Priorities for improving mental health services in the context of the current Syrian crisis

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Summary

Humanitarian emergencies have a major impact on both general, and mental health services. With an increased rate of mental health problems, weakened mental health infrastructure, and challenges with coordination of aid efforts, a special consideration is needed for mental health of impacted populations. Despite these challenges, emergencies should also be seen as opportunities and policy windows to work on plans for improving and re-innovating mental health services.

The Syrian crisis is entering its seventh year, with a number of causalities and displaced persons that looks unprecedented in the region. Many stakeholders are involved in the provision of mental health services in Syria, and developing a priority agenda for areas of improvement in mental health services may help to coordinate efforts, and ensure sustainable solutions.

The aim of the current study is to contribute to the development of a consensus-based agenda for these areas of work through the analysis of the responses from 40 surveyed professionals, both national and international, who have work experience with mental health services in Syria.

The results of the study showed that priority areas for improving mental health services in Syria are (in a descending order) developing mental health policy and plan, integration of mental health services into primary health care, plans for increase the number and promote training of human resources working in the mental health field, organization of mental health services, public education and awareness campaigns, financing of mental health services, establishing user/consumer associations and family associations, mental health legislation, inclusion of mental health categories in national health information system, and mental health research agenda.

Much of this consensus goes in line with initiatives and directions adopted by different stakeholders: government, UN agencies, and non-governmental organizations.

More efforts are needed to reflect the view of other actors from different sectors, and agree on an implementation framework that serves a strategic value.

Resumo

As emergências humanitárias têm um grande impacto em geral e nos serviços de saúde mental. Com o aumento de prevalência de problemas de saúde mental, fraca infraestrutura de saúde mental e desafios na coordenação dos esforços de ajuda, uma atenção específica é necessária para a saúde mental das populações afetadas. Apesar desses desafios, as emergências ainda são vistas como oportunidades e janelas políticas para trabalhar sobre os planos para melhorar e modernizar os serviços de saúde mental.

A crise Síria está entrando no seu sétimo ano com um número de mortes e de pessoas deslocadas que parece sem precedentes na região. Diferentes atores estão envolvidos na prestação de serviços de saúde mental na Síria, e o desenvolvimento de uma ordem de prioridade para as áreas de melhoria dos serviços de saúde mental pode ajudar a coordenar esforços e assegurar soluções sustentáveis.

O objetivo do presente estudo é o de desenvolver uma agenda baseada no consenso para essas áreas de trabalho através da análise das respostas a um questionário de 40 profissionais, nacionais e internacionais, com experiência de trabalho em serviços de saúde mental na Síria.

Os resultados do estudo mostraram que as áreas prioritárias para a melhoria dos serviços de saúde mental na Síria são (em ordem descendente) o desenvolvimento de uma política de saúde mental e de um plano de integração de serviços de saúde mental nos cuidados de saúde primários, planos para aumentar o número e a formação de recursos humanos que trabalham no campo da saúde mental, organização de serviços de saúde mental, campanhas de educação e sensibilização do público, o financiamento de serviços de saúde mental, criação de associações de utentes e de famílias, legislação de saúde mental, inclusão de categorias de saúde mental no sistema de informação nacional de saúde e uma agenda de investigação em saúde mental.

Muito deste consenso está em linha com as iniciativas e orientações adoptadas pelos diferentes atores: governo, agências das Nações Unidas e organizações não governamentais.

São necessários mais esforços para refletir a opinião de outros atores de diferentes setores e chegar a um acordo sobre um plano de implementação com valor estratégico.

Resumen

Las emergencias humanitarias tienen un importante impacto tanto en general, como en los servicios de salud mental. Con el aumento de la tasa de problemas de salud mental, la debilitada infraestructura y las dificultades en la coordinación de los esfuerzos de la ayuda, se requiere una atención especial para la salud mental de las poblaciones afectadas. A pesar de estos desafíos, las emergencias siguen siendo vistas como oportunidades para abogar y trabajar en planes que puedan mejorar e innovar los servicios de salud mental.

La crisis siria está entrando en su séptimo año, con un número de víctimas y de personas desplazadas sin precedentes en la región. Muchos actores participan en la prestación de servicios de salud mental en Siria, y el desarrollo de una agenda prioritaria sobre las áreas de mejora en los servicios de salud mental, puede ayudar a coordinar esfuerzos y garantizar soluciones sostenibles.

El objetivo del presente estudio es crear una agenda consensuada para estas áreas de trabajo mediante el análisis de las respuestas de 40 profesionales encuestados, tanto nacionales como internacionales, que tienen experiencia de trabajo con los servicios de salud mental en Siria.

Los resultados del estudio mostraron que las áreas prioritarias para mejorar los servicios de salud mental en Siria son (en orden descendente) el desarrollo de una política y un plan de salud mental, la integración de los servicios de salud mental en la atención de salud primaria, los planes para aumentar el número y la capacitación de los recursos humanos que trabajan en el campo de la salud mental, la organización de los servicios de salud mental, la educación pública y campañas de concienciación, la financiación de los servicios de salud mental, el establecimiento de asociaciones de consumidores/usuarios y asociaciones familiares, la legislación sobre salud mental, la inclusión de categorías de salud mental en el sistema nacional de información en salud, y el programa de investigación en salud mental.

Gran parte de este consenso está en consonancia con las iniciativas y direcciones adoptadas por diferentes actores: gobierno, agencias de la ONU y organizaciones no gubernamentales.

Se requieren más esfuerzos para reflejar la opinión de otros actores de diferentes sectores y acordar un marco de implementación que tenga un valor estratégico.

Attestation

I declare that this work is original except where indicated by special reference in the text and no part of the dissertation has been submitted for any other degree. Any views expressed in the dissertation are those of the author.

The dissertation has not been presented to any other university for examination.

Signed: Mohamed Elshazly

Date: 30/07/2017

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Part 1: The situation in Syria

1.1 Introduction

The Syrian Arab Republic (*Al-Jumhuriyah al-'Arabiyah as-Suriyah)* is situated in southwest Asia at the eastern end of the Mediterranean Sea, with an area of 185,180 sq km. It is bounded on the north by Turkey, on the east and south east by Iraq, on the south by Jordan, on the southwest by Israel, and on the west by Lebanon and the Mediterranean Sea. The population of Syria in 2016 was 22,712 million [(1]. Approximately 3% of the population was over 65 years of age, with another 37% of the population under 15 years of age. There were 101 males for every 100 females in the country. The UN estimated that 50% of the population lived in urban areas in 2005 and that urban areas were growing at an annual rate of 2.53%. The capital city, Damascus (Dimashq), had a population of 2,228,000 in that year. The population of Aleppo (Halab), a northern trading and agricultural center, was an estimated 2,505,000. Other main cities are Himş (Homs), 915,000; Hamāh (Hama); and Latakia (Al Lādhiqiyah). [(2)]

Syria is very mosaic in its nature, with a complex array of crosscutting, overlapping, and often interdependent religious, class, regional, and ethnic identities [(3).] Religion, ethnicity and tribal identity are crucial for the understanding of the various experiences and perceptions of the conflict and its impact by different groups in Syria. [(4), (5).]

Anti-regime demonstrations started in March 2011, and very soon later, a violent collision started between government and armed opposition groups creating the worst humanitarian crisis of our time. Around 5 million were forced to flee to neighbouring countries, and more than 6 million are internally displaced, and even the remaining around 13 million need humanitarian assistance.

1.2 General health and mental health services in Syria

As reported by the World Health Organization (WHO) [(6)], the ministry of health has developed a long-term health strategy (2000-2020) to develop the health sector. The strategy is based on three pillars: improving and strengthening primary health care, increasing the efficiency and capacity of

secondary and tertiary services, and enhancing both geographical and financial equity of the health care system.

The health system is based on primary health care, which is delivered at three levels; village (rural health centres and health units), district (larger health centres including training facilities and specialized physicians), and provincial (urban health centres staffed with specialized physicians and dentists in addition to various technicians, family planning services, control & prevention of communicable diseases, environmental control, preventive care, and health education).

The health care delivery system in Syria is represented by the role played by a mix of public and private sectors providers. Public service providers, funded by the government budget, are managed by the Ministry of Health, ministry of higher education, ministry of development, and ministry of social affairs and labour. The Ministry of Health runs 67 hospitals (including specialized hospitals) with a total of 11155 beds, and 1534 health centres, while the Ministry of Higher Education manages 12 university hospitals. Private health services include 376 hospitals with 6795 beds.

The situation of mental health services is more complicated, as mental health is not on a high rank in the priority agenda of health services, and has to face many challenges related to the lack of multi-disciplinary approaches, and lack of capacity of human resources. [7]

Available data on mental health services in Syria [8], [9] shows that both mental health policy and mental health plan exist and were revised in 2007. The latest mental health policy aims to 1) integrate mental health into the primary and secondary health care systems, including involving mental health professionals at primary health care centres, and adding psychiatric units in general hospitals; and 2) reduce stigma through awareness-raising campaigns. In addition, in 2001 the Ministry of Health established the Psychiatric Directorate to improve and develop mental health services. However, due to the collapse of the health system, most initiatives are currently on hold and priorities have been adjusted to the emergency context.

Mental health legislation exists since 1953, a new draft has been developed in 2010. Together with other laws in other sectors (e.g. welfare, disability, and general health), it works towards legal provisions concerning

mental health care. The updated law was expected to be finalized in 2011/2012; however the current situation has caused delays.

Mental health expenditure by governmental health services doesn't exceed 2% of the total health budget, and 93.54% of this budget is consumed by mental health hospitals.

Public (governmental) mental health services are provided mainly by the Ministry of Health, with some other ministries (Ministry of Higher Education, Ministry of Social Affairs and Labour, and Ministry of Defence) providing mental health services for specific groups of the population. Public mental health services are very much centralized in large cities. They include mental health outpatient facilities (25), day care treatment facilities (1), psychiatric beds in general hospitals (50), community residential facilities (35)- with a total of 175 beds-, and mental hospitals (5)- with a total of 1370 beds.

Ibn Sina in Damascus, and Ibn Khaldoun in Aleppo are both established psychiatric hospitals under the Ministry of Health. Ibn Sina Hospital is an in-patient treatment centre with 800 beds distributed across 18 wards. Six hundred of those beds are allocated to men and 200 to women, and approximately 100 patients across both genders are under legal confinement. Ibn Khaldoun Hospital has 400 beds, 250 of which are allocated for men and 150 for women. A day program including psychosocial components was recently initiated at Ibn Khaldoun, with great success. Tal Kalah Hospital (general hospital) in Homs has a small psychiatric ward. Care provided at this level (both inpatient and outpatient) is predominantly biomedical: diagnostic, long-term care and medication management.

In addition to the above, Tishreen Hospital, under the Ministry of Defence, has a small, 40-bed psychiatric ward, and Moasaat Hospital, under the Ministry of Higher Education, has a small psychiatric ward with 12 beds, used primarily for postgraduate training. A psychiatric unit has recently been established in the 30-bed Al Marsa Addiction Centre, with a multidisciplinary mental health team.

The Syrian government had significantly supported the development of the private sector to bridge the gap in mental health services and scale up mental health care. Most private general hospitals provide outpatient psychiatric consultations, and some of them may also provide inpatient treatment for some cases, but without having a dedicated psychiatric ward.

Damascus has two private psychiatric hospitals, which offer a wide range of services, from outpatient psychiatric consultations to admission of acute cases, both providing medical and psychotherapeutic interventions.

In 2010, Syria had approximately 65 private outpatient clinics mainly in and around the capital city: Damascus had 45 out of the 65. These clinics are run by psychiatrists who provide mainly biological medical interventions, with very limited psychotherapeutic services.

Integration of mental health into general health services was clearly seen as a priority by the Ministry of Health through opening of psychiatric wards in general hospitals and regular visits to primary health care centres by specialized psychiatrists for direct clinical services provision. Attempts to provide mental health services through trained primary care doctors was always challenged by the high turnover rate in primary health care staff which made the capacity building in mental health as an endless process. With the current situation, many psychiatrists left the country or were displaced within the country, and the movement is usually hindered by the security situation which impacted the regularity of their visits to primary health care centres, and consequently integration efforts. Primary health care doctors (and not nurses) are authorized to prescribe or continue prescription of psychotropic medications, but despite this authorization, the delivery of mental health care at the primary health care level remains very limited inactive. The majority of primary health care doctors and nurses didn't receive any training on assessment and management of mental disorders. On the other hand, referral pathways between primary care and other levels of care don't exist.

Training in psychiatry for medical students takes place like other specialties during the undergraduate education but it is a relatively short training course (8 weeks). Those who join psychiatry residency program after graduation, enrol in a training program for four years, which grants a lifetime license for providing psychiatric services. These four years of training cover general adult psychiatry and addiction medicine without formal training in other sub-specialties (e.g. child psychiatry). It puts a special focus on biomedical management with less emphasis on psychotherapeutic interventions. It is to be noted that medical education in Syria is made in Arabic language, which makes it difficult for some medical professionals to update their knowledge in the medical field throughout their careers. The number of Syrian psychiatrists in the country before the onset of the crisis was insufficient to cover the needs

(approximately one psychiatrist for 300,000 population), which resulted in over medicalization of the treatment.

Recently, the Ministry of Health in collaboration with international agencies, started to roll out a specialized training course for psychiatric nursing during general nursing training, which helped to move away from just reliance only on experience without proper education or training. The number of psychiatric nurses is extremely low (3.5 nurses per 300,000).

The role of psychologists and counsellors in Syria (0.3 psychologists per 300,000) is significantly undermined. There is no official registration nor licence requirements of psychological practitioners; there are no formal education or licensing in psychotherapy, and there is a lack of an accurate estimate of the number of qualified psychologists or counsellors in the country. The situation for social workers (0.3 social workers per 300,000) is even worse: during their studies in sociology departments, there is no curriculum for individual or community social work, nor any practical training.

Mental health information systems provide data on persons with mental disorders treated in primary health care, persons treated in mental health outpatient facilities, admissions and length of stay in mental hospitals, but no data on Interventions (psychopharmacological and psychosocial) delivered in primary health care for people with mental disorders. Documentation of mental health care response, services and epidemiological assessments in Syria is still developing. PHC clinics record gender, diagnosis and treatment data, which is shared with the Ministry of Health. Private clinics do not commonly collect data and have no clear overview of their patient profile. This results in difficulties in monitoring the services and in obtaining an accurate measurement of psychiatric morbidity.

1.3 Impact of the crisis on mental health services in Syria

Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality. Persons affected by humanitarian crises frequently suffer various stressors like loss of one's homes, livelihoods, material belongings, community and social support systems. They may also witness horrific events and atrocities, lose loved ones, become separated from family members and are at a greatly increased risk of

physical assault, gender-based violence and malnutrition. Specific population groups such as children and youth are especially vulnerable as they are often dependent on caregivers and may become orphaned or separated in situations of crises. **Mental health and psychosocial support (MHPSS)** during an emergency refers to any type of local or outside support that aims at protecting/promoting psychosocial wellbeing and/or preventing/treating mental disorders. [10]

During emergencies, mental health requires special consideration. This is due to three common issues: increased rates of mental health problems, weakened mental health infrastructure, and difficulties in coordinating agencies that are providing mental health relief services. [11]

Many emotional, cognitive, physical and behavioural sequelae of crises are considered as normal reactions and often gradually transit to normalcy, especially if adequate support is available (access to basic needs, and social support). Humanitarian emergencies are responsible for causing high rates of distress, but there are no precise estimates of prevalence in Syria. The percentage of those who develop mental disorders can be estimated according to the following projections from World Health Organization, and United Nations High Commissioner for Refugees [12]

	Before emergency: 12-month prevalence	**After emergency: 12-month prevalence**
Severe disorder (e.g. psychosis, severe depression, severely disabling form of anxiety disorder)	2 to 3%	3 to 4%
Mild or moderate mental disorder (e.g. mild and moderate forms of depression and anxiety disorders, including mild and moderate PTSD)	10%	15 to 20%
Normal distress / other psychological reactions (no disorder)	No estimate	Large percentage

Table 1. World Health Organization (WHO) projections of mental disorders and distress in adult populations affected by emergencies

The current crisis in Syria is not the first one to notably impact both the general and mental health services in this country. The influx of Iraqi refugees in 2006 highlighted the need to develop the mental health system in the country. According to government estimates in 2010, the Syrian Arab Republic hosted 750,000 Iraqi refugees, nearly half a million Palestinians and several thousand refugees from Somalia, Sudan and Afghanistan. [9]

The protracted conflict in Syria has led to the collapse of the health infrastructure, which aggravated infectious and non-communicable disease risks, poor maternal and child health outcomes, trauma, and mental health issues. In addition, systematic attacks on health care facilities inhibited health care delivery and assistance. [13] [14]. This situation particularly affected mental health services, due to several different factors: the increasing attrition of mental health professionals since 2012, the lack of psychotropic medications associated with the decline of the national pharmaceutical industry, the collapse of health infrastructures, impaired access due to safety and security reasons, and closure of most governmental services.

The main psychiatric hospital and addiction centre in Damascus (Ibn Sina Hospital) is still functioning, but in other major cities psychiatric wards are not functioning. Many psychiatrists have stopped visiting their local PHC centres, services have become even more urban centred, and mainly restricted to the city of Damascus and some parts of rural Damascus. [9]

While the challenges related to mental health care are considerable, emergencies also present unique opportunities for better care of all people with mental health needs. Following disasters, the media often focus on the plight of surviving people, including their psychological responses to the stressors they face. In some countries, senior government leaders express serious concern about their nation's mental health. This is frequently followed by national and international agencies' willingness and financial ability to support mental health and psychosocial assistance to affected people. [11]

For all these identified needs, and gaps, there is a great need to develop a consensus based agenda for priorities in order to improve mental health and psychosocial support services within Syria following the onset of the current crisis, and to provide a strategic framework for longer term development.

Part 2: Study of priorities for mental health services

2.1 Objectives of the study

The general objective of the study is to contribute to the identification of the priorities for improving mental health services in the context of the current Syrian crisis through an analysis of the perceptions of professionals with experience of work in Syria about the main gaps that currently exist in the delivery of care.

The specific objectives are:

1. To identify the existing gaps in services' provision
2. Providing guidance on strategic directions for different stakeholders involved in both the humanitarian response in Syria, and the post-conflict developmental plans

2.2 Methodology:

A questionnaire addressing the different priority areas for improving mental health services in Syria was the main instrument used in the study. The questionnaire was developed by the author, with the collaboration of professionals with experience in research, mental health policy development and responding to emergency needs.

2.2.1 Questionnaire development:

1- Thematic priority areas in the questionnaire were informed by the review of two important publications; WHO-AIMS Instrument, Version 2.2 [15] and Building Back Better: Sustainable mental health care after emergencies [11].

2- The WHO-AIMS Instrument, Version 2.2 is a WHO tool designed for collection of essential information on the mental health system in a country. Domains included in the tool can help to generate information on the strengths and weaknesses of mental health systems and services, and therefore can be seen as starting points for highlighting areas targeted by potential exploration and improvement. Building Back Better, shares experiences from 10 diverse emergency-affected areas, in which successful efforts were mobilized to re-build mental health systems after complex humanitarian emergencies. Strategic directions adopted in these countries helped to highlight the major areas that can inform future re-building strategy in Syria.

3- The first draft of the questionnaire was shared for initial feedback with 8 professionals who have experience in research, mental health policy development and responding to emergency needs. Feedback was incorporated, e.g. providing narrative explanation to some areas e.g. mental health policy & plans, mental health legislation …etc., and also adding a section for additional priority areas that may be suggested by some of the study participants.
4- The questionnaire was then shared with the research supervisor for review and approval.
5- The questionnaire was also translated to Arabic language by the researcher, and the translation was reviewed by a Syrian mental health professional to make sure that the used dialect is easily understood by non-English speaking participants.

2.2.2 Study participants:

The research plan aimed to include **40 professionals** (both national and international) who had direct work experience with mental health services in Syria, either in the regime controlled areas or in disputed zones. Efforts were made as best possible to include participants from both governmental and non-governmental sectors, and to target participants involved at different levels of mental health services, i.e. direct service provision, service planning, technical support, and link with other sectors e.g. health, protection, and education.

Total number of participants whose responses were included in the study is 40: ten international and thirty national professionals. The **10 international professionals included** 4 psychiatrists, 4 psychologists, and 2 clinical social workers, who worked for UN agencies, and international non-governmental organizations. All of them worked in Syria during the current crisis, and some had work experience even before the start of the crisis. Years of experience were variable, starting from 1 year as a minimum, and up to more than 3 years. They had different levels of involvement with mental health services provision: from direct service provision to technical support and services' planning. The **30 national professionals** included 7 psychiatrists, 9 psychologists, 2 clinical social workers, 8 community psychosocial counsellors, 1 school counsellor, and 3 general physicians who are providing mental health services at the primary health care centres using mhGAP- Intervention Guide. All of them worked for local non-governmental organizations, international non-governmental

organizations, and governmental sectors, mainly through direct services' provision with years of experiences starting from 2 years, and up to 15 years.

2.2.3 Procedure

1- After the questionnaire was developed , the author shared it, through his personal e-mail, with a group of professionals through personal and professional networks, attached to the following message:

> *Dear colleague,*
>
> *Hope this mail finds you well.*
> *As a partial fulfillment of my International Master in Mental Health Policy and Services at NOVA Medical School - Faculdade de Ciências Médicas-Lisbon, my thesis project will be about Priorities for improving mental health services in the context of the current Syrian crisis. The methodology involves surveying mental health professionals from governmental and non-governmental agencies with work experience in Syria either before or during the current crisis. They will score the highlighted priority areas and provide explanations from their points of view on why they think these areas would be priorities to improve mental health services. Responses will be later analyzed to set a consensus-based agenda that will help both governmental and non-governmental actors to guide their mental health programs.*
>
> *If you agree to participate, responses will remain anonymous, and your contact details will remain confidential and not shared externally. Also, if you would like to recommend some colleagues (who have worked or supported work inside Syria) to contact, this will be highly appreciated.*
>
> *Best regards,*
> *Dr. Mohamed Elshazly*
> *Consultant Psychiatrist- MHPSS Consultant*

2- The initial message was shared with 112 participants, and responses were received from 45 participants, 5 of which were excluded from the study either due to lack of relevant experience with mental health services in Syria, or lack of clarity in responding to the questionnaire (e.g. having

more than one score to the same priority area). Three of the participants asked for a verbal communication via skype to get more clarification about the purpose of the study and scoring of the questionnaire.

3- Scores and comments from participants were then inserted in an excel sheet, and the average score (1-10) for each priority area was calculated. Comments from participants were included in the discussion section later.

Priorities for improving mental health services in the context of the current Syrian crisis

Name:
Affiliation:
Brief about experience with mental health services in Syria:
For the following priority areas, please list them in a descending order from the most to the least important/urgent priority (10 is highest priority and 1 is the least). When possible, please provide narrative description under each of them, clarifying your point of view of why setting this area as a priority for improving mental health services in Syria. Also, at the end if you find specific areas that you'd like to address and not included here, you can reflect on them under 'Additional areas'.

Priority areas	Score
1- Mental health policy and plan (include narrative about the content) **Mental health policy** refers to an organized set of values, principles, and objectives to improve mental health and reduce the burden of mental disorders in a population. **Mental health plan** is a detailed scheme for action on mental health which usually includes setting priorities for strategies and establishing timelines and resource requirements. A mental health plan usually includes action for promoting mental health, preventing mental disorders and treating people with mental illnesses.	
2- Mental health legislation (include a narrative about the content) **Mental health legislation** refers to specific legal provisions that are primarily related to mental health. These provisions typically focus on issues such as: civil and human rights protection of people with mental disorders, treatment facilities, personnel, professional training and service structure.	
3- Financing of mental health services (include suggestions about estimated MH budget-in relation to general health budget-, and its distribution e.g. mental hospitals and community based services). Proportion of mental health expenditures from the total health expenditures by the government health department.	

4- Organization of mental health services: (i.e. proposed changes in mental hospitals, MH outpatient facilities, day treatment facilities, community based psychiatric inpatient units, and community residential facilities. Also, mental health services for special populations e.g. children, old age, substance abuse …etc., and access to psychotropic medications)	
5- Integration of mental health services into primary health care (e.g. undergraduate/postgraduate training of medical doctors, referral between primary health care doctors and mental health professionals, prescription of psychotropic medications, and training of non-physician staff in primary health care)	
6- Number and training of human resources in mental health facilities:	
7- Establishing user/consumer associations, and family associations:	
8- Public education and awareness campaigns on mental health	
9- Inclusion of mental health categories in national health information system.	
10- Mental health research agenda.	
Additional areas:	

Table 2. The study questionnaire

2.3 Study limitations

1- The study included a relatively small number of persons involved in provision of mental health services in Syria, and mostly working within the health sector. Better results could be obtained by including different stakeholders from diverse sectors (e.g. health, education, social services, professional associations, etc.). However, this was operationally impossible in the context in which this study was made.

2- The study didn't include the perceived needs of persons with mental illness or their caregivers. The design of the study didn't intend to get in direct communication with patients or their families, but this should be considered for any future planning or prioritization process.

3- The access to mental health professionals working inside Syria was always a challenge; the personal security issues, and sensitivity in disclosing any

data or information about the health/governmental systems were seen clearly during collection of data for this study.

Part 3 - Results

The responses obtained from the study participants yielded the following results:

	Priority areas	Total score	Average score
1	**Mental Health Policy and Plan.**	288	7.2
2	**Mental Health Legislation**	190	4.75
3	**Financing of mental health services**	220	5.5
4	**Organization of mental health services.**	240	6
5	**Integration of mental health services into primary health care.**	259	6.475
6	**Number and training of human resources.**	250	6.25
7	**Establishing user/consumer associations and family associations.**	196	4.9
8	**Public education and awareness campaigns.**	237	5.925
9	**Inclusion of mental health categories in national health information system.**	181	4.525
10	**Mental health research agenda.**	134	3.35

Table 3. Study results

Results show that implementation of a mental health policy and plan in Syria is seen as the main priority by the study participants, followed by integration of mental health into primary health care services, and number & training of human resources working in mental health services' delivery. This is followed by focusing on re-organization of mental health services in the country, and public education & awareness campaigns. Priority is then for adequate financing of mental health services, and establishing user/consumer associations and family associations. Mental health legislation, inclusion of mental health categories in national health information system, and mental health research agenda, despite being priority areas, but seen as less important than aforementioned areas.

Part 4 - Discussion

Synthesis of comments and feedback from the participants in the study during scoring and rating of priority areas for improvement of mental health services look very significant for the generation of both the practical and theoretical foundation for future strategies.

4.1. Mental Health Policy and Plan

Mental health policy and plan can vision future actions in mental health and psychosocial support projects and ensure that all country level services, either through the government, non-governmental sector, or civil society, are collaborating to achieve the same objective. Without this collaboration, efforts may contradict each other and decrease their expected impact. Despite the challenging political context, the revision and formalization of a national mental health policy and plan will inform identifying key priority areas in Syria and advocate for related legislation, financing, and implementation of recommended activities. Some participants suggest to develop a mental health plan over two phases: a phase one focusing on the emergency needs, helping to guide emergency response efforts and ensuring building services upon solid foundations once the post-conflict recovery stage begins, while the phase two will focus on channelling the current resources and efforts into more sustainable long term developmental plans. Although both mental health policy and plan are of significant importance for giving direction to the development of mental health services in one country, some participants see them as of less priority compared to other areas, such as financing and development of human resources, which would help a rapid restoration of services' efficiency. Currently, only the United Nations agencies are allowed to work with government and support policy type initiatives.

4.2. Mental Health Legislation

Mental health legislation in Syria hasn't been updated for decades, and terms such as "Madness" are still used in courts to describe mental health disorders. Many aspects of the legislation need to be addressed. Aspects related to the protection of both clients and service providers

need to be re-specified, and the same applies to social service legislations, as social workers are virtually inoperative due to lack of legal support. Advocating for mental health legislation would help to promote certain best practices, therefore increasing the likelihood of enforcing and advocating for key services as well as rights for those in need of such services. The current political situation is quite challenging to update and develop the mental health legislative framework, but despite the necessity, many participants see that directing resources to other priority areas may be more pragmatic and effective, with emphasis on introducing the legislative frameworks towards the recovery stage of the emergency.

4.3. Financing of mental health services

The total expenditure on health (% of GDP) in Syria is 5.1%, which is already very low, and thus a more comprehensive evaluation of health budget, and advocacy for its increase and for the inclusion of mental health should take place. It should be noted that a mental health budget does not exist, and that the % of health budget allocated to mental health is unknown in Syria. Advocacy, in accordance with WHO, should be in line with the country's mental health financing approach, which often is generated from taxes, out of pocket expenditure, and insurance (social or private). Given the substantial need for investment in mental health services as well as the proven high rate of return ($4 for every $1 spent) [(20),] it would be advisable that a minimum of 5% of health care budgets should be allocated to mental health. Many participants see the work on mental health financing as a later step following launching of mental health policy and plan that outline the financing and expenditure of mental health services, which should ensure the availability and accessibility to as many citizens as possible. An important consideration is the rational investment of available or future budget i.e. increase the number of non-specialized healthcare providers trained in mental health, rather than only supporting mental hospitals and psychotropic medications. Only after this task is accomplished, community-based mental health services can gradually be developed. This can be best done as pilot projects first allow to understand what works and what does not work. Development of community mental health services can be a long process and should not be rushed. It is more difficult to say how health

system in Syria will be financed in a long run. Three usual options are social insurance, private insurance and out-of-pocket money. Although money for health services in Syria is coming from external grants at the moment, it is questionable if this source of funding will continue and for how long in the future. If community mental health services are to be developed, the funds should be gradually shifted from mental hospitals to community based mental health services. However, at the beginning, some initial extra investment is needed because some community based mental health services should be developed first, before the number of beds in mental hospitals is reduced.

4.4 Organization of mental health services

Proper organization of mental health services looks as an essential step to ensure that mental health services are of sufficient quality and are most effective in terms of service design and delivery from a public health perspective. Disasters sometimes represent an opportunity for change and restructuring of mental health services and systems. In a war-torn country such as Syria, and with very few mental health human resources (specialized and non-specialized), it becomes almost necessary for United Nations agencies and INGOs to support efforts for the deinstitutionalization of mental health services, and focus on priority conditions, with attention to hidden and stigmatized disorders. This step should happen gradually, because shifting to community based mental health services is not only fundamental to promote the human rights aspects of mental health provision, it is also the most effective platform for the access to affordable, non-stigmatizing mental health care. Shifting the focus from specialized mental health services (dedicated mental hospitals and tertiary care) to community mental health services and care, is seen as a priority to scale up mental health services with the current limitation of resources. Task shifting efforts and experiences show that it is better to develop mental health services in one part of the country first as a pilot project, and then include those experiences from the pilot project in mental health policy and planning. Later, if the pilot is successful, it can be also rolled out to other parts of the country.

Reducing the number of beds and eventually closing up mental hospitals should be a gradual process and it should run parallel with the development of community mental health services. The integration of

mental health into primary health care is usually a realistic option at the beginning, because these health facilities already exist and are staffed with health personnel. Standards of care can be developed for mental hospitals at the beginning, to improve treatment of patients. Outpatient facilities are a realistic option in e.g. general hospitals, but of course staff will most probably need additional mental health training. Community residential facilities and development of mental health services for special populations usually comes only later in a process of developing community services. However, at least some community residential facilities can be started as pilot projects at the beginning. Task shifting seems an option to meet the needs of special population at the beginning before there is enough child, geriatric and substance abuse specialists to take over.

4.5. Integration of mental health services into primary health care

Because of the ongoing conflict in Syria, many mental health professionals (whose numbers were already low) left the country, creating a huge gap in delivery of mental health services to persons in need. Integration of mental health into primary health care is seen as a more effective strategy to bridge this gap, since the primary health care setting is the most common entry point for individuals with emotional distress and mental disorders, improving accessibility and reducing the burden of stigma associated with mental illness.

Different levels of integration need to be included in this plan, including a focus on lower level non-medical staff (such as counselors), and the need for training on an integrated package of mental health, gender based violence, and child protection case management, given the complex and comprehensive nature of needs of clients identified at the primary health care level and within vulnerable and affected communities. A huge element in the success of integration of mental health into primary health care is harnessing the role of the very few specialists in country, link with policy and mental health plan implementation, to act as referral points for complex cases, trainers and supervisors for non-specialized staff. The current scenario reveals a poaching approach adopted by agencies to hire these few specialists as staff whereby they are no longer working to support a mental health

system as a whole, but rather the goals of the agencies with which they have been employed.

Also some participants suggested to target doctors at under graduate level and encourage them to specialize in psychiatry, or to target fully qualified primary health care doctors who can be trained on Mental Health Gap Action Program- Humanitarian Intervention Guide (mhGAP-HIG). Both things need to occur as it is not fair on primary health care doctors to overload them with mental health clients when they also require psychiatrists to supervise and support their work and for someone to refer complex cases to.

4.6. Number and training of human resources

The number and the training of human resources working within the mental health field is far below the standards expected and needed to meet the growing existing needs. Training should start as early as possible during the undergraduate education, and numbers can be scaled up by focusing on increasing the number of psychosocial counsellors, psychiatric nurses, psychologists and social workers.

While direct inclination by UN and INGOs would be to develop the capacity of specialists in mental health facilities, or to increase the number of specialists, this has proven to be a flawed approach, as most of these specialists were consumed by agencies wishing to fill specialized positions within their agencies, rather than used as part of a more comprehensive, integrated and holistic approach to mental health care provision. What agencies fail to realize is that we need to work to build local capacity and expertise and support efforts as part of a local support mechanism/system that can sustain itself, rather than developing parallel systems that serve agencies' donors, goals and numbers. The mindset should shift to work towards a development phase even if we are still very much in a chronic emergency.

To uphold quality standards in mental health service design and delivery, all staff working in mental health facilities should receive ongoing training and capacity building. This should be prioritized for quality assurance and to ensure no harm is done at the very least; but furthermore, to improve the expertise of staffing in these facilities and build their capacity according to the latest research and best practices for those with chronic and severe mental disorders.

Also, with the concurrent crisis, there is a need to introduce terms and concepts related to mental health and psychosocial support during humanitarian emergencies, such as IASC guidelines, Sphere standards, etc.

4.7. Establishing user/consumer associations and family associations

This approach is new in Syria, but some organizations are attempting to make community empowerment an approach rather than a single project, ensuring that members of the community being served are directly involved in the planning and implementation of mental health and psychosocial support programs, with the goal of identifying key individuals to help establish user and family associations, particularly as it pertains to individuals or family of individuals with or who have overcome mental health problems.

In Syria, this remains a huge gap, and efforts to set up such associations are hindered by the reallocation of displaced populations residing in shelters, instability and violence in some locations where vulnerable Syrians are being served, rendering movement and activity within these communities limited. Other obstacles for the establishment of user and family associations include weak partnerships with government, and in some cases inactive government structures, that limit the platform from which these associations can speak and be linked to. It is recommended that the mental health policy and plan will include the establishment of user and family associations as an approach linked to mental health priorities and interventions identified for the country.

On the other hand, some participants see this is more of a development oriented initiative and it may not be possible in the current conflict environment as families may be unable to attend group meetings. In fact, families are often separated and displaced from home locations and the development of associations requires consistency, regular commitment and attendance. There is no enabling environment for this at present in Syria, so although it is really important, it is not seen as a high priority now.

4.8. Public education and awareness campaigns

While it is very important to tackle issues of stigma, support to persons with mental illness and their families, and to provide guidance on how and where to access services, awareness activities are indeed ongoing, and integrated into many agencies' planning and implementation of mental health and protection services. Because of the current circumstances, especially as public gatherings are rare, these efforts are often limited to use and orientation on **IEC** (Information, Education, and Communication) materials (individual and group), and community based (often center based) awareness activities involving community members who are direct or indirect beneficiaries of mental health services.

Many participants see this as a high priority area that goes parallel to efforts on integration of mental health into primary health care services for bridging the gap in access to mental health services for wider layers of population. Many participants highlighted the need to work on media and how they present and interact with mental health and mental illness.

4.9. Inclusion of mental health categories in national health information system

Systematic inclusion of mental health considerations when obtaining health background from individuals seeking medical services will inform the planning of services through estimation of prevalence of mental disorders and the distribution of psychotropic medications around the country. Documentation of mental disorders seen at the PHC level serves as a baseline information needed for implementation of mental health policies and plans, and during integration of mental health into primary health care services.

4.10. Mental health research agenda

While this is extremely important to ensure quality programming, assess impact of mental health and psychosocial support programming, and add to existing evidence base, the reality is Syria is still a L3 humanitarian emergency. Funding should thus be directed to humanitarian response activities at present and recovery efforts (where possible) rather than funding research initiatives which are difficult to be

planned, approved, and even implemented with limitations in bringing in external expertise to support.

4.11. Other additional areas

Some other additional areas were highlighted by some participants that need to be taken in consideration:

- Scalable psychological interventions: Adaptation and piloting of scalable psychological interventions (evidence based brief therapeutic interventions such as Problem Management Plus, and Interpersonal Group Therapy). This represents the new wave of psychological interventions that can be applied by non-specialists in low resource settings.
- Psychotropic medications: Procurement of psychotropic medication is problematic in the context of Syria as domestic production has collapsed and cross-border deliveries are becoming increasingly difficult. However a consistent supply of psychotropic medications is the corner stone of a mental health emergency plan if nothing else exist to support the persons with chronic and severe mental disorders (irrespective of the crisis).
- Coordination: Mental health coordination mechanisms that promote communication, coordination, and collaboration across national Ministry of Health initiatives, the UN, LNGOs, and INGOs.
- Individuals with special needs: Individuals with special needs require special care and design of dedicated services that ensure access and inclusion.
- Monitoring and evaluation: there is a need to design and implement suitable and relevant MEAL *(Monitoring, Evaluation, Accountability & Learning)* systems in mental health and psychosocial support projects especially in relation to the current emergency response.

Part 5: Conclusion and Recommendations

Much of the consensus generated by the study participants goes in line with many global guidance and local initiatives to improve mental health services in Syria from many facets. Here are some conclusions and future recommendations for this priority agenda.

5.1. Mental health policy and plan

Mental health policy is an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population. It defines a vision for the future and helps to establish a model for action. Policy also states the level of priority that a government assigns to mental health in relation to other health and social policies. Policy is generally formulated to cover a long period, e.g. 5 to 10 years. **Mental health plan** is a detailed pre-formulated scheme for implementing strategic actions that favor the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation. Such a plan allows the implementation of the vision, values, principles, and objectives defined in the policy. A plan usually includes strategies, time frames, resources required, targets to be achieved, indicators and activities [16].

Essential steps to develop a mental health policy include; **1) gathering information** and data for policy development through either formal research (e.g. epidemiological studies in general and special populations, burden of disease studies, in-depth interviews and focus groups) or rapid appraisal of data from existing information systems, **2) gathering evidence** for effective strategies either from the country or a specific region, evidence from other countries or regions, or evidence from literature, **3) consultation and negotiation,** using the available political windows to inform the decision making process to prioritize mental health in the action agenda, **4) exchanging with other countries** which reflects on experiences from both developed and developing countries, **5) setting out the vision, values, principles, and objectives**, 6) determining areas for action e.g. financing, legislation and human rights, organization of services, advocacy ..etc., **7) identifying the major roles and responsibilities** of different sectors e.g. governmental agencies, academic institutions, professional associations, consumers and family groups, non-governmental organizations …etc.

To develop a mental health plan, the following steps should be considered as well; **1) determining the strategies and timeframes** for different areas of action identified throughout the policy development process, **2) setting indicators and targets** to later assess whether the plan was effective or not, **3) determining the major activities**, detailed activities must be worked out with regard to how the strategy will be realized, and **4) determining the costs, available resources, and budget** accordingly [44].

In **Syria** [8], [9], even though a mental health policy exists at this moment, it is significantly outdated. Attempts to review and to make extensive adjustments were made in 2013, but were never finalized given the current crisis in Syria. Current mental health policy aims to 1) integrate mental health into the primary health care and secondary health care systems, including involving mental health professionals in primary health care centers, and adding psychiatric units in general hospitals; and 2) reduce stigma through awareness-raising campaigns. In addition, in 2001 the Ministry of Health established the Psychiatric Directorate to improve and develop mental health services.

Protracted emergencies like the current Syrian crisis often pose a challenge for mental health policy makers; with the quite challenging drop in resources, and the fluidity of the situation, they have to adopt policies that address both the emergency response efforts, and at the same time pay attention to longer term developmental perspectives which is not an easy process to start.

5.2. Integration of mental health services into primary health care

According to the **WHO Mental Health Atlas**, more than 45% of the world population is living in countries where there is less than one mental health specialist for every 100,000 populations [17]. This implies the fact that we need to develop other levels of care capable of providing mental health services: e.g. integrating mental health into existing primary health care services.

Within the WHO optimal mix of mental health services, integrated primary mental health care is a fundamental component, supported by other levels of care including community based and hospital services [16]. There are seven good reasons for integrating mental health into primary

health care [18]; **1) the burden of mental disorders is great**; mental disorders are prevalent in all societies and create a substantial personal burden for affected individuals and their families, **2) mental and physical health problems are interwoven;** integrated primary care services help ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders, 3**) the treatment gap for mental disorders is enormous**; in all countries, there is a significant gap between the prevalence of mental disorders, on one hand, and the number of people receiving treatment and care, on the other hand, **4) primary care for mental health enhances access;** when mental health is integrated into primary care, people can access mental health services closer to their homes, thus keeping their families together and maintaining their daily activities, **5) primary care for mental health promotes respect of human rights**; mental health services delivered in primary care minimize stigma and discrimination, and they also remove the risk of human rights violations that can occur in psychiatric hospitals, **6) primary care for mental health is affordable and cost effective;** primary care services for mental health are less expensive than psychiatric hospitals, for patients, communities and governments alike, and in addition, patients and families avoid indirect costs associated with seeking specialist care in distant locations, and 7**) primary care for mental health generates good health outcomes.**

Training of primary care staff in mental health is critical to building capacity for identification and treatment of severe and common mental disorders. In 2010 the WHO launched the Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) for mental, neurological and substance use disorders in non-specialized settings; its newest version was published recently [19]. The mhGAP-IG presents integrated management of priority conditions using protocols for clinical decision making. The target audience of mhGAP-IG are non-specialized healthcare providers working at first and second level healthcare facilities in low and middle-income countries. These include primary care doctors, nurses and other members of the healthcare workforce.

Principles for integration of mental health into primary health care are the following: **1. Policy and plans need to incorporate primary care for mental health**, **2. Advocacy is required to shift attitudes and**

behavior, **3. Adequate training of primary care workers is required**, **4. Primary care tasks must be limited and doable, 5. Specialist mental health professionals and facilities must be available to support primary care, 6. Patients must have access to essential psychotropic medications in primary care**, **7. Integration is a process, not an event**, **8. A mental health service coordinator is crucial, 9. Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required,** and **10. Financial and human resources are needed** [18].

In **Syria**, in 2013, WHO initiated an ambitious programme to respond to the increasing needs for mental health care and psychosocial support in the country. It was evident that there were not enough mental health-care specialists to address the emerging needs. WHO estimates that approximately 600 000 people in the Syrian Arab Republic are suffering from severe mental health disorders and another 4 million from mild to moderate mental disorders [21]. Using WHO's *mhGAP Intervention Guide* for treating people with mental, neurological and substance use disorders in non-specialized health settings, more than 500 non-specialist health-care professionals have since been trained in the Syrian Arab Republic to provide support for mental disorders [21].

Many challenges are facing this initiative of integration of mental health into primary health care: collapse of the health system, other priorities are considered more urgent [9], flee of many mental health professionals outside the country, who could be potential trainers in these care units, and limited access to remote areas due to security reasons. Many international non-governmental organizations include integration of mental health into primary health care as one of their mandates, which can be successful if they ensure coordination and sustainability.

It is recommended here also to work on advocacy efforts at both the higher decision-making level, and the field level (especially with health care delivery programmes) to endorse integration of mental health services as a priority and encourage steps forward. This will be much supported when included in mental health policy and plan.

5.3. Number and training of human resources

Globally, there is a shortage in the number and gap in the capacity of human resources dedicated to mental health services' provision, and of course this problem is magnified in low and middle income countries. Strategies to improve the mental health workforce should be informed by the anticipated changes in mental health services' organization i.e. shifting resources towards community based care. Provision of services outside dedicated mental hospitals, and focusing on building the capacity of general health system to respond to mental health needs at both primary and secondary levels of care. Health workforce can be a strong asset to mental health services.

Planning and implementation of a mental health workforce strategy should be guided by the following steps: 1). **Conduct a situation analysis and needs assessment**; *assessment of human resources policies, as well as the number and type of current health workers and their distribution. Estimate the mental health service needs in the community and the human resources required to meet those needs*, 2). **Set targets**; *identify human resource gaps and set targets to reduce these gaps, putting in consideration not just increasing the number of human resources but also re-distributing the available number and develop new competencies,* and 3). **Implement the strategy** [22].

In **Syria**, the problem has been complicated because of the current emergency. Many mental health professionals have left the country soon after the onset of the conflict, and the service mix relies heavily on specialized mental health services without adequate development of integrated care models. Deployment of international actors in response to the humanitarian emergency in Syria is promising to develop new models for capacity building and rational use of available resources.

Also, with the complications of integrating educational (capacity building) initiatives with the health care delivery systems, efforts should be directed to focus on undergraduate curricula to make sure that basic knowledge and skills are included in the general medical education. This will be also an opportunity to encourage more medical students to specialize in mental health.

5.4. Organization of mental health services

WHO guidance on organization of mental health services is based on the principle that no single service setting can meet all population mental health needs, so there is always a need to develop the optimal mix of services for mental health to span different levels of care: 1). **Self-care** (dealing effectively with stress, conflict management, regular physical activity, and awareness of hazardous alcohol, and drug use); 2). **Informal community care** (traditional healers, professionals in other sectors e.g. teachers, non-governmental organizations, user and family associations, and lay people) which is usually accessible and acceptable by the community; 3). **Primary care mental health services** (identification and treatment of mental disorders, management of stable psychiatric patients, referral to other levels of care when needed, and mental health promotion and prevention activities) which usually is the most affordable, accessible and acceptable to wider layers of community, 4). **Psychiatric services in general hospitals and community mental health services** (day centers, rehabilitation services, hospital diversion programs, mobile crisis teams, therapeutic and residential supervised services, group homes, home help, assistance to families, and other support services); and 5). **Long stay facilities and specialists services** (for people with treatment-resistant or complex presentations). Mental health services should always remain accessible, comprehensive, continuous and coordinated, needs-led, effective, equitable, and respectful to human rights [(16)].

Organization of mental health services in **Syria** is heavily reliant on specialized and dedicated mental health facilities. Syria has predominantly institutional mental health services, comprising two mental hospitals in Damascus and Aleppo (1200 beds in total). In addition, there is an addiction treatment center in Damascus (30 beds), mental health departments in two military general hospitals and a psychiatric ward (with 12 beds) at Damascus University Hospital. Syria has also two small private hospitals [(23)]. Community mental health services are rudimentary, comprising clinics in major cities, with the majority being private clinics. The number of mental health professionals is low (1 per 100000 population), with very few specialists in child and adolescent mental health and other subspecialties [(9)].

Four psychiatric health facilities estimated to provide mental health services to more than 11 000 patients are being renovated by

WHO. These are Ibn Roushed Psychiatric Hospital, psychiatric units at Al Mowassat and Al Afia fund hospital in Damascus and an outpatient centre at Ibn Khaldoun hospital, Aleppo [24]. More efforts are needed to shift services to lower levels of care rather than relying on specialized mental health services only. Also there is a need to de-centralize services to reach rural areas outside big cities with attention paid to services for special vulnerable population groups e.g. children and old age. The current crisis is an opportunity to introduce the concepts and practices related to community mental health services, and bringing the international experience to this area will help to institutionalize these practices within the current care delivery system.

5.5. Public education and awareness campaigns

Stigma of mental illness is one of the major barriers for accessing mental health services for both patients and their caregivers. Many factors are contributing to this increased stigma; lack of awareness of mental health and mental disorders, and cultural factors as well.

Stigma results in labeling, prejudice, stereotyping, separation, status loss, and negative discrimination [25]. It thus prevents many individuals with mental illness from obtaining treatment. Shame and low self-esteem in individuals with mental illness are common by-products of stigma. Societal stigmatization of the mentally ill can be internalized and thus threaten quality of life, disrupt social relationships, and decrease the likelihood that persons with mental illness seek mental health services or obtain employment. Stigma is, therefore, considered a barrier to recovery from mental illness, even for individuals who receive treatment [26].

Public educational anti-stigma interventions present factual information about the stigmatized condition with the goal of correcting misinformation or contradicting negative attitudes and beliefs. They counter inaccurate stereotypes or myths by replacing them with factual information. An example would be an education campaign to counter the idea that people with mental illness are violent murderers by presenting statistics showing that homicide rates are similar among people with mental illness and the general public [27]. Although generally aimed at combating public stigma, educational interventions have been found to be effective in reducing self-stigma, improving stress management, and

boosting self-esteem when delivered as a component of cognitive and behavioral therapy [28].

Mental health literacy campaigns have also focused on how to encourage individuals and families to seek needed services. This is an important goal because early diagnosis and treatment are predictive of improved outcomes, but high-quality, culturally informed treatment is not widely available, especially to racial and ethnic minority groups [29].

Despite all the challenges faced during humanitarian emergencies, they are still a valid opportunity to change public attitudes towards mental health and persons with mental illness, given the higher incidence and prevalence of mental disorders associated with emergencies. Despite working on public education and awareness campaigns need more stable environment and long term developmental plans that can design proper activities and measure their impact, still emergencies can be a good inlet to that.

5.6. Financing of mental health services

Investment and financial resources for mental health services remain an issue of concern especially for low and middle-income countries, which spend less than US$ 2 per capita per year on mental health whereas high-income countries spend more than US$ 50 [17]. Despite this low budget allocated to mental health services in most countries, the majority of spending still goes to psychiatric institutions, which provide services for a very small proportion of people in need. Bridging the gap in resources for mental health services requires adapting new strategies that focus on provision of mental health services through primary health and community care [30].

In **Syria**, the allocated funds for the health in general and for mental health are greatly diminished because of the current crisis with no soon expected improvement. Despite the growing needs, and increased awareness about mental health, in practice, mental health is often not given a high priority and inclusion of MHPSS within donor funding for humanitarian crises still often falls short of the total needs. In the 2016 Syrian Arab Republic Humanitarian Response Plan (SHARP), for example, MHPSS represented less than 0.1 % of the overall budget of the humanitarian response [31].

Continuous advocacy to increase financial resources for mental health services, should be combined with plans to shift to other models of care (community mental health services) which may not save budget immediately, but eventually will help to reach best use of available resources and bridge the existing gaps. Also, donors' and international communities should be always aware of the needs and best ways to address these needs, which may improve the funding situation for mental health services. It is important to mention that coordination of services' delivery among various actors, will ensure best use of existing limited resources.

5.7. Establishing user/consumer associations and family associations

The WHO guidance on user associations states: to be committed to an empowerment agenda is to be committed to identify, facilitate or create contexts in which heretofore silent and isolated people, those who are outsiders in various settings, organizations and communities, gain understanding, voice and influence over decisions that affect their lives [(33)].

Consumer associations have always played a major role in influencing policies and legislation concerning persons with mental disabilities, and also sensitizing the general public about their causes and needs. Family associations are sometimes distinct from consumer associations, and they have an important role as well in advocacy for best service delivery for persons with mental disabilities and improvement in human rights considerations, and mental health legislation. [(34)]

In **Syria**, international actors who are currently involving in providing mental health services should play a major role in establishing and strengthening consumer and family associations, this should parallel to efforts in shifting services to community based settings.

5.8. Mental health legislation

Worldwide people with severe mental disorders are at a higher risk for abuse and neglect, such as physical restraining, seclusion or isolation, and being denied basic needs and human rights [(35)]. Stigma related to mental illness is one of the major barriers against effective access to services for persons with mental disabilities and their caregivers.

Humanitarian emergencies in particular remain a medium for human rights violations especially those with mental disabilities. [36]

The UN Convention on Rights of Persons with Disabilities (CRPD) sets out a wide range of rights including, among others, civil and political rights, the right to live in the community, participation and inclusion, education, health, employment and social protection. Its coming into force marks a major milestone in efforts to promote, protect and ensure the full and equal enjoyment of all human rights of persons with disabilities.

In **Syria**, mental health legislation exists since 1953, with a new draft in 2010 that was never completed and was even more delayed by the current situation. Many incidents related to the current humanitarian crisis show violation of rights and lack of protection for persons with mental disabilities in Syria, which necessitate immediate action to be taken by the government to put revised mental health legislation in action. In Syria, psychiatrists, trained general practitioners, neurologists, and psychiatric residents may provide psychiatric services in Syria. Licensing for psychiatrists is lifetime, although there was an initiative to review licenses yearly in order to ensure higher standards of service provision. There is no current legal licensing system for psychologists, psychiatric nurses or social workers. There is also no governing law or monitoring structure for psychological practice in Syria, nor for social work, school counseling or psychiatric nursing [9].

Mental health legislation in **Syria** should address many facets related to mental health services' delivery; protection of persons with psychosocial disability, regulations for treatment especially admission to mental hospitals or psychiatric wards in general hospitals, and licensing procedures for mental health professionals (e.g. psychiatrists, psychologists, social workers, and psychiatric nurses).

According to WHO (2007), governments should take active steps to **1) develop and promote policies, plans, laws and services that promote human rights**; promote rights of people with mental disabilities and empower them to make choices about their lives, provide them with legal protections, and ensure their full integration and participation into the community, **2) improve access to good quality mental health treatment**

and care; increase investment in mental health, and replacing large institutions by community care facilities, **3) protect against inhuman and degrading treatment**; human rights oriented mental health policies and laws, obtaining free and informed consent for treatment, outlawing improper use of seclusion and restraints, and ensuring that people have the right to living conditions that respect and promote their dignity, **4) involve mental health services users and families**; empowerment of mental health service users and families by supporting the creation &/or strengthening of groups representing their interests, and involving mental health service users in decision making processes that involve design, and implementation of mental health policies, plans, laws, and services, and **5) change attitude and raise awareness;** combating stigma and requires a multi-sectoral approach, involving education, labor, welfare and justice sectors among others. [37]

5.9. Inclusion of mental health categories in national health information system

According to the **World Health Organization,** [38] a mental health information system (MHIS) is a system for collecting, processing, analyzing, disseminating and using information about a mental health service and the mental health needs of the population it serves. The MHIS aims to improve the effectiveness and efficiency of the mental health service and ensure more equitable delivery by enabling managers and service providers to make more informed decisions for improving the quality of care. In short, an MHIS is a system for action: it exists not simply for the purpose of gathering data, but also for enabling decision-making in all aspects of the mental health system.

Main stages of an MHIS include: 1) Collection of data (from a variety of different mental health services); 2) Processing; 3) Analysis,; 4) Dissemination; and 5) Use i.e. application of the data to improve service delivery, planning, development and evaluation. Steps necessary to design and implement MHIS usually include needs assessment, situation analysis, implementation and evaluation.

In **Syria**, strengthening health information systems (HIS) and provision of timely, relevant, high-quality data is a priority to ensure the correct identification of current and future health priorities. A lack of

information from particular areas inside Syria (e.g. Daesh controlled areas) is highlighted as a particular concern. Use of community-centred healthcare delivery models in order to collect data and participatory feedback loops to address continuity of care and accountability to donor populations is also important.

There are no reliable estimates of psychiatric morbidity in Syria, due to an insufficient health information system and lack of systematic research [39]. Additionally, the high level of social stigma associated with mental disorders inhibits reporting [9].

A frequently encountered problem facing establishing and maintaining of MHIS is the lack of adequate understanding by those involved in design and implementation of general health information systems.

A frequently used tool for collection of data related to health during humanitarian emergencies is the **UNHCR-Health Information System (HIS)** [40] which consists of 5 parts that include data collection at health facilities, data entry into excel sheet, submission of data to HIS database, data analysis and converted into indicators, reviewing of results. The objectives of the Health Information System (HIS) are: rapid detection and response to public health problems and epidemics, monitoring trends in public health status and continually address health-care priorities, evaluating the effectiveness of interventions and service coverage, ensuring that resources are correctly targeted to areas and groups of greatest need, and evaluating the quality of health programs.

HIS is appropriate for camp, urban, emergency, protracted, low and middle/high income settings. HIS collects population, mortality, morbidity, in-patient department and referral, laboratory, disease control, EPI, nutrition, reproductive health and HIV/AIDS.

Health information system has a section for reporting on mental health that includes 7 categories; epilepsy / seizures, alcohol or other substance use disorder, mental retardation / intellectual disability, psychotic disorder, severe emotional disorder, other psychological complaint, and medically unexplained somatic complaint. Reported data are classified based on sex, and different age groups.

5.10. Mental health research agenda

Research on mental health remains a cornerstone to bridge the gap between theory and practice, and inform more practical solutions and guidance to policy makers and programs' developers. It is important to understand that research is a resources intense process, which necessitates the need to set a research priority agenda for better allocation of available resources.

Tol et al [41] identified the need to develop an agenda for research priorities for mental health and psychosocial support in humanitarian settings. The 10 years consensus-based agenda reflects the high level of agreement among experts on the ten most highly prioritized research questions, which consisted of questions related to: *problem analysis* (four questions on identifying stressors, problems, and protective factors from the perspective of affected populations), *mental health and psychosocial support interventions* (three questions on sociocultural adaptation and on effectiveness of family- and school-based prevention), *research and information management* (two questions on assessment methods and indicators for monitoring and evaluation), and *mental health and psychosocial support context* (one question on whether interventions address locally perceived needs).

In **Syria**, various programs are already responding to the mental health needs of the population, but these programs need more support from the scientific evidence to ensure quality of services, and feed into an overall mental health strategy. Elshazly and Harrison (2016) [42] adapted the agenda developed by Tol et al (2011) to the Syrian context and came with the following recommendations for a research agenda: **1) community, stigma and culture**; researchers must pay special attention to how Syrian people affected by conflict perceive the idea of mental and psychosocial support, the role of stigma in relation to conditions such as epilepsy and psychotic disorders, and to what extent interventions are culturally appropriate; a common mistake is to blindly apply 'Western-produced and tested' interventions without considering the cultural diversity of Syrians; **2) Integrated health systems,** by questioning the different approaches to integrating services in a failing state. Such approaches might include training, supervision and mentoring, or offering support through other sectors such as education; and **3) Help for people on the move**, how to deliver services to a dispersed, mobile and

highly insecure population by making the best use of available personnel such as social workers or school counsellors and community health workers.

Recognizing the complexities of emergencies and the need for ethical recommendations to support MHPSS research in emergency settings, the Inter-Agency Standing Committee (IASC) Reference Group on Mental Health and Psychosocial Support agreed on specific guidance [43] to ensure MHPSS research in emergencies benefits affected people, design research to fill knowledge gaps in MHPSS theory and practice in emergencies, avoid bad practice, such as research without satisfactory consent of participants; and better understand how to manage ethical challenges in MHPSS research during emergencies.

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