EVALUATION STUDY FOR REDUCING ECONOMIC BARRIERS TO ACCESSING HEALTH SERVICES IN LEBANON

MENTAL HEALTH THEMATIC EVALUATION REPORT

Economic Development Solutions

EDS

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1 Introduction

Around one quarter of adults in Lebanon may suffer from at least one mental health issue in their lives (Karam EG et. al, 2008). Decades of war and insecurity, coupled with economic collapse and the influx of Syrian refugees into Lebanon due to the protracted crisis in Syria, are highly likely to have caused or triggered mental health issues. Yet, previous studies show that in Lebanon, access to treatment is ridden with challenges and obstacles (Yehia, Nahas, and Saleh, 2014; Karam EG et al., 2006) due to factors including stigma and lack of financing; and, as such, "inadequate access to mental health (MH) services in Lebanon, where prevalence is noteworthy, is a concern" (Yehia, Nahas, and Saleh, 2014).

Moreover, Lebanon has long been reliant on a privatized mental health care system and a lack of adequate mental health services on the primary health care (PHCs) level, leading to significant imbalances in access to mental health for multiple groups in the country. Private insurance, moreover, does not cover treatment of mental health illnesses. This imbalance directly contributes to cyclical inequality as those with mental health disabilities might face even further barriers to better livelihoods, societal integration, and community support. The Ministry of Public Health (MoPH) recognizes this. It notes in its 2015-2020 strategy report that, "[T]he burden of mental illness carries with it the burden of unaffordable costs. Because patients with mental illness in Lebanon often do not receive the care necessary to return to the community in a functional capacity, they suffer not only from the burden of disease itself but also loss of meaningful employment and loss of wages."

> *"Our vision is that everyone living in Lebanon should have the opportunity to enjoy the highest level of mental health and well-being. We are doing this in collaboration with WHO, UNICEF, the International Medical Corps and other partners. A major pillar of the reform is the integration of mental health care into primary health care."* - Rabih Chammay, Head of National Mental Health Programme (WHO Bulletin, 2016)

Interviewees, whom we spoke to amidst the early phases of the outbreak of COVID-19 and the consequent lockdown, noted that the number of people in Lebanon with mental health issues is likely to increase given recent events in Lebanon – from the severe economic and financial crisis to the global lockdown following the COVID-19 pandemic. In many ways, the unfolding crises in Lebanon have shed light on mental health and the significance of its inclusion into public debate (ACTED, 2020). Interviewees, including IMC staff, also reiterated that these events should sound the alarm across the country for policy-makers, international organizations, local authorities, and the government to adapt mental health services and contextualize them to these changing circumstances. It should particularly address the most vulnerable groups, including elderly

groups, people with disabilities, survivors of violence; additionally, these services should also consider how lockdown leads to protection concerns. Indeed, the increased isolation, coupled with high unemployment levels in the country and spiked prices of basic commodities, were often cited by interviewees as factors likely to exacerbate people's mental health. The NGO Embrace Lebanon, which runs a mental health and suicide prevention hotline, reported a significant increase in calls (Atoui, 2020); police data, as well, "reveals a 74 per cent increase in murder cases during the first five months of 2020 compared to the five previous months", with the majority of cases being domestic ones (Rose, 2020); and, as is the case globally, there has been an increase in domestic violence and, as reported by head of gender-focused NGO Abaad, there are more women seeking shelter and mental health support in recent times (Rose, 2020b; Kadi, 2020). While there has been a positive increase in mental health campaigns in Lebanon, there is a concern that the public health sector will mostly focus on preventing and mitigating COVID-19, and mental health may take a backseat.

Despite these challenges, and in tandem with the imbalances within Lebanon's mental health care system, many strides have been taken on a national level over the past decade. These have included initiatives by International Medical Corps (IMC) and other international organizations, national mental health reforms and campaigns, civil society's efforts to destigmatize and politicize mental health, amongst others. For the purposes of this paper, however, we will focus specifically on IMC's mental health intervention, via the REBAHS project, to build on the challenges and lessons learnt. IMC, which plays a leading global role in advocating for and implementing mental health care within emergency and humanitarian settings, continues to expand access to mental health services in Lebanon through working with PHCCs, community centers, training multidisciplinary case management teams, and providing mental health and psychosocial supports (MHPSS). In parallel to the focus on IMC, a brief overview of the country's mental health services will be done to understand the risk factors for vulnerable groups.

The present report is divided into six sections. The following section discusses the methodology of the study. Section three provides a context analysis of mental health in Lebanon including the provision of mental health services in response to the Syrian crisis. Section four focuses on IMC's mental health intervention while taking into account the MH package and the various roles of the MH program staff. Section five presents the main findings of the report, which include the challenges of mental healthcare in Lebanon, and the added value of IMC's program. Section six concludes and provides a series of policy focused recommendations.

2 Methodology

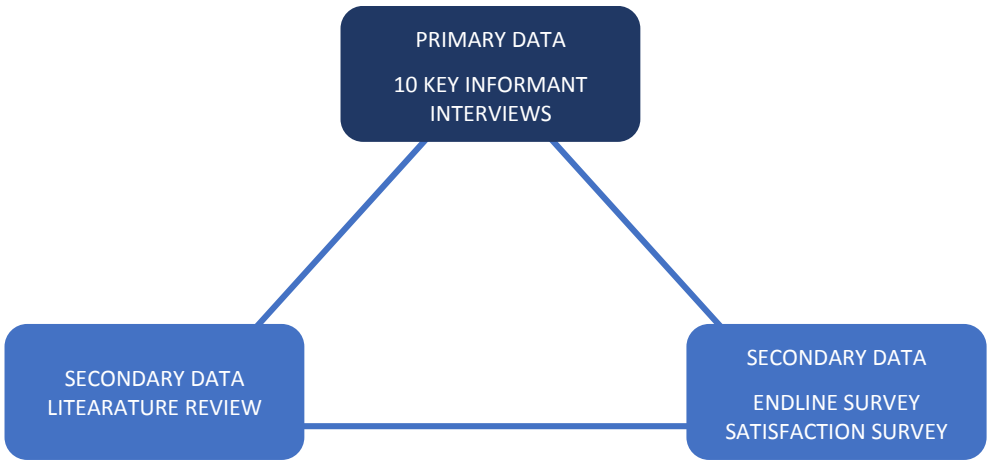
2.1 Methodological approach

Thematic evaluations provide the opportunity for programs to investigate whether a specific topic or thematic area will need more or less attention in the current or next program. EDS employed a case study methodological approach to explore the MH thematic area. As illustrated by Crowe et al., (2011), "The case study approach is particularly useful to employ when there is a need to obtain an in-depth appreciation of an issue, event or phenomenon of interest, in its natural real-life context." In their article examining the usage of case study approaches in health policy, they note that it is a tool that can explore policy initiatives or service development as a means of investigating a particular issue within its actual context. For this section, then, the aim is not to test a hypothesis but rather to gather explanatory information that enables an understanding of the how, what, and why (Yin 2009).

Furthermore, as the REBAHS project and its Mental Health program continues with its second phase, the focus of this thematic evaluation is to offer a more comprehensive look into IMC's mental health intervention within Lebanon's context and to track its challenges, successes, and lessons learned with the aim of generating recommendations for the program's sustainability and, more generally, mental health policy in Lebanon and the region.

The study relied on triangulating primary and secondary sources of data. The main sources of secondary data were the desk review of existing documents shared by IMC team, as well as the results of the end line survey, and in particular, the satisfaction of beneficiaries with the MH program services. As for the primary data, it relied on a qualitative data collection through a series of in-depth interviews. Below is an elaboration of the tools used and steps followed during the study.

Figure 1: Data triangulation



2.2 Tools and steps of implementation

1. Desk Review

An extensive desk review was conducted, and included academic articles, technical reviews by NGOs and INGOs, news articles, and reports by the MoPH. Academic articles included, but were not limited to the below[1]:

- Yehia F., Nahas Z., and Saleh. S (2014). *A Roadmap to Parity in Mental Health Financing: The Case of Lebanon.* The Journal of Mental Health Policy and Economics J Ment Health Policy Econ 17, 123-133
- Yehia, F. and Jerdali, F. (2015). *Applying knowledge translation tools to inform policy: the case of mental health in Lebanon.*
- Weissbecker, I. et al.'s (2019). *Integrative Mental Health and Psychosocial Support Interventions for Refugees in Humanitarian Crisis Settings.* Springer International Publishing AG, part of Springer Nature 2019 117 T. Wenzel, B. Drožđek (eds.), *An Uncertain Safety*.
- Hassan, G., Kirmayer, L. J., and Mekki-Berrada, A. (2015). *Culture, context and the mental health and psychosocial wellbeing of Syrians: a review for mental health and psychosocial support staff working with Syrians affected by armed conflict.*
- Hamadeh, R. et al. (2020). *The primary health care network in Lebanon: a national facility assessment.* Eastern Mediterranean Health Journal.
- MoPH's 2015-2019 national mental health strategy, campaigns, and policies.
- IMC's baseline survey, end line survey, and the REBAHS project's process evaluation

2. End line data analysis

Part of the end line survey conducted by IMC was dedicated to measuring levels of satisfaction among beneficiaries for the various services it offered. EDS analyzed the end line data and compared the results to the base line survey results, looking at specific indicators including:[2]

Indicator 1: Percentage of households who required PHCC services in the last 6 months received the required assistance

Indicator 2: Percentage of households who required mental health services at the PHCC in 2017 received the required assistance

Indicator 3: Percentage of beneficiaries reporting decreased expenditure on health

Indicator 4: Percentage of beneficiaries who report being satisfied with health services

Some of the relevant results pertaining to the MH program were incorporated into this report to support the study findings. However, it is worth noting that only six beneficiaries in the study had benefitted from MH services.

[1] For a full list of sources used, see bibliography

[2] EDS has produced an end line report detailing all the findings.

3. In-depth interviews

Ten in-depth interviews were held with IMC staff, the healthcare team of the MH program, and the roving social workers as presented in the table below (refer to Annex 1 for the set of interview guidelines). This sample of interviewees was selected on the basis of the information that they could provide us with. The IMC staff provided an in-depth understanding of the activities and management of the project. The healthcare professionals provided more information on their experience with patients and the challenges they faces on the ground. The social workers provided information on the community awareness aspect of the study.

Profile of interviewee	Number of interviewees
IMC staff	2 (project manager and technical advisor)
MH healthcare team	4 case managers 2 psychotherapists 1 psychiatrist
Roving social workers	2
Total	**10**

2.3 Limitations

Interviews and Focus Group Discussions (FGDs) had been planned with people who had attended community groups, therapy sessions, or benefited from any of the mental health services provided by IMC. However, due to the exceptional circumstances given the COVID-19 lockdown and social distancing measures, and the need to ensure confidentiality of patients be respected, no meetings were held. This is a major limitation to the case study. However, to mitigate that, researchers triangulated with findings from the end line report as mentioned above.

3 Context Analysis

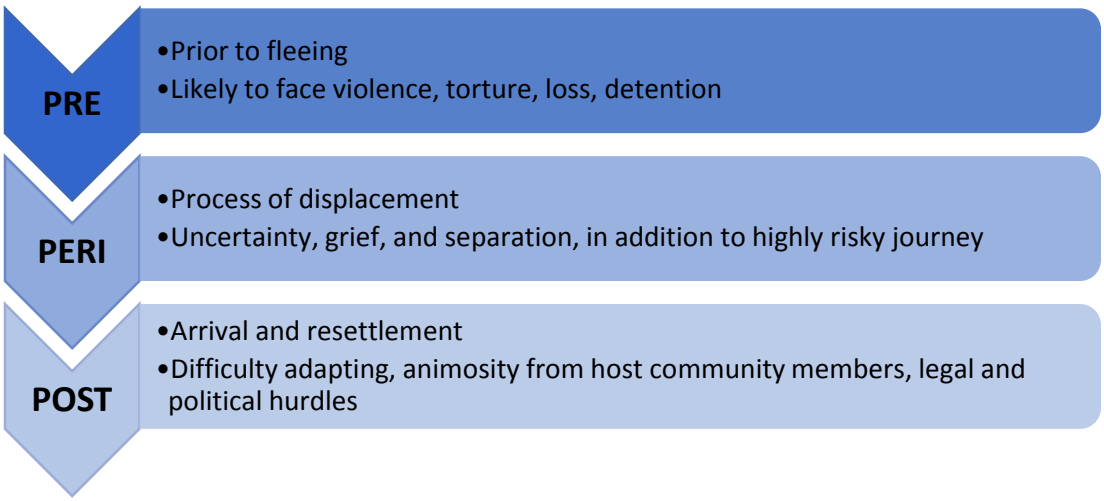
3.1 Understanding the risk factors for vulnerable groups

Mental health and emotional well-being are affected by individual predisposition and characteristics, in addition to social, economic, and political situations and circumstances. As a paper by WHO reports (2012) “Depending on the local context, certain groups in society may be particularly susceptible to experiencing mental health problems, including households living in poverty, people with chronic health conditions, minority groups, and persons exposed to and/or displaced by war or conflict.” Some other risk factors that heighten mental and substance use disorders include poverty, gender-based violence, conflict, dropping out of school, and chronic physical issues (Patel, Lund, Heatherill, Plagerson, Corrigal, et. al, 2009). Exposure to war and other war-related events increase the risks of mental health disorders, doubling the risk of anxiety disorders (Karam EG, Mneinmeh, Karam et al., 2006).

Taking this into consideration is crucial given Lebanon's context, whereby a significant portion of the country's inhabitants – including host communities and Syrian and Palestinian refugees – have had exposure to war, political turmoil, displacement, and conflict. This includes fifteen years of the Lebanese civil war, cyclical assassinations and clashes across the country, the 2006 war with Israel, geopolitical insecurity, the spilling of the Syrian war into Lebanon, and the ongoing Syrian refugee crisis. Indeed, from as early as the 1990s, a survey of 2220 children (aged 3-16) in Greater Beirut illustrated that 96% of them were exposed to at least one traumatic episode (Patel, Lund, Heatherill, Plagerson, Corrigal, et. al, 2009), leading to symptoms that include nervousness, PTSD, depression, and aggressiveness.

Certainly, the influx of Syrian refugees in 2011 has also been a crucial turning point when considering the changes within Lebanon's mental health services. Syrian refugees, who had to flee the country, arrived to a country with heavily weakened infrastructure. Within the literature, three key phases have been identified regarding the refugee process: pre-migration, peri-migration and post-migration (Reed et al., 2011).

Figure 2: Phases of the refugee migration process



The pre-migration phase is the stage prior to escaping from the country one lives, whereby households and communities' lives are highly like to face violence (in the form of combat, physical, and sexual violence), torture, loss of close family members and friends, imprisonment, loss of one's home, inability to leave one's surrounding (Lustig et al., 2004). The second phase, i.e. that of peri-migration, refugees are in the process of being displaced from their country and homes and bearing the heavy brunt of uncertainty, grief, and separation, while having to endure the highly risky process of fleeing. In the post-migration stage, when refugees are in the process of resettlement or have resettled, their daily experiences of life are just as challenging and stressful, as they have to adapt and engage with a new and foreign environment with a set of community beliefs and values that are challenging in and of themselves (Lustig et al., 2004).

In the case of Lebanon, resettled Syrian refugees have struggled with racism, extreme economic vulnerability, and highly precarious living conditions. The ad-hoc nature of the Lebanese government's refugee policies further deepen the sense of insecurity amongst Syrian refugees – from issues related to legal status, employment, housing, and others (Chammay, Kheir, and Alaouie, 2013). In Lebanon, the dynamic between refugees and host community members is multi-layered and has been prone to tensions. This in large part is due to competition on resources, distrust, political history, among others. Another issue is the perceptions host community members have of Syrian refugees – as people belonging to a different culture, or of a "lower" class, whose "women" are simultaneously "conservative" but also "provocative" – affect how refugees view themselves and make meaning of their place within the community they live in. Indeed, multiple studies since then have illustrated the consequences of the Syrian crisis on refugee communities' mental health and psychosocial well-being (DRC and Dignity 2018, Hassan et al., 2015). Survey data, based on slightly over 8000 Syrian refugees, shows that a staggering 42.9% of Syrian refugees suffer from PTSD while 40.85% have symptoms of major depression (PeConga & Thøgersen, 2018).

This had led local activists, policy-makers, and international organizations to focus on addressing the mental health needs of Syrian refugees. Indeed, the reality within Lebanon since 2011 "challenge[s] us to look beyond the material and physical needs in humanitarian settings, and raise the importance of the mental health and psychosocial wellbeing of people affected by humanitarian emergencies" (Chammay, Kheir, and Alaouie, 2013). The section below further outlines the changes within the country's mental health services following the influx of Syrian refugees.

3.2 Lebanon's mental health services before and in response to the Syrian crisis

Historically, in Lebanon, one of the main issues related to mental health services (and health services in general) are that they are largely delivered by the private sector and are relatively costly, making it nearly impossible for vulnerable communities to access them. The MoPH's Mental Health and Substance Use Strategy (2015-2020) reports that the overwhelming majority of those suffering from mental disorders do not receive professional treatment and for those who do try to receive professional treatment, there is a significant delay of between 6 to 28 years (Karam, Mneimneh, Dimassi, et. al, 2008). Similarly, a policy brief (Yehia and Jardali, 2015) problematized the "the limited access of a large proportion of individuals suffering from mental health problems and their families to mental healthcare services in PHC settings in Lebanon."

However, interestingly, the Syrian refugee crisis pooled in resources and funding to cater to the influx of refugees and the startling need for humanitarian aid. With this, there has been an increase in mental health services provided, in addition to the WHO's mental health Gap Action Programme (mhGAP) training for frontline workers and the mainstreaming of mental health

services into PHCs. Several NGOs and INGOs – including ACTED, Embrace Lebanon, Institute for Development Research Advocacy and Applied Care (IDRAAC), Save the Children, NRC, among others – focus on provision of MHPSS to vulnerable groups across the country, in addition to spearheading community support groups, mental health awareness campaigns, and psychosocial support to adolescents. The MoPH, as well, took on multiple initiatives and policies since then – particularly with the support of local groups and international organizations. In 2014, for instance, the MoPH established the National Mental Health Program, in coordination with UNICEF, WHO, and IMC, to address mental health care in Lebanon and improve treatment and services in line with a human rights approach. A draft law focusing on protection and treatment of people with mental health disorders has been pending parliamentary approval.

MoPH 2015 – 2020 Strategy

The strategy covers five domains; strengthening effective leadership and governance for mental health (domain 1); providing comprehensive, integrated and responsive mental health and social care services in community-based settings for all populations (domain 2) especially the needs of specific vulnerable groups (domain 5). Another domain covers implementing key promotion and prevention activities for mental health and substance use disorders (domain 3). Obtaining evidence-based knowledge to inform mental health policy and service development through an operational health information system and coordinated national research practice is another domain (domain 4).

The goal of the MoPH's Mental Health and Substance Use Strategy (2015-2020), which is in line with the WHO Global Action Plan for Mental Health (2013-2020), has been to "improve access to equitable evidence-based mental health services, preventive and curative, for all vulnerable groups living in Lebanon." Moreover, the MoPH chairs the Mental Health and Psychosocial Support (MHPSS) task force, which includes approximately 40 organizations that focus on the Syrian crisis, and seeks to synergize and mainstream MHPSS across all sectors. Since then, there have been yearly national campaigns with the latest focusing on "Mental Health in the Workplace" with the slogan "Don't miss the opportunity" "ما تضيعوا الفرصة", in collaboration with the World Health Organization (WHO), ABAAD, ACTED, Ecole Supérieure des Affaires (ESA), Human Resources Association of Lebanon (HRAL), International Medical Corps (IMC), Médecins du Monde (MDM), and SKOUN.

4 IMC's mental health intervention

In recent times, there has been an effort amongst policy makers and international organizations "to move mental health from the periphery to the center of the global health and development agenda" (Marquez and Saxena, 2016). It has become clearer that there needs to be a radical change in the way mental health is broached, with priority given to interventions that aim to

destigmatize, prevent, and restore mental well-being. Mental health programming, moreover, has come to encompass cross-cutting approaches that include community-based empowerment, child protection, health, education, and gender over the past few year. An enabling factor – given the international focus on mental health – has been the increase in funding and subsequent integration of mental health into other sectors (Marquez, 2017). Yet, although there are active efforts being put within humanitarian organizations to understand and address mental health issues, and train or inform staff about the basics of MHPSS (Weisbecker et al., 2019), in practice, "mental health is often not given a high priority, and inclusion of MHPSS within donor funding for humanitarian crises still often falls short of the total needs" (Weisbecker et al., 2019).

This is in light of the fact that there is an estimated 90% gap in mental health treatment (Shehadeh et al., 2020), with – as noted above – significant delays in professionally treating mental health disorders in Lebanon (Karam et al., 2008). There is also a substantial portion of the population who stigmatize mental health and don't have proper knowledge about it (Doumit, 2019), with 60% of Lebanese University nurses – for instance – believing that mental health issues are caused by "black magic", "evil eye", or a punishment by God (Rayan & Fawaz, 2018). In a presentation for TCSPP CMHC Online, Alameddine (2020) notes, "There is not enough supply for professionals to meet this demand." Indeed, evidence points to the fact that there is a scarcity of mental health professionals in the Middle East to address the demands of the population (Alameddine et al., 2016).

Within this context, IMC has been one of the leading organizations prioritizing mental health programming in Lebanon. It coordinates mental health integration into PHCCs, provides training to case managers, works alongside other international organizations and the MoPH on mental health mainstreaming, among others. As it has been operating in Lebanon for over a decade, it has had multiple approaches to mental health programming, including MH case management and PSS activities. However, as per interviews, IMC has been operating with the same model since 2015, with the same objectives and overall approach in terms of integrating MH into PHCCs, but with updated adaptations to current needs and contexts, as well as piloting of new MHPSS interventions.

The table below presents the number of beneficiaries from the various types of MH services in 2018, 2019, and two months into 2020. The number of consultations has significantly increased from 2018 to 2019. The highest number of consultations were those done by social workers.

Table 1: Consultations provided by MHPSS Team Staff

	2018			2019			2020			Project Cycle
	IMC	FPS	Total	IMC	FPS	Total	IMC	FPS	Total	IMC+ FPS
Consultations Social Worker	6,336	2,227	**8,563**	14,189	3,122	**17,311**	4,040	260	**4,300**	**30,174**

Consultations Psychotherapist	961	431	**1,392**	2,372	571	**2,943**	646	33	**679**	**5,014**
Consultations Child Psychotherapist/Occupational Psychotherapist (FPS)	313		**313**	383	84	**467**	67	23	**90**	**870**
Consultations Psychiatrist	1,385	1,511	**2,896**	2,588	1,436	**4,024**	731	155	**886**	**7,806**
Nurse		2,166	**2,166**		2,901	**2,901**		346	**346**	**5,413**
Total Consultations at PHCs	**8,995**	**6,335**	**15,330**	**19,532**	**8,114**	**27,646**	**5,484**	**817**	**6,301**	**49,277**
Consultations Roving SW	4,182		**4,182**	9,883		**9,883**	1,958		**1,958**	**16,023**
Total of All Consultations - PHC and RSW	**13,177**	**6,335**	**19,512**	**29,415**	**8,114**	**37,529**	**7,442**	**817**	**8,259**	**65,300**

Looking at the regional distribution of MH services, shown in the table below, we observe the highest number consultations in the Bekaa and North (including Akkar). These results appear to be in line with the observed increase in demand for MH services in these areas. The end line survey findings show that in Akkar, 36% of the respondents reported that someone in their household required mental health service, a substantial increase than that in 2017 (12%). Similarly, 35% of the respondents of Bekaa stated that they needed MH services, a significant rise from baseline at 6%.

Table 2: MHPSS Consultations provided by governorate

	2018			2019			2020			Project Cycle
Consultations	IMC	FPS	Total	IMC	FPS	Total	IMC	FPS	Total	IMC+FPS
Bekaa	3,796	6,335	**10,131**	10,052	8,114	**18,166**	1,989	817	**2,806**	**31,103**
BML	2,549		**2,549**	4,748		**4,748**	1,538		**1,538**	**8,835**
North	3,987		**3,987**	8,813		**8,813**	2,375		**2,375**	**15,175**
South	2,845		**2,845**	5,802		**5,802**	1,540		**1,540**	**10,187**
Total	13,177	6,335	**19,512**	29,415	8,114	**37,529**	7,442	817	**8,259**	**65,300**

This intervention is what the present study will focus on. Notably, IMC's mental health intervention is funded by different donors, some for a short while (and project-focused) and others for a longer duration (allowing more room for expansion of projects). Funds granted for one year, moreover, were renewable and enabled continuation of services. However, this is IMC's third year under MADAD funding, which has also enabled a broader scope and more focus on sustainable implementation.

4.1 What does IMC's mental health package include?

IMC provides free mental health, counseling services, and psychosocial support, while also working on the integration of mental health into primary health care centers. It also actively works on raising awareness, training community members to identify mental health needs and primary healthcare providers to diagnose and treat mild to moderate mental health conditions, and facilitating safe community spaces for discussion of mental health. Moreover, IMC closely coordinate with the MoPH's National Mental Health Programme to help integrate mental health into PHCCs and contributes to improving access to mental health care.

The target population was initially designed to largely seek out Syrian refugees; however, it is available now to both Syrian refugees and vulnerable Lebanese populations. Technically, IMC services are available to anyone, but the preference and dedicated targeting lean towards highly vulnerable groups who could not, under normal circumstances, afford or have access to mental health care. Palestinian refugees have, in the past, attended sessions at PHCCs or with psychotherapists and psychiatrists. However, as they do have mental health services under UNRWA, they are less likely to attend, particularly in MADAD-supported areas.

Additionally, IMC offers community-based sessions and activities for both youth and caregivers, including people with mental health conditions, to promote well-being amongst vulnerable groups, specifically Syrian refugees and vulnerable Lebanese. Clients are generally engaged in services for around six months; however, in some cases, clients are seen for a longer time due to the limited availability of community services, and in other cases, clients might stop attending earlier. Generally, IMC follows the brief MHPSS case management approach which includes psychotherapy (6 months on average) in order to allow for stabilization and the ability to optimize client functioning within a short period of time. Once stabilized, the client is discharged but does continue to receive the support needed from community local actors, such as mhGAP-trained PHCC staff who are able to manage mild to moderate MH cases and prescribe required medications Some of these sessions focus on parenting skills, early child development, awareness

raising, peer to peer sharing, and finding the helpful tools to address shared issues within families.

IMC has worked on 15 booklets on mental health disorders, from post-partum depression, to loss and grief, enuresis, psychosomatic disorders, depression, and schizophrenia. Only 13 are currently being administered. Although IMC provides an adequate list of medications, approved by the MoPH, interviewees reported that sometimes there are important medications that are unavailable, either because they are not on the list or because they are out of stock.

The mental health program uses tools to measure the well-being and daily functioning of beneficiaries; these tools aim to cover different criteria including personal care, bathing, being able to go to work, etc. It is also key to better understand the functionality of beneficiaries in future endeavors.

IMC'S Community Peer Support Groups

There are usually around nine community peer support groups sessions annually. People are selected to join under a specific criteria, for instance, they have family members suffering from schizophrenia or depression, and participate in a group session based on sharing their experiences, pain, and recommendations in a group-led and non-hierarchical manner. Sessions, facilitated by the roving social worker or the case manager, shed light on how those people can arrive to better emotional and mental health and how they can deal with the situation they're living through. Roving social workers, as per their capacity, contribute with tools on how participants can have more productive modes of thinking, while also facilitating a space to learn from one another. A roving social worker recalled one particular session that was highly memorable and potent, and was one held with females heading their households, specifically those who have had a divorce.

4.2 Who makes up the mental health team?

Generally, there are 17 case management teams spread out across all areas, as per the following: Akkar (2), Tripoli (3), Beirut-Mount Lebanon (4), South (3), Bekaa (5). Under the MADAD-supported centers, there are nine centers supported by IMC and one center supported by the FPS. Two centers are in Akkar; one in Tripoli; two in Beirut Mount Lebanon; one in the South; and four in Bekaa (one of which is under the FPS). The case management teams are made up of two case managers per area, with backgrounds in psychology or social work, who are usually the first line of contact and provide psychosocial support, awareness raising sessions, and referrals to specialized consultants. The specialized consultants are the psychiatrists and psychotherapists/child psychotherapists, who are part time and who visit the center three to four times a month. Finally, there are 12 roving social workers who work on outreach, awareness raising, and helping with referral processes by visiting different PHCs and NGOs across an area. Admin-support staff are based in Beirut and supervise, as well as ensure, that case management

teams have access to resources and support. When probed about the organization and structure of teams, there was general consensus amongst interviewees that it is well organized and neither understaffed nor overstaffed.

Case managers are responsible for debriefing beneficiaries or patients about the program and easing them into it in an implicit manner, in addition to differentiating between the services offered from support (with decision-making and listening), to therapy and psychiatric sessions or provision of psychotropic medication. Generally, the case manager takes care of appointments and preliminary assessment of patients and then it is either directed, immediately, to a psychiatrist (such as in cases of suicide or when an in-depth diagnosis or medication is needed) or a psychotherapist (who may later direct the patient to a psychiatrist). Case managers also play a major role in the provision of psychosocial support and case management of beneficiaries, which goes hand-in-hand with the specialized services being provided.

"It is beautiful to see the effect this intervention can have on people. A young woman came to the clinic and shared with me a problem that she had feared to share with anyone else. For seven years, she lived with this deep shame. But the space offered her the room to share, cry, and be accepted without judgment. People here are finding room to breathe. Even if we cannot solve their issues, to know that we can provide this room is very rewarding" – IMC Case Manager

Roving social workers rotate between the different PHCCs within the area or district they work in. They hold awareness raising sessions with patients waiting inside PHCs and, based on the patients, attempt to hold contextual discussions that can be beneficial for them. An interviewed roving social worker put it as such, "We have to stay alert to which group of people are in the PHCCs so that sessions can be catered to them. For instance, if clients are waiting to see a pediatrician, I will hold a session on enuresis and why children might be wetting their beds at night. If they are waiting to see a gynecologist, I will bring up the topic of post-partum depression. [...]. Sometimes, I might even ask what they'd like to hear more about." However, the range of topics are decided in consultation with mental health professionals. Some roving social workers also perform around four outreach sessions a month, on a decided-upon topic, in coordination with an NGO, independent local groups, or local community members. Outreach sessions also incorporate awareness sessions and referrals. A lot of active work is done regarding stigma by the roving social workers. While people are in the waiting room, roving social workers use simplified and friendly language to deconstruct the stigma and shed light on how important mental health is.

4.3 What do the mental health program staff have to say about their experience?

Interviewees agreed that guidelines and protocols are clear. Case managers, roving social workers, psychotherapists, and psychiatrists reiterated that there are clear guidelines on what their process is, what the working structure is, what tools they can use, and how to navigate particularly risky cases. For instance, IMC does not take cases autism, and generally tries to refer people with chronic conditions to more specialized treatments. However, in most cases, IMC does end up working with clients who attend. Case managers who have worked with IMC for several years, noted that there is now more clarity than ever about their roles.

> *"Before [the REBAHS project], there was some confusion, but now I know exactly which cases to take and which not to take, I've become better at diagnosis, and I know the rules and regulations very well."* - IMC Case Manager

This observation is also supported by the outcomes of the process evaluation that IMC conducted in 2019, which illustrated that guidelines were being met by the MH staff and specialists in terms of consultations, referrals, and all other related processes and procedures (AUB, 2019). The fact that these guidelines were being adhered to indicates that they were clear and practical.

While the guidelines are clear, there is enough flexibility and room for case managers, psychotherapists, and psychiatrists to "personalize" their approach. A psychotherapist noted, "My approach is eclectic and has had to adapt to IMC's guidelines. In my private clinic, I use psychoanalysis but because there is generally a short-term period with clients, a psychoanalytic approach is not ideal. I therefore change the approach depending on the client and the different training sessions with IMC, from the PM+ and IPT, have been helpful."

The MH program has been adaptive to the changing needs of the community and has thus remained highly relevant throughout the two years of implementation. A case manager noted, "We have evolved over the past couple of years on issues related to mental health. At first, our approach was more general and focused on depression and psychosomatic disorders. But now, with outreach and with more interaction with beneficiaries, we've broadened the scope and are working more on different preventative strategies and social issues, such as early child development, youth empowerment, support groups, G-IPT based intervention for people with depression. This was because we would see where there is a need and see what we can include to address these issues." A psychotherapist also added that IMC is constantly alert to any new training sessions that might be relevant. Similarly, according to an interviewed psychotherapist, "IMC's mental health package is comprehensive and attentive to details." A key approach that also continues to ensure relevance is the

> *"IMC are very responsive and it shows that they care and are not simply providing services without making sure that they fit in well with the community's needs."* – Interviewed Psychotherapist

involvement of community members in the design of booklets, as per the Mental Health Integration Toolkit, and continuous evaluation of their feedback (particularly that of beneficiaries). Moreover, IMC works closely with the National Mental Health Program within the MoPH, which enables it to better understand and engage with national campaigns and novel approaches to mental health.

Although interviewees agreed that the mental health package is comprehensive, most of them highlighted the lack of some psychotropic medications as a gap that needs to be filled. An interviewed psychiatrist said that the list of available medications is thorough, however there are some necessary psychotropic medications that are not included in the list and are too costly for some beneficiaries to purchase. Indeed, while the necessary psychotropic medications were available there were a few that were missing and whose availability are both highly needed and financially unavailable for a number of clients. The list of medications is largely based on the medication list, as per the WHO's essential list of medications and are all free of charge. The satisfaction survey conducted for the process evaluation shows that 87% of IMC beneficiaries were satisfied with the availability of medications at PHCs. However, a psychiatrist quoted in the process evaluation, noted that, 'in some cases, beneficiaries aren't showing improvement using a certain medication from the list and this has to change as to prescribe new types of medications from outside the list, but as psychiatrists, we don't have multiple choices to choose from."

5 Findings

This section presents the main findings of the report regarding the two main axes of research: (1) the challenges that the mental health care faces in Lebanon, and (2) the value added and breakthroughs of the IMC MH program that can be transferred to other mental health interventions.

5.1 Challenges to implementing mental health care

The MHPSS interventions are in large part to improve the emotional, social, and mental state of beneficiaries and empower them to manage stress (within their family, community, and individually), in addition to facilitating support networks, increasing mental health awareness and deconstructing stigmas, and addressing more crucial mental disorders that need professional intervention. Ultimately, MHPSS interventions within difficult circumstances – such as the protracted Syrian refugee crisis in Lebanon, the COVID-19 outbreak, and the country's economic collapse – can be particularly challenging. However, IMC's intervention, as indicated in the section above, is adapted and tailored to Lebanon's context, particularly Syrian refugees.

Some of these challenges have been addressed by IMC, but remain to be an issue where there is room for improvement or it continues to be a general challenge faced by mental health providers within humanitarian settings.

The identified challenges were grouped into two main categories: (1) Project related challenges that pertain to the project design and/or implementation, and (2) disabling environment factors that may be beyond the scope of IMC or any agency intervening in mental healthcare support in Lebanon.

5.1.1 Project related challenges

Time-frame may be insufficient to properly address clients' mental health. IMC generally has a cap of six months allocated to consultations, although there is room for extending or shortening the time-frame depending on each client. This is particularly the case when mental health practitioners begin to see results with clients towards the end of the six months and view that continuing to work with them might be potentially very helpful. While this flexibility is crucial, it was reiterated by interviewees that a challenge in emergency and post-emergency mental health provision is that the duration and provision framework might be insufficient to fully address the needs of clients. An interviewed psychotherapist, for instance, noted that, "Six months can be constraining because there isn't enough time to work adequately on behavioral changes [...], especially given the other external challenges within Lebanon."

Indeed, six months is a relatively short time to establish and build a relationship with clients before the forced disruption of treatment. Especially for those who have experienced trauma, this can be triggering or traumatizing. Moreover, the kinds of concerns clients come in with require systems-based changes that are hard to achieve in six months.

Receiving adequate feedback from beneficiaries is crucial, but not always achievable. IMC is committed to receiving feedback from clients about their improvement. During the interviews, case managers reiterated that it is a key element in their work. After all sessions, case managers and roving social workers open the floor for feedback, questions, and comments. It is similar for psychotherapists and psychiatrists albeit they also follow a separate evaluation that is updated every three months. The tools usually used are the Functioning Scale Assessment (FSA) and the Care Plan. Case managers also provide space for more general feedback and probe on issues related to how their family has responded to their treatment, what the main obstacles to "achieving progress" was, and what specific outcome they want to work on. During community support group sessions, as well there are pre and post evaluation tests that are done.

However, as is the case with many beneficiaries receiving free care, and taking into consideration power dynamics involved, there might be ambiguity or lack of full honesty when beneficiaries give feedback. This is noticeable in the fact that IMC staff might assist clients filling in the Client Functioning Scale Tool, which is aimed at assessing the daily functioning of beneficiaries during the first couple of sessions with clients (over the age of 16. Due to illiteracy or because the tool is "overwhelming", as reported by one case manager, it might be filled in with case managers which tends to bias answers and might make beneficiaries uncomfortable. Moreover, in the

process evaluation, case managers also critiqued the tool for not being "reflective of the situation the beneficiary is living in because the questions are too general."

This challenge is not unique to this particular project, and has in fact been a subject of debate among development actors. For instance, in a report entitled "Beneficiary Feedback in Evaluation", (DFID, 2015), "it is argued that it is a shared, normative value that it is important to hear from those who are affected by an intervention about their experiences. However, in practice this has been translated into beneficiary as data provider, rather than beneficiary as having a role to play in design, data validation and analysis and dissemination and communication." It is recommended that IMC rethinks the evaluation process and develops a tool that can be filled in more easily by beneficiaries while not compromising beneficiaries' confidentiality, ease, and well-being.

Outreach remains insufficient as awareness levels about the REBAHS MH program as well as about the importance of seeking mental health support are still low. The end line study conducted for the MHPSS program showed that, 71% of respondents who reported that they required mental health services but did not receive them, the most commonly mentioned reason for that was the perceived costs (59%), followed by concerns related to social stigma (45%). These were the two main reasons for not seeking mental health services in the baseline report as well.

When looking specifically at the MH catchment areas within the end line survey, 79% of those who required services did not receive them, indicating that people even within the MH catchment areas were still not aware or not seeking these services.

55% of respondents (15 respondents) who reported requiring MH services and were located within the MH catchment have participated in awareness sessions related to MH issues. In addition, only 30% of those who reported requiring services within the catchment area knew that MH services were being provided at their local PHCs.

Furthermore, 85% of total respondents as well as 85% of respondents within the MH catchment areas, reported that they had not heard of roving social workers discussing or distributing materials about mental health services in 2019. These results suggest that mental health interventions of the REBAHS did not fully succeed in raising awareness on the availability of free mental health support at the PHCCs and to decrease the stigma against mental health.

While IMC mental health providers noted there's a decrease in stigma, they added that it is still a significant challenge – especially in smaller areas where people know each other well – around the issue of mental health. This is particularly the case amongst male community members, many of whom refuse that they or their household members might be suffering from mental health conditions.

At the same time, interviewees reported that IMC's mental health services are operating at full capacity, with mental health practitioners reporting that their time schedules are usually full. Given this, it is important that both outreach and capacity be expanded to ensure that needs are addressed.

5.1.2 Disabling Environment Factors

Providing mental health when basic needs are not being met can be constraining. A study (DRC & Dignity, 2018) notes that according to interviews with Syrian refugees, it is important to ensure basic needs in combination with psychosocial support are provided. According to the study, "Some informants stated that the best way to reduce distress levels is to make sure that the humanitarian assistance includes basic supplies such as shelter and food. [...]. *"For our personal well-being? We need good work opportunities, enough humanitarian assistance, schools and education for our children, and a decent shelter."* (Female FGD participant, North Bekaa, Lebanon, March 2018).

Indeed, this should be problematized in most interventions as it is important to acknowledge the importance of mental health and the structural, systematic reasons that might trigger or exacerbate it. At the same time, it is also crucial to acknowledge that simply ensuring that the health system is reformed or improved is not adequate when considering humanitarian settings or even weakened infrastructures, such as in the case of Lebanon. An interviewed psychotherapist put it succinctly as, "Sometimes all we can do is provide space to listen because you can see that the solution to a client's problem is somewhat outside the scope of mental health provision but rather about unemployment, her children not being at school, or something economic."

The reality on the ground, particularly in light of one of the worst economic crises to hit Lebanon, has left the country's population reeling from unemployment, food insecurity, and lack of access to other basic needs. This has long been the case of Syrian refugees in Lebanon who, as per the annually updated Vulnerability Assessment for Syrian Refugees, face many barriers when it comes to accessing shelter, rent, food, and primary healthcare. While this further emphasizes the need for mental health care – given that financial insecurity exacerbates and/or ignites mental health disorders and afflictions – it also creates a vicious circle that is very hard to break.

> "We know that sometimes the biggest causes of mood disorders, such as depression and anxiety, are because of the economic and political situation. We know that it is very difficult for refugees, for instance, to find jobs and in some cases even have food to eat. How do we then deal with this?" – Psychotherapist

Findings from the interviews show that this particular issue is a huge challenge, especially when accounting for external circumstances that are beyond the scope of mental health practitioners

and clients themselves. While IMC has actively sought to coordinate with other relief-providing organizations and continues to update its system of referrals, it remains inadequate. Case managers also reiterated that sometimes referrals are not followed through and it feels like giving "false hope" to clients.

Indeed, this is particularly noticeable in the fact that one of the main impediments to attending community support group sessions or even therapy sessions are transportation costs and, in cases where psychotropic medication is unavailable, inability to purchase medicine. While there is petty cash available for transportation assistance, case managers report it is not enough. The process evaluation of 2019 also confirmed this through the results of its quantitative survey of beneficiaries, where 79% of respondents reported that it was not easy for them to get to the activity location, and 87% reported that the per diem they received was not sufficient to cover transportation costs to the activity location.

Limitations in funding are affecting the sustainability of mental health services. Certainly, although the MoPH aims to revise the budgetary allocations for mental health, this remains challenging, given the country's continuously fluctuating political and economic situation (WHO Bulletin, 2016). For IMC, funding in the past have usually been one-off payments for specific interventions, but MADAD has been more long-term, which has allowed IMC to develop a more sustainable model. Nevertheless, a main challenge remains the limitations in sustaining funds for mental health services through local actors, to ensure less dependence on international organizations and continuation in provision of services locally. Two interviewees brought this up in the discussion, noting that in the development sector, the question of funding – and how long it lasts for, what its constraints are, whether the donor is flexible or not – highly affects the implementation process of any intervention.

The Lebanese health care system does not invest or have enough funding and/or resources to tackle the dire need for free (or at least affordable) mental health care for the country's population. Health care expenditure in the country is mostly from the private sector. It is for this reason that international organizations continue to invest in mental health. IMC ultimately aims to fill in this gap. However, in the tenth year of the Syrian refugee crisis, funding from donors is decreasing globally. UN and other aid agencies continue to warn of critical gaps in aid funding for Syrian refugees. Within this context of dwindling funding, the question of how international organizations such as IMC can ensure sustainability and interventions that constantly adapt to changing contexts is key. This, for instance, includes IMC's mental health integration model into PHCCs and ongoing mHGAP training.

Although there is slight progress in terms of awareness on mental health issues, social stigma remains a main challenge hampering access to these services. Interviewees report that there remains a lot of work to be done in terms of deconstructing the stigma and taboo surrounding mental health. Case managers and roving social workers, for instance, said that there is a huge

difference in the approach towards mental health when clients first begin attending sessions and several months later. One roving social worker said, "You can tell that people are slowly beginning to understand that mental health disorders are common and not something to be scared of or to hide. I see more and more people coming into the clinics in the North and there is something like a snowballing effect. If your neighbor is open about her depression, you can become open about your anxious thoughts." However, all case managers added that while stigma might be decreasing, there are still many people in the country who find difficulty discussing mental health or still view it as an "illness not to be talked about." One case manager based in the South noted that in areas where people did not know each other well, there is a higher likelihood of busier schedules in the mental health section whereas in areas where people know each other well, such as Barja, people are less likely to ahead. She added, "People from Barja would rather go to the PHCs in Beirut or Nabatieh than the one in Barja."

Rabih Chammay, Head of National Mental Health Programme, concurred with this: "I work with a small nongovernmental organization in southern Lebanon, about 50 km south of Beirut, that attends to the mental health needs of Palestinian refugees and Lebanese host communities, people who are of low socioeconomic status and cannot afford to see a doctor in the private system. The stigma surrounding mental health is so great that some families prefer to take a day off, pay the transportation and the consultation fees so that they can come to see me in Beirut – all of which they can barely afford – rather than to see me at the clinic in the village. They are afraid that if people find out that their daughter or son is seeing a psychiatrist that he or she will have less chance of getting married" (WHO Bulletin, 2016).

However, as noted, this has been changing in large parts due to effort by the media, national mental health campaigns, the work civil society organizations have done normalizing mental health, and the integration of mental health into PHCCs. This is particularly the case for Syrian refugee men (for more, see the International Organization for Migration (IOM) "Self-Help Booklet for Men facing crisis and displacement", available in Arabic). Moreover IMC's sessions, whether with community groups or specialized one on ones, have created safe spaces to discuss taboo topics.

> "There is this perception that Syrian refugees stigmatize mental health. Of course, this exists, but I disagree with the general narrative because many refugees are open and actually come looking specifically for mental health services." – Interviewed Psychiatrist

5.2 The added value of IMC's experience and transferable good practices

Understanding IMC's intervention is crucial for building a better understanding of mental health services and how best to adapt policy and push for reforms within mental health services and institutions. This section focuses on best practices and lessons learnt from IMC's interventions,

particularly those that proved to be resilient and can be transferrable to other projects, programmes, and services.

5.2.1 The design/planning level

IMC's work on adapting mental health support tools has shown that provision of mental health support is facilitated when language and culture are not a barrier. Mental health development is exacerbated by mental health diagnosis that were developed in the West without proper adaptation to the particular experiences in Lebanon (Hinton & Lewis-Fernández, 2011; Rasmussen, Keatley, & Joscelyne, 2014). To address that, IMC has worked on tools that are locally adapted and culturally sensitive. Certainly, a core element of MHPSS workers is that they be culturally competent, or to be able "to respond appropriately and effectively to clients' cultural backgrounds, identities and concerns" (Kirmayer, 2012). Existing research shows that one of the main barriers to adequate mental health care is a lack of cultural competence and barriers to interacting with refugees. In Lebanon, there is a problem with social cohesion and there continues to be tensions between Syrian refugees and Lebanese, whereby Syrian refugees might view Lebanese as more culturally "open" and Lebanese might view Syrian refugees as more "conservative". Of course, these labels differ depending on issues related to location, class, sect, and economic tensions. However, regardless of these imagined and real cultural differences, Lebanese and Syrians have historically been very exposed to one another, speak very similar dialects of Arabic, and have many cultural similarities. This makes treatment, diagnosis, and follow-up much smoother than, for instance, Turkish psychotherapists treating Syrian refugees in Istanbul (Regional Refugee & Resilience Plan, 2016-17).

Interviewees also indicated that culture and language have not been barriers in work with refugees and, although there might be some "cultural" differences between the different groups attending services, there is understanding and awareness amongst mental health practitioners about how to navigate this and why or where such differences might arise. Syrians and Lebanese, that is, use the same language and phrases for their pain, distress, and self-diagnosis. For instance, in both countries, metaphors and expressions such as "atlan ham" (I carry worry), "iswadat el denye fi ouyouni" (life has darkened in my eyes), "hasis hali mashlool" (I feel paralyzed), are used. This makes work with Syrian refugees less challenging in terms of communication. At the same time, it also makes mental health reforms and training sessions and initiatives that respond to the refugee crisis more impactful on Lebanon's system, as ministries and public workers in Lebanon can adopt these changes and apply it on a national level.

That is not to say that there haven't been detrimental challenges in communication between Lebanese or international aid providers and refugees in Lebanon; in many cases, service providers have used bad or classist communication methods.

However, IMC's approach has been rooted in adaptable and engaging communication methods. Part of ensuring that beneficiaries understand their diagnosis and awareness is adequately raised

in “simplifying” the language around mental health and bringing it closer to people. IMC have worked on 15 booklets (13 of which are currently administered). A number of these booklets are based on real stories captured on the ground. According to interviews, a number of these booklets were also worked on in parallel to feedback given by beneficiaries or vulnerable groups to ensure that it is being understood and is culturally competent.

IMC’s holistic approach has allowed it to remain flexible, adaptable, and community-based. IMC’s approach to mental health has largely been rooted in an intersectional and holistic approach, and has – by and large, according to interviewees – been flexible to changing events. This, for instance, was identified during the pandemic and the ensuing lockdown. Case managers noted that as soon as the lockdown was officially institutionalized, and even slightly before then, the IMC teams across the country were having open conversations about how best to adapt to the situation. This was witnessed from the online therapy given to beneficiaries to working on awareness raising packages on the infection, and holding conversations within the team about how best to adapt to the mental health challenges caused by the pandemic. The consultants, for instance, agreed to give free mental health care sessions to the IMC staff in need.
However, even prior to COVID-19, IMC’s approach was to adapt mental health care treatments and frameworks to suit the community in need. Case managers discussed how they remained committed to guidelines but when there were changes within the community, it was important to adapt community support group sessions, themes discussed during outreach, and even the time framework of beneficiaries with the psychotherapists and psychiatrists. An interviewed psychotherapist noted that, “Interventions for clients are not seen as quick fixes. Even though our time frame is short, we try to ensure that we deal with clients’ complex problems with care and sustainability and we discussed this a lot during the training sessions for PM+ and IPT.”

Decentralization of services and ensuring their availability across different areas has contributed to the success of IMCs mental healthcare program. One of Lebanon’s structural woes is the centralization of services within the capital city. However, the influx of Syrian refugees, a majority of whom settled in rural and peripheral areas – most specifically Akkar and the Bekaa-Baalbeck area – has led to the spreading out of services. PHCCs in peripheral areas, given the additional funding, have been improved. Notably, in 1996, the MoPH founded the National PHC Network to ensure quality care and delivery, and currently comprises 226 primary health care centers (PHCCs) that serve slightly less than one million people on a yearly basis (Hemadeh et. al, 2020). However, approximately 78 PHCs, affiliated with NGOs and INGOs, offer mental health and diagnostic services. The PHC sector, to this day, does not have sufficient funding to develop its mental health services, particularly in more remote and rural areas.

Within this context, IMC has taken active efforts to ensure that mental health services are not centralized but rather available across the country’s different areas. In fact, interviewees said there is emphasis that mental health services in more remote and impoverished areas be

prioritized. Even within the different areas (i.e. North, South, Bekaa), roving social workers and case managers ensure that services are spread out. In the North, for instance, there are sessions not only in Akkar and Tripoli, but also in Zgharta. This can also be seen in the collaboration of IMC and PHCCs supported by other organizations, municipalities, volunteers, and health workers. This has brought mental health closer to cross-sectoral work.

“A key approach is to foster self-help within local communities as much as possible and to make use of internal support structures amongst displaced populations. […]”. Community mobilization and support are critical to care for people with mental distress or disorders (Weissbecker et. al, 2019).

However, there continues to be work that needs to be done, especially on a broader level targeting PHCCs. PHCCs in rural areas are still less funded and looked after than those in urban areas. A study shows that the percentage of PHCCs fulfilling national standard requirements is much more in Mount Lebanon (76.4%) and Beirut (71.4%), while in Akkar it is 36.4%, which is the lowest among the governorates (Hemadeh et. al, 2020)

5.2.2 The implementation level

Training and empowering mental health providers and community members is key to success and continuity. A recurring idea in the interviews was the importance of training sessions. Interviewees, including case managers, roving social workers, and consultants, all reiterated that they had received very strong training from IMC that was not just technical but also holistic in its approach.

This started with the mhGAP training, which IMC provided to many of its staff. The mhGAP-IG training is being given to service providers and organizations, across the board, who are working with host communities and Syrians to harmonize the response to refugees. Non-specialized staff are being trained, and case managers across the country are being equipped with tools to treat and support vulnerable groups. Within IMC, psychotherapists and psychiatrists are seen as “layer 3”, that is – cases are to be referred to them after they pass through case managers. This is important as creates a task shifting model, whereby non-specialized staff are given the training and tools needed to address the mental health needs of the population, while ensuring that specialized services are provided to those in need of them.

Psychotherapists received Problem Management Plus (PM+) and Interpersonal Psychotherapy (IPT), while some case managers received Group IPT based intervention. PM+ is a rather short and non-specialist version of cognitive behavioral therapy (CBT) provided to adults facing adversity (WHO, 2016). It addresses both psychological and social problems through problem-solving counselling, which includes a series of interventions aimed at managing stress and supporting social systems. “PM+ is a promising intervention for reducing depression and anxiety

symptoms in conflict-affected populations and there is potential for further developing and scaling up this intervention targeting refugee populations" (Weissbecker et al., 2019).

IPT is also a time-limited psychological treatment that focuses on the linkages between a personal's challenges functioning and other mental health symptoms with interpersonal crises such as war, conflict with others, loss, and social isolation. This can be used as treatment for depression, PTSD, and bipolar disorder, and can be conducted in group settings or on an individual basis, and also in community or primary care settings. "Evidence from low- and middle-income countries suggest that it is possible to train non-specialists, such as primary care staff, community health workers, community psychosocial workers and others, to successfully help people with depression in 8–16 session group IPT [150–153]." Group IPT, which is provided to some case managers in IMC, are implemented through supervised community health workers and within non-specialized health services and even outside health services (WHO, 2016).

Training through IMC, according to interviewees, is community-focused and sought to address the needs of Syrian refugees and vulnerable host communities through community-based interventions and preventative measures discussed during awareness raising sessions. Moreover, these sessions include thematic issues related to parenting, adolescence, economic crisis, etc. that connect problems to broader environmental, societal, cultural, and even legal challenges.

> *"It is very important that clients know exactly what we are doing, what their diagnosis is, and have full autonomy over any decisions made. There are some organizations that see clients as weak, but with our intervention, we make sure that patients are the ones with agency."* – Interviewed case manager

The same was applied to community members, and adhered to when community support group sessions are held. A case manager said, "Community based support group sessions are led by attendees and simply facilitated by us; they know better what are the main issues they face." However, this remains to be cross-validated by interviews with beneficiaries themselves. A case manager noted, "We're having good results because many clients are finally finding a language for their pain."

Such an approach is in line with human rights considerations. It is important that those being treated are not discriminated against as they, more often than not, are "at a higher risk for abuse and neglect, such as physical restraining, seclusion or isolation and being denied basic needs and human rights (Weissbecker, 2019). When working with people who have mental disorders, proper attention and legitimacy needs to be given to them, that is to acknowledge their strength and capabilities while also acknowledging their vulnerabilities.

Integration of mental health into PHCCs is very promising. As noted above, a core strategy for the MoPH has been to integrate mental health into PHCCs. This approach, which has been backed by multiple evidence, is key to promoting mental health, particularly in humanitarian settings. A majority of mental health services have long been "provided in parallel to physical health services and focus almost exclusively on treatment" (Greene et al., 2018). Studies show that the integration of mental health into primary health care is both crucial in terms of identifying needs, preventing mental disorders, raising awareness, and reducing stigma (Greene et al., 2018; Weissbecker et al., 2019).

Although integrating mental health into PHCs is quite complex (Silva & Caldas, 2014), due to barriers ranging from lack of national policies in PHCCs to financing mechanisms and lack of trainings, interviewees indicated that IMC's experience has been both very promising and successful. This is also largely because the MoPH's strategy emphasizes the importance of this. A case manager noted that PHCCs have become better equipped to deal with mental health because of the training sessions received and the support from IMC. IMC, indeed, has had a varied and long experience with supporting mental health integration across the world – from Sri Lanka and Sierra Leone to Iraq and Syria. In fact, it began supporting Lebanon's mental health integration into PHCCs from as early as 2006 (Weissbecker, Hijazi, Chammay, 2011).

This approach has been particularly helpful in decreasing stigma, as people seeking mental health but "ashamed" of it would feel comfortable visiting a PHCC. Additionally, even within PHCCs, the room designated for sessions is labeled as social services.

6 Conclusion and recommendations

Moving forward, there is a lot to take from IMC's mental health intervention for better national policies and reforms in PHCCs. Indeed, IMC's experience shows us that first and foremost, understanding the context within which mental health providers operate is important, in order to adapt to and contextualize services and language used. It is also crucial that funding is long-term in order to allow programming that is more sustainable and visionary. Challenges such as the time-frame of sessions and outreach are important to bear in mind in program design, as are deciding on the most suitable and effective feedback mechanism beneficiaries can use. IMC's experience also sheds light on threats or disabling factors in mental health care provision, including social stigma and harsh political and economic realities that

> "Indeed, a fundamental shift needs to occur in healthcare paradigm, from one of human rights violations and poor health outcomes associated with care delivered through psychiatric institutions, to one which respects human rights and promotes good health outcomes and recovery through the delivery of mental healthcare in the primary health-care system" (funk et al., 2008).

exacerbate or trigger mental health issues and remain outside the scope of mental health practitioners.

Building on IMC's lessons learnt is crucial for policy-makers working on reforms, both in the public and private sphere – from its holistic approach has integrated flexibility, adaptability, and community-orientation, to IMC's decentralization of services and the training and empowering mental health providers and community members.

Interestingly, a study lists a number of factors that might positively contribute to improving and reforming the mental health system during a refugee crisis. This list, which they refer to as "enablers of integrating refugee services to health-care services" includes:

- Sufficient funding
- Refugee and host population champions
- Government buy-in and support for need of mental health services
- MH services integrated with existing systems that serve both refugee and host populations (rather than parallel mental health services only for refugees)
- Good service organization
- Good rollout of both training and supervision

The present study shows that IMC has been able to achieve many of its objectives due to the presence of these "enablers", from sufficient funding to government buy-in and good rollout of both training and supervision.

Additionally, the Syrian refugee crisis provides an opportunity to improve Lebanon's mental health care system. Since the influx of Syrian refugees into Lebanon, there have been noticeable and rather remarkable changes within the country's mental health care system – from strategies to campaigns and active efforts to integrate mental health into PHCCs.

The Syrian refugee crisis, more than other refugee crises around the world, has brought in funding, reporting and media focus. The reasons for this are beyond the scope of this paper, but it does pose the question of how a terrible crisis has, in more ways than one, helped improve or - at the very least - create larger conversations about how to reform Lebanon's previously weak mental health care system. Indeed, as reported by Weissbecker et. al (2019), "The massive needs arising in acute refugee settings may prompt health authorities to accept piloting new initiatives for mental health-care provision, including the training of general health workers, the use of paramedical staff and working closely with communities which may provide the impetus to include mental health care in health sector reforms." Certainly, this can be seen in Lebanon as interviewees, particularly those who have been in the sector for quite a long time, all indicated that there has been a noticeable shift in the country's mental health system within MHPSS services being integrated more holistically, increased efficiency in provision, stronger attention being given public health in general, improved training and supervision.

Indeed, Lebanon's National Mental Health Plan was supported and launched in coordination with multiple agencies, including WHO, IMC, and UNICEF in 2014. The MoPH also launched a Mental Health and Psychosocial Support Task Force, which includes over 40 organizations responding to the Syrian crisis, in order to mainstream mental health support across different sectors. Moreover, the strategy adopts a human rights approach as it focuses on intersectionality and vulnerability of multiple groups including prisoners, survivors of torture, the LGBTQ community, and domestic workers.

Moving forward, the below recommendations for mental health services should be considered for further improvement, transferability of best practices and lessons learnt, and public mental health reform:

Incorporating an intersectional human rights approach to mental health care. IMC's experience, coupled with MoPH's 2015-2020 strategy, shows that community members are the main stakeholders to be engaged with, and mental healthcare needs to consider their particular problems while also ensuring they have control and agency over decisions being made about their well-being.

Ensuring that services focus on the self-reliance of local communities. Additionally, mental health care needs to be provided to all members of society, particularly vulnerable groups who are unable to access private mental health care, and should be tailored to these different groups including refugees, prisoners, those suffering from disabilities, among others. At the same time, it is important that mental health services are holistic enough to also include community group sessions and other events that might increase solidarity and inter-dependence on other community members.

Attentiveness to language used and cultural competence. Mental health provision needs to be spoken in a language that is both clear and inclusive, in order to reach out to and incorporate the different groups within society, especially those who feel "unheard" or structurally discriminated against. This is done through culturally validated tools, and in consideration of existing power dynamics within health services and communities in general.

Open-source research. IMC's varied experience is particularly helpful for other groups aiming to provide mental health services, in addition to academics and researchers working on developing more contextual or culturally sound tools outside the scope of Western-developed measures. For this, it is crucial that lessons learnt and best practices are shared on public platforms. Moreover, it is important affected communities are involved in research done on mental health and that findings are shared with them and made more accessible.

Coordination with other sectors, including governmental authorities. As the country spirals economically, and the global world struggles to deal with COVID-19, it is crucial that there is

effective coordination between different aid providers, local and international organizations, and local authorities including municipalities. This research shows that economic and political constraints are highly disabling, and it is important to work alongside other sectors focusing on these issues in order to advocate for the prioritization of mental health within them but also to refer beneficiaries where possible to other services or programs. **Indeed, working alongside relevant ministries and coordinating with other international organizations has led to multiple campaigns and reforms that have proven to be resilient.**

Supervision and training. Comprehensive and continuously updated supervision and training to staff across the board, including those in PHCCs, is key for the integration of mental health into PHCCs, the empowerment and growth of mental health providers, and the sharpening of skills related to mental health provision. It is also highly important that training incorporates a cultural and gendered lens, to ensure that services are tailored to different groups within society, including women and young girls and refugees. Moving forward, it is important to mainstream gender (including LGBTQ+ issues) into mental health services.

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