International Medical Corps

Rapid Mental Health and Psychosocial Support Assessment: Needs, Services, and Recommendations for Support to Refugees, Asylum Seekers, and Migrants in Northern and Central Greece

July 8th 2016

1. Goals

The overall goal of this rapid assessment was to inform the potential program design of International Medical Corps (IMC) MHPSS (Mental Health and Psychosocial Support) activities that would fill existing gaps as part of the refugee/asylum seeker response in Greece. Data collection focused on specifically on perceived needs, availability and access to mental health services and access to psychosocial activities and informal education.

For questions or to learn more about this assessment, please contact: Dr. Inka Weissbecker, IMC Global Mental Health and Psychosocial Advisor, iweissbecker@InternationalMedicalCorps.org

2. Methodology

The rapid MHPSS situational analysis was conducted by IMCs Global Mental Health and Psychosocial Advisor (Dr. Inka Weissbecker) and the IMC Greece MHPSS Coordinator (Dr. Andria Spyridou) from June 23rd to July 7th 2016 as part of a multi-sectorial rapid assessment carried out by the IMC Emergency Response Team (ERT). The assessment tools were adapted from the UNHCR/WHO (2012) MHPSS Assessment Guide[1] and included a basic mapping of MHPSS actors and an assessment of community needs, stressors, perceptions and ways of coping and help seeking for mental health related problems (Participatory Assessment: Perceptions of general and affected community members).

A desktop review of current relevant documents included:

- Multi-Agency Guidance Note for Mental Health and Psychosocial Support for Refugees, Asylum Seekers, and Migrants on the Move in Europe
- UNHCR Mission Report: Mental Health Technical Support Mission to Greece
- IMC 2016 MHPSS Assessment (Greek Islands and Athens)

Interviews, Focus Group Discussions and Site Visits:
Field visits were conducted to hosting sites in Northern and Central Greece (especially those away from urban centers shown in red on the map below, also see details in Table 2) including Katsika, Thermopiles, Nea Kavala and Veria.

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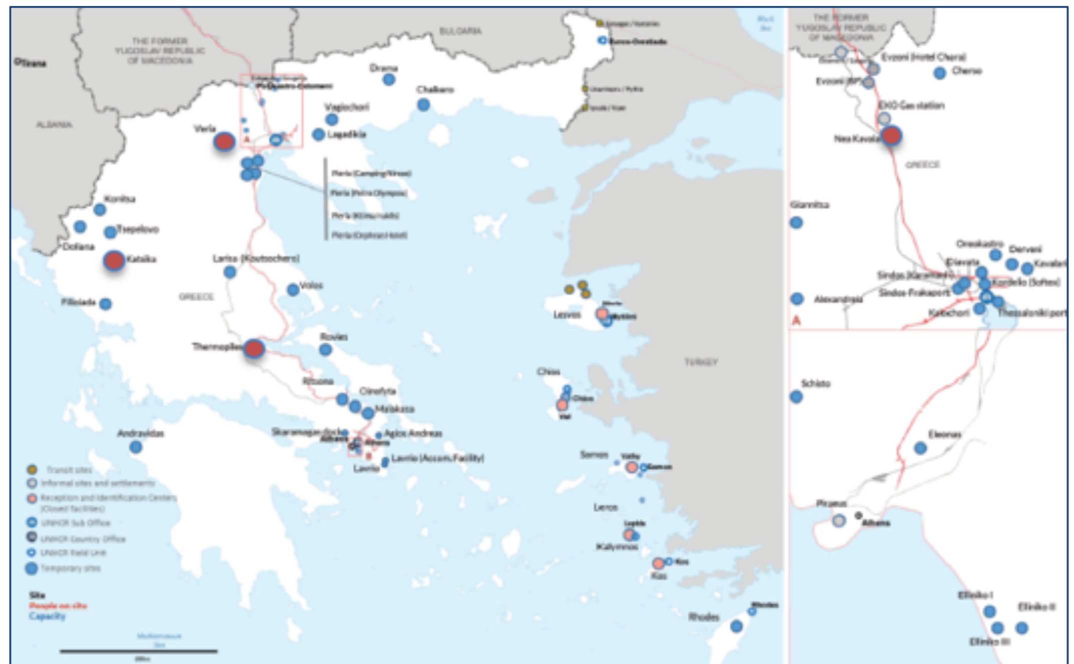
[1] WHO/UNHCR (2012). "Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Crises". Geneva.

MHPSS assessment data were collected from discussions with key informants, general discussions with various representatives of LNGOs/INGOs (e.g. MSF, MDM, IRC, Lighthouse, Arsis, Praksis), the Red Cross/Red Crescent, UNHCR, volunteers as well as from refugees/asylum seekers (adult males and females in Thermopiles and Veria).

3. Background and Context

3.1. Refugee and Migrant Crisis in Greece



As of July 8th, there are about 57,286 persons of concern in Greece. The number of new arrivals from the Mediterranean Sea has continuously and significantly declined (from 211,663 at the height of arrivals in October 2015 to only 1,488 in June 2016), but border closings and new restrictions have stopped affected populations from moving on. Since January 2016, the islands camps have shifted the population towards the mainland, and mainly to the two largest urban centers of Athens and Thessaloniki. Over the past several months, temporary sites including open camp/tent sites, and accommodation in vacant hotel buildings and warehouses have been set up to host refugees, migrants and asylum seekers in North and Central Greece (see map above) and there is a need to find longer term solutions. Applications for asylum have risen substantially and UNHCR estimates that up to 45,000 people plan to seek asylum on the mainland and 6,000 on the islands. As refugees and migrants begin to understand their stay in Greece will be longer than anticipated, more are seeking life outside the camps and integration with Greek society. Concerns have been expressed about the living conditions at camp sites which often lack minimum standards[2] and about continued and urgent mental health and psychosocial support needs[3].

3.2. Mental Health Policies and Systems in Greece

Greece has an officially approved national mental health policy (2001), and mental health plan (2010), which include the need for developing a community intervention network, promotion of community-based mental health services, and transition of mental health service users back into the workforce. Although there have been national efforts at de-institutionalization and reform in Greece, quality and accessible community level care is not always available. The integration of mental health into Primary Health Care (PHC) is limited, PHC providers typically refer cases (or only provide psychotropic medication) and the PHC system is not strongly developed or used. Psychiatric units in general hospitals are staffed by psychiatrists and psychologists and some community mental health centers exist in major cities. Mental hospitals in Greece are still often focused on medication management, are under-staffed and do not always provide comprehensive care and follow up. Diverse training programs for psychology and psychotherapy (e.g. CBT, systems therapy, psycho-analysis) exist, but there are no consistent licensing requirements (for further details see IMC Greece 2016 MHPSS Assessment/Islands).

[2] http://data.unhcr.org/mediterranean/country.php?id=83
[3] https://www.theguardian.com/global-development/2016/jun/08/experts-sound-alarm-mental-health-toll-migrants-refugees-depression-anxiety-psychosis

4. Assessment Results

4.1. MHPSS Coordination

Our assessment showed that several actors have expressed a need for better MHPSS coordination and that there is often a lack of understanding of the different activities and services which should be included and provided as part of a comprehensive MHPSS response based on global IASC guidelines. There are also different actors including local organizations and volunteers, who engage in MHPSS services and activities with limited technical knowledge, oversight and guidance. Camp managers and coordinators expressed being concerned about potential for harm and negative consequences with some of these activities (e.g. breaches of confidentiality). Given that most coordination groups (e.g. health and protection) are led by staff without expertise in MHPSS, there is limited awareness of the gaps or concerns. **This is leading to MHPSS activities and services which may not be consistent with guidelines and may have the potential to increase risks and harm to affected populations as well as to MHPSS gaps not being filled.**

There currently is no national level MHPSS coordination group and no specific regional MHPSS coordination groups on the mainland. However, there is an MHPSS coordination group in Lesvos. Earlier this year, IMC co-chaired an MHPSS coordination meeting with UNHCR and there is a need to continue regular meetings. MHPSS activities are currently discussed ad hoc as part of regional Health and Protection coordination groups. An online group for Greece has also been set up at www.mhpss.net. In Athens, Babel (Day Centre for migrants' mental health), supported by International Medical Corps and others, has set up a network of MHPSS professionals and field level representatives from different organizations to share experiences and strengthen referral pathways and collaboration in and around Athens. Their first meeting was on June 23rd 1016 in Athens and was well attended (e.g. Caritas, MDM, MSF, Praksis, SOS villages). The second meeting is planned for July 10th and a Referral Workshop is planned for July 12th. There is also a working group (including ministries and organizations such as Babel, Association of Greek Psychologists, Association of Greek Psychiatrists, CDC) who are translating relevant guidelines into Greek (e.g. IASC Guidelines, Sphere) and developing specific standards for emergencies. **However, those groups currently have limited resources and geographical scope. There is a need to support more systematic MHPSS coordination across the mainland including mapping of MHPSS actors and gaps and dissemination of best practices.**

4.2. Current problems and stressors among the affected population

> "We don't know what times doctors are coming and going, we don't understand medical care, they give you something and there is no follow up, like they just want to finish and leave" "I'm very afraid to give birth, doctors are very rude and there is no translation"
> ~ Women in Varia camp

> "I stopped being a woman, brushing my hair is not important now, I don't care, I don't think about it"
> ~Young woman, Daria Camp

Key informants including service providers and other staff working with affected populations in all four selected sites as well as focus groups (adult males and females in Thermopiles and Veria) were asked about current problems affecting refugees and migrants at the sites. Results are summarized in Table 1 below. In discussion with camp residents, there was an overall sense of frustration, anger and uncertainty about the future combined with the hardships of living in the camp environment. Many camp residents also did not have access to reliable information and were asking questions about the pre-registration and asylum process. There is an overall lack of control over day to day decisions and tasks such as food preparation and meeting basic needs. This is resulting in increasing frustration as well as apathy, a sense of helplessness, and a lack of motivation to engage in day to day tasks. One staff member working in a camp (Thermopiles) reported that it seems many people have "given up" and are not attending to personal hygiene and dressing. Aggression and fighting have increased among camp residents and have also been directed towards camp staff and visitors (in Thermopiles).

Table 1: Current problems and stressors among affected populations

<table>
<tr><th colspan="2">General (across visited sites and groups)</th></tr>
<tr>
<td>• Poor quality food (provided by army/catering) not acceptable (e.g. does not taste good, poor nutritional value, processed junk food, not culturally acceptable), there is a need for fruits and vegetables and milk (some people buy their own) and for refrigeration
• Frustration with registration process, they want to accelerate process of registration
• Difficulties accessing secondary health care due to lack of transport and not being able to pay for transport, lack of translators, negative experience with Greek health system and with camp health providers. Some people use savings to pay for private doctors.
• Asking for basic needs (e.g. chlorine, sugar, tea) but only receiving small amounts which is not enough. Volunteers used to bring food and NFIs but their numbers and capacity is decreasing
• Hot temperatures and lack of ventilation, lack of sheltered spaces (e.g. between tents, people get sunburned)
• WASH needs, no warm water and dirty toilets
• Crowded conditions and lack of privacy (e.g. a small room for a family of six)
• Mosquito and bedbug bites, rats, snakes and snake bites, head lice (especially children are affected, some have received shampoo for lice but have not used it)
• Lack of trust in organizations providing services and in camp management</td>
<td>• Financial difficulties an inability to work or bring in an income, diminishing financial resources
• Isolation at the camp sites, can not easily get to shops or services, nothing to do or see
• Poor internet connectivity
• Lack of lighting

Psychosocial issues:
• Apathy and mental fatigue are very common
• Limited ability and motivation for day to day tasks, many people have given up on cleaning their living space and on personal hygiene and dressing
• Anger, frustration, shouting, acting out and aggression
• Fear and uncertainty about the future
• Self harm and expressions of suicidal intent
• Depression, people also talk about depression more openly (although this usually is a stigmatized term)
• Psychological distress
• Sleep disturbance

Social issues
• Separation from family members in other camps (reunification not possible because of lack of space)
• Family arguments and fighting
• Domestic violence
• Discrimination, conflict and bullying among different ethnic groups (e.g. Afghan children did not go to school because others threw rocks at them)</td>
</tr>
<tr><th>Women</th><th>Men</th></tr>
<tr>
<td rowspan="3">• Exhaustion, feeling physically exhausted, crying every day
• Not feeling motivated
• Lack of dignity and humiliation by not being able to access basic needs and needing to ask for everything, “Waiting in line 2-3 hrs for sugar is humiliating”
• Financial difficulties and lack of money for basic needs
• High burden on female heads of households who are there with children but no husband or other family
• Lack of supervision and engagement of children, many children are neglected and left by themselves during the day
• Maternal depression, some mothers seem depressed and are unable to do their day to day work and to care for and feed their children. There are many infants and newborns in some of the camps (e.g. 7 in Varia).
• Headaches
• Conflict and threats by camp service providers who have threatened to take them to another camp if they “continue asking for things”</td>
<td>• Boredom and lack of activities, not having much to do during the day (spending time sleeping, playing cards, there is a volleyball net but no ball), they have asked for ping pong, billiard and tennis, they want to to work and be busy
• Sadness and apathy
• Inability to provide for themselves and their families
• Arguments, aggression and physical fighting
• Rising tensions between camp residents and host communities, host communities seen as hostile and “distant”</td>
</tr>
<tr><th>Children</th></tr>
<tr>
<td>• Lack of safe play areas and spaces
• Lack of access to needed healthcare (e.g. children missing vaccinations)
• Children do not like the food
• Behavioral difficulties, acting out and being ‘out of control”
• Nightmares (e.g. from bombings in Syria)
• Bedwetting
• Developmental disorders (such as autism) and developmental delays
• Many children have no boundaries with strangers which makes them more vulnerable to abuse (combined with parents who may be tired and apathetic)
• Children act more like adults (e.g. asking about registration)</td>
</tr>
</table>

• **Lack of access to MH care,** "there is no psychologist, there is no therapy, we are desperate"	• **Mental health problems** among children have been reported such as ADHD, autism, PTSD • Parents are afraid of having an "**unhealthy generation of children** who have not been receiving healthcare or schooling"

Coping with distress

Participants in FGDs were asked how they were coping with the difficult situation in the camp and how they were helping others cope.

Ways people are helping each other:

- Those who speak English accompany others to the hospital to translate
- Sharing information and resources
- Encouraging each other
- Sharing food, making breakfast for neighbors
- Meeting and talking

However, **concerns were also expressed about how to help people cope who are experiencing more serious forms of distress** such as people who are feeling very sad and unmotivated or those who are crying frequently and who have impaired day to day functioning.

"If we let out what is inside of us, our tears will fill the valley until the top of the mountain (….). We help each other hand to hand and we try to relief our neighbor but when she cries then I cry too"
~Woman, Varia Camp

"We have men here in the camp who are very sad, do not want to go out or do anything. We try to encourage them, make jokes, we take him out to different places to change his mood. But we are not sure if this is the right idea? We need someone with medical experience to come and learn how to help these men" ~Men, Varia Camp

4.3. Actors currently active in MHPSS

Several local and international organizations as well as volunteers are active in covering different aspects of MHPSS. Coverage of camps visited is shown below, gaps and challenges are discussed in the following sections.

Table 2: Services and activities at visited camp sites

Camp Location	Katsika	Thermopiles	Nea Kavala	Varia
Camp Type	Open camp (tents)	2 vacant hotel buildings	Open camp (tents)	Former military housing
Population	1075 (1,500 capacity)	492 (290 capacity)	2400 (4,000 capacity)	350 (350 capacity)
Population groups	80% Syrians, 5% Iraqis and 5% Iranians and 5% Afghans 5% Palestinians	80% of Syrian Kurdish, 10% Iraqis and 10% Iranians	80% of Syrian Kurdish and 5% Iraqis and 5% Afghans	80% Syrians and 20% Kurdish-Syrians
Specialized MH (psychiatry)	Yes (MSF psychiatrist)	**No** (acute hospital referral ony)	**No**	**No**
Psychosocial Treatment Interventions	Yes (MDM psychologist)	Planned (MSF-S psychologist)	**Limited** (Praksis social workers and psychologist)	**No**
Community Psychosocial Support and Outreach	Planned (MDM)	**No**	**No**	**No**
Psychosocial Activities, Learning and Safe Spaces	Yes (Lighthouse and Arsis), CFS, community space	**Limited** (regional teachers and volunteers), informal education for children, no staffed spaces or activity schedules	Yes (IHA, Safe the Children), CFS, community space	**Limited** (Intersos and volunteers), informal education for children, no staffed spaces or activity schedules

4.2. Access to Mental Health Services

It is estimated that rates of common mental disorders such as anxiety disorders and depression can double in the context of humanitarian emergencies from a baseline of 10% to 20%, while people with severe mental disorders (2-3%) are especially vulnerable in such contexts and need access to care.[4] A significant gap in the provision of mental health services in Northern and Central Greece has been noted in health and protection coordination meetings. As a result, several actors have started to scale up their activities. MSF-Belgium has announced planning to cover 10 camps around Thessaloniki for mental health[5], which would include psychosocial interventions (by psychologists) and clinical mental health care (by consulting psychiatrists). MDM France is planning to scale up to cover all 5 camps in the Ioannina area (already including Katsika), in addition to Athens and surrounding camps[6]. MSF-Switzerland is planning to continue outreach support (psychologist) to Thermopiles, Elleniko (mobile clinic) and Athens. MDM is providing psychological support (psychologist) in Cherso, Redestos (Thessaloniki area), Katsika (Ioannina), and planning to scale up to Konitsa camp (Ioannina). IRC is providing or planning psychosocial interventions (by psychologists) as part of their protection programs in Alexandria, Cherso and Giannitsa, Diavata. IRC and MDM do not provide psychiatric support but refer to available local services. Other actors who are active in the field of MHPSS engage in activities such as basic listening supporting and connecting people to services but do not provide mental health care. Although affected populations should be able to access health (and at times mental health) services at camp sites (e.g. MSF, MDM, Hellenic Red Cross) or at public Greek health facilities free of charge, several barriers have been identified to accessing health care including mental health care.

The following **challenges in coverage and access for mental health services** were identified (based on discussions with refugees and MHPSS service providers):

General Challenges:

- There is a **lack of trust among refugee communities towards agencies** providing services at camp sites.
- **Cultural and language barriers** (e.g. lack of translators, lack of health/mental health staff speaking language of affected populations)
- Many refugees/asylum seekers have had **negative experiences with the Greek health system** (e.g. being spoken to in rude or insensitive manner by health staff, feeling that health staff did not listen to their concerns, not understanding diagnosis and treatment plan, not knowing how and when to follow up)
- **Lack of understanding of how the Greek health system works** (e.g. how and where to get which services, waiting times)
- **Lack of transport to health facilities** (e.g. transport not provided, not being able to afford bus fare)

Mental health specific challenges:

- **No mental health care is available in some camps** which are smaller and/or further away from urban areas (e.g. Varia, Drama).
- **Mental health care in many camps is fragmented with only specific aspects being provided** (e.g. basic psychosocial support by psychologists but no access to clinical care).
- **Access to clinical mental health services (psychiatrists) is often limited** to acute emergency cases while those with mental and neurological disorders requiring clinical care and medication may have no coverage or no monitoring (e.g. for medication side effects) or follow-up.

> A father explained that his two and a half year old daughter has been in a house being bombed in Syria a year ago, she has been diagnosed with severe PTSD and autism while in Athens but there are no specialized services for her in the camp. He took her to the health staff here but he says nothing was done. “My daughter is getting worse every day, she is beating her head against the wall and I don’t know what to do!” ~ *Young father, Thermopiles camp*

[4]World Health Organization & United Nations High Commissioner for Refugees. *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings*. Geneva: WHO, 2012.

[5] Kalohori/Eskemarket, Karamanli/South Sindos, Fragapol, Softex, Derveni, Vasilika/Raidestos, Kavalari, Sinatex

[6] Elleniko, Malakassa, ELeonas, Ritsona, Pireas

- **Lack of follow up** after mental health care is provided through local services (e.g. some refugees with mental problems were referred to a hospital in Thermopiles and given medications but no one has followed up on them)
- Existing providers of mental health care (e.g. psychologists) have **limited training background and capacity** for the provision of **evidence based** psychosocial and psychotherapeutic interventions for the treatment of mental disorders (e.g. CBT based interventions, IPT) and for **working specifically with refugee populations**.
- **Community level mental health promotion and activities** aimed at the general populations (e.g. IEC materials and discussions about positive coping and helping children cope) are currently often not taking place and are only planned for a few camps.
- **There is a lack of entry and cross-referral points** (e.g. referral between mental health and other service providers, community engagement) for mental health services (e.g. one agency set up MH services in a camp but only received 2 cases in 10 days)

A mother who was a University student in Syria with her daughter in a stroller explained, "she is one year old and still cannot walk and has no teeth. I went to the doctor in the camp and he just said this was normal but I don't think it is. I want to see someone to help her but don't know where to go and have no money for transport, I'm really worried"
~ Young mother, Daria camp

4.3. Access to Information, Spaces and Opportunities for Learning and Structured Activities

Access to information

Access to information varied across sites. While some sites (e.g. Katsika, Nea Kavala) had information posted (e.g. boards with information about asylum procedures, schedules for English classes), others (e.g. Varia, Thermopiles) had no or limited information available as well as limited internet connectivity. Having questions about asylum procedures and hearing different rumors and not being aware of schedules for services and activities (e.g. when health care staff would be available, when and where recreational activities will take place) added to the sense of unpredictability and frustration among camp residents.

Safe Spaces

Safe Spaces that had been constructed for children (CFS) as well as community spaces supported by NGOs or volunteers were available at some sites (Katsika, Nea Kavala). Other sites (e.g. Varia, Thermopiles) had indoor space for child educational activities (organized by teachers), but no other structured safe spaces for women or the community (also see Table 2).

Community Space with Garden and Schedule for English Classes in Nea Kavala

Opportunities for Learning and Structured Activities

Many organizations as well as volunteers have started engaging camp residents in activities and informal education (e.g. English classes, gardening), which are conducted in safe and welcoming spaces including child friendly spaces (CFS), Women's centers and spaces, and community spaces (Katsika and Nea Kavala). Educational activities for children (up to age 12) were available at all of the sites. However, activities for adults or very young children has been a gap in some sites. In FGDs, camp residents (in Varia and Thermopiles) expressed frustration and boredom given the isolation and lack of activities. Men reported spending time sleeping or playing cards, while women reported focusing on children and housework such as washing clothes and preparing food. Men expressed that they wanted language classes, better

activities and money to spend so that they can do and buy things for themselves. Women also expressed the need for language classes, for materials (e.g. for sewing, wool) and for safe activities and spaces for their children.

Our assessment showed the following gaps and challenges:

- There is limited **geographical coverage**, with some camps having many actors and activities (Katsika and Nea Kavala) while others, especially those further away from urban centers, only have few or almost none (e.g. Varia, Thermopiles).
- **Coverage is often time limited or sporadic**. In some camps, residents were unsure who was organizing activities and when. They said that some volunteers would come occasionally and some organizations would come only briefly (e.g. half a day) once every week or two weeks. Some child educational activities (Thermopiles) are organized by volunteer teachers only, who take turns with a different teachers coming each day of the week.

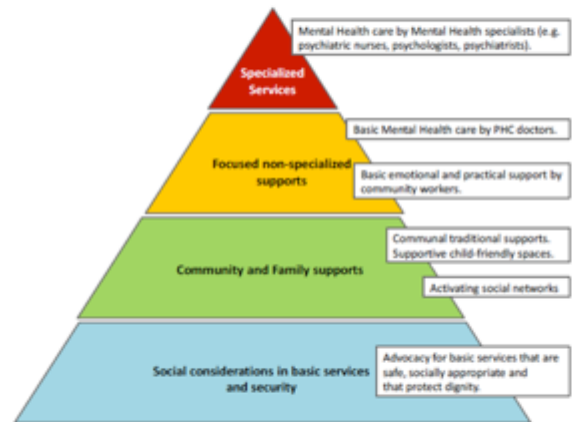
"An organization came once and they played Badminton with us and asked what we needed. We asked for table tennis and knitting supplies for the women but they did not come back" ~ *Young men, Thermopiles camp*

- **Most activities focus on specific groups such as women or children** under 12 only. Children younger than 5 and youth were regarded as gap groups not being sufficiently addressed by current child-friendly programming and informal education. Men have also expressed a need for activities and engagement.
- **Child participation in informal educational activities** was reported as one of the challenges. A Greek teacher (Thermopiles) explained that many children do not come to class and are not encouraged by their parents to attend. Refugee parents expect classes similar to what was available in their home countries (e.g. a lot of writing and memorizing) and they do often not see the value of engaging in informal education and structured games, they also expect teachers to physically punish children.
- **Parenting children** in this context has been reported as especially challenging. Mothers reported that they try to keep children confined to the small spaces of their shelter spaces/rooms but that they are "out of control" and there is nothing to entertain them (e.g. no TV, games or radio) or to help them let out their energy. Some organizations and volunteers hand out toys for children, which is meant well but can **undermine the role of parents as caregivers and providers**, further adding to a sense of helplessness among them. **A lack of supervision and engagement of children** has also been observed by camp staff, who reported that some mothers are tired and let children wander off without supervision, many children are neglected, many are physically punished. Some parents do not engage with children to help them learn and develop and do not encourage children to attend informal schooling and activities organized by different organizations.

5. Summary and Recommendations

The Inter-Agency Standing Committee (IASC) (2007) Guidelines on Mental health and Psychosocial Support in Emergency Settings recommend levels of mental health and psychosocial intervention based on a pyramid ranging from social considerations in basic services and security up to specialized mental health services (see Figure to the right). The following recommendations take different levels of the pyramid into account but focus specifically on coordination, access to mental health services and psychosocial and informal learning activities.

Figure 4. IASC MHPSS Intervention Pyramid



5.1. Improve coordination, mapping and dissemination of best practices for mental health and psychosocial support services and activities

IASC MHPSS Guidelines recommend having a MHPSS coordination group to help coordinate MHPSS activities and link to different groups and actors (e.g. health, protection). Some actors (e.g. Babel) have started specific coordination groups and activities (e.g. coordination meetings and referral workshops in Athens) that could be expanded. There is also a lack of common understanding and language of the scope and types of comprehensive MHPSS services and activities that are recommended by global guidelines and appropriate for the current crisis. There is a need for a culturally informed and sensitive approaches for connecting affected populations to available mental health services and psychosocial activities.

Recommendations:

- → Build on existing MHPSS coordination efforts (e.g. by Babel) to **expand MHPSS coordination groups** and workshops (e.g. referral workshops, workshops about best practices in MHPSS) to different regions including north and central Greece.
- → Conduct a **detailed 4Ws mapping of MHPSS services and activities** across the mainland to strengthen overall coordination for MHPSS, promote a common understanding of MHPSS terms and activities, fill existing gaps and improve effective linking of affected populations to activities and needed services.
- → Offer workshops on relevant aspects of **global IASC MHPSS guidelines** on mental health and psychosocial support in emergency settings to national and local governmental and NGO partners
- → Offer continued **Psychological First Aid** (PFA) training as well as additional tailored training components adapted to the Greek refugee crisis (e.g. communication and cultural sensitivities, training tailored towards the needs and tasks of specific professionals) and IEC materials on PFA and MHPSS principles that can be given to volunteers and different organizations.

5.2. Improve information dissemination and access to information especially in more remote camp sites

Affected population in surveyed camps often do not always have access to reliable up to date information, services and activities offered, which increased feelings of uncertainty, lack of control and frustration.

Recommendations:

- → Ensure access to information in more remote sites through: **public information boards** with information, better internet connectivity and access to information on the internet (e.g. public computers), dissemination of information of where to find **accurate and up to date information** (e.g. News that moves,

https://newsthatmoves.org/en/category/greece/) and public postings at camp sites of organizations working there, which types of services and activities they provide and a **schedule of times/locations of services and activities**.

5.3. Improve access to mental health services by strengthening the continuum of care, filling gaps and facilitating access

Affected populations with pre-existing mental health and neurological conditions or crisis induced mental health problems currently have limited access to mental health care due to limited geographic coverage and scope of organizations implementing mental health programs as well as difficulties accessing Greek mental health services. Most affected populations can **only access specific components of MH systems** (e.g. a psychologist in a camp providing counseling through a translator) but do not always have access to needed comprehensive mental health services which should include community level sensitization and education (e.g. coping with stress), evidence-based treatments for common mental disorders (e.g. depression) and pharmacological management as well as referral to other needed services and continued follow-up.

Recommendations:

- → Map out existing mental health and psychosocial support services provided by health facilities and establish **referral pathways** from each camp to relevant health facilities.
- → **Strengthen links between camps and health facilities** by facilitating translation as well as transportation to health facilities for patients needing referral as well as transportation for specialized mental health staff (e.g. psychiatrists) conducting outreach and follow up visits in camps.
- → Ensure provision of **comprehensive and seamless mental health and psychosocial support services** and adequate coverage through coordination and setting up additional programs where gaps exist.
- → **Build capacity of new and existing mental health and social service providers** who are part of local organizations or the Greek health system in delivering **evidence based psychosocial interventions, providing mental health case management** (following up over time and linking those with mental health problems to various available services and opportunities depending on their needs) and in **working with refugee and migrant populations.**
- → **Actively engage affected populations in community levels discussions** about mental health needs and ways of coping (including helping children cope), discuss ways of help-seeking and ensure knowledge of available services.
- → **Develop IEC materials** on mental health promotion and available services and supports.
- → Engage key members of affected populations with relevant background (e.g. in psychology, social work, education) as **community outreach workers (representing different ethnic groups)** who can help identify, support and refer people with mental health needs.
- → Establish **referral pathways with other agencies** (e.g. those working in education, health, protection, shelter, nutrition) to help them identify and refer people in need of mental health services.
- → **Actively engage camp populations** in obtaining information about needs and **feedback** about available services, activities and schedules to inform program planning and implementation.

5.4. Provide access to psychosocial activities and informal education

The assessment showed that affected populations felt they had limited control over their day to day lives and limited access to activities or opportunities for learning or obtaining resources. Yet, many of those affected have valuable skills and abilities and a desire to engage in purposeful activities and to help others. There is a strong need to systematically scale up access to daily structured activities and informal education for all demographic groups among affected populations (e.g. including men and older persons).

Recommendations:

- → **Provide Child Friendly Spaces (CFS) and other safe communal spaces** where they currently do not exist. This should include adequate staffing, schedules and activities throughout the entire week including weekends.

- → **Involve affected communities in selecting activities and opportunities** for learning and **identify key people** among affected populations who can participate in organizing activities, being **educators, and sharing their knowledge and skills.**
- → **Work with different local partners and organizations** to organize activities and structured learning sessions in the camps and provide access (e.g. needed fees, transport) for camp population to opportunities in urban areas.
- → Help fill **critical gaps in materials and supplies** needed for resuming day to day purposeful activities (e.g. communal cooking spaces and utensils, stationary, books, gardening tools and supplies etc.) to increase a sense of agency, control and decision making.

5.5. Support parents in caregiving/parenting and in helping children learn and develop

While some camp sites provide spaces, activities and informal education and supplies/toys for children, there is also a need to support parents in their role. Female caregivers expressed feelings of helplessness and frustration in dealing with child behavioral problems in the context of the camp environment, while service providers have expressed concerns about physical punishment and neglect of children. Some parents also feel overwhelmed and unable to function, which impacts their caregiving practices and parenting abilities. There is a need to empower parents to assume caregiving and parenting responsibilities and to help children learn and develop in this difficult context.

Recommendations:

- → Provide **information and space for discussion** to parents about normal stress reactions among children, how to help children cope and how to deal with their own psychological distress.
- → **Provide structured classes on positive parenting** (all ages) and on **Early Childhood Development** (ECD for children under 5). ECD for example has been shown to improve parenting skills, attachment/bonding as well as child development, health outcomes and maternal mood in humanitarian settings. Parenting and ECD can be integrated with health, protection or nutrition programs. Empowering parents to take control and initiative, learn new skills and help their children adjust and learn would be especially important in the current context.