IMC LEBANON COMMUNITY BASED MHPSS MODEL

A Guidance Document for Community Based Mental Health and Psychosocial Support (MHPSS)

Developed by: Zeinab Hijazi, Mental Health and Psychosocial Consultant with International Medical Corps.

Note from Author: *This guidance document is in full compliance with Inter Agency Standards For Mental Health And Psychosocial Support In emergency Settings.*

INTRODUCTION

Terminology

The IASC Guidelines use the term "mental health and psychosocial support" to describe any type of local or outside support that aims to protect or promote psychosocial well being and/or to prevent or treat mental disorders. The term includes both interventions from the health sector as those from non-health sectors.

When communicating with non-clinicians, terminology should be used that is understandable to non-specialists, normalizes common reactions to difficult situations, and reflects and reinforces the ability of people to deal with and overcome difficult situations. Care must be taken to avoid use of specialist terminology outside of specialized support services that could lead to disempowerment and stigmatization of people. For example, terms such as 'trauma focused intervention' should only be used in clinical contexts when referring to a minority of the affected population that may benefit from such intervention based on assessment by a specialized mental health care provider. For non-specialists, words such as "distress" or "stress," "reactions to difficult situations," "psychological and social problems/effects/difficulties," or "severely distressed children or adults" should be used.

(IASC MHPSS Advocacy Package, 2011)

Mental health is more than the absence of disease or disorder. It is defined as a state of complete mental wellbeing including social, spiritual, cognitive and emotional aspects.

Psychosocial - the term is used to underscore the close and dynamic connection between the psychological and the social spheres of human experience.

Psychological aspects are those that affect thoughts, emotions, behavior, memory, learning ability, perceptions and understanding.

Social aspects refer to the effects on relationships, traditions, culture and values, family and community, also extending to the economic realm and its effects on status and social networks.

The term is also intended to warn against focusing narrowly on mental health concepts (e.g., psychological trauma) at the risk of ignoring aspects of the social context that are vital to wellbeing. The emphasis on psychosocial also aims to ensure that family and community are fully integrated in assessing needs and interventions. If we help people psychologically, we improve their social relationships and effectiveness. If we help people function socially (cooperate, communicate and interact well with others, or find their role in the family and community and fill social roles as children and parents), we support their mental health.

Psychosocial well-being is holistic and reflects the mutual interaction between mental, emotional, spiritual, and physical dimensions, all of which are influenced by culture and social and political context. Keys to psychosocial well-being include healthy family and community relationships, engagement in meaningful roles and religious or spiritual practices as culturally defined, having basic needs met, physical security, and a sense of identity, dignity, and positive self-esteem.

Psychosocial supports are activities, relationships, and tools that support holistic well-being, mobilize the existing resources or introduce the new ones to alleviate the psychological and social consequences of an emergency on individuals and their social world by strengthening people to deal with them and ensure their active participation in rebuilding their lives.

Some of the best psychosocial support comes from friends, family, religious leaders, etc. Children, women and men affected by emergency should not be treated as helpless spectators and recipients of support, but must be actively involved from the outset in improving their situation. It is important to think of how psychosocial support is organized since it can be local, affected persons themselves who do the organizing.

Psychosocial support in an emergency should focus on improving security, bringing together family members, improving communication, and providing support during mourning process rather then isolated trauma therapy programs. In cases where community or family separation occurs, alternative social support mechanisms must be established, such as adult and youth support groups, child centered spaces, camp leadership and school.

Addressing mental health and psychosocial needs in conflict and post-conflict situations is critical for reducing the likelihood of future conflicts and ensuring effective and sustainable reconstruction.

Mental and Psychosocial impacts of armed conflict

The impacts of conflict are complex and wide ranging. They are not confined to countries at war - they ripple outward from the initial violence, spreading from individuals and communities to countries and regions. Conflicts cause widespread insecurity due to forced displacement, sudden destitution, the breakup of families and communities, collapsed social structures and the breakdown of the rule of law. This insecurity can persist long after the conflicts have ended as internally displaced persons (IDP), refugees, and asylum seekers try to adjust to new circumstances around them, cope with loss, and regain a sense of normalcy. Widespread insecurity and increased poverty, coupled with a lack of basic services such as healthcare, education, housing, water and sanitation, exacerbate levels of stress.

Psychosocial impacts of armed conflict often include not only changes in individual feelings, thoughts, and behavior but also changes in social roles, relationships, and status that arise from experiences such as family separation, loss of home and belongings, torture, stigmatization, social polarization, loss of social supports, and disruption of patterns of play, work, education, and religious and spiritual practice that create a sense of meaning and hope.

Most people do not develop mental disorders as a consequence of distressful experiences. Natural recovery over time i.e. healing without outside intervention will occur for many, but not all, emergency survivors.

In emergencies, the incidence of mental and psychosocial distress increases substantially. Population's responses to stressful environment caused by armed conflict or natural disaster can be outlined as:

- Most people in the emergency-affected areas experience increased distress due to loss of security and lack of access to basic necessities such as food, water, shelter, and health care [This seems to certain. In countries such as Angola, some areas were very affected by war, displacement, hunger, etc. Yet in others the population was insulated from these effects. It depends on how one defines "the population"—as all the people in the emergency affected country or all the people living in the site of the emergency situation. Also, the emphasis on symptoms again takes us to a clinical model, when the Guidelines point us in the direction of social impacts as well. It might be best to delete all the percentages and revert to an intervention focus rather than a needs focus, following the outline of the Introduction to the Guidelines.]
- A smaller group of people [best to shy away from numbers since these vary by context and are not determined exactly in any case] experience distress due to disruption of family and community networks and need family, community, traditional, religious, spiritual support;
- 10% have ongoing distress and might need focused support by trained and supervised MHPSS workers
- 1-3% suffers extensively and experience difficulty functioning in daily roles. [It may not only be the mentally ill but also people with intellectual disabilities, epilepsy and other neurological disorders, etc.]

Coping means that a person is able to manage, adjust, live with, adapt to their experiences and continue to lead a functional life. In order to cope, people use their **resilience** and **protective factors** and personal **coping style**.

Resilience is the **ability of individuals, families or communities to cope and respond adaptively in the face of adversity**. This resilience allows people to manage their experiences and continue with their lives without major destruction to their mental health or psychosocial well-being.

Protective factors are factors that help to offset the negative effects of exposure to risks and that increase well-being. They include: Security or safety, Family support, Prior coping experience, Community support, Access to adequate survival tools, income and employment, Constructive activity, Support for human rights, Free cultural and spiritual practice, Ability to find Meaning in the problems etc. After a traumatic event, people use their protective factors to assist them in coping. Every person develops his or her own coping style using his/her protective factors. There is no right or wrong way to cope. Some people talk to others in their family or community and ask for help, while others think privately until they come to a resolution. Some turn to activities like work or play to divert their thoughts, some try to forget, some try to find meaning or solace through prayer while others think about it over and over until they find an answer.

Some people are victim to extreme events and respond without a problem, yet have symptoms of stress later, while others never have symptoms. Other people have symptoms at the beginning, that later disappear. Some people experience, what appear to be minor traumas, yet develop serious psychological reactions so it does not seem to be the event alone that triggers symptoms of distress. The balance between the traumatic experience or stressors and protective factors has an impact on the reactions. This explains why there are differences in reactions even when people are exposed to the same events.

Not Everyone Who Experiences A Traumatic Event Is Traumatized

The word, traumatized is usually used to describe anyone who is disturbed, upset, distressed or shocked by an event. With this definition, everyone who has experienced a traumatic event is traumatized since they all feel some level of distress

due to the event. However, the psychological or psychiatric definition of traumatized refers specifically to someone who has experienced a traumatic event and is unable to cope with the event and develops a mental disorder.

- Only a small percentage of people actually develop mental disorders after a traumatic event. Commonly, people with severe mental disorders after a traumatic event had prior mental health problems and seem to have a predisposition to a major mental disorder
- People with severe mental health problems may fail to present at all because of stigma, fear, self-neglect, disability or poor access. These people are doubly vulnerable, both because of their severe disorder and because the emergency may deprive them of social supports that previously sustained them. The burden on families or communities taking care of them puts such individuals at elevated risk of abandonment in emergencies that involve displacement.
- Once they are identified, however, steps can be taken to provide immediate protection and relief, and to support existing caregivers.
- Only specialized agencies with health professionals are able to serve the small proportion of people affected in this way. This makes having referral networks important where agencies recognize their limitations in providing mental health assistance.
- Among conflict-affected populations, children are the most vulnerable. Armed conflict alters their lives in direct and indirect ways, and in addition to the risk of being killed or injured, they can be orphaned, abducted, subjected to sexual violence or left with deep emotional scars and psychosocial trauma from direct exposure to violence, dislocation, poverty and the loss of loved ones (UNICEF 2004).

Adapted from Source: CCF-2006-MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT MINIMUM RESPONSES IN EMERGENCY SETTINGS - Based on the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

I. BACKGROUND

International Medical Corps is working in Lebanon with Syrian Refugees and host population affected by the Syrian crisis, and continues to work with Iraqi Refugees whose needs have been further exasperated by the current situation. These populations have faced past stressful experiences, including violence and loss. Most have to adapt to the challenges of new environments, such as formal and informal shelters, where access to even basic needs is often difficult.

Distressing experiences and fragmented or insufficient services have lead to unaddressed mental health, psychosocial and protection issues, impacting the welfare and functioning of individuals and families, including children and youth. In response to the multiple and complex needs, International Medical Corps is providing comprehensive mental health, psychosocial and approach that identifies, supports and protects those who are vulnerable while promoting stability and recovery, through **community based mental health and psychosocial services** including:

- Psychological First Aid provided by frontline workers, including child care workers.
- Integrated Mental Health and Psychosocial Services provided by trained PHC providers
- Basic Psychosocial Support, Counseling and Problem Solving provided through clinic based and outreach case managers.
- Early Childhood Development sessions for caregivers, mothers and fathers, of children 0-3, 3-6 years, and tailored sessions for caregivers with children with disabilities.
- Life Skills Youth and Parent Activities provided through IMC support clinics and community centers.
- Community Education and Awareness activities around mental health, psychosocial and protection issues.
- Advocacy, Mapping & Coordination provided through the national MHPSS WG [get details from Jihane and Fadi on this in relation with NMHP WG at the MOH]

Overview of IMC's MHPSS Activities in Lebanon

International Medical Corps is committed to following up-to-date best practices and internationally accepted guidelines such as the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings to which International Medical Corps has contributed to WHO guidelines on mental health. International Medical Corps frequently distributes and promotes guidelines and resources since not all local or international actors are aware of them, especially in the early phases of an emergency.

Psychological First Aid

International Medical Corps delivers training on the principles of Psychological First Aid (PFA) among staff and volunteers responding to the crisis as recommended by global IASC MHPSS guidelines. PFA is a non-intrusive way of providing psychosocial support which teaches doing no harm, supportive listening, strengthening positive coping strategies, linking people to needed services including specialized referrals for those experiencing severe distress as well as staff self-care. In Lebanon, International Medical Corps also implements a training of trainers program that aims to promote sustainable capacity building of local staff.

Integration Of Mental Health Into PHC

International Medical Corps uses a comprehensive approach to MH and PHC integration. Globally, International Medical Corps contributed to the development of the WHO mhGAP guidelines on training general health care providers in the effective identification, management and referral of mental health cases. In Lebanon, International Medical Corps is working with the MOH and WHO, has adapted mhGAP training materials to the Lebanese context, is providing both theoretical training and on the job supervision, is supporting policy efforts, and institutional changes and capacity-building efforts, and evaluating results to inform practice and scale-up.

Community Education And Awareness

International Medical Corps carries out integrated community based awareness and psycho-education sessions organized by case managers and community volunteers. An awareness campaign is also being organized on an annual basis around women's rights and gender based violence prevention, awareness and response.

Early Childhood Development

International Medical Corps' Early Child Development (ECD) programming is integrated within existing PHC and community centers. ECD focuses on improving parent-child interactions and increasing parents' knowledge about the child's developmental milestones and emotional and cognitive needs. In Lebanon, ECD trainings are also conducted for parents/caregivers of children with disabilities.

Mental Health And Protection Case Management

International Medical Corps has trained case managers to work as part of a multi-disciplinary team and within the primary health care system and community centers to ensure a continuum of effective services for affected populations that have multiple and complex needs and require a comprehensive mental health, and psychosocial case management approach which identifies, supports and protects those who are vulnerable and promotes stability and recovery.

On Sexual and Gender Based Violence (GBV), International Medical Corps collaborates with partners such as the United Nations Populations Fund (UNFPA) and trains health care providers on the Clinical Management of Rape survivors. Case management teams, are also trained to provide focused support to GBV survivors and work with UN agencies and international and local NGOs to enhance referral mechanisms for survivors of GBV.

Parent, Child And Youth Activities

International Medical Corps' projects for children and youth, like those provided through the community center in Baalbek, are not only recreational, but also aim to build key life skills, involve families and community leaders, strengthen social support networks and make important contributions to community-building.

International Medical Corps also utilizes existing spaces within IMC supported centers and clinics, to implement a Youth Community Protection Program (YEP) for vulnerable adolescents. Using a 16-week curriculum, cohorts of adolescents, 13-18 years, meet at supported clinics and community centers to receive training on life skills and communication and engage in constructive dialogue regarding social responsibility and cultural awareness. . A key component to International Medical Corps' youth empowerment program is a community project that is identified, lead and implemented by youth in order to contribute to the support of refugee and vulnerable host populations.

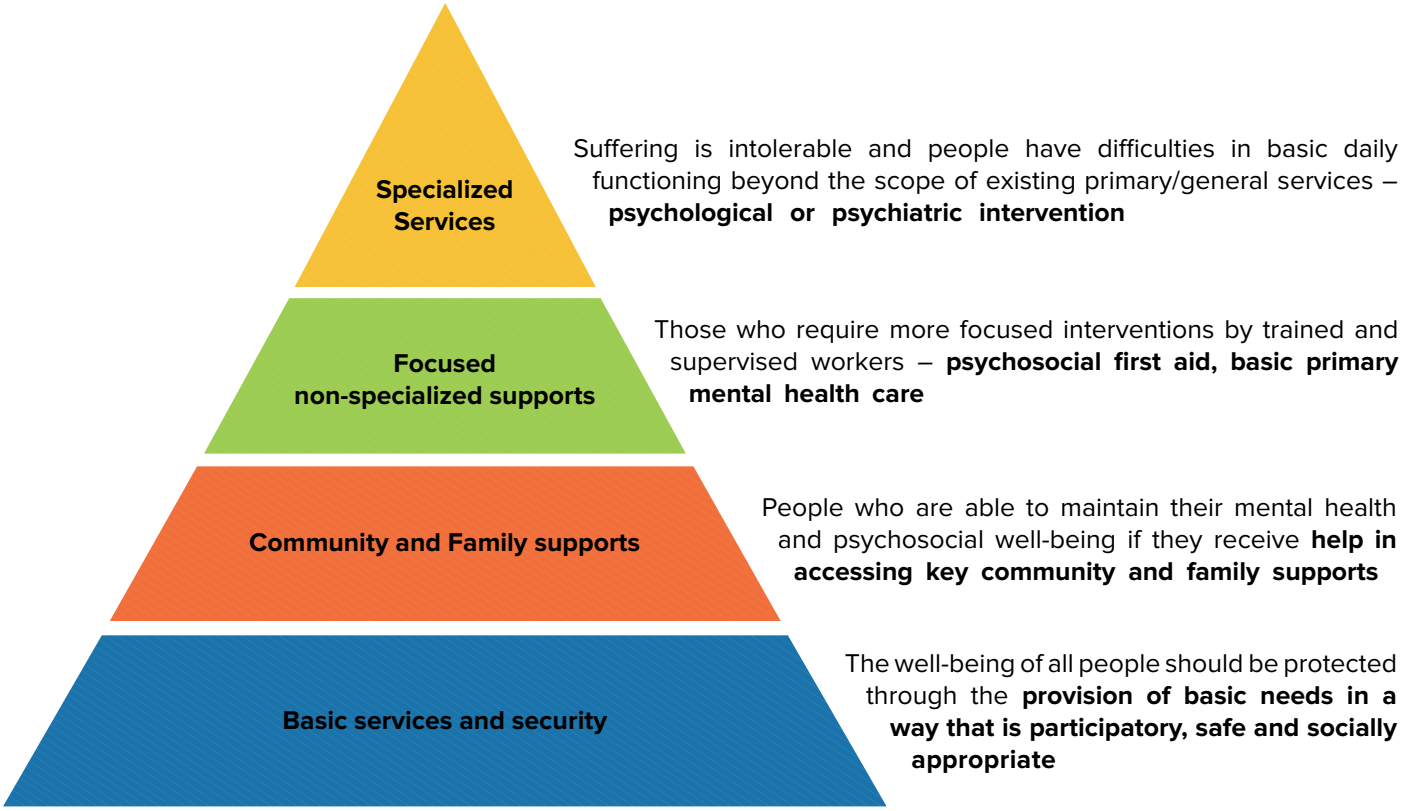
Ongoing efforts are being done to further develop a parenting skills program in which parents and caretakers are empowered through peer-to-peer support and by learning practical techniques that they could readily use to promote the coping and resilience of their children. The children are empowered through their parents' efforts.

II. ADOPTING A COMMUNITY BASED MODEL

Using best practice resources, guidelines, and IMC lessons learned from positive experiences in Lebanon, and globally, this guide will provide a model for community based MHPSS services set up through an IMC supported community center, with clear linkages and referral pathways to the PHC, linked to IMC's integration of MH into PHC program, and to other services and supports identified at the community level.

Approach:

Multi-layered, **Integrated**, **Community Based**, **Mental Health and Psychosocial Support**



IASC Guidelines Intervention Pyramid (adapted from IASC 2011 MHPSS Advocacy Guidelines)

Guidelines:

The IASC Guidelines on Mental Health and Psychosocial Support in Emergency

- Settings (IASC, 2007);
- The Sphere Handbook (The Sphere Project, 2011);
- The Minimum standards for child protection in humanitarian action (Child Protection Working Group, 2012);
- Mental health and psychosocial support for conflict-related sexual violence: 10 myths (WHO, 2012a);
- IASC Guidelines on Gender-Based Violence in Humanitarian Settings. (IASC, 2005).
- Community-based Rehabilitation: CBR Guidelines (World Health Organization et al., 2010).
- Assessing mental health and psychosocial needs and resources: Toolkit for major humanitarian settings (WHO & UNHCR, 2012).
- mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings (WHO, 2010).
- Assessment and Management of Conditions Specifically Related to Stress – mhGAP Intervention Guide Module (WHO & UNHCR, 2013).

Concepts:

Community mobilization & empowerment, Community Based PSS, Outreach, Safe spaces, Peer Support, social networking.

Who should IMC's Community based MHPSS services Assist?

Refugees, Displaced and Vulnerable Host population:

- Inadequate Basic Care including food, shelter/housing, water,
- Require basic information about services, rights and care available.
- Signs of psychological and social distress, including behavioral and emotional problems (e.g. aggression, social withdrawal, sleep problems) and local indicators of distress
- Signs of impaired daily functioning
- Disruption of social solidarity and support mechanisms (e.g. disruption of social support patterns, familial conflicts, violence, undermining of shared values)
- Mild, moderate and severe mental disorders

Activity Categories:

1. Focus on small group activities and Focused, non-specialized, semi-structured PS activities implemented by trained and supervised paraprofessionals from the community
2. In combination with specialized interventions and community/family support*
3. Awareness raising, psycho education, coordination and advocacy
4. Referral to other support and services systems

** Note: Within the context of a community based center, it is recommended that need for psychotropic medication, as part of overall management of a case, should be met with a referral to the nearest PHC clinic for receiving medication. With sustainability and do-no-harm as key principles of IMC's approach, provision of psychotropic medication is not introduced within a community center set up by IMC, but rather supported through existing health points such as a PHC that is sustained after IMC's support ends.*

III. SETTING UP IMC'S COMMUNITY BASED MHPSS CENTER
[Specific guidance for IMC Lebanon's center in Bekaa]

Participation Of Children And Families

- IMC should ensure that the purpose and services of the community MHPSS center are clearly communicated through participatory consultations and discussion with the community, parents, and children themselves before the commencement of the center.
- IMC coordinator shall write in local language and publicly display statement of purpose for the center. This will include description of purpose(s), objectives, services offered, and eligibility requirements.
- The services provided at the center are designed to give children and families the opportunity for psychosocial recovery and personal development. Therefore, their views should be heard and considered in key decisions about the center.
- Children, and community members participate in the choice of activities taking place at the center and are not forced to participate in an activity.

Initial Needs Assessment

Building on existing resources for MH and PS wellbeing:

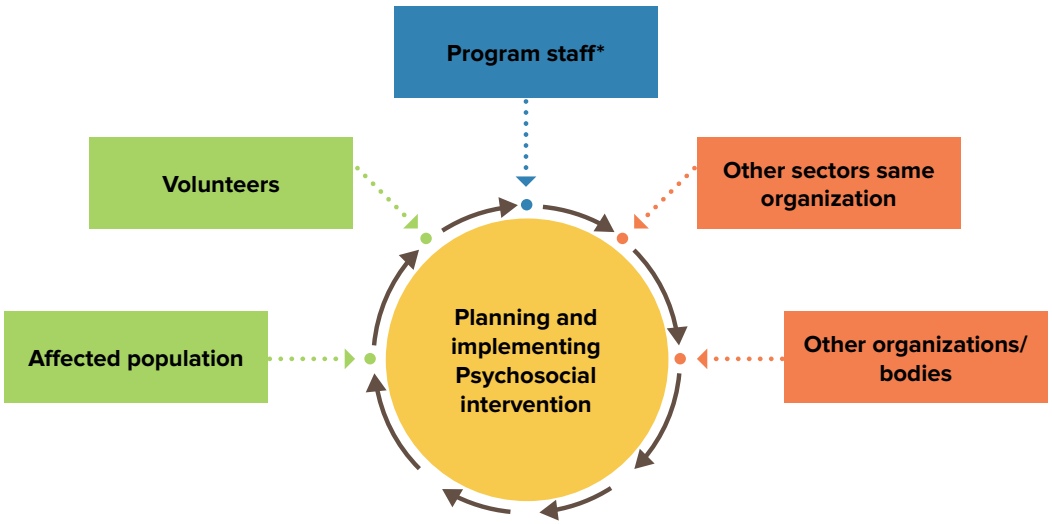
- Ways people help themselves and others i.e. ways of coping/ healing (e.g. religious or political beliefs, seeking support from family/friends)
- Ways in which the population may previously have dealt with adversity
- Types of social support (identifying skilled and trusted helpers in a community) and sources of community solidarity (e.g. continuation of normal community activities, inclusive decision-making, inter-generational dialogue/respect, support for marginalized or at-risk groups)

Staffing Structure

Who is involved in a MHPSS response?

The below diagram provides an overview of the different groups of people that are involved in planning and implementing a mental health and psychosocial response.

- The diagram shows that some of the volunteers are likely to be part of the affected population, and ideally these are the two groups that should have most influence and ownership over the psychosocial response.
- The program staff have the overall responsibility for planning the response, including activities that make sure the affected population and volunteers are part of the planning and implementation.
- Involving other sectors and organizations is necessary because psychosocial wellbeing is often interrelated with other needs, such as the need for food or housing. Working together with other sectors and organizations can help to ensure that a psychosocial intervention is implemented in conjunction with other responses, such as food and shelter, or medical attention.



* Program Staff includes IMC MHPSS management, field officers, and direct services providers recruited from the local community, such as social workers, mental health specialists, etc.

Selection

- Gender:
  - Try to aim at an equal gender balance, keeping in mind flexibility and cultural appropriateness.
  - In some places it is not appropriate for men and women to work together directly; and/or certain activities are suitable for only one gender. Avoid making assumptions, involve community members in discussions about these issues and ensure selections are locally appropriate.
- Caste, Ethnicity and Religion:
  - Ensure equal and balanced representation of the religious, class, ethnic and racial mix of the community at large, ensure not all your staff are of one religious or ethnic group, class, caste or clan.
- Qualifications
  - Acknowledge that competencies can be both formal qualifications as well as interpersonal skills.
  - Interviews for the selection of candidates should explore attitudes and behaviours towards target community.
  - Do not hire someone who has lots of qualifications but does not have the right attitude towards refugees and vulnerable populations. Avoid pulling qualified people away from other public sector jobs.

Staff support training and development

- A healthy communicative environment is fundamental to guarantee that staff feel supported and to enable a well run center.
- Provide orientations and on-going support and be aware of staff burnout and fatigue. Provide trainings, support, supervision and a structure that includes an on-going feedback system for staff members (daily wrap-ups and weekly staff meetings).
- Avoid situations where staff are over-stretched or feeling overwhelmed; this is especially true for younger or older facilitators or with staff who are reluctant to seek support for themselves.

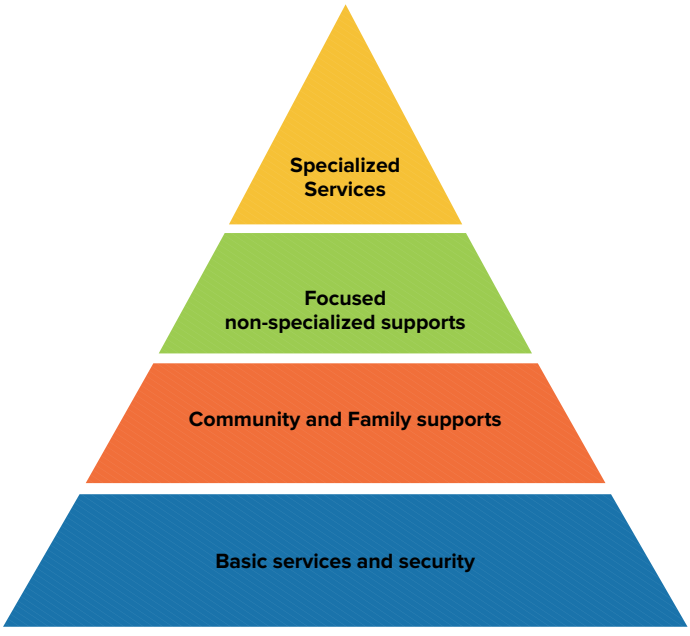
Review and evaluation

Regular review and evaluation enables you to ensure that staff selected for the center were a suitable choice and behave appropriately with children and their families, and the vulnerable at large. To review and monitor staff and facilitators talk with children and communities about how the management and facilitation is going. On-going monitoring is essential to ensure community are not being harmed.

Multi-layered MHPSS Interventions

It is important that parents, children and the community in general are involved in identifying the activities in the center, and that these activities and services are in line with initial needs assessment. Below is an overview of IMC's expertise and suggested MHPSS interventions across the Mulit-Layered IASC MHPSS Intervention Pyramid:

IMC's activities across the multi-layered IASC Guidelines Intervention Pyramid:



Layer 4: IMC MH specialists (Psychiatrist, Psychologist)

- Case management (specialist services)
- Emergency response / Referral to MH treatment
- Support / Supervision for CMs and PHC providers
- Advocacy for MH care

Layer 3: IMC Social Workers

- Case management (non-specialised)
- MH care provided by PHC providers
- Support groups
- Outreach / home based Basic counselling / Emotional support / Problem solving
- Psychological First Aid
- Referral

Layer 2: Community volunteers

- Community awareness raising to refugee communities
- Community mobilization for support to vulnerable persons
- Parenting skills
- Youth Peer to peer and life skills initiatives
- Parent education/support groups
- Safe Space for Children
- Social Networking

Layers 1: Social workers, community volunteers, and community mobilizers

- Advocacy to service providers to provide services in "dignified" way
- Build awareness of community about available services
- Advocacy to assist vulnerable clients to access available services
- Initiatives and coordination with partners to ensure basic needs are provided

A key element of setting up MHPSS services is empowering the community and working towards supporting and developing local skills to directly provide community based psychosocial supports. Empowering the community to develop strengths and supports to help themselves, this includes:

- Participation of families and community in the design and implementation of various constructive activities ensuring that services and activities are set up appropriately and meet individual, family and community needs.
- Trainings of community members in facilitating community based activities such as child and youth safe spaces, Early Childhood development, community outreach support, parenting skills, and peer-to-peer support activities, through training of trainers and a peer leadership model.

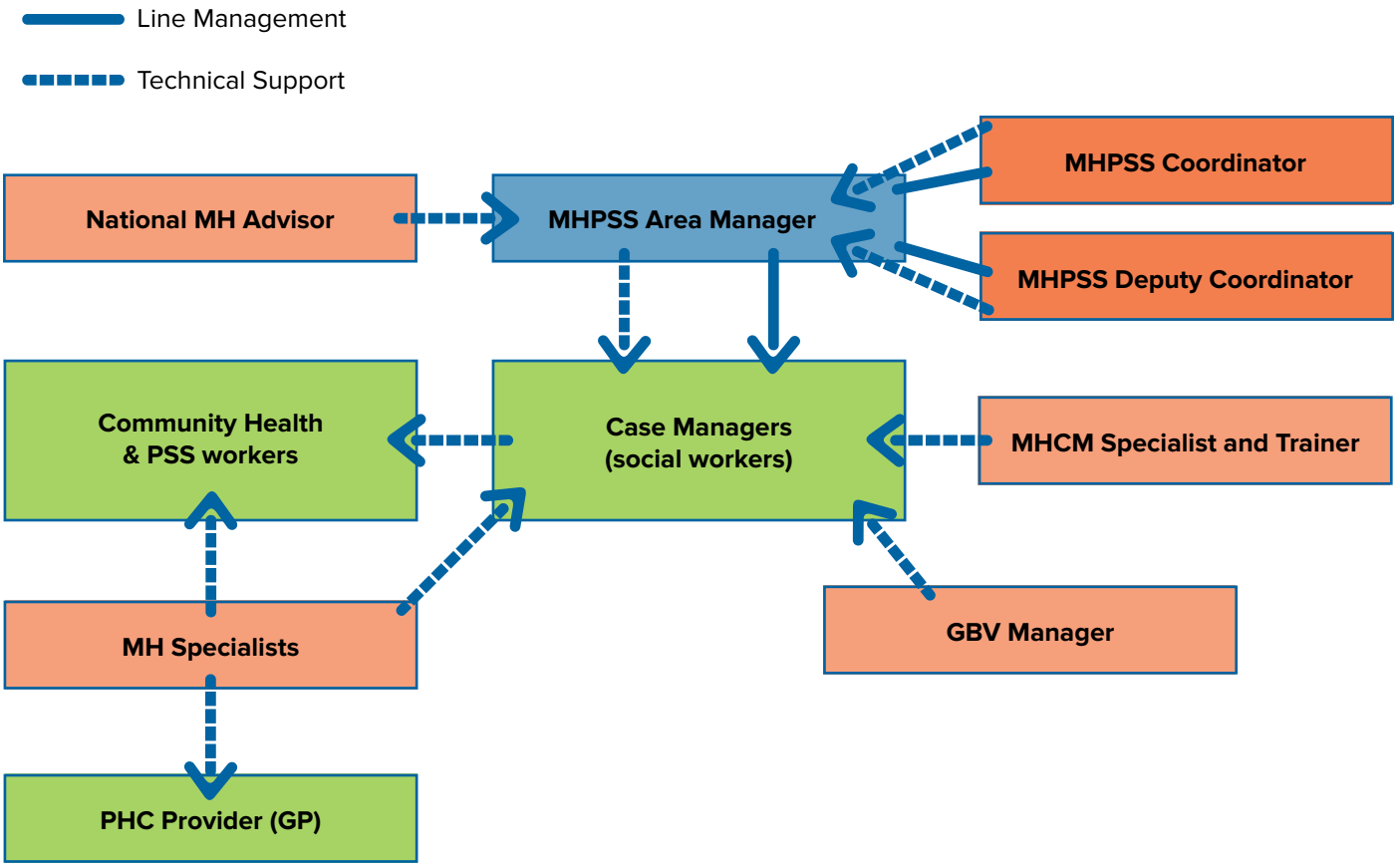
Referral Pathways

MHPSS programs should be conceptualized through a systems-based approach with multiple layers of complementary supports with functional referral systems between the different layers.
(UNHCR, 2013)

Coordinating Services and Referral Coordinating care both internally within IMC multi-sectoral and MHPSS service structures and between agencies is critical to meet the needs of refugees, displaced and vulnerable host populations. It is important to understand which layer of the IASC MHPSS pyramid IMC's activities and that of each agency fall under and who their operational partners are including which referral points exist for those requiring more specialized support.

IMC should also be aware of relevant national policies and guidelines that exist in Lebanon including mandatory reporting, professional licensing requirements, and national psychotropic drug lists. UNHCR has developed Standard Operating Procedures (SOPs) that are also relevant for IMC as an MHPSS actor and should be followed. Coordinating care, communication and referral within IMC's MHPSS levels of interventions and between service providers is especially important for cases requiring more specialized services such as intensive case management, mental health care, psychotropic medication or psychiatric hospitalization. A common referral form is available and was previously developed as part of the UNHCR and Restart co-chaired MHPSS sub-working group under health.

IMC Core Staff Structure and Levels of Service Provision



Stepped Care Levels of Integrated MHPSS and Basic Protection Services

The matrix below shows stepped care model of targeted beneficiaries, interventions, tasks, referral decisions points and documentation. It outlines which staff is responsible for what and at which level, what forms should be used for service provision, unified M&E indicators as well as what should be provided to beneficiaries at each level.

"In accordance with MHPSS Best Practices, IMC appoints community based psychosocial workers / case-managers, who serve as links between interventions on community level, interventions in the IMC supported primary healthcare centers, and more specialized interventions. They also assist people with mental health and psychosocial problems and their family in accessing appropriate services and supports."

Level of Support	Level 1 Community Interventions [IMC and non IMC services]	Level 2 Core Psychosocial Interventions [IMC core services]	Level 3 Pharmacological & Basic Non-Pharmacological Interventions [IMC core services]	Level 4a Pharmacological and Emergency Intervention [IMC and non IMC services] [Including MOH clinics with trained PHC providers in mhGAP as part of national mental health program]	Level 4b Complex Protection/GBV Interventions
Staff tasked with providing services	CHWs and Community PS workers (including facilitators of lower level community based support)	Case Manager (MH/ GBV training)	Psychologist	Psychiatrist Trainer National Psychiatrist GP (trained and supervised in MH)	GBV specialist/ GBV focal point
Target Beneficiaries	Refugee (primary target) and vulnerable host population	Individuals experiencing MH problems that impair functioning	Individuals with mental health problems	Individuals with MH problems in need of psychotropic medication or with severe MH issue (e.g. self-harm, severe MI). Clients are identified and referred by the Case Managers to a Psychiatrist.	Individuals with MH problems with severe or complex protection concerns

Level of Support	**Level 1 Community Interventions** [IMC and non IMC services]	**Level 2 Core Psychosocial Interventions** [IMC core services]	**Level 3 Pharmacological & Basic Non-Pharmacological Interventions** [IMC core services]	**Level 4a Pharmacological and Emergency Intervention** [IMC and non IMC services] [Including MOH clinics with trained PHC providers in mhGAP as part of national mental health program]	**Level 4b Complex Protection/GBV Interventions**
Criteria for Referral (regular, weekly)	To level 2: • Signs of psychological distress/MNS problems AND • Distress related impairment in day to day functioning	To level 3: 1. Severe/complex or does not improve over a one month period (using basic counseling and problem solving techniques) 2. Cases demonstrating risk to self, risk to others, risk of neglect or impending deterioration.	To level 4a: 1. 1-When medications are needed (Psychosis, Epilepsy, Moderate and severe depression, and Bipolar disorders) 2. Severe/complex or does not improve over a one month period (after discussion with CM) 3. Cases when underlying organic reason is suspected. 4. Cases demonstrating risk to self, risk to others, risk of neglect or impending deterioration. 5. Cases with complex comorbidity (comorbidity with serious medical conditions or comorbidity with other psychiatric disorders. 6. Cases with serious somatic symptoms, like severe loss of appetite or significant weight loss.	**1st line of referral from Levels 2 & 3:** GP (trained and supervised in MH), competency standards reached and maintained through ongoing support and supervision. • If trained GP (IMC or MOH) has not completed OTJ training and supervision, but completed theoretical training, referral can be made to GP under supervision of trainer/national psychiatrist. • If no trained GP in area, refer directly to national psychiatrist. • Emergency/ Severe cases referred to national psychiatrist. I	N/A

Level of Support	**Level 1 Community Interventions** [IMC and non IMC services]	**Level 2 Core Psychosocial Interventions** [IMC core services]	**Level 3 Pharmacological & Basic Non-Pharmacological Interventions** [IMC core services]	**Level 4a Pharmacological and Emergency Intervention** [IMC and non IMC services] [Including MOH clinics with trained PHC providers in mhGAP as part of national mental health program]	**Level 4b Complex Protection/GBV Interventions**
Tasks (Regular)	• Case finding • Provision of basic Psychosocial Support (e.g. listening, positive coping) • Follow-Up • Community Education • Service mapping (and updating) • Linking with internal and external services	Case Managers: • Conducting assessment (biopsychosocial and risk) • Develop Care Plan • Implement Care Plan • Assist in implementing safety plan (with MH/GBV specialists) • Conduct support and psycho-education groups • Follow-Up • Case discharge • Case documentation	Psychologists: • Mental health assessment and diagnosis • Mental health treatment plan and implementation • Follow-Up • Case discharge	MH team (national psychiatrist and mhGAP trained PHC doctors): • Conduct MH assessment for cases referred. • Formulation of the management plan (prescription of psychotropic medications, discussion of indicated psychosocial interventions with Case Managers and referral to other service providers). • Conduct training for the MH component for CHWs, Case Manager and PHC staff (detection and referral of mental health cases) • Conduct mhGAP training and on job supervision for PHC doctors (GPs) • Support MH case consultation.	• Conduct more specialized GBV assessment • Advise Case Managers on focused and basic GBV related tasks and interventions (depending on training level of CMs in GBV CM) • Suggest referral pathway to more specialized services as needed/ available
Criteria for Referral (Emergency-same day)	To National Psychiatrist/ MH advisor / GP: • Risk of harm to self or others • Suspected acute severe mental illness (e.g. psychotic episode) • Disclosure of sexual violence occurring within the past 48 hours.	To National Psychiatrist/ MH advisor / GP: • Moderate or severe risk for harm to self or others • Suspected acute severe mental illness (e.g. psychotic episode)	To National Psychiatrist/ MH advisor GP: • Moderate or severe risk for harm to self or others • Suspected acute severe mental illness (e.g. psychotic episode)	To Outside emergency care (hospital): • Acute and immediate risk for self-harm • Acute/severe mental illness episode that cannot be managed on site	TBD

Level of Support	Level 1 Community Interventions [IMC and non IMC services]	Level 2 Core Psychosocial Interventions [IMC core services]	Level 3 Pharmacological & Basic Non-Pharmacological Interventions [IMC core services]	Level 4a Pharmacological and Emergency Intervention [IMC and non IMC services] [Including MOH clinics with trained PHC providers in mhGAP as part of national mental health program]	Level 4b Complex Protection/GBV Interventions
Tasks (Emergency)	Referral and Linking with services	• Referral and Linking with Services • Risk Assessment (joint) • Basic safety protocol while linking (e.g. not leaving person alone, keeping safe) • Following up with monitoring and implementation of safety plan	Referral and Linking with services	• Risk assessment (joint with Case Manager) • Setting and implementation of safety plan (with Case Manager) • Making decision and arrangement for hospitalization if required	TBD
Training Needed	• PFA (1 day) • CHW MHPSS training (2 days) • Community Mapping and Updating • Referral	• MH case management • GBV case management (core) and protection framework • Basic Psychosocial Interventions (non-pharmacological interventions as per mhGAP regional priority conditions).		For GPs: identification, pharmacological and psychosocial interventions for mhGAP regional priority conditions	N/A
Training Process and Focal Points Training focal points are responsible for developing training materials and clear curriculum and for receiving input and sharing with other departments and HTU.	Training materials include WHO PFA guidelines and WHO mhGAP CHW guidelines Training focal points: Medical Unit (Medical Co-ordinator, Psychiatrist Trainers) Materials: CHW MHPSS training module (2 days) facilitated by Psychiatrist Trainers and National Psychiatrists.	Training materials include IMC MHCM materials from Jordan (adapted), IMC GBV materials (GBV team), Child Protection and mhGAP guidance on psychosocial interventions. Training focal points: Psychosocial department (CM), Medical Unit (Psychiatrist Trainers for MH disorders) and GBV (GBV Specialists).		Training materials include WHO mhGAP Intervention Guide and WHO mhGAP training slides and WHO supervision guide. Training focal points: Expat Psychiatrists and National Psychiatrists).	Training focal points: GBV Specialists.

Level of Support	**Level 1 Community Interventions** [IMC and non IMC services]	**Level 2 Core Psychosocial Interventions** [IMC core services]	**Level 3 Pharmacological & Basic Non-Pharmacological Interventions** [IMC core services]	**Level 4a Pharmacological and Emergency Intervention** [IMC and non IMC services] [Including MOH clinics with trained PHC providers in mhGAP as part of national mental health program]	**Level 4b Complex Protection/GBV Interventions**
M&E Indicators to track	**Minimum** • Number of activities • Types of activities • Number of beneficiaries (including breakdown of gender, age, type of refugee) • Beneficiary feedback and satisfaction with activities • # of referrals to Case managers • Number of house visits made by CHWs trained in PFA and GBV messages.	**Minimum** • Number of beneficiaries who received psychosocial support (including breakdown of gender, age, type of refugee) • # of sessions conducted by Case managers • Types of psychosocial support • Average percent of goal achievement (graded goal scale; target 60% for new grants) monthly • % of clients with improved functioning as measured by the Syria functioning scale for adults: monthly • % satisfaction of case management clients (sample taken every 2/ quarter) • # of referrals in and referrals out, disaggregated by age and sex	• Number of beneficiaries (including breakdown of gender, age, type of refugee, diagnosis) • Number of sessions • # of cases referred to psychological services.	• Number of beneficiaries (including breakdown of gender, age, type of refugee, diagnosis) • Number of sessions • # of cases referred to psychiatric services. For MH PHC Training: • # of doctors trained on mhGAP/ PHC unit. • % improvement in assessment and management of MH cases after mhGAP training (by on job supervision and follow up) • # of PHC staff trained on detection and referral of mental health cases.	Number of referrals
M&E Forms		• Case Manager weekly summary reports • Clinical audit sheets • Goal Achievement • Functioning Scale (part of Care plan) • Client Satisfaction Survey • GBV IMS data entry form (if trained) • Attendance logs, pre & post-tests, training reports.	• Clinical audit sheet (for # of cases referred • Clinical audit sheets (same as Case Manager sheet)	• Attendence logs (for mhGAP training , training of PHC staff) • ACE score sheets (for on job supervision) • Clinical audit sheet (for # of cases referred • Clinical audit sheets (same as Case Manager sheet)	GBV IMS forms and database

Level of Support	Level 1 Community Interventions [IMC and non IMC services]	Level 2 Core Psychosocial Interventions [IMC core services]	Level 3 Pharmacological & Basic Non-Pharmacological Interventions [IMC core services]	Level 4a Pharmacological and Emergency Intervention [IMC and non IMC services] [Including MOH clinics with trained PHC providers in mhGAP as part of national mental health program]	Level 4b Complex Protection/GBV Interventions
Service Provision Documentation and Forms	• Activity sheet / report (general) • Referral form (general with verbal consent) passed on to Case Managers through weekly joint CHW & Case Manager meetings. • For suspected GBV cases, survivor is directed to the nearest health facility.	• Consent and limits of confidentiality form (verbal consent) • Bio-psychosocial Assessment • Risk assessment and Safety Plans • Care Plan • Progress Note • External/Internal Referral form • Clinical audit sheets • Discharge Form	• Progress Note • Contribution to care plan during weekly CM team meetings	• MH Assessment form • Progress Note • Contribution to care plan during weekly CM team meetings	TBD • Progress note
Focal Points for Forms Forms focal points are responsible for collating input and requests for changes in forms (from all other relevant departments and TU) and for ensuring that any changes are communicated and implemented across sites	Forms focal point: MHPSS (MHPSS Coordinator and Deputy Coordinator)	Forms focal point: MHPSS (MHPSS Coordinator and Deputy Coordinator)	Forms focal point: MHPSS (MHPSS Coordinator and Deputy Coordinator)	Forms focal point: MHPSS (MHPSS Coordinator and Deputy Coordinator) MH Assessment: MHPSS Advisor	Forms focal point: GBV Specialist

Referral between levels

Clients should be managed at the lowest level of care possible and should move up or down levels depending on needs (stepped care model). The Case Managers play the primary role in monitoring client progress and advising on shifting clients up and down levels of care up to discharge in consultation and under supervision of technical advisors of the care team (National Psychologists, National Psychiatrists, GBV Manager, MHPSS advisor).

Coordination

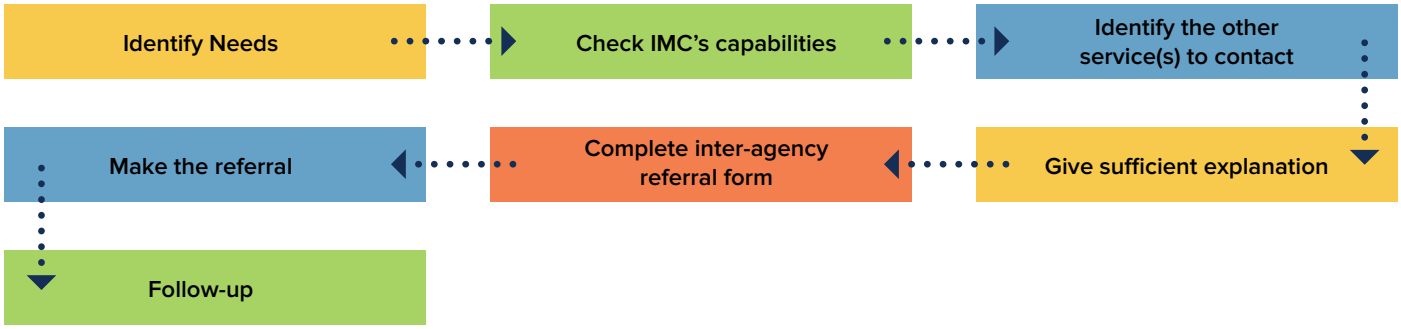
A minimum of one multi-disciplinary team meeting per week should be held (involving all staff listed above) to discuss clients, needs and coordinate services. The case manager should take a lead in coordination between service providers and among team members.

External Referral Pathways (Between IMC and other agencies)

Referrals can be made to and from MHPSS and non-MHPSS service agencies. There are two types of referrals: linking and transferring.

- "Transferring" a client means that you do not provide services to the client, but rather you direct them to another service because their need does not fit with your agency. Simply send or accompany the client to the other, appropriate service provider.
- "Linking" is the type of referral that is made when you bring in other services and add them on to the ongoing services you provide the client. That is, you continue seeing the client and the referrals you make add on new services in addition to the services your agency provides.

Steps in the Referral Process



Step 1: Identify Need(s)

Step 2: Identify whether or not IMC is able to assist with person's his/her need(s).

- If IMC is able to address the person's needs, begin doing so.
- If IMC is not able to adequately address all of the person's problems/needs, continue to step 3.

Step 3: Identify the other service(s) to contact.

- Which agencies are responsible for this need?
- Contact the service(s) to find out whether or not they can help this person.
- Confirm the other services' eligibility and admission criteria.
- Confirm other services' contact information.
- Verify date person would be able to receive services.

Step 4: Explain the referral to the person being referred.

- What? When? Who? How? And why?
- Given honest and complete information about possible referrals for services.
- Acquire informed consent for referral.
- Parental consent should be obtained in cases including children.
- The person can choose to not be referred.
- Certain protection cases require referral even without consent. Person being referred is still informed of the referral in this case.

Step 5: Complete the inter-agency referral form.

Step 6: Make the referral.

Step 7: Follow up to make sure services have been received.

Receiving a Referral

When a person is referred to IMC, these are the steps to follow:

- Review the referral form.
- According to the information on the form, does IMC have the capacity, services and resources to serve him/her?
- Verify the information on the referral form with the person being referred.
- Discuss with the person if you wish to seek further information from the referring agency or if there will be follow-up between the agencies.

IV. MONITORING AND EVALUATION

Who Should Be Involved With M&E

Monitoring and evaluation is everyone's responsibility. Although some IMC projects may have a staff member who is specifically responsible, all those engaged with the project should be involved with the process. Feedback and suggestions from community members are vital, for example, to ensure the relevance and quality of the activities as well as to provide indications of the overall impact of the intervention.

What Indicators Should Be Collected, And How?

Indicators on activity processes and outcomes should be culturally appropriate and collected in an informed and ethical way based on IASC guidelines and other guidance such as the WHO/UNHCR Assessment Toolkit and the Regional Refugee Response Plan (RRP) for Lebanon. This includes staff being aware of the types of indicators that need to be collected, the rationale behind data collection, sharing of current data and lessons learned with other agencies, as well as involving beneficiaries in defining indicators and feedback. Indicators should be useful and consistent across projects and different IMC proposals to the extent possible. IMC should also advocate for consistent reporting of mental health cases in line with the WHO/UNHCR Mental Health HIS categories among agencies through relevant platforms such as the National Technical Task Force on Mental Health lead by the National Mental Health Program of the Ministry of Heath.