LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

International Centre for Evidence in Disability

Disability and mental health among Syrian refugees in Sultanbeyli, Istanbul

Executive Summary

Mixed-methods assessment of physical rehabilitation and MHPSS needs

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Executive Summary

Background

Evidence suggests that refugee populations are at an increased risk of disability, especially mental health issues. There is, however, insufficient data regarding the prevalence and lived experience of Syrian refugees with disabilities in Istanbul. This study aims to provide reliable data on disability and mental health, with which to inform service provision, policy, and advocacy.

Study objectives

1. To estimate the prevalence of disability (all ages) and mental health disorders (children) among Syrians living in Sultanbeyli.
2. To estimate the need for physical rehabilitation and mental health and psycho-social support (MHPSS) among Syrian refugees living in Sultanbeyli.
3. To assess the impact of disability on key life areas, such as education, livelihoods, social inclusion, and Quality of Life.
4. Among Syrian refugees with disabilities and/or mental health disorders, explore priority needs, challenges, coping mechanisms, and barriers/facilitators to accessing MHPSS and rehabilitation services.
5. To explore community attitudes towards disability and mental health disorders.
6. To explore MHPSS and rehabilitation service capacity and service delivery at primary, secondary and tertiary health care.

Methods

The study comprised of three components:

1. A **population-based survey** to estimate the prevalence of disability (all ages), musculoskeletal impairment (all ages) and specific mental health issues (children)
2. A **nested case-control study** comparing people with and without disabilities across key life areas
3. A **qualitative component**, exploring the priority needs of people with disabilities and/or mental health issues

Population-based survey

80 clusters ('street') of 50 people were selected through random sampling methods (total sample size: 4,000). In each cluster, all eligible survey participants (aged 2+) were interviewed for self-reported disability using the Washington Group Short Set 'Enhanced' and Child Functioning Module..

Participants were also screened for Musculoskeletal impairment (MSI). Those screening positive underwent an in-depth standardised assessment with a trained physiotherapist to determine severity, diagnosis and service needs.

In addition, all children aged 8-17 were interviewed for self-reported symptoms of common mental health disorders. Children scoring at or above the cut-off score for significant symptoms of mental ill-health were considered to be at risk of a mental health disorder.

For the purposes of this study, disability was thereby defined as:

- Participants self-reporting "a lot of difficulty" or "cannot do" in any Washington Group functional domain

- Adults reporting daily experiences of depression and/or anxiety, with feeling described as “a lot”
- Children scoring at or above the cut-off score for significant symptoms of mental ill-health
- Participants identified as having moderate/severe MSI

Nested case-control study

A case-control study compared people with a disability (“cases”) with members of the same community without a disability (“controls”).

All participants aged 5+ screening positive for self-reported disability (“cases”) were invited to participate in the nested case-control study. For each case, we selected one “control” of the same age and sex.

People with and without disabilities were asked questions about key life areas, such as poverty, employment, healthcare, education, social participation, and their experiences of the war in Syria. People with disabilities were also asked questions on their access to, and awareness of, specialised rehabilitation, MHPSS, and assistive devices.

Qualitative component

In-depth interviews were held with 36 people with disabilities, exploring topics on key life areas, as well as their priority needs, coping strategies, help-seeking behaviours, and access to services.

Interview respondents were purposively selected to represent a diverse group across age, gender, and impairment type.

Focus-group discussions were also held with community members and service providers to explore perceptions and attitudes towards disability and mental health.

Situational analysis

In addition, a situational analysis, assessed the availability and capacity of physical rehabilitation and MHPSS services, detailing specific activities, personnel, and funding cycles.

Key findings

3,084 (response rate 77%) people were included in the survey. In line with the refugee registration database, the study population was relatively young; 50% were under 20 years and only 3% were aged 60+ years.

Prevalence of disability

Disability was common among Syrian refugees. The overall prevalence of disability, according to the study definition, was 24.3% (95% CI: 21.8-26.9).

When comparing people with and without disabilities from the survey, findings show that adults with disabilities were significantly less likely to be in paid work, and more likely to be divorced/separated or single.

Overall, 60% of the study households included at least one member with a disability, according to the study definition. These households were on average significantly larger, had an older average age, a higher dependency ratio, and a lower proportion of working age (18-65) adults in paid work. In addition, households containing at least one person with a disability were significantly more likely to be in receipt of food or cash assistance. However, overall access to two of these social protection schemes was relatively low.

Reported functional limitations

Results from the Washington Group/Child Functioning Module Questions only (thereby excluding mental health in children) report an overall prevalence of 14.7% (12.8-16.9), ranging from 7.5% in children to 39.2% in adults aged 50+ years. The most frequently reported functional difficulties among adults were anxiety (10%), walking (9.3%), and depression

(5.6%). Among children aged 5-17 years the most frequently reported difficulties were related to making friends (2.5%), walking (2.3%), and controlling behaviour (2.2%). For children aged 2-4 years difficulties controlling behaviour (5.3%) and communication (2.1%) were most commonly reported.

Self-reported causes of disability

Overall, 42% of people with self-reported functional limitations reported cause to be related to the war in Syria. Among people with mental health issues, 73% attributed elevated symptoms to violence/injury/trauma in Syria (40%) or Turkey (33%). Illness/disease was the most commonly reported reason for vision (49%), hearing (38%), and mobility (52%) difficulties.

Specialised service need and use

People with mental health issues and cognitive difficulties were least likely to report needing related support/services (50% and 60%, respectively), whilst this figure was over 80% for people with vision, hearing, and mobility difficulties. Qualitative interviews revealed varying conceptualisations about mental health and service utilisation, with many feeling support is only suitable to those with severe conditions. Moreover, mental health attracts stigma, and many expressed hesitation to reveal feelings of distress.

Unmet service need (i.e. the proportion of people who felt they need services/support and have not received, compared to those who have a need and have accessed them) was highest for mental health (73%) and cognitive functioning (63%) followed by hearing (28%), vision (25%), and mobility (15%).

Musculoskeletal impairment (all ages)

The overall prevalence of any MSI (according to standardised assessment by a physiotherapist) was 12.24% (95% CI: 10.8-13.7); prevalence increased by age ($p<0.001$) and was slightly higher among females. The prevalence of moderate or severe impairment was 8.6% (7.5-9.8). The war in Syria was identified as the direct cause for 8% of people with MSI. Unmet need for services related to MSI (as assessed by a physiotherapist) was relatively high; 83% of people with MSI who could benefit from physiotherapy had not received this, 38% for information/exercises, 37% for medication, 20% for surgery, and 14% for other rehabilitation. The most common reasons for not seeking services were ‘need not felt’, lack of awareness of services, lack of service availability, and financial barriers.

Mental health in children (aged 7-17)

Mental health issues were common, with 23.4% (95% CI: 19.9-27.2) of children aged 7-17 years meeting criteria for elevated symptoms of anxiety (8.9%), depression (12.4%), and/or PTSD (11.5%). Just over one-fifth of households included a child with symptoms of anxiety, depression or PTSD. Children with symptoms of depression had significantly poorer resilience scores

Symptoms of mental health conditions were significantly more common among girls, although this difference was only significant for anxiety.

> *“I will advise him, support him, and stand by him. I would tell him that we are struggling here. Actually, I would say this for all Syrians who are living here in Sultanbeyli, we are in this together. […] I would tell this friend and the others to have strong faith in Allah, and Inshallah, tomorrow you will return back home to your family, to your country and things will get better.”*
>
> ***(Male, 70s, mental health issue)***

Qualitative interviews revealed faith and family as key coping strategies for mental health issues, particularly important to refugees, as social support structures have largely broken down.

Case-control study

Work

Adults with disabilities were significantly less likely to have engaged in paid work in the past week compared to peers without disabilities (aOR 0.5, 95% CI: 0.3-0.9). Disaggregated by sex: men with disabilities were far less likely to have worked in the past week (31%) than men without disabilities (69%). Working in the past week was not common among women (<10%) and there was no significant difference by disability status.

Adults with disabilities were significantly more likely to report poor physical health/disability and mental health as the reason for not working (p<0.001).

People with disabilities, men in particular, unable to work reported feelings of stress and pressure, as they struggle to provide for their family. Inflexible working hours also meant they were likely to miss support sessions with health care providers.

Although people with disabilities are undoubtedly facing additional challenges, qualitative data suggests that all Syrians are struggling with work, and it remains top priority for many.

Children and school

Children with disabilities were significantly less likely to be currently attending school (aOR: 0.6, 95% CI: 0.3-1.0). Among those attending school, children with disabilities were less likely to report always receiving support from teachers (aOR: 0.5, 95% CI: 0.3-1.0); having friends to play with at breaktimes (aOR: 0.3, 95% CI: 0.2-0.7); or having friends look to them as a leader (aOR: 0.2, 95% CI: 0.2-0.7).

Children with disabilities were more likely to cite disability/health as a reason for non-attendance (19% vs 6%, p<0.01). Other common reasons for non-attendance included lack of interest and financial barriers.

The qualitative data suggests many children, both with and without disabilities, faced challenges with integration into schools, largely as a result of language barriers, stigma, and discrimination. These challenges were exacerbated for children with disabilities, who often couldn't express their needs and requirements to teachers and classmates.

> *"When I registered at the school they thought I was Turkish. The kids were playing with me normally. When they found out I am Syrian, they just stopped playing with me. They started saying 'go back to Syria, what are you doing here in our country?'"*
>
> ***(Male, 12 years, mental health issue)***

Access to health services

People with disabilities were 4.5 times more likely than people without disabilities to report having a serious health problem in the past year.

Of those reporting a serious health problem in the past year, the majority (>93%), both with and without disabilities, reported seeking treatment. The majority (>83%) of people with and without disabilities who had health care in the past year reported feeling respected. However, 6% of people with disabilities reported an experience in which they felt disrespected, while not one person without a disability reported this.

In addition, qualitative interview respondents reported experiences of mistreatment from medical professionals and support staff (translators etc.). For people with disabilities, being turned away from services, and asked to come another day, resulted in additional costs and difficulties that are difficult to overcome.

Social participation, attitudes, quality of life

There was evidence of social exclusion. People with disabilities were significantly more likely to report participating less often than their peers, and less than they would want to across all domains asked (visiting others, moving around at home/in the community, major social events, social activities, and community affairs; aOR between 2.1-3.1, p<0.01).

They were also significantly less likely to feel they received same level of respect in the community (aOR: 0.3, 95% CI: 0.2-0.7) or in family discussions (aOR: 0.5, 95% CI: 0.4-0.8).

Interview respondents, both with and without disabilities, experienced isolation, having been separated from friends and family. There were frequent references to life before the war.

> *"With whom will I speak? Turkey has changed people, no one is there for anyone anymore, I don't even tell my mother about what I am dealing with, I cried a lot yesterday as well."*
>
> ***(Caregiver of female, 20s, cognition, mobility, self-care)***

Moreover, the findings suggest evidence of negative attitudes towards people with disabilities. People with disabilities were more likely to report never/rarely feeling accepted (aOR: 4.7, 95% CI: 2.1-10.4) and respected (aOR: 2.4, 95% CI: 1.1-4.9), as well as problems getting involved in society due to the attitudes of others (aOR: 3.1, 95% CI: 1.8-5.3).

Quality of life scores, asked of adults (18+) only, were significantly lower (p<0.001) among adults with disabilities compared to adults without disabilities.

Environmental barriers

People with disabilities were significantly more likely to report that factors in their environment limited their activities and participation (including social engagement in the community, places of worship, work and education, and transport; aOR between 2.2 and 3.8, p<0.01). Difficulties accessing information was also more commonly reported by people with disabilities (aOR: 4.1, 95% CI: 2.0-8.5).

Recommendations

1. Given the high prevalence of disability, it is vital that inclusive practices and policies are implemented for refugee populations, across all sectors, including health, education, and social protection.
2. Mental health issues are common among children and adults. Increased service provision is needed, alongside awareness campaigns to reduce stigma towards mental health and increase uptake of services.
3. Barriers to health and rehabilitation access need to be addressed, including financial and attitudinal factors.
4. Support needs to go beyond rehabilitation and healthcare assistance and needs to address inclusion in broader key life areas, such as community integration, livelihoods, and social participation.
5. People with disabilities, including those with mental health issues, should be meaningfully involved in planning and implementation of service provision for displaced populations.
6. Further multi-sectorial needs assessment are required among refugees in different locations across Turkey to explore the needs of those in different circumstances.

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Authors: Dr. Sarah Polack, Nathaniel Scherer, Dr. Shaffa Hameed, and Dorothy Boggs, International Centre for Evidence in Disability at the London School of Hygiene & Tropical Medicine