

AN INVISIBLE CRISIS: EXPLORING MENTAL HEALTH NEEDS IN THE SYRIAN AND IRAQI CRISES

Médecins du Monde response and
challenges ahead



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Cover photo by: Olivier Papegnies

Introduction



The Syria/Iraq crises have severely impacted mental health and wellbeing

Mental health and neurological disorders are a considerable global health issue, said to impact one in four persons throughout the world.¹ With an estimated 450 million persons currently affected by mental disorders, **the World Health Organisation (WHO) has declared mental disorders as one of the leading causes of ill-health and disability worldwide.**² According to WHO, mental health is defined as a state of wellbeing in which every individual reaches his or her potential, can cope with the normal stressors of life, can work

productively and fruitfully, and is able to make a contribution to her or his community.³ The term psychosocial is a composite term referring to the psychological and social aspects of an individual's experience.

Armed conflict and natural disasters pose significant challenges to the long-term mental health and psychosocial wellbeing of affected populations. The Middle East has long been plagued by war and conflict, resulting in mass loss of life, displacement, and

1 http://www.who.int/whr/2001/media_centre/press_release/en/

2 As above.

3 http://www.who.int/features/factfiles/mental_health/en/



cross-generational changes to traditional familial and societal structures. The results can be devastating to the emotional wellbeing of affected populations throughout the region with notable increases in the prevalence of common mental disorders (CMDs) such as anxiety and depression. According to the 2018 Syria Arab Republic Humanitarian Response Plan, **one in five Syrians are at risk of developing moderate mental health issues, and one in 30 is at risk of developing severe or acute mental health problems.** Health services remain highly fragmented with no clear referral pathways for those who need specialized medical care.⁴

According to the World Health Report on Mental Health (2001), it is estimated that in situations of armed conflict, 10% of persons who experience traumatic events will go on to develop serious mental health problems, and another 10% will experience a reduction in functioning in their daily life due to psychological and psychosocial determinants.⁵ Mental Health and Psychosocial Support (MHPSS) programs aim to both prevent and treat mental disorders, whilst promoting the psychosocial wellbeing of individuals, families and communities.⁶

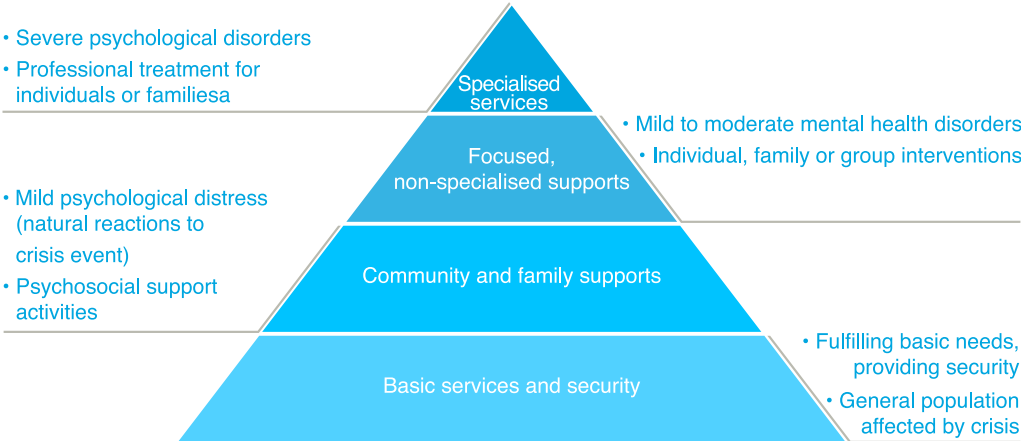
4 <https://reliefweb.int/report/syrian-arab-republic/2018-syrian-arab-republic-humanitarian-response-plan-january-december> Page 60

5 <http://apps.who.int/iris/handle/10665/42390>

6 http://www.who.int/mental_health/emergencies/9781424334445/en/



MHPSS activities, if not properly designed and implemented, can carry an inherent risk of harm to vulnerable populations. To mitigate this risk, the Inter-Agency Standing Committee (IASC) (2007) developed the Guidelines on Mental Health and Psychosocial Support in Emergency Settings with the aim of regulating the industry and improving overall quality of programming. The guidelines document core recommendations around minimum standards of MHPSS activities including recruitment processes, monitoring and evaluation of activities, and coordination mechanisms. The guidelines emphasise a multi-layered approach to MHPSS programming with an emphasis on strengthening familial and social supports for the wider community, whilst offering more focused and specialised intervention for those in need. The guidelines remain the core guidance document relating to MHPSS activities.



1. MdM is an essential MHPSS actor in the Syria / Iraq Crises context



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MdM is currently implementing MHPSS activities within Iraq, Syria and Lebanon in this specific crisis context. MdM three-fold approach towards MHPSS is based on the following activities:

- Integration of MHPSS services within primary health care settings, with direct service provision as needed,
- Supporting governments with an emphasis on reforming and/or developing national mental health infrastructures,
- Collaborating on mental health field research to establish evidence-based practice.

Lebanon



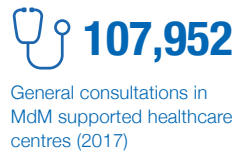
Since 2012, MdM in Lebanon has been actively engaged in providing access to MH-PSS services and reducing the impact of the Syrian crisis, on the physical and mental health of the Syrian refugees and vulnerable Lebanese host community. MdM intervention in Lebanon aims at strengthening the national primary healthcare system and at increasing access to quality primary mental healthcare.

MdM works in the Bekaa valley: in Zahle, Kamed El Loz, El Ain, El Qaa, Qab Elias. MdM also works in Beirut (Rafik Hariri University Hospital) and in Aley.

MdMs mental health activities cover two main components:

- **Strengthening the national mental health care program**

MdM supports the National Mental Health Program (NMHP) to consolidate a legal and strategic framework ensuring access to quality mental health services for all, utilising a rights-based approach.





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MdM works in line with the Ministry of Public Health (MoPH) strategy and supports the NMHP with:

- The strengthening of the MHPSS task force, a coordination body, which comprises around 60 organizations.
- Technical contributions to design key standardized documents and tools for mental health and psychosocial support reporting and data collection.
- The development of a MH information system (MHIS) to be implemented at the national level.
- **Contributing to the development of community-based mental health care service provision**

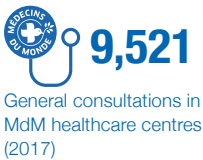
Since 2015, MdM has been contributing to the development of quality and accessible community-based mental health services through direct service provision and capacity-building of stakeholders.

MdM considers that MHPSS integration within primary care should be a priority with a focus on the promotion, prevention, and basic intervention for psychological and/or emotional distress.

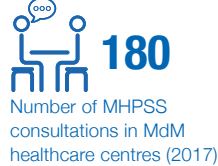
MdM's MHPSS intervention consists of awareness sessions, trainings, direct service provision within primary health clinics, and home visits to support persons with limited to no access to essential services.

MdM has also been a key actor in the development and implementation of Community Mental Health Centres (CMHC). In 2017, building on its previous experience in Zahle, MdM began working closely with the MoPH to open a CMHC within Rafik Hariri University Hospital, the largest public hospital in Lebanon. The CMHC offers psychological intervention, case management services and psychosocial support. It is hoped this model will continue to be developed and expanded at the national level.

Syria



(in Idlib governorate only)



In Syria, MdM aims to maintain, restore and develop access and direct provision of quality primary health care (PHC) services to the Syrian civilian population among both host communities and internally displaced persons (IDPs).

More specifically, MdM aims to ensure access to quality primary health care, in line with the

essential PHC package for Syria defined by the health cluster – with a focus on non-communicable diseases, mother and child care and mental health and psychosocial support – for over half a million vulnerable persons in north-west and northeast Syria.

To address specific vulnerabilities identified among the served communities, MdM activities are strongly focused on providing access to essential services to pregnant and lactating women, children under 5, individuals living with chronic diseases (including people with disabilities living with chronic diseases) and individuals in need of MHPSS support.

To respond to mental health needs, MdM has recruited a select team of primary healthcare physicians, mental health workers, psychosocial support staff and community health workers, providing support to vulnerable populations within Syria both in camp and urban settings. In response to the existent treatment gap in mental health services inside Syria, MdM works across multiple tiers and levels of intervention, and in turn, provides a more comprehensive and integrated package of mental health care responding to the needs of the population.



MdMs mental health activities cover four main components:

- **Psychological First Aid Training**

MdM, in coordination with other NGOs, has worked to equip NGO staff, national staff members within the healthcare system and key community leaders with Psychological First Aid (PFA) training. Training on PFA provides persons with key skills on how to communicate in a sensitive and supportive manner to persons affected by crisis.

- **Direct Service Provision**

MdM staff directly provide psychosocial support, counselling and basic management of common mental disorders. MdM implements a case management approach which means that case managers closely follow the progress of each beneficiary, conduct a holistic assessment of their needs, and link them to appropriate services such as essential healthcare, legal aid, family retracing, etc.

- **Strengthening capacities of the professional workforce within Syria in MHPSS**

MdM is also working to develop the capacity of specialist service providers in the manage-

ment of mental disorders. MdM offers mhGAP (WHO's mental health gap action programme) training to key primary healthcare physicians and allied health staff to support their ability to identify and refer persons with suspected mental disorders. In some cases, general practitioners are closely supervised by experienced psychiatrists, to support their development of skills relating to the basic management of common mental disorders.

- **Community-based programming**

MdM adopts a community-based approach which aims to put the community at the centre of program design and implementation. Through support of community health volunteers, MdM conducts regular outreach to vulnerable communities to identify their main concerns and to link them to necessary services and supports. The community health volunteers also support in disseminating information to the community at large, with the aim of strengthening familial and social supports, and supporting the beneficiary to be a core-contributor to their treatment plan.

Iraq



Since 1991, MdM has been implementing activities in Iraq and as a result, now enjoys a great level of acceptance among local authorities, key national and international actors and the population it serves.

In response to the latest crisis, MdM has been operational in Dohuk, Kirkuk and Ninewa Governorates, supporting internally displaced persons (IDPs), returnees and host communities to access primary health care services. To date, MdM delivers a comprehensive health response in areas of intervention, which includes the delivery of MHPSS at the primary care level.

MdM has two primary intervention aims in Iraq:

- **Direct Service Provision**

MdM is currently implementing MHPSS activities in Dohuk, Kirkuk and Ninewa governorates in both camp and urban settings. MHPSS staff operate within PHCs, where trained medical and allied health staff identify and refer persons who might benefit from mental health and/or psychosocial services. For persons who require individualised support, trained mental



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health workers provide counselling sessions to support vulnerable persons to develop proactive coping strategies, with the aim of fostering resilience at the individual, and familial levels. In addition, social workers conduct group sessions to reach the community at large on a range of relevant topics. These sessions aim to increase community understanding of important issues that can affect the mental health and psychosocial wellbeing of individuals and their families. Topics of group sessions range from raising awareness on common mental disorders such as depression and anxiety, to the provision of essential information on the potentially harmful effects of chronic stress. Group sessions utilise a strengths-based approach which encourages participants to brainstorm, with the guidance of the social worker on potentially helpful coping mechanisms. Furthermore, outreach awareness sessions are conducted at the community level to ensure community members within the service catchment area are provided with essential informa-

tion that supports their wellbeing and provides them with necessary information on where to access essential services.

• **Strengthening National Health Systems**

MdM aims at conducting high-quality trainings on evidence-based MH programs and techniques that build the capacity of healthcare staff to better understand, identify, and refer persons with mental disorders and/or psychosocial support needs. MdM is continuing to explore opportunities to strengthen the national system by working closely with relevant Ministries and Directorates with the aim to develop policies, support advocacy initiatives and develop a strategy for MHPSS system strengthening in the country.



2. MHPSS Research carried out by Médecins du Monde



MdM works in partnership with regional and international academic institutions to further expand mental health research taking place in the Middle East region. MdM believes MHPSS-focused research is an essential component to establish and strengthen the evidence-base around current interventions and programs. MdM engages in research that has real-world implications, meaning that the findings will translate to a foreseeable benefit to the communities served as results will lead to the development of strong quality, evidence-based programming. As such, MdM selectively works with academic institutions and partners who share the vision of sustainable, effective and evidence-based interventions for all.

MdM Lebanon is currently implementing three research projects, in collaboration with Queen Mary University of London:

- **BIOPATH Project** (*Biological Pathways of Risk and Resilience in Syrian Refugee Children*)

The primary objective of this multi-year research is to better understand and identify environmental and biological risk and protective factors for children and youth who have been impacted by war and displacement. The research findings will support the development of future MHPSS programs that support the development of resilience in children and youth affected by conflict.



- ***t-CETA Project***

The t-CETA pilot project aims to test the development, piloting and evaluation of a telephone-delivered psychological intervention (t-CETA) for Syrian refugee children in Lebanon. The common elements treatment approach (CETA) is a medium-intensity intervention based on cognitive-behavioural principles which already has an established evidence-base for use in populations affected by violence and conflict. The current project aims to develop, culturally adapt and then test a telephone delivered version of CETA. The two main objectives are the following: 1) development of telephone-delivered CETA (t-CETA) by adapting the existing face-to face CETA intervention and 2) scientific evaluation of the effectiveness of t-CETA through conducting a pilot randomised control trial. The research findings will allow for essential access to mental health care to populations in remote and/or hard to reach areas.

- ***Validating screening questionnaires for Syrian refugee children***

In collaboration with Queen Mary University of London this research aims to validate mental health-related screening tools for constructs such as anxiety, depression, trauma and behavioural problems, specifically for Syrian refugee children. Such research is essential as existing tools used to explore concepts like internalising and externalising behaviour, are not culturally sensitive or contextually adapted. For this purpose, existing data from the BIO-PATH and t-CETA research projects (described above) will be further analysed to validate the applicability of various screening tools for Syrian refugee children. Validating these tools is essential for academic institutions, NGOs, and other actors providing MHPSS services as it will support to more accurately identify children in need of support.

3. Recommendations

To regional and international decision-makers and donors

- **Mental Health Policy:**

- At the country-level, **national mental health policies and action plans are essential to ensure ownership and sustainability of mental health services.** Thus, advocating and working closely with national health authorities and government is considered a key recommendation. Developed mental health policies should also coincide with an adequate allocation of funding to support the implementation of government owned mental health services. Further, policy development should consider the need to target persistent stigma related to mental health that exists within the region.
- In addition to healthcare reform which highlights the importance of mental health and psychosocial wellbeing, **legislation is essential to protect persons with mental disorders and vulnerable communities.**
- **Where possible, it is recommended that national health authorities take the lead in MHPSS coordination mechanisms that exist in country** with the support of United Nations agencies and International NGOs (INGOs) with a strong expertise.

- **Funding:**

- **Multi-year funding for MHPSS programs is essential.** Year to year funding poses a significant barrier to sustainable MHPSS programming and the development of national capacities over time. Comprehensive training of national staff, and **strengthening of national health systems, requires a long-term commitment.** It is recommended that where possible, donors provide multi-year funding for MHPSS programs to ensure sustainability of interventions. Such multi-year funding is essential to be in place immediately after the start of this crisis.
- **It is recommended donors invest in MHPSS programming that aims to strengthen national health care systems and the capacity building of national mental health staff.** Traditionally training and capacity building activities have been seen as an “add-on” component of direct service provision, with little in the way of financial resources and time, dedicated to this component. Financial investment in capacity building and the offering of training and supervision is essential to ensure the development of the skills and capabilities of the local workforce, which will likely remain once humanitarian organisations have left.

- **MHPSS Programming:**

- **MHPSS programming, in accordance with IASC guidelines, should be multi-layered in approach.** Thus, government authorities in conjunction with INGOs, NGOs and CBOs (Community Based Organisations) must ensure effective coordination mechanisms are in place to build a comprehensive MHPSS system which includes accessibility to tertiary care, community-based services and mental health services integrated at the primary health care level.
- **When publicly accessible mental health services do not exist at the national level, MHPSS actors should aim to integrate mental health services within existing national health care systems to avoid creating a parallel healthcare system.** It is imperative

that mental health and psychosocial services are somehow embedded within the national healthcare system to ensure sustainability.

- **Evidence-based practice is key to ensuring effective and safe MHPSS.** Currently a dearth of research exists which outlines evidence-based psychological intervention techniques in Lower and Middle Income Countries (LMIC), and even less research demonstrates effective psychosocial intervention in emergency contexts. Further, culturally contextualized research is often not available, meaning interventions, activities, and tools being used for MHPSS programming are not subjected to scientific rigor to confirm the effectiveness of their use. It is recommended INGO and NGOs active in MHPSS, collaborate with established academic institutions to strengthen the existing evidence-based within the region.
- **Scalable, low-intensity interventions provide manualized direction for the implementation of psychological interventions with persons experiencing low to moderate levels of distress and/or CMDs.** These interventions (such as PM+) have undergone rigorous testing to ensure they are safe and effective for use. It is recommended that an emphasis continues to be placed on the development and testing of such interventions, along with scale-up once interventions are shown to be sound.

- ***Training and Supervision Considerations:***

- **In response to the shortage of specialized mental health professionals it is recommended that capacity building opportunities be developed.** Furthermore, trainings should not be one-off in nature but rather, as consistent with IASC guidelines, should regularly be refreshed with ongoing supervision offered, as appropriate. **In addition to the informal training opportunities that are offered by MHPSS actors, the development of formalized education opportunities (such as Master level qualifications) could be helpful to build the professional expertise of MHPSS staff within the region.**
- While many MHPSS staff possess formal education backgrounds (Bachelor level degrees in Psychology and/or Social Work, etc.), very few have been offered practical on-the-job training, meaning little clinical supervision has been provided to support staff in managing complex real-life cases and in developing practical skills. **It is recommended that MHPSS service providers ensure staff supervision occurs regularly and is tailored at the appropriate level of complexity to the role being performed by staff.** Ongoing clinical supervision of staff (for example, discussion of cases, observing clinical practice, etc.) is imperative to ensure that complex cases are well-managed, the risk to do harm is minimized and to ensure staff feel supported in conducting their roles and responsibilities.
- MHPSS staff, as with many humanitarian staff, are presented with high levels of stress, adversity and potentially traumatic experiences on a daily basis. Further, national staff themselves, might have experienced displacement, war and loss. **Therefore, it is essential the wellbeing of staff is prioritized as a part of all humanitarian programming.** Human resources within INGOs should adequately identify and respond to the need for staff care. Staff care initiatives might include providing education to staff on how to identify unhealthy stress and should promote positive and proactive coping strategies. Importantly, staff severely impacted by the stress of their role should be offered pathways to access counseling and/or psychological support as needed.

Testimony: Nada Was Fond of Orange Blossom and Green Fields...



She dreamed to learn the piano, she loved the way the music notes could speak to a person's soul... She believed in another version of reality, a reality far from the sound of war... far from the reality she had to crash in suddenly.

Nada is 25 years old, a mother of two girls, and a Syrian refugee in Lebanon since 2014. She comes from a village in Syria called Ghouta described as the oasis, formed by the Barada River. Ghouta, as she described, is "a village that you recall even if you are far away... recall the smell of the earth and the beauty of its blue sky."

In 2014, she had to move to Damascus because her green dream land transformed into military dark green. Her nightmare started then, as she told us. She had to escape to Lebanon because her husband was abducted by the pro-government forces. They took him from the house, leaving her alone with two little girls (3 and 1 year old). In a matter of seconds, she

became the only source of shelter and protection for her girls.

Her husband's family who escaped to Lebanon asked her to live with them. She followed them with her two little girls to Bekaa valley, at night. She had to leave her parents behind, respecting the traditions. Her fear from the dark started to develop stronger. From the deadly war she moved to a cold war, a mental war with herself. A war that does not leave apparent bruises behind.

During her first year in Lebanon, she felt that there was no tomorrow. She felt as if she was still stuck while the rest of the world continued moving. Drowning in loneliness, facing continuous harassments, feeling unworthy with her daughters, and losing any hope of return, she tried to kill herself many times. She wanted to have control at least over something in this shaking reality.



She felt she only had control over ending her life. But all her attempts failed.

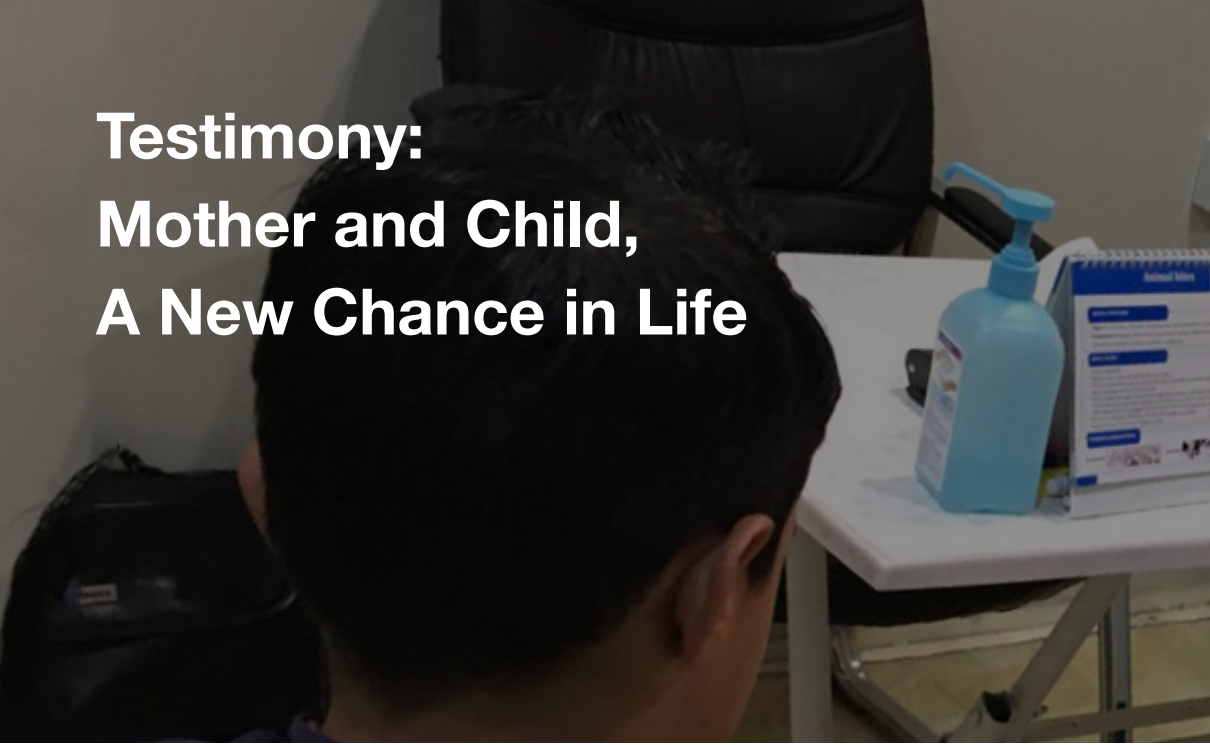
In 2014, during a home visit, she was referred to one of MdM's case managers, Fatima. At first, she found it difficult to discuss everything she had been through, but day after day she started to open up to Fatima. She began to feel that she could trust Fatima and that at least she could talk to and be heard by someone. It made her feel like someone cared to listen, and that was more than what she was used to. Soon she shared with Fatima that her husband's family were mistreating her, and her landlord continued to sexually harass her. Fatima referred Nada to an MdM psychologist, Noelle, and together they both continued to provide Nada with comprehensive support.

The MdM team linked her to organisations that could support her which eventually led Nada to find employment. By saving her new earnings,

within a year she was able to take her girls and rent a two room house in Rashaya El Wadi. This allowed her freedom from future mistreatment and helped to increase her independence. Nada even enrolled her daughters in school. One year later, Nada still recalls how, through support of MdM staff, she was able to breathe again. She never imagined that mental health mattered that much, having lost faith that someone can help her. She learned to cope with her surroundings. She told us: "When the war takes away all the colours, mental health support helps in bringing them back".

Now, she is still struggling with many challenges but she is more resilient and stronger, and she feels she can cope with the various challenges. She wants to go back to Syria once the green fields are back. She plans to visit her parents, but she is afraid to see the colours of Syria now.

Testimony: Mother and Child, A New Chance in Life



In August 2014, ISIS (Islamic State of Iraq and the Levant/ al-Sham) attacked Sinjar, targeting the Yezidi community. ISIS started executing men and abducting thousands of people, mainly women and children. One of the abducted families included an aged father and mother and an 8 year-old boy. Once abducted, ISIS members took the father away from the family to an unknown place, and then separated the 8 year-old boy from his mother.

The mother was subjected to physical, sexual and emotional violence, she was sold as a slave to various men in Mosul. After two years, relatives were able to find the mother and buy her freedom. The mother was taken to Chamesku camp. One year afterwards her son was also found, and brought to the camp to be reunited with his mother.

The mother arrived experiencing high levels of distress from the numerous traumatic events she had suffered. She started experiencing nightmares flashbacks, and constantly feared that ISIS fighters would kidnap her again. Once she arrived in Chamesku camp, she visited

MdM PHCC in the camp and was automatically referred by the medical doctors to MdM's mental health worker who provided emotionally-supportive counselling sessions for the mother and also referred her to a psychiatrist in Dohuk to receive specialist input.

Her son was also in need of mental health and psychosocial support. The boy had lived for 3 years under ISIS rule, the members of which also forced him to work as a servant. He experienced severe abuse and was subjected to ISIS education/propaganda materials which aimed to train him on various methods of violence. The boy was trained to identify different types of weapons and learnt how to make explosive devices. He was also trained in the ISIS boot camps which exposed him to methods of torture and beheadings. Immediately on arrival to the camp, the camp management identified a need for MHPSS support for the young boy and referred him to MdM's mental health workers.

The mental health workers noticed his behaviour was not typical for a child his age and he



endorsed strong radical beliefs. The boy had no interest in socializing with other children or adults. His mother also reported that he was aggressive at home. When in the camp, he continued following ISIS activities on social media and TV, and he refused to have sessions with our female MH worker due to her gender and the fact that she did not wear a hijab.

The MdM mental health worker conducted a home visit to the boy and over time began to build his trust and convince him to attend sessions at the PHC. The mental health worker supported the mother and extended family of the child to reduce the pressure they were placing on him in an attempt to change his beliefs and ideologies. The mental health worker emphasised the importance of the mother showing unconditional love and acceptance towards the boy, while refraining from engaging in ideological debates.

The mental health worker encouraged the boy to have a daily routine, which included helping his mother in some household tasks but also to socialise with other children and start

to play some sports. The boy agreed to be enrolled in group activities with other children, during these sessions he had the opportunity to communicate with children his own age. MdM also supported his registration to attend school as another opportunity to socialise with children and to help to build a healthy future. The mental health worker supported his transition to school by working closely with the school manager and the teachers to ensure he was fully supported and to ensure he felt safe and secure in the school environment.

The boy is now able to interact with other children, he has also begun to feel comfortable in his new school and is showing a strong commitment to achieving academically. He continues to join the group sessions with other children, and happily socialises, showing good communication skills. His favourite activities are drawing, singing and playing football. He no longer follows the videos or activities of ISIS and his relationship with his mother has improved greatly.

Glossary

MdM	Médecins du Monde
CBO	Community Based Organisation
CETA	Common Elements Treatment Approach
CMD	Common Mental Disorder
CMHC	Community Mental Health Centers
IASC	Inter-Agency Standing Committee
IDPs	Internally Displaced Persons
INGO	International Non-Governmental Organisation
ISIS	Islamic State of Iraq and the Levant/ al-Sham
LMIC	Low and Middle Income Countries
mhGAP	Mental Health Gap Action Programme
MHIS	Mental Health Information System
MHPSS	Mental Health and Psychosocial Support
MoPH	Ministry of Public Health
NGO	Non-Governmental Organisation
NMHP	National Mental Health Program
PHCC	Primary Health Care Center
PFA	Psychological First Aid
PM+	Problem Management Plus
t-CETA	telephone-delivered CETA
WHO	World Health Organisation

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