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2 MONTHS OF WAR IN LEBANON
What are the Mental Health and Psychosocial Support Needs of Persons Impacted and the Recommendations for Mental Health Service Delivery Post-war?

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Contents

Contextual Background 3

Assessment methodology 4

Key Findings 5

Basic Services and Security 5

Psychosocial Needs Among Children and Adolescents and Their Caregivers 6

1. A Strong Need for Play and Engagement for Emotional Safety 6

2. Longing for Home and Routing, Coupled with Feelings of Isolation and Disconnection 6

3. Coping Mechanisms and Mental Health Concerns 6

4. Observations among Caregivers 7

Mental Health Challenges Among Displaced 7

Characteristics of displaced individuals 7

Patient characteristics by shelter location 8

Qualitative Findings from Psychiatric Intakes: Access to Mental Health Care System, Quality of Service and Treatment Gaps 8

1. Long-Term Mental Health Needs and Impact of Prolonged Exposure to War 9

2. Over-Prescription and Mismanagement of Anxiolytics 9

3. Stigma and Changing Attitudes Towards Mental Health 10

4. Vulnerable Populations in Need of Protection 10

Future Recommendations 11

Short-Term Recommendations 11

Medium-Term Recommendations 12

Long-Term Recommendations 13

Conclusion 13

Appendix 1: Sample drawings of children from psychosocial activities 14

Appendix 2: Graphs on Type of Disorder and Severity of Illness 16

Contextual Background

Since October 8th, 2023, Lebanon has been at war with Israel, which had been confined to the Southern border of Lebanon. On October 17th thousands of pager attacks exploded in Lebanon, after which the conflict between Lebanon and Israel intensified and expanded across the South, Bekaa and Southern Beirut, leading to the unprecedented displacement of over 1.2 million persons in less than 72 hours. This war, which to the date of writing this report, has been ongoing for the past eight weeks, has led to massive destruction of infrastructure, more than 3,500 persons martyred, and more than 14,900 persons injured. Among the Israeli hostilities are several attacks on medical facilities and humanitarian and medical personnel, resulting in 167 first responders killed or wounded during Israel airstrikes, in a clear violation of International Humanitarian Law under the Fourth Geneva Convention and Additional Protocol I of 1977. The ongoing conflict has led to massive and urgent humanitarian needs in Lebanon estimated as per the latest Lebanese Government Flash Appeal to be 1 billion US dollars, of which 775 million is needed for basic humanitarian needs, and 204 million US dollars needed to support the Lebanese Armed Forces and Security forces.

To the date of November 19th, 981 shelters have reached their full capacity, out of a total of 1,173 accredited shelters. While the total number of internally displaced persons (IDPs) is estimated to be around 1.2 million, the total number of registered IDPs in accredited shelters reached 187,992 individuals (comprising 44,322 families), most of who have been displaced to the Governorates of Mount Lebanon and Beirut.

This report presents the findings from an assessment of internally displaced individuals housed in various shelters that took place during the first weeks of displacement and escalation of the war. The data was collected through on-site evaluations and individual assessments as well as awareness sessions with children, youth and their caregivers at several shelters listed below:

Name of School/Shelter	Location	Approximate number of IDPs	Intervention: Psychosocial Activities	Intervention: Clinical Consultations
Ecole Saint Francois Kabbouchie	Hamra, Beirut	625 persons	X	X
Jaber Al Sabbah School	Karakas, Beirut	520 persons	X	X
Ras Beirut Public School	Hamra, Beirut	300 persons		
Zahia Kaddoura School	Hamra, Beirut	700 persons	X	X
Skybar	Downtown, Beirut	300 persons		X
Dar El Hamra	Hamra, Beirut	100 persons		X
Othman Thu Nourayn School (Makassed Islamic School)	Koreitem, Beirut	130 persons	X	X
Sagesse School	Clemenceau, Beirut	377 persons	X	
Baakline Intermediate School	Baakline, Shouf	186 persons	X	
Baakline High School	Baakline, Shouf	214 persons	X	

Table 1. List of shelters where MHPSS interventions took place

The primary objective of this report is to outline the mental health conditions, psychosocial needs, and the level of care being provided to these individuals and to provide recommendations on the short, mid-term, and long-term mental health and psychosocial needs and interventions that will be required to support the affected population.

Assessment methodology

The findings documented in this report on the mental health and psychosocial support needs of internally displaced persons (IDPs) were gathered through three primary interventions:

1. **Brief Screening/Triage Interviews:** Conducted by clinical psychologists to identify initial mental health concerns.
2. **In-Depth Clinical Interviews:** Led by psychiatrists to establish clinical diagnoses and determine treatment needs, if any.
3. **Psychosocial Activities and Awareness Sessions:** Facilitated by clinical psychologists to engage children, youth, and caregivers, offering emotional support and raising awareness.

Findings were synthesized by the Managing Director of Embrace who is a clinical psychologist and the Director of Strategic Partnerships at Embrace who is a public health professional and holds a diploma in development and organization of mental health services. Findings were gathered from detailed field notes taken by psychologists who facilitated the youth and caregiver sessions within the shelters as well as field notes gathered by psychiatrists during shelter visits. In addition to psychiatrist field notes, data was entered exported to excel and analyzed from Embrace's Electronic Health Records (customer relationship management system), for all beneficiaries who were seen by a psychiatrist where each beneficiary's demographic information, detailed clinical history, current presentation, diagnosis, medical treatment and the clinician global index is entered.

Shelter residents were informed in advance or on the day of the mental health team's arrival about the availability of services on-site. During the first three weeks following the mass displacement, many shelter focal points contacted Embrace through personal networks, requesting mental health support after recognizing the growing needs among residents. As national coordination efforts improved, Embrace coordinated with the Ministry of Social Affairs (MoSA), who continued to follow up with Embrace and refer additional schools to it. Coordination efforts with MoSA became a starting point for intervening in any school to streamline the processes of intervention and prevent duplication of services being provided to the same shelters by civil society actors and other NGOs operating in the same sector.

Upon arrival, the mental health team conducted walkthroughs in the shelters, informing residents about the availability of psychiatric consultations. Volunteers accompanied the team, engaging with both children and adults to raise awareness about the services offered, including the National Lifeline for Emotional Support and Suicide Prevention, and distributed informational flyers. On days designated for psychosocial activities, psychologists coordinated with shelter focal points to identify suitable locations within the schools for the sessions. Children and adolescents were then invited to participate in these activities.

Each shelter typically required at least three initial visits, lasting five hours each, to conduct intake assessments for individuals who expressed a need for mental health services. Larger shelters, hosting more than 500 residents, required additional visits to accommodate the greater demand. During each visit, 10 to 15 individuals underwent comprehensive clinical interviews. Following the initial assessments, ongoing follow-up visits were scheduled, with a focus on individuals identified during the first round of consultations who were prescribed medication, for follow up on their treatment compliance. Follow-ups visits were conducted approximately one month after the initial assessment to ensure continuity of care and address any evolving needs.

Key Findings

Basic Services and Security

The lack of access to necessities such as adequate food and dignified living conditions in the shelters emerged as a pervasive and a deeply distressing issue affecting all displaced individuals, including both youth and their parents.

While food boxes and hot meals were being delivered to shelters, many internally displaced persons (IDPs) reported significant issues with food quality and distribution. Meals often arrived in poor condition, leading to cases of food poisoning. Additionally, the distribution of food boxes was inconsistent and insufficient, leaving many families feeling overlooked and frustrated by the inequities in access to such essential resources.

Overcrowding in shelters posed one of the most significant challenges. Classrooms or small partitioned spaces were converted into living quarters, often hosting up to 10 individuals—including men, women, and children—from extended families in a single room. This lack of personal space gave rise to serious privacy concerns, particularly for women, who felt compelled to remain fully dressed or always veiled due to the constant presence of unrelated men. Such conditions caused immense discomfort and exacerbated stress levels among women and families.

Mothers expressed heightened anxiety about their children's safety and security in these overcrowded shelters. Children, both girls and boys, were exposed to a large number of unfamiliar individuals, making it difficult for parents to monitor their interactions and behavior. Mothers were especially concerned about the risk of bullying, harassment, or even sexual abuse. These concerns were amplified for children with special needs or intellectual disabilities, as parents struggled to provide the close supervision required, particularly for hyperactive children (with special needs).

Disturbingly, during psychosocial activities, several children disclosed experiencing physical abuse at the hands of family members. These cases were promptly reported to the Ministry of Social Affairs and referred to the National Lifeline for further intervention and case management, highlighting the critical need for child protection measures within shelters.

In addition to safety concerns, access to clean water and basic hygiene facilities was reported as a major issue. Many IDPs described extreme difficulties in maintaining personal hygiene, often going days without the ability to shower. When showers were possible, the lack of hot water forced families to boil water and use makeshift containers to bathe, causing significant distress and feelings of humiliation. These challenges were compounded in some shelters where IDPs were living in tents near open sewage drains. The presence of visible and foul-smelling feces in playgrounds posed a severe public health risk, leaving residents vulnerable to waterborne diseases and other illnesses.

These overlapping issues of inadequate food, overcrowded conditions, compromised safety, and insufficient hygiene measures underscore the urgent need for ongoing monitoring and evaluation and targeted interventions to address the basic needs essential to the safeguarding of human rights and dignity. Without immediate action, these conditions pose a threat to both the physical and mental health of already vulnerable individuals.

Psychosocial Needs Among Children and Adolescents and Their Caregivers

The below findings were gathered from awareness sessions, psychosocial activities conducted with children and youth, and caregiver workshops in the identified shelters (see Table 1). A total of 71 children, 116 youth and 75 caregivers participated in these activities.

1. A Strong Need for Play and Engagement for Emotional Safety

Children and youth demonstrated a significant need for activities that promoted play, and alleviated feelings of boredom, frustration and emotional distress they were feeling at the shelter. In shelters where activities were conducted multiple times, children eagerly ran to welcome the team upon arrival, requesting to play or talk, highlighting a strong need for care, attention and emotional connection. Youth also expressed a strong desire for additional sessions, indicating their recognized need for continued support.
Children and youth were generally highly engaged in sessions, with noticeable increases in engagement from the start to the end of activities. This reflected the sense of safety and trust developed during the sessions, enabling them to express thoughts and feelings more openly.

2. Longing for Home and Routine, Coupled with Feelings of Isolation and Disconnection

In both psychosocial activities and awareness sessions, both children and adolescents frequently expressed missing their homes and routines, which were critical sources of stability and identity. This was evident in their drawings, which often depicted their homes, gardens, and balloons, symbolizing longing for familiarity and a sense of normalcy (See Appendix).
While most adolescents engaged with the team during activities, many expressed a feeling of not belonging or fitting in. They also expressed distress over being separated from extended family members and friends, many of whom were in distant shelters, or whom they had completely lost touch with since being displaced.

3. Coping Mechanisms and Mental Health Concerns

To cope with the stressors of war and the difficulties of living in overcrowded shelters, youth expressed using a variety of coping mechanisms, including drawing, writing, praying, and listening to music. However, many reported a lack of effective strategies to manage their stress and emotions. Alarmingly, in every shelter, several adolescents disclosed self-harm behaviors, suicidal thoughts and exposure to abuse and violence. These individuals were provided with psychoeducation and relevant resources including information about the National Lifeline for emotional support and suicide prevention (1564).

In all shelters where psychosocial activities were conducted, the team engaged with the youth in the absence of any family member or caregiver. Caregivers were either occupied with managing family needs within the shelter, and many mothers also reported that they were alone in their responsibility of caregiving as their husbands were either trying to maintain any kind of work they have or were among the fighters in the Southern borders.

4. Observations among Caregivers

Caregivers expressed significant concerns about the behavioral changes in their children, including heightened aggression, oppositional behavior, and irritability. These changes were attributed to exposure to peers from families with differing parenting styles and the chaotic shelter environment. Parents reported struggling to monitor or discipline their children effectively, as they were overwhelmed with managing basic family needs and coping with their own mental health challenges. Many mothers reported engaging in verbal abuse or physical discipline due to the stress they were under. While some of these behaviors predated their displacement, they had become more frequent and severe after moving to the shelters. Many mothers highlighted that they were the sole caregivers, and that this left them with little time or energy for self-care, compounding their stress. Additionally, all caregivers expressed frustration with the shared shelter environment, citing varied routines and approaches to cleaning, hygiene practices and cooking among different families as sources of stress. These conditions, combined with the loss of their homes and livelihood, contributed to feelings of grief, isolation and detachment from the community they were living in. They longed for the familiarity and support of their pre-war social networks.

Mental Health Challenges Among Displaced

The below findings were gathered from individual psychological and psychiatric assessments with children adolescents, adults and older adults. Most individuals assessed were persons who presented voluntarily to seek mental health consultations once they knew a psychiatrist and psychologist were available on site. The majority had already been diagnosed with a mental health disorder, or had been prescribed psychotropic medication, but without a clear diagnosis. Alarmingly, the majority were on anxiolytics and had been taking them for a long time and reported not being able to function normally without them. Another vast majority were on chronic psychiatric medications and sought the team's services to renew their prescriptions and obtain their medications as many of them had left their homes leaving everything behind including their medications, and many of them had lost contact with their health professionals because of displacement and destruction in their hometowns. A smaller minority were seeking services for the first time, because they believed they were struggling, but had not previously been diagnosed or treated.

Characteristics of displaced individuals

A total of 113 consultations were conducted for 91 unique patients, with 19 patients being seen more than once. Sessions were primarily conducted at Jaber Al Sabbah School (26.4%), Zahia Kaddoura Hamra Shelter (24.2%), and Ecole Saint Francois Kabbouchiyye (22.0%). The evaluated population had an average age of 36.31 years (±16.48), with 30.8% being male. Geographically, most patients originated from Southern Beirut (39.6%) and South Lebanon (24.2%), followed by Mount Lebanon (15.4%) and Nabatiyeh (11.0%).

The distress levels among patients were notably high, with an average score of 8.47 (±2.62) on a 0–10 scale, highlighting the severe psychological toll of the war. **Suicidal ideation was reported in 22.2%** of individuals, and 29.2% exhibited aggressive behaviors, underscoring the urgent need for mental health support.

In terms of illness status, 57.1% of patients had active illnesses, and 28.6% were identified with chronic conditions, while cases of full or partial remission were rare. Regarding illness severity, **28.1% were classified as severely ill, 24.7% as markedly ill,** and 22.5% as moderately ill on the Clinician Global Index Scale (CGI), indicating a high prevalence of severe mental health conditions requiring intensive care.

The most common mental health diagnoses included Major Depressive Disorder (20.9%), Generalized Anxiety Disorder (17.6%), and Adjustment Disorders (12.1%). Other notable diagnoses were Schizophrenia (7.7%), Intellectual Disability (8.8%), and Obsessive-Compulsive Disorder (5.5%), reflecting the diversity of mental health challenges faced by this population.

Pharmacological management highlighted the complexity of these conditions, with **SSRIs prescribed in 47.9% of cases, followed by atypical antipsychotics (40.6%) and typical antipsychotics (22.5%)**. Benzodiazepines (14.0%) were commonly prescribed for acute anxiety or agitation, while anticonvulsants and mood stabilizers (11.2%) were prescribed to address mood disorders. This medication profile underscores the focus on managing mood disorders, psychosis, and anxiety within this vulnerable group.

These findings highlight the profound psychological toll of the war, with high levels of distress, active illness, and suicidal ideation among the displaced population. The data emphasizes the critical need for targeted mental health interventions to address the complex needs of this population and mitigate the long-term impacts of the war, which will be discussed further in the Recommendations section.

Patient characteristics by shelter location

The analysis of patient distribution across shelter locations highlights trends closely tied to the ongoing war, which has heavily impacted Beirut, South Lebanon, and the Bekaa region. Age distribution varied significantly across shelters, with wide age ranges observed at locations such as Jaber Al Sabbah School and Zahia Kaddoura Shelter. In terms of gender, female patients outnumbered males in most shelters, particularly at Jaber Al Sabbah School and Ecole Saint Francois Kabbouchiyye, indicating a higher representation of women seeking mental health care. However, shelters like Zahia Kaddoura demonstrated a more balanced gender distribution.

Regionally, most patients originated from areas directly affected by the war. Shelters such as Ecole Saint Francois Kabbouchiyye and Jaber Al Sabbah School primarily hosted patients from Beirut and South Lebanon, while those in Zgharta served individuals from North Lebanon.

Findings on distress levels reveal that Nabatiyeh recorded the highest average distress score (9.78), followed by and North Lebanon (9.17) and Mount Lebanon (9.07). Furthermore, Beirut, Mount Lebanon, Nabatiyeh, North Lebanon, and South Lebanon exhibited a median distress score of 10, indicating that all respondents experienced the highest possible levels of distress.

Regarding illness status, Jaber Al Sabbah School reported the highest number of patients with active illnesses, followed by Zahia Kaddoura Hamra Shelter and Skybar. Both Jaber Al Sabbah and Skybar also had a higher proportion of severely ill patients compared to other locations, highlighting the burden of serious health cases they face. The significant presence of active and severe illness in these centers further emphasizes the necessity of focused interventions to manage the health crisis effectively and mitigate further complications.

Qualitative Findings from Psychiatric Intakes: Access to Mental Health Care System, Quality of Service and Treatment Gaps

The findings described above regarding the mental health problems assessed among a small sample of IDPs provides critical insights into several themes that highlight existing gaps and inform future priorities in

mental health service provision in Lebanon. Although the sample size of assessed individuals is relatively small compared to the scale of needs across the displaced population, the data gathered underscores significant patterns in mental health care and challenges that will be outlined below. The limitations of reaching a larger sample size which stem from time constraints, human resources shortages, funding limitations, and the sheer number of residents within each shelter – emphasize the need for systemic improvements to address the growing mental health crisis effectively and to deliver highly needed services, both during and after the war.

1. Long-Term Mental Health Needs and Impact of Prolonged Exposure to War

A recurring theme among displaced individuals from the South was the long-term presence and worsening of mental health symptoms that predated the mass displacement in September 2024. These symptoms were significantly exacerbated by the prolonged exposure to war-related stressors, such as airstrikes, bombings, and the constant fear of displacement, which began as early as October 7, 2023, with the onset of the conflict. Many of these individuals presented with conditions requiring treatment beyond normal adjustment reactions or acute stress. **This highlights the necessity of long-term mental health care and follow-up, as war-induced trauma often results in chronic mental health conditions requiring sustained intervention.**

2. Over-Prescription and Mismanagement of Anxiolytics

A concerning pattern of over-reliance on anxiolytics, such as Deanxit, Lexotanil, and Xanax, was observed among many IDPs seeking treatment. This dependence was often fueled by a need to avoid withdrawal symptoms, such as irritability, anxiety, and sleep disturbances and promoted the seeking of mental health services in the shelter for prescription renewal. Most patients reported little understanding of why they were prescribed these medications, except for temporary symptom relief, and many had been on them for years without proper follow-up or a comprehensive treatment plan. There was a significant lack of psychoeducation about their diagnoses, alternative treatment options (e.g., SSRIs, mood stabilizers, or psychotherapy), and the long-term consequences of anxiolytic dependence. Many patients had received these prescriptions from non-mental health professionals, such as general practitioners or specialists (e.g., neurologists and cardiologists).

The findings underscore the urgent need to:

- **Scale mental health services** in underserved areas, ensuring accessibility to specialized care.
- **Train and supervise non-mental health professionals,** often the first point of contact, to avoid inappropriate prescribing and promote proper mental health referrals.
- **Promote centralized care delivery** at primary health care centers to integrate mental health services comprehensively.

Patients who expressed reluctance to transition to appropriate psychiatric treatments (e.g., SSRIs or mood stabilizers) often overcame their hesitation through the psychiatrist's targeted psychoeducation and the provision of tailored care by Embrace's team and continuity of services through follow up visits to the shelter, and referring these persons for follow up at the Embrace Mental Health Center in Hamra. However, ensuring long-term follow-up for these individuals upon returning to their homes remains a pressing challenge.

3. Stigma and Changing Attitudes Towards Mental Health

The mental health interventions described in this report allowed for a closer observation and understanding of mental health related stigma and attitudes towards help seeking among a wide range of Lebanese people from different regions in the country. Mental health related stigma was markedly high among the populations that presented for treatment, with many women who were requesting help, also reporting stigmatizing attitudes from their male counterparts, as well as from their surrounding community. To add to this, the conditions of psychiatric assessments unfortunately and despite the best efforts of the team and shelter focal points, were not always conducive to privacy and confidentiality. Nonetheless, the conditions of war and displacement created an opportunity for many to overcome these barriers and seek support, and the influx of patients indicated a recognized need about the IDPs for mental health guidance and support.

Factors that contributed to overcoming stigma and accessing services in the shelter, and that need to be capitalized on, included:

- **Dependence on anxiolytic prescriptions:** These medications were often perceived as "stress-relievers" rather than treatments for mental illness, reducing the stigma associated with seeking them from the psychiatrist. Conversely, medications like SSRIs or mood stabilizers were viewed as "addictive" or indicative of “craziness” or mental instability. These misconceptions were clearly addressed during the sessions.
- **Family Concerns:** Many parents sought care for their children but were themselves identified as needing psychiatric attention, often revealing their own struggles during consultations.
- **Normalization through visibility:** Long waiting lines for psychiatric services within the shelters and word-of-mouth referrals encouraged others to seek care, reducing barriers of stigma.
- **Volunteer outreach:** Volunteers played a vital role in engaging families, raising awareness about mental health, and encouraging individuals to access available services.

These circumstances present a critical opportunity to further break down stigma through continued awareness campaigns and psychoeducation, leveraging the crisis as a moment to normalize mental health care and promote access to services.

4. Vulnerable Populations in Need of Protection

Finally, a main concern that is a primary priority in times of war remains the protection of the most vulnerable individuals including children, women, elderly, marginalized populations including migrant workers, refugees, persons from the LGBTQ community, and persons with special needs, intellectual disabilities and chronic and severe mental illness. **The interventions conducted and presented in this report highlight the impact of war on individuals with special needs, intellectual disabilities and chronic severe mental illnesses such as schizophrenia and bipolar disorder.** These individuals were often neglected, and many were found sedated and isolated in their rooms, as the extreme change in environment and loss of routine caused severe deterioration in their mental health, including psychotic relapses, increased agitation, and withdrawal.

Family members, despite their efforts, were often unable to provide adequate care due to the chaotic shelter environments and their own stress. In such cases, the mobile crisis team, operating under Lebanon’s National Mental Health Emergency Mechanism managed by Embrace and the National Mental Health Program, played a critical role in de-escalating crises and facilitating direct hospitalizations from the shelters.

Future Recommendations

The following section outlines immediate/short-term, medium term and longer-term interventions aimed at addressing and supporting the mental health and psychosocial needs and challenges identified in this report. These recommendations provide a roadmap for addressing immediate needs, strengthening systems, and building sustainable mental health care infrastructure in Lebanon.

Short-Term Recommendations

1. **Emergency Mental Health Services: Expanding the National Mental Health Emergency Response Mechanism (NMHERM) and Leveraging of Primary Satellite Units (PSUs)**
   There is a need for continued support to the National Mental Health Emergency Response Mechanism (NMHERM), currently operated by the National Mental Health Program and Embrace NGO to deploy mobile mental health teams to shelters to provide immediate assessment and crisis intervention for those experiencing acute distress, suicidal ideation, or psychotic episodes and ensure hospitalization when needed. For displaced persons, the World Health Organization in collaboration with the Lebanese Ministry of Public Health is currently covering the cost of inpatient psychiatric hospitalization in several public hospitals in Lebanon. This service should be sustained and expanded.

   The NMHERM has also been activated as of November 15th, to coordinate with the Primary Satellite Units being deployed through the National Primary Health Care Network to provide virtual psychiatric consultations through the General Practitioners of the PSUs. This mechanism will:

   - Help ensure the availability of psychiatric medication for displaced individuals, focusing on replacing lost prescriptions and addressing dependency concerns.
   - Enhance interdisciplinary collaboration and consultation networks whereby general practitioners can seek advice from psychiatrists on complex cases, minimizing inappropriate prescribing.
   - Expand access to qualified mental health professionals to reduce reliance on non-specialists for psychiatric care.
   - Ensure that IDPs are connected to and registered into the primary health care network and therefore can sustainably receive services, no matter where they are in Lebanon.

2. **Raising Awareness about National Mental Health Services:** Delivering psychoeducation/ awareness sessions to IDPs to enhance their awareness on recognizing mental health symptoms, proper medication use, and the benefits of psychotherapy and distributing informational materials about available national services, including the National Lifeline for Emotional Support and Suicide Prevention (1564) and Step by Step application (which can support mild to moderate symptoms of depression and anxiety) will be essential to ensure that persons in need are aware of existing services and can access them.

3. **Establishing Safe Spaces for Children and Adolescents:** Child-friendly spaces within shelters for structured psychosocial activities to alleviate boredom, frustration, and emotional distress are among the immediate needs to ensure that children and youth have appropriate emotional outlets and receive peer support that will help in alleviating the impact of the war and displacement related stressors they are enduring and prevent long-term mental health problems. In addition to the importance of this immediate recommendation, the health and safety of children should also be quickly addressed through the implementation of monitoring and evaluation systems that report on the living conditions in

shelters, including food quality, hygiene and overcrowding. This entails the investment in additional shelters across the country that are better equipped to meet dignified living conditions than schools.

4. **Strengthening Protection Measures for Vulnerable Populations:** The findings above underscore the importance of enhancing child protection mechanisms by ensuring the presence of social workers to monitor and report cases of abuse or neglect. While this is currently being done in several shelters through the Ministry of Social Affairs which has deployed its social workers into most shelters, there is a lack of clearly communicated information to stakeholders and actor organizations on how these cases once reported, are being handled and followed up with, especially in the absence of governmental centers or institutions that take on the protection of these children and adolescents, specifically in the case of unattended youth (no parents) and minors being subjected to abuse.

   Tailored support should also be provided for individuals with intellectual disabilities and chronic mental health conditions through direct engagement and care and assigned social workers advocating for their special needs by ensuring better living accommodations, such as larger rooms, or being placed in smaller shelters with a smaller number of residents. Training shelter staff to identify and support vulnerable individuals, specifically identifying safety and security risks, and emphasizing protection and inclusion and referring these individuals to organizations supporting the shelter or MOSA are also among critical short-term recommendations.

5. **Sustaining operations and expanding the reach of the National Lifeline for Emotional Support and Suicide Prevention (1564)** as a vital national tool for the provision of emotional support and orientation of IDPs to needed community resources and ensuring its dissemination in all shelters and utilizing the 4Ws mapping for referring persons to mental health services across Lebanon.

Medium-Term Recommendations

1. **Building Capacity of Non-Mental Health Professionals** through training of general practitioners and primary healthcare workers on mental health screening, appropriate prescribing practices, and referral pathways and ensure ongoing supervision of non-specialists by specialized mental health professionals to improve treatment outcomes and reduce inappropriate prescribing. This may also warrant strengthening regulations on who can prescribe anxiolytics, requiring additional certification for non-psychiatric physicians prescribing these medications.

2. **Ensuring access of IDPs to psychotherapy services** in addition to psychiatric services which are now scarcely available within shelters. Both medium term recommendations 1 and 2 will need to be integrated with long term recommendation of **supporting and expanding the integration of mental health into primary health care, detailed below**.

3. **Strengthening Coordination Among Stakeholders:** Stronger coordination between the Ministry of Public Health (National Mental Health Program) and Ministry of Social Affairs (MoSA) is needed to standardize interventions, avoid duplication, and expand reach to underserved shelters. Protection issues are central to the MOSA mission; however, they do overlap with services provided by mental health professionals and require stronger collaboration. For example, the development of a roster of PFA trained social workers is listed in the coordination and advocacy section of the National Mental Health Program Emergency plan, however there is no clear communication on how this roster can be mobilized and by which actors.

4. **Conducting Family Support Programs:** Workshops for caregivers focusing on stress management, positive parenting strategies, and coping with behavioral changes in children may go a long way in supporting caregivers and alleviating the burden they are experiencing and help reduce harsh disciplinary and abusive measures being reported by parents to improve child mental health outcomes. They will also support the identification of such cases and implementation of tailored protection interventions.

Long-Term Recommendations

1. **Supporting and Expanding Integration of Mental Health into Primary Care:** In line with the National Strategy for Mental Health, it will be essential to continue support, mostly in financial means, the establishment of mental health services within primary healthcare centers in remote and underserved areas to ensure continuity of care after IDPs return to their homes. This should also focus on advocating for the role of local organizations in the management and integration of these services, rather than international organizations to support localization and building local capacity and ensuring sustainability of these services on the long-term. The destruction of several primary health care centers from the war will also need to be supported through the rebuilding of those, or new PHCs in underserved areas.

2. **Integrating of Mental Health and Psychosocial support training into disaster risk management** through capacity building of key local stakeholders involved in disaster risk management (municipality personnel and other local stakeholders) on MHPSS and psychological first aid principles and on available mental health services and resources to orient persons to, given the critical role they are playing in the humanitarian response to this war.

3. **Advocating for and Sustaining Mobile Mental Health Units:** Advocating for increased funding to sustain mobile mental health units as well as integrating them into the national health care system, as these units have proven to be essential during the humanitarian response and should be a key component of long-term mental health strategy, and mobilized to support Primary Satellite Units.

4. **Trauma-Informed Education Programs:** Building the capacity of teachers and frontliners on trauma-informed practices to support children's reintegration into educational systems will be needed as teachers will play a vital role in supporting the re-integration period post-war. Incorporating mental health and resilience-building modules into school curricula to address the long-term impacts of war and displacement may also be needed.

Conclusion

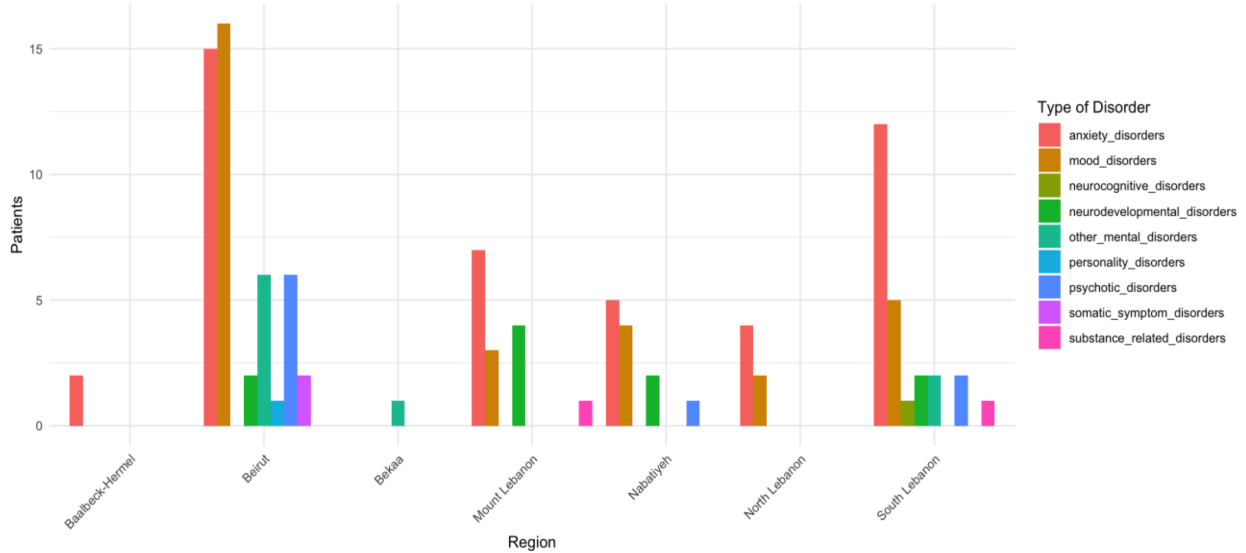
The findings in this report highlight a profound psychological toll of displacement and war on Lebanon's internally displaced populations, gathered only in the first few weeks of the war. The challenges of prolonged exposure to conflict, dependency on anxiolytics, stigma, and the neglect of vulnerable populations highlight the urgent need for targeted MHPSS interventions. Addressing these needs requires a multi-level approach that prioritizes immediate crisis intervention, strengthens medium-term support systems, and builds sustainable frameworks for long-term mental health care.

The ongoing conflict presents an opportunity to reshape mental health service delivery in Lebanon, integrating it into broader humanitarian and recovery efforts. By implementing these recommendations, stakeholders can ensure that displaced individuals receive the comprehensive care and support they need to rebuild their lives and foster resilience in the face of adversity.

Appendix 1: Sample drawings of children from psychosocial activities

Appendix 2: Graphs on Type of Disorder and Severity of Illness

Graph 1: Type of disorder against region where IDPs were displaced from



Graph 1: Severity of illness among IDPs across shelters where they were assessed