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The Mental Health and Psychosocial Wellbeing of Migrant Workers Under the Kafala System

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The study is published by the GIZ 'Mental Health and Psychosocial Support (MHPSS) – Strengthening of Psychological Resources for Crisis Coping in Lebanon' project on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ) in cooperation with the Committee on Advocacy for MHPSS for Migrant Workers in Lebanon under the umbrella of the MHPSS Taskforce coordinated by the National Mental Health Program within the Lebanese Ministry of Public Health.[1]

Due to the precarious conditions of migration and experiences of structural discrimination and exploitation, persons working under Kafala are exposed to a wide range of stressors which negatively impact their mental health and psychosocial well-being. In Lebanon, the convergence of crises over the past two years has led to increased levels of unemployment, homelessness and exploitation, thereby exacerbating the experiences of distress and trauma that persons under Kafala often suffer from. Drawing on consultations with migrant workers, including migrant community advocates, and MHPSS service providers and program managers, this study intends to inform organisations either conducting Mental Health and Psychosocial Support (MHPSS) activities with migrants or interested in implementing activities in a MHPSS-informed way. It provides a socially situated understanding of the ways in which persons under Kafala encounter and respond to different forms of distress, identifies best practices for supporting mental health and wellbeing and provides practical ideas for effective MHPSS interventions. While the analysis and recommendations draw on the example of Lebanon, they are also relevant for other countries in the MENA region in which the Kafala system applies. The study includes a qualitative assessment of the current MHPSS service provision landscape in Lebanon, its challenges in terms of quality, access and utilisation, as well as recommendations for improvements of existing services and gaps to be filled.

[1] Special thanks goes to the persons who are migrant workers and whose thoughts and experiences are the core of this study, as well as to Dr. Rabih El Chammay (NMHP), Nour Kik (NMHP), Noha Roukoss (Caritas), Vanessa Kyrillos (MSF), Dima Haddad (IOM), Julia Renck (Caritas), Ghina Alandary (KAFA) and all those who supported this research with input and guidance.

1. Methodology and Key Terms

The term migrants in the scope of this research refers to persons from African and Asian countries who arrived in Lebanon under the structure of the Kafala system. Population estimates of migrants in Lebanon vary widely, as many are undocumented and thus not counted. Further, as the multiple crises in Lebanon have unfolded, many migrants have left the country and returned home, while others have started to come back in as travel restrictions from the COVID-19 pandemic temporarily eased. Thus, population numbers and demographics are subject to significant fluctuations. The traditional estimate used for migrant domestic workers is 250,000.[2] In their assessment after the Beirut port explosion in August 2020, IOM used the estimate of 400,000 migrant workers, though this was inclusive of Palestinian and Syrian migrant workers.

Data collection for the research occurred over a period of 6 weeks in summer 2021 and consisted of literature review and interviews, focus group discussions and workshops with relevant stakeholders. Interviews were conducted with 17 migrants including 6 migrant community advocates,[3] and 14 MHPSS frontliners and management staff. They were facilitated from the same set of predetermined questions, but loosely structured to allow for new information and new lines of questioning to emerge organically from the conversation. Snowball sampling was used to select participants for the interviews, while seeking to ensure a broad representation in the sample. In terms of demographic characteristics, interviews included Ethiopian, Sudanese, Kenyan, Nigerian, Sierra Leonean, Filipino, Sri Lankan, Nepali, and Bangladeshi migrants, including both men (3) and women (13), current live-in domestic workers (2) and migrants living outside of employers' homes. The gender distribution reflects the gender distribution of the overall population of migrants defined in this study in the Beirut area, based on the most recent needs assessment survey conducted by IOM.[4] Because the conditions of migrants vary significantly by nationality, the primary focus was ensuring wide national diversity within the sample.[5] There is greater national diversity within the cohort of female migrants from Asian and African countries, as male migrants from the population defined in the study primarily come from the same national cohort (Bangladesh, Sudan).[6] Snowball sampling leads to a selection of interviewees that favors those connected with the community and information networks located near Beirut. Yet, interview questions asked for insights on those migrants that are more marginalised and face restrictions on mobility, such as migrant domestic workers living inside their employer's home. In addition to the interviews, focus group discussions were held with a group of 40 migrants from different nationalities and backgrounds (2 English groups, 1 Arabic group and 1 French group).

The data was analysed through the methods of grounded theory which entails coding of the different concepts and discourses that emerge from the data to identify central themes and recurring patterns. Research findings were triangulated through validation workshops and discussions with persons working under Kafala, the service providers/program coordinators of the organisations mentioned in this report and others, as well as the National Mental Health Program (NMHP) in Lebanon. In addition, 2 discussions with stakeholders in Jordan were undertaken to be mindful of regional implications.

2 Kanaan, A. (2020). 'Treated like slaves', migrant workers bear brunt of Lebanon crisis. Reuters; Human Rights Watch (HRW). (2020). Lebanon: Blow to Migrant Domestic Worker Rights.

3 The term community advocate refers to migrants who have voluntarily taken on a leadership role within the scope of an organized initiative or community group.

4 International Organization for Migration (IOM). (2021). Needs and Vulnerability Assessment of Migrants in Lebanon. May 2021.

5 Note: population parameters are based on best available estimates, as there is no systematic population census for migrants in Lebanon disaggregated by both nationality and gender; best estimates of population distribution by nationality (without gender disaggregation) can be found in: United Nations International Organization for Migration (IOM). (2021). Migrant presence Monitoring (MPM) baseline assessment - round first Displacement Tracking Matrix (DTM).

6 See: International Organisation for Migration (IOM). (2020). Lebanon — Migrant Worker Vulnerability Baseline Assessment Report.

The research design received ethical approval from the NMHP and Ministry of Public Health (MoPH). Informed consent was obtained from all participants before conducting interviews and collecting data. They were provided with a detailed explanation of the goals and process of the study and were guaranteed to have their personal information kept confidential. Participants were informed of their right to withdraw from the study at any point and were given contact info for researchers and program managers in case they had any questions or concerns about the research after the interview. Those needing assistance were referred to the appropriate service providers.

1.1 Understanding of MHPSS

Describing the psychosocial experience of people whose voice is structurally silenced (such as migrant workers in the MENA region) entails the risk of betraying their experiences by imposing on them frameworks of analysis (such as the MHPSS framework) that are not meaningful to them or of essentialising their experiences. In our research we intended to speak with (rather than speak to or speak about) migrant workers in Lebanon and we provide in this study as many original quotes as possible.

Mental health and wellbeing are always, at least partly, expressions of the socio-political contexts in which the persons or groups of persons are living. Understanding the psychosocial experiences of persons working under Kafala thus requires an understanding of the structural conditions that shape their daily lives. Otherwise, one risks labeling expressions of distress as abnormal, even though they are adequate reactions to what someone is going through, for instance experiences of discrimination and structural violence.[7] Without a robust understanding of and attention to the social determinants of mental health, there is a risk of over-pathologising social conditions using quick diagnoses and over-medicating in cases when it is not appropriate. Next to this socio-political understanding, an MHPSS approach for persons working under Kafala also needs to be culturally informed,[8] since expressions of mental health and wellbeing are partially learned and contingent on someone's social and cultural upbringing.[9] It is beyond the scope of this report to describe the various and culturally informed expressions of distress. However, it is within our scope to highlight that MHPSS with migrants is political, given that most of their MHPSS needs would not arise if they would be working in a system that respects their rights and dignity. In other words, the most powerful means for improved mental health and wellbeing would be dismantling the Kafala system and replacing it with a rights-based migration and residency system.

Overall, the MHPSS approach applied in this research is rooted in the socio-economic and political determinants of mental health and wellbeing. It assumes a politicised, community based, and culturally informed perspective, which considers the specific forms of social suffering and structural violence that persons experience under Kafala.

7 Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. Social science & medicine, 48(10), 1449–1462.

8 Culture is a constellation of practices, symbols, values, and ideals that are constructed and shared by a community, transmitted from one generation to the next, constantly renegotiated and subject to change.

9 Panter-Brick, C. (2014). Health, risk, and resilience: Interdisciplinary concepts and applications. Annual Review of Anthropology, 43, 431-448.

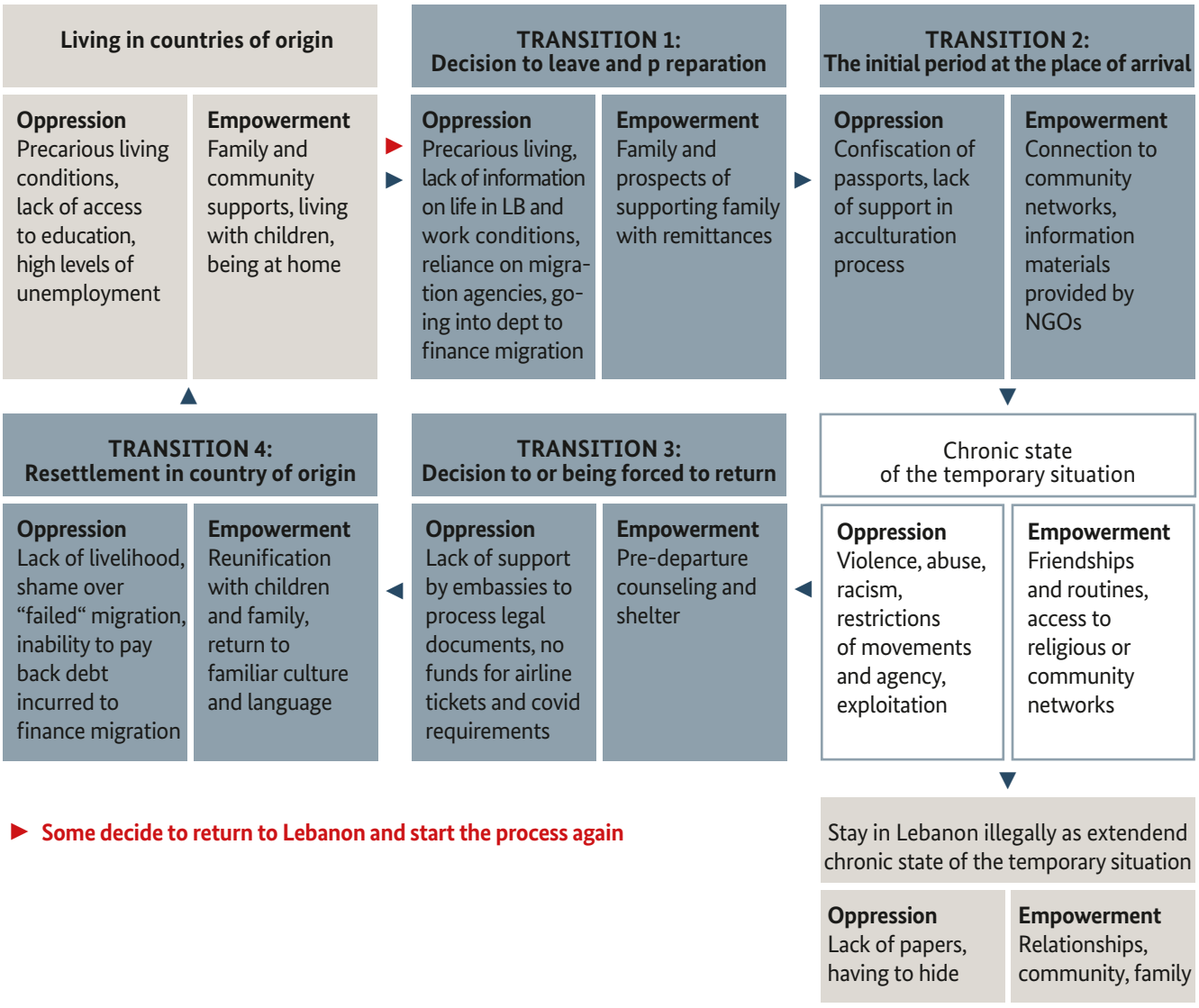
1.2 Understanding of Trauma in the Context of Migration

Migrants are more likely to suffer from mental health challenges than the local population in the country of immigration, as well as the country of origin. The migration process carries with it inherent stressors, which can lead to diagnoses of serious mental conditions such as (complex) post-traumatic stress disorder (PTSD), major depressive disorder, psychotic disorders and suicidal ideation. Risk factors identified in literature on MHPSS and migration include experiences of racial discrimination, detention or abuse by law enforcement, separation from families, deportation, limited social network/weak social integration, limited access to mental health services, socio-political vulnerability such as lack of legal status, unemployment and difficulties from acculturative stress (i.e., language and culture differences).[10] However, even though descriptions of the prevalence of mental health disorders among migrants are important to show that the migration experience can overwhelm any person's capacity to adapt, a symptom-based perspective falls short of expressing the complexity of the migration process.[11] More adequate is German-Dutch psychoanalyst Hans Keilson's model of sequential traumatisation, which conceptualises trauma as a chronological sequence of phases. Migrant workers' trauma is a systematic and oftentimes life-long process of disempowerment and struggle for agency. At the same time, the majority have developed powerful strategies for staying mentally healthy despite the abuse and exploitation. Sources of disempowerment or – to emphasise the sociopolitical significance – oppression, coexist(s) with sources of empowerment, either developed by migrants themselves or nurtured by the community and social contexts, as shown in the graph on the next page.

10 Bustamante, L. H. U., Cerqueira, R. O., Leclerc, E., & Brietzke, E. (2018). Stress, trauma, and posttraumatic stress disorder in migrants: a comprehensive review. Brazilian Journal of Psychiatry (2), 220–225.

11 German Cooperation (GIZ). (2018). Guiding framework for mental health and psychosocial support (MHPSS) in development cooperation: as exemplified in the context of the crisis in Syria and Iraq.

Based on Keilson's model, migrants' experiences are characterised by a constant state of being "in transition" (dark grey in the graph), which creates feelings of uncertainty and impedes planning and the development of routines. The graph shows a cycle, because some migrant workers decide to return to Lebanon (or another country where they work) after staying for some intermediate time in their countries of origin. Some migrants decide to stay in Lebanon but will never acquire formal recognition and are forced to hide from the authorities, thereby risking being sent to prison due to their illegal status at any point.



The sequential traumatisation of migrant workers, as adapted from Hans Keilson's model and GIZ's Guiding Framework for Mental Health and Psychosocial Support (MHPSS) in Development Cooperation.

2.
The Psychosocial Experience of Migrant Workers in Lebanon

There is no singular, universal experience for persons under Kafala in Lebanon. The system is a decentralised labor regime which applies standards and regulations according to nationality and bargaining power of the sending country, rather than a uniform and equitable system of regulation for all workers. In effect, it operates as a form of privatised labor regulation whereby migrants are subsumed under the authority of private employers upon their entry into the country, and then left to navigate whatever particular conditions or circumstances arise. As a result, migrants from different nationalities and backgrounds live under different sets of conditions and have different levels of access to networks of support and protection for mental health and psychosocial well-being. Further, due to the racial hierarchies that are reflected in the Lebanese society and reinforced by the Kafala system, different nationalities are subject to particular forms and degrees of racism and structural discrimination based on national origin. Thus, while migrants are often understood as a particular cohort, there is wide variability and diversity in their conditions and experiences. Needs and vulnerabilities regarding MHPSS may vary according to a wide range of factors, including nationality, gender, occupation, residency status, migration pathway and language, among others. While the MHPSS approach must be rooted in the structural context of the Kafala system, there must also be space and flexibility to accommodate the different intersections of identity and experience which characterise the diverse population of migrants in Lebanon.

2.1 Intersectional Discrimination (Racism, Sexism, Class)

The Kafala system, particularly as it relates to domestic work, is based on the gendered discrimination of racialised women and domestic labor. Domestic labor as 'women's work' is devalued within the social and economic structure of the country and exempted from the labor code. Thus, migrant domestic workers are excluded from legal protections and labor rights and are instead subsumed under the complete authority of their employers. The power dynamics of this system restrict their mobility and autonomy and incentivise dehumanising and infantilising treatment, which negatively impacts on mental health and sense of identity and agency.

Sexualised stereotypes and beliefs about migrant women, especially when they are seen outside their employer's house or alone on the street, add a further layer of discrimination. Domestic workers are expected to reside in the homes of their employers to have the capacity to renew their residency permits.[12] If domestic workers are contracted under an employer but do not live under the same roof, General Security personnel have reason to believe that they are working somewhere else therefore violating their residency conditions. Thus, the only options are to live under the complete supervision of the employer or risk the legal consequences of living independently and being suspected to be 'illegal'. Furthermore, because prostitution is one of the few survival options that migrant women have beyond the house of an employer, racialised women present in the public sphere are often assumed to be prostitutes, objectified, harassed and abused. As one woman from Kenya explained,

> *"They use bad language to talk about us, for example, okay, it's not my country, but we have freedom of movement, like the way you can dress in your own country is the way you can dress here. So a Lebanese woman, if she's wearing shorts here, and walking on the road, but they will never call her such kind of name. But if they see African women wearing shorts like that they start saying* ***prostitutes****. Yeah, even one, my friends, we were walking and a guy starts saying: Go back to your country! Go back to your country! Go back to your country!* ***He said you are taking money from our country.***"

Here we see how sexualised stereotypes about African women lead to sexual harassment of migrant women in public spaces. Further the comment about 'taking money from our country' exemplifies one of the impacts of the financial crisis on the treatment of migrant workers. Because migrant workers come here to work and send money back to their families, there is a false perception among Lebanese that migrant workers are a significant cause of the dollar crisis in Lebanon, thus creating a sense of anger and resentment.

12 Insan Association. (2016). Trapped: Migrant Domestic Workers in Lebanon.

The dynamics around race, gender, and socio-economic status also significantly impact male migrants, given their position as low wage, racialised labor with harsh working conditions, lack of legal protections, and exposure to experiences of racism and discrimination. Perceived social expectations of masculinity can create pressure on men to withhold feelings and prevent them from seeking support when in distress. In particular, the deterioration in socio-economic conditions can elicit experiences of significant mental distress due to an inability to provide financially.[13] In addition, while migrant women face particular vulnerabilities and thus require more support, male migrants can sometimes feel left out or ignored by support programs and services because most of these are targeted specifically at female migrant 'domestic' workers. It is important to keep in mind that while migrant women do face added vulnerability through their gendered position and the patriarchal structures of the system, male migrants are also vulnerable and require specialised support and advocacy. The confluence of all these factors - gender, race, and socio-economic status – compound to promote dehumanising treatment of persons under Kafala which expectedly has detrimental impacts on their mental health and psychosocial well-being.

2.2 Mental Health Amid Lebanon's Crises

The convergence of crises in Lebanon, including the economic crisis, the COVID-19 pandemic, the Beirut port explosion, and the fuel and electricity crisis, has exacerbated the conditions and experiences of distress and trauma for migrant workers already in a vulnerable socio-economic position prior to the onset of the crises. They have been subjected to forced evictions by landlords and employers, harassment, homelessness, loss of job, depreciation of salary, and nonpayment of wages.[14] This is on top of the daily difficulties brought on by the gendered and racialised oppression borne out by the Kafala system which excludes most migrants from any form of legal or social protection and restricts their autonomy and mobility.

The process of migrating and undertaking a new job, culture, language, etc. away from social support systems requires significant adaptation resources to accommodate the shift to a new environment. The series of ongoing crises in Lebanon continue to consume the adaptation resources of everyone, as the environment is constantly changing as new stressors emerge. This confluence of environmental stressors puts a massive strain on persons under Kafala and increases the risk of development of a mental health condition.[15] Providers of MHPSS services in Lebanon already saw the impact on migrant workers' mental health in the form of acute stress, trauma, panic and shock. The medical helpline set up by MSF in April 2020 revealed a widespread need for consultations and referrals, particularly for women under 30. Between April and November 2020, 170 migrant workers contacted the MSF helpline specifically for support with mental health needs, 60% of whom were considered to be in severe psychological distress. Half of the women reported to have suffered physical and/or sexual abuse. Further, women who called seeking assistance for mental health reported experiencing harassment, forced labor, exploitation and trafficking.[16]

13 Morgan, D. (2006). The crisis in masculinity. In Davis, K., Evans, M. & Lorber, J.Handbook of gender and women's studies (pp. 109 - 124). SAGE Publications Ltd; Devkota, H. R., Bhandari, B., & Adhikary, P. (2021). Perceived mental health, wellbeing and associated factors among Nepali male migrant and non-migrant workers: a qualitative study. Journal of Migration and Health, 3, 100013.

14 Cheeseman, A. (2020). Alone and unpaid, Lebanon's migrant maids in grip of mental health crisis. Thomson Reuters Foundation; Bassam, Z. (2021). Expatriate workers at gas stations in Lebanon face insults, threats, and assault amid fuel shortage. Arab News.

15 Bustamante, L. H. U., Cerqueira, R. O., Leclerc, E., & Brietzke, E. (2018). Stress, trauma, and posttraumatic stress disorder in migrants: a comprehensive review. Brazilian Journal of Psychiatry, 40(2), 220–225.

16 Medecins Sans Frontieres (MSF). (2020). COVID-19 and economic downfall reveal migrant workers' mental health crisis in Lebanon.

2.3 Primary Stressors for Migrant Mental Health

Socio-Economic and Legal Conditions

The primary sources of distress reported by migrants were the socio-economic conditions under which they live, which derive from the various forms of structural violence that they face. For those living outside of the employer's house, the primary source of distress reported was inability to meet basic needs in terms of food, shelter and medical care. One migrant woman who escaped the house of her employer described the difficulties of sustaining her health and peace of mind amid the struggle for daily survival:

> *"Okay, so what I can say, it's hard especially for us. When you come from our countries, I come because of my kids. It's hard for me to keep my health good, because I can't eat well, I don't have any job, right now I am sick, I have a skin disease… I can't go to the hospital, cause even selling me a panadol, if I have a pain somewhere, you cannot go anywhere, for black people here, that is the problem. If I want to keep my health, I can't, because I'm jobless, I don't have anything, we are like that. But right now, I've been starving myself since I came here, I can't even go to the doctor because I don't have anything. Because one thing, if I go the hospital they are asking for the papers."*

From her experience we can see how the confluence of multiple interlinked stressors compound. Without the ability to find work, buy food or access medical care, sustaining mental health becomes nearly impossible. It also may lead to negative coping mechanisms and even suicidal ideations.

In May 2021 IOM released a follow-up needs and vulnerability assessment of migrants from a baseline assessment conducted a year prior. The reported priority needs were assistance for food and rent, which have increased since the baseline assessment. Migrant workers are still living with substandard and insecure shelter conditions, rising food insecurity, insufficient household access to clean drinking water or adequate toiletry facilities, cooking and cleaning facilities. These deteriorating conditions have implications for mental health outcomes, as studies have identified inhumane or substandard living conditions as significant risk factors for psychological distress for migrants.[17] Furthermore, half of those surveyed reported that they were unemployed, and half reported they were in debt. 20% reported health problems, half of whom were suffering from physical and mental chronic health issues that required continuous treatment. Furthermore, for those who do not reside in the homes of the employers, the precarity in legal status and having interactions with General Security is a significant source of fear and anxiety, as they are at risk of being detained and imprisoned with limited due process or ability to access support.

Working Conditions

For migrant domestic workers living inside their employers' homes, working conditions are the primary source of distress.[18] One study, which examines the psychoanalytic and social factors in the abuse by employers in Lebanon, indicated that the occupation of domestic work in particular has a high risk of psychological exploitation given the private sphere of the work space, the lack of any legal accountability for employers and the tendency for employers to project psychological and emotional issues onto their employees within the confines of the private home.[19] Because the legal system confers complete authority over the worker to the employer, migrant domestic workers lack privacy and autonomy and are often forced to work throughout the entire day and night without breaks or time for themselves.

17 Zahreddine, N., Hady, R. T., Chammai, R., Kazour, F., Hachem, D., & Richa, S. (2014). Psychiatric morbidity, phenomenology, and management in hospitalized female foreign domestic workers in Lebanon. Community mental health journal, 50(5), 619-628; Anbesse, B., Hanlon, C., Alem, A., Packer, S., & Whitley, R. (2009). Migration and Mental Health: a Study of low-income Ethiopian women working in Middle Eastern countries. International Journal of Social Psychiatry, 55(6), 557–568.

18 Jureidini, R. (2011). An Exploratory Study of Psychoanalytic and Social Factors in the Abuse of Migrant Domestic Workers by Female Employers in Lebanon. Beirut: KAFA (enough) Violence & Exploitation.

19 Aoun, R. (2021). COVID-19 impact on female migrant domestic workers in the Middle East. GBV AoR Helpdesk.

When asked about the sources of her feelings of stress and anxiety, one migrant domestic worker described this lack of control and ownership of her time:

> *"My madam she is always watching at my back, whatever I do... you have to steal your time just to eat."*

and another explained,

> *"The stress it's not only from, coming from the explosion or something, it's stress from inside the work also, because there are, you know work here is also, you're paid only a little, you have to steal your time just to eat and even if you're working at the same time, and most of us are eating somewhere, in the bathroom because we have to finish our work, because there's another work to do, so it's a long, long day for us."*

The constant surveillance experienced by many domestic workers inside their employers' homes is a major trigger for anxiety and can lead to conflicts with employers which put domestic workers at further risk. COVID-19 exacerbated this risk as it left migrant domestic workers stuck in the house at all times with the employer and their family (on the impact of COVID-19 on female migrant workers in the Middle East see Aoun[19]). One interviewee described always feeling scared of making a mistake and getting yelled at which is something her employers do often. When her employer checked the grocery receipt she brought back and saw the large amount - due to the unprecedented inflation occurring amid Lebanon's economic crisis - she became angry and started shouting at her. She explained that,

> *"Sometimes I feel like shouting and getting angry, but instead I try to calm myself down and stop from getting angry, because it's not going to help anything to get angry."*

Another domestic worker from Ethiopia who lives inside her employer's house explained that while her employer 'treated her well', she often 'baby talks' to her and would not allow her to go out to meet friends, as she didn't want her socialising with men.

Employers expect migrant domestic workers not to get pregnant while in the country and thus assume authority over their sexual and reproductive behavior.

Some of the domestic workers she knows from her community even have their food intake monitored by their employers. As she explained,

> *"They act as if they have bought you, they say you're on my name, I will send you back."*

Constantly experiencing this infantilising and dehumanising treatment creates a sense of disempowerment, affects self-esteem and delimits autonomy and sense of agency. Given the links between experiences of social defeat and development of mental health challenges such as depression and anxiety, these stressors faced inside the homes of employers are a major risk factor.

Especially as many domestic workers are confined to the employer's house, identifying and intervening in this deterioration of mental health becomes impossible until the case becomes severe.

One migrant community advocate who regularly helps migrant domestic workers facing distress or abuse explained:

> *"These madams don't treat their maids according to the law... I was at houses, this lady works double, they are not following the law... we, outside, we have to help them, we have dealt with different insanities, different cases, they take our sisters to the psychotic home, they ask us for 3,000, 4,000 dollars. Because they are crazy. We took one to the hospital, she was sick, 'I want my mom', that is all that she is saying. Straight for 3 to 4 hours that she was telling us. She became crazy because she worked 8, 9 months,*

no salary. And the madam promised her I will take you home, gave her a fake ticket and dropped her at the embassy…. There are different scenarios, why these ladies go insane."

Finding ways to reach those confined inside the home is essential to identify and prevent severe cases of mental health deterioration. Usually, it is community advocates that are best positioned to get in touch/contact them, often via phone through WhatsApp or social media. Once the case becomes severe and the employer wants to "remove" the worker, then the embassy or the recruitment agency become the point of contact. However, agencies and some embassies/consulates are not equipped (or willing) to handle these cases, which can lead to the involuntary use of sedatives on patients, sending them to a shelter without proper care or/and involuntary repatriation.

Racism and Discrimination

Furthermore, the frequent experiences of racism that persons under Kafala face are significant sources of stress and trauma. As one interviewee explained,

"*Today, I was almost made to feel less of myself, because of racism... So, the point is, every day, every day, even in the taxi, no one wants to sit next to you, it affects us mentally. Believe me, it does. Because now, for the first time I wouldn't want to go eat in a restaurant because it's filled with Lebanese. And in there they look at me in a much different way. To sit down, to have your peace time, it's difficult.*"

Being subject to this dehumanising environment and treatment can be traumatising. Racial trauma is the psychological, emotional, and physical injury from experiencing racism.[20] It is related to sadness, anger, anxiety, helplessness and powerlessness and is particularly harmful when internalised. Internalised racism is the acceptance by oppressed racial populations of negative social beliefs and stereotypes, which impacts self-worth and self-care. In interviews and focus group discussions, migrants reported that participating in anti-racist activism and organising is a crucial source of empowerment which helps to counteract the damaging impact of racism and discrimination on mental health and psychosocial well-being. Cultivating this culture of resistance by calling attention to racism, raising awareness and creating space to celebrate migrants' identities is a way to attenuate the psychological impact of racism.

Migration Process

Many persons experience significant levels of acculturative stress from having to adjust to a different language and sociopolitical environment. The stress from this adjustment process is particularly high when there are big differences in expectations and reality of the migration process. Many people are not informed or lied about where they are going or what they will be doing in Lebanon. This is especially true for migrant domestic workers, many of whom are not aware they will be going to live inside an employer's house, and then are immediately brought to a house and forced to live and work under very difficult conditions. One interviewee explained:

"*I couldn't make sense of my arrival in Lebanon, I did not expect that Lebanon is bad, I got into a depression, I lost my rights.*"

Another woman described her experience encountering an unexpected reality upon her arrival to Lebanon:

"*When we came here, our agents from our country lied to us, we are coming to another country, we are going to earn this much money. But when I come, I go to my madam house, and I didn't get food for two days, I was living like a slave, I was downstairs down in the basement, my salary was decreasing. It was like the worse kind of hell. So, as a freelancer you don't deal with such, but when you come outside, you don't have any documents. Even when we go to our embassy, our embassy does not have room for us. They will tell you to go get $400 to pay for a ticket. No job, it's hell I swear. So, you know at the end of the day we have this house, we have a toilet, we have 3 or four of us in one room, we live with migrants, we share.*"

[20] ibid

This gap in expectations and reality is a serious source of distress, particularly for those newly arrived in Lebanon. This emphasises the importance of implementing effective monitoring and enforcement mechanisms to ensure that the employer is able to pay and provide adequate housing and to ensure domestic workers coming into the country are informed about where they are going and what they are doing. Embassies can play an effective role in this regard as they have the purview to monitor the activities of labor recruiters in the country of origin and establish pre-departure training and information. Some migrants have embassies with the capacity and political will to do this to some extent. As one migrant community advocate from Bangladesh described, their embassy takes measures to monitor the placement and conditions of Bangladeshi domestic workers in Lebanese homes.

> "*Anybody come to Lebanon, embassy make sure, the person have eligibility, gets dollar, before you take visa, you, the Lebanese person go to embassy and make a new job request, and give dollar, just to accept them to come to Lebanon.*"

Yet, persons from countries without a significant institutionalised presence in Lebanon do not have access to this type of support and must fill the void themselves. As one migrant community advocate from an African country explained:

> "*We go to prisons, we go to airports, we do all these things, all the things that the embassy should be doing. We do it for ourselves. Because, we have four, five cases, women say this one doesn't pay me, and they take her to prison. Because she doesn't want her anymore. She doesn't want to pay for the ticket, and she'll take her to the prison, so, three, four months in the prison. So, we just, we tell you, she became too, she became crazy, forgot her name and everything. And she's been in prison, in nabaa, for five months, her madam dropped her there. No charges, nothing. We had to help her… We have an embassy, but they don't care. That is it. And they maybe can stay one year. We have to wait until they tell us there is a citizen in crisis before we go there. One year, we go to the airport, we have to stop them, we are not equipped financially, materially, we are not, we just help ourselves, cause that is the only thing we can do for ourselves here.*"

Another interviewee from Kenya explained facing similar dynamics:

> "*Yeah, we go meet every Sunday. Like last week we had a discussion, the way our embassy was not helping us, like at all, at all. Like right now, let's say I went to the embassy, the embassy will... I went to the embassy to take my case; the embassy threw me out. We are two of us. They tell me I have to go because, … they don't want to see, they don't help us anything… yeah, they are not good, they mistreat us, they call us names, they don't help or do anything about the situation… because we don't have a black person there.*"

Thus, the capacity and presence of the country-of-origin government plays a significant role in the levels of support available - and those who come from the poorest countries are more vulnerable. Persons arriving these days are more likely to be from such countries, as labor recruiters intentionally seek out persons, who will lack institutional protection or interference, as it makes business easier and cheaper.

Guilt

Many migrants express feelings of guilt over their inability to sufficiently support family back home – whether emotionally or financially – for example, not being able to attend funerals of parents or leaving children behind. Some migrants said their children were calling and saying things like 'why aren't you here', 'why don't you love me.' This feeling of guilt, i.e., a painful feeling of regret for non-fulfillment of moral obligations that is believed to have harmed others, has then been exacerbated by socio-economic conditions in the country and the depreciation of salaries which has restricted the ability to send money back home. The sense of duty or pressure (both internal and external) to provide is an immense stressor that can leave people feeling helpless and alone.

The feeling of guilt is also very much interlinked with a feeling of not being able to do it right. One migrant community advocate from the Philippines described the complexity of repatriation decisions:

> "*I can't blame anybody or any nationalities who want to stay in Lebanon, even though, getting a small*

salary or having an income that you get just to survive, like paycheck to paycheck, ***I think they prefer to suffer by themselves than going back home,*** *for the whole family, to be, that she would be a burden, or the family that needs help also will be,* ***they all will be suffering.***"

In other words, because of the guilt and shame over having received some support from the family to travel to Lebanon but then not being able to provide as much as expected, migrant workers may stay in a state of chronic temporariness in Lebanon, instead of taking the (shameful) decision to go home.

Chronic Temporariness

"*It's a common feeling that is present with migrant workers in Lebanon,* ***they're always stuck.*** *They're always stuck in a position where they're hiding in Lebanon because of the whole situation... And they're always stuck between choices that are either worse or worse [...] are these really choices that the migrant workers have? And what kind of choices do they have? It's not like they have to choose between a good thing and a bad thing, it's always between the bad and what's more bad. [...] So I think the idea of them being stuck, being always in a position where they don't have many choices... freedom of agency, no freedom of mobility.*" - Service provider for migrants.

Many migrant workers have a feeling of stagnation and paralysis, a position of waiting and waiting until their time in Lebanon is over. This puts psychological processes on hold that are essential for wellbeing, such as: experiences of self-efficacy, which is the beliefs in one's capabilities to organise and execute the courses of action required to produce given attainments[21] and self-actualisation, which is the experience of realising one's potential. Spheres of decision-making are extremely limited for migrant workers, since, as expressed in the quote above, none of the possibly available decisions can ever lead to a satisfying outcome. Feelings of "being stuck" can be even more distressful against the backdrop of a global mindset that glorifies change and denigrates stability.

"*Contemporary cultures, especially in the West, have wholeheartedly embraced (and perhaps corrupted) the humanistic values of improvement, betterment, growth, progress, and so on. We constantly hear that the world is changing fast, and we had better change with it.*"[22]

A life "on hold", waiting for the time in Lebanon to be over, is hard for many, no matter how meaningful it is to send money to children or family members abroad.

Parenthood

While many persons come to Lebanon to provide for their children and families back home, some become parents in Lebanon. Many hide their children as they cannot legally register them and risk being expelled by their employer. The responsibility for providing for their children adds another layer of stress, particularly as the pandemic has uprooted the routines and (few) spaces available to children and thus increased the pressure on parents. As one migrant community advocate from the Philippines explained:

"*Yeah they are from my country and some from Africa, the kids you know needs to learn English and to be in school, and they have their homework because they're online, and nobody is, nobody can reach out, like to help them to do these things for their kids, so it's not easy for them also, that their kids will stay home, like doing nothing, or online, and understand what, and no one is assisting them in their studies.*"

Furthermore, as the economic crisis has depreciated wages and reduced access to employment, working parents are struggling to balance childcare responsibilities with the exigency to secure an income.

"*You know we are trying to also, we are asking for the kids, especially for mothers who have children who, they cannot work for sure, so we need a daycare center for them to just, somebody is taking care of the kids and they can go to work, yeah to find work. Yeah, I know it's not easy this time because of also the crisis in Lebanon, so yeah that is that, our focus.*"

21 Bandura, A. (1997). Self-efficacy: The exercise of control. W H Freeman/Times Books/ Henry Holt & Co.

22 Petriglieri, G. (2007). Stuck in a moment: A developmental perspective on impasses. Transactional Analysis Journal, 37(3), 185-194.

2.4 Manifestations of Distress and Coping

These stressors can manifest in a variety of behaviors and responses, including feeling upset easily or having bad relationships with employers, friends, and family, as well as feelings of shame, anger, sadness, exhaustion, and disempowerment. Participants reported signs of anxiety (e.g., worry, hypervigilance, fear) and trauma (e.g., mistrust, nightmares, irritability). For those who have witnessed more severe cases of psychological distress, signs included an inability to take care of themselves, like bathing or doing simple tasks, crying for their families, and having suicidal ideation and behavior. The confluence of multiple stressors magnifies the impact and the person's ability to cope effectively, which can lead to negative coping mechanisms, such as disordered eating and alcohol or substance abuse, and the development of more severe psychological conditions. Symptoms reported among migrant domestic workers who were victims of violence, exploitation or trafficking included mutism, non-responsiveness/deliriousness, absenteeism, insomnia, psychosomatic symptoms, reduced appetite, or irregular eating patterns.

Yet, due to differences in cultural practices and manifestations of distress, there is a risk of mis-diagnosing normal expressions of severe distress as signs of clinically relevant mental disorders (for example hitting themselves in the chest, shouting loudly, avoiding eye contact).

The positivist underpinnings of Western biomedicine often rather promote universalist understandings of mental health which belie cultural differences in mental health epistemologies and fail to adequately account for the context of social suffering and structural violence which condition the way migrants experience mental health.

Mental health professionals do frequently not learn in their training to discern these differences and nuances in cultural expressions of distress. Particularly for those without significant clinical experience working with migrants, there is a tendency to rush to diagnose symptoms rather than to work to understand the social context and environment in which the symptoms emerge. The language barrier as well as constraints and uncertainty on time available to work with the patient in order to arrive at a more context-informed understanding of mental health symptoms further increase the risk of misdiagnosing. Diagnostic frameworks are a source of hold and comfort for psychologists and psychiatrists alike, but could be harmful especially to clients from cultural contexts the practitioner is not familiar with.

Especially in the case of persons being subject to oppression such as migrant workers, prematurely labeling mental health conditions as certain disorders is critical and can even be retraumatising, when the client feels overpowered, not heard and understood in his*her expression of unwellness. Some culture-specific expressions of distress (so called "culture-bound syndromes") have diagnostic overlaps with severe mental disorders such as schizophrenia that are assumed to have biological reasons and are treated with psychopharmaca.[23] Thus, misdiagnosing when dealing with clients from unfamiliar contexts is as likely as it is potentially harmful.

Internalising Instead of Externalising Oppression

Even though the experience of migrant workers in Lebanon is unique on many levels, it reflects some of the psychological patterns that were frequently identified in writings on oppression (for instance Freire, 1993; hooks, 1993[24]; Mosley et al., 2021[25]). Patterns related to the area of self and identity include a sense of inferiority, lack of self-worth and self-doubt, while those related to emotions include fear, hopeless-

[23] Niehaus, D. J. H., Oosthuizen, P., Lochner, C., Emsley, R. A., Jordaan, E., Mbanga, N. I., Keyter, N., Laurent, C., Deleuze, J.-F., & Stein, D. J. (2004). A culture-bound syndrome 'amafufunyana' and a culture-specific event 'ukuthwasa': Differentiated by a family history of schizophrenia and other psychiatric disorders. Psychopathology, 37(2), 59–63.

[24] Freire, P. (1993). Pedagogy of the oppressed (2nd ed.). New York: Continuum; Hooks, B. (1993). Sisters of the yam: Black women and self-recovery. Boston: South End.

[25] Mosley, D. V., Hargons, C. N., Meiller, C., Angyal, B., Wheeler, P., Davis, C., & Stevens-Watkins, D. (2021). Critical consciousness of anti-Black racism: A practical model to prevent and resist racial trauma. Journal of counseling psychology, 68(1), 1–16.

ness, anger and shame. It was remarkable in the focus group discussions that participants highlighted the capacity for self-care as an important resource and contrasted it with self-neglect (i.e., not washing or wearing dirty cloth) as a sign of worsening mental health. Psychological patterns such as a sense of inferiority or helplessness are also part of what maintains oppression because they impair a person's ability to become more proactive in improving their living conditions and that of their community. In the interpersonal realm, internalised oppression is often manifested in distrust and a tendency for upward-directed social comparisons or competition. Given the preeminence of good relationships for mental health, practitioners could address psychological processes that may impede migrant workers from building social relations with others and self-isolate instead. Some are confined in their employers' houses and cannot build social connections, but others do have a day off and do not use it to build friendships because of shame, lack of self-worth and/or distrust.

Most migrant workers in Lebanon internalise problems (withdrawal, sadness, guilt) instead of expressing them visibly to the outside world in forms of anger outbursts or agitation. Since those externalising behaviors would mean potentially losing employment or social support, internalisation is a survival strategy. The community encourages its members to stay calm in the face of mistreatment and exploitation, because aggression or other socially ostracised behaviors would cause reputational damage to the whole migrant community on the one hand and could lead to the expulsion of the individual by the employer on the other hand, resulting in homelessness and illegality. In this sense and as is the case in many oppressive systems, the community is involuntarily complicit in the internalisation of oppression, acting in the presumably best interest of the person and community.

Coping Strategies

Coping strategies are important tools people use to adjust to or manage stressful events or circumstances in order to stay emotionally balanced and stable. Interviewees reported that the most frequent coping strategies used to deal with stress, in the absence of any official MHPSS services, is having community gatherings and cultural celebrations that provide a source of relief and help them to forget their problems. This narrative of forgetting or finding distraction was a mentality that emerged often when talking about sources of relief or coping: denying, forgetting, seeking distraction from problems through music, dancing, watching movies, social media etc. As one migrant woman from Sri Lanka explained:

> "*To make forget, all the day we are somewhere, staying, singing, dancing, eating... any Sunday, they are free to forget, all that they have, like this.*"

In addition, religion often offers an important source of relief, including having prayer groups, or also praying individually, reading the bible or other religious texts and sending daily prayers through WhatsApp groups. Furthermore, in conversations about experiences of distress, there was a common tendency to normalise the suffering or abuse:

> "*It's normal for madam to shout... the shouting has to pass... we're used to it, it's normal.*"

This acceptance or normalisation of the suffering is a strategy many use to manage and sustain composure during distressing situations. Participants also reported tendencies to cope through substance use and disordered eating, including smoking, drinking alcohol, overeating or restricted eating.

Role of the Community in Coping: Mutual Aid Networks and Economies of Survival

Beyond the personal coping strategies, the migrant community and support networks are a vital source of support and empowerment and are the primary conduits for information about services or other external forms of support available. As a newly arrived woman from Kenya explained:

> "*Okay we have a group. When I came here, I met one girl from Kenya, she took me into the group. That group, we have a church, we go on Sunday. So, when we went to that church, they will take you into the group. So, whatever is going on, maybe there is someone or some help, they tell you everything.*"

When someone from the community has a problem like a medical issue and needs to pay hospital bills, the other community members will pool money to help support that person or help connect them to available services. Community groups are more often organised along the lines of nationality, though there are also

cross-national groups that organise and mobilise support for all migrants or subsections such as migrant domestic workers.

Within the communities there are migrant community advocates who have voluntarily taken on a leadership role to help, organise and advocate for migrant communities. These advocates help to organise activities and events, raise funds for those in need and facilitate access to external services. One migrant community advocate explained the strategy she uses for providing support to migrant domestic workers from her community who have limited mobility outside their employers' house:

> "*Yeah the needs, so for me as I always go around, I like to go around and see people and asking questions, like how can we be able to help them and how to reach them out, and then asking for their needs, right now we are working to giving them not only relief but also buying the medicine if they have anything to do with medicine or their personal things that they need from the groceries so we will be able to provide those for them also.*"

In the context of mental health issues, migrant community advocates are often the ones who are acting as informal counselors and first responders in cases of moderate or severe mental distress. One community advocate who acts as a first responder for emergency situations within his community described the experience of encountering a migrant domestic worker in distress:

> "*We just try and support as much as we can. There is no way we can take someone to hospital. So, we just try to, you know, get ourselves, you know give them shelter and food, and some, once they see us, cause the other lady,* ***she saw us black like her****, she has been in this country for four years and she's never seen a black person. She works in a home. Now she sees a black person, you know a black man, she was smiling, she was smiling. And her host said to me, is she okay? And I said no, I have to take her.* ***I knew she wasn't okay****, because we speak the same language, so that is because she's been confined to a little world. They need to let them loosen a little bit, you know, loosen their grip. And let them go, and let them talk to people, and buy things they want, and eat themselves.*"

His experience exemplifies the high risk that confinement to the employer's home poses to the mental health of domestic workers, when social isolation expedites the internalisation of racism and of exploitation experiences. Being around others from the community with the same background and shared language is an important bulwark against oppression and also provides a platform for building solidarity and resistance.

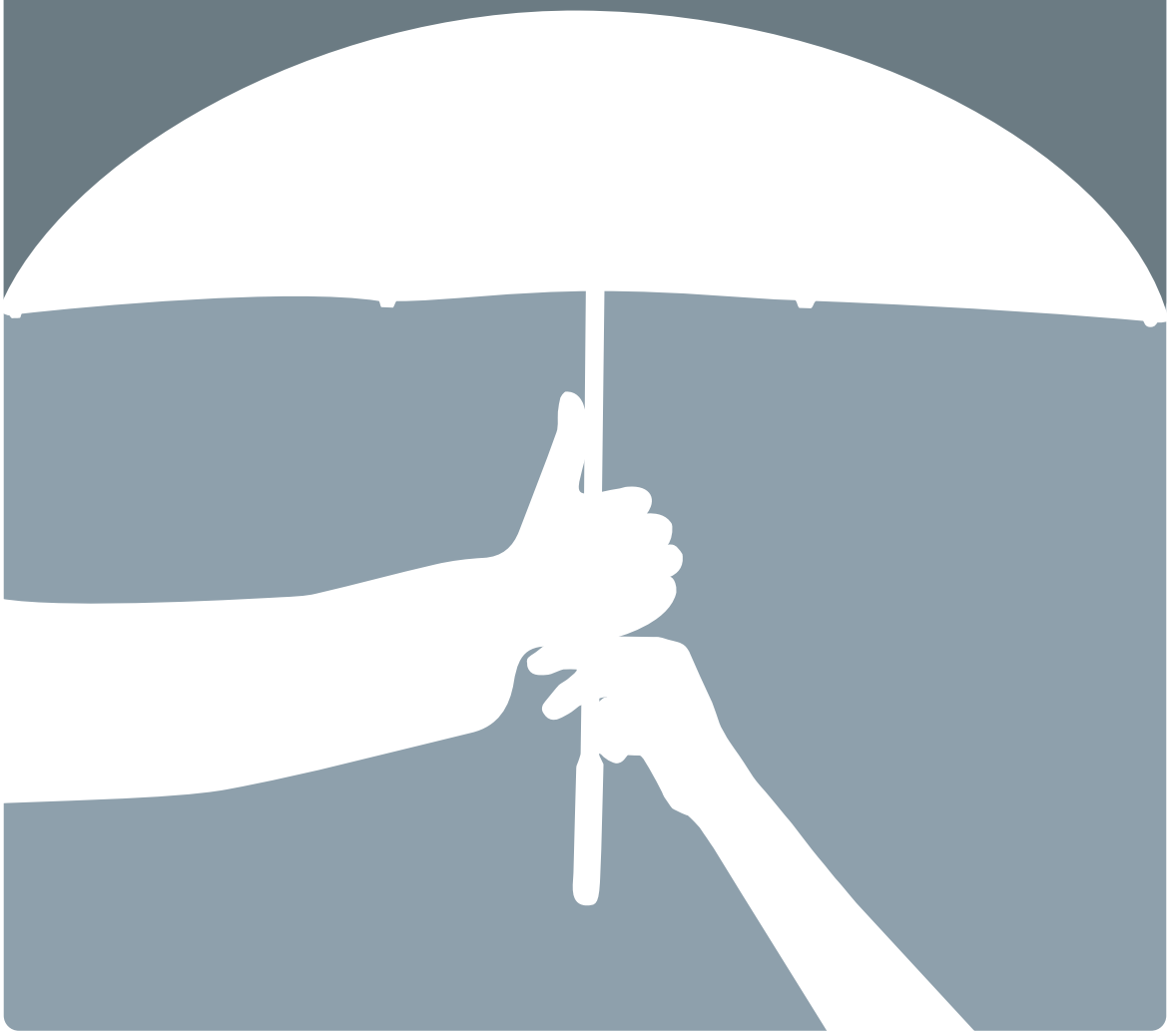
Yet, given that maintaining good social relationships is essential for mental health and well-being, there is a certain risk when this support is non-existent or lost. Furthermore, there is the common problem of stigma associated with talking about mental health issues. Many said that people would not talk openly about facing mental health issues, out of fear of judgement or being gossiped about by others in the community:

> "*People they are afraid to share (…) if you are sick you keep quiet.*"

Accusations of madness can result in individuals being excluded from community groups, as a strategy for maintaining the function and reputation of the group. Therefore, while communities can be a great source of material support, solidarity and access to information, when it comes to mental health concerns there is also a need for outlets external to the community for expressing distress or seeking support for mental health problems:

> "*That's why we need you. You know with you I can tell you my problems, I will never hear it outside.*"

3. Individual- and Group-Level MHPSS Approaches for Supporting Migrants



Given those experiences of disempowerment, all MHPSS interventions, no matter whether done on individual- or group-level, should aim at creating spaces for empowerment. The common ground of most empowerment-based approaches is that they stress decision-making power of the client/participant of the intervention, giving him*her the maximum possible level of control over the process and acknowledging him*her as the expert about what may be most helpful. While this understanding rather addresses the way in which support is provided, the idea of empowerment can also help to find appropriate contents and goals for interventions.[26] Examples of interventions fostering empowerment are:

- Normalising mental health conditions as adequate reactions to an oppressive environment
- Encouraging narrations on traumatic experiences of racism as that help clients develop a sense of critical consciousness for race and class dynamics
- Assertiveness and communication exercises such as role-plays for situations of racism or harassment
- Identification and nurturing of role models, taken for instance from the client's history or culture, the family etc.
- Developing a sense of history and identity, by exploring the client's sociocultural background
- Nurturing creativity through expressive arts, drama workshops, etc.

3.1 Individual Psychotherapy

It is a long-standing debate in the field of clinical psychology how much stability in life circumstances is needed to provide support that goes beyond immediate problem solving. Given that many migrant workers stay in Lebanon for several years and risk a worsening of their mental health condition when not accessing professional help, service providers need to provide relevant psychotherapeutic support. However, since live-in migrant workers have very limited time off and lack ownership over their own time management, profound analytical approaches may not be suitable – also because they often lead to a worsening of symptoms at first. The concept of psychotherapy is new to many persons and requires careful introduction regarding its scope and limitations. The big potential in psychotherapy with migrant workers lies in providing a corrective experience to the dehumanising treatment many face, as the client-psychotherapist relationship is the key "active ingredient" for intervention effectiveness. A relational encounter of authentic respect and acceptance can stimulate positive changes in self-esteem and self-confidence.

Especially for psychologists newly supporting migrant populations, it is worth exploring the potentials of approaches with fixed protocols that have worked well when adapted to clients with migration background. One of those approaches is Interpersonal Psychotherapy (IPT) which frames therapy around one or more central interpersonal problems in current life circumstances, such as death of a loved one, disputes, role transitions, and loneliness and social isolation. These interpersonal crises and difficulties, which are particularly relevant to the lives of migrant workers, disrupt social connections and increase interpersonal stress. IPT seeks to enhance social support, decrease interpersonal stress, facilitate emotional processing, and improve interpersonal skills, all of which are highly relevant for migrants given that relations are a major resource for health and wellbeing.[27] One of the aforementioned main problem areas that IPT focuses on is role transition which arises when someone must adapt to a change in life circumstances, which would be of particular relevance for migrants when arriving to Lebanon, preparing for repatriation or changing from live-in to freelancer status. Practitioners could also recur to logotherapy, which aims at nurturing meaning and purpose even in situations of structural oppression and has proven valuable when working with migrants.[28]

26 Morrow, S. L., & Hawxhurst, D. M. (1998). Feminist therapy: Integrating political analysis in counseling and psychotherapy. Women and Therapy, 21(2), 37–50.

27 Lipsitz, J. D., & Markowitz, J. C. (2013). Mechanisms of change in interpersonal therapy (IPT). Clinical psychology review, 33(8), 1134–1147.

28 Rahgozar, S., & Giménez-Llort, L. (2020). Foundations and Applications of Logotherapy to Improve Mental Health of Immigrant Populations in the Third Millennium. Frontiers in psychiatry, 11, 451.

The Common Elements Treatment Approach (CETA) is another transdiagnostic multi-problem approach intervention, which has been adapted to migrant populations given its short duration, often-times rapid results, and the ability to have it administered by non-professional but trained lay counselors. It can be customised to address symptoms of depression, anxiety and traumatic stress, as well as substance use and also includes caregiver skills. It is usually delivered in eight sessions but can be made longer or briefer as needed. In initial trials, CETA was found to be effective in working with migrants and other populations in Iraq[29] , Zambia[30], Thailand[31], and Ukraine[32] among other countries. **However, every protocol is only as good as the attitude and skills of the practitioner applying it and thus will work best when used on a fundament of anti-racism and empowerment.**

3.2 Group Formats

Group settings facilitate shared communication that can lead to new knowledge and ideas for action.[33] Relatedness and attachment are core to health and wellbeing and the community has consistently been mentioned as the main protective factor within this research. The ideal approach would be individual-level psychosocial or psychological support for personal empowerment, recognition and/or symptom relief in combination with a group format for **interpersonal empowerment.** As much as possible, participants should be grouped based on similarities in problem areas. In group IPT for instance, those could be specific role transitions or disputes. Other shared problem areas could be suicidal ideations, experiences of gender-based violence, recovering from psychiatric care, etc. Even though groupings based on sources or forms of distress instead of nationality may imply that participants cannot express themselves in their mother tongue, the feeling of not being alone in one's stigmatised and tabooed mental health condition or painful experience remains powerful. A classic in capturing the "active ingredients" of group psychotherapy is Irvin Yalom's work, who divided the therapeutic experience into eleven primary factors, amongst others the instillation of hope, universality, imparting information, altruism, group cohesion, interpersonal learning and imitative behavior. Example implications for group psychotherapy with migrant workers are:

Universality: Migrant workers with mental health problems, who are not well connected to the community, are likely to have the disquieting thought that they are unique in their fears, ambivalences and anxieties. Group therapy offers relief through the experience of we are all in the same boat if group members disclose their thoughts and emotions. Given that the experience of migrant workers in Lebanon has strong common denominators (the experience of discrimination, chronic sense of temporariness, restricted sense of agency and mobility, etc.), it will be easy to find shared experiences. However, the real power of group dynamics unfolds when participants disclose what really bothers them and what they would usually not talk about, because it is socially undesired, stigmatised or experienced as shameful.

29 Weiss, W. M., Murray, L. K., Zangana, G. A., Mahmooth, Z., Kaysen, D., Dorsey, S., Lindgren, K., Gross, A., Murray, S. M. I., Bass, J. K., & Bolton, P. (2015). Community-based mental health treatments for survivors of torture and militant attacks in southern Iraq: A randomized control trial. BMC Psychiatry, 15(1).

30 Kane, J. C., Skavenski Van Wyk, S., Murray, S. M., Bolton, P., Melendez, F., Danielson, C. K., Chimponda, P., Munthali, S., & Murray, L. K. (2017). Testing the effectiveness of a transdiagnostic treatment approach in reducing violence and alcohol abuse among families in Zambia: Study protocol of the violence and alcohol treatment (VATU) trial. Global Mental Health, 4.

31 Bolton, P., Lee, C., Haroz, E. E., Murray, L., Dorsey, S., Robinson, C., Ugueto, A. M., & Bass, J. (2014). A transdiagnostic community-based mental health treatment for comorbid disorders: development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. PLoS Medicine, 11(11).

32 Murray, L. K., Haroz, E. E., Doty, B., Singh, N. S., Bogdanov, S., Bass, J., Dorsey, S., & Bolton, P. (2018). Testing the effectiveness and implementation of a brief version of the Common Elements Treatment Approach (CETA) in Ukraine: A study protocol for a randomized controlled trial. Trials, 19(1).

33 Shapiro, E. R. (2020). Liberation psychology, creativity, and arts-based activism and artivism: Culturally meaningful methods connecting personal development and social change. In L. Comas-Díaz & E. Torres Rivera (Eds.), Liberation psychology: Theory, method, practice, and social justice (pp. 247–264). American Psychological Association.

Hope: Allowing space for hope and optimism despite all the injustice faced by migrants in Lebanon is not obscene, but a necessity for being able to carry on. Even though MHPSS interventions cannot change the oppressive system migrants work in, they can provide some relief and prevent the worsening of mental health conditions. During a group process, practitioners will see participants who are improving faster than others, or who are dealing better with the crisis situation than others. It is important to highlight those examples to instill hope (i.e., "I can get there too"), while at the same time stressing that everyone has his*her own path and pace to avoid jealousies and toxic social comparisons.

Facilitating group psychotherapy with a focus on self-disclosure is challenging for practitioners because negative feelings, jealousies, conflict and transferences of trauma need to be contained. Such formats need 2 co-facilitators with solid psychotherapeutic experiences. Alternatively, less problem-focused group formats could be used, such as information sessions, for instance on migrant workers' rights and helpful resources, or vocational training, language courses, etc. An MHPSS approach can be integrated into every possible gathering when facilitated in a way that strengthens interpersonal exchanges and reduces social isolation, for instance by inviting participants of a course to help each other or by building tandems or having mentorships between longstanding and recent group members. Also, awareness raising on mental health can be integrated into a wide range of meetings or trainings. Be mindful that not all forms of psychoeducation are helpful. If participants have high levels of distress and relatively severe mental health syndromes, knowing more about disorders can increase symptom focus and can worsen a condition if not accompanied with adequate support. Awareness raising should therefore focus on normalisation of distress as a response to exploitation and oppression rather than on imparting information on the manifestation of specific disorders. In group formats, it is important to pay tribute to the intersectionality in migrant workers' experiences explained above by valuing diversity and solidarity. Given the language barriers, non-language-based group approaches (arts, music) are always a great option.

3.3 Critical Consciousness

> *"Critical consciousness is when a person becomes aware of and thoughtfully problematises their lived experience and sociopolitical environments (e.g., exposure to racism) and then engages in actions (e.g., speaks up again racism) in response to their critical reflection."* [34]

It is important to note that migrant workers in Lebanon have no legal security and can be expelled or imprisoned anytime. Following the "safety first" paradigm, in many cases "taking action" makes most sense below the radar and not in the political arena, for instance in the form of activism and dialogue. Also, sociopolitical action requires confidence and motivation. For many participants and clients, it is first necessary to focus on building personal strengths and finding relief from distress, before thinking of taking action for the community.

[34] Mosley, D. V., Hargons, C. N., Meiller, C., Angyal, B., Wheeler, P., Davis, C., & Stevens-Watkins, D. (2021). Critical consciousness of anti-Black racism: A practical model to prevent and resist racial trauma. Journal of counseling psychology, 68(1), 1–16.

An approach based on critical consciousness has three components:

1. **Practitioners reflect on their own skills** when it comes to recognising racism and nurture their critical thinking skills when it comes to white supremacy,[35] racism and social justice. **Practicing anti-racism requires knowledge on historical connections and systems of oppression, ongoing self-evaluation, and peer support, for instance through spaces for collective reflection among those involved in the support of migrant workers** (social workers, cultural mediators, psychologists, etc.). Given Lebanon's history, working with Lebanese MHPSS practitioners on critical consciousness needs to address two layers of white supremacy: the psychosocial, transgenerational impact of the French mandate (1921-1943), which may have left some Lebanese people with feelings of inferiority or glorification of the French culture on the one hand, and internalised supremacy dynamics towards migrants, especially with darker skin color, on the other hand, both of which stem from Lebanon's position within French imperial hierarchies and the involvement of Lebanese entrepreneurs in capital accumulation in African countries.[36]

2. **Practitioners support the development of critical consciousness to racism in their interventions with clients/participants**. This can imply creating space for clients to engage in storying about survival around their experiences of racism, and about their process of becoming aware about Whiteness or acting critically in resistance to racism. Practitioners can support persons under Kafala in looking for opportunities to emphasise historical connections and other contextual factors and assist individuals in naming the systems and processes of oppression at work.[37] This can nurture:

- **Cognitive growth,** through the experience of becoming aware of racism as a longstanding systemic phenomenon by drawing linkages between racism and White Supremacy and, ultimately, increasing capacity for systemic and historical analyses of racism.
- **Intersectional growth,** through the deepening of intersectional self-awareness based on an exploration of one's own ethnic identity, religious and/or spiritual identity, gender, and sexuality. The process involves beginning to recognise difference, learning one's positions of privilege and oppression, considering them in context, and owning them.
- **Behavioral growth,** through finding ways to cope with the personal experience of racial trauma and becoming connected to people and settings that will fill gaps in one's development as a racial justice activist.

3. **Practitioners support critical action against racism.** This is easiest in a group setting in which the group is reflecting on ideas and strategies for action, which suit their capacities and interests, and which give them a sense of control and agency. The group could be mixed, consisting of both practitioners and persons working under Kafala, for a maximum level of creativity. Mosley et al. put together a black liberation work compendium defining different categories of actions. Those most applicable to the context of migrant workers in Lebanon are:

- **Artivism:** Migrant Workers using creative arts in a group setting to express their experiences, in the form of joint storying, visual arts, etc.
- **Organising:** Developing goals, identifying outcomes, and determining approaches for liberation of Migrant Workers in Lebanon in support group settings; involves leading, organising, and developing interventions.
- **Modeling/Mentoring:** One-on-one contact with another migrant worker of the same group and in complementarity to the group setting.
- **Space-making:** Intentionally creating physical or virtual spaces for migrant workers to convene, heal, organise, and/or celebrate, for instance in Migrant Community Centers, churches and mosques.
- **Teaching:** Educating others and encouraging them to constantly learn more about racism and liberation.

35 Beliefs and ideas purporting natural superiority of the lighter-skinned, or "white," human races over other racial groups. Derived from this is the idea of the "white man's burden" as duty of European to bring civilization to nonwhite peoples through beneficent imperialism (https://www.britannica.com/topic/white-supremacy).

36 Hage, Ghassan. (2005) White Self-racialization as Identity Fetishism: Capitalism and the Experience of Colonial Whiteness. In Murji, K. & Solomos, J (Eds.),Racialization: Studies in Theory and Practice. (pp. 187-207). New York: Oxford University Press

37 Based on a qualitative study with Black Lives Matter activists by Mosley et al.

3.4 Dealing with Differences

One of the few systematic studies of mental health and psychiatric hospitalisation outcomes among migrant workers in Lebanon evaluates a cohort of hospitalised migrant domestic workers and assesses psychiatric morbidities and phenomenological occurrences in comparison with a control group of hospitalised Lebanese patients with similar characteristics and compares the mental health care received by both groups. The study found a higher prevalence of psychotic episodes followed by major depressive episodes, compared to the Lebanese control group which was more likely to be diagnosed with affective disorders.[38] The observed differences in treatment administered to migrant domestic workers (more frequent use of electroconvulsive therapy (ECT), medication and physical restraint with injection of tranquilisers) may be impacted by the influence of the employer over the medical team, the existence of cultural and language barriers which impede effective communication between patient and medical team, as well as effects of racism and social discrimination among practitioners (particularly in the absence of an advocate for the migrant worker, which precludes any sort of accountability for mistreatment of the patients).[39] Other studies have suggested there is a tendency by practitioners to over-diagnose psychotic disorders and under-diagnose affective disorders among minority communities, revealing a greater need for introducing cultural assessment frameworks into diagnosis and treatment practices.[40]

Culture is a constellation of practices, symbols, values, and ideals that are constructed and shared by a community, transmitted from one generation to the next, constantly renegotiated, and subject to change.[41] Migrant workers, who have been in Lebanon for a long time, are likely to experience an alienation from their home context and the Lebanese context at the same time. They are often excluded from developments at home and lose touch with their families when employers, travel costs, lack of papers or regulations in their home countries restrict them from visiting. Psychotherapists and psychologists need to be aware of ambivalent feelings towards "home" and must be careful not to romanticise it. Minorities are often taken as tokens of their culture and are expected to talk about and represent it, as though it was homogeneous and exotic.[42] Supervisions and trainings for practitioners need to address the cultural (mis)attribution bias, which is the tendency to see ethnic minorities as members of a group and cultural beings whose traits and behaviors are shaped more by cultural processes than by psychological processes; and oppositely, to perceive members of the majority as individual actors whose traits and behaviors are shaped more by psychological processes than by cultural influences.[43] In other words, **while it is important to learn about the cultural influences on migrants' mental health, their mental health conditions should not be essentialised as expressions of culture only, but a complex mix of individual-level variables (biography, personal experiences, traits) and social-level influences (cultural, socioeconomic and political context).**

The best resources for gaining an understanding of the cultural-level variables are clients/participants themselves and networks of psychologists in the countries of origin. For organisations supporting predominantly specific nationalities, it is money well invested to establish a short-term remote consultancy contract with a psychologist or mental health service providers in the countries in question. In addition to this, given that culture is not bound to the country-level, but several cultures coexist in every national setting, practitioners need to ask clients questions on their background to fully grasp practices and symbols that materialise in the expression of mental health syndromes.

38 Zahreddine, N., Hady, R. T., Chammai, R., Kazour, F., Hachem, D., & Richa, S. (2014). Psychiatric morbidity, phenomenology and management in hospitalized female foreign domestic workers in Lebanon. Community mental health journal, 50(5), 619-628. 7

39 Kerbage, H. (2014). Foreign Domestic Workers in Lebanon: The Missing Psychiatric Link. The Legal Agenda.

40 Kerbage-Hariri, H. (2017). The implications of work related vulnerabilities of migrant domestic workers in Lebanon. International Labor Organization (ILO). Jackson, A. P.,(2006). The use of psychiatric medications to treat depressive disorders in African American women. Journal of Clinical Psychology, 62(7), pp. 793-800.

41 Causadias, J. M., Vitriol, J. A., & Atkin, A. L. (2018). Do we overemphasize the role of culture in the behavior of racial/ethnic minorities? evidence of a cultural (mis)attribution bias in American psychology. American Psychologist, 73(3), 243–255.

42 Feagin, J. R. (2020). The white racial frame: Centuries of racial framing and counter-framing. Routledge.

43 Causadias, J. M., Vitriol, J. A., & Atkin, A. L. (2018). Do we overemphasize the role of culture in the behavior of racial/ethnic minorities? evidence of a cultural (mis)attribution bias in American psychology. American Psychologist, 73(3), 243–255.

3.5 Do's for MHPSS Service Provision

1

Provide supervision and intervision for those involved in MHPSS with persons under Kafala

Feelings of helplessness and powerlessness are contagious. As soon as practitioners lose the belief and confidence that they can actually contribute to improving the health and wellbeing of their clients, their interventions will become less effective. This is due to the mere power of expectations. Expectations on a positive outcome are as contagious as feelings of powerlessness and are transferred from the practitioner to the client. High expectation of the practitioner of being able to help before the start of therapy or counseling is significantly correlated with a positive therapy outcome.[44] At the moment in Lebanon, psychologists and social workers are themselves heavily affected by the overlapping crises and often feel as drained and exhausted as their clients. In supervisions and intervisions, it is important to acknowledge this suffering, while at the same time focusing on the small successes in support processes so that practitioners are not sucked into the spiral of powerlessness. While MHPSS will not change the Kafala system, it creates small islands of relief, connectedness, recognition and wholeness, that positively impact migrant workers' health and wellbeing and can reach far beyond the very moment of the session.

2

Find a balance between avoiding stigma and working against mental health taboos

One dilemma of the MHPSS sector is that when addressing mental health conditions openly, for instance by overtly offering psychotherapy, there is a risk of stigma for those making use of the services. On the other hand, it is only when talking about mental health as something that concerns everyone that taboos around it will slowly lift. Therefore, when offering MHPSS for migrant workers, services need to name mental health concerns as such, for instance when using social media for awareness raising, while at the same time making sure to offer low-threshold services, for instance by integrating counseling into vocational training or livelihood coaching.

[44] Yalom, I. (2005). The Theory and Practice of Group Psychotherapy (5th Edition). Basic Books.

3

Avoid a siloed approach

Consider using resources from the countries of origin of clients/participants as much as possible. This can imply making contracts with local service providers for remote support, asking practitioners from those countries for guidance on cultural questions and liaising with organisations in place to support migrants after their return. It will not be possible to cover all sub-contexts in a given country, for instance by having psychotherapists from a range of ethnic backgrounds or liaising with service providers from all regions, but already some level of country-of-origin expertise would increase service quality significantly.

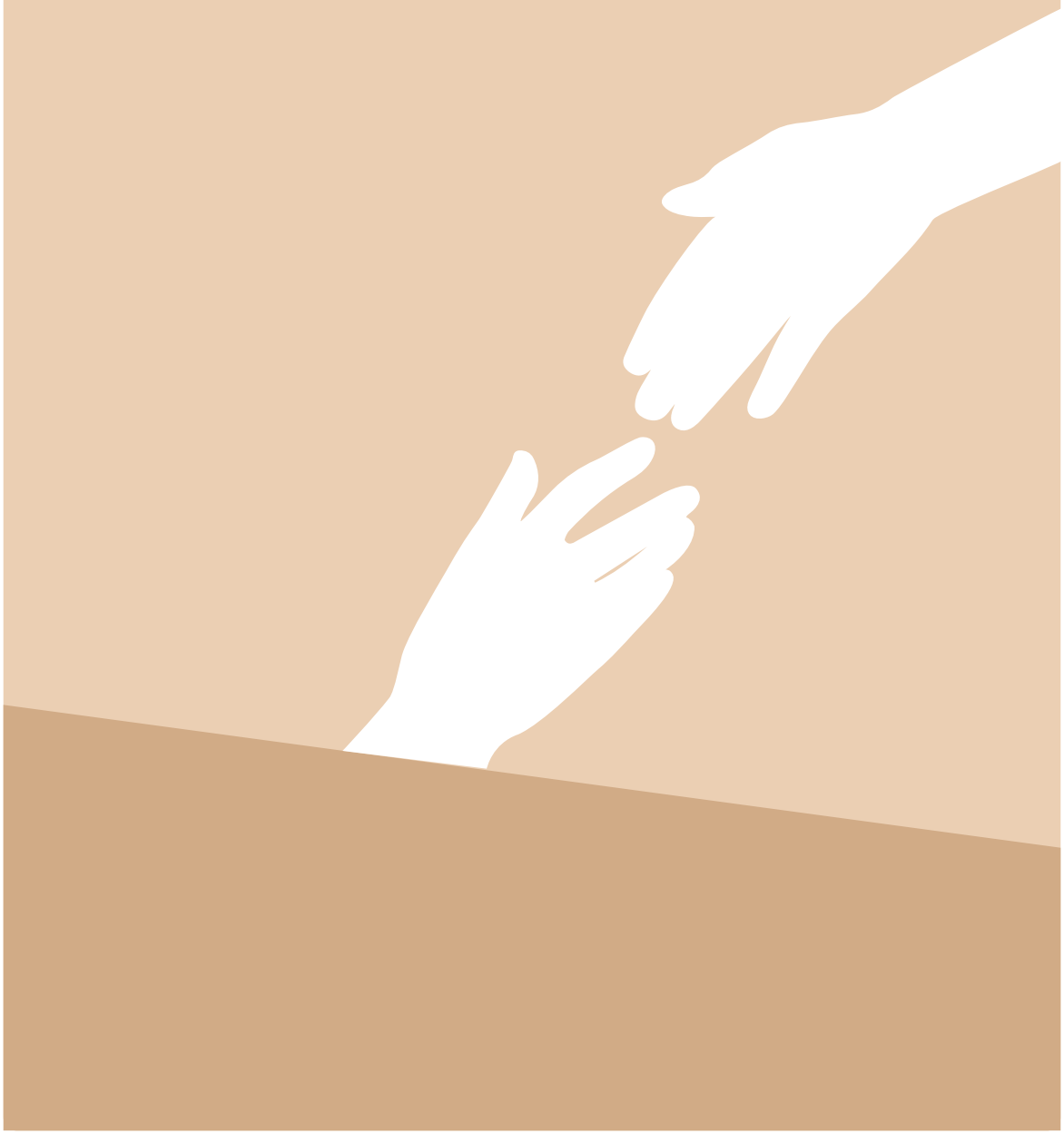
Furthermore, it is necessary to invest time and efforts in making sure migrants who are benefitting from a certain service have knowledge about and access to other services that they might also be in need of. All different levels of the intervention pyramid are important, and they should be complimentary. For example, a person benefitting from psychotherapy would experience a maximum benefit when their other more basic needs are met, and a referral to those needs would improve mental health service provision.

4

Get creative with translations

Given that psychological support is language-based, translation is THE key issue for supporting migrants. Community members, who very often translate for basic service provision, are not best positioned to translate in MHPSS, because those in distress fear that the former could breach confidentiality which would lead to the community knowing about their problems and stigmatising them. Possible solutions are: using remote translation through someone based in the country of origin or outside of Lebanon, even though it can raise trust issues if this person and his*her background are not transparent; or specifically recruiting and training translators that are not part of the migrant community (possibly shared by service providers), and stressing confidentiality and professional ethics in the training.

4.
Analysis of Service Landscape in Lebanon



Mental Health resources in Lebanon are already scant; given the lack of public investment in mental health care, most existing services are provided by the private sector and are thus very costly without any form of coverage.[45] On top of that, persons under Kafala face additional barriers in accessing mental health care and services due to various factors such as lack of legal status, financial difficulties, restrictions on autonomy by employers, lack of information, language barriers, stigmatisation and racism. Various local and international non-governmental organisations (NGOs) have helped provide MHPSS services and protection for migrant workers, particularly after the onset of the pandemic and the increasing levels of vulnerability among migrant workers. The existing network of MHPSS includes local NGOs with migrant-focused programs, including for instance the Anti-Racism Movement (ARM), Egna Legna, Kafa, Caritas Lebanon, and Amel, among others, as well as international organisations like MSF, Caritas International and IOM. These organisations and others provide a range of services and support for mental health and psychosocial well-being including recreational activities, capacity building, advocacy and awareness raising, psychosocial counseling and activities, medical referrals, in addition to support for basic needs such as food, shelter and medical care. Yet, information and awareness about existing services is often lacking. Of those surveyed in IOM's baseline vulnerability assessment of migrant workers in May-July 2020 across four municipalities, 84% reported they were unaware of the services available in their neighborhood. Female migrants were more likely than their male counterparts to be unaware of services available for them, particularly in the case of phone and data services, suggesting they may be more cut off from social support and information networks due to their live-in status. These figures suggest a potential gap in dissemination and access to information amongst migrant workers (particularly women domestic workers) and points to a need for greater community outreach and translation assistance.[46]

This section analyses the current service provision landscape in Lebanon, identifies the challenges faced by service providers and program managers as well as the barriers to access and utilisation of services faced by migrants, and concludes with recommendations for the support of persons working under Kafala. However, as service provision changes fast, not all organisations currently involved in this area may be represented. We invite you to send updates on your organisation's services to contact-rp-mhpss@giz.de to be included in the analysis.

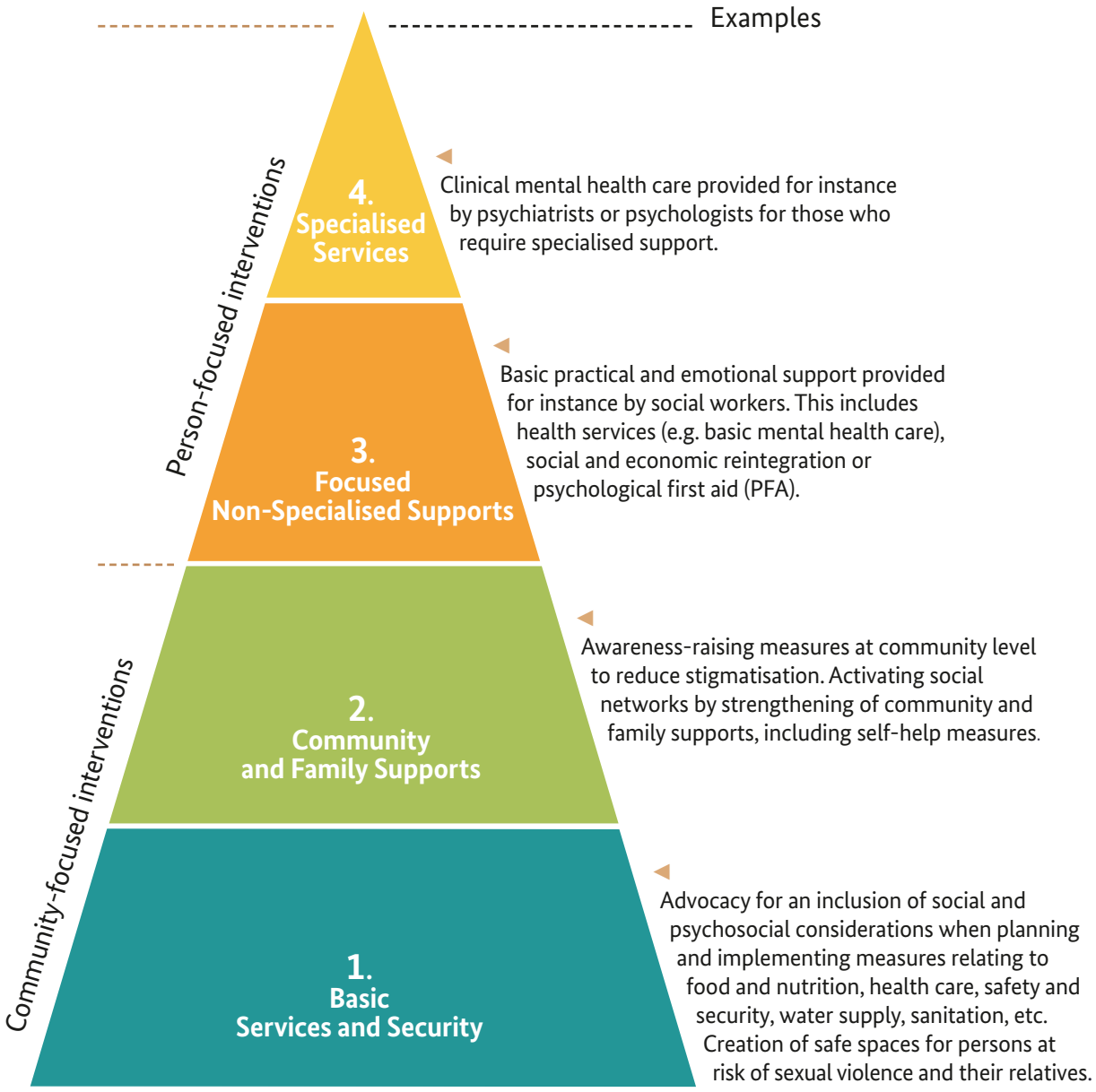
4.1 Assessing the MHPSS Service Provision Landscape

There are multiple levels of intervention for mental health and psychosocial well-being based on the type and severity of distress. Ensuring effective support requires a MHPSS support infrastructure which integrates all levels of the psychosocial response. The Inter-Agency Standing Committee (IASC) model of four interlinked layers of intervention (visualised in the form of a pyramid) is the most common framework for evaluating and ensuring integration of all levels of the psychological and psychosocial response in contexts of crises. The structure of the pyramid does not imply a hierarchy of quality value, as MHPSS services for migrant workers can only be effective when services on all layers are provided at the same time and in very close coordination between the different service providers involved. The framework is imposed on a pyramid to reflect the size of the population needing support for each layer of intervention. Thus, as you go up the pyramid, there are fewer people requiring services (the higher up the pyramid, the more severe the case and thus the more intensive intervention is needed). Once a person develops a more severe form of psychological disorder, accessing support becomes more difficult and costlier. Without effective support at the lower levels of the pyramid, moderate mental health distress may devolve into more severe forms of psychological distress. Therefore, focusing on prevention through ensuring adequate access to services and support at the bottom levels of the pyramid is essential.[47]

45 Zahreddine, N., Hady, R. T., Chammai, R., Kazour, F., Hachem, D., & Richa, S. (2014). Psychiatric morbidity, phenomenology, and management in hospitalized female foreign domestic workers in Lebanon. Community mental health journal, 50(5), 619-628.

46 United Nations International Organization for Migration (IOM). (2020). Lebanon— Migrant Worker Vulnerability Baseline Assessment Report.

47 Inter-Agency Standing Committee. (2008). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Setting: Checklist for field use. In IASC Guidelines on Mental Health and Psychosocial Support in Emergency Setting: Checklist for field use (pp. 39-39).



Graphic: IASC Intervention Pyramid as printed in GIZ Guiding Framework for Mental Health and Psychosocial Support in Development Cooperation [48]

Particularly in the context of marginalised populations subject to structural violence, mental health is often a social, economic and political issue before it is a clinical one. While of course clinical forms of mental distress exist and it is important to ensure access to specialised clinical interventions when needed, the overall MHPSS approach should be rooted in community-based support rather than the application of individualised clinical interventions.[49] Otherwise, an outsized focus on the clinical and diagnostic aspects of mental health may risk pathologising the effects of structural violence and conflating social and economic inequality with mental illness.[50] The following section will assess the existing MHPSS service landscape according to the IASC layers of intervention and provide recommendations for improving quality of and access to services at each tier of intervention.

48 German Cooperation (GIZ). (2018). Guiding framework for mental health and psychosocial support (MHPSS) in development cooperation: as exemplified in the context of the crisis in Syria and Iraq.

49 Kerbage, H., & Marranconi, F. (2017). Mental Health and Psychosocial Support Services (MHPSS) for Syrian refugees in Lebanon: Towards a public health approach beyond diagnostic categories. European Scientific Journal, 13(10), 208-219.

50 Moghnieh, L., & Marranconi, F. (2017). Mental health strategy in Lebanon: an anthropological critique. The Legal Agenda.

Basic Needs and Security – Food, Shelter, Medical Care

The first level of the pyramid addresses support structures which facilitate access to basic needs (food, shelter, and medical care). Given the clear links between inability to meet basic needs and mental distress, ensuring access to support networks for these basic services is essential to promote mental health and psychosocial well-being, particularly in light of the high incidence of homelessness and food insecurity among migrants in Lebanon. Further, these support structures should be MHPSS-informed. This means that they should be provided in a safe, dignified, participatory, community owned, and socially and culturally acceptable way that strengthens social networks and reinforces community building.[51] This can get especially tricky when it comes to safe houses and shelters supporting survivors of sexual and gender-based violence (SGBV) or trafficking or for migrants who are deemed "illegal" and are awaiting repatriation. Inhabitants are often not allowed to leave the safe house for legal restriction of movement, "protection" against the abuser or to prevent inhabitants from unintentionally divulging the location of the safe house/shelter. Thus, some safe houses/shelters perpetuate the experience of lack of agency and control that persons under Kafala experience in employers' houses, especially when spaces for decision-making are tight knit (what to eat, when to sleep and get up, what activities to do, etc.). There are also examples of shelters that are very aware of those dynamics and for instance take inhabitants on accompanied walks so that they get to know the surroundings and feel more comfortable leaving the shelter on their own.

The shelters and safe houses below are very diverse in terms of whether they are open or closed, which admission criteria they have and how long inhabitants can stay. Since those factors change fast, it is important to check with the respective organisations on the current conditions.

Shelter/safe houses

Concern Worldwide:	shelter for migrant domestic workers (MDWs) facing homelessness
Kafa:	shelter for all MDW victims of violence, exploitation and trafficking experienced within the employment relationship and as a result of the sponsorship system dynamics; women in shelter receive interdisciplinary assistance, including social, medical, legal, and psychosocial
Al Makan:	Ahlan shelter for migrant domestic workers facing homeslessness
Caritas Lebanon:	safe house for migrant domestic worker women who are victims of SGBV or trafficking
IOM:	specialised and mainstream shelter for migrant victims of trafficking
Embassy support:	Sri Lankan, Philippines and Ethiopian embassies have safe houses attached for their nationals

Food security and basic needs

Concern Worldwide:	food assistance
Egna Legna:	distribution of food, hygiene kits, diapers, essential items; provide referrals for those in need as well as support for repatriation
Migrant Domestic Workers Alliance (MDWA):	food distribution and needs identification (via community social networks); support to domestic workers with limited mobility outside the employer's home through phone support, dropping things off at their houses when possible
Afro-Asian Migrant Center (AAMC):	food distribution; ad hoc referrals; AAMC works in partnership with Caritas to support relief operations and provide pastoral care
Migrant community groups:	informal support networks organised by nationality provide communal support for those who need help securing access to food or medical care or need a place to stay

[51] Inter-Agency Standing Committee. (2008). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Setting: Checklist for field use. In IASC Guidelines on Mental Health and Psychosocial Support in Emergency Setting: Checklist for field use (pp. 39-39).

Access to medical care (for physical health)

ICRC:	medical support for migrant domestic workers in Rafic Hariri University Hospital
Amel:	access to Amel's primary health care clinics (PHCC) throughout Lebanon
Amel in collaboration with IOM:	coordination of vaccination drives
MSF:	Migrant Medical Helpline - management of non-urgent medical conditions with general doctors through appointments taken on the helpline
Caritas Lebanon:	financial support to cover costs of treatment and access to 10 PHCCs and their services including medication
IOM:	medical screening of diseases or disorders of public health importance; basic primary health care services and medications; secondary health care services including lifesaving interventions and medical aids for migrant victims of trafficking

Hotlines for urgent support

Kafa:	24/7 helpline which provides immediate emergency intervention in cases of violence against migrant domestic workers when case meets criteria (same criteria outlined on previous page); also socio-legal and psychosocial counseling through the helpline for all migrant domestic workers and not restricted by above mentioned criteria
Al Makan / Ahlan Shelter:	shelter needs assessment and intake
Caritas Lebanon:	3 different helplines for migrants (open 24/7)
General Security 1717 hotline:	can be used by migrant workers to file complaints of abuse (for those who have access to phone and have legal residency)
Amel:	specialised helpline for migrants; also has hotline for mental health community clinic, which is not tailored specifically for migrants, but they can call
ARM:	helpline for case management support for migrant domestic workers (both live in and those that have left their employers) facing various issues including legal and medical needs
Embrace:	the national emotional support and suicide prevention helpline, Embrace lifeline is reachable 24/7 on 1564 for every person in distress, including migrants

Challenges in Providing Support for Basic Needs and Security

Lack of Trust and Awareness

Due to the conditions of structural violence set up by the Kafala system, many migrants have become undocumented which increases vulnerability to exploitation and detention. Without a valid residency permit, they are at constant risk of being arrested, detained and deported, which forces them to limit their movement. To protect themselves, persons under Kafala must be vigilant and circumspect about who they give their trust and information to. As one migrant community advocate explained,

> *"Yes they, this is the problem that many migrant domestic workers, they don't have, they're not strong enough to ask for help from many NGOs or any organisations which they don't know very well, and they don't know what they are, what is this organisation doing, so all these things, especially at the moment, this is not easy for them to approach or to talk about their situation, cause then they'll say maybe talk to the NGOs they will let us to be catched by immigration because she doesn't have any legal papers. This is also one main issue."*

The primacy of trust is why the organisations that are most effective in providing services are those that have been working with migrant populations for many years and have developed significant expertise and built relationships within migrant communities and amongst community advocates. While mainstream services for the general population may be nominally available for migrants, requirements to provide identity documents or disclose personal information in effect excludes them from accessing these services. Reaching more migrants requires establishing links with community leaders and building trust within communities through sustained and effective service provision. Furthermore, structures to safeguard the information of migrant workers from authorities must be put in place and clearly communicated to migrant communities.

In addition, most persons under Kafala are not aware of what services are available as there is a lack of information dissemination and intake in the channels of communication that they use, such as WhatsApp, Facebook and other social media channels. Engaging these communication networks is important for improving awareness and access to services, particularly for live-in migrant domestic workers who have limitations on mobility and communication outside their employer's house. Also, given the gatekeeper function of community advocates, it is important not to channel all information through them, no matter how helpful and committed they are, but to use those more universally accessible channels. Yet, migrant domestic workers may have their phone use monitored by their employers and thus face limitations in the hours that they can make and receive calls, particularly during regular working hours. These access barriers reveal the importance of effective outreach and communication mechanisms tailored specifically to migrants to ensure they are aware what services are available and can easily access them.

Furthermore, there is a significant lack of awareness around mental health issues and the warning signs for more advanced stages of distress. This points to a need for more expansive needs-identification processes and referral pathways for MHPSS services. Because inability to meet basic needs is one of the primary sources of distress, integrating MHPSS into the provision of other forms of support and community building activities will help to reduce stigma, circulate knowledge about warning signs and self-protection and provide opportunities for identifying needs for more intensive interventions. This could involve the creation of mobile teams of support (i.e., social worker, psychologist, legal advisors and health counselors) that join community gatherings.

Utilisation Difficulties

Difficulties in accessing available support systems was repeatedly brought up in interviews, focus group discussions and workshops. This non-responsiveness of hotlines/helplines (or the perception of non-responsiveness) can create a sense of disillusionment and mistrust of NGOs and other service providers and thus detter people from attempting to utilise services in the future. As one participant explained:

> *"So I want to say this thing, if I know someone that is suffering mentally, they are tired of telling organisations that they have issues. You want to talk to someone from maybe a hotline or something, they are telling you to wait for a place. Then from there you'll be calling and calling, and they don't answer. and that is the one thing that maybe makes migrants want to get tired of explaining and stop giving issues. Which was, an example, maybe I come to you telling you I'm thirsty. I see you have water to give me, but you keep me waiting. My glass is empty, but I get none of it. So, this is the thing that migrants recognise, right now they can't say."* ...

> *"People on the line on the phone, they keep them waiting and waiting and waiting. So, people are tired, they lose hope, you understand."*

This potential for disruption of trust with service providers points to a need for greater transparency and clarification of the limitations of services offered. Employing a trauma sensitive approach means considering the risk of re-evoking traumatic experiences during implementation of programs and services. Especially considering that many persons under Kafala are lied to in the process of coming to Lebanon by labor recruiters, have their papers confiscated and may have gone through other traumatic experiences on the migration journey and in Lebanon, not to mention the Beirut port explosion. Ensuring trust, predictability and reliability in the provision of services is crucial. MHPSS services need clear referral pathways and shared practice networks so the diverse and particular needs of migrants can be addressed.

Recommendations

Integrate MHPSS into a comprehensive support structure which addresses basic needs, community support and capacity building:

- Improve transparency and functioning of existing migrant specific helplines (with referral procedures for connecting migrants with the services they need) and provide access to helplines beyond traditional working hours, create communication mechanisms through services like WhatsApp and Facebook for migrants without access to phone lines and implement clear data protection policies
- Include MHPSS awareness raising material and hotline numbers (for instance flyers with information) when distributing essential items
- Train staff responsible for basic service provision, shelter management etc. in conducting their activities and providing their services in a MHPSS- and trauma-sensitive way, one that fosters agency, dignity, respect and avoids repeating experiences of helplessness and powerlessness
- When providing basic services and imparting information at community gatherings, consider adding specialists (social worker, psychologist, legal advisor, health counselor) to your team. Aim at having the same persons reiteratively visiting the same locations for trust-building
- Evaluate satisfaction with services using both quantitative and qualitative data

Community Building and Family Supports

For many, having access to support from community and family is sufficient to maintain mental health and psychosocial well-being. However, because persons under Kafala are often separated from their families and can sometimes face social isolation or acculturative stress alienating them from their social surroundings, activities aiming at facilitating and reinforcing community and social networks of support can have a huge impact. This also includes formal and non-formal educational activities, livelihood activities, recreational activities or women's groups and youth groups.

ARM/MCC:	classes, workshops, activities, events, advocacy, awareness sessions on topics like mental health, the Kafala system, etc. for all migrants with a focus on migrant domestic workers
Egna Legna:	language classes, workshops and information on reproductive health and family planning; workshops on conflict management, anger management and communications skills for a variety of different scenarios; workshops for grant writing and launching individual initiatives for migrant women; their office in Ethiopia provides livelihood support for return migrants, including skills and vocational classes and grants for further education
Caritas Lebanon:	classes, workshops, vocational training and support through the Caritas Lebanon Migrant Center (CLMC); education support for children of migrants at Beth Aleph preschool
AAMC:	pastoral care, space for prayer groups and community gatherings
Amel:	empowerment classes, skills trainings, vocational training
IOM:	education and language courses, vocational training and support for employment opportunities for migrant victims of trafficking

Opportunities for Expanding Community Building

The networks of mutual aid that migrants have assembled, as well as the community building structures offered by NGOs, are the main channels through which they are informed about and connected to available services. Community building and advocacy have also proven to be powerful antidotes to the experiences of racism, discrimination and exploitation which negatively impact mental health. Further, migrant community advocates are the ones who are often acting as first responders and informal counselors in urgent cases of distress that occur. They are often best positioned to identify and respond to cases of distress, as they speak the same languages, have a better understanding of cultural background and communication channels. Yet, the pressures of handling these cases can also negatively impact the mental health of community advocates who take on this role. In line with a community-based approach for MHPSS, expanding access to community capacity building and MHPSS training can help reinforce these essential communal networks of support.

Recommendations

Reinforce community building, family support and social networks of support:

- Foster peer support structures for migrants and disseminate mental health awareness information on WhatsApp/social media
- Expand services integrating MHPSS into livelihood activities on community level (skills trainings, workshops etc.); sensitise trainers to MHPSS and co-design and co-evaluate activities with migrants to enhance trust and satisfaction with services
- Provide training to migrant community advocates in MHPSS, psychosocial self-protection and self-care

Focused, Specialised Non-medical Supports

The third layer of the pyramid is where more focused, problem-specific supports are provided for individuals, families or groups, for instance by psychosocial workers and community workers. This tier of support includes among others legal support, psychological first aid (PFA) and counseling by primary health care clinics/workers.

Amel:	access to PHCC where they have social workers and can also get referrals for specialised services; hotline for mental health community clinic; psychosocial support including art therapy, drama therapy, group therapy; psychosocial support activities online; repatriation support for those needing to return home
Kafa:	psychosocial support, including group and individual counseling for migrant women at their shelter (MDW victims of violence, exploitation and trafficking); systematic social counseling provided on a weekly basis; psychosocial and recreational activities on project basis (such as art therapy, yoga classes, etc.)
IOM:	support for migrants who are victims of trafficking, including shelter as well as psychosocial counseling and psychotherapy assistance
Caritas Lebanon:	psychological support and counselling at shelter for migrant domestic workers; also liaison support for migrants in General Security detention centers
Egna Legna:	psychosocial support and counseling to women from Lebanon who have been repatriated through their office in Ethiopia

Specialised Services

Specialised services for mental health include psychological, psychotherapeutic or psychiatric support for people with severe mental disorders whenever their needs exceed the capacities of existing primary or general health services. In this case severe mental disorders include any type of condition that impedes basic daily functioning. Those needing these types of specialised services will constitute the smallest proportion of the population of migrants.

MSF:	support for psychiatric emergencies including hospitalisation, psychotherapy, counselling, psychiatric consultations, psychotropic medication, as well as referrals to other NGOs providing specific services
ICRC:	psychiatric services at RHUH - has a presence in the emergency rooms to facilitate access to hospital care for migrants (and refugees)
Amel:	psychiatric and psychotherapeutic support as well as social assistance at a PHCC, so migrants can receive referrals to those specialised supports through other PHCCs or through the migrant specific projects
IOM:	counseling for individuals and groups as well as psychotherapy assistance for migrant victims of trafficking
Kafa:	referrals for psychotherapy and psychiatric support for migrant domestic workers at their shelter, and medication when needed
Caritas Lebanon:	psychiatrists in PHCCs are available for migrants
Restart Centre:	provision of specialised Mental Health services through remote and face to face modalities: psychological assessments and follow-up, psychiatric, neurological, general and pediatric consultations, physiotherapy, speech therapy, psychomotor therapy, special education, laboratory diagnostics services, as well as dispensing of psychotropic, neurological and general medications. Provision of community-based psycho-social support including at shelters

Gaps and Challenges in the Provision of Specialised MHPSS Services

From conversations with both service providers and migrant advocates, access to hospital care for severe emergency cases emerged as a major gap. While the more severe cases needing access to hospitalisation or specialised forms of mental health intervention are less frequent, the gaps in that regard are quite serious given the significant risk to safety. Providing this type of specialised support is challenging as it is costlier and scarce given the already limited capacity of Lebanon's mental health infrastructure, exacerbated by the ongoing crises.

MSF identified several challenges in accessing specialised care for migrant psychiatric patients, including slow referral admission processes, limited capacity in psychiatric hospitals, lack of insurance, high costs of treatment and medication and reluctance of patients to be hospitalised due to experiences of trauma. Often hospitals are unable to adequately support migrant patients in distress and tend to sedate the patient without providing further treatment. There have been reports of women facing severe distress being sedated and repatriated without proper assessment and management of care.[52] One of the major barriers to specialised support is the high costs of securing treatment. For those migrant workers who are covered by the Ministry of Labor health insurance scheme, mental health services should be included in the services covered which primarily address physical health needs. Including mental health services in the insurance scheme will help mitigate the incentive of the employer to block access to or shorten the treatment they require.

[52] Medecins Sans Frontieres (MSF). COVID-19 and Economic Downfall Reveal Migrant Workers' Mental Health Crisis in Lebanon.

Migrant advocates who respond to cases of severe distress have enormous difficulties in getting the support and information they need to secure safety and treatment for the person in need. As one migrant community advocate explained:

> *"You know like when they have this hospitalisation when they are in emergency or something, it's very difficult for us to find someone to reach out for the, in case of emergency, because we have to be like, call this one hotline and then they will refer us to another one and then until somebody will just tell them okay let me help you, let me come this place where she can be in the hospital, so they don't have really like a connection where we can just immediately get some help for an emergency."*

These situations can cause significant distress for the migrant community advocates who discover the case and struggle to find access to professional support. Thus, having a singular point of contact for emergency mental health cases is a significant need.

The incidence of severe cases of distress also speak to the importance of prevention and outreach, and ensuring persons under Kafala have access to existing MHPSS services before a more severe mental health condition can develop. So, while the MHPSS approach should be primarily targeting the lower layers of the pyramid, as these are the preventative measures that prevent deteriorations in mental health which require more intensive services, there still needs to be better coverage and clarity on ways to respond to emergency cases. Also, given challenges with availability of psychotropic medication (shortages in market, high prices), medication should be prescribed and used with caution, and in severe cases only, given the high risk of discontinuation with possibly severe adverse withdrawal effects.

Moreover, the provision of counseling and specialised mental health interventions for migrants in prison (particularly MDW), emerged as a pressing need. Often women in prison face false accusations and are subjected to traumatising experiences during arrest and detention, as they are not informed properly about their rights and procedures for detention. These conditions create a risk for mental distress, particularly as they are confined and cut off from social support networks. Therefore, there is a need for provision of MHPSS services within prisons and detention centers to address these risks. This could involve integrating mental health support with legal services provided to migrants, so that a trained social worker or mental health professional can provide mental health support to those facing the traumatising experience of arrest and detention and identify further needs and high-risk cases.

Recommendations

Fill gaps in existing service landscape to address high risk cases:

- Integrate MHPSS support with legal support provided to migrant workers in prisons
- Implement sensitisation trainings for General Security, including how to communicate properly with migrants and how to spot warning signs for mental health risks
- Always ask about suicidality and implement safety planning with clients/patients

Barriers to Effective Service Delivery for Specialised Support

The influence of employers, cultural and language barriers which impede effective communication, as well as effects of racism and social discrimination among practitioners pose a major challenge and present the risk of re-traumatisation. This points to a need to train mental health professionals in a practitioner-oriented, non-theoretical way in critical consciousness and decolonial approaches to mental health, for instance in partnership with a university. Practitioners should be equipped with the appropriate theoretical and practical knowledge to treat migrants as well as other patients from marginalised groups. Because services are provided in Arabic, English or French, there is a need for more translation assistance within existing practice networks so that persons under Kafala can access services in their own languages. Furthermore, given that there are different cultural expressions of distress, there is a need for incorporating greater ethno-cultural sensitivity in the clinical aspects of care to prevent overmedicalisation and misidentification of symptoms of distress. One successful strategy that existing migrant-specialised providers have used to address this challenge, is assigning social workers to work in parallel with mental health professionals to ensure that clinical interventions are situated in and relevant to the individual's socio-cultural context and background. Given the effectiveness of this approach, building a pool of trained cultural mediators/interpreters and establishing practice networks between cultural mediators, social workers, psychotherapists and psychiatrists can help to overcome these challenges to utilisation of specialised mental health support.

Recommendations

Fill gaps in existing service landscape to address high risk cases:

- Create a singular point of contact for emergency mental health cases available 24/7
- Develop a strategy and protocol for addressing cases of severe distress requiring hospitalisation
- Include mental health services in the Ministry of Labor health insurance scheme
- Evaluate satisfaction with services using both quantitative and qualitative data

KEY RECOMMENDATIONS [53]

Integrate MHPSS into a holistic support structure which addresses basic needs and capacity building:

- Integrate MHPSS support with legal support provided to women in prisons
- Establish mobile teams (social worker, psychologist, legal advisor, health counselor) dispatched to community gatherings
- Improve transparency and functioning of existing migrant specific helplines (develop more concrete referral procedures for connecting migrants with the services they need) and provide access to helplines beyond traditional working hours
- Create communication mechanisms through services like WhatsApp and Facebook for migrants without access to phone lines
- Train community advocates in MHPSS

Reinforce community building, family support and social networks of support:

- Foster peer support structures for migrants and disseminate mental health awareness information on WhatsApp/social media
- Expand services integrating MHPSS into livelihood (life coaching, skills trainings, workshops etc.); sensitise trainers to MHPSS
- Co-design and co-evaluate activities with migrants to enhance trust and satisfaction with services

Fill gaps in existing service landscape to address high risk cases:

- Create a singular point of contact for emergency mental health cases available 24/7
- Develop a strategy and protocol for addressing cases of severe distress requiring hospitalisation
- Include mental health services in Ministry of Labor health insurance scheme
- Always assess risk and implement safety planning if there is risk

Address challenges in delivery of professional MHPSS support (language barriers, cultural differences, racism and discrimination):

- Establish pool of trained cultural mediators/interpreters and create practice networks between cultural mediators, social workers, psycho-therapists, psychiatrists
- Train psychologists/psychotherapists in decolonial, empowerment-based approaches to mental health – create practitioner-based course within universities on the practical application of these methods
- Incorporate non-language based MHPSS methods, such as arts and drama

[53] Recommendations were selected from a list of interventions that emerged from interviews, focus group discussions and desk review, based on crowdsourced prioritisation methods. The recommendations stem from considerations of both what is most needed in terms of addressing high risk cases and filling gaps, but also what is practically feasible given the constraints in resources and capacity amid Lebanon‘s ongoing crises.

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