



Syrian American Medical Society



Human Devastation Syndrome

The Impact of Conflict on Mental Health

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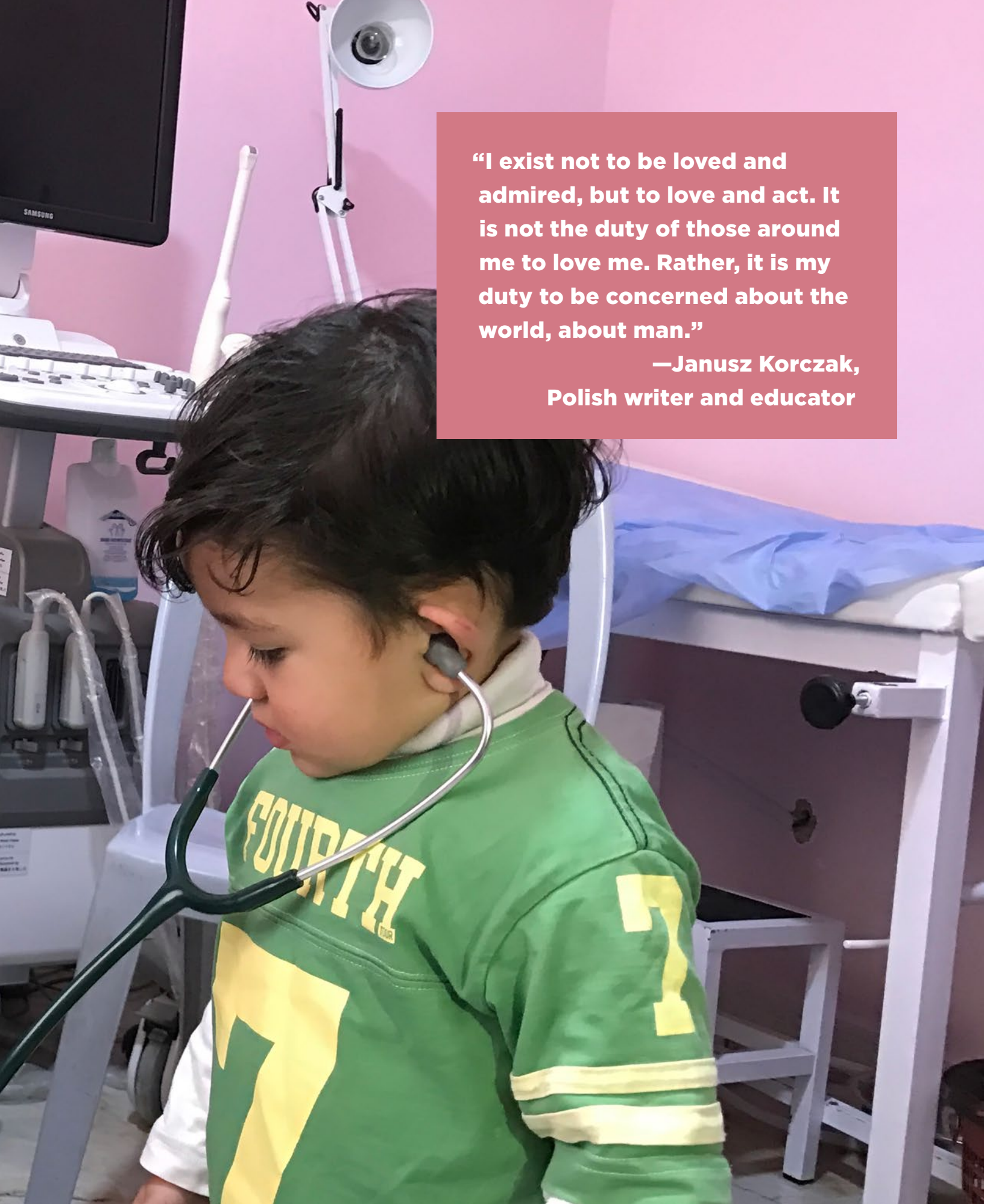
ABOUT THE SYRIAN AMERICAN MEDICAL SOCIETY

SAMS is a global medical relief organization that is working on the front lines of crisis relief in Syria, neighboring countries, and beyond to alleviate suffering and save lives. SAMS is one of the most active and trusted international NGOs on the ground in Syria. **In 2017, SAMS provided more than 3.5 million medical services, including 3.2 million inside Syria.** SAMS was founded in 1998 as a professional society, working to provide physicians of Syrian descent with networking, educational, cultural, and professional services. When the conflict in Syria began in 2011, SAMS expanded its capacity significantly to meet the growing needs and challenges of the medical crisis.

The Mental Health Committee of SAMS exists to serve the mission of SAMS, “alleviating suffering and saving lives” through mental health programming, support and training.







“I exist not to be loved and admired, but to love and act. It is not the duty of those around me to love me. Rather, it is my duty to be concerned about the world, about man.”

**—Janusz Korczak,
Polish writer and educator**

INTRODUCTION



As the Syrian conflict enters its eighth year, violence and displacement are on the rise inside the country, inflicting more trauma and hardship on a civilian population already pushed far beyond what any human being should have to endure. For refugees in the neighboring countries, they continue to await an unknown fate, often suffering from the invisible wounds of war.

In our work providing medical services to civilians in Syria and to refugees in neighboring countries, we often hear from our doctors and staff that there is a serious gap in attention towards mental health services. These services extend far beyond individuals affected by trauma and life under siege—they also include support for amputees, reconstructive surgeries, and women whose newborns do not survive birth. Yet the civilians facing these challenges often feel abandoned. In many ways, the world has indeed failed them. But it's not too late for the international community to help support these individuals. This report provides an in-depth look at the dire mental health situation inside Syria and for refugees in neighboring countries, and provides recommendations for policymakers and donors to support programs which address these needs.

SAMS is committed to supporting mental health in our programs throughout the region, and it is our sincere hope that members of the international community join us in these efforts. Only together will we be able to overcome the significant challenges that lie ahead.

DR. AMJAD RASS

Chair, SAMS Foundation



Like other Syrians who suffered the pain of losing his homeland and its human capital to vicious war crime, I realize the significance of being a member of the SAMS family and of being one with my family. I also realized the importance of being an agent of change. **Be the change.** The effective leadership of SAMS needs support that is methodical, systematic, innovative, and creative at all levels.

Change has to be concrete and measurable, implemented by the highest standards of leadership qualities with distinct devotion to rebuild a mental health system that is second to none. Our infinite motivation, vigorous advocacy, visionary leadership, and immense dedication are focused on those in need. For eight years, we witnessed and understood their psychological injuries and devastation. Hence, it is our sincere passion to continue our services in the field, aid all those in need, and build a new mental health system.

Throughout my life and my professional career, I believed it is imperative to improve systems and the vision of placing mental health in its rightful place—a significant entity in efficacious health systems. I must also note that during this time of Syria's significant health care crisis and human tragedy, mental health is in the best position to lead and be the change the decomposed Syrian health system needs.

DR. M.K. HAMZA

Chair, SAMS Mental Health Committee

“This woman physically recoiled and became pale when we discovered she was a school teacher and encouraged her to consider teaching again in the camps and later when resettled. Confusion must have been written all over our faces when she shut down and would not speak about her career any more. Her husband later told us that she had been recruited by ISIS but when she refused to teach their propaganda they threatened to kill her children in front of her, torture her husband, and then her unless she promised never to teach again. Even in Greece her fear persisted. She vowed to never again have a teaching role—to protect her family.”

—Wendy Sexton, RN SAMS Global Response volunteer

HUMAN DEVASTATION SYNDROME (HDS)



The Syrian tragedy is an unceasing nightmare. It is vicious and has taken over the lives of millions for seven horrific years, diminishing human dignity, wellbeing, morality, and hope. The humiliation reaches into the core of one's own being and existence. It radiates its agony and grief to the hearts of a collapsed nation.

I have witnessed how the psychological injuries inflicted by the Syrian conflict can paralyze both the patient and the healer. How can our human minds comprehend the absence of humanity? Is there a way to scientifically describe the complete physical, cognitive, and emotional destruction of a human being? The wounds engraved into each sufferer's mind and psyche bring a treating mental health professional to the humility of the unknown. The only seemingly sane response is to kneel and pray for the pain of the helpless to end.

When treating patients traumatized by the Syrian conflict, doctors, nurses, specialists, and mental health workers struggle to maintain equilibrium as they confront the very worst of humanity. Through their own tears, they wipe the tears of the mother who has lost everything. They mourn alongside the father who collects the remains of his children, murdered by a barrel bomb. A surgeon tries desperately to hold herself together psychologically while she works to physically stitch together a mangled body in the operating room. And yet—the pain of the healers is a mere shadow of the devastation in the hearts and minds of Syria's victims.

I use the label "**Human Devastation Syndrome**" to describe the particular mental health effects of the Syrian conflict because no other term can describe the level of human suffering Syrian refugees have endured. I have searched the repertoire of mental health texts, looking for a description of the purposeful and total demolition of a human being. Imagine the worst nightmare you've ever experienced—but it occurs while you're awake, on a daily basis for many long years. People just walk by you while you are bleeding and in pain; they ignore you or cannot hear you or just do not acknowledge your existence. I searched the criteria of all psychiatric stressors and traumas and could not find a description for those psychological injuries. I am perplexed and humbled by our lack of ability to define, diagnose, and treat this complex condition, which I refer to as Human Devastation Syndrome.

For the past seven years, men, women and children throughout all corners of Syria have been tortured, bombed, starved, and targeted. Children have seen their friends and families die before their own eyes, buried under the rubble of their homes, or killed in a mass celebration of power and tyranny. They have watched

their schools and hospitals being demolished. They were denied food, medicine and vital aid. They have been torn from their own families and friends. Most importantly, dignity and humanity were forcefully stripped away from their lives. Many have lost their childhood. So, they fled the known daily catastrophic massacres to the unknown, and the unknown was not as merciful as they had hoped. Their human devastation continues in the refugee camps, taking different shapes that threaten to destroy what little is left of their lives and sanity.

This report aims to capture the attention of those who believe in humanity. While many of us struggle to exactly describe Human Devastation Syndrome in a precise scientific and medical term, we have sensed it, felt it, and experienced it through the pain and devastation of those who have experienced it.

The report attempts to introduce the reader to the multidimensional nature of the mental health disorders faced by Syrians. The magnitude and complexity of these mental health conditions necessitates a new approach and diagnosis to fit the unique context of the Syrian conflict.

The SAMS Mental Health Committee members are SAMS volunteers from all walks of life who have rendered compassionate and professional clinical mental health aid to devastated Syrians and all those in need since 2011. But more importantly, they are dedicated to mending broken hearts and building a better future for all. Those healers are restoring humanity to a mentally healthy nation and people, one human at a time. They invest in a globally brighter future.



“No video can depict our true feelings of suffering and pain we are experiencing. How can you ever explain the feelings of a father who has buried his son and visits the grave site, asking his forgiveness for leaving him alone? How can you describe the feelings of families trapped in underground shelters seeking protection from the relentless bombardment, not knowing if they will make it out alive? How do you describe the feelings of a young man who buried his entire family, including his wife and children, in a public park as he couldn't properly bury them because of the relentless bombing? Now he has to walk away.”

—SAMS Doctor in East Ghouta

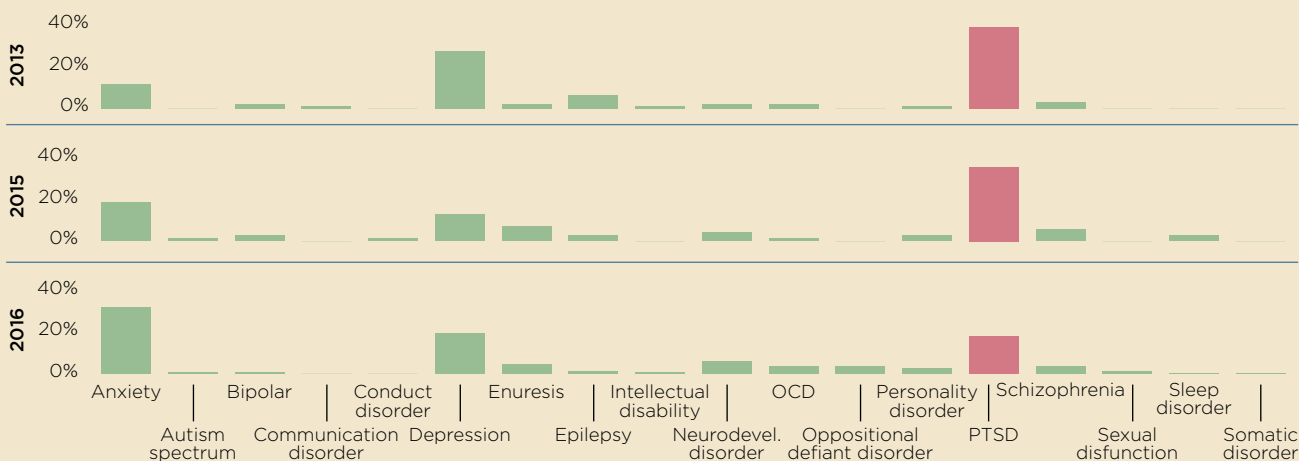
BEYOND PTSD



The ongoing Syrian tragedy has been described as the worst humanitarian crisis since WWII. More than half a million people have been killed since the beginning of the conflict in 2011. 13.5 million Syrians are in dire need of humanitarian assistance. More than 6.4 million are internally displaced and over 5 million are living as refugees. It is not difficult to see how devastation, loss, tragedy, and trauma have resulted in a high number of people who are in desperate need of mental health intervention. In the first years of this tragedy, many Syrians experienced mental health symptoms that were consistent with established mental health disorders, such as anxiety, major depression, obsessive-compulsive and post-traumatic stress disorders (PTSD). This is not surprising, given what the mental health community already knows about people's ability to manage and process stress and traumatic events. We are proud to report that SAMS's use of evidence-based psychotherapy treatments for anxiety, depression, and PTSD have resulted in significant patient improvement.

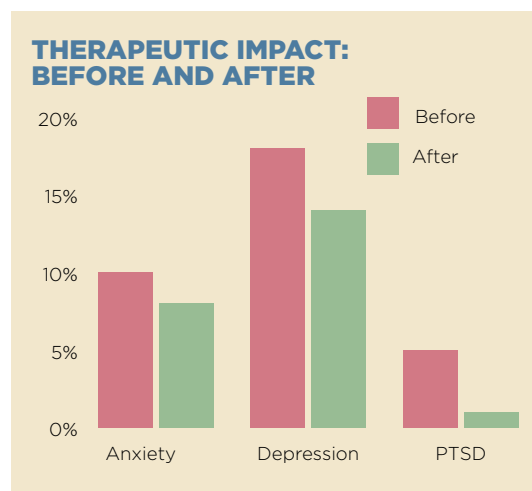
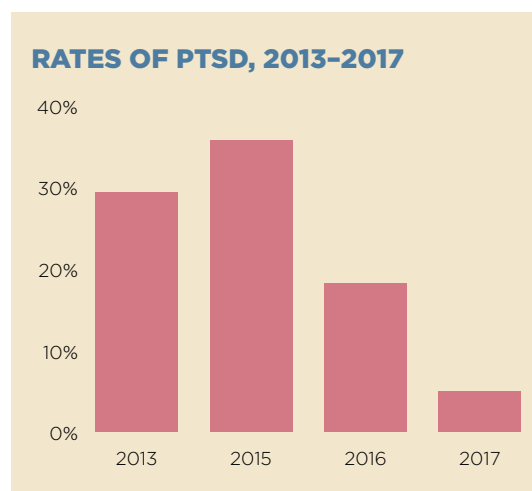
We celebrate these success stories and continue to work hard to replicate them across our different programs. However, we also have observed that there remains a consistent worsening of the scale and scope of mental health disorders as the conflict continues and humanitarian and medical actors are unable to meet the full need of the Syrian people. Internally displaced peoples are unable to find respite or shelter from the dangers and threats to their lives. Traditional safe spaces such as hospitals, places of worship, and schools are no longer safe. Aerial attacks do not

COMPARISON OF DIAGNOSIS FOR 2013, 2015 AND 2016



distinguish between military personnel, terrorists groups, and civilians. The trauma observed since 2011, as large and impactful as it appears, we fear is only the beginning stage of a mental health crisis that goes beyond acute stress and PTSD as we have seen them before. It is the result of the collective trauma shouldered by the Syrian people. We consider this as we have observed the rates of PTSD gradually decrease among those that have been in refugee camps for a number of years. As the presentations of PTSD have decreased over time, anxiety, depression, and obsessive-compulsive disorders have increased.

What does this apparent decrease in PTSD presentations suggest? We suggest that what is being presented by scores of Syrian refugees extends beyond PTSD. It is the intersection of PTSD, anxiety, depression, and obsessive-compulsive disorders all being experienced at once as a result of the devastation inflicted on the Syrian population. . The survivors of this devastation, like most trauma survivors, have problems with trust, intimacy, communication, and problem solving. Many patients suffering from these symptoms are stuck, numb, and/or focus exclusively on the relief of their pain. They dismiss the outside world as dark and threatening, withdrawing themselves from social support networks that are critical to recovery. It is the collective trauma experienced by the Syrian people with its dehumanizing power that causes their experiences to stand apart. We need to explore their condition further to better understand how it differs from traditional PTSD in order to develop more effective treatments. The Syrian people deserve it, and we (and the mental health community) will be enriched by it.



THERAPEUTIC IMPACT: BEFORE AND AFTER

A pre-assessment is conducted during the initial intake with the patient, and the post assessment is conducted during the termination period of individual therapy. The diagnostic assessments used as pre and post measures in individual therapy (18+) are the Hopkins Symptoms Checklist (HSCL) for patients presenting with symptoms of depression and anxiety and the Harvard Trauma Questionnaire (HTC) for patients presenting with PTSD symptoms. These are two of the most frequently used assessments among our therapists. However, depending on the patient presentation and need, other assessments may be used as well. Once the pre and post assessment data is collected from each therapist, the Data Analyst transfers the results into the main database sheet, filters the results and count for specific diagnoses then translating into percentages and applies final results Tableau data software for statistical graphing.

SAVING THE LOST GENERATION



Many studies have examined the effects of exposure to war, conflict and terrorism on young children and have revealed a wide array of consequences, including post-traumatic stress symptoms, psychosomatic symptoms, depression, anxiety, disturbed play, behavioral, emotional and sleep problems, substance use, suicide risk, and physical disease risk. The particular trauma currently being experienced by Syrians is the result of a continuous and persistent exposure to war and conflict. They have lived through non stop exposure to traumatic events, death, killings, bombing, airstrikes, loss of loved ones, vicious violence, distressful memories, profound nightmares, disappointments, fears, lack of support at all levels, and lack of avoidance of those traumatic events. The severe psychological problems, mental health complications, debilitating physical trauma, profound psychological injuries, and social and cultural complexities, are all sustained without any coping apparatus and without adequate mental health services. Displaced populations and refugees continue to suffer the humiliation, agony, and pain of this devastation. Young children who endure the pain of devastation seem to suffer the deepest of all injuries, both physical and psychological. The greatest negative effects on children occur when they not only witness violence but experience it in ways no human mind can imagine, or when their parents are killed in vicious ways, harmed, terrorized, or unable to function as parents. It is important to note that children's responses to trauma will vary according to their physical, emotional, psychological and intellectual development level, and the situation they experienced or are still experiencing.

The resilience of Syrian victims is empowered by a number of spiritual, cultural, and genetic factors aimed at survival—most importantly, physical and safety needs. The SAMS Mental Health

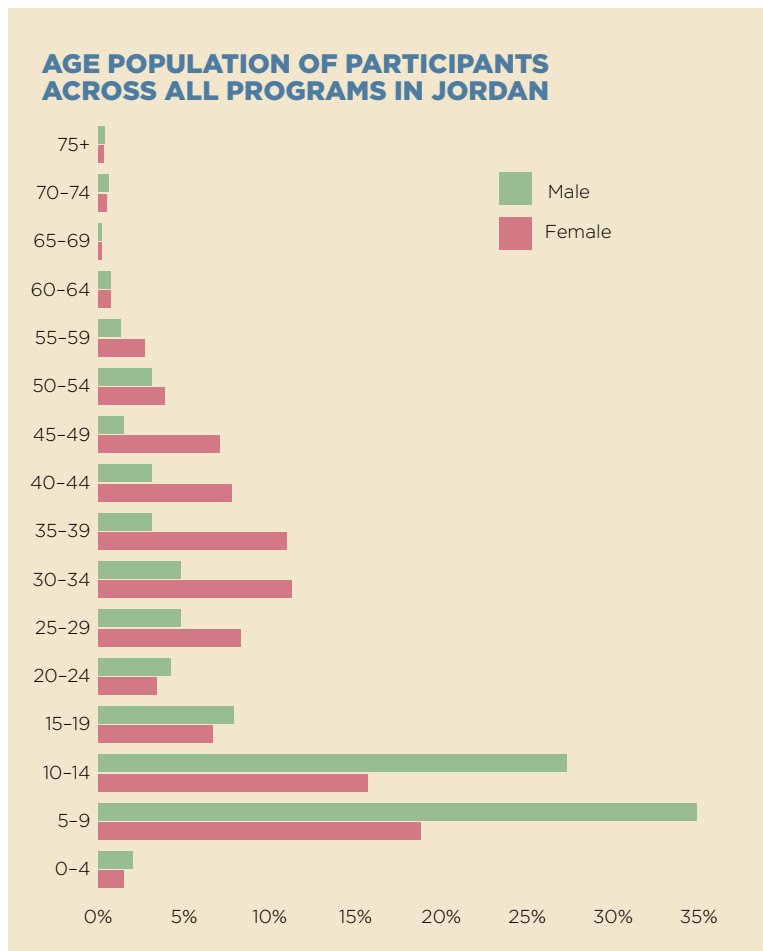
HUMAN DEVASTATION AMONG CHILDREN

A five-year-old boy we treated was described to me as being a “feral animal.” He was a previously healthy boy with no health problems, living with his parents and three siblings. They were all sleeping when an aircraft dropped a barrel bomb that landed on their house. Miraculously, he survived along with his eight-year-old sister, but the rest of his family was obliterated.

He was rescued by relief efforts and went to live with his grandmother and other relatives. Eventually, all of them were forced to flee and became internally displaced persons. The child initially became mute after fleeing, and regressed even further several months later. His sleeping patterns became irregular, and he started communicating his needs by grunting and using physical violence. He would wake abruptly during sleep with odd cries and weeps. He also began to urinate and defecate inappropriately.

—Dr. Saleem Al-Nuaimi, SAMS Tele-Psychiatry Clinical Director

Committee has worked diligently for years to render psychosocial services that develop and implement best practices for trauma recovery. The Psychosocial Services (PSS) system attempts to re-establish a sense of normalcy for the child. The goal is to heal a broken spirit and injured psyche by creating a sense of community, rebuilding a rudimentary social network, and educating young minds. SAMS has established PSS programs to provide treatment and care to Syrian victims in Jordan, Lebanon, Turkey and Syria. PSS offers social support, social activities, psychotherapy (counseling), and psychopharmacology (psychiatric treatment). So, what does it take other than the great skills of gifted mental health professionals? It takes hearts of gold. It takes unprecedented dedication, devotion, and vision to build or rebuild one child, one family, one human at a time. The following pages give a glimpse of the breadth and depth of the mental devastation affecting the Syrian population, and the hope and healing SAMS mental health professionals are bringing to its sufferers.



PSYCHOSOCIAL SERVICES (PSS)



There are an estimated 1.6 million Syrian refugees who are seeking safety in neighboring countries Jordan and Lebanon.³ The real number, however, is much higher. Refugees sometimes live in informal settlements, tents, and garages. They struggle to access consistent health care, clean water and sanitation, and education. Access to mental health care may even be more difficult than access to general health care, despite the large number of NGOs providing psychosocial support (PSS) to refugees. As determined by UNHCR (United Nations High Commissioner for Refugees), the need for mental health care among refugees far exceeds the services available.⁴ Out of 4,966 surveyed households in Lebanon, 2.5% reported one or more members requiring care. Of this group, 37% were reported to have received the required care, while 62% did not. The main barriers to accessing mental health care were reported as not being accepted at a facility (35%), consultation fees (27%), cost of medicine/treatments (24%), and not knowing where to go (14%). Nonetheless, SAMS's Mental Health and Psychosocial Support programs (MHPSS) in Jordan and Lebanon provide mental health care to refugees and even non-refugees at no cost.

SAMS is currently one of the main PSS providers in Syria and the surrounding countries. Its previous and ongoing interventions include regular cross-border interventions from north of Jordan to south of Syria, as well as ongoing health and protection services provision in Dara'a. In 2013 SAMS established PSS to serve refugees in the Jordanian state of Irbid and three Lebanese governorates in 2017: Akkar, Beqaa and Baalbek-Hermel.

The PSS programs of SAMS are staffed by mental health professionals who are qualified to provide psychotherapy and psychiatric assistance. Through this program, SAMS provides psychological and psychiatric care to Syrian refugees in urban areas. Services include a specialized psychiatric clinic for patients with PTSD, depression, anxiety, and other mental disorders. The SAMS program also offers group therapy, which focuses on providing support to children, women, and survivors of torture, domestic violence, and sexual abuse. Most of these beneficiaries are women and children suffering from trauma as a result of living in crisis for a prolonged time, escaping to Jordan and Lebanon, and experiencing significant hardship as a refugee in Jordan and Lebanon. SAMS has supported PSS programs because it is essential to address mental health issues in a timely manner. If mental health is not prioritized, the problems faced by individuals will worsen rapidly, which can lead to more mental and physical conditions among these individuals, tensions within the family,

and their surrounding community. With proper intervention, refugees suffering from various forms of mental distress will learn how to cope with anxiety and trauma in a way that will help them integrate and be productive members of their community. This will increase access to livelihood opportunities and restore a sense of dignity to those fleeing war and living in dire conditions.

SAMS PSS teams survey the basic and psychosocial needs of Syrian refugees in various community settings, including camps, settlements, health centers, and schools. Families who reported one or more members requiring mental health care were referred to our mental health clinics to receive evaluation and psychotherapy at no cost. In addition, our teams have strengthened referral pathways with psychiatrists, specialized centers, UN agencies, and NGOs in order to provide adequate support to beneficiaries. Our social workers are trained to navigate clients through the service options for improving their mental and social well-being. This way, if people with depression symptoms come to us and discuss their circumstances, we don't just take them to the psychotherapist. We help them find appropriate resources that can address their issues while staying aligned with the patient's goals and values.

SAMS staff conduct in-home visits to survey individuals living in the selected locations. In these house visits, mental health staff complete a needs assessment in order to identify needs in terms of mental health support. As a result, SAMS offers individual and group psychosocial support sessions tailored to the needs of the individual or group through the MHPSS. In addition, public health awareness workshops and counseling sessions will be conducted for mothers and separate sessions for children.

These programs will help children, adolescents, and adults learn how to manage emotions, and cope with their trauma and the stress of a new environment. It will provide them with the skills to safely express their feelings and to effectively integrate into their communities. Through these workshops, mothers will also learn how to help their children through this difficult time by learning how to facilitate their children's adaptive coping with anxiety, depression, and trauma symptoms.

CLINICAL CASE STUDY

Identifying Info: 45 year old, married, unemployed male with 4 children

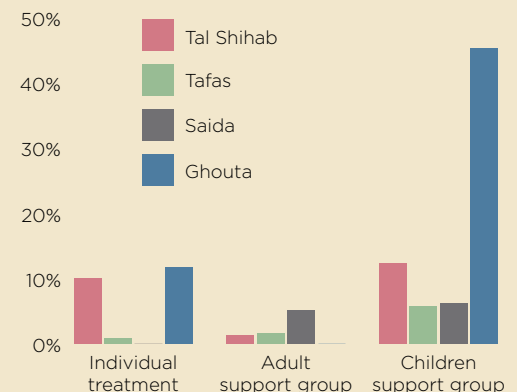
Complaints: Trouble sleeping, nightmares, severe anxiety, and panic attacks

Trauma History: Victim of home intrusion, beating, imprisoned and tortured

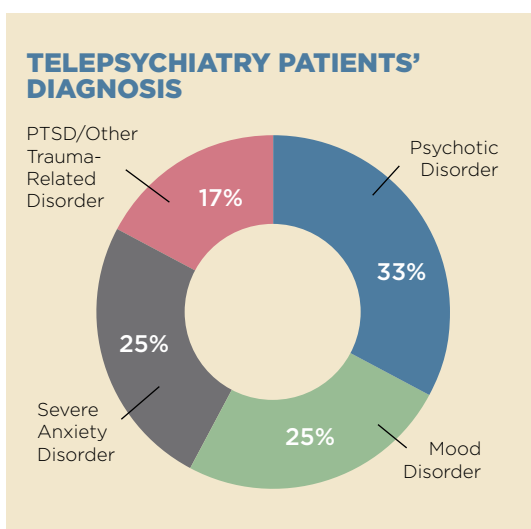
Diagnoses: PTSD, major depression, anxiety

Treatment Plan: Antidepressant, psychotherapy, relaxation/breathing

PERCENTAGE OF BENEFICIARIES IN MENTAL HEALTH PROGRAMS IN SYRIA



PSS: TELE-PSYCHIATRY



The conflict in Syria effectively destroyed the already impoverished mental health infrastructure in the country. Many organizations provide counseling and social service help addressing the mental health needs of the millions of Syrians displaced and affected by the war. However, due to a lack of psychiatrists, medications and specialized mental health services, Syrians suffering from severe mental illnesses such as severe depression, bipolar disorder, PTSD, and psychotic disorders were left to fend for themselves.

In order to fill this enormous gap in care, SAMS established a Tele-Psychiatry Clinic in northern Syria that has been in operation since July 2015, expanding to Southern Syria in 2018. By using the internet and secure methods of telecommunications, highly qualified psychiatrists from North America have been successfully connected to patients in Syria, providing direct psychiatric care. The Tele-Psychiatry Clinic is staffed by local professionals working in medication management, psychotherapy, and managing overseas connections to the mental health specialists. Neurology specialists from North America are commonly used to answer questions regarding headache syndromes and seizures.

The Tele-Psychiatry Clinic provides its services and medications to all the people of Syria strictly on a humanitarian basis and free of cost. The Tele-Psychiatry Clinic was established in response to the lack of qualified psychiatrists in Syria and accessibility of mental health resources inside Syria. The efficacy of this model and service delivery is reinforced in the medical literature and found to be cost effective as psychiatrists volunteer their time. SAMS tele-psychiatry success is measured in connecting patients with highly qualified psychiatrists and neurologists that are fluent in Arabic and have a cultural understanding that they otherwise would not have access to. The Tele-Psychiatry Program follows recommendations outlined in the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings. The Tele-Psychiatry Program also follows the "Practice Guidelines for Videoconferencing-based Tele-mental Health" by the American Telemedicine Association. Validated assessment tools like Harvard Trauma Questionnaire and the Hopkins Symptom Checklist provide objective measures of treatment progress and allow for research.

The Tele-Psychiatry Program is proud to report a team that consists of 7 psychiatrists and 1 neurologist from North America. Patients of all ages present with severe mental illnesses requiring some specific clinical mental health specialties. For one, up to date psychopharmacology helps to manage and maintain their

HUMAN DEVASTATION IN SYRIA

I will never forget this lady. She was extremely calm and spoke with no emotion, having ice cold eyes with a hollow expression. She described being in the kitchen with one of her children making bread. Her husband and eldest son were in the market, while her three other children were playing outdoors in front of the house. She recalled hearing planes flying over the area, and then a thunderous explosion. She shared how her heart sank because she knew the market where her husband and son were had just been bombed.

At the same moment, she heard a louder explosion nearby—a bomb fell in front of her house, knocking her out. She woke up under some rubble, as most of the house was destroyed. She and the child with her were not seriously injured, but the bombing continued and everyone started to flee in panic. She was about to flee but then remembered her three children playing in front of the house. She then got up and reenacted how she walked around the rubble and picked up various body parts of her dead children and put them into a bag. I asked her why she did that; her reply was, “so I could properly bury them.”

She left with her last surviving child and others from her village and relocated to northern Syria. She was extremely traumatized, with severe PTSD symptoms. She was disconnected from herself and the world. She had no energy, no interest in life, and felt isolated, hopeless and helpless.

—Dr. Saleem Al-Nuaimi, SAMS Tele-Psychiatry Clinical Director

baseline and safe functionality in the community. The clinic also treats patients with common neurological diseases that tend to overlap with mental health diseases such as migraines/headaches, seizure disorders, Parkinson’s disease, and brain injuries. Psychological care for patients of all ages is available through individual and group-based psychotherapeutic interventions including: cognitive behavioral therapy (CBT), supportive therapy, and psychoeducation. Psychological care is provided by a team on the ground in Syria consisting of a physician—who operates as the clinical director, a psychiatric nurse, psychologists, and support staff that offers security, accounting, and housekeeping. A telephone crisis line is available to patients and/or family members 24/7 to address any acute concerns they may have.

CLINICAL CASE STUDY

Identifying Info: 20 year old single, unemployed, man living with mom and siblings in a Jordan camp

Complaints: Nightmares, isolation, aggression, social anxiety, panic attacks, low self-esteem, and bedwetting

Trauma History: Witness to public beheadings of his father, cousins and friends

Diagnoses: PTSD, major depression, anxiety

Treatment Plan: Anti-anxiety medications, psychotherapy, relaxation/breathing

PSS: JORDAN/SYRIA



PSS teams in Jordan and Southern Syria include clinical, group, and outreach teams. The clinical team conducts individual therapy and facilitates psychiatric care for their patients. The group team implements programs that provide behavioral, emotional, and physiological care and psychoeducation to parents and children. The outreach teams are trained on the in-home assessment tool, and conduct home visits, workshops, and referrals to other organizations.

PSS in Jordan and Southern Syria exist to provide psychological and social interventions to those in need. Outreach is done by an outreach assistant, a social worker and volunteers in the medical clinics, refugee camps, and schools. **Workshops** are regularly held with a goal of decreasing the stigma associated with psychosocial and/or mental health care through psychoeducation on topics such as gender-based violence, life skills, various forms of child abuse, and hygiene. **In-home assessments** are primary needs assessments, inquiring about medical and social needs with follow up referrals to SAMS programs and/or other providers who can meet the identified needs. The in-home assessment acts as a guide for counselors who can recommend programs that will meet the identified needs of individuals, children, adolescents, mothers, and fathers separately. Programs run six to eight weeks and provide psychoeducation and empowerment to the aforementioned age groups. Individuals that convey a more severe presentation or require additional services are referred to individual psychotherapy. All programs utilize evidence-based practices and are continually evaluated by the program evaluation consultant. Weekly one-on-one psychotherapy is offered by psychologists for those with impairing mental health conditions, such as depression, PTSD, and various anxiety disorders. Individuals with impairing mental

PSS PROGRAM NUMBERS FROM JORDAN/SYRIA

	# of groups	# participating
Adults	73	1,017
Adolescents	13	641
Children	208	2,441

1,805 households assessed in 2017
13,967 individuals assessed in 2017

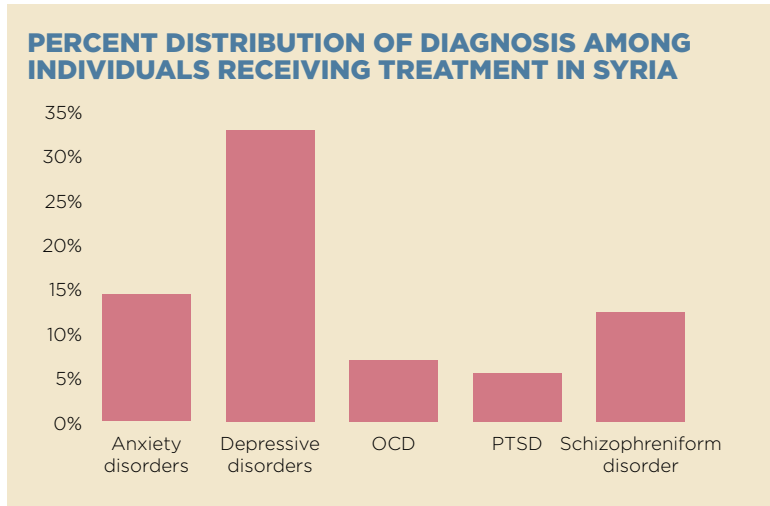
HUMAN DEVASTATION IN JORDAN

Omar is an 8 year old boy, originally from Syria, now living in Irbid, Jordan with his mother and 2 older brothers. At the age of 4, his home was in Syria and was surrounded and attacked frequently by different groups. Omar, among other children, used to watch the piling of bodies, blood flowing in the streets, and he used to always ask his mother “who is with us and who is against us?” One day the regime forces attacked their area and started shooting at Omar’s home. One heavily armed soldier entered their home, Omar began to scream from fear and his mother stormed into the room to protect her son. The soldier threw her to the side and took Omar outside with him. He took this 4-year-old child into the middle of the street, among the bodies and the smell of blood and death, and handed him the gun, pointing it towards the 4-year-old. The gun was heavier than he was and that was the end of what Omar remembers from that day.

—Allaa, a psychotherapist in Jordan

health conditions and in need of medication management are referred to the psychiatrist by the treating therapist where care and medications are provided at no charge to the patients. The psychiatric provider is also available for consultation to psychotherapists with complex case presentations. A gender-based violence specific program to female survivors of gender-based violence is provided in three women's and girls' safe spaces in Dara'a and formerly in Ghouta, Syria. Each safe space is located near a reproductive health facility for referrals as needed.

Supervision and training provided by a training coordinator and a group of supervisors is essential to the ongoing efficacy of the PSS programs in Jordan and Southern Syria. Trainings to SAMS staff inside Jordan and Syria include group programs for mothers and children, in-home consultations and assessments, individual therapy format and techniques, diagnosis and treatment of PTSD/trauma, and anxiety disorders. The training program has hosted consultants from Poland, Jordan, and the U.S. In addition, each team receives separate supervision regarding the aforementioned and dealing with difficult cases, self-care protocol and stress management techniques.



PSS IN BESIEGED GHOUTA

SAMS was providing PSS in the city of Ghouta, wherein a population of 500,000 were besieged since 2012, during which no medicine, nor food was allowed to enter Ghouta. This area was attacked and bombarded repeatedly, resulting in many casualties, and injuries. The program in Ghouta consisted of 6 psychotherapists, 6 social workers and 2 support staff along with one psychiatrist.

Group and individual therapy was provided to children, adolescents and mothers to help them cope and manage their severe mental health symptoms such as aggression, isolation, bed wetting, insomnia, impulsivity, hyperactivity, substance abuse and truancy. Our programs also taught children and adolescents adaptive communication and social skills to encourage them to express their thoughts and feelings accurately and clearly as well as to listen to others effectively. Children were also provided with schooling and with meals to prevent sexual exploitation given food was scarce.

SAMS Ghouta PSS temporarily closed during the months of Feb and March 2018 due to excessive bombardment of the Ghouta area. Unfortunately, on March 25, 2018 the PSS program was terminated and most of the staff were forced to be displaced to Northern Syria.

Type of Program	# of beneficiaries
Adult Support Group	134
Children Support Group	1,586
In Home Assessment	1,627

PSS: LEBANON



PSS centers were recently launched in three Lebanese governorates: Beqaa (Dec. 2016), Ballbak-Hermel (Feb. 2017) and Akkar (March 2017), which overall is home to over 350,000 Syrian refugees.^{5,6} The Lebanon PSS team consists of psychologists, social workers, and psychiatrists across the three sites. PSS provides services at each respective center and conducts outreach to camps, schools, and health centers. Individuals who report being in need of mental health care are directed to the mental health centers. The project is conducted within the socio-ecological model framework. This framework recognizes the dynamic interrelatedness among factors at multiple levels of a system, including an individual's personal experiences, their family, school, community, and the broader culture. Within such a framework, our project emphasizes collaboration and cooperation between community structures, such as schools and health centers, in order to improve the population's mental and social well-being.

PSS in Lebanon focus on training and support, community outreach and psychosocial needs assessments, increasing access to mental health and psychosocial services for children, providing psychosocial services at the centers, establishing and strengthening referral pathways, and a volunteer specialist program.

PSS in Lebanon is supervised by an American-based psychiatrist who delivers the World Health Organization's mhGAP intervention training to physicians and nurses who work in SAMS supported

HUMAN DEVASTATION IN LEBANON

"He is a seventeen year old young man who is not living as his teen friends do," his mother tells us as tears roll down from her eyes. She explains that their house in Al Quasar in the governorate of Homs was bombed right in front of her son's sight as he was tying his shoes to go outside. He was only eleven years old then.

This bombing caused him, who was the only child of his parents, to lose his hearing and start showing some mental health deterioration resulting from the shock he experienced from the bombing of his house. She says they now suffer together in the small tent in which they live with his father. She has sold all of her jewelry in order to buy food and be able to buy his very expensive medications. Doctors have diagnosed him with schizophrenia and when she cannot get him his medications, he has intense episodes of anger, violence and paranoia. When his situation deteriorates like this, he has assaulted her, kicked neighbors out of the tent and thrown food outside.

His mother's facial wrinkles show the suffering and the exhaustion she has been through during the last few years. They had a big house in Al Quasar; she still remembers the lemon tree in the middle of their house. She used to grow lots of vegetables in her own small garden where she used to give away a lot of produce to her neighbors. Her only wish now is for him to heal and for them to be able to go back home.

— Muhannad, a psychotherapist in Lebanon

facilities. Training topics address the most common issues found in the community, including depression, developmental and behavioral disorders in children and adolescents, self-harm, suicide, and other significant emotional or medically-unexplained complaints. This training provides internists with the skills to identify cases that need to be referred to a psychotherapist for further mental health assessment. Because burnout of providers to the refugee population is common, the PSS team regularly offers support and stress management intervention for medical and support staff.

Community workers conduct outreach visits to various community points, which include refugee health centers, camps, vocational centers, and schools. In those outreach visits, community workers conduct interviews and a psychosocial needs assessment which informs intervention. Partnerships have been established with a number of schools in order to provide specialized services for children in a safe, secluded environment. A psychotherapist and a special education specialist will provide care and support at a select school at least once a week to children who have emotional or behavioral problems or learning and communication difficulties. Implementing this program requires collaboration between the specialists, teachers, and parents. Teachers will be trained to detect emotional, behavioral, and developmental concerns in children and how to manage symptoms in class. In addition, both parents and teachers will be taught how to implement behavioral therapy.

Helping Hands Happy Kids is a school-based program designed to prevent anxiety and depression. The program's purpose is to promote resilience and positive thinking among Syrian refugee children and improve their problem-solving skills.

The community mental health center is open for patients six days a week where they can receive mental health evaluations, psychotherapy as needed, support groups, and medication management. Individual and group psychotherapies are grounded in an evidence-based treatment called cognitive-behavior therapy. Psychotherapy and support groups utilize a variety of relaxation interventions to reduce anxiety, the number one mental health issue.

In order to improve the psychosocial well-being of our patients, our team often makes referrals to humanitarian NGOs, education and vocational programs, health centers, organizations and centers that provide assistive devices, and rehabilitation to individuals with disabilities, and the UNHCR protection department. Making these referrals helps us address the medical, socioeconomic, or psychosocial factors that are causing psychological distress for our clients. Therefore, our team continuously works on strengthening partnerships and establishing referral pathways.

CLINICAL CASE STUDY

Identifying Info: 12 year old female living with her family in a Lebanon camp

Complaints: Fear, anxiety, daydreaming, learning problems, cognitive delays, lack of attention, and significant depression

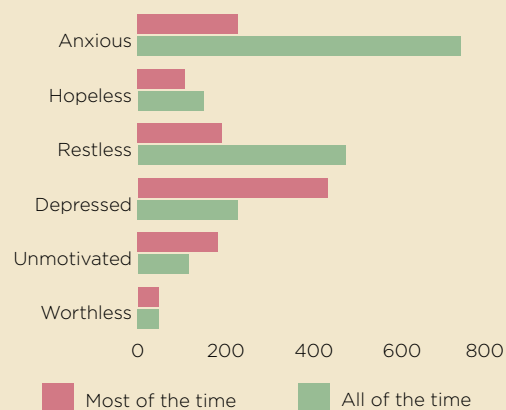
Trauma History: Exposure to extreme violence and bloody scenes

Diagnoses: PTSD, depression, anxiety

Treatment Plan: Play therapy, role play, relaxation

MOOD QUESTION RESPONSES

This chart shows the frequency of people (n = 1,261) who responded with either "all the time" or "most of the time" to the question: During the past 30 days, about how often did you feel:



PROFESSIONAL DEVASTATION



A SURGEON'S STORY OF EMOTIONAL TRAUMA

Our hands touched accidentally as we both reached for the last biscuit. A few awkward apologies and formalities followed, which was when I noticed his name-tag: Dr. Ragheb, a surgeon from Syria. It was July 2017, and we were both attending an international conference about the healthcare situation in Syria. I introduced myself, and as we drank our coffee, Dr. Ragheb began to share some of his harrowing experiences with me.

At the beginning of the uprising in early 2011, he was living with his wife and children in southern Syria, where he worked as a surgeon. Eighteen months into the conflict, with the fighting showing no signs of abating, he felt it safest to send his family out of the country. As painful as it was, he elected to stay behind and help the people of Syria.

Shortly after his wife and children left, Dr. Ragheb's town came under siege. The barrel bombs and sniper attacks escalated, as did the patient load, and some days he had no more than a few minutes of sleep. Dr. Ragheb and most of the doctors he worked with eventually chose to move into the hospital, and when medical facilities were directly targeted a few months later, they were forced to move again into makeshift underground bunkers beneath the hospital for their protection.

As the siege intensified, food and other provisions became increasingly scarce. For two years he ate only one small meal per day, and as a result lost approximately 12 kilograms. He remembered performing 19 consecutive operations without even a cup of tea, after which the only thing he could find to eat was a small sandwich. There were times when he would cry from hunger pangs and the fear of not being able to find food.

Dr. Ragheb witnessed countless patients, most of them women and children, being rushed into the emergency unit, some bleeding silently to death and others screaming in pain. Many required urgent operations due to blast injuries to their chests and abdomens, or due to loss of limbs. He found that the suffering of the children profoundly affected him. He would often weep while operating on them, imagining they were his own children.

When he was able to emerge from the hospital for some much-needed fresh air or to escape the intensity of the suffering inside, Dr. Ragheb would take a short walk through the town. He increasingly found that this offered little relief, as he would return feeling grieved by the sight of buildings utterly destroyed and desperate, traumatized people searching for food and water in the streets.





Due to significant shortages of staff, resources, hospital beds, and incubators, doctors and nurses were often forced to make triage and treatment decisions that haunted them later. Dr. Ragheb's eyes filled with tears as he recounted an instance when the reality of these decisions affected him personally. A friend of his, having been injured in an explosion, was rushed into the emergency room with an exsanguinating chest wound. He was immediately taken to surgery, but just as Dr. Ragheb was gaining control of the bleeding, a nurse shouted for him to come to the emergency unit for a young girl with a shrapnel injury who was bleeding and had collapsed on the floor. Dr. Ragheb reluctantly left the operating room and ran to the emergency unit to assess the young girl. He diagnosed a punctured heart, and in that moment he had to decide which patient to prioritize. With the girl lying on the floor of the emergency unit, he quickly changed his gloves and scrubs, opened up the girl's chest and repaired the damage to her heart. Once she was out of immediate danger, he left her in the care of an anesthetist and rushed back to the operating room only to be met with the heartbreaking news that his friend had succumbed to his injuries.



Innumerable situations like these, along with significant shortages of food, lack of sleep, exceedingly long working hours, no opportunity for a break, fear of being kidnapped, imprisoned, and tortured, the constant threat of the hospital being targeted, separation from his family, and the four long years of blood, grief, and death, took their toll on Dr. Ragheb's psychological health. Eventually, when confronted with the usual chaos of the emergency unit, his whole body would shake uncontrollably and waves of unbearable emotions would overwhelm him. This rendered him unable to operate or to assist in any way with patient care. After a month of these debilitating symptoms, he and his colleagues felt that his only chance of recovery from the trauma to his body, soul, and spirit would be for him to leave Syria. Escaping from his besieged town would entail passing through dangerous underground tunnels, paying traffickers enormous amounts of money to help him traverse the country, and eventually leaving Syria.

After six failed attempts Dr. Ragheb made it across successfully in late 2016. In spite of being out of Syria for several months, Dr. Ragheb described himself as still not emotionally well enough to attend to patients. This difficult situation is compounded by the pain of not being able to reunite with his wife and children, as they are in another country and, being Syrian, are subject to complex travel restrictions.

(Please note: owing to the continuing volatility of the situation in Syria, names and other details have been changed in order to protect Dr. Ragheb's anonymity.)

"I quietly put an arm around her and to my surprise, she leaned on my shoulder. I realized then that this grandmother was not only carrying the weight of her own trauma—of the loss of her career, her home, and her son, but she was also carrying the burden of her entire family. Here she was fearlessly dragging them forward towards a better life. 'Back in Syria I was a teacher. Very happy...' her voice trailed off as the paramedics slammed the side door of the rickety ambulance shut and we caught one last glimpse of her son looking at her with his tiny nephew nothing more than a bundle on his lap. 'Now...this.'"

—Madison Williams, Nursing Student, SAMS Global Response Volunteer

A DENTIST'S STORY

I first met Dr. Mahmoud when he spoke at a conference, sharing stories of indescribable suffering and devastation that enabled a glimpse into the realities of life inside his country. Within moments of meeting Dr. Mahmoud, he began to share more of his journey with me. He was a dentist whose hometown had come under siege. As the frequency of barrel bombs and sniper attacks increased, the need for general and orthopedic surgeons grew and complaints of toothaches all but vanished. Care was difficult to find though; hundreds of healthcare workers left Syria when the uprising began, and scores had been killed in targeted attacks. As no new doctors were able to enter besieged towns, necessity demanded that Dr. Mahmoud obtain other medical skills. He began to read whatever he could about emergency procedures, and gleaned many new skills from his colleagues who would use every operation and procedure as a teaching opportunity.

Dr. Mahmoud recalled a day after a particularly vicious spate of bombings when his hospital's emergency unit was flooded with patients requiring urgent surgery. With the only anesthetist busy in an adjacent town, the surgeon looked at Dr. Mahmoud and said, "You are the patient's only chance of survival. Either he dies because we do nothing, or he has a chance of survival in your hands. I know you can do it." Dr. Mahmoud chose to operate, and four exceedingly stressful hours later, the patient was transferred to the ICU in stable condition. After that day, Dr. Mahmoud found himself often called upon to perform operations and tasks he was not adequately trained for, including vascular surgery, caesarean sections, and abdominal surgery. A year later, he became the official anesthetist for all the orthopedic and vascular cases. There were occasions when he had to perform both the anesthesia and the surgery—each time because it was the patient's best or only chance of survival.

When chemical attacks began, their emergency unit would be inundated with terrified people struggling to breathe, frothing at the mouth, convulsing, and even dying as a result of exposure to the nerve poison. At times, the health workers themselves would become victims by inadvertently inhaling the odorless toxin or as a result of direct contact with exposed patients. Dr. Mahmoud spoke of situations where the severity of patients' injuries left the doctors with no choice but to perform operations despite being compromised by blurred vision and difficulty breathing. Unaffected non-medical staff would guide them by describing the injuries and attempting to locate the sources of bleeding.





As the conflict progressed, the siege on his hometown intensified to the extent that it became impossible to even smuggle in food or medical supplies. Dr. Mahmoud described times when he would have nothing to eat for two days. He and his colleagues resorted to boiling grass and leaves in the hope that this would strengthen them sufficiently to care for their patients. As a result, they would require chairs with backrests while operating and their operating times increased markedly as they became weaker.

By far the most painful memories Dr. Mahmoud recounted were moments when he had to choose which patients should be left to die and which should be given a chance at survival. Health workers were forced to prioritize the patients who had the best chance of recovery, would not consume too much precious medication or generator fuel, or would be least likely to occupy an ICU bed or incubator for a lengthy period. Dr. Mahmoud became emotional as he described how cruel and calculated these decisions felt, and how he and his co-workers are still haunted by having to let many patients die who might otherwise have been able to recover.

Dr. Mahmoud and his colleagues were aware of the importance of self-care and emotional health; however, the conventional guidelines felt academic, inappropriate, and virtually impossible to apply in their context. Suggestions of self-care felt like an insult when he was weak with hunger and unable to find anything to eat, or when the hospital was being intentionally shelled and there was no safe place to which he could escape. Sometimes the health workers were too physically and mentally exhausted to speak even a word, let alone debrief or write about their experiences. When Dr. Mahmoud did feel the need to express some of his anguish, he struggled to do so. He felt obliged to appear strong and hopeful, and did not want to exacerbate anyone else's psychological distress. There were occasions when his extreme and erratic emotions left him wondering whether he was having a mental breakdown, but he knew he did not have the luxury of becoming unwell.

A staggering twenty percent of the people in Dr. Mahmoud's city died in a single year. His city reluctantly entered into talks with the Syrian government in order to try to negotiate a ceasefire or lifting the siege. Three years later, after numerous breaches of agreements, Dr. Mahmoud and his wife, carrying their day-old infant and their one allotted suitcase, gathered with many others at the designated meeting place. They were instructed to board the buses and then made to wait for eight hours, after



which Russian military vehicles escorted them through the night to another province. Three months later, with their lives still in danger, Dr. Mahmoud and his family managed to leave Syria.

Since his displacement, Dr. Mahmoud can only watch helplessly as the horrors worsen inside Syria. Devastating memories of violence and loss threaten to overwhelm him at times, made worse by the unbearable weight of the triage decisions he was forced to make. Recently, when I asked Dr. Mahmoud if there was anything specific I could pray for or if there was any way in which I could help him and his family, he paused before replying, “The souls of the Syrians are damaged. We are broken on the inside. We need to fix our souls.”

(Please note: owing to the continuing volatility of the situation in Syria, names and other details have had to be changed in order to protect Dr. Mahmoud’s anonymity.)



MENTAL HEALTH IN PRIMARY CARE



The role of a primary care practice is to provide encompassing care that treats all aspects of one's health to meet the needs and demands of the population it serves, and to be accessible to all individuals within its community. It is important to address both the physical and behavioral health of the individual to provide proper treatment.

Mental illness affects hundreds of millions of people worldwide. Mental disorders are prevalent in all countries, in both men and women, and at all stages of life. They occur in the rich and the poor, in rural and urban settings, during peace and in times of conflict. Up to 60% of people attending primary care clinics have a diagnosable mental disorder, and approximately 20% of American adults are suffering from mental illness. The incidence during times of conflict is obviously much higher. This creates significant personal burdens for the patients and their families. It also affects society as a whole through reduced economic productivity and increased utilization of services. Given the high prevalence rates of mental health concerns and the low rates of mental health treatment, primary care providers often serve as the main source of intervention for mental healthcare needs. There has therefore been significant debate regarding best practices for integrating mental health care into primary care.

Research shows that integrating mental health and primary care will lead to many positive outcomes for both patients and providers.⁷ Reasons to support such an integration include:

1. Mental and physical health problems are interwoven
2. The enormous treatment gap for mental disorders
3. Enhancement of access to mental health care
4. Promotion of respect of human rights in this field
5. Increased affordability and cost effectiveness
6. Generation of good health outcomes

MENTAL AND PHYSICAL HEALTH PROBLEMS ARE INTERWOVEN

People with mental disorders are more likely than others to develop significant physical health conditions. Individuals suffering from serious psychiatric conditions are more likely to have a stroke or develop cardiovascular disease before the age of 55 years.⁸ Anxiety and mood disorders can affect endocrine and immune function resulting in infections and delayed wound healing. Mental disorders are also associated with alcohol and tobacco use,

and the side effects of some psychiatric medications result in metabolic syndrome and/or diabetes mellitus. Certain physical disorders can generate mental health problems; for example, cancer and cardiovascular disease can lead to depression, anxiety, and cognitive impairment. HIV/AIDS also substantially increases the risk of developing a mental disorder.⁹ It is also important to assess for mental health concerns in primary care because mental health concerns often present as somatic symptoms. Panic attacks are mistaken for heart attacks. Anxiety is often experienced as a racing heart beat or sweaty palms. Depression often presents with fatigue, aches, and other somatic complaints.

HUMAN DEVASTATION IN CLINICS

The clinic opened and your typical cases presented—chronic conditions, pain, insomnia, depression, burns and infections. People presented with various complaints or non-specific pain symptoms. About mid-afternoon an argument occurred outside the window, and I heard shouting and yelling. I watched as the police came to drag away a man who's anger seemed to be escalating. A young girl about 10 years old stood by sobbing as the police and her dad began to wrestle a bit. It broke my heart to see this little girl watching this disaster unfold.

It wasn't long after when I heard yelling and looked out the window to see the same girl lying on the ground, and others picking her up rushing her inside our clinic. They put her on the table as her body jerked, her eyes rolled back, and she appeared to be having a seizure. I began to assess her as her mother stood sobbing next to me. Initially, I was certain it was a seizure but as soon as I began to assess, I knew this was not. Her neurological exam responded in a way that was not typical during a seizure. I turned to her mom and told her it was going to be ok. I asked her if this had happened before, and her mother responded that it did once. She began to tell me how a bomb landed next to their home, and her daughter began to shake uncontrollably like this. I looked down at the small and fragile little girl and held back my own tears as I thought about the horrible things she had been through, even at her young age. I held a cool cloth to her forehead and held her hand, comforting her mother until she was able to open her eyes.

As I watched the little girl rest, I started to wonder if it is possible that these people have been through so much trauma that it's presenting as neurological disorders? Could complete devastation of all you know and love affect you so deeply that it presents as actual physical neurological symptoms? If this is true, how will this affect my treatment in the future? How can I be better prepared as a volunteer to ensure I provide the best care? How can I incorporate psychosocial care into my medical practice?

This thought process has changed how I approach care for those I serve while on medical missions. We are no longer responding to an acute crisis. As we shift to the need to care for these people long-term, it is imperative that we change from our medical model to a multi-modality approach. With multi-modality, including medical and mental health care, we can focus on treatment of the whole person, taking into account mental and social factors, rather than just the physical symptoms of a disease. As the need for these people change, so must our model of care.

— Minnesota Chapter President Lindsey Smith, CNP, in Greece



THE ENORMOUS TREATMENT GAP FOR MENTAL DISORDERS

The global neglect of mental health results in a significant gap existing between the prevalence of mental disorders and the number of people receiving care and treatment. Treatment gaps between 45% (high income countries) and 85% (lower income countries) have been documented. Primary care services are often inadequate, and identification of mental disorders by primary care workers is low to moderate at best. Potential reasons for this include patients choosing to focus on physical health problems, inadequate training of primary care providers on mental health issues, fewer financial and human resources devoted to mental health, poorly structured mental health systems, and stigma and discrimination towards mental health disorders.



ENHANCEMENT OF ACCESS TO MENTAL HEALTH CARE

Primary care facilities are usually closer to the patient's home, which enables families to be kept together and daily activities to be maintained. Primary care facilities also provide opportunities for family and community education, which improves health outcomes, as well as long-term monitoring of affected individuals.



PROMOTION OF RESPECT OF HUMAN RIGHTS IN THIS FIELD

Mental health services in primary care settings minimize stigma and discrimination, as patients are treated in the same way as people with other conditions. This is important for patients, their families, the community, and for the health care workers. It also reduces risk of human rights violations that are often associated with psychiatric hospitals.

INCREASED AFFORDABILITY AND COST EFFECTIVENESS

Primary care services are less expensive than psychiatric hospitals for patients, communities, and governments alike. In addition, patients avoid the indirect costs associated with seeking specialist care in distant locations. The further a person must travel to receive care, the more expensive it becomes, and the more likely they are to drop out of treatment programs. Local mental health services enable patients and their families to maintain their daily activities and sources of income. Primary and community-based care is also less costly for governments, as health workers, equipment and facilities are less expensive than those needed at secondary and tertiary levels.

GENERATION OF GOOD HEALTH OUTCOMES

There is compelling evidence from thousands of studies across a range of settings demonstrating that mental disorders can be successfully treated, and that primary care-led service systems result in good health outcomes. This is enhanced when linked with networks of services at secondary and tertiary levels and in the community.

SUMMARY

Worldwide, mental, behavioral, and neurological disorders are major contributors to disabilities and premature death. They are common globally and cause immense suffering, if left untreated. Primary care services for mental disorders are the best way of ensuring that patients get the mental health care they need. They are accessible, affordable, and cost effective. They promote early diagnosis, respect of human rights, and social integration. They help ensure people are treated holistically, having both their physical and mental health needs addressed. The quality of life for hundreds of millions of patients and their families can be improved.



“We met a pregnant mother traveling with her husband and two young children. She and her desperate husband would attend our busy clinic at every opportunity, spending hours at each visit literally pleading for help. She was withdrawn and teary, her son had scratches on his face and both children would cry when approached by our volunteers. It was obvious that this family was particularly traumatized. She and her husband told us that her mental health had been deteriorating in Syria with her continued exposure to violence and destruction. During their first winter in Europe she had given birth to their third child, at a time when they were living in a freezing damp tent, with no medical facilities available. The newborn baby died on a cold night in their tent, most probably from hypothermia. She woke to find the lifeless body of her baby next to her. Since then he told us that her mental health had reached the breaking point. She was constantly crying or withdrawn, with frequent violent outbursts. They both told us that she had caused harm to the other two children, scratching her young son and at one point throwing him across their room. She said that she did not want to be this way. They told us that on one occasion she had covered their caravan with petrol with her children inside, before being stopped by her husband. He was doing all he could for his family, but said he could not cope. Our team at SAMS did everything we could to safeguard the children and support her, but the available social and mental health support in the camp and surrounding area was almost non-existent. We made referrals to the highest levels, but every week we would return with nothing to offer her but our deepest sympathy.”

—Lizzy Smeaton-Russel, RN SAMS Global Response Volunteer

A CASE FOR HDS

MENTAL HEALTH PROGRAMS MAKE A DIFFERENCE!

1. **Mental Health Programs promote dignity and self-worth.**
2. **Mental Health Programs relieve emotional suffering.**
3. **Mental Health Programs reduce distressing symptoms** by teaching coping skills, processing emotions, and providing medication management as needed.
4. **Mental Health Programs foster awareness** of personal competency and increases self-confidence.
5. **Mental Health Programs encourage** community engagement and independent living skills.
6. **Mental Health Programs reduce stressors on education and health systems:** SAMS partners with schools in refugee camps for skills instruction, especially for children with emotional and behavioral issues.

We need to know and do more in response to the human devastation experienced by the internally displaced inside Syria, Syrian refugees and providers/volunteers working with SAMS. The Mental Health Committee of SAMS has established these priorities in addressing Human Devastation:

1. Expand MHPSS Programming to Turkey. Turkey hosts 3.5 million Syrian refugees,³ the most of any country. The Government of Turkey has gone to great lengths to provide comprehensive, quality medical assistance to all refugees. We recommend expanding on this even further to include MHPSS programming. Those refugees who were exposed to severe trauma and violence inside Syria could benefit from this programming, which in turn leads to greater overall health and stability among the refugee population.

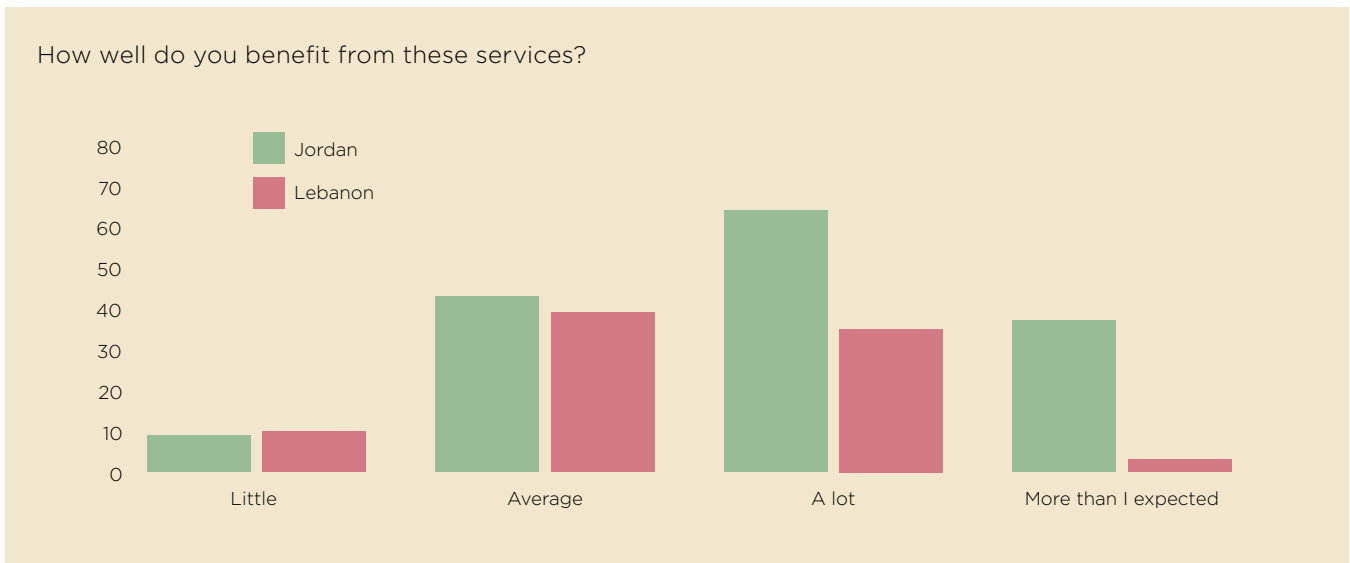
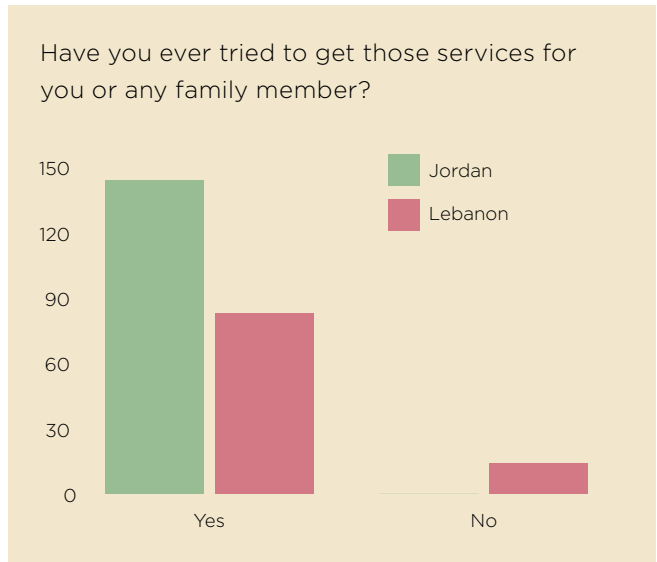
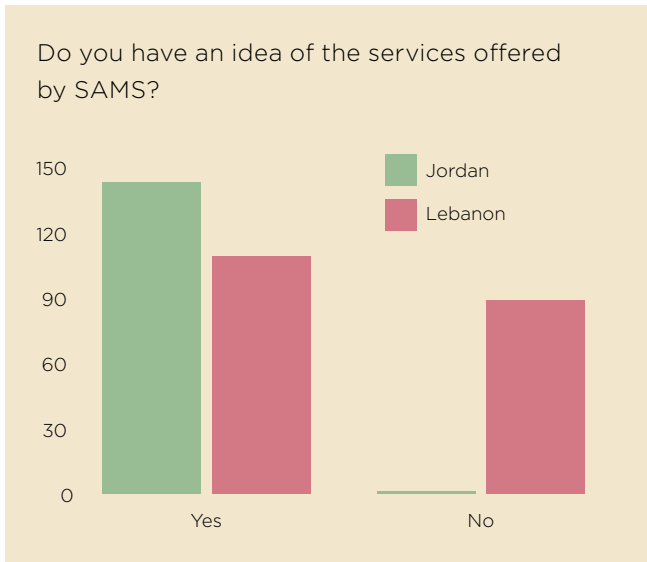
2. Standardize MHPSS Programming in Global Humanitarian Emergencies. It is anticipated that more than 141 million people across the world will need humanitarian assistance and protection, and this number is set to increase.¹⁰ As people are displaced, recovering from natural disasters or fleeing an ethnic cleansing, mental health providers are needed to provide psychological first-aid and emotionally support volunteer providers. UN agencies and humanitarian organizations should include MHPSS programming as a component of their emergency response planning.

3. Development of Mental Health Support Programming for Mental Health Providers and Humanitarian Workers. With so much focus on the patients themselves, what is often overlooked is the toll such work takes on mental health providers themselves. In addition, humanitarian workers and volunteers who work directly with these populations are themselves susceptible to trauma from a result of exposure to difficult and painful cases. Donors and humanitarian organizations should develop programs to support providers and volunteers following completion of their humanitarian work.

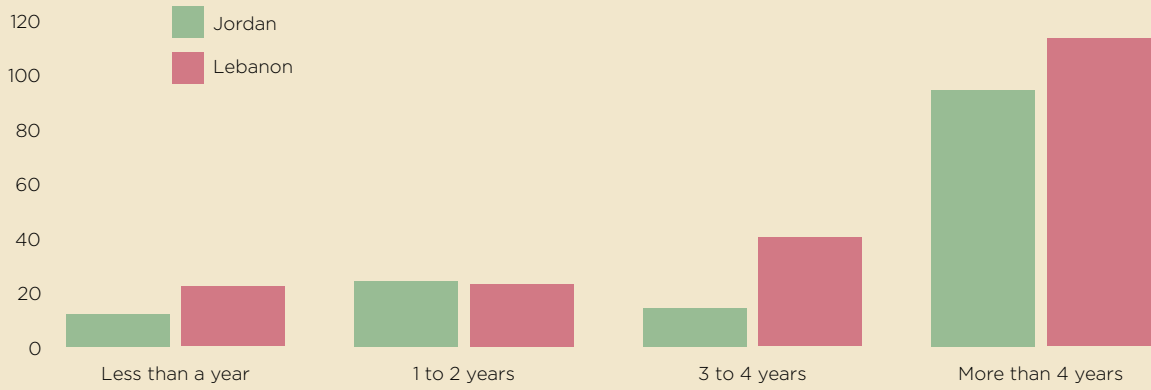
4. Incorporate Mental Health into Primary Care. 30 percent of Syrian refugees experience clinical depression and between 50 and 57 percent experience Post-Traumatic Stress Disorder (PTSD).¹¹ Mental health issues often complicate management of chronic diseases, exacerbate conditions, and present through physical symptoms (ie. chest pain, shortness of breath, fatigue, bed-wetting etc). As we move from crisis response to long-term management of patients, it is imperative we incorporate mental health as part of primary care. Through screening and multi-modality care, we treat the whole person taking into account mental and social factors, rather than just the physical symptoms of the disease.

IMPACT SURVEYS

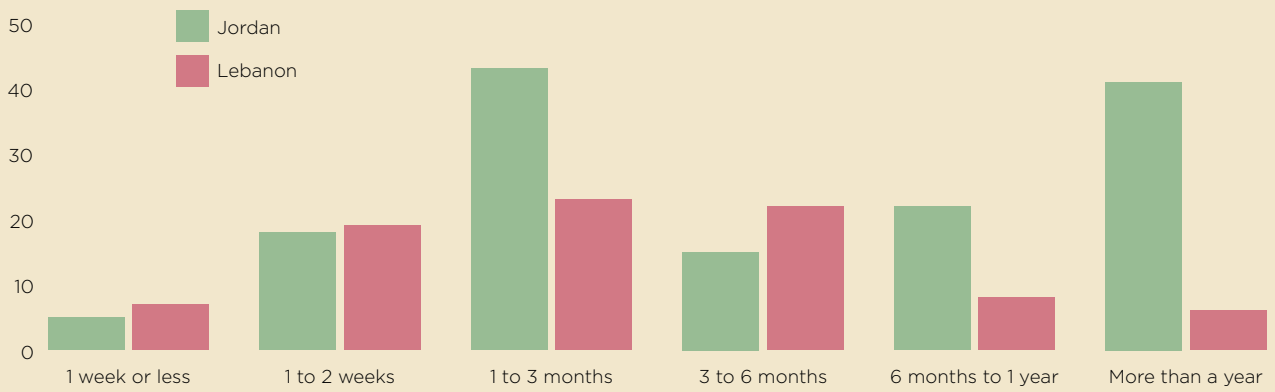
With the understanding that the Jordan mental health program has been operational for almost five years and the Lebanon program for only one, we asked 200 Syrians living in Jordan and Lebanese Refugee Camps respectively the following five questions to understand the impact our programs are having.



How long have you been displaced or a refugee?



How long did you continue to use services?



SOURCES

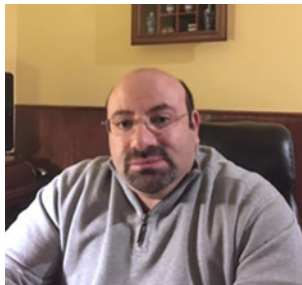
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MENTAL HEALTH COMMITTEE



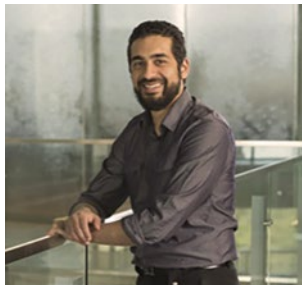
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Dr. Ammar Traboulsi is a general and child/adolescent psychiatrist. He is the medical director of the Connecticut Institute of Behavioral Health. Dr. Traboulsi serves as the vice chair of the SAMS Mental Health Committee, and director of the SAMS PsychoSocial Services (PSS) in Jordan.



Yassar Kanawati, M.D.

Dr. Yassar Kanawati is board-certified in child, adolescent, adult, and addiction psychiatry. She is an assistant professor at Emory Medical School and Morehouse School of Medicine and medical director of CHRIS Counseling Center in Atlanta, GA. With the support of SAMS, Dr. Kanawati started a psychosocial support team in Amman, Jordan. Her areas of expertise include depression, mood disorder, ADHD, disruptive disorders, PTSD, and the effects of trauma and war on family members, particularly on children.



Saleem Khaldoon Al-Nuaimi, M.D., MSc., FRCPC

Dr. Saleem Al-Nuaimi is a practicing child and adolescent psychiatrist at the University of Alberta in Edmonton, Canada. Dr. Al-Nuaimi is a member of the SAMS Mental Health committee. He is the director of the Tele-Psychiatry Program, which has successfully established a tele-psychiatry clinic in northern Syria that provides psychiatric care through the internet to patients suffering from serious mental illness.



Bassam Awwa, M.D.

Dr. Bassam Awwa is a practicing addiction psychiatrist and medical director at Connecticut Behavioral Health Associates. Dr. Awwa has been a member of SAMS since its inception. He presented on behalf of the Mental Health Committee during the 2017 SAMS International Conference. He has traveled and provided mental health services to refugees in Jordan and Lebanon.



Tarif Bakdash, M.D., M.HSc., MEHP fellow, FAAN

Dr. Bakdash is an associate professor at the University of Mississippi Medical Center. He is a pediatric neurologist, epileptologist and specializes in movement and behavioral sleep disorders. For the last three years, Dr. Bakdash has been treating Syrian refugee children at camps in Jordan.

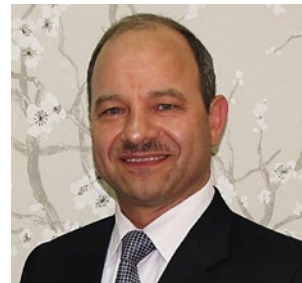
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Dr. Symons is a trauma doctor in emergency units in Durban, South Africa, and also assists surgeons in operating theatres. She has post-graduate diplomas in Mental Health and Anaesthetics, has completed an Aviation Medicine exam, and is Cat 138 accredited. Dr. Symons volunteers as a disaster relief doctor with Gift of the Givers (a South African humanitarian NGO), and worked with them inside Syria during the revolution in April 2013. She regularly serves with SAMS in Jordan, and has visited the SAMS work in Beirut and the Biqa'a Valley in Lebanon.



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Dr. Abou-Allaban is board-certified in general psychiatry. He is the CEO of the American Center for Psychiatry and Neurology, UAE, and the medical director of Neuro Behavioral Center in Walpole, MA. Dr. Abou-Allaban has extensive experience in lecturing and teaching. He has conducted workshops on different psychiatric and psychological topics in the USA, UAE and internationally. He acts as a liaison to other NGOs and coordinates conferences for SAMS.



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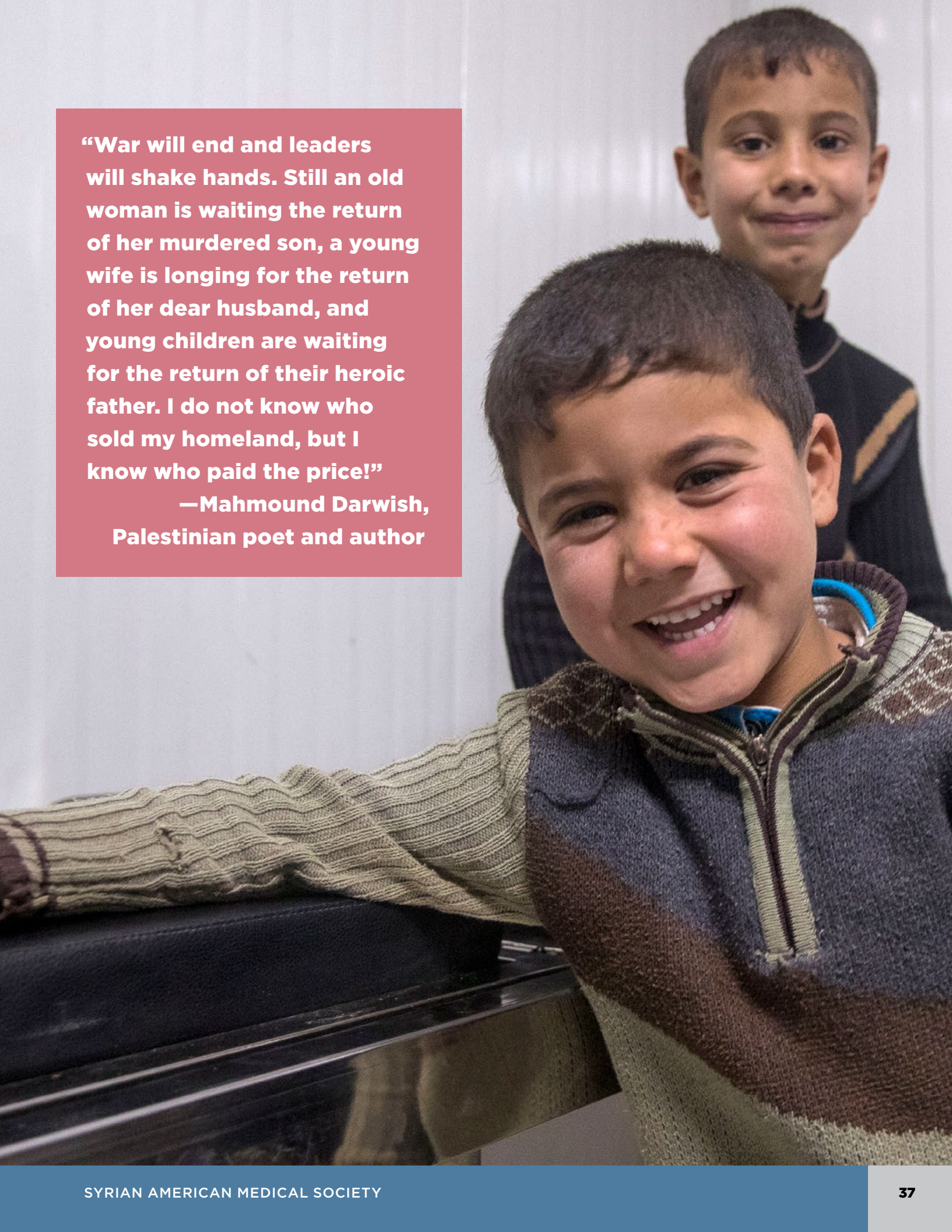
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“War will end and leaders will shake hands. Still an old woman is waiting the return of her murdered son, a young wife is longing for the return of her dear husband, and young children are waiting for the return of their heroic father. I do not know who sold my homeland, but I know who paid the price!”

**—Mahmound Darwish,
Palestinian poet and author**



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