D2.1 RAPID APPRAISAL FOR MENTAL HEALTH SYSTEMS (WORK PACKAGE 2)

DELIVERABLE D2.1

SCALING UP PSYCHOLOGICAL INTERVENTIONS WITH SYRIAN REFUGEES

STRENGTHS

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List of abbreviations and acronyms

IASC	Inter-Agency Standing Committee (IASC)
IDIs	In-depth interviews
FGD	Focus group discussion
KI	Key Informant
KIT	Koninklijk Instituut voor de Tropen (KIT, Royal Tropical Institute)
LMIC	Low and Middle Income Country
LSE	London School of Economics and Political Science
LSHTM	London School of Hygiene and Tropical Medicine
MHPSS	Mental Health and Psychosocial Support
mhGAP	Mental Health Gap Action Programme
NGO	Non-governmental organisation
PM+	Problem Management +
PTSD	Post traumatic stress disorder
PR	Provider
RA	Rapid appraisal
STRENGTHS	Syrian REfuGees MeNTal HealTH Care Systems
WHO	World Health Organization
WP	Work Package

Executive summary

Introduction: There has been an unprecedented upsurge in the number of Syrian refugees since 2011. A total of 13 million Syrians has been displaced by the ongoing conflict, the majority to neighbouring countries (Lebanon, Jordan, Turkey, Egypt). In Europe, Germany, The Netherlands, Sweden and Switzerland have also accepted large numbers of Syrian refugees. These refugees are often vulnerable to situational forms of psychosocial distress as a consequence to the exposure of war and violence, and traumatic events experienced during the individual's flight from Syria in addition to current life circumstances (such as living in unstable and insecure locations, e.g. dense urban areas or camps, including prolonged detention, insecure residency status, challenging refugee determination procedures, restricted access to services, loss of social networds and lack of opportunities to work or study). These forms of distress may manifest in post-traumatic stress disorder, depression and/or anxiety disorder if they remain untreated. There is a lack of comprehensive mental health and psychosocial support (MHPSS) services in many of the countries that are hosting these refugees, and the services that exists often overwhelmed or ill-equipped to respond to the large number of Syrian refugees who may need to access services. For this reason, the STRENGTHS study (Syrian REfuGees MeNTal HealTH Care Systems) has been initiated to develop effective strategies for scale up of an effective low intensity mental health intervention that can help to meet these needs in settings where resources are limited.

This report summarizes the work of work package (WP2) since the start of the project (reporting phase one out of four reporting phases), and specifically the rapid appraisal (RA) methodology which aims to assess the responsiveness of the mental health systems to the needs of Syrian refugees. RA is generally understood as a relatively quick and inexpensive way to gather relevant information on health systems. Other characteristics of the RA methodology include its use of multiple methods that seek to capture a diverse range of perspectives from different stakeholders (e.g. patients, health care providers, key informants such as policy makers and NGO workers). It achieves this by means of triangulation of data from multiple data sources.

The RA builds upon a conceptual framework which was specifically developed for this study. Our conceptual framework highlights three concepts: health system inputs, intermediate health system goals/responsiveness measures and final health system goals. It understands responsiveness as a concept indicating how the system performs relative to non-health aspects, e.g. meeting or not meeting a population's expectations of how it should be treated by providers of prevention, care or services. It is a multifaceted concept incorporating different domains, and links and overlaps with intermediate health system goals such as access, coverage, quality and safety. These intermediate health system goals link health system inputs (such as facility and services, human resources, governance, etc) and the ultimate health system goal (i.e. improved psychological outcomes) by ensuring adequate access to and coverage for effective health interventions, without compromising efforts to ensure provider quality and safety.

Aim and Objectives: The aim of the RA is to assess the responsiveness of the health care system to the psychosocial needs of Syrian refugees in all partner countries, based on an assessment of the way Syrian refugees with mental health needs navigate the health care system. The specific objectives are to:

1. Describe systems for MHPSS in each country generally and for Syrian refugees specifically.
2. Describe how service users, including Syrian refugees, obtain MHPSS.
3. Identify what obstacles confront both people with mental health needs and health professionals providing MHPSS and how they seek to overcome these obstacles.

4. Assess how well MHPSS care is integrated within the health system generally and for Syrian refugees specifically.
5. Explore co-operation between the government and parallel health systems for MHPSS for Syrian refugees.
6. Inform the implementation and scaling up of PM+ in partner countries.

Methods: The RA applies three different methods, each complementing the others. First, desk-based studies were conducted to collect specific information on mental health system inputs (such as leadership, governance, financing, facilities and services, medicines, human resources and information) providing information on the structure of the health system and any bottlenecks to implementation of effective interventions. Second, analysis of existing qualitative data collected by STRENGTHS partners for their formative intervention work (particularly data of WP 3). Third, a series of semi-structured interviews or FGDs will be conducted in the future among key informants, such as government officials and policy makers, MHPSS providers, Syrian refugees receiving care and their family members in the partner countries. This is to elicit detailed information on pathways to care, access, coverage, quality and safety of existing mental health services. By combining the findings obtained using these methods, it will be possible to generate an understanding of the ability of the mental health system to respond to the MHPSS needs of Syrian refugees in each country. It will also provide a situational analysis informing the implementation of the PM+ intervention, and the health system's capacity for scaling up.

Ethics approval has been obtained by country partners for the existing qualitative work summarized in this report. Ethic procedures and issues related to confidentiality or informed consent procedures for the existing qualitative work have been described in the previous deliverable – (Report D9.3 and D9.5 ethics approvals and related documents; and D3.1 – report on cultural adaptation). Qualitative data (specifically collected for the RA) will take place in 2018/2019, and findings will therefore be summarized in the next reporting period. We are currently working together with country partners to obtain the additional ethics approval for this future work, where required.

Results: Narrative country reports are presented in chapter 4. These country-specific data was collected through the first two methods mentioned above (i.e. desk-based studies and analysis of existing qualitative data conducted for the formative intervention work). Narrative reports were verified through partner expert review; these won't be summarized in the executive summary due to page length considerations. Annexes for each country (containing key data from the literature extracted by country) are available upon request, and will be made available on the STRENGHTS website.

Next steps: The next steps for WP2 in 2018/2019, and until the next reporting period in month 36 are the following:

- Obtain relevant ethics approval in all partner countries (to conduct additional qualitative interviews/FGDs in 2018/2019 to assess the responsiveness of mental health systems to the needs of Syrian refugees)
- Develop country-specific topic guides for RA qualitative work
- Decide with partners on the amount of qualitative interviews and FGDs to be conducted in partner countries (decision will be guided by existing data and country needs as summarized in this report)
- Provide additional training on qualitative interviews for RA in partner countries (if needed/required by partners)
- Conduct qualitative work (semi-structured interviews/FGDs) in countries, and analyse qualitative data according to the conceptual framework as outlined in this report

- Synthesize all primary and secondary data by country, and draw up implications of the responsiveness of the mental health system, and for the implementation of PM+ in partner countries

1. Introduction

1.1 STRENGTHS Study

The STRENGTHS (Syrian REfuGees MeNTal HealTH Care Systems) study is a 5-year study funded by the European Commission's Horizon 2020 scheme which started in January 2017. STRENGTHS is led by Marit Sijbrandij from the Vrije Universiteit in Amsterdam. STRENGTHS brings together academics, non-governmental organisations (NGOs), international agencies and local partners, each working to develop, implement, and scale-up evidence-based mental health and psychosocial support interventions for Syrian refugees, in different national contexts.

The war in Syria has created a refugee crisis that affects countries across Europe and the Middle East. It has impacted particularly on the psychological well-being of individual refugees, many of whom face extreme stressors in their flight from their home country, but also on the healthcare systems of those countries hosting them. In response to this crisis, the STRENGTHS project seeks to provide a framework for scaling-up the delivery and uptake of effective community-based mental health strategies to address the specific needs of Syrian refugees within and outside Europe's borders. It seeks to do this by integrating evidence-based low-intensity psychological interventions (Problem Management+ (PM+)) for common mental disorders into health systems in Syria's neighbouring countries taking up the majority of refugees (Turkey, Lebanon and Jordan), Egypt and European countries (Germany, Switzerland, the Netherlands and Sweden).

STRENGTHS consists of eight Work Packages (WP) led by the different project partners. The London School of Hygiene and Tropical Medicine (LSHTM) is leading WP 2, collaborating with the Koninklijk Instituut voor de Tropen (KIT, Royal Tropical Institute) in the Netherlands and input from the London School of Economics (LSE). The objectives of WP2 are:

1. To analyse the responsiveness of health systems across European host countries and Low and Middle-income Countries (LMICs) bordering Syria in addressing the mental health care needs of refugees.
2. To examine how contextual factors such as socio-economic, cultural, and political-economy factors influence the responsiveness of health systems to the mental health care needs of refugees in the project countries.
3. To explore how scaling-up of low-intensity PM+ programmes can support health system responsiveness to the mental health care needs of refugees in the project countries.
4. To compare the responsiveness of the health systems before and after implementation of the PM+ programmes of the health systems of European and LMICs bordering Syria (Turkey, Lebanon, Jordan, Egypt, Germany, Sweden, Switzerland and the Netherlands).

The methods to be used in WP 2 include:

1. Rapid appraisals (RA) of health systems in all eight study countries (Objectives 1 and 2)
2. Community-level cross-sectional surveys with Syrian refugees in two study countries (Objectives 1 and 2)

3. Analysis of quantitative data recorded in other WPs for all the study countries (Objectives 3 and 4)
4. In-depth qualitative research on potential for scaling-up PM+ in all study countries (Objectives 3 and 4)

1.1.1 Rapid Appraisal of mental health systems

This report summarizes the RA work of WP2 since the start of the project, and is the first deliverable of WP2. It presents narrative country reports summarizing health system inputs and initial responsiveness data extracted through the literature (desk-based reviews methods), and through review of secondary qualitative research (conducted by the STRENGTHS partners during their formative research phase in 2017). Subsequent deliverables of WP2 (due next in month 36) will incorporate additional qualitative research collected in the form of semi-structured interviews and focus group discussions (FGDs). These will follow topic guides which will be specifically developed for the RA, following the conceptual health system's framework outlined below. Topic guides will build on the data incorporated in this deliverable, and will be tailored to the partner country taking their existing primary and secondary data into account.

1.2 Rapid appraisal background

The RA described here aims to analyse the responsiveness of the health system, including the role of contextual factors, in addressing the mental health and psychosocial support (MHPSS) needs of Syrian refugees in the STRENGTHS study countries.

We define MHPSS needs according to the Inter-Agency Standing Committee (IASC) guidelines which conceive MHPSS as any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders (IASC, 2007). MHPSS is a composite term that acknowledges the need for continuing and comprehensive care for people who are facing or have faced adversity. Consequently, MHPSS incorporates services for both prevention and treatment, provided by multiple players. MHPSS services may be delivered through different platforms of care but should, overall, provide holistic MHPSS; i.e. through community programmes that offer psycho-social support to prevent the onset of mental disorders and to build resilience for persons with mild or moderate mental distress, and through health care platforms offering more targeted health system interventions for persons who are in need of more specialised support (UNHCR, 2013a/UNHCR,2013b).

LSHTM staff have previously developed a RA methodology to analyse health system responsiveness. This methodology has been used for analysis of health system responsiveness for chronic conditions such as diabetes and hypertension in a range of high and middle income settings such as Georgia, Kyrgyzstan, Malaysia, Philippines and Colombia (Balabanove et al., 2009; Risso-Gill et al, 2015). However, the RA methodology has not so far been used to examine health system responsiveness to the needs of forcibly displaced persons such as refugees experiencing MHPSS needs. We have therefore adapted this methodology for MHPSS based on discussions with experts at LSHTM, LSE and other STRENGTHS partners.

RA is generally understood as a relatively quick and inexpensive way to gather relevant information on health systems (Kumar,1993). This makes it appropriate for this study, whose aim is to inform the implementation and scale-up of PM+ in each project country during and after the study period. Other characteristics of the RA methodology include its use of multiple methods that seek to capture a

diverse range of perspectives from different stakeholders (e.g. patients, health care providers, key informants such as policy makers and NGO workers). It achieves this by means of triangulation of data from multiple data sources (IASC, 2007; WHO/UNHCR, 2012; WHO/UNHCR, 2008; Petevi et al., 2001).

1.3 Conceptual health system framework

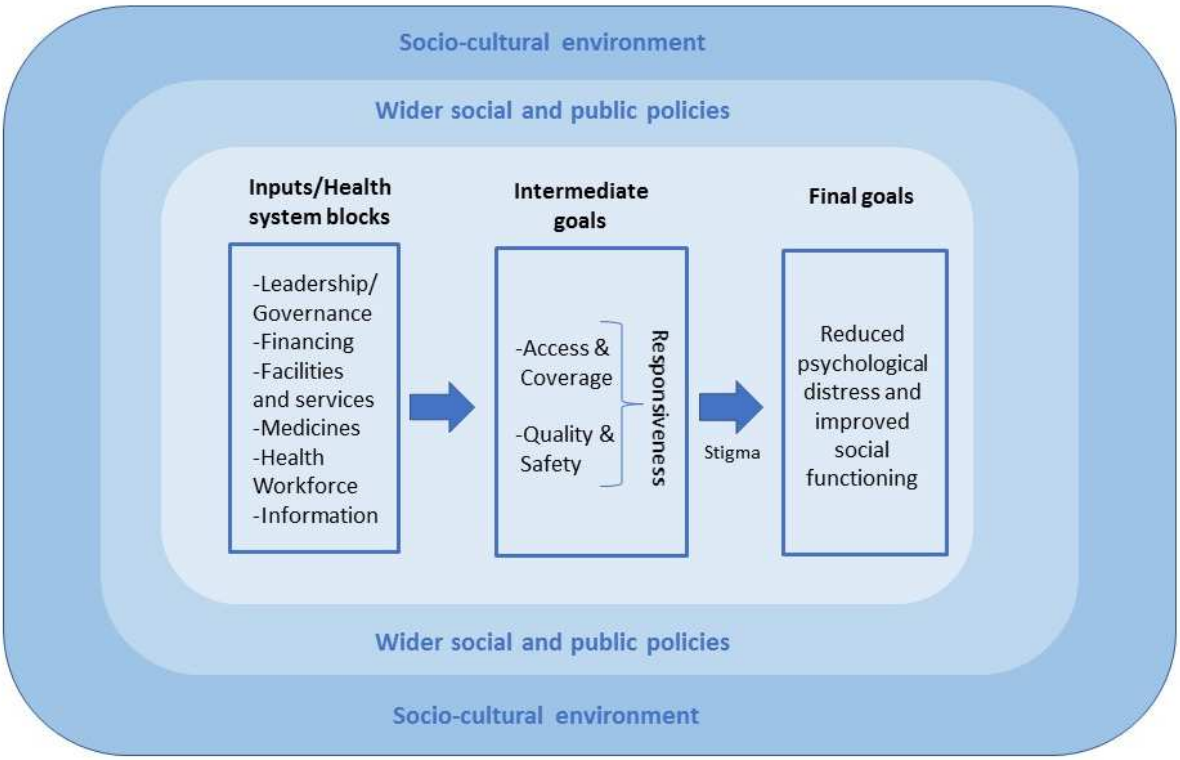
In this section, we introduce the conceptual framework which guides the RA data collection tool on health system inputs (presented in annex 1).

WHO defines health systems as all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities (WHO, 2007). We conceive the health system according to the definition of the WHO by incorporating both the general mental health system and any parallel mental health system in our study definition.

We define a parallel mental health system as a health system or service structure which provides essential mental health services for refugees or people in need. The nature and characteristics of parallel systems may vary considerably between countries, and some of those service structures may not be formalised as parallel systems. Examples of a parallel service structure or parallel health system might be a network of NGOs funded by donors or United Nations agencies providing MHPSS services to refugees.

Our conceptual framework is presented in figure 1. For the purpose of this exercise, we focus primarily on provision of treatment and care, and address promotion and prevention activities only peripherally. In the RA, we do not collect information about individual coping and resilience mechanisms of refugees.

Figure 1: Conceptual framework (for health system analysis)



1.3.1 Socio-cultural context

We understand the health system as being nested in the wider socio-cultural environment of the country, which influences, and is influenced by, social and public policies.

- **The socio-cultural environment:** The economic and social climate of the country in which the health system is embedded in. Economic and social indicators may provide information about the social and economic development of the country, influencing the design, operation, and underlying world vision of the health system and the population for which it is responsible.
- **Wider social and public policies:** Policies, legislation and social protection schemes influence the health system in many ways. They reflect the values, principles and objectives of a society which can influence health outcomes but also broader societal outcomes such as employment.

1.3.2 Health system inputs/health system blocks

We define **health system inputs** according to the structure of the **WHO building blocks**.
These inputs or investments will vary according to country income group, overall disease burden, needs and priorities of the government to provide treatment for mental disorders. They will also vary according to the intervention elements and specific requirements needed to deliver an evidence based intervention like PM+. Health system inputs are generally understood as follows (WHO, 2007):

- Leadership/governance: ensures strategic policy frameworks exist for health (including mental health) and are combined with effective oversight, coalition building, the provision of appropriate regulation and incentives, attention to system design, and accountability.
- Financing: raises adequate funds for mental health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them
- Facilities and services: ensures the delivery of effective, safe, quality health interventions to those who need them, when and where needed, with minimum waste of resources
- Medicines/psychotherapeutic drugs: ensures equitable access to essential psychotropic drugs of assured quality, safety, efficacy and cost–effectiveness
- Health workforce: works in a responsive, fair and efficient way to achieve the best mental health outcomes possible, given available resources and circumstances
- Information: ensures the production, analysis, dissemination and use of reliable and timely information on mental health

Specific health system blocks are required for the delivery of the different components of the PM+ intervention. To guide the rapid appraisal methodology and the assessment of the **current responsiveness** of the mental health systems, we have chosen an established and evidence-based intervention for mild or moderate common mental disorders as outlined in the mhGAP intervention guide (to be used as the nearest current equivalent to PM+).

Annex 2 outlines best practices of mhGAP for the treatment of common mental disorders. Each intervention element (e.g. social worker identifies cases of common mental disorders in the community) is linked up with specific health system need and requirement for realising each treatment step (e.g. mental health training for social worker needs to be provided so that cases of mental disorders get recognized in the community). Finally, each intervention element and system requirement is associated with a larger health system block (e.g. health workforce) as outlined above.

1.3.3 Health system goals

The health system may have multiple goals. According to the World Health report (2000), “improved health and equity” making efficient use of available resources should be the final goal of any health system (WHO, 2000).

In addition to improved health outcomes, the WHO 2007 health system framework (and the World Health Report 2000 before it) includes responsiveness as goal*.* WHO defines responsiveness as the way in which individuals are treated and the environment in which they are treated in, encompassing the individual’s experience of contact with the health system (Valentine, 2003). Responsiveness is therefore not a measure of how the system responds to health but of how the system performs relative to non-health aspects, meeting or not meeting a population’s expectations of how it should be treated by providers of prevention, care or services (Papanicolas, 2013). It is a multifaceted concept incorporating different domains (see table 1 below), and links and overlaps with intermediate health system goals such as access, coverage, quality and safety. These **intermediate health system goals** link inputs and the final health system goal by ensuring adequate access to and coverage for effective health interventions, without compromising efforts to ensure provider quality and safety (WHO, 2000).

For the purpose of this exercise we consider responsiveness as intermediate goal, and access, coverage, quality and safety as precursor of the responsiveness measure leading to improved mental health outcomes for Syrian refugees. This conceptualization is supported by the work of others such as the OECD who also understand access as one component of responsiveness (Kelley, 2006).

In the next section, we provide definitions of our key intermediate outcomes, and illustrate how these link with the responsiveness measure as defined above.

1.3.3.1 Intermediate goals

Access and coverage:
We apply Penchansky and Thomas' (Penchansky and Thomas, 1981) elements of access to our conceptual framework which also includes measures of coverage:

- Availability – the volume and type of existing services and whether this is adequate for the volume and needs of service users.
- Accessibility – the relationship between the location of the services/supply and the location of the people in need of them. This should take into account transportation, travel time, distance, and cost.
- Accommodation – the relationship between the organisation of resources (appointment systems, hours of operation, walk-in facilities) and the ability of service users to accommodate to these factors. User perceptions on the appropriateness of these factors should also be taken into account.
- Affordability – the prices of services in relation to the income of service users. The user perception of the worth relative to total cost should also be taken into account.
- Acceptability – the relationship of attitudes of service users about personal and practice characteristics of services to the actual characteristics of the existing services, as well as to provider attitudes about acceptable personal characteristics of service users.

Quality:
We conceive quality as:

- The quantity of care which is provided to the patient (conceived as the amount of care necessary to achieve the desired result).
- The clinical quality of the service provided to the patient (skills of provider, and his/her decision making)
- The acceptability of the service: hotel services (e.g. food, cleanliness, etc.); convenience (e.g. travel time, waiting time, opening hours, etc.); and interpersonal relations (e.g. whether providers are polite, emotionally supportive and whether patients receive appropriate information and respect).

Safety:
Safety is defined as the degree to which health care processes avoid, prevent and ameliorate adverse outcomes or injuries that stem from the processes of health care itself (Kelley & Hurst, 2006). This would include provision of adequate medication for refugees in times of need (e.g. appropriate type of medication and adequate dose), and immediate referral of severe cases requiring more intensive care.

Responsiveness and linkage with key intermediate health system goals:
Table 1 provides an overview of the conceptualisation of responsiveness, providing definitions of its different domains, and linking its domains with intermediate health system goals such as access and coverage, quality and safety.

Table 1: Responsiveness domains and links with intermediate health system goals

Responsiveness domains	Domain operationalization: Description of items for measurement of responsiveness at the individual level	Links with other intermediate health system goals such as
1.Autonomy: Involvement in decisions	- Involvement in decisions about MHPSS health care, treatment and services - Obtaining information about other possible types of mental health services	- Quality and safety
2.Choice: Choice of health care providers and services	- Freedom to choose health care provider - Freedom to choose health care facility or service	- Access
3.Communication: Clarity of communication	- Mental health service conducted in mother tongue of patient (or interpreter available) - Health care provider explains things clearly and listens carefully - Allowing patient time to ask questions about mental health and treatment available	- Quality
4.Confidentiality: Confidentiality of personal information	- Personal information about medical history is kept confidential - Talks with doctors or nurses are done privately, and other people are not being able to overhear what is being said	- Quality
5.Dignity: Respectful treatment and communication	- Health care professionals treat patient with respect/talk to patients in a respectful manner	- Quality
6.Quality of basic amenities: Surroundings	- Cleanliness of facility where mental health service is provided - Basic quality of waiting room and office where mental health service is provided (space, seating, fresh air)	- Quality and access (accommodation)
7.Prompt attention: Convenient travel and short waiting times	- Travelling time to facility/service - Short waiting times for appointments and consultations - Getting fast care in emergencies	- Access (availability, accessibility)
8.Access to family and community support: Contact with family and maintenance of regular activities	- Facility/service provider encourages interaction and collaboration with family/friends during course of mental health treatment - Facility/service provider encouraged to continue social and religious customs during mental health treatment	- Access (availability, accessibility)

*Adapted from Papanicolas & Smith, 2013

1.3.3.2 Final goal

A health system responsive to the mental health needs of Syrian refugees should provide evidence-based mental health services leading to improved mental health and psycho-social functioning. Access to care should be facilitated ensuring that people in need of services are covered without compromising efforts to ensure provider quality and safety. However, we acknowledge that there are demand side factors as well. Stigmatization and/or discrimination of people with mental disorders might hinder those in need to access services, and might have a negative impact on recovery.

Reduced psychological distress and improved social functioning are conceived as final goals of our conceptual framework. This is in line with the primary and secondary outcomes of the STRENGTHS study. Reduced psychological distress can be operationalized by measures of improvement in depressive symptoms and anxiety, reduced levels of stress, fear and helplessness (WHO, 2016). Improved social functioning can be conceived as an individual's ability to perform and fulfil normal social roles without disruption such as domestic responsibilities, interacting with other people, self-care and/or participating in community activities (Hirschfeld et al, 2000; WHO, 2010).

1.3.4 Existing care pathways based on mhGAP

The World Health Organization (WHO) developed the Mental Health Gap Action Programme (mhGAP), to facilitate scaling up of care for mental and substance use disorders in 2008. A key part of mhGAP is the evidence-based guideline, published in 2010 and available through the mhGAP Evidence Resource Centre (http://www.who.int/mental health/mhgap/evidence/en/). The guidelines consist of packages of care for priority conditions (depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children) outlining prevention and management for each of these disorders.

Since PM+ is not yet implemented in countries, we employ mhGAP for common mental disorders to assess pathways of care in the RA. Figure 2 outlines one possible evidence-based pathway of care based on mhGAP for the treatment of common mental disorders (CMD) by taking into account the conceptual framework in figure 1. On the left-hand side of Figure 2 key health system inputs are included which are required to deliver an evidence-based intervention like mhGAP. Please note that only **key** health system inputs are included in Figure 2. A comprehensive list of health system inputs required for **each** mhGAP intervention step are provided in Annex 2. The intermediate and final goals of a successfully delivered mhGAP intervention are presented on the right-hand side of Figure 2 (see boxes highlighted in blue, i.e. improved responsiveness and reduced psychological distress/improved social functioning respectively).

The pathway of care is briefly described below:

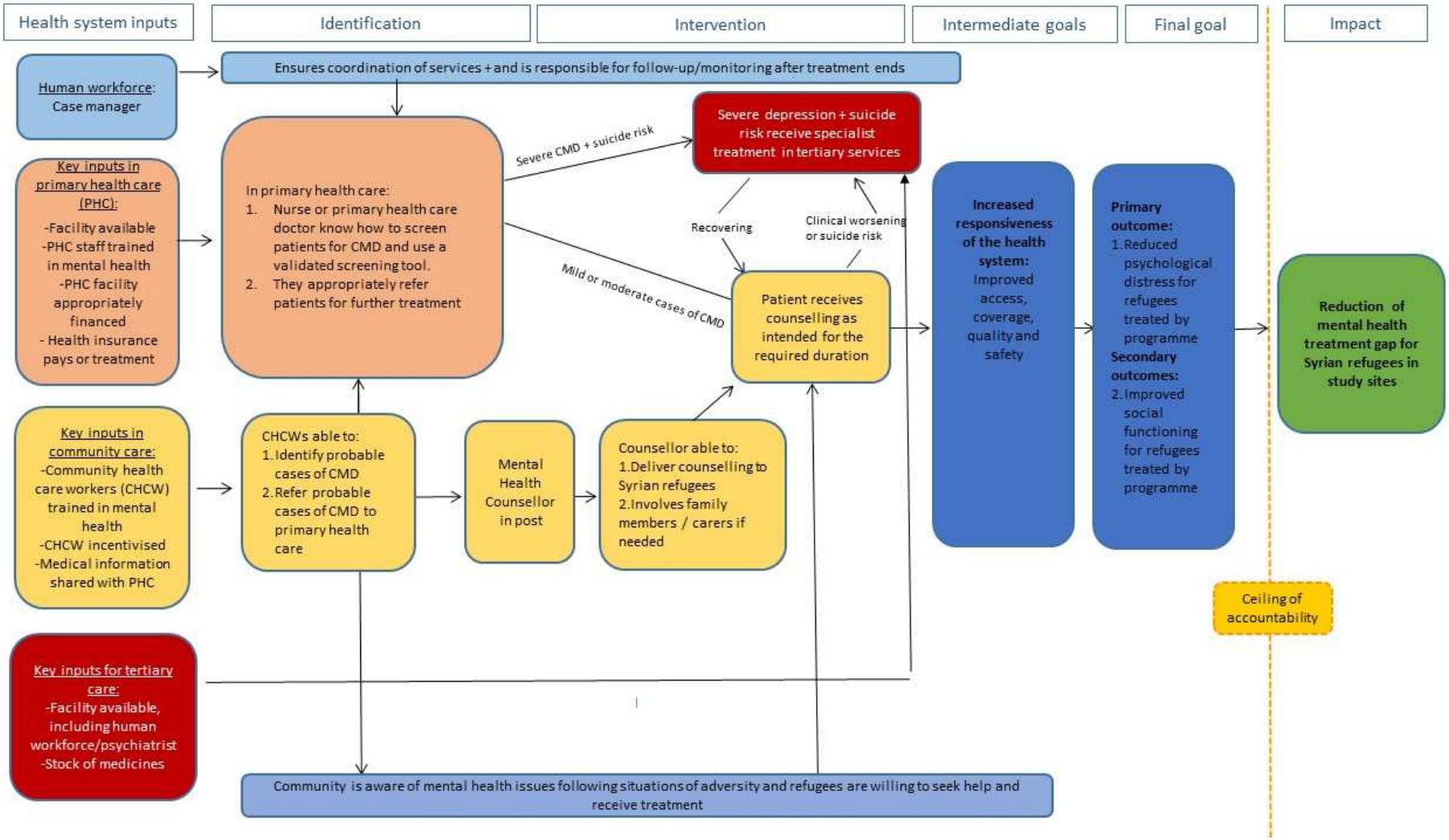
- Community care (boxes highlighted in yellow): Cases of CMD are identified in the community by a community health care worker (CHCW). For this to happen, certain health system inputs need to be in place. For example, CHCW need to be trained in the recognition of CMD, and need to refer the patient to primary health care (PHC) to receive an appropriate diagnosis and referral.
- Primary health care (boxes highlighted in orange): PHC staff screen patients with a validated screening tool, and confirm diagnosis. For this to happen, a PHC facility needs to be in near reach of the patient. PHC staff need to have received training on the screening tool, and the patient needs to have medical insurance to cover cost for treatment (or needs to have sufficient financial means to pay for treatment out of pocket).
- PHC staff refers patient to appropriate treatment depending on symptom severity, i.e. to either counselling in the community (for mild or moderate cases of CMD) or tertiary care (for severe

cases of CMD, including risk of suicide). Patients in tertiary care may be referred back to counselling in case of symptom improvement. Vice versa, patients receiving counselling may be referred to tertiary care in case of clinical worsening. For this to happen, tertiary care facility (see boxes highlighted in red) need to be in easy reach of the patient, and need to be staffed with mental health experts (e.g. a psychiatrist who can start prescribing medication).

- Case manager (boxes highlighted in blue at the top of the figure): A case manager should be in place ensuring coordination of services from community care to tertiary care, and provides follow-up and monitoring after treatment ends.
- Community involvement: The intervention is supported by the community who are informed about the intervention and refugees' mental health.

The pathway of care which is displayed in figure 2 only presents one possible pathway of care. Other pathways of care are possible, and will be explored in the semi-strucctured interviews to be conducted in 2018/2019.

Figure 2: Care pathways based on mhGAP



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2. Aim and objectives

The overall aim of the RA is to assess the responsiveness of the health care system to the psychosocial needs of Syrian refugees, based on an assessment of the way Syrian refugees with mental health needs navigate the health care system.

The specific objectives are to:

1. Describe systems for MHPSS in each country generally and for Syrian refugees specifically.
2. Describe how service users, including Syrian refugees, obtain MHPSS.
3. Identify what obstacles confront both Syrian refugees with mental health needs and health professionals
providing MHPSS and how they seek to overcome these obstacles.
4. Assess how well MHPSS care is integrated within the health system generally and for Syrian refugees specifically.
5. Explore co-operation between the government and parallel health systems for MHPSS for Syrian refugees.
6. Inform the implementation and scaling up of PM+ in partner countries.

3. Methods

3.1 Desk-based review on health system inputs

3.1.1 Eligibility criteria

The following study eligibility criteria were applied to our desk-based reviews (literature search):

- *Population and settings:* Refugees (including asylum seekers and IDPs) in the Netherlands, Germany, Switzerland, Sweden, Egypt, Jordan, Lebanon, Turkey.
- *Health outcome of interest:* Reduced psychological distress and improved social functioning as defined in section 1.3
- *Health system elements of interest:* Health system inputs and intermediate goals (e.g. access, coverage, quality, safety and equity) in relation to MHPSS defined as any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder'(1).
- *Study types:* Quantitative and qualitative studies, primary and secondary sources were included.
- *Languages:* English, Dutch, German, Arabic, French, Swedish and Turkish
- *Dates:* Sources since the beginning of the Syrian uprising and conflict (from 1 Jan 2011 until 30 August 2017).

3.1.2 Data sources

The following data sources were searched:

- *Published literature:* Database search PubMed/MEDLINE, PsycInfo, PsychExtra, Embase, Web of Science, CINAHL, hand-search of relevant journals, search for citations of key papers on Google Scholar.
- *Grey literature (international):* Sources included: Google; UN agencies, funders (WHO, UNHCR, World Bank, UNICEF, UNFPA, UNDP, red cross, etc.); International NGOs working on MPHSS for refugees (MSF Field Research, ICRC/IFRC, HealthNet TPO, IMC etc.); Networks/repositories (ReliefWeb, MHPSS (Mental Health and Psychosocial Support) network etc.); Statistics (WHOSIS, United Nations Statistics Division etc.)
- *Grey literature (local):* Policy documents from the Ministry of Health and/or Finance (legislative, regulatory, financial (budget for mental health, private/state insurance/out-of-pocket payments)), including clinical standards); National Statistics Bureau; facility-level statistics, guidelines and regulations for patients with mental health issues, treatment, referral, follow up etc.; relevant publications (e.g. reports/policy brief/statistics) from MHPSS-related organisations/associations for health professionals/academic researchers/patients; relevant publications (e.g. process or outcome evaluations) from Governmental and nongovernmental organisations/donors that work on/support MHPSS programmes for refugees were consulted.

3.1.3 Secondary data collection and analysis

We reviewed the literature to search for data informing country-specific health system inputs, and to start collecting responsiveness data which may have been reported in the literature. This data was compiled in an annex (see appendix 1) , and country partners were asked to complement and verify this data. The validity of the collected information was ensured during data analysis and synthesis by triangulating different data sources, and by seeking expert opinion and approval from local partners on the collected information. Synthesis and analysis of the existing literature was based on the health system conceptual framework (Figure 1), and followed the synthesis procedures as outlined in section 3.4.

3.2 Analysis of existing STRENGTHS qualitative data

We also used existing qualitative data collected by the STRENGTHS partners in addition to secondary data. The existing qualitative data was collected as formative work for the intervention study and to support the adaptation of the PM+ intervention (please refer to STRENGHTS D3.1 – report on cultural adaptation for further information on the methods used).

Existing qualitative data was analysed thematically using a deductive approach, based on the conceptual framework (figure 1). Data analysis was led by the LSHTM and KIT teams. The findings were then triangulated with the findings from the desk-based review. Partners were consulted on key issues and were asked to clarify any issues or fill any gaps where necessary.

3.3 Qualitative methods to investigate health system responsiveness

New primary qualitative data will be collected using semi-structured interviews and FGDs with key informants, MHPSS providers, and Syrian refugees receiving MHPSS services/care in 2018/2019. Questions of the topic guide will be aligned with the conceptual framework (Figure 1), the pathways of care (Figure 2) and elements of inputs required based on mhGAP (Annex 2). Topic guides will strongly focus on intermediate goals such as access, coverage, quality and safety but will also take account of the information which has previously been collected via the desk-based review, to ensure that key aspects of the required intervention inputs are assessed. The development of topic guides will therefore be country-specific. Questions will largely focus on Syrian refugees, but may be for the country more generally, as appropriate.

3.3.1 Description of study sites

The qualitative work will take place in the countries participating in STRENGTHS: Lebanon, Jordan, Egypt, Turkey, Sweden, Germany, Netherlands, and Switzerland. The exact locations of the interviews are yet to be determined as it is dependent on the locations selected by the study partners. It is likely that interviews will take place in locations with large numbers of Syrian refugees and also in the capital city or other major cities where key stakeholders reside and where the PM+ intervention will be delivered.

3.3.2 Selection of respondents

A mix of respondents from different tiers of the health system and specialties is required to gather a range of perspectives. Some respondents will need to have a wide perspective on the policy context,

including how 'things work' overall. Others may be able to provide in-depth information drawing on their area of expertise. They should also represent national-level knowledge and local-level knowledge (e.g. related to the STRENGTHS study site).

Respondent sampling will include purposive (including convenience) sampling to select a diverse range of respondents on the basis of their characteristics, roles or experiences; and snowball sampling, asking respondents to nominate other people they know. The specific sampling approach should be adapted to local circumstances. The respondents are likely to include the following:

- *Key informants* with detailed knowledge of how the system(s) for mental health work, such as from government (including government officials at national and district levels), health system/service managers, donor agencies, NGO, academia.
- *MHPSS providers*. These will include: nurses, peer support workers, counsellors, volunteers, social workers, psychiatric nurses, therapists, psychologists, and psychiatrists.
- *Syrian refugees receiving MHPSS services/care* recruited from primary health care, community psychosocial support centres.
- *Family members/guardians of Syrian refugees* receiving MHPSS services/care.

3.3.3 Qualitative data collection process

Qualitative research will involve semi-structured interviews lasting up to approximately 1 hour. FGDs may be conducted if deemed appropriate, according to the country team's decision. We anticipate to conduct approximately 10-15 interviews per country (this is based on previous experience of RA and following principles of saturation).(3, 4) This may include up to 2 FGDs (e.g. 1 FGDs with health care providers and 1 FGDs with patients, by gender if appropriate) which will last approximately 1.5 hours each.

Interviews will follow a topic guide with optional prompts/probes. These will be treated flexibly and vary depending on the country context and respondent type/experience/expertise, but seek to ensure some consistency and coherence between interviews.

Interviews will be undertaken in the local language, English or Arabic by a trained interviewer (with training provided by WP2 staff). The interviews / FGDs should be recorded in writing or in audio with the permission of the respondent(s). Edited transcripts should be prepared for all interviews and FGDs. Edited transcripts exclude repetitions and irrelevant information. Interviews will take place in a mutually agreed place, and will ensure the interviewer's and respondent's safety, comfort and convenience, dignity, and participant confidentiality. Some interviews with stakeholders such as government officials or head of NGOs may be conducted over the phone.

3.3.4 Qualitative data analysis

Data will be analysed thematically in two steps. The first step is a deductive analysis,
coding units of data according to the elements of the conceptual framework. This will be followed by an inductive analysis, seeking to elicit new themes or unexpected findings through coding and categorising, according to grounded theory. Principles guiding the analysis include:

- Taking the patient perspective and follow the patient as they move through the health system
- Triangulate findings with existing data, evidence, research, and policies, and information collected via the desk-based review

- Compare data by source of information: patients, family members, providers, government officials
- Start broadly identifying a range of problems then narrow down to the several key obstacles
- Look for unintended consequences of policies and procedures.

The country team member will produce an initial descriptive report with key findings in the local language or English. LSHTM/ country partner members will provide feedback and after the report is finalised, it will be translated into English by the country teams. The comparative analysis will be further developed and written up for publication by LSHTM/country partner. Partners will be consulted on key issues and asked to clarify any issues or fill any gaps.

3.4 Data synthesis

We followed the Cochrane Consumers and Communications Review Group guidance to synthesise all available country data: Secondary data (existing studies/government reports retrieved from the literature), primary data (formative research conducted by country partners in 2017), and RA primary data (qualitative interviews to be conducted in 2018/2019 for the purpose of the RA).

The synthesis involved the following steps:

1. Review existing secondary data, and explore if additional findings (which were published after August 2017) can be integrated in the narrative reports.
2. Develop a preliminary synthesis of all findings by data source: This will include first summaries of key health system inputs (guided by annex 2), and intermediate health system goals (as outlined in conceptual framework) for each data source. Qualitative data will be analysed using thematic analyses to identify areas in common between qualitative work.
3. Develop a preliminary synthesis of all findings across data sources: This will include summaries of key health system inputs (guided by annex 2), and intermediate health system goals (as outlined in conceptual framework) across both data sources.
4. Assess the robusteness of the synthesis: The robusteness of the synthesis will be assessed by the amount and quality of the evidence, and by critically reflecting on the strengths and weaknesses of the synthesis. Country partners and experts will be consultated for the latter, and will be asked to critically review the summarized evidence.

3.5 Quality assurance

<u>Desk-based study (including analysis of existing qualitative data):</u>
Quality of the desk-based studies was ensured in the following way: First, a comprehensive set of databases including websites for grey literature were searched with terms specifically developed for the RA. This was to identify relevant studies, such as country-specific research on mental health and refugee service provision. Partners complemented the collected information by providing key additional literature. Data was extracted into a data extraction sheet once all studies/reports for inclusion were identified. Second, partners verified the data collected through the desk-based study, and made amendments if necessary. Third, existing qualitative data from partner countries were analysed thematically as outlined above using a deductive approach, based on the conceptual framework. Qualitative data which was collected in partner countries (for the purpose of intervention delivery) followed stringent methods as described in ”STRENGHTS D3.1 - report on cultural

adaptation". Finally, qualitative findings were triangulated with the findings from the desk-based review. Partners were consulted when there were inconcistencies and to help validate findings and their interpretation.

Interviews and focus groups:
The quality of the interviews and focus groups will be assured in the following way: First, the interviews will be led by researchers who are experienced in qualitative research methods and who will receive additional training specifically in the RA methodology. Second, the interview topic guides will be developed following a rigorous process of expert consultation, group discussions and piloting to ensure relevance, reliability, and appropriateness. Third, the transcription, translation and analysis will include group discussions between the interviewers and others involved in the analysis to ensure common understanding and avoid subjectivity and bias associated with relying on just one individual. Fourth, a transparent process for the analysis will be employed. This will be supported through triangulation (e.g. with other data sources) and peer review and discussion. Fifth, a limitations section will be included in any project outputs to clarify limitations in the study. Sixth, regular meetings will be held between the researchers to discuss and maintain quality assurance. Finally, the qualitative research will be underpinned by agreed principles of good practice including transparency, comprehensiveness, reflexivity, ethical practice, and being systematic.

3.6 Ethical issues and approval

Our research is guided by the Declaration of Helsinki and the ethical principles for medical research as outlined therein. Ethics approval has been obtained by country partners for their existing work (primary qualitative research for intervention delivery). These and other ethical issues related to confidentiality or informed consent procedures are described elsewhere (STRENGHTS report D9.3 and D9.5: Ethics approvals and related documents; D9.7: Informed consent procedures; and D9.1 and D9.9: Templates of informed consent forms and information sheets, and D3.1 – report on cultural adaptation).

Qualitative interview data from country partners were password protected and then sent to WP2 staff for review. Qualitative interviews did not contain any identifying information on participants, and are stored at LSHTM in a secure space which is only accessible to approved WP 2 staff.

We are currently working together with country partners to obtain additional ethics approval for the RA qualitative interviews to be conducted in 2018/2019. For this we have developed a study information sheet and informed consent sheet which will be included in the next deliverable.

4. Results

The following sections describe inital findings of the country RA aiming to evaluate the responsiveness of the mental health system to the needs of Syrian refugees in the partner countries.

Data for the country reports included in this section were primarily obtained through desk-based reviews and existing qualitative data collected during the cultural adaptation phase by study partners.

RA qualitative work to inform the work of WP2 is planned in 2018/2019 with key stakeholders in all partner countries. This is to provide further information on pathways to care, coverage, access, quality and safety of current care practices. A comprehensive assessment of the responsiveness of the mental health system to the needs of Syrian refugees in partner countries will therefore be included in the next deliverable of WP2 in month 36.

4.1 Egypt

Data presented in this section is based on a besk-based review (existing literature). The final annex for Egypt (containing key data from the literature) is available upon request, and will be made publically available on the STRENGHTS website.

In addition, secondary data was complemented by analysis of one qualitative interview (with a key informant (*KI*), a NGO worker). Ethic approval for this interview was provided by the Ethics committee of the Department of Education and Psychology at Freie Universität Berlin (submitted in Germany by FUB, dd. June 12, 2017). Data collection took place in October 2017.

4.1.1 Wider environment and policies

Egypt has the smallest percentage of registered Syrian refugees of the five countries that are part of the Syria Regional Refugee Response (Turkey, Lebanon, Jordan, Iraq, Egypt) (UNHCR 2018). On 28 February 2018, 128,034 refugees with Syrian nationality (male 51.6%; female 48.4%) were registered with UNHCR in Egypt; 42% were below 18 years of age (UNHCR 2018). Syrian refugees in Egypt do not live in camps; they are living amongst local communities (3RP 2017). Egypt, a lower middle-income and predominantly Muslim country has an umeployment rate of 11.6% (global average is 5.8%) (The World Bank 2018). Unemployment rates amongst Syrian refugees in the country are unknown.

4.1.2 Health statistics in host population

The life expectancy for men and women in Egypt is 69 and 74 years respectively (The World Bank 2018). Adult mortality rate was 159 per 1,000 population and maternal mortality 33 per 100,000 live births in 2015 (WHO 2017). While the adult mortality rate in Egypt is similar to the average for the Eastern Mediterranean region, its maternal mortality rate falls below this average (155 and 116 respectively) (WHO 2017)

It is estimated that around 3.5% of the general population suffer from depression, and 4.2% of anxiety disorders (Institute for Health Metrics and Evaluation 2016). These figures are similar to predictions for lower middle-income countries (3.5% depressive; 3.5% anxiety) (Institute for Health Metrics and Evaluation 2016). 0.98% of the Egyptian population died by self-harm in 2015 and 0.45% of deaths were estimated to be caused by mental and substance use disorders (Institute for Health Metrics and Evaluation 2016)

4.1.3 Mental health system inputs

4.1.3.1 Leadership and governance

Egypt has a mental health legislation, a mental health policy and mental health plan (WHO 2011, WHO 2014). The mental health legislation was considered 'fully' and the policy and plan 'partially' implemented in 2014 (WHO 2014). A variety of organisations take part in coordinating mental health care for refugees, including the Egyptian Ministry of Health and Population (MoHP), UNICEF Egypt, Terre des Hommes, and the Psychosocial Services and Training Institute in Cairo. The MoHP in collaboration with UNICEF Egypt is working on the integration of psychological support services in primary healthcare to facilitate access to care for Syrian refugees (Deif 2016).

4.1.3.2 Financing and expenditure

In 2014, the Egyptian Government spent 5.6% of its GDP on health (The World Bank 2018). Mental health expenditures made up 2.29% of the total health budget in 2011 (WHO 2011). Donors contributed $30.84 million to the Egyptian health sector in 2016 (OECD 2018), although spending on mental health is unknown. The social protection system for health insurance in Egypt is fractured, with inequitable access to services and a mixed public-private system (Jenkins, Heshmat et al. 2010, Pande, El Shalakani et al. 2017). Efforts are being made to offer health insurance to all people in Egypt (Mahmoud 2017).

MHPSS support is offered at no cost to refugees through a collaboration between UNICEF Egypt and the Egyptian Ministry of Health and Population, but the extent and uptake of the program are unknown (Deif 2016). It is equally unclear whether psychotropic medications are provided at no cost to Syrian refugees in either the public or parallel system, although the WHO AIMS report stated that "at least eighty percent of the population have free access to essential psychotropic medicines" (p9) (WHO and Ministry of Health Egypt 2006). A qualitative study on the challenges faced by Syrians in Egypt reported that primary care is usually covered via UNHCR but not tertiary specialised services and medications (Bahgat 2016).

4.1.3.3 Mental health workforce

There were 7.3 mental health workers per 100,000 population in the country in 2014 (WHO 2014), which equals the regional average (7.3) (WHO 2014). The Ministry of Health is the main provider of mental health services in Egypt (Jenkins, Heshmat et al. 2010). Distribution of mental health professionals and facilities between urban and rural areas was considered "disproportionate" (WHO and Ministry of Health Egypt 2006).

4.1.3.4 Facilities and services

There has been a shift towards the integration of mental health services into primary care (particularly in community settings), although the precise services offered are unclear (WHO 2011). The number and caseload of community mental health facilities is unknown (WHO 2011, WHO 2014).

NGOs provide different types of support for refugees in Egypt such as medical services, family and social support, psychosocial support (e.g. CARE 2017, Refuge Egypt 2017, Caritas 2018).

4.1.3.5 Psychotherapeutic medicines

An essential list of drugs does exist for the country and covers psychotherapeutic medicines for treatment of anxiety and depression (WHO 2012).

4.1.4 Process outcomes and responsiveness

4.1.4.1 Care pathway

Since MHPSS care is not (yet) fully integrated into primary health care (Deif 2016), patients (including Egyptians and refugees) wanting psychological support in the formal health system are required to make an appointment with a psychologist or psychiatrist (KI). These specialists commonly need to be paid out-of-pocket by the patient (KI). As Syrian patients generally cannot afford this, the 'parallel' system (i.e. NGOs) are typically used, offering generally free face-to-face and online mental health services (KI).

4.1.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas 1981) of MHPPS.

Availability:
This key informant interviewed for this study lamented the lack of treatment for depression and PTSD in the public health system. However, the key informant believed to have sufficient resources, including staff, to be able to provide an online mental health service for Syrian refugees.

(Geographic) Accessibility:
A disproportionate distribution of mental health services and providers in the country limits access for rural patients (WHO and Ministry of Health Egypt 2006).

Accomodation:
Data on accommodation could not have been identified in secondary or existing primary data sources; therefore, the concept of accommodation needs to be explored in future qualitative work.

Affordability:
Syrian refugees, like Egyptians, are required to pay for psychological treatment (treatment with a psychologist or psychiatrist) (KI). These specialists were regarded by a key informant as "expensive, even for Egyptians".

Acceptability:
Syrian refugees may experience similar cultural barriers in accessing care as Egyptians. (KI) They commonly refuse to see specialist mental health providers as "they feel ashamed and are afraid" (KI). Online mental health services may facilitate access to care as patients are not required to directly engage with a therapist.

4.1.4.3 Quality and safety:

It remains unclear how long refugees generally wait to receive mental and psychosocial services.

4.1.5 Mental health outcomes

A study amongst Syrian refugees in Cairo reported a prevalence rate of 33.5% rate for PTSD, and prevalence rate of 30% for depression (Kira, Shuwiekh et al. 2017). This appears to be the only data available on mental health outcomes among Syrain refugees in Egypt.

4.1.6 Discussion

In this report we have analysed initial data to assess the responsiveness of the Egyptian health system to the MHPSS needs of Syrian refugees in the country. Our appraisal was predominantly based on available statistics and literature, and secondary analsyis of one interview with a key informant conducted by a STRENGTHS partner. We will conduct the additional primary qualitative research needed to further investigate the perceived barriers and facilitators of accessing MHPSS for Syrian refugees. This report should therefore be seen as evolving. Primary evidence will be added once available.

Initial findings suggest a high mental health needs among Syrian refugees in Egypt, albeit based on limited evidence. Our findings also indicate that the 'parallel' health system (i.e. NGO services) are the only realistic route for Syrian refugees to access mental health as they are more accessible, including being free of cost. Treatment for PTSD and other mental disorders are available in the public sector but is expensive, principally due to out-of-pocket payments.

Given these circumstances, the free online mental health services being developed by STRENGTHS for Egypt seem to be a good option for Syrian refugeees. This may help to overcome the treatment gap for mental disorders in the country. Awareness raising strategies conducted within the community may help to increase treatment demand for online mental health services, and to overcome stigma associated with seeking mental health care. There appear to be no similar online interventions currently being used in Egypt (and certainly none that have been documented and written about). Therefore perceptions on the appropriateness and acceptability of online MHPSS services would need to be explored through the future qualitative work to be conducted for the rapid appraisal work in Egypt.

4.1.7 References

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4.2 Germany

Data presented in this section is based on a besk-based review (existing literature). The final annex for Germany (containing key data from the literature) is available upon request, and will be made available on the STRENGHTS website.

In addition, secondary data was complemented by analysis of two qualitative interviews (two MHPSS providers). Ethics approval for both of these interviews was provided by the Ethics committee of the Department of Education and Psychology at Freie Universität Berlin (submitted in Germany by FUB, dd. June 12, 2017). Data collection took place between October 2017 and November 2017.

4.2.1 Wider environment and policies

Germany has seen the greatest influx of refugees in the EU in absolute numbers. Applications for asylum increased 12-fold from 2009 to 2015 (Murray, 2016). In 2016, 266'250 Syrian refugees applied for asylum in Germany (in 2015 158.657 Syrian refuges sought asylum, and in 2017 48.974 Syrian refugees respectively (BpB, 2018). Data on the gender and age distribution of Syrian refugees seeking asylum in Germany is not available, however, data from the Federal Centre for Civic Education indicates that the majority of all refugees in Germany are male and below 30 years of age (BpB, 2018). Syrian refugees are allowed to work in Germany and the country puts much effort into integration by offering language and education classes.

4.2.2 Health statistics in host country

Germany has a life expectancy of 79 and 84 years for men and women respectively (World Bank, 2017). Adult mortality rate was 68 per 1,000 population and maternal mortality 6 per 100,000 live births in 2015 (WHO, 2017). Recent evidence shows that almost one third of the general population is affected by mental disorders. Most frequent are anxiety (15.3%), mood (9.3%) and substance use disorders (5.7%). Overall, rates for mental disorders are substantially higher in women (33% versus 22% in men), younger age group (18–34: 37% versus 20% in age group 65–79), when living without a partner (37% versus 26% with partnership) or with low (38%) versus high socio-economic status (22%) (Jacobi, 2014).

4.2.3 Mental health system inputs

4.2.3.1 Leadership and governance

Germany does not have a government unit or programme working specifically on mental health or refugee health. There is also no formally approved mental health legislation, policy nor a national mental health action plan (WHO, 2014). Despite this, mental health is covered in other laws and mentioned in the general health policy (WHO, 2014). The Migration Integration Policy Index suggests that for Germany the country's overall score is 'slightly favourable' (which includes measures for health as well) (MIPEX, 2015). This indicates that policies in Germany slightly promote equal opportunities and provide a welcoming culture for migrants, including refugees.

4.2.3.2 Financing and expenditure

In 2014, the German Government spent 11.3% of its GDP on health (World Bank, 2017). The German health system is mostly funded via social security (77.0%) (WHO, 2017). 11% of the total expenditure on health is used for mental health (WHO, 2011). All German residents are required by law to have health insurance (IQWIG, 2015). The majority of the population – around 70 million people – have statutory health insurance. About 11 % of residents have private health insurance.

4.2.3.3 Information and research

Data on the epidemiology of mental disorders among refugees in the general health system is collected at the national level. However, there is no national mental health information system which collects data on mental health service delivery specifically among refugees.

4.2.3.4 Mental health workforce

Germany lies above the regional average for the number of psychiatrists (15.23 vs. 8.59 per 100,000 population) (WHO, 2011). The number of mental health nurses per 100 000 population are 56.06 (WHO, 2017). Mental health service providers are usually paid by a fixed salary, or they receive a fee for service or capitation (Bluemel and Busse, 2018). The proportion of psychotherapists working in Germany is greatest in cities (56.3 psychotherapists per 100 000 population). In rural areas there are 10.1 psychotherapists per 100 000 population (Statistica, 2018). There is no mental health training or education on mental health provided for undergraduate medical students (Chenot,2009). The majority of primary health care doctors and nurses have not received official in-service training on mental health within the last five years (WHO, 2014).

4.2.3.5 Facilities and services

Mental health services and treatment are not systemically integrated in primary health care although prescription regulations authorize primary health care doctors to prescribe and/or continue prescription of psychotherapeutic medicines (WHO, 2014). All psychosocial services (e.g. cognitive and behavioural interventions, counselling, family therapy) are available in the public sector (IQWIG, 2016).

NGOs provide services to refugees in Germany who are otherwise limited in their right to access health services available to Germans. Some of these organizations include: Berlin's Charité University Hospital (which operates the Arab Outpatient Unit that provides long-term treatment or a quick diagnostic evaluation regardless of insurance or asylum status), Albatros GmbH (offers counselling and social support services to refugees), IsraAID (deployed "a team of Arabic- and English-speaking psychosocial specialists to help support the refugee resettlement" and began providing psychosocial support training to shelter staff and directly to refugees in 2016), Medinetz (a group of medical students in Magdeburg who "are offering consultations for refugees"; they advise patients and arrange appointments for them with specialists, who then treat them anonymously and free of charge), and Malteser International (The Malteser Migrants Medicine organisation can be found in 14 German cities. People without valid residence status or health insurance can find a doctor here to carry out initial examinations and provide emergency care). In addition, there are also Psychosocial Centres for Refugees (e.g. in Duesseldorf) which provide support for approximately 400 people a year (Baff, 2016).

4.2.3.6 Psychotherapeutic medicines

An essential drug list is available in the country, although 'mental health' is not listed as a separate disease group; anti-depressive drugs are covered under neurological diseases (Federal Office for Public Health 2017).

4.2.4 Process outcomes and responsiveness

4.2.4.1 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas 1981) of MHPPS.

Availability:
Services for the treatment of mental disorders are available for refugees, however, according to Bajbouj demand exceeds current supplies (Bajbouj 2016). Access to health care for Syrian refugees does not equal the access to health care for German nationals (Bozorgmehr and Razum, 2016). The law (German Asylum Seeker's Medical Benefits Act) restricts health care for asylum seekers to instances "of acute diseases or pain", in which "necessary medical or dental treatment has to be provided. In addition, the law states that further benefits can be granted "if they are indispensable in an individual case to secure health" (Aida, 2018). MHPSS services, treatment by family doctors, specialists and psychotherapists are covered if needed (IQWIG, 2015). Prescribed medication is free for refugees. A co-payment might be needed in some cases, however, this will then be covered by the health insurance or the social welfare office. Full coverage of health care (as nationals receive) is only available after a 15-month waiting period (Aida, 2018). These accounts taken from the literature were confirmed by the providers who were interviewed by the STRENGTHS partners. One provider disagreed with the law and demanded to lift the 15 months restriction so that refugees are able to enjoy the same level of health care as nationals do once refugees enter the country.

Refugees in Germany are usually treated in psychosocial centres (Psychosozialen Zentren für Flüchtlinge und Folteropfer) and some of the other centres outlined under "facilities and services". However, they have limited capacity and approximately only 3600 refugees can be treated in these centres a year (BAfF, 2015) which equates to around 4% of all refugees with mental disorders in Germany. Psychotherapists working individually in the public or private sector are unable to close this treatment gap. Waiting times for receiving treatment with a psychotherapist is around 6 months (BPtK, 2015).

Accessibility:
The current healthcare provision in Germany is characterized by many restrictions for Syrian refugees. Different residence permits are associated with a limited access to medical and psychotherapeutic services. In addition, there are several barriers limiting access to the healthcare system (e. g. low level of training of mental healthcare staff in responding to the needs of refugees, language and cultural barriers and lack of financing for interpreters, individual and institutional stigmatisation of mental disorders, insufficient knowledge of therapy options (Böttche et al, 2016; Bajbouj, 2016). One provider interviewed for this study suggested travel expenses as barrier in accessing and continuing treatment (this is due to the large geographical areas that specialized treatment centers for refugees cover which may require a 2 hour train trip in some cases).

Accomodation:
Data on accommodation could not have been identified in secondary or existing primary data sources; therefore, the concept of accommodation needs to be explored in future qualitative work.

Affordability:
There are no costs to refugees who need to access psychosocial treatment as costs are covered by the Office of Social Work or by health insurance companies. However, as noted above, transports costs may be an issue.

Acceptability:
MHPSS providers highlighted a variety of reasons why Syrian refugees with mental health needs refuse, or delay, or seek support. This included family and cultural background, religiosity, nature and severity of psychological symptoms, somatisation, age, educational level, and trust in German providers. Improving intercultural competence in mental health professionals was suggested to improve acceptability of MHPSS among Syrians.

4.2.4.2 Quality and safety

The current health care act for refugees limits access to care for Syrian refugees in the first 15 months since entering Germany. Refugees are not allowed to visit a doctor themselves; the need for treatment will have to be checked and verified by the Office of Social Work which can lead to significant treatment delays. Access to psychotherapies are restricted as outlined above and waiting times for receiving treatment with a psychotherapist is on average 6 months (BPtK, 2011). A translator is usually required during psychotherapy sessions; however, these costs are not taken over by German health insurances and an application to cover these costs has to be made separately at the Office of Social Work (Bajbouj, 2016). Providers in Germany have also discussed the introduction of a nationwide health insurance card for refugees which would allow them to see a doctor directly thereby improving access to treatment (Hyde, 2016).

A recent study interviewing psychotherapists in Germany indicated that German psychotherapists are willing to treat refugees, however, they mention concerns regarding application of translators, the high formal costs, and the insecurity regarding the reimbursement of therapy sessions (Mewes et al, 2016).

4.2.5 Mental health outcomes

There are no population-wide estimates assessing the prevalence of mental disorders among refugees in Germany. Available studies focus on population groups in treatment and are often limited in their sample size. The prevalence of PTSD in German psychosocial centres treating refugees is estimated to range between 18,2% and 43,5% (Bajbouj, 2016; Ullman et al, 2015). In addition, refugees show other signs of psychosocial distress which are even seen more frequently: Somatoform disorders (38–88%), affective disorders (54,7%) and anxiety disorders (40,2%) (Bajbouj, 2016; Fuehrer et al, 2016; Ullman et al, 2015).

4.2.6 Discussion

The German mental health care systems offers adequate treatment for German nationals, however, there seems to be a substantial inequity in access when it comes to treatment for mental disorders for refugees. Access to psychotherapies is restricted within the first 15 months of residence. This may lead to delayed diagnosis and late treatment onset which may exacerbate the severity of symptoms and worsen overall functioning. Additional qualitative interviews planned for the rapid appraisals need to investigate pathways of care, and key determinants of responsiveness such as access, coverage, quality and safety from multiple perspectives. It is also imperative to investigate how PM+ can be nested and scaled up in the German health care system, and how this barrier of accessing treatment within the first 15 months of arrival in Germany can be overcome by the delivery of Step-by Step.

The literature indicates that Syrians enjoy the full range of health care options (as German nationals do) after the 15 months waiting period but still face socio-cultural barriers to accessing care (e.g. language, stigma, (cultural) preferences regarding treatment). These may partially be overcome by making PM+ available online. However, the uptake of PM+ as online version may depend on cultural treatment preferences, and the acceptance of this form of therapy. Interviews with Syrian refugees and their family members have yet to be conducted, however, initial results from the literature indicate that awareness about all kinds of therapy options, and knowledge transfer of its effectiveness needs to be raised among refugees in Germany.

Researchers and practitioners agree that treatment and services need to be more readily available for Syrian refugees. Bajbouj (2016) and Boettche (2016) have suggested that besides specialized interventions provided by psychotherapists or psychiatrists, non-expert, low threshold interventions of low intensity should be provided as those offer a more unbureaucratic and easier access to the German health system. Therefore, Step-by Step may make an important contribution to the German health care system once effectiveness is proven and once it is made more readily available among Syrian refugees in Germany.

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4.3 Jordan

Data presented in this section is based on a desk-based review (existing literature). The final annex for Jordan (containing key data from the literature) is available upon request, and will be made available on the STRENGHTS website.

In addition, secondary data was complemented by analysis of summaries of individual interviews with key informants (n=3; *KI*), MHPSS providers (n=6; *PR*), and Syrian refugees *not* accessing MHPSS services (n=15; *SR non-user*). Additionally, results from eight focus groups with Syrian non-users/community-members (4 female, 4 male; n=52) were included. Syrian refugees were aged 18 years and above and were based in urban settlements (Irbid, Karak, Amman, Zarqa, and Mafraq) and two camp locations (Azraq and Zaatari). Local ethical approval was granted by the Jordan Ministry of Health (submitted in Jordan by IMC, approval June 11, 2017). Data collection took place between 29 June and 20 July 2017.

4.3.1 Wider environment and policies

Jordan has the third largest number of registered Syrian refugees of the five countries part of the Syria Regional Refugee Response (Turkey, Lebanon, Jordan, Iraq, Egypt) (3RP 2017). On 18 September 2017, 654,582 refugees with Syrian nationality (male 49.5%; female 50.5%) were registered with UNHCR in Jordan (about a fourth were below 18 years of age (3RP 2017)). The majority of Syrian refugees (79%) are dispersed in urban, peri-urban and rural areas and a minority (21%) live in camps (3RP 2016).

Jordan, a lower middle-income and predominantly Muslim country has an unemployment rate of 13.2% (global average unemployment rate is 5.7%) (The World Bank 2017). The majority of Syrians are not eligible for employment in Jordan, according to labor laws. Therefore, unemployment rates among Syrian refugees in the country were estimated at 55% for men and 100% for women (Washington and Rowell 2013). In March 2016, the Government of Jordan announced to implement several measurements to increase access to the labour market for Syrian workers (3RP 2016). Work-related issues (e.g. difficulty finding employment, challenging working conditions, child labour) were still highlighted as key issues in interviews with Syrian refugee non-users in this study.

4.3.2 Health statistics in host population

Jordan nationals have a life expectancy of 73 and 76 years for men and women respectively (The World Bank 2017). Adult mortality rate was 112 per 1,000 population and maternal mortality 58 per 100,000 live births in 2015 (WHO 2017). Both mortality rates are lower compared to their regional average rate of 155 and 116 respectively (WHO 2017).

An estimated 4% of Jordanian nationals had a depressive and 4.3% an anxiety disorder in 2015 (Institute for Health Metrics and Evaluation 2016). These figures are slightly above average predictions (3.5% depressive; 3.5% anxiety) for lower middle-income countries (Institute for Health Metrics and Evaluation 2016). 0.98% of the Jordanian population reportedly died by self-harm in the same year and 0.45% of deaths were estimated to be caused by mental and substance use disorders (Institute for Health Metrics and Evaluation 2016)

4.3.3 Mental health system inputs

4.3.3.1 Leadership and governance

While there is no specific mental health law in Jordan (WHO 2014), legal provisions related to mental health are covered by other laws (e.g. disability, welfare, general health legislation) (WHO 2011). A mental health policy and plan was introduced in 2011 and was considered partially implemented in 2014 (WHO 2014). The policy and plan addresses integration of mental health into primary health care (PHC) and promotion of mental health, although it does not specifically mention the needs of refugees other than Palestinians (Ministry of Health 2011). Under this new policy, a Mental Health Unit (under the PHC administration) is planned to become the central governance unit for mental health (Hijiawi, Elzein Elmousaad et al. 2013).

The Ministry of Planning and International Cooperation (MOPIC) leads the Jordan Response Plan (JRP) of the Syrian refugee crisis at the national level, with the Ministry of Health overseeing the health component of the response (Ministry of Planning and International Cooperation 2017). Key informants in this study declared that the mental health of Syrian refugees receives sufficient attention within the national government. A point of improvement raised by one key informant was that current mental health efforts focus on treatment rather than prevention.

4.3.3.2 Financing and expenditure

In 2014, the Jordanian Government spent 7.5% of its GDP on health (The World Bank 2017). The national health system is partially funded via social security (8.7%) and through patient fees (20.9%) (WHO 2017). The proportion of total expenditure on health used for mental health is unknown (WHO 2017) although there was a plan to develop a budget through establishing a Mental Health Unit (Ministry of Health 2011). Budgets for strengthening various mental health services, including at community level, are part of the national Syrian response strategy (Ministry of Planning and International Cooperation 2017).

The National Aid Fund covers costs for vulnerable families, although refugees are not eligible for government funded social protection programmes (Röth, Nimeh et al. 2017). UNHCR facilities are accessible to refugees at no cost. The majority (89%) of NGO services are accessible at no cost as well (IMC 2016). The majority of Syrian refugees have a security card which gives them access to free or subsidized governmental health services in the areas where their cards are registered (UNHCR 2016). Additionally, cash-based assistance and vouchers are provided by international donors and NGOs so that refugees can pay for various services and goods (Röth, Nimeh et al. 2017).

4.3.3.3 Information and research

Mental health data among refugees is not systematically collected by the government. There are plans, however, to improve the health information system and to disaggregate data by refugee status (Ministry of Planning and International Cooperation 2017).

4.3.3.4 Mental health workforce

There were 7.8 mental health workers per 100,000 population in the country in 2014 (WHO 2014), which is similar to the regional average (7.3) (WHO 2014). In 2010, 36% of psychiatrists worked in government-run facilities and 41% in private care. Other mental health professionals predominantly (77%) worked in government facilities (WHO and Ministry of Health 2011). The distribution of mental health professionals between urban and rural areas was considered “relatively proportionate” (WHO and Ministry of Health 2011). The latest 4Ws country report concluded there was a high staff turnover,

limited availability of qualified workers, and few training programs offering clinical supervised practice as part of the formal education of mental health professionals in Jordan (IMC 2017a).

4.3.3.5 Facilities and services

In 2011, 0.99 mental health outpatient and 0.02 community-residential facilities per 100,000 population were reported (WHO 2017). While mental health was hardly available in PHC in 2010 (WHO and Ministry of Health 2011), partly through the introduction of mhGAP, it currently is more widely available at primary care level (Hijazi and Weissbecker 2014).

A mapping exercise reported about 37 organisations (mostly not-for-profit) were collectively delivering MHPSS services and activities for communities in Jordan in 2017 (IMC 2017a). The majority of Syrian refugees (in camps and outside) use NGO' mental health services (WHO and IMC 2013). IMC is the lead MHPSS service provder in Jordan and integrates MHPSS services into MoH clinics. Stand-alone NGOs are involved in community-focused, case-focused and general MHPSS activities (IMC 2017a), including counselling, family and individual therapy, livelihood and social support (Hijazi and Weissbecker 2014). MHPSS providers interviewed for this study explained that comprehensive mental health and psychosocial support services are offered through professionals like psychiatrists, psychologists, and counselors. Case management services, referrals, and linking vulnerable beneficiaries to resources are being provided by nearly half of organisations (IMC 2017a).

4.3.3.6 Psychotherapeutic medicines

An essential drug list exists for the country and covers psychotherapeutic medicines for the treatment of anxiety and depression depression among other mental and neurological disorders (Nuseirat and Qusous 2011).

4.3.4 Process outcomes and responsiveness

4.3.4.1 Care pathway

Syrian refugees typically have two routes into the mental healthcare system in Jordan: 1) via governmental providers in the public health system; or 2) via non-governmental (NGO) providers in the public health system (for example, IMC as an NGO delivers all of its MHPSS services through the Jordanian Ministry of Health clinics). MHPSS services are increasingly being integrated into primary health care. This means the first route is becoming more accessible but the second route remains the most commonly used by Syrian refugees (WHO and IMC 2013, IMC 2017a). Referrals to specialised mental health services are possible via both governmental and non-governmental services providers (PR).

4.3.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas 1981) of MHPSS.

Availability:
Half of the providers interviewed for this study thought their facilities had sufficient resources available to address the mental health needs of Syrian refugees, while the other half did not. More trained mental health staff was believed to be required. Key informants in another study reported gaps in professional expertise to manage epilepsy cases, and services for children with developmental disorders (IMC and SIGI-JO 2015). Previous research reported a lack of available services to be a barrier to mental health service utilisation in Jordan (IMC 2017b). Nearly half of Syrian refugees (46%) in a camp setting believed that psychological therapy and support was needed and from these 14.5%

reported receiving such support (Basheti, Qunaibi et al. 2015). Similarly, 13.3% of Syrian refugees responded positively to the question as to whether they received any help since coming to Jordan to address their mental health issues (WHO and IMC 2013).

(Geographic) Accessibility:
Two MHPSS providers in the qualitative research conducted by the STRENGTHS partner reported an unequal geographic distribution of mental health services across Jordan. A lack of accessibility was raised as issue in interviews with Syrian refugees: a shortage of services in selected areas came up in a focus group and the need to increase availability of MHPSS for refugees in urban areas was highlighted in several individual interviews (note: geographic accessibility related to urban and rural areas needs to be investigated further in next round of interviews). Transportation to access services was more of an issue for Syrian refugees compared to the Jordanian host community (IMC 2017b). Whether Syrians were unable to afford transportation costs or had insufficient knowledge about how to use local transport needs further exploration.

Accomodation:
Data on accommodation could not have been identified in secondary or existing primary data sources; therefore, the concept of accommodation needs to be explored in future qualitative work.

Affordability:
MHPSS providers in this study believed that financial reasons may explain why some people do not seek care for mental health services in Jordan. A previous study found that cost of services was perceived to be problematic for Syrian refugees, and that this impacts help seeking (IMC 2017b). Another study reported that the relatively high cost of prescribed psychotropic medicines in the country is as a barrier for managing neurological and psychiatric conditions (IMC and SIGI-JO 2015).

Acceptability:
Stigma and limited awareness on mental health were reported barriers for seeking professional MHPSS care mentioned by all interviewees. These findings are congruent with previous research (IMC 2017b). Several providers in this study expressed that some refugees prefer to seek care from traditional healers, possibly because it is seen as less stigmatising compared to visiting a psychiatrist (PR). A study showed that Syrian refugees in Jordan preferred to remain self-reliant (wanting to rely on their faith rather than seeking mental health support (IMC 2017b)).

4.3.4.3 Quality and safety

From the literature, it is unclear how long refugees generally wait to receive mental and psychosocial services. A system of supervision for social and community health workers is generally not available, although IMC does have a system of supverpision of MHPSS services according to an IMC employee. .

Key informants in a needs assessment expressed concerns about the lack of specialised and qualified mental health workers in Jordan. They reported limited screening, identification, and referral to specialised service providers as well as inadequate training opportunities in mental health, and a lack of a formal accreditation system and quality assurance (IMC and SIGI-JO 2015). Another assessment pointed to similar concerns from a key informant perspective about a shortage of skilled MHPSS staff (IMC 2017b). Two MHPSS providers in this study highlighted the need to increase training and clinical supervision opportunities for mental health workers in Jordan and to improve the selection criteria of these workers. One provider added that it would be necessary to enhance monitoring of service provision in the country.

4.3.5 Mental health outcomes

Higher proportions of mental health symptoms have been found amongst Syrians in camp settings (IMC and SIGI-JO 2015) than in urban settings, although self-reported distress and mental health symptoms were more severe among urban Syrian refugees (IMC 2017b). Camp-based studies reported 55% of Syrian men feeling anxious and 49% depressed (Al-Fahoum, Diomidous et al. 2015). Another study reported that 56% of Syrian refugees showed signs of psychological distress (Basheti, Qunaibi et al. 2015). 1.3% of all consultations in the Zaatri camp were for mental health reasons (UNHCR 2016).

4.3.6 Discussion

In this section we have started to analyse the responsiveness of the Jordanian health system to the MHPSS needs of Syrian refugees in the country. Our rapid appraisal was predominantly based on available statistics and literature, but also on qualitative research conducted by the STRENGTHS partner.

According to the IMC, MHPS activities in Jordan are implemented by 35 different organizations (IMC (2017b). In addition, IMC has supported mental health primary health care integration through capacity building of health care providers in Jodan for more than eight years. NGO services for Syrian refugees remain generally easily accessible in camp settings, however, sustainability of those services may depend on long-term funding of local NGOs.

Our preliminary findings highlight barriers in accessing mental health services for Syrian refugees in Jordan. These include acceptability barriers (limited awareness about mental health and stigma), availability (insufficient trained staff), geographic accessibility (unequal distribution of services with services particularly limited in urban areas) and affordability (costs of services and medicines). Specific pathways of care, and the responsiveness of the different players in Jordan towards the needs of Syrian refugees will be explored in further qualitative work.

The literature and our initial findings shed little light on the quality and safety of mental health care in Jordan. This is an area that needs to be explored in more depth during additional interviews to ensure that beneficiaries of MHPSS services are receiving the most optimal, effective, and appropriate services possible.

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4.4 Lebanon

Data presented in this section is based on a besk-based review (existing literature). The final annex for Lebanon (containing key data from the literature) is available upon request, and will be made available on the STRENGHTS website.

In addition, secondary data was complemented by analysis of three qualitative interviews (three MHPSS providers, all working in the NGO sector). Ethics approval for these interviews was provided by St Joseph's University, Beirut, Lebanon (submitted in Lebanon by War Child Holland, approved March 24, 2017). Data collection for those interviews took place in May 2017.

4.4.1 Wider environment and policies

Lebanon has the second largest number of registered Syrian refugees of the five countries neighbouring Syria (3RP 2017). At the end of 2016, 1,011,366 refugees with Syrian nationality (male 47.5%; female 52.5%) were registered by UNHCR in Lebanon, 27% were below 18 years of age (3RP 2017). The actual number of Syrian refugees in Lebanon, however, is estimated to be larger. UNHCR stopped registering Syrians in 2015 and figures from August 2016 show that about 60% had no valid legal residency (Government of Lebanon and United Nations 2017). Overall Syrian refugees comprise approximately one fifth of the total population in Lebanon (The World Bank 2017).

Lebanon is considered upper middle-income and has an unemployment rate (6.8%) slightly above the global average (5.7%) (The World Bank 2017). Employment is less stable for Syrian refugees in the country: on average 70% of working-age (18-65 years) men and 7% of women were working the month prior to an assessment, mostly (65%) received income from temporary jobs (UNHCR, UNICEF et al. 2016). However, employment for Syrians is only allowed for registered Syrians, therefore a considerable number work illegally and many get exploited which has a direct impact on their wellbeing.

4.4.2 Health statistics in host population

In 2015, Lebanese men had a life expectancy of 78 years and women 81 years respectively (The World Bank 2017). In the same year the adult mortality rate was 98 per 1,000 population and maternal mortality 15 per 100,000 live births (WHO 2017). Both mortality rates are lower compared to their regional average of 155 and 116 respectively (WHO 2017). Lebanese nationals have an estimated prevalence rate of 4.7% for depressive and 5.5% for anxiety disorders (Institute for Health Metrics and Evaluation 2016). These figures are slightly above average predicted rates (4.3% depressive; 4.2% anxiety) for higher middle-income countries (Institute for Health Metrics and Evaluation 2016).

4.4.3 Mental health system inputs

4.4.3.1 Leadership and governance

In Lebanon, mental health legislation was enacted in 1983, was found partially implemented in 2014 (WHO 2014) and was being revised in 2015 (WHO and Ministry of Public Health 2015).

A National Mental Health Programme (NMHP) was launched in May 2014 which aims to integrate mental health into primary health care (Ministry of Public Health 2017, El Chammay, 2014, 2016). NMHP also coordinates the development of the Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon for the period of 2015-2020 and established the Inter-

ministerial Substance Use Response Strategy for Lebanon 2016-2021 (Ministry of Public Health 2017, El Chammay, 2014,2016).

There is also a Lebanon Crisis Response Plan which focuses on Syrian refugees and is based on a regional plan (3RP 2016). It is implemented by the Government of Lebanon and partners, including UN agencies (i.e. UNHCR, WHO) and NGOs (Government of Lebanon and United Nations 2017). These partners provide support to local government institutions and work through the national health system to respond to the needs of Syrian refugees (3RP 2016). There is also a MHPSS Task Force which is chaired by the Ministry of Public Health (MoPH) with support of WHO and UNICEF and includes about 60 organizations working on the MHPSS response (e.g. UN agencies, local and international NGOs and ministries) (Ministry of Public Health 2017). Despite this effort, all providers interviewed for this study believed that MHPSS was insufficiently prioritized at the local policy level.

Social protection of Syrian refugees is overseen by UNHCR which is also responsible for their registration, although this was suspended in May 2015 (Government of Lebanon and United Nations 2017). UNHCR has contracted selected public and private hospitals in Lebanon to provide care for Syrian refugees (Ammar, Kdouh et al. 2016). The majority of primary health care (PHC) centres are owned and managed by NGOs and most hospitals belong to the private sector (WHO 2016). Both primary and secondary care for Syrian refugees is partially subsidized by UNHCR (Ammar, Kdouh et al. 2016).

4.4.3.2 Financing and expenditure

In 2014, the Government of Lebanon spent 6.4% of its GDP on health (The World Bank 2017), with about half (52.5%) of the total expenditure on health covered by social security and 36.4% by out-of-pocket payments (WHO 2017). For mental health, 4.8% of the total expenditure on health was used (WHO 2017), with over half (54%) going towards mental hospitals (WHO and Ministry of Public Health 2015).

Psychotherapeutic services are generally not covered by social insurance schemes, however, access to essential psychotropic medicines is free for the majority of Lebanese nationals (78%) (WHO and Ministry of Public Health 2015). Mental health care and medications for Syrian refugees are available without cost at UNHCR' subsidised PHC centres but there is a consultation fee. Refugees pay between LBP 3,000 and 5,000 LBP ($ 2-3.30) for a consultation at such centres (UNHCR 2016, Government of Lebanon and United Nations 2017).

Donor funding for health in Lebanon was US$33.2 million in 2015. It is unknown how much of this money is used for mental health care and refugee mental health.

4.4.3.3 Information and research

The national health system does not disaggregate data on mental health service delivery or epidemiology of mental disorders by status (i.e. registered/unregistered refugees) (WHO and Ministry of Public Health 2015). The database of the Lebanon Crisis Response Plan encourages partners to collect disaggregated data for displaced Syrians, although it only includes limited data on mental health indicators (3RP 2017).

4.4.3.4 Mental health workforce

There were 17.4 mental health workers (psychiatrists, psychologists, social workers) per 100,000 population in the country in 2014 (WHO 2014), which is above the regional average of 7.3 (WHO 2014). Nearly all mental health professionals (93%), except for primary care doctors, are working for NGOs, private practices or for-profit facilities (WHO and Ministry of Public Health 2015). In 2013 about 7-9

psychiatrists and 30-45 psychologists were involved in the Syrian refugee response (El Chammay and Kheir 2013). Health professionals working in mental health facilities only are working predominantly in mental hospitals (33%), community-based psychiatric inpatient units (35%), and mental health outpatient facilities (33%) (WHO and Ministry of Public Health 2015).

Only a limited amount of time is dedicated to mental health in the education of medical and nursing students (WHO and Ministry of Public Health 2015). It is unclear what this training comprises. Training gaps are addressed by implementation projects like The WHO Mental Health Gap Action Programme (mhGAP) (WHO 2016) and The Psychological First Aid Training and Support for Children Exposed to Trauma (Akoury-Dirani, Sahakian et al. 2015); however, these programmes are not yet offered at scale. Supervision takes place in mental health facilities, although psychologists expressed a need for these to be more frequent and in-depth (El Chammay and Kheir 2013).

4.4.3.5 Facilities and services

In 2011, 0.24 mental health outpatient facilities and 0.16 community residential facilities per 100,000 population were available (WHO 2017). A variety of MHPSS services are offered to the general population (e.g. counselling, family therapy and school-based activities) (WHO and Ministry of Public Health 2015, Lebanese Psychological Association 2017). Activities for refugees often fall under psychosocial support and include child-friendly spaces, art-therapy, and support groups (El Chammay and Kheir 2013). More livelihood projects are being planned and youth targeted to improve their literacy and numeracy skills (Government of Lebanon and United Nations 2017).

NGOs are greatly involved in the provision of care in Lebanon: in 2006 over 80% of the 110 PHC centres and 734 dispensaries spread across Lebanon were owned by NGOs (Kronfol 2006). However, referral, and follow-up to inform the referrng party rarely takes place between providers of services (El Chammay and Kheir 2013). Insufficiently developed links between service providers and a lack of awareness amongst NGO workers about the different programmes offered by other NGOs are possible explanations (El Chammay and Kheir 2013).

4.4.3.6 Psychotherapeutic medicines

An essential list of drugs is available at the national level, which includes psychotherapeutic medicines (Ministry of Public Health 2014). Primary health care doctors are allowed to prescribe medication for mental disorders (WHO and Ministry of Public Health 2015). It is unclear if this is also true for primary providers in the NGO sector, as one provider in our study commented that patients had to be referred to a psychiatrist in case medication was required.

4.4.4 Process outcomes and responsiveness

4.4.4.1 Care pathway

Respondents from interviews conducted by the STRENGTHS partner reported that Syrian refugee adults and children with mental health needs are usually first recognised through mental health awareness and promotion programmes in the community or at schools. Interviewees added that Syrians are then provided with contact details of a psychologist or social worker at a NGO, whom they can contact directly if a need for treatment has been identified. One of the providers being interviewed mentioned that social workers will work closely with psychologists during this process. Syrian refugees with mental health issues can also be detected through triage nurses at general health clinics. Interviewees added that nurses can refer the patient to a medical doctor, and this doctor will make an initial diagnosis and then refer the patient to a psychotherapist or psychologist for further treatment.

Previous research showed that most Syrian refugees receiving care for their mental health were treated at a primary health care centre (60%), followed by private clinics (16.7%), hospitals (6.7%), and other facilities (16.7%). The majority received care by a psychologist or psychiatrist (73.5%), and a minority by a social worker (14.7%) (Lyles and Doocy 2015). Syrian refugees are commonly treated by mental health professionals in the NGO sector since primary health care centres in Lebanon are predominantly owned by NGOs.

4.4.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas 1981) of MHPSS.

Availability:
While interviewees felt there were sufficient mental health workers at their facilities, numbers are lacking at the national level. There is a perceived lack of psychiatrists and this was also mentioned by one of the providers we interviewed. The same interviewee raised the need for more family and music therapy for adolescents. More training on mental health, especially for social workers and nurses, was highlighted by another interviewee. Restriction of psychotherapeutic medicines was not mentioned by our interviewees, however, previous research reported issues with availability of psychotherapeutic medicines (El Chammay and Kheir 2013).

Despite these positive developments, our interviewees raised the need to further improve awareness about mental health. They indicated that many patients have unrealistic expectations about mental health care and demand immediate improvements in their psychological health. Another provider mentioned that some refugees refuse or delay help seeking as they have competing priorities in life like housing. Providers also mentioned that a subset of Syrians tend to rely on their religious beliefs instead of seeking professional support.

Participants in our study made suggestions towards increasing mental health awareness. One provider indicated that it would be beneficial to educate parents to improve awareness and acceptance of mental health care amongst their children. Another provider added that the media (tv and radio) could potentially play a role in raising awareness on mental health in the community.

(Geographic) Accessibility:
MHPSS providers who were interviewed did not raise any physical access concerns. However, previous research did. A 2013 evaluation on MHPSS amongst Syrian refugees involved focus group discussions with Syrian refugees and showed that most mental health services (including IASC pyramid levels 2-4) are facility-based while refugees are spread across different areas in Lebanon; interviewed health providers were of the opinion that male refugees find it difficult to travel due to safety concerns and that female refugees are restricted in their mobility because of traditional customs. The literature reports accounts of NGO workers who found it challenging to plan structured long-term psychosocial support activities because of the refugees' immobility in Lebanon (El Chammay and Kheir 2013).

Accomodation:
Data on accommodation could not have been identified in secondary or existing primary data sources; therefore, the concept of accommodation needs to be explored in future qualitative work.

Affordability:
Previous research shows that one third of Syrians with mental health issues (33.3% of n=42) paid out-of-pocket for their care, with the mean cost of mental health care being 9,700 LBP (US$6) (Lyles and Doocy 2015). Two participants in our study highlighted that affordability might be an obstacle for

Syrian refugees to access mental health services. Even if services are free, transportation costs were mentioned as an obstacle in accessing care.

Acceptability and help seeking:
Stigma associated with mental health and a lack of awareness were raised as important barriers by our interviewees, which is in line with an account by a mental leader in Lebanon (Fleck 2016). One provider in our study commented that stigma was prevalent amongst Syrians and Lebanese alike, and mentioned that those with mental health issues are afraid of other people's opinions. Therefore, as explained by the provider, patients need a lot of reassurance to normalize their behaviour telling them that they are not 'crazy' and that all services keep patient records confidential. Two providers highlighted that they experienced a reduction in stigma over the last years among the patients they work with, with people being increasingly aware about mental health and more accepting of mental health issues.

4.4.4.3 Quality and safety

Two MHPSS providers perceived referrals for patients with mental health needs to be inefficient. There were long waiting times according to one provider, and a lack of patient choices in services and providers. Interviewees believed that these issues are caused by the limited mental health workforce available in Lebanon. Another quality concern which was raised by one provider was related to the diagnosis of mental disorders, and additional training on proper diagnosis was requested. Recent evidence also highlights that there is not yet a certifying body for psychotherapists in Lebanon (El Chammay and Kheir 2013).

4.4.5 Mental health outcomes

Anxiety and depression are the most frequently reported mental health problems among Syrian refugees (International Medical Corps 2011, Pérez-Sales 2013, Hijazi and Weissbecker 2014), including the elderly (>60 years) (Chahda, Sayah et al. 2013, Strong, Varady et al. 2015) and youth (UNFPA 2014). Nervousness and anxiety were common in refugee children (5-17 years) (Escot, Mahfouz et al. 2016) in addition to suicidal thoughts (UNFPA 2014). A recent household survey among Syrian refugees (18-65 years, n=452) in six camps of the Central Bekaa region found a lifetime prevalence of PTSD of 35.4% (Kazour 2017)

4.4.6 Discussion

In this narrative report we have started to analyse the responsiveness of the Lebanese health system to the MHPSS needs of Syrian refugees in the country. Our rapid appraisal was predominantly based on secondary statistics and the available literature, but also on some initial qualitative research conducted by the STRENGTHS partner. More primary qualitative research is needed to further investigate perceived barriers and facilitators of accessing mental health care for Syrian refugees, especially adolescents. Additional interviews need to investigate their pathways of care, and key determinants of responsiveness for this age group such as access, coverage, quality and saftey from multiple perspectives.

The current evidence suggests an adequate number of mental health facilities available at the tertiary level in Lebanon but inadequate resources at the community and primary health care level for Lebanese nationals. Mental health care for Syrian refugees is predominantly provided by NGOs. Accounts from our interviews and the literature highlights a lack of communication between the different providers operating at the public and parallel health system, and indicate that even within the parallel health system coordination of care and pathways of care can be improved. Accounts from

key informant also highlighted that the implementation and scaling up of mh-GAP faced challenges. These need to be investigated further with key informants as it may provide important information about the scaling up of PM+.

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4.5 Sweden

Data presented in this section is based on a besk-based review (existing literature). The final annex for Sweden (containing key data from the literature) is available upon request, and will be made available on the STRENGHTS website.

In addition, secondary data was complemented by analysis of three qualitative interviews (with one key informant (*KI*), a policy maker), and two MHPSS providers (*PR*)). Ethics approval for these interviews was provided by the Ethics committee of the Department of Education and Psychology at Freie Universität Berlin (submitted in Germany by FUB, dd. June 12, 2017). Data collection took place between October 2017 and February 2018.

4.5.1 Wider environment and policies

From April 2011 to June 2017, 112,397 Syrians sought asylum in Sweden, which is 11.4% of the total Syrian Asylum Applications in Europe (UNHCR 2017). Nearly a fifth (17%) of all asylum applications in Sweden (received during 2000-2016) were from Syrians out of which 34% were women/girls, 66% men/boys, and 32% children (Migrationsverket 2017). The majority of Syrians (91%) applying for asylum in Sweden were granted a residency permit in 2016 (Migrationsverket 2016).

Duration of such residency permits depend on the status granted: 'persons in need of subsidiary support' receive a permit of 13 months, 'refugees' 3 years, and 'quota refugees' (i.e. those who apply via UNHCR) permanent status. Refugees in the two former groups may be given permanent status if they can financially support themselves (Migrationsverket 2017), although stricter regulations enforced in July 2016 make this more difficult (Government Offices Sweden 2016).

Sweden, a high income country has an unemployment rate of 7.1% (global average is 5.7%) (The World Bank 2017). Figures for the Syrian refugee workforce in the country are unknown. In 2015, a fast-track process was introduced for refugee health professionals to enter into the labour force (Regeringskansliet 2015).

4.5.2 Health statistics in host population

The life expectancy in Sweden is 81 and 85 years for men and women respectively (The World Bank 2017). Adult mortality rate was 53 per 1,000 population and maternal mortality was 4 per 100,000 live births in 2015 (WHO 2017). Both mortality rates are lower compared to their regional averages (WHO 2017).

4.9% of the general population were diagnosed with depressive disorders and 4.8% with anxiety disorders in 2015 (Institute for Health Metrics and Evaluation 2016). These figures are similar to estimated rates (4.8% depressive; 5.6% anxiety) in high-income countries (Institute for Health Metrics and Evaluation 2016). 1.5% of the Swedish population have died by self-harm that year and 0.78% of these deaths were likely caused by mental and substance use disorders (Institute for Health Metrics and Evaluation 2016).

4.5.3 Mental health system inputs

4.5.3.1 Leadership and governance

Sweden has mental health legislation, policy and plan (WHO 2011) which were considered partially implemented by the WHO atlas in 2014 (WHO 2014). Sweden scored 'slightly favourable' in migration

integration policies (MIPEX 2015). Various NGOs, like Red Cross and Caritas, provide MHPSS services for refugees. It is unclear to what extent these services are regulated by the Swedish government.

4.5.3.2 Financing and expenditure

In 2014, the Swedish Government spent 11.9% of its GDP on health (The World Bank 2017). The Swedish health system is largely funded via taxes, although 14.1% of total expenditure on health was out-of-pocket (WHO 2017). 10% of total expenditure on health was used for mental health in 2011 (WHO 2017).

Asylum seekers and refugees are required to pay for health services and medicines in the general health system. An asylum seeker can receive a compensation from the Migration Agency if his/her health expenses exceed 400 Swedish Kroner (SEK) (approximately 40 Euros) (Migrationsverket 2017). Individuals with refugee status pay the full cost of prescribed medications up to SEK1,100 (107Euros) annually. While county councils set copayment rates for health visits, nationally, annual out-of-pocket payments for refugees are capped at SEK1,100 (107 Euros) per individual (Mossialos, Wenzl et al. 2016). An MHPSS provider interviewed for our study suggested that refugees who receive public welfare support might be exempt from paying for medications.

4.5.3.3 Information and research

The Asylum Healthcare Platform" is a newly developed platform that compiles data from the Swedish Migration Agency on asylum statistics and healthcare data for asylum seekers as well as from county councils/regions (Sveriges Kommuner och Landsting 2017). NGOs involved in MHPSS for refugees publish data on their activities on their websites (MSF 2016, Tinghog, Arwidson et al. 2016).

4.5.3.4 Mental health workforce

The number of psychiatrists in Sweden is above its regional (European) average (18.31 vs. 7 per 100,000 population), number of nurses (52.90 vs. 24.1) and number of social workers (18.42 vs. 1.7) but has fewer psychologists (0.93 vs. 2.7) (WHO 2014, WHO 2017). Primary care providers (public and private) are "paid a combination of fixed payment for their registered individuals (about 80% of total capitated payment), fee-for-service (17%–18%), and performance-related payment (2%–3%) for achieving quality targets" (Mossialos, Wenzl et al. 2016). There is a similar payment system for specialist providers of outpatient services (Mossialos, Wenzl et al. 2016). It is unclear how MHPSS providers in the NGO sector are reimbursed.

Whether training of primary care professionals includes psychological first aid, basic mental health care, or protection of human rights is unknown. It is unclear if refresher trainings are being offered. The Transcultural Centre provides cross-cultural psychiatric training for health professionals (public and private) in Stockholm county and beyond (Transkulturalltcentrum 2017). An evaluation of this training showed participating health professionals had an improved knowledge on refugee' needs and an increased empathy towards refugees with mental health issues (Bäärnhielm, Edlund et al. 2015).

4.5.3.5 Facilities and services

Mental health services and treatment are integrated in primary health care (PHC) in Sweden (Mossialos, Wenzl et al. 2016). Common mental disorders can be treated at PHC level, with providers allowed to prescribe psychotherapeutic drugs (Patana 2015). A variety of mental health services (e.g. CBT, counselling, family therapy) and health promotion activities (e.g. ambassador network to reduce stigma) are offered to the public (Swedish Association for Family Therapy 2012, Patana 2015, (H)jarnkoll 2017). Internet-based cognitive behavioural therapy is increasingly used as means to address shortages of mental health providers, particularly for the treatment of depressive and panic

disorders (Patana 2015). Interviewed MHPSS providers added that psychotherapy, EMDR, and narrative exposure therapy were being offered to Syrian refugees.

In addition, a range of county- and NGO-run mental health services are available to refugees, including preventative (e.g. livelihood and social support) and curative (e.g. counselling and trauma therapy) (UNHCR 2013, MSF 2016, OECD 2016, Flyktinggruppernas Riksrad (FARR) 2017). Health communicators are active in selected municipalities, who inform newly arrived asylum seekers and refugees about the health system. Sweden ensured that these communicators speak the same language and have a similar cultural background (UNHCR 2013).

4.5.3.6 Psychotherapeutic medicines

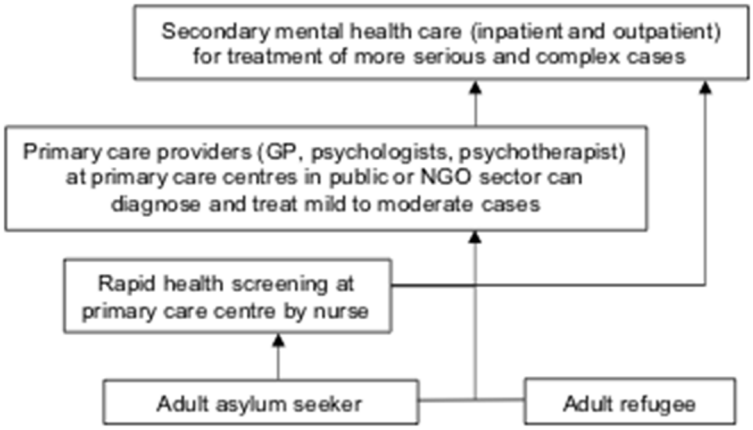
Essential drugs lists are determined at county level in Sweden, meaning the availability and content of such lists may differ. The drug list for Stockholm County Council includes psychotropic medicines for anxiety and depression (Stockholm County Council 2015).

4.5.4 Process outcomes and responsiveness

4.5.4.1 Care pathway

The routes followed by adult Syrian patients from their first contact with the Swedish health system until they receive professional MHPSS care is shown in figure 3 below.

Figure 3: Typical routes followed by adult asylum seekers and refugees with mental health needs in the health system in Sweden



Typically asylum seekers are invited for a health screening by a nurse at a primary health centre after arrival in Sweden (Migrationsverket 2017) (KI). For both refugees and asylum seekers, primary health care is commonly the entry into the health system and is the place where diagnosis by a medical doctor takes place (KI).

Primary care providers (e.g. psychologists, psychotherapists) at these units can offer treatment to Syrian patients with minor to moderate mental health issues. While residents in Sweden can freely choose their primary care provider, either public or private (Patana 2015), asylum seekers and refugees are generally directed to health providers specialised in treating these groups, often NGO workers (KI). These specialist providers, however, are not equally available across the country (KI). The type of treatment given in primary care varies but can be medication, therapy (face-to-face or Internet), or a combination of these (Patana 2015) (KI). Prescriptive medicines can be bought at the

pharmacy and are often 50 kroner (5 Euros) for adult asylum seekers and are free for those under 18 years of age (Migrationsverket 2017).

Severe cases who do not benefit from treatment in primary health care are referred to secondary care (KI), which can be inpatient or outpatient. Patients can also access secondary care directly via self-referral (Patana 2015).

4.5.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas 1981) of MHPSS.

Availability:
A policy maker in this study believed there were insufficient specialised care clinics and a need for more staff trained in trauma treatment. An MHPSS provider expressed that health providers in areas with limited numbers of migrants require further training in working with translators and refugees.

(Geographic) Accessibility:
Two participants (KI;PR) in this study raised that Syrian refugees may have to travel up to a day to reach specialist centres like the Red Cross.

Accommodation:
An MHPSS provider commented that arranging an appointment for primary care might be challenging to Syrians as this requires making a phone call in Swedish.

Affordability:
Affordability issues need to explored in future qualitative work.

Acceptability:
Acceptability related facilitators and barriers were most commonly mentioned by study participants. Every foreigner who accesses the health system but does not speak Swedish well enough has the legal right to a translator, according to an MHPSS provider. This decision for a translator is based on the persons own assessment of his/her ability to understand Swedish, which "works most of the time" (PR).

An MHPSS provider explained that newly arrived Syrians commonly prioritise more practical things (like taking care of children or learning Swedish) over seeking mental health treatment. Additionally, this interviewee outlined that less educated Syrians with low mental health awareness might not seek professional support because they do not know about treatment options or are embarrassed to seek help. Reluctance to seek treatment due to stigma was also raised by another provider: many patients "don't want to be seen as mad or psychotic". Somatisation amongst Syrian patients was another perceived reason for their limited or delayed access to mental health care (KI).

4.5.4.3 Quality and safety:

By law, county councils need to invite asylum seekers for a voluntary health assessment. Previous research shows that not all adult respondents received such an invitation letter and several other (12.4%) did not undergo the assessment (Pacheco, Jonzon et al. 2016). A policy maker in our study explained that the percentage of asylum seekers attending these health checks has increased over the years (currently about 50%). Additionally, this interviewee commented that screenings focus on physical issues and that "questions linked to mental health rarely come up". This is in line with findings

by Pacheco and colleagues (2016) who showed that while health assessments were generally positively received by asylum seekers, their psychological needs were overlooked (Pacheco, Jonzon et al. 2016). Screening for mental health problems among asylum-seeking minors was similarly reported to be inadequate (Sandahl, Norredam et al. 2013, Human Rights Watch 2016).

Waiting time for specialised psychiatric care was considered to be long (6-12 months) by a policy maker interviewed in our study. National statistics on waiting times in health care do not seem to gather data on mental health outpatient treatment. Generally, 79% of patients have waited 90 days or less for a first visit to specialised care in the public or private sector (Väntetider 2017).

Health care providers are assessed by county councils (based on certain quality targets). Additionally, there are about 90 national quality registers used for monitoring and evaluating quality among providers (Mossialos, Wenzl et al. 2016), including one on "Internet-Based Psychological Treatment" which focuses on common mental disorders (Nationella Kvalitetsregister 2017).

4.5.5 Mental health outcomes

A cross-sectional study found that among newly resettled refugees from Syria (between 2011-2013) 40.2% had symptoms of depression, anxiety (31.8%), and PTSD (29.9%) (Tinghög, Malm et al. 2017).

4.5.6 Discussion

In this section we haveanalysed the responsiveness of the Swedish health system to the MHPSS needs of Syrian refugees in the country. Our appraisal was predominantly based on available statistics and literature, but also on initial qualitative research collected by the STRENGTHS partner. Further primary research is needed to investigate the perceived barriers and facilitators of accessing mental health care for Syrian refugees. This document should therefore be seen as evolving. Additional primary data will be added and relevant secondary data will be regularly updated.

This preliminary rapid analysis suggests that Syrian refugees refuse or delay care seeking due to a limited knowledge of mental health care, somatisation, and stigma. Language seems less of an issue during therapy because translators are available and accessible, although not speaking Swedish might hinder Syrians of making an appointment in primary health care. Health screenings for asylum seekers seem to insufficiently inquire about mental health, hampering early detection of psychological issues.

Initial findings also indicate that there is a lack of health centres and providers specialised in refugee and/or trauma care in rural areas in Sweden. Consequently, Syrian refugees may experience physical access barriers (needing to travel far to attend health centres specialised in refugee and/or trauma care) and do not receive culturally appropriate care. Positively, these barriers might create a demand for an online mental health service like Step-by-Step that is culturally adapted to Syrian refugees.

Affordability was not raised by study participants as an issue which seems suprising as the literature indicates that refugees have to make out-of-pocket payments for their health visits and medications. While rates are capped, this might be a considerable barrier to access (face-to-face) mental health care. Further exploration is required on this issue.

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4.6 Switzerland

Data presented in this section is based on a besk-based review (existing literature). The final annex for Switzerland (containing key data from the literature) is available upon request, and will be made available on the STRENGHTS website.

In addition, secondary data was complemented by analysis of individual interviews with key informants (n=5; KI), including two policy makers, and healthcare providers (n=5; PR) out of which two work in MHPSS care and three in primary health care. Individual interviews (n=4) and two focus groups (1 male; 1 female; 20 individuals) with Syrian refugees not using MHPSS (SR non-user) were also included. A waiver for these interviews was provided by the Ethics Committee of Canton Zurich KEK-ZH REQ-2017-00404 (submitted in Switzerland by UZH, dd. 2 June 2017). Data collection took place in June and July 2017.

4.6.1 Wider environment and policies

From April 2011 to June 2017, 14,966 Syrians sought asylum in Switzerland; this is 1.5% of the total Syrian asylum applications received in EU+ countries (UNHCR 2017). Asylum seekers arriving at the Swiss border are distributed to reception and procedure centers across different cantons or the 'test center' in Zurich that offers an accelerated asylum procedure (Asylum Information Database 2018) (PR). In 2016, 37% of all Syrian nationals in Switzerland (56% male; 44% female) were aged 17 or under (Swiss Federal Statistical Office 2017). The majority of Syrians (37%) are in Switzerland as provisionally admitted persons (holding a F-permit which is a permit for provisionally admitted foreigners), followed by 34% on residency B-permits (permit which allows foreigner to stay/work in country), 24% as asylum seekers/N-permits (special permit for asylum seekers only) and 5% on settlement C-permits (to be obtained after having a B permit for several years) (Swiss Federal Statistical Office 2017).

Several participants (KI; SR non-user) interviewed for this study perceived that integration of Syrians in the Swiss society depends very much on the type of residency permit. Some Syrian refugees explained that refugees holding a F-permit are limited in terms of visiting family abroad (they are not allowed to leave the country unlike those on a B-permit), learning German (two language courses are paid for by the state while those on B-permits are offered more courses), and in securing a job (which requires "more administrative procedures" for the employer than those on a B-permit). Asylum seekers with an N-permit may be even more constrained (by law) than those with an F-permit; a Syrian refugee who used to hold a N-permit mentioned that it was not possible to attend language classes and seek work (KI; SR non-user).

Switzerland has an unemployment rate of 4.6% (The World Bank 2017). Figures for the Syrian refugee workforce in the country are unknown; however, unemployment amongst foreign-born workers is higher than the national average (7.9% vs. 4.6%) (OECD 2017). Interviews with Syrian refugees confirm the challenge of finding employment. As a consequence, many Syrian refugees are dependent upon social welfare which was considered insufficient by some Syrians interviewed for this study; a few reported difficulties with paying for local travel, clothing, and social events.

4.6.2 Health statistics in host population

Switzerland has a life expectancy of 81 and 85 years for men and women respectively (The World Bank 2017). Adult mortality rate was 49 per 1,000 population and maternal mortality 5 per 100,000 live births in 2015 (WHO 2017). Both mortality rates are lower compared to their regional averages of 124 and 16 respectively (WHO 2017).

Estimated prevalence rates of depression and anxiety disorders are 5% among the general population (Institute for Health Metrics and Evaluation 2016). These figures are similar to average predicted rates (4.8% depressive; 5.6% anxiety) for high-income countries (Institute for Health Metrics and Evaluation 2016). 1.4% of the Swiss population was estimated to have died by self-harm in 2016 and 0.87% of deaths were predicted to have been caused by mental and substance use disorders (Institute for Health Metrics and Evaluation 2016).

4.6.3 Mental health system inputs

4.6.3.1 Leadership and governance

Switzerland does not have a formally approved mental health legislation or policy (WHO 2014). However, mental health is covered in other laws and mentioned in the general health policy (WHO 2011). A mental health plan does exist and includes the integration of mental health into primary health care (PHC) (WHO 2011). As for migration integration policies, the country's overall score was 'halfway favourable' and for health 'favourable' (MIPEX 2015).

Various NGOs, like the Red Cross and Caritas, provide MHPSS services for refugees. It is unclear to what extent these services are regulated by the Swiss government. This needs to be explored further through additional key informant interviews.

4.6.3.2 Financing and expenditure

In 2014, the Swiss Government spent 11.7% of its GDP on health (The World Bank 2017). The Swiss health system is funded via social security (71.5%) but also through patient fees (26.8%) (WHO 2017).

Health insurance is mandatory in the country since 1996 (De Pietro, Camenzind et al. 2015). Cantonal authorities and social welfare institutes arrange and pay for the health insurance of asylum-seekers and refugees (Navarra 2011) (KI). Counselling by a psychologist is however not covered except if it is carried out under a doctor's or psychiatrists supervision (Migraweb 2017). Costs for interpreters are not covered by health insurance (KI).

4.6.3.3 Information and research

The latest national survey on the health of migrants took place in 2010. This survey included refugees from Somalia and Sri Lanka, not Syria, and did not seem to incorporate mental health (Federal Office of Public Health 2010).

4.6.3.4 Mental health workforce

Compared to regional averages, Switzerland has a high number of psychiatrists (41.42 vs. 8.59 per 100,000 population) and psychologists (40.78 vs. 2.58) working in the country (WHO 2011, WHO 2011). Primary care providers (public and private) are predominantly paid by fees for service (90%) but also via capitation (10%) (De Pietro, Camenzind et al. 2015). It is unclear how many mental health professionals work for NGOs and how they are reimbursed. Cultural competency training is provided in undergraduate and postgraduate curricula for medical students and residents (Weiss 2015).

4.6.3.5 Facilities and services

Psychiatric care (generally private) is not systematically integrated in primary health care in Switzerland. Those with less acute mental health symptoms are often treated in socio-psychiatric facilities and day-care institutions, which are mainly funded and provided by the government (Mossialos, Wenzl et al. 2016). Psychotherapy is the main service offered in psychiatric care and can

be supplemented by drug treatment (Mossialos, Wenzl et al. 2016). Study participants (PR) highlighted the availability of outpatient clinics for the victims of torture and war.[1]

These services are complemented by some NGO-run psychosocial support services which include livelihood, social support, and counselling for refugees (e.g. Der Verband Schweizerischer Jüdischer Fürsorgen, Migraweb, Salvation Army).

4.6.3.6 Psychotherapeutic medicines

Essential drug lists are available in the country[2], although 'mental health' is not listed as a separate disease group; anti-depressive drugs are covered under neurological diseases (Federal Office for Public Health 2017). According to a primary provider interviewed for this study, GPs are allowed to prescribe antidepressants.

4.6.4 Process outcomes and responsiveness

4.6.4.1 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas 1981) of MHPPS.

Availability:
Several availability barriers were raised by study participants (PR; KI). This included insufficient numbers of psychiatrists (PR; KI), psychologists (KI), qualified therapists and interpreters (PR), Arab speaking doctors at trauma units (KI), and short supply of trained supervisors at asylum centres (PR). In terms of services, a key informant raised the need for the expansion of facilities for torture victims as those are only available in a limited number of cities across the country.

(Geographic) Accessibility:
A key informant interviewed for our study mentioned that while there are some Arabic speaking doctors in Switzerland, refugees may need to travel a long distance to reach those doctors and this can increase cost (indirect costs due to transport).

Accommodation:
The concept of accommodation needs to be explored in further qualitative work.

Affordability:
Providers interviewed for our study experienced a lack of clarity about the payment for using professional translation services. One provider explained that while outpatient clinics generally have a budget for interpreters, psychotherapists do not. Even at primary care level, according to a GP, there was the question of "who is paying" after using an interpreter.

[1] These outpatient facilities provide survivors of war and displacement with medical psychotherapeutic and psychosocial counselling, treatment and advice. Clinics are based in five cities/areas across Switzerland (i.e. Bern, Zurich, Geneva, St Gallen, and Canton Vaud) Ambulatorium für Folter- und Kriegsopfer SRK. (2018). "The association: Support for Torture Victims." Retrieved 2 May, 2018, from http://www.torturevictims.ch/en/support-for-torture-victims..

[2] For further reference see BAG and SWUPP websites:
https://www.bag.admin.ch/bag/de/home/themen/versicherungen/krankenversicherung/krankenversicherung-leistungen-tarife/Arzneimittel.html;
https://swupp.ch/blog/krankenkasse/medikament-liste-nlp-sl-lppv-km

Acceptability:
The most commonly mentioned barriers among participants interviewed for this study concerned acceptability. Stigma and prejudice about mental illness and help seeking were frequently mentioned as reasons for refusing or delaying MHPSS care (SR non-user; KI; PR). A Syrian refugee explained that Syrians may not accept the diagnosis of mental illness as some believe that someone with a psychological problem is "crazy". A key informant added that while some Syrians may seek help for their psychological issues, others are too "shy", "lost and lonely", "ashamed", or afraid (fear of someone taking their children away). A provider commented on the issues of 'medicalisation' and 'psychiatrisation' and that labelling patients from a different culture with a mental health diagnosis may be offending to them. Another provider believed that the European mental health care system "conflicts with" Syrian culture and that the professional support on offer is often viewed by Syrians as unhelpful.

Syrian refugees (SR non-users) explained that Syrians with minor psychological complaints are usually seeking support from their relatives. A refugee outlined that mental health care in Syria predominantly consists of psychiatrists who only treat severe disorders. For mild issues Syrians are usually talking to their family members and friends. Another Syrian refugee had a similar view and perceived that Syrians with psychological needs search for Arabs, particularly relatives and friends.

Interviewees (SR non-user; PR) highlighted that highly educated Syrians and those who have lived in Europe for a while may be more accepting of professional MHPSS care. Participants (PR; KI; SR non-user) explained that this has to do with the increased knowledge and awareness about mental health and its care system (e.g. GP as gatekeeper).

These accounts have been confirmed by the literature. A study about the views of access barriers amongst asylum seekers (not specific to Syrians) reported similar issues: "a negative representation of psychiatry, fear of being stigmatized by their own community and poor information about existing psychiatric services" (Bartolomei, Baeriswyl-Cottin et al. 2016).

Somatisation was another issue highlighted by interviewees (PR; SR non-user). A primary care provider felt that Syrian refugees were not very open to psychological explanations on their somatic issues (e.g. headache, sleeping problems). This may explain why another refugee highlighted that there is a general belief amongst Syrians that they will not receive proper care when seeking help for their health problems.

Accounts by Syrian participants indicate that trust in the effectiveness of the Swiss mental health care system affects their health seeking behaviour. A female Syrian refugee (SR non-user, focus group) distrusted health providers and was not convinced that her health problems could be solved by these professionals. For these reasons, she sought help for her "negative feelings" through an online church community. Other women in this focus group agreed that they waited for God to resolve their issues. Like Syrian women, men also spoke about religion as a source of support for their problems.

Selected participants (PR; KI) commented on the lack of acceptance of psychotherapeutic drugs amongst Syrian patients. A provider experienced mistrust amongst Syrian patients towards medication use, particularly among adults. Another provider observed that painkillers were generally accepted by Syrians but sleeping pills were not, and a key informant spoke about a Syrian patient who was dissatisfied with being prescribed antidepressants by a GP. The underlying reasons for this scepticism amongst Syrians towards (psychotherapeutic) drugs needs to be further explored.

Language barriers also often impede access to care (PR; KI). Several key informants expressed that Syrians find it hard to clearly express their psychological needs due to linguistic challenges.

Consequently, providers need to work with interpreters, but this was found difficult (PR; KI). One provider believed that while diagnosis of a Syrian patient was possible without a professional interpreter (through a simple screening instrument and the presence of the patient's relative who has some knowledge of English or German), treatment was not. Even professional interpreters with a certificate from the BAG (Federal Office of Public Health) were regarded as unfit to translate by this provider (as during psychotherapy translators have to preserve "a high degree of neutrality" and "linguistic precision"). A key informant was of the opinion that cultural barriers are not necessarily solved by using an interpreter. Similarly, a provider highlighted the need to match the cultural and religious backgrounds of the patient and the interpreter; however, this will be difficult to achieve in practice as the pool of professional interpreters is limited.

Several strategies were raised by participants to overcome some of these acceptability barriers. On the provider side, interviewees (PR; KI) suggested the need to increase cultural awareness amongst health professionals. A provider believed that practitioners should use terms that are "less stigmatising" and evoke "less resistance" during diagnosis. Along the same lines a key informant felt that it would be important to address Syrian refugees in their own "language and style" through experts who speak Arabic and have a similar cultural background. On the patient side, strategies proposed by participants (PR; KI; SR non-user) focused on improving access to information about MHPSS for Syrian refugees. Examples of specific activities included: psychoeducation at arrival in Switzerland (PR), mental health awareness campaigns (SR non-user), and online information about mental health in Arabic (SR non-user). Additionally, increasing the availability of low-threshold psychosocial activities (SR non-user) and investment in language courses for refugees (KI) were suggested as ways to improve acceptance of MHPSS amongst Syrian refugees.

4.6.4.2 Quality and safety

Several quality and safety concerns were raised by interviewees in this study. A key concern (KI; PR) was the timely diagnosis of mental health issues amongst Syrian asylum seekers and refugees. A key informant reported that psychological issues amongst Syrian refugees often stay hidden with only "the tip of the iceberg" being apparent. Similarly, a provider stated: "It just takes way too long until they [Syrian refugees] even go and see someone. There's either nothing provided or a comprehensive therapy involving many intervention components but nothing in-between..." Low-threshold assessments conducted by case managers was suggested to improve early detection of mental health issues amongst refugees.

Another safety matter is accurate diagnosis and treatment. Accounts by participants (KI; SR non-users) reveal that somatisation has led to Syrians with mental health needs being incorrectly diagnosed and treated. A key informant believed professionals lack awareness of psychological issues as these are often not discussed in consultations with Syrian refugees. Even if the correct diagnosis is made, as explained by a provider, health workers may be uncertain what treatment to give as some professionals believe that treatment through interpreters may not be effective. This same provider outlined that the 'interpreter setting' is often ineffective because multiple people (i.e. therapist and interpreter) are insufficiently trained.

The availability and skills of interpreters were commonly addressed by interviewees (KI; PR) as critical component influencing the quality of MHPSS care. A key informant viewed interpreters as either a "barrier or bridge"; with the quality of the care being dependent upon how clearly interpreters can translate psychological suffering. One provider recalled a scenario in which Syrians took their children to the consultation for translation; this may be sufficient if the patient has physical symptoms only but was not regarded as sufficient when it comes to the discussion of psychological problems. A 2004 survey amongst healthcare providers in Switzerland showed that for Arabic speaking patients the most

commonly used strategy was using professional interpreters (31%), followed by patient's relatives/friends (24%), untrained volunteers (17%), and bilingual employees (7%) (Bischoff and Hudelson, 2010).

Besides the accessibility and skills of interpreters, quality of MHPSS care depends on the competencies of health practitioners. With regards to safety and appropriateness of treatment, a provider spoke about the challenge of communicating the side effects of antidepressants to Syrian patients. Additionally, a key informant believed that psychiatrists (due to language barriers) may want to prescribe medication more quickly (instead of prescribing talking therapy). In terms of culturally appropriate care, a provider positively perceived that family doctors are becoming increasingly aware about the mental health needs of Syrian patients and are gaining confidence in working with interpreters. However, one provider believed that it may be difficult for some providers to empathise with Syrian refugees due to linguistic and cultural differences.

Several participants (PR; KI) commented on the long waiting time to receive outpatient treatment in the clinics for victims of war and torture. A key informant indicated that the trauma unit at the University Hospital Zurich has a three-year waiting period. This finding needs to be validated by additional interviews. National statistics on waiting times in health care do not seem to gather data on mental health care and/or refugees in Switzerland.

Although participants raised various quality and safety concerns, several (KI; PR) perceived the quality of specialist MHPSS treatment as good.

4.6.5 Mental health outcomes

15.6% of asylum seekes and refugees from the Middle East (which included 25.2% people from Syria) presented with psychiatric symptoms at an emergency department in Switzerland over a period of 3 years. Patients from Syria were significantly younger and were more likely to present symptoms of PTSD. 24.0% of patients had psychiatric comorbidities (Pfortmueller, Schwetlick et al. 2016).

Mental health prevalence rates among refugees and asylum seekers in Switzerland differ according to the sample and location from which participants were recruited from. Studies report prevalence rates among asylum seekers and/or refugees in Switzerland (not specific to Syrians) to vary from 65-31% for depression, 54-23% for PTSD (Heeren, Mueller et al. 2012, Saraga, Clément et al. 2012, Premand, Baeriswyl-Cottin et al. 2013, Heeren, Wittmann et al. 2014), and 84-40% for anxiety disorders (Saraga, Clément et al. 2012, Heeren, Wittmann et al. 2014).

4.6.6 Discussion

This narrative report summarizes initial data on the responsiveness of the Swiss health system to the MHPSS needs of Syrian refugees. Our rapid appraisal was based on available statistics and literature, but also on a few qualitative interviews collected during the cultural adaptation phase in our partner country. Additional primary research is needed to further investigate the perceived barriers and facilitators of accessing mental health care among Syrian refugees who are using MHPSS care in Switzerland.

The current accounts highlight that Syrian refugees seem to have adequate treatment options in Switzerland, however, might not seek treatment themselves. Acceptability of care has been mentioned as one of the main obstacles for Syrian refugees hampering access to health care in Switzerland. Distrust in the system and in health care providers have emerged as key themes which calls for the need to educate Syrian refugees about the mental health care system and treatment options to decrease mistrust. Cultural awareness training for Swiss health care providers seems to be equally important. Initial accounts indicate that interpreters are key to the successful delivery of the

psychotherapeutic session and need to build bridges between the patient and the therapist; therefore, it is imperative that interpreters are trained to translate psychotherapeutic content - this may require a different skill set which not all translators may have. Syrian refugees might be more drawn to PM+ (as compared to other treatment options in Switzerland) since the programme of care is delivered by lay health care providers (Syrian Refugees themselves) for whom acceptability has been determined during the cultural adaptation phase. However, distrust of Syrian refugees in the Swiss health care system may remain and might need to be addressed during the implementation of PM+. Awareness raising and education on mental health among Syrian refugees may need to be strengthened to ensure treatment demand during the later scale up phase. To increase contact coverage in the community and reach of the intervention, PM+ may need to be supplement with a demand seeking intervention once effectiveness has been proven in the RCTs.

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4.7 The Netherlands

Data presented in this section is based on a besk-based review (existing literature). The final annex for the Netherlands (containing key data from the literature) is available upon request, and will be made available on the STRENGHTS website.

In addition, secondary data was complemented by analysis of semi-structured interviews with key informants (n=11) and MHPSS providers (n=10). Additionally, summaries of individual interviews (n=10) and four focus groups (1 all male; 3 mixed; 14 individuals) with Syrian refugees *not* using MHPSS (*SR non-user*) were included. Data was collected between May and August 2017. A waiver for these interviews was obtained by the VU Medical Center Medical Ethics Committee (submitted in the Netherlands by VUA, 20 April 2017).

4.7.1 Wider environment and policies

From April 2011 to June 2017, 33,897 Syrians sought asylum in the Netherlands, which is 3.5% of the total Syrian Asylum Applications in Europe (UNHCR 2017). In 2016, 27,971 Syrian nationals were given a residence permit (61.3% male; 38.7% female; 36.1% below 18 years of age) (CBS 2017). Refugees whose temporary permit expires (after five years) can be given a permanent one if they still require protection and have successfully completed the Dutch integration exam (Government of the Netherlands 2017).

Key informants interviewed for this study explained that Syrians are usually given refugee status within six months, although it may take up to two years before they are provided with a house. The speed of settlement depends, according to a policy maker, on family size; Syrians with 2-3 children are most easily placed as Dutch houses commonly accommodate 4-5 people.They may be moved from the time of arrival in the Netherlands to settlement in a municipality.

4.7.2 Health statistics in host population

4.8% of the general population were estimated to have a depressive and 7.3% an anxiety disorder (Institute for Health Metrics and Evaluation 2016). The anxiety figure is above the average rate for high-income countries (i.e. 4.8% depressive; 5.6% anxiety) (Institute for Health Metrics and Evaluation 2016). 1.3% of deaths within the Dutch population are attributed to self-harm in 2015 and 0.42% of all deaths were estimated to have been caused by mental and substance use disorders (Institute for Health Metrics and Evaluation 2016).

4.7.3 Mental health system inputs

4.7.3.1 Leadership and governance

The Netherlands has a mental health policy and plan (WHO 2011) which was considered fully implemented by the WHO Atlas in 2014 (WHO 2014). Dedicated mental health legislation exists and legal provisions for mental health are covered by other laws such as the Health Insurance Act (WHO 2011, Kroneman, Boerma et al. 2016). As for migration integration policies, the country scored just ‘slightly favourable’ overall and ‘halfway favourable’ for health (MIPEX 2015).

While governance of health services for refugees is organised at council level, it is arranged nationally for asylum seekers. The Centraal Orgaan opvang Asielzoekers [Central Agency for the Reception of Asylum Seekers] (COA) is responsible for overseeing shelter, security, food, language courses, and health of all asylum seekers in the Netherlands. For curative health, the COA works closely together

with the contracted insurer. By law the insurer changes every four years, which is Arts & Zorg [Dokter & Care] from 1 January 2018. Some interviewees were concerned that this regular change might mean losing health providers with culturally relevant knowledge and experience. For public health, the COA cooperates with the GGD-GHOR Nederlands, Gemeentelijke Gezondheids Dienst - Geneeskundige Hulpverleningsorganisatie in de Regio [Community Health Services - Regional Medical Emergency Preparedness and Planning] and Centrum Jeugd en Gezin [Centre for Youth and Family] (CJZ). The latter is responsible for preventative health of minors across the country.

4.7.3.2 Financing and expenditure

In 2014, the Dutch Government spent 10.7% of its GDP on health (The World Bank 2017). Of the total expenditure on health, 10.7% was used for mental health in 2011, of which 59.2% went towards mental health hospitals (WHO 2011). The Dutch mental health system is financed through various means: the Social support act (WMO) and Youth act (via the councils), Health insurance act (via health insurers), Justice (in criminal cases), and the Long-term care act (Wlz) (via care offices) (GGZ Nederland 2018).

Basic health insurance is mandatory for all citizens, including mental healthcare (Kroneman, Boerma et al. 2016). Asylum seekers are insured collectively under the Asylum Seekers Healthcare Scheme (RZA) and are entitled to nearly all the care, including mental health, provided under the standard package and the Wlz (Government of the Netherlands 2017). Once refugees receive refugee status and are settled into a council, they need to start paying a monthly insurance premium and up to €385 per year of 'excess' health care costs (out of pocket) (including prescribed medicines and tests, excluding GP consultations and care for children under age 18) (Kroneman, Boerma et al. 2016). Citizens, including refugees, with a low-income can apply for care allowance to help pay for health insurance, although this process is, according to a key informant, complicated.

Interpreters are covered by the insurance for asylum seekers, however, this is not the case for refugees. Due to a policy change in 2012, health care providers are unable to be compensated for the costs of using professional interpreters. Another policy change was implemented in May 2017, allowing GPs to claim for interpreter costs for care provided to recognised refugees. However, claims can only be done for a duration of six months which was considered insufficient by interviewees (PR;KI;SR non user) (as it usually takes longer than six months for refugees to sufficiently master Dutch).

4.7.3.3 Facilities and services

In 2011, there were 1.19 mental health outpatient, 260.1 day-treatment, and 0.12 community residential facilities per 100,000 population (WHO 2011). Mild to moderate mental disorders are usually treated in basic ambulatory care settings, such as GP offices (Mossialos, Wenzl et al. 2016). More severe and complicated cases are referred by GPs to specialist mental care providers and/or institutions, also called 'GGZ-instellingen' [Mental Health Care institutions], which provide care for all people of all ages (Mossialos, Wenzl et al. 2016, GGZ Nederland 2018). Specialised institutions mentioned in interviews with MHPSS providers are: Centre'45[3] and i-Psy [4].

A variety of psychosocial services are provided in the publicly funded sector, including cognitive and behavioural services, counselling, family and trauma therapy. Additionally, two user organisations for mental health are present at the national level (Government of the Netherlands 2017) and a selection

[3] National centre for specialist diagnostics and treatment of people with complex psycho-traumatic complaints. It is a partner of Arq, which is a psychotrauma expertgroup (Centrum'45 2018).
[4] Specialist in intercultural psychiatry. Treats and supports people of all ages, socio-cultural backgrounds, and psychological issues (i-Psy 2018).

of social support and prevention programmes are available to asylum seekers and refugees, mostly in the NGO sector (Van Schayk and Vloeberghs 2011, Rode Kruis 2017, Vluchtelingenwerk Nederland 2017). Mind-Spring[5] (psycho-education) and Mind Fit[6] (integration) are peer-guided group programmes commonly mentioned by study participants as well as voluntary support services by VluchtelingenWerk [RefugeeWork][7], and culturally appropriate care by Sensacare[8] (Kieft et al, 2008). The types of services being offered locally differ across the country since councils decide how they spend their budget and since there are 380 councils in the Netherlands (CBS 2018).

4.7.3.4 Mental health workforce

The Netherlands have a high number of psychiatrists working in the country (20.2 per 100,000 population vs. 7 per 100,000 population for the regional average) and psychologists (90.76 vs. 2.7 regional average) but a low number of nurses working in mental health (2.87 vs. 24.1 regional average) (WHO 2014, WHO 2014). An estimated 11% of all doctors work in mental healthcare (Van der Velden and Batenburg 2014). Larger GP practices are generally supported by a mental health care worker (PO-GGZ) or social-psychiatric nurse (SPV) who are able to diagnose, offer basic treatment, and make referrals in consultation with the GP, although exact numbers of these types of providers are unavailable.

From the literature it is unclear to what extent basic mental health care and cultural competency is included in the training of primary health care workers. However, an interviewee (PR) perceived that this was likely to be insufficient. Another provider commented that additional multi-cultural courses are being made available for healthcare workers.

Participants explained that refugees are generally assigned a paid or voluntary worker for practical support (e.g. provision of social, financial, justice support). These are client managers from Service Work and Income (DWI) In the council of Amsterdam and the council of Rotterdam often works with peers from the Foundation New Home Rotterdam (SNTR). Other councils appoint volunteers from RefugeeWork – a network of 13,500 trained volunteers working in all asylum centres and 300 councils across the country (Vluchtelingenwerk Nederland 2018). Interviewees outlined that these support workers play a role in the detection and referral of clients with possible psychological problems.

4.7.3.5 Information and research

Sources collecting information on mental health care at the national level do not seem to disaggregate data for refugees (Government of the Netherlands 2017). NGOs involved in livelihood and provision of social support for asylum seekers and refugees, do not consistently publish data on their activities on their websites (except for the Dutch Refugee Council). Two knowledge centres, Pharos and Arq, were commonly referred to by key informants. Both centres are active in gathering and distributing information on refugee' (mental) health.

[5] Psychoeducation for groups of adult and junior refugees and asylum seekers by trained peers (Mind-Spring 2018). Selective prevention, overseen by a GGZ-provider. Offered in asylum centres and can be made available to refugees outside of the centres. Within the asylum centres this programme is implemented and funded by COA. In the councils, it is implemented by Arq, on request by Vluchtelingenwerk, and funded by either the council or via another fund.

[6] Support and education for groups of refugees by trained peers (similar language/cultural background). Focuses on how to deal with differences in raising children in the Netherlands and country of origin, handling of psychological symptoms, and integration and participation (Vluchtelingenwerk Nederland 2016).

[7] Regionally organised voluntary organisation that informs and supports asylum seekers and refugees in various ways, including request for family reunion, language and job coaching, provides information about asylum procedure, offers practical help (support in arranging (health) insurance, financial support, subscribe to GP practice etc.) (Vluchtelingenwerk Nederland 2018).

[8] Specialist in provision of care, including mental health, to clients that are not from the Netherlands (zorg 2018).

4.7.3.6 Psychotherapeutic medicines

The country does not have an essential drug list (WHO 2017). Primary care providers prescribe drugs to treat common mental health disorders.

4.7.4 Process outcomes and responsiveness

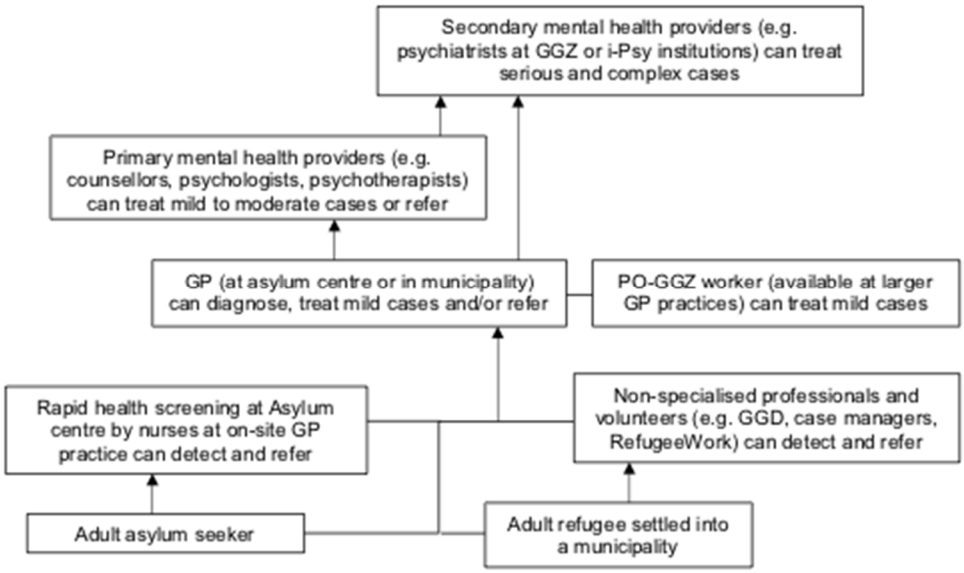
4.7.4.1 Care pathway

The routes followed by adult Syrian patients from their first contact with the Dutch health system until they receive professional MHPSS care is shown in figure 5 below. Adult asylum seekers typically receive a medical screening at the GP practice that is linked to the asylum centre they are residing at. A key informant mentioned that this initial screening does not include psychological inquiries. Primary findings indicate that early detection and referral also happens through MindSpring volunteers, case managers, RefugeeWork volunteers, and GGD workers. Self-referral is also possible. Asylum seekers are assigned to a GP practice at the Asylum centre, while refugees in the community can choose their own GP.

Syrian refugees follow a similar route as Dutch nationals through the health system. The GP diagnoses a patient and, if needed, treats or refers. GPs are responsible for treating those with milder forms of mental illness (Rijksoverheid 2018). A PO-GGZ worker (often available at larger GP practices) may also support a patient, but the GP retains ultimate responsibility (Rijksoverheid 2018). Those with mild to moderate mental illness can be referred to other providers (e.g. counsellors, psychologists) and those with more serious problems to secondary mental health services. People suffering from severe and complex mental disorders are generally admitted to a mental health care institution (Rijksoverheid 2018, Rijksoverheid 2018).

Providers highlighted that referral is possible at the community level via MindSpring and case managers. Community level workers, however, are generally not mental health specialists, meaning it is difficult to ascertain whether they have sufficient skills to ensure early detection and referral. A provider at an asylum centre felt that referral could be made easier at the centre, particularly for those with suicidal tendencies. Guidance, being developed by Pharos, with the aim to inform volunteers and professionals about referral pathways for refugees with mental health needs (KI) may enhance referral.

Figure 5: Typical routes followed by adult asylum seekers and refugees with mental health needs in the public health system in the Netherlands.



Underage asylum seekers commonly undergo a full physical examination at the Asylum centre by a CJG' doctor or nurse within six weeks of arrival. Once a child is settled into the municipality, the local CJG will take over health monitoring and prevention from the CJG at the centre. Like adults, Syrian minors can register with the GP of their choice once settled. The GP and other medical professionals such as paediatricians can refer a child with psychological needs to more specialised paediatric mental health services (GGZ-youth) (Rijksoverheid 2018).

4.7.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas 1981) of MHPSS.

Availability:

Several providers interviewed for this study were of the opinion that ample resources were available to provide care for refugees. Selected key informants were of the opinion that mental health of asylum seekers and refugees receives adequate attention in asylum centres and local councils. The high coverage of consultation services for refugee children (PR) suggests these services are appropriate too. A few other participants though, raised availability concerns.

A number of key informants and providers highlighted a lack of culturally appropriate MHPSS care and workforce. Additionally, the current workforce was perceived limited in capacity: an MHPSS provider complained that the PO-GGZ worker part of their primary care practice only worked for one day a week. Another (PR) explained that it is sometimes difficult to have the right amount of care available due to fluctuating numbers of asylum seekers.

(Geographic) Accessibility:

A few providers and key informants commented that travel costs, time, and logistics may be a barrier for Syrian refugees to access MHPSS services. Similar results were found amongst health professionals in the literature (Van Berkum, Smulders et al. 2016). A provider in our study explained that refugees generally receive social benefits and have limited financial means. Moving house, (which some refugees have to undergo regularly) could also lead to drop-out during treatment (KI). Several

providers were concerned about the accessibility of mental health services for Syrians residing in rural areas, where less (culturally appropriate) services are available. In a focus group, Syrian refugees discussed that women in their culture are not allowed to travel or attend appointments without their husbands. This suggests that physical access to services may be particularly constrained for women. Geographic barriers are less relevant for asylum seekers, as key informants explained that most health services for this group are available at the asylum centres.

Accommodation:
A refugee (SR non-user) highlighted that Refugee Work was only open one day a week for two hours which limits accommodation. The concept of accomodation needs to be explored further.

Affordability:
Several barriers to affordability of MHPSS were raised by study participants. Key informants believed that Syrian refugees may experience barriers in seeking MHPSS due to the need to pay for excess services (i.e. 'own risk'), which is in line with views from health professionals (reported in other studies) (Van Berkum, Smulders et al. 2016). This 'own risk' applies to settled refugees only, not asylum seekers. A participant (KI) explained that refugees can be uncertain about what is covered by health insurance, and what isn't. Out-of-pocket health costs, according to a health provider, can also be a barrier for referral to specialised mental health services.

'Health insurance' may be a foreign concept to Syrian refugees (KI). Other key informants felt this concept is difficult to explain to a refugee, especially the 'own risk' component. Another informant highlighted that while refugees on social welfare can get the majority of their 'own risk' costs refunded, this reimbursement process is complicated.

Financial barriers were also raised concerning professional interpreter services. While these services are financially covered for asylum seekers (Asylum Seekers Healthcare Scheme (RZA)), it is more complicated for refugees. The health insurance of settled refugees does not cover interpreter services. While primary care providers can be reimbursed for using professionals interpreters in the first six months after a refugee is settled, study participants felt this timeframe to be unrealistic as it usually takes longer for Syrians to master the Dutch language.

Acceptability:
The most commonly mentioned barrier in this study was acceptability. Participants explained that stigma is an important reason why Syrian refugees refuse, or delay mental health care. Syrian non-users expressed a fear of being labelled as 'crazy'. While seeking professional support for mental health issues is becoming more socially acceptable amongst Syrians, particularly for young and more highly educated, most Syrians prefer to keep these issues to themselves or within their families. A few Syrian non-users described that Syrians worry that their psychological complaints are reported in their 'file' and that this may negatively affect their citizenship status, child custody, and/or work opportunities. Additionally, some Syrians believed that psychological treatment will not be beneficial to them. This issue of shame and taboo surrounding mental health was confirmed by a previous study amongst Syrian refugees (Van Berkum, Smulders et al. 2016).

Participants (PR;KI;SR non-user) perceived that Syrians regularly delay seeking psychological support as they prioritise other life issues like gaining citizenship and learning Dutch. Findings also suggest that Syrians who *do* seek support may not always receive appropriate treatment. Interviewees (PR;KI) mentioned that Syrian refugees commonly express their psychological needs in terms of physical complaints (e.g. headache, fatigue). Healthcare workers, according to several interviewees (PR;KI) are insufficiently trained to recognise that mental health needs may underlie somatic symptoms.

Participants outlined that this may be particularly true for providers based in more rural areas, as they are less exposed to patients from other cultures than providers based in cities, meaning their cultural knowledge and experience is generally limited.

Besides cultural and stigma-associated barriers, language was regarded as key obstacle for Syrians to seek support and to receive appropriate MHPSS care in the Netherlands (PR; KI; SR non user). Both Syrian refugees and health providers which were interviewed experienced communication problems. Refugees found it difficult to clearly express their mental health complaints to professionals in another language or through an interpreter. Likewise, providers perceived it challenging to fully comprehend their patients' psychological complaints, even if interpreter services were used.

Language was one of the most common challenges raised by Syrian non-users in this study. Previous research amongst Syrian refugees revealed similar language and knowledge barriers. Mulders and Tuk (2016) found that education about the health system for Syrians varied between municipalities in the Netherlands. Families interviewed in their study who were insufficiently informed about the health system struggled to seek and access care. Their findings showed a lack of understanding amongst refugees about health insurance, and language challenged communication with health professionals (Mulders and Tuk 2016).

Several initiatives are available to overcome some of these acceptability issues, as explained by key informants and providers. For example, Mind-Spring offers psycho-education to refugees (e.g. help refugees to understand how their psychological state may express itself somatically), and Refugeework informs refugees about the national health system, including the difference between public health and regular healthcare, and the gatekeeper role of the GP. Another initiative that aims to increase the knowledge of Syrian refugees about the Dutch health system is a website called 'Gezond in Nederland' [Healthy in the Netherlands]. This website contains information in Arabic about different health topics (e.g. health insurance, GP, medicines, children) and is linked to a Facebook page (GGD and Pharos 2018).

Participants described areas for further improvement of MHPSS care. Interviewees suggested to have "good interpreters who are being reimbursed…and ideally Syrian Arabic speaking care providers" (PR), and to employ primary and specialist care providers who understand mental health issues amongst Syrians (PR), and are knowledgeable about the Syrian culture (PR). Employing Syrian mental health providers was considered as good option, however, according to interviewees (KI;PR) their qualifications are usually not recognised in the Netherlands. Additionally, Syrians in focus groups perceived that while a Syrian provider may be more acceptable in terms of language and culture, some Syrians may distrust a provider from their native country. The ability of a mental health provider to build trust with his/her patient seemed to be important.

4.7.4.3 Quality and safety

Long waiting times in mental health care was the most frequently mentioned quality concern. While interviewees (PR;KI) were unaware how long a Syrian with psychological needs exactly had to wait in order to start specialist treatment, estimates ranged from zero to seven months. Several providers and key informants found current waiting times unacceptable. Waiting times were regarded particularly problematic for larger specialist intercultural services like i-Psy (PR;KI). According to a provider, smaller culturally sensitive centres have shorter waiting times but are less well-known than the larger ones. Key informants explained that providers commonly refer refugees with mental health needs to i-Psy as its facilities, unlike the regular GGZ institutions, are known to employ providers from different cultural backgrounds and employ staff with wide-spread language abilities. Some informants highlighted that regular GGZ-institutions are less willing to accept patients with refugee status as they

cannot get reimbursed for using interpreter services. All of this has led to specialist intercultural psychiatry services like i-Psy being overburdened and having long waiting times.

While long-waitng times were perceived to be a major concern, participants felt that emergency cases can be immediately referred and treated. This is confirmed by regional statistics on waiting times in mental healthcare (national statistics are unavailable). For example, in Westelijk Noord Brabant waiting times vary from none (in crisis situations) to 14 weeks (for adult FACT care) for a first therapeutic session. Additionally, new clients wait 4-23 weeks to start treatment (GGZ Westelijk Noord Brabant 2017). Currently, efforts are made to reduce waiting times in mental health care across the country (GGZ Nederland 2017).

Another quality issue raised by participants (PR;KI) was continuity of care. The fact that many refugees are forced to move between different locations before being settled was perceived to challenge treatment continuity. A key informant explained that it is often difficult to find a new culturally appropriate provider for a Syrian patient who moved into a new area and then for this patient and provider to build up trust.

4.7.1 Mental health outcomes

Authors of a knowledge synthesis about the health of newly arrived refugees in the Netherlands concluded that there are "few to no relevant numbers about about the mental health condition of the current larger groups of refugees from Syria and Eritrea" (p40) (Haker, Van den Muijsenbergh et al. 2016). Based on medical intakes from the Health centre for Asylumseekers in 2013, Syrian refugees seem to present with fewer mental health issues than refugees of other nationalities. Exact prevalence data does not exist, however, Ikram and Stronks (2016) estimate that 13-25% of the refugees resettled in high-income countries suffer from PTSD.

4.7.2 Discussion

Initial findings indicate that acceptability barriers are key for Syrian refugees in the Netherlands, and that these hinder help-seeking. Further interviews need to be conducted to supplement initial results, especially from the perspective of Syrian health care users. Trial participants for PM+ will be recruited from i-Psy (who are waiting to receive specialist care). This will reduce their waiting time, and will likely reduce the high workload of i-Psy providers which was reported in this study. Results from the literature confirm findings of the cultural adaptation phase and indicate that PM+ providers will likely be acceptable to patients. This will help overcome the lack of culturally-appropriate MHPSS providers in the country which was a commonly reported barrier in this rapid appraisal.

However, findings also suggest that some Syrian patients may distrust providers from their own country, which could be an obstacle for accepting PM+. Trust-building and being an emphathetic treatment provider will therefore be an important selection criteria for PM+ providers.

Another implication of our findings concerns the affordability of PM+ which needs to be considered for scale up. Integration of PM+ into the public health system would require for treatment to be covered by health insurers in order to be financially viable. Insurance companies, however, do not commonly cover services provided by those who are not professionally registered. Another option is for PM+ to be offered outside the public health system. This means that alternative funding may need to be sought (e.g. (inter)national donors, local municipalities). The cost-effectiveness and financial sustainability of scaling up PM+ will therefore be critical. Geographic accessibility of PM+ needs to be

considered during scale up as well. If PM+ is provided in i-Psy centres only (which are based in larger cities in the Netherlands (mainly in the West)), it will be less accessible to Syrians residing in other parts of the country.

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4.8 Turkey

Data presented in this section is based on a besk-based review (existing literature). The final annex for Turkey (containing key data from the literature) is available upon request, and will be made available on the STRENGHTS website.

In addition, secondary data was complemented by analysis of individual interviews with MHPSS providers (n=7; 3 Syrian providers, 4 Turkish providers) and key informants (KI) (n=7) which included local managers of refugee projects in Turkey. Ethics approval for these interviews was provided by the Istanbul Sehir University's (ISU) Research Ethics Committee (submitted in Turkey by ISU, dd. April 12, 2017) and the Immigration Authority of Turkey (dd. March 29, 2017). Data collection took place in May and June 2017.

4.8.1 Wider environment and policies

There are currently 3'584'179 Syrian refugees registered in Turkey (54.2% male, 45.8% female, and 45.6% below 18 years of age) (UNHCR, 2018). A key informant with a legal background explained that Syrian asylum seekers usually receive temporary protection status within two months of arrival. This only applies to Syrians entering from the Turkish-Syrian border; those from "third countries" are not allowed to enter the country. Protection status gives Syrian refugees the same rights as Turkish citizens, including access to education, work, and healthcare. A Temporary Protection Identification is necessary for receiving services, otherwise refugees can only access health care in emergency situations (IMC, 2017). These accounts have been confirmed by the literature (IMC, 2017).

Around 300,000 Syrian refugees live in camps located in Syrian border cities (Sanliurfa, Gaziantep, Kilis, Hatay, Kahramanmaras, Adiyaman, Adana, and Osmaniye). The majority of refugees are living outside camps, who are spread throughout Turkey from the south through central and western cities including Istanbul, Ankara, and Izmir (Doganay & Demiraslan, 2016).

Life in Turkey is expensive, therefore, there is a great pressure for Syrian refugees to find employment. Interviewees (one Syrian MHPSS provider and other KI's) spoke about Syrians experiencing difficulties with work (e.g. unemployment, no fair wage, long hours, jobs not in their areas of expertise/below their intellectual ability, child labour, different work culture) and education (i.e. children usually not attending school because of child labour). The majority of Syrians do not speak Turkish which challenges their ability to obtain work and hampers integration into Turkish society. In 2016, 13,298 work permits were issued to Syrian refugees; therefore, the majority of Syrian refugees are believed to be working illegally (Anadolu Agency, 2017; SGS, 2017).

4.8.2 Health statistics in host population

Life expectancy in Turkey is 72 and 79 years for men and women respectively (World Bank, 2017). Adult mortality rate was 105 per 1,000 population and maternal mortality 16 per 100,000 live births in 2015 (WHO, 2017a).

Estimates from 2017 show that around 4.4 % of the general population suffer from depression, and 4.0% from anxiety disorders (WHO, 2017b). The total number of suicides was 3,064 in 2016; 76.1% of people who committed suicide were males and 23.9% of them were females (Turkish Statistical Institute, 2017).

4.8.3 Mental health system inputs

4.8.3.1 Leadership and governance

Mental health services in Turkey are overseen by the Turkish Government's Ministry of Health (MoH) (WHO, 2014). Health services are organized from a central governmental level, down to each consecutive level of government. There are 81 provinces in Turkey, and in each province health services are overseen by the Public Health Director and a Deputy Public Health Director. Distinct types of health services are broken down into twenty-one separate units, one of which is the Mental Health Programme Unit (IMC, 2017). A national mental health policy is in place which was implemented in 2006 (Munir et al, 2006). There are several laws protecting and ensuring the rights of people with mental illness which also includes payment of a disability pension in times of need. A national mental health action plan was developed in 2011 (WHO, 2011). However, recent evidence shows that progress is slow and that the national mental health policy is only partially implemented; public health professionals voiced concerns regarding the integration of mental health care into the community and were criticising the limited budget which is available for mental health (Soygür, 2016). One of our interviewees also raised concerns regarding the cooperation between different public institutions (Ministry of Health, Ministry of Education, etc) and highlighted the need for further policy alignment with regards to mental health. The Migration Integration Policy Index suggests that for Turkey the country's overall score is 'slightly unfavourable' (MIPEX, 2015). This indicates that policies in Turkey do not promote equal opportunities and provide a welcoming culture for migrants.

4.8.3.2 Financing and expenditure

In 2014, the Turkish Government spent 5.4% of its GDP on health (World Bank, 2017). There is no information how much of the total expenditure is spent on mental health (WHO, 2011). Refugees who have registered and received their Temporary Protection Identification are able to access secondary and tertiary health services with a fee comparable to one paid by Turks (IMC, 2017).

4.8.3.3 Mental health workforce

1.51 psychiatrists per 100'000 population are working in Turkey (WHO, 2018), and there are 1.43 psychologists and 0.76 social workers per 100'000 population respectively (WHO, 2011). Mental health service providers are usually paid by a fixed salary (OECD, 2014; Soygür, 2016). The majority of primary health care doctors and nurses have not received official in-service training on mental health within the last five years (WHO, 2011). One provider interviewed for this study reported that Syrian doctors are allowed to work in the Turkish health system. However, a Syrian MHPSS provider interviewed in this study reported that the Turkish government does not recognise a medical specialist degree unless an additional exam in Turkey has been completed. Without this exam Syrian mental health specialists are allowed to work as family practitioners only. These practitioners are allowed to diagnose and refer patients to specialist treatment but can not treat patients themselves. To date, the Turkish Ministry of Health has hired over 400 trained Syrian health workers, physicians and nurses to serve in more than 80 refugee clinics throughout Turkey (WHO, 2017c).

4.8.3.4 Facilities and services

There is an effort to integrate mental health services and treatment in primary health care but this is hampered by lacking financial resources to support this endeavour (Soygür, 2016). According to the National Mental Health Plan, in 2011 the Ministry of Health (MoH) was largely responsible for mental health service provision in Turkey. 27.2% of psychiatric beds in Turkey were within one of the MoH's general hospitals, 53.5% beds were within a MoH mental health and disorders hospital (Altaş et al., 2011; IMC, 2017). University and general hospitals had 13.1% of psychiatric beds in Turkey, and the private sector covered 6.2% (Altaş et al., 2011). According to data presented in the National Mental

Health Policy (2006), the majority of adults with mental disorders are referred to psychiatrists (39.2%), other mental health specialists (33.1%), and general practitioners (20.7%) (Munir et al, 2006). A smaller category seek traditional services, with 3.6% seeking care from spiritual leaders and 3.4% reportedly seeking services from a category labelled as "other" (IMC, 2017). The rate of admission into psychiatric hospitals was 70.59 per 100,000 population (World Health Atlas, 2011).

Syrian refugees can access mental health care through the public funded health system but MHPSS is also provided by NGOs. Many different organizations have played a role in implementing MHPSS services for Syrian refugees in Turkey. They include the Union of Medical Care and Relief Organizations, International Medical Corps, the Turkish Ministry of Health, WHO, and UNHCR (IMC, 2017; WHO, 2017c; UOSSM, 2018).

4.8.3.5 Psychotherapeutic medicines

There is no essential list of drugs in the country (WHO, 2011). Prescription regulations authorize primary health care doctors to prescribe and/or continue prescription of psychotherapeutic medicines with restrictions (WHO, 2014).

4.8.4 Process outcomes and responsiveness

4.8.4.1 Care pathway

Providers which were interviewed indicated that the care pathways depend on the immigration status. Syrians who do not have temporary protection status typically access the health system by going to emergency care/acute care of a Turkish hospital (Key Informant/KI). This is where a patient gets diagnosed and if needed referred and treated. A comment by a key informant suggests that this route may be problematic because there is no medication follow-up or monitoring. As a result, it is preferable for Syrain to get their temporary protection status (KI)

Syrians with temporary protection status can get an appointment at primary care level and follow the same route as Turkish citizens thereafter (KI). Providers at community Mental Health Centers can diagnose and if required refer and treat patients (KI). Psychotropic medications are usually provided by psychiatrists and talking therapy by psychologists (KI).

4.8.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas 1981) of MHPPS.

Availability:
A Syrian MHPSS provider reported a lack of psychological support services for Syrian refugees. Another Syrian provider believed there were not enough doctors in the Turkish health system in general to address the needs of Syrian patients. Two Turkish providers, however, perceived the mental health workforce at their facilities as sufficient.

Key informants raised the need for more group psychotherapy and programmes for adolescents. Both Turkish key informants and MHPSS providers believed that it was necessary to increase the number of translators. Particularly female translators are in demand according to a Turkish provider.

(Geographic) Accessibility:
A key informant who was being interviewed felt it was difficult to reach out to Syrian refugees for different reasons. The KI reported that women are often not able to leave their houses because of

childcare, and men are often occupied with work. Another informant further highlighted that women may be unable to find or afford childcare and, therefore, were also unable to access healthcare. In addition, simply a lack of financial resources, even to cover indirect services costs such as transportation or medication deters some refugees from getting the care that they need (Hassan et al., 2015).

Accomodation:
The concept of accommodation needs to be explored further (in subsequent qualitative work to be conducted in 2018/2019 in Turkey).

Affordability:
Out-of-pocket costs for services provided at Turkish hospitals may be an obstacle for Syrians refugees to access care according to one of the Syrian providers which were interviewed. A Turkish MHPSS provider explained that psychologists commonly request for a certified translator to be present at the consultation and "fees are too high" for the majority of Syrian refugees.

Acceptability and help seeking:
Primary findings from interviewees indicate barriers regarding acceptability. Participants (KI; Turkish PR) reported a lack of knowledge and awareness on mental health and MHPSS within the Syrian community. This included limited knowledge about mental health symptoms and where to seek treatment, and limited understanding of what MHPSS treatment involves. As a consequence, Syrians often do not seek treatment.

Providers also experienced a reluctance among Syrians to see a doctor (Turkish PR) and to seek psychological help (Syrian PR); this was out of fear of being labelled as "crazy". Some Syrians, according to a Turkish provider, believe that those with mental health issues are "possessed by the Jinn". Participants also observed that Syrian refugees fear mistreatment by health professionals (Syrian PR; KI), and fear that treatment is not confidential (Turkish PR).

Acceptability issues have also been observed amongst Syrians who seek help. A Turkish provider observed that Syrian patients believe that treatment will result in a "quick solution" (by giving medicines instead of talking therapy). This means that providers need to manage patient's expectations during therapy. Additionally, a Syrian provider reported a lack of cultural sensitivity in some psycho-social activities, using an example of a project that made Syrian girls dance with boys.

Language barriers were most commonly raised by interviewees (KI; Turkish PR). Not speaking Turkish formed an obstacle for Syrians to integrate into Turkish society and also made it difficult for Syrians to "express themselves" when seeking MHPSS (Turkish PR). Participants commented that Syrian children are quicker to master a new language than the older generation. Illiteracy and low educational levels also limited Syrians learning another language and some did not feel it necessary to learn Turkish as "they have their own community" (KI). As a consequence, health professionals and Syrian patients are often required to work with translators during therapy.

A Turkish provider, however, preferred not to work with a translator for ethical reasons as this means involvement of a third person in the consultation process. This provider believed that translators are ineffective as spoken Arabic differs from its written form. For these reasons, the provider being interviewed refers patients to an Arabic speaking colleague instead of treating the Syrian patient him/herself. A key informant who did work with translators highlighted that Syrian women often request a female translator.

Participants (KI; Turkish PR) came up with several ways to overcome acceptability barriers. This included awareness raising and psycho-education among Syrians and community leaders as well as awareness raising and cultural sensitivity training amongst Turkish healthcare providers. Additional suggestions from key informants were that Syrians who benefitted from psychological services should "spread the word" and be involved in advocacy activities. They also requested to have a translator available at every hospital.

4.8.4.3 Quality and Safety

It remains unclear how long refugees generally wait to receive mental and psychosocial services. Quality and safety needs to be explored in additional qualitative research.

4.8.5 Mental health outcome

There are no population wide estimates on the prevalence of mental disorders among refugees in Turkey. Acarturk (2018) investigated the prevalence of probable posttraumatic stress disorder (PTSD) and depression among adult Syrians residing in a camp (N = 781) near the Syrian / Turkish border, and reported that a total of 83.4% (n = 608) of the sample was classified with probable PTSD, and a total of 37.4% (n = 261) with probable depression. In a cross-sectional study conducted in a tent city in Gaziantep, Turkey, Alpak reports that 118 (33.5%) Syrian refugees have been diagnosed with PTSD; 11 (9.3%) of these 118 participants had acute PTSD, 105 (89%) had chronic PTSD, and 2 (1.7%) had late-onset PTSD (Alpak, 2014).

4.8.6 Discussion

Findings of the rapid appraisal have been based on the literature and a limited number of qualitative interviews conducted in Turkey. Additional interviews need to be conducted to fully understand and assess the responsiveness of the health care system in Turkey to the mental health needs of Syrian refugees. Initial findings depict a situation in which services are made available for refugees however, access falls short because of poor acceptability and accommodation, and financial affordability issues (out of pocket payments, and other indirect costs such as transport which are needed to access services). It is important that issues around accomodation and acceptability are considered and adressed during the implementation of PM+. Another key point which became apparent was the lack of treatment demand among the Syrian population. Raising awareness and provision of information about PM+, its comonents and positive outcomes need to be an integral part during scale up. This also means that lay care providers need to be trained to manage patient's expectations during therapy.

There seems to be inequity in access to health care when it comes to the difference in temporary protection status of refugees. These different pathways of care need to be further investigated and outlined in the subsequent version of this narrative report.

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5. Next Steps

The next steps for WP2 in 2018/2019 up until the next reporting period in month 36 are the following:

- Decide with partners on the amount of qualitative interviews and FGDs to be conducted in partner countries (decision will be guided by existing data and country needs as summarized in this report)
- Obtain relevant ethics approval in partner countries to conduct additional qualitative interviews/FGDs
- Finalise country-specific topic guides for RA qualitative work
- Provide additional training on qualitative interviews for RA in partner countries (if needed/required by partners)
- Conduct qualitative work (semi-structured interviews/FGDs) in countries, and analyse qualitative data according to the conceptual framework as outlined in this report
- Synthesize all primary and secondary data by country, and draw up implications of the responsiveness of the mental health system, and for the implementation of PM+ in partner countries.
- Update the Rapid Appraisal report for Deliverable 2 (month 36)

6. Annexes

Annex 1: STRENGHTS Rapid Appraisal Tool For Health System Inputs

This annex presents the Rapid Appraisal (RA) Tool for mental health systems. It is used to collect information informing the responsiveness of mental health systems addressing the Mental Health and Psycho Social Support (MHPSS) needs for Syrian refugees residing in Turkey, Lebanon, Jordan, Egypt, Sweden, Germany, the Netherlands and Switzerland.

This tool focuses mainly on health system inputs and has two parts. Part 1 of the tool collects health system indicators in the (government-funded/publicly funded) general health care system while part 2 focuses on the parallel mental health system. We define a parallel mental health system as a health system or a service structure which provides essential mental health services for refugees or people in need. It may be operating independently from the general health system or may be linked with it. An example of a parallel health system might be a network of NGOs funded by donor aid or United Nations agency providing MHPSS services to refugees.

I.I. THE GENERAL MENTAL HEALTH SYSTEM

Section 1: General population - Socio-economic and health indicators

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
1.1 COUNTRY SOCIO-ECONOMIC INDICATORS		
1. GDP per capita (USD)		
2. Population density and growth (annual %)		
3. Unemployment (%)		
4. Adult literacy rate (%)		
5. Languages spoken (%)		
6. Religion practised in country (%)		
1.2 GENERAL HEALTH INDICATORS		
1.2.1 Main population in host country		
1. Life expectancy (male/female) (years)		
2. Adult mortality rate (total and male/female)		
3. Maternal mortality rate		
4. Infant mortality rate		
5. 5 main causes of death (rank)		
6. Death rate (and %) for people of all ages with mental and substance use disorders		
7. Prevalence rate (and %) of common mental disorders (i.e. depression, anxiety, PTSD)		
8. Suicide rate (and %) (i.e. death by self-harm)		
1.2.3 Contact Coverage		
Number of people with disorder (CMD) in contact with services / estimated prevalence		

Section 2: Health system inputs – Leadership and mental health governance

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
2.1 LEADERSHIP		
1. Government department/programme/unit in Ministry of Health working specifically on Mental Health (yes/no)		
2. Government department/ programme/unit in Ministry of Health working specifically on refugee health (yes/no)		
2.2 MENTAL HEALTH GOVERNANCE		
2.2.1 Mental health policy		
1. Availability of national mental health policy (yes/no) and year of implementation		
2. Last year of revision of national mental health policy (date)		
3. National mental health policy addresses special populations such as refugees (yes/no)		
4. Integration of protection of human rights in national mental health policy (yes/no)		
5. Degree of implementation of mental health policy (if it exists) (fully implemented, partially implemented, not implemented at all)		
2.2.2 Mental health legislation		
Degree of implementation of national mental health legislation (fully implemented, partially implemented, not implemented at all)		
2.2.3 Mental health action plan		
1. Mental health action plan in place (yes/no)		
2. National mental health action plan addresses: a. integration of treatment for mental disorders into primary health care (yes/no) b. suicide prevention (yes/no) c. mental health promotion (yes/no) d. needs of special populations such as refugees (yes/no)		

Formal collaborative programmes addressing the needs of people with mental health issues between: (i) the department/agency responsible for mental health and (ii) the department/agency responsible for: a. Primary health care/community health b. HIV/AIDS c. Reproductive health d. Child and adolescent health e. Substance abuse f. Child protection g. Education/Schools h. Employment i. Housing j. Welfare k. Criminal justice l. The elderly m. Migration n. Refugees (yes/no; specify)		
2.3. MIGRATION INTEGRATION GOVERNANCE		
1. Overall MIPEX score		
2. MIPEX score for health		

Section 3: Health system inputs – Health care financing

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
3.1 HEALTH CARE FINANCING IN THE PUBLICLY FUNDED HEALTH CARE SYSTEM		
3.1.1 Public sources		
1. Public source health expenditure as a proportion of GDP (%)		
2. Social security expenditure on health as a percentage of general government expenditure on health (%)		
3. Public source mental health expenditure as a proportion of total health expenditure		

4. Percentage of mental health expenditure towards mental hospitals (%)		
5. Funding specifically for refugees' mental health (yes/no and USD value if available)		
3.1.2 External non-governmental sources		
1. Total donor health spending, most recent year (USD, Gross Disbursements, Constant Prices)		
2. Total donor mental health spending, most recent year (USD)		
3.1.3 Social insurance		
1. Description of social protection system in country (e.g. public and/or private insurance) for the: a) General population b) Refugees		
2. Following covered by social insurance schemes: a) MHPSS services (yes/no) b) Psychotherapeutic medications (yes/no)		
3.1.3 Out of pocket costs		
1. Out-of-pocket expenditure as a percentage of total expenditure on health (%) (general population)		
2. Free psychotropic medication for refugees in the publicly funded health care system, i.e. without any out-of pocket payments (yes/no) If no, describe out of pocket payments for psychotropic medication which need to me made. If no, describe if any payments are retrospectively reimbursed		
3. Free MHPSS for refugees in the publicly funded health care system, i.e. without any out-of pocket payments (yes/no) If no, describe out of pocket payments for MHPSS services which need to me made. If no, describe if any payments are retrospectively reimbursed		

3.2. GOVERNMENT BENEFITS FOR PEOPLE WITH MENTAL DISORDERS		
1. The general population receive social welfare benefits because of disability due to mental disorders (yes/no) (specify social welfare benefits people with mental disorders receive, e.g. illness benefit, invalidity pension, disability allowance, etc)		
2. Refugees receive social welfare benefits because of disability due to mental disorders (yes/no) (specify social welfare benefits refugees with mental disorders receive, e.g. illness benefit, invalidity pension, disability allowance, etc)		
3.3 ENTITLEMENTS FOR REFUGEES		
3.3.1 Health system		
1. Refugees have the same rights and entitlements as national citizens to use the publicly funded health care system (yes/no; specify further if restrictions are in place)		
2. Refugees are entitled to use services provided by players outside the health sector ONLY e.g. NGOs, faith based organizations) (yes/no) (specify players involved in treatment/care provision)		
3.3.2 Other entitlements: employment and education		
1. Refugees are formally allowed to work in host country (specify minimum/maximum time; specify type of work/sector of work)		
2. Refugee children/adolescents (3-18 years) are entitled to go to school (yes/no) specify if regular school, or camp-based school (as applicable)		
3. Refugees (above 18 years) are entitled to attend higher education institutions (yes/no) (specify if institution for refugees only/in camp-settlements, or outside the camp-settlements (as applicable))		
4. Refugees who are health and medical personnel are allowed to work (yes/no) or volunteer (yes/no) in the publicly funded health system (specify place where they are allowed to work)		

Section 4: Health system inputs – Information and research

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
MENTAL HEALTH INFORMATION SYSTEM		
1. Mental health information system collecting data on mental health service delivery among refugees in general health system (national, district level) (yes/no)		
2. Mental health information system collects data on the epidemiology of mental disorders among refugees in general health system (national, district level) (yes/no)		

Section 5: Health system inputs – Mental health workforce

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
5.1 HUMAN RESOURCES IN ALL SECTORS		
5.1.1 Number of health professionals (including health professionals working in public, private and NGO sectors)		
1. Psychiatrists working in mental health (# per 100'000 population)		
1. Psychologists working in mental health (# per 100'000 population)		
2. Psychiatric nurses / nurses working in mental health (# per 100'000 population)		
3. Social workers working in mental health (# per 100'000 population)		
4. Primary care doctors working in the general health sector on mental health (# per 100'000 population)		
5.1.2 Provision of treatment		
Health care providers: Specify minimum qualifications/education/training for health care providers to provide psychosocial treatments/psychotherapy		
5.1.3 Remuneration		

1. Which payment mechanisms are used to pay primary care services in the publicly funded health service? a. Fixed Salaries for Primary Care Providers (Yes / No) b. Fee For Service (Yes / No) c. Capitation (Yes / No) d. User Charges (Yes / No) e. Other (please specify)		
2. Which payment mechanisms are used to pay for community delivered mental health services in the publicly funded health service? a. Fixed Salaries for Service Providers (Yes / No) b. Fee For Service (Yes / No) c. DRG payments (Yes / No) d. Capitation (Yes / No) e. User Charges (Yes / No) f. Other (please specify)		
5.1.4 Other		
1. Proportion of mental health professionals working in private vs public sector (%)		
2. Proportion of mental health professionals working in primary vs tertiary care (%)		
3. Proportion of mental health professionals working in rural vs urban areas (%)		
5.2. TRAINING		
1. Training of… • Primary health care doctors • Primary health care nurses • Community workers • Social workers Includes training in: a) psychological first aid and basic mental health care; b) protection of human rights; c) refugee needs (i.e. socio-cultural, past events). (yes/no)		

2. There is a refresher training for… • Primary health care doctors • Primary health care nurses • Community workers • Social workers On: a) psychosocial first aid, and basic mental health care; b) protection of human rights; c) refugee needs (i.e. socio-cultural, past events). (yes/no, specify after how many years refresher training is offered)		
5.3 SUPERVISION		
System of supervision: Social and community health care workers are regularly supervised by a mental health professional (yes/no)		

Section 6: Health system inputs – Facilities and services

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
6.1. FACILITIES IN THE PUBLICLY FUNDED SECTOR		
6.1.1 Outpatient care in the community		
1. Community facilities (# per 100'000 population)		
1. Beds/caseload* in community facilities (# per 100'000 population) *caseload that community facilities can manage		
6.1.2 Primary health care		
1. Mental health services and treatment is integrated in primary health care (yes/no; describe what services are integrated in primary health care)		
2. Primary health care doctors allowed to prescribe medication for mental disorders in PHC (allowed/not allowed, restricted e.g. PHC doctor can continue but not initiate prescription/only in emergencies/only certain medication; specify)		
6.1.3 Other platforms of care		

Treatment of mental disorders integrated into other platforms of care (e.g., HIV clinics, maternal health care clinics, NCD clinics, any other platform of care) (yes/no; specify which platform of care)		
6.2 SERVICES		
6.2.1 Psychosocial services in the publicly funded sector		
2. Cognitive and behavioural interventions available (yes/no)		
3. Counselling available (yes/no)		
4. Family therapy available (yes/no)		
5. Trauma therapy available (yes/no)		
6.2.2 User organisations and social support programmes		
1. Formal/institutionalised user organisations for mental health (yes/no) (# per 100'000 population)		
2. Programmes to activate social networks such as women's groups and youth clubs for refugees (yes/no)		
3. Social support programmes for marginalized or at risk groups such as refugees (yes/no)		
4. Community integration programmes for marginalized or at risk groups such as refugees (yes/no)		
6.2.3 NGOs		
1. Proportion of refugees with mental health needs using NGO vs. public sector health services (%)		
2. Types of care NGOs provide: e.g. clinical services, livelihood support, social support, social skills training, prevention (specify type of care)		
6.2.4 Prevention and Promotion		
1. School-based activities to promote mental health and to prevent mental disorders are implemented (yes/no; at national level, in specific regions/districts only) for the general population		
2. Information campaigns on supporting people with mental health and psychosocial problems are conducted among the general population (yes/no)		
3. Livelihood and other necessary supports are provided for refugees to enable participation in community activities/education (yes/no)		

4. Adult literacy courses offered for refugees (yes/no)		
5. Educational opportunities for young refugees (adolescents) are offered including vocational training (yes/no)		
6. Availability of programmes to activate social networks among refugees and the larger society (yes/no)		
6.3 WAITING TIME IN THE PUBLICLY FUNDED SECTOR		
Average waiting time for mental health outpatient treatment (yes/no waiting time; days)		

Section 7: Health system inputs – Psychotherapeutic medicines

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
PSYCHOTHERAPEUTIC MEDICINES		
1. Essential list of drugs available in country (yes/no)		
2. Psychotherapeutic medicines for anxiety and depression included in the essential list of drugs (yes/no)		

I.II. PARALLEL MENTAL HEALTH SYSTEMS FOR REFUGEES

In this section, we are collecting data on the parallel mental health system for **Syrian refugees** (including asylum seekers) which may be operating in the country. Indicators have been modified from the previous section to accommodate the different service structure of the parallel health system which may be in place. A parallel health system or service structure could for example be led by UN agencies (in collaboration with the country government) with support from NGOs, and focusing specifically on the needs of refugees. Therefore those are unlikely to be formalized as parallel systems and the nature and characteristics of them will vary considerably between the different study countries. Please also note that data collected in this section also refers to *registered* Syrian refugees unless otherwise specified.

Section 1: Refugee population - Socio-cultural and health indicators

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
1.1 SOCIO-CULTURAL INDICATORS OF SYRIAN REFUGEES IN HOST COUNTRY		
1.1.1 Host country		
1. Number of Syrian refugees in host country (% male/female; % below 18 years of age)		
2. Religions in Syria (%)		
3. Languages in Syria (%)		
4. Adult literacy rate in Syria (%)		
5. Unemployment amongst Syrian refugees in host country (%)		
6. Proportion of Syrian refugees living in camps in host country (%)		
1.1.2 STRENGTHS implementation site		
1. Number of Syrian refugees (male/female; % below 18 years of age)		
2. Religions amongst Syrian refugees (%)		
3. Languages amongst Syrian refugees (%)		
4. Proportion of Syrian refugees living in camps		
1.2 GENERAL HEALTH INDICATORS OF SYRIAN REFUGEE POPULATION IN HOST COUNTRY		

1. Prevalence of common mental disorders (depression, anxiety, PTSD)		
2. Suicide rate		
1.3 REGULATORY FRAMEWORK ON RESIDENCY STATUS FOR SYRIAN REFUGEES		
1. Legal definitions of: a) asylum seeker b) refugee c) other relevant status		
2. Border regulations for admission of Syrian refugees to host country		
3. Regulations to receive and renew legal residency for Syrian refugees (e.g. obtain UNHCR certificate, sponsorship of local citizen, other, combination)		
4. Average waiting time to receive (temporary) legal residency		
5. Duration residency permit is valid (months)		
6. Residency renewal fee (USD)		
7. Proportion of Syrian refugees without valid legal residency (%)		

Section 2: Health system inputs - Leadership and mental health governance

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
LEADERSHIP AND GOVERNANCE		
1. Services for parallel health system are implemented by "institution/organisation" *(specify* which institution(s)/organisation(s) implementing services)		
2. Services of parallel health system are overseen/governed and/or regulated by national government (yes/no)		

Section 3: Health system inputs - Health care financing and expenditure

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
HEALTH CARE FINANCING FOR PARALLEL REFUGEE HEALTH SYSTEM		
3.1 Sources of funding		
1. Indicate the principal sources of funding (e.g. international agencies, international community, World Bank and other loans, other donor aid, national or local government funding etc) for parallel mental health system		
2. Identifiable donor expenditure on mental health services in parallel system, most recent year (USD) (specify which donor)		
3. Donor mental health funding goes to medication, services, etc (*specify* what service/care donor funds in parallel mental health system)		
3.2 Out-of-pocket payments for medications and MHPSS services		
1. Free psychotropic medication for refugees in parallel system (yes/no) If yes, describe any conditions for receiving free psychotropic medication (documented refugees, asylum seekers) If no, describe out of pocket payments which need to be made and if any payments are retrospectively reimbursed		
2. Free MHPSS for refugees in parallel system (yes/no) If yes, describe any conditions for receiving free MHPSS (documented refugees, asylum seekers) If no, describe out of pocket payments which need to be made and if any payments are retrospectively reimbursed		

Section 4: Health system inputs - Information and research

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
MENTAL HEALTH INFORMATION SYSTEM		
4.1 Service delivery and epidemiology data		
1. Mental health information system collecting data on mental health service delivery among refugees in the parallel mental health system (national/district level) (yes/no)		
2. Mental health information system collects data on the epidemiology of mental disorders among refugees in the parallel mental health system (national/district level) (yes/no)		
4.2 Monitoring and Dissemination		
1. Health cluster/sectoral group to address health needs of refugees available (yes/no; specify organisation responsible for monitoring and evaluation (e.g. WHO/Ministry of Health))		
2. Regular assessments of the accessibility and quality of mental health care are conducted by lead agency/agencies of Health cluster/sectoral group on a national level (yes/no)		
3. Results and lessons from MHPSS' assessments, monitoring and evaluation activities are disseminated by international agencies or NGOs (yes/no) (specify where disseminated)		

Section 5: Health system inputs - Mental health workforce

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
5.1 HUMAN RESOURCES IN PARALLEL HEALTH SYSTEM		
5.1.1 Number of health professionals		
1. Psychologists working in parallel health system (# per 100'000 refugee population)		

2. Psychiatric nurses / nurses working in parallel health system (# per 100'000 refugee population)		
3. Social workers working in parallel health system (# per 100'000 refugee population)		
4. Primary care doctors working in parallel health system (# per 100'000 refugee population)		
5. Volunteers working in parallel health system providing social support (# per 100'000 refugee population)		
5.1.2 Provision of treatment		
Health care providers: Specify minimum qualifications/education/training for health care providers to provide psychosocial treatments/psychotherapy		
5.1.3 Remuneration		
Which payment mechanisms are used to pay providers in the parallel health services? a. Fixed Salaries for Service Providers (Yes / No) b. Fee For Service (Yes / No) c. Capitation (Yes / No) d. User Charges (Yes / No) e. No payment – provided by volunteers (Yes / No) f. Other (please specify)		
5.1.4 Other		
1. Health professionals working in the parallel system are employed by the national government (yes/no)		
2. Health professionals working in the parallel sector are allowed to work in general health system (yes/no)		
5.2 TRAINING		
1. Training of… • Primary health care doctors • Primary health care nurses • Community workers • Social workers Includes training in: a) psychological first aid and basic mental health care; b) protection of human rights;		

c) refugee needs (i.e. socio-cultural, past events). (yes/no)		
2. There is a refresher training for… • Primary health care doctors • Primary health care nurses • Community workers • Social workers On: a) psychosocial first aid, and basic mental health care; b) protection of human rights; c) refugee needs (i.e. socio-cultural, past events). (yes/no, specify after how many years refresher training is offered)		
5.3 SUPERVISION		
System of supervision: Social and community health care workers are regularly supervised by a mental health professional (yes/no)		

Section 6: Health system inputs - Facilities and services

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
6.1 SERVICES		
6.1.1 MHPSS		
1. Cognitive and behavioural interventions (yes/no)		
2. Counselling (yes/no)		
3. Family therapy (yes/no)		
4. Trauma therapy available (yes/no)		
6.1.2 Coverage and distribution		
Data exists on coverage of MHPSS services (4 W's: Who does what, where and when) (yes/no) If data on coverage is available, describe gaps of MHPSS service delivery (e.g. only concentrated in towns/certain geographical regions; focus on specific population groups like adolescents, etc).		
6.2 WAITING TIME		
Average waiting time for mental health outpatient treatment (days)		

6.3 LINKS WITH GENERAL MENTAL HEALTH SYSTEM AND OTHER SYSTEMS		
1. Resources (e.g. medication, treatment providers) from general mental health system are shared with parallel system (yes/no)		
2. Severe cases are referred to the general health system (yes/no)		
6.4 PREVENTION AND PROMOTION		
1. Prevention and promotion activities implemented by the parallel mental health system only: a. Livelihood and other necessary supports for refugees to enable participation in education and prevent drop-out (yes/no) b. Adult literacy courses (yes/no) c. Vocational training (yes/no) d. Social programmes to activate social networks such as women's groups and youth clubs (yes/no)		

Section 7: Health system inputs - Psychotherapeutic medicines

Indicator	Data (add year collected where possible)	Data source (author, year, web link)
PSYCHOTHERAPEUTIC MEDICINES		
1. Psychotherapeutic medicines for mood disorders and anxiety disorders available for prescription/distribution in parallel system		
2. General practitioners are allowed to prescribe medication for mental disorders in parallel mental health system (allowed/not allowed; restricted e.g. general practitioners can continue but not initiate prescription; only certain medication can be prescribed)		

TERMINOLOGY

Community facilities	Services which involve outpatient contact between mental health staff and patients for some purpose related to management of mental illness and its associated clinical and social difficulties.
Disability Allowance	A (weekly) payment to people that have an injury illness or disability which is expected to last more than a year.
Illness Benefit	A (one time/weekly) payment made to people who are unable to work because of an illness.
Invalidity Pension	Invalidity Pension is a social insurance payment that may be paid to people who cannot work because of a long-term illness or disability.
Lay health care provider	A person such as a volunteer without formal/accredited training in mental health
Long term rehabilitation	Facilities which manage non-acute but chronic conditions and provide some form of treatment for problems related to mental disorders, structured activity, and social contact or support.
NGO	Non-governmental organisations including faith based organisations
Parallel mental health system	A system funded by foreign aid, or local/international non-govenrmental organisations which provide treatment, care and support for refugees with mental health problems outside the general mental health system.
National mental health action plan	National mental health action plan: A programme of work / plan outlining a comprehensive and coordinated response at the country level to the burden of mental disorders. The plan covers services, policies, legislation, plans strategies and programmes

Annex 2: Elements of health system inputs required (based on mhGAP) used for guiding rapid appraisal methodology

	BEST PRACTICES based on mhGAP	NEEDS AND RESPECTIVE REQUIREMENTS	ASSOCIATED HEALTH SYSTEM BLOCK
Identifying people in need of treatment: Community			
	Social worker or community health care worker (CHCW) identifies probable cases (depression/anxiety/PSTD) in the community	- Training in mental health for CHCW and on existing resources and pathways - Supervision for CHCW - CHCW incentivised to take on additional task - CHCW having to tools to identify such patients	Health workforce
	Social worker/CHCW supports the patient and their family, educating them about mental health/its symptoms and the need for treatment (i.e. social worker provides initial psychoeducation)	- Training in psychoeducation - Supervision - CHCW incentivised to take on additional task - CHCW having to tools to support patients and families	Health workforce Facilities and Services
	Social workers/CHCW refers cases to primary health care for assessment and further treatment	- Primary health care facility available - Primary health care facilities offers mental health screening and appropriately refers patient to further treatment	Health workforce Facilities and Services
	Social worker/CHCW/case manager follows up with patient ensuring he/she made an appointment/receives appropriate care / services in primary health care	- CHCW having to tools to follow-up patients and families - Information sharing and collaboration between primary health care facility/ CHCW/ family and community - Staff member/s (e.g. case manager to assist patient during the course of treatment	Health workforce Facilities and Services Information
Identifying people in need of treatment: Primary health care			
	Patient gets registered in primary health care	- Primary health care facility available	Information

		- Registration system in place, sharing medical information between primary/secondary and tertiary care - Patient got medical insurance or has sufficient means to pay out of pocket for treatment and for transport	Facilities and Services
	Patient is screened by primary health care doctor or nurse in a private room with a validated screening tool, and receives correct diagnoses	- Nurse received training on screening tool, and received basic mental health training - General mental health training available for primary health care staff - Facility is big enough, offering a private room for screening purposes - Primary health care nurse has the time and motivation to screen for “probable” cases of depression/anxiety/PSTD	Facilities and Services Human workforce
	Patient sees primary health care doctor who takes medical history, and performs a general physical assessment (to screen for any concurrent medical conditions)	- Primary health care facility in place - Doctor in place who can see patients without much waiting time - Doctor has training on mental health - Co-morbidities identified and recorded	Human workforce Facilities and Services
	Primary health care doctor creates a management plan that respects patient preferences of care, informs about side effects of the intervention, any alternative treatment options, the importance of adherence to the treatment plan and likely diagnosis	- Doctor is sensitive to cultural needs of patients, and leaves the patient a choice for treatment - Alternative treatment providers and treatment options need to be available - Patient has financial means to pay for treatment, or has a medical insurance which covers expenses and travel - Care for co-morbidities integrated in the plan.	Human workforce Facilities and Services Information Medication
	Patient with mild or moderate depression/anxiety/PTSD is referred to a counsellor by primary health care doctor + receives treatment for any other concurrent (chronic) conditions in primary health care	- Counsellor in post - Counselling provided in a facility which is in the same neighbourhood as primary health care facility (does not involve long travelling)	Human workforce Facilities and Services Medication Information

		- Counsellor has the capacity to take on additional patients	
	Patient with severe depression/anxiety/PTSD is referred to tertiary care to receive pharmacotherapy	- Tertiary care facility available within district - Psychiatrists in post in tertiary care overseeing treatment of patient - Medication in stock	Human workforce Facilities and Services Medication
Provision of psychoeducation and any other advanced psychosocial intervention (e.g. problem-solving counselling, behavioural activation, interpersonal psychotherapy, cognitive behavioural therapy)			
	Counsellor receives information on diagnoses, medical history, and treatment plan from primary health care centre	- Information sharing system (between different treatment providers) in place	Information
	Counsellor establishes contact with patient, and has the capacity to take on additional patients (ensuring timely treatment after diagnoses)	- Counsellor in post - Counselling provided in a facility which is in the same neighbourhood as primary health care facility (does not involve long travelling) - Counsellor has the capacity to take on additional patients	Human Workforce Financing
	Counsellor provides a form of an advanced psychosocial intervention (which may include additional psychoeducation in the first sessions)	- Counsellor trained in any form of advanced psychosocial intervention, including formal and on-the-job training - Counsellor is A) a mental health expert with an accredited degree in psychology who has experience in providing advanced psychosocial interventions; OR b) a lay health care worker who received general training about mental health and in the content and delivery of a low intensity psychosocial intervention + underwent a clinical internship phase. Lay health care provider receives continuous supervision from a mental health expert during intervention delivery - Accreditation system for counselling in place	Facilities and Services

		- There are guidelines, standards, or regulations for advanced psychosocial interventions/mental health and psychosocial support management services and care in place, and counsellor follows them. - Counsellor has support available, or triage systems is in place (e.g. in case of unexpected complications) - Counsellor provides the intervention in the patient's mother tongue, is sensitive to age, gender, culture and language differences, and provides information to patient's health status in terms they can understand - Counsellor receives some form of socio-cultural training, respecting patient's needs. - Where appropriate, counsellor involves family member or carer in the patient's care - Counsellor pays special attention to confidentiality, and the right to persons privacy and ensures that counselling is provided in a private room in a community facility or the counsellor's own home or patient's home	
	Counsellor or case manager identifies possible other sources of social and community support for patient in local area, including education, housing or vocational supports (if appropriate)	- Counsellor or case manager coordinates with schools to mobilize any educational and social supports - Other community supports are available and free of charge for patient - Patient entitled to work and is allowed to attend school or further education	Facilities and Services
	Patient completes all counselling sessions	- Patient has sufficient financial means to pay for counselling, i.e. either through insurance or out of pocket; feels not ashamed of seeking treatment, has the time and motivation to attend all sessions; and faces	Financing

		no barriers in accessing the service e.g. through lack of transportation)	
	Counsellor continues to assess patient through the course of treatment/intervention and recognizes clinical worsening, and refers patient to tertiary care if needed	- Counsellor uses screening tool to monitor patients mood or clinical worsening throughout treatment - Counsellor has support available, or triage systems is in place (e.g. in case of unexpected complications) - Tertiary facility available/in district which has capacity to take on additional patients	Human resources Facilities and Services
Tertiary care referral for severe cases			
	Tertiary health care provider receives medical history from primary health care + assessment from counsellor	- Information sharing system (between different treatment providers) in place	Information
	Patient is re-assessed, and receives antidepressant medication (prescribed by psychiatrist) + may continue counselling or switch to other form of psychotherapy (decided by psychiatrist)	- Psychiatrist in place who confirms correct diagnoses, and who develops treatment plan for severe cases For co-morbid medical conditions: Drug-disease and drug – drug interaction is considered before prescription of antidepressants - Medication available to treat patient - Patient has sufficient financial means to pay for medication, i.e. either through insurance or out of pocket	Information Facilities and Services Medication
	Quality antidepressants are available, and selected by the psychiatrist appropriate to the patient's age, need and symptoms	- Medications in stock - Medications are of good quality, and appropriately stored - Patient experiences no side effects, and adheres to the medication and takes the appropriate dose - Patient is monitored during antidepressant medication by psychiatrist: A. If inadequate response (symptoms worsen or do not improve after 4-6 weeks): Dose will be increased	Medication Leadership and Governance

		or maximum dose will be prescribed (or consider switching to another class of antidepressants) B. Terminate drug treatment if no or minimal depressive symptoms for 9-12 months (by slowly reducing dose), and continue to monitor for withdrawal symptoms.	
Monitoring and follow-up			
	Patient is monitored in the community by a case manager or community health care worker after discharge	- Case manager in post (sensitive to cultural issues) - Case manager has received patient's medical history from treatment providers, and continues to work with patient - Feedback loops to capture practices and view of patients/ families/ communities	Human workforce Information