Response International

Mental Health Needs Assessment in Palestinian Refugee Camps, Lebanon

Final Report

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1. INTRODUCTION

It is patently obvious that the life of the refugee is subject to a number of stressors, some of which are absent in the lives of the indigenous population. It is true that the indigenous Lebanese population also experiences a high level of stress, but for the refugee the problem is compounded by a number of factors.

Stress manifestations, in addition to the expected level of functional, psychotic and other mental disorders, pose specific problems to those responsible for the health of this community, not least with those experiencing these problems first hand as carers. But rather than responding to this issue with appropriate resources, this vulnerable population, like many other vulnerable populations, is one of the least well served by coordinated health interventions. All facilities, including UN, are aid-dependent, whether from governments, charitable bodies or donating foundations. Sources of funds are finite and their use is subject to decisions as to priority.

Of necessity, food, housing, education and general health and security are at the top of the priority list. When even funds for these are below the desired level, less attractive issues, however needy, receive little or no allocation. In its report "Utilization of Healthcare Services Among Palestinian Refugees in Camps in Lebanon", the United Medical Group (2004) concluded that, "there are certain services such as physical rehabilitation, mental and psychological health that are not provided by any provider". They recommended that, "any future donor investment should focus on addressing unmet health and health-related needs including early detection and management of disabilities, psychological counselling and support to at risk groups……..".

In response to these conclusions, the lack of detailed mental health data and the lack of a dedicated mental health service, Response International (RI) undertook a comprehensive assessment of mental health needs within the refugee camps and larger "gatherings". This assessment informed a series of awareness raising workshops for UNRWA managers, field staff and wider population, and identified areas of concern within existing services. This information will be used to plan, and secure the funding for, a mental health training programme for a multidisciplinary group of UNRWA health, education and social care workers, and staff from NGOs with an interest in these issues. RI's relevant experience in Lebanon and elsewhere is detailed in Appendix 1.

Changing attitudes and behaviour in relation to mental health and illness will inevitably take some time. However, it is anticipated that, at the end of the resulting training programme, accessible community mental health workers will be available in all 12 camps in Lebanon, able to: promote mental health; identify mental illness at an early stage; provide simple therapeutic interventions; and provide community-based support for those with enduring mental illness.

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2. BACKGROUND

Palestinian Refugees in Lebanon – Historical Background

On 29th November 1947, the United Nations announced a Partition Plan for Palestine. This caused a breakout of violent conflict between Palestinians and the Israeli-British alliance. The Arab Palestinians were driven away from their homes from 15th May, 1948. Groups of Palestinian refugees moved to Lebanon in several phases.

1947

In the summer of 1947, individual families had gone to Lebanon for vacation. They extended their vacation with the outbreak of conflict, but expected to return when it was all over. However, they remained in Lebanon as refugees. This group has a legitimate right of residence and therefore they have special identity cards and travel documents. In the winter of 1947, at least 100,000 Palestinian refugees went to the south of Lebanon. They gathered in the Tyre district and used Bourj El Shamali and Rashedeyya Camps as transit from which they went to camps elsewhere in Lebanon.

1948

After a short period of allowing entry of the Palestinian refugees who were running away from Israeli attacks in the summer of 1948, the Lebanese government closed the southern Lebanese borders and considered all new Palestinian refugees as illegal entrants. The conditions imposed by the Lebanese forced many refugees to go back to their villages in order to regain their possessions so as to provide for their families. However, the migration of northern village inhabitants continued because they were continuously exposed to attacks, in spite of a cease-fire declaration.

1949

The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) was established by the UN General Assembly – Resolution 302(V) – in December 1949. It is the primary international body mandated to provide assistance to Palestinian refugees. In May 1950, the Agency officially took over the humanitarian relief operations in the Jordanian-controlled West Bank, Egyptian-controlled Gaza Strip, Jordan, Lebanon and Syria.

1956

In 1956, Britain, France and Israel launched a combined attack on Egypt. The Israeli military forces occupied Gaza (which was then under Egyptian control) and killed many Palestinians. As a result, a number of inhabitants migrated to Egypt and Syria; and about 5,000 refugees went to Lebanon by sea. The Lebanese government granted them a white residence card issued by the Lebanese General Security. However, UNRWA did not agree to transfer their names from Gaza to Lebanon and therefore they were prevented from using its services. They obtained laisser-passer documents which enable them to move and travel. Later they were given the right of family reunification, but this was only rarely carried out by the Department of Refugee Affairs.

1967 onwards

This phase started with the fall of the West Bank and Gaza Strip under the Israeli occupational force in 1967 and with the establishment of the Palestinian resistance movement. A number of the movement's members and leaders went to Lebanon, whether in camps or bases of the movement. Their number increased after the campaigns in Jordan including 'Black September (Aylool) in **1970** and Jerash in **1971**, which drove the resistance movement away from Jordan. As a result, many of the movement's leaders and fighters went to the south of Lebanon. Subsequently their

number increased after the outbreak of civil war in Lebanon in **1975**. However, due to the Israeli invasion of the south of Lebanon in **1982**, many of these Palestinians (about 14,000 refugees) fled to Tunis, Libya, Sudan, Yemen and Syria. Some stayed in the north and Beq'a district and some of those who left have since returned to Lebanon. Due to the conflict between FATEH factions in **1983**, many of these movement members (about 5,000 refugees) moved again with their families. But, at the same time, the camps in Beirut and Tyre were attacked and therefore many families were forced to leave either within or outside Lebanon. Persecution, detention and torture were common at this time. In Shatilla and Sabra camps in Beirut, thousands were massacred. Those in this latter group, in addition to all the Palestinians who were expelled later, were not registered in the official records, were not given any identification documents and were not included in any statistics. Their residence is considered illegal by the Lebanese government.

Palestinian Refugees in Lebanon – Current Situation

Of the original 16 official camps in Lebanon, three were destroyed during the years of conflict and were never rebuilt or replaced: Nabatieh camp in south Lebanon, and Dikwaneh and Jisr el-Basha camps in the Beirut area. Most of the displaced refugees in Lebanon, approximately 6,000 families, are originally from these three camps. A fourth camp, Gouraud in Baalbeck, was evacuated many years ago and its inhabitants were transferred to Rashidieh camp in the Tyre area.

The number of Palestine refugees registered with UNRWA in Lebanon is currently **394,532**, or an estimated 10% of the population of Lebanon. Of these, **223,956** actually live in the 12 remaining camps. The rest live in and around Lebanon’s major urban centres, often in the environs of official camps. While all of UNRWA's services are available to both camp and non-camp residents, the latter receive no public services and often suffer from their isolation. Lebanon has the highest percentage of Palestine refugees who are living in abject poverty and who are registered with UNRWA’s "special hardship" programme (12% of the total): the most disadvantaged and vulnerable refugees, such as women whose husbands have died or whose husbands have divorced or abandoned them, the elderly, the chronically ill, refugees with disabilities, or the very young, are provided with direct material and financial assistance under this programme. There are a further **10,092** unregistered refugees in the camps. In effect, these refugees have no rights to any assistance whatsoever.

Palestine refugees in Lebanon face specific problems. They do not have social and civil rights, and have very limited access to the government's public health or educational facilities and no access to public social services. The majority rely entirely on UNRWA, supported by local and international NGOs, to provide education, health, relief and social services. Considered as foreigners, Palestine refugees are prohibited by law from working in more than 70 trades and professions. This has led to a very high rate of unemployment amongst the refugee population.

All 12 official refugee camps in the Lebanon Field suffer from serious problems - living conditions are characterized by high population densities and inadequate basic infrastructure, with open sewers, limited supplies of clean water and unsatisfactory drainage systems which make flooding commonplace in the often harsh winters. In addition, the years of conflict and hostilities, and the feeling of an insecure future all

affect the health of the refugees. Non-communicable diseases such as diabetes, hypertension, cardiovascular diseases and cancer are all on the increase. Birth rates are among the highest in the world and intervals between births are short, thus affecting women's health. Diarrhoea and intestinal parasites, particularly affecting children, are highly prevalent due to poor environmental conditions in the camps. UNRWA remains the main provider of basic health care, and provides assistance towards the cost of secondary medical care at a variety of public, non-governmental and private hospitals. However, with the rise in hospital costs in the 1990s, and a reduction in the Agency's budget, UNRWA has been forced to increase the percentage of cost sharing by the refugees themselves to between 12-40 per cent of treatment costs, as well as limit the number of referrals and discontinue reimbursements for certain treatments. This has caused particular problems in Lebanon, where most of the refugees are unable to cover their share and so cannot get the treatment they need.

Map to show the twelve official Palestinian refugee camps in Lebanon

Key data relating to each of the 12 camps is provided in Appendix 2.

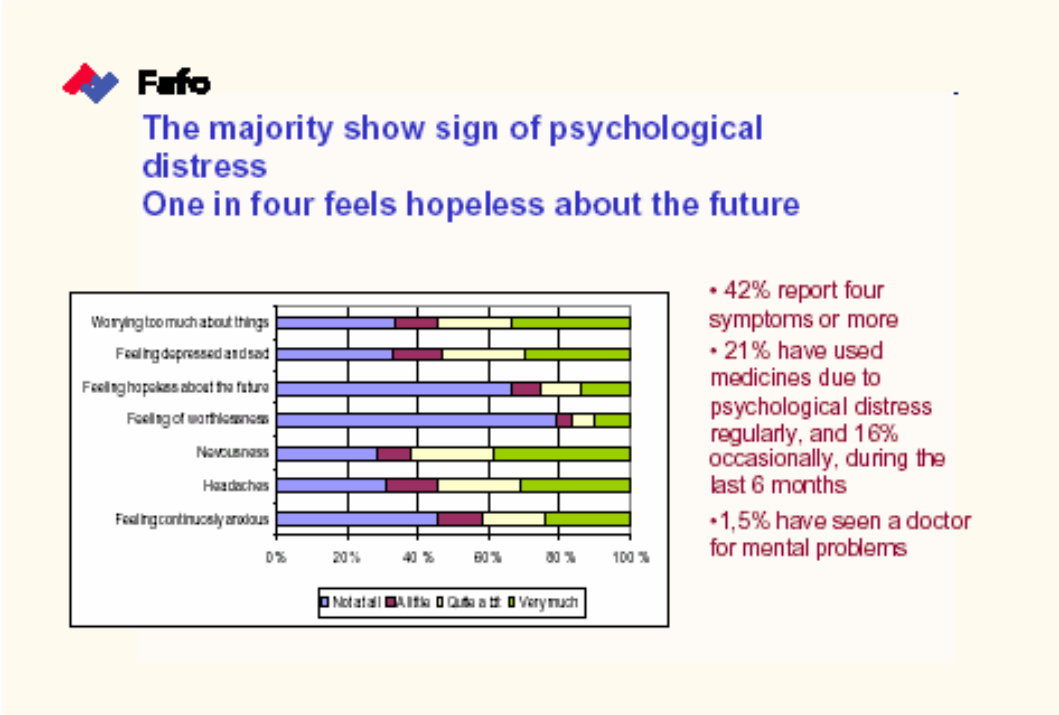
3. JUSTIFICATION FOR THE NEEDS ASSESSMENT

The UNRWA Health Division Annual Report of 2003 states, "7. **A programme of psychological counselling and well being** was implemented in *Gaza Strip and the West Bank within the framework of the Agency's programme of emergency humanitarian assistance to the occupied Palestinian territory. However, the human and financial resources available to the programme are limited and there is* ***need to integrate this programme within the Agency's regular programme activities in order to ensure its future sustainability, and possibly, expand it to other Fields".***

A mental health needs assessment project was proposed by the International Federation of Red Cross and Red Crescent Societies in 2003 as part of its comprehensive Mental Health Programme for the Palestinian community. However the IFRC subsequently focussed the programme on the West Bank and Gaza Strip. The Palestinian families living in Lebanese refugee camps have experienced displacement and lengthy periods of conflict, and now face a daily battle for survival with little immediate prospect of a change in fortune. Most have suffered bereavements and disability as a result of conflict and disease. Successive generations of children are growing up in a situation that is both abnormal and demoralising. Family life, play, education, the opportunity to travel and widen horizons have all suffered and will have a lasting effect into maturity. Women, who are already disadvantaged through the lack of educational opportunities, have further suffered from broken families, the death of husbands and fathers, poverty, reduced marriage prospects and the absence of accessible reproductive health care. The lack of employment opportunities creates greater poverty and further reduces self-esteem among those searching for work.

In times of stress people develop coping mechanisms to deal with their situation. However, these coping mechanisms break down with time and the disintegration of normal social support networks. This contributes to the high level of stress-related illness within the refugee community, and to the disturbing increase in cases of severe mental illness (depression and psychotic illness). Although UNRWA and local/international NGOs provide basic primary healthcare services within the camps, there is no specialist mental health service, either hospital-based or in the community. This means that the prevention, identification and management of mental illness is haphazard at best, and often non-existent. There is one trained mental health nurse working in the UNRWA Poly-clinic in Sidon, one peripatetic nurse with mental health training and the "medic" at Sibline Vocational Training Centre is also a trained mental health nurse (but not employed as such). Referral of overtly mentally ill for assessment in Lebanese Mental Hospitals is possible, although the referral procedure is not generally known or followed consistently. Those presenting with somatisation of stress are generally offered medication for their physical presentations, such as analgesics, ant-acids, or hypnotics. The doctors have insufficient time to enter into discussions on stress and its management, even if they had skills to do so. Clinic nurses, whilst having more opportunity to do this, lack skills or the encouragement to gain them.

A recent study of Palestinian refugees identified that a significant proportion exhibited feelings of hopelessness and helplessness (FAFO 2002). These are well documented predisposing factors in the development of such things as anxiety states and depression. They also contribute to the emergence of many serious forms of mental illness.



UNRWA health and social care workers are painfully aware of the lack of mental health care provision within Lebanese camps. However, they are handicapped by the lack of any specialist mental health training and the lack of meaningful mental health data from the camps. Response International was approached by UNRWA's Chief of the Field Health Programme and asked to consider ways in which these needs could be addressed.

4. FRAMEWORK FOR THE NEEDS ASSESSMENT

According to the United Nations, "Everyone in need should have access to basic mental health care" (UN Principle 1(1)).

1) Mental health care should be of adequate **quality**, (UN Principle 1 (1) (2):
   a) Preserve the **dignity** of the patient (UN Principle 1 (2);
   b) Take into consideration and allow for techniques which **help patients to cope by themselves** with their mental health impairments, disabilities and handicaps;
   c) Provide accepted and relevant **clinical and non-clinical** care aimed at reducing the impact of the disorder and improving the quality of life of the patient;
   d) Maintain a mental health care **system** of adequate quality (including primary health care, outpatient, inpatient and residential facilities);
2) Access to mental health care should be **affordable** and **equitable**;
3) Mental health care should be **geographically accessible**:
4) Mental health care should be available on a **voluntary** basis as health care in general (UN Principle 15 (1);
5) Access to health care, including mental health care, is contingent upon the **available human and logistical resources**

In addition, **The World Health Report of 2001** recommended "**ten feasible solutions**" to address current and future mental health needs. None of these recommendations is beyond the reach of countries. These recommendations can help close the gap between the current mental health situation and that which can be achieved:

1. Provide treatment in primary care
2. Make psychotropic medicines available
3. Give care in the community
4. Educate the public
5. Involve communities, families and consumers
6. Establish national policies, programmes, and legislation
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support more research

The following, derived from both of the above, was used as the framework for this analysis:

1. Promotion of mental health and prevention of mental illness as a cross sector responsibility (ie. health, social services, education)
2. Education of the public
3. Access to basic mental health care as part of primary care provision
4. Provision of care in the community involving communities, families and consumers
5. Mental health assessment in accordance with internationally accepted principles
6. Respect for human rights of the mentally ill individual (consent, self-determination, restraint, admission etc).
7. Establishment of policies, procedures, programmes and legislation
8. Availability of a range of psychotropic medicines
9. Development of human resources
10. Monitoring, evaluation and research
11. Vulnerable groups

The following definitions of concepts were used throughout:

Health	"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"	WHO Alma Ata, 1978
Mental Health	A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community	WHO Fact Sheet 220 Revised November 2001
Mental disorder	"The mind expressing its discomfort through thoughts, feelings and behaviours" 25% of individuals develop one or more mental or behavioural disorders at some stage in their life, in both developed and developing countries. Most disorders can be diagnosed reliably and accurately as the common physical disorders; some can be	Burgess, 1990 WHO Fact Sheet 220 Revised November 2001

	prevented, all can be successfully managed and treated	
Mental Health Promotion	Mental health promotion is an umbrella term that covers a variety of strategies, all aimed at having a positive effect on mental health. The encouragement of individual resources and skills and improvements in the socio-economic environment are among them.	WHO Fact Sheet 220 Revised November 2001

The definition of health was re-affirmed by WHO in the Declaration of Alma-Ata in 1978 (International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 – Education Policy for Health for All). That declaration went further, emphasising that health "is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector." (Paragraph I)

5. OBJECTIVES AND STRUCTURE OF THE NEEDS ASSESSMENT

Key objectives were as follows:

- To undertake a comprehensive assessment of mental health needs within the refugee camps.
- To use this assessment to inform a series of awareness raising workshops for UNRWA managers and field staff, and identify areas of concern within existing services.
- To use the assessment and feedback from the workshops to plan, and secure the funding for, a mental health training programme for a multidisciplinary group of UNRWA health, education and social care workers and workers in associated NGOs.

RI staff developed a network of key UNRWA and NGO staff at national, regional and camp level in order to facilitate the collection of data related to mental health issues. Data were collected according to the agreed framework and using standard documentation. Information was gathered from each of the 12 Palestinian refugee camps in Lebanon. All data were entered into a central database. Anecdotal and narrative information was also used to supplement quantitative data. Although the project funding was not agreed until mid-April 2005, work commenced as early as October 2004 and continued until the end of September 2005. Key elements were as follows:

- Initial meetings with UNRWA Deputy Director and Division Heads to gain approval and consult on strategy
- Agreement with UNRWA on data collection strategy
- UNRWA wrote to all health clinics to prepare for visits and data collection
- Visited UNRWA Area Officers
- Visited all UNRWA Medical Clinics – initial interviews
- Re-Visited to collect data forms
- Re-Visited to assist with Anxiety Questionnaires

- Other visits to clarify issues and collect further data
- Key schools visited and teachers interviewed
- All relevant NGOs visited and interviewed
- A number of patients with mental issues followed through their journey through the "system"
- Pharmacies visited and staff interviewed
- Links formed with Beirzeit University and WHO on formulation of version of WHO Quality of Life Questionnaire (Brief)
- Focus groups held on WHOQOL to test validity of questionnaire
- Data from Beck Anxiety Inventory entered into database
- All other data collected and analysed using objective analytical framework derived from UN and WHO papers
- Interim report made to KRSF and UNRWA
- Recommendations and training proposals shared and discussed in workshops of UNRWA and NGO staff
- Final report drawn up and disseminated to UNRWA senior managers and participating NGOs

6. RESULTS OF THE NEEDS ASSESSMENT

The results will be presented according to the agreed framework:

i). Promotion of mental health and prevention of mental illness as a cross sector responsibility (ie. health, social services, education)

The reminders of the definitions are given above because they are not always evident to all concerned. This is because the term "health" is invariably used to denote issues related to sickness and ill-health. Thus the term "health clinic" really refers to a sickness clinic. Healthy people do not generally attend a health clinic to learn how to stay healthy. They go because they perceive their health as being compromised to the point where they feel they are in need of some intervention by a health professional to make them "well".

The ability to intervene when a person is sick is vested in healthcare professionals. However, the responsibility to promote and maintain health rests with all members of a community, not least is the individual responsibility for ones own heath and well-being.

Mental health is an integral component of whole health, alongside physical and social health. It cannot be divorced from the other components. All three are part of a dynamic state of relationship between the individual and environment. At any time, that state can be threatened by a number of factors (internal and external). Mental health promotion, therefore, like any other health promotion "covers a variety of strategies, all aimed at having a positive effect on mental health. The encouragement of individual resources and skills and improvements in the socio-economic environment are among them."

The socio-economic environment of the Palestinian refugee is perceived by most as presenting a threat to their mental health. Initiatives to promote mental health must go

hand in hand with moves to improve this environment. However, there are obvious limitations to how much camp life can be improved. It is not acceptable to dismiss all efforts to improve mental health in the face of these limitations. Forty-eight years have passed and the Palestinian refugee situation is still considered by many to be a "temporary" problem. It is possible to make an improvement if strategic initiatives are taken. These initiatives demand cooperation between all sectors, disciplines and the general population.

Health professionals do not have the monopoly on health. Indeed, their very existence, in the most part, depends on the continued incidence of ill-health. But the impact on the community of a mentally healthy population pervades into all aspects of life from conception to grave.
For example:

Stage of Life	**Mental Health Issue**	**Key People**
Conception	Risk of genetic or congenital mental health problems	Genetic counsellors
Pregnancy	Risk to foetus	Ante-natal midwives: Dieticians; smoke cessation counsellors
Birth	Risk of birth injury or anoxia	Midwives, obstetricians, paediatricians
Infancy	Need for stimulation and play in safe environment	Parents, nursery nurses
Childhood	Need for education in safe environment	Parents, teachers
Adolescence	Need to develop personal identity	Parents, teachers, peer group
Young adulthood	Need to be employable, to find a partner, to be independent	Teachers, mentors, employers, civic society
Middle age	Issues of being a parent, of passing on experience, of being a leader	Children, colleagues, workforce
Retirement	Issues of loneliness, physical health, status, bereavement	Children, friends, ex-employers, leisure activity providers
Old age	Thoughts of death of self and others, frailty, sensory impairment, confusion	Children, professional carers, specialist helpers
Dying	Fear, preparation, incapacity of carers	Spiritual advisors and counsellors, residential facilities

In the face of all the undoubted factors that lead to mental ill-health, it may be more profitable to identify why some people manage to cope better than others and retain their health. The answer may be a combination of personality type, coping mechanisms, social support and education. Personality type is fairly well established early in life. Parenting and teaching styles may play a role. Coping mechanisms develop as a result of learned behaviours. Again these can be influences by parents and teachers. Social support networks are built by everyone. Some are better at this

than others. The ability to network and take responsibility for oneself are learned mainly in childhood and adolescence. Education is a life-long activity. In general, the more a person knows about their body and its responses to stress and effects of stress reduction, the better they are to survive life's knocks when they occur in the various critical stages of life.

As far as UNRWA staff is concerned, the Social Services and Education Divisions seem to have more key roles in the promotion of mental health than does the Health Division. However, the staff of the Health Division is also well placed to see those exhibiting the effects of mental ill-health, especially stress-response it manifests itself in somatic symptoms presenting at Health Clinics. If mental health promotion and prevention of mental ill-health are seen to have benefits for the whole community, then the development of human resources will be given higher priority. Promotion and management of mental health requires expertise from a number of disciplines, working together in teams dedicated for that purpose. These teams typically include: family doctors; psychiatrists; psychologists (educational/clinical); mental health nurses; mental health social workers; and counsellors, as well as teachers, community workers and mental health lawyers. Each of these professions has its own set of skills developed as a result of initial training, experience and on-going professional development. The work of this team would be enhanced by the mobilisation of community groups made up mentally ill, their families and anybody else with and interest.

Recommendations:

A. An action team should be formed to address mental health promotion, drawn from representation across sectors. Where expertise does not exist, consultants should be employed to inform and focus discussions and direct action.
B. A cross-sector mental health training programme should include elements of health promotion and prevention.

ii). Education of the public

There is no coordinated initiative for education of the public in matters related to health. Most health practitioners see their role as diagnostic and treatment orientated, rather than informative, empowering and preventative. Some local, national and international NGOs do hold regular sessions in the camps for groups such as women. Others hold sessions in response to national and international campaigns related to specific issues such as cancer, smoking, diabetes, heart disease, nutrition etc. There is no evidence of any campaign to address the issue of mental health. Most agencies indicate that they would welcome specialist assistance in addressing mental health issues with their clients and staff.

Apart from general awareness of mental health issues, those who care daily for mentally ill relatives need specific support and education to carry out their role and complement the work of professional staff.

Recommendations:

C. Public meetings should be held to raise awareness of mental health and its prevention and promotion; the early detection of stress induced and other

psychological disorders; and the procedure for accessing appropriate assistance and care.

D. NGOs should be mobilised to complement such activities amongst their staff and clients.

iii). Access to basic mental health care as part of primary care provision

In its Annual Report of 2003, UNRWA's Department of Health asserted the following: "The UNRWA health programme places special emphasis on implementing effective prevention/promotion primary health activities". UNRWA also asserts that it work reflects the implementation of UN Principles. The UN principles related to mental health are listed above, and will be dealt with individually:

Mental health care should be of adequate quality

Doctors working in all UNRWA clinics see a large number of patients in each session. A large proportion of these consultations are for physical signs and symptoms associated with responses to stress (somatisation). Some patients attend with no rational cause at all other than for the need (born out of social isolation) to meet and chat with others in the waiting rooms. The result is that doctors are overwhelmed by sheer numbers of people they see and that each patient only sees a doctor for a very brief time, insufficient in the main to assess other than the overt presentation and to enter into a meaningful therapeutic relationship. Most consultations result in the issue of a prescription. In the case of somatisations, this often serves to reinforce the patients' beliefs that they have a primarily physical disorder. Despite the doctors' best intentions, they can offer little in the way of counselling or advice on stress management. The issue of large crowded waiting rooms and its consequences continues unabated. Many doctors interviewed were showing signs of stress themselves.

Prolonged unmanaged stress undoubtedly leads to many presenting with general or focussed anxiety and other chronic neuroses. Some of these may also go on to develop altered personalities and psychoses. All are at risk of an overlying clinical depression, exacerbated by the hopelessness of feeling that nobody cares or understands. All are also at risk of chronic physical conditions associated with stress ie. hypertension, duodenal ulcers and diabetes. Those who are aware of their stress and its consequences hide that fact because of the risk of being labelled a "mental case". The stigma attached to such a label prevents people (especially men) from exposing their true feelings and anxieties. The label of the physical condition "hypertension" is more acceptable and attracts more sympathy from relatives and friends than a less understood diagnosis of a mental illness such as "chronic anxiety state".

As part of this project, a sample of those patients attending UNRWA clinics completed a short questionnaire which gives a crude index of anxiety level (Beck Anxiety Index). Predictably, the results show that there is a high proportion with identifiably high levels of anxiety, even in those who are not attending with any overt medical disorder.

Each UNRWA clinic maintains a register of patients with a diagnosed mental illness. The incidence of psychotic illness is probably similar to that in any similar

population. However, these registers are of limited value. They are used to provide UNRWA Field Medical Chief with a monthly report. However the description of the diagnoses is crude, bearing little relationship to the WHO International Standard Diagnosis criteria. It does not break down patients by sex and there is no indication of follow up beyond initial diagnosis. Each register contains a significant number of patients with a diagnosis of "epilepsy". This seems to assume that patients with epilepsy are deemed to have a mental illness rather than a neurological disorder. It may be that some of these have associated depression, anxiety or other disorder, but this is not evident in the register. This issue is a reflection of the lack of distinction when public and some professionals refer to psychiatrists and neurologists (or even psychologists), let alone psychotherapists and counsellors.

There is a procedure for referral to specialised consultation. However, this procedure is not well known or followed by medical officers or other health workers. Any UNRWA medical officer may refer a patient directly to the psychiatrist at Dar El Salib Hospital in Beirut. The patient pays a 200 000LL consultation fee. This is not reimbursed by UNRWA. This consultation may result in initiation or change in treatment and/or admission to hospital for observation and/or treatment. There are four standards of treatment and care in the hospital depending on the ability to pay. Palestinians invariably receive care conditions of the basic level.

Preserve the dignity of the patient

As in many countries of the world, the label "mentally ill" is regarded as something of a stigma. Mentally ill may be the subjects of derision, ignorance, fear and shame. It is important that healthcare workers do not fuel these feelings but take steps to maintain patients' dignity. Privacy and confidentiality are often lacking in both waiting and consulting rooms. Conversations are held in the presence or ear-shot of others and it is not uncommon for interruptions to be made or of more than one patient to be seen at the same time. This again creates difficulties for patients who may want to reveal real anxieties, fears or other, more bizarre symptoms, to a busy medical officer.

Take into consideration and allow for techniques which help patients to cope by themselves with their mental health impairments, disabilities and handicaps

The ability to cope by oneself with mental health impairment depends on the availability of clear information and advice, the ability to understand and assimilate that advice and the resources available to use it. The availability of information and advice is a product of staff trained both in mental health, health promotion and communication. This is not merely in the domain of medical staff or other healthcare workers. Social workers, teachers and other community workers are also potential vehicles for this. Cycles of anxiety and distress can be modified by interventions from wide sources, not least by public education. The resulting neurotic conditions may be preventable or at least more manageable if people understand their own stress responses and simple techniques in reducing them. This again demands a cross-sector approach aimed at empowering individuals and groups.

Provide accepted and relevant clinical and non-clinical care aimed at reducing the impact of the disorder and improving the quality of life of the patient

This is largely covered in other sections, but emphasises the importance of having a range of clinical and non-clinical options. The quality of life issue is central to

promotion and maintenance of mental health. Quality of life measurement tools for use with groups have been developed by WHO. A version of the WHO Quality of Life (Brief) Index will be developed as a result of this project and that development and its use are discussed below.

Maintain a mental health care system of adequate quality (including primary health care, outpatient, inpatient and residential facilities)

No matter how adequate the parts of the health system operate, they do not serve the best interests of patients and clients if they do not act in a coordinated fashion. This may be the case with Palestinian refugees. When a client is in a vulnerable position and acting out of fear or ignorance, he is not able to make dispassionate choices as to the best course of action. Each agency and division response for responding to health needs should be able to call on the services of other agencies with speed and with clear procedures. These procedures need to be agreed, published and disseminated among professionals and non-professional staff and those using the service.

Although primary health care facilities are available in each camp on a full or part-time basis, there is no specialist mental health primary care team to respond to crisis situations. Mental health is largely marginalised from mainstream primary health care. Patients with mental health problems are referred, often without adequate risk assessment, to outpatient, inpatient and residential facilities centred mainly in Beirut. A crisis intervention team would be able to effectively respond to high risk situations. This type of service would be able to support patients and their carers and lessen the incidence of need to refer to services some distance away, reduce the need for admission to hospital, and, in some cases, reduce the risk of self harm or harm to others.

Access to mental health care should be affordable and equitable

Access to mental health care for Palestinian refugees depends on the advice given to the patient and the family. Although mental health care is funded by UNRWA as available through its camp medical clinics, access to any specialist facilities incurs a cost in terms of transport, time and non-refundable consultation fees. Consultation with a psychiatrist entails a trip to Beirut, usually accompanied by a family member. For those living in Beirut, this expense is relatively small. However, for someone travelling from Tripoli, Beq'a or the South, the expense can be demanding on already low resources.

Mental health care should be geographically accessible

In addition to the above, the time taken to access mental health resources is often a key issue in the risk assessment of the patient. In the cases of those with diagnoses of mental disorder, the risk of travelling long distances, surrounded by strangers, when exhibiting bizarre behaviour, may be considerable. The difference in the time travelled from each camp is considerable and inequitable.

Mental health care should be available on a voluntary basis as health care in general

Mental health care provided by UNRWA clinics is usually in the form of medication. Its impact is dependent on the compliance of the patient in taking that medication. Such compliance is taken as the implied consent of the patient to the treatment. However there is little evidence of patients being given information with which to

consent ie. information about effects, side-effects, contraindications, alternatives to medication etc.
For those who require in-patient observation and/or treatment without adequate risk assessment, the decision is largely in the hands of a medical officer and/or relatives. *(see note on consent)*

Recommendations:

E. Patients presenting with mental health problems should be managed in UNRWA clinics with the same or greater level of professionalism, respect, dignity and choice as would be expected by patients presenting with physical disorders.
F. Every patient presenting with manifestations of mental illness should be given a comprehensive physical examination.

iv). Provision of care in the community involving communities, families and consumers

Mental health is not just an issue for professionals. The individual, the family and the community all have their part to play in addressing this issue. The cross sector approach needs to take account of the value of contributions from NGOs, community groups, family groups and, not least, those with a personal experience of mental illness. This may involve self-help groups, carer groups, human rights groups in order to ensure that no section of the community is marginalised or patronised. Cases which were followed during the project highlight the need for family/carer support. Many families are at a loss for what to do next, many are afraid, either of their relative, or of public attitudes towards mental illness. Professionals with a variety of training and approach can contribute to the functioning of mental health teams. This is valuable in risk assessment, crisis intervention and in follow-up/monitoring of care in the community.

Recommendations:

G. Multidisciplinary mental health teams should be set up in each of the geographical areas of Lebanon. They should be suitably trained to:
    i. Answer queries about mental health issues
    ii. Make health assessments which include mental health
    iii. Make preliminary risk assessments
    iv. Act as advocates for clients needing specialist mental health services
    v. Follow up patients on discharge from hospital and/or change in medication
    vi. Provide an educational and supportive service to schools
    vii. Provide basic crisis management counselling
    viii. Initiate other activities designed to promote mental health
H. Client user groups should be set up to support the mentally ill and their families/carers.

v). Mental health assessment in accordance with internationally accepted principles

Each UNRWA clinic sees patients with a diagnosis of mental health disorder. Each clinic maintains a register of such patients. However, the entries in these registers suggest that doctors are not using diagnostic criteria with any sophistication. This

may be the result of inadequate training, or because insufficient time is available to make a comprehensive assessment and diagnosis (or both).

The vast majority of entries are for patients with functional disorders such as epilepsy. However, epilepsy is not a mental illness. This may be due to the lack of distinction between the roles and titles of psychologist, psychiatrist and neurologist. This, in turn, may be partly due to the prevailing stigma amongst the general public and some medical practitioners around anything associated with mental illness. Since the term "brain disease" and "neurological condition" are more acceptable, then referral to a "neurologist" has also become an easier option. However, neurologists, because of their speciality, are more likely to ascribe neurological labels to the presenting patients.

If patients are prescribed traditional anti-psychotic drugs for a range of diagnoses, then side effects are likely to occur. These side effects (or effects of sudden withdrawal/non-compliance) may, in turn, be interpreted as neurological signs and symptoms, again with resulting neurological labels such as epilepsy.

It is rare for an individual to attend a clinic voluntarily to tell a doctor of suspicions of having a mental illness. It is much more common for one of their family members to approach a doctor with their own somatisations as a result of the stress of having someone with strange or threatening behaviour in their house. Family members may suffer a great deal before admitting and exposing the problem of their relative. Other families may bring a mentally disordered relative against their will to see a doctor at an overcrowded clinic. The time and personal resources at clinics may be insufficient for adequate history taking, medical assessment, risk assessment, diagnosis and referral of such patients. Procedures for referral do exist, but may not be clear to all concerned.

Risk assessment and risk review

There is no obvious objective risk assessment strategy. Risk assessment is one of the fundamental aspects of comprehensive management of mental disorder. Accurate determination of level of risk is important in making an informed choice as to the type of therapy and place of care (home, community clinic or hospital). It could be argued that medical officers do use sound clinical judgement in deciding the best course of action. However, the use of an objective tool would reduce the risk of contention and help the doctor to convince patient, family and specialist of the level of risk, whatever that level might be. Many useful tools exist to assist risk assessment. The introduction to one such tool reads as follows: "The form is a tool to help structure your clinical judgement. The form will not assess the risk – only your clinical judgement can do that. It will help you to make defensible assessments based on consideration of all the relevant factors. There will be times when a different format for assessment is more helpful, for example if you need to consider factors not specifically mentioned here or if more detailed or specialist risk assessments are appropriate". The important thing is that assessments are appropriate to the situation and are clearly documented, and that staff are prepared to justify the assessment tool selected. A separate assessment is done of each risk area identified. Although this may mean some information is duplicated, it allows staff to identify the specific factors for that risk. Some things may increase one risk while reducing another.

Referral to a psychiatrist and/or hospitalisation

There are three designated hospitals for the mentally ill in Lebanon:

Al Fanar Hospital, near Sidon, may more reliably be called a 'refuge' since there is little in the way of treatment beyond custodial care as a place of safety. However, Al Fanar Hospital does employ four nurses who are Registered Mental Nurses. They trained in Beirut on a course which no longer exists. Three of these nurses are Palestinian.

The other two hospitals are in Beirut:

- **Dar el Salib Hospital** (purpose built as a mental hospital)
- **Dar Al Ajaza Islami** (converted from refuge to hospital in 1959)

Both Christians and Muslims have always put emphasis on the care for the mentally ill. In the outskirts of Beirut, the Lebanese Hospital of Mental and Nervous Disorders was established in 1898. It provided good care, first by English psychiatrists and later by Lebanese specialists trained in England. This hospital was to be rebuilt elsewhere, but the war stopped the construction.

There is only one functional and generally accessible psychiatric hospital. The 1500-bed **Psychiatric Hospital of the Cross (Dar el Salib Hospital / Hopital de la Croix)** was founded at the beginning of the 1950s and is run by a Maronite order of nuns. The psychiatrists are chiefly of French background and specialization, but the hospital is open to all professionals. The number of psychiatrists is relatively low but increasing. The senior consultant is Dr. George Haddad. All schools of medicine, nursing and psychology use the hospital for placement of their students. However, these may be quite short placements and, for the most part, are unsupervised. Although the hospital belongs to a completely Christian charity, it has a noticeable proportion of non-Christian patients. Nursing is performed by nuns and nurses trained "in the field". The hospital, as any other mental hospital, is constantly at full capacity. This is, as in other countries, due to the lack of follow-up for discharged persons, the tendency of mental illness to recur and to become chronic, and the increasing number of mental disorders. The situation has remained unchanged since 1950. Psychoses account for 60% of the admissions, but unfortunately most of them are readmissions. Male schizophrenics outnumber females in a proportion of 2 to 1. The Ministry of Public Health supports a large majority of hospitalized patients while only about 100 patients are paying patients. Patients who attend the hospital pay a consultation fee of 100 000LL, the cost of which is born by the patient/family. In-patient fees are paid through a contract with UNRWA. However, recent financial cuts now mean that UNRWA will only support patients presenting in urgent need of care.

Dar Al Ajaza Islami Hospital was originally established for the care of elderly and has now extended to other specialities. It is, in fact, in two parts:

- A neuro-psychiatric hospital for the treatment of mental and nervous disorders
- A home for the invalids, disabled and old-aged senile patients.

There are 25 doctors specialising in a variety of fields. In fact, the published list of medical staff includes three as having a speciality of "Neuro-Psychiatry" (Dr. Majed Kanj; Dr. Mohammed Jamal Hafez and Dr. Dana Al Amin). The hospital employs qualified and unqualified nurses. Some have had a module of mental health nursing

in their courses. Most learn "on the job". The hospital is used for the placement of nursing, medical, psychology and sociology students from all universities.
Patients may be referred directly from any medical officer with a referral letter. Fees are around 500 000 LL per month for short, medium or long-term care. This includes all accommodation, food, clothing, treatment, investigations and any social activities.
The hospital has formal contractual agreements with the Ministry of Health and with UNRWA. Although funding for short to medium stays are fairly straightforward, long-term stay in the "home" often requires considerable contribution from families.

Recommendations:

I. UNRWA doctors, nurses and social workers should receive professional development and update training in practical clinical mental health.
J. UNRWA Divisional Chiefs should review policies and procedures which have a bearing on mental health and mental illness.
K. All UNRWA staff in Medical, Social and Educational Divisions should be informed, in writing, of the relevant procedures for management and referral of actual and potential clients with mental health problems.
L. Mental health specialists review and audit the quality of experience of patients receiving mental health in-patient care.

vi). Respect for human rights of the mentally ill individual

Human rights are the rights that all people possess as a result of being human. As legally protected interests, rights imply obligations on the part of duty-holders to respect and observe the rights of those that hold them. Human rights are grounded in the concepts of natural law and positive law theory; they are universal, equal, and inalienable.

The interests of human rights workers and public health workers coincide in a common concern for the health and well-being of people: the alleviation of suffering and want, the assurance of social justice, the protection of vulnerable populations. The right to the attainment of the highest standard of health is dependent on the achievement of such public health goals as the availability of safe food and water supplies and a healthy environment. The achievement of health is conversely fundamental to the full enjoyment of other human rights.

Provision of least restrictive type of mental health care

This is only possible in states where there is an available range of such provision. For the Palestinian in Lebanon, that range is not available. Consequently the choice is often only one of home v. hospital. This choice is often made as a result of family pressure or pressure from enforcement bodies resulting from acts of violence, self harm or neglect. It is less often made in order to make comprehensive psychiatric assessment or to initiate therapy other than medication or electro-convulsive therapy (ECT). The other consideration is finance. Families can ill-afford to pay for their relative's stay in a hospital for any more than emergency life-threatening treatment. In some ways this is beneficial to the patient, in that being cared for at home is least restrictive. However, if this decision is made primarily for financial reasons, it can result in families placing their own restrictions on movement and freedom either in a well-meaning effort to protect the patient, or in an attempt to hide the fact that there is a mentally ill member of the family. It is not unknown for a family to shackle a demented relative who persistently wanders off.

Consent
Consent to treatment in mental disorder is usually either ignored or at the least, merely implied. The patient is often seen, by reason of the diagnosis, as being incapable of consent or otherwise. Sometimes consent is obtained from relatives. Most times it is abdicated to the medical officer, specialist or hospital staff. This applies to administration of regular medications, emergency medication or electro-convulsive therapy.

Self-determination
This is closely related to the issue of consent. However, it goes further into the exercising of informed choice. Again, it should not be assumed that, because a person has a diagnosed mental disorder, that he/she is unable to make choices, or at least be involved in the process of decision making. This would apply to the type or alternative to medication, route, frequency of treatment (eg. use of depot anti-psychotics), cost etc. Involvement in the process would improve future compliance, family involvement and general understanding of the patient's circumstances holistic approach to health and well-being.

Restraint
Physical restraint is seldom justified in the management of mental illness. Families may resort to restraining their relative who they consider at risk of wandering off into traffic or other dangers. This restraint may range from locking of doors to use of ropes or chains. Its use is born out of fear and/or ignorance and desperation. However use of constraint by professional healthcare workers implies that all other forms of management within their repertoire have been rejected. Insufficient access was obtained to in-patient facilities to assess whether restraint is used to any degree. No evidence was found of professional health care staff using or recommending constraint in the community, including health clinics or in transporting to a hospital. Most writers on the use of constraint also include in its definition the use of behaviour modifying medications without the consent of the patient, either in an acute emergency or prolonged use. Rendering a patient semi-conscious by use of medication may be considered acceptable by some healthcare workers. Whenever restraint is used, the rationale for its use should be clear and documented.

Involuntary admission
(See notes in other sections).
There is no published law related to involuntary admission to hospital, or any other aspects of mental health. Even if there were Lebanese legislation, it is unclear whether it could be applied in Palestinian camps or to Palestinians admitted to Lebanese hospitals. Such law would be for the benefit of patients, families and professional health care workers.

Recommendations:

M. UNRWA staff should be made aware of human rights issues related to mental health.
N. UNRWA should publicly affirm the UN Basic Principles of Mental Health Law in its operational policies and human resource management.
O. UNRWA should seek to promote the adoption of these principles by other agencies to whom refugees may be referred.

vii). Establishment of policies, procedures, programmes and legislation
UNRWA policy on mental health provision is that it is integrated into primary care. There are procedures for implementing that policy. However, these procedures are not widely disseminated either to healthcare practitioners or to the public. There is no clear policy on the promotion of mental health or on the prevention of mental illness. As the legal status of refugees is variable, any mental health law present in Lebanon (if indeed that exists) is not applied equitably to Palestinian refugees.

viii). Availability of a range of psychotropic medicines
The range of drugs used in the treatment of mental disorders is growing rapidly. Drugs are available tailored to manage patients' individual presentations and circumstances. For instance, the development of Selective Serotonin Re-uptake Inhibitors (SSRIs) has vastly advanced the treatment of some depressive illnesses. This has decreased the appropriateness of tricyclics with their associated side-effects, contra-indications and dangers. Anti-psychotics drugs have been developed to manage thought disorders and behaviours and associated risk factors. These make many of the traditional phenothiazines obsolete. Compliance in their use is much better than traditional medications, improving the quality of life for patients and their carers. The selection of drugs available for prescription in UNRWA clinics for the treatment of mental disorders is limited to those listed by the Lebanese Ministry of Public Health, the WHO list and by financial constraints. Although limited, the list of relevant drugs prescribed in UNRWA clinics is probably no less restricted than that in Lebanese Government clinics.

Pharmacies
In each camp there are a number of pharmacies. These are either attached to clinics run by Palestinian Red Crescent Society or by factions such as Fatah or Hammas. There are also private pharmacies. However, pharmacy is one of the occupations proscribed for Palestinian refugees. These pharmacies are subsequently run by unqualified staff who gain experience "on-the-job". Consequently none of the pharmacies in the camps are able to obtain a licence to stock and supply any drugs deemed to be drugs of addiction eg. hypnotics, anxiolytics, benzodiazepines, phenothiazines, barbiturates or narcotics. Camp pharmacies are therefore restricted to selling such things as fluoxetine and an assortment of tricyclic antidepressants. It would be technically possible for a Lebanese pharmacist to open a licensed pharmacy in a camp, but this has not been done. The range of drugs prescribed to in-patients in **Dar el Salib Hospital** depends on the level of funding received. UNRWA referrals are offered a basic or unclassified level of care. This usually means that they are prescribed medication from a basic, narrow range. Even if drugs are prescribed and patients stabilised in hospital, these drugs may not be readily available or affordable to Palestinian refugees after discharge.

Recommendations:
P. UNRWA should review the list of drugs prescribed in its clinics for mental disorders.
Q. UNRWA medical staff should be updated in the use of recently developed psychotropic drugs.
R. Representation should be made to the Lebanese Government to allow pharmacies in camps to stock and supply a comprehensive range of psychotropic drugs.

S. Staff of pharmacies in camps should be updated in their knowledge of psychotropic drugs.

ix). Development of human resources

Doctors

Doctors who work in UNRWA medical centres are well trained, experienced and competent practitioners. However, few have received any specialised training in mental health issues beyond that which they might have received in their undergraduate programmes. There is no planned post-graduate or professional development programme in this speciality. In 2001, it was estimated that there were 45 psychiatrists in Lebanon, some of them attached to the Dar el Salib Hospital, where they work part-time while having private practice. The others are working in private clinics and refer their patients to one or other general hospital. This gives a ratio of psychiatrists to Lebanese population of 1.2 to 100 000 approximately. Since Palestinians have less access to psychiatrists, the ratio for that population is considerably lower than this. All of the psychiatrists, after graduating in medicine from Saint Joseph University or the American University of Lebanon faculties, finish their specialised training in hospitals and institutions in France or the USA. In 1987, Dar el Salib signed an agreement with Paris University to enable Lebanese physicians to get trained in psychiatry in Beirut and take the final examination for the Special Studies Certificate in Paris.

Nurses

The curriculum for nurse training in Palestinian Nurse Training Schools contains a module in mental health nursing. However, this is a classroom module only and does not include a placement in a mental hospital or with any specialist psychiatric primary care team. There is no specific training programme for midwives.

Psychologists

The education of psychologists follows predominantly psychodynamic /psychoanalytical approaches. There is little attention paid to the clinical or educational uses of cognitive/behavioural approaches apart from those coming from or having some training outside Lebanon. Access to clinical psychologists is not common. Psychologists mainly work in schools. However, there are no educational psychologists employed in the refugee camps.

Social Workers

Social workers are recruited and appointed on the basis of having a social science related degree. There is no professional training in social work. Neither is there a professional body for the monitoring of the quality of social workers. Some may have a psychology degree, but this does not imply any clinical, therapeutic or assessment skills or experience. UNRWA social workers recently undertook training designed to raise their professional and practical skills and standards.

Teachers

Teachers invariably are highly educated, skilled and motivated. But teachers face daily problems associated with mental health. These include hyperactivity, withdrawal, aggression and violence, bullying, substance abuse, compulsive behaviour, relationship problems etc. Most are experienced in dealing with these as

they occur. However, all need to have up-dated skills, support mechanisms, policy and procedures to effectively manage these issues, for the best interests of their students and themselves. Teachers also play a vital role in the personal growth and development of their students. Life-skills training is increasingly forming an integral part of the curriculum. But this subject may not lend itself to the more formal educational methods with which they are familiar and comfortable. Recently some schools have introduced more creative, non-traditional approaches to social education.

In discussions with staff of Handicap International it was identified that they were carrying out a similar needs analysis but with a specific focus on children and adolescents. Thus their main point of contact with UNRWA has been through the Division of Education. One aspect of Handicap International's work is to introduce mental health elements to the training of Palestinian teachers at the Vocational Training Centre at Sibline. See Section on Mental Health and Children below. In view of this work, it is not proposed to duplicate or compete with Handicap International; rather we would seek to applaud, complement and cooperate with their initiatives.

Recommendations:

T. The curriculum for the training and development of doctors, nurses, social workers and others should be reviewed and amended to include issues related to mental health and mental ill-health.

x). Monitoring, evaluation and research

Monitoring and evaluation takes the following forms:

- Use of tools to measure indicators of change (eg. Quality of Life, Anxiety Indices) in order to measure the impact (or otherwise) of projects.
- Measures of the quality of service provision by reference to satisfaction of users of the service.
- Other indicators such as hospital re-admission rates, number of prescriptions for medications etc.

Much of this documented evidence is also of value when attempting to attract donors to related projects. There is a need for on-going academic and non-academic research into mental health issues. Many new mental health issues present themselves as a result of change. Since change is inevitable, there will be a need to re-assess needs and responses from time to time. During this needs assessment project, RI made working links with staff at Bierzeit University in Palestine. That university is working in collaboration with WHO in Geneva to produce a version of the WHO Quality of Life (Brief) Index, tailored to be used with Palestinian refugees in the Occupied Territories. RI took that version and held focus groups with Palestinian refugees in camps in Lebanon to inform the production of a further version of the questionnaire. It is hoped that this version will be used to monitor Quality of Life as an indicator of mental health in this population.

RI staff also used an Arabic translation of the Beck Anxiety Questionnaire with random samples of patients in UNRWA Health Centres (with a small comparison sample drawn from other camp residents). The Beck Anxiety Questionnaire is a 20 item instrument. The subject self-scores for each item statement, each response given a score from 0 to 3, thus the overall score range is from 0 to 60. Those scoring from 0

– 21 are considered to have low anxiety (or to be denying anxiety symptoms); those with 22 – 34 are considered to have medium anxiety. Some of these will be presenting somatisation symptoms. 35 and over is considered high level anxiety and subjects may be presenting overt anxiety and/or other neurotic presentations. Anybody presenting with medium or high anxiety will make demands on doctors' time which they are often unable to give due to the large numbers of patients seen per session. Initiatives to provide alternative management of such patients (eg. stress reduction groups; short counselling) can be followed up by repeat administration of the instrument to show the impact of such initiatives.

Summary of Data from Beck Anxiety Index:
400 refugees completed the questionnaire (f=257; m=143)
The average overall score was 17.83
The average for females was 26.67 (Medium anxiety)
The average for males was 13.15 (Low anxiety)
Distribution of Low, Medium and High Anxiety Scores:

ALL			**FEMALE**			**MALE**		
LOW	MED	HIGH	LOW	MED	HIGH	LOW	MED	HIGH
276	109	15	160	86	11	116	23	4
69%	27%	4%	62%	33%	4%	81%	16%	3%

This sample indicates that approximately one third of all those attending UNRWA clinics have medium to high anxiety levels which may be presenting as either somatisation illnesses or acute neuroses.

Recommendations:

U. The impact of initiatives designed to improve mental health in Palestinian refugees in Lebanon should be monitored.
V. Research should be commissioned into mental health issues among refugees.
W. Training should be given in the collection of data and use of instruments designed to measure indicators such as quality of life indices.

xi). Vulnerable groups

Mental health and women
Women's health issues are almost exclusively addressed in terms of their role as mothers – reproduction and child rearing. De Vecchio Good (2000) says that what is required is "a broad-based definition of health for women that addresses well-being across the life-cycle and in domains of both physical and mental health." Women disproportionately suffer from mental health disorders. The origins of much of the pain and suffering particular to women can be traced to the social circumstances of many women's lives: depression, hopelessness, exhaustion, anger and fear grow out of hunger, overwork, domestic and civil violence, entrapment and economic dependence. This calls for a concerted effort to improve and enhance social and mental health services and the competence of professionals and programmes in concert with the improvement of health services overall.

Across all cultures, symptoms of depression and anxiety, as well as unspecified psychotic disorder and psychological distress, are more prevalent among women, whereas substance disorders and violence are more prevalent among men. It is to be

expected that this gender difference is also present in Palestinian refugees. There is also evidence that poor women experience considerably more severe life events than does the general population (Brown et al. 1975; Makosky 1982), they are more likely to have to deal with chronic sources of social stress such as low quality housing and dangerous neighbourhoods (Makosky 1982; Perlin and Johnson 1977); they are at higher risk for becoming victims of violence (Belle 1990: Merry 1981); and they are especially vulnerable to encountering problems in parenting and child care (Belle et al 1987). Social networks can represent additional stress for poor women as well as sources of support. Since men are more likely to externalise their suffering through substance abuse and aggressive behaviour, much of their psychological distress is under-reported. Women, in turn, more often suffer distress in the form of depression, anxiety, nerves and somatisation illnesses. This is also true in Palestinian refugees. UNRWA clinics report a higher attendance rate by women than men with manifestations of stress. However, since this distress has its origins in social suffering, current medical facilities are impotent to have any lasting impact. If medical and nursing staff were to invest time in teaching women how to manage their own stress and distress, without recourse to medication, after a while the numbers seen in clinics would diminish leaving more time for each patient. NGOs have a considerable part to play in providing facilities for women to share, to be empowered, to gain self-worth, to generate income, and to escape.

Recommendations:

X. Stress management groups (especially but not exclusively for women) should be introduced, with the aims of improving stress self-management and ultimately reducing the workload on clinic staff.

Y. NGOs working with women (or access through their children) should receive training in the identification of psychological problems associated with womanhood.

Mental health and children

In the autumn of 2003, Handicap International was commissioned by UNRWA to take a look at psychosocial issues among refugee children in Lebanon. With funding from ECHO, Handicap International set up a pilot facility for psychosocial work with children and adolescent Palestinian refugees. The key activities and findings of the Handicap International project are summarised as follows:

- Supporting Professionals Working with Children and Adolescents
    - Speak-up Groups

      Five groups involving 45 professionals (teachers, counsellors, social workers and youth and community workers). Discussion groups, supported by a psychologist, using case-studies to develop best practice in psychosocial support of children and adolescents
    - Training Workshops

      Three training sessions of three days for members of speak-up groups to empower them to intervene in such issues as domestic violence, sexual abuse, and aggression in children and adolescents (esp. 11 – 15 age group).
    - Referral Practice

      In 2004, 140 requests were made to HI for treatment through the professional network. A referral system was set up and structured working arrangements have been in place since October 2004.
    - The Clinical Group

This effectively acted as a supervision group for clinical psychologists associated with the initiative.

In the course of these activities a number of key findings were made relating to:

- The incidence and impact of violent outbreaks in schools;
- Referrers looking for ready-made solutions;
- Malaise in the education resulting from gaps in training of professionals;
- The impact of family dynamics on the behaviour of children;
- The content and process of the training sessions proved appropriate;
- Social workers were particularly receptive to the training programme;
- Psychologists were able to make objective assessments because they saw children away from the camp environment;
- Because counsellors were limited in number, their main activity was crisis intervention; and
- The referral system was often, of itself, sufficient intervention to bring about a solution to problems.

Although many other organisations have a key role in the development of mental health in children and some specialise in supporting children with learning disabilities, there are few who have the capacity for intervention in cases of mental disorder in children and their families. One of these is the National Institution of Social Care and Vocational Training (NISCVT) who run The Family Guidance Centre (FGC). NISCVT was established in 1976 after the Tal Al Zaarar massacre to provide assistance and accommodation for surviving children. According to its information leaflet the FGC was established in 1997 and is currently the only centre in Lebanon that provides mental health services for Palestinian children and adolescents. FGC offers the following services:

- Psychiatric and psychotherapeutic assessment and interventions for children, adolescents and their carers
- Psychotropic medications
- Speech and language problems assessment and follow-up
- Psychomotor and Educational Therapy
- Training of social workers and kindergarten teachers in preliminary assessment and referrals for children in need of therapeutic interventions
- Community awareness raising about mental health through lectures and workshops
- Supervision of special needs cases
- Research on mental health conditions of Palestinian children and adolescents."

The FGC team includes a psychiatrist, a child and adult psychologist, a research psychologist, a speech therapist, a psychomotor and educational therapist, and a social worker. The work is done in conjunction with the ten NISCVT centres in the refugee camps. Referrals to FGC are made via the social workers and kindergarten teachers or other NGOs working in the camps.

The French NGO, Enfants Refugies du Monde, has a project in partnership with the General Union of Palestinian Women (Lebanon) and Najdeh. The project title is "Educational and psychosocial supporting programme for the Palestinian children refugees in Lebanon". Its aim is to maintain and develop education and psychosocial

supporting activities for the most vulnerable children and young refugees within "animation centres" located in the camps (restricted to the camps of Rashidiyeh, Qasmieh, Borj el Shemali, Borj el Barajneh and Beddawi). They have a staff of 33 socio educative animators, 6 social workers and 6 centre managers. Through play and other activities they assess and identify social and mental health issues and institute appropriate interventions and referrals.

Mental health and the elderly

The elderly represent a vulnerable group in most societies, being more susceptible to both physical and mental disorder. However, such disorder is not merely an inevitable consequence of ageing. Many factors contribute to elderly health and ill-health – sociological, economic and political priorities tend to favour those in the population who are wage earners and other net contributors to communities.

In autumn 2004, Handicap International published a Working Paper "From Autonomy to Dependency: Barriers to independent living encountered by elderly Palestinian Refugees in Lebanon". The summarised results of the survey are:

- There is a significant gap between self-perceived and actual physical and mental health
- The level of dependency is less than anticipated
- More than 50% of the elderly surveyed show no or slight mental impairment
- A third of the elderly surveyed were entirely reliant upon others (physical and or mental dependence) and 84% of these presented a medium or heavy burden on carers
- The main obstacles to improvement in the quality of their environment were seen as shortage of health, social and public services combined with lack of networking among service providers, and political and social exclusion (esp. access and mobility)

Handicap International proposed four initiatives which would help meet some of the needs of this group:

- To set up home care services and day care centres;
- To promote elderly self-help groups, social clubs;
- To empower all those concerned professionals, volunteers, families; and
- To develop networks and partnerships.

Networking, self-help groups and empowerment are also central to the recommendations made below by RI.

In the summer of 2005, a project was developed in two of the camps in Tyre (Al Bas and Borj al Shemali) to set up home care services for the elderly. This project was set up within the Women's Humanitarian Organisation and funded by Medical Aid for Palestinians. Under the supervision of an experienced manager (seconded from RI for two days per week), staff were recruited and trained to provide home care and basic nursing to vulnerable elderly residents. This includes support for those with physical and/or mental health problems. It is hoped that lessons learned from this project can be used to extend this service to other camps.

Recommendations:

Z. The recommendations related to the care of elderly refugees made in 2004 by Handicap International should be encouraged and implemented as resources become available, and the project currently underway in Al Bas and Borj el Shemali should be extended to other camps and gatherings.

7. SUMMARY LIST OF RECOMMENDATIONS FOR CHANGE (with or without training implications)

A. An action team should be formed to address mental health promotion, drawn from representation across sectors. Where expertise does not exist, consultants should be employed to inform and focus discussions and direct action.

B. A cross-sector mental health training programme should include elements of health promotion and prevention.

C. Public meetings should be held to raise awareness of mental health and its prevention and promotion; the early detection of stress induced and other psychological disorders; and the procedure for accessing appropriate assistance and care.

D. NGOs should be mobilised to complement such activities amongst their staff and clients.

E. Patients presenting with mental health problems should be managed in UNRWA clinics with the same or greater level of professionalism, respect, dignity and choice as would be expected by patients presenting with physical disorders.

F. Every patient presenting with manifestations of mental illness should be given a comprehensive physical examination.

G. Multidisciplinary mental health teams should be set up in each of the geographical areas of Lebanon. They should be suitably trained to:

i. Answer queries about mental health issues
ii. Make health assessments which include mental health
iii. Make preliminary risk assessments
iv. Act as advocates for clients needing specialist mental health services
v. Follow up patients on discharge from hospital and/or change in medication
vi. Provide an educational and supportive service to schools
vii. Provide basic crisis management counselling
viii. Initiate other activities designed to promote mental health

H. Client user groups should be set up to support the mentally ill and their families/carers.

I. UNRWA doctors, nurses and social workers should receive professional development and update training in practical clinical mental health.

J. UNRWA Divisional Chiefs should review policies and procedures which have a bearing on mental health and mental illness.

K. All UNRWA staff in Medical, Social and Educational Divisions should be informed, in writing, of the relevant procedures for management and referral of actual and potential clients with mental health problems.

L. Mental health specialists review and audit the quality of experience of patients receiving mental health in-patient care.

M. UNRWA staff should be made aware of human rights issues related to mental health.

N. UNRWA should publicly affirm the UN Basic Principles of Mental Health Law in its operational policies and human resource management.
O. UNRWA should seek to promote the adoption of these principles by other agencies to whom refugees may be referred.
P. UNRWA should review the list of drugs prescribed in its clinics for mental disorders.
Q. UNRWA medical staff should be updated in the use of recently developed psychotropic drugs.
R. Representation should be made to the Lebanese Government to allow pharmacies in camps to stock and supply a comprehensive range of psychotropic drugs.
S. Staff of pharmacies in camps should be updated in their knowledge of psychotropic drugs.
T. The curriculum for the training and development of doctors, nurses, social workers and others should be reviewed and amended to include issues related to mental health and mental ill-health.
U. The impact of initiatives designed to improve mental health in Palestinian refugees in Lebanon should be monitored.
V. Research should be commissioned into mental health issues among refugees.
W. Training should be given in the collection of data and use of instruments designed to measure indicators such as quality of life indices.
X. Stress management groups (especially but not exclusively for women) should be introduced, with the aims of improving stress self-management and ultimately reducing the workload on clinic staff.
Y. NGOs working with women (or access through their children) should receive training in the identification of psychological problems associated with womanhood.
Z. The recommendations related to the care of elderly refugees made in 2004 by Handicap International should be encouraged and implemented as resources become available, and the project currently underway in Al Bas and Borj el Shemali should be extended to other camps and gatherings.

8. NON-GOVERNMENTAL ORGANISATIONS

In addition to those mentioned above, there are many NGOs active in or near the camps and gatherings. Some are Palestinian, some Lebanese and others are international. In June 2004, and funded by ECHO, the Spanish organisation MPDL published a comprehensive Directory of Rehabilitation and Complementary Service Providers i.e. all NGOs serving the needs of Palestinians in the area of disability. All NGOs have a part to play in the promotion of mental health and all occasionally need to deal with mental health issues. However, the central theme for many studies of the work of NGOs is that there is a lack of cooperation and coordination between these agencies. As can be seen in our recommendations and those of Handicap International, there is a need for greater networking and collaboration between organisations if duplication and/or competition is to be avoided.

A list of those NGOs committed to sending health, education and social care workers to the mental health training programme arising from this needs assessment is provided in Appendix 3. This will hopefully produce a network of skilled and motivated individuals able to network effectively.

9. DISSEMINATION OF FINDINGS AND RECOMMENDATIONS

In the final month of the project the results of the needs assessment were shared with UNRWA staff. The first session involved UNRWA's health, education and social care chiefs in Beirut, and this was used to plan a series of workshops within each of the 12 camps. The results of the needs assessment and feedback from each of these sessions was then used to plan/refine the curriculum of a subsequent mental health training programme for a multidisciplinary group of UNRWA and other health, education and social care workers drawn from NGOs (see Appendix 4). We already have UNRWA's support for such a programme, and the quality of the information this project will provide will significantly increase the chance of attracting additional donor interest.