Policy Brief

Dynamics of Mental Health and Psychosocial Support Services in Lebanon: Access, Utilization and Delivery

Our Next Steps

- The team will next study MHPSS service provision in Greater Beirut and Beqaa.
- Specifically, we will focus on whether providers are able to integrate MHPSS services in daily practice and on how MHPSS conditions are currently identified, managed and referred.
- This study will generate evidence on the burden of mental health disorders, with a specific focus on the prevalence of depression, and will additionally identify opportunities for strengthening MHPSS service delivery.

NIHR Research Unit on Health in Situations of Fragility (RUHF)

The National Institute for Health Research (NIHR) RUHF seeks to identify sources of resilience within formal health systems and local community processes to facilitate effective provision for health priorities – particularly mental health and non-communicable diseases (NCDs) – in situations of fragility.

To this end, the Global Health Institute at the American University of Beirut (AUB), has joined with the Institute for Global Health and Development, Queen Margaret University (QMU), and the College of Medicine and Allied Health Sciences (COMAHS), University of Sierra Leone, in a research programme initially funded between 2017 and 2021.

The Research Unit on Health in Fragility (RUHF) will support the national Ministry of Public Health and key stakeholders to effectively address mental health needs in Lebanon.

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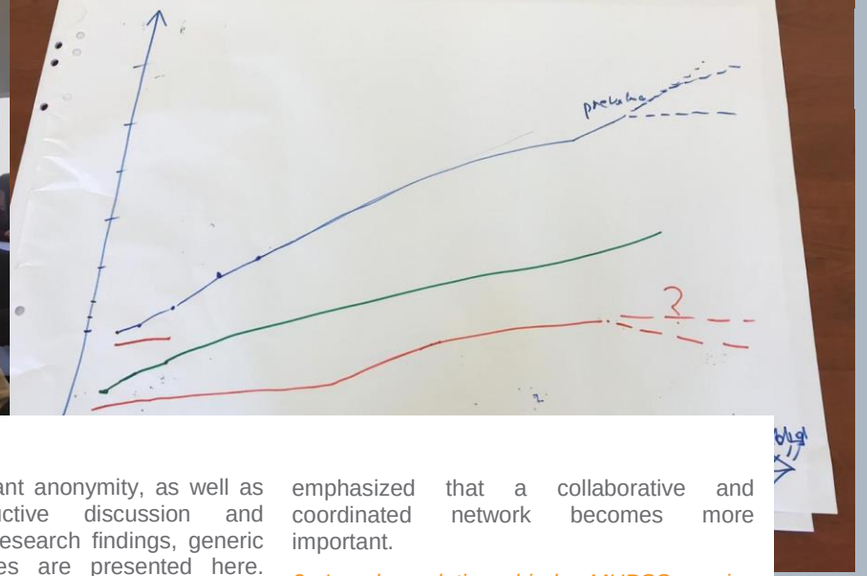


Background on the Context

Lebanon is a small middle-income country with a long history of war and political unrest. It has a population of around 4,350,000, including 400,000 Palestinian refugees (UN DESA 2017). Since the beginning of the Syrian crisis, Lebanon has witnessed a population increase of 37%, having 1 million displaced Syrian refugees, of which more than half are women and children (UNHCR 2018).

Available evidence on mental health disorders in Lebanon (among any of its populations) is limited; however, 1 in 4 adults (Karam et al., 2008) and children (Maalouf et al, 2016) suffer from one or more mental health disorder (Karam et al. 2008,). In addition, a significant treatment gap was noted where the minority who have sought help and received professional treatment experienced substantial delays between the onset of disorders and onset of treatment (Karam et al. 2008; Maalouf et al, 2016). While the rate of health seeking for mental health conditions is low in Lebanon, in a recent study to be published, half of participants stated their willingness to consult a professional (Karam et al, 2016).

Research Methods

In this brief, we present the preliminary findings of 20 semi-structured interviews and six Group Model Building (GMB) workshops conducted between March and April 2019. Target populations that participated in the research included healthcare providers, Syrian refugees, and Lebanese host community members living in the Greater Beirut and Beqaa. The two areas represent contrasting settings: Beirut is the capital city, reflecting the main urban center of the country and (2) Beqaa area is the rural setting.

The two settings differ in terms of fragility levels, particularly in the domains of health service delivery and community dynamics. Beqaa hosts a larger percentage of the Syrian refugees (36%) compared to Beirut (24%) (UNHCR 2018), and according to the UN-Lebanon Interagency taskforce, Beqaa region is in need of major health institutional support (UN Lebanon 2017).

Second, poverty rates are generally estimated to be the lowest in the GB area (between 16% and 22%) and the highest in the Beqaa governorate (38%) (CAS & WB, 2015). The economic situation in Beirut attracts more wealthy Syrian refugees; by contrast, in the Beqaa region most refugees live in the tented settlements (Vliet et al, 2014), which places enormous pressure on the host community in the area leading to inadequate provision of social services for refugees (Vliet et al, 2014).

Key Findings

To protect participant anonymity, as well as stimulate constructive discussion and engagement with research findings, generic summary messages are presented here. Detailed analysis and results linked to outputs from the GMB sessions will follow in due course.

1- MHPSS service delivery is hampered by the limited communication and coordination between various stakeholders including public and private providers, as well as Ministries

Health providers across public and private institutions (both non-governmental organizations (NGO) and otherwise) welcomed the existence of the National Mental Health Taskforce and spoke positively about its activities and attempts to ensure communication and coordination between diverse MHPSS providers. However, they noted that no unique health information system for MHPSS patients or a clear referral network or system yet exists in Lebanon, resulting in gaps in service delivery or duplicated effort.

Additionally, communication between providers at health facility levels, across both public institutions and the NGO network, is limited. Similarly, gaps in communication between MHPSS providers and representatives of other Ministries (e.g. Social Affairs and Education and Higher Education) is limited. This affects the quality of the delivered services, especially in Beqaa, where a limited number of providers and centres exist for admitting patients with mental health issues; in such situations, participants emphasized that a collaborative and coordinated network becomes more important.

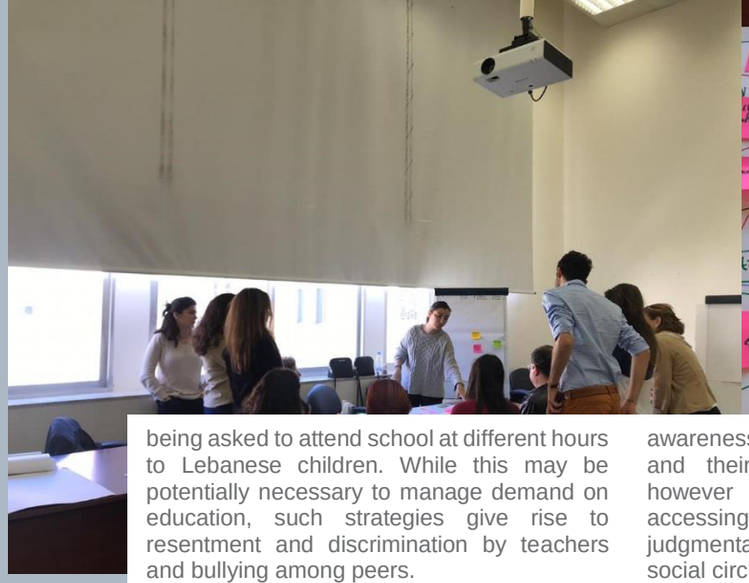
2- Legal regulations hinder MHPSS service delivery for emergency care

Currently, MHPSS providers are unable to admit extremely vulnerable patients (e.g. homeless persons) with urgent mental health issues to emergency care due to health regulations, which require the signature and consent of a family member or guardian.

Both health providers and community members disclosed that people with severe mental health conditions are often isolated from the family and potentially abandoned; therefore caregivers may not be available to provide consent for admission.

3- Integration challenges between host communities and Syrian refugees exacerbate MHPSS issues

Both Syrian and Lebanese participants acknowledged that limited integration between these two communities shapes, and potentially gives rise to, mental health and psychosocial support issues. For example, Syrian participants mentioned that they are often paid less than their Lebanese counterparts, leading to situations where Lebanese employers preferentially employ Syrians. The difference in wages creates resentment among the Syrian community, while the increased unemployment contributes to feelings of resentment and opposition among the Lebanese community. Another example includes Syrian children



being asked to attend school at different hours to Lebanese children. While this may be potentially necessary to manage demand on education, such strategies give rise to resentment and discrimination by teachers and bullying among peers.

4- Tense family dynamics and violence give rise to mental health issues that affect future generations

Both Lebanese and Syrian community members noted that poverty is a major stressor for vulnerable communities and family life. Limited parenting skills were identified as aggravating family tensions, often resulting in parents verbally and physically abusing their children, thus modelling behaviour which is replicated across future generations.

Participants also stated that limited mental health awareness and stigmatization in relation to MHPSS contributed to parents' inability to recognize their child's distress.

5- Stigmatization of mental health issues persists between the Lebanese and Syrian populations

Participants across both community groups agreed that mental health issues are highly prevalent. For the Lebanese community they reflected that the previous wars as well as current socioeconomic status and inequality contributed to this, while the Syrians associated onset of conditions with the recent crisis.

Stigma towards mental health is one of the strongest impediments to accessing MHPSS services. Generally, participants expressed awareness of their own mental wellbeing and their readiness to seek support, however they revealed being afraid of accessing the appropriate care due to the judgmental and unaccepting attitude of their social circle.

Women in general and the Syrian community more specifically were more likely to say that they would speak to a MHPSS healthcare provider.

Future directions:

- **Strengthening collaboration and communication strategies both horizontally and vertically within the systems for mental health care (involving both public and private care providers and other sectors) is key to the advancement of mental wellbeing. Introduction of referral guidelines and unified procedures may be a first step in this direction.**
- **Amending the mental health decree (ACT#72) to address main issues such as the standards and regulations for involuntary admissions is necessary to ensure current mental health policy is sensitive towards Lebanon's most vulnerable population.**
- **Given Lebanon's limited resources, current policy strongly leans towards Syrians returning to their home country. However, short-term integration challenges among communities must be addressed, and educational policy and practice should in particular needs to address discrimination and bullying.**
- **While tackling poverty alleviation and social inequality is necessary for securing health in the long term, family-based participatory programs to strengthen communities and family support systems are currently needed to diffuse family tensions and provide parents with adequate parenting skills.**
- **Addressing mental health stigma is imperative for strengthening individual, family and community health. Awareness raising initiatives for community members as well as health care staff through social media campaigns and other effective mechanisms are required to shift the discourse on mental health, normalize discussions of these issues and raise awareness of available mental health services.**