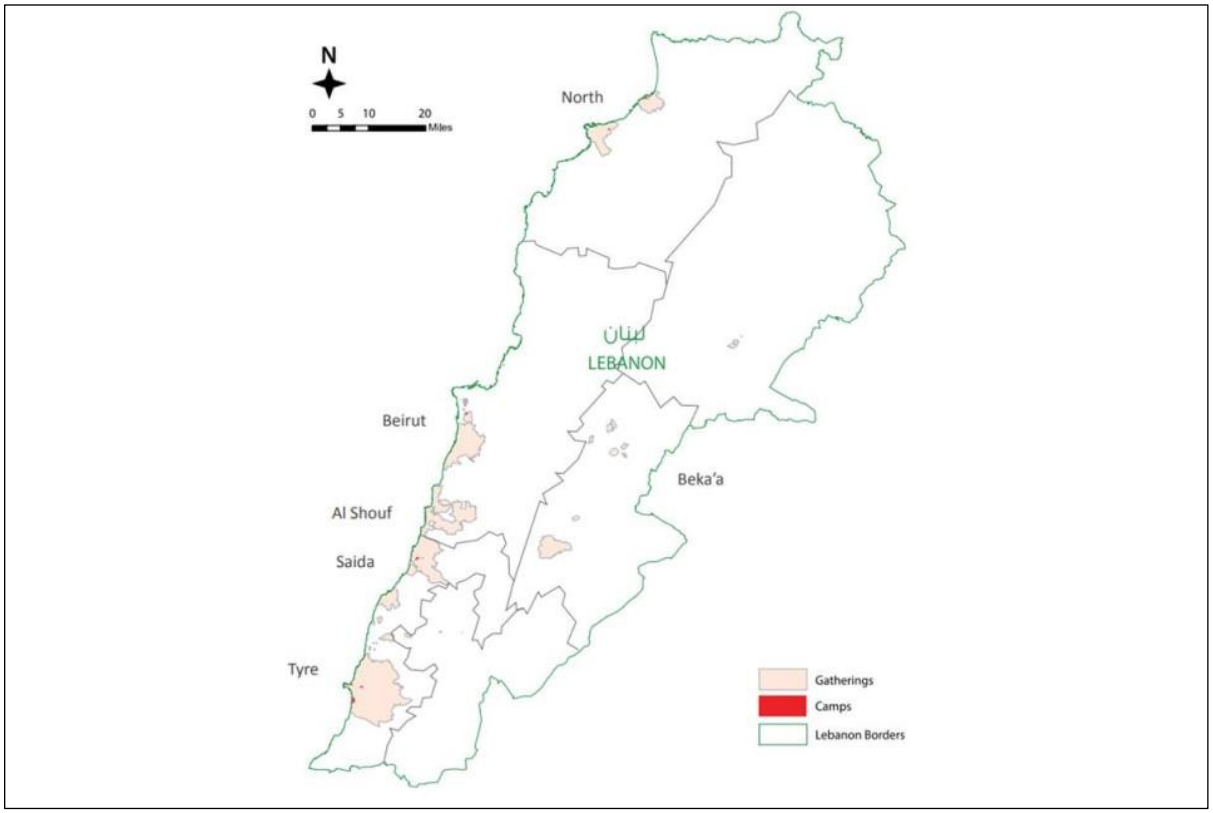
Access and Barriers to Mental Health Care for Palestinian Refugees in Lebanon (PRL)

Joint report of the Danish Refugee Council and VIA University College following a mission to Beirut, Lebanon conducted 29 May to 4 June 2024.



VIA University College

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Disclaimer

This report was researched, written and edited by the Danish Refugee Council (DRC) and VIA University College.

This report contains information about the access and barriers to mental health care for Palestinian refugees in Lebanon (PRL). The information is based on four interviews supplemented with publicly available information.The report is not, and does not purport to be, a detailed or comprehensive survey of all aspects of the issues addressed. It should thus be weighed against other country of origin information available on the topic.

Great efforts have been made to ensure the accuracy and reliability of the presented information. Users of the report are encouraged to independently verify the information or consult the original sources for more in-depth information.

The drafting of the report was initiated in May 2024 and was finalized in June 2024.

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Frontpage: Map from The Population and Housing Census in Palestinian Camps and Gatherings in Lebanon 2017, url.

DRC is a private, humanitarian organization working with refugees and displaced persons in more than 40 countries, as well as providing advice to asylum seekers in Denmark.VIA University College is a public higher learning and research institution.

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Introduction

The following report is the result of a joint mission between Danish Refugee Council (DRC) and VIA University College based on interviews held in Beirut from 29 May 2024 until 4 June 2024.

The purpose of the mission was to gather detailed and up-to-date information regarding access and barriers to mental health care services in Lebanon for Palestinian refugees from Lebanon (PRL) for use in the asylum determination processes in Denmark and in other countries.

The report presents information on a situation that is unstable and unpredictable: The mental health treatment for PRL, mainly available through UNRWA, is inevitably tied to the critical and unforeseeable funding situation of UNRWA, just as the dire economic situation for PRL is tied to the economic crisis in Lebanon, especially due to effects of the hyperinflation. In other words, the report reflects the present situation, but this can rapidly change, and consequently the presented information can quickly become outdated.

The purpose of the mission was also to prepare and present information differently from what is often the practice for Fact Finding Missions. This approach included choosing a narrow topic, publishing the gathered information from each interview separately without synthesizing it into a summary, in turn allowing for quick publication of the gathered information. It also involved increasing transparency by publishing interview guides and detailing methodological and practical challenges encountered during the process.

This report contains a section on methodology, where the above-mentioned approach is further elaborated on. Then follows a brief introduction to the current, general economic situation in Lebanon, including an overview of the status of PRL, and the notes from interviews with UNRWA, The National Institution for Social Care and Vocational Training (NISCVT/Beit Atfal Assumoud), UNICEF and Medical Aid for Palestine (MAP).

The methodology of the mission and report is based on the EU Common Guidelines on (joint) Fact Finding Missions[1] and reflects the guiding principles for COI as outlined in the EUAA Country Of Origin Report Methodology[2] and ACCORD Training Manual: Researching Country of Origin Information[3].

Sincere gratitude is extended to Asylos and ACCORD for their thorough peer review of the terms of reference and the methodology section of this report, and to the Danish Immigration Service (DIS) for their invaluable assistance in the initial process of source identification and for their peer-review of the terms of reference for the mission.

[1] EU 2010: EU Common Guidelines on (joint) Fact Finding Missions. url
[2] EUAA 2023: Country of origin information. Report Methodology. url
[3] Austrian Red Cross/ACCORD 2024: Researching Country of Origin information. Training Manual. url

Methodology

This section describes the process for preparing and conducting interviews with sources as well as the subsequent drafting and approval of notes. It also includes some of the methodological choices made for this report during the process along with some of the challenges encountered, in order to add methodological context to the information provided in the interview notes.

Design and Collection of Information

Terms of reference (ToR)

The terms of reference have undergone peer review with the following organizations ACCORD, Asylos and the Country-of-Origin Unit within the Danish Immigration Service and have been adjusted accordingly. The peer reviews led to a more narrowed and detailed focus on the access and potential barriers to mental health for PRL, replacing a broader focus on the Lebanese mental health system in general.

Identification of sources

Based on previous COI-reports regarding PRL[4], four organizations were identified as potential sources with updated, detailed knowledge and hands-on experience regarding access to mental health care for PRL. In this process, the Country-of-Origin Unit within the Danish Immigration Service assisted by providing a deeper understanding of the role and activities of the sources consulted in their more general report from February 2023 on access to health for PRL.[5]

The primary criterion when identifying relevant sources was the current activities of the sources directly linked to mental health services and PRL. This criterion entailed hands-on experience, meaning that sources needed to be present in Lebanon, within or in proximity to the refugee camps or within the Lebanese mental health system.

Based on this criterion, on-line research led to the initial identification of four sources: UNRWA, Medical Aid for Palestinians (MAP), the National Institution for Social Care and Vocational Training (NISCVT/Beit Atfal Assumoud) and an international NGO assisting refugees.

Each organization was contacted by email with a request for an interview in Beirut. The email provided details about the purpose and topic of the interview, its relevance to asylum

[4] Danish Immigration Service (2023): Lebanon. Access to Health Care Services for Palestinian Refugees. url
Medical Aid for Palestine (2018): Health in Exile. Barriers to the Health and Dignity of Palestinian Refugees in Lebanon. url
Baroud M. (2023): Right to health in times of crisis. A review of barriers and challenges to achieving the right to health in Lebanon. url
[5] Danish Immigration Service 2023: Lebanon. Access to Health Care Services for Palestinian Refugees. url

determination procedures, the planned publication, and included the terms of reference for the report. Additionally, the organizations were asked to suggest other relevant sources. All four organizations accepted the request to be interviewed.

At the same time, three other sources with updated and detailed knowledge regarding the situation for PRL in general, were identified through the mentioned previous reports and online-research: UNICEF, Health Care Society and SIDC Lebanon. They were contacted by email and asked if they knew of relevant sources with updated information and hands-on experience specifically regarding access to mental health care for PRL.

These initial efforts made it possible, through a snowballing approach to 1) confirm the identification of the before mentioned four sources: UNRWA, Medical Aid for Palestinians (MAP), the National Institution for Social Care and Vocational Training (NISCVT / Beit Atfal Assumoud) and an international NGO assisting refugees as the most relevant sources, as they were recommended by other sources and 2) to identify three other potential sources - two local NGOs and one governmental source.

Since the three suggested, additional sources did not meet the primary criterion of having activities directly related to mental health and PRL, they were contacted for potential interviews for a broader understanding of the Lebanese mental health system. Unfortunately, meeting arrangements could not be made or replies arrived after the visit to Beirut was concluded.

Finally, due to UNICEF's current Mental Health and Psychosocial Support (MHPSS) activities within the PRL community and recent research regarding needs assessment of mental health care for PRL, UNICEF was added to the list of sources.

Accordingly, five interviews in Beirut were planned, plus one online pre-meeting with UNRWA to clarify the purpose and topics of the interview and to identify relevant staff members.

Access and potential barriers to mental health treatment for Palestinian Refugees registered with UNRWA in Lebanon is a narrow topic with only a limited number of organizations possessing detailed, updated knowledge and direct practical experience concerning any potential barriers to such access. This research aimed at seeking information regarding the *accessibility* to mental health services for PRL, rather than the general *availability* of mental health services in Lebanon. Therefore, the primary criterion for selecting sources was updated and detailed knowledge based on direct experience with mental health services within the PRL community.

This approach involved identifying fewer sources with in-depth knowledge instead of a higher number of sources, of which some would most likely have more general knowledge on access to mental health care for PRL, thereby prioritizing the quality and relevance of the source over other methodological values such as securing a high number of sources representing as broad a variety as possible.

Within the more narrow range of sources, it has still been an aim to ensure variety and balance. On an organizational level, the sources consulted for this report range from UN agencies to a local NGO and an international NGO. During interviews, participants represented different perspectives from various professions and sectors; health, social work, mental health and protection.

This position enabled more in-depth and detailed interviews since the sources were not asked to comment on a range of different topics; instead, the entire interview could focus on a specific topic, giving the sources the opportunity to elaborate on details and aspects critical for a better understanding of the topic.

Interviewing sources

During the visit to Beirut, May 29th – June 4th, 2024, five interviews were conducted with the identified sources. However, the interview with the international NGO assisting refugees provided only general information about the Lebanese health system and the status of PRL, and therefore only notes from four interviews are included in this report. At the end of the meeting, the international NGO assisting refugees was informed that the information provided was useful for understanding the general health care system in Lebanon.

The interviews were conducted in English and recorded with the sources' consent. The sources were informed that the recordings would be deleted after drafting of the interview notes, as the recordings were only meant for ensuring accurate notes. By informing the sources of this at the beginning of the interview, the aim was to create a more open and safe interview situation, where participants would not have to worry about their appearance or the purpose of the recording.

Immediately after the interviews – while in Beirut – the interview notes were drafted. Each note was sorted into themes corresponding to the terms of reference. All notes were sent to the sources for approval shortly after the interview.

All sources were given full opportunity to add or edit the interview notes in order to make sure that the notes correctly reflect the perspectives of the source. The sources were asked to return their comments within a week, and all sources edited and approved the notes within this period. All revisions from the sources were implemented. No major changes were suggested, and the interview notes in this report have been approved for publication by the sources.

Presentation of information

This report consists of the full notes from the four interviews conducted, and there is therefore no summary or section synthesizing information across the four interviews. A report in this format can be ready for publication as soon as the notes are approved, ensuring currency and updated information. As the report presents information on a narrow, limited topic based on few in-depth interviews, it provides for an opportunity to try out this presentation format in order to see if it enhances the traceability of the provided information and the transparency of the context in which specific information is presented.

Accordingly, the notes have been written to reflect the contextual remarks, often repeatedly, expressed by the source, e.g. the desperate economic situation for PRL or the permanent underfunding of UNRWA services. This contextual information has not been sorted together and presented in a section or theme of its own but has been repeatedly noted every time it was

mentioned by the source as a relevant context to more specific types of information, e.g. availability of medicine or transport to access treatment.

This, of course, means, that the published notes include a certain number of repetitions. But these repetitions reflect the repetitions made by the source during the interview, continuously linking context to different types of specific information.

The general situation in Lebanon and the status of Palestinian Refugees in Lebanon (PRL)

The general economic and financial situation

Lebanon continues to grapple with a series of interconnected political, economic, and financial crises, exacerbated by a protracted humanitarian and protection emergency. Lebanon remains a country hosting the largest number of refugees per capita and per square kilometers in the world[6], with an estimated 1.5 million Syrians, along with 180,000 Palestine Refugees in Lebanon (PRL) and 31,400 Palestinian Refugees from Syria (PRS) living in the country.[7] The socio-economic situation in Lebanon is worsened by the spill-over effects of the Gaza war into Lebanon, with the looming threat of a full-scale conflict adding another layer of complexity to the already strained country.[8]

Since the onset of the multifaceted crisis in Lebanon, the Lebanese currency has lost more than 98 percent of its value.[9] However, in March 2024, the local currency saw a continued easing of inflation, with annual inflation reaching double digits for the first time since 2020.[10]

In August 2023, hyperinflation drove food prices up by over 278%.[11] Earnings have not kept up with the exponential rise in the exchange rate and the dollarized inflation in the country, causing many to earn less than a quarter of their pre-crisis income. As the Lebanese lira has depreciated drastically, people's savings are being wiped out, resulting in an estimated 80% of the Lebanese population living in poverty, with 36% falling below the extreme poverty line.[12]

The general situation in the Lebanese health system

Since 2019, there has been a massive emigration of healthcare workers from Lebanon and according to the Lebanese Order of Physicians (LOP), approximately 3,000 doctors and 5,000 nurses left the country since 2019 causing the LOP to warn that the health sector is on the brink of collapse.[13] While there are reports of some healthcare workers returning to Lebanon[14], the

[6] UNRWA 2024: Syria, Lebanon and Jordan. Emergency Appeal 2024, p. 14.v url
UNHCR 2024: Lebanon. Needs at a glance 2024. url
[7] United Nations & the government of Lebanon, january 2023: Lebanon Crises Response Plan, page 7. url
[8] UNDP 2023: Expected socioeconomic impacts of the Gaza war on neighbouring countries in the Arab region, page 5. url
[9] World Bank, February 2024: Lebanon: New World Bank Project to Restore Basic Fiscal Management Functions in Support of Public Service Delivery. url

[10] World Food Program, May 2024: WFP Lebanon Situation Report - April 2024. url
[11] ACAPS, October 2023: ACAPS Thematic Report - Lebanon: The effect of the socioeconomic crisis on healthcare. url
[12] Anera, February 2024: Inflation continues soaring in Lebanon. url
[13] The Media Line, May 2023: Mass Exodus of Doctors, Nurses Threatens Lebanese Health System. url
[14] L' Orient Today, February 2024: Emigrant Doctors return to Lebanon. url

Lebanese healthcare sector has faced severe strain due to the Ministry's budget on the health sector decreasing by 92 % from 486 million USD in 2018 to 37 million USD in 2022.[15]

There is a severe shortage of basic and life-saving medications as restrictions on foreign currency limit the ability to import drugs and medical supplies.[16] On 9 November 2021, the Ministry of Public Health announced the lifting of all foreign exchange subsidies on all medications (except for medications used for cancer and for some other chronic illnesses) causing the prices of most medicines to rise exponentially.[17] According to Amnesty International the prices of some blood pressure medicine have increased beyond the average monthly salary.[18]

According to Amnesty International's research, the challenges in importing medicine, combined with the inability of most people to afford unsubsidized medications, have led to a decline in the amount of medicine being brought into the country.[19]

Two Ministry of Public Health officials and four directors of Primary Health Care Centers (PHCCs)[20] have reported that all types of medications are regularly in short supply at the PHCCs and the director of a PHCC pharmacy unit told Amnesty International that they consistently face shortages, as supplies are never sufficient.[21] Likewise, pharmacists, doctors, hospital directors, and patients with chronic or other diseases told Amnesty International that even when they could afford unsubsidized medicines, these were often unavailable in Lebanon.[22]

Multiple news outlets have also reported deaths among patients due to the lack of essential medicine.[23] and how some patients have been forced to reduce their daily dosage of medication because they cannot obtain or afford further supplies from pharmacies.[24] UNICEF also reports

[15] Amnesty International, February 2023: Lebanon: Government must ensure medication is available and affordable, p.6. url
World Bank, November 2023: Lebanon: Health Transformation Project, p.4. url
[16] Amnesty International 2023: Lebanon. Government must address medication shortages and health care crises. February 2023. url.
[17] Amnesty International, February 2023: Lebanon: Government must ensure medication is available and affordable, p.4. url
[18] Amnesty International, February 2023: Lebanon: Government must ensure medication is available and affordable, p.1. url
[19] Amnesty International, February 2023: Lebanon: Government must ensure medication is available and affordable, p.8. url
[20] Amnesty International, February 2023: Lebanon: Government must ensure medication is available and affordable, p.5. url
[21] Amnesty International, February 2023: Lebanon: Government must ensure medication is available and affordable, p.7. url
[22] Amnesty International, February 2023: Lebanon: Government must ensure medication is available and affordable, p.9. url
[23] Alarabiya News, July 2021: Lebanon to investigate sick baby's death amid healtcare crises. url
Arab News, August 2021: Lebanese patient's deaths due to medicine shortages 'will become common'. url
[24] UNICEF, November 2021: Humanitarian Situation Report No.1. January - June 2021. url
Amnesty International, February 2023: Lebanon: Government must ensure medication is available and affordable, p.11. url

that patients refrain from visiting health clinics as they cannot afford to pay for treatment or transportation.[25]

The status of PRL

The total number of Palestinian refugees in Lebanon (PRL) is estimated to be around 174,422. This figure is based on a census conducted in 2017 by the Lebanese-Palestinian Dialogue Committee (LPDC) in collaboration with the Central Administration of Statistics (CAS) and the Palestinian Central Bureau of Statistics (PCBS).[26]

There are a total of 12 official refugee camps in Lebanon[27], and in addition, several 'gatherings' and informal housing, also inhabited by Palestinian refugees and other nationalities.[28] According to the census conducted in 2017, 45.1 percent of Palestinian refugees live in the refugee camps, while 54.9 percent reside in the so-called 'gatherings'.[29]

According to Lebanese law, Palestinian refugees are denied access to work in certain professions, such as legal work, medicine, and engineering. To obtain permission to work in professions allowed for Palestinians, one must apply for a work permit, which is a lengthy administrative process. These restrictions have resulted in many Palestinians working in low-income jobs in the informal sector, thereby lacking any form of social assistance[30], as social protection[31] is only available to individuals formally employed in either the private or public sectors.[32]

Palestinian refugees in Lebanon do not have access to the public healthcare system. Primary healthcare services for Palestinian refugees are instead provided by UNRWA in cooperation with the Palestine Red Crescent Society (PRCS), as well as by international and local NGOs.[33] The

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[25] UNICEF, November 2021: Humanitarian Situation Report No.1. January - June 2021. url

[26] Lebanese Palestinian Dialogue Committee, Central Administration of statistics, Palestinian Central Bureau of Statistics 2018: The Population and Housing Census in Palestinian Camps and Gatherings - 2017, Key Findings Report, p. 10, 20. url

[27] UNRWA 2024: Lebanon. Where we work. url

[28] UNDP 2018: Assessing vulnerabilities in Palestinian gatherings in Lebanon: Results of the 2017 household survey. url

[29] Lebanese Palestinian Dialogue Committee, Central Administration of statistics, Palestinian Central Bureau of Statistics 2018: The Population and Housing Census in Palestinian Camps and Gatherings - 2017, Key Findings Report, p. 10, 20. url

[30] Migrationsverket 2019: Lifosrapport: Palestinier i Mellanöstern – uppehållsrätt och dokument, p. 60. url

[31] The Lebanese government established a national social security fund in the 1960s, providing support in healthcare, education, and retirement. The social security fund covers only individuals formally employed in the private sector. Those employed in the public sector are covered under a similar program. Individuals employed in the informal sector are not covered. According to Anera, Lebanon's social safety net has always been weak, but due to the current economic and financial crisis in the country, Anera states that the social safety net is non-existent. Anera, November 2021: Falling through the social safety net in Lebanon. url

[32] Anera, November 2021: Falling through the social safety net in Lebanon. url

[33] Migrationsverket 2019: Lifosrapport: Palestinier i Mellanöstern – uppehållsrätt och dokument, p. 60. url

healthcare system for Palestinian refugees is divided into primary, secondary, and tertiary care.[34] Primary healthcare is managed by UNRWA, which operates 27 health clinics. About half of these clinics are located within the 12 refugee camps, while the remaining clinics are outside the camps.[35]

Secondary healthcare is primarily managed by PRCS under an agreement with UNRWA. PRCS operates a total of 5 health clinics/hospitals[36], and in some cases, PRCS purchases access to treatments at other hospitals.[37] Tertiary healthcare for PRL is only available at private hospitals. This treatment usually consists of highly specialized care or surgeries[38], such as cancer treatments, heart surgeries, or specialized psychiatric care.[39] Treatment at private hospitals is extremely expensive and only available for PRL if financing can be achieved through UNRWA, NGO's, religious communities or through private networks.[40]

According to UNRWAs latest emergency appeal, 80 % of Palestine Refugees are living below the national poverty line as of March 2023 with the poverty level rising to 93 % without the distribution of quarterly cash assistance from UNRWA.[41]

[34] Valente de Almeida, S., Paolucci, G., Seita, A. et al. 2022: Co-payments and equity in care: enhancing hospitalisation policy for Palestine refugees in Lebanon. BMC Health Serv Res 22, 121 (2022). p.1-2. url
[35] Medical Aid for Palestinians, May 2018: Health in Exile, Barriers to the health and dignity of Palestinian refugees in Lebanon, p. 5-6. url
UNRWA, May 2021: Department of Health, Annual Report, p.70 url
UNRWA 2024: Health in Lebanon. url
[36] UNRWA 2024: Health in Lebanon. url
[37] Medical Aid for Palestinians, May 2018: Health in Exile, Barriers to the health and dignity of Palestinian refugees in Lebanon, p. 5. url
[38] Medical Aid for Palestinians, May 2018: Health in Exile, Barriers to the health and dignity of Palestinian refugees in Lebanon, p. 5. url
[39] Medical Aid for Palestinians, May 2018: Health in Exile, Barriers to the health and dignity of Palestinian refugees in Lebanon, p. 7. url
[40] Danish Immigration Service 2023: *Lebanon.* Access to Health Care Services for Palestinian Refugees, p. 56. url
Medical Aid for Palestinians, May 2018: Health in Exile, Barriers to the health and dignity of Palestinian refugees in Lebanon, p. 5. url
[41] UNRWA 2024: Syria, Lebanon and Jordan. Emergency Appeal 2024, p.2. url

Interview notes

Notes from interview with UNRWA

UNRWA Beirut Field Office, May 30th, 2024.

Present

Tamara Abu Nafiseh (Acting Protection Team Leader), Protection unit

Alaa Murrah (Mental Health Programme Coordinator), Health Programme

Hadia Chanaa (Field Social Services Officer), Relief and Social Services Programme

Source of knowledge

UNRWA is the main provider of services to Palestinian refugees in Lebanon (PRL). UNRWA delivers direct services through UNRWA installations and staff. UNRWA has four programmes: relief and social services, health, education and field infrastructure and camp improvement, in addition to the Protection unit.

The Relief and Social Services Programme (RSSP) is contributing to the Agency's mission of helping Palestine refugees to achieve their full human development potential and a decent standard of living.

The Agency promotes the development and self-reliance of less-advantaged members of the Palestine refugee community – especially women, children, people with disabilities and the older persons.

RSSP social workers provide social work interventions through case management to individuals and families, identified being in need for social intervention, addressing situations of violence and family/social distress, for example Gender Based Violence (GBV) and child protection.

The health programme operates 27 primary health centres across Lebanon. Since 2017 primary mental health services have been integrated into the services of the health centers. In this process mainstreaming MHPSS (Mental Health and Psychosocial Support) is a key priority.

The number of installations fluctuates, but there are over 160 installations throughout Lebanon, i.e. health centers, relief and social services offices, schools, sanitation offices, area offices.

UNRWA serves a refugee population of approximately between 200.000- 250,000 individuals including around 24,000 Palestinian Refugees from Syria (PRS).[42] According to survey data gathered in March 20245, 72 per cent of Palestine refugees described themselves as "poor" or "extremely poor", PRL are almost entirely dependent on UNRWA services.

[42] This report has focused on PRL, but the discussion with UNRWA included a brief on the vulnerabilities facing PRS.

The status and current situation for Palestinian refugees registered with UNRWA in Lebanon

PRL have the right to reside in Lebanon and have full access to services provided by UNRWA in Lebanon. There are 12 refugee camps across Lebanon. Approximately 45% of the PRL community lives within the camps, while the remaining 55% lives in adjacent areas, gatherings close to the camps, or in the cities.

Multiple crises have affected Lebanon since 2019, economic instability, the collapse of the Lebanese currency, hyperinflation, the COVID 19 pandemic, the Beirut Blast explosion, and now ongoing conflict in the south of Lebanon, created compounded challenges. While these multiple crises have had a significant negative impact on the Lebanese society, the situation for PRLs is particularly dire. This population was already vulnerable and marginalized, making them especially susceptible to the adverse effects of these multiple crises.

Despite residing in Lebanon for 76 years, PRL face a rights environment that limits their ability to fully enjoy all their rights. They lack access to public healthcare and are entirely dependent on the UNRWA health programme. Similarly, education is provided through UNRWA-schools. There are restrictions on the right to work as they are barred from 39 professions, including syndicated professions like lawyers, doctors and engineers, and these are professions that would allow and enable PRL to escape a cycle of poverty and reduce their reliance on humanitarian aid from UNRWA and others NGO's. Additionally, PRL are restricted from the right to own non-moveable property outside of the camps. Access to justice is also a concern. In the main Lebanese authorities do not access to the camps. There are popular committees amongst the Palestine refugee community that take on some of these services, but access to justice and governance remains challenging. Armed clashes related to personal disputes, political fractions or drug trafficking are common in some camps.

Accordingly, the multiple crises affecting Lebanon must be understood in conjunction with the already incredibly vulnerable situation for the PRL population.

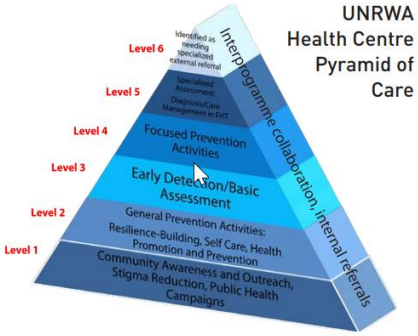
In this environment, Palestine refugees have become almost entirely reliant on UNRWA services. Furthermore, with constraints on UNRWAs funding, the situation becomes even more challenging for PRL. In 2015, 65% of PRL lived below the poverty line and in March 2023 this number had reached 80%.

The instability caused by the escalation in the border region with Israel after October 7th and fear of further escalation and displacement adds significant stress on PRL coping with an already very difficult situation.

Identification of persons in need of mental health care

UNRWA developed a programme to mainstream MHPSS across its services. Since 2017, UNRWA has integrated Mental Health and Psychosocial Support (MHPSS) services into primary health clinics care centers, training medical staff members in different MHPSS-approaches, including screening patients for mental health issues.

The MHPSS conceptual framework is based on the WHO-model which consists of different levels of activities forming a pyramid. Basic activities aim to reach the whole PRL community, while more specialized activities are at the top of the pyramid and aim to reach patients in need of specialized care. Within this framework, basic levels of activities include community awareness and outreach, stigma reduction and general prevention activities; self-care and resilience building. Middle-level activities include screening and focused prevention activities, and the most specialized activities include specialized assessments, medical interventions and the possibility for external referral of acute or high-risk patients, such as those at suicidal risk, to contracted mental health hospitals.



1: Conceptual framework for mental health and psychosocial support within the UNRWA primary health clinics. UNRWA (2016)

The number of individuals in need of mental health services has significantly increased, rising from 500 beneficiaries in 2017 to over 3500 beneficiaries currently. The MHPSS strategy involves raising awareness, conducting both formal and informal screening activities (especially targeting high-risk population groups such as pregnant women), and providing voluntary access to MHPSS services at the primary health clinics.

Underreporting of mental health needs remains a challenge, partly due to stigma within the community. However, awareness activities and the mainstreaming of MHPSS into the primary health clinic have reduced the stigma associated with seeking support for mental health issues.

Referral to specialized mental health treatment

Building upon the described framework of MHPSS, the health programme adopted a "stepped-care-approach" in line with the pyramid levels. Nurses, midwives and medical officers in the primary health clinics can identify individuals in need of more advanced mental health support and refer them to a specialized mental health team consisting of a psychologist and a psychiatrist for further assessment and medical intervention. However, the specialized team is only available to the clinics on a limited basis as all specialized mental health care staff are project-funded making it impossible for UNRWA to secure a more frequent presence in clinics within the current budget.

The specialized team assesses the need for intervention and determines the type of intervention needed (i.a. consultation, medical intervention with the psychotropic medications available to UNRWA at the current time, or external referral for hospitalization).

In 2020-2021, a referral system was formalized that integrates all services provided by UNRWA. The formalization of linking up the different programmes aims to provide a holistic approach and as comprehensive care as possible. However, the coordination across programmes is challenged, as each programme is challenged by scarce resources, restricted services and the overwhelming needs that exceed the allocated resources and services in each program.

UNRWA formalized referral pathways to clarify the pathways between different programs. One of these pathways is the referral to external, specialized services, but access to external services is also challenged, partly due the restricted budget of UNRWA and partly due to the general shortage of health care services in Lebanon under the current multiple crises. One of the external referral pathways includes referral to hospitalization within contracted mental care hospitals. UNRWA has contracted four mental health hospitals: two in Beirut and two in the north.

PRL cannot afford hospitalization fees, and UNRWA covers hospitalization fees for PRL in need of mental health hospitalization. On average, patients are hospitalized for 2-3 weeks, but in high-risk cases, i.e. suicidal cases, hospitalization can extend to a maximum of one month. However, this is very costly and puts heavy pressure on UNRWA's budget. Coverage of mental health hospitalization is a significant challenge within the UNRWA budget on a yearly basis. All costs related to mental health care hospitalization, including those for UNRWA's specialized mental health care staff, is project funded, making it continuously challenging to secure funds for treatment.

Sometimes funding constraints mean that UNRWA is unable to schedule new appointments for specialists, even for very serious cases, due to uncertainty about resources for paying a psychiatrist in the following month. Recently it became unclear whether there would be enough funds in the following months, so the mental health programme stopped accepting new appointments for specialists and only provide the basic mental and psychosocial support interventions to avoid harm to patients as cancellation and thereby interrupted treatment can be very harmful to the patient.

UNRWA also faces significant challenges when a patient suffering from mental health issues no longer in need of hospitalization is discharged from a mental health hospital without a family or social network to support them. This situation is particularly difficult as UNRWA lacks the financial resources to keep the patient in the hospital and has no facility for the patient to stay outside of the hospital. This highlights broader issues such as the limitation on available services nationally, their prohibitive costs and the difficulties for Palestine refugees to access them. Shelters for GBV survivors, for instance, often do not have the capacity to accept individuals with mental health issues. Despite continued efforts to find solutions, i.e. with the assistance of local NGOs or other partners, the limitations of funds and the restriction of services constitutes severe challenges, making it hard to find sustainable solutions for discharged patients in vulnerable positions. Medical follow up can take place within UNRWA clinics, when specialized mental health staff visit the clinic.

Patients at risk of self-harm need a caregiver on a 24-hour basis. For those without a support network this remains a challenge, as restricted funds and lack of specialized services make it hard or even impossible to find solutions.

Mental health services for children also remain a critical challenge, as specialized mental health care services for children are very limited in Lebanon. UNRWA is detecting an increasing number of children and adolescents in need of mental health care. UNRWA is not contracting any hospitals that can provide mental health treatment for children. Institutions do exist, but are few, and the cost is very high. The financial restrictions at this level prevent UNRWA from referring children to these institutions. Instead UNRWA teams provide the needed support within the available capacities including the medical and psychological support from the psychiatrists and psychologists as well as referrals to Relief and Social services for case management process.

Barriers to access mental health treatment for Palestinian refugees in Lebanon

Insufficient number of qualified mental health professionals nationally

One of the most significant challenges for UNRWA in terms of securing mental health care is recruiting qualified mental health staff. In general, there is a shortage of specialized mental health care staff in Lebanon, exacerbated by the exodus of medical professionals following the economic crisis. Currently, there are only approximately 10 licensed psychiatrists in Lebanon. UNRWA requires 5 psychiatrists to rotate between the primary health clinics but recruiting this number in the current situation is impossible. Additionally, trained medical staff within the Palestine refugee community are not allowed to obtain a license to work in Lebanon.

The recruitment crisis is further challenged by insecure funding, resulting in insecure, short-term contracts. Due to restricted and insecure funding, UNRWA can only offer contracts lasting a few months at the time, causing psychiatrists and psychologists to seek more stable job positions elsewhere. This situation is quite challenging and within the last few years, UNRWA has been unable to retain psychiatrists that have been recruited.

The working conditions for psychiatrists and psychologists also contribute to recruitment difficulties. The workload is extremely high with specialists rotating among all clinics trying to meet a demand that far exceeds available resources. Currently each of the 27 UNRWA health clinics in Lebanon receive only one visit by a psychiatrist/psychologist per month.

The situation at the health clinics is difficult, as the clinics are often overcrowded. This is also due to lack of community spaces within the camps, and clinics can sometimes see up to 1000 visitors in a single day. Often, two doctors (medical officers) must handle 100-150 consultations per day. Sometimes a mental health patient needs all-day care, e.g. suicidal risks, creating a shortage of staff for the large number of other waiting patients. When psychiatrists visit the clinics, the number of patients referred to them exceeds the recommended standards due to the needs within the community, resulting in an extreme workload and difficult working conditions.

Medication availability

Medication availability continues to pose a significant challenge for mental health care services. UNRWA aims to have seven types of basic psychotropic medicine available in the

clinics, based on an essential list from the WHO. This means that the variety of medication is limited, which poses a challenge for those in need of more advanced types of medication.

The seven types of psychotropic medication are available free of charge in the health clinics if they are available to UNRWA at the time. However, UNRWA faces several challenges in terms of securing the availability of the seven types of medicine, partly due to the general situation of shortage of medicine supplies in Lebanon, and partly due to the funding situation of UNRWA, which lately has become increasingly restricted. More than 2300 patients are seeking psychotropic medication through UNRWA clinics, but the shortage of medicine and restrictions on funding makes it very challenging to secure the presence of basic psychotropic medicine for all persons in need. Problems in securing basic psychotropic medicine occur on a weekly basis, with the health programme struggling to find financial resources within a strained UNRWA budget and challenged by unstable deliveries of medicine shipments.

Sometimes patients need more advanced psychotropic medicine than the seven types of essential medicine provided in the health clinics. UNRWA can provide the prescription currently through the specialized team if there is a contract, but the patient must cover the medication expenses themselves, which is not a realistic possibility for PRL due to prohibitive costs. When possible, the mental health team strives to use the available medicine in the best possible way to find an acceptable solution.

If a person returns from abroad and has been diagnosed and assessed in need of specialized psychotropic medicine not in stock in UNRWA health clinics, UNRWA cannot provide or cover such medicine. The psychiatrist within the specialized mental health team can assess the needs of a returning person and try to find a solution with the available medicine. However, changes in psychotropic medicine can be harmful to the patient, and it can take a long time to adjust to new types of medication, and even minor adjustments can severely impact the patient's wellbeing.

Seeing a psychiatrist outside of the UNRWA system in the Lebanese private health care system is prohibitively expensive for PRL. The cost is at least 100 dollars for consultations and 50 dollars if only a prescription is needed.

Financial barriers

Even though UNRWA can cover hospitalization fees for mental health hospitalizations, there are expenses related to mental health hospitalization, that must be covered by the patients themselves: Buying food during hospitalization, personal needs (due to prolonged stay at hospitals). Adding to this, some Mental Health Hospitals require blood tests, i.a. testing for HIV, PCR, screening lab tests prior to admitting any patient. These additional costs are beyond the financial capacity of PRL.

Transportation costs to reach treatment pose a significant barrier in accessing treatment. UNRWA does not cover transportation costs, and some patients must travel long distances to access mental health treatment. While protection emergency funds or alternative solutions might occasionally cover these expenses, even small costs constitute severe barriers for PRL, who lack the financial means to cover expenses. Even symbolic fees can be impossible to pay

for PRL, especially given the vulnerability of mental health patients combined with the high poverty levels and the lack of access to income and jobs.

The relief and social services program work on external referrals for specialized services that are beyond UNRWAs capability. There are challenges related to costs, and UNRWA's social workers struggle to find long-term solutions for mental health patients with more permanent needs. The UNRWA health programme can offer mental health treatment for a limited duration of time within contracted hospitals, but for those needing long-term care and who do not have any community support, social workers struggle to find solutions. Additionally, the social workers also find it a challenge to find solutions for elderly people without a network, who risk ending up living on the streets.

There are long waiting lists for institutions that offer free of charge help for substance users, and private institutions are non-affordable for PRL.

UNRWA cannot cover substance use rehabilitation treatment. Individuals with substance use issues can receive acute and lifesaving medical interventions and treatment under admittance to a contracted hospital, but there is no possibility to cover a full programme of detoxification and rehabilitation treatment as it is very costly.

Social-cultural barriers

UNRWA highlights that MHPSS services operate within a context where mental health issues are stigmatized and where there is some community resistance to seeking mental health support. The significant increase (from 500 in 2017 to currently 3500) in the numbers of individuals seeking mental health and psychosocial support services should be understood in this context as the increase reflects how dire the general situation has become for PRL.

Stigma remains a challenge within the community and the mental health patients themselves are often in denial of need of help. However, since the startup of the mental health programme, stigma is decreasing, and awareness of mental health is increasing. The mainstreaming of MHPSS into UNRWA programmes and the integration of mental health services within the ordinary health clinics has decreased the tabu and sensationalism of seeking mental health care support.

Practical barriers

The costs of transportation to reach specialized services are prohibitively expensive for PRL. With the collapse of the lira, the economic crisis and the high poverty rate within the PRL community, covering transportation costs have become a significant barrier to reach services. Services are not equally distributed across all areas, and since transportation costs must be self-financed, it becomes prohibitively expensive for PRL to access specialized services that are not within their local area.

Notes from interview with the National Institution of Social Care and Vocational Training (NISCVT/Beit Atfal Assumoud)

NISCVT Office Beirut, May 26th, 2024

Present:

Kassem Aina (General Director)

Khawla Khalaf (Mental Health Programme Coordinator)

Source of knowledge

The National Institution of Social Care and Vocational Training (NISCVT), known as Beit Atfal Assumoud, is a humanitarian, non-sectarian and non-governmental organization.

NISCVT programs reach out to Palestinian refugees in 13 centers located inside camps and gatherings around Lebanon. Ten of these centers are located inside the refugee camps, while three are in adjacent areas.

NISCVT's mental health program started in 1997, and the organization provides mental health services for children below 18 years and their families in five centers in Lebanon. Each center has a multidisciplinary team consisting of psychiatrists, psychologists, speech- and language therapists, psychomotor therapists, occupational therapists, and in some centers, special educators and musical therapists.

The first mental health center was established in Beirut in 1997. The second and third centers opened in 2005 in the North of Lebanon in Badawi and Nahr El Bared camps. In 2007, another center opened in Tyre, and in 2010, a center opened in Saida.

Every year, NISCVT organizes a conference on mental health. This year, the focus will be on the multiple crises and their impact on children, parents, and frontliners.

The activities of NISCVT are funded by Norway and Finland, among other contributors.

The status and current situation for Palestinian refugees registered with UNRWA in Lebanon

Palestinian refugees in Lebanon (PRL) face significant challenges as they lack basic rights, including human and civil rights. Discrimination is rampant, with Palestinians barred from working in 39 professions and owning property. Additionally, they lack access to essential services like education, healthcare, and social services, relying heavily on UNRWA and NGO's.

The socioeconomic situation is dire, with approximately 80% of Palestinians unemployed and 95% living below the poverty line. These factors contribute to a complex humanitarian and political situation for Palestinian refugees in Lebanon.

Identification of persons in need of mental health care

The lack of basic rights and the harsh living conditions and economic instability faced by Palestinian refugees in Lebanon, compounded by ongoing regional instability, exacerbate mental health issues. Children in the southern area are in addition to the general situation, also affected by daily clashes, bombings, and shelling, significantly impacting their well-being.

The need for mental health services in Palestinian communities is significant, yet resources are severely limited. UNRWA, the primary service provider for Palestinians, faces substantial financial challenges, leading to insufficient services, particularly due to funding cuts in recent years. This has resulted in an increased presence of NGOs delivering mental health care services for Palestinians, including NISCVT, which also struggles to maintain its services due to lack of funding.

While UNRWA provides some psychiatric services for adults in some clinics, there is a notable gap in services for children with mental health needs and their families. NISCVT has focused its activities on addressing this gap, offering support to children and teenagers below the age of 18 and their families, filling a critical need in the community.

Palestinians in need of mental health care services are often identified through UNRWA's primary health clinics as well as social and educational organizations operating in the camps and gatherings. However, UNRWA's psychiatrist only visits the health clinics once a month, which isn't frequent enough to meet the mental health needs of the community. Consequently, many patients experience long waiting times and lack the means to pay out of pocket for consultations with psychiatrists within the private health sector in Lebanon, which can cost around $100 to 150 per session. A price that is unaffordable for PRL.

Many Palestinian refugees seek out NISCVT directly instead of being referred, as NISCVT is well-known in the community due to its long-standing presence and activities. Sometimes UNRWA or other organizations refer cases to NISCVT, if they fall within the organization's target criteria of children and teenagers below the age of 18 and their families.

Occasionally, adults are also referred to NISCVT. Depending on availability, NISCVT can, in certain circumstances, provide a single session with a psychiatrist, but in most cases, will refer adults to other organizations for psychiatric evaluations.

There is a considerable gap between the availability of services and the need, as well as a lack of consistency, in services provided. Sometimes certain international NGO's initiate mental health projects, but due to lack of continued funding, they wrap up their projects after a short period or move their services to other camps. This inconsistency in services provided can be harmful as many patients need consistent follow-up. Many of these services also lack psychiatric care and often only offer psychological services, referring their cases to NCISTV for psychiatric consultations.

NCISTV's mental health program also faces challenges with funding, as many contributors only pledge donations on a yearly, sometimes monthly, basis. This affects the sustainability and continuation of the services that NCISTV can provide.

Where UNRWA is providing education to children without special needs, NISCVT offers programs specifically designed for children with multiple special needs. Under certain

conditions, NISCVT can provide financial support for these children to continue attending specialized schools. However, due to limited resources, these services cannot cover all children with such needs, resulting in long waiting lists at NISCVT centers. Notably, NISCVT is the sole organization offering services for children through multidisciplinary teams, providing psychiatric therapy, a service not offered by other organizations.

Referral to specialized mental health treatment

If hospitalization is deemed necessary, NISCVT forwards psychiatric evaluations of patients to UNRWA, highlighting the need for further specialized treatment. UNRWA's psychiatrist assesses the situation and determines if there is available space for admission. If not, patients are instructed to return home and continue with medication. However, obtaining permission from UNRWA for hospital admission can be challenging, particularly when Lebanese specialized hospitals lack available space and UNRWA is struggling with permanent and increased underfunding of their services. These challenges underscore the immense difficulties Palestinian refugees face in accessing mental health care.

NISCVT lacks precise data on the number of patients referred to hospitals by UNRWA each month and on the duration of the hospital stays, but they estimate the numbers to be relatively low. As per NISCVT's information, UNRWA has agreements with two private hospitals, namely Deir al Salib and another private hospital in Beirut. These hospitals possess a very limited number of beds, approximately around 8, serving the entire population, encompassing both Lebanese citizens and Palestinians. While UNRWA has contracted with psychiatric hospitals and covers admission costs, these agreements typically do not extend to longer hospital stays. UNRWA can encounter funding challenges in severe mental health cases that often necessitate long-term specialized psychiatric treatment.

Barriers to access mental health treatment for Palestinian refugees in Lebanon

Lack of qualified staff

After the Beirut blast, Lebanon experienced a significant exodus of qualified healthcare staff, including three psychiatrists from NISCVT's program. Despite efforts to fill these positions, the loss of experienced professionals was substantial. NISCVT's mental health staff work part-time, with only social workers employed full-time. Mental health workers visit the camps a maximum of 2-3 times a week, and the psychiatrist visits once a week. Despite the high need for full-time mental health care staff, NISCVT cannot afford to assign them full-time due to the high costs. Hiring qualified staff is expensive, and when funds are not provided on a long-term basis, it is difficult to cover salaries consistently.

Despite the existence of trained psychologists within the PRL community, NISCVT is not allowed to recruit them, as PRL cannot obtain a license to work as a psychologist in Lebanon.

Availability of medicine

There is a general shortage of medication in Lebanon, including psychotropic medicine, and the costs are prohibitively high. NISCVT operates with a limited budget to provide the necessary medication for children's psychiatric treatment. However, it's quite common that the required medication for psychiatric disorders is unavailable.

Often, international non-governmental organizations (INGOs) specializing in healthcare, present in the camp, will reach out to NISCVT to request specific types of medication. NISCVT's medication stock is typically donated by organizations like Anera and UPA, but these donations are limited and sporadic. Additionally, the donations often consist of medicine with an expiration date within 6 months. NISCVT accepts all donations, recognizing the critical need for medication, but acknowledges the limitations of such donations. If NISCVT does not have the required medication, they will refer the patient to UNRWA, which may have some medication in stock. NISCVT typically has only 1-2 types of medication in stock.

For conditions like ADHD and autism, NISCVT may adopt a wait-and-see approach to monitor if patients can progress without medication. Nonetheless, for other mental health disorders, where patients require immediate treatment, there may be instances where the required medication is unavailable, and the only alternative is to prescribe another type of medicine for the patient than what was needed.

At times, NISCVT is forced to resort to purchasing medication from Syria or Turkey, although psychiatrists state that they prefer the original brands. However, the availability of medication fluctuates; some months NISCVT have an adequate supply, while other months medicine is out of stock. Last month's budget constraints limited the ability to procure medicine, and NISCVT were only capable of securing a couple of boxes of medicine per health center. The shortage of medication is pervasive across all organizations involved in mental health and healthcare in general.

Financial barriers

The primary barriers to treatment include the high costs of treatment and medication, limited availability of medicine and the extremely challenging financial situation faced by Palestinian refugees.

Accessing specialist psychiatric treatment or hospitalization is extremely challenging, even for Lebanese citizens, let alone Palestinians. While UNRWA contributes financially to the most severe and acute cases that require hospitalization, UNRWA cannot cover all the expenses, leaving families to bear some of the costs themselves. For many families, these expenses are simply unaffordable due to extreme poverty within their community. As a result, some families opt to keep patients at home, self-regulating the frequency of doctor appointments and administering treatment themselves.

UNRWA provides some types of medication for psychiatric disorders, but not all, forcing some patients to cover the costs of certain medicines out of pocket. This situation presents significant difficulties, especially for severe cases like bipolar disorder and severe depression.

When families have to cover expenses associated with hospitalization, such as transportation or the cost of specific medicines not covered, they are compelled to initiate fundraising efforts for treatment. This poses a significant challenge. Medication is crucial and discontinuing it can lead to severe consequences. Unlike missing school or forgoing certain foods, not taking life-saving medicine can have dire outcomes. Raising funds for medication or mental health treatment is not as straightforward as for somatic diseases. Fewer organizations are willing to support mental health treatments compared to surgeries or direct life-saving procedures. Stigma also exists, particularly for severe cases requiring hospitalization. Some patients require medicine that reaches the cost of $160-$170 every month, a cost that NISCVT cannot even partially cover. However, following an assessment of the patient's family's economic situation by NISCVT's social worker, they may assess how much NISCVT can contribute towards covering the costs of medication, albeit on an ad-hoc basis. This contribution may cover the entire cost, a portion of it, or cover the cost of a single medication. Unfortunately, this assistance is not sufficient to meet the needs of every patient.

One family approached the psychiatrist of NISCVT seeking advice on which medication to cancel, underscoring the necessity for patients to prioritize among different medications due to the extremely challenging financial situation faced by Palestinian refugees. NISCVT refers to recent research showing that the increase in poverty includes an increase in food insecurity in the homes of PRL, forcing families to downscale the number of meals a day.

Despite having 2 or 3 family members employed, Palestinian families struggle to cope with the financial burdens. Inflation and the economic crisis have made basic living costs in Lebanon extremely expensive and many families, despite multiple family members working, still face significant hardships. While UNRWA supports the most vulnerable groups, including elderly people and children below the age of 18 who are still in school, through its cash assistance program, this assistance has been reduced from $50 every three months to $30 every three months due to lack of funding.

For children with severe mental health needs requiring specialized schools, the expenses for both the schools and transportation are prohibitively high. Many parents are unable to afford these costs, even with partial support from NISCVT. As a result, they are forced to keep their children at home.

Socio-cultural barriers

NISCVT provides therapy sessions and community-based rehabilitation, including awareness sessions, mental health campaigns, home visits, and training for other NGOs working in the camps. These awareness sessions are crucial for reducing the stigma surrounding mental health and ensuring early referral to family guidance centers.

When NISCVT first started working with mental health it was a tabu within the PRL community and attached with much stigmatization. However, during the years NISCVT has registered a change in attitude towards mental health issues and a growing acceptance of the need for mental health support.

While there is no discrimination for Palestinians to access private hospitals, NISCVT is unaware of any cases where a Palestinian has been able to afford hospitalization out of pocket. It is simply impossible for Palestinians to afford such expenses.

Practical barriers

As services are not equally distributed among the camps, costs for transportation in order to reach treatment constitute a significant barrier. 95% of the PRL community lives below the poverty line, 80% is unemployed and the employed are mostly working in the informal sector without social or medical insurance, most families are unable to cover transportation costs themselves. Consequently, they cannot access mental health care services located far from their place of residence. For this reason, NISCVT has sometimes had to provide transportation for children and their families to ensure they can reach the centers and receive treatment.

However, NISCVT's additional services, such as expenses for medication, scholarships and transportation, depend on supplementary funds. NISCVT has recently lost funding that was used to cover transportation costs, further complicating access to essential mental health services.

NISCVT explains that, for instance, children in treatment for example who live in Burj Shemali Camp and Rashidieh Camp need to transport themselves to El Buss Camp, where the mental health center is located. The transportation costs from Burj Shemali Camp and Rashidieh Camp are prohibitively high, posing a real risk that children will not be able to afford the transportation, thus being unable to access the necessary treatment. In some cases, NISCVT has provided transportation assistance.

For the camps in Beirut (Shatila and Burj Barajneh), transportation costs are also a barrier, as the mental health center is located outside the camps. The situation is similar in Saida. However, in Nahr El Bared and Beddawi camps, the mental health centers are located within the camps, so transportation costs do not pose a barrier to accessing treatment for Palestinians living there. In Mieh Mieh and Ein El Hilweh camps, transportation costs remain a significant barrier.

Notes from interview with UNICEF

UNICEF Beirut Office, 4th June 2024

Present:

Riwa Maktabi, Child Protection Officer (MHPSS)

Bochra El-Moghrabi, Programme officer: Child Protection (CP) and Gender Based Violence (GBV) Palestinian programme. Focal point for mental health programme

Source of knowledge

UNICEF supports the education of Palestinian children in Lebanon by providing kindergartens for children aged 3 to 5. This helps ensure their transition to primary education in coordination with UNRWA. Also, UNICEF runs a program for children aged 6 to 14 at risk of dropping out of school.

Beyond education, UNICEFs Palestinian programme addresses mental health, child protection (CP), and gender-based violence (GBV). UNICEF's approach includes community-based child protection activities to create safe environments for children, focus and structured PSS, in addition to specialized services and case management for both CP and GBV. UNICEF also offers training to improve the skills of child protection workers and provide case management for children needing personalized care. UNICEF collaborates with partners such as Al-Jana/ARCPA and Medical Aid for Palestinians (MAP) and their sub-partners and works closely with UNRWA to coordinate these efforts effectively. These initiatives aim to enhance educational opportunities and overall well-being for Palestinian children in Lebanon, helping them thrive despite their challenging circumstances.

MHPSS survey

UNICEF has recently concluded an MHPSS Needs Assessment to understand the mental health and psychosocial support (MHPSS) needs of Palestinian Refugees in Lebanon, focusing on children, youth, caregivers, and MHPSS staff. The study aimed to better comprehend the services provided to Palestinians Refugees in Lebanon, and revealed several key findings as well as identify gaps, and offer recommendations for UNICEF's future actions and advocacy efforts with various stakeholders. The study was conducted in collaboration with UNICEF partners, which means it must be considered a snapshot, and this limitation affects its representation breadth.

The MHPSS Needs Assessment was conducted between January and May 2024, in seven different locations, including Palestinian camps such as Ein el Hilweh, Burj Barajneh, Beddawi, and El Buss. In Beddawi, participants from Nahr El Bared also took part, while in El Buss, individuals from Burj Shemali and Rashidieh camps were involved.

The MHPSS Needs Assessment revealed that there are various events causing emotional distress. These include conflicts and safety concerns within the camps, as well as the broader

situation in southern Lebanon and Gaza, which contributes significantly to stress. Socio-economic challenges, such as poor employment prospects, limited civil rights, concerns related to education, such as access to schools, attendance, and the quality of education, also add to this emotional distress. Furthermore, harassment, violence, SGBV, and bullying for younger children, within and outside the camps are likewise major sources of emotional strain.

Geographical variations in distress were observed. In southern camps, the conflict in the south has a more pronounced impact, while in northern camps, socio-economic conditions and internal conflicts and clashes within the camps are the primary stressors.

These adverse events lead to long-term physical, social, emotional, and mental health issues, especially affecting children. The community suffers collective trauma, weakening social structures, reducing resilience, and straining support networks, fostering intergenerational trauma in the camps.

There is a pervasive trend of emotional numbing and desensitization of violence among Palestinians within and outside the camps. Individuals, particularly older adolescent boys, tend to numb their emotions, perceiving distress as immaturity. Older boys, youth, males, and caregivers report that they have become accustomed to violence, due to constant exposure, leading to complete desensitization, which is a significant concern.

Children and youth are the most affected due to their difficulty in processing events and emotions. The survey revealed that women are more open to specialized mental health services, while men tend to internalize emotions and strive to appear strong and stoic. A perceived lack of support for men from the community may lead to prolonged mental and emotional issues such as anxiety, depression, and feelings of abandonment.

Caregivers and older generations, who have endured past duress, are also heavily impacted. Persons with disabilities and chronic illnesses are particularly vulnerable due to heightened challenges during the economic crisis. The use of violence and substance abuse as coping mechanisms exacerbates mental and physical health problems, perpetuating distress and disfunction.

The negative impact on community resilience negatively affects family and neighborhood dynamics and increases community vulnerabilities. Key concerns include widespread hopelessness, desensitization, and emotional numbing.

The survey also examined the community's influence and found reliance on external organizations as the primary source of support. Beneficiaries highlighted a lack of support from organizations, contrasting with MHPSS staff who reported ongoing support. Some beneficiaries indicated that the support provided is insufficient or nonexistent, perceiving it as inadequate or irrelevant to their needs.

The survey examined the current landscape of mental health and psychosocial support (MHPSS) services available. While there are psychotherapists and psychiatric services in place, there is a notable gap in specialized services for children with autism, learning and speech difficulties, and ADHD.

Service availability and concerns were also highlighted. There is a demand for more activities and greater support for staff. Some redundancy was noted in the MHPSS themes offered, and

there are ongoing safety and security concerns. Additionally, equity in the distribution of services emerged as an issue. Some groups felt the selection of beneficiaries for activities and support was unfair, despite UNICEF and partners' efforts to ensure a fair selection process.

The status and current situation for Palestinian refugees registered with UNRWA

Palestinian refugees in Lebanon reside in 12 official camps and 42 informal gatherings. There are approximately 180,000 Palestinian Refugees from Lebanon (PRL) and 30,000 Palestinian Refugees from Syria (PRS). The economic situation within these camps is dire, with 93% of the refugee population living in poverty, according to the latest UNRWA snapshot. These conditions are exacerbated by stringent legal and civil rights restrictions, employment limitations across 39 professions, and barriers to property ownership. Such constraints further entrench the Palestinian refugees' economic hardship.

The situation of Palestinian children in the camps is particularly alarming. They face numerous protection concerns, including child labor, exploitation, and susceptibility to violence and abuse. The dire economic conditions force many children to work at a young age, exposing them to hazardous environments and depriving them of their childhood. The vulnerability to abuse and exploitation is heightened by the lack of adequate protective measures and support systems within the camps.

A study conducted by UNICEF, known as the LIMA survey, highlights severe food insecurity affecting over 41% of Palestinian households. This food insecurity translates to high levels of child food poverty, impacting 90% of young children. Such conditions contribute to significant malnutrition issues, with 12.7% of children under the age of five experiencing stunted growth, indicating long-term developmental challenges due to inadequate nutrition.

The educational prospects for Palestinian children in these camps are also grim. Around 30% of Palestinian children are not engaged in early childhood education, which is crucial for their cognitive and social development.

The camps also face significant security challenges. Violence as well as insecure infrastructure pose serious risks to residents. Some camps experience security incidents such as clashes between factions, which can lead to injuries or fatalities. In other camps, infrastructure problems threaten civilian safety. For instance, in Burj al-Barajneh, 55 individuals died in one year due to issues related to water and electricity, highlighting the difficult living conditions.

Referral to specialized mental health treatment

UNICEF provides psychologists in all 11 camps and 3 gatherings, but psychiatric care is referred to UNRWA. UNRWA's psychiatrists, who visit health centers once a month, are met with overwhelming needs, resulting in long waiting times. Beit Atfal Assumoud also offers psychiatric services, but both organizations face overwhelming demand and have long waiting lists. In some situations, where the patient is not able to wait any longer, there will be a need for an urgent consultation with a psychiatrist, which will be prohibitively expensive for Palestinians as a consultation in the private sector costs around $100 per session.

Within the Palestinian program run by UNICEF's partners, there are two centers, one in Ein el Hilweh and one in El Buss providing specialized MHPSS services (psychologists). However, these centers cannot meet all the needs due to high demand. Employment restrictions for Palestinians in Lebanon necessitate the contracting of Lebanese specialists who visit the centers once a week for a few hours. These services are free when available at the centers, but for needs beyond what is provided, families must seek costly private sector services.

There is a notable gap in specialized services, including case management, and there is a widespread need for more psychiatrists. A critical gap also exists in long-term funding for MHPSS work. The needs are deteriorating and urgent, requiring comprehensive support across all levels of the MHPSS pyramid. Due to worsening funding situations, organizations are forced to prioritize only the most critical, life-saving services. Long-term mental health support often needs years of follow-up, not just a few months, which highlights a significant funding shortfall.

The funding crisis has further impacted services for many organizations. UNRWA faced a two-month closure and strikes due to financial shortages. UNICEF attempts to bridge the gaps in UNRWA services but cannot cover all needs. For instance, UNICEF provides psychosocial support in UNRWA schools and conducted a drug abuse project last year.

Barriers to access mental health treatment for Palestinian refugees in Lebanon

Financial barriers

The MHPSS survey also underscored the challenge of service fees. Specialized mental health services often incur costs that are not covered, leaving Palestinian families unable to afford them.

Given the financial crisis and widespread poverty among Palestinians, most families cannot afford private treatment costs. Many families in the camps prioritize their basic needs, including health, but often neglect some due to limited resources. There are additional services available, but they lack sustainability. Referrals to clinics or charity organizations are possible, yet these often operate under limited durations.

Socio-cultural barriers

In terms of MHPSS support, there is a growing acceptance of receiving mental health assistance among adolescents, indicating an increasing recognition of its importance. There is a shift in attitude, with enhanced acceptance of psychotherapy, particularly among mothers, reflecting a positive change towards mental health care in society. However, ongoing challenges, stigma, and a lack of recognition of mental health's importance persist, posing continuous hurdles.

The MHPSS study also revealed that perception towards mental health varies across different Palestinian camps. For instance, in El Buss, there's a strong sense of collective struggle that diminishes discrimination against individuals with mental distress, fostering unity over division. In Ein El Hilweh, changes in perception have been influenced by education, advocacy, and social media, leading to heightened sensitization towards MHPSS and greater acceptance. The recognition of past stigmas has led to a trend of normalization and destigmatization of help-

seeking behavior. However, in Burj Barajneh, mental health issues are still associated with stigma and secrecy, causing individuals to seek therapy discreetly.

Notes from interview with Medical Aid for Palestinians

MAP Beirut field office, May 30, 2024.

Present:

Wafa Dakwar (Lebanon Director)

Mahmoud Aladawi (Programme Manager coordinating the UNICEF supported mental health and psychosocial support programme)

Source of knowledge

MAP has been working with medical and health support for Palestinian refugees in Lebanon for more than 35 years. MAP is an UK-based NGO, that has programmes in the West Bank, Gaza, East Jerusalem and Lebanon.

Currently MAP has activities across 11 refugee camps and some gatherings for Palestine refugees in Lebanon. These activities include mental health and psychosocial support, maternal and child healthcare, emergency and complex hospital care. MAP delivers direct services as well as through partnerships with local NGOs.

Regarding mental health support MAP currently has a large-scale project implemented across camps supported by UNICEF focusing on child-friendly drop-in spaces providing structured, recreational and learn-through-play psychosocial support activities for children, women and families.

The status and current situation for Palestinian refugees registered with UNRWA in Lebanon

Palestinian refugees in Lebanon (PRL) have historically faced significant obstacles to the realization of their right to health. Private healthcare in Lebanon is prohibitively expensive, meaning that PRL are reliant on healthcare services from UNRWA and the Palestinian Red Crescent Society (PRCS), both of which are seriously under-funded. Palestinians also face legislative and practical obstacles to their right to work, including in health-related fields. The restrictions on the right to work are directly interrelated to the issues of access to healthcare, as the PRL community is impoverished, with the vast majority of 93% living in poverty.

Around half of the PRL community live in the 12 official camps across the country, where overcrowding, limited essential services and poor sanitary conditions mean conditions are among the worst in the region. Despite their longstanding presence in Lebanon, Palestinian refugees remain excluded from key aspects of social, political and economic life in the country. They are barred from accessing public services, owning or inheriting property, and working in 39 professions.

Identification of persons in need of mental health care

The Child Friendly Spaces project (CFS) is a component of Mental Health and Psychosocial Support program which also include Gender Based Violence (women and girls' safe spaces) and partial child development multidisciplinary service components. The program is operated by MAP in partnership with five implementing local partner NGOs with the support of UNICEF. The CFSs are open to all Palestinians in Lebanon, including those displaced from Syria and those already in Lebanon, as well as children of other nationalities living in the Palestinian refugee camps/project locations.

The CFSs are used as gateways for delivering multi-level MHPSS services, i.e. prevention activities and response services. The CFSs are an entry point for further continuum of care for children. Basic activities involve group based recreational and preventive activities, and if identified in need of more specialized care, the project employes part-time psychologists that can offer focused individual sessions. Referrals to other service providers are also provided as needed.

In general, there is a tendency that the availability of primary mental health care services is known to families who are enrolled in existing community-based programs run by local NGOs, or international NGOs, or UN agencies. Being in contact with existing organization service means better opportunity to also be in contact with mental health services as information on its availability usually will be channeled through organizations coordination, referrals and information sharing. There are higher chances for access if the organization in which the family is enrolled in has mental health service as one of its multi services components. In all, often these services are project based with fixed periods and dependent on availability of funding among others. On the other side, not all families within the community might be aware of availability of mental health service particularly those families with limited access to support networks.

Referral to specialized mental health treatment

The program does not include psychiatry service staff or medication associated as part of MHPSS community-based services, instead, if cases in need for psychiatry consultation are identified within service, referral to allied serve providers will be made, depending on availability. In one service gateway in northern Lebanon, MAP local partner NGO staff in charge of service can refer children with special needs to a psychiatrist service which is available within location as an allied service and consultation fees are covered by the program. In acute cases with individuals at risk of self-harm referred to MAP by local partner-NGO staff in charge of service, both MAP and the local NGO-staff will work to find resources from the program to cover the consultation fee for at least one session with a private psychiatrist in order to obtain an assessment of the need for further care as urgent as possible.

As UNRWA is the main service provider for the PRL community, most often persons in need of mental health care will seek treatment through UNRWA health clinics. UNRWA has a psychiatrist consultant that will visit the health clinics and assess whether further specialized treatment is needed. UNWRA has contracted with a few private mental health hospitals, but the resources are limited. For persons assessed as being in acute or severe need of treatment,

UNRWA can cover the hospitalization fee, however MAP advised to refer to UNRWA for details on this coverage to be obtained from as being the proper source (i.e. the room cost/bed, the associated costs of medicine and specialist consultations, number of admission days, ceiling, coverage percentage, age specifics, number of consultations, and others).

Secondly, Palestine refugees in need of mental health treatment can in principle seek treatment within the private mental health sector in Lebanon if they can afford the costs, but this is prohibitively expensive and not a realistic option.

Some international or local NGOs from time to time start limited period projects such as a one-year phase -funded mental health projects in some of the camps, but they often close down at the end of the project period. When services are closed at a given site or camp, or at best shifted to other locations, it will become difficult for mental health service users in this event of sudden non-availability of alternative service centers within vicinity, to know where to reach a distant alternative service (in other camps, town or city).These solutions are not sustainable, and the instability and sudden closure of treatment can be harmful to patients.

Rehabilitation treatment for drug abuse remains a severe challenge. The treatment is prohibitively expensive for PRL (100-150 dollars per consultation). UNRWA cannot cover rehabilitation costs for PRL, and there are no referral possibilities outside the private sector.

Barriers to access mental health treatment for Palestinian refugees in Lebanon

In general, access to mental health care for PRL is limited, complicated to navigate and the available resources cannot meet the needs. There is a scarcity of available services, medicine and qualified staff, and it is a struggle for persons in need of treatment to find support. The services are costly, not easily accessible and often patients will have to go to multiple places to secure treatment. The cost of medicine is a significant barrier. There are continuous gaps within the UNRWA health services, especially in the light of the decrease in funding for UNWRA.

Lack of qualified staff

In general, since the economic crisis, many health care workers left the country. But even before the crisis there was a lack of mental health medical staff, especially psychiatrists, in Lebanon.

This also affects the current availability and accessibility of mental health care for PRL. To the knowledge of MAP the UNRWA contracted psychiatrists visiting UNRWA health clinics must rotate between clinics in camps as being the focal person in charge of assessing individuals in need for specialized mental health hospitalization. Either through scheduled sessions arranged by the UNRWA PHC staff, internal or self-referred, or in the event of external referral pathway scheme through direct contact with the focal person from service agency, or the local NGO who identified the case.

However, it is only to highlight that this is what is available given the resources for all PRL population, challenged by coverage, geography, case load and waiting lists, while the tendency remains towards further under-resourced services.

Financial barriers

Before the economic crisis of Lebanon, the collapse of the Lebanese lira and the following hyperinflation, 65% of PRL lived below the poverty line. Now, in the light of the multiple crises affecting Lebanon and the restrictions for PRL in accessing jobs around 93% live in poverty. In this situation costs for specialized treatment and medicine (not provided by UNRWA) becomes prohibitively expensive for PRL, not to mention treatment within the private mental health sector, which is unaffordable to PRL.

Within an impoverished household facing daily hardships and struggling to secure food, buying the needed medicine becomes a priority that some families cannot afford. Midwives working for MAP report that food insecurity is rising with families struggling to secure basic nutritious food.

In general, accessing any service or treatment that is not free of charge or covered by UNRWA will constitute a severe barrier to PRL. In effect, any cost of treatment, including associated costs of transport and medicine, will make access to mental health treatment prohibitively expensive to PRL.

Socio-cultural barriers

Stigma related to mental health issues has been reduced significantly within the last years. There is more acceptance, including acceptance of seeking mental health support.

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Annex 1: Terms of reference

Lebanon. Access to mental health care services (including specialized treatment) for Palestinian refugees registered with UNRWA (PRL).

1. **Source of knowledge:** The role, work and access to updated, empirical information of the source, both organization and informant.

2. The **identification** of PRL's in need of specialized mental health treatment, including medication and hospitalization.
    a. Procedures.
    b. Qualified staff
    c. Potential barriers.

3. The **referral pathways** to specialized psychiatric treatment, including hospitalization, for PRL.
    a. Referral pathways
        - Procedures
        - Waiting time
        - Potential barriers
    b. Other possibilities for referral pathways

4. Potential barriers in accessing mental health care services and specialized psychiatric treatment for PRL registered with UNRWA in Lebanon

    a. Financial barriers
    - Covering costs of specialized treatment (such as therapy sessions, psychiatric evaluations, medication management and hospitalization)
    - Covering costs of medication
    - Costs compared with average income/average poverty among PRLs Insurance, grants, etc. available to PRLs (availability, barriers, procedures)
    - Effect of the financial crisis and the UNRWA funding crisis

    b. Socio-cultural barriers
    - Stigma
    - Discrimination

    c. Geographic, logistical and practical barriers

Annex 2: Interview guides

Two interview guides are included, a general and a more detailed one. The latter was used for the interview with UNRWA. As the role of UNRWA, being the main service provider and operating as a quasi-state body for PRL, is unique, the interview guide for the interview with UNRWA contains a number of more detailed and technical questions but addressing the same themes and main questions as the interview guide used for the other interviews.

General interview guide

Applied at the interviews with The National Institution for Social Care and Vocational Training (Beit Atfal Assumoud), Medical Aid for Palestine (MAP), UNICEF.

Theme	Questions	Supplementary questions
Introduction	Thanks for participating Introduction of DRC/VIA University College Brief introduction to themes/terms of reference Purpose of interview. Report publicly available. Asylum determination process. Approval of notes. Possible to add, make amendments, edit to ensure accurate quoting. Recording? Deleted after finalizing notes. Any questions? Please feel free to express if there are questions or topics, that you or your organization are not familiar with.	
Source of knowledge	*The organization* Role Relevant activities with PRL Access to information *The informant* Title, professional background and tasks and role within the organization. Relevant/current activities	Does the informant have direct access to information, or primarily informed by colleagues How long have you worked with the organization
Identification of PRL's in need of specialized mental	How are PRL's in need of specialized mental health care treatment identified? Returnees from abroad (potentially diagnosed abroad)	Person in search for help Persons identified by others in need of help

health treatment	Potential barriers to being identified? • Barriers within the community • Barriers within the organization/health clinic	Resources
Referral pathways to specialized psychiatric treatment	When PRL's in need of treatment have been identified, what will happen then? Examples of different types of mental health conditions that are referred for specialized treatment? • Assessments of severity? What are the procedures if a person is identified as needing specialized external referral? • Are these procedures challenged by any practical barriers For returnees from abroad? Insights from cases that have been referred? Was treatment actually obtained?	Can you describe the procedures? Can it be illustrated like this? What happens if resources cannot meet the needs? Do you have other examples?
	Waiting time, due to • Lack of qualified staff? • Lack of resources? • Volume of cases? How are cases prioritized?	

	Alternative ways of accessing specialized treatment? • Costs	The possibility and extent of self-referral?
Now we would like to understand more about any potential barriers, that might hinder og reduce the access to specialized treatment for Palestinians in Lebanon. We'll start with potential financial barriers.		
Financial barriers	How are costs for specialized treatment (such as consultations, psychiatric evaluations, medication management and hospitalization) paid for? • How much does UNRWRA cover? • How much is out-of-pocket? • Alternative ways of financing? Do you know of examples of prices for hospitalization, psychiatric evaluation, consultation, medicine management, etc?	Is this percentage possible within the current funding situation? How are UNRWA coverage obtained? As part of the referral?
	How are costs for psychotropic medicine paid for? • Does UNRWA cover any costs for psychotropic medicine • How much is out-of-pocket?	

	Are there any possibilities for alternative ways of financing specialized psychiatric treatment psychotropic medicine for PRL? • Availability • Procedures • Barriers If a PRL in need of spezialised psychiatric treatment does not have a willing network to assist in finding financing, how would this affect the possibility of financing treatment?	Insurance, grants, etc. available to PRLs
Financial barriers	How are these costs (for treatment AND medicine) compared with the average income/average poverty amongst PRL? In the light of inflation/financial crisis in Lebanon (poverty, food insecurity)	Would it be realistic to finance for the average/majority of PRL?
Socio-cultural barriers	Are there any socio-cultural barriers in accessing mental health care for PRL? • Within the community? • Within the tertiary health system?	For instance, stigma or low awareness about metal illness For instance, informal discrimination against PRL?
Geographical, logistic, practical barriers.	Are there any logistic og practical barriers in accessing mental health care for PRL? • Transport to treatment (including costs) • Administrative procedures (need of documents) •	If a person is too ill to go to consultations etc. on their own?
Any other potential barriers or important perspectives on PRLs access to specialized psychiatric treatment? Thank you very much We'll send you the notes from the interview within a few days. Possible to make amendments or corrections, and then we hope for your approval as soon as possible, as we would like to publish the report mid-June in order to publish the most updated and accurate information as soon as possible.		

Interview guide for UNRWA

Theme	Questions	Supplementary questions
Introduction	Thanks for participating	

	Introduction of DRC/VIA University College Brief introduction to themes/terms of reference Purpose of interview. Report publicly available. Asylum determination process. Approval of notes. Possible to add, make amendments, edit to ensure accurate quoting. Recording? Deleted after finalizing notes. Any questions? Please feel free to express if there are questions or topics that you or your organization are not familiar with.	
Source of knowledge	*The organization* Role Relevant activities with PRL Access to information *The informant* Title, professional background and tasks and role within the organization. Relevant/current activities	Does the informant have direct access to information, or primarily informed by colleagues How long have you worked with the organization
Identification of PRL's in need of specialized mental health treatment	How are PRL's in need of specialized mental health care treatment identified? Person in search for help Persons identified by others in need of help Returnees from abroad (potentially diagnosed abroad)	What types of staff do the initial identification?
	Potential barriers to being identified? Barriers within the community Barriers within the organization/health clinic	Stigma Resources Work overload
Referral pathways to specialized psychiatric treatment	When PRL's in need of treatment have been identified, what will happen then? Who does what and when and it which cases Examples of different types of mental health conditions that are referred for specialized treatment? Assessments of severity? What are the procedures if a person is identified as needing specialized external referral? Are these procedures challenged by any practical barriers Are procedures standardized? Local deviations? For returnees from abroad?	Can you describe the procedures? Can it be illustrated like this? Stepped-care-approach? How does it work? Any barriers? What happens if resources cannot meet the needs?

	Insights from cases that have been referred? Was treatment actually obtained?	Do you follow up afterwards?
	Waiting time, due to Lack of qualified staff? Lack of resources Volume of cases How are cases prioritized?	
	Alternative ways of accessing specialized treatment? Costs?	The possibility and extent of self-referral?
Now we would like to understand more about any potential barriers, that might hinder og reduce the access to specialized treatment for Palestinians in Lebanon. We'll start with potential financial barriers.		
Financial barriers	How are costs for specialized treatment (such as consultations, psychiatric evaluations, medication management and hospitalization) paid for? How much does UNRWRA cover? How much is out-of-pocket? Alternative ways of financing? Do you know of examples of prices for hospitalization, psychiatric evaluation, consultation, medicine management, etc.? Administration of UNRWA coverage/reimbursement? Must the patient wait for reimbursement? Does the UNRWA Medical Hardship Fund cover specialized psychiatric treatment? Examples hereof? Would the described procedures for coverage/reimbursement also apply for PRL returning from abroad?	Is this percentage possible within the current funding situation? How is UNRWA coverage obtained? As part of the referral?
	How are the costs for psychotropic medicine paid for? Does UNRWA cover any costs for psychotropic medicine How much is out-of-pocket?	
	Are there any possibilities for alternative ways of financing specialized psychiatric treatment psychotropic medicine for PRL? Availability Procedures Barriers	Insurance, grants, etc. available to PRLs

	If a PRL in need of specialized psychiatric treatment does not have a willing network to assist the path to financing, how would this affect the possibility of financing treatment?	
Financial barriers	How are these costs (for treatment AND medicine) compared with the average income/average poverty amongst PRL? In the light of inflation/financial crisis in Lebanon (poverty, food insecurity) Would it be realistic to finance for the average/majority of PRL?	
	Effect of the current funding crisis for UNRWA Directly: Does it affect the possibilities for coverage/reimbursement Indirectly: Does the funding crisis affect PRLs average budget (through reduced cash-assistance, need to pay for other expenses)	Future outlook? For tertiary mental medical care?
Socio-cultural barriers	Are there any socio-cultural barriers in accessing mental health care for PRL? Within the community? For instance, stigma or low awareness about metal illness Within the tertiary health system? For instance, informal discrimination against PRL?	
Geographical, logistic, practical barriers.	Are there any logistic og practical barriers in accessing mental health care for PRL? Transport to treatment (including costs) Administrative procedures (need of documents)	If a person is too ill to go to consultations etc. on their own?

Any other potential barriers or important perspectives on PRLs access to specialized psychiatric treatment?

Are there any other perspectives that we are missing?

Thank you very much

We'll send you the notes from the interview within a few days. Possible to make amendments or corrections, and then we hope for your approval as soon as possible, as we would like to publish the report mid-June in order to publish the most updated and accurate information as soon as possible.