HESPER).²⁰ The third section focused on exposures to traumatic events; physical violence, experience of arrests, detainments and imprisonments, as well as loss of a close family member. Initially, exposure to violence was divided into violence related to war in the home country, violence related to fleeing and violence related to displacement. The variable was later recoded into a binary variable. Direct questions on exposure to torture were considered too sensitive to address in this setting. As torture most frequently takes

-
- 18 Bo Burström & Peter Fredlund, "Self-rated health: Is it as good a predictor of subsequent mortality among adults in lower as well as in higher social classes?" *J Epidemiol Community Health*, 55 no. 11 (2001), 836-840
- 19 World Health Organization, *Disability Assessment Schedule 2.0*. http://www.who.int/classifications/icf/more_whodas/en/ (Accessed May 15, 2018).
- 20 WHO & King's College London, *The Humanitarian Emergency Settings Perceived Needs Scale (HESPER): Manual with Scale* (Geneva: World Health Organization, 2011).



Photo by: Louise Watering/DRC

place in detentions, during police arrests and in prisons, a question composed of these three parameters, was used as a proxy for torture.²¹ The loss of a significant other can lead to serious mental health issues including depression, PTSD and complicated grief.^{22, 23} Therefore, an item on the loss of a close relative, defined as a sibling, spouse, parent or child, was included in the questionnaire. Finally, the last component addressed awareness and use of psychosocial programmes, help seeking behavior and coping strategies, barriers and obstacles to seeking psychosocial support, and perceived needed services. The questions on help-seeking behavior were derived from the Libyan Needs Assessment Study developed in collaboration with Benghazi University.²⁴

Data collection process

DRC conducted a thematic assessment on MHPSS, in which the aforementioned items were added to the standard monthly PM activities of March 2018. DRC's areas of operation are coordinated at the inter-agency level, with the work of other PM agencies. DRC prioritises data collection from communities with significant concentrations of refugees. For this particular

assessment, DRC and DIGNITY collaborated on a methodology that consists of two complementary research tools:

- **Focus Group Discussions:** DRC undertook 32 FGDs with Syrian refugees across Akkar, Tripoli and the Bekaa governorates. The FGD interview guide consisted of questions concerning the same themes as in the quantitative questionnaire and were carried out at the same time as the quantitative survey. The FGDs allowed the respondents to openly discuss and reflect on their psychosocial wellbeing and provided the researchers with in-depth knowledge of the challenges faced by the respondents.
- **Protection Monitoring Surveys (PMS):** A standardised monthly household survey is implemented to collect quantitative data focused on physical, material and legal safety in the form of open-ended survey questions filled by enumerators on mobile tablets linked to DRC's online database Alpha. A single household member is interviewed in a private setting, taking into account gender and age balance. MHPSS survey questions were incorporated in March 2018, and consisted of both conditional and unconditional responses.

Data analysis

Quantitative and qualitative data analysis

Quantitative data analysis was performed using SPSS 25.0 statistical software. To examine differences in help-seeking behavior and perceived barriers to access MHPSS, as well as symptoms on reduced well-being across gender and ages, a chi-square test of independence was performed for comparisons. The exposures, including violence, exposure to arrests and loss of a close family member were analysed in relation to the symptom outcomes that are pain, self-rated health, distress and functionality. The analysis was based on the binary logistic regression adjusted for age, gender and amount of time as refugee in Lebanon. All analyses were tested for statistical significance at the $p \leq 0.05$ level. Finally, frequency tables were made for describing the study population and their suggestions for future services.

Qualitative data was coded and analysed to explore the predominant themes that arose during focus group discussions with Syrian refugees. Relevant quotations were highlighted to substantiate the quantitative results.

-
- 21 Jason Payne-James, Jonathan Beynon & Duarte Vieira, *Monitoring Detention, Custody, Torture and Ill-treatment. A Practical Approach to Prevention and Documentation*, (Taylor and Francis Group, 2013)
- 22 Lonneke, I. M. Lenfenrik et al. "Toward a Better understanding of Psychosocial Symptoms in People confronted with the disappearance of a loved one: A systematic review," *Trauma, Violence and Abuse*, 2017, 1-16.
- 23 Man Cheung Chung et al. "The impact of trauma exposure characteristics on post-traumatic stress disorder and psychiatric co-morbidity among Syrian refugees," *Psychiatry research* 259 (2017) 310-315.
- 24 Fathi Ali et al. *Consequences of torture and organized violence: Libya Needs Assessment Survey*, DIGNITY publication series no. 8., 2014.

Results

Respondents Characteristics

For the qualitative and quantitative components combined, 1,440 respondents completed either the MHPSS questionnaire or attended an FGD. The quantitative survey consisted of 1,104 participants, of which 22 were excluded because they were below 18 years old.

Demographic data of respondents

Gender	Refugees (n=1082)	(%)
Male	353	32.6 %
Female	723	66.8 %
Missing	6	0.6 %

Age categories

Young adults (18-25 years)	199	18.4 %
Early adults (26-35 years)	370	34.2 %
Late adults (36-50 years)	331	30.6 %
Older adults (+51 years)	178	16.4 %
Missing	5	0.5%

Nationality

Syrian	1079	99.7 %
Lebanese returnees	2	0.2 %
Other	1	0.1 %
Missing	0	0 %

Registration with UNHCR

Yes	1027	94.9 %
No	51	4.7 %
Don't know	4	0.4 %

Districts

Central and West Bekaa	352	32.5 %
Kobbayat	116	10.7 %
North Bekaa	142	13.1 %
Tripoli	473	43.7%

Table 1. Demographic data

There were twice as many females (66.8 %) as males (32.6 %). The mean age for the respondents was 37.48 years, with most respondents (34.3%) in the age group of early adulthood (26-35 years). Almost all respondents were Syrians (99.7%), whereas two were Lebanese returnees and one person was placed in the category other. The majority (94.9%) had registered with the UNHCR. The average household size for Syrians in this survey was 4.9 persons. Most interviewees lived in Tripoli (43.7%), followed by Central and West Bekaa (32.5%).

The distribution of the amount of time Syrians have spent as refugees in Lebanon is illustrated below.

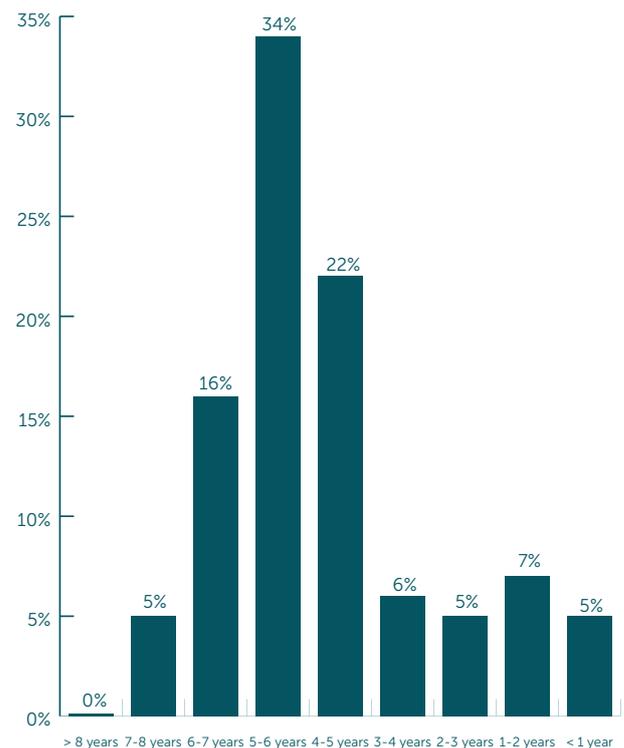


Figure 1. Number of years as a refugee

The average time the respondents have spent in Lebanon is 5.3 years, and more than half of the participants, 532 individuals, have been displaced to Lebanon from Syria in the last five to seven years. About 15% have been displaced between 0-3 years, and another 5.3% have been living in Lebanon for the past seven years or more.

Basic needs

When asked about which basic needs were the most important, shelter and rent (35%), food (27%), and primary and secondary healthcare (17%) were the top priorities for the refugees in March 2018. These top services were reported unavailable, hard to access, or accessible to some extent by 83% of the respondents. The vast majority of respondents (90%) conveyed that the price was the main impediment to accessing these services.

The importance of ensuring the basic needs prior to, or in combination with psychosocial support was emphasised by the respondents. *"We need someone to feel our pains. When the economic situation is good the psychosocial situation of the family will be better."* (Female FGD participant, Central and West Bekaa, Lebanon, March 2018). Some informants stated that the best way to reduce distress levels is to make sure that the humanitarian assistance includes basic supplies such as shelter and food. Yet, a number of refugees reported not receiving any help or support because there were no services in their areas, particularly in the Bekaa. Others have benefited from training activities, which they found useful. *"For our personal well-being? We need good work opportunities, enough humanitarian assistance, schools and education for our children, and a decent shelter."* (Female FGD participant, North Bekaa, Lebanon, March 2018).

Exposure to traumatic events

Based on a hypothesis that refugees who fled the war have been exposed to several traumatic events, the prevalence of exposure to three main events was investigated: 1) Experience of physical violence, 2) Having been arrested, detained or imprisoned and 3) The loss of a close family member.

The descriptive findings on violence and trauma within the Syrian refugee population in Lebanon is summarised below:

Figure 2 shows that surprisingly few respondents had been exposed to physical violence (8%), or arrest and detention (7.9%). Within the group of people exposed to violence, the majority (59.3%) were male respondents. Similarly, 81.4% of the respondents who reported having experienced arrest, detainment or imprisonment were male. The exposure to violence may have been underreported due to a gender bias, stigma or a different perception of violence, where violence to a larger extent is accepted as a part of everyday life. This will be further elaborated in the discussion.

Moreover, 25.8% of respondents had lost a close family member. Looking at all three types of traumatic exposures, we find that 32,5% of the respondents had been exposed to one or multiple traumatic events. Experience of physical violence was divided into three subgroups; war-related violence, violence during flight and violence caused by displacement.

	n	%
Yes, during war in my home country	51	4.7 %
Yes, on my way to Lebanon	8	0.7 %
Yes, in Lebanon	27	2.5 %
No	994	91.8 %
Prefers not to answer	6	0.6 %

Table 2. Respondents' experience of violence

Experience of violence was most prevalent in the home country (4.7%), followed by violence related to displacement in Lebanon (2.5%). The prevalence of violence during flight was very low (0.7%). It is assumed that underreporting of violent incidents is highly likely, as the prevalence is very low compared to other research.²⁵

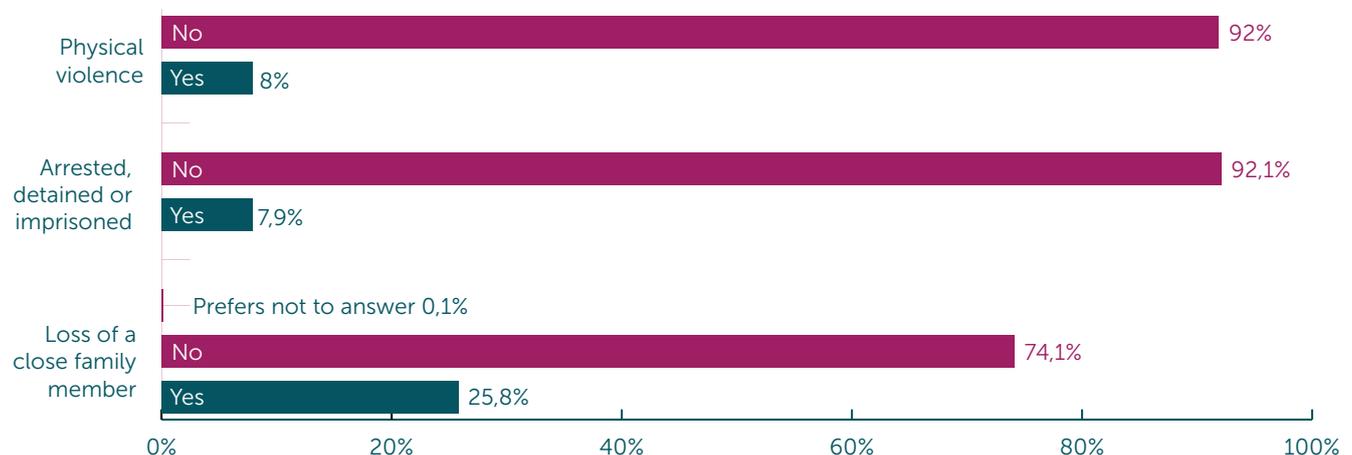


Figure 2. Exposure to traumatic events.

Psychosocial symptoms and needs assessment

Distress levels

The levels of distress were prominent for both men and women, as approximately 55% reported to have a problem because they feel distressed most of or all the time. There was no statistically significant difference in distress levels between men and women ($p=0.281$).

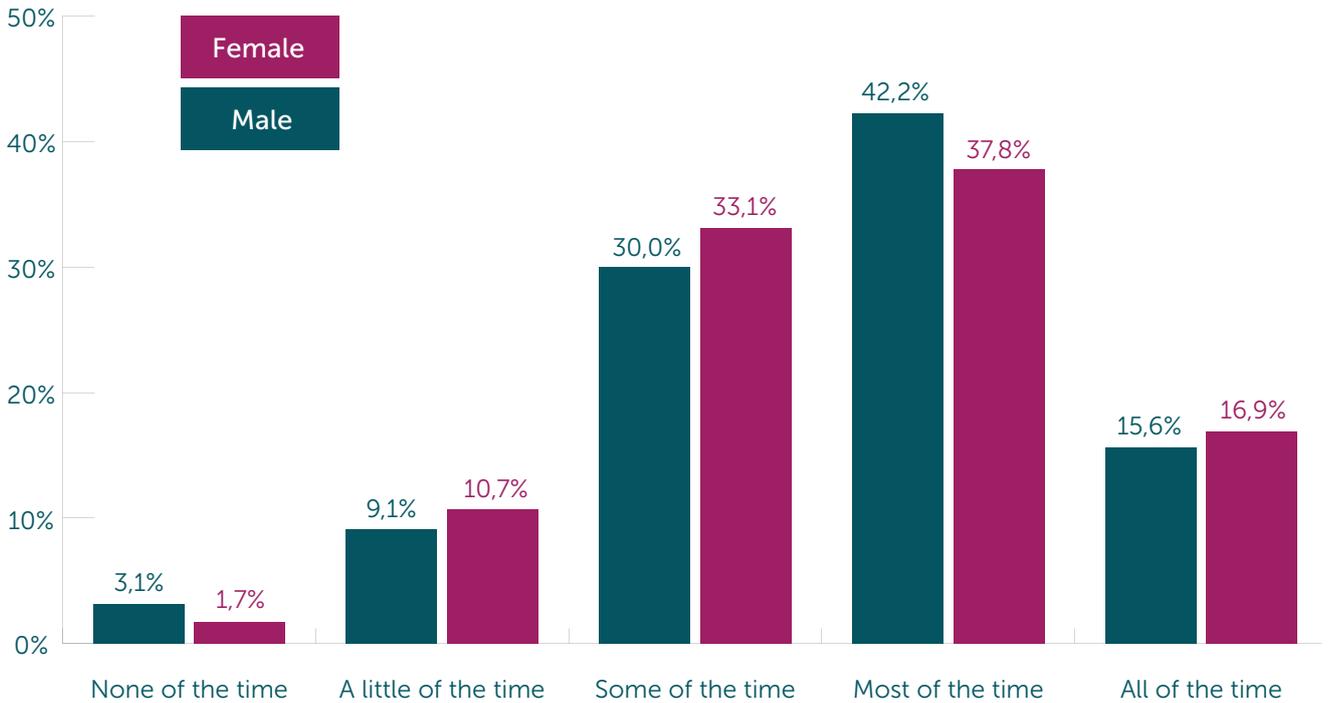


Figure 3. Do you have a problem because you feel life stress or very distressed?

The underlying causes of high distress levels were investigated during FGDs and by logistic regression. The qualitative analysis showed that Syrian refugees mostly linked stress and distress to the tough financial situation and living conditions in Lebanon, as well as their inability to afford rent and meet the household needs. "Our living conditions are very bad: no food no life". (Female FGD participant, Tripoli, Lebanon, March 2018).

The challenging living conditions are also affecting the family dynamics and relations. "Family problems between the husband and his wife are due to the economic situation, and inability to meet our children's needs or rent." (Female FGD participant, Central and West Bekaa, Lebanon, March 2018).

Refugees felt the most distressed after they had exhausted all the solutions available to them, increased their debt levels and were still unable to meet the basic needs, including healthcare and education. "We feel less distressed when we have some money to ensure the basic needs of the family." (Male FGD participant, Central and West Bekaa, Lebanon, March 2018). They have consequently felt more at ease and less distressed when they managed to pay all the due expenses and provide for their families.

Potential influencing factors on levels of distress were investigated by logistic regression. Though it seemed plausible that exposure to violence, arrest, losing a loved one, years of displacement, as well as gender and age could influence the level of distress, the analysis showed that the only factor influencing distress was the loss of a loved one. In fact, the risk of experiencing distress is almost twice as high among those who have lost a close family member $Exp(B)=1.960$, ($p=0.006$).

Self-rated health

The self-rated health was distributed almost evenly between genders with insignificant p-values and gender-specific details are therefore not presented in the figure below. In general, the levels of self-rated health were shocking, as 34% rated their health as fair and 23% rated their health as poor.

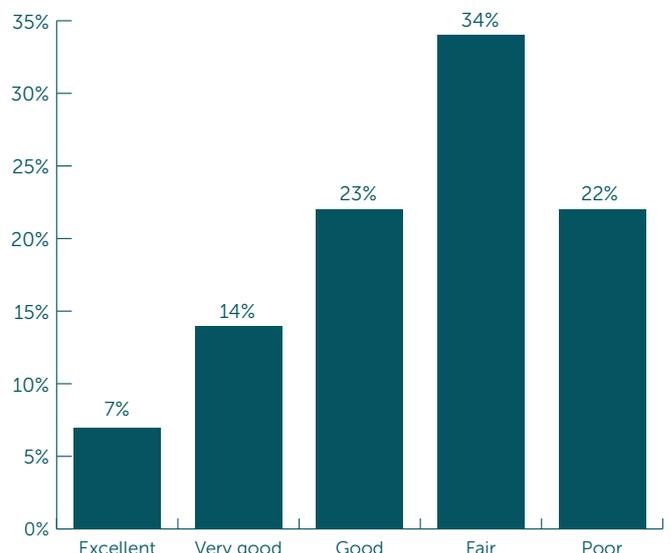


Figure 4. Self-rated health

There was a strong association between age and self-rated health, indicating that the older refugee population is significantly more vulnerable than the younger population ($p=0.000$): only 3.3% of the older adults (+51 year) rated their health as "excellent" or "very good", whereas 47% within the same age category rated their health as poor. The association between poor self-rated health and increasing age is not surprising; however, it is alarming that 30.7 % of respondents between the age of 18 and 25 reported their health as fair.

To investigate potential influencing factors on self-rated health such as exposure to violence, arrests, loss of a close family member and number of years as displaced in Lebanon, self-rated health was recoded into two categories "Good" and "Bad". The category "Good" consisted of the answers: "excellent", "very good" and "good", whereas the category "Bad" included "fair" and "poor".

	Odds ratio (Exp(B))	p-value
Loss of a close family member	2.108	0.000
Gender	0.752	0.041
Age	1.050	0.000

Table 3. Logistic regression for self-rated health

The analysis showed that the factors influencing self-rated health negatively were loss of a close family member, age and gender. The risk of rating one's health as fair or poor is over twice as high if respondents experienced losing a close relative, whereas men have a 25% reduced risk of rating their own health as poor or fair compared to women. Finally, there is a tendency to rate own health 5% worse with every aging year. Looking at the direct link between violence exposure and self-rated health reveals a weak association ($p=0.021$), indicating that the persons exposed to violence rate their health slightly worse than the those who had not experienced violence.

Pain

Physical pain can be one of the results of mental health challenges. The perceived extent of physical pain during the four weeks prior to the survey is presented below. There were no significant gender differences, and thus the distribution of perceived pain is presented in totals.

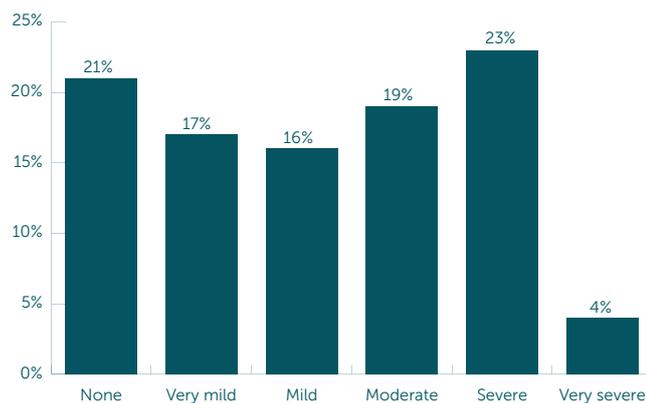


Figure 5. Physical pain during the last 4 weeks

Pain is a dominant phenomenon among Syrian refugees: 27% of respondents rated their pain as "severe" or "very severe", whereas only 21 % did not feel pain at all. There was a highly significant correlation between age and pain levels ($p=0.000$): almost 50% of the older adults (51 years +) felt severe or very severe pain, compared to 32% of the 36-50 year old respondents and 20% of the 26-35 year old. Furthermore, pain and distress levels were correlated ($p=0.000$).

Logistic regression shows that the risk of having moderate to very severe pain increases significantly with age ($p=0.000$): Every year, the risk of enduring pain increased by 4.5%. Furthermore, the risk of feeling pain was 86% higher with the loss of a close family member ($p=0.000$). Finally, the risk of having moderate to severe pain was 2.6 times higher if the respondent was exposed to multiple traumas, which includes violence and loss of a close family member ($p=0.019$).

Functionality

The four questions from the WHODAS questionnaire examined respondents' physical and emotional difficulties in the 30 days prior to the survey. The questions explore difficulties ranging from joining community activities, emotional affection following health problems, ability to maintain friendships, as well as difficulties completing day to day activities. The response categories range from "none" to "extreme/ cannot do".

	None	Mild	Moderate	Severe	Extreme/ cannot do
Community activities	74.4%	10.4%	5.3%	7.3%	2.6%
Emotionally affected by health problems	29.8%	22.5%	19.2%	23%	5.5%
Maintaining friendships	72.5%	10.4%	9.4%	6.7%	1.1%
Doing day to day work	28.4%	27.5%	23.7%	17.7%	2.8%

Table 4. WHO Disability Assessment Schedule

The majority (72-74%) had no problems in maintaining friendships and participation in community activities. However, 28.5% of respondents felt severely or extremely emotionally affected by their health problems. More than 20% felt a severe or extreme level of difficulty in daily work during the last 30 days. This was predominantly the case of male respondents, as 25% had difficulties doing day-to-day work or daily activities, compared to 17.5% of female respondents ($p=0.000$). A plausible underlying cause could be the fact that women maintain their household responsibilities, whereas men are traditionally dependent on



Photo by: Mais Salman/DRC

“Despite feeling tired, we benefited from the training activities, we worked and they provide us with sewing kits. These activities have positively influenced our daily lives”

external employment opportunities, which are limited for Syrian refugees in Lebanon. Therefore, more men would be unemployed in Lebanon causing more men to report that they have difficulties in doing day-to-day work.

Functionality was affected by the situation of Syrian refugees on two parameters: one is being emotionally affected by health problems, and two, having problems doing day-to-day work. Potential influencing factors for these parameters were therefore further investigated.

Emotionally affected by health problems	Odds ratio (Exp(B))	p-value
Loss of a close family member	1.756	0.000
Age	0.959	0.000
Problems doing day-to-day work		
Loss of a close family member	1.567	0.002
Age	0.975	0.000
Gender	1.351	0.029
Years as refugee	0.894	0.003

Refugees who had lost a close family member had an increased risk (76% higher risk) of being emotionally affected by their health problems compared to those who had not lost a loved one. There was a slight reduction in being emotionally affected by health problems with increasing age, indicating a higher acceptance with mental and physical challenges every year. Likewise, the loss of a close family member (OR=1.567) and being male (OR=1.351), increased the risk of having problems doing day-to-day work, whereas age (OR=0.975) and number of years as refugee (OR=0.894) slightly reduced the risk of having problems doing day-to-day work.

Table 5. Binary logistic regression for functionality - WHODAS

Correlations between pain, distress, functionality and self-rated health

Potential correlations between the four mental health outcomes were tested using Pearson's product moment correlation.

Correlated mental health symptoms	p-value	Pearson's r
Pain * Functionality – emotionally affected by health problems	0.000	0.694
Self-rated health * Functionality – emotionally affected by health problems	0.000	0.602
Pain * Self-rated health	0.000	0.564
Pain * Functionality – Doing day-to-day work	0.000	0.499
Distress * Functionality – emotionally affected by health problems	0.000	0.429
Pain * Distress	0.000	0.411
Distress * Functionality – doing day-to-day activities	0.000	0.385
Distress * self-rated health	0.000	0.376
Self-rated health * Functionality – doing day-to-day work	0.000	0.338
Pain * Functionality – joining community activities	0.000	0.228
Pain * Functionality – maintaining a friendship	0.000	0.226
Self-rated health * Functionality – participating in community activities	0.000	0.224
Self-rated health * Functionality – maintaining a friendship	0.000	0.195
Distress * Functionality – joining community activities	0.000	0.176
Distress * Functionality – maintaining a friendship	0.000	0.155

Table 6. Correlations between mental health symptoms

The test resulted in highly significant associations with positive internal correlations, indicating that pain for instance increases simultaneously with increasing distress levels. The strength of the correlations varied from strong positive correlations to weak positive correlations, which is illustrated by colour codes in table 6. The table shows that especially pain, self-rated health and being emotionally affected by health problems were internally correlated. The weakest positive correlations were distress levels and the two functionality parameters concerning being able to join community activities and maintaining friendships. This could be explained by the fact that these two parameters are more pleasurable and require less concentration and deliverables from the individual than labour would.

Awareness, needs and use of MHPSS

This study found that awareness about psychosocial support mechanisms or programmes in the community was very low, as only 21% of respondents knew about such services. A total of 10% of refugees have made use of, or knew someone who benefitted from MHPSS programmes. The findings indicated that women are more likely to enroll in such programmes, as significantly more women than men (12.4% versus 5.4%) knew someone or benefitted from MHPSS services.

62% of the respondents expressed that they needed assistance to deal with physical pain, life stress or distress, and yet, only one out of four received this support. Of the subpopulation that stated they often felt distressed, only 28% received help. There is a gap between the psychosocial support needed and the support provided to refugees.

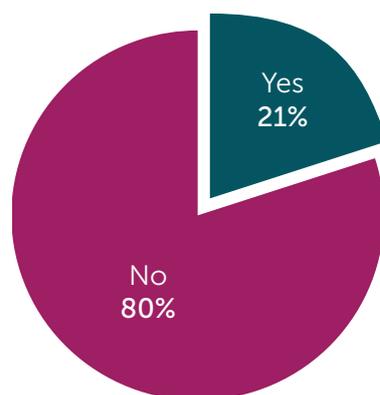


Figure 6. Knowledge about psychosocial support programmes in the community

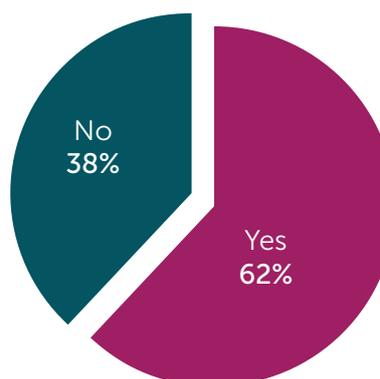


Figure 7. Percentage who needed assistance to deal with physical pain, life stress or distress

Help-seeking behavior and coping with life stress

Figure 8 illustrates the sources of support and help refugees had received: Syrian refugees predominantly received help from their families (15%), then from NGOs (11.4%). Only 1.4% received help from a medical doctor who helped them deal with their life-stress or distress issue.

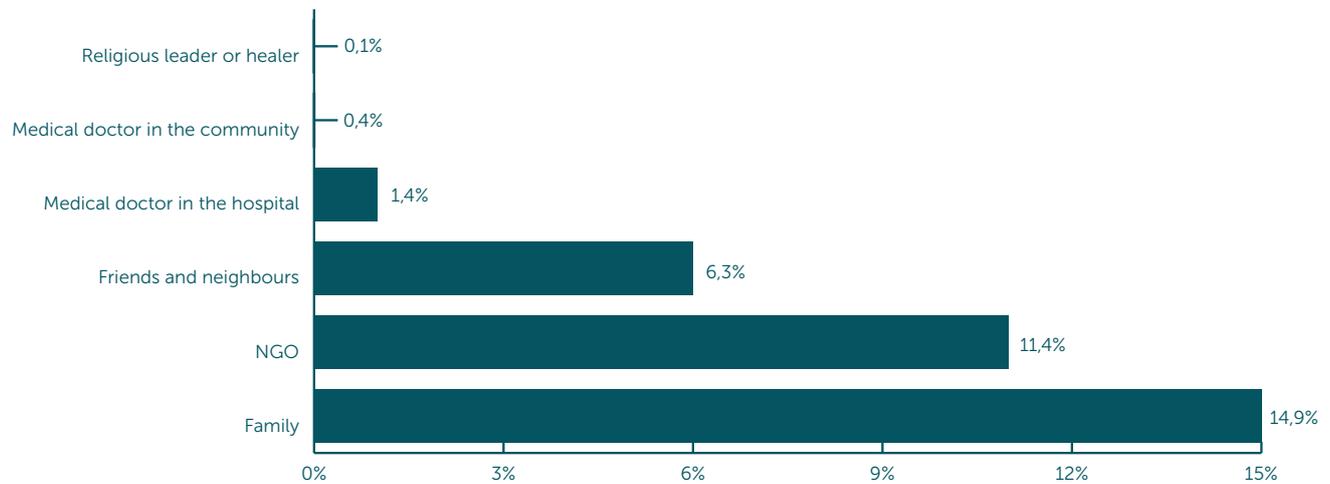


Figure 8. Providers of support for dealing with life stress or distress

Around 42% of Syrian refugees saw themselves recovering from distress over time with help from others. Notably, significantly more men than women saw themselves recovering from distress on their own.

The qualitative data showed that the deteriorating economic situation among refugees living in Lebanon is linked to mental stressors, as well as physical distance to the needed services. "Everything is hard in Lebanon, and we live in an area very far from all the services." (Female FGD participant, Tripoli, Lebanon, March 2018). As a way to cope with distress, some refugees would enjoy gatherings with friends and family members to vent, as well as communicating with their relatives in Syria. Yet, the sense of hopelessness is ever-present. "We feel the most stressed when our people in Syria are under the bombings, and we are unable to do anything for them." (Female FGD participant, Tripoli, Lebanon, March 2018). A few Syrians have never managed to overcome stress, and resorted to medication instead. Some refugees said that they just cried or smoked cigarettes as a way to handling stress.

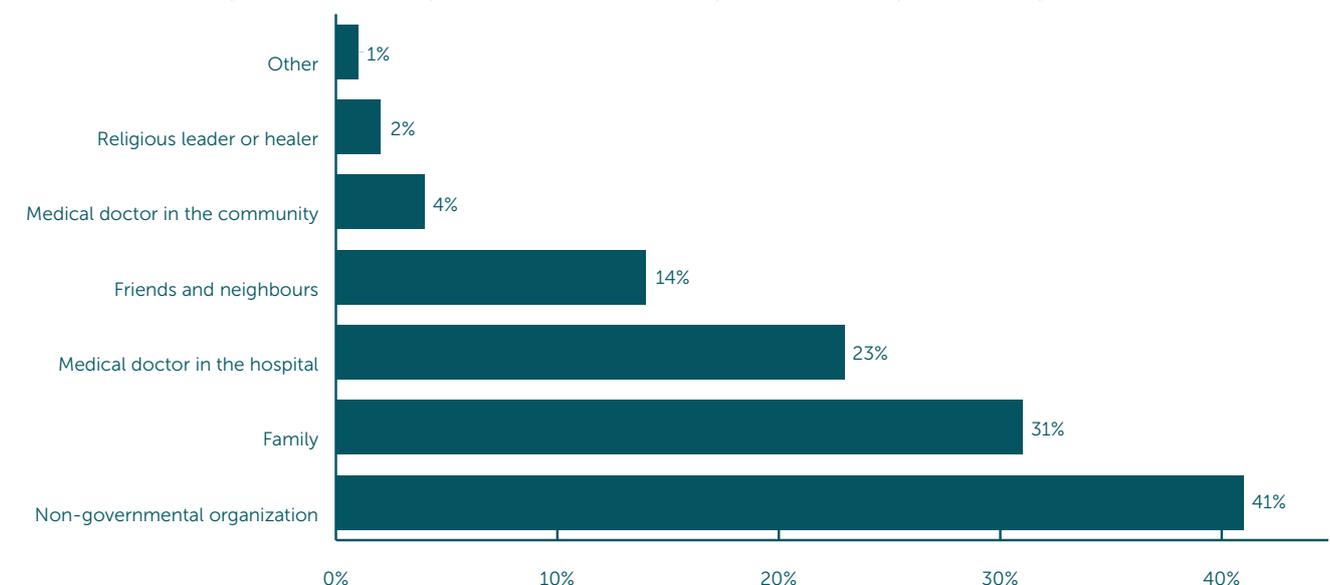


Figure 9. Preferred assistance provider to deal to with physical pain, life stress or distress

Among the 62% respondents who stated that they need assistance for dealing with physical pain, life stress or distress, 41% preferred NGOs to be the main provider in the future. Family was the second most preferred support mechanism. Almost one out of four respondents preferred support from a medical doctor in the hospital. Surprisingly, of the 41% who stated they need assistance from an NGO to deal with pain and distress, only one out of five received help from an NGO. This gap indicates that there are barriers to accessing MHPSS services, or lack of NGOs' psychosocial support services in the humanitarian context. This finding must be considered as a call for NGOs to strengthen the quality and quantity of psychosocial support programmes in the refugee setting.

"We feel less distressed when we have some money to ensure the basic needs of the family"





Photo by: Mais Salman/DRC

Barriers to accessing Mental Health and Psycho Social Support

One out of three respondents reported obstacles or barriers to seeking or accessing mental health and psychosocial support. Among refugees in need of assistance for dealing with physical pain, life stress or distress, 42% experienced barriers.

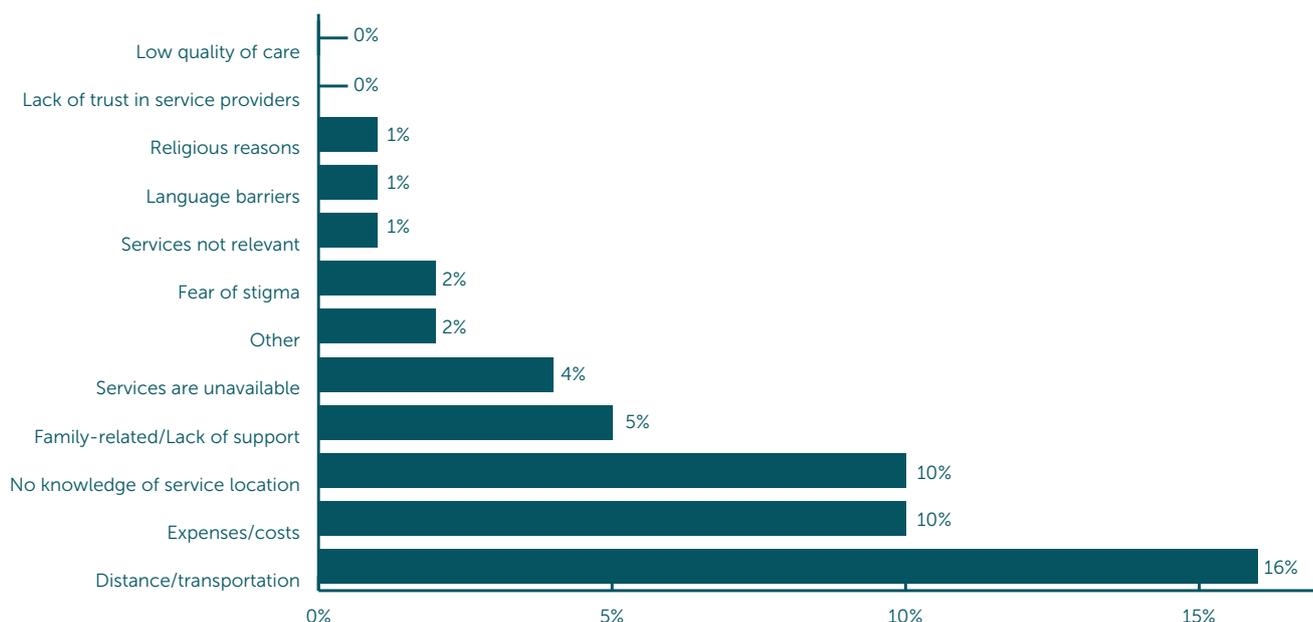


Figure 10. Obstacles to seeking or accessing MHPSS

Looking into the specific obstacles to seeking or accessing MHPSS, respondents reported transportation, expenses and lacking knowledge of location as the top three obstacles; Another 4% reported that the services were not available. These findings were validated during FGDs conducted across areas, whereby participants wanted the psychosocial support centres to be in their areas to avoid paying transportation fees. This suggests that, when refugees encounter obstacles to seeking or accessing mental health or psychosocial support, the challenge would be practical unavailability; long distances and transportation prices, knowledge of location, and lack of money, which also aligns with previous findings on the subject.²⁶ These barriers are tangible, and it could be argued that they are easier to solve than obstacles of stigma, lack of trust in service providers or low quality of care, which were not present in this study. However, it should be noted that the respondents might not be able to assess the quality of the services because of the difficulties in accessing services.

Attitudes for future use and suggestions for MHPSS services

About 67% had a positive attitude towards using MHPSS programmes. Of them, significantly more women than men would consider using a MHPSS programme in the future ($p=0.023$).

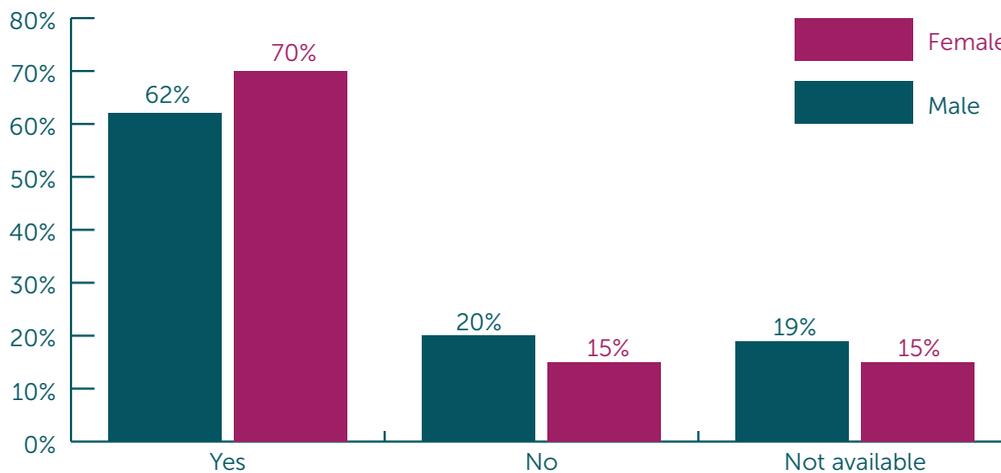


Figure 11. Percentage who would consider using psychosocial support programmes in the future

A large number of refugees require help with life stress and distress, and their willingness to use MHPSS services in the future, stresses the importance of implementing more MHPSS activities. Furthermore, only one in ten respondents have – or know someone who have – made use of MHPSS programmes in their community. One suggestion might be, that since only 20% of respondents knew of psychosocial support mechanisms in their area, very few of those in need would actually know where to go to receive support.

Asking the respondents which complementary services they believed would support people in need of mental health assistance showed a demand for empowering activities (Figure 12).

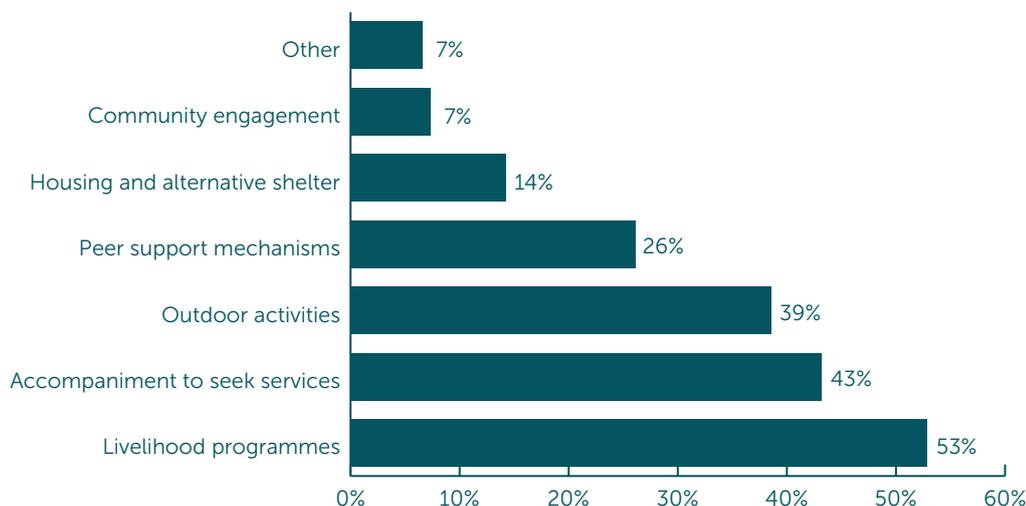


Figure 12. Suggestions for complementary services for people in need of MHPSS

Over one half of survey respondents believed that livelihood programmes would support people in need of mental health assistance in their community, which could be the underlying cause of why they prefer assistance from NGOs. These suggestions align with qualitative findings whereby refugees have linked tangible aid and support to personal well-being. As such, securing basic needs, enjoying valid residency and livelihood opportunities were predominantly noted by refugees as essential for their well-being. Livelihood programmes could therefore empower, as lack of work and money is a huge issue among Syrian refugees. "Despite feeling tired, we benefited from the training activities, we worked and they provided us with sewing kits. These activities have positively influenced our daily lives." (Female FGD participant, North Bekaa, Lebanon, March 2018).

Another 43% of refugees suggested that "accompaniment to seek services" would support people in need of mental health assistance. During FGDs, refugees also noted that people in need of mental health assistance need to have access to psychosocial support services, which are sometimes far from the area. By far, refugees believed that case workers and experts would support refugees in need of mental health services, as would vocational and other livelihood courses and training. Refugees have also favoured outdoor and recreational activities. Compared to the previously mentioned findings, only 14% suggested "housing and alternative shelter" as possible solutions for people in need of MHPSS. However, a decent shelter is considered a basic living condition, which might be the reason why the score is low compared to more empowering activities.

Discussion and recommendations

Syrian refugees in Lebanon face multiple challenges that are affecting their wellbeing and mental health situation. In this survey, 62% expressed a need for assistance to deal with physical pain, life stress or distress. Furthermore, the majority do not have access to mental health support because they are either not aware of the availability of the services, cannot afford the costs associated with the services or the services are completely missing from their areas. This is supported by similar findings from Jordan in 2017,²⁷ indicating a general need for improving both access and awareness of MHPSS in the region.

The most crucial factors influencing the mental health symptoms; distress, pain, functionality and self-rated health among the refugees were; loss of a close family member, age and basic needs such as lack of work and money, decent shelter and school for children. Figure 13 summarises the associations between exposures and outcomes, relations between other influencing factors and outcomes, correlations between mental health outcomes, as well as perceived barriers and suggested solutions for future services. These conclusions are based on the findings from the qualitative and quantitative analyses. We tested the different associations using the backwards stepwise selection in logistic regression and ended up with a model consisting of only significant associations. The most pronounced causes, barriers and suggested solutions from the qualitative data material have been selected to substantiate the quantitative findings.

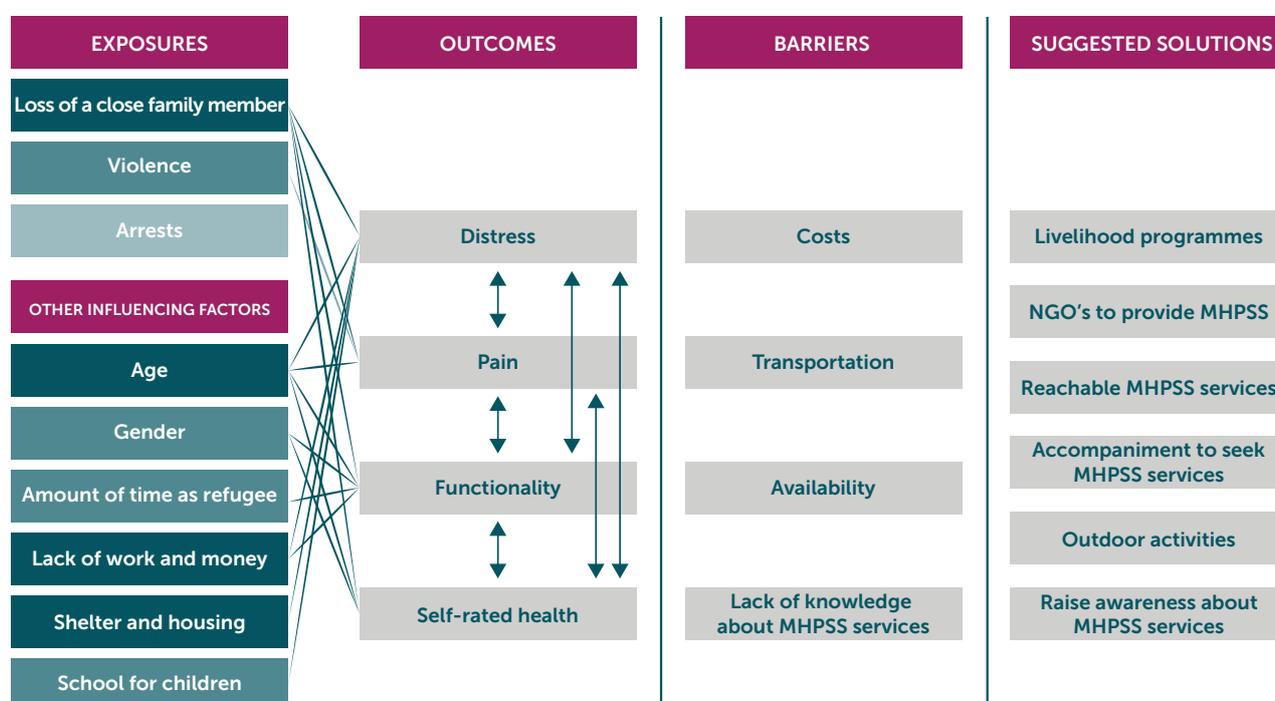


Figure 13. Causal diagram including perceived barriers and suggested solutions

In terms of loss of a close family member, there is no doubt as to the strong and negative effect on mental health symptoms. Approximately 25% of the respondents had lost a close family member, and this sole exposure was significantly related to all mental health outcomes. Less convincing but still significant was the association between exposure to violence and experiencing pain. In this study, we found positive correlations between distress, pain, functionality and self-rated health. This finding is confirmed by modern pain science that provides neuroscientific explanations of the underlying causes of pain occurrence and describes the interaction between pain and mental health challenges, such as distress and functionality.^{28,29} The majority of respondents (80%) are not aware of any mental health or psychosocial support services in their community, and among the most frequently mentioned obstacles are distance and lack of knowledge of the service locations. We can therefore conclude that there is a high demand for increased MHPSS provided by NGOs, with reference to the fact that almost 60% of respondents have distress and approximately 70% are positive towards using MHPSS in the future.

27 International Medical Corps 2017, *Understanding the Mental Health and Psychosocial Needs and Service Utilization of Syrian refugees and Jordanian Nationals*. Retrieved from <https://data2.unhcr.org/en/documents/download/62036> on the 22nd of May 2018.

28 Butler D, Moseley L. *Explain pain*. 2nd Edition Noigroup publications 2013.

29 Butler D, Moseley L. *Explain pain Supercharged, The clinician's manual*. 1st edition Noigroup 2017





In general, women were more likely to seek help from others than men. To attract the interests of men, the services could include other elements, such as livelihood or outdoor activities, which was also suggested by the respondents. Old age increased the risk of reporting negatively on all mental health outcomes in this survey, indicating a need to focus on interventions for the elderly. Securing the basic needs was a recurring issue in the qualitative findings. With reference to Maslow's pyramid of needs, the basic physiological needs, such as food and sleep, will outweigh other needs e.g. psychosocial support needs, if the basic needs are not met. This perspective might have emerged during the FGDs, resulting in quotations concentrating on basic needs. Moreover, the quantitative findings provide strong evidence supporting the need of MHPSS among refugees and other vulnerable populations in Lebanon, as well as positive attitudes towards using it. MHPSS programming should take the basic needs into account to avoid that it becomes a barrier to a successful intervention focusing on psychosocial needs.

As figure 13 show, the barriers to seek help were primarily practical – transportation, costs, lack of knowledge about MHPSS services. In conclusion, this means that there is limited access to and availability of services. Furthermore, the suggested solutions from the respondents in this study were mainly focused on strengthening the outreach and

awareness about MHPSS, as well as participatory activities, such as livelihood programmes, accompaniment to seek MHPSS services and outdoor activities. Accompaniment and increased awareness about services might link more people in need of mental health assistance to the services. As stated earlier, this also suggests that NGOs should increase delivery of psychosocial support services in nearby communities, compared to the demands in the informal settlements. Concerning functionality levels, the Syrians were not affected on their ability to maintain a friendship or to participate in community activities despite of their war- and displacement related experiences. It could be argued that this is reflected in their suggested solutions for complementary activities for people in need of MHPSS, as these are community oriented.

Limitations

The prevalence of experiences of violence and arrest was relatively low, which might be explained by a gender bias. Female respondents were over-represented (67%), mostly due to a majority of men being out of home working or looking for work during data collection hours. Although DRC did introduce flexible schedules based on consultations with men, safety and security concerns prevented data collection in the late evening in certain high-risk areas causing



a potential selection bias in the findings. In general, men are more often arrested than women, which can have led to an underreporting of arrests in this study, and therefore a lack of association between arrests and distress, pain, functionality levels and self-rated health. In this study, 81.4% of the arrested, were men. Likewise, 60% of the respondents who had experienced violence were men. If there were more men in the study, we might have seen an association between violence exposure and distress, pain, functionality and self-rated health. However, gender-based violence would be more prevalent among women, which argues against underreporting in this study. Still, the low prevalence of violence does not correspond to findings from other surveys on Syrian refugees. One study showed that 50% of a Syrian refugee sample in Greek refugee camps have experienced violence in their home country, and an equally high number reported experiencing violence during flight (33%).³⁰ Violence during refuge was less prevalent, as 3.8% of displaced Syrians in Greece had experienced violence inside the refugee camp. Another explanation could be

a different perception of how violence is defined and therefore a higher degree of acceptance of violence as part of every-day life. Furthermore, violence and arrest levels may also be underreported due to taboo. For instance, sexual violence against men during arrest in Syria has been documented.³¹ These experiences may have been so traumatic and shameful, that the victim would choose not to disclose it. Since sexual violence was considered too sensitive to investigate in this survey, this hypothesis could not be tested. The results show a very positive attitude towards future MHPSS services provided by NGOs. This result can be an example of information bias, as the enumerators very obviously represented a NGO by wearing vests with logos. This might have led the respondents to see them as a solution to their problems, causing the respondents to answer NGOs as potential providers of MHPSS. Finally, self-reported measures will always be associated with bias, and informants can have withheld information for different personal reasons.

30 Jihane Ben Farhat et al. "Syrian refugees in Greece: Experience with violence, mental health status and access to information during the journey and while in Greece," *BMC Medicine* (2018) 16:40 1-12.

31 UNHCR, *We keep it in our heart: Sexual violence against men and boys in the Syria Crisis*, 2017, https://data2.unhcr.org/es/documents/download/60864#_ga=2.121844236.641198675.1512507880-2095888809.1417795315 (Accessed May 14, 2018).

Recommendations

NGOs should provide MHPSS services with a focus on empowerment and self-reliance. Respondents demanded service provisions by NGOs, which indicate the visibility of the NGOs' work in this region as well as a high degree of trust in NGOs. Wherever possible, MHPSS programming should aim to be empowering in nature and create sense of autonomy and control, to fight the present sense of helplessness among the Syrian refugees. Moreover, the participatory and relational aspects of functionality are essentially intact among the respondents, which serves as a strong basis for empowering activities, such as outdoor and recreational activities. The FGDs also showed great willingness and satisfaction with participatory activities. Since stigma does not seem to be a barrier, and because of the positive results on maintaining friendships and being able to join community activities, there is a potential for introducing group based interventions.

Introduce interventions focusing on pain mechanisms, coping strategies and physical resilience. This assessment revealed severe pain levels, and a strong association between feeling pain and feeling distressed. Suffering from chronic pain can be caused by mental challenges that are not recognised by the individual. Identification of people in need of MHPSS can therefore be strengthened by focusing on pain mechanisms, coping strategies and physical resilience. Furthermore, this study highlights that the refugee population in Lebanon are severely emotionally affected by their health problems, even at a relatively young age. At the same time, they have difficulties in doing day to day work because of limited functionality. Focused pain interventions addressing the overall bio-psycho-social consequences of long-lasting distress and trauma, including promotion of positive coping mechanisms can therefore improve the well-being, functionality and efficiency in the target group's daily lives.

Implement livelihood programmes. According to the Syrian refugees in this study, lack of work and money to support the family increases the levels of distress and results in hopelessness and sadness. Promoting livelihood programmes was the top priority for the respondents when asked for complementary activities for people in need of MHPSS. However, the psychosocial state of the target group might be a barrier for a successful livelihood programme. If functionality levels are improved and pain levels are decreased by a focused approach on bodily symptoms, the likelihood of completing a training programme will increase. Completion of the training directly affects the chances of having a successful livelihood programme with tangible outcomes, such as food and shelter.

Increase service accessibility and outreach activities. The top three barriers to seeking support for mental health problems were transportation, costs and lack of awareness

about service location. Suggestions for ways to overcome these barriers include 1) Promote outreach activities to ensure identification of those in need, 2) Conduct home visits to reach remote locations, 3) Set up mobile clinics 4) Provide cash for transportation for those in need of specialised services at hospitals or like, 5) Include MHPSS activities in existing programmes to increase number of participants.

Provide support groups for people who have lost a close family member. Losing a close family member was significantly associated with all the mental health symptoms in this survey. This finding has programming implications as it touches upon grief - a life condition that cannot be fixed, but needs attention and care. To further explore the best way to help people in grief, it is recommended to conduct a few FGDs among refugees who have lost a close family member.

Highlight the importance of supervision and training. Addressing the well-being of helpers is a key concern for staff working with traumatized populations. It is recommended to include Training of trainers in supervision for humanitarian MHPSS work, as this is a cost-effective way of addressing the need of self-care for staff. Furthermore, support and training for health professionals both ensures quality in delivery of services as well as preventing burn-out.

Ensure high quality service provisions by applying relevant outcome measures and to further contribute to the evidence base for MHPSS. Increasing access to MHPSS services is only one part of improving mental health support for vulnerable populations. The effects of the provided services should be measurable in terms of improved mental health symptoms and social outcome measures, such as resilience, coping, social support, substance misuse and suicidal ideation.³² Systematic collection of data on specific outcomes can contribute to ensuring cost-effective use of development assistance, continuous evaluation of results on an individual basis and to further contribute to research on humanitarian mental health assistance.

Diversify MHPSS activities to different target groups, including men and women, and address the needs of elderly and individuals with disabilities. Recent mapping of MHPSS services from Jordan highlights a gap in services directed at individuals with disabilities, as well as the elderly.³³ The results from this study show high levels of pain and low self-rated health levels, especially among the elderly. If a MHPSS intervention is focusing on physical resilience and management of pain, it could be worth considering addressing the needs of the elderly and people with disabilities.

32 Bangpan Mukdarut, Anna Chiumento, Kelly Dickson & Lambert Felix, *The impact of mental health and psychosocial support interventions on people affected by humanitarian emergencies: A systematic review*. Humanitarian Evidence Programme. (Oxford: Oxfam 2017)

33 International Medical Corps, *Who is doing what where & when (4WS) in mental health & psychosocial support in Jordan?* 2017, <https://reliefweb.int/sites/reliefweb.int/files/resources/IMC%202017%20Jordan%20MHPSS%204Ws%20Mapping%20Report.pdf> (Accessed May 15, 2018)



This study was a joint collaboration between Danish Refugee Council Lebanon and DIGNITY - Danish Institute Against Torture with support from American University of Beirut, Center for Civic Engagement and Community Service (CCECS). We would also like to thank Rabih El Chammay, MDHead of Programme National Mental Health Programme, Ministry of Public Health Lebanon for kind advise and support during the process.



The Danish Refugee Council (DRC) is a humanitarian, non-governmental organisation that provides assistance to conflict-affected populations and host communities. Active in Lebanon since 2004, DRC's protection programming in Akkar, Tripoli, Bekaa and South encompasses child protection, gender-based violence and legal aid and is structured around three pillars of intervention: prevention, response and systems strengthening and advocacy.



DIGNITY - Danish Institute Against Torture is a knowledge generating self-governing development institution. DIGNITY is organized in three broad themes: Rehabilitation in Denmark and abroad, Prevention of violence in Detention and Prevention of Urban Violence. In all three areas, DIGNITY undertakes interventions and implements research. Our national rehabilitation department offers professional, multidisciplinary support to victims of torture and traumatized refugees in Denmark based on more than 30 years of experience. Our international rehabilitation department supports local rehabilitation services around the world focusing on capacity building, teaching of treatment teams as well as effect-monitoring of interventions.