Mental Health and Psychosocial Impact

of the Communities affected by the Occupation-related violence

North West Bank

Nablus, Qalqilya and Salfit Governorates
and the Northern Jordan Valley (Tubas Governorate)

Periodic report:
October 2016 to February 2017

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East-Jerusalem, March 2017

Preamble and acknowledgements

Since the beginning of the project qualitative and quantitative data has been collected and analysed with the aim of monitoring and improving our psychosocial intervention, and for Advocacy purpose. Bi-yearly, since November 2014 a technical psychosocial report is released, presenting the results of 5 or 6 months' data collection.

This technical MHPSS report is the 6th report of its kind, presenting the results of 5 months' data from October 2016 until February 2017 (and comparing it with previous data, from May to September 2016). An additional special Report on Duma's critical incident was released on November 2015. All the reports can be provided by writing to: genco.palestine@medecinsdumonde.net

The author gives warm thanks to Nablus coordination and psychosocial teams for their daily commitment to alleviate the psychological and psychosocial suffering of the Communities of the North West Bank affected by the Occupation.

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Through this drawing, Hala, 11 years old from Beit Ameen village, Qalqilya Governorate, is expressing the difficulty of feeling safe in her own house. Drawings are not meant to be analysed after the intervention, but are used in situ to facilitate discussions with children and teenagers (about coping with difficult emotions).

Acronyms

ASD	Acute Stress Disorder
CMHC	Community Mental Health Centre
CRIES-R	Children Revised impact of event scale
CYRM	Children and youth resilience measure
DSM	Diagnostic and Statistical manual (of psychiatric Disorders)
IASC	Inter-Agency Standing Committee
ISF	Israeli Security Forces
IES-R	Impact Event Scale-Revised version
MdM	Médecins du Monde (Doctors of the World)
MSF	Médecins sans Frontières (Doctors without Boarders)
MHPSS	Mental health and psychosocial support
OPT	Occupied Palestinian Territory
PCC	Palestinian Counselling Centre
PHCC	Primary Health Care Centre
PFA	Psychological First Aid
PTSD	Post-Traumatic Stress Disorder
WHO	World Health Organization
YMCA	Young Men Catholic Association

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Executive summary

Context and objectives

In line with its MHPSS strategy, MDM is implementing a project aiming to prevent and limit the psychological and psychosocial impacts of the Occupation related violence (settlers' violence, demolitions and Israeli Security Forces (ISF) violence) on the Palestinians psychosocial well-being in the North West Bank Communities (including North Jordan Valley) particularly exposed to this kind of violence. The main objectives of the report are:

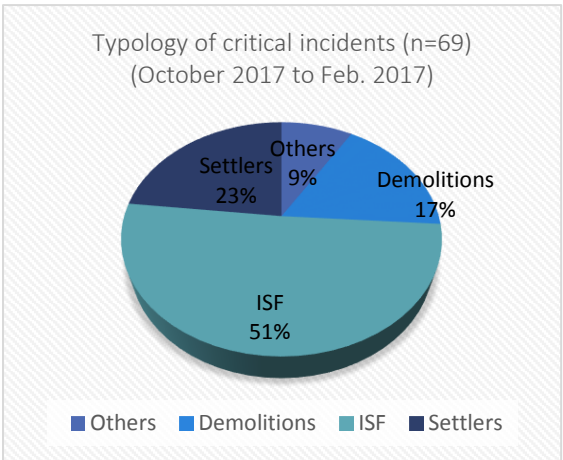
> (1) To have a global picture of the psychological and psychosocial impacts of the critical incidents directly and indirectly related to the Israeli occupation violence (mainly: settlers' violence, demolitions and excessive use of force by the ISF) from October 2016 to February 2017;
> (2) To compare these results with previous data from May to September 2016 (evolution of the situation)
> (3) To present and discuss the results of our resilience-based peer support group interventions for children, adolescents and adults.

Methodology

Assessing mental health and psychosocial well-being of our beneficiaries is really challenging as many factors influence their (mental) health. The MdM France internal psychosocial assessment form (adapted from the one used by MdM France in Lebanon), the revised Impact Event Scale for adults (IES-R) and children (CRIES-R) were used for collecting quantitative data. The MHPSS team collected qualitative data during the different steps of their intervention through observations and personal notes. Our first sample is composed of all the 115 individuals (the most affected ones, out of the 416 visited during the psychosocial support visit) who have received the first emotional support (PFA) within 72 hours and then a follow-up session including a psychosocial assessment, from October to February 2017. Our second sample is composed of 180 individuals (children, teenagers and adults) participating in the resilience-based peer support group intervention. For the 'limitations' mentioned in this report (methodology part, on page 11), certain caution is more than recommended when reading, interpreting and further presenting the following figures and results externally

Results

Typology of critical incidents: from October to February 2016 (graph below), 51% of the of the critical incidents (for which MdM intervened according to specific criteria) were related to ISF use of force, 23% to settlers' violence and 17% to demolitions. From May to September 2016: 62% were related to ISF use of force (live ammunition, violence against schools and injuries after physical assault), 32% were related to settlers' violence (casualty/injuries, killings, property damages or intimidation) and 4% to demolitions. During the last 10 months, MdM is observing a **downward trend of settlers' violence and an upward trend of demolitions related critical incidents. ISF violence remains the main cause of critical incidents for which MdM France is intervening.**

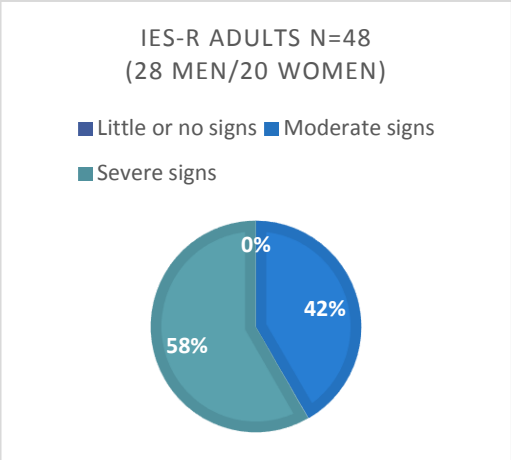


A certain caution must be taken when communicating these results, indeed MdM is not intervening for all the critical incidents[1] which happen in the North West Bank, therefore these results cannot be generalized to the North West Bank or to the whole West Bank.

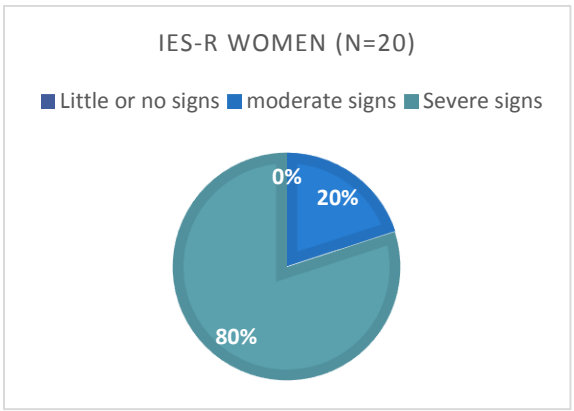
The psychological and psychosocial impact

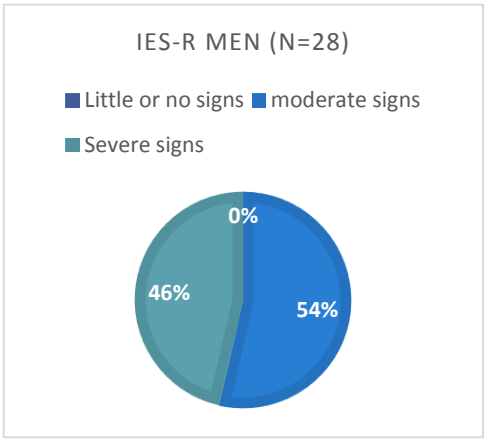
If a minority of people presents severe and moderate disorders, which would need the intervention of professional mental health people, a large percentage of people experience legitimate distress and other psychological reactions, which continuously affect them and increase the risk of developing mental health difficulties. This is the case of our beneficiaries, indeed. Let's have a look at the results of the IES –R and CRIES scales (see graphs next page):

[1] Our HR capacity is limited (6 PSS staff). Moroever some other local and international organizations are providing PSS in emergency as well (most of the time, in coordination with MdM).



-58 % of the adult population who received Psychological first aid (115 individuals out of 416 visited) report severe signs of acute stress and are at risk of developing PTSD;
-42% report moderate signs of acute stress;
-0 % only report little or no signs of acute stress;
This % is lower than the percentage of 78% of individuals (n=49) reporting severe signs of acute stress, from May to September 2016. However, it is difficult to do comparisons as the analysed samples are not equivalent (there is not the same proportion of men and women in the 2 samples).
-According to our sample, women seem as well more affected than men, but again as the samples are not equivalent, let's interpret these figures with caution.





These data are not consistent with the previous report (data from May to September 2016), showing that men were equally affected than women (71% of men versus 78 % of women reporing severe acute stress reactions). Let's have a look now at Children scales (CRIES-13) results. As our sample for children/adolsecents is relatively small (n=18), let's be cautious as well with the interpretation of the results. It is interesting to see that 56% of boys and girls report severe signs of acute stress while 44% of them report normal signs of stress. As the size of the 2 samples is not equivalent (12 girls versus 6 boys), it is not possible to make any significant comparison between the sexes. If the data slightly differ from the ones analysed from May to September 2016, where 47% of boys and girls reported severe signs of acute stress while 53% of them reported normal signs of stress, we can definitively say that children and teenagers are reporting less stress reactions than adults. To explain the difference (between, adults and children) we could hypothesize that chidlren are receiving emotional support and protection by their parents (when facing critical incidents).

It is now interesting to compare the results of IES and CRIES with the results of MdM internal psychosocial assessment questionnaire (which are consistent with the previous data, collected from November 2015 to May 2016, please see page 17 for more details):

- 66% of the people who received PFA report more than 2 psychological signs, the feeling of insecurity being the main difficulty faced by our beneficiaries. These figures are in line with the results of the IES-R scale.
- 28, 4 % of the whole sample (half of the people who received PFA) report more than 2 physical signs, sleeping disorder being the main problems faced by children, teenagers and adults (56,8%) followed by headaches – It is important to mention that the sleeping disturbances have been constantly and consistently identified among our beneficiaries as a major problem since the beginning of the project;
- 47,4% of the whole sample (half of the people who received PFA) report more than 2 trauma-related signs. The most reported signs are flashbacks, intrusive feelings and thoughts (about the critical event) and concentration problems;
- Regression in academic progress is identified among 27% children and teenagers;

The psychosocial support

Following 69 critical incidents, 416 individuals were visited. During these visits, 115 beneficiaries identified in need of psychological support (27,6%) received the psychological first aid intervention, which consists in the

first emotional support to people affected by critical incidents, using active listening and reflecting emotions skills. It involves practical, humane and supportive help in order to mitigate the impact of the reactions linked to the incident. If both adult and children are affected by critical incidents, the psychological first aid was performed to 67% of adults vs 33 % of children and adolescents (under the age of 18 years old). The numbers of PFA performed with children and adolescents is lower than the number of PFA performed with adults. We could hypothesize that children - as emotionally supported and physically protected by the parents - might be less in need of psychological support. 13% (16 out of the 115 individuals who received the psychological first aid intervention) were referred to specialized mental health services. If we come back now to our strategy, MdM approach is a preventive approach with the aim of mitigating the legitimate distress of our beneficiaries. To do so, and considering that 50% of our population has already been involved at least in one similar critical incident, peer support is organised in the most vulnerable villages of the North West Bank (7-9 sessions with the same group/once a week). Peer support is based on the idea that others who are in similar situations, or have similar challenges are best able to understand and provide support. MdM experience shows significant evidence of using such technique to help people coping with stress and emotional difficulties, social support being one of the main identified ways of coping of the communities. 12 peer support group interventions (7 group interventions with children, 2 with teenagers, 3 with adults) involving 180 individuals have been implemented from September to February 2017, totalizing on average 96 sessions. The balance between children, adults and teenagers is distributed as follow: 41 female adults, 112 children, and 27 male teenagers. Regarding the adult groups indeed, 100% of the participants are women, not because women have more needs of support, but because they are more available (men are working) and are undoubtedly more inclined to talk and share about emotions. Regarding the children population, 64% are males, 36% are females. Regarding the teenagers, MdM mainly worked with male teenagers. In the future, we will definitively put our efforts in ensuring more balanced groups. If Peer support has been widely accepted as an evidence based practice, we have been working on a new pre and post assessment tool (internal questionnaire) to replace the CYRM (child and youth resilience measure) not adapted enough the specificity of our intervention. This questionnaire (that you can find in the annexes) is being implemented now. Despite the fact 67% of our sample (n=31) reported a lower score after the intervention which could mean that the analysed population has improved its coping mechanisms, it is today impossible to confirm that this assumption is statistically significant (indeed our Probability value exceeds 0,05). We will wait for a bigger sample to continue our analyses.

Conclusion

The context of violence in which the North West Bank communities are living has an impact on the psychosocial well-being and the mental health of the populations to whom we are providing support, even when they are not directly involved in critical incidents. In the villages where MdM is intervening, acute stress seems to be the norm. What could be sometimes mistaken for resilience is the necessary adaptation to a stressful environment in which conflicts are part of the daily 'usual' life.

How can the communities then find emotional balance when they know it will happen again?

Consequently, these results show the importance of providing a psychological and psychosocial support of quality in emergencies. If our intervention has a significant impact on the communities, we still need to question ourselves and improve our practices. We need first to improve our MHPSS follow-up (to reach at least 75% of the beneficiaries who received PFA). Then, we will continue to improve our intervention by being more accountable to the beneficiaries. Concretely, through focus groups and satisfaction surveys, we will collect more (qualitative) data about the relevance and the quality of support which is provided. Speaking of qualitative data, we still need to improve our Case Study methodology. Concerning the peer support groups, we will put our efforts into involving more men in the sessions (for a better gender balance). Last but not least, in 2017, we will complement our actual PSS Emergency strategy by developing low intensity psychological interventions for people suffering from moderate psychological problems (who are not reaching the appropriate services for security and stigma-related reasons) and by implementing for the most vulnerable Communities awareness psychoeducation sessions focusing on the psychological and psychosocial impacts of Occupation related critical incidents and on the available resources to cope with adversity.

Context and objectives

Goals of the project:
1. The victims who are the most affected by the violence linked to the Occupation (settlers' violence, ISF demolitions and use of force by ISF) have a quality psychosocial support provided by a team of experienced social workers and psychologists within 72 hours after the critical incident.
2. Resilience based peer support interventions are offered to the people who are the most affected by violence to improve their mechanisms of coping during and after critical incidents.

Médecins du Monde (Doctors of the world, hereafter called MdM) has been working in the occupied Palestinian territory (OPT) since 1996 and currently developing interventions in the North West Bank and the Gaza Strip. Since 2002 in the North West Bank, MdM France strategy, in line with the Palestinian mental health strategy is mainly focused on Mental Health and Psychosocial Support through different projects. The Palestinian villages and Bedouin communities in the North of West Bank are regularly targeted by Israeli military operations, settlers' attacks and demolitions. In line with its MHPSS strategy, MdM is implementing a project aiming to prevent and limit the impacts of Occupation-related violence on Palestinians psychosocial well-being in the villages of the North West Bank, as well as to promote its resilience (see Key concepts in the Annexes for detailed definitions). In this regard, different activities are implemented:

- ✓ Provision of emergency MHPSS support after critical events in the North West Bank: within the 72 hours[2] after an act of violence (or critical incident, see key concepts in the Annexes for the definitions) MdM psychosocial team (1 or 2 trained and supervised social workers or psychologists) provide the first psychosocial support consisting in the first contact with the victims and perform Psychosocial First Aid (here after called PFA) to the most emotionally affected people (adults, children and adolescents), according to the needs. PFA consists in actively listening to the victims, normalizing and reflecting their emotions. Ten to fifteen days after this first intervention, MdM team always returns to visit the beneficiaries who received PFA, to continue with the support, to check how people are coping and to identify people who would need further interventions (referrals to external mental health services as CMHCs, PCC and/or MSF).

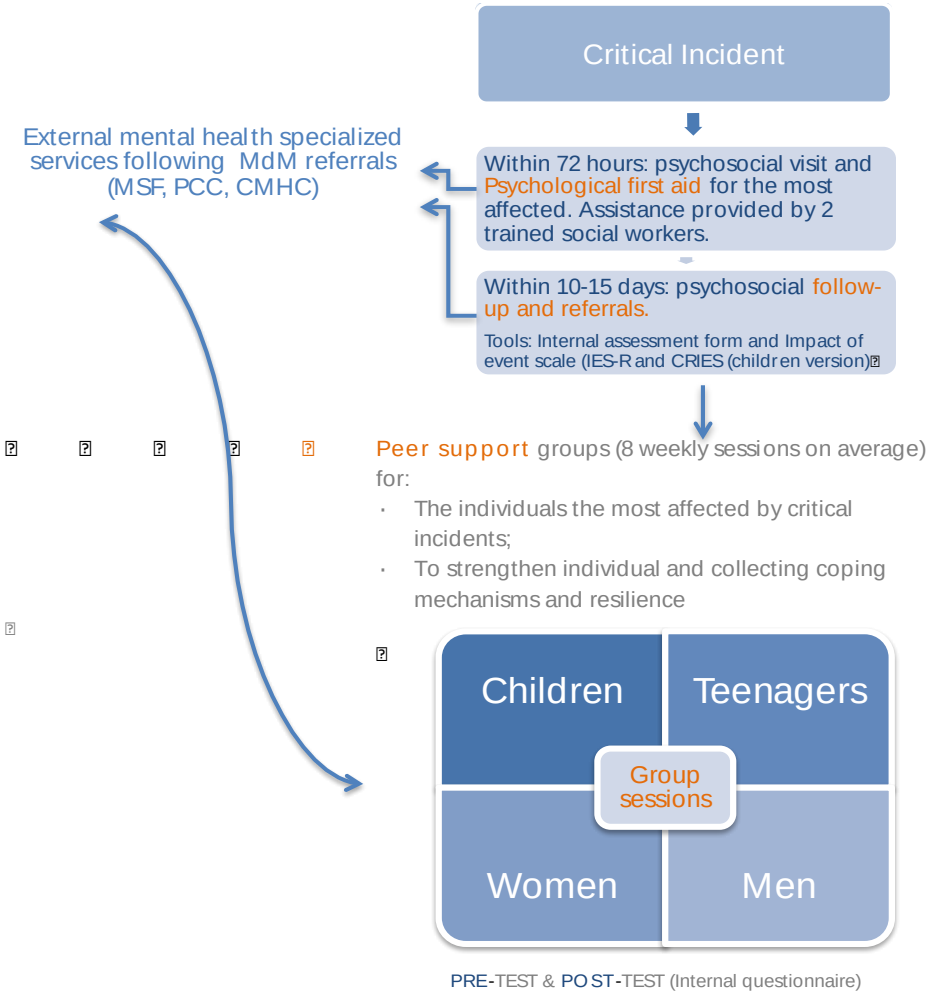
- ✓ Capacity building of volunteers and Primary Health Care staff: in order to ensure the sustainability of the MHPSS emergency interventions, MDM is involving the community and building up their capacity to provide these services. As part of this pilot activity, MdM in cooperation with the municipalities and village councils is selecting and training volunteers (social workers or psychologists, but not exclusively) in provision of immediate psychosocial services. During the first interventions in their own villages, the MHPSS volunteers are accompanied and supervised by MdM PSS team. So far, 67 volunteers from 14 villages of the North West were trained in Emergency PSS intervention (7 days of training) – the volunteers (2 people maximum per intervention) are now gaining experience and practice by accompanying MdM PSS team in the field. During the last 3 years in Nablus Governorate, 85 medical staff (nurses and doctors) of 25 primary health care structures have been extensively trained in the detection, basic management and referral of mental health cases.

- ✓ Promotion of the resilience of the Palestinian communities through peer support groups:
  Peers support groups involve vulnerable persons that have similar characteristics and who have experienced or are at risk of experiencing similar kind of incidents (for ex. settlers attack in the house, demolitions…) with the general objective of increasing resilience and reinforcing positive coping mechanisms. 2 different modules with specific objectives have been designed for adults, teenager and children, according to the needs of each one of these groups. Each module has around 8 sessions and is facilitated by a main facilitator and a co-facilitator (as per peer support group methodology). The number of participants per group is between 10 and 15. Based on the needs of participants, our methodology has evolved during the last year, from a pre-structured activities oriented model to a more flexible and open model through which participants feel free to share with their peers any difficulty (related to the context) at any time of the process.

- ✓ Advocacy: In order to obtain long-term changes for Palestinians and address the root causes of the problems, MdM develops advocacy activities. The impacts of occupation related violence on the psychosocial well-being of Palestinians are documented and these quantitative and qualitative findings are shared in Palestine and Israel, but also within France and European Union, in order to raise awareness on the issue and influence decision-makers position and policies on the matter.

[2] For some critical incidents (i.e demolitions), this rule of 72 hours should be flexible as basic needs (protection and medical needs mainly) are to be covered first before any psychosocial intervention.

The project in a snapshot



Objectives of the Report:

- ✓ To have a global picture of the psychological and psychosocial impacts of the critical incidents directly and indirectly related to the Israeli occupation violence (mainly: settlers' violence, demolitions and excessive use of force by the ISF) from October 2016 to February 2017;
- ✓ To compare these results with previous data from May to September 2016 (Evolution of the situation)
- ✓ To present and discuss the results of our resilience-based peer support group interventions for children, teenagers and adults (women and men).

Case study: *Earning one's bread with the sweat of his brow*

Mohammad (fictive name)[3] is a 49 years old man. He is married and has 8 children, 7 girls and one boy. The family is living in a modest two-storey house. The family is leaving upstairs. Downstairs is the sheep farming, which provides some more resources to the family.

Mohammad is a construction worker; he does not have a permanent job. Sometimes he is working in West Bank and sometimes he is working inside Israel without any working permit (all his requests to get a permit have been rejected).

End of September 2016, Mohammad left his house in the direction of Israel. All the usual paths used by the Palestinians were impassable. He decided to climb the 8 meters high wall of separation, in desperate need of earning his bread. When he reached the top he looked at the other side seeing the remaining distance to touch the floor (by using the pipe which was fixed on the wall).

Mohammad was scared. He felt hesitant, but the other workers accompanying him told him to hurry up before being caught by ISF soldiers. Mohammad took a deep breath and slid on the pipe, he fell on the ground and broke his leg. He could not move anymore. He was really scared. Israeli forces would come and catch him. So he told his companions to leave him. One hour later, a Military Jeep arrived. Soldiers got off the Jeep and started to shout at him.

"What are you doing here?" "Reply, what are you doing here?"

Mohammad tried to tell them that his leg was broken but they didn't care and used the guns to hit him at different parts of his body including the broken leg. Then they left him alone.

Two hours later two soldiers came and called an ambulance. Medical First Aid was provided to him and Mohammad was transferred then to Rafidia Hospital in Nablus.

MdM Psychosocial team provided 2 psychological support visits, one directly after the incident and a follow-up visit twelve days later.

He told the team:
"Since the incident, I have some difficulties to sleep, I see the movie of the incident in my head, I want to forget bu I can't…..I am stressed, because I cannot work and fulfil the needs of my family, the treatment for the leg will take more than 6 weeks, I am frustrated because no organization is able to provide financial assistance, they only visit me to write reports…."

After the psychological support provided, MdM referred him to organisations which could help me financially.

Mohammad told us: "*you help me to see some hope and to start thinking how can I help myself".*
However, it was quite obvious that first line psychological support was not enough.
Therefore, MDM-F referred Mohammad to MSF for advanced mental services considering the acute signs of trauma he was experiencing. No one should have to risk his life for a job….Unfortunately this story reflects the daily life of some Palestinian workers.

[3] Published with the written consent of the beneficiary.

Methodology

The MdM France internal updated psychosocial assessment form (adapted from the one used by MdM France in Lebanon) and the revised Impact Event Scales for adults (IES-R) and children (CRIES-R) were used for collecting quantitative data. A new internal questionnaire has been developed as a pre and post assessment measure for the peer support intervention for adults and adolescents[4] (in replacement of the International CYRM scales which are not adapted enough to our specific intervention, you can find it in the annexes b.3). Moreover, the MHPSS team collected qualitative data during the different steps of the intervention through observations and personal notes. Qualitative data collection will be improved during the coming months by implementing focus group discussions with the beneficiaries.

Our sample is composed of:

- 115 individuals, 48% of females vs 52% of males[5] (the most affected ones out of the 416 people visited) who have received the Psychological first aid (or first emotional support in emergency) within 72 hours after the critical event and then a follow-up session including a psychosocial assessment, from (5 months)
- 180 people (children, teenagers, women and men) involved in our peer support group intervention.

Presentation of the MdM internal psychosocial assessment form

(For your information, you can find all the scales/questionnaires in the Annexes)

This forms includes the following parts:

- General biographical and demographical information;
- Checklist for potential reactions or signs (as psychological or behavioural reactions);
- Vulnerability criteria (involvement in any past critical situation);
- Resources and coping mechanisms
- Psychosocial and mental health needs (no need/specialized mental health services/peer support)

This form has been updated and improved in February 2016 according to the field experience. Social workers and psychologists take notes and collect observations during the intervention and only fill in the form afterwards.

Why did we choose revised impact of event scales (for adults and children)?

Horowitz Impact of Event Scale (IES; Horowitz et al, 1979) was created for the study of bereaved individuals, but soon it was used for exploring the psychological impact of a variety of traumas. It was constructed before the diagnosis of post-traumatic stress disorder (PTSD) was entered into the DSM—III (American Psychiatric Association, 1980), and although many measures of PTSD symptoms have emerged (Wilson & Keane, 1997), the IES remains widely used. It is a short, relatively easily administered self-report questionnaire to measure acute / traumatic stress reactions related to critical incidents. Moreover, a good discriminant validity and reliability was identified for the Arabic version (Davey and all, 2014).

[4] We are not using (quantitative) questionnaires with children. Methodology wise, it is preferable to collect (only) qualitative data through drawings, talks and observations (as children by experience don't necessarily understand well the written questions of the questionnaires and the aim of administering such questionnaires).

[5] In the previous report (May to September 2016), 60% of females versus 40% of males were in need of Psychological First Aid. Without jumping into hasty conclusions, we could hypothesize than men and boys are more and more aware about the services provided and maybe more inclined to talk about their difficulties.

Limitations

- Collecting quantitative data is challenged by some factors including: translation from English/Western concepts to Arabic concepts; the administration of the tools, which differs from one staff to the other.
- Collecting qualitative data and testimonies from the victims is challenging. Some of them feel ashamed to share their story (by fear of being stigmatized), others are afraid of the potential negative consequences of sharing stories (loss of working permits or security clearance for example), despite the fact confidentiality is ensured.
- The psychosocial assessment form is an internal MdM France tool (adapted from the one used in Lebanon), whose scientific validity and cultural appropriateness could still be questioned even if most of the items have been adapted according to the Palestinian culture.
- The Impact Event Scales and Children Impact Event and Children have been used in Middle East including Palestine so far. However, if they are promising scales they have not strictly been scientifically validated for Palestine.
- We should not underestimate the confirmation bias or "myside" bias, which is a tendency of 'assessors' to favour information that confirms their beliefs (Ex "All people are stressed!"). People display this bias when they gather or remember information selectively. The effect is stronger for emotionally charged issues and for deeply entrenched beliefs. They also tend to interpret ambiguous evidence as supporting their existing position.
- Simple descriptive statistics were done and some statistical errors are still possible.

> Consequently, certain caution is more than recommended when reading, interpreting and further presenting the following results and figures internally and externally.

Through this drawing, Maya, 12 years old is expressing her feeling of safety (when she is in her house). Drawings are not meant to be analysed after the intervention, but are used to facilitate discussions on coping mechanisms in situ (during the intervention).
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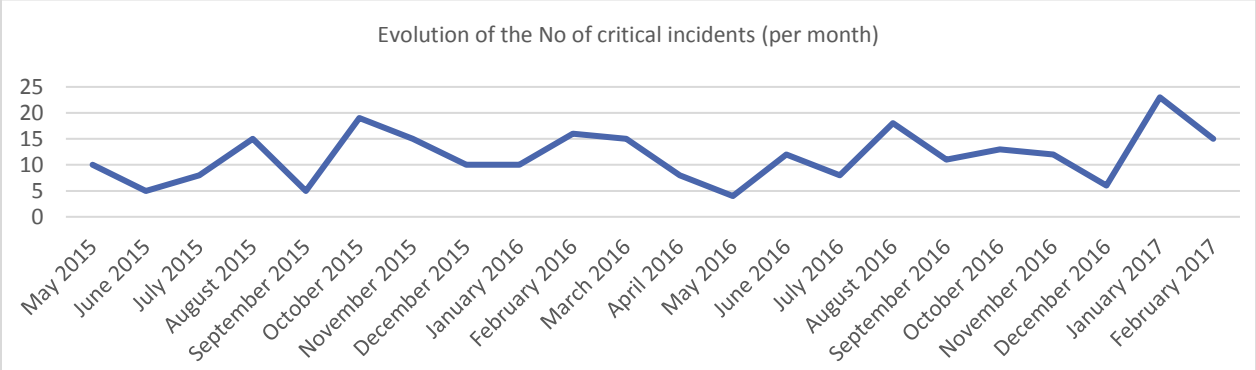
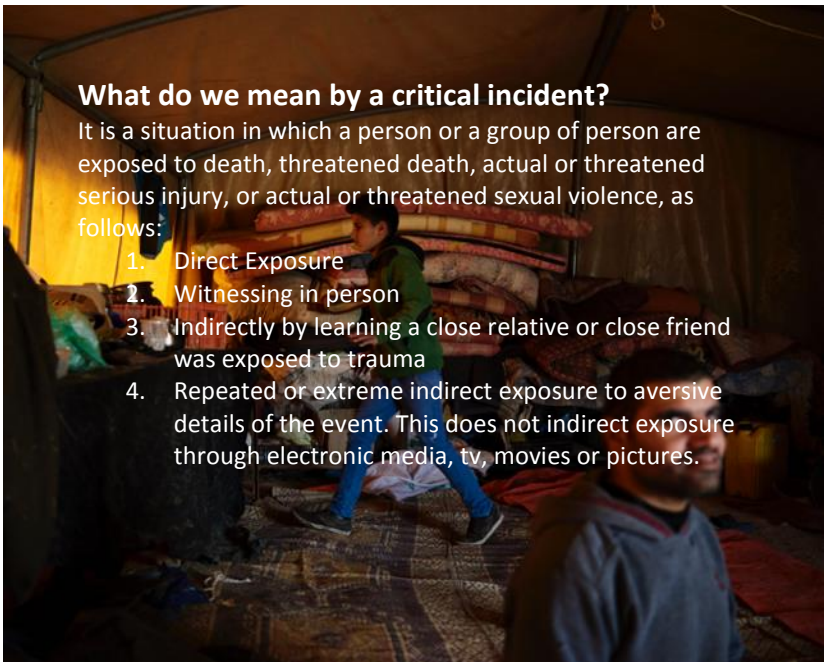
Results

Evolution of critical incidents



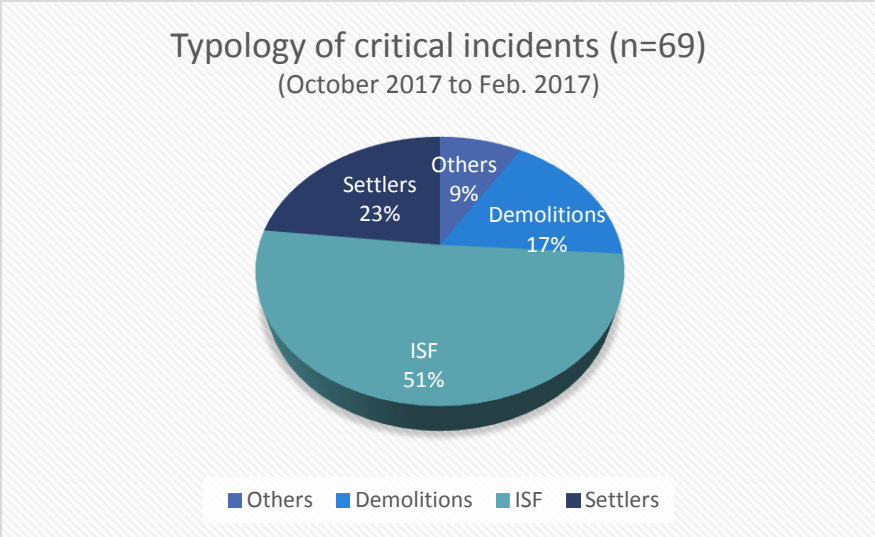
From the 1st of October to the 28th of February 2017, 416 beneficiaries have received the first psychosocial visit (within 72 hours) following 69 critical incidents. We are talking here about the critical incidents happening in the most vulnerable communities of the North West Bank, for which MdM is intervening, according to specific criteria of intervention: 3,45 incidents per week on average. During the previous period from May to October 2016, MdM intervened for 2,65 incidents per week. If we compare now the above mentioned period (3,45) with the last 10 months, from December 2015 to September 2016, MdM intervened for 112 critical incidents: 2, 8 incidents per week on average. This slight increase of critical incidents during the last 5 months could be explained by the peak of demolitions, the temporary forcible transfer (due to military trainings inside the communities of the North Jordan Valley) and livelihood confiscations end of 2016 and beginning 2017.

In conclusion, as shown in the graph, we could say that the number of critical incidents for which MdM is intervening each week is quite stable. For the last 22 months, MdM intervenes on average for 3 critical incidents every week.

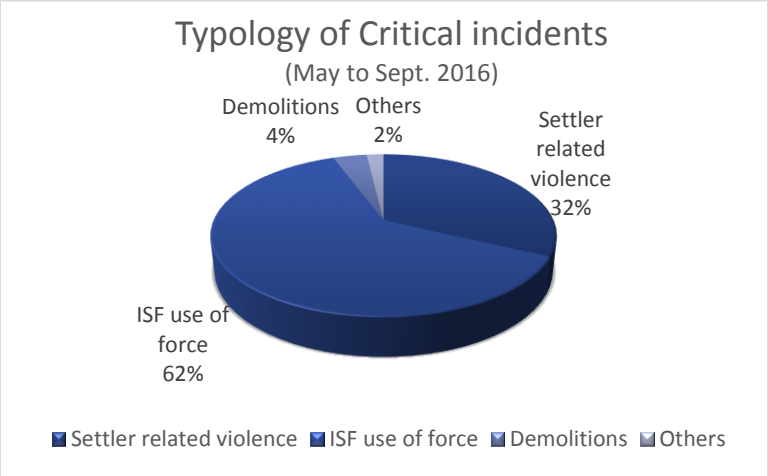


Typology of critical incidents

From October 2016 to February 2017, the nature of critical incidents could be described as follow:



From May to September 2016, the nature of critical incidents was distributed as follow: 62% of the of incidents (for which MdM intervened according to specific criteria) were related to ISF use of force, 32% to settlers' violence and 4% to demolitions.



During the last 10 months, MdM is observing a downward trend of settlers' violence and an upward trend of demolitions related critical incidents. ISF violence remains the main cause of critical incidents for which MdM France is intervening.

A certain caution must be taken when communicating these results, indeed MdM is not intervening for all the critical incidents[6] which happen in the North West Bank, therefore these results cannot be generalized to the North West Bank or to the whole West Bank.

[6] Our HR capacity is limited (6 PSS staff). Moroever some other local and international organizations are providing PSS in emergency as well (most of the time, in coordination with MdM).

Case study: "They have just killed my son's dream"

Mrs. Fatema (fictive name)[7] is a 67 years old lady, living in Qusra village located in the south eastern of Nablus city. She's a widow who lives with her 30 years old single son in a simple and rudimentary house closed to one of the surrounding settlements of Qusra.

Mrs. Fatema was a very active member of our Peer Support Group (MdM resilience-based intervention involving women suffering from Occupation related problems); she always came early to the sessions, never hesitated to start talking and sharing her experience with the group. She never missed a session during the period of the intervention.

Fatema seemed really sad, stressed and worried when MdM social worker met her for the first time. In the fifth session, she expressed in a suffocated voice:
"My son suffers from mental health as a consequence of ISF demolition. For years, he has had difficulties to sleep and nightmares. The story started 4 years ago when my son decided to start his own business; he invested all his savings and money in a small gas station project in the village. Three months later while the family was happy with the success of such project, my son was shocked to receive a demolition order from Israeli Forces saying that this project is on Area C and should be demolished. My son didn't believe the demolition would happen. Unfortunately, one week later, ISF came with bulldozers and killed my son's dream, happiness and future, they demolished the whole project with no mercy."

Mrs. Fatema continued by crying:
"Since that day, my son has been psychologically sick, he stays at home and does not talk to anyone. I convinced him to go to a psychiatrist. He went once and took some medication, but now he refuses to continue with the medication or any kind of intervention, since the drugs are very expensive and hardly to be found. Four years of suffering, sadness and sorrow, but today I feel good because I can share this with the group, I feel much relieved by talking about this with the group".

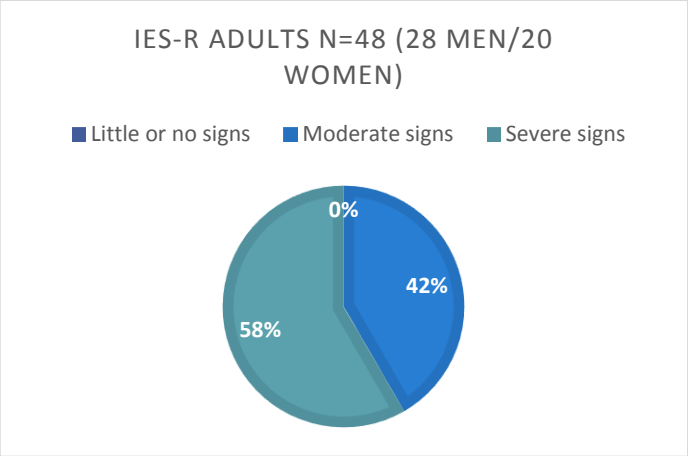
The group supported Mrs. Fatema with encouraging words:
"You are a good mother; despite adversity you are continuously supporting your son" which had a positive impact on her self-esteem.

MdM team and the group calmed her down, and finished the session by sharing joyful feelings.
Mrs. Fatema continued attending the sixth, and seventh session (which it the last session). In the last session, MdM social worker asked her to meet her individually; after the session as Mrs. Fatema seemed still depressed and really worried, the social worker talked with her about the possibility for her and her son to be referred to advanced mental health services.

Mrs. Fatema showed her acceptance and willingness to receive additional support. She was referred then to Doctors Without Borders (MSF France), hoping she would receive psychological comfort.

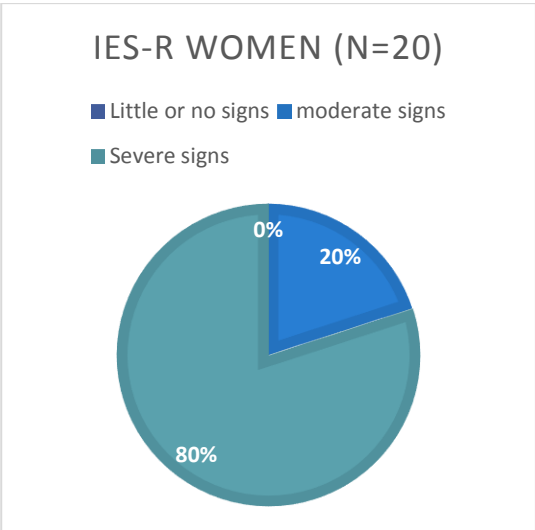
[7] Published with the written consent of the beneficiary.

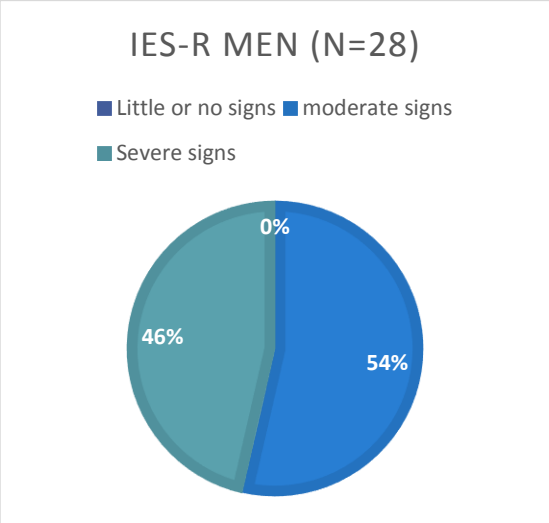
Mental health and psychosocial impact



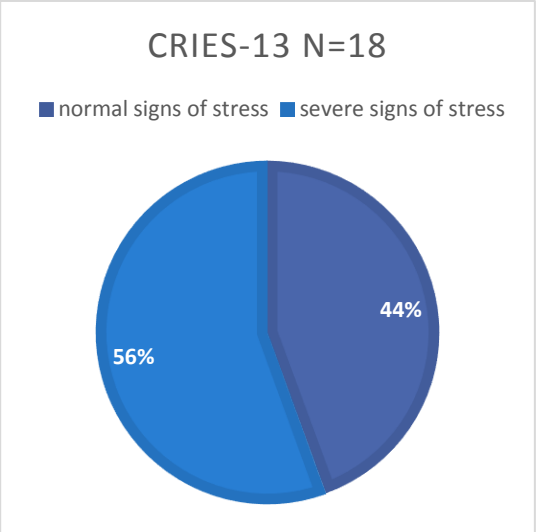
If a minority of people presents severe and moderate mental health disorders, which require the intervention of professional mental health specialists, a large percentage of people present legitimate distress and other psychological reactions, which continuously affect them and increase the risk of developing mental health disorders. This is the case of our beneficiaries, indeed. Let's have a look at the results of the IES –R (Impact of event scale, revised version) and CRIES (Children revised impact of event scale – please have a look at the methodology chapter to know more about these scales, which are reported in the Annexes at the end of the report).

- No one is reporting no sign of stress;
- 42% report moderate signs of acute stress (it means they are experiencing acute stress reactions, such as numbing, emotional detachment and re-experiencing the event, but these reactions are not severe and will decrease with time).
- 58 % of the adult population who received Psychological First Aid report severe signs of acute stress and are at risk of developing Post-Traumatic Stress disorder;
- This % is lower than the percentage of 78% of individuals (n=49) reporting severe signs of acute stress, from May to September 2016. However, it is difficult to do comparisons as the analysed samples are not strictly equivalent (32 women and 17 men in the previous sample).
- According to our sample, women seems as well more affected than men, but again as the samples are not equivalent (n=20/n=28), let's interpret these figures with caution:





These data are not consistent with the previous report (data from May to September 2016), showing that men were equally affected than women (71% of men versus 78 % of women reporing severe acute stress reactions). Let's have a look now at Children scales (CRIES-13) results. As our sample for children/adolsecents is relatively small (n=18), let's be cautious as well with the interpretation of the results.



It is interesting to see that 56% of boys and girls report severe signs of acute stress while 44% of them report normal signs of stress.

As the size of the 2 samples is not equivalent (12 girls versus 6 boys), it is no possible to make any significant comparison between the sexes.

If the data slightly differ from the ones analysed from May to September 2016, where 47% of boys and girls reported severe signs of acute stress while 53% of them reported normal signs of stress, we can definitively say that children and teenagers are reporting less stress reactions than adults.

To explain this difference, we could hypothesize they are receiving emotional support and protection by their parents (when facing critical incidents).

It is now interesting to compare the results of IES and CRIES with the results of MdM internal psychosocial assessment questionnaire (which has been recently updated and improved according by the team under the supervision of the Mental health coordinator):

Results of MdM Psychosocial Assessment questionnaire (number of questionnaires = 64):

- 66% of the people who received PFA report more than 2 psychological signs, the feeling of insecurity being the main difficulty faced by our beneficiaries. These figures are in line with the results of the IES-R scale.
- 28, 4 % of the whole sample (half of the people who received PFA) report more than 2 physical signs, sleeping disorder being the main problems faced by children, teenagers and adults (56,8%) followed by headaches – It is important to mention that the sleeping disturbances have been constantly and consistently identified among our beneficiaries as a major problem since the beginning of the project;
- 47,4% of the whole sample (half of the people who received PFA) report more than 2 trauma-related signs. The most reported signs are flashbacks, intrusive feelings and thoughts (about the critical event) and concentration problems;
- Regression in academic progress is identified among 27% children and teenagers;

These results are consistent with the previous data collected from May to September 2016

- 68% or 2/3 of the people who received PFA report more than 2 psychological signs, stress, anxiety and feeling of insecurity being the main difficulties faced by our beneficiaries. These figures are in line with the results of the IES-R scale.
- 48.4% of the whole sample (half of the people who received PFA) report more than 2 physical signs, sleeping disorder being the main problems faced by children, teenagers and adults (77,9%) followed by headaches – It is important to mention that the sleeping disturbances have been constantly and consistently identified among our beneficiaries as a major problem since the beginning of the project;
- 50% of the whole sample (half of the people who received PFA) report more than 2 trauma-related signs. The most reported signs are flashbacks, intrusive feelings and thoughts (about the critical event) and concentration problems;
- Regression in academic progress is identified among 30% children and teenagers;

- Impairment in daily functioning is reported by 20% of our population, the inability to carry out daily work or school work, and the inability to carry out family responsibilities being the main problems identified.

Referrals to mental health Specialists

From October 2016 to February 2017, **13%,** 15 out of the 115 individuals who received the psychological first aid intervention have been identified as in need of specialized mental health services, this % is quite consistent with the previous data (from May to September 2016 15,5% of the individuals who received PFA were referred to mental health specialized services)

Type of incident	Referred		Refused to be referred	
	Male	Female	Male	Female
Settlers' violence	1	1	0	0
ISF use of force	5	6	1	0
Demolitions	1		0	0
Total			0	0
Grand Total	14		1	

One man refused to be referred. Most of the time individuals refuse to see specialists for the following reasons:

- Stigma attached to MH Services: it is still really difficult for a majority of people to recognise that they have mental health and psychosocial problems. It is still perceived as a sign of weakness to go and see psychologists/psychiatrists.
- Economic reasons: services are far away from some villages. Transportation is costly, and sometimes consultations are not fully covered.
- Safety reasons: as the families often refuse to leave their place as they are concern that the rest of the family and/or their belongings could be attacked meanwhile they are absent.

The actual number of MdM beneficiaries, who need specialized mental health services is in line with the worldwide WHO projections of mental health disorders in adult population affected by emergencies[8]

	Before the emergency: 12-month prevalence (median across countries and across level of exposure to adversity) i	After the emergency: 12-month prevalence (median across countries and across the level of exposure to adversity)
Severe disorder (for example, psychosis, severe depression)	2% to 3%	3% to 4% ii
Mild or moderate mental disorder (for example, mild and	10%	15% to 20% iii

[8] Observed rates vary with setting (for example, time since the emergency, socio-cultural factors in coping and community social support, previous and current disaster exposure) and the assessment method.
I The assumed baseline rates are the median rates across countries as observed in the World Mental Health Survey 2000.
ii This is a best guess based on the assumption that traumatic events and loss may contribute to a relapse in previously stable mental disorders, and also may cause severely disabling forms of mood and anxiety disorders.
Iii It is established that traumatic events and loss increase the risk of depression and anxiety disorders, including posttraumatic stress disorder.

moderate forms of depression and anxiety disorders, including mild PTSD)		
Normal distress / other psychological reactions (no disorder)	No estimate	Large percentage

Concerning the West Bank context, the high prevalence of beneficiaries in need of specialized mental health services can be explained by the fact 50% of them have already been involved in an occupation-related critical event in the past and are living in a context of continuous trauma;

It is important to mention, there is no correlation between the MHPSS impact and the type of incidents. Any incident can cause acute stress and emotional reactions. In other words, the MHPSS impact does not depend on a certain type of incident, but more on the intensity of this incident, the personality of the victim, his/her experience/past history (if she/he's been already involved in any other critical situations in the past) and his/her perceptions of available resources at the moment of the incident.

Coping mechanisms

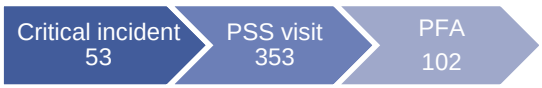
The communities we are supporting are using "Family support" as the main coping mechanism, followed by "Religion" and "Social Support". 10% of the beneficiaries' report "giving up" (inability to do something) when the team asks the question: "How do you cope with adversity?". Without jumping into hasty conclusions, a significant percentage of our beneficiaries feel discouraged and unable anymore to cope with the situation.

Psychosocial Support (PSS)

From October 2016 to February 2017, following 69 critical incidents, 416 individuals were visited.

During these visits, 115 beneficiaries, 27, 6% were in need of psychological support and received the psychological first aid, which consists in the first emotional support to people affected by critical incidents, using active listening and reflecting emotions skills. It involves practical, humane and supportive help in order to mitigate the impact of the reactions linked to the incident.

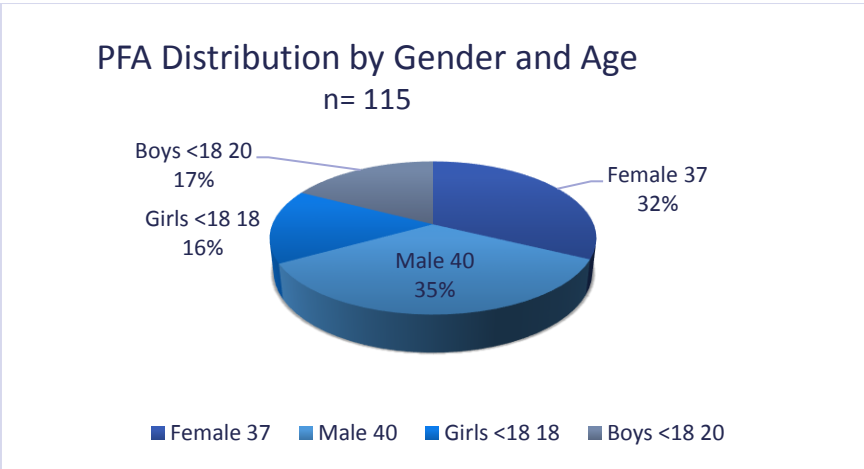
In the previous period,



from May to September2016, following 53 critical incidents, 353 individuals were visited. During these visits, 102 beneficiaries, 29% were identified in need of psychological support and received the psychological first aid intervention.

For the last 2 years, MdM observes at a constant level that about 1/3 of the persons affected by critical incidents are in need of psychological first aid (PFA).

If both adults and children are affected by critical incidents, the psychological first aid was performed to 67% of adults vs 33% of children and adolescents under 18 years old. (in the previous report (data from May to September 2016: 55% of adult vs 45 % of children and adolescents. The numbers of PFA performed with children and adolescent is lower than the number of PFA performed with adults. We could hypothesize that children - as emotionally and physically protected by the parents - could be less in need of psychological support. As shown by the CRIES-13 scores, children report less acute stress reactions than adults. Concerning the gender balance within the adult population, PFA was equally provided adult men (35%) and adult women (32%).



According to MdM Strategy, all the beneficiaries who have received the psychological first aid (PFA) are seen a second time by our team, within 10-15 days, for a psychosocial follow-up. This follow-up visit consists in:

- The continuation of the psychological support (active listening, reflecting emotions, exploring resources to cope with difficulties);
- A deeper assessment of the mental health and psychosocial needs

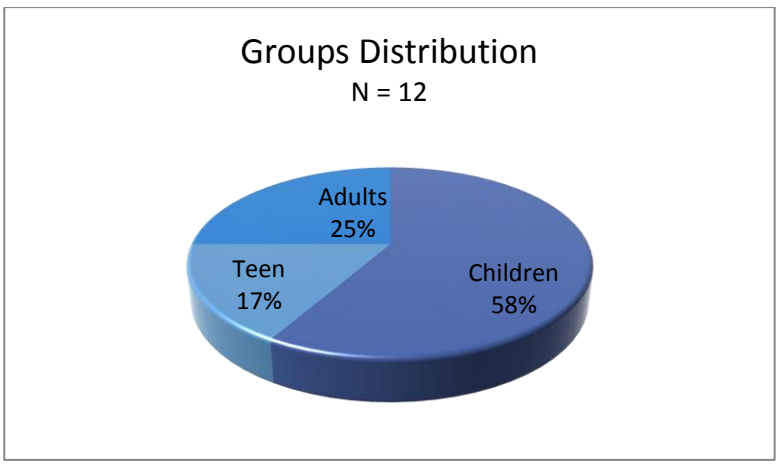
55% of our beneficiaries have been seen a second time. If some beneficiaries say they don't need a second visit, other are not available at the time of the visit. The figure is an indicator that MdM should improve its follow-up.

If we come back now to our strategy, MdM approach definitely is a preventive approach in the sense of mitigating the legitimate distress of our beneficiaries, in order to prevent moderate/severe mental health disorders.

Peer support

"I learned from the experiences of the others" (Nuha, 40 years old)

To do so, and considering that 50% of our population has already been involved at least in one similar critical incident, peer support is organised in the most vulnerable villages of the North West Bank (7-9 sessions with the same group/once a week). Peer support is based on the idea that others who are in similar situations, or have similar challenges are best able to understand and provide support. MdM experience shows significant evidence of using such technique to help people coping with stress and emotional difficulties, social support being one of the main identified ways of coping of the communities. Each group (10-15 persons on average per group), from the first introduction session to the last session, is facilitated by the same facilitator and co-facilitator, with the general objective of increasing resilience and coping mechanisms of people facing continuous adversity. At the end of the process, participants should be better equipped to face the emotional consequences of such incidents. Let's have a look now at the results: 12 peer support group interventions (7 group interventions with children, 2 with teenagers, 3 with adults) involving 180 individuals have been implemented from September to February 2017, totalizing on average 96 sessions.



The balance between children, adults and teenagers is distributed as follow: 41 female adults, 112 children, and 27 male teenagers. Regarding the adult groups indeed, 100% of the participants are women, not because women have more needs of support, but because they are more available (men are working) and are undoubtedly more inclined to talk and share about emotions. Regarding the

children population, 64% are males, 36% are females. Regarding the teenagers, MdM mainly worked with male teenagers. In the future, we will definitively put our efforts in ensuring more balanced groups. If Peer support has been widely accepted as an evidence based practice, we have been working on a new pre and post assessment tool (internal questionnaire) to replace the CYRM (child and youth resilience measure) not adapted enough the specificity of our intervention. This questionnaire (that you can find in the annexes) is being implemented now. Despite the fact 67% of our sample (n=31) reported a lower score after the intervention which could mean that the analysed population has improved its coping mechanisms, it is today impossible to confirm that this assumption is statistically significant (indeed our Probability value exceeds 0,05). We will wait for a bigger sample to continue our analyses. We can however rely on anecdotal evidences by collecting the feedbacks from the participants.

To the questions:
What is the main skill you have learnt from the Peer support group?
ما هي المهارة الاساسية التي تعلمتها من مجموعة القرناء؟
What changes have you observed in your life since you have participated in the Peer Support group?
ما هي التغييرات التي لاحظتها منذ مشاركتك بمجموعة القرناء؟

Here are some responses:

Kefil Haris mother group
F, 46
Q1- no answer
Q2: "I feel more self-confident now".

F, 29
Q1- "My personality is strengthened".
Q2: "I have more self-esteem".

Al-Aqabih (NJV) mother group
F, 36
Q1: "Just general relief".
Q2: "I am able to deal better with myself, my family, my daughter".

F, 27
Q1: "Dealing simply with different issues in my life, which facilitates my life. Knowing the problems of the others which decrease my perception to my problems".
Q2: "I love my family and my house more, life became easier".

F, 21
Q1: "I am able to control my emotions, serenity (psychological relief)".
Q2: "I would say self-strength (more than before)".

F, 32
Q1: "New ways to change my life, (psychological relief)".
Q2: "Excellent!"

F, 28
Q1: "The problem solving skill".
Q2: "how to speak with my children quietly, I learned new ways to solve the problems, I have the ability now to ignore some problems, and able to concentrate only on the big issues".

F, 45

Q1: "I feel more open for new knowledge and experiences, more aware, more relaxed (my body is less stressed)".
Q2: "I better deal with my children, my husband, and even people around, I was very nervous, now I have more patience".

F, 40
Q1: "I have learned new ways to deal with the big problems".
Q2: "I learned from the experiences of others".

F, 41
Q1: "I feel better able to deal with my children".
Q2: "I feel more relaxed, more calm especially when I deal with my family".

F,53
Q1: "I am able to express my feelings".
Q2: "when you listen to the problems of others, you know that you are OK"

New MHPSS developments in 2017: "PFA is not enough!"

The theory and practice of Emergency psychology is in constant evolution. Palestine is a complex context in which communities are facing multiple or continuous potentially traumatizing events.
Most of the existing psychosocial emergency interventions in the world are thought for people facing a single event. The growing popularity of Psychological first aid might be to the detriment of the development of new innovative approaches more adapted to the needs and challenges that Palestinian communities are facing in the field. If PFA is useful, *'PFA is certainly not enough'* to support people experiencing complex or multiple critical incidents. However, as we hardly have any tools or interventions for people who are living in violent situations for years with no hope it will change in the near future (and who are reluctant to see specialists for stigma related and economic reasons), we have to tinker the best we can.
Regarding the latter, and to partially address this issue, MdM France employs well trained social workers and psychologists who provide PFA (not to everyone facing a critical incident in order to avoid psychologising legitimate human reactions), but only to those most affected. They always come back to see people who received PFA to continue giving support and for a deeper follow-up, as MdM does not believe in the efficiency of large scale 'one shot sessions' which are still often provided after emergencies in the world. In 2017, the Palestine mission will develop new emergency interventions with the aim of providing low intensity[9] psychological support directly in the field following critical incidents, for people presenting moderate psychological difficulties. This measure won't replace but complement referrals to appropriate specialized mental services when needed.
In addition to the creation of the Low Intensity Psychological Interventions Unit (*LIPIU*), Community awareness psychoeducation sessions focusing on the psychological and psychosocial impacts of Occupation related critical incidents and on the available resources to cope with adversity will be implemented in the field for the most vulnerable communities.

[9] The term 'low intensity' indicates a less intense level of specialist human resource use. It means that the intervention has been modified to use less resources when compared to conventional psychological treatments by specialists. As a result, aspects about the intervention are changed to make them feasible in communities that do not have many specialists. Such modifications can thus create more accessible mental health care that reaches a larger number of people (WHO, 2014). Web: http://www.rcpsych.ac.uk/pdf/WHO-%20Volunteering%20and%20Internships-%20Brochure.pdf

Conclusion and recommendations

The context of violence in which North West Bank communities are living has an impact on the psychosocial well-being and the mental health of the populations to whom we are providing support, even when they are not directly involved in critical incidents.

In the villages where MdM is intervening, acute stress seems to be the norm. What could be sometimes mistaken for resilience is the necessary adaptation to a stressful environment in which conflicts are part of the daily 'usual' life. Everyone is unique and reacts differently, according to his/her own coping mechanisms, resources and strength. While a minority of beneficiaries needs specialized mental health support, a majority of people are continuously emotionally affected by the situation.

Critical incidents are happening continuously.

How can the communities then find emotional balance when they know it will happen again?
How can parents ensure the physical and emotional security of their children, when they feel stressed, anxious and depressed about the situation? What can children do when they cannot turn to their fathers as protectors?

Everyone can feel powerless.

Indeed, if the beneficiaries are primarily affected, MdM PSS team is secondarily affected by listening traumatic stories. An external supervision is therefore provided to the team (individually and in group) to prevent the risk of vicarious traumatization (which could be described as a transformation in the self of a trauma worker or helper that results from empathic engagement with traumatized clients and their reports of traumatic experiences).

Consequently, these results show the importance of providing a psychological and psychosocial support of quality in Emergencies, even if this is really challenging, as there is still nowadays a lack of evidence-based approaches and tools within emergency settings. One of the tools, PFA which has become very popular and somehow really "fashionable" within the humanitarian aid world is an important element in preliminary care of disaster victims (despite the need for more for more research and further scientific evidence on its effectiveness), but it is limited. Specially to support people who are living in violent situations and experiencing complex or multiple critical incidents.

If our intervention has a significant impact on the communities, we still need to question ourselves and improve our practices. We need first to improve our MHPSS follow-up (to reach at least 75% of the beneficiaries who received PFA). Then, we will continue to improve our intervention by being more accountable to the beneficiaries. Concretely, through focus groups and satisfaction surveys, we will collect more (qualitative) data about the relevance and the quality of support which is provided. Speaking of qualitative data, we still need to improve our Case Study methodology and approach. Concerning the peer support groups, we will put our efforts into involving more men in the sessions (for a better gender balance). Last but not least, in 2017, we will complement our actual PSS Emergency strategy by developing a low intensity psychological intervention unit (LIPIU) for people suffering from moderate psychological problems (who are not reaching the appropriate services for stigma related and economic reasons).

Annexes

A. Key concepts

What is a critical incident (or a potentially traumatic incident or event)?

It is a situation in which a person or a group of person are exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s). This does not include indirect exposure through electronic media, television, movies, or pictures.

What do we mean by mental health and psychosocial support (MHPSS)[10]

The composite term mental health and psychosocial support is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. Although the terms mental health and psychosocial support are closely related and overlap, for many aid workers they reflect different, yet complementary, approaches. Mental health and psychosocial problems in emergencies are much interconnected, yet may be predominantly social or psychological in nature. Significant problems of a predominantly social nature include:

- Pre-existing (pre-emergency) social problems (e.g. extreme poverty; belonging to a group that is discriminated against or marginalised; political oppression);
- Emergency-induced social problems (e.g. family separation; disruption of social networks; destruction of community structures, resources and trust; increased gender-based violence); and
- Humanitarian aid-induced social problems (e.g. undermining of community structures or traditional support mechanisms).

Similarly, problems of a predominantly psychological nature include:

- Pre-existing problems (e.g. severe mental disorder; alcohol abuse);
- Emergency-induced problems (e.g. grief, non-pathological distress; depression and anxiety disorders, including post-traumatic stress disorder (PTSD); and Humanitarian aid-related problems (e.g. anxiety due to a lack of information about food distribution).

Thus, mental health and psychosocial problems in emergencies encompass far more than the experience of ASD (acute stress disorder) and PTSD (Post-traumatic stress disorder). Indeed, the subjective experience of a potentially traumatic event and subsequent expression of reactions vary considerably over space and time, and we, as humanitarian workers should emphasise that not all normal psychological distress after a critical incident should be termed PTSD.

What do we mean by psychological first aid or PFA?

It can be defined as the first emotional support to people affected by critical incidents, using active listening and reflecting emotions skills. It involves practical, humane and supportive help in order to mitigate the impact of the reactions linked to the incident.

What do we mean by resilience?

Resilience is one's ability to bounce back from a negative experience with "competent functioning". Resilience is not a rare ability; in reality, it is found in the average individual and it can be learned and developed by virtually anyone. Resilience should be considered a process, rather than a trait to be had. It is a process of individuation through a structured system with gradual discovery of personal and unique abilities.[11]

[10] IASC guidelines on mental health and psychosocial support in emergency settings (2007)

[11] Rutter, M. (2008). "Developing concepts in developmental psychopathology", pp. 3–22 in J.J. Hudziak (ed.), Developmental psychopathology and wellness: Genetic and environmental influences. Washington, DC: American Psychiatric Publishing

B. Tools

B.1 MdM internal psychosocial assessment form (Updated version February 20016)

- Please, be ready and read deeply all the assessment form before starting the interview!!!!
- Please remind that this interview is strictly confidential, and information can only be transmitted with the consent of the beneficiary (to a MH specialist for ex.)
- This form must be filled directly after the interview (and not during the interview!); only the first page can be filled with the beneficiary during the interview;
- This assessment must be systematically implemented following each PFA (psychological first aid), within 10-15 days after the first intervention;
- The team member who implemented the PFA must be the same person who implements this assessment;
- In some circumstances, according to psychosocial identified needs in the field, this assessment might be implemented even if the first psychological intervention (PFA) was not done;
- If the beneficiary is not able to provide substantial information (a small child for ex.), this assessment should be implemented with the assistance of persons having a significant link with her/him;
- If the beneficiary is not available, please take an appointment and come back to visit him/her;
- The team member who implements the assessment must implement the follow-up;
- For mental health referrals, please attach the referral + the counter- referral forms (2) to this form;
- For peer support follow-up, please use the table on page 4.

Ass date: _____ Protection Report Nr (if available):_____

Incident date:_____ Name of interviewer:_____

A. GENERAL INFORMATION

Name:_____ Gender: F/M Age:_____

Village:_____ Phone No _____

Direct victim □ Indirect victim □
If indirect victim, relationship to the direct victim: _____

Civil status: Single □ Married □ Divorced □ Widow □

Number of people in household: ____ Children (0-18) : _____

Work status: works □ Workless □ Student □ Minor □ Housekeeper □ Other □ _____

Education: Illiterate □ Primary □ Secondary □ College □ University □

Source of information:
Victim himself/herself ☐
Other: ☐ Specify: Father ○ Mother ○ Brother ○ Sister ○ Uncle ○ Aunt ○ Grandfather ○ Grandmother Daughter ○ Son ○ Other significant person _____
Both: ☐

B. CHECKLIST OF POTENTIAL SIGNS

1. Physical signs	2. Trauma related signs	4. Behavioural signs	6.Individual functioning
1.1 ○ Eating problems 1.2 ○ Sleeping problems 1.3 ○ Headaches 1.4 ○ Stomach pain 1.5 ○ Breathing difficulties 1.6 ○ Accelerated heartbeats 1.7 ○ Chest pain 1.8 ○ Sweating increase 1.9 ○ vomiting 1.10 ○ Joints Pain 1.11 ○ Pallor 1.12 ○ Other _____	2.1 ○ Intrusive feelings, thoughts 2.2 ○ Flashbacks 2.3 ○ Avoidance 2.4 ○ Hyper vigilance / Exaggerated startle response 2.5 ○ Nightmares/night terror 2.6 ○ Concentration/ Memory/attention difficulties	4.1 ○ Alcohol / drug /stimulants/Cigarettes use increase 4.2 ○ Aggressiveness 4.3 ○ Usual behaviour changes 4.4 ○ Social/inter-personal isolation 4.5 ○ Impulsive behavior 4.6 ○ change in attachment to family 4.7 ○ Nails biting 4.8 ○ Bedwetting 4.9 ○ Regression in Academic process 4.10 ○ Crying without reason 4.11 ○ Irritation 4.12 ○ Apathy 4.13 ○ Anger 4.14 ○ Regression 4.15 ○ Not allowing kids to play outside 4.16 ○ Other	6.1 ○ Inability to carry out daily work or school 6.2 ○ Inability to carry out family responsibilities (cleaning, cooking, educating kids…) 6.3 ○ inability to attend personal hygiene 6.4 ○ Inability to attend social activities 6.5 ○ inability to play a useful part in life 6.6 ○ Other
	3. Psychological signs		
	3.1 ○ Anxiety 3.2 ○ Stress 3.3 ○ Low self-esteem 3.4 ○ Nervousness 3.5 ○ Frustration 3.6 ○ Feeling guilty/self-blame 3.7 ○ Insecurity 3.8 ○ Discomfort 3.9 ○ Sad mood 3.10 ○ Self-harm 3.11 ○ Lack of focus 3.12 ○ Fear 3.13 ○ Forgetfulness 3.14 ○ Hopelessness 3.15 ○ Feeling threatened 3.16 ○ Suicidal thoughts 3.17 ○ Other	5. Social signs	7. Other signs (not 1-6)
		5.1 ○ Change of household 5.2 ○ Changes in social relations 5.3 ○ Deterioration of social support network 5.4 ○ Loss of income sources	7.1 ○ 7.2 ○
Main category of signs:			8. ○ No sign

C. COMPLAINT IN THE WORDS OF THE BENEFICIARY (“quotes” from the beneficiaries)

……

……

……

……

D. VULNERABILITY

In the past, have you been directly involved in any critical incident(s)? YES / NO

If YES, how many and when?

Type of incident	Date

E. COPING STRATEGIES

What does the beneficiary usually do, in order to cope with difficult situations?
"Positive" Coping Strategies (what could be considered as positive)
□ Religion/Spiritual beliefs □ Family support □ Self-distraction (TV, reading…) □ work
□ physical activities □ friends and social support □ artistic activities (playing music, painting…) □ expressing feelings □ accepting the reality
Other: _____
"Negative" coping Strategies (what could be considered as negative)
□ use of excessive amount of alcohol or cigarettes □ giving up □ Self-blaming/criticizing □ use of drugs (psychotropic or other)

Other: _____

F. NOTES AND OBSERVATIONS

G. PSYCHOSOCIAL AND MENTAL HEALTH NEEDS

It is the responsibility of the social worker to decide which type of support is the most appropriate. In some cases peer support group sessions and specialized support can be proposed at the same time. The proposed option should always be discussed and agreed by both parties (social worker and beneficiary).

☐ No need

☐ Peer support group sessions

Some orientation: when social support is weak. When people have been involved in more that one critical incident (people at risk).

☐ Referral to specialized mental health services Some orientation: always when suicidal thoughts/psychotic behaviour. When the intensity of reactions is high and not manageable. When functioning is low (inability to care for self) and coping mechanism are weak. Problematic alcohol or drug use.

G. FOLLOW UP

Type of Intervention	Need for FU	When to FU	FU sessions recommended
No need	NO	NA	NA
Referral to Advanced MH services	NO, BUT MDM to fill in the referral form and to ask the counter-referral form from the external provider. If impossible to get the counter-referral form, ask an email from the provider (to confirm the beneficiary is taken in charge). If not possible ask direct feedback from the beneficiary.	NA	NA
Peer Support Group	YES	3 months after finalizing the group sessions	1 session

NB: PEER SUPPORT GROUPS (TO BE DIRECTLY FILLED IN THE EXCEL DATA FILE)

B.2 IES-R and CRIES-R

المقياس تأثير الحدث البالغين – النسخة المنقحة
Revised Adults Impact Event Scale (IES-R)

يجب ان تستخدم مع البالغين فوق سن 18 سنة

To be used with Adult population above 18 Y old

في الاسفل مجموعة من التعليقات التي ادلى بها اشخاص بعض تعرضهم لحدث مكرب ، الرجاء ان تحدد ضمن كل سؤال ما مدى صحة تكرار هذه التعليقات بالنسبة لك/ي خلال السبع ايام الماضية .

Below is a list of comments made by people after a stressful life event. Please mark each item, indicating how frequently these comments were true for you during the past 7 days.

كثيرا Extremely	بعض الاحيان Quite a bit	احيانا Moderately	قليلا A little bit	لا على الاطلاق Not at all	التعليق Comment
4	3	2	1	0	1. كل ما يذكرني بالذي حصل ، يوقظ لدي احاسيس قوية 1. Any reminder brought back feelings about it
4	3	2	1	0	2. لدي صعوبة في النوم 2. I had trouble staying asleep
4	3	2	1	0	3. اشياء حولي تذكرني بالذي حصل 3. Other things kept making me think about it
4	3	2	1	0	4. شعرت بانني غاضب ، مغتاظ و سريع الانفعال 4. I felt irritable and angry
4	3	2	1	0	5. احاول ان لا اغضب عندما افكر بالذي تعرضت له ، او عندما يذكرني شخص بذلك 5. I avoided letting myself get upset when I thought about it or was reminded of it
4	3	2	1	0	6. اذكر باستمرار ما حصل رغما عن ارادتي 6. I thought about it when I didn't mean to
4	3	2	1	0	7. لدي احساس بان الذي حصل ليس واقعيا او انه ليس حقيقة 7. I felt as if it hadn't happened or wasn't real
4	3	2	1	0	8. احاول تجنب كل ما يذكرني بما حدث 8. I stayed away from reminders about it
4	3	2	1	0	9. صور لما حدث تخطر في ذهني 9. Pictures about it popped into my mind
كثيرا	بعض الاحيان	احيانا	قليلا	لا على الاطلاق	التعليق

Extremely	Quite a bit	Moderately	A little bit	Not at all	Comment
4	3	2	1	0	.10 اشعر بانني اجفل سريعا وانني سريع العصبية 10. I was jumpy and easily startled
4	3	2	1	0	.11 ابذل جهدي لتجنب التفكير بنا حدث 11. I tried not to think about it
4	3	2	1	0	.12 انا ادرك بانه لدي احاسيس قوية لها علاقة بما حدث ولكن ليس باستطاعتي التخلص منها 12. I was aware that I still had a lot of feelings about it, but I didn't deal with them
4	3	2	1	0	.13 احساسي بما حدث هو احساس متزعزع 13. My feelings about it were kind of numb
4	3	2	1	0	.14 اكتشف بانني اتصرف و اشعر كأن الذي حدث سوف يحدث مرة اخرى 14. I found myself acting or feeling as though I was back at that time
4	3	2	1	0	.15 لدي صعوبة ان اغرق في النوم 15. I had trouble falling asleep
4	3	2	1	0	.16 تنتابني موجات من الاحاسيس القوية عندما افكر بما حدث 16. I had waves of strong feelings about it
4	3	2	1	0	.17 حولت ان انزع ما حدث من ذاكرتي 17. I tried to remove it from my memory
4	3	2	1	0	.18 اواجه صعوبة في التركيز 18. I had trouble concentrating
4	3	2	1	0	.19 عندما افكر بما حدث تصيبني اعراض جسدية كالتعرق او صعوبة في التنفس او غثيان او خفقان في القلب 19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart
4	3	2	1	0	.20 احلم بما حدث 20. I had dreams about it

.21 اشعر بانني متيقظ /ة باستمرار 21. I felt watchful or on-guard	0	1	2	3	4
.22 احول تجنب الحديث عما حصل 22. I tried not to talk about it	0	1	2	3	4

المجموع Sum	=

المقياس تأثير الحدث على الاطفال – النسخة المنقحة
Revised Child Impact Event Scale

هذه قائمه بأستجابات أناس تعرضوا الى أحداث مكربة . الرجاء قراءتها وذكر مدى تكرارها خلال السبعة أيام الماضية،ضع علامة (صح) أمام الإجابة المناسبة.أما في حالة عدم حدوثها فالرجاء أن تضع علامة صح في حقل أبدا.

Below is a list of comments made by people after stressful life Event. Please tick each item showing how frequently these comments were true for you during the past seven days. If they did not occur during that time please tick the 'not at all' box.

غالبا Often	احيانا Some-times	نادرا Rarely	أبدا Not at all	السؤال Question
5	3	1	0	1. هل تفكر بالأمر حتى لو لم تقصد أن تفعل ؟ 1- Do you think about it even when you don't mean to?
5	3	1	0	2. هل تحاول أن تمحوها من ذاكرتك ؟ 2- Do you try to remove it from your memory
5	3	1	0	3. هل لديك صعوبات في التركيز و الانتباه؟ 3- Do you have difficulties paying attention or concentrating
5	3	1	0	4. هل تنتابك موجات من المشاعر الشديدة حول هذه الحادثة ؟ 4- Do you have waves of strong feelings about it
5	3	1	0	5. هل تجفل بسهوله أو تشعر بأنك متوتر أكثر بعد الحادثة؟ 5- Do you startle more easily or feel more nervous than you did before it happened?
5	3	1	0	6. هل تبقى بعيدا عما يذكرك بها (مثل الأماكن أو المواقف)؟ 6- Do you stay away from reminders of it (e.g. places or situations)
5	3	1	0	7. هل تحاول تجنب الحديث عن الحادث؟ 7- Do you try not talk about it
5	3	1	0	8. هل تقفز صور الحادثة إلى مخيلتك من حين لآخر؟ 8- Do pictures about it pop into your mind?
أبدا Not at all	نادرا Rarely	احيانا Some-times	غالبا Often	السؤال Question
5	3	1	0	9. هل هناك أمور أخرى تسبب لك التفكير بالحادث ؟ 9- Do other things keep making you think about it?

5	3	1	0	10. هل تحاول أن تمتنع عن التفكير بالحادث ؟ 10- Do you try not to think about it?
5	3	1	0	11 . هل تستثار بسهوله؟ 11- Do you get easily irritable
5	3	1	0	12. هل تشعر بأنك مترقب ومتحفز دونما داعي لذلك ؟ 12- Are you alert and watchful even when there is no obvious need to be?
5	3	1	0	13. هل لديك مشاكل في النوم ؟ 13- Do you have sleep problems?

SCORE (SUM) =

B.3

Pre and post-test questionnaire

MdM Peer Support Group Intervention
(Teenagers and adult)

نوع المجموعة : Type of Group	مجموعة اهالي ☐ Adults Group	مجموعة مراهقين /ات ☐ Teenagers Group
التاريخ : _____ Date	نوع الاختبار : اختبار قبلي ☐ اختبار بعدي ☐ Identify if : Pre –test ☐ , Post test ☐	القرية : _____ Village
الاسم : _____ Name	العمر : _____ Age	الجنس : ذكر ☐ ، انثى Gender : Male ☐, Female☐
الاخصائي المسؤول :_____ MDM team member in charge		

Tick the box beside the reply that is closest to how you have been feeling in the past 2 weeks. Don't take too long over you replies: your immediate is best.

ضع اشارة على الاجابة الاقرب لما تشعر به خلال الاسبوعين الماضيين ,لا تأخذ وقت طويل للإجابة الفورية افضل .

For everyone:

A	I can cope with my stress استطيع التأقلم عندما اتوتر	B	I can get angry easily اغضب بسهولة
0	Most of the time معظم الوقت	3	Nearly all the time تقريبا طوال الوقت
1	A lot of the time الكثير من الاوقات	2	Very often غالبا
2	From time to time, occasionally من وقت لاخر	1	Sometimes احيانا
3	Not at all ليس كثيرا	0	Not at all ابدا
C	I am open to talk about my emotions انا منفتح للتحدث عن مشاعري	D	If I can't handle my mental health problems I am weak اذا لم استطيع التعامل مع صحتي النفسية فانا ضعيف
0	Yes, really open نعم انا منفتح	0	I diasgree لا اوافق
1	Yes but not to everyone نعم و لكن ليس مع الجميع	1	I neither agree nor disagree لا اوافق و لا اعارض
2	Only a little قليل	2	I agree اوافق
3	Not at all ابدا	3	I strongly agree اوافق بقوة

E	I can cope with critical incidents (attacks, harassment….) استطيع التأقلم مع الاحداث الصادمة (اعتداءات مضايقات .....),	F	I feel close to my family اشعر باني قريب من عائلتي
0	Absolutely اوافق بشدة	0	Most of the times معظم الوقت
1	Yes نعم	1	Sometimes بعض الوقت
2	Only a little قليلا	2	Not often ليس كثيرا
3	Not at all لا على الاطلاق	3	Very seldom نادرا جدا
G	I can deal with my problems استطيع التعامل مع مشاكلي	H	I feel pain in my body after hard times اشعر بوجع في جسمي بعد الاوقات الصعبة
0	Yes, most of the time نعم معظم الوقت	3	Nearly all the time تقريبا طوال اليوم
1	Quite much كثيرا جدا	2	Very often غالبا
2	Only a little قليلا	1	Sometimes بعض الوقت
3	Hardly at all على الاطلاق	0	Not at all على الاطلاق
I	Worrying thoughts go through my mind: افكار مقلقة تمر في ذهني	J	I think people with mental illness are crazy اعتقد ان المرضى النفسين مجانين
3	A great deal of the time وقت كبير من الوقت	3	I strongly agree اوافق بشدة
2	A lot of the time وقت كثير	2	I agree اوافق
1	From time to time, but not too often من وقت لأخر ,	1	I neither agree or disagree لا اوافق ولا اعارض
0	Only occasionally فقط بالمناسبات	0	I disagree لا اوافق
K	I can take care of my family استطيع ان اهتم بعائلتي	L	I have difficulty falling or staying asleep لدى صعوبة بان اغرق بالنوم او ان انام
0	As much as I ever did بقدر ما افعل في السابق	0	Only occasionally
1	Rather less than I used to اقل من العادة	1	From time to time
2	Definitively less than I used to اقل كثيرا مما اعتدت عليه	2	A lot of time
3	Hardly at all بالكاد	3	Always
M	I feel easily frustrated اشعر بالإحباط بسهولة	N	I can deal with difficult emotions استطيع التعامل مع المشاعر الصعبة
3	Most of the time معظم الوقت	0	Definitively نهائيا

2	Sometimes بعض الوقت	1	Yes نعم
1	Not Often ليس كثير	2	Only a little قليل
0	Not at all ابدا	3	Hardly at all بالكاد على الاطلاق

Additional questions for teenagers only:

O	I have goals in my life and I have a plan to reach them. لدي اهداف في حياتي و لدي خطط للوصول لها	P	I can easily talk with my family about important things. اتكلم بسهولة مع عائلتي بأمور مهمة
3	Not at all لا نهائيا	0	Often غالبا
2	Yes, but really few نعم , و لكن قليله	1	Sometimes بعض الاحيان
1	Yes نعم	2	Not often ليس كثيرا
0	Definitively لا قطعيا	3	Very seldom نادرا جدا

POST-TEST ONLY: questions for everyone

What is the main skill you have learnt from the Peer support group?
ما هي المهارة الاساسية التي تعلمتها من مجموعة القرناء؟

What changes have you observed in your life since you have participated in the Peer Support group?
ما هي التغييرات التي لاحظتها منذ مشاركتك بمجموعة القرناء؟

Score ADULT: Score TEENAGERS:

C. Bibliographic references and useful links

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