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ASSESSMENT OF

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT
SERVICES FOR SYRIAN REFUGEES IN LEBANON

by
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Acknowledgements

ACRONYMS LIST

ABAAD	ABAAD-Resource Center for Gender Equality
AMEL	Amel asocial international
APEG	Association for the protection of children in war
AUB	American University of Beirut
UOB	University of Balamand
CLMC	Caritas Lebanon Migrant Center
DRC	Danish Refugee Council
DSM	Diagnostic and Statistical Manual of Mental Disorders
EMDR	Eye Movement Desensitisation and Reprocessing
FGD	Focus Group Discussion
GBV	Gender Based Violence
HI	Handicap International
HI-Emergency	Handicap International- Emergency
IASC	Inter Agency Standing Committee International
ICD	Classification of Diseases (WHO)
IDRAAC	Institute for development research advocacy and applied care
ISF	Imam El Sader Foundation
IFRC	International Federation of Red Cross and Red Crescent
IMC	International Medical Corps
iNGO	International Non Governmental Organization
IRC	International Rescue Committee ISF
IOCC	International Orthodox Christian Charities
Kafa	(ENOUGH) Violence & Exploitation
MC	Mercy Corps
MDM,	Médecins du Monde
mhGAP	Mental Health Gap Action Programme
mhGAP-IG	Mental Health Gap Action Programme Intervention Guide for management of mental, neurological and substance use disorders in non specialized health settings
MHPSS	Mental health and psychosocial support
MOPH	Ministry of Public Health
MOSA	Ministry of Social Affairs

MSF	Médecins Sans Frontières
NISCVT	National Institute for Social Care and Vocational Training - Beit Atfal Soumoud
NGO	Non Governmental Organization
PFA	Psychological First Aid
PHC	Primary Health Care
QRC	Qatar Red Crescent Society
PoCs	Persons of Concern
Restart	Restart Center for Rehabilitation of Victims of Torture and Violence
SC	Save the Children
TDH	Terre des Hommes
Tf-CBT	Trauma focused Cognitive Behavioural Therapy
UNHCR	United Nation High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Work Agency for Palestinian refugees in the Near East
WASSS	WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings
WHO	World Health Organization
WVI	World Vision International

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EXECUTIVE SUMMARY

Syria's third year of civil war has caused a rapid acceleration in influx of the refugees to Lebanon with the intensification of clashes in recent months. In fall 2013 more than 2000 Syrian refugees are fleeing to Lebanon on daily basis. The mental health needs of Syrian refugees in Lebanon have not received thorough assessment. Information about the nature, the quality, and coverage of these services for the Syrian refugees is lacking.

Methodology

The Syrian refugee assessment for Mental Health and Psychosocial Support (MHPSS) took place in August and September 2013. The assessment had two main parts:

1. A mapping exercise according to the 4Ws (Who is Where, When, doing What). Input from 20 participating organizations was collected and analyzed for 4W mapping.
2. Fieldwork consisting of interviews with professionals, focus group discussions with refugees, and site visits.

Main Findings and Recommendations

4Ws (Who is Where, When doing What?)

For the 4Ws mapping the activities were divided in four main categories:

Category	
Specialized or clinical services (Level 4)	Case-focused (targeted at individual people)
Focused non-specialized psychosocial support (Level 3)	
Strengthening community and family support (Level 2)	Community-focused (targeted at communities or segments of communities)
MHPSS considerations in basic services (Level 1)	

Of all activities being implemented 52% fall under level 3 of the IASC pyramid, while 37.3% range in Level 2 and the remaining 10.7% focusing on specialized services are in Level 4. Baalbak has the highest percentage of activities among the different districts, 34% of these activities are Case focused MHPSS activities. The highest percentage of activities in Beirut (62%) is for Community focused MHPSS and Protection. Akkar and Hermel are among the least served districts.

Field Work

Level One: MHPSS considerations in Basic Services and Security

Many Syrian refugees' basic needs such as shelter, health services, and food are still unmet. Refugees often do not register with UNHCR for many reasons ranging from misconceptions about the impact of the registration on their ability to return to Syria to logistical challenges in reaching the registration centres.

Recommendations:

- Deliver a short training, a three hours workshop, on the IASC guidelines on MHPSS for key policy makers in iNGOs, NGOs.
- Providing Psychological First Aid (PFA) training for the registration staff and some basic MH conditions detection skills. This can be done through a four hours workshop that can be delivered in two sessions of two hours each.

Level 2: Strengthening Community and Family Support

The relation with the host community is complex due to multiple factors. Some of these factors are: competition on economic resources, employment opportunities, prostitution, and domestic violence. In addition there is a sense of distrust within the refugees' community, which makes it challenging for individuals to rely on the community as a source for support. Most actors mentioned prostitution of young girls as being a challenging area that needs to be better addressed. In addition, refugees are not receiving information about the available services.

Recommendations:

- Strengthen ethical considerations in recruiting staff for MHPSS interventions ensuring that issues of diversity and confidentiality are taken into consideration. This is even more important now the refugees' community - as well as the host community- is getting polarized with regards to the ongoing conflict in Syria. It is very important that staff should be able to differentiate between their professional role and their own personal views and make sure that the latter will not affect their work. All organizations are recommended to be cognizant of this and take appropriate measures such in recruitment and teambuilding.
- Address the prostitution of young girls as a priority intervention by steering GBV programme more towards being more inclusive of this group by prioritizing groups of woman, families with the mother as the only parent, unaccompanied young girls who are have limited resources and are at a higher risk for survival sex. These groups can be supported by direct item provision or by empowering them to generate income. In addition, awareness raising about sexually transmitted infections and unwanted pregnancies alongside working collaboratively with the authorities to target more the persons using these women for prostitution than condemning the women themselves.
- Design programs in a more inclusive way to address also the host community that is in some cases as poor as the refugees ensuring equity and by that also reducing the tension between the Persons of Concern (PoCs) and the host community

- Design a media campaign to tackle this issue focusing on what does it mean to be a refugee.

Level 3: Focused non-specialized Psychosocial Support

In all FGD's, real or perceived fear of being mistreated was a major obstacle for refugees in seeking services. Most activities targeted women and children rather than men or young male adolescents. There is a lack of clarity as to what is called psychosocial activities and what is the general framework in which such activities are being conducted and how these might link to other services or or to the humanitarian response for Syrian refugees' as a whole. In addition the level of training of the staff varies considerably. Basic psychosocial skills, including good communication skills, providing PFA or being able to detect and refer persons who need for more specialized mental health services, can and should be strengthened.

Recommendations:

- All NGOs and UN agencies need to ensure that staff involved in policy decisions is familiar with the IASC guidelines on MHPSS. An option would be that actors organize 1-day introduction for the key staff of NGOs and UN agencies.
- All staff working directly with persons of concern need to be trained in PFA. An option would be to conduct 1-2 days workshop.
- Clearly defining the conceptual and operational framework of the PSS starting by defining the activities such as for example what is a support group, a self-help group. This task can be coordinated by the MHPSS Taskforce.
- Improve the referral links between level 3 and level 4 through interventions such as training level 3 field workers on detecting and referring persons in need of specialized MH services and training of staff in level 4 to do proper referrals to non-clinical services.
- Providing training on a 'MHPSS core competencies' including skills such as good communication skills, detection of persons with mental health conditions and adequate referral and follow-up.
- Use already existing networks such as scouts, Lebanese Red Cross, etc to improve referral and feedback between NGOs. This can be done through creation of local MHPSS working groups linked to the central MHPSS Taskforce.

Level 4: Specialized or Clinical Services

Most psychiatric services are being provided in community mental health centres or by multidisciplinary teams based in PHC centres. However, access remains challenging for many refugees, who are y scattered over large areas. The total number of specialized mental health professionals (7-9 psychiatrists, 30-40 psychologists) is low with many of them working with different NGOs. The psychologists have diverse background each using their own school of thoughts. |Many having limited experience in working in refugee settings. Supervision is partly conducted but in widely different ways. Psychotropic medications are available with some interruption in the supply. Different NGOs use different Health Information Systems and this shows mainly in widely varying diagnostic categories making comparisons both within Lebanon as well as with other refugee settings difficult.

Recommendations:

- Make sure that all geographical areas are covered, avoiding overlap between different NGOs. Akkar, Bekaa and the South are areas need more attention.
- Strengthening the link of mental health services with general PHC centers and train and supervise general health workers in basic identification and management of mental disorders. The most appropriate training tool to do this is mhGAP-Intervention Guide (mhGAP IG) as developed by WHO. Trainers should be the mental health professionals of NGOs.
- Include psychiatrists and psychologists in mhGAP-IG training to harmonize the language, referral and interventions at all levels.
- Provide regular clinical supervision.
- Establish a solid referral and feedback system both centrally and locally in the different districts including pathway for urgent cases that might occur outside working hours
- Identify and agree on specific evidence based psychotherapy methods to be used by the psychologists. Such methods can be selected from the mhGAP-IG.
- Agree on one diagnostic classification with clear case definitions. We recommend the 7 item classification of the UNHCR Health Information System as the basis, with reference to the ICD-10 categories in case there is a need to be more disorder specific.

Coordination:

One of the most challenging finding of this assessment is the lack of coordination on all levels. The current mechanisms are not sufficient to ensure the required level of coordination. Improved coordination is one of the most important elements to ensure a better MHPSS response for the Syrian refugees.

Recommendations:

- One model would be creating a cross-sectorial group: MHPSS Task Force. This task force would include all actors engaged in MHPPS, and would be co-chaired by a Health and Non-health organization with a clear ToRs to coordinate the activities coordinating the fieldwork among the actors whether for geographical areas, types of activities (level 2, 3, or 4), referral and feedback, sector (health, education, etc.), and harmonizing the activities and interventions with the international guidelines such as the IASC guidelines, and UNHRCs Operational Guidance on Mental Health & Psychosocial Support Programming for Refugee Operations and using available resources like, the PFA manual by WHO and the mhGAP-IG.
- Keep an updated 4Ws matrix and share information regularly with the refugees.
- It is advisable that UN agencies, iNGOs, local NGOs governmental organization and if needed independent experts will be part of the MHPSS Taskforce. This will improve accountability among different actors once different tasks have being allocated to designated parties.
- This coordination should also be done on a district level to coordinate the referral and feedback locally in the different regions.

Conclusion

This assessment has several limitations to be taken into consideration when reviewing the results and recommendations. Based on it, the most important recommendations would be the creation of an inter-sectorial MHPSS group, the harmonization of psychosocial activities and programmes bringing them closely to evidence-base and linking them more closely with clinical mental health services.

I. Background:

1) Situation in Syria

Over a short period of time, Syria went from the third largest refugee hosting country, primarily for Iraqi refugees (United Nations High Commissioner for Refugees (UNHCR), 2012a), to the largest refugee producing country, with more than1.9million Syrians escaping its borders in less than two years. (Quosh, 2013)

The pace of deterioration of the health and humanitarian situation in Syria has increased since April 2013 with most healthcare facilities being severely damaged. As such field hospitals took over to provide the basic need and services. However, the drawback is that they lack the indispensable equipment and medical supplies to treat wounded people. In addition, over 70% of the medical communities have left the country because of the conflict (Coutts & Fouad, 2013).

Local NGOs, estimated to be over 250, are working on providing services such as water supplies, medical equipment's, food baskets, clinical supplies and storage facilities. As for the international NGOs they are working in operating field hospital, vaccination programs and mobile clinics Although the local and international NGOs are providing support but assistance is still in short supply due to the rapid increase in need and the deterioration of the situation (Coutts & Fouad, 2013).

2) Asylum

The UN News Centre (UN News Centre, 2013), announced on September 3rd, 2013, that it is estimated that around 5000 Syrian are leaving the country every day adding up to more than 2 million refugees.
In fact based on the UNHCR (UNHCR, 2013) website data the total number so far has reached, 2,181,291 million distributed as such: 125,962 In Egypt, 197,301 in Iraq, 545,035 Jordan, 504,419 Turkey and 793,615 Lebanon.

3) Situation in Lebanon

With civil war in Syria in its third year, the influx has accelerated rapidly with the intensification of fighting in Syria in recent months. Lebanon has 793.934 refugees, 51% females, and 160.884 households. While 90,681 are not registered yet with an average waiting day to be registered of 37 days fluctuating between 4 days in the south and 42 days in Beirut and Mont Lebanon (UNHCR, 2013)

a) Geographical distribution:

More than 2000 Syrian refugees flee to Lebanon on a daily base (IRC, 2012) Syrian refugees are free to move around the country. Most of them reside in areas close to the Syrian borders, these areas being also the poorest ones: the North and the Bekaa area. Based on the UNHCR, there are 221,417 Syrian refugees in the North, 235,460 in the Bekaa while 152,545 in Beirut and Mount Lebanon and 93,512 in the South of Lebanon. This accounts only for the registered ones. The total number as estimated by actors on the field being more than 1 million.

b) Health care services

Ensuring access to quality health care treatment is becoming increasingly challenging, as preventative services; chronic disease treatment and referral care for a largely dispersed and urban population comes at considerable cost. Mental, neurological, and substance use disorders are common in all regions of the world, affecting every community and age group across all income countries.

While 14% of the global burden of disease is attributed to these disorders, most of the people affected - 75% in many low-income countries - do not have access to the treatment they need. In Humanitarian settings the needs gets even more important and the services are in general weakened.

The Mental Health need of the Syrian refugee population in Lebanon has not been assessed thoroughly. Médecins du Monde (Perez-Sales, P. & MdM, 2013) conducted an assessment of trauma experiences, mental health and individual and community coping resources of refugee Syrian population displaced in North and the Bekaa in Lebanon. The key findings highlighted that the main worry of refugees is income (66%), mainly due to lack of employment (91.4%). IN addition around 40% of the refugees consider that they have a severe problem in getting enough food. When asked about their experiences in Syria showed that 83.1% have experienced shootings or direct bombing; families fled united although there was forced separation of family members in almost half of the cases

As for psychological well-being of the refugees some measures as done by the WASSS (WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings) showed that 58% refugees had feeling of fear (15% all the time), 56% were hopeless (15% all the time), 62% were uninterested in things (27% all the time), and 65% were unable to carry essential activities for daily living because of these feelings (20% all the time). These negative emotions increase with time (Perez-Sales, P. & MdM, 2013).

A similar assessment by IMC (IMC, 2011), at the northern Syrian/Lebanese border showed that participants reported anxiety, feeling depressed, lethargy, eating and sleeping problems, anger and fatigue. In particular anger, fear, anxiety, feeling depressed and stress affected relationships within families, daily functioning and health. Mothers described changes in the behaviours of their children, and expressed difficulties in handling them, as well as an inability to show affection. Positive coping mechanisms included going out, exercising, and playing with one's children

The health sector in Lebanon is predominantly private; this is especially particularly apparent when it comes to the provision of mental health services. Limited in-patient services are provided free of charge in mental hospitals for eligible low-income patients through the Ministry of Public Health (MOPH), but these are capable of accommodating only a limited number of patients. This limitation is especially dramatic given that specialized mental health services generally very limited, being available at only three private mental hospitals, and 4 psychiatric units within general hospitals, all of which are located centrally around the capital, Beirut. There is a lack of community-based mental health services, and services are not available in every catchment area (WHO-AIMS Lebanon, 2010).

Lebanon has relatively few mental health specialists; with an average of 1.5 psychiatrists per 100,000 of the population (WHO-AIMS, 2010), and with 60 psychiatrists registered in the Lebanese Psychiatric Society and approximately another 15 registered in the Order of Physicians but not in the Lebanese Psychiatric Society. The training of these psychiatrists is variable depending on the country in which they specialized and trained and on the programs they followed. The majority work exclusively in the private sector with a few having part-time positions working with NGOs.

The budget for Mental Health constitutes 5% of the general health budget. Available resources are mainly allocated for long-stay in-patient costs in mental hospitals and the provision of some psychotropic medications. Outpatient and community based services are the responsibility of the private sector. Mental Health care provided through primary health care (PHC) is limited and typically restricted to prescription of medication through the general physician without supervision by specialists.

A limited number of health centres have social workers or nurses that are trained in mental health.

Data from the country suggests that only 10% of those with mental disorders seek care. Those mainly seek care from general physicians at clinics, or polyclinics that are operated by private doctors, or charities, but not by Mental Health professionals (Karam et. al., 2006).

Available data further suggests that of those who do receive services, 85% are treated in the general medical sector and the Mental Health care system, while the rest resort to religious or spiritual healers.

A few private hospitals have in recent years opened psychiatric wards. As much as this is a positive development, the cost of the hospitalization and the lack of coverage by a third party makes the cost extremely expensive to the majority of the population and would allow only a minority of persons to benefit from a lesser restrictive environment than a psychiatric hospital.

The country has a total of 42 available psychiatric beds per 100,000 persons. On average, patients spend 279 days in psychiatric hospitals, with 19% of patients spending less than 1 month and 14% of patients spending between 1-4 years (WHO AIMS, 2010).

As for refugee population, a 2006 study undertaken among Palestinian refugee women and adolescents in Lebanon (Mehio-Sibai, 2006) found that 30.4% of women and 20% of adolescents suffered from distress. Moreover, a substantial proportion of women (31.2%) reported violent behaviour as a coping mechanism.

In an earlier study, the lifetime rate of major depression in Beirut was reported to be 19%, and higher proportions of mental disorders were found in respondents exposed to multiple war-related distressing events (Weisman et al., 1996).

In a study titled "Assessment of the Prevalence of Mental Health Disorders Among Adults" which was jointly conducted by the Lebanese American University (LAU) and *Médecins Sans Frontières* - Switzerland, and based on interviews with 748 adults from 283 households that took place between June and November 2010 in Burj el Barajneh camp for Palestinian refugees in Lebanon, the prevalence of mood disorders was found to be 21% followed by anxiety disorders 13% and psychosis 3%. The study also found that 96% of the persons with mental disorders did not seek help (MSF, 2010). This is mainly due to the absence of service provision within the UNRWA clinics in the camp.

With the Iraqi refugees situation in Lebanon, a lot of work to improve mental health service provision has been done through training PHC doctors, nurses and social workers on Mental Health and through opening community mental health centers in different areas. These services have already benefited the local population (Hijazi et. al., 2011).

Currently several actors are providing Mental Health and Psychosocial Services for Syrian refugees with little information about the nature, the quality, coverage of these services.

II. Objectives

Base on the above, UNHCR commissioned this assessment for the MHPSS services provided for Syrian refugees in Lebanon.
The main objectives of this assessment can be summarized as below:

1. Review existing data on MHPSS provided for Syrian refugees in Lebanon
    2. Map the NGOs providing MHPSS services in Beirut, Bekaa, South and North Lebanon (4Ws)

3. Assess the conformity of programmes and services to international guidelines such as IASC guidelines, PFA and the mhGAP-IG, taking into consideration the accessibility, the acceptability, the affordability and the quality of care.
4. Assess the coordination between different actors.
5. Analyse existing models, highlight the gaps, reflect on the particular context of Syrian refugees in Lebanon and provide practical recommendations to UNCHR.

III. Methodology:

The assessment took place during the month of August and September 2013. Due to various factors, the start date of the assessment was delayed several times. It started finally on August 2013. Although the initial duration was supposed to be one month, the fieldwork had to be extended due because August was the month for summer vacation for many NGOs in addition for coinciding with "Ramadan" month and the festivities of the "Feetr". Another element that added to the duration was due the difficulty in having the 4Ws filled and sent on time by the different actors.

For the sake of this assessment, a team of Mental Health and Public health professionals (1 psychiatrist, 2 psychologists, 1 public health professional) worked on adapting and editing the 4Ws tool used recently in Jordan so it fit the needs of this assessment.

This exercise had 2 major sections:

1) The 4Ws mapping
2) The field work with mainly 3 parts:
    a. Interviews with key stakeholders
    b. Focus Group Discussions with Syrian refugees
    c. Site visits to centres providing the services for Syrian refugees

Further the team worked on developing a set of semi-structured interviews to conduct with: Program directors, Centre directors, Team coordinators, focal points of MHPSS in iNGOs and local NGOs, social worker, psychiatrist, psychologists. Further a FGDs guideline was developed and used while conducting FGDs with beneficiaries.

The main tool used by the team to set the FGDs and adapt the 4ws mapping tools was "the WHO UNHCR 2012 Toolkit for humanitarian settings- Assessing mental health and psycho social needs and resources."

1) The quantitative part:

a) 4Ws Mapping Process: (Who, What, When and Where)

The "4Ws: Who's doing What, Where and until When?" is a tool proposed in the WHO-UNHCR toolkit aiming at mapping the MHPSS services in humanitarian setting in a coded manner. This exercise if done regularly would help all actors to be informed about the current services given at a point in time and about the future planning for activities. In addition it helps highlighting gaps in the services.

For the sake of this assessment, the "4Ws" was the one recently used in Jordan in which there was an addition of protection services mapping. After contacting WHO Jordan and having received the 4Ws and adapting it to Lebanon (e.g. geographical districts) we added a section on services delivered for Victims of Torture as we knew of many centers who provided these services for victims of torture in Lebanon who also provide Mental health services and because victims of torture are a group with high protection and health needs. The MHPSS services mapping was the main focus but many NGOs had also Protection activities alongside their MHPSS programmes and we aimed at capturing it

Then the team drafted a list of all potential organization working on MHPSS with Syrian refugees, checked the UNHCR page under section of partner (http://data.unhcr.org/syrianrefugees/partnerlist.php). The list kept growing along the assessment exercise, iNGOs, NGOs as well as governmental organizations because the team used also the snowball method asking the interviewees if they know of other actors working in the same field, or area reaching information saturation half way through the assessment.

Also we had the opportunity to be invited by UNICEF to attend a PSS working group meeting where we had the chance to meet a lot of NGOs working in Protection and PSS.

Once the team finalized the tool and the list of organization to be contacted, an email was sent introducing the team, the objective of the assessment and its components as well asking for potential meeting to either conduct interviews, or FGDs. After this first contact a second email explaining the "4Ws" exercise and including the Excel document was sent for all actors. (Annex 1)

A total of 36 organizations (Annex 2) were contacted via emails including two Ministries: Ministry of Social Affaire and Ministry of Public Health followed by phone called to the concerned person. Input from 20 organizations was collected and analysed. A total of seven organizations participated in the study but five ended up not sending the "4Ws" despite the many reminder emails. The remaining two others were the MOPH and the MOSA. Four organizations replied having no activities that match the assessment. Last, the remaining five

organizations did not respond to the first email sent, we tried to contact them through different ways but did not succeed to get an interview.

2) The qualitative part:

The "4Ws" as a tool allows mapping the activities, the human resources, the geographical areas, the funds, the duration of the programmes, the number of persons receiving the services, etc. However, this exercise does not shed light on the quality of services delivered, on the challenges faced by the service providers, on the needs of the community nor does it capture the recommendations of the persons on the field to improve the services. To compliment the "4Ws" additional qualitative fieldwork was conducted, divided in three parts:

- ➢ Interviews with key stakeholders
- ➢ Focus Group Discussions with Syrian refugees
- ➢ Site visits to centres providing the services for Syrian refugee

a) Interviews:
We aimed at interviewing as many organizations and professionals working in the different levels of the IASC or in different positions within the programmes to try and capture as much as possible information.
More than 44 interviews were conducted with programmatic, technical and service provider professionals from MOSA, MOPH, Universities, iNGOs and local NGOs to have a panoramic view of the services provided, the challenges faced and the recommendations (Annex 5).

b) Field visits:
The field visits aimed at observing the sites, the organization of work, talking with the professionals and when possible conducting FGDs with Syrian refugees. We tried to select sites known for proving MHPSS services and tried to diversify actors and geographical areas. A total of 7 field visits were conducted during which more the one site was visited the assessment:

 i.   Bekaa: International Medical Corps, MOSA Centre, DARI association
 ii.   West Bekaa: Amel (Kemid Loz)
 iii.   Akaar, Halba: (Women's charity league centre)
 iv.   Zahle: Handicap International
 v.   Tripoli: RESTART
 vi.   Saida: Danish Refugee Council
 vii.   Tyr: AMEL, Family Guidance Centre, Imam Sader Foundation

c) Focus Groups Discussions (FGDs)

Further to have a comprehensive picture of the current situation, 4 FGDs where conducted with the beneficiaries. (Unfortunately we were not able to set a meeting with a group of male). Focus groups were organized by the help of the organizations working with the refugees. 3 FGDs took place with women and 1 with youth (above 18 years old). The aim of the study was explained to participants' prior conducting the FGDs. The participants were informed that participation is voluntarily. Further they were insured that the information will remain confidentiality and anonymous. As well as it was stated that no direct benefit from the study but they are helping in the assessment of the current situation. The questions of the FGDs (Annex 3) address: main problem faced after leaving Syria, the people that are mostly affected, how the problem are affecting the day to day activities, how to dealing with the problems, where to seek support, type of support needed.

    i. Bekaa with 4 women
   ii. Sad El Bawshriyeh with 8 women
  iii. Tripoli with 3 women
  iv. Akkar with 4 youth (18 years-24 years)

IV. Results:

To present the results and the recommendation we will use the IASC pyramid with the different level of services as shown in the pyramid below. We will present first the main results of the "4Ws" then results from the qualitative part.

Specialized pr
clinical services

Focused non-specialized
psychosocial support

Strengthenning community and
family support

MHPSS considerations in basic services and
security
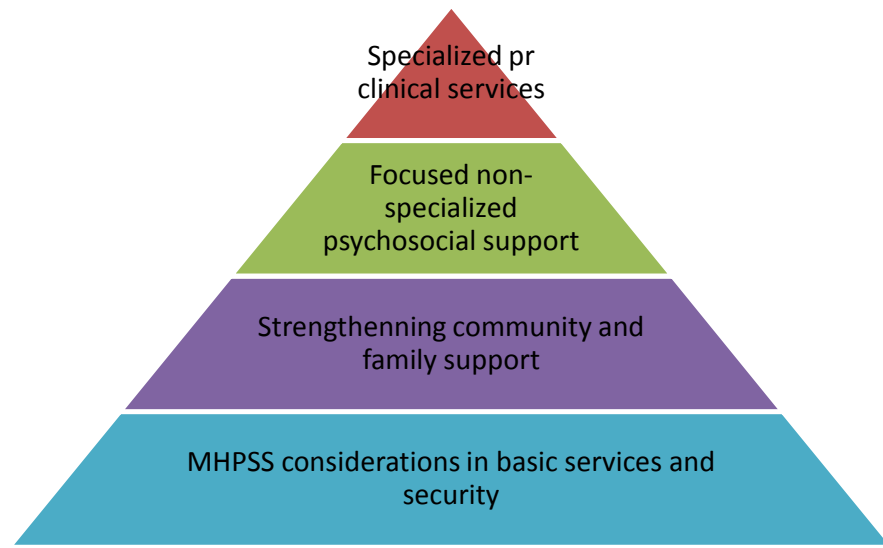
Levels of the IASC pyramid	Categories in the 4Ws
Specialized or clinical services (Level 4)	Case-focused (targeted at individual people)
Focused non-specialized psychosocial support (Level 3)	
Strengthening community and family support (Level 2)	Community-focused (targeted at communities or segments of communities)
MHPSS considerations in basic services (Level 1)	

3) Results of the "4Ws"

Collecting the data from the organization proved to be a challenging task as some organizations sent incomplete data, others sent it after the first deadline. The initial period of two weeks allocated for the 4Ws had to be extended to two months in total in order to receive as much as possible information.

We are grateful for all the organizations that took the time to send the fully completed excel sheet. Although not comprehensive these results are able to give us an idea about the reality on the field. Some information gathered during the interviews but not included in these results mainly concerning Mental Health services will be mentioned in the appropriate sections below.

The data gathered on excel was analyzed using SPSS (Please see Annex 4 for a detailed list of activities codes and sub-codes).

4) Where:

d) Distribution of the activities per Casa:

NORTH
Akkar
Tripoli
Minieh-Dinnieh
Hermel
Zgharta
Koura
Bcharre
Batroun
MOUNT LEBANON
Jbail
Baalbek
Kesrouan
BEIRUT
El Metn
Baabda
Zahle
Aley
BEKAA
Chouf
West Bekaa
Rachaya
SOUTH
Jezzine
Saida
Hasbaya
Nabatiye
Sour
Marjaayoun
NABATIYE
Bent Jbail

■ Community Focused MHPSS & Protection
■ Case focused MHPSS
■ General MHPSS & Protection
■ Protection
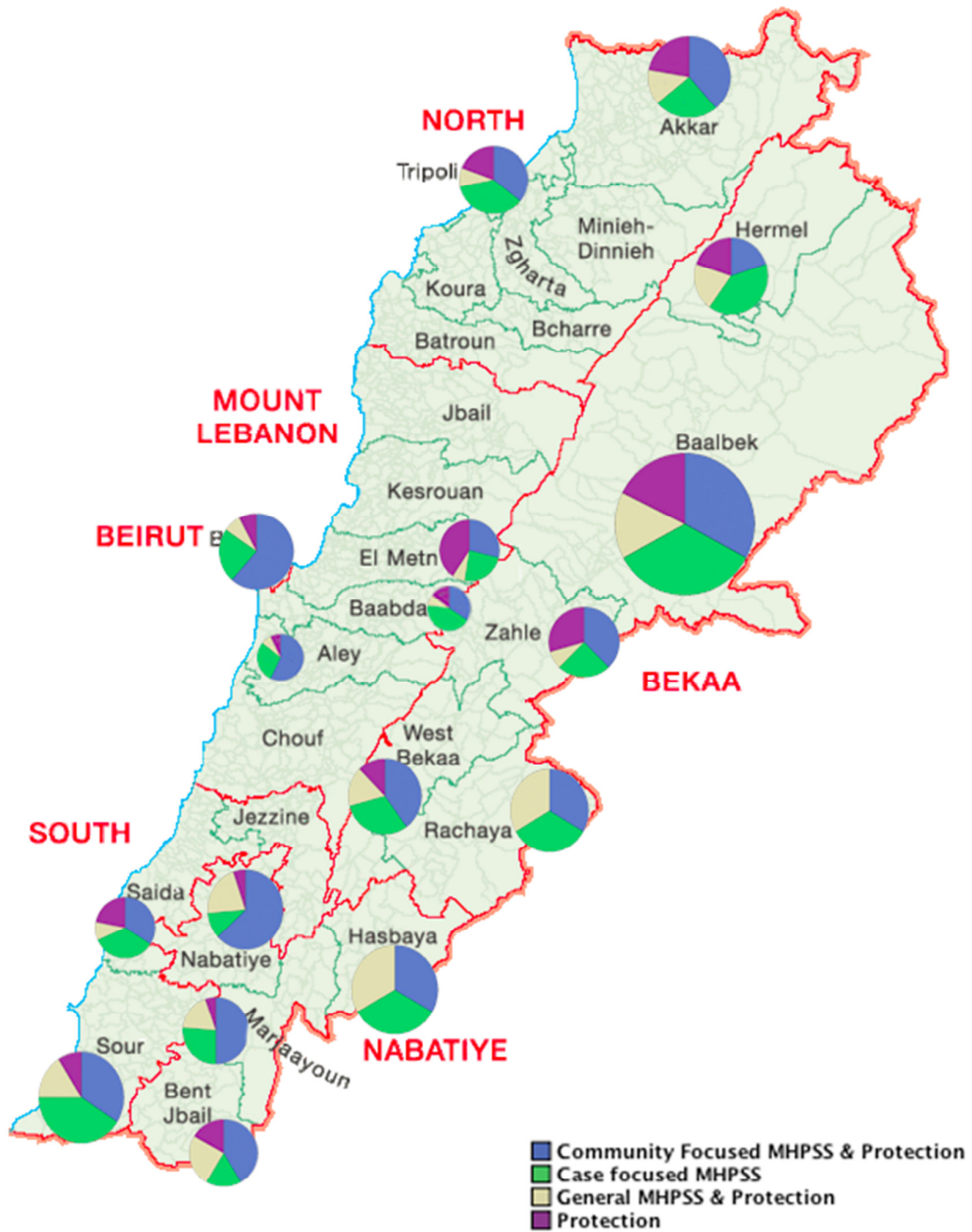
This table shows the division per casa of the main 4 categories of activities.

It is clear from the Map and the table that Baalbak has the highest concentration of activities with about 34% of these activities being case focused MHPSS.

In Beirut the highest percentage goes to Community focused MHPPS and Protection activities with 61.5 %.

In Akkar most activities are community focused MHPSS and Protection activities.

For more details please refer to the table on the right.

| Caza			
Caza	Akkar	Community Focused MHPSS & Protection	38.9%
		Case focused MHPSS	25.0%
		General MHPSS & Protection	13.9%
		Protection	22.2%
	Aley	Community Focused MHPSS & Protection	57.1%
		Case focused MHPSS	28.6%
		General MHPSS & Protection	7.1%
		Protection	7.1%
	Baabda	Community Focused MHPSS & Protection	34.0%
		Case focused MHPSS	42.6%
		General MHPSS & Protection	8.5%
		Protection	14.9%
	Baalbek	Community Focused MHPSS & Protection	32.9%
		Case focused MHPSS	34.1%
		General MHPSS & Protection	15.3%
		Protection	17.6%
	Beirut	Community Focused MHPSS & Protection	61.5%
		Case focused MHPSS	23.1%
		General MHPSS & Protection	7.7%
		Protection	7.7%
	Bint Jbeil	Community Focused MHPSS & Protection	41.7%
		Case focused MHPSS	16.7%
		General MHPSS & Protection	25.0%
		Protection	16.7%
	Hasbaya	Community Focused MHPSS & Protection	33.3%
		Case focused MHPSS	0.0%
		General MHPSS & Protection	33.3%
		Protection	33.3%
	Hermel	Community Focused MHPSS & Protection	20.0%
		Case focused MHPSS	40.0%
		General MHPSS & Protection	20.0%
		Protection	20.0%
	Marjeyoun	Community Focused MHPSS & Protection	50.0%
		Case focused MHPSS	26.3%
		General MHPSS & Protection	18.4%
		Protection	5.3%
	Metn	Community Focused MHPSS & Protection	28.8%
		Case focused MHPSS	23.7%
		General MHPSS & Protection	6.8%
		Protection	40.7%
	Nabatieh	Community Focused MHPSS & Protection	63.2%
		Case focused MHPSS	10.5%
		General MHPSS & Protection	21.1%
		Protection	5.3%
	Rashaya	Community Focused MHPSS & Protection	33.3%
		Case focused MHPSS	0.0%
		General MHPSS & Protection	33.3%
		Protection	33.3%
	Sidon	Community Focused MHPSS & Protection	34.1%
		Case focused MHPSS	34.1%
		General MHPSS & Protection	9.8%
		Protection	22.0%
	Tripoli	Community Focused MHPSS & Protection	35.9%
		Case focused MHPSS	35.9%
		General MHPSS & Protection	9.0%
		Protection	19.2%
	Tyre	Community Focused MHPSS & Protection	34.1%
		Case focused MHPSS	40.9%
		General MHPSS & Protection	15.9%
		Protection	9.1%
	Western Beqaa	Community Focused MHPSS & Protection	40.0%
		Case focused MHPSS	30.8%
		General MHPSS & Protection	16.9%
		Protection	12.3%
	Zahle	Community Focused MHPSS & Protection	37.7%
		Case focused MHPSS	24.6%
		General MHPSS & Protection	8.2%
		Protection	29.5%

5) MHPSS core activities (Level 4):

e) Concerning Activity 8: Psychological intervention

The distribution was as showing on the map below: it is worth noting that Baalbak has the highest concentration with approximately 25% while Tyr, Hermel and Beirut are at the lower end with around 1%. If we take into consideration the number of refugees per area we can see that Beirut and Akkar are among the most underserved areas.

Syrian Refugees in Lebanon
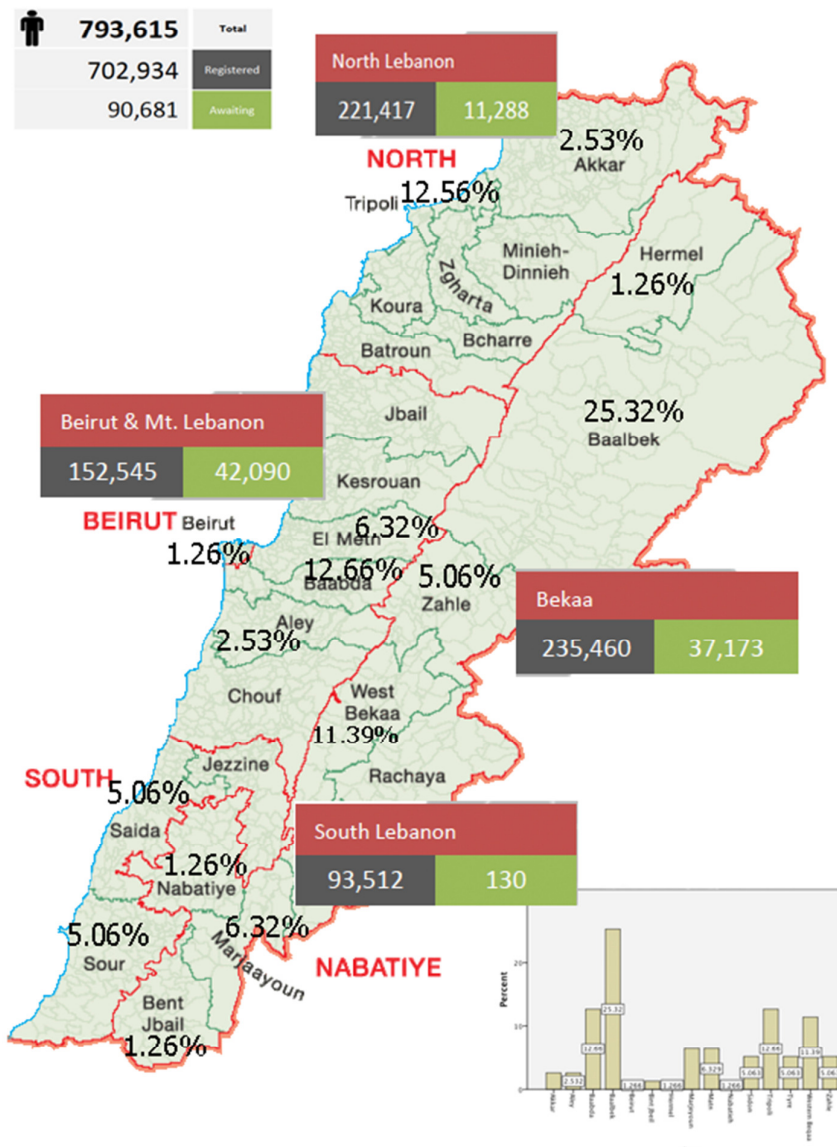
f) Concerning Activity 9: Clinical management of mental disorders by non-specialized health care providers (e.g. PHC, post-surgery wards)

Zooming in on the Clinical management by non-specialized Health care providers a similar distribution with slightly different percentages. This type of services is key to improve access through integration of Mental Health into primary care for example and would be a key area for action when looking into scaling up services.
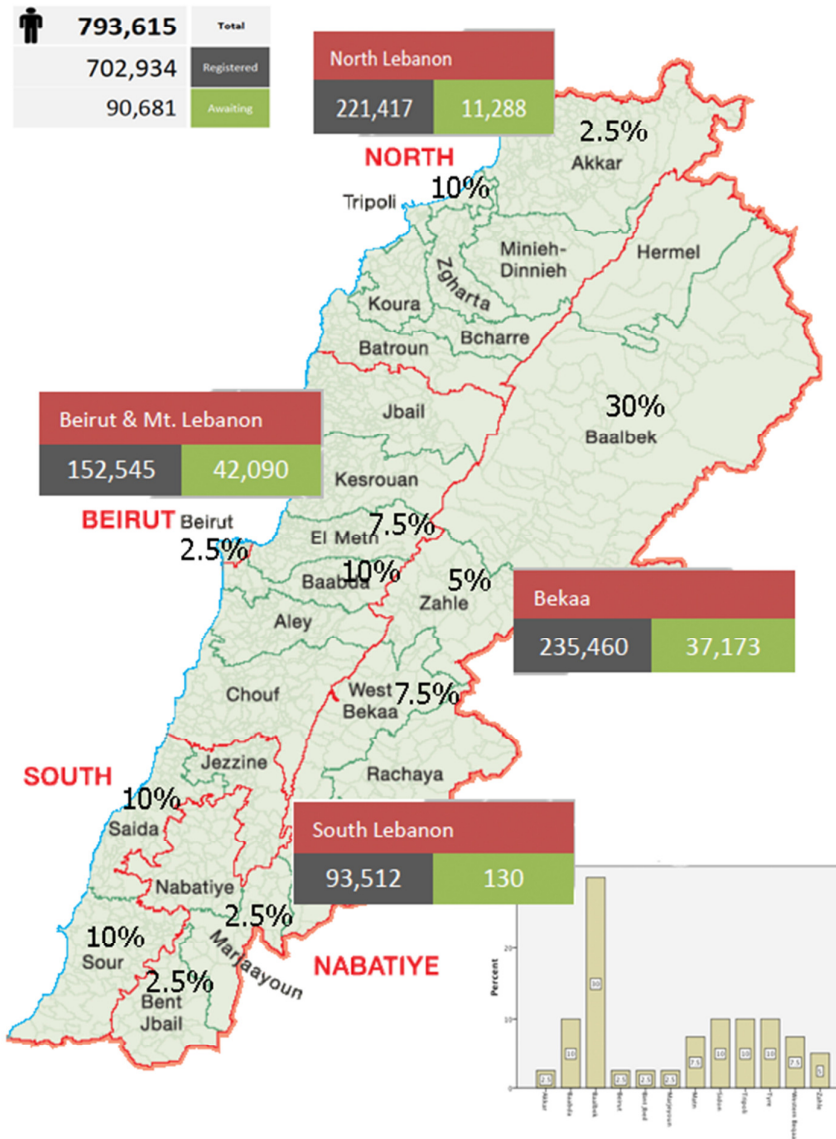
g) Concerning Activity 10: Clinical management of mental disorders by specialized mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/ general health facilities/ mental health facilities)

Tripoli and Baalbak take the lead with 22% of the activities, while Akkar and Beirut are the most underserved areas compared to the number of refugees.

It is worth noting that the services in Saida and Tyr are for the majority services that were present before the Syrian refugees mainly serving Palestinian refugees.

In addition, MSF-CH is operating on Ain-el helwi camp and in Saida serving Syrian and Palestinian refugees with a multidisciplinary mental health team and DRC recruited a part time psychiatrist in Saida as they felt that the need is growing with the increasing number of refugees and the scare mental health services in the area. None of these activities figure in the 4Ws analysis that we did.

The numbers of Syrian refugees are taken from UNHCR website on October 19, 2013

Syrian Refugees in Lebanon
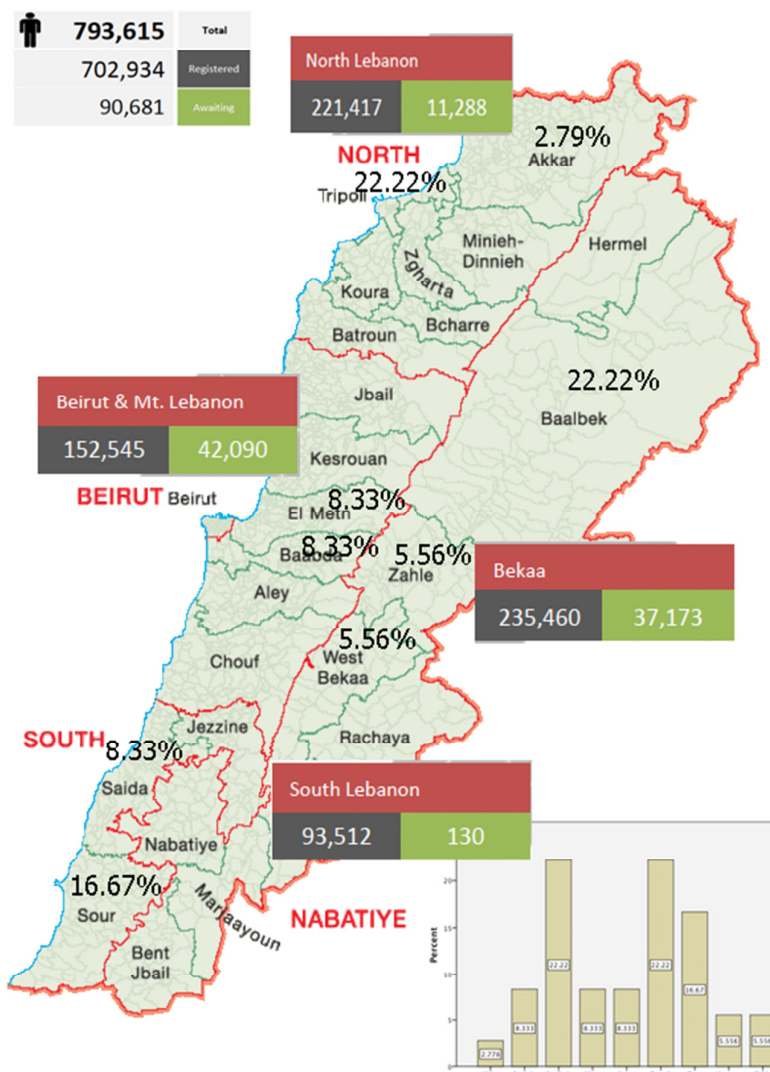
h) Concentration of the activities per Casa

Baalbak takes the lead with about 24% of the total activities while Beirut figure among the least served with almost 2% of the activities.

Taking into consideration that the North of Lebanon and mainly Akkar hosts an important number of refugees 5.5% of the activities allocated to Akkar makes this casa also among the most underserved.

Caza		
	Akkar	5.1%
	Aley	2.0%
	Baabda	6.6%
	Baalbek	23.9%
	Beirut	1.8%
	Bint Jbeil	1.7%
	Hasbaya	0.8%
	Hermel	0.7%
	Marjeyoun	5.3%
	Matn	8.3%
	Nabatieh	2.7%
	Rashaya	0.4%
	Sidon	5.8%
	Tripoli	11.0%
	Tyre	6.2%
	Western Beqaa	9.1%
	Zahle	8.6%
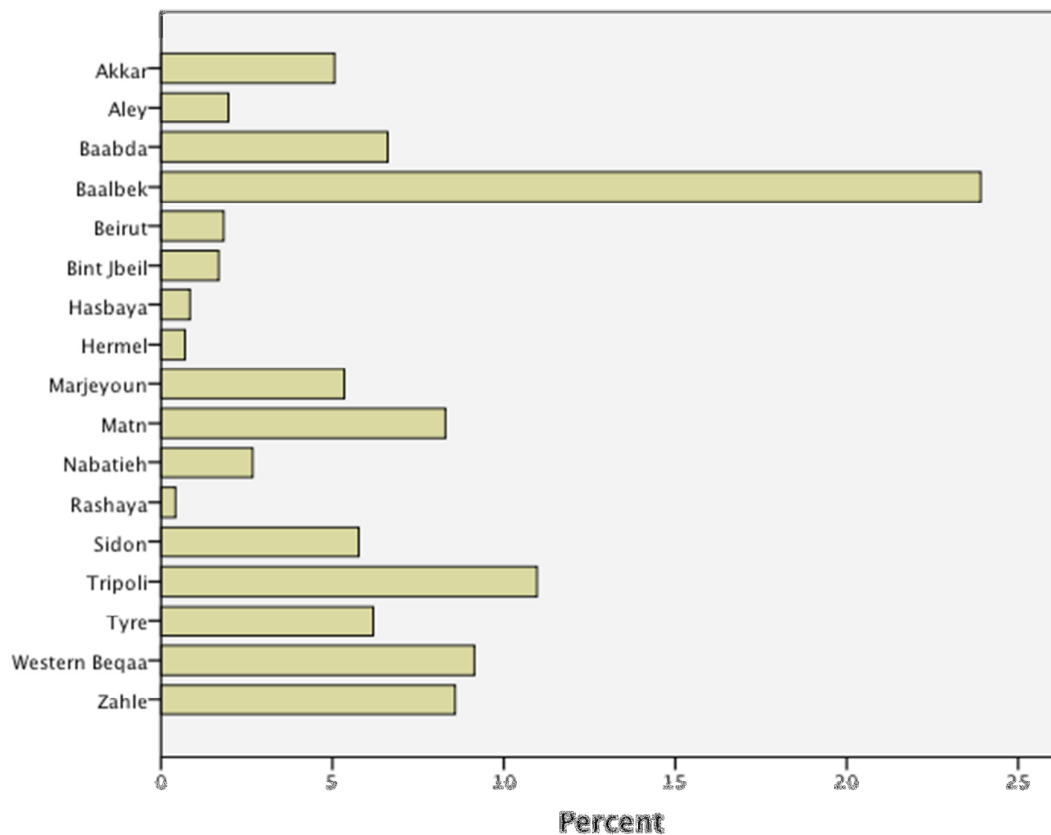
i) What and Where:

i. Distribution of activity per level of intervention according the IASC pyramid

The pyramid below shows the main actors involved in the response.

Most activities (52%) figure in Level 3: focused non-specialized support, with 37.3% in level 2 aiming at strengthening community and family support and 10.7% specialized services.

Level 4 — 10.7% - Specialized Services

Irshad & Islah Beneficiary Association, MdM-France, NISCVT-FGCs, RESTART, IMC

Level 3 — 52% - Focused (person-to-person) non-specialized supports

AMEL Association, Caritas Lebanon Migrants Center, Danish Red Cross (DRC) and Italian Red Cross (ITRC), Handicap International- Development action team (HI-DAD), Imam Sadr Foundation (I.S.F.), International Medical Corps, International Organization for Migration (IOM) Dari Center for Recreational Activities and Family counselling, International Rescue committee (IRC), Irshad & Islah Beneficiary association, Kafa (ENOUGH) violence and exploitation, Medecins du Monde France-MdM France, Medicins sans frontiers operational centre Brussels, MSFOCB, Mercy Corps, National Institution of Social Care and Vocational Training - NISCVT - Family Guidance Centers - FGCs, RESTART Center for rehabilitation of victims of torture and violence

Level 2 — 37.3% - Strengthen community & family supports

AMEL Association, Caritas Lebanon Migrants Center, Danish Red Cross (DRC) and Italian Red Cross (ITRC), Handicap International- Development action team (HI-DAD), Imam Sadr Foundation (I.S.F.), International Medical Corps, International Organization for Migration (IOM), International Organization for Migration (IOM) Dari Center for Recreational Activities and Family counselling, International Rescue committee (IRC), Irshad & Islah Beneficiary association, Kafa (ENOUGH) violence and exploitation, Medecins du Monde France-MdM France, Medecins sans frontiers operational center Brussels, MSFOCB, Mercy Corps, National Institution of Social Care and Vocational Training - NISCVT - Family Guidance Centers - FGCs, RESTART Center for rehabilitation of victims of torture and violence, Save the Children, World Vision International (WVI)

ii. The break down of different activites:

The below pie shows that Child Protection and GBV activties take the lead with 13% of the total activties followed by strengthening of community and family support. Information dissemination occupies 5% of the total activties constitute a relatively important part but apparently is not as effective as it should be as discussed later on in this report.
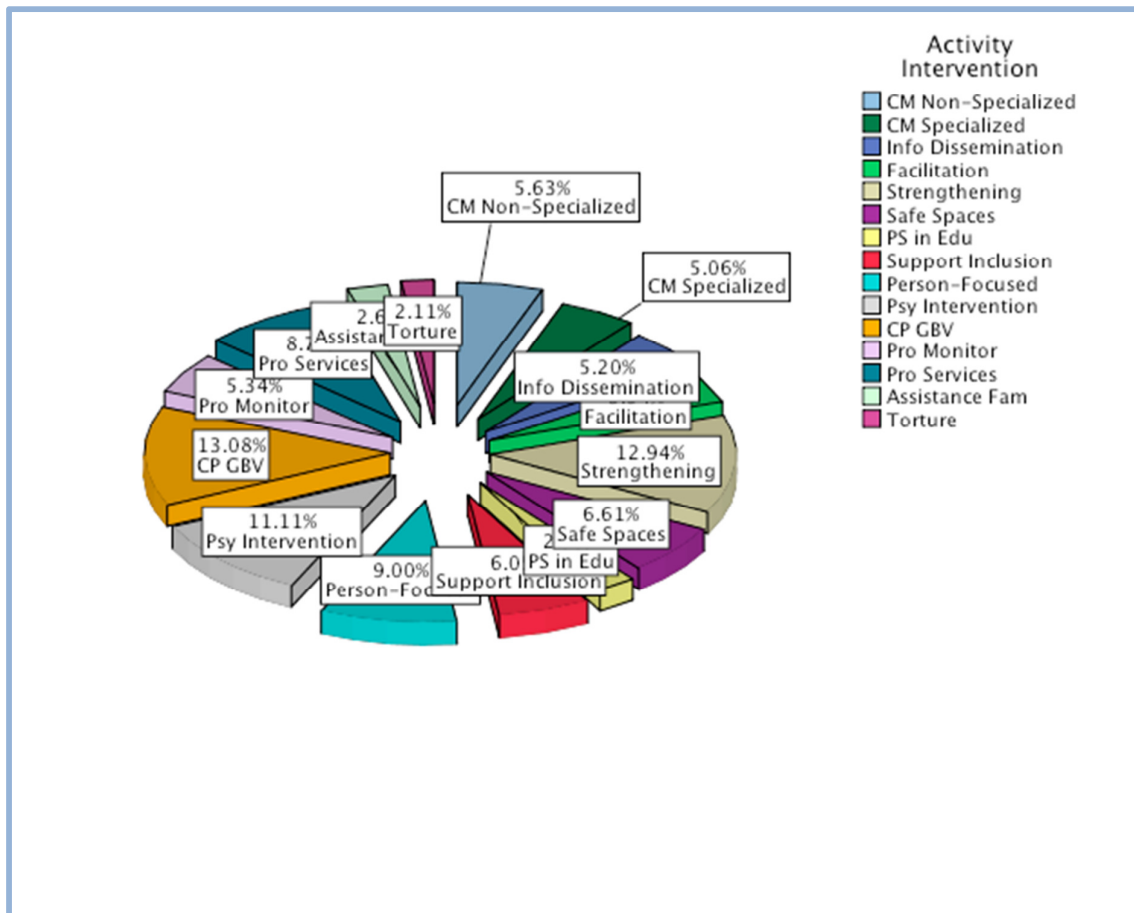
iii. The break down of sub-activites:

The table below shows the breakdown of the sub-activities: we have highlighted the non-specialized interventions (1.6% non-pharmacological, 0.9% pharmacological) with the specialized services (4.4% non-pharmacological, 0.8% pharmacological). these numbers as such are not important. However this reflects that there is room for scaling up services mainly at the PHC level through the mhGAP.

Sub Activity Codes

	Percent
Info of Situation	1.6
Messages +Cop	1.1
Messages CP	1.5
Mass Campaigns	.1
Others	.3
Support of ER	1.0
Support of CSpaces	2.8
Support for SSA	2.0
Strengthening of parenting	5.6
Facilitation of CS	.5
Structured social activities	.8
Structured recreational activities	.6
ECD activities	.5
Facilitation of conditions for religious supports	.3
Livelihoods projects	1.3
Community DevProj in communities	1.1
Child–friendly spaces	3.9
Youth–friendly spaces	2.8
PSS to teachers	.9
PSS to classes	1.4
Orientation, training or advocacy	5.4
PFA	3.9
Linking Indiv to resources	4.2
Basic counseling for individuals	6.3
Basic counseling for groups	2.7
Interventions for ALC	.5
Psychotherapy	2.0
Debriefing	.3
Non-pharmacological management Non-Spec	**1.6**
Pharmacological management Non-Spec	**.9**
Action by CW to identify & refer	3.5
Non–pharmacological management Spec	4.4
Pharmacological management Spec	.8
Inpatient MH Care	.1
Situation analyses/assessment	4.2
Monitoring/evaluation	1.9
Training/orienting	4.7
Technical or clinical supervision	1.9
PSS for staff/volunteers	1.5
Research	.6
Monit & Report of protection issues	3.5
Safety audits	.1
Advocacy on protection issues	1.4
Multisectoral services for GBV	3.7
Case management for GBV	1.3
Shelter for GBV	.8
Medical services for GBV	1.0
Ref of Prot cases to Non–Port services	1.4
Legal services	.1
Specific services for persons with disabilities	.1
Financial assistance to families	1.8
Material assistance to families	.8
Shelter for families	.6
Protection of Victims of Torture	.5
Monitoring and reporting of protection issues	.1
Refer to specialised centers	1.3
Total	100.0

iv. Activities status: concerning funding and implementation:

We noticed that an important percentage of the activities fell under 'not specified'. We created this category to include the activities for which none of the designated categories (Currently being implemented, Funded Not yet implemented, Not funded) was selected.

However the majority of the activities are being implemented as shown in the figure below.
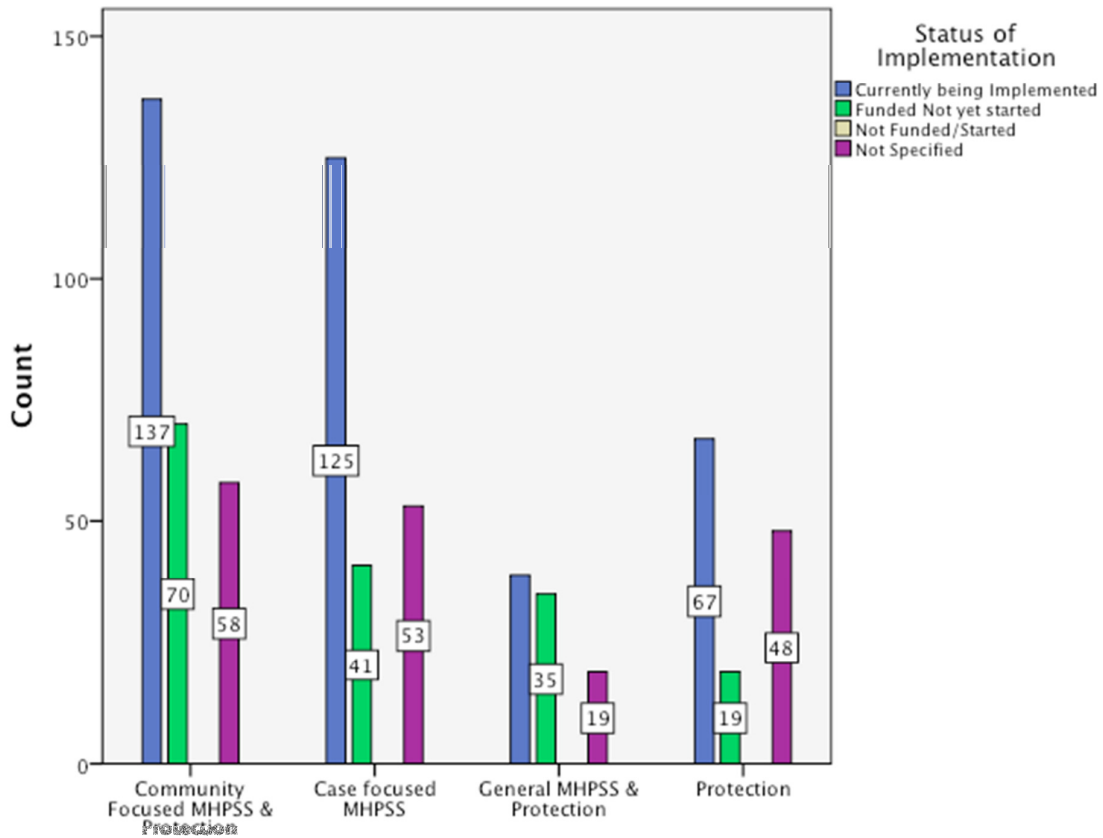
V. Results of the Fieldwork:

This section takes into account information gathered from the following activities:
     a. Interviews with key stakeholders
     b. Focus Group Discussions with Syrian refugees
     c. Site visits to centers providing the services for Syrian refugees

1) Level one: MHPSS considerations in basic services and security

a) Concerning basic needs services:

Data collected from FGDs with Syrian refugees and interviews with service providers and actors on the ground were congruent. Basic needs are still unmet with refugees struggling to ensure adequate shelter, health services, food "*we stopped milk for the children because it is too expensive*" and education and for their children. In fact, even refugees who succeeded at renting a shelter are not being able to pay the rent – which is extremely high compared to the premises and not necessary equipped with the necessary facilities (some families are living in garages). Others are living in tented settlements, which pose a real threat with the winter approaching. Another issue that was also evident related to schooling. At the start of the academic year the schools were asking parents to pay the tuitions fees (60$ per child) and to be reimbursed later on by the UN. This was a source of big distress for parents. Fortunately, this changed in October as the UN and the Ministry of education dealt with it. However, due to lack of information –as we will discuss later on- we are not sure if this information reached all refugees and if all school aged children ended up being in school for the academic year 2013-2014.

In addition, during the field visits and as shown in the FGDs, it seems that there is a lack of actively seeking to include vulnerable individuals in the services such as persons with Mental or physical disabilities. In addition, it was mentioned by some interviewees that women are being sometimes subject to sexual harassment by some service providers when asking for food or non-food items.

b) Concerning registration:

Information on registration was collected from the fieldwork and from an interview with UNHCR registration office. Registration poses many challenges. In fact not all refugees crossing the border are registering with UNHCR and this might be due according the service providers to different reasons: people may be afraid to register because they are afraid that this might affect them negatively if they decide to go back to Syria once the conflict is over, others think that if you register it might mean that you are with one side of the conflict in Syria, others

are afraid to move and go to the registration points, others lack the information about the possibility to register. On the other hand, many interviewers reported that Syrian living in Lebanon before the conflict are also registering as refugees to benefit from the services. Two vulnerable groups are also reported as being "left out": Lebanese returnees and Palestinian refugees coming from Syria.

The registration process as described by UNHCR registration office is made of 3 stages:

i. Reception

   In Beirut people are received in a large area with 11 persons organizing the group. There are usually around 2000 persons per day. The aim being to channel the flow to the registration office

ii. Registration
   There are 30-registration assistants with 6 senior registration assistants in Beirut. They work endure pressure because they are expected to have a certain number of interviews and collect high quality data. They received different types of training on interviewing skills and specific needs identification but no specific training on mental health conditions detection.

iii. Post-registration counselling
   After the registration the refugee receives counselling about the available services and are given brochures

There are no experienced social workers or other mental health professionals present in the reception area or readily available to assist the registration personal if needed. The type of work and the stories heard by the registration assistants can be extremely heavy, there is a certain level of supervision with senior personal on daily basis to help them deal with it. It is noteworthy that some NGOs providing mental health services are serving both registered and unregistered refugees.

   c) **Security / safety**
Perez-Sales (2013) mentioned in his report that security was more an issue for the host community then the refugee population. Although the host community is concerned by the Syrian refugee situation in general and the security situation in particular moreover due to the history between Lebanon and Syria, the FGD revealed some security concerns "Men are stopped on the road for hours for interrogation, their phone are taken… we feel we're observed all the time… *UNHCR can't protect the Syrian, in Lebanon the situation is not okay…"*

2) Level two: Strengthening Community and family support

At the community level, the relation with the host community is complex due to many factors: competition on economic resources and on employment opportunities in particular the Syrian refugees constituting a cheaper labour force, competition on marriage as it was described by many fieldworker and as it was mentioned in one FGD, prostitution. The perceived rejection by the host community is confirmed also by the interviews with the service providers that pointed out this as a challenge they face dealing with the host community. Some even reported that sometimes the field workers themselves have negative attitude towards the refugee community.

Another challenge, also noted by Peres-Sales (Peres-Sales, 2013), concerns the refugee community itself: the Syrian refugees community lacks a common identity with a weak organization and a sense of distrust within the community. This is key information for service organization where usually one would look for community workers or more specialized professional from the refugee community to serve the community. This was also evident in the assessment done by Médecins du Monde where most people preferred that the community worker would be Lebanese.

When asked about their own resources to deal with situation, the refugees conveyed a sense of isolation and a lack of community support. A woman said: *"We have no time to visit each other, each has her own problem and even there is no space to receive people."* while an adolescent said: *"While in Syria I used to talk to mom, but now to my friend. Mom has enough problems on her own to worry about".*

In addition many respondents pointed out to 2 main issues that consist at the same time a protection priority and a health priority: Prostitution and Domestic violence. Many programmes are trying to address these priorities and it is important to keep in mind that such programme can and should be entry points to provide adequate PSS activities and clear links with mental health services.

When asked about the vulnerable groups in their communities, the Syrian refugees mentioned the following: Young males, Persons with disabilities, older persons, Unmarried persons, Families currently made only of women and girls.

Information about the available services is lacking. This was reported both by the Syrian refugees and the service providers. In addition this was clear during the site visits where the FGD with the refugees made it clear that they didn't know about the Mental Health services provided in the same center *"We are not aware that mental health services exit for adolescent we know that they are only available for kids The problem is clear we need to life in a safe environment… Even when providing helps kit, they change the days of distribution without informing us!"*

We have also noticed that the refugees came to the centre to ask questions about basic services concerning Non-food items or education and were given oral information.

a) Nature of services provided

A lot of activities in the field go under "psychosocial support". It ranges from organizing one entertainment event to having regular recreational activities; child-friendly spaces, "Art-therapy", vocational training, "support groups", "group therapies" and parental training all the way up to fully structured intervention. The staff delivering recreational activities, group support, group therapies, "art therapy" where not always able to explain why they did it or how this can enhance psychosocial wellbeing.

b) Coverage

Most services in layers 2, 3, and 4 are centre-based which make access difficult to the refugees being scattered in different areas and in urban settings as reported by the FGDs. Although some services cover transportation access is still not optimal. Most of the service providers reported that male refugees are afraid to move around and come to the centre because of the safety concerns and they are not allowing their wives, daughters to come alone to the centre due to traditional customs. Young boys are also difficult to reach because they are the bread owners for their families.

Another challenge that was reported by NGOs is the mobility of the refugees within Lebanon and between Lebanon and Syria, which is making it very difficult to plan services for mid-term especially when it comes to planning structured Psychosocial support activities that might take up to 3 months.

3) Level three: Focused non-specialized psychosocial support

This section concern the services provided by different actors, UN agencies, iNGOs, NGOs, MOSA and MOPH centres. We will present the following points:

a) Perception by the Syrian refugees of the services

The quality of the services differ between the different actors, the refugees feel they are not treated in a respectful manner "*First I stayed home for 7 months than went to that dispensary! I was not treated well. I went and spoke to the UNHCR personal that referred me to MOSA centre…Every time go to centre you get humiliated except in a few ones…You go seek services because you are sick, you get out of the centre even sicker…We Told them if don't want to treat us tell the UNHCR to remove your name from the list of dispensaries providing services to refugees*".

Although this is not the case for all the services, it needs to be addressed. We will discuss ways of addressing this later on. In all FGDs, real or perceived fear of being mistreated was a major obstacle to access.

b) Access

The access to the refugees and the access of the refugees to the services are hindered by many factors such as the huge number of refugees, the unstable security situation in Lebanon, the urban distribution of the refugees in addition to the fact that most services are centre based.

Adding to that as mentioned previously, the high mobility of the refugees, cultural factors with women not being allowed to move unaccompanied by a man form the family, men avoiding movement to the services to avoid any problems with the security forces and young boys working as the bread owners of their families.

c) Target population

Most activities are targeting children and women. Reaching men and young male adolescent seem to be more challenging. It is not clear who the selection of the target group is made as in most cases it seemed that the group was formed with persons that were easy to reach instead of a set criteria and an active search for groups or persons who would be more in need of such services.

d) Structured v/s Unstructured activities

Most PSS activities are unstructured activities ranging from recreational activities to support groups with a few NGOs such as Mercy Corps, War Child - Holland having structured methods, some of these interventions would run for 3 months with the same group of children.

e) Staff training

The staff working in PSS varied in training, experience, age and background with persons fully aware of the PSS concepts and having long experiences working in the field to others having background not related to PSS and in need of proper training. This might be due mainly to the increase demands for PSS workers that increased pressure on the sector to hire more human resources.

Although most mentioned having received training in psychosocial support, it was noted through observation of their interaction with the refugees that were present in the centre or who came to inquire about services that "soft skills" such as proper communication and empathy could be improved. It seemed at points that there might be a certain level of confusion between their role as service provider and their own personal views and opinions on one hand and to differentiate between the own experiences and the stories they hear.

f) Link with Mental Health services

The link between Psychosocial Support and Mental Health services should be bidirectional. The link in the field seemed weak. Detection and identification and referral to Mental Health services are weak. Referral from mental health services of persons with mental health conditions is not done on a regular basis.

Impact assessment:

For all these activity it is advisable to have some kind of monitoring for input, output and ideally some outcome measurement. This also can help select the activities that has proven to be effective and eliminating those that are not. This type of work can also fall under the MHPSS inter-sectorial group.

4) Level four: Specialized or Clinical services

a) Service organization

i. At Primary Care level

Some PHC centres whether dependent from the MOSA or the MOPH received training on the mhGAP-IG previously with the Iraqi refugees crisis and some have received trainings with the start of the Syrian refugees. These centres usually are supported by iNGOs that provides technical support and psychotropic medication. However in most cases, there is a social worker on a full time basis and the persons in need of a mental health consultation would be given an appointment with the psychologist or the psychiatrist that would visit once weekly or once every two weeks.

Currently WHO and the MOPH are starting to roll out the mhGAP-IG in 20 PHC centres specifically selected in areas of high concentration with Syrian refugees.

ii. At secondary level

At this level, few NGOs are providing Mental health services namely, Restart, IMC, MSF-CH. Aside from Restart, these NGOs are mainly operating through local partners and from PHC centres or local NGOs. Multidisciplinary teams composed by psychiatrists, psychologists, social workers, nurses and community workers deliver the services mainly in a centre-based with some level of outreach teams for detecting and referring persons in need to the centre and in some other cases delivering specialized services at home-level. This later option would have prevented the hospitalization of many persons suffering from acute psychosis as reported by one of the psychiatrist in the Bekaa.

All agree that the demand supersedes by far the needs and that mental health does not seem to be high on the agenda and that funds for it are not secure for the next year.

iii. At tertiary level

Persons in need of hospital care were mainly referred by NGOs (85%), namely IMC and MSF-CH, to the Cross hospital. An interview with the treating psychiatrist at the hospital revealed that for the last 12 months an approximate number of 40 persons were admitted with a majority of 70% having a diagnosis of schizophrenia, bipolar or major depressive disorder with 5% having substance abuse disorder, 5% Post-Traumatic disorder and 5% an Obsessive-Compulsive Disorder. The mean duration of hospitalization was 17.4 days. 60% were 18-30 years old, 25% 30-60 years, with 10% under 18 years old and 5% over 60 years old. A main challenge being that families were hard to reach and that feedback after discharge was not always done by the concerned party.

b) Human resources

i. Psychiatrists

The total number of psychiatrists involved in this response would be around 7-9, this being on a part time basis. Most of them giving one or two days per week and a few of them moving around Lebanon and working with different NGOs. Most of psychiatrists are young with an experience varying from 3-5 years. However 1 or 2 few have long experiences.

Most of the psychiatrists have being working with the iNGOs in refugee settings for a few years. Around half of them have good knowledge of the mhGAP-IG.

ii. Psychologists

The panorama of the psychologists involved in the responses varies a lot as to experience, age, method used. Although some have a long experience in psychotherapy or in the refugee settings most are freshly graduated psychologists with no prior experience in refugee settings.

It is more difficult to give an accurate number of psychologists involved in the response and this is also due to the fact that many work in different NGOs on a part-time basis. A rough estimation would put the number somewhere between 30-45.

iii. Other Mental Health professionals

In this section we include social workers, nurses, health promoters trained in mental health. The panorama here also varies tremendously with some social

workers having a full skillsets for MHPSS services while the majority is very young with very limited training in Mental Health and Psychosocial Support.

In a few centres, the refugees had access to neurologists and child neurologists.

iv. Supervision

Most organizations are providing some level of supervision for their staff. This supervision can vary from having ad hoc meetings with their manager when needed to regular monthly meetings with senior psychologists. However, when asked about the need for supervision most psychologists asked for more regular, frequent and "in-depth" supervision to be able to deal with the level of complexity they are facing in their day-to-day work.

c) Coverage

i. Geographical

Please refer to the 4Ws for geographical coverage

ii. Population

Services are mainly provided for Syrian refugees. However NGOs are also providing services for Iraqi refugees, and to a lesser Palestinian refugees and vulnerable Lebanese. This being said, NGOs in Palestinian camps such as Beit Atfal Soumoud who have been providing community mental health services for Palestinian refugees in Lebanon are now providing also services for Palestinian coming from Syrian and for Syrian refugees living in the vicinity of the camps.

The relatively high percentage of Palestinian refugees is due mainly to tine inclusion of the NISCVT (Beit Atfal Soumoud) that usually provides community mental health services for Palestinian children refugees and is now providing also services for Palestinian children coming from Syria as well as for Syrian children refugees
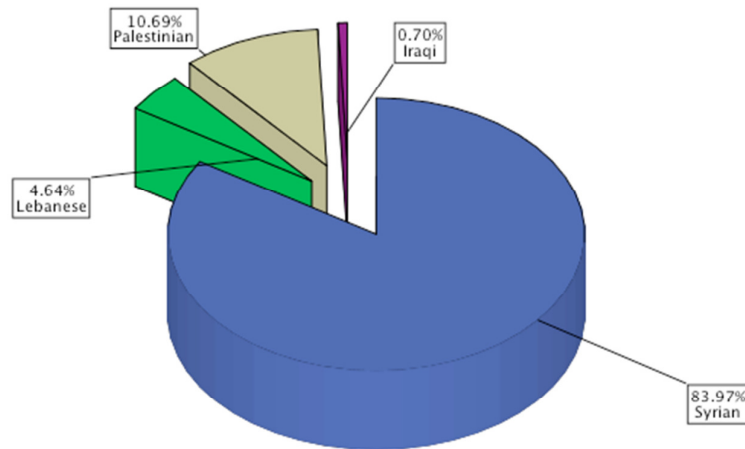
10.69% Palestinian

0.70% Iraqi

4.64% Lebanese

83.97% Syrian

iii. Financial

Mental health services are mostly provided free of charge. However when some NGOs are asking for symbolic fees this could create an obstacle to access as described by a 40 years old Syrian woman "*The 7000 L.L consultation fees for each session with the psychologist are too expensive if we are to come for multiple sessions adding to that transportation fees*"

d) Psychotherapy methods

This poses a real challenge in Lebanon. In fact there is no certifying body or mechanism in Lebanon for psychotherapists, this means that anyone with a BA in psychology could easily consider him/herself as a therapist as corroborated by the president Lebanese Psychological Association. Adding to that a number of local groups of senior psychotherapists training junior psychotherapists on diverse training method such as psychoanalysis, systemic therapy.

e) Psychotropic medication

Psychotropic medications from the essential drug list are available with 2 types of SSRI antidepressant (mainly fluoxetine and sertraline), an atypical antipsychotic (risperidone) and mood stabilizers such as lithium and valproic acid. However all service providers reported shortage in medication that might be due sometimes to lack of funds or in some other cases to the procedure for procurement.

When asked about the medication, the refugees expressed that it was difficult to have the needed medication and that most of the time it is not available and that

what does the doctor prescribe is not available in the center *"To get medication you need prescription! And to see a doctor you need to pay."*

f) Health information system

Organizations have their own Health information system, which makes it difficult to compile data in away to have clear indicators.

For example, organizations are using different diagnostic classifications varying from UNHCR categories to DSM-IV.

However we noticed that they are, sometimes, using their own diagnostic classification – it is noteworthy that this was the case of the diagnosis provided by the psychologists, the diagnosis provided by the psychiatrists seemed to be inline with the DSM-IV-TR with no clear rational as to the choice of such entities with:

   i. Some entities being only symptoms such as *"Anhedonia, panic attack, low self-esteem, depressed mood"*,
   ii. Others that may be indicative of a disorder but not necessarily such as *"academic difficulties, relational difficulties"*,
   iii. Others that are not disorders *per se* although they might constitute a high risk to develop a mental health conditions such as *"Incest, Gender Based Violence"*,
   iv. Entities that shouldn't exist in such classification as a diagnosis because they are not a disorder such as *"homosexuality"*
   v. And lastly entities that are somehow a new construct such as *"frustration and confusion, premorbidity comorbidity disorder, Pseudo neurotic psychosis"*

It is noteworthy that almost all clinical staff reported that they are noticing that they are receiving a lot of children suffering from epilepsy and developmental delay. Most of these children have already received the diagnosis in Syria and were already receiving antiepileptic medication. However, even when they showed signs of developmental delay or had developmental disorders, parents didn't mention such diagnosis.

g) Settings:

i. Centre based

Most services are centre-based with some mobile teams for out reach activities especially in the Bekaa where patients are visited in their home. The access to the centres can be difficult for an urban and scattered population as reported in the FGDs especially for regular follow-ups like psychotherapy.

ii. Mobile teams

A few NGOs have adapted to the situation, mobile teams with a social worker and a psychiatrist have been created and patients in need of acute treatment or are not

able to move are visited at home and this have avoided hospitalization of a number of persons according to the team interviewed.

iii. Surgery wards

War-wounded persons in the hospital also receive regular visits by a psychologist once a week. This is more of a psychological support visit than psychotherapy as reported by the visiting psychologist who also pointed out that the hospital stay is very short.

h) Special group

i. Survivors of Torture

Survivors of torture need multidisciplinary teams ranging from physical care, to medical care, mental health, to social and legal support. In Lebanon there are specialized centers providing the rehabilitation of survivors with experiences and range of services varying among them. Few psychologists are trained in Trauma-focused evidence based psychotherapies.

ii. Adolescent in prisons

A local organization, APEG, is providing psychological support for adolescent in the prison. However when there is a need for a psychiatrist opinion the association is having a difficulty getting this approved by the prison authorities who are referring to the prison doctor instead.

iii. Child soldiers

During this assessment there was anecdotal mentioning of child soldiers starting to come to Lebanon. However this needs still further evaluation as to its accuracy and scope.

5) Coordination

This area is one of the most challenging as reported by ALL stakeholders and as observed during the site visits. This is a cross cutting issue on all levels.
The current coordination mechanisms are:
  i. PSS working group under Protection/UNICEF
  ii. Sub working group on MHPSS in the North that had a few meetings
  iii. Mental health discussed in the health meetings

Starting at donor agencies, it was noticed in certain regions different iNGOs were basically implementing similar activities and competing to work the same

local partners at one hand while on the other hand local NGOs are sometimes depleted from there staff who is being recruited by the iNGOs.

On a lower level, the NGOs are not necessarily aware of the programmes run by others and referral between different actors is a challenge. When this referral is made, follow-up rarely takes place to inform the refereeing party. Not all NGOs use a referral form.

The link between actors providing level 2, level 3 and level 4 services is not optimal, referral is rarely made and this might be due in part to the lack of proper detection and identification at the PSS level.

VI. Discussion and recommendations

Based on the above and on international documents, namely the *Operational Guidance Mental Health & Psychosocial Support programming for refugee operations* (UNHCR, 2013) the recommendation would be presented by level of the IASC pyramid. At the end of this section we will provide the priority recommendations to be addressed first.

1) Level 1: MHPSS considerations in basic needs and security

a) Considerations in basic needs:
As described in the results, the refugees are struggling to meet their basic needs, things like ensuring house rent, food, education, medication and health services, security are still a source of distress. In addition, the refugees are complaining about the way they are being treated when asking for any kind of service

Recommendations:
- Deliver a short training, a three hours workshop, on the IASC guidelines on MHPSS for key policy makers in iNGOs, NGOs.
- Providing PFA training for the registration staff and some basic MH conditions detection skills. This can be done through a 4 hours workshop that can be delivered in two sessions of two hours each.

b) Registration:
Registration is a crucial moment for a refugee in the sense that the person is recognized as such and that he could have access to certain services. Most importantly is a contact point where the person suffering from extreme distress or mental health conditions can be detected and referred to the appropriate services.

Currently not all refugees are registering with UNCHR for different reasons ranging from accessibility of the registration sites to the perceptions of the refugees of the registration process.

In addition no specific training for the registration personnel on mental health and no presence of a senior social worker or psychologist on the sites to support the registration officers and to help detecting and properly managing referrals of the persons in need of Mental health services.

Recommendations:
- In order to ensure a higher coverage of registration it would be advisable to work with the partners to encourage registration among refugees through campaigns aiming at explaining the importance of registration and addressing misconceptions about it.
- Also mobile registration should be considered as persons reported that they feel it is unsafe for them to travel in the country.
- Providing PFA training for the registration staff and some basic MH conditions detection skills. This can be done through a 4 hours workshop that can be delivered in two sessions of two hours each.

c) Coverage:

Most services are not meeting the needs. Areas such as the south are hosting a growing number of refugees whilst the services are still limited and mostly centre-based.

Recommendation:
- Scaling-up all services for basic needs as it is reported to be an important source of distress for the refugees, namely health services, for Communicable and Non-communicable diseases and housing. Considering mobile services might also be more appropriate.

d) Security:

Security and safety seem to be an issue both for the refugees' community and the host community. It is a complex and delicate situation with the ongoing situation in Syria and the political/geographical relationship between Lebanon and Syria.

Recommendations:

- Giving any recommendation in this matter definitely surpasses the scope of this work. However security and safety are crucial and since both sides (refugees and host community) have a shaken sense of their security.

2) Level 2: Strengthening Community and family support

a) Refugees' Community:

It was reported by the interviewers more than the FGDs that there is a sense of distrust within the community. This is mainly fuelled by the ongoing conflict in Syria. Persons from both sides of the conflict fled to Lebanon. As one Syrian doctor reported, patients or their families try to ask directly or indirectly about the doctor's political affiliation and it takes time to build some trust.

This has important repercussions, making the informal community support that persons usually rely upon lesser and portraying the community as a source of stress than a source of comfort. In addition, it makes it very delicate to hire from the Syrian refugees staff in general and for MHPSS in particular where a person needs to feel secure enough to share his/her emotions, and thoughts.

Recommendations:

- Strengthen ethical considerations in recruiting staff for MHPSS interventions ensuring that issues of diversity and confidentiality are taking into consideration. This is even more important for the current situation taking into consideration that the refugees' community - as well as the host community- can be polarized as to the ongoing conflict in Syria and that staff should be able to differentiate between their role and their own personal views and make sure that the later won't affect their work.

b) Refugee-host community relationship

Yet another sensitive topic to address, Syrian refugees feel rejected while the Lebanese community feels overwhelmed by the number of refugees and the competition for resources. Add to that, social problems such as the perception of Lebanese women that they competing also for the men because of they are marrying Syrian women. All actors reported that there would be also a significant level of prostitution among young Syrian girl, which in addition to be a high priority for protection and health of these girls, add to the negative attitude of the host community.

A recent study conducted by Christophersen et al. (2013) showed that "the attitudes towards Syrian refugees in Lebanon are characterized by contradiction. In addition, the Lebanese fear that the sectarian conflict in Syria would spill over to Lebanon and that this might lead to a new civil war. This definitely makes the situation very difficult for the Syrian refugees with more than 50% of the surveyed thinking that no more Syrian should be allowed to enter Lebanon and that most Lebanese now want UN refugees camps for refugees already in the country. Such attitudes definitely impact also the refugees-host community relationship

Recommendations:

This is an important issue to be addressed, especially that it will contribute to the well being of both communities. This can be done on different levels:

- Address the prostitution of young girls as a priority intervention by steering GBV programme more towards being more inclusive of this group by prioritizing groups of woman, families with the mother as the only parent, unaccompanied young girls who are have limited resources and are at a higher risk for survival sex. These groups can be supported by direct item provision or by empowering them to generate income. In addition, awareness raising about sexually transmitted infections and unwanted pregnancies alongside working collaboratively with the authorities to target more the persons using these women for prostitution than condemning the women themselves.
- Design programs in a more inclusive way to address also the host community that is in some cases as poor as the refugees ensuring equity and by that also reducing the tension between the PoCs and the host community
- Design a media campaign to tackle this issue focusing on what does it mean to be a refugee and highlighting the similarities refugees and the host community have in common as human being. Such a campaign can prove to be very delicate. Messages to be diffused need to be well studied taking into consideration the sensitivity of the situation. Experts in health behaviour change should be consulted.

c) Information

Information about availability of services is lacking, with refugees sometimes not knowing about the services within the same center they go to for their English course for example.

Recommendations:

- Revise the existing brochures that different NGOs or UN agencies have about available services and agree on one format that is shared by all actors and updated and disseminated on a regular basis " to be initiated by the MHPSS task force"

3) Level 3: Focused non-specialized Psychosocial support

a) Perception by the Syrian refugees of the services

Syrian refugees are concerned about the way they are treated when receiving the services. They feel disrespected by the persons providing the services.

Recommendation:

- All NGOs and UN agencies need to ensure that staff involved in policy decisions are familiar with the IASC guidelines. An option would be that actors organize 1-day introduction for the key staff of NGOs and UN agencies.
- All staff working directly with persons of concern need to be trained in PFA. An option would be to conduct 1-2 days workshop.
- Clearly defining the conceptual and operational framework of the PSS. This should be done at the basic level of define for example what is a peer support group, a support group, a group therapy. What are the conditions to use this activity instead of the other and what are the necessary conditions to conduct them (e.g. for a group therapy there should be a specific number of participants committing to X number of sessions, it should be a closed group and there should be a certified psychotherapist, etc.)
- Improve the referral links between level 3 and level 4 through interventions such as training level 3 field workers on detecting and referring persons in need of specialized MH services and training of staff in level 4 to do proper referrals to non-clinical services.
- Providing training on a " core MHPSS competencies" module including good communication skills
- Use already existing networks such as scouts, Lebanese red cross, etc.
  Improve referral and feedback between NGOs. This can be done through creation of local MHPSS working groups linked to the central MHPSS working group.
- Ensure regular visits to the field for supervision and monitoring.
- Develop indicators for the M&E system and ask NGOs to report on it.

b) Access

Most services are centre based, the population is dispersed on large areas and refugees have difficulties reaching the centre.

Recommendations:
- Focus on developing mobile clinic to ensure better access. Some NGOs have already started doing this. This needs to be also assessed for acceptability by the refugees before scaling it up as in some case, especially when it comes to mental health services, people are discrete and might want to go out of their communities to seek help in order to avoid the stigma related to mental heath.
- Studying the preference of the refugees prior to heavily shifting the model through some focus group discussions would be advisable

c) Target population

Most activities are targeting children and women. Reaching men and young male adolescent seem to be more challenging. It is not clear who the selection of the target group is made as in most cases it seemed that the group was formed with

persons that were easy to reach instead of a set criteria and an active search for groups or persons who would be more in need of such services. In addition, people reaching the services are not necessarily the ones most in need of it.

Recommendations:
- Psychosocial activities can benefit a wide range of persons from children to elderly. Working with the child is a good entry point to reach the parents for example if workers are trained on the general framework for working with Children and the behavioural and developmental modules from the mhGAP-IG. Developing such framework could ensure for example that parents are met least and their needs rapidly assessed, including Mental Health needs according to the mhGAP-IG.
- Young boys and adolescents seem to be working to support the families and thus are very difficult to reach. This needs to be more studied and addressed as a priority. Access to this group should be considered as a priority as they might be at a high risk of abuse and thus could constitute a target group for protection more so on the work location. Having a programme where mobile teams would regularly visit the working places would at least ensure some level of protection by their presence.
- Other vulnerable groups such as persons with disabilities intellectual disabilities and severe mental disorders should be actively sought in the community through focusing on these conditions when training front-liners in the community. Simple symptoms or signs can by identified by using the mhGAP-IG framework.

d) Structured v/s Unstructured activities
Most PSS activities are unstructured activities ranging from with a few NGOs such as Mercy Corps, War child having structured methods, some of this intervention would run for 3 months.

Recommendations:
- There is no strong evidence to choose structured or unstructured activities. What is more important is the quality of interaction with the child in order to support and foster a sense of stability and normalcy. Providing high quality training for the persons delivering these intervention by focusing on the quality of the work in addition to having an inclusive framework taking into consideration the family and the community of the child are key.
- Children with parents able to provide the needed support might benefit more from supporting the parents than supporting the child directly whereas children without parents or with parents unable to provide

support might benefit from both a more direct interaction in addition to the work with the parents.

- The criteria behind choosing structured or unstructured activities should not be "symptom-based" but more "resource-based" with the child' resources thoroughly analysed, activated and used when possible. Ensuring proper care for the mother's depression, is key to a child psychosocial wellbeing and should be addressed as priority; providing structured or unstructured activities to this child is only part of what might be done and maybe not the most pertinent one in this case. Activating the mother role, through treating her depression is crucial in this case. PSS workers or animators should be able to understand the overall framework and be able at least to detect, and refer the mother to the proper care as part of the PSS activities with the child.

e) Nature of services provided

A lot of activities in the field go under "psychosocial support". It ranges from organizing one entertainment event to having regular recreational activities; child-friendly spaces, "Art-therapy", vocational training, "support groups", "group therapies" and parental training all the way up to fully structured intervention. None of the activities that go under recreational activities, group support, group therapies, "art therapy" have a solid evidence-based background and seem to be conducted out of convenience more then based on a proper needs assessment of the population.

Recommendations:

- An in depth analysis of all the existing PSS material in order to agree on some core concepts, competencies and methods used seem to be a priority in order to have an agreement among all actors on what should be provided and how it should be delivered.
- This is a priority as for the time being there is a certain level of confusion what PSS is and whom does it address.
- While doing this different target groups should be included such as persons with mental health conditions, elderly, vulnerable groups.

f) Staff training

The staff working in PSS varied in training, experience, age and background with persons fully aware of the PSS concepts and having long experiences working in the field to others having background not related to PSS and in need of proper training.

This might be due mainly to the increase demands for PSS workers that increased pressure on the sector to hire more human resources.

Although most mentioned having received training in PSS, it was noted that "soft skills" such as proper communication and empathy could be improved. It seemed at points that there might be a certain level of confusion between their role as service provider and their own personal views and opinions on one hand and to differentiate between the own experiences and the stories they hear.

Recommendations:

- Training of the staff is crucial this training could address 3 areas:
  i. "Soft skills": Communication skills, empathy, professional conduct, etc.
  ii. PFA: Psychological First Aid
  iii. Detection of important signs and symptoms of person in need of mental health services: this can be taken from the mhGAP-IG
- Taking into consideration the number of the refugees and the number of NGO staff implicated. It might be relevant to consider mapping the already existing networks such as scouts or youth associations and engage also the Lebanese Red Cross if possible. A lot of these networks are already active, investing in training them on PFA for example might be useful especially that these network will stay long after the iNGOs leave.
- In addition this would also benefit Lebanon in general by raising awareness about mental health and contributing to bridging the gap in treatment and decreasing the related stigma among the Lebanese population as well.

g) Link with Mental Health services

The link between Psychosocial Support and Mental Health services is bidirectional. The link in the field seemed weak. Detection and identification and referral to Mental Health services are weak. Referral from mental health services of persons with mental health conditions is not done on a regular basis.

In general PSS aims at helping persons cope with the distress, promoting mental health and would constitute some of catchment area to detect persons in need of mental health services. Whereas persons having mental health conditions will benefit from proper PSS

Recommendations:

- Strengthen the links on all levels between Mental Health and PSS. Having an intersectoral group would be the first step.
- A second step would be to identify the "linking" points in different Standard Operating Procedures for Protection case management and making these links explicit through linking them with the PFA and the mhGAP
- Developing proper referral and feedback mechanisms between iNGOs. Although this mechanism exists it is not working properly and needs to be reviewed. The interagency referral form is not used by all and there is no clear way for feedback when the referral is made.

4) Level 4: Specialized or Clinical services

a) Service organization

i. At Primary Care level \

Some PHC centers whether dependent from the MOSA or the MOPH received training on the mhGAP-IG previously with the Iraqi refugees crisis and some have received trainings with the start of the Syrian refugees. These centers usually are supported by iNGOs that provides technical support and psychotropic medication. However in most cases, there is a social worker on a full time basis and the persons in need of a mental health consultation would be given an appointment with the psychologist or the psychiatrist that would visit once weekly or once every two weeks.

Currently WHO and the MOPH are starting to roll out the mhGAP-IG in 20 PHC centers specifically selected in areas of high concentration with Syrian refugees.

Recommendation:
- Support this initiative and roll out more mhGAP-IG training. Currently a pool of mhGAP-IG base course is being formed by WHO – *please refer to 3rd bullet below*. Shortly, there should be a number of mental health professionals able to deliver the mhGAP-IG base course to more PHC doctors, nurses and social workers. However, ensuring a regular supervision, after the initial training with regular visits to the centre where challenges and cases are discussed and clinical skills are supported, is crucial to ensure continuation and improvement of the newly acquired skilled. This supervision part is partly covered currently with the trainers being able to visit the centre once within the current WHO program. On another hand NGOs like IMC are also training on the mhGAP. Cooperation between the 2 organizations has already started and this will hopefully lead to a sustainable supervision system.

- Linking these centres with the Secondary level community mental health services run by iNGOs such as IMC or MSF-CH run centres. In addition to the support and supervision by mental health professionals that can be provided by these NGOs to the PHC centres, a solid referral system for complex cases can be put in place. This system can be built on the mhGAP-IG framework
- Building on the above, WHO is conducting a ToT for the mhGAP-IG base course in which; the psychiatrists and psychologists, from many NGOs, are participating. This will create a pool of trainers and will strengthen the links between these NGOs, MOPH, WHO and the PHC centres.

ii. At secondary level

All agree that the demand supersedes by far the needs and that mental health does not seem to be high on the agenda and that funds for it are not secure for the next year. With the number accessing the services not exceeding 2000 persons for the period (August 2012- August 2013), while persons in need of specialized services in such situations would be a the lesser estimation around 2% of the population making the potential number of persons in need of specialized services 15.600 persons.

Recommendations:
- Ensure continuity of already existing services through secure funding.
- Make sure that all geographical areas are covered, avoiding overlap between different NGOs. Akkar, Bekaa and the South are areas in need of more attention.
- Strengthening the link with PHC centres and focusing on training and supervising them on the mhGAP-IG by the mental health professionals of these NGOs. This will optimize the role of the mental health professionals once these professionals are well trained and familiar with the mhGAP. In December WHO will conduct a Support and supervision training for the mhGAP trainers who would have successfully completed their training period as "mhGAP-IG Base course trainers".
- Studying the possibility, acceptability and feasibility of increase outreach activities and mobile teams as discussed earlier.

iii. At tertiary level

Persons in need of hospital care were mainly referred by NGOs (85%), namely IMC and MSF-CH, to the Cross hospital. An interview with the treating psychiatrist at the hospital revealed that for the last 12 months an approximate number of 40 persons were admitted with a majority of 70% having a diagnosis of

schizophrenia, bipolar or major depressive disorder with 5% having substance abuse disorder, 5% Post-Traumatic disorder and 5% an Obsessive-Compulsive Disorder. The mean duration of hospitalization was 17.4 days. 60% were 18-30 years old, 25% 30-60 years, with 10% under 18 years old and 5% over 60 years old. A main challenge being that families were hard to reach and that feedback, after discharge, was not always given to the treating psychiatrist.

Recommendations:
- Ensure better collaboration with the referring party and the family
- Ensure follow-up by the referring party -NGOs in most cases- during the hospitalization and provide feedback to the treating physician once the person is discharged.
- Ensure that the quality of care is inline with the international scientific and Human rights guidelines through ensuring regular visits to the hospitalized persons after engaging the hospital administration in a discussion about it.
- Set a high level meeting with the psychiatric hospital where agreement is made about the quality of services expected and the M&E system to put in place. A Memorandum of Understanding referring to the international conventions namely concerning the patients' rights and the quality of care, such as the CRPD can be part of such MOU.

b) Human resources

i. Psychiatrists

The total number of psychiatrists involved in this response would be around 7-9, this being on a part time basis. Most of them giving one or two days per week and a few of them moving around Lebanon and working with different NGOs.
This makes the system a bit fragile but at the same time constitute an advantage to harmonize the response.

Recommendations:
- Involve the psychiatrists in the mhGAP-IG TOT and supporting them to become trainers and supervisors for the mhGAP-IG base course., this would ensure harmonization of the work and would prepare them to supervise and train PHC doctors. This has already started by having 4 psychiatrists working with different iNGOs attend the TOT

ii. Psychologists

The panorama of the psychologists involved in the responses varies a lot as to experience, age, method used. Although some have a long experience in psychotherapy or in refugees' settings, most are freshly graduated psychologists with no prior experience in refugees' settings.

It is more difficult to give an accurate number of psychologists involved in the response and this is also due to the fact that many work in different NGOs on a part-time basis. A rough estimation would put the number somewhere between 30-40.

Recommendations:

- Include them in the mhGAP-IG Base course training to make sure they have the same mind set as other mental health professionals in the field. This will also help a lot with harmonizing the diagnostic categories currently in use as described below.
- Include a few of them in the mhGAP-IG TOT and support and supervision training. This has been done.
- Provide training on evidence based brief therapies most suited for refugees' settings. Specific therapies can be selected from the list proposed in the mhGAP and agreed upon between different actors.
- Provide proper, regular clinical supervision

iii. Other Mental Health professionals

In this section we include social workers, nurses, health promoters trained in mental health. The panorama here also varies tremendously with some social workers having a full skillsets for MHPSS services while the majority is very young with very limited training in Mental Health and Psychosocial Support.

Recommendations:

Training of the staff is crucial this training could address 4 areas:

i. "Soft skills": Communication skills, empathy, professional conduct, etc.
ii. PFA: Psychological First Aid
iii. Training on the mhGAP-IG base course with a specific focus on the psychosocial part of the intervention with the person and the family depending on the mental health condition at hand according the mhGAP-IG

c) Supervision

Most organizations are providing some level of supervision for their staff. This supervision can vary from having ad hoc meetings with their manager when needed to regular monthly meetings with senior psychologists. However, when asked about the need for supervision most psychologists asked for more regular, frequent and "in-depth" supervision to be able to deal with the level of complexity they are facing in their day-to-day work.

Recommendations:
- Agreeing among all actors, maybe within the MHPSS intersectoral group, on the proper way to provide supervision for the staff namely to the psychologists. This can also be clearly defined once the psychotherapy methods used are identified and that psychologists are trained in them
- Providing regular and continuous clinical supervision

d) Coverage

i. Geographical

Please refer to the 4Ws for geographical coverage. However Akkar, Bekaa and the South seem to be the areas most in need of scaling up the services.

ii. Population

Services are mainly provided for Syrian refugees. However NGOs are also providing services for Iraqi refugees, and to a lesser Palestinian refugees and vulnerable Lebanese. This being said, NGOs in Palestinian camps such as Beit Atfal Soumoud who have been providing community mental health services for Palestinian refugees in Lebanon are now providing also services for Palestinian coming from Syrian and for Syrian refugees living in the vicinity of the camps.

Recommendations:
- Keep on providing services for all of the above
- Support local NGOs already providing Mental Health services such as Beit Atfal Soumoud in the Palestinian camps. Such NGOs are providing good quality mental health services but are under a lot of strain because of the increasing demands and the limited resources.

iii. Financial

Mental health services are mostly provided free of charge. However when some NGOs are asking for symbolic fees this could create an obstacle to access "*The*

7000L.L consultation fees for each session with the psychologist are too expensive if we are to come for multiple sessions adding to that transportation fees!"

Recommendations:

- Monitor that free services are always provided for free as even what is supposedly symbolic might be a burden for the refugees especially when regular follow-up is needed. As much as it is important to pay a symbolic fee for psychotherapy work in normal situations, it should never become in obstacle to accessing these services under current circumstances where refugees are struggling to cover vital expenses such as food, and housing.

e) Psychotherapy methods

This poses a real challenge in Lebanon. In fact there is no certifying body or mechanism in Lebanon for psychotherapists, this means that anyone with a BA in psychology could easily consider him/herself as a therapist as corroborated by the president Lebanese Psychological Association. Adding to that a number of local groups of senior psychotherapists training junior psychotherapists on diverse training method such as psychoanalysis, systemic therapy.

To our knowledge little or no training is done by a local "therapy school" on evidence-based trauma focused therapies. However if it was not for the EMDR training that was given for a group of psychologist who now have an association.

Recommendations:
- Have a discussion among experts from different actors and agree on one or more evidence-based therapy. The mhGAP-IG proposes a range of different interventions that can be a starting point for the discussion. Interpersonal psychotherapy would be a good option.
- More specifically, for trauma intervention, the mhGAP recently published an additional module with specific therapies such as EMDR or Trauma focused CBT as treatment modalities for PTSD

f) Psychotropic medication

Psychotropic medications from the essential drug list are available with 2 types of SSRI antidepressant (mainly fluoxetine and sertraline), an atypical antipsychotic

(risperidone) and mood stabilizers such as lithium and valproic acid. However all service providers reported shortage in medication that might be due sometimes to lack of funds or in some other cases to the procedure for procurement.

When asked about the medication, the refugees expressed that it was difficult to have the needed medication and that most of the time it is not available and that what does the doctor prescribe is not available in the center *"To get medication you need prescription! And to see a doctor you need to pay."*

Recommendation:

- Ensure continuous availability of psychotropic medications, as it is crucial to avoid relapses and contribute to the person's well being
- Provide proper psychoeducation for the person and the family psychotropic medication.
- Ensure a minimum coverage of laboratory explorations that are necessary to rule out medical conditions or to monitor the treatment. Such as TSH, in case of a clinically presentation suggestive of hypothyroidism or CBC if the presentation is suggestive of anemia. Some medications might need a regular liver check (e.g. Valproic Acid, carbamazepine,) or Kidney check (Lithium).
- The set of tests required and the protocols to prescribe these tests can be agreed upon in the MHPSS group..

g) Health information system

Organizations have their own Health information system, which makes it difficult to compile data in away to have clear indicators.

For example, organizations are using different diagnostic classifications varying from UNHCR categories to DSM-IV TR.

However we noticed that they are, sometimes, using their own diagnostic classification– it is noteworthy that this was the case of the diagnosis provided by the psychologists, the diagnosis provided by the psychiatrists seemed to be inline with the DSM-IV TR- with no clear rational as to the choice of such entities with:

    i.   *Some entities being only symptoms such as "Anhedonia, panic attack, low self-esteem, depressed mood",*

    ii.   *Others that may be indicative of a disorder but not necessarily such as "academic difficulties, relational difficulties",*

iii.   *Others that are not disorders per se although they might constitute a high risk to develop a mental health conditions such as "Incest, Gender Based Violence",*

iv.   *Entities that shouldn't exist in such classification as a diagnosis because they are not a disorder such as "homosexuality"*

v.   *And lastly entities that are somehow a new construct such as "frustration and confusion, premorbidity comorbidity disorder, Pseudo neurotic psychosis"*

Recommendations:

It is clear that there is a need to harmonize the case-definitions and the diagnostic reference and to make sure that the all clinical staff have the same understanding of what a disorder is and what are the criteria to diagnose such a disorder. It is of a high priority to agree on the same classification system and used it by all.

- Agree on one diagnostic classification with clear case definitions. We recommend the 7 items classification of the UNHCR Health Information System as a starting point with reference to the ICD-10 in case there is a need to be more disorder specific.
- We recommend classification rooted in the UNHCR categories as a starting point with reference to the ICD-10 in case there is a need to be more disorder specific
- Avoid classification that are not used or understood by persons outside the organization and refer to international classification such as the ICD or the DSM if the UNHCR categories are not enough.
- More broadly, a set of M&E indicators for input, output and if possible simple outcomes measurement should be reinforced and used by all actors. The MHPSS group can lead this process once formed.

h) Special groups:

i. Survivors of Torture

Survivors of torture need multidisciplinary teams ranging from physical care, to medical care, mental health, to social and legal support. In Lebanon there are specialized centers providing the rehabilitation of survivors with experiences and range of services varying among them. Few psychologists are trained in Trauma-focused evidence based psychotherapies.

Recommendations:

- Ensure that psychotherapists are trained on evidence based trauma therapies such as EMDR or tf-CBT or other techniques with some level of evidence base such as the Narrative Exposure therapy.
- Ensure proper interdisciplinary diagnosis and intervention
- Ensure regular and preferably external supervision for the team taking into account the psychological weight of hearing torture stories and the importance for the team to be able to channel this outside the team.
- Reinforce protection measures, as this group might be still at a security risk.

ii. Adolescent in prisons

A local organization, APEG, is providing psychological support for adolescent in the prison. However when there is a need for a psychiatrist opinion the association is having a difficulty getting this approved by the prison authorities who are referring to the prison doctor instead.

Recommendation:
- Support this work and collaborate with the other NGOs providing MHPSS services in detention places and in places.

iii. Child soldiers

During this assessment there was anecdotal mentioning of child soldiers starting to come to Lebanon. However this needs still further evaluation as to its accuracy and scope.

Recommendations:
- Explore and document the validity of such information as soon as possible
- If necessary design a specific program or intervention for this group

5) Coordination:

This might be one of the most challenging finding of this assessment and is lacking on all levels – the current mechanisms are not being able to ensure the needed level of coordination - and yet one of the most important element to ensure a better response for the Syrian refugees situation

Recommendations:

- One model would be creating a cross-sectorial group with all sectors implicated in MHPPS represented and Co-chaired by a Health and Non-

health organization with a clear ToRs to coordinate the activities, and the fieldwork among the actors whether for geographical areas, types of activities (level 2, 3, or 4), referral and feedback, sector (Health, education, etc.), and harmonizing the activities and interventions inline with the international guidelines such as the IASC guidelines, and the Operational Guidance Mental Health & Psychosocial Support programming for refugee operations and using available resources like, the PFA and the mhGAP-IG.

- Keep an updated 4Ws matrix and share information regularly with the refugees
- It is advisable that UN agencies, iNGOs, local NGOs governmental organization and if needed independent experts be part of it. This will also ensure to certain extent accountability among different actors once, different tasks have being allocated to designated parties.
- This coordination should also be done on a regional level to coordinate the referral and feedback locally in the different regions.

Summary of Priority Recommendations

1. **Have MHPSS Task Force, keep an up-to date 4Ws and develop a minimal set of built-in M&E indicators that would be agreed upon within the group.**
2. **Familiarize programme staff on the IASC guidelines MHPSS and streamline an MHPSS approach in all sectors.**
3. **Carefully select and train field workers on PFA and other 'core MHPSS competencies' including detection of persons with mental health conditions.**
4. **Train and supervise PHC staff on mhGAP-IG. A shorter version 'mhGAP-IG in humanitarian settings' is under development and can be useful if resources are limited to conducted a full mhGAP-IG base course.**
5. **Harmonize the HIS using the UNHCR 7 mental health categories**
6. **Make sure that the psychotropic drugs from the Essential Drug list are always available in the health facilities.**
7. **Establish a solid referral and feedback system both centrally and locally in the different districts including pathways for urgent cases that might occur outside working hours.**
8. **Train and supervise psychologists in evidence-based psychotherapy methods. Preferably Interpersonal Psychotherapy (IPT) and, in addition, a selected number on EMDR or tf-CBT.**
9. **Have a media campaign to improve refugees –host community relations.**
10. **Promote access of host community, and other persons of concern such as the Palestinian refugees and the Lebanese returnees to the services available for the Syrian refugees.**
11. **Use mobile teams to improve access to services.**

VII. Conclusion:

This assessment was able to shed light on the MHPSS services delivered to Syrian refugees in Lebanon highlighting the geographical distribution, the resources invested, the distribution of the interventions within the IASC pyramid, the number of refugees reaching mental health services, and was also able to give us an idea about the quality of the work and the challenges as expressed both by the refugees and the service providers.

We do recognize however that this exercise had its own limitations:

- Most of the organizations contacted were cooperative and we were able to meet with almost all of them, however few never sent their 4Ws.
- A thorough assessment of the materials used for PSS was not done
- FGDs with the refugees community were limited
- No impact assessment of the mental health programs was done

However, it was able to point out the main areas of actions in order to improve the response.

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Annex 1: Email explaining the 4W exercise:

We are seeking to map all services /activities that have been taking place/ implemented within the past 30 days particularly for/with mainly displaced Syrians.

The mapping will cover national and international organizations as well as governmental institution that provide MHPSS services in Lebanon.

You will find attached an Excel-based Data Collection Spreadsheet, with 4 sheets, which shows the kind of information that we are seeking:

1. Introduction sheet
2. Organization info and coordination
3. MHPSS and Protection services info Sheet
4. Activity/Sub-Activity list – that can also be accessed from "click here" in columns E and F" of the MHPSS and Protection services info sheet. This sheet will provide you with the exact code for column **"E"** and the exact Sub code for Column **"F".**

Annex 2: Participating NGOs

	Organization	Contact person	Response
1.	IOM	Ms. Amal Ataya	x
2.	WHO	Ms. Lucie Sagharian	x
3.	IMC	Ms. Zeina Hassan	x
4.	Restart	Ms. Suzanne Jabbour	x
5.	QRC	Ms. Amani Kibrit	x
6.	IRC	Ms. Sinead Murray	x
7.	UNFPA	Ms. Naja	No 4Ws sent
8.	MSF-CH	Dr. Ghada Abou Mrad	No 4Ws sent
9.	MSF Belgium	Mr. Kevin Davies	x
10.	HI	Ms. Sophia Maamari	x
11.	HI emergency	Ms. Valentina Di Grozia	x
12.	Caritas Migrant Center	Ms. Maureen Mahfouz	x
13.	MDM	Ms Ana De La Cuadra	x
14.	TDH	Ms. Milhorgne	No response
15.	WVI	Ms. Ghaoui – Waiting to hear from Mr. Bayoud	x
16.	DRC/ IFRC/ITRC	Ms Despina Constandinides	x
17.	WCH	Ms. Nashawi	No response
18.	ABAAD	Ms. Ghida Anani	No 4 W sent
19.	KAFA	Ms. Zoya Rouhana/Ms Rima Abi Nader	x
20.	MOSA	Ms. Hala Helou	N/A
21.	IOCC	Mr. Hajjar	N/A
22.	MPH	Ms. Randan Hamadeh	N/A
23.	IDRAAC	Dr. Elie Karam	No response
24.	AUB	Dr. Laila Dirani	No 4 W sent
25.	Balamand	Ms. Habouba Aoun	No 4 W sent
26.	UNICEF	Ms. Catherine Jones	No 4 W sent
27.	Hymaya	Ms. Brounian	N/A
28.	Amel	Dr. Kamel Zein	x
29.	Imam El Sader Foundation	Mr Mohammad Basssam, Ms. Ghda Zein,	x
30.	Lebanese Psychological Association	Dr. Laila Dirani	No 4 W sent
31.	NISCVT	Ms. Liliane Younes	x
32.	Khiam center	Khiam_center@hotmail.com	No response
33.	Center Nassim	info@centrenassim.org	No response
34.	Mercy Corps	Ms. Colleen Fitzgerald	x
35.	IFRC	Ms. Ea Akasha	x
36.	Save the children	Ms. Yvonne Agengo	x

Annex 3: FGDs questions

1. Since you left Syria what are the main problems you have been facing as individual, family and community at the social level and emotional one?
   a. Social (domestic violence; community violence, children abuse, substance abuse , family separation, rape)
   b. Psychosocial (Feeling, thinking, behavior)
2. Who are the people that are mostly affected by situation? Vulnerable.
3. How are those problems affecting daily life/ performance of usual task?
4. How are you trying to deal with these problems?
   a. What did you do 1st and later
5. Did you look for support?
   a. Other family member
   b. Community members /leaders
   c. Professional
6. What kind of support did you receive?
7. While asking for support, did you face any problem with providers, people
   a. Stigmatization
   b. Marginalized
   c. Refused to provide support
8. To what extend the provided support help in dealing with the problem?
9. Do you feel that other type of support is needed?

Annex 4: MHPSS Activity Codes and Subcodes

MHPSS ACTIVITY CODES AND SUBCODES

READ THIS FIRST!
- MHPSS stands for mental health and psychosocial support.
- The list includes the most common activities that are conducted under the heading of MHPSS in large humanitarian crises.
- The list is not exhaustive. You should use the category 'other (describe in column C of the data entry sheet)' to document activities not included in the list.
- The list is descriptive rather than prescriptive. No judgement is passed whether included activities are appropriate or not. A number of the mentioned activities are or can be controversial. For guidance on recommended practices, see IASC (2007).
- **INSTRUCTION: FILL IN THE RELEVANT MHPSS ACTIVITY CODE (SEE COLUMN A BELOW) AND SUBCODE (SEE COLUMN B BELOW) IN COLUMNS A AND B OF THE DATA ENTRY SHEET. IF ONE WORKS BROADLY IN AN AREA, THEN CHOOSE THE SUBCODE 'OTHER'.**

	Column A: MHPSS activity code (4Ws)	Column B: Examples of interventions with subcodes. Record all that apply.
Community-focussed (targeted at communities or segments of communities)	1. Disseminating information to the community at large	1.1 Information on the current situation, relief efforts or available services in general 1.2 Raising awareness on mental health and psychosocial support (e.g., messages on positive coping or on available mental health services and psychosocial supports) 1.3 Other (describe in column C of the data entry sheet)
	2. Facilitating conditions for community mobilisation, community organisation, community ownership or community control over emergency relief in general	2.1 Support for emergency relief that is initiated by the community 2.2 Support for communal spaces/meetings to discuss, problem-solve and plan action by community members to respond to the emergency 2.3 Other (describe in column C of the data entry sheet)
	3. Strengthening community and family support	3.1 Support for social support activities that are initiated by the community 3.2 Strengthening parenting/family supports 3.3 Facilitation of community supports to vulnerable people 3.4 Structured social activities (e.g. group activities) 3.5 Structured recreational or creative activities (do not include activities at child-friendly spaces that are covered in 4.1) 3.6 Early childhood development (ECD) activities 3.7 Facilitation of conditions for indigenous traditional, spiritual or religious supports, including communal healing practices 3.8 Other (describe in column C of the data entry sheet)
	4. Safe spaces	4.1 Child-friendly spaces 4.2 Other (describe in column C of the data entry sheet)
	5. Psychosocial support in education	5.1 Psychosocial support to teachers / other personnel at schools/learning places 5.2 Psychosocial support to classes/groups of children at schools/learning places 5.3 Other (describe in column C of the data entry sheet)
	6. Supporting including social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation	6.1 Orientation of or advocacy with aid workers/agencies on including social/ psychosocial considerations in programming (specify sector in column C of the data entry sheet) 6.2 Other (describe in column C of the data entry sheet)
Person-focused (targeted at identified people)	7. (Person-focused) psychosocial work	7.1 Psychological first aid (PFA) 7.2 Linking vulnerable individuals/families to resources (e.g., health services, livelihoods assistance, community resources etc.) and following up to see if support is provided. 7.3 Other (describe in column C of the data entry sheet)
	8. Psychological intervention	8.1 Basic counselling for individuals (specify type in column C of the data entry sheet) 8.2 Basic counselling for groups or families (specify type in column C of the data entry sheet) 8.3 Interventions for alcohol/substance use problems (specify type in column C of the data entry sheet) 8.4 Psychotherapy (specify type in column C of the data entry sheet) 8.5 Individual or group psychological debriefing 8.6 Other (describe in column C of the data entry sheet)
	9. Clinical management of mental disorders by nonspecialized health care providers (eg PHC, post-surgery wards)	9.1 Non-pharmacological management of mental disorder by nonspecialized health care providers (where possible specify type of support using categories 7 and 8) 9.2 Pharmacological management of mental disorder by nonspecialized health care providers 9.3 Action by community workers to identify and refer people with mental disorders and to follow-up on them to make sure adherence to clinical treatment 9.4 Other (describe in column C of the data entry sheet)
	10. Clinical management of mental disorders by specialized mental health care providers (eg psychiatrists, psychiatric nurses and psychologists working at PHC/general health facilities/mental health facilities)	10.1 Non-pharmacological management of mental disorder by specialized mental health care providers (where possible specify type of support using categories 7 and 8) 10.2 Pharmacological management of mental disorder by specialized health care 10.3 Inpatient mental health care 10.4 Other (describe in column C of the data entry sheet)
General	11. General activities to support MHPSS	11.1 Situation analyses/assessment 11.2 Monitoring/evaluation 11.3 Training / orienting (specify topic in column C of the data entry sheet) 11.4 Technical or clinical supervision 11.5 Psychosocial support for aid workers (describe type in column C of the data entry sheet) 11.6 Research 11.7 Other (describe in column C of the data entry sheet)

Annex 5: Interviewees list

1.	**People interviewed**	**Post**
2.	Abaad, Ms Ghida Annani	Director
3.	Amel Association, Mr. Sam Van Vliet	Emergency coordinator Syrian response
4.	Amel Association, Dr. Malak Wehbe,	Medical coordinator
5.	Amel Tyr SW, Muna Chaker /	Social Worker
6.	APEG, Dr. Mirna Ghannaji,	Psychologist, Director
7.	AUB, Dr. Brigitte Khoury	Psychologist
8.	AUB, Dr. Laila Dirani	Psychologist, LPA president
9.	Caritas, Maureen Mahfouz	Head of Psychology department
10.	DRC Saida, Zeinab Hussein	South protection coordinator
11.	DRC, Mr. Carlos Bohorquez	Protection coordinator
12.	FGC, USJ, Dr Jihane Rohayme	Psychiatrist
13.	HI-Emergency, Ms. Valentina Di Grazia	Psychosocial Technical advisor
14.	IFRC, Ea Akasha,	Regional psychosocial coordinator
15.	IFRC, Lebanese Red Cross, Ms. Despina Constandinides	Psychosocial advisor
16.	IMC , Ms. Zeina Hassan	Field coordinator
17.	IMC, Dr. Hala Kerbage	Psychiatrist
18.	IMC, Mr. Ghassan Assaf,	Psychologist
19.	IMC, Ms. Samar Abu Assly	Social workers Coordinator
20.	IMC, Dr. Michel Soufia	Mental Health Advisor
21.	IMC, Dr. Nicole Haddad	Psychiatrist
22.	IMC, MSF-Belgium, Ms. Farah Mokadem	Psychologist
23.	IOM, Ms. Amal Ataya,	Psychosocial program manager
24.	IRC, Ms. Sinead Murray	Women's Protection and empowerment coordinator
25.	ISF Tyr, Ms. Ghada Zein	PHC coordinator
26.	Kafa, Ms. Rima Abi Nader	Listening and Counseling Center director
27.	MDM, Ms. Ana de la Cuarda	Mental Health Coordinator
28.	Mercy Corps, Ms. Alexandra Chen	Regional Psychosocial coordinator
29.	Mercy corps, Ms. Colleen Fitzgerald	Psychosocial coordinator Lebanon
30.	MOPH Ms. Randa Hamadeh	PHC director
31.	MSF-Belgium, Mr. Kevin Davies	Mental Health Coordinator
32.	NISCVT, Ms. Liliane, Younes	Mental Health Coordinator
33.	QRC, Irshad & Islah Amani Kibrit	Executive chief, Disaster management Department
34.	Restart Staff, Ms. Suzanne Jabbour Ms. Farah Hassan,	Center Director, Programme coordinator
35.	Restart, IMC, MSF , Dr. Abbas Alameddine	Psychiatrist

36.	Restart, Ms. Sana Hamza and 4 psychologists for the team	Senior Psychologist
37.	Save the Children, Ms. Yvonne Agengo,	Psychosocial field coordinator
38.	Save the Children, Ms. Isabella Castrogianni	Psychosocial coordinator
39.	UNFPA, Ms. Rana Ibrahim	Humanitarian Youth manager
40.	WHO, Lucie Sagharian	Project officer, Emergency & Humanitarian Action
41.	UNICEF, Mr. Anthony Macdonald	Chief, Child Protection
42.	UNICEF, Ms. Catherine Jones	Child protection specialist
43.	UNICEF, Ms. Laila Atshan	Psychosocial expert
44.	War Child Holland, Ms. Barbara Boekhoudt	War Child Lebanon