



Rapid Mental Health and Psychosocial Support Situational Assessment in Serbia Services, Perceived Needs, and Recommendations following the Refugees, Asylum Seekers and Migrants on the Move in Europe



January, 2016

1. Goals

The primary goal of this rapid mental health and psychosocial support (MHPSS) needs assessment¹ is to obtain an understanding of existing services, strengths and identified needs following the Refugees, Asylum Seekers and Migrants on the Move in Serbia. The results will inform the program design of International Medical Corps' (IMC) MHPSS initiatives to address existing gaps in services and supports.

Data collection focused on assessing the availability and accessibility of existing mental health and psychosocial support services as well as community aspects of mental health and wellbeing among affected populations. This assessment focused on identifying needs as well as resources.

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2. Methodology

The rapid MHPSS needs assessment was conducted by IMC's MHPSS Consultant **Marcio Gagliato** from January 14th – 27th 2016. The assessment tools were adapted from the UNHCR/WHO publication (2012), "Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Crises". This assessment is based on a desk review of current policy documents and field research that included interviews with key stakeholders as well as observations at transit sites in Serbia.

¹ This report presents a snapshot of the situation in a rapidly changing environment. The report reflects key informant knowledge, perceptions and experience at the time of data collection. Given that the situation is rapidly changing, the report may therefore have gaps in terms of information or regarding, interventions, coordination, support system, referrals, etc.

A desk review of current policy documents included:

- [WHO's Mental Health Atlas 2014 – Serbia profile](#)
- Latest Situation Reports:
 - [UNHCR Data Base on Refugees/Migrants Emergency Response - Mediterranean – Reports](#)
 - [ACAPS Published scenarios, analysis briefings, maps](#)
 - Internal IMC Serbia Situation Reports
 - [MSF Report - Obstacle Course to Europe: A Policy-Made Humanitarian Crisis at EU Borders](#)
- MHPSS background Papers:
 - [Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians - A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflict.](#)
 - [Reform of mental health care in Serbia: ten steps plus one](#)
 - [Study of the Mental health of Asylum Seekers in Serbia](#)
 - [Secretariat of the Ministry of Labour and Social Policy in Serbia - Support for de-institutionalization and social inclusion of persons with mental disability and mental illness - 2011](#)
 - [Torment not Treatment: Serbia's Segregation and Abuse of Children and Adults with Disabilities](#)
 - [Mental Healthcare Befitting Human Dignity – collection of papers about the Mental Health system in Serbia](#)
- Needs Assessment of the Migration Crises:
 - [Gender assessment of the refugee and migration crisis in Serbia and former Yugoslav Republic of Macedonia](#)
 - IFRC Psychosocial Center Field visit report: Psychosocial support in the migration crisis - Assessing the psychosocial activities and support provided by the Hellenic Red Cross and ERUs in their psychosocial response to refugees, asylum seekers and migrants on the move in Europe
 - IMC Inter-Sectoral Humanitarian Assessment across 4 Greek Islands (Lesvos, Samos, Leros, Kos) December, 2015
 - [Needs Assessment for ACT Alliance Response to the Refugee Crisis in Europe – Greece, Macedonia \(FYROM\), Serbia and Hungary](#)
 - [Serbia: assessing health-system capacity to manage sudden large influxes of migrants](#)
- [Multi Agency Guidance Note on Mental Health and Psychosocial Support for Refugees, Asylum-seekers and Migrants on the Move in Europe](#)
- [Other documents available at mhps.net dedicated migration crisis group.](#)

Interviews, Focus Group Discussions, and Site Visits:

MHPSS assessment data was collected from discussions with key informants (e.g. the Serbian University Professor on MH & member of the Serbian MH reform - Vladimir Jovic), with International and Intergovernmental organizations working on MHPSS in Serbia (MSF, UNICEF, UNHCR, DRC, IRC, RC, WAHA, SC, WV, CPWG, ECHO, TdH, Intersos), local stakeholders and NGOs (IAN, Atina, Novi Sad Humanitarian Centre, SOS Children's Villages Serbia, Commissariat for Refugees and Migration); as well as from Child Protection Working Groups coordination meetings in Serbia. Field visits were conducted to the Transit sites and information centers (Sid stations, Belgrade and east border with Bulgaria), discussions with refugees were held in three occasions.

3. Background and Context

3.1 Migration Crisis

Protracted conflict, ongoing violence and insecurity, reduced education and livelihood opportunities and uncertain futures in countries of the Middle East, Africa and Central Asia has fueling an unprecedented displacement of people, risking dangerous sea and land crossings, to flee war and persecution in an attempt to reach safety in Europe. Over half a million people have crossed the Mediterranean and Aegean in 2015. More than 3,000 people have drowned or gone missing. Yet, the number of people arriving and seeking to travel across Europe continues. Routes across Europe are constantly changing as national policies react to the pressures of the numbers of people on the move.

Local people, along with local organizations and services and international humanitarian organizations are all facing the unfamiliar challenges of responding to the needs of huge numbers of people who are moving through. Most of these people are fleeing from violence and war, endure life-threatening and undignified journeys at sea and by land, and continue witnessing atrocities and deaths throughout their journey. Arrival on shore, being 'processed' through reception centers and transit camps and crossing borders can each bring particular stresses and dangers. Families are not rarely separated during the journey, the sick or elderly left behind, and the vulnerable exposed to exploitation and abuse.



Figure 1 - Transit routes as of 31 December 2015

3.2 Migration Crisis in Serbia

Serbia is situated along the preferred route through the Western Balkans for refugees originating from the Middle East and Asia, aiming to seek asylum in Europe. Serbia is essentially a country of transit, and refugees mostly remain in the country for only a few days. The majority cross into Serbia from the former Yugoslav Republic (fYR) of Macedonia border. The Bulgarian route is said to be a cheaper but a more dangerous option due to the difficult terrain, the reliance on smugglers, and the reported brutality of the Bulgarian police. Many asylum-seekers claim they have no funds to continue their travel, often because they have allegedly been robbed on the way, mainly in Bulgaria and some in the fYR of Macedonia. This creates protection risks and makes them more vulnerable to trafficking and exploitation.



Figure 1- Migration Routes in Serbia

In mid-November several European Union and Western Balkan countries began selective admission practices allowing only Syrian, Afghan and Iraqi nationals (believed to be legitimate refugees coming from conflict affected countries) to cross into their territory. This situation has led to increased tensions as well as incidents of violence. These restrictive border policies are likely to increase smuggling routes and related increases in protection risks as people try to reach Western Europe through irregular channels.

UNHCR estimated that at any given time some 2,500 refugees were on Serbian territory during the last half of December. The map below shows UNHCR 3ws (Who's doing what and where?) as of January 28th 2015.

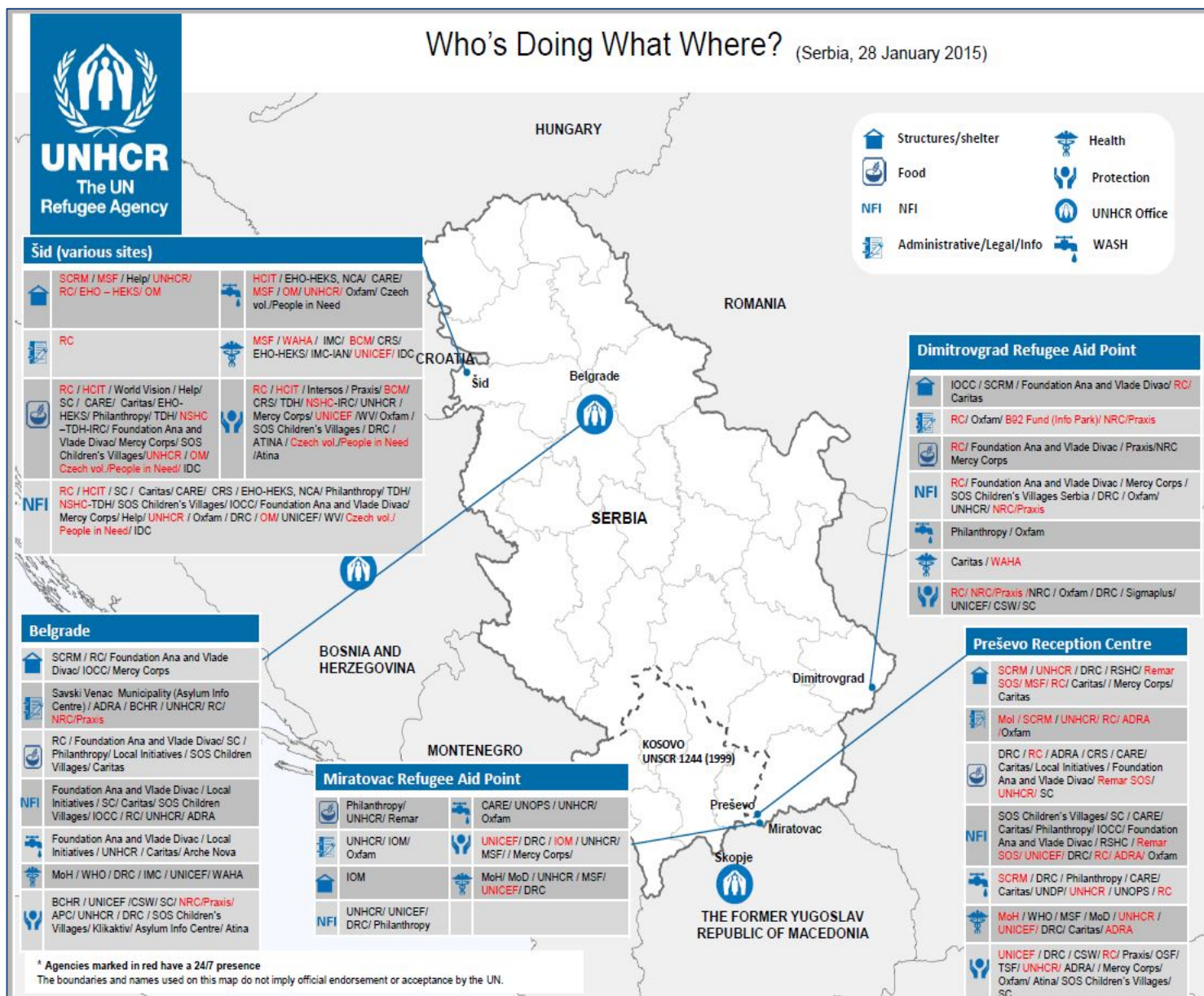


Figure 3 - available at <http://data.unhcr.org/mediterranean>

3.3 Mental Health Policies and Strategies in Serbia

Mental health services remain the responsibility of the Ministry of Health. The services are largely institution-based, with few community services developed to date. A new law on mental health has been adopted in 2013, and according to professor Vladimir Jović M.D.Ph.D., psychiatrist, professor at the Faculty of Philosophy of the University of Pristina, the new law has improved the overall situation for long-term patients as the number of beds has been reduced and the same applies to the average number of days per hospitalization. Many buildings and facilities have been renovated and some psychosocial rehabilitation activities have been initiated, however it does not yet support the transformation of the psychiatric system into community-based mental health care. They are typically still functioning like asylums isolated from urban areas, located in big enclosed buildings, with a large number of beds per room, with patients spending most of their time being idle without purposeful activities, while their treatment is based on medicines, without a developed system of psychosocial rehabilitation. This has been

strongly criticized by Civil Society Organizations that advocate for deinstitutionalization of patients with mental illness. In the past decades Serbians have been through many stressors, such as Yugoslav wars (1991-1999), UN sanctions and a collapse of the former state, creating a large number of refugees and internally displaced persons in the country and forcing many Serbian people live in exile. It is important to take the relevancy of these events into consideration as it had an important influence in the psyche of the population and its perception towards refugees. The current refugee crisis has been often mentioned as something that causes people (e.g. front line workers, police officers) to bring back the past, their own past experience from the war of for being a refugee themselves. It has been mentioned in some interviews with MHPSS actors that sometimes they hear complaints from Front Line workers saying that “in the past nobody cared and helped when we were refugees, and now the refugees have all the support and attention”.

According to 2014 WHO Mental Health Atlas, there are 45 inpatient psychiatric institutions in Serbia (8 Psychiatric Hospitals and 37 psychiatric departments in general hospitals) and 87 outpatient services in the municipal health centers (73 MH outpatient facility and 14-day treatment center). The entire mental health sector has a total of 6,247 beds at its disposal, 50% of which are in large psychiatric hospitals. There are 21.8 Mental Health workers per 100,000 population, and the distribution is as the following graphic description of current mental health providers, services and clientele in Serbia:

MENTAL HEALTH SYSTEM GOVERNANCE

Mental health policy

Stand-alone policy or plan for mental health: (Year of policy / plan):	Yes 2007
Implementation status:	Available and partially implemented
Policy / plan is in line with human rights covenants (self-rated 5-point checklist score; 5 = fully in line)	5

Mental health legislation

Stand-alone law for mental health: (Year of policy / plan):	Yes 2013
Implementation status:	Available and partially implemented
Law is in line with human rights covenants (self-rated 5-point checklist score; 5 = fully in line)	5

Involvement of service users and families (as reported by MoH focal point)

a. INFORMATION gathered / disseminated by MoH	Partially implemented	d. PARTICIPATION in MoH planning, policy, service development and evaluation	Partially implemented
b. POLICY on participation developed / published by MoH	Fully implemented	e. RESOURCES available for participation and reimbursement	Not implemented
c. EARLY INVOLVEMENT in mental health policy and law	Partially implemented		

RESOURCES FOR MENTAL HEALTH

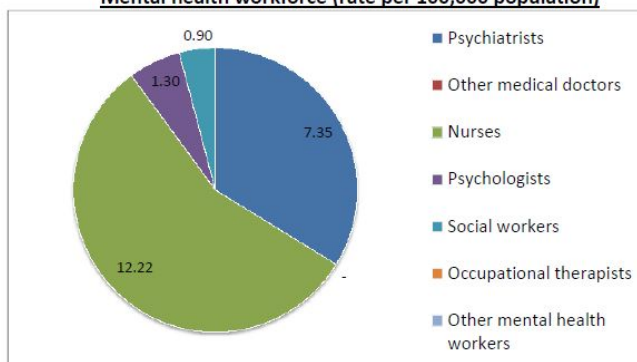
Mental health financing

Main source of funds for care of severe mental disorders	Government
Inpatient / outpatient budget breakdown reported	No
If yes, estimated mental health spending per capita (US\$)	Not applicable

Human resources for mental health

Total reported staff (mental health inpatient care)	2,717
Total reported staff (mental health outpatient care)	355
Total mental health workers per 100,000 population	21.8

Mental health workforce (rate per 100,000 population)



MENTAL HEALTH SERVICE AVAILABILITY AND UPTAKE

Psychologists have a generalist based training at the main graduation studies, and if one wants to engage in clinical work, they normally continue private studies in post-graduation associations or universities.

4. Assessment Results

The refugee crisis is a substantial and consistently changing challenge to the health care system in Serbia and to the overall humanitarian response. In particular, for transitory refugee populations, the focus is on the provision of basic health care, which needs to be made available quickly and often in small locations near borders.

*“People don’t want help; they want to move”
Vladimir Sjekloća - Asylum Info Centre Manager*

The fluidity of the population movements and relocation of transit sites is one of the central characteristics of the challenges in the assistance, including the MHPSS response. For example, some of the transit points change, the number and length of staying in the centers changes its functionality and possibilities of interventions. Depending on the flux of refugees and registration process, refugees can stay just few minutes in transit centers, or even hours and less often few days. It is very difficult to predict. For example, on 27 January, the cancellation of the morning train from Serbia to Croatia (allegedly because of a registration problem) created immediate reactions downstream. In the morning already 1 400 persons (28 buses) were stranded in Sid. Serbia was not allowing passage from Tabanovce (former Yugoslav Republic of Macedonia) to Miratovac (Serbia). As a consequence, Skopje authorities immediately suspended entrance at the southern border ([ECHO Daily Flash, 28 Jan 2016](#))

People are on the move, and all humanitarian assistance is being modeled accordingly. Refugees in general don’t want to delay their travels for any reason, they fear the borders might close at any time and don’t want to stay behind. Several organizations mentioned that often the humanitarian assistance is limited because people on the move don’t want to delay their journey. This has led to complications in providing aid, including medical assistance. Several organizations reported cases where people would be even bleeding but would not stop to go for a more specialized service outside of the transit camps.

4.1. MHPSS coordination and assessments

The internal coordination mechanism of the UN system in Serbia is the UN Refugee Theme Group (RTG) under UNHCR chairmanship. RTG coordinates the 4 sectorial working groups (WGs):

- a) **Refugee Protection WG – RPWG** (Co-chaired by the Ministry of Labour & UNHCR),
- b) the WG on Shelter/NFI/WASH (Co-chaired by Serbian Commissariat for Refugees and Migration (SCRM), MoL & UNHCR),
- c) WG on Health/Food/Nutrition² (Co-chaired by the Ministry of Health & WHO) and
- d) WG on Local Community Support (Co-chaired by the Ministry of Local Self-Government & UNDP).

The Refugee Protection Working Group (RPWG), co-chaired by the UNHCR and the MoL, currently serves as the key coordination mechanism for agencies/NGOs operational in the country. RPWG has over 150 members, and is constantly growing. Under UNHCR lead, RPWG has given rise to three sub-working groups (SWGs) on: a) Information for Refugees, b) **Child Protection** and c) Non-Food Items (NFIs).

There is no MHPSS technical coordination group responding to the current migration crisis in Serbia. However, the matter has been raised by IMC with the different actors, and has been perceived as an emergent need by the Sub-Working Group on Child Protection (led by UNICEF).

At the global level, important steps have been taken to better support the MHPSS migration crisis response, such

² The WG on Health with MOH has not been meeting regularly and is not clear to which extent nutrition and food is involved.

as the creation of a dedicated [working group](#)³ on the MHPSS migration crisis on the mhps.net technical global network (since November 2015), and also the development and publication of the “Multi-Agency Guidance Note on Mental Health and Psychosocial Support for Refugees, Asylum Seekers, and Migrants on the Move in Europe” in December 2015.

At the regional level, IMC together with UNHCR has facilitated the creation of an **MHPSS technical working group** in Lesvos (Greece)⁴ in January 2016.

In Serbia, there is a notable gap in terms of coordination mechanisms on MHPSS, such as information on MHPSS services, basic case management systems, mapping of existing MHPSS services (4Ws), and even transit camps information management on MHPSS services has been sparse, including for the medical teams. Some information about activities of different actors has been collected as part of recent previous assessments:

- [Gender assessment of the refugee and migration crisis in Serbia and former Yugoslav Republic of Macedonia - UN Women’s Regional Office for Europe and Central Asia report](#)
- [Needs Assessment for ACT Alliance Response to the Refugee Crisis in Europe – Greece, Macedonia \(FYROM\), Serbia and Hungary](#)
- [Serbia: assessing health-system capacity to manage sudden large influxes of migrants - joint assessment by the Ministry of Health of Serbia and the WHO Regional Office for Europe](#)
- UNICEF and TdH has conducted a Capacity Building Needs Assessment

4.2. Mental health care access

Refugees in Serbia have access to basic medical care at asylum centers and transit camps, and if higher specialized care is required, refugees have access to the relevant health-care institution. The same applies for the Mental Health System. Access to psychotropic medications is also available, but only possible if provided by a licensed psychiatrist.

The organizations interviewed did not have specific data of MH specialized referrals, but stated that it rarely happens due to the rapid transit of the refugees. This is the reality not only for MH specialized services but also for all general health assistance. Most patients are not willing to go to hospital because they want to leave the country as fast as possible. One case was reported by MSF, but this person was referred to specialized services only because he was severely dysfunctional with dissociative symptoms. Another organization had a case to refer but the patient refused to go due to the fear of losing the journey continuation.

“A woman from Iraq was traveling together with her pregnant cousin, two younger children and a baby who was one day old. She is traveling from Iraq to Turkey. In Turkey they went on an inflatable boat to Greece. In the middle of the trip, motor broke on the boat and they were left to waves, until 4 a.m., when the Greece coast guard saved them. Everything they had, all the belongings were lost at the sea. In Macedonia, she gave birth to a baby but didn’t want to stay at the hospital, so she signed consent form to be released. The day after she gave birth, she continued with the journey” ~IAN Psychologist report

Even though refugees have the access to specialized care, the service is generally not facilitated. There is no case management system to ensure that the needed links to different services are made, access to services is facilitated and that there is follow-up. For example, transit site medical units have reported that it is possible to provide the

³ This group is designated to provide a forum for MHPSS discussion, sharing knowledge and practices on the ongoing Europe-Mediterranean 2015 Migration Response. This can include sharing practices, case studies, guidelines, research results or work in progress which can support practitioners, researchers, policy makers or programmers supporting settlement of refugees in Europe

⁴ IMC MHPSS updates for Greece – January 20th

transportation to the hospital but not with the accompaniment of cultural mediators and interpreters.

It is reasonable to affirm that people with mental disorders in need of specialized mental health referral are probably not being identified, are not receiving needed care, and are not followed up.

4.3. Current problems and stressors

Refugees and migrants who come to Europe often faced war, persecution and extreme hardships in their countries of origin. Many experienced displacement and hardship in transit countries and embarked on dangerous travels. Lack of information, uncertainty about immigration status, potential hostility, changing policies, undignified and protracted detention all add additional stress. Forced migration erodes pre-migration protective supports – like those provided by extended family - and may challenge cultural, religious and gender identities.

Forced migration requires multiple adaptations in short periods of time. People - especially but not only - children, become more vulnerable to abuse and neglect. The risk for developing mental health problems increases while pre-existing social and mental health problems can be exacerbated. Importantly, the way people are received and how protection and assistance is provided may induce or aggravate problems, for example by undermining human dignity, discouraging mutual support and creating dependency. An acute sense of urgency among the people on the move may prompt them to take extreme medical and psychosocial risks and their fast-paced mobility through several countries, leaves only very little time for service provision.

Refugees and migrants may feel overwhelmed or confused and distressed, and experience extreme fear and worries, outbursts of strong emotions such as anger and sadness, nightmares and other sleep problems. Initially, on immediate arrival in Europe, some may be elated. Many are affected by multiple losses and are grieving for people, places and life left behind. They may feel fearful or anxious, or numb and detached. Some people may have reactions that affect their functioning and thinking capacities and therefore undermine their ability to care for themselves and their families and cope with dangers and risks on their path. It is important to realize that many stress responses are natural ways in which body and mind react to stressors and should not be considered abnormal in highly demanding circumstances. The effects of stress can be buffered by basic services, safety, and social support.

Rates of disorders related to extreme stress, such as posttraumatic stress disorder (PTSD), are higher in refugees than in people who are not forcibly displaced. However, for most refugees and migrants potentially traumatic events from the past are not the only, or even most important, source of psychological distress. Most emotional suffering is directly related to current stresses and worries and uncertainty about the future. Being a refugee or a migrant does not, therefore, by itself, make individuals significantly more vulnerable for mental disorders, but refugees and migrants can be exposed to various stress factors that influence their mental wellbeing.

(Excerpt taken from the “Multi-Agency Guidance Note on Mental Health and Psychosocial Support for Refugees, Asylum Seekers, and Migrants on the Move in Europe”.)

Protection Risks

A number of organizations pointed out that the registration systems are not comprehensively identifying and referring at-risk groups, for example unaccompanied minors, persons with disabilities, and victims of violence. The linkages to protection responses is weak and qualitative data on vulnerable groups is limited. It is not clear whether or how existing disaggregated data is being used for operational response.

GBV - Refugee and migrant women face specific challenges and protection risks in transit, especially if they are travelling without male family members and depending on smugglers, increasing risk of sexual exploitation or trafficking. It has been reported many of the women have suffered violence, including sexual and gender based violence (GBV) while attempting transit. In October 2015, UN Women's Regional Office for Europe and Central Asia (ECA) commissioned a gender assessment of the humanitarian response in Serbia and FYR Macedonia, and found that there is a need for more systemic and sustained attention to gender and gender-based violence (GBV) issues within the broader coordinated response, including strengthening the national capacity of front-line actors to systemically identify, refer and respond to issues of gender, GBV and protection of vulnerable groups.

Victims of Violence and Torture - Particular observations have been consistently shared, including with physical evidences, regarding cases of ill-treatment and violence during the journey by several organizations. IAN Psychologists, for example, have received several cases of refugee survivors of violence, especially the ones coming from Macedonia and Bulgaria. They describe getting robbed, beaten up and humiliated by the local population or police. Often, they get unlawfully arrested or put in prison in very bad conditions. The police often fail to provide them with valid information as to why they are in detention or how long they will be there. Cases of organ trafficking has been also reported by different groups of refugees.

“Many refugees that I spoke to, stated that they were in prison in Bulgaria, not just Afghans but Syrians too. Bulgarian police put in prison whole families, and children and women are together with men in the same prison. They are imprisoned because of crossing the border illegally. All refugees that were in prison, stated that they took their money and phones. One woman, 30 years old is travelling alone with her children, her husband stayed in Syria. She was in prison in Bulgaria together with her children for 4 days. When they released her they were very afraid that Bulgarian police are going to captured them again. They were running through woods trying to reach Serbia” IAN psychologist

Refugees from other nationalities - There is limited information of the refugees that are not from the three nationalities (Afghanistan, Iraq and Syria) and are being held back. Persons rejected by Croatia were transported back to Belgrade and other asylum centers and asked to register again or to apply for asylum in Serbia. A small number of them are requesting asylum in Serbia and most of them are believed to be using smugglers activities to continue the travel.

Unaccompanied minors – UAM has been one of the major concerns among the Child Protection organizations, there has been an increase in the arrival of unaccompanied minors and children having been separated from their parents and families, leaving them particularly at risk of trafficking, abuse, and exploitation. There has been a notable gap and discussions on the lack of SOPs for UAM and complaints that the government is not identifying UAM. The UAM that have been identified are often being referred to the juvenile justice centers in Serbia, which has been highly criticized by the Civil Society Organizations.

Refugees with Disabilities - Refugees with specific needs due to disability, injuries or chronic disease constitute an identified at risk group and has been acknowledge by the CPWG members as a gap in terms of the actual response. No specific data was identified.

4.4. Mental health services and psychosocial activities

The main actors providing MHPSS response are the INGOs and local NGOs. The human resources capacity for MHPSS consists of local MHPSS workers, such as Psychologists, Social Workers, Cultural Mediators and educators. Psychiatrists were not identified during the mapping exercise.

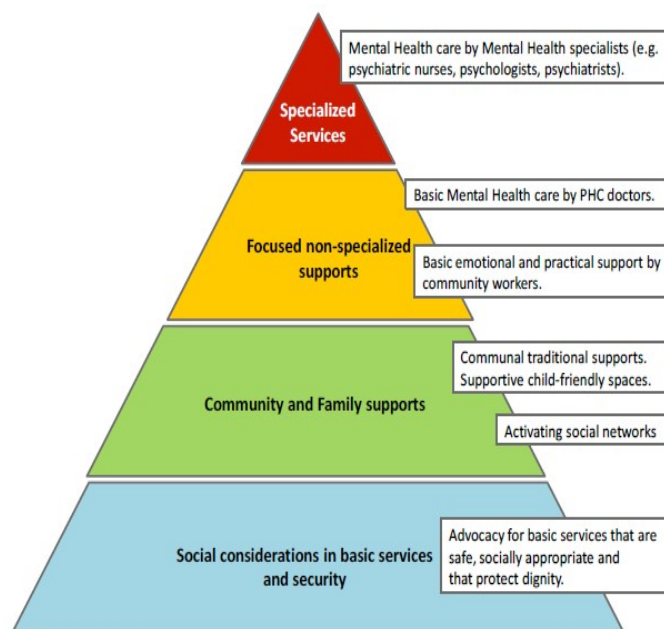
The general MHPSS response consists of two main structures – the mobile teams for outreach work and fixed stations. The mobile teams are either medical mobile teams or protection mobile teams. The medical mobile teams are in general composed by medical doctor, nurse, interpreter and a psychologist. The protection mobile teams are composed by Protection Officer, Cultural mediator and social worker. All mobile teams have been reported to have some capacity for delivering emotional support or Psychological First Aid (PFA). The fixed stations are Child Friendly Spaces, Woman Friendly Spaces, Youth Spaces, baby corners and medical units where psychologists are often working.

According to the information received by the humanitarian organizations operating in Serbia, MHPSS services are being provided across the transit sites. The main MHPSS activity is PFA, but sometimes called “basic PFA” in the field.

There has been some skepticism regarding the PFA that organizations are providing. Some informants are questioning what is meant specifically by the PFA that many organizations are saying they are providing. There is some criticism that MHPSS and PFA have become fashionable buzzwords without actual meaning behind them and that those activities are easy to mention in donor reports without any accountability for the quality or impact of the activities.

Snapshot of MHPSS Services Offered Across Serbia

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 Level 1 - social considerations in basic services and security up to Level 4 - specialized mental health services (see Figure).



The table below shows current MHPSS activities and services categorized according to the IASC MHPSS Intervention Pyramid (designated with an “v” for available activities and services, see Table below).

Snapshot of MHPSS Services Offered Across Serbia

		Level 1: Social Considerations <i>Basic social services; orientation information</i>	Level 2: Community & Family Supports <i>Example - Child-Friendly Spaces; Women-Friendly Spaces</i>	Level 3: Focused (person-to-person) Non-specialized MHPSS Services <i>Psychosocial Support; Referrals to Needed Services</i>	Level 4 ⁵ : Specialized Services / Psychological Interventions
Sid	Adasevci	√	√	√	√
	Train station	√	√	√	√
Belgrade	Asylum center Krnjaca	√	√		√
	Parks in Belgrade	√	√	√	√
	Asylum Info Centre	√	√		√
South	Miratovac	√	√		√
	Presevo	√	√	√	√
Bulgarian border	Dimitrovgrad	√		√	√

⁵ Even though the refugees have the access to specialized care, the service is generally not facilitated. There is lack of case management system to ensure that the needed links to different services are made, access to services is facilitated that there is service flow is properly provided and followed up

Snapshot of MHPSS Actors & Services Offered as of 28/01/2016

Agency	Activities	Sid		Belgrade			South		Dimitrovgrad	Other sites - Specify	MHPSS Staffing ⁶
		Adasevci	Train station	Asylum Info Centre	Asylum center Krnjaca	Parks in Belgrade/ Miksliste	Mirato vac	Presevo	Nearby Registration center		
IMC (IAN)	Level 3 (individual, family support) mobile team		√								2 local psychologists Arabic Interpreter
Save the Children	Level 2 - Child Friendly Space/Safe Spaces;					√		√			Belgrade: 5 facilitators (1 social worker, 1 lawyer, 3 pedagogues) Presevo: 6 facilitators + 2 cultural mediators for Arabic.
	Level 2- Mothers and babies corner			√				√ (will start soon)			4 facilitators conducting also outreach work
	Level 2 - Capacity Building of Non-specialized MHPSS staff/interventions (including PFA for children, and PSS activities in Safe Spaces)	√	√	√	√	√	√	√	√		1 international trainer
	Level 3 - Direct Support with PFA in outreach work staff using PFA ⁸ by Mobile Unit)	√				√		√	√	√	3 in Belgrade, 4 in Adasevci, 4 in Dimitrovgrad, 3 in Presevo (social workers, special pedagogues, psychologists, andragogic), 2 cultural mediators in Adasevci (arabic), 1 farsi and Pasto (Dimitrovgrad), 3 in Presevo (Arabic)
MSF	Level 3 (individual, group, family support) mobile team -	√						√			2 local psychologists Arabic interpreter
	PFA Training and support to MSF staff only	√						√			
Danish Refugee Council	Level 1 – Social Considerations in Basic Services & Security *Provision of information/Protection, Distribution service * NFY, etc.	√	√				√	√	√		4 distribution officers; 1 worker, 1 Women Protection Counselor, 1 Child Protection Officer; SID/ADASEVCI: 4 Protection Officers, 1 Protection officer/Farsi, Pashtu Interpreter, 3 Arabic Interpreters; DIMITROVGRAD 4 Protection Officers, 2 Interpreters *Arabic and Farsi/Pashtu; MIRATOVAC: 4 Protection Officers, 1 Protection Officer/Farsi, Pashtu Interpreter, 2 Arabic Interpreters;
	Level 2 - Child Friendly Space; Mother and Baby corner;						√				MIRATOVAC – 4 Child Protection Officers; 4 Nurses; 4 Child Facilitators
	Level 2 - Child Friendly Space; Mother and Baby corner;							√			PRESEVO – 5 Child Protection Officers; 6 Child facilitators, 2 Arabic interpreters; 6 nurses; 2 Child Protection Facilitators
	Level 1 – Basic information dissemination	√	√							√	7 Protection Officers; 5 Arabic interpreters; 5 Farsi interpreters;

⁶ MHPSS Staffing – e.g. Psychologists, Psychiatrists, Social Workers, Educators, trained Interpreters, Cultural Mediators, etc

⁷ Safe Spaces and day care centers not with structured activities such as CFS as they are not tailored for children who stay more than few days. But we are developing tailored activities. In the near future according to trends and influx facilities might become more similar to CFS

⁸ Consider the PFA provided is specific to children

HCIT⁹	Level 1 – referrals to medical care and Centers for Social Work	√	√						√	7 Protection Officers; 5 Arabic interpreters; 5 Farsi interpreters;
	Level 1 – distribution of NFIs (clothing, shoes, blankets, hygiene kits, dignity kits)		√							8 distributors;
	Level 2 - Community & Family Supports – Family Reunification	√	√						√	7 Protection Officers; 5 Arabic interpreters; 5 Farsi interpreters;
	Level 3- Focused (person-to-person) Non-specialized MHPSS Services – Individual interviews and Incident reporting	√	√						√	7 Protection Officers; 5 Arabic interpreters; 5 Farsi interpreters;
	Level 4 - Specialized Services – psychosocial counseling and referrals for individuals in need of psychiatric evaluation and/or prescription of psychotropic medications	√	√							2 psychologists (PhDs in Psychology)
Group 484¹⁰	Level 1 – distribution of NFIs and provision of basic information	√ To start soon						√		1 psychologist in Šid (planned)
	Level 2 – mobile team providing information, referral and basic psychosocial support to vulnerable persons (including UASCs)			(SC) - youth corner		√ (pipeline) [probation and planning phase]				2 psychologists, 1 andragogue, 1 actress (trained and experienced facilitators)
World Vision	CFS WV	x (with SOS)	x							Psychologists and educators
	Baby Corner	x								
	Mobile Protection Team focused on: Victims of Violence, Vulnerable cases, and provision of PFA								√	Psychologist Cultural Mediator Protection officer
	Youth Center starting 22 nd Presevo							√		
SOS Children	CFS with WV since 21.12	√								Educator and Psychologist Arabic interpreter available
	Mobile Team – Referral, Information, PFA			√				√		2 local Psychologist
	Youth Center (about to open in Presevo)							√		
Atina¹¹	Mobile team (Funded by GYZ) focused on Vulnerable Children	√	√					√		Social Worker, Translator and Cultural Mediator
	Victims of trafficking (with IRC)							To start soon		
IRC	Vulnerable groups (Partnering with IAN and PIN) and Victims of Trafficking (ATINA) Location and star date to be confirmed									
Novi Sad Humanitarian Centre¹²	Outreach and recreational activities for children, psychological first aid to children and parents, distribution of NFI (clothes, hygiene packages)	√								6 Psychologists, 1 Social Worker 2 pedagogues, 1 Interpreter

⁹ <http://hcit.rs/>

¹⁰ <http://grupa484.org.rs/en/>

¹¹ <http://www.atina.org.rs/en>

¹² <http://www.nshc.org.rs/>

Capacity Building of Non-specialized MHPSS staff/interventions (i.e. psychosocial First Aid for volunteers, migration officials, police)	√																				
Direct Support with specialized MHPSS staff (using PFA by psychologists and social workers)	√																				6 Psychologists, 1 Social Worker 2 pedagogues, 1 Interpreter

5. Summary and Recommendations

5.1. Summary

Serbia has a relatively well structured system of MHPSS support, including national level mental health policies and guidelines, mental health services and professionals working towards increasingly decentralized & deinstitutionalized based models of mental health care, academic programs for general and specialized mental health training as well as some local and international partners for mental health capacity building in line with global standards. However, the psychiatric reform is still ongoing and has suffered long delays.



There are several psychological associations and institutes dedicated for training and supervision in psychotherapies such as psychodrama, psychoanalyses, Cognitive-behaviorism treatment, Gestalt and various local civil society organizations are engaged in psychological support since the Balkan war.

In the context of the current refugee crisis, and based on this situational analysis, several recommendations can be made as outlined below. In sum, there is a need to establish the MHPSS coordination system in order to strengthen the connections between services and referral pathways, to avoid overlapping services and to increase the quality of MHPSS services in refugee transit areas. There is also a continued need to ensure that all front line workers interacting with the refugees are trained in basic support, such as cultural and social awareness, Psychological First Aid and appropriate follow up and linking to services. It is also important to facilitate psychiatric assistance and access to other services for those with more chronic, complex and severe mental health problems (e.g. through designated staff who take on case management roles).

5.2. Recommendations

Significant efforts to integrate **more and better** mental health care and psychosocial support into the transit sites should be made to protect and support the psychological wellbeing of the refugee population on the move and to address needs of those with complex, severe and chronic mental health problems. The psychological needs are notable in all transit sites and have been repeatedly emphasized by the medical teams and MHPSS staff. Such needs are expected given that the affected population has often been exposed to multiple stressors and potentially traumatizing events, not only from the journey but also the prior experiences in the country of origin, while also

having to cope with current hardships and the uncertain future ahead of them.

There is no one-size-fits-all model to provide mental health and psychosocial support to refugees and the response is constrained by the rapid mobility of the affected population. However, it is important not to ignore mental health needs and key guidelines such as the Inter-Agency Standing Committee (IASC) (2007) Guidelines on Mental Health and Psychosocial Support in Emergency Settings as well as the recently developed guidance note as well as the Multi-Agency Guidance Note on Mental Health and Psychosocial Support for Refugees, Asylum Seekers, and Migrants on the Move in Europe outline important principles that can be used to frame, adapt and improve the response. The recommend levels of mental health and psychosocial intervention are based on a pyramid ranging from social considerations in basic services and security up to specialized mental health services. The following recommendations take each of the levels of the pyramid into account.

5.2.1. Improve coordination and mapping for mental health and psychosocial support services and activities.

The IASC MHPSS Guidelines recommend to set up an MHPSS coordination or working group, but this can be a common challenge in various settings including Serbia.

Coordinating MHPSS response efforts involves minimizing the duplication of services, whether by filling gaps or preventing overlap, and ensuring that various organizations are harmonized to work together to promote psychosocial wellbeing and address mental health needs and enabling a more coherent, effective, and efficient response - including linking MHPSS activities and crosscutting initiatives with other sectors (e.g. health, protection, nutrition).

It has been unusually difficult to gather basic information of 4ws in MHPSS (who is doing what, when and where) for the simple fact that there is no existence of any level coordination and information sharing mechanisms. This has been noticed also in the field level when partners were asked to provide information on MHPSS services available at the transit sites for basic referral.

Following the IMC Needs Assessment interviews with several organizations, including UNICEF, IMC facilitated the first joint MHPSS agenda discussion meeting involving various actors (Ministry of Labor, Save the Children, World Vision, IRC, DRC, UNICEF (also the Regional office in conference call), UNHCR, ATINA, MSF, Red Cross of Serbia, Serbian Commissariat for Refugees and Migration, Asylum Protection Center, Terres des Hommes, Intersos and ADRA). IMC presented the Multi-Agency Guidance note on MHPSS and also discussed the preliminary results of the Rapid MHPSS Needs and Resources assessment.

Recommendations:

- **Identify experienced specialist to lead MHPSS coordination group:** The coordination of information and program planning would be greatly improved if an MHPSS specialist with expertise in emergencies and humanitarian mechanisms, could be deployed to Serbia, or to the region, in order to co-facilitate the MHPSS coordination mechanisms. Even though there is a good pool of well-trained clinical psychologists and psychiatrists, the relevance of an MHPSS specialist to be deployed for this context is due to the fact that there is no local capacity with combined experience of the IASC MHPSS framework and MHPSS as part of the rapid humanitarian response mechanisms.
- **Support functioning and tasks of MHPSS Coordination Group:** There are various needed tasks that should be taken on by a functioning MHPSS coordination group. Several organizations mentioned that there is a lack of understanding from relevant local authorities, regarding MHPSS activities, which has created many challenges for several organizations in getting authorization to implement activities. This problem could be

mitigated with a well-functioning MHPSS coordination group with robust leadership or co-leadership in place, which could help to frame, guide and advocate for MHPSS activities and services. Participation of a qualified MHPSS representative in humanitarian coordination meetings and other relevant sectors (e.g. Protection, Shelter, Community mobilization) would also further aid cross sectoral integration and communication. It is important to ensure that all MHPSS planning, services and response, for the refugee and migrant crisis, are in line with guidelines outlined in the MHPSS IASC Guidelines (2007) and other relevant guidelines such as the Sphere Standards.

- In the same principle, harmonization of concepts and scope of interventions in MHPSS would be beneficial to MHPSS operational actors, this could be achieved by developing a MHPSS Minimum and Comprehensive Quality Standards, and creating forums for sharing and learning of good MHPSS interventions for the current crises.

“It is impossible to make the government understand the importance of MHPSS but we have to find a way to present it” (UNHCR official)

5.2.2 Support the development of a regional MHPSS coordination mechanism with the countries where there is a humanitarian response for the current crisis.

Efforts have been made by several actors who are part of the overall humanitarian response to ensure that the refugee crisis response shifts from a country based model of intervention towards a regional response model. The MHPSS sector should also strengthen its efforts for better regional coordination, building and connecting a network of regional organizations and coordinated interventions.

Recommendations:

- **Strengthen regional level MHPSS response.** Ensure synergy between IMC MHPSS initiatives in the region, particularly in Greece and Serbia, sharing information, resources and learnings. The website www.mhps.net¹³ has already a dedicated group focused on the migration crises and efforts can be made in order to better facilitate a regional approach, identifying more operational actors in all migration route, network and ensure that there is sufficient communication and coordination between the different regional initiatives. A private dedicated [sub-group for Serbia](#) and [Greece](#) has been created and local actors will have access to share information and resources.
- Bring together MHPSS actors from across the transit countries to establish a regional data base, knowledge sharing and information flow collaboratively, promoting the MHPSS guidance note principles & practices in order to conduct activities in regional coordination efforts.

5.2.3 Improve the capacity of specialized and non-specialized front line workers to respond to mental health and psychosocial support needs of the refugees (including considerations on cultural and social aspects)

Psychological First Aid and social /cultural considerations: Mental health and psychosocial interventions are a combined responsibility of health workers and non-health workers and require a cross cutting approach.¹⁴ All

¹³ mhps.net is an initiative created to better support MHPSS emergency response in the world, and has been widely used by the MHPSS global Reference Group members.

¹⁴ A difference is made between **MHPSS approach**, which is here used as means of providing assistance in ways that are also beneficial to the mental health and psychosocial wellbeing of beneficiaries, emphasizing its relevance for all actors involved in assistance and as a cross-cutting best-practice to be integrated in different assistance sectors; and **MHPSS interventions** consisting of specific tailored activities aiming, directly, to improve the mental health and psychosocial wellbeing of beneficiaries¹⁸.

humanitarian actors have a role in creating a supportive environment that can positively impact the psychosocial wellbeing of the affected population. In this sense, the integration of an MHPSS approach and interventions could be further strengthened with local non-specialized actors (employees of local PHCC, social workers, UNHCR local staff, asylum office officials, Security officials, psychologists and volunteers) receiving and scaling up PFA trainings, including sessions on cultural and social considerations in providing humanitarian services and support to refugees. Psychological First Aid (PFA) is defined by the World Health Organization (WHO) as a humane, supportive response to a fellow human being who is suffering and who may need support. It includes basic, non-intrusive pragmatic care with a focus on listening, comforting, assessing needs and concerns, helping people to connect with others and providing information and practical support to ensure that basic needs are met. The practice of PFA is not restricted to mental health professionals but should also be considered as an approach and interventions by lay people. These interventions are consistent with IASC MHPSS guidelines and the Sphere Standards and offers a framework that supports people in ways that respect their dignity, culture and abilities, that together in principle ease the transition to normality.

UNICEF is currently planning several capacity building initiatives on Child Protection and PFA for local partners, including governmental staff of the Centre of Social Work. They would be open to design the activities together with partners (such as IMC) to further scale up PFA training.

Self-care: It is equally relevant to integrate the considerations for mental health and psychosocial wellbeing of staff and volunteers into such activities. When asked about the relationship between police and the refugees for example, stakeholders reported a strong need for training the police to better interact and understand the social and cultural aspects of the moving population, as well as understating the potential effects of armed conflict and displacement on the mental health and well being of affected populations. Humanitarian actors also stressed the need for mechanisms of psychosocial support for the police. Similarly, staff and volunteers providing assistance to refugees and migrants have to witness and listen to the distress and traumatic experiences of many refugees and migrants, this means being repeatedly exposed to stories of terror and tragedies. Witnessing suffering and unmet needs in a daily basis, in combination with limited sources and possibilities to help, can be overwhelming and can cause various forms of stress. This is particularly relevant when the transit country has suffered themselves from war and many of them have experienced hardships, were refugees or hosting refugees, which is the reality in Serbia.

Information, Education and Communication (IEC) materials: Unverified but plausible-sounding rumors have been the basis for serious distress throughout the refugees journey, whether or not the stories are real, it is important to identify and address common rumors. Effective IEC materials can also play an active role in supporting people on the move to cope with the stress. Being informed about where they are, their situation and what is going to happen with them next, provide a stronger sense of control. The frontline workers have already a level of information regarding the concerns of the migrants that are very useful in the later development of IEC approaches, messages and materials. For example, developing basic Questions & Answers information material, helping migrants to understand their current location, what will happen to them on that specific transit site, services available, etc. It would also be relevant to develop psychoeducation materials using simple language, drawings, and adapted to the culture and context, which would cover topics such as stress, coping mechanisms, and supporting children,.

Translation and interpreters:

Language and translation have been a challenge given the limited number of available translators, and the variety of languages and nationalities from the population in transit. The majority of the population in transit does not speak English and neither the language of the transit countries. This matters because refugees with limited communication capacity are less likely to communicate details of their needs, which can negatively impact their ability to receive sufficient information about their situation or participate in decision making. Some organizations acknowledged that there is reliance on informal interpreters (people living in Serbia who speak Arabic, Farsi and

Pashto) as a pragmatic response to intermediate the interventions (PFA, medical consultations, interviews, protection reporting). Sometimes, no interpreter is used at all and there is an attempt to communicate with gestures and body language. In general, it appears that the majority of the local translators and interpreters have not been trained in their role, for example, two organizations mentioned that after some interviews using translators with refugees, the translators sometimes take the lead in the interviews in asking questions when not requested, or do not translate the answer. Yet, interpreters are key to effective interventions. It does not mean simply translating a language, but also translating a culture, explaining its meaning, thus becoming the interpreter for the “outsiders”, in this case, health and protection actors in transit sites.

Recommendations:

- **Scaling up workshops in PFA and social/cultural considerations:** There is a need to further scale up training in PFA tailored to different audiences (e.g. police, different types of aid workers). UNICEF has already started with an initiative focused on child protection PFA and there is an opportunity for IMC and other actors to further support tailored scale up workshops on PFA and social/cultural considerations in the refugee crisis. Workshops could also be developed that focus on or include the relevant components of the Multi-Agency Guidance Note on Mental Health and Psychosocial Support for Refugees, Asylum Seekers, and Migrants on the Move in Europe (which have already been translated to Serbian).
- **Training and recruitment of interpreters and engaging Arabic speaking MHPSS staff:** It is recommended to provide training for interpreters in order to ensure adequate triangular conversations between the refugee/migrant, care provider and the interpreter, helping the interpreters to clearly understand what is expected from them (e.g. making sure that the clients feels safe and trust the provider, helps with cultural considerations, ensure confidentiality aspects, whether or not the interpreting will be done in consecutive or simultaneous style). Trainings for interpreters engaged in supporting MHPSS activities and services should include relevant topics (e.g. confidentiality, speaking about sensitive subjects, also see: [Guidelines for working effectively with interpreters in mental health settings](#)) as well as PFA training. Organizations involved in the response should also consider hiring Arabic speaking MHPSS staff who have relevant experiences. IMC for example has various current or previous Arabic speaking staff (e.g. interpreters, psychosocial workers) who have been involved in the regional Syria response and could be engaged as trainers, cultural mediators and MHPSS staff.
- **Staff support:** Some basic principles of managing stress when responding to humanitarian crises are included in PFA training and this would be a useful and important component in the current crisis as well. In addition, organizations may consider ways in which mutual support and team work can be encouraged

5.2.4. Improve access to mental health services, including access to psychotropic medications, especially in transit sites

The assessment suggests that persons with mental health problems are not likely to be identified and if they are, they may not be able to access appropriate interventions (e.g. not willing to leave the site, wanting to keep moving, language barriers, no one engaging in linking to services and follow-up to ensure care is received). Given that people stay only short periods of time, it is difficult to initiate treatment for mental disorders that need longer term treatment (e.g. depression). However, people with chronic mental and neurological disorders who have already been diagnosed but have ran out of medication (e.g. epilepsy) or those who are experiencing severe mental health problems (e.g. psychotic episode) would benefit from immediate care. Providing specialized mental health services will require collaboration between transit site management, mental health services in the nearest general hospital, for identification, management, and referral of cases in-need. At the moment, it is likely that once a person with MH disorder is identified, he/she will not want to go to the specialized or Primary Health Care. In this case efforts

should be made to facilitate referral and access to the extend possible.

Recommendations:

- **Referral system and process for specialized mental health care:** Develop an operational procedure for mental health referral processes to other organizations within the transit sites (mental health services as part of Primary Health Care), and outside of the sites for specialized mental health services. Improved access could also be facilitated by having a mobile psychiatrist “on call” who can come to the transit site when needed.
- **Provision of basic mental health care:** Train health workers in the identification and management of priority mental disorders. Consider additional training in mental health for current general health care providers to ensure appropriate intervention, for example, social and cultural considerations, prescribing refills for people who have ran out of medication (which is likely to be available in other countries), providing basic psych-education.
- **Mental health service guide:** Key informants report that there is a lack of information about other available services (and who is doing what where) among aid workers providing services and support at transit sites. Consider making a page-file mapping with existing services and referral pathways in the transit sites (including MHPSS), with clear description of services, capacities and working hours.



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