IMC Libya
Mental Health and Psychosocial Support Assessment Report

November 2011

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Contents

1. Assessment Goals

The aim of this assessment was to: obtain an understanding of the mental health context (e.g. at risk groups, expressions of distress, coping and community sources of support; attitudes towards people with mental Illness and help-seeking patterns); existing formal and informal mental health services and human resources (availability as part of health care and existing training and educational opportunities). This assessment focused on identifying needs as well as resources and concludes with recommendations based on the findings and interviews with key stakeholders.

2. Assessment Methodology

The assessment was conducted from July to October 2011 by the IMC Libya Mental Health and Psychosocial Support (MHPSS) team including the MHPSS program manager, and program officers with technical support and supervision from IMC DC headquarters.

2.1. Site Visits, Interviews and Focus Group Discussions

The assessment was focused on major conflict affected areas including Benghazi, Misrata, Tripoli and the Nafusa mountains and included the following:

<table>
<tr><th colspan="2">Site Visits and Key Informant Interviews</th></tr>
<tr><td>

Libyan Ministries:

Ministry of Health
Ministry of Social Affairs
National Protection Against Violence Committee (MOH)

Libya medical facilities in Benghazi, Misrata, Tripoli, and the Nafusa Mountains (see section 3.3. for details)
Local NGOs

Attawasul Organization (Benghazi)
Labaik Misrata Association
Haraver Misrata Association
Roaa Civil Association (Misrata)
Libyan Female Doctors Association (Benghazi and Tripoli)
Voice of Libyan Women (Tripoli)
Alleqa Foundation (Tripoli)
Women of Zintan Association

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International Organizations

WHO
UNICEF
UNHCR
UNFPA
OCHA

International NGOs

Danish Church Aid
Hilfswerk International
Malteeser International
Medicines Sans Frontieres (MSF)
Mercy Corps
Save the Children

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<tr><th colspan="2">Focus Groups</th></tr>
<tr><td colspan="2">

Social workers at Benghazi Medical Center
Psychologists at Benghazi Medical Center
Psychologists and social workers from hospitals and social institutions in Benghazi
Doctors, psychologists, and a social worker in Tripoli at the Center for Disease Control

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<tr><th colspan="2">Other Sources of Information</th></tr>
<tr><td>Conversations with participants in IMC PFA trainings

Medical professionals
Humanitarian workers
Volunteers
School teachers

</td><td>Coordination meetings

Health Cluster
MHPSS Sub Cluster
Child Protection Sub-cluster
Gender Based Violence coordination group
Protection Cluster
Education Cluster

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2.2. Assessment Instruments

The assessment tools were adapted from the World Health Organizations (WHO) "Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Crises" (May 2011 Draft version) including the "Checklist for integrating mental health in PHC in humanitarian settings", "Template for desk review of pre-existing information", "Participatory Assessment I: Free listing and ranking of problems with further assessment on daily functioning and coping", "Participatory Assessment II: Example Questions for Key Informant Interviews on Distress and Supports in Different Population Subgroups" and "Interview with traditional/ religious/ indigenous healers on local perceptions of mental health, available resources and coping."

3. Assessment Results

3.1. Sociopolitical Context and Recent Developments

Libya Country Statistics [1]

Population	6,597,960
Religion	Sunni Muslim (official) 97%
Human Development Index	55 (out of 172)
Economy	Upper middle class (oil resources account for approximately 95% of export earnings)
Per capita income	Over US$ 7000 per annum
Total Land area	1 775 500 square kilometers (3rd largest in Africa)
Urban population	85%
Population under the age 15	32%
Life expectancy	73 years
Maternal Mortality	51 per 100,000 live births
Infant mortality	24 per 1000 live births
Literacy Rate for population over 15	86 % (male 91%, female 81%)

3.1.1. Recent Crisis in Libya

Major unrest against the regime of Muammar Gaddafi erupted in Benghazi, eastern Libya on February 17th, 2011, days after the resignation of former president of Egypt, Hosni Mubarak. Gaddafi and his supporters violently retaliated against the protesters as the uprisings gained in popularity throughout the country and the situation soon after devolved into intense armed conflict between the two sides. The opposition gained significant ground at first, with the establishment of the Transitional National Council (NTC) in Benghazi on February 27th and control of several, major population centers. However, Gaddafi's better-equipped and organized forces launched major offensives leading to sustained active combat. NATO coalition forces became involved in the conflict when clashes continued despite the March 17th adoption of UN Security Council Resolution 1973, which imposed a no-fly zone over Libya.

The conflict has been characterized by a series of offensives and counter-offensives between opposition and rebel-led forces as control of major population centers along the Northern coast were regained and lost by one side or the other. However, opposition forces continued to make significant gains. In the Western Mountain region, rebel forces took control of Tiji and Badr following heavy fighting leaving no major frontlines in this region. They also took control of Gharyan to the far east of the Western Mountains.

On August 13th, rebel forces pressed into Az-Zawiya, 30km west of Tripoli, seizing control of the port, a crucial oil refinery and eventually the entire city. They also took full control of several towns to the west of Az-Zawiya, including Al-Ujaylat, Sabrata, and Surman. On August 21st, rebels advanced through Mayah and Janzur in to Tripoli. Forces also arrived at the port from Misurata enabling rebels to take control of the port and Green Square, renaming it to its original name of Martyr's Square and in several days had also taken full control of Tripoli. Following fierce fighting in September and October, rebels gained control of these remaining loyalist pockets, with Sirte being the last remaining loyalist stronghold to fall on October 20. On this day, more than eight months after the Libyan revolt began, the developments in Sirte ultimately led to the death of the former Libyan leader,

[1] Source: EMRHSO, 2007

liberating the country of the Gaddafi regime. The situation in many conflict-affected parts of Libya that experienced fighting has continued to stabilize. In these areas, humanitarian organizations are phasing out their response and switching to longer-term planning and recovery activities.

In all conflict-affected population centers, the violence has severely impacted social services, the health infrastructure, and the daily lives of civilians. Normal supply chains have been disrupted resulting in shortages of food and critical medical supplies and equipment; key medical staff have fled at a time when health facilities are attempting to treat and manage increased caseloads; and electricity and water cuts as well as destroyed physical infrastructure are adding to the hardships faced by civilians. Chronic illnesses could be properly treated anymore as health workers have fled or have had to prioritize trauma cases. To date there have been hundreds of deaths and thousands of injuries, some of which have led to amputations.

3.1.2. International Medical Corps in Libya

International Medical Corps has been on the ground in Libya, providing assistance to the Libyan people from the rise of the Arab Spring to the fall of the Gaddafi regime. As the people of Libya recover and begin to rebuild, International Medical Corps remains ready to respond to the ongoing and future needs in the country.

International Medical Corps has been responding to the crisis in Libya since February 27, 2011. As access permitted and as needs were identified, teams expanded activities for a country- wide response, including eastern Libya, Misrata and Sirte, the Western Mountains, Tripoli, as well as the Egyptian and Tunisian border regions that received large numbers of Libyans and third country nationals fleeing the violence. International Medical Corps was one of the first international NGOs to arrive in Benghazi, the first to arrive in Misrata, as well as in Tripoli and the northern front of the Western Mountains. More recently, International Medical Corps has continued to provide support in Libya, including response activities for the high numbers of casualties and internally displaced persons as a result of the conflict in Sirte, Sabha, Jufrah and Bani Walid.

Since the start of its Libya emergency response mission, International Medical Corps has performed lifesaving operations on more than 2,000 individuals, evacuated nearly 500 severely wounded casualties from Misrata, delivered millions of dollars of essential medical supplies, and conducted capacity building trainings for health professionals and first responders on emergency medic training, ambulance equipment and safe transport, clinical management of rape survivors, and mental health and psychosocial support (e.g. PFA, IASC Guidelines).

3.2. Mental Health and Psychosocial Context

3.2.1. Prevalence of Mental Illness

It appears that there have not been any published figures of the prevalence of mental disorders in Libya prior to the conflict. According to general estimates of mental health problems following humanitarian emergencies, the Word Health Organization (WHO) predicts that most people will experience psychological distress reactions (e.g. having trouble sleeping, feeling anxious or hopeless or having physical symptoms such as headaches, stomach aches or body pain related to stress) while the number of people with common mental disorders (e.g. depression, anxiety disorders) may double from a baseline of 10% to about 20%. The percentage of individuals with severe mental disorders is expected to increase from about 1% to 2%. Furthermore, people with pre-existing mental disorders especially vulnerable during times of conflict and instability as they may not be able to access needed care and medication.

3.2.2. At Risk and Vulnerable Groups

When questioned regarding at risk and vulnerable groups, and those most affected by the conflict, most respondents in key informant interviews identified the following groups:

- Children
- Women, especially mothers
- Families who lost loved ones in the conflict, or whose family members have gone missing
- Freedom fighters, especially amputees, and those who fought for the duration of the conflict
    - There is an overall concern for reintegrating civilians who were fighting back into their old lives
- Released prisoners, especially those held captive for 6 or more months, and those who were sexually assaulted
- Medical first responders

In addition, the Protection Cluster in Libya has identified five vulnerable groups who are facing protection threats or direct violence in relation to their previous actual or perceived association with the former Gaddafi regime. According to the protection cluster, "some 60,000 persons part of these minority groups suffered direct act of violence and have been displaced, are still displacing in the country or seeking asylum in Tunisia." (UNHCR, October 2011). The groups include:

Tewergha • Place of origin: 50 Km south east of Misrata. • Sub-Saharan origin population. • Original population of 35,000 individuals. • 100% Population forced displaced between 12th and14th August 2011 Mushashya • Place of origin: East Nafusa Mountains – Area of Yafran. • Arab origin. • Population 8,000. • 8000 individuals forced displaced in June 2011. - Tripoli (100% in June – 70% to date after resettlement). • Reconciliation process ongoing with Zintan council. • Resettlement proposed by Zintan Council to Mizdah. 30% reported resettled	Gwalish • Place of origin: 160 km south of Tripoli (eastern part of Nafusa mountains – West of Bani Walid). • Arab origin. • Population size: 12,000. • Reconciliation ongoing with Zintan Council. • Return reported. Siaan • Place of origin: West Nafusa mountains: Tiji (population of origin: 18,000) – Badr (population of origin: 11,000). • Arab origin. • Original population: 15,000. • Population displaced from Tiji 11,000 and Badr 5,000 Taminah • Place of origin: 30 km south of Misrata. • Arab origin. • Population size unknown. • Protection threats: Misrata NTC.

3.2.2. Mental Health Related Problems, Coping and Community Sources of Support

Various key informants asserted that the armed conflict has had a clear impact on the community. In health facilities medical staff identified increased stress reactions from patients including aggressive behaviors, grief, despair, and anxiety. Examples of stress reactions among children given by a Tripoli pediatrician included enuresis, nightmares, regressive behaviors, and somatic symptoms in many of his young patients. In five key informant interviews using questions adapted from the WHO Toolkit (Tools 11 and 12, see Appendix 2), the following groups were identified by the interviewee as the "most at risk". Detailed information regarding perceived mental health and psychosocial support issues and resources is summarized in the following table.

Table 1. Mental Health Related Problems, Coping and Community Sources of Support.

Stressors and priority MH related problems	Coping methods	Community sources of support	What more could be done to support this group?	Community attitudes
At Risk Group:: Children				
1. Aggression 2. Fear 3. Stress/ conflicts within families 4. Hyperactivity 5. Increased sexual behavior 6. Enuresis 7. Insomnia	"Children do not know what to do." Parents/ families are coping by: 1. Beating their children 2. Being overprotective 3. Waiting for services to begin	Some NGO's are trying to connect families with distressed children to clinics/ supportive centers. Otherwise, nothing is being done.	1. Community awareness raising/ educating parents 2. Encouraging parents about the dangers of TV programs and exposing children to violence 3. More funding/ support to existing centers that help children	Most people understand that children have been affected by the conflict. When children have special needs, including mental health problems, the community feels pity for them. A child with any disability is seen as a "burden on a family, especially girls."
At Risk Group:: Women				
1. Loss of security and routine 2. Fear 2. Loss of loved ones 3. Hopelessness 4. Financial fears 6. Unemployment 7. Weakened social connections 10. Symptoms of anxiety and depression	1. Organizing charity groups 2. Working with Freedom Fighters support groups 3. Organizing bazars 4. Leaving homes to work together 5. Keeping themselves busy 6. Cleaning hospitals 7. Isolating themselves 8. Refusing to return to old routines 9. Denying/ acting like things aren't happening 10. Sewing revolutionary flags	All support being provided is financial, but no emotional psychosocial support is offered for women. Charity organizations are offering some material support, and social services are paid for internally displaced people, but there is nothing else.	1. Training local professionals to help women would help more than approaching women directly. 2. Teaching people the right approach to work with women. 3. More media attention regarding supportive services for women 4. More groups/ organizations for women (including women's centers)	People are not as judgmental as they were before, but still women with mental health problems are afraid that the community will judge them.
At Risk Group:: Freedom Fighters (generally ages 16-30)				
1. Isolation 2. Risk taking behavior 3. Resentment 4. Inability to reintegrate into society 5. Feeling a sense of authority (acting as if they are the law, there are no repercussions and that they have no responsibilities, resulting in chaos and instability in society)	1. Isolate themselves to their "brigade" and their "barracks to avoid dealing with civilians 2. Seek out any conflict and sometimes create conflict over minor issues 3. Alcohol and substance abuse 4. Surrounding themselves with their friends 5. Travel abroad for a while 6. Charity and community work to help rebuild Libya 7. Talking about what happened with family and friends.	1. Charities raise money to help injured but funds are paying for hospital stays and food rather than psychological treatment (which new government has said it will pay for, but is not currently) 2. Organizations are gathering information regarding the wounded and missing, 3. Charities are organizing local blood donation centers 4. Local youth organization arrange gatherings at Martyr Square for youth where professionals give lectures about Libya's political future and information about possible future roles for the FFs in the community 5. Community members visit the injured to provide support, they provide them with basic personal items (clothes toiletries) , some charities gathering money to pay their medical treatment. 6. Many organizations who talk about helping but none focus on helping freedom fighters reintegrate into society	1. The Temporary Government should treat those with physical injuries with transparency so people can follow the progress. 2. The NTC should reassure them that they will not be oppressed by a Gadaffi like regime. 3. Give them information regarding their future as combatants and the strategy for the future so they can ultimately lay down their weapons. 4. Government must pay them a salary and give them a feeling of importance and respect. 5. Arrange job opportunities for them as a way to integrate them into society and keep them busy. 6. The government must create a database of all injured so follow up can take place and money is directly allocate to those in need.	The community initially loved the FF and rejoiced at their presence, however recently it has become negative due to: 1. Community members don't want to praise them for fear of feeding their entitlement to power, status or money. So, community members are belittling them and dismissing their efforts. 2. Some FFs looted and are squatting in people's houses; this has resulted in an attitude change towards all FFs even those who are upholding the law.

3.2.3. Attitudes Towards People with Mental Illness

Severe social stigma exists regarding those affected by mental illness. Both the Benghazi and Tripoli Psychiatric Hospitals are known to be "frightening" places only for "crazy" people with severe mental disorders. Women receiving care at a psychiatric hospital are marked as "crazy" her chances for getting married are greatly diminished, and she is likely to be perceived as a burden on her family for the remainder of her life. There are fewer female than male inpatients in psychiatric hospitals, because of stigma. In order to protect the family, sometimes individuals are sent to the opposite side of the country for care (ie: a girl from Tripoli will be sent to Benghazi Psych Hospital) or even to another country (e.g. Egypt). Families who have the means will seek out private psychiatric services.

Comments regarding people diagnosed with mental illness from key informant interviews:

- *"Once a person is identified as having a mental illness, everyone assumes that s/he is lost, and that there is no hope for their future. There is a stigma that will remain with a person for the rest of his or her life."*
- *"Many times it is assumed that marriage will 'fix' mental health problems, but this often makes things worse. For women, it is worse because her husband will divorce her, and her family will disown her. Even if a man with a mental illness gets married, his wife often cannot divorce him, she has to learn to deal with it."*
- *"People with mental illness are pitied, isolated, and shamed. Families carry great burdens when their son or daughter have a mental illness."*
- *"People who have mental disorders due to substance abuse are viewed as weak."*
- *"The community thinks that they (people with mental illness) are crazy and should be kept away from society as they fear them. If a family member has a mental illness they keep them hidden and isolated from other people and if an outsider they make fun of them or avoid them."*
- *I advise patients to lie in order to avoid stigma take their medication. The stigma of taking medication or going to the psychiatric hospital is so severe, "a girl has better chances to get married who is hearing and responding to voices, while being treated by a sheik; rather than one seeing a psychiatrist and taking antidepressant medication." Furthermore, the girl who is taking antidepressant affects all of her sisters' chances of getting married as well.*

3.2.4. Help-Seeking Patterns

Key informants reported that psychiatric health services are only sought out as a desperate measure after other alternatives have failed and mental health problems are severe or urgent. Families typically seek help from traditional healers and Sheiks first. When families do seek psychiatric help, there is often little psychoeducation, long lapses between appointments, and inconsistent follow-up. Average psychiatry sessions may only last 6 minutes, leaving little to no time for patients and families to understand how medications work.

3.3. The Mental Health System

3.3.1. General Health Care

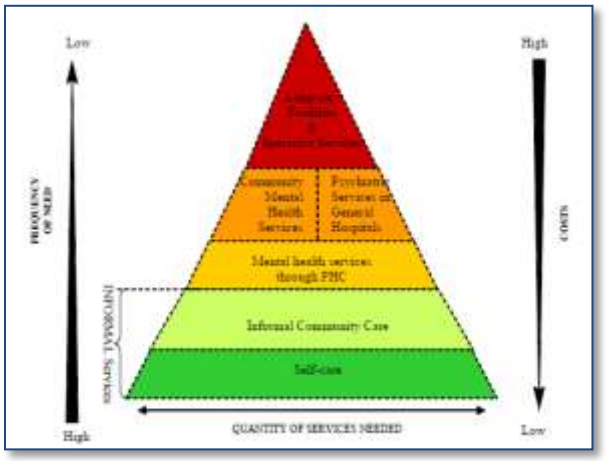
According to the Libya Health and Environment Report of 2010 there were 97 hospitals, 37 polyclinics, and 535 health centers functioning prior to the conflict. A WHO assessment conducted in May- June 2011, reported that the primary health care system has been "shrinking and collapsing" in recent years, and that public hospitals function as primary health facilities since the majority of people seek out hospitals as a first point of contact for health problems and not polyclinics or health centers (Shibib, 2011). Libyans have access to medical specialists, without a GP gate keeping role. The 2010 Health and Environment report estimates that 100% of the Libyan population have access to local health care services, but there is no mention in the report of mental health services available to the Libyan population.

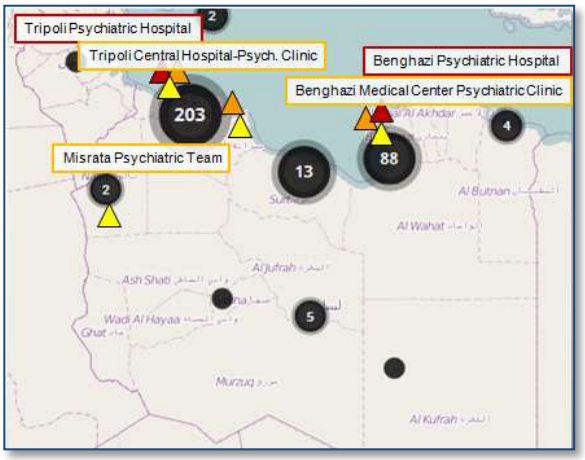
It has been reported that Libya has been educating an excess of doctors with 15000 students in medical faculties, compared to only 9000 practicing doctors, and a total population of around 6 million (Libya Social Services Draft, July 2011). At the same time there is a shortage of other specialized health workers such as pharmacists.

The recent conflict has impacted the health care system by damaging infrastructure and compromising the availability of medical equipment, supplies and medications. The flight and absenteeism of workers has also led to a shortage of medical staff. According to WHO 16% of doctors (1,618) were foreign workers before the conflict. Similarly, historically significant numbers of nurses were hired from other countries. According to the 2007 Libya Demographic Health Survey (DHS-EMRO) there were 2,080 foreign nurses/midwives working within Libya's health structure. The emphasis on in-sourcing foreign nurses, beginning in the 1980's, was influenced in part by a national trend towards "outsourcing to experts."[2] As a result, the perceived value of Libyan nurses diminished and they were increasingly removed from "hands-on" activities at the patient's bedside. Today, nursing is often seen as the lowest possible rung on the professional ladder functioning as "white-coated mop handlers". When the conflict occurred, the majority of these workers fled the country, leaving the Libyan medical system in nursing shortage crisis. In addition to missing foreign workers, another obstacle faced with the onset of the conflict was absenteeism of medical staff from hospitals and polyclinics. For example, in the Tripoli psychiatric hospital alone, approximately 165 Libyan nurses out or 177 have been absent for periods of time since the conflict. Many medical students volunteered to take on nursing roles to fill the gaps and some organizations and NGOs (including IMC) brought in short term volunteer doctors and nurses from other Arab countries such as Jordan.

3.3.2. Mental Health Care in Affected Areas

Mental health service provision in Libya is highly centralized. Two national psychiatric hospitals are located in Tripoli and Benghazi. According to key informants, there were some efforts to begin decentralizing services prior to the conflict. According to the WHO optimal mix of services, health systems should provide multi-layered services to support the mental health and psychosocial support of the community (see pyramid below). The map of conflict affected areas (armed confrontations[3]) below shows the distribution of mental health services in Tripoli, Benghazi, Misrata and the Nafuza mountains.





[2] Nagia Naweji Bu Naweji, WHO/Libya Nurse Liaison, Meeting at WHO, October 23, 2011

[3] Source: OCHA , Feb-July http://libyacrisismap.net/#

I. Inpatient Psychiatric Facilities

There are two psychiatric hospitals in the country, one in Tripoli and one in Benghazi. There are no facilities or services for adolescent or child psychiatry, forensic psychiatry, or older-adult psychiatry.

Table 2. Inpatient facility overview.

Name: **Tripoli Al Razi Psychiatric Hospital** Location: Tripoli	Catchment Population: Western Libya (4 million)	Furthest distance traveled by patients to access clinic: across country	Average number of patients per day (past month): 150-250 in OPD	Number of beds: 60 (m and f) for acute ,120 (m and f) for chronic, 40 (m) for forensic cases
Staffing	Psychiatrists	Psychologists	Social workers	Other staff
Number	20 (14 Junior psychiatrists)	6 (none studied clinical psychotherapy)	12	177 Nurses
Training provided	Experiential	Some trained by MSF in PFA and basic counseling skills 3 trained by IMC in PFA	Some trained by MSF in PFA and basic counseling skills 1 trained by IMC in PFA	Approx. 12 trained in the Philippines.
Name: **Benghazi Psychiatric Hospital** Location: Benghazi	Catchment Population: Eastern Libya (2 million)	Furthest distance traveled by patients to access clinic: across country	Average number of pts per day (past month): 50 in OPD[4]	Number of inpatients: 300 (full capacity 400)
Staffing	Psychiatrists	Psychologists	Social workers	Other staff
Number	17 (12 Junior psychiatrists)	40	20	Nutritionist, Community Medical Doctor, Dentist, Dermatologist
Training provided	3 JPs trained in PFA by IMC	3-4 have some training in CBT, 35 trained in PFA by IMC	20 trained in PFA by IMC	

Context: In the 1980s the Tripoli Psychiatric Hospital (TPH) hospital was under the direction of Ministry of Social Affairs (MoSA) with a capacity of 1200 beds. The hospital also served community members with developmental and learning disabilities. In 1985 the hospital was restructured under the Ministry of Health (MoH) to treat only psychiatric cases and there was a severe reduction of staff. The addiction treatment center of the hospital was closed in 2007, and now all addiction cases are sent to the Benghazi Psychiatric Hospital (BPH) which is the only option for addiction treatment in Libya.

Impact of the Conflict:

- Mental Health: The TPH reported that initially, due to security issues, the number of patients dropped drastically. As Libya has been stabilizing, the numbers of patients visiting the OPD increased from 100 patients per day to 200 per day and continues to increase. TPH staff stated that they have not seen many "victims" of the war, or freedom fighters coming in for treatment, although there is large public awareness of the need of psychosocial support for this group. BPH reported a slight increase of cases of PTSD and expects the general caseload to increase in the post conflict environment.
- Staff: TPH and BPH reported that there has been a shortage of staff due to employees not showing up during the conflict or being absent from work for various reasons.
- Medications: There also is a shortage of medications including sedatives, mood stabilizers and anti psychotics which has been exacerbated by the conflict.

Current Reported Needs

- Human Resources: TPH reported a shortage of qualified staff including psychiatrists, psychologists and nurses. The average time spent with a patient is 6 minutes, and staff are reporting that they are beginning to recognize signs of burn-out. At BPH there is an excess in psychologists since the hospital is perceived as the only place where psychologists can receive quality training but they lack appropriate qualification and

[4] 2 doctors available to see patients at a time (consultant and psychiatrist)

skills. One of greatest reported needs was additional staff nurses, and particularly those who have psychiatric backgrounds/ training from other Arab countries.

- Training: TPH identified several training needs for psychiatrists, psychologists, social workers, and nurses including communication skills/ interview skills, medical ethics, boundaries, international standards for different professions (social work, psychology, nursing, psychiatry), documentation, leadership/management and working in a multidisciplinary team approach. BPH identified similar needs including counseling/ psychotherapy for psychologists, and basics in psychiatric nursing for nurses.

II. Psychiatric Services in General Hospitals

Context: In October 2010, a group of psychiatrists from Benghazi and Tripoli submitted a proposal to the Ministry of Health to integrate mental health into general health care, by creating psychiatric units in hospitals in highly populated areas. In addition, a conference had been planned for March 2011 for Libyan psychiatrists to create a national mental health policy, and to begin strategizing to decentralize mental health services from the psychiatric hospitals. Although the conference never occurred due to the conflict, two psychiatric offices were successfully established in Benghazi Medical Center (BMC), and Tripoli Central Hospital (TCH). However, it is reported that TCH is under the direction of the Psychiatric Hospital, and not the Central Hospital leadership and that services at the TCH are not well integrated with the Psychiatric Office. There are psychologists in each inpatient department, but they rarely collaborate as a team with the psychiatric office. Patients are typically referred to the psychiatric office from doctors, only through inpatient units, and many of them refuse care. Sometimes patients come to the clinic from the community, if a family member or friend works in the hospital encourages them to come in for treatment.

In Misrata, Psychiatrists were not available prior to the conflict. Psychologists provided some treatment (reportedly even at times prescription of psychiatric medications) and one neurologist was available to fill repeat prescriptions of psychotropic medications. Those with mental health problems had difficulty accessing psychiatric hospitals or private clinics in Tripoli and Benghazi due to the high costs of travel (and additional costs of care provision and medication).

Impact of the Conflict

- Mental Health Services: As a result of the conflict, psychiatric services are now also provided in Misrata (for a useful detailed report on mental health services development and needs in Misrata (see Seweheli, 2011). Starting in May and June, two psychiatrists started providing psychiatric services in polyclinics and officially formed the Misrata Psychiatry Team (MPT). In September of 2011, the team moved to the National Cancer Institute in Misrata due to lack of suitable place offered by clinics and refusal of others to have mental patients seen on their grounds.
- The Misrata Committee for Mental Health (MCMH) initiated services when the conflict and started working with 15 psychologists under the direction of one psychologist. Those psychologists have also received some basic mental health training and supervision by MSF. The Amal Alghad Private Clinic has started offering reduced fee services for those with mental health problems due to the conflict.
- Mental Health: The TCH psychiatric office reports an increase in suicidal patients early on in the conflict, but notes that the numbers have decreased the past few months. TCH has also seen an increase in anxiety disorders, and people experiencing panic attacks. The MPT reported that some of the most common mental health problems are depression, PTSD and OCD.
- Medication: In Misrata, the availability of psychotropic medication in health facilities and pharmacies has historically been irregular, resulting in patients not having access to the type of medication that worked well for them and patients relapsing. Furthermore, many patients are on too high doses of psychotropic medications or on medications unsuitable for their illness.

Current Reported Needs

- Human Resources: The TCH as well as BMC psychiatric office and MPT are in need of additional specialized staff (nurses, psychologists, social workers) to function as a multi-disciplinary OPD (MPT is requesting 10

psychiatric nurses and 5 psychologists). The MPT is in need of financial, medical, administrative and logistical support to build a proper functional service in Misrata.

- Training: The TCH psychiatric office, the MPT, and MCMH noted that medical staff in the hospitals should be trained in recognizing and referring patients with mental health problems while psychologists and social workers need basic skills in their professions. BMC also expressed needs for training of existing and potential new specialized staff. The MPT noted the need for training psychologists in basic clinical psychology and CBT, and training for medical specialties in managing acute mentally unwell patients. MCMH also noted additional training needs for psychologists including health psychology, behavior modification, trauma, psychotherapy techniques, and speech therapy.

Table 3: Community Mental Health Services Overview

Name: **Tripoli Central Hospital Psychiatric Office** Location: Tripoli	Catchment Population Western Libya:	Furthest distance traveled by patients to access clinic: Nafusa mountains	Average number of pts per day (past month): 3-4 (clinic is open 4 days a week in the mornings)
Staffing	Psychiatrists	Psychologists	Social workers
Number	2	1 (MA in psychology)	0
Training provided		Trained by MSF in PFA	-
Name: **Benghazi Medical Center Psychiatric Clinic** Location: Benghazi	Catchment Population: Eastern Libya (2 million)	Furthest distance traveled by patients to access clinic: unknown	Average number of pts per day (past month): 5 Number of inpatients: 300 (full capacity 400)
Staffing	Psychiatrists	Psychologists	Social workers
Number	2 (2 days/week)	0 [8 psychologists work at the BMC but not the psychiatric clinic]	0 [12 social workers work at the BMC]
Training provided	Trained for 4 months by MSF-F; foundations of clinical psycho-therapy, CBT, and treatment of trauma	[7 social workers and psychologists attached to the BMC but not psychiatric unit participated in IMC PFA training]	
Name: **Misrata Psychiatric Office** Location: Misrata	Catchment Population: Misrata, and surrounding areas (700,000)	Furthest distance traveled by patients to access clinic: unknown	Average number of pts per day (past month): 30
Staffing	Psychiatrists	Psychologists	Social workers
Number	2	1 (MA in psychology)	0
Training provided	-	Trained and supervised by MSF, since August 2011	-
Name: **Misrata Amal Alghad Private Clinic** Location: Misrata	Catchment Population: Misrata, and surrounding areas (700,000)	Furthest distance traveled by patients to access clinic: unknown	Average number of pts per day (past month): 10-13; 150 psychiatric patients per week
Staffing	Psychiatrists	Psychologists	Social workers
Number	1 (psychiatrist from Zlintin plans to come 1 day/ per week to support)	10	3-4
Training provided	-	10 Trained and supervised by MSF since August 2011 (basic counseling, CBT, and trauma workshops)	-

III. Mental Health Services through General Health Clinics

Impact of the Conflict:

- Mental Health Services: As a result of the conflict, several psychologists and social workers have started working or volunteering at general health clinics. However, they often work unsupervised and without the needed clinical skills.
- *In Misrata* MSF has provided some training and supervision for psychologists since August 2011. Several psychologists have been working under supervision of MSF in 2 hospitals (Anoor Hospital (2 psychologists), Ras Atuba Hospital (2)), 2 Medical Centers (Ras Atuba Medical Center (1), Health Center Askerat (1)), 6 Polyclinics (Almahjub poly clinic (3), Red crescent poly clinic (2), Red crescent poly clinic (private, 2), Asafwa private clinic (1), Red crescent "Arwesat" private clinic (1), Qasar Ahmed clinic (2)) and Altadhamon Physical Rehabilitation Center (1). Reportedly, MSF-B plans on remaining in Misrata until February, while MSF-F will be departing in early November.
- *In Benghazi*, the Office for Medical and Psychosocial Support for Freedom Fighters has been operating and is employing 15 psychologists (1 psychologist was trained by Tawassel Organization in treatment of trauma/ PTSD) and 10 social workers. Benghazi Rehabilitation Center is employing 5 psychologists and 5 social workers.
- *In the Nafuza mountains*, Zintan Hospital has received visits from two psychologists for six days a week and Yefrin Hospital from one psychologist for two days a week while both have received visits from a psychiatrist every two weeks. The two psychologists who provided the services were from Tunisia and received some training and their salary from MSF-Ch. After departure of MSF, IMC has taken over funding for one of the Tunisian psychologist and is in the process of identifying national psychologists for further training.

Table 4. Number of hospitals and polyclinics in affected areas

	Tripoli	Benghazi	Misrata	Nafuza Mountains
Hospitals	15	15	6	9
Polyclinics	11	6	4	1

Integration of Mental Health

The IMC MHPSS team visited 7 health facilities in Tripoli (one medical center, one pediatric hospital, one women's hospitals and 4 polyclinics) and two in Zintan (two Polyclinics) and administered the IMC adapted version of the WHO MH PHC integration checklist (see Appendix 2).

Table 5. Health facilities visited.

Name of Health Facility	Location	MHPSS Staff	Staff Trained in MH	Staff refer to MH Services
Al Jala Obstetrics and Gynecology Hospital	Tripoli	2 psychologists 4 social workers	6 (20 hrs)	Yes
Al Jala pediatric hospital	Tripoli	2 psychologists (1 trained by IMC in PFA)	1 (10 hrs)	Yes
Tripoli Medical Center	Tripoli	5 psychologists (4 trained in PFA by MSF-B) 20 social workers (Visiting FF in hospitals)	4 (6 hrs)	Yes
Alhureya Polyclinic	Tripoli	3 social workers	0	No
Al Rada Souk Juma Polyclinic	Tripoli	3 social workers (were absent due to fighting in war)	0	No
Fashlum Polyclinic	Tripoli	0	0	No
Tajura Polyclinic	Tripoli	0	0	No

Awlet Kalifa Polyclinic	Zintan	1 Tunisian Psychologist	5 (5 hrs)	Yes
Qwasin Polyclinic	Zintan	1 Tunisian Psychologist	0	Yes

1. Mental health Training and Skills
   - Staff in 3 facilities had received limited MH training (see table above) but none received follow up supervision.
   - It was reported that none of the clinics staff (except Tripoli Medical Center) had skills in assessing people with mental health problems or in managing some of the WHO mhGAP priority conditions for general health care (depression, epilepsy, alcohol/substance use, intellectual disabilities, psychotic disorders, unspecified somatic complaints, suicide and self-harm) or in providing basic psychosocial interventions.
2. Mental Health Service Provision
   - At least one female health care provider is on staff in all facilities and patients are seen in private (except for one facility)
   - Two health facilities reported having seen cases of depression, anxiety and somatic complaints , the children's hospital reported having identified cases of epilepsy and intellectual disabilities
   - None provided management or maintenance treatment for mental disorders
   - None discuss MH cases in team meetings
   - None of the clinics (except Tripoli Medical Center) had any of the WHO essential psychotropic medications in stock
   - None engage in MH community mental health education
3. Referral:
   - 5 of 9 facilities refer "sometimes" or "rarely" to MH specialists but referral occurs mainly to the psychiatric hospital. All of the health facilities identified the Tripoli AL Razi Psychiatric Hospital as the only referral point for mental health cases.
   - Referrals are made through personal contacts at the psychiatric hospital. It was reported that a significant reason why patients are not utilizing the existing psychiatric resources outside of the psychiatric hospitals (BMC and THC psychiatric clinics) is because doctors are unaware of their existence, and do not have relationships with the psychiatrists working there.
   - None have referral links with protection or community services
4. Data Collection:
   - 4 health facilities recorded mental health problems in charts but none tracked or analyzed this data.

Current Reported Needs:

- Training: All of the facilities that IMC visited reported that training was needed for psychologists and social workers. Out of ten visits with psychologists in the facilities listed above, not a single psychologist reported having been trained in assessment, diagnosis, clinical interventions. When asked in each of these interviews, psychologists described ways of trying to support patients including, "listening to their problems, talking to family members, and giving them advice." Social workers reported needing training in basic social work skills and protection issues (e.g. child abuse, domestic violence, family conflict).
- Human Resources: Findings from the majority of the visits suggest that not more staff was needed, but that roles needed to be clarified and promoted. In a focus group discussion with social workers in

Some examples of problems which are addressed by social workers include "illegal pregnancy", family problems, violence in the home, or disappointment of family members when a daughter, rather than a son is born. One social worker stated that they are mandated to report all cases of "illegal pregnancy" to authorities. They explained that prior to the conflict, there was a police officer stationed at the hospital that they were to call when cases present. The social workers explained that most women who come in with an illegal pregnancy do not report sexual assault, and that they think most of the cases are consensual intercourse. Although the police are supposed to seek the man involved in the illegal pregnancy, the social workers described that the men "never" are found, and women bear the burden alone. Women who are found to be illegally pregnant are sentenced up to 5 years in jail, but are typically released after a few months (usually because of family connections in the legal system.) Many of these women never return to the hospital, and their children are abandoned.

Benghazi, we found that their only task was taking patient satisfaction surveys. Similarly, psychologists in Benghazi Medical Center explained that they were not respected or referred patients.

Perceived Barriers to Mental Health Service Provision

Respondents and key informants working in specialized and general health facilities named the following barriers to the provision of accessible and high quality mental health services in Libya:

- Mental health in Libya has historically been underfunded and there is no official allocation for MH funding in the health sector
- Lack of knowledge of clinical skills or best practices across disciplines and including directors of clinics
- New leadership can be an asset, but also a barrier. In the interviews, all of the clinic and hospital managers were new to their roles, and did not have the administrative knowledge or experience.
- Short staffing hours (typically 9-2 daily across all medical facilities)
- Many senior medical staff are not seeing patients, while younger staff bear most of the burden of heavy case load, and little experience (especially in the psychiatric hospitals).
- Absence of a national health information system
- Psychotropic medications are available only with a prescription from a psychiatrist

IV. Informal Service Providers

Local Non-Governmental Organizations

Prior to the conflict, there were few local NGOs offering social welfare services and those that existed were closely monitored and controlled by the government. Since the start of the conflict there have been over 500 new NGOs registered by the Transitional National Council TNC's Ministry of Social Affairs in Libya and 200 in the eastern Part of Libya alone. There has also been an increased number of organizations appearing in Tripoli. In May 2011, the TNC Public Engagement Unit conducted a one-day workshop for 27 Benghazi based NGOs to assess capacity building needs. Findings revealed that lack of financial resources and facilities, the difficult security situation, and insufficient supplies were major limitations. NGOs expressed the need for stronger communication and relations with the public authorities and international NGOs and other relevant stakeholders.

Some of these new organizations are motivated to provide "psychosocial support" particularly to vulnerable groups (Freedom Fighter's families, people whose family members have gone missing, and children.) One of the organizations identified has committed 4 social workers and 2 psychologists. The majority of the groups do not yet have clear mission statements, sustainable funding sources, or long-term plans. The sustainability of such organizations is unpredictable, as many of their workers are volunteers, who eventually plan to go to work. However, it is expected that some of those organizations continue to grow and function, taking on key roles in development and rebuilding efforts in Libya.

The School System

Nine years of basic education are compulsory and free for all children and youth between the ages of 6 and 15 years of age. As a result, school enrollment rates are estimated at close to 100% reaching both boys and girls. Some schools have been damaged in the conflict and it is reported that many expatriate teachers have left although exact numbers still remain unknown. School systems have been disrupted as a result of the conflict and many students in affected areas had to stop classes for extended periods of time.

IMCs assessment suggests that public schools in Libya are frequently overcrowded, physical punishment in schools is frequent, and the learning style tends to be non-participatory. Teachers are often overwhelmed having to cope with large class sizes and with emotional as well as behavioral problems such as aggression and hyper-activity among children. Social workers in schools are poorly prepared for their roles as existing educational institutions do not provide sufficient training and skills building for functioning effectively as a social worker. As a result, social workers at schools are under-utilized and under-appreciated and often function merely as disciplinarians for students. Indeed during IMCs needs assessment, a major obstacle identified in re-establishing disrupted linkages to social welfare interventions to vulnerable groups such as children in schools is the lack of well-qualified social work professionals.

The most significant needs identified by service providers, social leaders and key stakeholders in Libya were gaps in human capacities and training. In the post-conflict period, it been noted that there will be a need to adjust existing methods of teaching and revise school curricula to encourage free expression, access to knowledge outside of Libya and practical skills acquisition (Libya Social Services Draft, 2011). Now that students are returning back to school, there have also been increased concerns about finding ways to help children and youth cope who have been affected by the conflict and creating supportive school systems. Many parents are concerned about their children's' behavior and teachers will have to respond to increased behavioral and emotional problems and need for support among children and their families. This will entail trainers of teachers, administrators and supportive staff such as social workers in pedagogical child-centered, participatory and psychosocial approaches.

Some international NGOs such as Save the Children, Act Alliance and IMC have provided training and workshops for parents, teachers and support staff in basic psychosocial support and helping children cope. Longer term needs will include more sustainable capacity building of staff to function in their roles and support children within the school system.

Traditional Healers

There are variety of traditional healers in Libya, ranging from those who practice in rural communities from their home, and those who have services provided in medical clinics. One key informant interview was conducted with a traditional healer in a medical clinic. He explained that one the main method he practices is "cupping" in which he makes an incision in the skin and then uses a glass cup (after heated with fire on the edges) to suction the blood. The healer explained that the practice should not be painful, and is based on years of Sharia/ Muslim law and the cycle of the moon. The healer explained that he uses a holistic approach and encourages patients not to smoke, drink caffeine, or consume fat or sugar. He also uses massage and "basic therapy" through conversations during treatment. The healer explained that he has seen incredible results, and people healed from Hepatitis and high blood pressure.

The healer reported that the most frequent mental health problems he sees include schizophrenia, depression and anxiety. Treatment methods used for schizophrenia are basic, and he explained that all he typically does is provide some herbal remedies and honey. Meanwhile for depression and anxiety, he described a more detailed treatment with the following steps:

- Prior to treatment: No eating, drinking, stimulants, or sex for 24 hours
- Treatment: 3 consecutive days of cupping on the back of the neck and on top of the head. The same treatment is repeated every 15 days after the initial 3, and then every 2 months for 6 months.

He lamented that untrained traditional healers give the qualified healers a negative reputation. He cited some examples of healers who use methods such as cutting, burning skin, and beating to release "evil spirits." Furthermore, he explained that sheiks typically treat people with water and honey, and reading the Koran. If the affected person does not show improvement, untrained sheiks may use methods such as burning and beating.

V. Self Care

There are currently no known psychiatric service user organizations in Libya. Some Libyan mental health professionals and international NGOs (e.g. IMC, Save the Children, see details in section 3.5) have been engaged in community psycho-education and awareness raising about positive coping and available mental health and psychosocial support services. On World Mental Health day (October 10th), the Tripoli Psychiatric Hospital organized an event inviting people affected by mental health problems and the wider community to hear speeches about mental health promotion and engage in recreational psychosocial support activities. With new leadership and emerging civil society organizations, there is also an opportunity for better representation of those affected by mental illness and for advocacy work and promotion of an inclusive society.

3.4. The Educational System and Training Opportunities

3.4.1. Medical Professions

Psychiatrists: For an individual to become a psychiatrist, they have to obtain their MD and work at a psychiatric hospital. There is no formal training and no standards for professionals to transition from "junior psychiatrist to psychiatrist." The only mental health/ psychiatry training that students receive in medical school is 1 month of classroom instruction, and some students may select to have a month rotation in the psychiatric hospital. There is no professional licensing/ board of psychiatry. There have been attempts with Alexandria University and with the UK to develop educational partnerships, but they have not been successful

Medical Doctors: Limited mental health training occurs in medical school (see syllabus in table below). It has been reported that medical doctors are generally not recognizing/ referring patients who could benefit from mental health treatment.

Psychiatric Nurses: There is no formal training for psychiatric nurses in Libya. The Psychiatric Hospital three year training course for nurses was terminated in 2008. It has also been reported that nurses working in psychiatric care (e.g. psychiatric hospital) are in need of skills building and training in best practices as well as ending potentially harmful practices (e.g. tying patients to beds, isolating them, and locking them behind doors for extended periods of time).

3.4.2. Psychologists and Social Workers

Psychologists: Educational opportunities for psychologists typically are limited to BA level degrees which typically focus on general or educational psychology but do not provide any clinical training in mental health. Focus groups discussions with psychologists revealed that they are using old texts in Libyan universities, and feel unprepared to work directly with beneficiaries/ clients once they obtain their degree. From IMCs conversations with psychologists from over eight health facilities, not one of them had on-the-job training. Some of them reported that they have asked senior psychologists for guidance, but most of them work independently following graduation, with no supervision or support. The exceptions seem to be in the Psychiatric Hospitals, where "the best" psychologists go for training. Furthermore, from our conversations with psychologists, only 5 were identified in all of Libya who have skills in clinical interventions (the only intervention mentioned typically was CBT). When asked how the treatment process develops, psychologists generally explained that they typically do some type of assessment (based on their own judgment) and then intervene in an ad-hoc manner by "listening and giving advice." There typically is no follow-up or referral, unless the person is identified as someone needing psychotropic medications. They expressed the need for practical training to improve their skills including working with people with disabilities due to the war.

Social Workers: Social workers typically have a BA level degree in sociology or social work. They have an "internship" the last 2 years of study where they work one day per week for a few hours in a social work type position. While there are many individuals in many parts of society with the title "social worker," very few of these individuals can actually perform tasks/duties expected of social work professionals. The majority of the existing social workers attached to medical facilities are clerks "collecting social and occupational data from patients in different hospitals," and "disciplinarians" in elementary and secondary schools." Some social workers do have MA and PhD level training in sociology, but they typically remain in universities, rather than practice. Many social workers that were interviewed wished their roles were more integrated into communities and more supportive of individuals and families, but they feel unsupported and unappreciated. They expressed the need for basic skill based social work training, in communication and referral and in helping patients cope (including those with disabilities caused by the war).

One social worker described her internship at an elementary school as "very frustrating" since she was not supported by the senior social worker at all. She tried to take the students on field trips and organize activities, but she was criticized, and had to spend her own money on all of her activities.

Table 6. MHPSS degrees offered in Libya

University	City	MD	Psychology	Social Work
University of Garyonis	Benghazi		✓	✓
Al Arab Medical University	Benghazi	✓		
Nasser University	Tripoli		✓	✓
Tripoli University (prev. Alfatha)	Tripoli	✓	✓	✓
Omar Mukhtar University	Albayda		✓	✓
Misrata University	Misrata	✓	✓	✓
Sabha University	Sabha	✓	✓	✓
AlTahadi University	Sirte	✓	✓	✓
Alzawya University	Alzawya	✓	✓	✓
Almargib University	Khoms	✓	✓	✓
Open University (16 branches)	Across Libya		✓	✓

Table 7. Overview of Mental Health and Psychosocial Support Related Professions

Total years of study	Institution and Department	Degree Obtained	Place of Internship	Duration of Internship	Further Education and training	Career options	Most popular career path	Main Universities offering degree	Private Sector
Psychiatrist									
Medical school	University, Department of Medicine (No official education after medical school for psychiatrists. Only one month of study of psychiatry)	BSc Medicine	Tripoli Psychiatry Hospital - Benghazi Psychiatry Hospital	No official internship, GPs work in hospital until officially employed by hospital as junior psychiatrist	Can go abroad to continue in specialty but training within Libya not available	Working in public sector hospitals or private clinics.	Working in Tripoli and Benghazi Psychiatric Hospitals		Some choose to work in private clinic
Psychologist									
4 years	University (National Vocational diploma prior to 1986[5]), Dept. of Education and Psychology	BA Psychology	Hospitals, Polyclinics, Schools, Orphanages, Residential Homes, Nurseries, Social Service department.	1 year with prospect of employment	Masters from several Libyan Universities, Training in workplace (work specific), Scholarship for PhD abroad	Work within schools, hospitals or place of internship.	Working in schools, hospitals.	Benghazi university syllabus includes clinical psychology with clinical training.	Psychologist are becoming more and more available in private sector health care
Social Worker									
4 years	University (National Vocational diploma prior to 1986), Dept of Sociology and Social work	BA Social Work	Hospitals, Polyclinics, Schools, Orphanages, Residential Homes, Nurseries, Social Service department.	1 year with prospect of employment	Masters from several Libyan Universities, Training in workplace (work specific), Scholarship for PhD abroad	Work within schools, hospitals or place of internship.	Working in schools, hospitals and as administrators in various public sectors.	The Open University teaches Sociology and Social Work as a joint degree.	
Nursing (MH specialization)									
Nursing Diploma + 3 years	Nursing diplomas vary from Middle Institutes of Nursing (no high school diploma) to Higher Institute of Nursing (after high school diploma)	Psychiatric nursing diploma	Alrazi Psychiatric Hospital	Work placement during 3 years of study.	NA	Continue employment at Al Razi Hospital	Working in Tripoli Psychiatric Hospitals		Private Nursing colleges offer psychiatric nursing however registration often too low to run the course.

[5] Prior to 1986 students would enter college after middle school (no high school diploma) and study 4 years for a GNVQ. This was phased out in the mid 80s.

Table 8. Sample Libyan Curricula MHPSS Related Professions[6]

Psychiatrists			
Taught in final semester to fifth years medical students:	Psychosis and neurosis Depression Anxiety	Bipolar Mania OCD	Schizophrenia Drug abuse Medication in psychiatry
Psychologists[7]			
First year Introduction to Psychology Principles of counseling and guidance The basics of scientific research Descriptive statistics Introduction to Sociology Arabic Language History of the Arab Islamic civilization Islamic culture	**Second year** Childhood and adolescence mental health Psychology and physiology Schools of Psychology Educational Psychology Social Psychology Mental Health Terminology Research Methodology Constructive Recommendation Measurement and Evaluation Behavioral problems	**Third year** Research Design Psychology Contact Psychological tests Theories of learning Think of a mass Applications of psychological Psychopathology Professional Psychology Environmental Psychology Psychology of language Theories of Guidance and Counseling	**Fourth year** Psychology of Geriatrics Psychopathology Field Exercises Graduation Project Psychology of Special groups Cognitive Psychology Clinical Psychology Experimental Psychology Forensic Psychology Psychology
Social Workers			
First year Arabic Language Islamic culture Principles of Economics Principles of Statistics 1 General Psychology The foundations of social science Anthropology Introduction to Social Welfare Introduction to Social Work The history of Civilization	**Second year** A service of the individual Community service 1 The organization of society Institutional Management Social Psychology Service areas of social development 1 Economic Development English Language 1 Social problems	**Third year** Individual Service 2 Community Service 2 The organization of society 2 Research Methods Statistics Principles 2 Terms and Concepts Psychology of special categories Policy & Procedures Fields of Social Work 2 Field Training 1	**Fourth year** Individual Service 3 Community service 3 Development and Underdevelopment Policy and Planning Care of special categories Cooperation Mental health Security legislation Field Training Thesis

[6] Psychiatric nursing syllabus not available as course no longer running

[7] According to syllabus different branches of Psychology were to be added to 2011-2012 curriculum

3.5. International Organizations Involved in MHPSS Work

IMC facilitated a very simple mapping of international organizations in Libya involved in MHPSS work as part of a coordination group of international agencies. The table below shows a snapshot of current activities (as of October 2010) of international organizations.

Who	What	Where	When
Medicin Sans Frontier (MSF)- France/ Belgium (Barbara/ Helene / Maria) Tel: 0919393782 maria.palha@gmail.com	Provide sensitization sessions in 4 areas in Misrata MSF-B and MSF-F have been supervising a group of psychologists in 13 clinics in Misrata and providing training for psychologists in Tripoli (psychiatric hospital) Some areas that trainings have covered include: Psychological First Aid, basic counseling, and supporting people who have experienced trauma. MSF-B will be working in schools to provide teacher sensitization and training social workers in schools MSF also is providing psychosocial support in 3 prisons	Misrata, Tripoli	MSF- France leaving early November MSF- Belgium staying through early 2012
Save the Children Libya: Nicole Bohl: nicole.bohl@gmail.com	Child Friendly Spaces Child Resiliency Programme (PSS programme for children 10-14 years) Youth Development/Resiliency Programme (PSS program for adolescents aged 14-17 years)	Libya: Benghazi, Ajdabyia, Tripoli and possibly Nafua Mountains Tunisia: Choucha Camp	Operational
International Medical Corps (IMC) Colleen Fitzgerald: cfitzgerald@internationalmedicalcorps.org Tel: 091 860 0301	Psychological First Aid Training (English and Arabic) to health care workers and humanitarian responders (doctors, nurses, volunteers, community leaders, etc.) Workshops to school teachers on psychosocial support for children Community awareness well-being pamphlets Supporting IMC Rehabilitation Center for people wounded from the conflict; training and human resources Assisting in Gender based violence trainings to train doctors and clinic staff to support sexual assault survivors Supporting MHPSS Working Group in Tripoli	Benghazi, Misrata, Tripoli, Nafusa Mountains	Operating since April 2011 Elements of the program will continue through 2013
ACT Alliance/ CoS/ NCA/ LWF Sarah Harrison Sarah.harrison@svenskakyrkan.se	Phasing out of activities for women & youth (women's centre & protection circles) in Remada town camp, due to the return of Libyan refugees. Project will be closed by end of September 2011.	Southern border point Libya – Tunisia, Remada town.	Project phase out September 2011. Sarah visiting Remada camp 19 – 24 September, 2011.
ACT Alliance/ Danish Church Aid Lisa de la Rubia ldla@dca.dk	After school clubs for children in 20 schools in Misrata, training of teachers on Psychosocial support within an educational environment, rehabilitation of 5 play/ recreational areas. GBV/ CEDAW awareness raising project for women (in collaboration with UNFPA & Protection Against Violence Committee (NPAVC) in Benghazi)	Misrata Benghazi	October 2011 – March 2012 (PS project) October – December 2011 (GBV project)
Hilfswerk Austria International	Will be creating a center for children that will house a child psychiatrist and PSS activities for children	Tripoli	Activities will begin in December 2011

A local NGO in Benghazi conducted a week-long training for psychologists in post-traumatic stress disorder identification and treatment. The training was conducted by the psychologist from the UAE, and there was no follow up afterwards, since she had to return to her work.

5. Conclusions

The conflict in Libya combined with the effects of decades of oppression has resulted in increased mental health and psychosocial problems, while those with pre-existing mental health problems and at-risk groups are especially vulnerable. This has important public health implications, especially for Libya where capacity for mental health service provision is already low. The conflict in Libya has presented a unique opportunity to improve a mental health system in "crisis" with identified urgent short term as well as longer-term needs.

Various stakeholders in Libya including leaders in the field of mental health and civil society have already started addressing emerging mental health and psychosocial needs and have made significant progress over a short time period. IMCs role is to support existing efforts under the guidance of the new government and key global actors such as the World Health Organization. The following is a brief outline of areas which have emerged as critical MHPSS need and in which IMC has technical capacity and experience and may be of support.

Short term:

- Training: Basic training and capacity building of staff at all layers of the mental health services pyramid including specialized staff (e.g. psychiatric nurses, psychologists social workers) and general health care workers in hospitals and polyclinics as well as informal service providers (e.g. teachers and social workers in the school system)
- Provision of training, on the job supervision and temporary support by qualified staff from other countries (especially Arab speaking)
- School outreach: Continued psycho-education and mental health promotion for teachers, parents and social workers within the school system.
- Psychological First Aid: Continued training of health care workers, NGO staff, volunteers and other non-specialized professionals in Psychological First Aid
- Mapping: Continued and more detailed mapping of MHPSS service providers in Libya (international and national) for with the aim of improving coordination and informing planning.

Longer term:

- Training and capacity building: Institutional capacity building by supporting the integration of mental health into general health care through creating updated policies and procedures, effective referral networks (based on mapping) and promoting improved institutional standards.
- Training and education: Designing and implementing standardized training curricula for specialized and non-specialized professionals in partnership with Universities in Libya and based on global guidelines such as WHO mhGAP.
- Creating linkages with other higher level educational institutions in the Arab speaking world to enhance knowledge transfer.
- Strengthening Schools: Creating child friendly schools, providing training for teachers and social workers and supporting informational workshops for parents.
- Supporting Civil Society: Supporting psychosocial support events and meaningful activities which are inclusive of vulnerable groups, strengthen social networks and improve communities.
- Community Awareness and Service User Associations: Promoting mental health, supporting self-care and reducing the stigma of mental illness though community awareness raising and support of mental health service user and family associations.

Limitations of this Assessment

This assessment has several limitations. The accuracy of the figures presented has not been verified and IMC often received different accounts from different people at different times. All opinions and figures presented in this document are in need of and open to further verification and investigation. This assessment has also only focused on four conflict affected areas (Tripoli, Benghazi, Misrata, Nafusa mountains) while other areas such as Sirte or

Sabha have not been included. Further assessments are needed which cover a wider geographical area. Furthermore, this assessment has focused on mental health service provision primarily within the formal health sector. More information and detail is needed for other sectors and informal service providers. More information is also needed on vulnerable populations identified by UNHCR including those who are internally displaced and/or perceived as Gaddafi supporters. While the situation in Libya is stabilizing, available mental health and psychosocial support services and activities as well as staffing levels are constantly changing. This assessment therefore presents only a brief snapshot of Libya in November of 2011. However, we believe that this assessment may be helpful in shedding light on a few relevant aspects of mental health and psychosocial support needs and capacities in Libya which can be updated and build upon in the coming months.

5. References

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6. Appendix

Appendix 1: IMC PHC MH Integration Checklist

IMC PHC MH Integration Checklist
Adapted from WHO MHPSS Assessment Toolkit (Draft)

I. Basic Clinic Information

Name of Interviewer: Date: Duration:

Name of **PHC clinic:** Affiliation:

Name & Title of Contact: Address:

Catchment Population: Furthest **distance** traveled by patients to access clinic:

General Qualitative Questions:

Since the Libya conflict, have you observed a changing need for MH services?

Are MH services integrated into current care provision?

How well is staff trained in addressing MH problems and what are current challenges and possible training gaps?

Where are people with MH problems referred and are those referrals effective?

Average **number of patients** visiting per day (past month):

Staff Providing initial consultation: O Nurse O GP O Other:_____

Clinic Staff Data						
Number and type of staff	**Male**	**Female**	**Average work hours/day**	**Average # of patients seen/day**	**Average time (minutes) spent in clinical evaluation of patient**	**Tasks if DIFFERENT from traditional tasks of defined jobs/roles**
GPs					☐ <5 ☐ 5-15 ☐ 15-30 ☐ > 30	
Nurses					☐ <5 ☐ 5-15 ☐ 15-30 ☐ > 30	
Social workers					☐ <5 ☐ 5-15 ☐ 15-30 ☐ > 30	
Psychologists					☐ <5 ☐ 5-15 ☐ 15-30 ☐ > 30	
Other *(only if involved in clinical evaluations)***:**						

Basic Pharmacy Data for WHO Essential Psychotropic Medications		
Medication	**Availability in the PHC clinic or nearby pharmacy in the previous week**	**Specify types available:** (examples)
Generic antidepressant medication	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never	(amitriptyline, fluoxetine)
Generic anti-anxiety medication	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never	(diazepam)
Generic anti-psychotic medication	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never	(haloperidol, chlorpromazine, fluphenazine)
Generic anti-epileptic medication	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never	(phenobarbital carbamazepine, diazepam inj, lorazepam inj, phenytoin, valproic acid)
Generic bipolar disorder medication	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never	(lithium carbonate, valproic acid, carbamazepine)
Medication as part of substance use programs	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never	(nicotine replacement therapy, methadone)

II. Clinic MH PHC Standards

Staff Skills and Competencies					
Training conducted	**Staff**	**Number trained**	**How many hours of training was provided?**	**Were these trainings followed by supervision?**	**If yes, how many hours of supervision?**
The following staff received **training in** mental health?	GPs			☐ Yes ☐ No	

	RNs			☐ Yes ☐ No	
	SWs			☐ Yes ☐ No	
	Psychologists			☐ Yes ☐ No	

Staff Skills and Competencies			**Service provision**
Skill areas	**Is <u>at least one</u> staff trained? Yes/No**	**If yes, specify if trained staff uses…** (check all applicable)	**How often used in practice?** ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Interviewing skills specific to mental illness	☐ Yes ☐ No	☐ Empathic listening ☐ Communication skills	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Assessment of people with mental health problems	☐ Yes ☐ No	☐ Clinical history taking ☐ Mental Status Exam	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Management of depression	☐ Yes ☐ No	☐ Pharmacological ☐ Non-pharmacological	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Management of anxiety	☐ Yes ☐ No	☐ Pharmacological ☐ Non-pharmacological	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Management of epilepsy	☐ Yes ☐ No	☐ Pharmacological ☐ Non-pharmacological	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Management of alcohol or other substance use disorders	☐ Yes ☐ No	☐ Pharmacological ☐ Non-pharmacological	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Management of Mental retardation/intellectual disability	☐ Yes ☐ No	☐ Pharmacological ☐ Non-pharmacological	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Management of psychotic disorder	☐ Yes ☐ No	☐ Pharmacological ☐ Non-pharmacological	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Management of medically unexplained somatic complaints	☐ Yes ☐ No	☐ Pharmacological ☐ Non-pharmacological	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Assessment & management of self-harm/suicide	☐ Yes ☐ No	☐ Pharmacological ☐ Non-pharmacological	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Psychosocial interventions	☐ Yes ☐ No	☐ Stress Management ☐ Problem-Solving ☐ Other:	☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N ☐ F ☐ S ☐ R ☐ N
Psychological First Aid	☐ Yes ☐ No		☐ F ☐ S ☐ R ☐ N

Service Provision

Staff Roles	Yes/No	Specifics	
Have staff defined roles in identification, management and referral of mental disorders ?	☐ Yes ☐ No	If **yes**, specify how:	
Does discussion about MH cases takes place in regular meetings?	☐ Yes ☐ No	☐ weekly ☐ biweekly	If **yes**, specify who participates:
Is staff engaged in mental health community education and awareness raising?		☐ Yes ☐ No	If **yes**, specify how:

Type of Case	Yes/No	If yes, # of cases	In the past month, the following was provided for this diagnostic category…			
According to the clinic's database in the last month, service was provided for:			Identified at the PHC level	Initiated treatment & managed at the PCH level	Provided mainte-nance (med)	Referred (MH)
Epilepsy	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Alcohol or Substance Use Disorder	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Intellectual Disabilities	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Psychotic Disorders	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Depression	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Medically unexplained somatic complaints	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (specify):				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

At least 1 health care provider per clinic is competent in:	
Managing acute trauma-induced anxiety that is so severe that it limits basic functioning	Yes ☐ No ☐ DK ☐ NA ☐ Comment:
Clinical management of severe neuropsychiatric disorders, including pharmacological and non-pharmacological treatment of psychosis, severe depression and epilepsy	Yes ☐ No ☐ DK ☐ NA ☐ Comment:

Reporting	
If mental illnesses are identified at the PHC level, it is documented in clinical charts?	☐ Yes ☐ No
If **yes**, these are collected from charts and tracked in weekly or monthly data collections?	☐ Yes ☐ No
If **yes**, these reports are also separated by gender and age for analysis?	☐ Yes ☐ No

Social indicators	
The PHC has the following characteristics:	
There is at least 1 female health care provider	☐ Yes ☐ No

Patients are interviewed alone in a private room	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never
Human rights violations (e.g. rape, torture) are shared with:	☐ Those specified by patient ☐ Supervisors ☐ Other:
	☐ PHC protocol exists ☐ PHC protocol does not exist
Information in patient files is accessible to:	☐ GPs ☐ RNs ☐ SWs ☐ Psychologists ☐ Volunteers ☐ Admin ☐ Any clinic staff ☐ External actors (specify:)
Services are provided:	☐ free of charge ☐ $ per consultation:___ ☐ Other:_
What is the percentage of people living in this area who cannot afford services?	☐ <10 ☐ 10-25 ☐ 25-50 ☐ 50-75 ☐ 75-100

Referral indicators			
Knowledge of and **protocol** for referral options			
PHC staff knows location and contact (name and or/phone) of at least <u>one</u> referral option to a specialized mental health service provider (e.g. psychiatrist, psychologist, psychiatric nurse) (e.g. staff know the location, costs and referral procedures for nearby mental health services)	☐ Yes ☐ No Contact:	PHC staff knows location and contact (name and or/phone) at least <u>two</u> referral options to social services or support systems in the community (e.g. social worker, social agency, community center, educational/vocational opportunities)	☐ Yes ☐ No Contacts:
PHC staff knows how to link with protection agencies/ social services to address physical and sexual abuse	☐ Yes ☐ No Contacts:		

Generally, mental health referrals occur **to the PHC clinic <u>from</u>**	
Mental health specialist care (secondary, tertiary or private care)	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Other healthcare providers	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Community workers	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Schools	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Social services and other community social supports	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Traditional /religious healers	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Generally mental health-related referrals occur **from the PHC clinic <u>to</u>**	
Mental health specialist care (secondary, tertiary or private care)	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Other healthcare providers	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Community workers	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Schools	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Social services & other community social supports	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Traditional /religious healers	☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Appendix 2: Tool for Assessing Mental Health Related Problems, Coping and Community Sources of Support

IMC INTERVIEW DATA SHEET

Date: **Location:**

Moderator: **Note taker:**

Demographics of participants (please circle)

Key informant affiliation/organization	
Age range (do not ask age, only range)	18-25 25-64 <64
Gender	M/F
Verbal Consent	Yes No

V. Questions

1. At risk groups

Who do you think is suffering the most from the current crisis? Who else? [list all groups at risk which respondent can think of]

2. Priority Mental Health Related Problems

What kind of problems do _____ [GROUP OF INTEREST (e.g. FF and F)] have because of the humanitarian situation? Please list as many problems that you can think of.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
….

Select those problems which are especially relevant from a mental health perspective (e.g. problems related to social relationships, feelings, thinking, behavior, sleep, appetite, somatic symptoms)

"You mentioned a number of problems, including [READ OUT PROBLEMS NAMED ABOVE] Of these problems, which are the three most important problems?" "Why?"

1.
2.
3.

3. Coping methods
What kind of things do _____ [INSERT GROUP OF INTEREST (e.g. FF and F)] people do to deal with such problems [mentioned above]? E.g. by themselves, with their families, or their communities?
Would doing that help with the problem? [indicate yes or no for each coping method)

4. Community Resources
What are community members or organizations doing right now to help [Risk group]?

What more could be done to help [Risk group]?

5. Community Attitudes
In general, what do community members think about people who are [Risk group (e.g. FF and F)]? How do they treat them?

6. Attitudes toward people with mental illness (serious problems that people experience related to their feelings, thinking or ways of acting which limits their ability to function in their daily lives)
In general, what do community members think about people with mental disorders? How do they treat them?

What kind of problems do they have?

Where do they seek help?

7. Experience of the emergency (for interviews with representatives from organizations only)
How has the conflict affected services provided by your organization?