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Disability Inclusion Helpdesk Report No: 15

Query title	Mental health and psychosocial support (MHPSS) in Syria: concepts, reality and effectiveness of interventions
Authors	Harri Lee, Davide Ziveri and Lauriane Pfeffer
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Query	1) Define mental health and psychosocial support (MHPSS) and intended outcomes of these interventions (at the global level). 2) What is the evidence on the nature of the problem and the scale of need for MHPSS services in Syria? 3) What is the evidence on effectiveness of MHPSS interventions in Syria?
Enquirer	DFID Syria

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1. Overview

This report is a rapid review of the evidence on mental health and psychosocial support (MHPSS) in Syria. After outlining the approach and methodology in section 2, it begins by defining key concepts in MHPSS (section 3) and intended outcomes of related programmes (section 4), before presenting a summary of the available evidence on the nature of the problem and scale of need in Syria (section 5). This is followed by evidence on the effectiveness of programming (section 6). The purpose of this query is to support DFID Syria in their work on MHPSS and has been developed in the context of their strategic objectives, which are:

- Protection and Humanitarian
- Influencing the international response
- Future proofing the DFID Syria portfolio
- Regional resilience

DFID's Strategy for Disability Inclusive Development (2018-2023) recognises mental health as a "fundamental part of being human",[1] and international momentum has recently grown on the promotion of mental health, including prevention and care, and protection of the rights of those with mental health conditions (DFID, 2018). First formally recognised in the World Health Organization's (WHO) inaugural Global Mental Health Action Plan 2013-2020

[1] Please note pages are not numbered.

(WHO, 2013), mental health has become a global health and development priority. Since then, international and high-level commitment has been reinforced through various international frameworks.[2]

The international mental health sector has started to look beyond the historically narrow focus on mental disorders, to incorporate "a full spectrum from everyday wellbeing through to mental health conditions and long-term psychosocial disabilities"[3] (DFID, 2018). Emerging data is beginning to demonstrate the increasing contribution of mental health conditions and psychosocial disabilities to disability prevalence worldwide and secondly, that there is routinely poorer quality of care in mental health compared to physical health conditions (Patel et al., 2018). According to the WHO, it is low- and middle-income countries (LMICs) however facing a triple disadvantage as they bear the greatest burden of poor mental health outcomes, with the most limited evidence, and significant care gaps of up to 85% (WHO, 2017).[4]

Humanitarian emergencies and aid interventions can create new and exacerbate pre-existing psychological and social problems (IASC, 2010). A recent review of data from 39 countries published in June 2019 by the WHO estimates that in conflict settings, 22% people will have mental health disorders such as depression, anxiety, post-traumatic stress disorder (PTSD), bipolar disorder or scHIzophrenia (Charlson et al., 2019).

Box 1: key definitions (see section 3 for further discussion of key terms)

Mental health: "mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO Global Action Plan on Mental Health, 2013, p. 1).

Psychosocial: "the interaction between social aspects (such as interpersonal relationships and social connections, social resources, social norms, social values, social roles, community life, spiritual and religious life) and psychological aspects (such as emotions, thoughts, behaviours, knowledge and coping strategies) that contribute to overall well-being" (IASC, 2010, p. 10). IASC defines mental health and psychosocial problems as being interconnected and including a set of pre-existing, emergency-induced and humanitarian aid-induced psychological and social problems (IASC, 2010).

Mental health and psychosocial support (MHPSS): "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat a mental disorder" (IASC, 2010, p. 1).

Publicly available data and evidence on MHPSS in Syria, both in terms of the nature of the problem and effectiveness of programming is extremely limited. There have been no national prevalence studies conducted, and most of the available data comes from Syrian refugees in neighbouring countries. In addition, there are several challenges associated with epidemiological studies in the Syrian context, including the lack of contextualised, tested and adapted tools, meaning data should be treated with caution.

The eight-year conflict in Syria has claimed at least 500,000 lives and resulted in more than 12 million persons becoming displaced. In addition to the immediate direct impact of violence on people's lives, including their mental health, the conflict has led to additional severe stressors, including pressures on livelihoods, increased poverty and malnutrition (FAO, 2016, The Humanitarian Forum, 2015; UNOCHA, 2019). The social fabric in Syria has been severely damaged, leading to upheavals in households and communities and limited avenues for community support for those affected by the conflict (expert input from L. Pfeffer; FAO, 2017). The available evidence suggests 20% internally displaced people are suffering acute, daily feelings of anxiety and depression (PRDWG & REACH, 2018). For Syrian refugees, recent data suggests 10% children aged 5-17 and 12% adults in Jordan and Lebanon suffer from anxiety (HI, 2018). Further data on psychological distress, mostly from neighbouring countries, shows high rates of

[2] Including relevant targets within the UN Sustainable Development Goals (SDG) (e.g. 3.4, 3.5, and 3.8) (Patel et al., 2018) and the Global Reference List of 100 Core Health Indicators (WHO, 2018), ratification of the Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006; DFID, 2018), and development of leadership in knowledge generation and priority setting through collaborative bodies such as the Lancet Commission on Global Mental Health (Patel et al., 2018).
[3] Pages are not numbered.
[4] Please note these two paragraphs are summarised from Haegeman, E. and A. Palfreyman (2019) *Mental health, maternal health and sexual and reproductive health and rights*,
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trauma and feelings of fear, anger and hopelessness (Dietrich, 2019; Almoshmosh, 2013; Hassan et al., 2015; Al Akash et al., 2014). Despite demand for services, there are a range of demand and supply-side barriers to access, including cost, availability and awareness of services, trained staff and stigma faced by those accessing support (Danish Refugee Council, 2018; TWG, 2017; ABAAD, 2016; Viller Hansen et al., 2018; Asfour & Baca, 2017).

It is difficult to assess what works in MHPSS programming in Syria due to the lack of publicly available evaluations. This rapid review found no published evaluations of MHPSS interventions from inside Syria. However, available evaluations from neighbouring countries suggest a range of different approaches which can alleviate symptoms of anxiety, depression and posttraumatic stress disorder (PTSD), including group-based activity sessions for youth, eye movement desensitisation and reprocessing, and mobile-based applications for children's literacy and psychosocial wellbeing. There is less evidence on the impact of these programmes on positive coping strategies and building resilience, both due to the lack of measurement in this area as well as a lack of impact found in the available studies. It is important to note that several evaluations are planned and forthcoming related to other interventions in Syria and neighbouring countries; it is therefore likely that the evidence base will grow over the coming years.

There are a number of implications from this rapid desk-based research:

- There is a need to improve understanding of the mental health and psychosocial wellbeing of the Syrian population, particularly inside Syria, and what works to address psychosocial needs and barriers to access to services and participation and foster resilience in a volatile regional context.
- Existing evaluations of MHPSS interventions in the Syrian crisis tend focus on the effectiveness of specific therapies and approaches which suggests a lack of multisectoral, cross-cutting interventions.
- Due to the emphasis on interventions provided to individuals and small groups and a tendency to measure outcomes immediately after interventions, an understanding of the long-term impacts of the crisis on communities may be missed.
- Links between interventions with Syrian refugees and those affected by the conflict inside Syria could be strengthened, both in terms of sharing lessons and knowledge and developing cross-border harmonised, coordinated, and synergic activities.
- It was not possible to assess the extent to which MHPSS interventions are designed with a rights-based approach in mind in Syria, ie. by identifying and removing barriers to individual rights and participation in programming. It was clear that the available evidence tends to refer to needs rather than rights or barriers.[5]

2. Methodology

This rapid research query has been conducted as systematically as possible within 6 days of researcher time. For Question 1, definitions and outcomes were identified in the available literature. This involved searching key survey reports and instruments from the WHO , UNICEF, Demographic and Health Surveys (DHS), and the UNICEF-led Multi-Indicator Cluster Surveys (MICS)[6], as well as key systematic reviews, evidence reviews, frameworks and guidance, to identify definitions for MHPSS and intended outcomes for these programmes. In order to answer Question 3, a rapid mapping was undertaken with key evaluations mapped in a spreadsheet (see Annex 1 for a summary table of the findings from this mapping and the attached excel spreadsheet with full details).

The methodology is described below.

Search strategy: Studies were identified through a variety of search strategies;

- **The review prioritised existing syntheses, evidence reviews, and systematic reviews** where possible in order to draw on the fullest range of evidence possible (including Bangpan et al., 2017; Hassan et al., 2015).

[5] DFID's strategy on disability inclusion (DFID, 2018), which includes psychosocial disabilities adopts a rights-based approach where programmes are encouraged to identify and remove barriers to rights and participation.
[6] Designed to collect data on the situation of women and children.

- **DFID Disability Inclusive Development Programme consortium partners**[7] **and relevant experts were contacted** for evidence recommendations (see Section 7 for experts who responded).
- **Google and relevant electronic databases** (PubMed, Science Direct, and Google Scholar) for priority sources using a selection of key search terms[8] used in other systematic reviews to identify more recent materials. The review also considered programmes which may have useful lessons but were excluded from systematic reviews, due to less rigorous evaluation methodologies.

Criteria for inclusion: To be eligible for inclusion in this rapid review of the literature, studies had to fulfil the following criteria:

- **Focus**: Mental health and psychosocial support in Syria.
- **Time period**: 2011 – 2019.
- **Language**: English.
- **Publication status**: publicly available – in almost all cases published online.
- **Geographical focus**: Syria (please note due to the lack of data and evidence from inside Syria, the scope of this query was widened to include studies related to Syrian refugees in neighbouring countries, and in a handful of cases, European countries).

3. Defining mental health and psychosocial support (MHPSS)

This review finds that mental health and psychosocial wellbeing or support are often referred to together without explicit definitions or discussion about the differences and relationship between them. Defining mental health itself is a complex and evolving task (see box 2, page 6 on key challenges). In recent years, there has been increasing recognition of the importance of wellbeing as a concept, rather than simply the absence of mental illness (Westerhof and Keyes, 2009). The WHO's widely-accepted definition, outlined in its 2013-2020 Global Mental Health Action Plan focuses on wellbeing; "mental health is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2013, p. 1). According to the 2017 Inter-Agency Standing Committee (IASC) M&E framework on MHPSS in humanitarian contexts, the term "psychosocial," despite lacking a widely-agreed definition, is often used to describe the "interaction between social aspects (such as interpersonal relationships and social connections, social resources, social norms, social values, social roles, community life, spiritual and religious life) and psychological aspects (such as emotions, thoughts, behaviours, knowledge and coping strategies) that contribute to overall well-being" (IASC, 2017, p.10). In this sense, psychosocial wellbeing may be seen as a broader concept than mental health, though these definitions also suggest that aspects of mental health and psychosocial wellbeing overlap and are interdependent (Dodge et al., 2012).

These definitional issues are also reflected in international survey instruments used in LMICs, where the focus on measures related to mental health is on feelings, diagnoses or treatment for anxiety or depression, rather than on the presence of mental health or wellbeing. The DHS module on mental health has the narrowest

[7] The Disability Inclusion Helpdesk is funded under the DID programme. The DID consortium partners are ADD International, BBC Media Action, BRAC, Institute of Development Studies (IDS), International Disability Alliance (IDA), Humanity & Inclusion, Leonard Cheshire Disability, Light for the World, Sense, Sightsavers and Social Development Direct.
[8] Key search terms included: mental health/psychosocial/MHPSS + Syria/Whole of Syria/inside Syria

focus, measuring the presence of diagnosis and/or treatment for depression.[9,10] The MICS use material from the Washington Group Questions Extended Set on Functioning[11], which includes relevant questions on difficulties with self-care, remembering, concentrating and communicating (please note a module on psychosocial functioning is currently being developed by the Washington Group). The MICS also include questions assessing difficulties in making friends, controlling his/her own behaviour and in coping with changes to daily routine,[12] as well as direct questions on how often the child feels nervous, anxious, worried and depressed.[13]

In practice in humanitarian contexts, the definitions appear to be clearer. IASC defines mental health and psychosocial problems as being interconnected and including a set of social problems (pre-existing such as marginalisation, emergency-induced such as family separation, and humanitarian aid-induced such as overcrowded camps) and a set of psychological problems (pre-existing such as severe mental health disorders, emergency-induced such as grief or alcohol/other substance misuse, and humanitarian-aid induced such as anxiety due to a lack of information about food distribution) (IASC, 2010). Despite this, programming reportedly tends to focus on emergency-induced disorders such as PTSD and depression. IASC argues that this focus is inadequate and focuses on defects rather than assets and resources (ibid.).

MHPSS interventions are defined by IASC as "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat a mental disorder" (IASC, 2010, p. 1). Their 2007 guidelines note that despite the closely linked nature of mental health and psychosocial support, many in the humanitarian sector often treat MHPSS as two separate yet supporting sets of interventions: health-focused interventions to prevent and treat mental health disorders (both pre-existing and emergency-induced - mental health) and other, cross-sectoral approaches to support psychosocial wellbeing (IASC, 2007; IASC, 2010).

IASC's pyramid of interventions is a widely-used model which frames four levels of MHPSS interventions (see diagram 1 below, taken from IASC, 2010). IASC's (2012) *Who is doing What, Where and When in MHPSS (4Ws)* mapping tool outlines 11 activity codes which break down MHPSS interventions further, although they do not directly map across the four levels of the pyramid. They are highlighted in diagram 2 on the following page. UNICEF has recently adapted this model in their 2018 guidelines on community-based MHPSS which focuses on nine "circles of support" (providing specialised care to caregivers suffering from mental health disorders is one of these, whilst strengthening health systems is another) at three levels (that of the child, the family/caregiver, and community). The guidelines highlight that interventions that address both the psychological and social aspects of wellbeing should occur at all four levels of the IASC pyramid, including specialised care (UNICEF, 2018).

Challenges remain in the design and implementation of MHPSS interventions across the pyramid in humanitarian settings. The lack of clarity on definitions and measurement has reportedly led to inconsistent approaches, large disparities in quality, and in the development of activities lacking depth and relevance (recreational activities that are called psychosocial support for a lack of better definition for instance) (Melville, 2009). There appears to be a lack of clarity over which interventions should be included under the MHPSS umbrella and how to measure

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[9] Definition of 'depression' in the DHS Non-Communicable Diseases Module Interviewer Instructions: "Depression is a mood disorder that affects how a person feels, thinks, and handles daily activities. The most common symptom is sadness, but sadness is a normal emotion usually triggered by something. Depression affects one's mood over an extended period of time and affects one's mood about everything, and it not usually triggered by anything in particular. It is common for a depressed person to have little or no interest in normal activities or activities they used to enjoy."

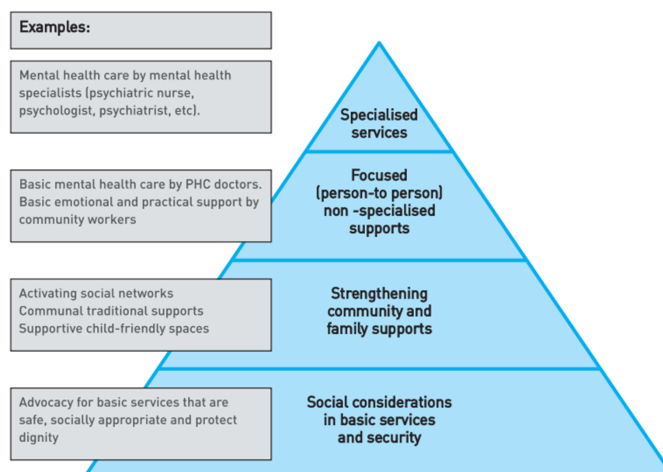
[10] The WHO's World Mental Health Survey Initiative, in partnership with Harvard University, developed a comprehensive suite of survey tools in the early 2000s measuring a full range of disorders and associated treatment, from common disorders such as anxiety and depression, alcohol and substance abuse, more severe disorders such as bipolar disorder and schizophrenia, and childhood disorders such as attention-deficit/hyperactivity disorder, conduct disorder, and oppositional-defiant disorder. Find out more here: https://www.hcp.med.harvard.edu/wmh/index.php

[11] See here for more info: http://www.washingtongroup-disability.com/

[12] As with the Washington Group Questions, these questions have four response options: no difficulty; some difficulty; a lot of difficulty; and cannot do at all.

[13] Answer options here are: daily, weekly, monthly, a few times a year or never.

Diagram 1: IASC's MHPSS Intervention Pyramid (taken from IASC, 2017, p. 6)



them, particularly in qualitative terms (expert input from L. Pfeffer). The WHO estimates on the prevalence of mental health disorders (22% for all mental disorders and 5% for severe disorders) suggests that provision of MHPSS specialised care by specialised practitioners at the top of the pyramid should therefore be minimal (Charlson et al., 2019; expert input from L. Pfeffer). However, in practice, many MHPSS programmes reportedly tend to pathologise[14] emotional distress (which is a normal response to extreme adversity), often focusing on building capacities of specialists (which is not realistic considering taskforce and academic levels) without developing community resilience (expert input from L. Pfeffer).

Box 2: Key global challenges in MHPSS concepts and measurement

- **Mental health and psychosocial wellbeing are overlapping and interlinked concepts**, involving psychological and social aspects of life which can impact each other, although psychosocial wellbeing can be said to be a broader concept than mental health.
- **Definitions related to MHPSS have evolved over time.** There has been a shift in the global definition of mental health towards a focus on wellbeing rather than the absence of mental health disorders, and psychosocial wellbeing is defined as a result of the interaction between psychological (feelings, thoughts and behaviours) and social aspects (interpersonal relationships, networks etc.) of wellbeing. There is a lack of global consensus on how to measure the latte, contributing to a lack of evidence on what works in MHPSS.
- **There appears to be a lack of consensus on what constitutes MHPSS programming.** According to IASC, MHPSS in humanitarian contexts has a broad definition including not only emergency-induced psychological and social problems but impact on pre-existing issues, such as marginalisation and alcohol abuse, however in practice, programmes and measurements are more likely to address direct effects of conflict such as PTSD.
- **The focus on measurement, both in international surveys and impact evaluations, remains on the presence of mental health disorders**, for example PTSD, anxiety and depression, rather than on positive mental health and psychosocial wellbeing. Measurement is evolving, however, with the Washington Group on Disability Statistics currently developing a module on psychosocial functioning. There is less consensus, however, on how to measure psychosocial wellbeing, however there are a few commonly-used scales including the Children's Hope scale, a six-item scale with questions focused on children's agency.
- **Programmatic M&E appears to measure broader, non-pathological outcomes**, for example strengthening family and community support, psychological interventions and general support for MHPSS. However recent analysis suggests there are significant weaknesses across the board in M&E approaches (Jura et al., 2018).

The literature is contradictory on the extent to which MHPSS practice echoes the IASC intervention pyramid. Whilst there has been a historical emphasis in global mental health work on specialised services, the

[14] I.e. to treat as psychologically abnormal.

reality in many contexts, particularly in emergencies, means that specialist support is not able to meet existing needs. Wider interventions at the other three levels of the pyramid are common, however they are less likely to be rigorously evaluated due to challenges in defining and measuring broader psychosocial wellbeing in contrast

Diagram 2: IASC's 11 MHPSS activities (taken from IASC, 2012)

Activity Code	Description of 4Ws Activity Codes
Activity 1	Information dissemination to the community at large
Activity 2	Facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general
Activity 3	Strengthening of community and family support
Activity 4	Safe spaces
Activity 5	Psychosocial support in education
Activity 6	Supporting the inclusion of social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation
Activity 7*	(case-focused) psychosocial work
Activity 8*	Psychological intervention (e.g., counselling, psychotherapy)
Activity 9*	Clinical management of mental disorders by non-specialized health care providers (e.g. PHC, post-surgery wards)
Activity 10*	Clinical management of mental disorders by specialized mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/ general health facilities/ mental health facilities)
Activity 11	General activities to support MHPSS

* Of note: some activities under Activity 7 or 8 may also be coded under Activity 9 and 10 when these occur in health care settings. Categories 7-10 are thus not mutually exclusive.

to the presence of mental health disorders (expert input from L. Pfeffer). A 2016 systematic review on interventions for children found a lack of programmes relating to family and community support (Jordans et al.), whilst a 2011 Lancet systematic review found strengthening community support as the second most common intervention type (Tol et al.). The Lancet review found only three studies meeting their inclusion criteria relating to family and community support and no studies related to basic services, with the majority of studies sat at the top two levels of the IASC pyramid. This contradiction might suggest that, as highlighted in a 2017 DFID-funded systematic review, "community support" often lacks community mobilisation and participation. This can be prejudicial to the overall quality and coherence of MHPSS interventions, as without solid foundations, mobilisation and community buy-in, it unlikely that MHPSS interventions can have meaningful impact (Bangpan et al., 2017; expert input from L. Pfeffer).

4. Intended outcomes of MHPSS interventions globally

This rapid review found a **disconnect between MHPSS evaluations**, which tend to measure the presence of mental health disorders **and monitoring and evaluation (M&E) processes** which typically measure a wider set of outcomes related to psychosocial wellbeing.

A small number of recent systematic reviews show that rigorous impact evaluations tend to focus on measuring pathological outcomes, i.e. symptoms of mental health disorders, rather than outcomes relating to the wider definition of MHPSS, such as resilience (Purgato et al., 2018; Bangpan et al., 2017; Tol et al., 2011). However, it should be noted that this may be due to the lack of comparability of data on outcomes which go beyond pathology, such as feelings of hope, quality of parental support and scores against wellbeing scales, as highlighted in one evidence review (Tol et al., 2011). According to a 2018 systematic review published in the Lancet, common primary outcome measures have focused on symptoms of PTSD, stress disorders, anxiety and depression, rather than outcomes related to the wider aspects of psychosocial wellbeing. This review also suggests a secondary focus on other outcomes such as family support (Purgato et al., 2018). A DFID-funded systematic review (Bangpan et al., 2017) examining 46 randomised controlled trials (RCTs) analysed the most to least commonly-used outcomes (see table 1 below). This table shows a tendency to prioritise the measurement of mental health disorders rather than broader aspects of MHPSS-related outcomes. It is worth noting that for MHPSS interventions with adults the more positive outcomes such as hope and social support do not appear to have been measured by any of the reviewed studies.

Table 1: Outcomes in MHPSS RCTs (adapted from Bangpan et al., 2017)

	Adults (based on 20 RCTs)	**Children and youth** (based on 26 RCTs)
Three most commonly-used outcomes	• Depression (12 studies) • PTSD (7) • Anxiety (6)	• PTSD symptoms (21 studies) • Depression (14) • Conduct problems (8)
Three least commonly-used outcomes	• Social support (2 studies) • Partner violence (2) • Grief (2)	• Hope (5 studies) • Social support (2) • Somatic complaints (2)

Commonly-used measures in MHPSS research and evaluation include (expert input from L. Pfeffer; results from the rapid mapping of evaluations in Syria):

- WHO-5, a five-question wellbeing index, widely-used since the late 1990s to measure depressive symptoms.[15]
- SRQ-20, a 20-question index gathering self-reported data on general psychological distress, developed by the WHO for primary healthcare settings in LMICs.[16]
- Impact of Event scale-Revised (IES-R): a 22-item scale to measure intrusive thoughts and avoidance related to traumatic experiences and symptoms of PTSD. [17]
- Beck Depression inventory, a 21-question multiple choice index measuring depressive symptoms.[18]
- Strengths and Difficulties Questionnaire, a 25-item questionnaire for children and young people measuring emotional and conduct problems, as well as prosocial behaviours.[19]
- Less frequently used tools include Rosenberg's self-esteem scale and the Children's Hope scale.

In practice, M&E of MHPSS interventions tend to measure broader, less tangible outcomes related to psychosocial wellbeing, such as hope, resilience, and family and community support. In 2017, IASC published their common M&E framework for MHPSS, which sets out an overarching goal and five key outcomes, along with a set of outcome indicators, including those related to do no harm, safety, protection and human rights, promotion of wellbeing,

[15] For the questionnaire, see: https://www.psykiatri-regionh.dk/who-5/Documents/WHO5_English.pdf
[16] For the questionnaire, see: https://apps.who.int/iris/bitstream/handle/10665/61113/WHO_MNH_PSF_94.8.pdf?sequence=1&isAllowed=y
[17] For the questionnaire, see: https://www.aerztenetz-grafschaft.de/download/IES-R-englisch-5-stufig.pdf
[18] For the questionnaire, see: https://www.ismanet.org/doctoryourspirit/pdfs/Beck-Depression-Inventory-BDI.pdf
[19] For the questionnaire, see: https://depts.washington.edu/dbpeds/Screening%20Tools/Strengths_and_Difficulties_Questionnaire.pdf

support for people with mental health conditions and focused care for those who need it (see diagram 3 below taken from IASC, 2017[20]). These have been reproduced by UNICEF in their 2018 guidelines on community-based MHPSS (UNICEF, 2018). Four of these five outcomes relate to psychosocial support interventions, whilst only one speaks directly to the provision of specialised mental healthcare. A recent review of MHPSS M&E practices (Jura et al., 2018) which included 38 logframes and 89 academic articles found impact and outcome measurement focused on six areas, including resilience and psychosocial wellbeing, capacity building, and the protection of vulnerable groups such as women, children, the elderly and people with disabilities (ibid.). It is in the context of this complexity that this query now considers MHPSS in Syria and amongst Syrian refugees in neighbouring countries.

Diagram 3: IASC's MHPSS outcomes (taken from IASC, 2017)

Goal: Reduced suffering and improved mental health and psychosocial well-being

Outcomes:

Community-focused	1 Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable	2 People are safe, protected, and human rights violations are addressed	3 Family, community and social structures promote the well-being and development of all their members
Person-focused	4 Communities and families support people with mental health and psychosocial problems	5 People with mental health and psychosocial problems use appropriate focused care	

Underlying core principles: 1. Human rights and equity, 2. Participation, 3. Do no harm, 4. Integrated services and supports, 5. Building on available resources and capacities, 6. Multilayered supports

5. Mental health in Syria: the nature of the problem and the scale of need for MHPSS services

The eight-year conflict in Syria has claimed at least 500,000 lives and resulted in more than 12 million persons displaced (Carpanelli, Li, and Schwarz, 2018). According to the WHO, this protracted crisis has had a huge impact on the social determinants of mental health (WHO and Calouste Gulbenkian Foundation, 2014). According to UNOCHA (2019), half of the Syrian population are potentially at risk from explosive hazards, meaning that fear of landmines, explosive remnants of war and improvised explosive devices characterises everyday life. Despite the reduction in violence in many parts of the country over the past year, an estimated 11.7 million people require humanitarian assistance, of which five million are in acute need (UNOCHA, 2019).

[20] These were developed following a literature review on frequently measured MHPSS constructs; an expert panel and consultation on a draft framework and key terms; field consultations in humanitarian settings in Africa, Asia and the Middle East; an in-depth review of commonly used indicators and measurement tools.

In addition to the immediate direct impact of violence on people's lives, including their mental health, the conflict has led to additional severe stressors, including pressures on livelihoods, increased poverty and malnutrition (FAO, 2016, The Humanitarian Forum, 2015; UNOCHA, 2019). According to UN data, children are the most vulnerable populations: 2.1 million children in Syria are out of school and 1.3 million children are at risk of dropping out; 85% of assessed communities reported a high occurrence of child labour; and in 45% of the assessed communities early marriage related issues were reported as occurring (UNOCHA, 2019). The protracted conflict has generated profound changes in the social fabric in Syria, resulting in psychological distress and negatively affecting social support and available coping mechanisms. Community networks which have previously served as a source of support by families have been severely impacted by forced displacement. The well-established link between conflict, crisis and the disruption of gender norms within households and communities is playing out in the Syrian crisis (expert input from L. Pfeffer; FAO, 2017). Household gender dynamics have shifted as a result of the losses and crippling physical and/or psychological injuries amongst the Syrian male population, leading to changes in family composition, increased numbers of female headed-households and women taking on responsibility for income generation, increases in child labour, domestic violence and children's psychological distress (expert input from L. Pfeffer; FAO, 2017; ACTED, 2013; Buecher & Aniyamuzaala, 2016).

Data is limited on the scale of mental health issues and disorders inside Syria, although more data is available with relation to Syrian refugees in neighbouring countries (HI, 2018; Hedar, 2017). To date, there has been no comprehensive data collection at the national level on prevalence of mental health disorders (Hedar, 2017). A 2015 UNHCR-commissioned literature review highlights a number of challenges with epidemiological studies within the context of the Syrian crisis. The review notes that the use of standard instruments does not take local cultural symptoms or language used to articulate distress into account and are rarely validated in the context of the Syrian crisis. Instruments used tend to focus on PTSD and depression with a limited focus on coping mechanisms and resilience. In terms of the cultural expression of mental health and psychosocial wellbeing, indirect and general phrases, many of which are related to physical symptoms, are often used to discuss mental health (for example feeling tired, having pain in the heart, stomach or head, cramps in the gut or numbness). In Syria, the terms mental health and psychosocial wellbeing carry negative connotations due to the stigma faced by those with mental health disorders (Hassan et al., 2015).

Recent available data from inside Syria suggests high rates of anxiety and depression (PRDWG & REACH, 2018). A recent survey by the Physical Rehabilitation and Disability Working Group, Humanity & Inclusion (HI) and the WHO, with a sample of 4,865 adults in 34 accessible sub-districts in Aleppo, Idleb, and Ar-Raqqa[21] found high rates of reported anxiety and depression, with 20% of IDPs reporting acute, daily feelings of anxiety or depression in comparison to 13% of residents and 14% of returnees (PRDWG & REACH, 2018). Existing estimates are relatively consistent, with the WHO estimating that 20% of the Syrian population are at risk of moderate mental health disorders, whilst 3.3% are at risk of severe mental health disorders (OCHA, 2017; Thompson, 2017). The Syrian Arab Association of Psychiatrists estimates 4% of the Syrian population suffer from severe disorders (Hassan et al., 2015).

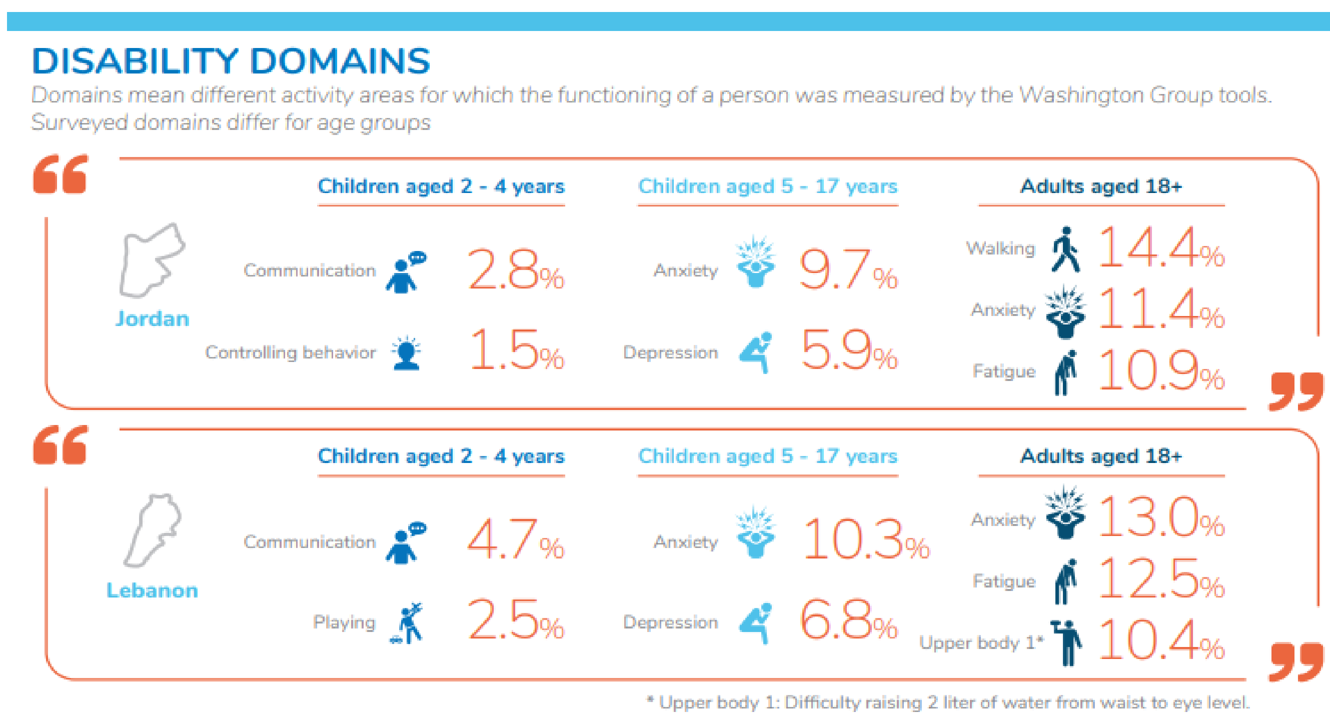
Data from neighbouring countries suggests the prevalence of mental health disorders and lack of psychosocial wellbeing are significant amongst Syrian refugees. Evidence includes:

- A recent HI survey using the Washington Group Questions with 8,876 Syrian refugees in Jordan and Lebanon found approximately 10% of children aged 5-17 and 12% of adults experienced anxiety (see diagram 4 below for breakdown between Jordan and Lebanon) (HI, 2018.
- A 2013 International Medical Corps survey of7,964 adults and children found:
    - 15.1% of respondents felt so afraid that nothing could calm them down;
    - 28.4% felt so angry that nothing could calm them down;

[21] Sample representative at sub-district level with a 9% confidence level.

    - 25.6% felt so uninterested in things that they used to like;
    - 26.3% felt so that they tried to avoid places, people, conversations or activities that reminded them of such events;
    - 18.8% felt unable to carry out essential activities for daily living because of feelings (WHO/IMC, 2013).
- In 2012, around 7% of Medicine Sans Frontier's (MSF) mental health patients in Domeez Syrian refugees' camp in Iraq displayed symptoms of a severe mental disorder, but one year later this number had more than doubled to 15% (MSF, 2013).
- A 2014 mixed-method study of 6,357 mental health cases managed by the IMC in Syria, Lebanon, Turkey and Jordan found that 54% of respondents reported severe emotional disorders, including 11% reporting psychotic disorders, and 3.6% of children reporting severe emotional disorders (Hijazi et al., 2015).
- A 2019 survey of 2,057 Syrian refugees in Germany aged 18-24 found 59% respondents reported at least one traumatic experience (Dietrich, 2019).

Diagram 4: Prevalence of disability, including anxiety and depression, amongst Syrian refugees in Jordan and Lebanon (HI, 2018)



The reasons for the high prevalence of mental health disorders and feelings of distress among Syrian refugees are multifaceted, of which the direct impact of traumatic events is one part of the picture. Several studies with Syrian refugees and a handful of studies conducted directly inside the country show high exposure to violent and traumatic events and high rates of losses (Hassan et al., 2015; Snider, 2017; Dietrich, 2019; Viller Hansen et al., 2018). Key direct effects of the conflict on mental health are related to worry about disappeared relatives, worry over material losses, and a pervasive sense of hopelessness due to the protracted nature of the crisis (Almoshmosh, 2013; Hassan et al., 2015; Al Akash et al., 2014). The reasons given for worsening mental health often include daily stressors including around basic needs and social interactions. For example:

- According to the results from a survey with a sample of 4,865 adults in Aleppo, Idleb, and Ar-Raqqa governorates, the difficulties in addressing basic needs, lack of resources, access to mental health care, and stress or trauma were identified as the most common reasons for worsening mental health in Syria (PRDWG & REACH, 2018).
- A 2018 Relief Internationl rapid assessment in Idlib with a sample of 255 people found the most common reasons were:
  - boredom due to lack of activity leading to rising tension and substance abuse amongst men;
  - lack of dignity and humiliation in not being able to access basic needs for women;
  - lack of safe play areas and spaces, a lack of healthcare, and under or overprotective parents for children (Relief International, 2018).

In addition, some groups may be at higher risk of mental health conditions and psychosocial problems for a number of reasons, including:

- For women and girls, shifting gender norms related to an increased role in income generation and decision making can increase the risk of intimate partner violence (Buecher & Aniyamuzaala, 2016; Dababneh et al., 2018; UNFPA, 2019);
- The effects of conflict-exacerbated gender-based violence (GBV) including fear, anxiety, depression, aggression, stress and distrust (MADRE et al., 2014);
- Restrictions on mobility due to fear of sexual violence which may affect women's and girls' ability to access psychosocial amongst other services (UNFPA, 2019);
- Trauma associated with Daesh (also known as ISIL, Islamic State or ISIS) practices including stoning of women and girls charged with adultery, executions of lesbian, gay, bisexual and transsexual (LGBT) groups and forced marriages of girls to ISIL fighters (Human Rights Council, 2018);
- The impact of abuse perpetrated towards women and girls by government forces in detention, including rape and sexual abuse (Human Rights Council, 2018);
- Children may have higher rates of psychological distress in Syria, with a recent Save the Children survey with 313 parents, caregivers and adolescents aged 13-17 in seven Syrian governates reporting 89% children's behaviour has become more fearful and nervous as the war goes on (McDonald et al., 2017);
- Those with physical disabilities may be at greater risk of psychosocial problems. A Handicap International (now Humanity & Inclusion) and HelpAge International 2014 study found that 30% of Syrian refugees in Jordan and Lebanon had specific needs.[22] Those with specific needs are twice as likely as the general refugee population to report signs of psychological distress; and 65% of older refugees present signs of psychological distress (Handicap International and HelpAge International, 2014);
- Other factors that may influence poor mental health include family status and employment in Syria; for example, Syrians who have been widowed, are separated/divorced and Syrian men who are unemployed are more likely to feel anxious or depressed (PRDWG & REACH, 2018).

There is very little evidence on the impact of mental health disorders and psychological distress on the Syrian population, however reviews of the available evidence suggest a profound impact on the day to day functioning of individuals and communities. According to a 2015 literature review (Hassan et al., 2015), psychological distress leads to a broad range of problems, spanning emotional, cognitive, physical, behavioural and social issues. These include emotional problems: sadness, grief, fear, frustration, anxiety, anger, and despair; cognitive problems such as loss of control, helplessness, boredom; physical problems such as fatigue, problems sleeping, loss of appetite, and social and behavioural problems including withdrawal, aggression and interpersonal problems (ibid.). A 2016 capacity assessment of mental health practitioners in Syria (ABAAD) found that a number of

[22] Ie. those living with impairments, injuries and/or chronic disease.

factors relating to the impact of the conflict, many of which may result from and/or exacerbate mental health and psychosocial problems:

- At the individual level: the most common reasons included despair, pessimism, concerns around the future, feelings of insecurity and instability, self-neglect, helplessness, isolation and social withdrawal, as well as loss of material possessions and homes and difficulties coping with new environments.
- At the family level: family disruption, tension, challenges dealing with children and violence and aggression by male household members.
- At the community level: feelings of alienation, distrust, increased tension, intolerance and sectarianism.

There is limited evidence on the coping mechanisms and help seeking behaviours of those affected by the Syrian conflict (HI, 2018). Positive reported coping strategies include praying, listening to music or watching TV, social and community activities, whilst negative strategies include withdrawal, smoking and obsessively watching the news (Hassan et al., 2015).

Despite data suggesting high demand for MHPSS services, recent evidence suggests a number of key barriers to accessing MHPSS in Syria and for Syrian refugees in neighbouring countries (Danish Refugee Council, 2018). Primarily, the lack of services and the impact of the crisis on an already sparse provision appear to be the most significant barriers to improved mental health and psychosocial wellbeing in Syria. Before the crisis, there were reportedly just 70 psychiatrists serving a population of 22 million people, and no psychiatric nurses (WHO, 2017; ABAAD, 2016). Services, which were focused on psychiatric consultations and medical interventions, provided at two psychiatric hospitals, in Damascus and Aleppo, both of which shut as a result of the violence (ABAAD, 2016). The increase in the number and scale of targeted attacks on healthcare providers presents a significant challenge to healthcare provision in Syria (Thompson, 2017). The UN estimates that almost half (46%) of health facilities in Syria are either non-functional or partially functional as a direct result of hostilities (UNOCHA 2019). As result, access to services is very limited: 92% of severe mental health cases cannot reach any support or follow up (ABAAD, 2016). In addition, whilst psychology students have continued to graduate during the conflict, graduates receive no practical training and therefore enter the job market with no clinical experience (expert input). Before the conflict, Syrian schools tended to have trained psychologists to support children, however this is often no longer the case, with 41% of 44 surveyed schools in Northern Syria camps did not provide any psychological support (ACU, 2017). A 2017 study interviewing 238 key informants in five governorates including Idlib and North Aleppo found 91.6% Syrian refugees reported that MHPSS services in their areas were not enough (TWG, 2017). A lack of trained mental health workers, community centres, lack of financial resources and stigma were also reported to be common barriers (TWG, 2017). Access is also restricted by the lack of knowledge about available services, particularly mental healthcare, as reported by communities in the Aleppo, Idleb, and Ar-Raqqa governorates (PRDWG and REACH, 2018) and the health insurance that in Syria does not cover psychiatry, psychiatric medication or any other type of psychiatric treatment (Hedar, 2017). A 2016 survey of 64 mental health practitioners inside Syria found that psychologists, psychotherapists and counsellors reported a lack of training and experience, with 58% stating they needed support on identifying and diagnosing disorders, and 73% wanted contextualized resources on MHPSS in Arabic (ABAAD, 2016).

In neighbouring countries, key documented barriers for Syrian refugees to access interventions cover a range of demand and supply-side barriers. In Lebanon, the most commonly cited barriers were cost of transportation, expenses and lack of knowledge about services (Viller Hansen et al., 2018; TWG, 2017). A 2017 study with Syrian refugees in Jordan found that stigma surrounding mental health issues was frequently reported by respondents and that women in particular reported an increased need for privacy when accessing mental health services due to fear of experiencing stigma (Asfour & Baca, 2017).

6. Effectiveness of MHPSS interventions in Syria

Despite the growing number of MHPSS interventions in Syria, the evidence base on what works is very limited, due to the lack of available evaluations in the public domain. This appears to be due both to the sensitivity of the political and diplomatic situation and the challenges collecting data inside Syria. As mentioned above, the fragmentation of the Syrian territory (government-held areas vs. rebel-held areas) has limited access to both facilities and professionals who would be able to carry out this work (expert input from L. Pfeffer). This rapid review did not find any publicly available evaluations focused on MHPSS interventions from inside Syria.[23,24] However, the review found 14 recent evaluations of 13 MHPSS interventions working with Syrian refugees in neighbouring countries, particularly in Jordan, Lebanon and Turkey.[25] Given this lack of evidence, it is not possible to make generalised comments on what works in MHPSS in Syria. The following therefore synthesises the existing evidence on what works in MHPSS interventions in the Syrian crisis.[26] The review has highlighted a handful of rigorously-evaluated interventions from neighbouring countries, including the use of eye movement desensitisation (EMDR) and reprocessing with individuals with PTSD, a mobile-based literacy games app to support psychosocial wellbeing in children (Antura and the Letters), and a group-based intervention for adolescents including sports, creative and recreation activities alongside a community development initiative (Advancing Adolescents – Mercy Corps). There are also a number of notable emerging interventions which are promising however they have yet to be rigorously evaluated in the Syrian context or in the wider crisis context. These include Problem Management+, Culturally Adapted Cognitive Behavioural Therapy (CA-CBT) and Teaching Recovery Techniques (TRT). Further details on these interventions are provided below.[27]

Key findings from a review of existing evaluations include:

- **Geographical spread:** Most of the evaluations identified took place in Jordan (five), followed by Turkey (three), Lebanon (two), and one evaluation each in the UK and Germany, Egypt and Sweden.[28]
- **Interventions:**
  - Available evaluations of MHPSS interventions with Syrian refugees in neighbouring countries cover a diverse range of interventions, from group-based support, clinical support, online and remote support.
  - In terms of IASC's pyramid of interventions, the most evaluated intervention level was focused, non-specialised services (11 evaluations), followed by basic services (six evaluations), strengthening family and community supports (four evaluations), and finally specialised services (three evaluations). It should be noted that all evaluations assessing interventions around basic services were multi-component interventions which also addressed at least one other intervention level.
  - Although the interventions evaluated are implemented across IASC's pyramid of interventions, a closer look at the activities shows that seven of the interventions evaluated focus on interventions at the individual or group level, with very few examples of community and system strengthening. Save the Children has recently noted the lack of a strong and clear definition of community-based interventions in the Syria response and the significant knowledge and research gap on activities implemented at the level of community and family support (Soye and Tauson, 2018).
- **Methodology and quality of evidence:**
  - Most evaluations were non-experimental (did not involve a control group – eight evaluations); followed by experimental (randomised controlled trials – four evaluations); and finally, one quasi-experimental evaluation (involving a control group but was not randomised).

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[23] Since this report was written, the International Medical Corps Syria has completed a review of its community psychosocial support and early childhood development programming in rural Damascus. This report is available upon request – please get in touch with the Disability Inclusion Helpdesk at enquiries@disabilityinclusion.org.uk

[24] Please see annex 1 for a summary and the attached Excel spreadsheet for full details on the available evaluations.

[25] Please note the helpdesk team asked the experts consulted for this query however they could not share any available evaluations from inside Syria.

[26] Please see box 3 for the main findings from a DFID-funded 2017 systematic review on MHPSS interventions in emergencies.

[27] Please see the annex attached for a more detailed mapping of existing evaluations.

[28] These evaluations which took place in the UK and other European countries were included due to the lack of available evidence from inside Syria.

- Of the 14 evaluations identified, this rapid review identified methodological concerns with eight, including the use of small samples, high attrition rates, unclear methodologies as well as methods used which may increase the risk of bias.
- The most commonly-measured outcomes were PTSD (four evaluations), depression (three), anxiety (two), insecurity (two), stress (two) and resilience (two). Less common measures included prosocial behaviours, trauma, levels of cortisol and parenting (one evaluation each). Several evaluations used standardised tools which had been tested and adapted either with Syrians or in other emergency settings in the Middle East. These tools included the Strengths and Difficulties questionnaire, the Beck Depression Inventory, the Human Insecurity (HI) and Human Distress (HD) scales and the Impact of Event scale.

- **Impact:** All the available interventions demonstrated positive impacts on mental health and psychosocial wellbeing. It may be that evaluations with less positive findings exist but not in the public domain.

Box 3: findings from a 2017 DFID-funded systematic review on MHPSS programmes

A 2017 systematic review commissioned by the Humanitarian Evidence Programme and carried out by a team from the EPPI-Centre, University College London (UCL) investigates both the process of implementing MHPSS programmes, as well as assessing their intended and unintended effects (Bangpan et al., 2017). Of the 82 studies, 13 evaluated the process of implementation of MHPSS programmes and 69 evaluated the impact of MHPSS programmes either with children (n=40) or with adults (n=29). The majority of studies were conducted in man-made disaster settings (n=54), such as civil wars, including refugee settings with children and adults. Programmes delivered during humanitarian emergencies were in ongoing conflict settings (n=17), many of which were in the Middle East (i.e. Syria). The review suggests that among MHPSS programmes for children and youth population:

- CBT may have no impact on social support (two medium risk of bias studies);
- NET (one low risk of bias study) may have a negative trend on anxiety and somatic complaints, and no impact on school performance;
- Psychotherapy programmes show a positive trend (from four studies, one medium and three high risk of bias: mind and body skills group, counselling and a school-based trauma-grief intervention) in reducing PTSD symptoms;
- Psychosocial interventions may improve social support (low risk of bias study) and have no impact on psychological distress (low risk of bias study);
- Psychosocial interventions may increase anxiety symptoms (low risk of bias study) and may slightly decrease prosocial behaviours;
- Psychosocial interventions probably make no improvement to functional impairment.

When programs addressed adults, the review suggests a positive trend in favour of other psychotherapy interventions in reducing PTSD symptoms (eye movement desensitization and reprocessing (EMDR) and interpersonal psychotherapy (IPT); depression (EMDR, counselling, IPT, Thought Field Therapy (TFT); anger (TFT and IPT); anxiety symptoms (TFT and IPT); fear and avoidance (TFT); partner violence (IPT); and common mental health problems (counselling). Specific techniques may play a role in defining the relevance and effectiveness of the MHPSS interventions, including as:

- Community engagement;
- Sufficient numbers of trained MHPSS providers;
- MHPSS programmes need to be socially and culturally meaningful to local populations;
- Benefits of group-based programmes;
- Building trusting and supporting relationships was important to recipients and helped to maximize their engagement and increase the impact of programmes.

The following bullets describe the three MHPSS interventions which have been evaluated using RCTs or quasi-experimental evaluations and found to be effective with Syrian refugees in neighbouring countries:

- **Eye Movement Desensitization and Reprocessing (EMDR), Turkey:** EMDR is a psychotherapy treatment involving a patient working with a therapist to focus on traumatic experiences for short periods whilst following the therapist's finger moving across the patient's eye line. The patient reports sensations and emotions during this process and it is repeated until the patient reports minimal distress. A recent pilot RCT in Turkey found

that EMDR lowered trauma and depressive symptoms for the treatment group in comparison to a waitlist amongst Syrian refugees in a camp setting (Acarturk et al., 2015). It should be noted that this study involved a small sample of 29. A separate study from Turkey in 2018 investigated the efficacy of EMDR the Group Traumatic Episode Protocol (G-TEP) in treating post trauma symptoms and depression and preventing the development of chronic PTSD among refugees living in a refugee camp. EMDR G-TEP was found to significantly lower PTSD and depression symptoms, however it is important to note the small sample size of 47 (Yurtsever et al., 2018).

- **Advancing Adolescents, Jordan:** an 8-week programme for young people aged 12-18 run by Mercy Corps (2014-16). The programme was designed for mixed gender groups meeting twice a week and included activities such as fitness, arts and crafts, vocational skills and technical skills, plus a community development project led by the project participants. The programme was informed by a profound stress attunement (PSA) framework, which focuses on developing safe emotional spaces, managing stressors and developing healthy relationships. An RCT in Jordan found positive effects on psychosocial wellbeing for both Syrian refugees and Jordanian host communities, including medium to small effect sizes for all psychosocial outcomes such as insecurity, distress and stress, with greater impact for those young people who had been exposed to four trauma events or more. No impact was found for prosocial behavior or posttraumatic stress reactions (Panter-Brick, C., et al., 2018). Advancing Adolescents was also evaluated using biomarkers to track cortisol levels in project participants. The RCT found positive impact on cortisol levels which was supported by reported improvements in psychosocial wellbeing (Dajani et al., 2018). It should be noted that there were high attrition rates for both of these studies.
- **Antura and the Letters, Jordan:** a mobile-based games app designed to improve children's literacy and psychosocial outcomes. The player's task is to help a character working with a dog called Antura to watch over the "little Living Letters" who have minds of their own. A series of mini-games which takes the player through a basic literacy curriculum. A non-randomised evaluation comparing a treatment group with a control found the app to be a well-designed and engaging game for children regardless of literacy level, age or gender. The evaluation found positive effects on social outcomes through a survey and parental feedback, including improved emotional states and social behaviours, feelings of motivation, accomplishment and ownership, and increased peer interaction (Koval-Saifi, N., & Plass, J., 2018). This study also experienced high attrition between baseline and endline.

Other, non-experimental evaluations have also highlighted positive findings:

- **IRC mobile GBV response, Lebanon:** this programme offers free access to emotional support groups, recreational activities and case worker support including counselling and referrals to legal, health and other services. The programme is innovative in that case workers meet women and girls where they are. A qualitative evaluation involving semi-structured interviews and observations found that the mobile services improved the women's and girls' psychosocial wellbeing in a number of different ways, including broadening social networks and building social cohesion, increasing access to support, improving communication skills and coping mechanisms, breaking down barriers and combatting stigma against refugees, regaining a sense of self and purpose and bolstering self-worth (IRC, undated).
- **Action Contre La Faim psychosocial support programme, Jordan:** a multisectoral programme delivered through psychosocial support centres aimed at improving psychosocial wellbeing, fostering resilience and promoting positive interactions between members of refugee and host communities. The programme includes a maternal and child health group and psychosocial group support sessions. A 2018 field report based on interviews and focus groups found that group sessions helped participants feel less isolated and feel more social cohesion amongst refugees and host communities. Parents noted positive changes in their parenting approach, including increased listening and interaction, as well as positive changes in children's behaviour. Adolescents reported increased self-confidence and sense of responsibility towards communities (Acosta & Chica, 2018).
- **Step by Step (SbS), Germany, Egypt, Sweden (Syrian refugees):** a web-based e-mental health intervention for depression developed by the WHO, part of the STRENGTHS programme (Syrian REfuGees MeNTal

HealTH Care Systems). SbS is an online self-help version of WHO's evidence-based Problem Management Plus (PM+) programme. It is rooted in cognitive behavioural therapy (CBT). A rapid qualitative assessment found that the majority of respondents were positive about the app, in particular its flexibility and potential to have a positive impact on health. Participants also reported they liked being about to customise it and were able to learn how to use it easily, however they were less positive about the way the app looked and the length and pace of the sessions. The report recommends contextual adaptation of the app with a focus on usability and user experience (Burchert et al., 2019). E-mental health approaches have been noted as having relevance to emergency settings where interventions are implemented remotely (McGrath et al., 2018). Suggested benefits include increasing convenience, improving relevance and equity, reducing stigma and increasing quality and efficiency (McGrath et al., 2018; expert input from D. Ziveri). However, further studies of such potential use may be needed (Jefee-Bahloul, 2014).

- **Malteser Foundation MHPSS intervention, Turkey:** the programme was delivered in three stages including the training of the MHPSS team and non-specialised healthcare providers; psychological interventions and a social intervention including education and recreational activities. An evaluation using a pre-post test design suggested the training of healthcare providers improved knowledge on MHPSS, whilst resilience and wellbeing scores improved for participants. However, the report highlights that the results cannot solely be attributed to the intervention due to the contribution of other programmes and improvements in psychosocial wellbeing amongst Syrian refugees in Turkey over time (Budosan et al., 2016).
- **Generation Freedom Teaching recovery techniques (TRT) and parenting programme, Turkey:** TRT is an established, evidence-based programme for children (El-Khani et al, 2018). This non-experimental evaluation involved adding a parenting skills component through group sessions to test the feasibility of conducting an RCT in the near future. Preliminary data from the small sample suggests positive shifts in children's adjustment and behaviour, and improvements in parenting skills and style, however there was no significant effect on parental mental health (ibid;).

Examples of promising practice, innovation and application of tested models in the Syrian crisis yet to be rigorously evaluated include:

Inside Syria

- **A DFID-funded education programme in North-West Syria:** this programme seeks to mainstream child protection into the education sector improve children's psychosocial wellbeing through prevention of violence against children in schools, homes and communities. Activities include the setting up of safe spaces where group-based activities and awareness raising take place, as well as identifying children for specialist service referral. A midline pre-post test evaluation using the Strengths and Difficulties Questionnaire (SDQ) found improvements in children's resilience (draft blog post, date unclear, shared by DFID staff member).
- **Problem Management Plus (PM+):** PM+ is an evidence-based low-intensity psychological intervention for adults affected by distress in communities exposed to traumatic events. PM+ is part of the STRENGTHS (Syrian REfuGees MeNTal HealTH Care Systems) programme. The STRENGTHS programme aims to improve the responsiveness of mental health systems in Europe and key Middle Eastern countries by integrating mental health services for adult and adolescent Syrian refugees into primary and community care systems. The approach is based on CBT and implemented by non-specialised providers (WHO, 2018).
- **Mental Health Gap Action Programme (mhGAP):** The WHO mhGAP programme aims to scale up services for mental, neurological and substance use disorders in LMICs. The mhGAP Humanitarian Intervention Guide contains first-line management recommendations for mental, neurological and substance use conditions for non-specialist health-care providers in humanitarian emergencies. More than 1,500 doctors from 400 health centres have been trained under this programme in Syria. The innovative element of the programme is the trainers' ongoing follow-up with the doctors through field visits to their workplaces and collective follow-up sessions. Social media was also used, with the doctors of each governorate having a group on the instant

messaging application WhatsApp Messenger, where they could propose and discuss persistent cases with each other or with the specialist consultant trainer (Hedar, 2017). The WHO has trained more than 60 psychologists in CBT, family therapy and psychological first aid (PFA). A mental health programme in schools is currently being developed, in which psychological counsellors and teachers will be trained on how to identify and deal with the major mental disorders in schools (Hedar, 2017).

- **Psychological First Aid (PFA):** PFA has recently become a widely recognised and utilised frontline approach to MHPSS for affected people in emergencies following guidance from WHO. A five-year PFA retrospective survey (Snider, 2017) was recently conducted involving 105 respondents from 37 countries, including Syria, where PFA is used mainly to scale up national capacity. According to survey results, INGOs worked in Syria to train NGO staff, national staff within the healthcare system and key community leaders on PFA. Training on PFA provides develops key skills on how to communicate in a sensitive and supportive manner to people affected by crisis (MDM, 2018). The study findings indicate that:
    - the simplicity and accessibility of PFA has helped to capitalise on existing human resources in emergency settings and it has also helped to demystify MHPSS.
    - PFA has also been used where other MHPSS responses don't exist or in the absence of other accessible, clear guidance for next steps after PFA.
    - there appear to be many misconceptions about what PFA is –including its limitations – and, as PFA has been widely and freely disseminated, fidelity to the original model was not always guaranteed.
    - PFA cannot cover the range of complex and longer-term issues of distress and mental disorders in emergency settings including complicated grief, exposure to extreme loss, the impact of displacement and migration and exposure to serious adversity and human rights violations (Snider, 2017).
- **Narrative Exposure Therapy (NET):** short-term therapy for individuals with PTSD symptoms as a result of traumatic experiences. It was originally developed for use in LMICs and has since been used to treat asylum seekers and refugees in high-income settings. Emerging evidence suggests that NET is an effective treatment for PTSD in individuals who have been traumatised by conflict and organised violence, even in settings that remain volatile and insecure (Robjant, 2010). In May 2016 members of VIVO International traveled to Beirut to offer a NET training to mental health professionals working with the affected populations all over Syria. The participants were psychologists, psychiatrists and counsellors from different governmental and non-governmental organisations in Syria from Homs, Hama, Aleppo, Damascus and other places (expert input from D. Ziveri).
- **Outreach counselling, North-East Syria:** a recent survey evaluating a short set of outreach counselling sessions as part of an integrated programme including livelihood assistance (Ziveri et al., 2019), found that participants reported improvements in their self-perceived wellbeing higher than the control group, with people with disabilities reporting greater improvements than those without disabilities. Disaggregated data analysis showed that women with disabilities who received the intervention reported a better score improvement than men with disabilities in the treatment group.

In neighbouring countries

- **Sesame Seeds**, an early childhood education programme led by IRC with Sesame Workshop. The programme is delivered through home visits and through care and learning centres and aims to build resilience and overcome trauma. It is implemented through in-person support as well as video and audio content through a locally-produced television show (Save the Children, 2018). The programme aims to help children to understand their experiences, manage and overcome toxic stress as well as improving language, literacy, numeracy and socio-emotional skills. In 2018, IRC and New York University won funding to evaluate the Sesame Seeds approach in Syria, Jordan and Lebanon.[29]

[29] Find out more here: https://www.sesameworkshop.org/what-we-do/refugee-response and here: https://www.nyu.edu/about/news-publications/news/2017/december/macarthur-grant.html

- An RCT is planned for a **Culturally Adapted Cognitive Behavioural Therapy (CA-CBT) programme** targeting Syrian women under temporary protection in Turkey. This programme is a group therapy intervention involving seven sessions. This intervention is led by Refugees and Asylum Seekers Assistance and Solidarity Association in collaboration with research partner Istanbul Sehir University. The evaluation will measure psychological distress symptoms, depression, anxiety and psychological trauma.[30]
- **#ME/WE SYRIA:** a refugee-led education and community engagement platform using storytelling and interpersonal communications as tools for healing and community building in Turkey, Lebanon and Jordan. The programme is implemented by training "replicators" selected by #ME/WE SYRIA staff and trained to adapt the approach for their communities with 15-24 year olds. The group has 30 hours of activity over eight to ten weeks, involving the development of community projects, mentoring new participants, and holding storytelling events. Piloting a psychometric scale developed by Beyond Conflict and North Eastern University has shown positive effects on participants' stress and leadership skills (Save the Children, 2018).[31]
- **The Common Elements Treatment Approach (CETA):** the CETA model was developed specifically for LMIC settings that rely on non-specialised providers working within sustained supervisory systems by the John Hopkins University. CETA expands upon traditional treatment approaches that are designed to focus on one specific disorder and has been found through multiple rigorous trials to reduce the burden of multiple common mental health problems and improve functionality among men and women living in low resource settings (Murray et al., 2014). Médecins du Monde is carrying out a study on the 't-CETA pilot project' that aims to test the development, piloting and evaluation of a telephone-delivered psychological intervention for Syrian refugee children in Lebanon (MDM, 2018)
- **Trauma-focused and Control-Focused Behavioral Treatment (CFBT):** this approach is designed to treat posttraumatic stress and related emotional and behavioural problems in children. It is based on learning theory of anxiety, offering one-shot treatment to survivors. It is designed to enhance the sense of control over distress or fear associated with traumatic events. This is achieved by encouraging the person not to avoid distressing or feared trauma-related situations. It has proved effective in reducing symptoms of PTSD in other contexts (Başoğlu et al., 2003; 2005; 2007). According to the DABATEM (Istanbul Center for Behavior Research and Therapy) a treatment study with traumatised Syrian refugee children will take place in 2019 by Sıla Ulutaş, Senior Psychology Student in Boğaziçi University, Turkey.

This query has found the evidence base on mental health, psychosocial wellbeing and related interventions in Syria to be extremely limited. Whilst there is some evidence from the broader Syrian crisis working with refugees in neighbouring countries, particularly Jordan, Lebanon and Turkey, there are a number of important implications from this rapid research:

- There is a need to improve understanding of the mental health and psychosocial wellbeing of the Syrian population and what works to address needs and barriers to participation in interventions.
- Existing evaluations of MHPSS interventions in the Syrian crisis tend focus on the effectiveness of specific therapies rather than multisectoral approaches to addressing MHPSS. This may reflect a lack of multisectoral interventions and interventions that focus on community and systems-strengthening.
- Due to the emphasis on therapies provided to individuals and small groups and a tendency to measure outcomes immediately after interventions, an understanding of the long-term impacts of the crisis on communities may be missed.
- The review found a separation between the literature on MHPSS inside and outside Syria. Links between interventions with Syrian refugees and those affected by the conflict inside Syria could be strengthened, both in terms of sharing lessons and developing cross-border activities.
- It was not possible to assess the extent to which MHPSS interventions are designed based on a rights-based approach in Syria, ie. by identifying and removing barriers to individual rights and participation in programming.

[30] For more information see: https://clinicaltrials.gov/ct2/show/NCT03912077
[31] Find our more here: https://meweintl.org/mewesyria/

It was clear that the available evidence tends to refer to needs rather than rights or barriers, whilst DFID's strategy on disability inclusion is grounded in the rights-based approach.[32]

[32] DFID's strategy on disability inclusion (DFID, 2018), which includes psychosocial disabilities adopts a rights-based approach where programmes are encouraged to identify and remove barriers to rights and participation.

Expert contributors

Emma Haegeman, Senior Technical Expert, SDDirect
Davide Ziveri, Mental Health and Psychosocial Support Global Specialist, Humanity & Inclusion
Lauriane Pfeffer, clinical psychologist, MHPSS specialist and independent consultant
Alexis Palfreyman, PhD candidate, London School of Economics (LSE)

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Annex: Summary table of mapping of MHPSS evaluations in the Syrian crisis[33]

Reference	Country	Intervention	Approach and methods, including concerns	Results
Acarturk, C., et al (2015).	Turkey	Eye Movement Desensitisation and Reprocessing (EMDR)	RCT (small sample of 29)	**Positive impact on PTSD and depression symptoms.**
Acosta & Chica, 2018	Jordan	Action Contre La Faim psychosocial support programme including two components: maternal and child health group, and psychosocial group support sessions.	non experimental qualitative evaluation -sample frame, approach and size unclear; please note focus groups facilitated by individuals leading intervention sessions with likely bias in results.	Group sessions helped participants **reduce their sense of isolation**. Parents reported **positive changes in their parenting styles**, including listening, talking and interacting with them. Parents also observed **positive changes in children's behaviour**. Adolescents reported feeling **more self-confident and able to express their feelings positively**.
Budosan et al., (2016)	Turkey	Malteser International and International Blue Crescent MHPSS intervention including training of non-specialised healthcare providers; psychological intervention; and social intervention including education and recreational activities.	non-experimental (pre-post test - please note methodology often unclear; 60% sample were men; sample frame and approach unclear	Findings suggest the training **increased knowledge and understanding of non-specialised healthcare providers**, and **increased resilience and wellbeing** for project participants. However, the study notes that attributing these results to the intervention is not justified due to other factors such as other NGO interventions, time and gradual adjustment by urban Syrian refugees to life in Turkey.

[33] See attached mapping spreadsheet for further details on these evaluations.

Burchert, S., et al., (2019)	Germany, Egypt, Sweden (Syrian refugees)	IFRC Step-by-Step, a web-based e-mental health self-help intervention for depression based on WHO's evidence-based Problem Management Plus (PM+) programme. It is rooted in CBT	non-experimental formative evaluation - Rapid Qualitative Assessment (RQA); sample frame and approach unclear	**Positive response to the app prototypes**, stressing the potential health impact of the intervention, its flexibility and customisability as well as the easy learnability of the app. Aesthetic components and the length and pace of the intervention sessions were criticised in regard to their negative impact on user motivation. Acceptability, credibility, and technical requirements were identified as main barriers to implementation.
Dajani, R. et al. (2018)	Jordan	Mercy Corps Advancing Adolescents	RCT (high attrition - over half sample lost)	**Positive impact on cortisol (stress hormone) levels:** measured using biomarkers (hair samples). This data corroborated self-reports of improved psychosocial wellbeing.
El-Khani, A., et al. (2018)	Turkey	Generation Freedom Teaching recovery techniques (TRT) intervention delivered by teachers in classrooms, plus parenting skills.	non-experimental feasibility study (small sample of 14 families); sampling approach unclear	**Positive changes in children's behaviour and parenting skills** were found, however there was no impact on caregiver mental health.
Hough, H. et al., (2019)	UK	UK Home Office Global Mental Health Assessment tool pilot - computerised clinical assessment tool developed to rapidly assess and identify mental health problems with adult Syrian refugees due to be resettled to the UK.	non-experimental, mixed methods evaluation (sample size 200 though sample frame and approach unclear)	The tool identified **9% of pilot participants with a likely diagnosis of mental illness** but 1.5% additional referrals were made based on clinical judgement, highlighting the importance of not relying upon this tool in isolation. Feedback suggested a need to adapt and test the tool in resettlement contexts.
IRC (undated) – please note the full evaluation	Lebanon	IRC mobile GBV response (i.e. meets women and girls where they are); involving free access to emotional	non-experimental (purely qualitative); sample frame, approach and size unclear	The mobile services **improved the wellbeing of Syrian refugee women and girls** by: • Broadening Syrian women's and girls' social networks and building social cohesion; • Improving communication skills and coping mechanisms;

report was not available.		support groups, recreational activities and counselling, referrals to legal, health and other services.		• Breaking down barriers between Syrians and Lebanese and combatting stigma against refugees; • Helping Syrian women and girls regain a sense of self and purpose and bolstering self-worth.
Koval-Saifi, N., & Plass, J. (2018).	Jordan	ACR GCD, Digital Learning for Development (DL4D) Antura and the Letters: a games app for children's literacy and psychosocial outcomes	quasi-experimental study – sample frame unclear; high rate of attrition - lost over half the sample	**Positive impact on psychosocial outcomes:** improvements in emotional and conduct problems, and positive parental feedback, for example children feeling a sense of accomplishment, ownership and attachment, as well as peer interaction contributing to improved emotional states and social behaviours.
Panter-Brick, C., et al., (2018)	Jordan	Mercy Corps Advancing Adolescents, 8-week programme of structured group activities for 12–18 year olds (fitness, arts & crafts, singing & folklore, vocational and technical skills)	RCT (35% attrition)	**Positive impact on psychosocial wellbeing,** including alleviating fears and worries, feelings of distress, perceived stress and mental health difficulties (anxiety and depression). **No impact on prosocial behaviour or posttraumatic stress symptoms.**
UNHCR (2013)	Lebanon	UNHCR MHPSS interventions for Syrian refugees in Lebanon	non-experimental qualitative study; sample frame and approach unclear (study is out of date - 2013)	Many Syrian refugees' **basic needs such as shelter, health services, and food were unmet**; the refugee-host community relations were strained, there was a **lack of understanding of MHPSS and limited training amongst staff, limited coherence and coordination of interventions, as well as a lack of support services for men and boys**. Finally, access to specialised services was challenging for refugees.

Van der Veen, A., et al, (2015)	Jordan	UNICEF's MHPSS support for Syrian refugee children in Jordan, including community-support child and adolescent friendly spaces (CFSs) and community-based child protection mechanisms and processes.	non-experimental evaluation – sample frame unclear; please note results not statistically representative and planned comparison between treatment and control not possible.	The study found **UNICEF's response for Syrian children in Jordan was relevant and coherent**. Challenges included the physical limitations of the infrastructure, and the impact of stressful material and social conditions refugees find themselves in.

Disability Inclusion Helpdesk Report No: 15

About Helpdesk reports: The Disability Inclusion Helpdesk is funded by the UK Department for International Development, contracted through the Disability Inclusion Team (DIT) under the Disability Inclusive Development Programme. Helpdesk reports are based on between 3 and 4.5 days of desk-based research per query and are designed to provide a brief overview of the key issues and expert thinking on issues around disability inclusion. Where referring to documented evidence, Helpdesk teams will seek to understand the methodologies used to generate evidence and will summarise this in Helpdesk outputs, noting any concerns with the robustness of the evidence being presented. For some Helpdesk services, in particular the practical know-how queries, the emphasis will be focused far less on academic validity of evidence and more on the validity of first-hand experience among disabled people and practitioners delivering and monitoring programmes on the ground. All sources will be clearly referenced.

Helpdesk services are provided by a consortium of leading organisations and individual experts on disability, including Social Development Direct, Sightsavers, Leonard Cheshire Disability, ADD International, Light for the World, BRAC, BBC Media Action, Sense and the Institute of Development Studies (IDS). Expert advice may be sought from this Group, as well as from the wider academic and practitioner community, and those able to provide input within the short time-frame are acknowledged. Any views or opinions expressed do not necessarily reflect those of DFID, the Disability Inclusion Helpdesk or any of the contributing organisations/experts.

For any further request or enquiry, contact enquiries@disabilityinclusion.org.uk

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