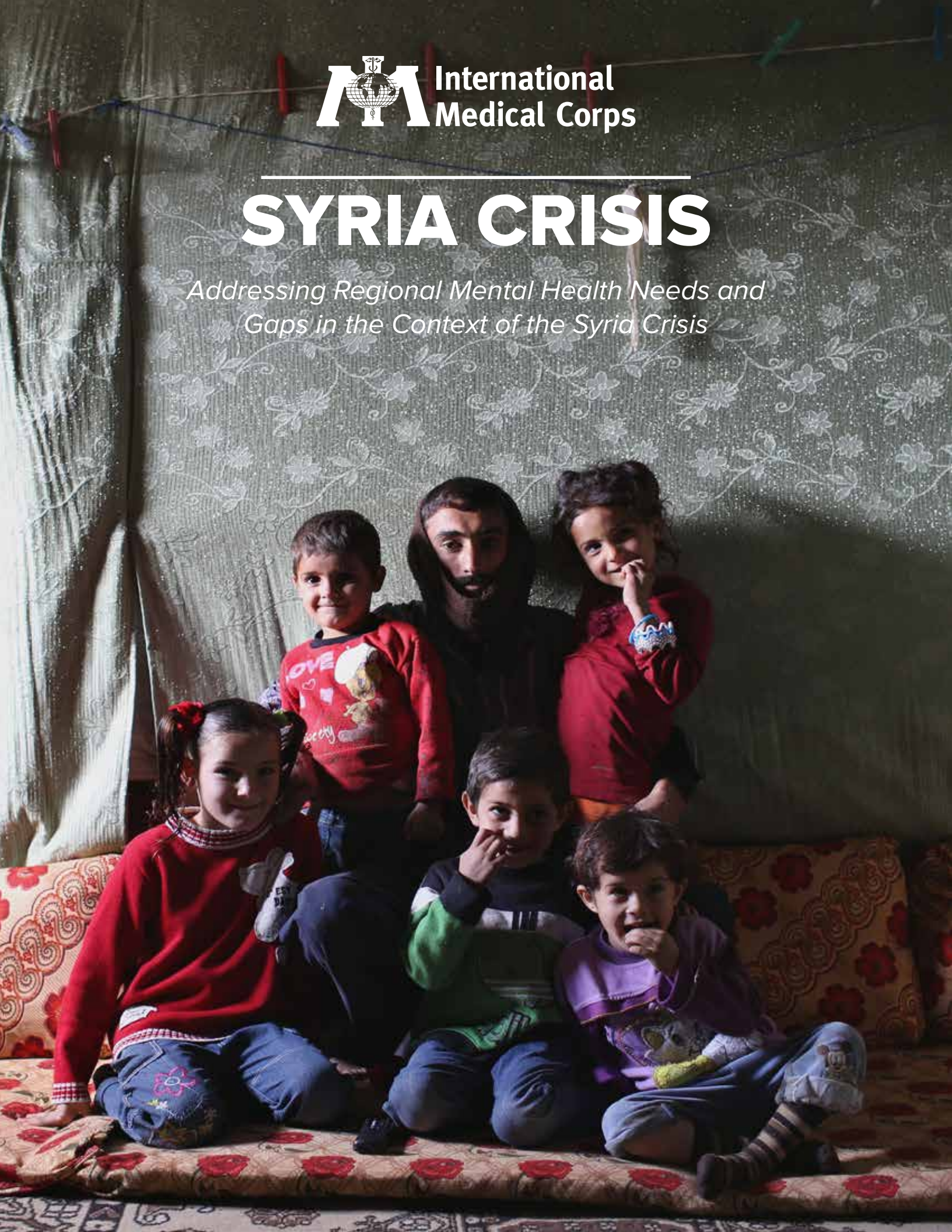
International Medical Corps

SYRIA CRISIS

Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis



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SUMMARY: The ongoing conflict in Syria has resulted in massive population displacement and growing needs for humanitarian services including mental health care inside Syria and in surrounding countries. This assessment describes information about current stressors and available services as well as clinical outpatient data on mental, neurological and substance use (MNS) problems at International Medical Corps supported health facilities serving the Syrian refugee and internally displaced populations in Syria, Lebanon, Turkey and Jordan. Methods: Data were collected from March to October 2014. Mental health service data was collected on seven MNS categories, disaggregated by country, sex and age. Key informant interviews asked about current stressors, available services and supports and service gaps. Findings: Stressors faced by Syrians include security and protection risks, access and availability of basic services and resources as well as family, community, and sectarian tensions. National mental health systems tend to be overburdened and inaccessible. Gaps include a limited geographical reach of mental health services, lack of mental health professionals, and limited community and family supports. Rates for MNS problems among Syrians accessing International Medical Corps supported facilities were relatively consistent across countries. Severe emotional disorders (54%), including depression and anxiety, were the most common, followed by epilepsy (17%) and psychotic disorders (11%). Epilepsy (26.6%), intellectual and developmental disorders (26.6%), and severe emotional disorders (3.6%) were the most common among children. Conclusions: There is a need to improve the overall quality, availability and accessibility of mental health services and supports provided as part of the Syria response. Agencies and organizations should support the coordinated scale up of accessible and sustainable mental health services and use the Syrian crisis as an opportunity to strengthen national mental health systems and to build local human resource capacity among Syrian and host country professionals and communities.

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ABBREVIATIONS

AFAD	Disaster and Emergency Management Presidency of Turkey
CBO	Community-based organization
ECD	Early childhood development
FIPL	Foreigners and International Protection Law
GAD	Generalized anxiety disorders
GOJ	Government of Jordan
GOL	Government of Lebanon
HIS	Health Information System
HRC	Higher Relief Council
IASC	Inter-Agency Standing Committee
IDP	Internally displaced persons
INGO	International NGO
IOM	International Organization for Migration
MH	Mental health
MHPSS	Mental health and psychosocial support
MOH	Ministry of Health
NGO	Non-governmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
PHC	Primary health care
RRP	UNHCR Regional Response Plan
SHARP	Syrian Humanitarian Assistance Response Plan
UN	United Nations
UNHCR	United Nations Humanitarian Commission of Refugees
UNICEF	United Nations International Children's Emergency Fund
WG	Working Group
WHO	World Health Organization

INTRODUCTION

The ongoing conflict in Syria, which started in March 2011, has resulted in continuous massive population displacement and growing humanitarian needs inside Syria and in surrounding countries, becoming the largest humanitarian and protection crisis globally. Heavy fighting continues between the Syrian army and various opposition forces through intense ground battles, air assaults and shelling. The United Nations (UN) estimates that 7.6 million people are displaced inside the country, and a total of 12.2 million are in need of humanitarian assistance inside Syria. There are over 3 million registered Syrian refugees largely in neighboring countries, including Lebanon, Jordan, Iraq and Turkey [1]. The humanitarian response continues to be challenging due to the protracted nature of the crisis and the high number of Syrians affected. The growing number of refugees is placing an increased burden on existing governmental and non-governmental service providers, and is outpacing their ability to respond. The role of national and international non-governmental organizations (NGOs and INGOs) is increasingly important in addressing the needs of the Syrian population. Yet, funding gaps remain. According to United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), only 55% of both humanitarian appeals linked to the Syria response were funded in 2014, with the Syria Humanitarian Assistance and Response Plan (SHARP) funded at 47%, and the Syria Regional Refugee Response Plan (RRP) funded at 59%, leaving significant unmet funding requirements across the region.

International Medical Corps has been providing mental health service programming since the beginning of the crisis in Syria as well as in surrounding countries. The aim of this article is to explore the mental health needs among the Syrian refugee and internally displaced populations (IDPs) in Syria, Lebanon, Turkey and Jordan within the context of mental health systems, services, and programming by government, national and international agencies. This article aims to inform ways forward by national actors and by the humanitarian and international community at large. Common analyses of mental health in conflict settings tend to narrowly focus on trauma and mental health service provision by specialists. This paper offers an alternative analysis that is consistent with a comprehensive public health approach to mental health.

MATERIALS AND METHODS

International Medical Corps uses a comprehensive approach to The data analyzed and information presented in this article has been obtained from a multi-method assessment. A thorough desktop review was conducted between February and March 2014 of publicly available as well as International Medical Corps reports and documentation. Qualitative data on stressors and mental health problems, MHPSS coordination, and international agencies and NGOs' involvement in providing MHPSS services, were sourced from discussions and responses to questions to one to two key International Medical Corps technical and program staff who were engaged in MHPSS service provision and capacity building in each of the four countries (Lebanon, Syria, Jordan and Turkey) and who agreed and expressed interests in participating in the discussions. These discussions were held jointly with one author (Z.H.) with support from graduate student assistants. Qualitative data was summarized and anonymized before theme coding by one author (Z.H.). Final theme coding and organization was undertaken by another author (I.W.). Data on mental disorders was collected from International Medical Corps-supported Government and local NGO primary health care facilities and community based social centers. None of the authors or graduate assistants involved in the data collection and analyses received any identifying patient information. International Medical Corps did not seek IRB approval because all qualitative and quantitative data collected were part of routine program monitoring and evaluation and/or health service provision.

Diagnostic data was categorized according to the UNHCR Health Information System Categories for Mental Illness [2] with additional sub-coding. Interviews with country teams, and collection of data from MHPSS delivery points took place from March 2014 to October 2014. Quantitative data was entered and analyzed using Microsoft Excel software. Qualitative data was theme coded and grouped for analysis.

RESULTS

Stressors Faced by the Syrian Population

The most frequently cited stressors faced by Syrians according to four country interviews can be classified into three major categories. First, security and protection risks and concerns are present inside Syria but also result from infiltration of armed groups into host countries (Lebanon), difficulties obtaining legal status and protection in host countries and child protection concerns such as child labor and unaccompanied minors or orphans in all countries. Secondly, access and availability of basic services and resources (e.g. education, employment, health) is a challenge in Syria due to damaged systems and infrastructure, lack of medical staff and medication supplies and disrupted services especially in insecure areas. Access to services in host countries is often limited to refugees with legal status and to those living in hubs of service provision (e.g. camps) while existing services are often overstretched. Those with chronic conditions and mental health problems who require continued care and follow up are especially vulnerable. Inability to find work and dependency on family savings places additional pressure on refugees. Third family, community, and sectarian tensions exist inside Syria but also between refugees and host communities. Across all host countries, Syrian refugees are often perceived to be exploiting their refugee status, diverting resources from local people, and disrupting national laws, resulting in tensions, discrimination and violence.

Mental Health Problems among the Syrian Population

International Medical Corps' mental health services are provided through a multidisciplinary team of trained primary health care (PHC) staff (general practitioners and nurses trained in WHO mhGAP Intervention Guidelines), social workers, mental health nurses, psychologists, psychiatrists and community outreach workers. Syrians receiving International Medical Corps' mental health services have varying and complex needs and are managed through a stepped care model, starting with lower level management through social workers and community health workers, and receiving referrals to specialized services as needed. The services include a combination of assessment, care planning and coordination, evaluation, and advocacy for services, to meet the comprehensive needs of individual Syrians and families.

Types and Frequency of Mental Health Problems

Data was collected on the most common mental health diagnoses from outpatient records by International Medical Corps trained PHC and case management staff in supported clinics (see Table 1). Severe emotional disorders (54%), including depression and anxiety, are the most common, cumulative of the four countries (see Graph 1). Rates of epilepsy (17%) and psychotic disorders (11%) were high across the region. Among all countries, epilepsy (26.6%), intellectual and developmental disorders (26.6%), and severe emotional disorders (3.6%) are the most common among children receiving mental health services in Lebanon, Turkey and Syria*. The high rates of epilepsy can likely be attributed to local doctors in hospitals and PHC units having limited capacity to diagnose, manage and follow up on cases of epilepsy, and accordingly making almost immediate referrals to more specialized services often provided by INGOs such as International Medical Corps. It is also of note that previous research has suggested that rates of service use for severe mental and neurological disorders may be higher than service use for other MNS problems in humanitarian settings and that refugee populations, in particular, may be at an increased risk for psychotic disorders, epilepsy and other neuropsychiatric conditions [3,4]. Multi-country studies of MNS problems in humanitarian settings [3,4] have found that epilepsy and psychotic disorders were the most frequently diagnosed problems by health care providers trained in mental health in the PHC setting. This contrasts from the finding of this assessment, where emotional disorders are the most frequent.

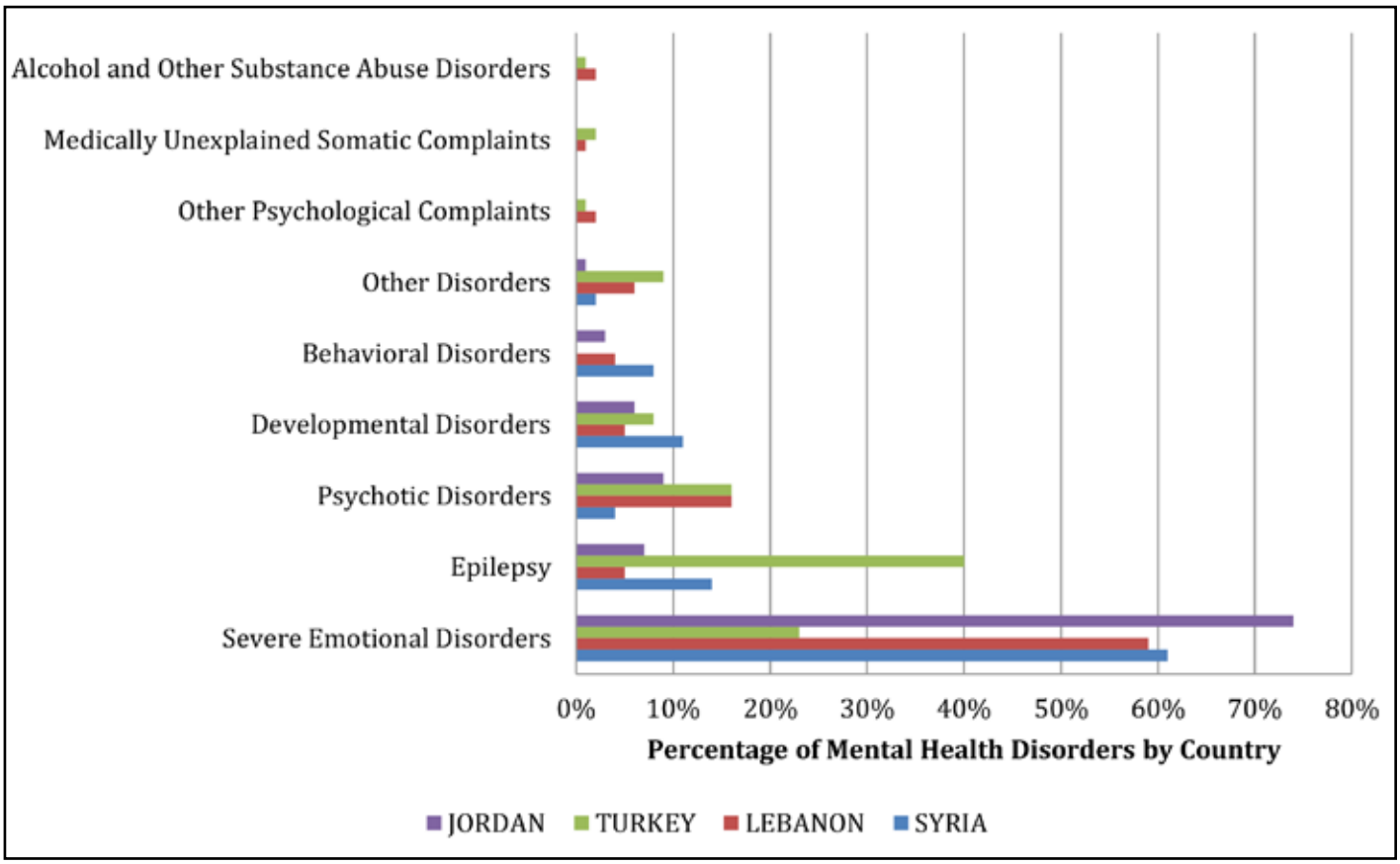
There is variability in rates of mental health disorders across the region, which can likely be explained by different proportions of adults and children accessing services. For instance, the rate of epilepsy in Syria and Turkey where more children are receiving services is reportedly higher than that in Lebanon and Jordan.

Table 1. Descriptive Statistics: 6357 Mental Health cases managed by International Medical Corps in Various Regions of the Syria Response

Gender (n)	**Syria**	**Lebanon**	**Turkey**	**Jordan**	**Total**
Male	73	1950	368	1011	3402
Female	110	1661	277	907	2955
Age Groups (n)*					
Children, under 18 years[1]	75	549	199	353	1176
Adults, above 18 years	108	3062	446	1565	5181
UNHCR Categories of Mental Illness (%)					
Severe Emotional Disorders	61%	59%	23%	74%	
Psychotic Disorders	4%	16%	16%	9%	
Epilepsy	14%	5%	40%	7%	
Developmental Disorders	11%	5%	8%	6%	
Other Disorders	2%	6%	9%	1%	
Behavioral Disorders	8%	4%		3%	
Alcohol & Other Substance Abuse Disorders		2%	1%		
Other Psychological Complaints		2%	1%		
Medically Unexplained Somatic Complaints		1%	2%		
Total (n)	183	3611	645	1918	

** Age breakdown by disorder was not available in the Jordan data submitted as part of this report*
In Syria, Lebanon and Turkey, cases were tracked from September 2013 through March 2014. Only Jordan cases were captured in a shorter time frame, from April 2014 through June 2014.
[1]"Under 18" for children does not apply to all countries, except Lebanon where children were considered all aged "under 16"

Figure 1. Diagnosed Mental Health Disorders through International Medical Corps MHPSS Case Management Teams in Syria, Lebanon, Turkey and Jordan.



Types and Frequency of Mental Health Problems

Across all countries, slightly more men are seeking services than women (54%, 57% and 52% men for Lebanon, Turkey and Jordan respectively), except for Syria where more women (60.1%) seek mental health services than men. No notable gender differences in frequencies of mental health disorders were observed.

The percentage of children receiving mental health services is higher in Syria (69%) and Turkey (45%) than in Lebanon (18%) and Jordan (23%). According to field interviews, this could be a result of fewer opportunities in Turkey and Syria for children and youth for social outlets and activities (e.g. safe spaces and life skills). Such opportunities are limited due to government restrictions in number of NGOs allowed to work in specific areas and more specific to Turkey, the language barrier preventing children from participating in locally existing activities.

MHPSS COORDINATION PLATFORMS IN THE REGION

Global Inter Agency Standing Committee (IASC) guidelines (2007) [5] recommend MHPSS coordination groups that work across and report to different clusters, most frequently health and protection. Responsibilities of a typical MHPSS coordination group can include mapping of MHPSS activities and services, coordination of efforts, information sharing, providing a forum for technical support and discussion, advocating to donors and others for MHPSS services, as well as sharing resources and tools. MHPSS coordination varies greatly depending on the current environment of the countries hosting displaced Syrians. Syria and Jordan have active MHPSS formal working groups while all working groups are engaged in mapping of MHPSS activities (see Table 2).

Table 2. MHPSS working groups in countries affected by the Syrian crisis

	Active Working Group	Members	Participation and Effectiveness
Syria	✓*	-Co-chairs: International Medical Corps and UNHCR -10 participating organizations	- Few agencies are attending with limited participation by local NGOs, especially those working outside of Damascus, due to security reasons and limited capacity for MHPSS services.
Lebanon	X	MHPSS task force** recently launched under MOH, Cochairs: WHO and UNICEF, with technical and financial support from International Medical Corps. - 18 participating organizations	- Active participation from both local and international organizations - Coordination groups have ceased to operate in some regions - Mapping activities restricted to limited and brief mappings; no formal or comprehensive service mapping activities in place
Southern Turkey	X	No 'active' working group in place, informal coordination meetings in Kilis currently include 3 INGOS and 1 local Turkish NGO	- Formal coordination has been limited by governmental controls on INGOs and NGOs - Limitations result in limited and brief mapping activities; no formal or comprehensive service mapping activities in place -MHPSS updates are sometimes included under other WGs, including under the protection WG lead by UNHCR
Jordan	✓	Co-chairs: International Medical Corps, WHO - 45 participating organizations	- Current decline in participants from national organization - While comprehensive and regular 4WS mapping have been lead by the WG (International Medical Corps and WHO), the mapping has yet to provide a means for analyzing gaps related to the geographic concentration of activities as compared to the geographic concentration of vulnerable populations. - Harmful and non evidence based practices continue to take place in Jordan with the high number of NGOs assuming their expertise in the MHPSS field with little to no coordination and linkages with the MHPSS WG. An example of harmful practice includes 2-day specialized trauma training with no follow up

[a] Defined as a group that meets regularly

* Technical Reference Group is not officially a coordination platform, but includes coordination and mapping as one of its core functions. Ongoing discussions exist around creating a formal MHPSS working group linked to health and protection working groups.

** The Task Force under the MOH National mental health Program is not a coordination platform, but will work towards establishing MHPSS coordination efforts as part of its action plan for 2014/2015.

MHPSS ACTIVITIES AND SERVICE PROVISION

With limited or no MHPSS capacity in existing services within countries affected by the Syrian crisis, the burden of care falls mainly on international agencies and NGOs to build and provide comprehensive services. IASC 2007 Guidelines for MHPSS in Emergency Settings [5] categorize services within four distinct layers covering social considerations in the provision of basic services and security, community and family supports, focused non-specialized supports and specialized services (e.g. psychological and psychiatric support). Based on interviews with country teams, revisions of formal and informal mappings of who is doing what where and when (4Ws), and activity reports, International Medical Corps mapped MHPSS activities per country using the IASC MHPSS 4Ws mapping tool [6]. The majority of activities fall into case focused MHPSS activities, while social considerations in basic services and security and strengthening community and family supports are limited, especially in Syria (see Table 3). Self-care activities and programs to help MHPSS staff deal with their own potential psychological distress are also limited. Efforts undertaken by WHO, International Medical Corps and others include strengthening the capacity of health professionals for recognition and management of priority mental disorders and training emergency responders in psychological first aid, utilizing a training of trainers approach, whereby national trainers are established. Other agencies are also developing capacity of mental health professionals in Syria through the training of psychologists on evidence-based psychological interventions organized and led by WHO, and a Masters program in MHPSS for Syrian professionals and non professionals, organized and taught by IOM. With access to services being a barrier across the region, but more particularly in Syria, UNHCR and International Medical Corps are carrying out psychosocial support training for childcare workers from national NGOs working with children and their families in shelters outside of Damascus.

Table 3. Provision of MHPSS Services by international agencies and NGOs

MHPSS activities & sub-activities			Available Services (✓=yes/ X =no)			
	Activity/ intervention	sub-activities (examples or details of activities)	Syria	Lebanon	Turkey	Jordan
Community-Focused	Information dissemination to the community at large	Information on the current situation, relief efforts or available services	✓	✓	✓	✓
		Messages on positive coping	✓ limited*	✓	✓	✓
	Facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general	Support for emergency relief that is initiated by the community	✓	X	X	X
		Support for communal spaces/meetings to discuss, problem-solve and organize community members to respond to the emergency	X	X	X	✓
	Strengthening of community and family support	Support for social support activities that are initiated by the community	X	X	✓	✓
		Strengthening of parenting/ family supports	X	✓	✓	✓
		Facilitation of community supports to vulnerable persons	X	✓	✓	✓
		Structured social activities (e.g. group activities)	X	X	✓ limited*	X
		Structured recreational or creative activities	✓	✓	✓	✓
		Early childhood development (ECD) activities	✓	✓	X	✓
		Facilitation of conditions for indigenous traditional, spiritual or religious supports, including communal healing practices	X	X	✓	✓
	Safe spaces	Child friendly spaces	✓ limited*	✓	✓	✓
		Youth friendly spaces	X	X	✓	✓
	Psychological support in education	Psychosocial support to teachers/ other personnel at schools/ learning places	X	X	✓	✓
		Psychosocial support to classes/ groups of children at schools/ learning places	X	X	✓	✓
	Supporting the inclusion of social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation	Orientation of or advocacy with aid workers/ agencies on including social/ psychosocial considerations in programming	✓	X	X	✓

* "limited" is included to clarify that while service is available to Syrians, it's availability is limited to a very small number of Syrians or a specific location, and is still largely unavailable to displaced Syrians in general.

MHPSS activities & sub-activities			Available Services (✓=yes/ X =no)			
Activity/ intervention		**sub-activities (examples or details of activities)**	**Syria**	**Lebanon**	**Turkey**	**Jordan**
Case-Focused	Case-Focused (Case-focused) psychosocial work	Psychological first aid (PFA)	✓	✓	✓	✓
		Training of Trainers	✓	✓	✓	X
		Linking vulnerable individuals/ families to resources (e.g. health services, livelihoods assistance, community resources, etc) and follow up to see if support is provided	✓	✓	✓	✓
	Psychological intervention	Basic counseling for individuals	✓	X	✓	✓
		Basic counseling for groups or families	✓	X	✓	✓
		Interventions for alcohol/ substance use problems	✓ limited*	✓	✓	✓
		Psychotherapy	✓ limited*	✓[2]	✓ limited*	✓
	Clinical management of mental disorders by non-specialized health care providers (e.g. PHC, post-surgery wards)	Non-pharmacological management of mental disorder by non specialized health care providers	✓	✓	✓	✓
		Pharmacological management of mental disorder by non specialized health care providers	✓	✓	✓	✓
		Action by community workers to identify and refer people with mental disorders and to follow up on them to ensure adherence to clinical treatment	X	X	✓	X
	Clinical management of mental disorders by specialized mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/ general health facilities/ mental health facilities)	Non-pharmacological management of mental disorder by specialized mental health care providers	X	✓	✓	✓
		Pharmacological management of mental disorder by specialized health care	✓	✓	✓	✓
		In-patient mental health care	X	✓	✓	✓
General	General activities to support MHPSS	Situation analyses/ assessment	✓	✓	✓	✓
		Training of Trainers	✓	✓	✓	✓
		Technical or clinical supervision	✓ limited*	✓	✓	✓
		Psychosocial support for staff/ volunteers (including self care)	✓ limited*	X	✓	X
		Research	X	X	X	

[2]In Lebanon, Psychotherapists are exercising long-term therapeutic interventions.

NATIONAL SYSTEM AND EXISTING MENTAL HEALTH INFRASTRUCTURE

Data on mental health systems has been extracted from the 2011 WHO Mental Health Atlas [7] and supplemented with updated information from International Medical Corps country teams (see Table 4). The relatively weak national mental health systems in Syria, Turkey, Jordan and Lebanon, have resulted in governments and organizations quickly becoming overburdened, as the Syria crisis continues. At the same time funding for the response is decreasing annually [8].

However, the influx of displaced Syrians has also been met with an influx of humanitarian agencies and additional funds into Syria and host countries. This in turn has led to national system strengthening and emergency preparedness efforts by different agencies in coordination and in partnership with local ministries and WHO.

*Table 4. Overview of Country resources available for Mental Health**

		Syria	Lebanon	Turkey	Jordan
POLICY AND LEGISLATION		✓	✓	✓	✓
		Dedicated mental health legislation exists (outdated) National Mental Health Strategy in draft form	Dedicated mental health legislation exists (outdated) Approved mental health policy does not exist, however, a mental health strategy was recently adopted by the national mental health program of the MOH	Dedicated mental health legislation does not exist. An officially approved mental health policy exists and was approved or most recently revised in 2006	Dedicated mental health legislation does not exist. National 10-year Policy was launched in 2011 through wide consultative process. A 2-year Action Plan on Mental Health was also developed in January 2011
FINANCING		✓	✓	X	X
		Mental health expenditures by government health department/ ministry are 2.0% of total health budget. Mental hospital expenditures are 93.59% of total mental health budget.	Mental health expenditures by the government health department/ministry are 4.8% of the total health budget. Mental hospital expenditures are 54.17% of the total mental health budget.	Mental health expenditures by the government health department/ministry are not available. Mental health and mental hospital expenditures by the government health department/ministry are not available.	
MENTAL HEALTH CARE DELIVERY	**Mental Health in Primary Care**	✓	✓	✓	✓
		Prescription regulations authorize PHC doctors, but not nurses, to prescribe and/or to continue prescription of psychotherapeutic medicines. The majority of PHC doctors and nurses have not received official in-service training on mental health within the last five years.			
	Referrals between levels of care	X	X	X	X
		Procedures for referring persons from primary care to secondary/tertiary care do not exist. Referral procedures from tertiary/secondary to primary care also do not exist.			
	Community based Mental Health Services	X	✓	X	X
		People with mental disorders are primarily treated at mental hospitals	People with mental disorders are primarily treated at mental health outpatient facilities	Information largely unavailable	
HUMAN RESOURCES	**Work-force and training**	✓	✓	✓	✓
		Approx 1 psychiatrist, 1 medical doctor, 3.5 nurses, 0.3 psychologists, 0.3 social workers, and 0 occupational therapists per 300,000	Approx 4 psychiatrists, 0.75 medical doctor, 5 nurses, 6 psychologists, 1.5 social workers, and 3.5 occupational therapists per 300,000	Approx 3 psychiatrists, 0.1 medical doctor, 12 nurses, 0.6 psychologists, 0.75 social workers, and 0.1 occupational therapists per 300,000	Approx 3 psychiatrists, 0.1 medical doctor, 12 nurses, 0.5 psychologists, 0.75 social workers, and 0.1 occupational therapists per 300,000
		MHPSS Systems are fragmented and not set up for provision of comprehensive MHPSS, whereby psychiatric services are offered through the MOH, and social services through the Ministry of Social Affairs.			
	Informal human resources (Family and User Associations)	X	✓	X	X
		Information unavailable	Rare or Absent Participation in the formulation/implementation of policy/plan/legislation	None present in country	None present in country
HUMAN RESOURCES		✓	✓	✓	X
		Basic medications are provided from the WHO essential drug list	Very few medications are provided from the MOH essential drug list	Very few medications are provided from the MOH essential drug list	Information unavailable
INFORMATION SYSTEMS		✓	X	✓	✓
		Syria & Turkey: Data available on: - Persons with mental disorders treated in primary health care, - Persons treated in mental health outpatient facilities, -Admissions and length of stay in mental hospitals - No data on Interventions (psychopharmacological and psychosocial) delivered in primary health care for people with mental disorders. **Lebanon & Jordan:** Little to No data collected through the Health Information System		

*** Key: ✓ Indicates presence X Indicates absence**

CONCLUSIONS AND RECOMMENDATIONS

Many displaced Syrians both inside or outside Syria continue to face ongoing displacement in under-resourced urban areas and camp or shelter facilities with 1) limited access to needed services including basic health, education, food, shelter, MHPSS and other services which are often concentrated in service hubs, 2) Overstretched capacity of local governmental and non-governmental services to respond, 3) Shortage of mental health services and professionals in both governmental and non-governmental health and community-based systems.

Gaps are due to a lack of funding, human resources, situational instability, and resistance from governmental structures. The gaps in MHPSS services and activities continue to be significant but vary by the types of services and the countries involved in the response. Based on information gathered and analyzed from this assessment, the following overarching and country specific recommendations aim to improve the overall quality, availability and accessibility of MHPSS services provided for the Syria response.

CHALLENGES AND RECOMMENDATIONS

Limited geographical reach of services for refugees including mental health. In Jordan, basic services, including mental health, are more accessible in camps than in urban settings due to distance and expense of travel to service locations in Jordan. In Syria it is difficult to reach vulnerable communities outside of Damascus in conflict affected areas, due to ongoing security concerns and restrictions in setting up services

➔ Expand availability of basic services to locations where services are limited or unavailable (e.g. in Jordan), and facilitate access to existing services through outreach support.

➔ Build capacity of local NGOs outside of Damascus in Syria through training of trainers in PFA, trainings in setting up child and youth friendly spaces, and peer-to-peer support.

Limited ability for Syrians to access services of Turkish organizations and the public system (health, MHPSS and social services) due to language barrier

➔ Advocate for changes in law and government policy to allow Syrian (or Arabic speaking) doctors permission to work with Syrian refugees through national health facilities.

➔ Train and hire more Turkish-Arabic translators to be located at Turkish public hospitals and other service delivery points.

Insufficient availability of trained non-specialized mental health care providers to provide community based integrated care. Integration of mental health into general health and training of general health care providers in mental health is already underway in all countries by WHO, International Medical Corps and other agencies, but needs remain for expanding reach in urban settings and for ongoing support and supervision

➔ Dedicate percentage of national health budgets, which are currently either unavailable (Jordan, Turkey) or limited to specialized mental health services (2% in Syria, 4.8% in Lebanon) for community mental health services provided as part of general health care.

➔ Other countries should follow Jordan's' example and include priority mental conditions (using WHO mhGAP-IG) [9] in the national basic health delivery package.

➔ Further scale up the availability of mental health services by trained staff by systematically strengthening the capacity of non-specialized health personnel for providing evidence based and quality services for priority mental disorders (identified in the WHO mhGAP Intervention Guide) supported and supervised by specialized mental health professionals (e.g. psychiatrists) through expanding on existing efforts for training of trainers and ensuring follow up and supervision as well as use of innovative approaches (e.g. e-learning).

➔ Develop innovative approaches that can reach large segments of affected populations such as e-mental health and self-help interventions.

Insufficient availability of trained specialized mental health care providers to provide community based integrated and quality care. In Syria there is a lack of qualified clinical psychologists due to absence of academic psychology programs and licensure and inadequate institutional oversight contributing to unreliable quality of available services. In Lebanon, mental health specialists available but exercising long term rather than short term therapeutic interventions which are better suited in the Syrian context (e.g. scale of people needing services, short treatment periods due to end of project funding periods or refugees relocating).

➔ Training and supervision of unlicensed psychologists, and counselors in Syria to deliver evidence based band brief psychological interventions.

➔ Advocate for inclusion of psychologists into the national list of health providers in Syria to establish a clear role and set qualifications for psychologists to practice.

➔ Develop capacity of national host country psychologists in evidence based brief interventions such as solution-focused therapy, CBT or IPT.

Limited existing capacities to address developmental disorders among children. Developmental disorders among the most common in children, yet needed services or supports often do not exist. Developmental disorders have been adapted as part of mental health priority conditions only in Jordan (national level) and Turkey (by International Medical Corps).

➔ Develop capacity of non-specialists and specialists in providing community-based holistic services and supports for children with developmental disorders, and their families.

Current mental health service provision relies heavily on international INGOs and humanitarian funding. Yet, funding for the Syrian response does not meet increasing needs (e.g. 55% of SHARP and RRP was funded in 2014 [10]) and will likely be further reduced over the coming years. In Turkey, health and mental health services are provided through INGO run clinics and INGO paid and trained Syrian doctors

supervised by Turkish doctors, but such services would cease with discontinuation of funding.

➔ Strengthen national mental health policies and systems (in Syria and host countries) and invest in Syrian human resources to respond to mental health needs

➔ Support organizations working in line with government efforts rather than setting up parallel systems that are unsustainable.

➔ Engage Syrians in promoting well-being through paraprofessional training and peer leadership models that empower Syrian communities to develop strengths and help themselves, increase availability of family based and community support and promote sustainability (e.g. child and youth safe spaces and activities, ECD, parenting skills, and peer-to-peer support).

➔ Advocate for Syrian doctors to receive temporary license to provide services through existing national health facilities.

➔ Train Turkish doctors working in high refugee concentration areas in mental health (using WHO mhGAP-IG and relevant national guidelines), to ensure sustained capacity for managing mental health problems.

Limited psychosocial support and self-care for national, Syrian and expatriate staff and volunteers who are likely to be exposed to work related stress.

➔ Provide staff and volunteers working as part of the Syrian response with staff care support activities and services including access to information or self help programs.

LIMITATIONS

This paper utilized information gathered from secondary sources as well as International Medical Corps field teams but did not use key informant interviews or focus group discussions conducted directly among the Syrian community and with other relevant stakeholders. This limited the depth of country field teams' responses and amount of information that they provided as well as the perspective of the information gathered.

CONCLUSIONS

The mental health needs of displaced Syrians are significant and continue to expand given the protracted nature of the crisis. Governmental Capacities of governments, national and international organizations, within Syria and in surrounding countries are limited and cannot absorb all of the needs and gaps including limited reach of services, lack of mental health professionals, and limited community and family supports. Accordingly, agencies should Syrian crisis as an opportunity to strengthen national mental health systems and build local human resource capacity among Syrian and host country professionals and communities.

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APPENDIXES

Annex 1: International Medical Corps MHPSS Syria Report Interview Guide

Questions and Data/Reports Needed from Country Offices (Jordan, Lebanon, Turkey, Syria)

- ➔ Please answer each question from your perspective within the context of Syrians in your country
- ➔ For each question please include the source if applicable- e.g. specific persons, data etc.
- ➔ Please include supporting documentation and original data where possible
- ➔ If specific questions are already answered by supporting documentation you are sending along, no need to answer them here

2.1.) Problems and difficulties

Questions:

- What are the current main stressors (e.g. problems, difficulties, challenges) faced by the Syrian population?
- How have stressors changed for refugees from when they were inside Syria to once they have left?
- How has this affected the life and daily activities of Syrians?

Please send supporting documents (if applicable):

- MHPSS assessments conducted by International Medical Corps or other agencies, which include questions about current problems, stressors or difficulties
- Country reports or publications about current stressors

2.2.) MHPSS related problems

Questions:

- What are the main mental health and psychosocial problems among Syrians? (what specific problems are prevalent among men, women, youth and children?)

Please send Supporting documents and data (if applicable):

- Data on the type (diagnosis) and number of Syrian refugees who have received International Medical Corps mental health services (broken down by gender and age if possible (e.g. under 18, 18 to 64, 65+)
- MHPSS assessments conducted by International Medical Corps or other agencies, which include questions data on prevalence of mental health problems among population or data on frequency and types of MHPSS problems of people receiving services

2.3.) Current MHPSS services and response activities

Questions:

- Government: What existing structures are available to provide mental health services? Are they accessible/free of charge to Syrians?
- International agencies and NGOs: What MHPSS services and activities are available to meet the needs of the Syrian population?
- Is there an MHPSS coordination group? (if so, who is leading it, who is attending, how is it functioning?)
- Are there any organizations or groups engaging in problematic or harmful MHPSS activities and services?
- What are the main gaps in MHPSS services and activities?

Please send supporting documents and data (if applicable):

- MHPSS 4Ws mapping reports and tables

2.4.) Coping and Help Seeking

Questions:

- What do Syrians do as individuals, families and communities to cope with the MHPSS problems associated with the crisis? Are these coping strategies helpful in dealing with the problem(s)?
- What are current ways of help seeking for mental health problems among Syrians (e.g. where do they go? Do they access health facilities? Other services? Informal community supports?)

Please send supporting documents (if applicable):

- MHPSS assessments conducted by International Medical Corps or other agencies, which include questions about coping and help seeking
- Publications or reports that talk about ways of coping and help seeking among Syrians

2.5.) Recommendations

- What more would you recommend should be done to address mental health and psychosocial needs of the Syrian population (e.g. services, supports, supporting ways of coping)?

Additional information
Question:

- Is there any other aspect of the MHPSS needs that you feel is important but has not been covered by the above? If so, please add?

Annex 2: Detailed Categories Of Mental Health Disorders

GENERAL
UNHCR HIS Categories for Mental Illness [With International Medical Corps Specific Sub-Coding]
UNHCR categories and International Medical Corps specific sub-coding is the minimum HMIS information that should be collected as part of any International Medical Corps mental health programs. Please note that sub-coded categories have been chosen based on mhGAP list of mental health priority conditions (mhGAP-IP plus mhGAP draft guide for disorders specific to stress. The exception to this are panic disorder and generalized anxiety disorder as well as post-partum depression).

DEFINITION OF MENTAL HEALTH CATEGORIES
These definitions are based on IASC MHPSS Guidelines action sheet 6.23 and were developed with the support of staff of the following agencies: WHO, International Medical Corps, MSF-H, WHO Collaborating Centre Verona, HealthNet TPO, and UNHCR. All seven categories are "probable" and have been developed for use in a primary health care setting. Consultation by a specialist would be needed to make a confirmed diagnosis.

1. Epilepsy/seizures
Case Definition
A person with epilepsy has at least two episodes of seizures not provoked by any apparent cause such as fever, infection, injury or alcohol withdrawal. These episodes are characterized by loss of consciousness with shaking of the limbs and sometimes associated with physical injuries, bowel/bladder incontinence and tongue biting.

2. Alcohol or other substance use disorder
Case Definition
A person with this disorder seeks to consume alcohol (or other addictive substances) on a daily basis and has difficulties controlling consumption. Personal relationships, work performance and physical health often deteriorate. The person continues consuming alcohol (or other addictive substances) despite these problems.
Exclusion criteria: The category should not be applied to people who are heavy alcohol (or other substance) users if they can control their consumption.

3. Intellectual disability
Case Definition
The person has very low intelligence causing problems in daily living. As a child, this person is slow in learning to speak. As an adult, the person can work if tasks are simple. Rarely will this person be able to live independently or look after oneself and/or children without support from others. When severe, the person may have difficulties speaking and understanding others and may require constant assistance.

4. Psychotic disorder
Case Definition
The person may hear or see things that are not there or strongly believe things that are not true. They may talk to themselves, their speech may be confused, or incoherent and their appearance unusual. They may neglect themselves. Alternatively they may go through periods of being extremely happy, irritable, energetic, talkative, and reckless. The person's behaviour is considered "crazy"/highly bizarre by other people from the same culture.
3 See http://www.who.int/mental_health/emergencies/en/

5. Severe emotional disorder (please specify: depressive or anxiety features)
Case Definition
This person's daily normal functioning is markedly impaired for more than two weeks due to (a) overwhelming sadness/apathy and/or (b) exaggerated, uncontrollable anxiety/fear. Personal relationships, appetite, sleep and concentration are often affected. The person may be unable to initiate or maintain conversation. The person may complain of severe fatigue and be socially withdrawn, often staying in bed for much of the day. Suicidal thinking is common.
Inclusion criteria: This category should only be applied if there is marked impairment in daily

functioning.

Additional International Medical Corps sub-Coding:
5.1. Depression
5.1.2. Post Partum Depression
5.2. Bipolar Disorder
5.3. Post Traumatic Stress Disorder
5.4. Panic Disorder
5.5. Generalized Anxiety Disorder
5.6. Other severe emotional disorders (all cases that do not fit into sub-categories 5.1. to 5.5.)

6. Medically unexplained somatic complaint
Case Definition
The category covers any somatic/physical complaint that does not have an apparent organic cause
Inclusion criteria: This category should only be applied (a) after conducting necessary physical examinations.(b) if the person is not positive for any of the above six categories and (c) if the person is requesting help for the complaint

7. Other psychological complaint
Case Definition
This category covers complaints related to emotions (e.g., depressed mood, anxiety), thoughts (e.g., ruminating, poor concentration) or behavior (e.g., inactivity, aggression). The person tends to be able to function in all or almost all day-to-day, normal activities. The complaint may be a symptom of a less severe emotional disorder or may represent normal
distress (i.e., no disorder).
Inclusion criteria: This category should only be applied if (a) if the person is requesting help
for the complaint and (b) if the person is not positive for any of the above five categories.
Additional International Medical Corps sub-Coding:
7.1. Bereavement
7.2. Acute Stress Symptoms
7.3. Dissociation
7.4. Enuresis (Bedwetting)
7.5. Insomnia
7.6. Hyperventilation
5.6. Other severe emotional disorders (all cases that do not fit into sub-categories 5.1. to 5.5.)

8. Additional International Medical Corps Categories
8.1. Dementia
8.2. Behavioral Disorders: ADHD
8.3. Behavioral Disorders: Conduct Problems
8.4. Self Harm/Suicide

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