Arabikansojen ystävyysseura (AKYS) yhteistyössä Beit Atfal Assumoudin (BAS) (The National Institution of Social Care) kummiohjelman kanssa

Arabikansojen ystävyysseura (AKYS)

*Finnish-Arab Friendship Society (FAFS)*

**REPORT 7/2017**

# Community based mental health framework at NISCVT/BAS Family Guidance Centers in North Lebanon. Report of final External Evaluation

**Khalidi, Aziza (2017) Implementing Community Based Mental Health Framework at NISCVT/BAS Family Guidance Centers (FGCs) in North Lebanon, Expressions from the Family Guidance Center (FGC) Community, Report of Final External Evaluation submitted to FAFS covering 2016 - Project number 85 201 601**



**Beirut, 24th September, 2017**

Evaluation of the Development Cooperation with The National Institution of Social Care and Vocational Training (NISCVT), funded by Ministry for Foreign Affairs of Finland, Project number 85 201 601

FAFS: FGC Baddawi, FGC Nahr el-Bared,

Project Title:
Mental health services for children in Northern refugee camps of Lebanon.

Implementing
Community Based Mental Health Framework at NISCVT/BAS Family Guidance Centers (FGCs)
in North Lebanon

**Final External Evaluation**

# Expressions from the Family Guidance Centers' (FGC) Community

## Final Report

Prepared by Aziza Khalidi, ScD

citation: Khalidi, Aziza (2017) Implementing Community Based Mental Health Framework at NISCVT/BAS Family Guidance Centers (FGCs) in North Lebanon, Expressions from the Family Guidance Center (FGC) Community, Report of Final External Evaluation submitted to FAFS covering 2016 - Project number 85 201 601

Beirut 24th September 2017

**Tiivistelmä: PSL, hankekoordinaattori Sirkku Kivistö**

Hankekauden mittaisiksi asetettuina tavoitteina oli mahdollistaa mielenterveyspalvelut lapsille mukaan lukien Syyriasta paenneet, neuvonta- ja hoitoryhmien järjestäminen, henkilökunnan taitotason kehittäminen, paikallisen lastentarhojen ja koulujen kanssa, perheiden tukeminen sosiaalityöhön sisältyvällä kummiohjelmalla.

Tohtori Aziza Khalidin tehtävä oli seurata NISCVT:n mielenterveyshankkeen kehittämistä yhteisöperustaisen toimintatavan suuntaan.

Hän seurasi NISCVT:n Beddawin ja Nahr el-Baredin perheneuvoloiden työtä kolmen vuoden ajan kenttäkäynneillä, kyselyillä ja perehtymällä NISCVT:n dokumenttiaineistoon.

Käytännössä toimintatapaan on pohjoisissa perheneuvoloissa kuulunut sosiaalityöntekijöiden kiinteä yhteistyö hoitotiimin kanssa, sosiaalityöntekijöden kotikäynnit, hoito- ja valistusryhmät myös jonotusaikana, terapioiden täydentäminen esim musiikkiterapialla ja valistustyö. Toimintatapaan kuuluu myös yhteyksien luominen muihin organisaatioihin ja perheiden mukaan ottaminen perheneuvolan toimintaan ja resurssien varaaminen tällaista yhteistyötä varten.

Yhteisöperustaisen toimintatavan tarkoituksena mielenterveystyössä on
1) lisätä yhteisön tietoisuutta hoitomahdollisuuksista ja vähentää lasten ja nuorten mielenterveys- ja kehitysongelmien leimaavuutta, siten poistaa esteitä avunhaulta ja edistää ongelmien varhaista havaitsemista
2) varmistaa että hoitokäytännöt ovat toimintaympäristöön ja kulttuuriin sopivia
3) järjestää ohjaus ja seuranta erityislapsille, jotka tarvitsevat perheneuvolan avun lisäksi erityisopetusta ja -kuntoutusta (vammaiskomponentti)

Yhteisöperustainen toimintatapa auttaa mielenterveys- ja kehityshäiriöiden ennaltaehkäisyssä, ongelmien varhaisessa havaitsemisessa (early detection), hoidossa ja ohjauskäytännöissä.

Hankevuosina 2014-2016 Beddawin ja Nahr el-Baredin perheneuvoloihin ohjattiin 877 uutta lastaa, joista 66 % oli poikia. Lapsista oli Libanonissa asuvia palestiinalaisia 658, Syyriasta paenneita palestiinalaisia 105, syyrialaisia 7 ja libanonilaisia 6. Neuvolat ohjasivat 68 lasta erityispalveluihin (Perheneuvoloiden vuosiraportit 2014-2016).

**Tuloksellisuutta (effectiveness) evaluoija arvioi selvittämällä vanhempien (n=87) tyytyväisyyttä palveluihin**. Hyvin tyytyväisiä vastaajista oli 80,5 %, melko tyytyväisiä 11,5 %, ei vastausta kysymykseen 8 %.

Tyytyväisyyden syiden valottamiseksi evaluoija poimi 53 otosta haastatteluista (Taulu 2.1.). Palvelun sopivuus toimintaympäristöön tulee esiin mm lausunnoista “he eivät ole tärkeilijöitä, käyvät ihmisten kotona”, “he antoivat monia neuvoja, joista oli hyötyä, minä olen kärsimätön, mutta he neuvoivat olemaan ymmärtäväisempi tytärtäni kohtaan, en enää

lyö häntä", "he ovat herkkiä, hyvin kunnioittavia, avoimia, kuuntelevat tarkasti ongelmia, ja ratkaisevat niitä meidän kanssanmme". Valtaosa tyytyväisyyden aiheista liittyy lapsen ongelman lievittymiseen, voinnin paranemiseen ja että vanhemmat tuntevat saaneensa apua lapsen tukemiseen.

**Tehokkuutta (efficiency) arvioitiin potilaiden alkuarvioinnin kestolla**.
Neuvolaan kirjautumisen jälkeen lasten alkuarviointiajan pituus oli lähes aina (78 %) vähemmän kuin kuukausi, kuukausi 17 %, kaksi kuukautta 5 %. (Taulu 2.2.). "Hoito on hyvää, tapaamisajoista pidetään kiinni".

Tehokkuuteen kuuluu myös resurssien hankkiminen lapsille lähiyhteisön muista voimavaroista. Lähtökohtaraportissa (baseline) raportoidaan 27 järjestöä tai toimintayksikköä, joista 14 järjestön kanssa perheneuvolat olivat tehneet yhteistyötä 1-5 vuotta ja 13 järjestön kanssa 8-10 vuotta. Hankkeen keskimmäisenä vuonna evaluoija haastatteli yhtä järjestöä kummankin perheneuvolan verkostosta. Yhteistyömuodoiksi todettiin lasten ohjaus NISCVT:n lastentarhoihin ja perheneuvoloihin sekä yhdessä toteutetut valistustapahtumat. Community based rehabilitation associationin (CBRA) mukaan NISCVT/BAS on parhaita organisaatioita CBRA:n laatukriteereiden mukaan. The General Union of Palestinian Women (GUPW) arvostaa myös Nahr el-Baredin keskuksen lastenlääkäripalveluita. Perheneuvolaan ohjataan GUPW:n mukaan lapsia useimmiten ylivilkkauden ja oppimisvaikeuksien takia (Kumppanijärjestöjen haastattelut arvioinnissa 2015).

**Merkityksellisyys (relevanssi)** tuli esiin haastatteluissa monin tavoin
Mielenterveyspalvelut lapsille ja perheille ovat seudulla ainoat, palvelu vastaa tarpeisiin ja palvelun käyttäjiä kohdellaan hyvin eikä hinta ole palvelun esteenä. (Taulu 4). "ei ole muita tällaisia paikkoja leirissä", "maksu on vain symbolinen, muutoin psykiatrille meneminen on kallista".

**Vaikuttavuusarviota (impact)** varten vanhemmilta kysyttiin lapsen tilanteen muutoksen suunnasta ja kattavuudesta. Muutosta parempaan oli Nahr el-Baredin vanhemmista raportoinut 81,1 % ja Beddawin vanhemmista 87,1 %. Tuloksissa oli vaihtelua kahden perheneuvolan välillä: huomattavaa muutosta parempaan raportoitiin Nahr el-Baredista 38,2 % ja Beddawista 64,5 %. Ero heijastanee sitä, että Nahr el-Baredin perheneuvola oli vuoden ilman psykiatria (vuoden 2015 alusta maaliskuuhun 2016).

Evaluointiaineiston vanhempainosion (Statistical findings from Beneficiary Survey – 20.4.2016) mukaan vajaalla puolella lapsista oppiminen koulussa parantui perheneuvolahoidon alettua. Samoin puolella lapsista päivittäisistä toimista suoriutuminen parani.

Haastatteluista tulee lasten toimintaympäristöstä esiin myönteisiä muutoksia, mutta myös ongelmia:
Vanhempien kanssa "esimerkiksi minä löin häntä, nyt en lyö, nyt hän kuuntelee minua niin ettei tarvitse lyödä", "vanhempani hyväksyvät, mutta mieheni ei hyväksy"
Sisaruusryhmässsä "hänestä tuli vähemmän ujo ja hän alkoi tulla paremmin toimen

veljensä kanssa”
Vertaisryhmässä “hän alkoi olla tekemisissä toisten lasten kanssa, hän alkoi puhua”
Lähiympäristössä “hän on nykyisin paljon rauhallisempi kodin ulkopuolella”.

Mielenterveystyöhön kohdistuvat ennakkoluulot vaikeuttavat edelleen ongelmien varhaista tunnistamista. Tehdyn kyselyn (n=87) mukaan vanhemmista vajaa puolet (40 %) arvioi, että mielenterveyspalvelut hyväksytään. Yli puolet arvioi, että mielenterveyspalvelut hyväksytään vain jossain määrin (46 %) tai ei ollenkaan (14 %). Niille, jotka eivät hyväksy, ei perheneuvolakäynneistä kerrota.

Hyväksyntä:
perheen sisällä “isä oli ensin epäilevä, sitten hän vakuuttui”
leirissä: “on paljon ihmisiä, jotka hyväksyvät, ei ole mikään häpeä mennä psykiatrille … sodan jälkeen asiat muuttuivat leirissä”, “en kertonut kenellekään, se olisi häpäisset tyttäreni heidän silmissään”, “ihmiset muuttavat mielensä, kun näkevät miten lapset muuttuvat”

**Evaluoinnin suositukset Arabikansojen ystävyysseuralle**

Evaluointiraportin perusteella voidaan todeta, että ammattitaitoinen, hyvä mielenterveystyö voi vähentää mielenterveystyötä kohtaan tunnettua varauksellisuutta. Yhteisöperustainen työtapa on asiakkaiden arvostamaa. Siinä korostuu hyvän hoidon ohella sosiaalityöntekijöiden työskentely perheiden kanssa, auttaminen kodin ja koulun yhteistyössä ja perheneuvolan yleinen huoltapitävä ja aito välittämisen kulttuuri. Asiakkaat korostavat, että perheneuvola on heille ainoa tarjolle oleva lasten mielenterveys- ja kehityshäiriöihin apua tarjoava palvelu, joka ei ole liian kallis. Asiakkaat tunnistavat moniammatillisen tiimin resurssien takaavat hyvän hoidon. Esimerkiksi psykiatrin puuttuessa perheneuvolasta hoito ei edisty yhtä hyvin kuin tiimin ollessa kokonainen (psykiatrin puuttuminen vuoden ajan toisesta perheneuvolasta heijastui vanhempien raporteissa).

Palvelutarpeesta pohjoisissa perheneuvoloissa:
- tarvitaan tuki sosiaalityöntekijöiden kouluttautumiselle ja työn jatkuvuudelle
- erityislasten koulutukseen ja kuntoutukseen lisää tukea (vammaiskomponentti)
- psykologin ja puheterapeutin työajan lisääminen perheneuvolassa
- tuki BAS:ille insentiivien lisäämiseksi pohjoisten neuvoloiden työntekijöille vaihtuvuuden vähentämiseksi
- tuki BAS:in valistustyölle ennakkoluulojen vähentämiseksi ja ongelmien varhaisen toteamisen mahdollistamiseksi
- vedottava UNRWAan sen yhteisöpohjaisen mielenterveys- ja opetustoiminnan kattavuuden lisäämiseksi ja että NISCVT:n perheneuvoloita hyödynnetään ideointi- ja tiedontuottajakeskuksina.

# Contents

# Part 1- General overview

## 1.1 Introductory Note

NISCVT/BAS started to incorporate community oriented mental health care to complement the clinical core of ambulatory mental health services it provides in its five FGCS in north and south Lebanon. Such an approach started with the FGC at Al Bass then it spread to other FGCs.

Main findings from Baseline and midterm external evaluation demonstrated the relevance of community based mental health care model and the organizational commitment to implement it, these evaluations also demonstrated the existence of a learning environment at NISCVT/BAS and availability of motivated resources both mental health specialists/ therapists as well as social/community workers. Also findings from the previous two evaluations demonstrate strong indications of satisfaction among caregivers as well as tangible signs of collaboration with grass roots and other relevant organizations in terms of exchange of information and services and also of general ongoing networking. Finally findings from both evaluations affirm that the community Based Mental Health Care Model is as its name implies is applied in various forms across the four NISCVT/BAS community each FGC serves.

As stated in the terms of reference, the general objective of the external evaluation across its three phases is to "help the staff to reflect on the ongoing work and identify the new innovations which might emerge during the project."[1]
The focus of the final external evaluation is to consolidate indications of community expressions derived from the two previous evaluations into more concrete evidence by conducting a beneficiary survey with a larger sample size, this survey is based on an instrument developed by Sirkku Kivistu which was fine-tuned across the baseline, and the midterm evaluations. Such expressions are expected to contribute to the reflection process by NISCVT/BAS staff.

## 1.2 Goal of the final external evaluation:

The goals of the final external evaluation are the following

- to sum up knowledge gained, identify strengths, weaknesses, threats and opportunities in the process of applying the community based mental health care model
- to present evidence to support continuing of work using that model.

## 1.3 Objectives of the final external evaluation

The final external evaluation is designed to generate information on criteria of the value of the work of FGCs in implementing community based mental health care model. The focus is on sustainability and impact; however criteria of coherence, Aid Effectiveness, Efficiency - building on previous analysis, Effectiveness - building on previous analysis, and Relevance will be addressed during the analysis.

[1] Terms of Reference.

## 1.4 Community Based Mental Health Care Model - a working definition, and identifying processes

The final evaluation consists of an interface with the segment of the community benefiting from the services of the FGCs and discerning factor that facilitate and others that act as barriers to implementing mental health care at the community level in a vulnerable setting.

### 1.4.1 Working definition of the community mental health care delivery model for children and youth:

For purposes of this final evaluation, and as a synthesis from the findings from the baseline and midterm external evaluation, community mental health care delivery model is defined as the set of activities that are not included in the one to one patient physician/therapist clinical management activities, such activities include the following:

1. Prevention, early detection, treatment, and referral activities

These are support activities that target children and youth and their families and community

   a. Activities to cope with the limited human resources
      i. Therapy delivered by trained social workers - the aim is to cope with limited number of therapists,
      ii. Group therapy initiated to enhance access to services due to long waiting lists,
   b. Complementary therapy to psychotherapy e.g. music therapy delivered by therapists and trained social workers,
   c. Awareness raising activities about mental health and mental health problems,
   d. Psycho social support activities for families of children
   e. Community initiatives by FGC staff and beneficiaries e.g. parents initiatives, school activities,

2. Organizational Activities
   a. Networking and building alliances and partnerships with other organizations in related fields
   b. capacity building of staff in the community mental health model
   c. Involving families in FGC operation

Implementing agents:
Therapists, social workers, parents, and youth.
Venue:
Such activities can be performed in the FGC, at home or in other spaces in the community
**The proposed goals** of the community based mental health care model are the following:

1. to increase community awareness of mental health care and thereby reduce the related social stigma associated with mental health problems among children and youth; and ensure early detection of mental health problems.
2. to ensure treatment strategies that are consistent with the community context
3. to provide referral services for children with special needs outside the scope of the available resources of FGCs

### 1.4.2 Processes of community based mental health care model

Implementation of the community based mental health model consists of the following processes conducted in the two FGCs in the South:

1. **Registration** - this is the first contact phase with the FGC, it includes statement of problem and socioeconomic profiling of the beneficiary and his/her caregivers
2. **Evaluation** -this process aims at arriving at a diagnosis of the problem of the beneficiary as well as the decision pertaining to venue of treatment. Evaluation duration varies with the situation of the child and the capacities of the FGC.
3. **Clinical management** -
   - Beneficiary appointments are actively monitored by the FGCs and they serve as an indirect support system for care givers
   - The two FGCs expanded clinical management space to include the community space. In the 'portage' project, social / community workers apply active management in the homes.
4. **Engaging families and other care givers**: care givers who are mostly mothers are engaged in the process through education, psychosocial support activities as well as community projects.
5. **Outreach and networking**

## Part 2 - Assessment of the community based mental healthcare model - Findings for North Lebanon FGCs

This section focuses on the North FGCs and it includes an update on the context, a section on the strengths, and challenges facing the implementation of the model as applied at the two FGCs in Nahr el Bared and Baddawi during the evaluation period (sections 2.2 and 2.3). This is followed by a forward look describing threats and opportunities facing implementation of the model.

### 2.1 Update on the context

There is no significant changes since the midterm evaluation. The communities in Nahr el Bared and Baddawi Palestinian refugee camps are still vulnerable. The reconstruction of Nahr el Bared camp is advancing at a slow pace, UNRWA services in the North of Lebanon are affected by financially challenged. Moreover, the negative impact of the prolonged Syrian refugee crisis on the refugees themselves as well as their already vulnerable host communities compounds the vulnerability of the situation of refugees and displaced at Baddawi Palestinian refugee camp with its increase in population density and with Nahr el Bared camp where its economic situation once thriving impeded by the security measures implemented at camp entrances.

> "To date 2,514 families have benefitted from the reconstruction of their homes and another 662 families are expected to return to their homes by 2019. In order to complete the reconstruction of NBC and allow the remaining 1,700 families to return home, a funding gap of US$ 105 million would need to be filled."
> Joint Statement by The United Nations Special Coordinator For Lebanon And The UNRWA Director

In Lebanon [https://www.unrwa.org/newsroom/official-statements/joint-statement-united-nations-special-coordinator-lebanon-and-unrwa]

## 2.2 Strengths of the community based mental health model as applied at FGCs

This mix of processes has a positive impact on caregivers in terms of the satisfaction they expressed - indicating effectiveness, and the improvement they perceived on the situation of their children - indicating impact.

**Table 1 Satisfaction of respondents with services in Nahr el Bared and Baddawi FGCs**

| satisfaction with services of FGC | FGC | | | | | |
|---|---|---|---|---|---|---|
| | Bared | | Baddawi | | Total | |
| very satisfied | 46 | 83.6% | 24 | 75.0% | 70 | 80.5% |
| somewhat satisfied | 8 | 14.5% | 2 | 6.3% | 10 | 11.5% |
| do not want to answer | 1 | 1.8% | 6 | 18.8% | 7 | 8.0% |
| Total | 55 | 100.0% | 32 | 100.0% | 87 | 100.0% |

| Chi-Square Tests | | | |
|---|---|---|---|
| | Value | df | Asymp. Sig. (2-sided) |
| Pearson Chi-Square | 8.607[a] | 2 | .014 |
| N of Valid Cases | 87 | | |
| a. 3 cells (50.0%) have expected count less than 5. The minimum expected count is 2.57. | | | |

### Reasons for satisfaction - Nahr el Bared Baddawi

According to comments from respondents on reasons for their satisfaction, in both FGCs, the positive impact on the condition of the child is most cited reason, other respondents noted the good quality of care in terms of that provided by the clinicians, and the follow-up of the appointments by the social workers as well as the general caring environment and the genuine concern that the respondents felt the team show to their children and their situation. In Nahr el Bared FGC there was mention of the integrated services with the pediatrician which was noted as a plus by one respondent.

**Table 2 Reasons for Satisfaction with FGC Services - Nahr el Bared and Baddawi**

| **Table 2.1 Nahr el Bared FGC** |
|---|
| I feel my son is improving, they [the staff] are doing their best |
| [satisfied] to the greatest extent because the improvement was observed in a short period. |
| The therapist gave me advice that were useful to me |
| First, medicine is for free, the psychologist is excellent, I have a boy and a girl who are sponsored, I was assisted in hospital cost for operations, they are not snobs, they visit people at home |
| I feel that my son is improving, I am hopeful he gets better in reading and writing |
| I feel comfortable just because of the good treatment, they make me feel welcome |
| There is caring - persistent follow-up of appointments, the social worker makes sure I keep my appointment |
| The presence of speech therapy, a pediatrician and a preschool all in the same center. |

| |
|---|
| Two out of three problems are solved for my son J. - studying and involuntary urination.. what remains is leaving home without my knowledge |
| My children are brought up by Sumud [NISCVT/BAS], my husband also was brought up by Sumud |
| You are more comfortable when you talk with the psychiatrist/psychologist |
| They make a person feel comfortable even by just talking to you, they are always on your side |
| They treat children well and take care of them very well. |
| They talk pleasantly with people |
| I am content and feel comfortable because they [the staff] are amiable |
| They gave me many pieces of advice that I benefited from, I am impatient but they advised me to be understanding to my daughter, I do not hit her any more. |
| I am satisfied because there is some change in my son's condition |
| They are providing a good service to my son |
| The reception is out of this world.. the doctor is out of this world |
| There is concern |
| Reception, good dealing, compassion .. from everyone even the director |
| Whatever is needed for the child is done, they are improving more and more for the benefit of the child |
| Because my son benefits in the center, I felt he benefited a lot |
| Because I saw my daughter.. how she was and how she became.. the evidence is in front of me |
| Because i see improvement of my daughter.. this is the most important thing |
| Because he is benefiting, he is getting calmer, he used to give me lots of problems at home |
| Because they are very responsive, and very respectable, open minded, listen carefully to problems, and work with us to resolve them. |
| Because they work with the people conscientiously and ethically |
| The social workers always invites me, and all specialists followed his case |
| It is necessary to increase the number of therapy sessions. |
| The responsiveness of the staff reflects positively on my son's and on my wellbeing. |
| There is an improvement in her condition and she is quite comfortable and very happy. She is also comfortable with other activities [of NISCVT/BAS] |

| **Table 2.2 Baddawi FGC** |
|---|
| I am very pleased with the therapists because they play with my child, and because there is improvement. I felt they like to help him, they worry about him |
| Very satisfied because I observed the change in a very short time |
| I have never seen people like Joelle and Edith..I leave everything [and come to the appointment].. my son benefits.... [he] is comfortable here and I am comfortable here too |
| 100 percent satisfied because I observed progress in his condition, and their treatment is very good, I feel that they care for him, they care for the interest of the child |
| 90 to a 100 percent satisfied and may be more! Seriously, what they offered, I will never forget, I am sure that every child gets the same degree of attention |
| Treatment is good, appointments are kept, God Bless their efforts, I registered my son in their [NISCVT/BAS] preschool downstairs |
| They care about the child, they do not neglect the child, the child to them is someone who is important |
| [satisfied with] everything.. they are polite and respectable, and communicate well, you do not feel shy and a stranger.. satisfied with the social worker.. she gives from her heart |
| [satisfied because] my children like this center very much and they feel comfortable here. |
| [satisfied because] the therapist is very good to me and to my daughter and does not hide anything from us. I trust her. Have known them for quite a while. I like them all [staff]. |
| [satisfied because] this is the only agency that care, this is the last wall I can lean on. |
| I like their style, if you don't know anything and asked them for help they help |
| Because she improved.. I know now how to deal with her |
| Because you feel they care about him, they look after his papers, and they discover the difficulties he has and schedule appointments for him |
| There are mixed results.. sometimes positive and sometimes negative but I have to get results, I am committed to all appointments because I would like to see the [positive] result |

| |
|---|
| My daughter M. used to like engaging in activities |
| Excellent, seriously! there are activities, play, and treatment through play |
| A hundred percent, the therapist and the social workers are marvelous |
| A hundred percent.. I imagine myself living abroad.. there is caring for the child.. I am happy that there is doctor I can turn to in the future.. this will make things easy for the future |
| A million percent! because of the conditions of my boy, I was not confident that my son would skip a grade, I was afraid for him but Thank God they [FGC staff ] gave me more than I asked for- M. when you tell him you are going to Sumud [FGC] he promptly responds |

## Efficiency - evaluation time

In general evaluation time for the vast majority of respondents in Nahr el Bared and Baddawi FGCs is one month or less.

**Figure 1 Length of evaluation period (months) - Nahr el Bared, Baddawi FGCs**

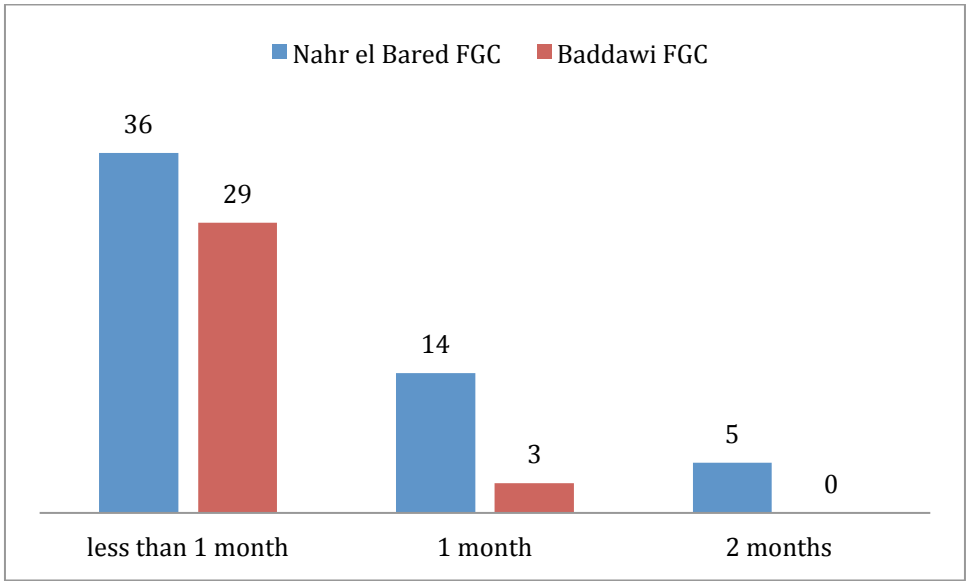



**Table 3 Length of evaluation period (months) - Nahr el Bared, Baddawi FGCs**

| | Nahr el Bared FGC | | Baddawi FGC | |
|---|---|---|---|---|
| | # | % | # | % |
| less than 1 month | 36 | **65.5** | 29 | **90.6** |
| 1 month | 14 | **25.5** | 3 | **9.4** |
| 2 months | 5 | **9.1** | 0 | **0.0** |
| | 55 | **100.0** | 32 | **100.0** |

## Relevance:

Testimonies from beneficiary comments during the field survey focused on the uniqueness of services provided by the FGCs- quality services - mentioning the presence of specialists- and services that are responsive to the needs and treat beneficiaries well. They focused on the presence of specialists as an indicator of quality, they also focused on the financial accessibility.

**Table 4 Comments of beneficiaries pertaining to the relevance of the services provided by Nahr el Bared and Baddawi FGCs.**

| Nahr el Bared | Baddawi |
|---|---|
| First: we did not have clinics for such illnesses, Second - the financial situation - the FGC lessens the burden on people | excellent, there is none else in the camp |

| | |
|---|---|
| This is the only center here that offers such service, do not know of any other center | A rare service with specialists and lots of people comning and benefiting - we used to think the general (physical health is important) it turned out that mental health has equal importance. |
| A symbolic almost free service, if a person wants to consult a psychiatrist it is very expensive, there is saving for people. - the camp of Nahr el Bared is tragic | Provides services on how to deal with children in ways other than hitting |
| They work hard to benefit my son and this community, they respond to the situation we are in, they help us | |
| Thank God there is a center, because they are helping me so that my daughter gets better, and they give me guidance that help me to survive | |

**Impact - improvement**

Findings from the survey indicate that the majority of respondents expressed a perception of a positive impact of the treatment on the children on the part of their care givers the FGCs of Baddawi and Nahr el Bared (81.8 percent in Nahr el Bared FGC, and 87.1 percent in Baddawi FGC). Chi Square test however indicates a statistically significant variation between the two FGCs, 64.5 percent of respondents in Baddawi FGC reported sizeable progress whereas 38.2 percent more than one third reported sizeable progress in Nahr el Bared FGC. One factor that may explain this finding is the case mix variation between the two FGCs with Nahr el Bared having more severe cases, or there are more cases that are in early stages of treatment. Another factor may be that Nahr el Bared FGC stayed for approximately one year without a psychiatrist. Or both factors work synergistically. Another factor is the isolation of Nahr el Bared camp compared to Baddawi camp which may reflect negatively on the general mental health status of the population including children. Comments from some respondents reflect aspects of these findings.

**Table 5 Direction of change in the condition of the child - Nahr el Bared and Baddawi FGCs (counts)**

| | FGCs | | | | | |
|---|---|---|---|---|---|---|
| | Nahr el Bared | | Baddawi | | Total | |
| | # | % | # | % | # | % |
| For better, sizeable change | 21 | 38.2 | 20 | 64.5 | 41 | 47.7 |
| For better, limited change | 24 | 43.6 | 7 | 22.6 | 31 | 36.0 |
| for the worse | 1 | 1.8 | 1 | 3.2 | 2 | 2.3 |
| there was no change | 9 | 16.4 | 1 | 3.2 | 10 | 11.6 |
| no answer | 0 | 0.0 | 2 | 6.5 | 2 | 2.3 |
| Total | 55 | 100.0 | 31 | 100.0 | 86 | 100.0 |

| **Chi-Square Tests** | | | |
|---|---|---|---|
| | Value | Df | Asymp. Sig. (2-sided) |
| Pearson Chi-Square | 11.982[a] | 4 | .017 |
| N of Valid Cases | 86 | | |
| a. 5 cells (50.0%) have expected count less than 5. The minimum expected count is .72. | | | |

### Table 6 Comments on Impact - Nahr el Bared and Baddawi FGCs

| **5.1 Nahr el Bared FGC** |
|---|
| She sends Whatsapp messages, she started to focus, writes good dictation.. good improvement |
| She is better than before, she did not accept me addressing her.. now if I address her she listens to me .. she accept.. she understands. |
| The progress is slow |
| My child improved when his father returned from his travelling. |
| Still we have the letter 'r' to deal with, the specialist assured me that my son AH. has time till he is six.. my son leaves the session happy |
| At first i used to feel he was depressed.. now he plays.. watches TV.. participates in recreational activities [of NISCVT/BAS] |
| There are indications of progress |
| [my daughter] is improving gradually |
| [my son] improved as far as nervousness is concerned - he became calmer, he stopped doing the speech exercise, i was advised to bring him back when he wants to. |
| He improved, he listens to me at home, in the neighborhood I notice that he is a lot calmer |
| He overcame stuttering but it came back.. |
| Noticeable progress but did not yet reach what we were aiming for |
| Good progress but I want his nervousness to be a bit less |
| Even the doctor is pleased with her |
| He became less shy and became more accommodating to his brother |
| My daughter [Sh. } overcame behaviors I did not approve of |
| He became interactive with children, he started to talk |
| He now converses inside and outside the home, but still has lack of focus |
| He now focuses |
| He started to utter some words completely-[the whole word] |
| She started to go to the bathroom, she started to pick her clothes on her own, she now calls for her brothers, and frightens us with cockroaches! |
| We have mental stress at home, we live in a garage |
| As to reading and writing i try to provide M. [my daughter] with incentives but she is focused on play |
| He used to be excessively active, watching TV 24 hours, now he sits, plays, understands us, learns how to swim. he changed a lot. |
| Before he did not recognize sentences, did not focus, now he started to distinguish where he is going to and started to like to come here [to the FGC] |
| At first I did not comprehend what he says now I do |
| There is no progress |
| God Bless her, she is fine |
| She used to utter few words, now S. [my daughter] talks fluently |
| I expect that the treatment will take a while |
| For example I used to hit him, now I do not, now he listens to me without needing to hit him. |
| Two problems out of three are resolved |
| The problem is from my son and not from the doctor |
| At first he was afraid, he was hesitant afterwards he became encouraged |
| W. [my son] likes to come to the center |
| He promised her [the therapist] that he would study, he studied and succeeded |

| **5.2 Baddawi FGC** |
|---|
| More than 180 degrees change.. a foreign committee visited and they were very happy [about her results] |
| He got rid of his stuttering |

| |
|---|
| My son changed a lot in three months |
| He has gained self confidence, he has become self reliant |
| Now she speaks in sentences |
| He has now the ability to speak in sentence form, he makes a plural of the words cucumber and tomato |
| Even his laugh changed... a great difference.. when I just glance at him I become ecstatic.. before he did not even touch the toy.. even the ball he did not play with.. Thank God he is better than before, but he needs time.. he needs a lot of time [to improve] |
| [The therapist]taught her discipline, she became less aggressive, in two weeks her depression and suicidal thoughts ended. |
| Because her case is difficult, she needs treatment for a long period of time |
| To the better... whoever hears him understands what he says |
| [A big change] from heaven to earth, letters were not legible to [my son] M., he used to read them backwards |
| [My daughter] H. changed she does not torment herself, her personality strengthened |

## 2.3 Challenges facing implementation of the model

Two challenges are identified by the evaluation, negative stereotyping and a high demand for care.

### 2.3.1 Negative Stereotyping

Findings from beneficiary survey indicate that negative stereotyping of mental health problem - an indicator of coherence - remains a barrier of early detection of mental health problems, this results in getting more advanced cases and consuming more of the limited mental health human resources available.

Findings from beneficiary survey indicate variation in levels of acceptability in both FGCs - Baddawi and Nahr el Bared. The majority of respondents in both FGCs regarded acceptability of mental health care as acceptable to a limited extent to not acceptable at all. There was no statistically significant variation between the two FGCs. In total, approximately half of respondents (46 percent) in both FGCs in the north report that mental health care is acceptable to their surrounding acquaintances to a limited extent, in addition 13.8 percent report that mental health care is not acceptable at all, this brings the total proportion of limited to no acceptability of mental health to 59.8 percent - a majority reporting negative stereotyping (see table 6).

**Table 7 Cultural acceptability of mental health care - Nahr el Bared and Baddawi FGCs**

| | Nahr el Bared FGC | | Baddawi FGC | | Total | |
|---|---|---|---|---|---|---|
| | # | % | # | % | # | % |
| acceptable to a sizeable extent | 21 | 38.2 | 14 | 43.8 | 35 | 40.2 |
| acceptable to a limited extent | 29 | 52.7 | 11 | 34.4 | 40 | 46.0 |
| not acceptable at all | 5 | 9.1 | 7 | 21.8 | 12 | 13.8 |
| Total | 55 | 100.0 | 32 | 100.0 | 87 | 100.0 |

| Chi-Square Tests | | | |
|---|---|---|---|
| | Value | df | Asymp. Sig. (2-sided) |
| Pearson Chi-Square | 4.035[a] | 2 | .133 |
| N of Valid Cases | 87 | | |

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 4.41.

**Table 8 Comments from respondents on cultural acceptability by FGC - Nahr el Bared and Baddawi**

| **Table 7.1 Nahr el Bared FGC** |
|---|
| Society here is backward - I did not tell any body |
| I have developed a fear of people telling me my son has mental illness .. a person who has not been exposed to a psychological problem does not understand and consider him ill |
| There are two sides - the interest of the child [which is the more important] and the community opinion where each one has his/her own. It happened with my friend where her husband refused that his son be treated for his mental health problem. |
| The father and his family make fun of M. [my son] |
| The environment around me is educated, they accept |
| People around me have a negative view, I do not tell people around me where I go |
| The father was not convinced at first, then he became convinced |
| There are many children in a similar condition as my son, people referred me to Sumud [NISCCVT/BAS] |
| In my condition, I wish I see a mental health doctor, but our society is backward.. society does not accept, accuses a person to be mad |
| Do not tell anyone, I fear that people think my daughter is mad |
| Even I like to be treated because it makes one more comfortable |
| So people say: what do you want with the doctor? other say - pity .. he should be treated |
| There is a large group who accept, there is no shame that one goes to a psychiatrist... after the war that occurred in the camp, things changed. |
| There is acceptance in my family and with my husband |
| There are people who accept and people who don't.. my husband and I agreed and he told me to go [to the FGC] |
| There are people who say there is no use [of the treatment], our community start mocking my child's speech, his morale is negatively affected because of them |
| There are people who accept and people who don't |
| There are people with retroactive views, but in general there is increased awareness among people especially those who try. |
| Before the war it was frowned upon but now mental health has become a necessity in view of the stressful circumstances |
| Every one is entitled to an opinion, i follow the interest of my son |
| No one accepts... |
| I did not tell anyone... they would shame her [my daughter] |
| I did not tell my inlaws - our situation in the camp we are exposed to mocking by others.. |
| Some people find it shameful |
| There is variation... there is a sizeable proportion who are accepting this thing.. everything comes down to the home environment - culture in the home is what decides |
| His aunts encouraged me.. initially I refused the idea... his aunt [father's sister] is a mental health specialist |

| **Table 7.2 Baddawi FGC** |
|---|
| I do not open such a subject [ acceptability] |
| There is encouragement |
| My parents approve but my husband does not |

| |
|---|
| The educated are regressive, they consider disability a stigma [the mother is a preschool educator] |
| Society used to regard speech problems a kind of retardation, now there is increase awareness |
| People who are suffering from [mental health problems] are accepting them |
| There is demand on [addressing ] speech problems.. people do not have an idea that there is a speech therapist, they think it is a physical problem in the tongue<br>I live in an encouraging environment |
| [mental health care] is viewed as normal |
| My friends guided me to the FGC |
| Many women say I do not care about other people's opinions, when I came here I challenged the whole world. |
| [people change their mind] because they saw how the children changed [Syrian accent] |
| No one knew when I first brought my child to the FGC |
| There is a fear of dependency on drugs |

### 2.3.2 High demand for mental health care

Despite the stereotyping, there is the challenge of the high demand for care, and the limited institutional capacity to handle the demand for care. This has been voiced throughout the three year evaluation by staff as well as by parents of children.

Up to the present efforts on the part of UNRWA to integrate mental health care and psychosocial support (MHPSS) into its primary health care Family Health Team Model in Lebanon have not been moving in the same pace as they are in West Bank and Gaza Strip consequently FGCs at NISCVT are still first contact mental health care centers to be referral centers rather than first contact centers. Such deficiency in the infrastructure with UNRWA the whose mandate is to provide health services is reflected by waiting lists and some frustrations on the part of caregivers who are already satisfied but desire more sessions for their children[2].

## 2.4 Threats facing the future implementation of the model at NISCVT/BAS

**Limited resource capacities and staff turnover:** Threats exist in terms of funding limitations, and consequent limited resource capacities in NISCVT/BAS. as well as UNRWA - the principal health care provider.

**Increase demand for services:** Another threat consists of the increase demand for services The burden of Syrian refugees and the volatile situation in Ein el Hilweh camp pose a serious threat to mental health in addition to its threat to the basic survival of inhabitants.

Such an overall increase in the level of vulnerability poses a serious threat to the relative coverage of the mental health problems in the foreseeable future.

## 2.4 Opportunities available for model implementation

The initiative of the Lebanese Ministry of Public Health[3], and the involvement of the Al Buss FGC in such an initiative, poses a definite opportunity to increase the networking capacity thereby increasing access to services.

[2] UNRWA (2017) UNRWA Health Annual Report 2016, p.16
[3] for further detail refer to: http://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program

Another opportunity involves the rich experience that the two FGCs have accumulated that enables NISCVT/BAS to present argument for increasing funding allocations and increase access to new donors.
The positive impact perceived by beneficiaries according to the field study is proposed to be regarded as an opportunity for combating negative stereotyping.

### Sustainability - opportunities and threats

Community based service provision is the predominant feature of the work of NISCVT/BAS. It is a cherished value of the organization. Consequently such a value system provides a suitable frame within which community based mental health care services are delivered in the FGCs. Such a value system is demonstrated by the motivation of the community /social workers observed by evaluator during field visits throughout the three year evaluation process and is reflected by comments from the caregivers that underscore the positive relationships they hold with the FGC staff.

## A note on the project's Aid Effectiveness

Aid Effectiveness - analysis of effectiveness pertinent to donor's specific activities. Aid from FAFS to NISCVT/BAS focused on sponsorships that is in alignment with the need for children with multiple special needs and children with learning difficulties. The main challenge that faces the community wide impact of such aid is the volume of needs and the challenges facing the internationally mandated health service provider for Palestinian refugees - UNRWA - to create a system to meet those needs including that of FGCs and a network of referral services that are accessible to a wider range of the refugee population.
However, there is a positive feature of such aid which is its sustainability as limited as it is, also the areas of focus has acted synergistically with other sources of financial and technical support NISCVT/BAS receives. The ongoing support has provided evidence of credibility to the FGCs that attracts other funders. Moreover, this ongoing support has created a positive effect on the morale of the staff at NISCVT/BAS FGCs in the north who are working under challenging security situation as well as high demand for care.
Moreover, the monitoring and evaluation component of the aid process exercised in the form of periodic field visits, and an external evaluation serves to link with stakeholders by providing input on the operation of the aid provided.
Criteria of relevance, efficiency, effectiveness, relevance and impact are shown to lend strength to the model. These indicators of strength lend more credence to aid effectiveness as a matter of principle. However the principle of aid effectiveness is proposed to be addressed from the perspective of actual needs and demand for care, rather than a sole focus on the effectiveness and efficiency of the funds spent. This aid helps in minimal sustaining of the FGCs in the north of rough integrating frontline social work activities, however, creative strategies adopted by NISCVT/BAS in the North appear to have mitigated to an extent the challenge of the low ratio of community workers to specialists in the North FGCs compared to the Al Buss Flagship FGC that represents an embodiment of the community based mental health care.

## Conclusions and Recommendations

This section on conclusions and recommendations represents a summation based on findings from baseline, midterm evaluation, as well as the final evaluation.

**Conclusion 1 - NISCVT/BAS FGCs in the north play a crucial role in removing barriers of access to mental health services for children in refugee camps in North of Lebanon by adopting a community based model in service delivery which contributes to increasing coverage through positive impact of interventions at the FGCs.**

Given the preliminary structure of UNRWA mental health services in Lebanon, the FGCs run by NISCVT/BAS in general and in the North in particular are filling a crucial niche for mental health service delivery targeting children in the two Palestinian refugee camps in the north of Lebanon, an area of concentration of Palestinian refugees from Lebanon, as well as a sizeable concentration of refugees from Syria both Palestinian and Syrian. In addition, the community based mental health adopted by NISCVT/BAS is compatible with UNRWA's approach which uses a model configured according to its health service structure. The two FGCs - Nahr el Bared and Baddawi - act as first contact mental health care centers as well as referral centers by UNRWA and NGOs in view of the professional resources and expertise available at the centers which attracts the Lebanese community. The presence of psychiatrists and psychologists as well as speech therapists, special education specialist is well regarded by the beneficiaries because they address specific problems children face. The role of social workers/ community workers as facilitators to sustainable care is noted in view of their proactive role in reminding mothers and providing them with informal psychosocial support. Also the role of the psychiatrist, psychologist as clinical team leaders is also noted. The psychologist in Nahr el Bared FGC has filled the gap made by the lack of psychiatrist of almost a year.

**Conclusion 2 - Innovative strategies in meeting challenges in resource availability**

- Psychiatrist/psychologist role as team leader
- Referral to the Baddawi FGC psychiatrist for cases in Nahr el Bared FGC
- Role of speech therapist in Nahr el Bared as a first contact care provider in cases where the speech problem is obvious during absence of psychiatrist and psychologist.
- Social worker assumed the role as inducers for mother to keep their appointments by the reminder system using 'Whatsapp' smart phone application - a popular communication tool used by majority of women - in addition to providing informal psychosocial support.
- Continuing education of social workers act also as orientation for new comers consequently ameliorates the challenges incurred from turn over.
- Integration and coordination among programs and projects that work with the community has contributed towards mitigating the challenge of the low ratio of community workers to specialists in the North FGCs compared to the Al Buss Flagship FGC that represents an embodiment of the community based mental health care. Beneficiaries view the whole network of services provided by NISCVT/BAS as one system of services. Their satisfaction is that with the whole system including the FGCs.

**Conclusion 3 - overcoming negative stereotyping of mental health problems for children**

Findings from the accounts of mothers underscored the prevalence of negative stereotyping of mental health problems in general and the impact of interfacing with the FGCs in changing mothers' perceptions and in providing them with incentives to encourage others to utilize the services given their success. Such is another evidence of the usefulness of the community based approach in mental health services delivery.

**Recommendations to FAFS**

**1. Conclusion 1 The community based mental health care model is appreciated by beneficiaries**

Evidence from the survey, and from field observations in the final evaluation - as demonstrated in part 2, point to the conclusion that the community based mental health model – using the working definition sections 2.2 and 2.3 this document - is well received by beneficiaries. Conclusions from baseline and midterm evaluations point to a high level of satisfaction among caregivers.

**2. Contributing to meeting service needs - NISCVT/BAS FGS in the North as referral centers**

In view of the need of services expressed by beneficiaries, coupled with input from the baseline and midterm evaluations:

Consider,

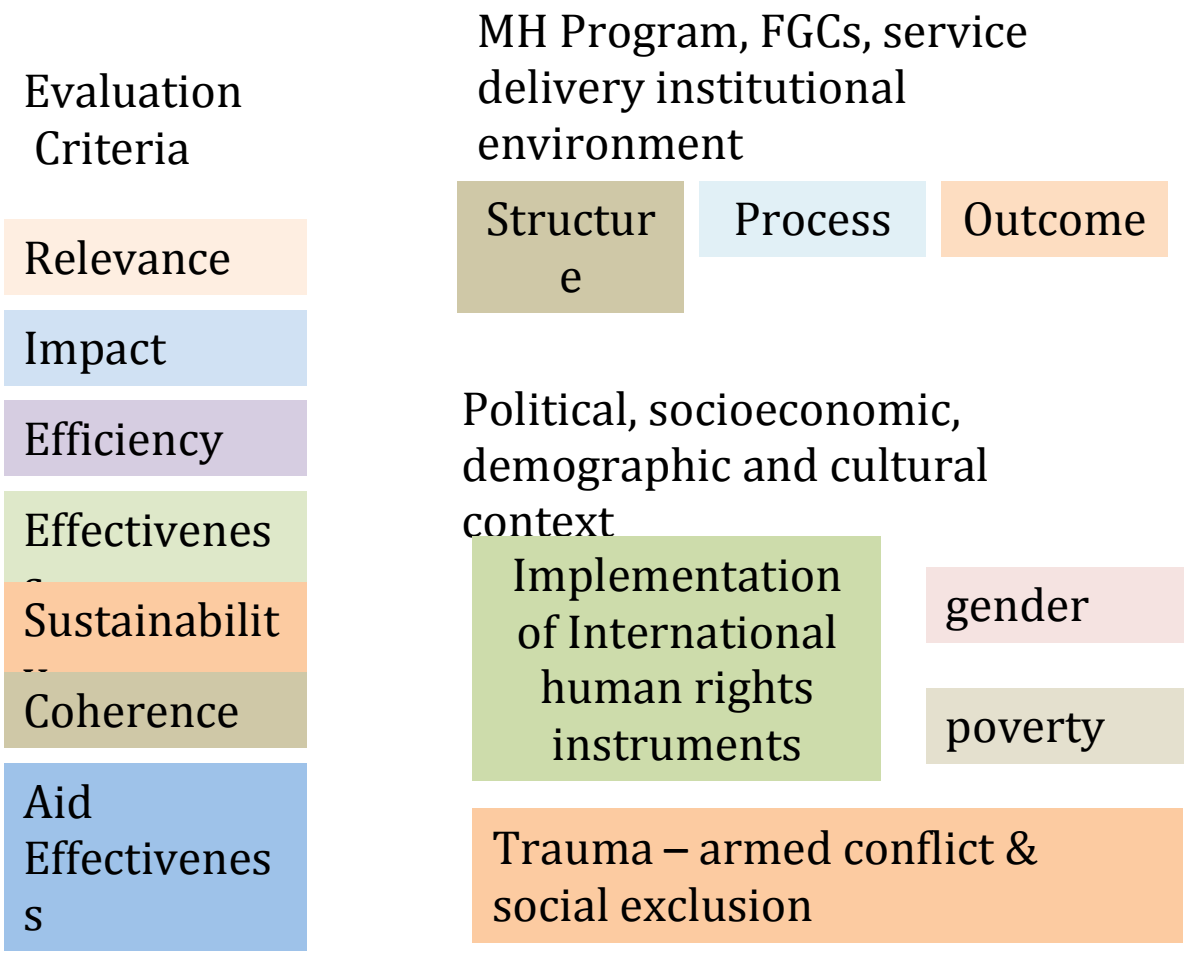
- support NISCVT/BAS system of continuing education targeting social/community workers to maintain quality of care and reduce the negative effects of turnover among community workers especially in the FGCs of Nahr el Bared.
- Increase support for special education grants/sponsorships
- Support NISCVT/BAS in its efforts to increase time of psychotherapists, and speech therapists in view of the demand for care
- Support NISCVT/BAS in their efforts to increase incentives to minimize turnover and increase retention of mental health clinicians in the FGCs of the north.
- support NISCVT/BAS in community awareness raising efforts to reduce stigmatization of mental health care and for early detection of cases.
- Advocate for UNRWA to upgrade their community based mental health services in their health as well as their education services in order to expand coverage and allow the two FGCs in the north to assume their role as centers of innovation and knowledge generation in the field of community based mental health care targeting vulnerable children.

Annexes

## Annex 1 Method

### Final External Evaluation Framework

Figure 2 General conceptual framework of the External evaluation - baseline, midterm and end of project




source: inception report

## Evaluation Questions

The evaluation questions of the final evaluation focus on project purpose related criteria namely impact, sustainability coherence and aid effectiveness as well as revisiting relevance, efficiency and effectiveness based on indicators extracted from the baseline and midterm evaluations[4]. In the analysis of findings Integrating Human rights and cross-cutting objectives in evaluation questions

Table 9 Evaluation Matrix - Impact Criterion

| Evaluation Question | Organizational Perspective | Beneficiary Perspective | Mechanism of data collection |
|---|---|---|---|
| • Progress made towards achieving the objectives of implementing community based mental health model? Within the context of application of the Convention for the Rights of the Child. | Was there a change on measures of quality of health care delivery in FGCs attributable to introducing the community based mental health care model? If yes, in what areas ? and for each area what is the direction and magnitude of such change? | Did the introduction of community oriented mental health care model exert a change in the lives of the beneficiaries? If yes, what are the areas where change occurred and for each area what is the direction and magnitude of such change? | *Survey of beneficiaries*<br><br>*Discussion with FGC Staff*<br><br>*Comparing baseline profile of FGCs with current profile in matters related to indicators of implementation of community based mental health model* |

[4] Criteria are based on the Evaluation Manual - Finnish Foreign Ministry (see Table 4 pp 27 - 29)

Table 10 Evaluation Matrix - Sustainability Criterion

| Evaluation Question | Organizational Perspective | Beneficiary Perspective | Mechanism of data collection |
|---|---|---|---|
| Assess the likely continuation of achievements | Assess the likelihood of continuation with the community based mental health model - facilitating factors and barriers | Assess the likelihood of continuation with beneficiary receptiveness with the activities related to the community based mental health care model - facilitating factors and barriers | *Survey of beneficiaries,*<br><br>*Discussion with FGC Staff* |

Table 11 Evaluation Matrix - Coherence Criterion

| Evaluation Question | Organization related Coherence | Beneficiary related Coherence | Mechanism of data collection |
|---|---|---|---|
| Assess the alignment of implementing community based mental health care with existing policies and cultural norms | Assess the likelihood of continuation with the community based mental health model - facilitating factors and barriers | Assess the alignment of the community based mental health care model with cultural norms | *Survey of beneficiaries,*<br><br>*Discussion with FGC Staff* |

Table 12 Evaluation Matrix - Aid Effectiveness Criterion

| Evaluation Question | Indicators | Mechanism of data collection |
|---|---|---|
| Assess implementation of relevant points of the Paris Declaration on Aid Effectiveness | • "alignment of support with NISCVT/BAS mental health program priorities, systems and procedures and helping to strengthen their capacities."<br>• Enhancing FAFS, FiPSR and NISCVT/BAS mental health program respective accountability to their stakeholders for their strategies and performance.<br>• Strengthening NISCVT/BAS mental health program | *Field observation, NISCVT/BAS annual report* |

| | | |
|---|---|---|
| | strategies and associated operational frameworks in relation to implementing community based mental health care model (e.g., planning, budget, and performance assessment frameworks). | |

Table 13 Evaluation Matrix - Effectiveness Criterion

| Evaluation Question | Organizational Perspective | Beneficiary Perspective | Mechanism of data collection |
|---|---|---|---|
| Assess the achievement of implementation of the community based mental health model | Meeting planned objectives pertaining to implementing community based mental health care model | The two outcome measures are satisfaction, and recommending the FGC service to others. The other four process measures are 'discussing problem and difficulties with therapists', perception of volume of assistance offered by therapist, and home visits by social/community workers | *Survey of beneficiaries,*<br><br>*Discussion with FGC Staff* |

Table 14 Evaluation Matrix - Efficiency Criterion

| Evaluation Question | Organizational Perspective | Beneficiary Perspective | Mechanism of data collection |
|---|---|---|---|
| Assess the implementation of the community based mental health model within the resources available | Indicators of collaboration with partner organization - example information sharing, group therapies, portage program, Innovative communication strategies with beneficiaries, beneficiary record systems and timely access to information | Waiting time (indicator generated by midterm evaluation) | *Survey of beneficiaries,*<br><br>*Discussion with FGC Staff* |

Table 15 Evaluation Matrix - Relevance Criterion

| Evaluation Question | Organizational Perspective | Beneficiary Perspective | Mechanism of data collection |
|---|---|---|---|
| Are the objectives and achievements of the activities pertaining to implementing community based mental health program consistent with the problems and priorities of the stakeholders, including all final beneficiaries? | Objectives and achievements of activities pertaining to implementing community based mental health program are consistent with those of the mental health program at NISCVT/BAS | Objectives and achievements of activities pertaining to implementing community based mental health program are consistent with those of the beneficiaries | *Survey of beneficiaries,*<br><br>*Discussion with FGC Staff* |

## Annex 2 Instrument

**Sumud Final Evaluation - Beneficiary Perspective**

**Sampling Frame number**

**Informed consent clause**

My name is....., I am involved in an evaluation of the work of the FGC as it relates to the community. As the person who is followed up...., or is currently following up, and who has been selected at random, I would like to ask you a few questions on your opinion regarding your experience with the FGC. The interview would take around 10 minutes of your time at the most. Information will be kept confidential.

Do you agree to participate?

- Agree
- Decline (in case of decline inquire about the reason)

**Admin info**

**Center name:.....**

**Date of filling questionnaire:.....**

| | |
|---|---|
| **Interview Status** | Available - agreed<br>Available - refused<br>Not available |
| | Interview is Done |

**I. Background**

Respondent profile

| | | | |
|---|---|---|---|
| | Gender of respondent | □ Female □ Male | |
| | Relationship of respondent with child | □ mother, □father, □aunt, □uncle, □grandmother, □ grandfather, □Other, Specify..... | |

**II. Activities the child is engage in**

**Profile of activity(ies) that the child is <u>currently</u> engaged in (for children who are not engaged, the <u>last</u> activity):**

**<u>To be filled by respondent</u>**

- **Type of activity:** therapy, social support, special education
- **Venue of activity**: within FGC, at home, within FGC and at home, referred by FGC (within NISCVT/BAS, outside NISCVT/BAS)
- **Current principal Service provider**: psychiatrist, therapist, social worker, special educator, other
- **Duration of activity: (months)**
- **In case the child is no longer engaged in FGC activity -** how long was the duration?

Responsibility of follow-up of the child

| | | | |
|---|---|---|---|
| | In your case, how is the responsibility of engagement with FGC regarding ..... treatment? | Mother and father share the responsibility of treatment equally<br>The mother assumes principal responsibility of treatment<br>The father assumes principal responsibility of treatment<br><br>Comment:..... | 3<br><br>2<br><br>1 |

## III. Evaluation Questions - Beneficiaries' Perspective

The following questions are evaluation of activities/ interventions you have just mentioned

**Impact:** Did the introduction of community oriented mental health care model (expressed by activities) exert a change in the lives of the beneficiaries? If yes, what are the areas where change occurred and for each area what is the direction and magnitude of such change?

| | | | Impact 1 | Impact 2 |
|---|---|---|---|---|
| **Specify Activity** | **Provider of activity** | **Did you participate?** | **In your opinion did your child's situation change because of this activity?** | **What was the direction of the change and its extent ?** |
| ..... | *Psychiatrist<br>*Therapist<br>*Social Worker<br>*Other | Yes<br>No | Yes<br>No | Much better<br>Slightly better<br>Worse |
| ..... | *Psychiatrist<br>*Therapist<br>*Social Worker<br>*Other | Yes<br>No | Yes<br>No | Much better<br>A bit better<br>Worse |

***evaluation, therapy, social support, special ed, other**

**Sustainability:** Assess the likelihood of continuation with beneficiary receptiveness with the activities related to the community based mental health care model - facilitating factors and barriers

| | | | Sustainability 1 | Sustainability 2 | Sustainability 3 |
|---|---|---|---|---|---|
| **Specify Activity*** | **Provider of activity** | **Did you participate?** | Will you continue with a similar activity / | If you answered yes, What factors would encourage you | If you answered no, What factors discourage you from |

| | | | | | |
|---|---|---|---|---|---|
| | | | intervention in the future? | to continue? | continuing? |
| | *Psychiatrist<br>*Therapist<br>*Social Worker<br>*Other | Yes<br>No | Yes<br>No<br>No need ( go to coherence question | | |
| | *Psychiatrist<br>*Therapist<br>*Social Worker<br>*Other | Yes<br>No | Yes<br>No<br>No need ( go to coherence question | | |

***evaluation, therapy, social support, special ed, other**

**الاستمرارية**

| | | | | Sustainability 2 | Sustainability 3 |
|---|---|---|---|---|---|
| **حدد/ي النشاط / التدخ** | **من قام بالتدخل؟** | **هل شاركت في التدخل؟** | هل ستستمر في التدخل مستقبلا بعد انتهاء العلاقة مع المركز | What factors would encourage you to continue? في حال الإجابة بنعم، ما هي العوامل التي تشجعك على الاستمرار؟ | What factors discourage you from continuing? في حال الإجابة بالنفي (لا)، ما هي العوامل التي تمنعك من الاستمرار؟ |
| | *طبيب/ة نفسي عصبي *معالج/ة * عاملة إجتماعية *آخر، حدد/ي | نعم لا | نعم لا لا داعي (أنتقال إلى سؤال الترابط) | | |
| | *طبيب/ة نفسي عصبي *معالج/ة * عاملة إجتماعية *آخر، حدد/ي | نعم لا | نعم لا لا داعي (أنتقال إلى سؤال الترابط) | | |

*** تقييم، علاج، دعم إجتماعي، تعلم مختص، آخر

**Coherence:** Assess the alignment of the community based mental health care model with cultural norms

| | | | Coherence 1 | Coherence 2 |
|---|---|---|---|---|
| **Specify Activity*** | **Provider of activity** | **Did you participate?** | Do you think this activity is acceptable among acquaintances and to what extent? | If the answer is no, what are the reasons your acquaintances do not accept this activity |
| *** | *Psychiatrist *Therapist *Social Worker *Other | Yes No | Acceptable to a large extent Acceptable to a limited extent Totally unacceptable | |

***evaluation, therapy, social support, special ed, other**

**المقبولية الثقافية**

| | | | Coherence 1 | Coherence 2 |
|---|---|---|---|---|
| **حدد/ي النشاط/ التدخ** | **من قام بالتدخل؟** | **هل شاركت في التدخل؟** | برأيك هل هذا النشاط مقبول عند معارفك وإلى أي حد ؟ | في حال الإجابة بالنفي ، ماهو السبب أو الأسباب التي برأيك تدفعهم إلى عدم |

| | | | | |
|---|---|---|---|---|
| *** | *طبيب/ة نفسي<br>عصبي<br>*معالج/ة<br>* عاملة إجتماعية<br>*آخر، حدد/ي | نعم<br>لا | | قبول هذا النشاط أوالتدخل؟ |
| | | | نعم إلى حد كبير<br>نعم إلى حد ما<br>غير مقبول أبدا | |

*** تقييم، علاج، دعم إجتماعي، تعلم مختص، آخر

**Effectiveness:** The two outcome measures are satisfaction, and recommending the FGC service to others. The other four process measures are 'discussing problem and difficulties with therapists', perception of volume of assistance offered by therapist, and home visits by social/community workers.

satisfaction question

| | | | |
|---|---|---|---|
| | **To what extent do you consider yourself satisfied with the services provided by the FGC?** | Greatly satisfied<br>Somewhat satisfied<br>Not satisfied at all<br>Comment:..... | 3<br>2<br>1 |

| | | | |
|---|---|---|---|
| | **لأي مدى تعتبر/ين نفسك راضية /راضيا عن خدمات مركز الإرشاد الأسري ... ؟** | راض/ية كثيرا<br>راض/ية إلى حدما<br>غير راض/ية على الإطلاق<br>تعليق | 3<br>2<br>1 |

recommending FGC to others

| | | | |
|---|---|---|---|
| | **Do you encourage others to seek this FGC ?** | Yes<br>No<br>Why?..... | 1<br>2 |

**Efficiency:** Waiting time (indicator generated by midterm evaluation)

**Waiting time**

| | | | |
|---|---|---|---|
| | **Date of the first visit** | Month ..... Year..... | |
| | **Date of first visit for therapy/ intervention** | Month ..... Year..... | (in case of first therapy visit move to question 12 after |

| | | | |
|---|---|---|---|
| | | | recording the date of the visit) |

**Relevance:** Objectives and achievements of activities pertaining to implementing community based mental health program are consistent with those of the beneficiaries.

| | | | |
|---|---|---|---|
| | **What is the extent of improvement ..... have you observed (up to now) that you attribute to the intervention received at the FGC?** | Plenty of improvement<br>Some improvement<br>Little improvement<br>Comment: ..... | 3<br>2<br>1 |
| | If ..... is not in school, **Is he/she capable of conducting his/her daily activities better since starting treatment at the FGC?** | Much better<br>Better to an extent<br>Not better at all<br><br>Comment: ..... | 3<br>2<br>1 |
| | If ..... is going to school, **is he/she learning better in school since he/she have been treated at the FGC?** | Much better<br>Better to an extent<br>Not better at all<br>Comment: ..... | 3<br>2<br>1 |

TO BE FILLED FROM DOCUMENTATION - W STAFF