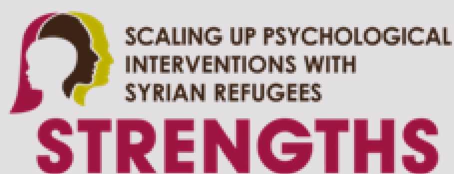
D 2.4 RAPID APPRAISAL FOR MENTAL HEALTH SYSTEMS (WORK PACKAGE 2)

DELIVERABLE D2.4



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List of abbreviations and acronyms

CMD	Common mental disorder
FGD	Focus Group Discussion
IASC	Inter-Agency Standing Committee (IASC)
IDIs	In-depth interviews
IFH	Institute for Family Health
IMC	International Medical Corps
IRC	International Rescue Committee
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
MoH	Ministry of Health
MoPH	Ministry of Public Health
NGO	Non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care
PM+	Problem Management +
PTG	Post Traumatic Growth
PTSD	Post traumatic stress disorder
PR	Provider
RA	Rapid appraisal
STRENGTHS	Syrian REfuGees MeNTal HealTH Care Systems
ToC	Theory of Change
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WP	Work Package

Executive summary

Introduction: A total of 13 million Syrians have been displaced by the Syria 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 networks and lack of opportunities to work or study). These forms of distress may manifest in post-traumatic stress disorder, depression and/or anxiety disorder and other disorders 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) was implemented 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.

Work Package 2 (WP2) in the STRENGTHS study has four deliverables, all related to the Rapid Appraisal (RA) methodology in WP2. The RA methodology in WP2 seeks 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 elements: 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. The specific objectives are to: (i) Describe systems for MHPSS in each country generally and for Syrian refugees specifically; (ii) Describe how service users, including Syrian refugees, obtain MHPSS; (iii)

identify what obstacles confront both people with mental health needs and health professionals providing MHPSS and how they seek to overcome these obstacles; (iv) assess how well MHPSS care is integrated within the health system generally and for Syrian refugees specifically; (v) explore co-operation between the government and parallel health systems for MHPSS for Syrian refugees; (vi) inform the implementation and scaling up of PM+ in partner countries by using Theory of Change and in-depth qualitative interviews on scaling up.

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. These were updated periodically, including for this final deliverable. Second, analysis of existing qualitative data collected by STRENGTHS partners for their formative intervention work (particularly data from WP 3). Third, a series of semi-structured interviews or Focus Group Discussions (FGDs) were conducted in 2020/2021 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, in addition to barriers/facilitators to future scaling up. By combining the findings obtained using these methods, it is 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 also provides a situational analysis informing the implementation of the PM+ intervention, and the health system's capacity for scaling up. Ethics approval for the work summarized in this deliverable report was obtained by country partners and London School of Hygiene and Tropical Medicine (LSHTM). Ethics procedures were described in the previous WP2 deliverables (D2.1-D2.3).

Please note that WP2 also has other methods/activities including cross-sectional surveys in Turkey and Germany, secondary analysis of health access data collected through the various STRENGTHS trials, and research on the potential for scaling-up PM+ in the study countries through three Theory of Change workshops, and qualitative interviews in the study countries. These other methods/activities are not part of the WP2 deliverable requirements and so are not reported in detail in the WP2 deliverables. However, we have included their summary results as they help inform understanding of the health systems in the study countries.

Results: This current and final deliverable for WP2 updates the RA findings from previous deliverables. The updated narrative country reports are presented in Chapter 4 and are not summarised here due to page length considerations. Annexes for each country (containing key data and literature extracted by country) are available upon request and will be also made available on the STRENGHTS website. We are currently also drafting a journal paper synthesising and comparing the RA findings from across the study countries.

Our remaining work in WP2 will focus on the other WP2 methods/activities of: completing the survey in Leipzig in Germany; finalising the secondary data analysis of the health access data from the STRENGTHS trials teams; completing the analysis of the qualitative interviews on the potential for scaling-up PM+; writing-up the results of how COVID-19 impacted on the study implementation.

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 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 (CMDs) 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)
5. Theory of Change workshops to develop pathways to scaling up PM+ in selected partner countries (Objective 3)

Please note that the WP2 deliverables relate only to the Rapid Appraisal (RA) method (Objectives 1 and 2). As a result, there is inevitably some repetition between WP2 deliverables as the core findings remain the same. However, we have updated this deliverable with new data and publications as they become available.

Please also note that because the WP2 deliverables focus only on the RA method, we do not specifically report on progress with the other WP2 methods/activities (e.g., cross-sectional surveys, Theory of Change workshops, qualitative methods). However, we have included summary results of these other methods as they become available as this helps inform the rapid appraisal findings. These summary results are replaced or updated for each deliverable to avoid too much repetition between WP2 deliverables.

1.2 **Rapid Appraisal of mental health systems**

This report summarizes the RA work of WP2 since the start of the project. 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). Further information about the use of RA methods for the STRENGHTS study have been published elsewhere.[1]

1.2.1 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.[2] 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.[3, 4]

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.[5, 6] 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.[7]This makes it appropriate for this study, whose aim is to inform the

implementation and scale-up of PM+ [1] 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.[2, 8-10]

1.2.2 Conceptual framework

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

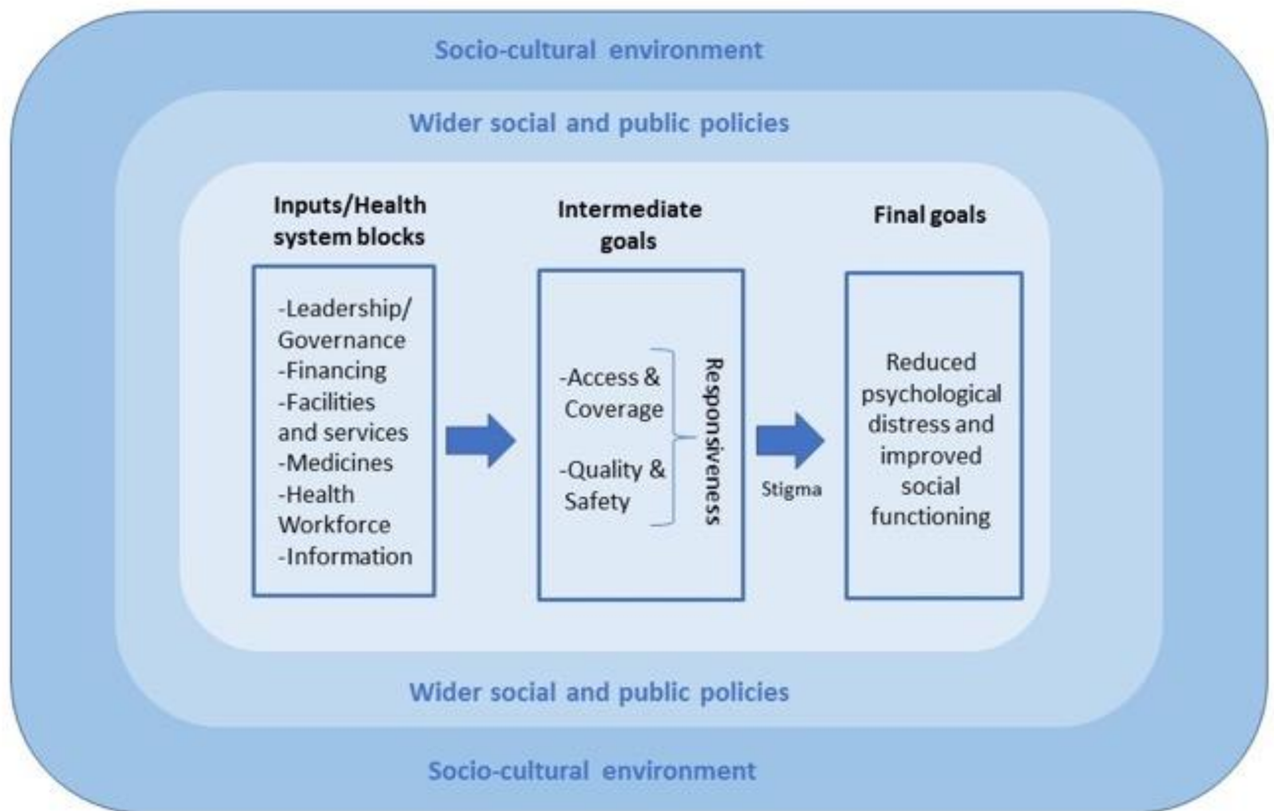
WHO defines 'health systems' as all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities.[11] We conceive the health system according to the definition 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 1.2.1. 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.

[1] The STRENGTHS project involves evaluations of different versions of PM+ (e.g PM+ individual and group, SbS, and EASE) but for the sake of brevity we refer to only PM+ in this document.

Figure 1.2.1: Conceptual framework for health system analysis



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.

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:[11]

- 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 CMDs as outlined in the Mental Health Gap Action Programme (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 CMDs 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.

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.[13] 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.[14] 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.[12] It is a multifaceted concept incorporating different domains (Table 1.2.1 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.

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.[15]

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

Intermediate goals

Access and coverage:
We apply Penchansky and Thomas' elements of access to our conceptual framework which also includes measures of coverage:[16]

- 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.[15] 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 1.2.1 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 1.2.1: 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**
<u>1.Autonomy</u>: 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
<u>2.Choice</u>: Choice of	- Freedom to choose health care provider	- Access

health care providers and services	- Freedom to choose health care facility or service	
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 [12]

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.[17] 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.[18]

Existing care pathways

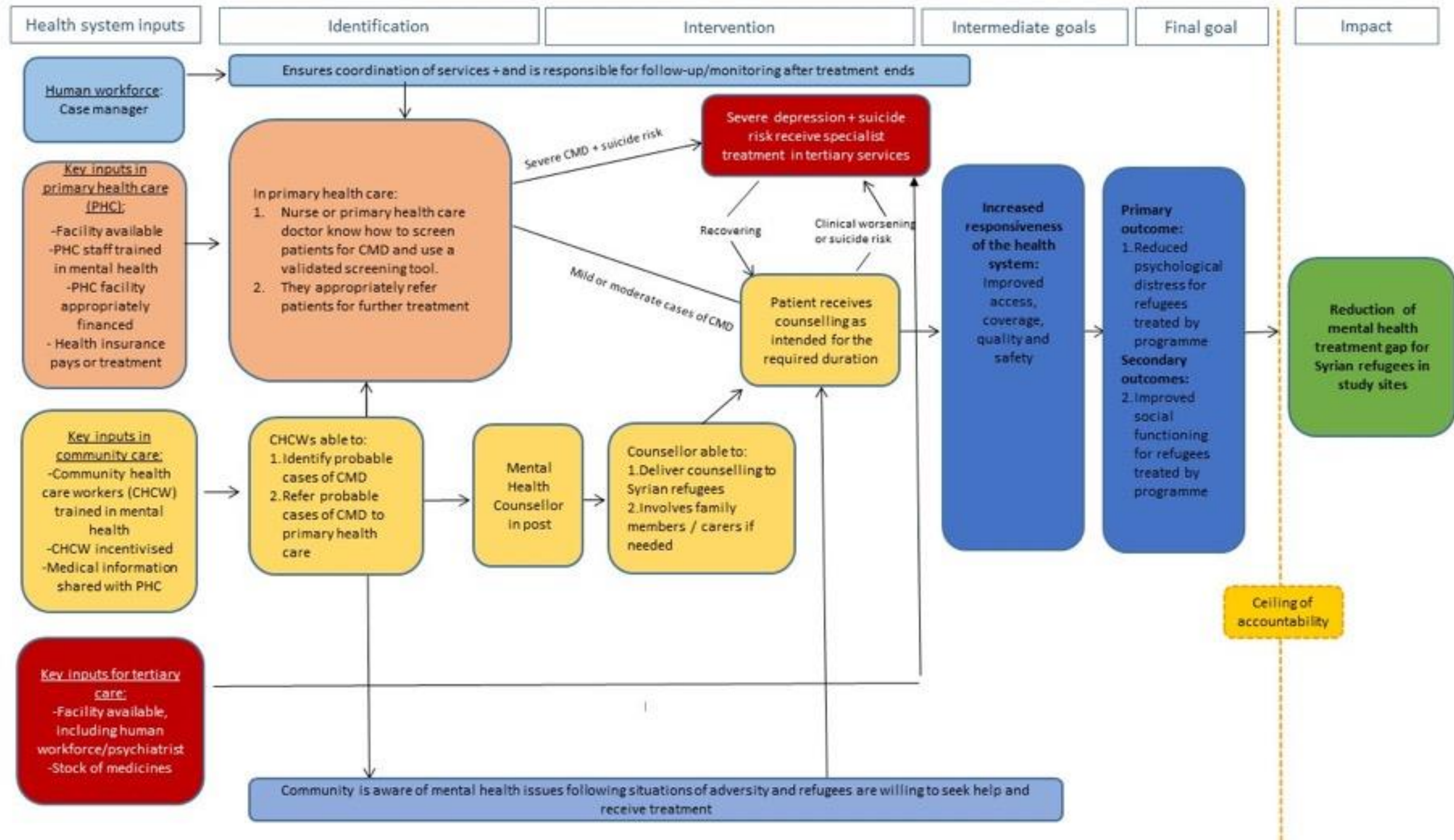
To support our conceptual framework, we also explore existing care pathways. The World Health Organization (WHO) developed the mhGAP, to facilitate scaling up of care for mental and substance use disorders in 2008. A key part of mhGAP is the evidence-based guideline, published in 2010 and available through 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 CMDs to assess pathways of care in the RA. Figure 1.2.2 outlines one possible evidence-based pathway of care based on mhGAP for the treatment of CMDs by taking into account the conceptual framework in Figure 1.2.2. On the left-hand side of Figure 1.2.2 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 1.2.2. 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 1.2.2 (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 (PHC) (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 Figure 1.2.2): 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 1.2.2 only presents one possible pathway of care. Other pathways of care are possible and were explored in the other research methods used by WP2 including the Theory of Change (ToC) workshops in Istanbul (2018), Beirut (2019) and Amsterdam (2019), and semi-structured interviews in the study countries (2020/2021). As noted above, these additional activities/methods are not part of WP2's deliverables which focus only on the rapid appraisal component, however we have summarised their key results in previous deliverables (and so not repeated here to avoid repetition) and further details and results from these methods have also been published in academic journals.[19-24]

Figure 1.2.2: Care pathways based on mhGAP



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 through ToC workshops in partner countries

3. Methods

3.1 Desk-based review on health system inputs

3.1.1 Wider environment and policies

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

- Population and settings: Refugees (including asylum seekers and IDPs) in Egypt, Germany, Jordan, Lebanon, the Netherlands, Sweden, Switzerland, and Turkey.
- Health outcome of interest: Reduced psychological distress and improved social functioning
- 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'.[2]
- 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 31 August 2021).

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.

The literature searches were repeated for the WP2 Deliverables. This final deliverable including key sources and findings identified in an updated search conducted in 2021.

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 were compiled as Annexes for each country (see Annex 1 for template), 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 1.2), 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 were collected as formative work for the intervention studies 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). These existing qualitative data were analysed thematically using a deductive approach, based on the conceptual framework (Figure 1.2.1). 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.

3.2.1 Qualitative methods to investigate health system responsiveness and barriers to scaling up

Additional primary qualitative data have been collected using semi-structured interviews and FGDs with key informants, MHPSS providers, and Syrian refugees receiving MHPSS services/care in 2020/2021. Questions of the topic guide were aligned with the conceptual framework (Figure 1.2.1), the pathways of care (Figure 1.2.2) and elements of inputs required based on mhGAP (Annex 2). Topic guides strongly focused on intermediate goals such as access, coverage, quality and safety but also took 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.

We also utilised the findings from the ToC maps for scaling up in Turkey, the Netherlands, and Lebanon to test assumptions on barriers and facilitators which were discussed in the ToC stakeholder workshops.

3.2.2 Description of study sites

The qualitative work took place in the countries participating in STRENGTHS: Lebanon, Jordan, Egypt, Turkey, Sweden, Germany, Netherlands, and Switzerland.

3.2.3 Selection of respondents

The respondents were from different tiers of the health system and specialties and experiences. A combination of purposive, snowball and convenience sampling was used, depending on the respondent type. Respondents included:

- 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, including 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.

3.2.4 Qualitative data collection process

The qualitative research consisted of semi-structured interviews lasting up to approximately one hour. Approximately 10-15 interviews were conducted per country (this was based on previous experience of RA and following principles of saturation [5, 6]). Interviews followed a topic guide with optional prompts/probes. These were treated flexibly depending on the country context and respondent type/experience/expertise, but nevertheless sought to ensure some consistency and coherence between interviews.

Interviews were undertaken in the local language, English or Arabic by a trained interviewer (with training provided by WP2 staff). Edited transcripts were prepared for all interviews. Interviews took place in a mutually agreed place or over Zoom/MS Teams due to COVID-19-related restrictions.

3.2.5 Qualitative data analysis

Data were analysed thematically in two steps. The first step as a deductive analysis, coding units of data according to the elements of the conceptual framework. This was 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 included: (i) taking the patient perspective and follow the patient as they move through the health system; (ii) triangulate findings with existing data, evidence, research, and policies, and information collected via the desk-based review; (iii) compare data by source of information: patients, family members, providers, government officials; (iv) start broadly identifying a range of problems then narrow down to the several key obstacles; (v) look for unintended consequences of policies and procedures. The country team members produced an initial descriptive report with key findings which were then discussed with the WP2 team.

3.3 **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 primary data (qualitative interviews). The synthesis involved the following steps: (i) Review existing secondary data, and explore if additional findings (which were published after August 2017) can be integrated in

the narrative reports; (ii) develop a preliminary synthesis of all findings by data source; (iii) Develop a preliminary synthesis of all findings across data sources; (iv) assess the robustness of the synthesis, including consultation with country partners and experts.

3.4 Quality assurance

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 were 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 inconsistencies and to help validate findings and their interpretation.

The quality of the interviews and focus groups was assured in the following way: First, the interviews were led by researchers with experience in qualitative research methods and who received additional training specifically in the RA methodology. Second, the interview topic guides were developed following a rigorous process of expert consultation, group discussions and piloting to ensure relevance, reliability, and appropriateness. Third, the transcription, translation and analysis included group discussions between different team members. Fourth, a transparent process for the analysis was employed. Finally, the qualitative research was underpinned by agreed principles of good practice including transparency, comprehensiveness, reflexivity, ethical practice, and being systematic.

3.5 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 shared with WP2 staff for review. Qualitative interviews did not contain any identifying information on participants, and are stored on approved secure drives only accessible to approved WP2 staff and named individuals from STRENGTHS partners.

4. Results

The following sections describe initial 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. In addition, brief findings from the additional activities/methods in WP2 (e.g., survey in Turkey, ToC workshops, in-depth qualitative research) have been included where they strengthen understanding of health system responsiveness to the needs of Syrian refugees.

4.1 **Egypt**

Data presented in this section are based on a desk-based review of existing literature. The final Annex for Egypt (containing key data from the literature) is available upon request and will be made publicly available on the STRENGTHS website. In addition, secondary data were complemented by analysis of four qualitative interviews with key informants (*KI*; n=4) and three MHPSS providers (*PR*; n=3). Ethical 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) and the Observational Committee of the London School of Hygiene & Tropical Medicine (14330 -1) in the UK. Local approval has been granted in Egypt. Data collection took place in October 2017 and August to October 2021.

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) [25]. On 30 September 2021, 131.232 refugees with Syrian nationality (male 31.5%; female 28.9%) were registered with UNHCR in Egypt; 39.5% were below 18 years of age [26]. Syrian refugees in Egypt do not live in camps; they are living amongst local communities [27]. Egypt, a lower middle-income and predominantly Muslim country has an unemployment rate of 10.45% (global average is 6.741%) [28]. 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 69.742 and 74.35 years respectively [29]. Adult mortality rate was 165 per 1,000 population and maternal mortality 37 per 100,000 live births in 2016 [30].

It is estimated that around 3.5% of the general population suffer from depression, and 4.2% of anxiety disorders [31]. These figures are similar to predictions for lower middle-income countries (3.5% depressive; 3.5% anxiety) [32]. Furthermore, it is estimated that 0.11% of the general population suffer from post-traumatic stress [33]. 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 [32].

4.1.3 Mental health system inputs

4.1.3.1 Leadership and governance

Egypt has mental health legislation, a mental health policy and a mental health plan [34, 35]. The mental health legislation was considered 'fully' and the policy and plan 'partially' implemented in 2014 [34]. A national mental health council oversees regional mental health councils in following up the implementation of previous provisions of the laws in mental health facilities (PR). 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 [36]. The General Secretariat of Mental Health (GSMH) is the overall coordinating body responsible for mental health and addiction treatment, including supervising tertiary psychiatric hospitals across Egypt (KI, PR). The government recently began working on developing an online platform for mental health services, supported by the WHO (PR).

4.1.3.2 Financing and expenditure

In 2014, the Egyptian Government spent 5.6% of its GDP on health [37]. Mental health expenditures made up 0.5% of the total health budget in 2011 [38]. Donors contributed $30.84 million to the Egyptian health sector in 2016 [39], 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 [40, 41]. Efforts are being made to offer health insurance to all people in Egypt [42]. One informant reported that Egypt had launched a new universal health insurance in 2019, and that the final phase is set to begin in 2030. They stated that "mental health is a major component" and that including mental health services in all three levels of care (primary, secondary, and tertiary) is being considered (KI).

MHPSS support is currently 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 [36]. 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) [43]. One provider interviewed reported that in the national system, medication is free and a psychiatric consultation costs one pound; in contrast, they stated that treatment within the private sector costs 500 pounds or more per month (PR). 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 [44]. Nevertheless, a representative survey of 506 refugee households conducted by the UNHCR found 61.5% of Syrians had spent money on healthcare consultations, investigations, medications and medical supplies in the past month (with average household expenditure totalling US41.20) and 49.7% had sought care from a private hospital or clinic (average household expenditure US$25.70) [45].

4.1.3.3 Mental health workforce

There were 8.40 mental health workers per 100,000 population in the country in 2017 [38], which exceeds the regional average (7.7) [46]. The Ministry of Health is the main provider of mental health services in Egypt [41]. Distribution of mental health professionals and facilities between urban and rural areas was considered "disproportionate" [43].

4.1.3.4 Facilities and services

There has been a shift towards the integration of mental health detection and management services into primary care (particularly in community settings), although the precise services offered are unclear [35, 45]. According to a provider interviewed, Egypt has implemented the Mental Health GAP action program (mhGAP), training health professionals in primary healthcare to provide treatment for common mental health problems (PR). The number and caseload of community mental health facilities is unknown [34, 35]. One provider reported that there are not refugee-specific clinics (PR). NGOs provide different types of support for refugees in Egypt such as medical services, family and social support, psychosocial support [47-49]. The church may also offer some counselling services, according to informants (KI).

4.1.3.5 Psychotherapeutic medicines

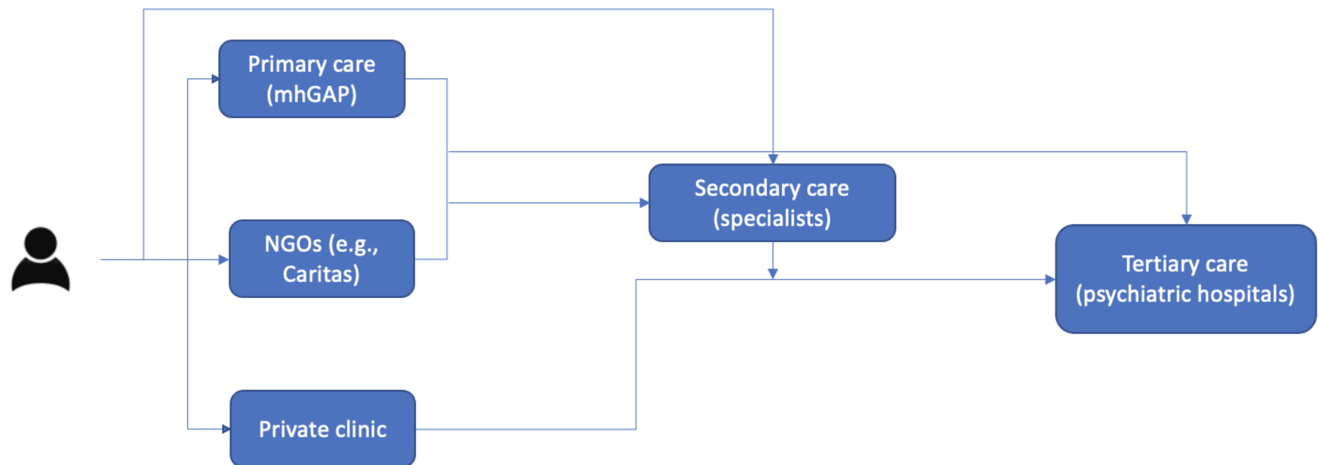
An essential list of drugs does exist for the country and covers psychotherapeutic medicines for treatment of anxiety and depression [50].

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 [36], 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, therefore the ‘parallel’ system (i.e., NGOs) are typically used, offering generally free face-to-face and online mental health services (KI). The care pathway is outlined in Figure 4.1.1.

Figure 4.1.1: Care pathway of Syrian refugees in Egypt



4.1.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability [16] of MHPPS.

Availability:

One key informant interviewed for this study lamented the lack of treatment for depression and PTSD in the public health system. However, the KI believed there to be sufficient resources, including staff, to be able to provide an online mental health service for Syrian refugees (KI). Two other KIs noted the limited time of psychiatrists, and a PR mentioned the same limitation for those doing mhGAP in primary healthcare (KI, PR). A focus on secondary and tertiary services has resulted in a lack of MHPSS services at primary care level, making the availability of MHPSS to Egyptians and Syrian refugees a challenge (PR).

(Geographic) Accessibility:

A disproportionate distribution of mental health services and providers in the country limits access for rural patients [43]. One provider stated that the highly specialised, best quality care is only available in tertiary mental health hospitals which are not present in all the governates. This unequal distribution of services was considered a barrier (PR). Informants and providers overall thought offering internet-based services would increase accessibility, but many noted that internet, smartphone, and computer access could be a barrier to the accessibility of these tools (KI, PR).

Accommodation:

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" (KI). However, a provider interviewed described only the private sector as expensive, while a "psychiatric interview" at a government-run hospital reportedly cost only one pound (PR).

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). One provider stated that while refugees may not be explicitly targeted or stigmatised, services are not adapted for non-Egyptians and practitioners may not understand the psychological challenges specific to refugees (PR). 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 [51]. This appears to be the only data available on mental health outcomes among Syrian 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 analysis of seven interviews with key informants and providers conducted by STRENGTHS partners. Albeit based on limited evidence, our findings suggest Syrian refugees in Egypt face barriers in accessing the public health system: availability of MHPSS services remains limited at primary care level; mental health stigma reduces acceptability of MHPSS; unequal distribution of reduces access to MHPSS in rural areas; and out-of-pocket payments for psychological treatment influences affordability.

Findings from this rapid appraisal combined with initial findings from semi-structured interviews on the scalability of Step-by-Step (an online psychological intervention) indicate that the 'parallel' health system (i.e. NGO services) is the most 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 and private sectors but can be expensive, principally due to out-of-pocket payments. However, the government's move towards creating a universal health insurance plan could mitigate these concerns and make mental health care more accessible within the public system.

Given the current circumstances, the free online mental health services being developed by STRENGTHS for Egypt seem to be a good option for Syrian refugees. The government's ongoing plans to build its own online mental health platform makes the integration of Step-by-Step into the public health system more feasible. This could be achieved by working with governmental bodies (such as the Ministry of Health, the GSMH, and the National Mental Health Council) and prominent NGOs playing a role in healthcare provision (such as Caritas, Médecins du Monde, and Save the Children).

With technical, political, and financial support from the government and these large NGOs, Step-by-Step could potentially be integrated into the public health system as well as the parallel NGO system.

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. Informants report an upcoming mental health awareness campaign by the government, and an overall increased focus on mental health due to the Covid-19 pandemic. This could be capitalised on to disseminate information about Step-by-Step to the general population and raise interest. Covid-19 further served to normalize the use of digital health interventions such as tele-health. One tool described by an informant as similar to Step-by-Step was Iljanafsy, an Arabic online therapy tool. Another provider described the help hotline set up by the GSMH, which used lay counsellors to offer advice but had specialists to refer to on call. These existing services, and the reported increase of digital health measures due to Covid-19, speaks to the increasing acceptability of interventions like Step-by-Step in Egypt.

While there appears to be a demand for mental health services, political will to increase and improve mental health services, and increased acceptability surrounding digital health tools, scaling up Step-by-Step would certainly face some barriers. The involvement of the government could slow the process due to bureaucratic procedures, and the current fragmented service provision – split between local NGOs, large international NGOs, private services, and the public health system – could also make scale up a challenge.
Further interviews are being conducted in Egypt, including with Step-by-Step users, which will give us more in-depth information about possible ways to integrate this novel intervention, including the factors influencing its potential integration. These findings are then compared and combined with those from other countries involving Step-by-Step trials (i.e. Sweden and Germany).

4.2 **Germany**

Data presented in this section are predominantly based on a desk-based review (existing literature), which was last updated in March 2021. The final annex for Germany (containing key data from the literature) is available upon request and will be made available on the STRENGTHS website.

In addition, secondary data was complemented by analysis of 27 semi-structured interviews, including MHPSS providers (PR; n=9); key informants (KI; n=9) like NGO workers and researchers; and Step-by-Step (SbS) RCT participants (SP; n=9). Ethical 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, application number 161/2017) and the observational committee of LSHTM (14330-1) in the UK. Most interviews were conducted between March 2021 and June 2021, except for four with SbS participants (May 2020) and two with MHPSS providers (Oct-Nov 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 refugees sought asylum, and in 2017 48.974 Syrian refugees respectively).[52] The number of asylum-seeking applications from Syrians has decreased since then and reached 44.167 in 2018 and 26.722 in 2019.[52, 53] 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.[52] 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 83 years for men and women respectively (Life expectancy at birth, female (years), 2021; Life expectancy at birth, male (years), 2021). Adult mortality rate was 69 per 1,000 population and maternal mortality 7 per 100,000 live births in 2017.[54] Evidence suggests that almost one third of the general population is affected by mental disorders. Most frequent are anxiety (5.8%), 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%).[30, 55]

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. However, there is an approved mental health policy, although there is not a reported national mental health action plan.[56] Mental health is additionally covered in other laws and mentioned in the general health policy.[57] There is also a dedicated body to assess mental health legislation compliance with international human rights.[57] The Migration Integration Policy Index suggests that for Germany the country's overall score is 'slightly favourable' (which includes measures for health as well).[58] This indicates that policies in Germany slightly promote equal opportunities and may provide a welcoming culture for migrants, including refugees.

4.2.3.2 Financing and expenditure

In 2018, the German Government spent 11.43% of its GDP on health.[59] The German health system is mostly funded via social security (77.0%).[59] 11% of the total expenditure on health is used for mental health.[30] All German residents are required by law to have health insurance.[60] The majority of the population – around 70 million people or 88% – have statutory health insurance. About 11% of residents have private health insurance.[61]

One informant noted that "for the longest time in Germany, it was tricky to offer any kind of digital intervention in health care and mental health care. But in recent years, especially the last two years, this has changed to some extent and there are new laws that allow us to implement e-mental health into regular care and also have this being paid by the health insurance companies" (KI). Another informant confirmed that their health insurance already covered some mindfulness and mental health apps (KI). In terms of financing apps, this can currently happen through contracts with individual health insurance companies. However, these 'selective' contracts make up less than 5% of total expenditure volume of statutory health insurance for outpatient services.[62] Alternatively, if an app is deemed a 'medical device,' it would be subject to stricter regulations but once approved could become part of standard care and be reimbursed by all health insurance schemes.[62] Furthermore, the health insurance companies now have a Federal Innovation Fund into which they pool resources, which can be applied to for financing new health innovations (KI). It should be noted that a different informant felt strongly that financing an app through the healthcare system was an "unrealistic" scenario (KI).

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.[63, 64] 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 EU average for the number of psychiatrists (27.45 vs. 17.17 per 100,000 population).[65] The number of mental health nurses per 100 000 population are 56.06.[30] Mental health service providers are usually paid by a fixed salary, or they receive a fee for service or capitation.[66] Special training, lasting three to five years, is offered to psychologists and doctors in order to become licensed psychotherapists. 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.[67] There is no mental health training or education on mental health provided for undergraduate medical students.[68] The majority of primary health care doctors and nurses have not received official in-service training on mental health within the last five years.[69] In one study on refugee child health, 73% of health care professionals agreed they needed better training in mental health issues.[70]

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.[69] All psychosocial services (e.g. cognitive and behavioural interventions, counselling, family therapy) are available in the public sector.[71]

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), Zentrum Überleben (an NGO who offers a broad range of programs aimed at social integration and participation), 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.[72] Furthermore, there are 37 specialized centres organized under the umbrella organization BafF (German Association of Psychosocial Centres for Refugees and Victims of Torture) which offer a variety of mental health services and serves in total about 14,000 people per year (between 100 to 1,900 clients per centre).[73] One informant thought it was important to note that the psychosocial centres or other NGOs that focus on psychosocial counselling do not offer psychotherapy, and that there is a distinction between counselling and therapy (KI).

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.[74]

4.2.4 Process outcomes and responsiveness

4.2.4.1 Care pathway

Health care provision for asylum-seekers in Germany is decentralized and fragmented. Upon arrival, asylum-seekers are resident in reception centres run by one of the 16 German states. Some of these reception centres have in-house clinics which do an obligatory health assessment and may offer basic health services; otherwise, asylum-seekers are referred to the public health care system.[75] After a maximum of 18 months asylum-seekers are reassigned to one of the states according to a quota system; during the first 18 months or until legally recognized as a refugee, health benefits are covered by the Asylum Seekers Benefits Act (AsylbLG).[75] The AsylbLG does not guarantee psychological or psychiatric treatment unless the case is deemed ‘acute,’ and mental health care generally requires explicit municipal approval.[76, 77] If an asylum-seeker were to seek mental health care during this first 18 months, or prior to being recognized as a refugee, they would often first need to seek approval from their local welfare office. This also applies to those living in reception centres.

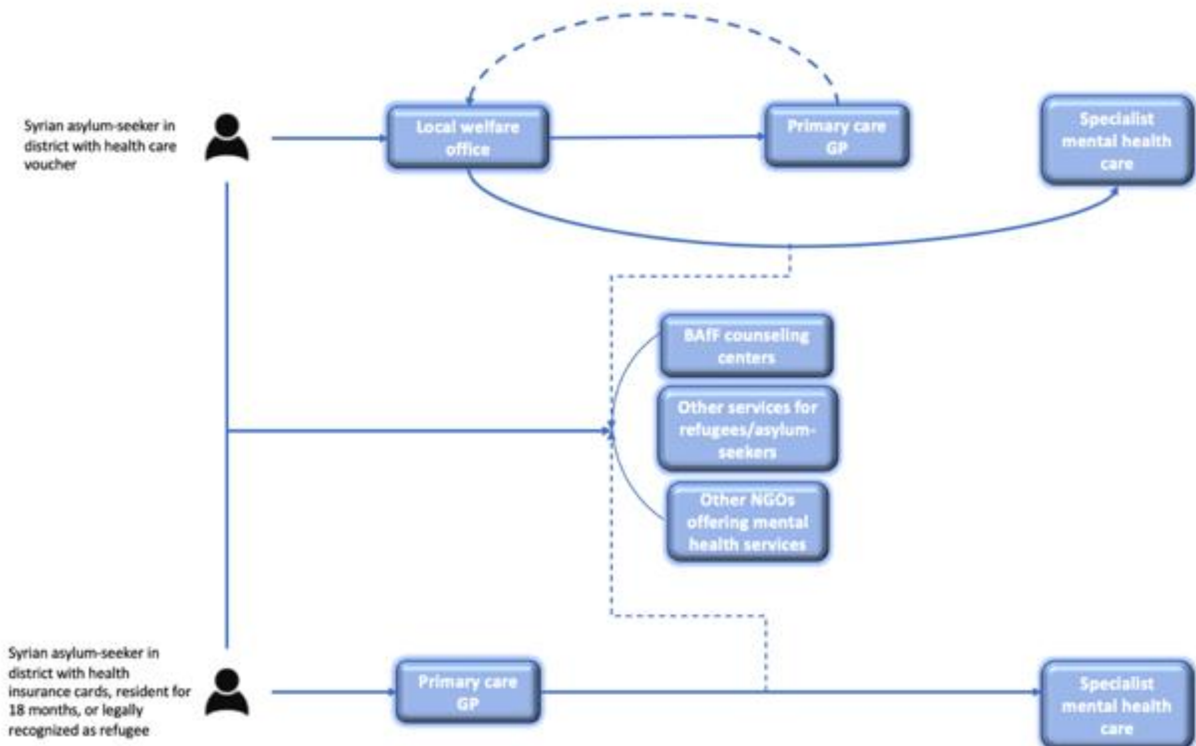
Seven of sixteen German states use healthcare vouchers for asylum-seekers. Asylum-seekers in these states are either granted a voucher (upon request or unsolicited) for primary care that is valid for three months, or they must request a specific voucher in person each time they seek care. In either case, an asylum-seeker would need to go to their local welfare office to obtain a voucher for mental health care upon referral from their General Practitioner (GP).[75] Thus, local welfare offices maintain much authority over what is and is not covered by the AsylbLG and what constitutes an acute emergency, essentially gate-keeping mental health care.

For asylum-seekers in municipalities using health insurance cards (nine states have fully or partially implemented their use), asylum-seekers are able to access health services in the same way as Germans with statutory health insurance.[75] They would not need to have every referral approved by their local welfare office. In this case, an asylum-seeker seeking mental health care would likely have their GP as their first point of contact, and be referred onward to mental health specialists such as

psychotherapists. Most psychosocial services are offered by specialists, not the primary care system, despite this being the first point of contact. Those presenting with acute psychiatric emergencies, whether their resident state uses cards or vouchers, would likely be referred to inpatient care.

Due to long wait times for specialist care and difficulties in getting it approved, asylum-seekers and refugees may also seek mental health care in the parallel system made up of civil society and NGOs. There are many organizations that offer psychosocial counselling. Some organizations that offer other services to refugees, such as job training, now additionally offer psychologists or counsellors to support clients (PR). The BAfF centres play a large role in service provision as well. Informants and providers both recognized that the waiting period for mental health care was an important gap in the care pathway to fill (KI, PR). A visual of potential care pathways for Syrian asylum-seekers and refugees can be seen in Figure 4.2.1.

Figure 4.2.1: Potential care pathways for Syrian asylum-seekers and refugees in Germany



4.2.4.2 Access and coverage

Access and coverage encompass the availability, accessibility, accommodation, affordability and of MHPPS.[16]

Availability:

Services for the treatment of mental disorders are available for refugees, however, according to reports, demand exceeds current supplies.[78] Access to health care for Syrian refugees does not equal the access to health care for German nationals.[79] The AsylbLG 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'".[80] MHPSS services, treatment by family doctors, specialists and psychotherapists are covered if needed.[60] 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 in most districts after an 18-month waiting period or upon legal recognition of refugee status.[75]

Asylum-seekers and 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 which equates to around 4% of all refugees with mental disorders in Germany. A more recent estimate of the number of refugees treated in centres associated with BafF is about 14000 per year across all 37 centres, ranging from 100 to 1900 per centre per year.[73]

Accessibility:

The current healthcare provision in Germany is characterized by many restrictions for Syrian asylum-seekers. Different residence permits are associated with a limited access to medical and psychotherapeutic services. The healthcare provision policies also depend on the state in which an asylum-seeker resides, impacting access. 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).[78, 81] A state-wide cross-sectional population-based study in Germany's third largest state showed 32% of refugees reported unmet needs for specialist care.[82] One informant for this study supported language as a major barrier, with most services offered in German (KI). A provider interviewed for this study further suggested travel expenses as barrier in accessing and continuing treatment (this is due to the large geographical areas that specialized treatment centres for refugees cover which may require a 2-hour train trip in some cases) (PR).

Accommodation:

Informants in interviews expressed that an online or app-based intervention may be more accommodating than existing structures, particularly due to transportation barriers and waiting times (individuals could utilize the intervention on their own time from home) (KI, PR).

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, transport 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 (PR).

Some informants noted that they thought having mental health support provided by someone from refugees' own cultural and linguistic background would have a positive impact on acceptability (KI). Others, however, mentioned that having a provider from the same background could decrease likelihood of seeking help if they came from a culture where mental health or other aspects (i.e. sexual orientation) were stigmatized (KI, PR). One participant described attending psychotherapy with a provider from a similar background. He stated that this provider did not believe his concerns, and thought he was using therapy as a means to apply for residency (SP).

Mental health stigma in general was described as a major barrier among Syrians in particular, and within Germany overall (KI, PR, SBS, SP). Literature described concepts such as 'mental health' and 'psychological wellbeing' as not being commonly understood and having negative connotations. Informants and providers suggested using careful language choice to ensure acceptability (KI, PR).[83]

4.2.4.3 Quality and safety

The current health care act for refugees limits access to care for Syrian asylum-seekers in the first 18 months upon entering Germany.[75] Asylum-seekers in many districts 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 is restricted as outlined

above and waiting times for receiving treatment with a psychotherapist is on average 6 months (BPtK, 2018), but can sometimes be shorter.

One informant in our study confirmed that civil society organizations often had long waiting lists for MHPSS services (KI). Psychotherapists working individually in the public or private sector are unable to close this treatment gap. These accounts taken from the literature were confirmed by interviews conducted for our study with providers. Informants also emphasized that even with full health care coverage, waiting times are "eternally long" for psychological therapy (KI, PR).

A recent study indicates that out of 44 study participants who were referred to psychotherapy after enrolment in a study, none of those 44 study participants had received outpatient psychotherapeutic treatment after three months. To facilitate access to care authors of that study call for low-threshold, cultural adapted psychotherapeutic treatment for asylum seekers to be made available in the community.[84]

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.[78] One informant confirmed that interpreter costs are not covered by health insurance companies, noting that health insurance does not see its primary task as providing anything for refugees (KI). 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.[77] While there is still no nationwide card, as above mentioned at present nine states use a health insurance card to varying extents. The 2015 asylum procedure acceleration bill made this possible, authorizing local authorities to provide asylum-seekers with health insurance cards upon arrival.[75] However, introducing the health insurance card requires states and public Sickness Funds to make an agreement defining methods of asylum-seeker health care provision and specifying the obligations and rights of contractual partners.[75, 77] Thus far, five states have comprehensively introduced health insurance cards (Bremen, Hamburg, Berlin, Schleswig-Holstein, Thuringia). Four additional states (Brandenburg, Lower Saxony, North Rhine Westphalia, Rhineland-Palatinate) have agreements that made implementing health insurance cards possible, but left implementation up to local authorities and only some municipalities are using them.[75]

A 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.[85] A more recent qualitative study with German psychotherapists already working with refugees also described major barriers. They indicated that major challenges included communication, as well as different expectations of what psychotherapy could offer and different illness explanatory models.[86]

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%.[78, 87] A recent study done at a Central Clearing Clinic for refugees in Berlin found that PTSD and unipolar depression were some of the most common disorders, at 24.3% and 40.4% respectively.[78] A state-wide population survey also showed high rates of common mental disorders among refugees in Baden-Württemberg, with 46% of respondents reporting depression and 45% reporting anxiety.[82] In addition, refugees show other signs of psychosocial distress which are seen even more frequently: Somatoform disorders (38–88%), affective disorders (54.7%) and anxiety disorders (40.2%).[78, 87, 88] Almost half of respondents in a register-based study done by Borho, et al., (2020) were identified as being at risk of somatic distress.[89]

In a recent study in Leipzig, Nesterko et al. (2019) assessed mental health outcomes among recently settled refugees. According to established cut-off scores, 49.7% of respondents screened positive for at least one common mental disorder, with 31% suffering from somatisation, 21.7% from depression and 34.9% from PTSD; prevalence rates for major depression, other depressive syndromes and PTSD were calculated according to the DSM-5, which indicated rates of 10.3%, 17.6% and 28.2%, respectively.[90] A later study also done in Leipzig by Nesterko et al. (2020) found that lack of information about family members, and subjective need for health care were significantly associated with anxiety, somatization, and depression.[91]

Georgiadou et al. (2018) specifically investigated common mental disorders among Syrian refugees in Erlangen, Germany. Symptoms of PTSD were found in 11.4% of the participants. Moderate to severe depression was confirmed in 14.5% and moderate to severe generalized anxiety in 13.5% of the sample. The criteria for at least one diagnosis were met by 30.5% of the participants. More severe PTSD symptoms were associated with older age, shorter validity of the residence permit, larger number of traumatic events and higher generalized anxiety symptoms. Depression symptoms were associated with younger age, shorter duration of escape journey, larger number of traumatic events and higher generalized anxiety symptoms. Generalized anxiety symptoms correlated with female gender, PTSD, and depression symptoms.[92] In a cross-sectional analysis of a large sample of adult refugees in Germany, Walther et al. (2020) also showed that nearly half (41.2%) of the representative sample surveyed experienced moderate or severe levels of psychological distress, with particularly high prevalence of distress among females and older refugees.[93]

A high burden of psychosocial distress has also recently been reported among asylum-seeking *children* and adolescents in Bavaria, Germany.[94] 64.7% of unaccompanied refugee minors (URM) and 36.7% of accompanied refugee minors (ARM) in facilities across Bavaria scored above the clinical cut-off for PTSD (42.6% of URM and 30% of ARM for depression, and 38.2% of URM and 23.3% of ARM for anxiety).[95] A study by Pfeiffer et al. (2019) further showed that symptom representation of psychological distress may be different among minors compared to adults; the study showed that the most central symptoms were nightmares, physiological or psychological reactivity, concentration problems, and re-experiencing symptoms.[96]

There is also evidence to suggest that asylum-seeking *children* and adolescents are at a higher risk of mental disorders if asylum applications have been rejected.[94, 95, 97]. Similar data has been reported among adults which show that adult asylum seekers in Germany present on average nine times more often with mental and behavioural disorders than resettlement refugees.[98] A study by Borho et al. (2020) also found that a shorter duration of residence permission in Germany was an important predictor of psychological stress in Syrian refugees.[99]

4.2.6 Discussion

The German mental health care system 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 largely restricted within the first 18 months of residence. This may lead to delayed diagnosis and late treatment onset which may exacerbate the severity of symptoms and worsen overall functioning.

Interviews with providers and informants revealed that SbS had the potential to be scaled in Germany within two different pathways: through civil society organizations, and through the formal health system. Informants within the civil society pathway seemed confident and enthusiastic about acceptance and uptake of SbS, although providers noted it would have to be used as a supplement rather than a treatment. If SbS were integrated in this pathway, asylum-seekers would have access to

SbS during the initial 18-month period, since they would not have to go through administrative barriers to access it. Barriers to scaling up within the civil society organizations included financing of the intervention on a larger scale as well as trust in the app's utility, effectiveness, and privacy.

SbS could also be scaled up within the formal health system, however many informants described this as a less realistic and more challenging scenario. In this case, the developers of SbS would have to negotiate a contract with a single health insurance company, and beneficiaries of that health insurance would then have SbS covered. Alternatively, if SbS were deemed a 'medical device,' it would be subject to even stricter regulatory standards but if approved could become part of standard care and be reimbursed by all health insurance. Apps are deemed medical devices if they aid in "the detection, prevention, monitoring, treatment or alleviation of diseases, b) the detection, monitoring, treatment, alleviation or compensation of injuries or disabilities, c) the investigation, replacement or modification of the anatomical structure or a physiological process or d) the regulation of conception".[62] One informant noted that SbS does not technically treat disorders so does not fall under this purview, but due to the novelty of the regulations there is a possibility it would be categorized as such. If SbS were to be scaled up within the health system, asylum-seekers could still face some initial difficulty in accessing care during the 18-month period. However, once they got to their GP they could be referred to SbS during the waiting period for specialist mental health care. The biggest obstacles to scaling up within the formal health system are legal restrictions, political will to drive integration, willingness to uptake digital mental healthcare by providers, and financing.

The literature indicates that once Syrians do enjoy the full range of health care options (as German nationals do), they still face socio-cultural barriers to accessing care (e.g. language, stigma, (cultural) preferences regarding treatment). These may partially be overcome by making SbS available online and via mobile phones. However, the uptake of SbS as an online and mobile version may depend on cultural treatment preferences, and the acceptance of this form of therapy. 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. Furthermore, the literature indicated that awareness on internet-delivered therapies also needs to be raised among the general public and GPs, who expressed low knowledge regarding and reticence towards digital health measures.[100-103] Interviews with providers and informants additionally showed that there may be some reluctance to accept a digital intervention like SbS within the formal health system. They further revealed that mistrust towards the utility and confidentiality of a digital intervention like SbS could be a barrier to acceptance and scaling, in any integration pathway.

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.[78, 81] Therefore, SbS 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.

4.3 **Jordan**

Data presented in this section are based on a desk-based review (existing literature, data and polices) which was updated in September 2021. 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 were complemented by analysis of individual interviews with key informants (n=7; *KI*), MHPSS providers (n=14; *PR*), Syrian refugees *not* accessing MHPSS services (n=15; *SR non-user*), and summaries of group interviews with Syrian refugees who had either completed or dropped out of group Problem Management Plus (PM+) randomized control trial in Jordan (1 female drop-out group, 1 female completer group, 1 male drop-out group, 1 male completer group; n=20). 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 June-July 2017 and March 2020-Sept 2021.

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) [104], and the second highest share of refugees per capita globally [105]. On 31 August 2021, 670,637 refugees with Syrian nationality (male 50.0%; female 50.0%) were registered with UNHCR in Jordan (about one-half were below 18 years of age) [106]. The majority of Syrian refugees (80.6%) are dispersed in urban, peri-urban and rural areas and a minority (19.4%) live in camps [106].

Jordan, a lower middle-income and predominantly Muslim country has an unemployment rate of 18.5% (global average unemployment rate is 6.47%) [107]. The majority of Syrians are not eligible for employment in Jordan, according to labour laws. Therefore, unemployment rates among Syrian refugees in the country were estimated at 55% for men and 100% for women [108]. As of 2020 the unemployment figure for Syrian refugees was estimated to be around double that of Jordanian nationals [109], leading to a slightly lower estimate of 37%. In March 2016, the Government of Jordan announced it would implement several measurements to increase access to the labour market for Syrian workers [110]. 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. Key informants and providers also mentioned Syrian refugees would likely prioritize employment-seeking and work over psychosocial support due to the difficulties of finding and keeping a job.

4.3.2 Health statistics in host population

Jordan nationals have a life expectancy of 73 and 76 years for men and women respectively [111]. Adult mortality rate was 111 per 1,000 population in 2016, and maternal mortality 56 per 100,000 live births in 2017 [112]. Both mortality rates are lower compared to their regional average rate of 150 and 164 respectively [54, 113].

An estimated 4.0% of Jordanian nationals had a depressive and 4.3% an anxiety disorder in 2015 [32]. These figures are slightly above average predictions (3.5% depressive; 3.5% anxiety) for lower middle-income countries [32]. In Jordan, 2.90 per 100,000 population reportedly died by self-harm in 2016 [114] and 0.45% of deaths were estimated to be caused by mental and substance use disorders in 2017 [115].

4.3.3 Mental health system inputs

4.3.3.1 Leadership and governance

While there is no specific mental health law in Jordan [116], legal provisions related to mental health are covered by other laws (e.g. disability, welfare and general health legislation) [117]. A mental health policy and plan was introduced in 2011 and was considered partially implemented in 2014 [116]. 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 [118]. Under this new policy, a Mental Health Unit (under the PHC administration) is planned to become the central governance unit for mental health [119].

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 [120]. 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. However, key informants in another study felt Syrian political, religious and tribal leaders prioritised "basic needs" (such as humanitarian relief parcels) over psychosocial support services [121].

4.3.3.2 Financing and expenditure

In 2018, the Jordanian Government spent 7.71% of its GDP on health [122]. The national health system is partially funded via social security (8.7%) and through out-of-pocket fees (30.67%) [123]. The proportion of total expenditure on health used for mental health is unknown [112] although there was a plan to develop a budget through establishing a Mental Health Unit [118]. Budgets for strengthening various mental health services, including at community level, are part of the national Syrian response strategy [120].

A series of policy changes have seen out-of-pocket expenses for healthcare change for Syrians in Jordan. Between 2011 and 2014, Syrian refugees in Jordan who had registered with the UNHCR could access health services free-of-charge. New policies implemented in 2015, saw Syrians charged at the rate of uninsured Jordanians, allowing them access to free or subsidised government health services in areas where they had registered for a security care [124]. From January 2018, they were again reclassified and were charged for health services at 80% of the prices applied to foreigners. In April 2019, government policy again changed, meaning Syrians could once again access government hospitals and healthcare centres as uninsured Jordanians [124].

UNHCR facilities are accessible to refugees at no cost and the majority (89%) of NGO services are accessible at no cost as well [125]. However, in recent years donor funding of humanitarian NGO health programming has decreased in the region, and this in concert with limited funding of the Ministry of Health has resulted in a strain on providing free or low-cost services to refugees [126]. This was confirmed by providers interviewed, who stated that the decreased funding has also led to a strain on human resources as staff have to be let go. Cash-based assistance and vouchers are also provided by international donors and NGOs so that refugees can pay for various services and goods [127].

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 [120].

4.3.3.4 Mental health workforce

There were 1.125 psychiatrists, 1.266 psychologists, 3.297 nurses, and 0.218 social workers working in mental health per 100,000 population in 2016 [128]. This compares to 7.8 mental health workers per 100,000 population in the country in 2014 [116], which was similar to the 2014 regional average (7.3) [129]. 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 [130]. The distribution of mental health professionals between urban and rural areas was considered "relatively proportionate" [130]. The latest 4Ws country report concluded there was a high staff turnover, limited availability of qualified workers, and few training programmes offering clinical supervised practice as part of the formal education of mental health professionals in Jordan [131]. Aid workers in the country also reported unmet supervision, preparation, and training needs in the workplace [132]. Another cross-sectional study conducted among doctors, nurses, midwives and dentists working at refugee health centres reported that 73% believed their knowledge of MHPSS programming to be insufficient, and 88% said that they needed additional training [133]. There have also been efforts to support Syrian refugees who are mental health professionals to provide mental health services for fellow refugees [134]. Key informants and providers emphasized an overall lack of mental health specialists in the country.

4.3.3.5 Facilities and services

In 2011, 0.99 mental health outpatient and in 2016 0.055 community-residential facilities per 100,000 population were reported [112, 135]. While mental health was hardly available in PHC in 2010 [130], the introduction of mhGAP has seen some improvement in the availability at primary care level [136]. However, while key informants confirmed mhGAP was being implemented, one provider described a lack of supervision, with doctors being trained but not utilizing these skills or having refresher trainings. Despite the implementation and scaling-up of MHPSS by both international NGOs and local Syrian-led organisations, international donor funding priorities limit programme design and sustainability [121].

A mapping exercise reported about 37 organisations (mostly not-for-profit) collectively delivering MHPSS services and activities for communities in Jordan in 2017 [131]. The majority of Syrian refugees (in camps and outside) use NGO mental health services [137]. One study found that among Syrian refugees, 90% preferred NGO facilities as a first option for health services, and 87% reported preferring public health facilities as a second option [138]. IMC is the lead MHPSS service provider in Jordan and integrates MHPSS services into MoH clinics. Stand-alone NGOs are involved in community-focused, case-focused and general MHPSS activities [131], including counselling, family and individual therapy, livelihood and social support [136]. MHPSS providers interviewed for this study explained that comprehensive mental health and psychosocial support services are offered through professionals like psychiatrists, psychologists, and counsellors. Case management services, referrals, and linking vulnerable beneficiaries to resources are being provided by nearly half of organisations [131].

4.3.3.6 Psychotherapeutic medicines

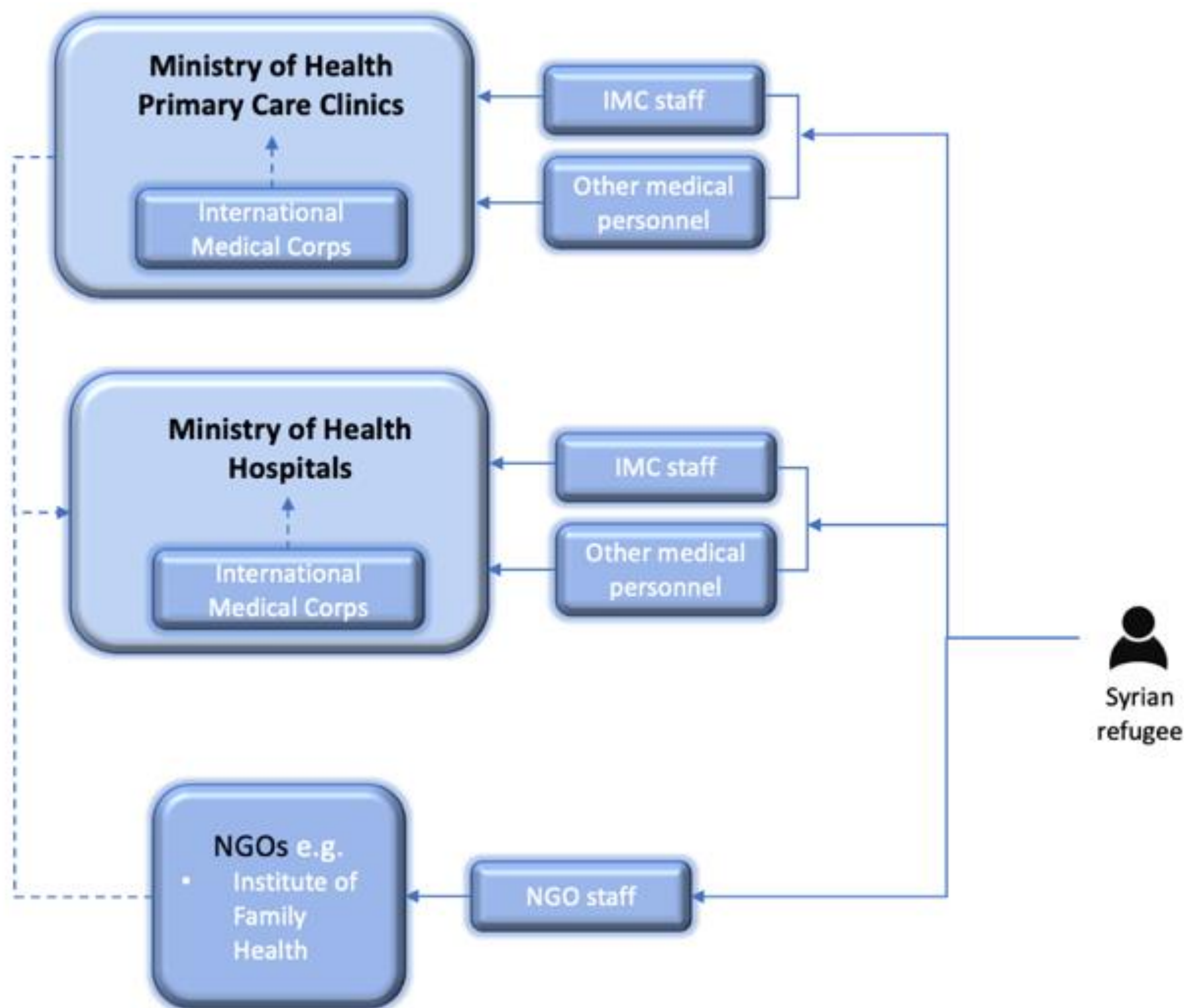
An essential drug list exists for the country and covers psychotherapeutic medicines for the treatment of anxiety and depression among other mental and neurological disorders [139].

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). However, advanced mental health services offered by The National Center for Mental Health are only free for Syrian refugees with a valid UNHCR Asylum Seeker Certificate and the service card provided by the Ministry of Interior. This means they must be registered and have their documents fully processed by UNHCR before having free access to this care [140]. Unregistered refugees often experience long waiting times for their interview with UNHCR, and up until that point must pay out-of-pocket. If they are registered but don't have the proper documentation, they may have to pay 60% higher than the uninsured Jordanian rate [141]. 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 [131, 137]. Referrals to specialised mental health services are possible via both governmental and non-governmental services providers (PR). The pathways are summarised in Figure 4.3.1:

Figure 4.3.1: Pathways to care for Syrian refugees in Jordan



4.3.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability [16] of MHPSS.

Availability:
Three of the providers interviewed for this study thought their facilities had sufficient resources available to address the mental health needs of Syrian refugees, while three 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 [142]. Previous research reported a lack of available services to be a barrier to mental health service utilisation in Jordan [143]. 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 [144]. 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 [137]. In order to fill

gaps in care, it was reported that refugees may seek care from traditional healers or other non-physician providers, seek medications from pharmacies without attending a physician, or skip or lower doses of medication to make it last longer [126]. Another study reported that only 53.4% of respondents agreed with a statement claiming there was availability of their prescription medications at their health facility [138]. Four MHPSS providers interviewed as part of STRENGTHS described a culture oriented toward psychiatry, with a focus on medication rather than counselling or other forms of treatment. They described this as prevalent at all levels, from the government ministries to mental health providers to individuals seeking treatment and expecting medication. However, one provider thought that increasing the availability of MHPSS services aside from psychiatry could aid the bottleneck of service provision, since some individuals would need less resource intensive care than others and not everyone would need medication.

(Geographic) Accessibility:

Four MHPSS providers and one key informant 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). This is supported by a recent study reporting that Syrian refugees felt a general shortage of services available in urban areas was a barrier to accessing care [145]. Transportation to access services was more of an issue for Syrian refugees compared to the Jordanian host community [143]. Whether Syrians were unable to afford transportation costs or had insufficient knowledge about how to use local transport needs further exploration. However, certain studies indicate it is the former, with one study reporting that Syrian refugees prioritised expenditure on transport costs for medical care they valued over MHPSS, and that they described co-payments in combination with transport costs as unaffordable [146]. This is further supported by another study in which Syrian refugee women reported transportation and distance of services from refugee neighbourhoods as major barriers in accessing health services [147]. Four MHPSS providers confirmed that transportation was logistically and financially challenging for both Syrian refugees and providers themselves. Fear of harassment and sexual violence, insecurity and lack of community accountability have been reported to both exacerbate psychological distress and limit the accessibility of MHPSS for Syrian children and young people (and in particular, for girls) [148].

Accommodation:

Data on accommodation was identified from the randomized control trial of PM+ group sessions as part of STRENGTHS and does not apply outside of the context of this research. Both male and female participants who dropped out shared that the time commitment of the sessions were a barrier. Female participants who dropped out shared that it would have been easier to complete the sessions if there was a nursery or play area for children. Among both male and female participants who completed all five sessions, no barriers were mentioned in terms of location and timing. The concept of accommodation should be explored in future work.

Affordability:

Successive policy changes since 2014 have increased the cost of services in government hospitals and primary health centres for Syrian refugees, putting some services beyond the reach of many [149]. MHPSS providers in our 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 [143]. 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 [142]. While the updated policy in 2019 meant that Syrian refugees could access health services at the uninsured Jordanian rate (subsidized

80%), a report by the Jordanian government found that only 35% of Syrian refugees were aware of the change and only 27% had accessed public health services since the change. Among 70% of respondents stated that affording public health remained the biggest barrier, and more than 53% of Syrian households reported spending greater than 10% of their expenditure on health expenses.[150] However, The International Rescue Committee (IRC) conducted a study after this policy change to see if Syrian refugees' views on affordability had changed: 71% of respondents agreed that the amount they were charged was affordable (up from 55% the month prior) [138].

Acceptability:
Stigma and limited awareness of mental health were reported barriers for seeking professional MHPSS care mentioned by all interviewees. These findings are congruent with previous research, which has highlighted stigma, fear of discrimination and a limited understanding of available mental health services as key barriers to accessing care amongst both adults [121, 143, 151] and children and young people [148]. Additional cultural barriers may exist regarding women's attendance to MHPSS without a male family member [152]. 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). Staff in health centres have reported worrying that patients being referred to MHPSS services would perceive this as being labelled "crazy," and emphasized that framing psychosocial activities as "living well" as well as modifying language seemed to be received well and minimize stigma [152]. Another study showed that Syrian refugees in Jordan preferred to remain self-reliant and wanted to rely on their faith rather than seeking mental health support [143]. One provider similarly stated that Syrian refugees may seek help through their religion before going to MHPSS services.

As noted above, there have been efforts to use Syrian refugees who are mental health professionals to provide care for other Syrian refugees and this may support greater levels of acceptability among fellow refugees [134]. This relates to broader efforts to also train lay workers from the Syrian refugee communities which are more akin to the MHPSS services provided by NGOs, than the more formal mental health services provided by government and private providers. This seeks to utilise sources of support from within the communities. The work of STRENGTHS supports this approach of utilising lay-workers [153]. One provider interviewed did emphasize that through their experience and their organisation's own research, there was no preference for Syrian providers over Jordan providers. They stated that culturally and linguistically, they were similar enough for this not to be a major barrier.

4.3.4.3 Quality and safety

From the literature, it is unclear how long refugees generally wait to receive mental and psychosocial services, although Syrian refugees living in camps have reported long waiting times for chronic disease services [151]. Rizkalia et al. (2020) also found that among Syrian refugee women, long waiting periods to see professionals, in addition to limited professionals and a lack of trained professionals were barriers to accessing health services [147]. A system of supervision for social and community health workers is generally not available, although IMC does have a system of supervision 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 [142]. Other studies have pointed to similar concerns from a key informant perspective about a shortage of skilled MHPSS staff [143] and gaps in service provision due to the poor identification and referral of mental health problems by primary care providers [149]. 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. Multiple informants and providers described the MHPSS technical working group as important for both monitoring service provision as well as coordinating it. In this group individuals from different MHPSS providers across the country meet monthly to discuss their service provision and referral pathways. A small sample of Syrians accessing psychotherapy in Jordan (n=67) reported very high levels of satisfaction with their therapeutic relationship with their doctor or nurse [154]. The IRC report supported this finding of high levels of satisfaction, although it was for general health services and not MHPSS specifically: 61.7% of respondents were satisfied or very satisfied with the quality of medical care received [138].

4.3.5 Mental health outcomes

Higher proportions of mental health symptoms have been found amongst Syrians in camp settings [142] than in urban settings, although self-reported distress and mental health symptoms were more severe among urban Syrian refugees [143]. Camp-based studies reported 55% of Syrian men feeling anxious and 49% depressed [155]. Another study comparing populations inside and outside of camps found that Syrian refugees outside of camps had higher perceived psychological health [156]. A further study reported that 56% of Syrian refugees showed signs of psychological distress [144]. More recently, Bryant et al. (2020) found that among a sample of adults screened at Azraq refugee camp, 96% met the cut-off for psychological distress, 76% met criteria for functional impairment, 85% met criteria for depression, and 84% met criteria for anxiety and PTSD [157]. 1.3% of all consultations in the Za'atari camp were for mental health reasons [158]. Studies have also highlighted a large range of psychosocial concerns among Syrians living in Jordan, and how these were exacerbated by both environmental (financial, housing, employment) and psychosocial outcomes (loss of role and social support, inactivity), which are themselves stressors [159].

Among youth, one study found high levels of social phobia [160]. Similarly, Halasa et al. (2020) found moderate levels of social anxiety among Syrian refugee children and found 50% had moderate levels of traumatic stress [161]. Another study with Syrian refugee youth found that 51.8% had significant depressive symptoms and 27.8% endorsed suicidal ideation [162] This is greater than findings by Khader et al. (2021), who reported that 28.3% of Syrian adolescents had depression compared to 27.2% of Jordanian adolescents [163]. Among school-age Syrian refugees, the prevalence of moderate to severe PTSD was found to be 31% [164]. This is in line with findings from Sellouti et al. (2020), who found that among war-exposed children in Za'atari camp, 42% could be diagnosed with PTSD [165].

Regarding PTSD among adults, one study found a prevalence of 38.7% for PTSD, with males reporting significantly worse symptoms compared to females [166]. Another study found that 45.6% of the respondents had developed PTSD, with excessive risk of emotional dysregulation comorbidity [167] Among a large sample of adult Syrian refugees, Bryant et al. (2021) found 15.1% experiencing prolonged grief disorder [168].

4.3.6 Discussion

In this section we explore 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 STRENGTHS.

Our 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), geographical accessibility (unequal distribution of services with services particularly limited in urban areas) and affordability (the increasing costs of services and medicines).

There was less information on the quality and safety of mental healthcare in the country. However, based on initial results it appears staff themselves feel they are undertrained in MHPSS. In terms of general health care, satisfaction among Syrian refugees seems to have improved.

These findings also shed light on existing care and referral pathways in Jordan, and how PM+ could potentially be integrated. There are two main pathways of care for Syrian refugees seeking MHPSS: through NGOs, or through INGOs and the public health system (see 4.3.4.1). PM+ has previously been implemented by International Medical Corps (IMC), an INGO that works closely within the public health system and jointly runs some clinics and hospitals with the Ministry of Health. One potential integration scenario would be to incorporate PM+ into the public health system through IMC, and have it offered by IMC staff at the jointly run clinics and hospitals. This would require integrating PM+ into the duties and salaries of employees, and would need political and possibly additional financial support from the Ministry of Health. Syrian refugees also access MHPSS through NGOs; one NGO that has worked with PM+ is the Institute of Family Health (IFH). This is another potential integration scenario, in which NGOs train their staff to implement the intervention. They could either integrate PM+ as part of their ongoing duties, or hire additional staff focused solely on delivering PM+. This would likely require additional financial support; most of IFH's funding comes from the King Hussein Foundation, run by the royal family. Funding from international donors has notably dwindled according to informants and providers, which may put a strain on integrating any new services. However, the government and royal foundations are reportedly much more aware of the need for MHPSS services within the country and there is political momentum behind this cause. A key piece of integrating PM+ would be working with the MHPSS technical working group, in order to coordinate between providers, inform the ministries, and avoid the duplication of pathways.

The quality and safety of mental healthcare is an area that needs to be explored in more depth to ensure that beneficiaries of MHPSS services are receiving the most optimal, effective, and appropriate services possible. The literature also highlights the need to build on sources of support and expertise from within the Syrian refugee communities to increase access to MHPSS services. Finally, additional exploration of potential implementation partners and funding possibilities could further clarify how to effectively integrate PM+ in the country.

4.4 **Lebanon**

Data presented in this section are based on a desk-based review of existing literature, data and policies, updated in September 2021. 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 were complemented by analysis of three qualitative interviews (three MHPSS providers, all working in the NGO sector). A ToC workshop was also conducted by the WP2 team with STRENGTHS partners and the findings used to support the RA in Lebanon. Ethics approval for these was provided by St Joseph's University, Beirut, Lebanon (submitted in Lebanon by War Child Holland, approved March 24, 2017). Data collection for the interviews took place in May 2017, and the ToC workshop was conducted in 2019.

4.4.1 Wider environment and policies

Lebanon has the second largest number of registered Syrian refugees of the five countries neighbouring Syria [169]. At the end of 2020, some 865 531 Syrian refugees were registered with UNHCR in Lebanon, a decrease of 49 117 (5.4%) since the end of 2019 (28% were below 18 years of age and 52.5% were female [170]. 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 [171]. Overall Syrian refugees comprise approximately one fifth of the total population in Lebanon [172].

Lebanon is considered upper middle-income and has an unemployment rate (6.8%) slightly above the global average (5.7%) [172]. 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 [173]. 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.

The political and financial crisis in Lebanon should also be noted as this has caused major stress to the Lebanese population and institutions, with over half of the Lebanese population now living under the poverty line.

4.4.2 Health statistics in host population

In 2020, Lebanese men had a life expectancy of 77 years and women 81 years respectively[174]. Recent Global Burden of Disease data shows that the adult mortality rate was 98 per 1,000 population and maternal mortality 15 per 100,000 live births in 2017[112]. Both mortality rates are lower compared to their regional average of 155 and 116 respectively [112]. Lebanese nationals have an estimated prevalence rate of 4.7% for depressive and 5.5% for anxiety disorders [32]. These figures are slightly above average predicted rates (4.3% depressive; 4.2% anxiety) for higher middle-income countries [32].

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 [175] and was being revised in 2015 [176].

A National Mental Health Programme (NMHP) was launched in May 2014 which aims to integrate mental health into primary health care [177]. 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 [177, 178].

There is also a Lebanon Crisis Response Plan which focuses on Syrian refugees and is based on a regional plan [110]. It is implemented by the Government of Lebanon and partners, including UN agencies (i.e. UNHCR, WHO) and NGOs [171]. These partners provide support to local government institutions and work through the national health system to respond to the needs of Syrian refugees [110]. 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) [177]. 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 [171]. UNHCR has contracted selected public and private hospitals in Lebanon to provide care for Syrian refugees [179]. The majority of primary health care (PHC) centres are owned and managed by NGOs and most hospitals belong to the private sector [180]. Both primary and secondary care for Syrian refugees is partially subsidized by UNHCR [179].

4.4.3.2 Financing and expenditure

In 2020, the Government of Lebanon spent 6.0% of its GDP on health [172] which accounted for about half (52.5%) of the total expenditure on health covered by social security and 36.4% by out-of-pocket payments in 2017 [112]. For mental health, 4.8% of the total expenditure on health was used in 2017 [112], with over half (54%) going towards mental hospitals [176].

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%) [176]. 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 [171, 181].

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) [176]. 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 [182].

4.4.3.4 Mental health workforce

There were 1.21 psychiatrists working in mental health sector per 100.000 population in the country in 2017[183]. Nearly all mental health professionals (93%), except for primary care doctors, are working for NGOs, private practices or for-profit facilities [176]. In 2013 about 7-9 psychiatrists and 30-45 psychologists were involved in the Syrian refugee response [184]. 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%) [176].

Only a limited amount of time is dedicated to mental health in the education of medical and nursing students [176]. It is unclear what this training comprises. Training gaps are addressed by implementation projects like The WHO Mental Health Gap Action Programme (mhGAP) [180] and The Psychological First Aid Training and Support for Children Exposed to Trauma [185]; 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 [184].

4.4.3.5 Facilities and services

In 2017, there were 12 mental health outpatient facilities attached to hospitals in Lebanon [183]. A variety of MHPSS services are offered to the general population (e.g. counselling, family therapy and school-based activities) [176, 186]. Activities for refugees often fall under psychosocial support and include child-friendly spaces, art-therapy, and support groups [184]. More livelihood projects are being planned and youth targeted to improve their literacy and numeracy skills [171].

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 [187] and it appears this pattern continues to the present day (personal communications). However, referral, and follow-up to inform the referring party rarely takes place between providers of services [184]. 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 [184].

4.4.3.6 Psychotherapeutic medicines

An essential list of drugs is available at the national level, which includes psychotherapeutic medicines [188]. Primary health care doctors are allowed to prescribe medication for mental disorders [176]. 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%) [189]. 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 [16] 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 [184].

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 [184].

Accommodation:

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) [189]. 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 [190]. 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 [184].

4.4.5 Mental health outcomes

Anxiety and depression are the most frequently reported mental health problems among Syrian refugees [136, 191, 192], including the elderly (>60 years) [193, 194] and youth [195]. A 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). According to a new study, an estimated one in four Syrian refugees in Lebanon show moderate to severe depression symptoms. In the entire sample the authors have investigated (n = 3255), the prevalence of moderate to severe depression symptoms (PHQ-2 ≥ 2 and then PHQ-9 ≥ 10) was 22% (n = 706). [196]

Nervousness and anxiety are common in refugee children (5-17 years) [197] in addition to suicidal thoughts [195]. Results from a recent study indicated that 45.6% of the adolescent refugees have developed PTSD with excessive risk for comorbidity with emotion dysregulation. Emotion dysregulation was reported by older refugee children and adolescents. PTSD symptomatology and emotion dysregulation in children and adolescents varied according to coping styles, family relationships, and school environment [198]. In another study in the Bekaa valley, 50.5% of the refugees were <30 years old, and among those younger participants, 83.5% believed that they have no future for themselves and their families, while 15.4% lost hope in a better life.[199]

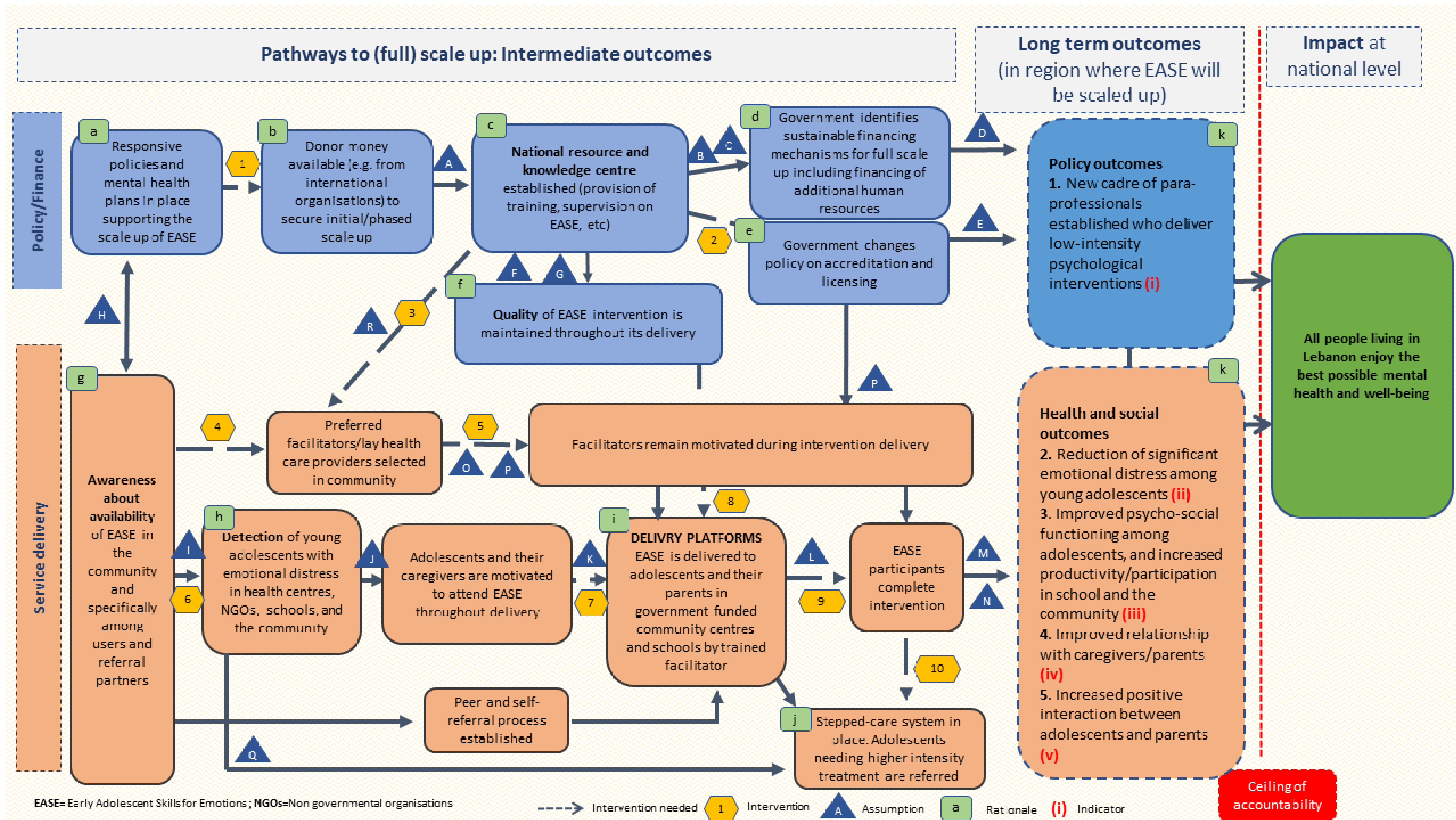
Recent reports also suggest that the specific needs of elder refugees are often overlooked. A study conducted in 2018 indicates a high prevalence of depression and cognitive deficits in elder Syrian refugees in Lebanon, who expressed concerns surrounding illness, loneliness, war, and instability [200].

4.4.6 Theory of Change map

A ToC workshop was conducted on 13 September 2019 in Beirut to discuss the potential of scaling up the EASE intervention of STRENGTHS in Lebanon. Fifteen stakeholders participated in a one-day ToC workshop: three academics and mental health/conflict researchers from universities in the Netherlands and the United Kingdom; six staff from local non-governmental organisations such as War Child Holland; three staff from international organisations such as UNHCR Geneva and UNHCR Beirut;

two staff working in community mental health services with Syrian refugees; one mental health service provider; and one representative from the Ministry of Public Health (Mental Health section) in Lebanon. The main components of the ToC map produced from the workshop in Beirut are given in Figure 4.4.1.

Figure 4.4.1: Theory of Change map for EASE in Lebanon



1 **Interventions**

1.Targeted advocacy to UN donors about EASE and effectiveness of low-intensity psychological interventions as such to obtain funding for (initial) or phased scale up
2. Advocacy to key actors in government to pass new law on accreditation and licensing for new cadre of para-professionals who deliver low-intensity psychological interventions like EASE
3. Psychologists/social workers are master trainers of EASE, are part of the knowledge and resource center and conduct training of new facilitators
4. Key actors in community identify and approach possible/suitable facilitators for EASE in the community
5. Staff motivation activities conducted (e.g. prizes, staff of the week; becoming trainers or co-trainers, certificate)
6. Community health care workers/teachers are trained in the use of the community-case detection tool
7. Intake of patients: Screening conducted with validated screening tool, and exclusion criteria applied (e.g. suicidality, harmful to themselves and others, psychotic behavior)
8. Quality standards are employed by National Resource Center (e.g. fidelity checklist, how sessions are delivered) through unannounced but regular inspections
9. Facilitators receive supervision by trained mental health professional in group sessions
10. Adolescents who need higher intensity treatment after completion of all EASE sessions are refereed to tertiary care

A **Assumptions**

A. NGOs (=user organisations) are required to go through National Resource Center for training and supervision before they can implement and deliver EASE
B. Initial scale up shows positive outcomes on mental health of adolescents, and has a positive impact on the health system
C. Government adopts EASE and supports its full scale up
D. Scaling up strategy aligns with National Mental Health Strategy of Lebanon, and priorities of national government
E. There is a college or technical university which provides training on EASE and other low-intensity psychological interventions to para-professionals . College/technical university works together with National Resource Centre. Para-professionals receive diploma after attending and completing course.
F. Establishment of a national resource centre introduces a system of self-regulation through the delivery of accredited training and supervision thereby preventing unregulated "mushrooming" of EASE
G. There is an adequate management system and logistics in place to observe quality of implementation by National Resource Center
H. Government raises awareness about mental health issues (EASE is a key component of the National Mental Health awareness strategy)
I. Community-case detection tool is being used to identify adolescents in need of EASE
J. Adolescents and parents have heard about EASE and its benefits in the community (adolescents/parents have come across it as part of the national mental health awareness strategy)
K. There are no structural barriers (transport, remote location) hindering uptake of appointments (e.g. access to EASE is in walking distance of patient's house)
L. There is a feedback and complaint system mechanism in place which allows patients to voice concerns to user organisation. User organization is monitored by National Resource Center.
M. There is a outcome monitoring and evaluation system in place, and this data is monitored by National Resource Center.
N. EASE remains effective if also delivered by Lebanese people
O. Government allows non-Lebanese (e.g. Syrians) to be paid so that they receive an incentive/stipend for their work.
P. Accreditation scheme and career pathway for facilitators in place
Q. Adolescents with severe symptoms such as psychotic symptoms are identified and referred to higher intensity treatment
R. Qualified master trainers with the right professional, cultural and linguistic background are available. Master trainers are motivated and can be retained.

a Rationale	(i) indicators

Rationale

a) Responsive mental health plans and scale up of mental health services are key components of the National Mental Health Strategy of Lebanon, and outlined in their 2015-2020 plan. Reference: National Mental Health Programme Lebanon and Strategy available at https://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program (accessed 21.10.2019)
b) Some mental health ad psychosocial support services in Lebanon are funded by international organisations such as UNICEF. International donors could fund an initial scale up phase of EASE (view of stakeholder, ToC workshop)
c) There needs to be a national planning mechanism or resource center to regulate the delivery and implementation of EASE (view of stakeholder, ToC workshop)
d) Initial funding by international organisations won't be sufficient nor sustainable for full scale up; sustainable and long-term funding needs to be identified by the government (view of several stakeholders, ToC workshop)
e) Sustainable scale up requires the establishment of a new cadre of para-professionals who deliver low intensity psychological interventions such as EASE. This also requires a policy change on accreditation and licensing (view of stakeholder, ToC workshop)
f) National resource center maintains quality control over the delivery of EASE, thereby also preventing "mushrooming" of EASE (i.e. unregulated delivery of EASE by NGOs) (view of stakeholder, ToC workshop)
g) The community needs to be aware about EASE and its potential benefits prior of scaling up. This is important to increase treatment demand and help-seeking (view of stakeholder, ToC workshop)
h) Potential recipients of EASE need to be identified in multiple places such as schools, community centers and health care centers as help-seeking might (initially) be low (view of stakeholder, ToC workshop)
i) It is important that EASE is delivered in multiple places which are most convenient and accessible to adolescents and their parents. This is to decrease barriers to accessing treatment such as transport problems, inconvenience with child care (e.g. mother needing to look after younger siblings, etc.) (view of stakeholder, ToC workshop)
j) EASE is a low intensity psychological intervention relying on the availability of a stepped-care system in which adolescents who need further intensity treatment are referred to additional care or higher intensity treatment (view of stakeholder, ToC workshop)
k) Long-term outcomes: **i.** A new cadre of para-professionals needs to be established for full scale up as current human resources wont be sufficient (view of key stakeholders, ToC workshop). **ii & iii.** Reduced symptom severity (psychological distress) and improvement in psychosocial functioning are primary and secondary outcomes of the EASE trial in Lebanon. An improvement in mental health symptoms may also improve adolescent's participation in the community and may positively improve school attendance. (view of NGO provider, ToC workshop). **iv.** EASE is hypothesized to positively influence the relationship of the adolescent with their parents or caregivers (view of EASE researcher, ToC workshop). **v.** EASE may have a positive impact on the interaction between adolescents and parents, and may decrease adolescent's aggression (view of stakeholder/EASE implementer, ToC workshop).

indicators

Policy outcomes

(i) New cadre of para-professionals established (who deliver low intensity psychological interventions), and accreditation system in place (e.g. accreditation through a technical university or college)

Health and social outcomes

(ii) Significant reduction of severe psychological distress among young adolescents (measured with the PSC-35 youth report* or any other equivalent tool)
(iii) Significant improvement of psycho-social functioning among adolescents (measured with Impairment of Daily Functioning Questionnaire*), and increased productivity/participation in school or non-formal education (e.g. measured by number of days absent from school or non formal educational activities)
(iv) Significant improvement in relationship with caregivers/parents (e.g. by asking parents/adolescents questions around attitudes towards child/parent, and change in parenting practices measured with the Alabama Parenting Questionnaire-42*)
(v) Increased positive interaction between adolescents and their parents (e.g. investigated through qualitative interviews)

**As measured in the EASE trial in Lebanon (Brown et al, 2019. Early Adolescent Skills for Emotions (EASE) intervention for the treatment of psychological distress in adolescents: study protocol for randomised controlled trials in Lebanon and Jordan. Trials, 20, 545)*

Intermediate outcomes and pathways to scale up
ToC workshop participants identified two separate pathways to scale up (a policy/finance pathway; and a service delivery pathway) which are required to achieve the long-term outcomes outlined above.

Policy/Finance pathway
The earliest intermediate outcome on the policy/finance pathway is the availability of responsive policies and mental health plans supporting the scale up of EASE. Stakeholders discussed that the Lebanese National Mental Health Strategy 2015-2020 could act as political framework of the EASE scaling up effort. The National Mental Health Strategy would provide legitimacy to advocate for donor money from international organisations to secure an initial/phased scale up of EASE (i.e. in one region or district). A National Resource and Knowledge Centre (providing training and supervision on EASE) would have to be established afterwards. This would introduce a system of quality control, self-regulation, and prevent unregulated "mushrooming" of EASE in Lebanon. Any user organisation or NGO intending to implement EASE would need to go through the National Resource and Knowledge Centre. A successful initial scale up phase (showing positive outcomes on population's mental health and positive health system outcomes) would then support the government's decision to identify sustainable financing mechanisms for full scale up. This would include financing of a new cadre of health care workers (or para-professionals) to deliver low intensity psychological interventions at scale. This would imply that policies on accreditation and licensing would need to be changed.

Service delivery pathway
Awareness about the availability of EASE in the community and specifically among users and referral partners was identified as the earliest intermediate outcome on the service delivery pathway. It was hypothesised that this would legitimise and enable teachers, community health care workers and social workers to identify adolescents in need of EASE in the community by applying the community case detection tool. Adolescents having the required criteria for treatment entry would receive the EASE intervention in different places/platforms of care such as schools, community centers or primary health care services. This would facilitate access to care and minimize barriers to treatment entry such as transport problems. Adolescents would finish the EASE intervention as required according to the manual, however, cases of clinical worsening or adolescents not responding to EASE would be refereed to higher intensity treatment. Referral to higher intensity treatment was also suggested to be necessary at the detection stage (e.g. for adolescents showing clear exclusion criteria of EASE such as adolescents with psychotic symptoms). A peer and self-referral process was also proposed, enabling adolescents and their parents/caregivers to enter EASE without being identified via the community case detection tool.

Awareness about EASE in the community was anticipated to lead to increased awareness of EASE among service providers and other key actors in the community. It was discussed that this would also facilitate selection of preferred facilitators/lay health care providers by key community actors in the community. EASE facilitators would be trained by the National Resource and Knowledge centre via master trainers (i.e., trained mental health professionals). Motivation of facilitators was seen as a key component mediating the effectiveness of EASE; it was discussed that motivation could be ensured by several mechanisms (e.g., by awarding prizes, staff of the week, etc) but most importantly by licensing facilitators/para-professionals and by accrediting their work.

4.4.7 Discussion

Our rapid appraisal was predominantly based on secondary statistics and the available literature, but also on some initial qualitative research conducted by the STRENGTHS partners and also informed the

ToC workshop in Beirut. More primary qualitative research was collected as part of WP2s other activities and this will help to further inform understanding on the responsiveness of the Lebanese health system for meeting the mental health needs of Syrian refugees.

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+.

Conducting a ToC workshops on scaling up EASE provided valuable insights for policy and practice. The two pathways to scale up, 'finance and policy' and 'service delivery highlight the need for both vertical and horizontal scale up. Vertical scale up is defined as efforts to institutionalize the intervention in the policy and legal framework of the country and is realised if the government is formally adopting the intervention. Horizontal scale up refers to expansion of the intervention to new geographically areas, and this is usually done by the implementing organisation. We conclude that both horizontal and vertical scaling up are imperative for a sustainable scale up as expansion or replication is understood to be insufficient on its own. We found ToC to be a valuable methodological tool; its methodology helped to unpack the complexity of scaling up and provided a structured means of working together with key stakeholders. The ToC map highlighted key barriers and health system bottlenecks which may hamper scaling up; these will be further explored through in-depth qualitative interviews in Lebanon.

The findings from the ToC workshop for Lebanon were also compared and synthesised with ToC workshops also led by WP2 for STRENGTHS and these have been written up as a journal publication.[21]

Finally, the current major political and financial crisis is placing huge strain on populations in Lebanon and the health system's ability to meet those needs and further research is required to explore this further.

4.5 **Sweden**

Data presented in this section are based on a desk-based review of existing literature, last reviewed April 2021. The final Annex for Sweden (containing key data from the literature) is available upon request and will be made available on the STRENGTHS website.

In addition, secondary data were complemented by analysis of thirteen qualitative interviews: four (mental) health providers (PR) and nine key informants (KI), such as researchers, NGO workers, policy advisors. Ethics approval for these interviews has been provided by Freie Universität Berlin Research Ethics Board in Germany and the Observational Committee of the London School of Hygiene & Tropical Medicine (14330 - 1) in the UK. Local approval has also been granted by the Swedish Ethical Review Authority (2020-00261) in Sweden. Data collection took place between February 2021 and June 2021.

4.5.1 Wider environment and policies

From 2011 to 2020, 123,431 Syrians sought asylum in Sweden [201], which is 9% of the total Syrian Asylum Applications in Europe [202]. Over a quarter (26%) of all asylum applications in Sweden (received during 2011-2020) were from Syrians, out of which 36% were women/girls, 64% men/boys, and 33% children [201]. The majority of Syrians (89%) applying for asylum in Sweden were granted a residency permit between 2011 and 2020 after an average wait of over 8 months [201]. Syrian asylum applications to Sweden have progressively slowed from a peak of 162,877 in 2015, dropping to 20-30,000 per annum in the succeeding years, to 12,991 in 2020. The proportion of decisions granted has also decreased from 90% in 2015 to 63% in 2020 [201].

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 granted a temporary residence extension of two years, and permanent status can only be granted by meeting the requirements of Swedish language skills, civic knowledge, the ability to financially support themselves, and holding a temporary residence permit for over 3 years [203].

Sweden, a high-income country has an unemployment rate of 8.5% (global average is 6.5%) [204]. Figures for the Syrian refugee workforce in the country are unknown, although employment amongst foreign-born workforce is 8.6% [205]. In 2015, a fast-track process was introduced for refugee health professionals to enter into the labour force [206] and the Swedish government are currently working on strengthening legislation to attract international competence and strengthen the position of (highly skilled) labour immigrants in the labour market [207]. A recent study of adults attempting suicide in Sweden found that 32.2% of refugees were unemployed, compared to 19.8% of Swedish-born [208].

4.5.2 Health statistics in host population

The life expectancy in Sweden is 81 and 84 years for men and women respectively [209, 210]. Adult mortality rate was 52 per 1,000 population [211], 58 for male [212], 38 for female [213], and maternal mortality was 4 per 100,000 live births in 2017 [214]. All mortality rates are lower compared to their regional averages [214].

5.0% of the general population were diagnosed with depressive disorders and 5.3% with anxiety disorders in 2019. These figures are similar to estimated rates (4.3% depressive: 5.4% anxiety) in high-

income countries. 1.5% of the Swedish population have died by self-harm and 0.9% of deaths were caused by mental health and substance use disorders [215].

4.5.3 Mental health system inputs

4.5.3.1 Leadership and governance

Sweden has a mental health policy and plan which contains specified indicators or targets against which its implementation can be monitored [216]. Regulation of mental health is decentralised. As explained by a research partner, each municipality has its own unit for mental health, although each municipality is required to follow recommendations by the National Board of Health and Welfare and there is an agreement between the government and Municipalities and Regions (SKR) which is called "Uppdrag Psykisk Hälsa" (i.e. an umbrella for working with mental health). This research partner also outlined that policies and programmes for refugees vary across municipalities.

Sweden scores 'favourable' in migration integration policies and amongst the top 10, with a Health score of 83 [217]. Various NGOs, like Red Cross and MSF, provide MHPSS services for refugees. It is unclear to what extent these services are regulated by the Swedish government, although a key informant advised that the Swedish government provides funding to the Swedish Red Cross to deliver MHPSS services to refugees in Sweden (KI).

4.5.3.2 Financing and expenditure

In 2018, the Swedish Government spent 10.9% of its GDP on health [218]. The Swedish health system is largely funded via regional taxes, although 13.8% of total expenditure on health was out-of-pocket [219]. Proportional health spend on mental health is unknown, however 7-8 % of hospital care spend is dedicated to mental health [220].

In 2009, new legislation enabled a quasi-market for mental health service provision by municipalities, promoting consumer choice of provider. As providers entered and left the market, findings were that the market was so financially constrained that there were no profits to be had in the mental health market [221].

All asylum seekers are offered a free health assessment [222]. Asylum seekers and refugees with a permit are required to pay for health services and medicines in the general health system. An asylum seeker can receive a reimbursement from the Migration Agency if his/her health expenses exceed 400 Swedish krona (SEK) (approximately 40 Euros) during a 6-month period [223]. Individuals with refugee status are treated the same as all citizens and pay the full cost of prescribed medications up to SEK1,125 (109 Euros) annually for drugs covered on the national drug benefits scheme, or up to SEK 2,250 for prescribed drugs not within the scheme. While county councils set co-payment rates for health visits, nationally, annual out-of-pocket payments for all citizens are capped at SEK1,100 (120 Euros) per individual [61]. 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

Sweden has a strategy to be a world leader in e-health by 2025. High quality information systems are deployed in hospital and primary care settings and adoption rates are high. Patients aged 16+ can access the medical records online, read physician notes, view their personal health data and schedule appointments. 99% of Swedish prescriptions were e-prescriptions in 2017 [61]. The Asylum Healthcare Platform compiles data from the Swedish Migration Agency on asylum statistics and healthcare data

for asylum seekers as well as from county councils/regions [224]. NGOs involved in MHPSS for refugees publish data on their activities within their annual reports, for example the Swedish Red Cross [225].

4.5.3.4 Mental health workforce

The number of mental health professionals in Sweden is above many of its regional counterparts [226], with 20.86 psychiatrists and 50.57 mental health nurses per 100,000 population [227]. Primary care providers (public and private) are "paid a combination of fixed payment for their registered individuals (60-95% of total capitated payment), fee-for-service (5%–38%), and performance-related payment (0%–3%) for achieving quality targets"[61]. It is unclear how MHPSS providers in the NGO sector are reimbursed, although a key informant has advised that the government provide funding towards the Red Cross MHPSS services (KI).

Primary care nurse education comprises approximately 2 weeks of theoretical education in mental illness and 5 weeks of clinical education in psychiatric wards. However, nursing students report lacking theoretical knowledge during clinical practice, especially within psychiatric care [228]. It is unclear if refresher trainings are being offered.

The Transcultural Centre provides cross-cultural training for health professionals (public and private) in Stockholm County and beyond [229]. 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 [230].

4.5.3.5 Facilities and services

The 290 municipalities and 20 regions are responsible for organising and providing primary and secondary mental health services respectively, integrating treatment within primary health care (PHC) in Sweden [61, 231]. CMDs can be treated at PHC level, with providers allowed to prescribe psychotherapeutic drugs [231]. 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 [231-233]. Internet-based CBT is increasingly used as means to address shortages of mental health providers, particularly for the treatment of depressive and panic disorders [231]. Furthermore, a recent ICBT study to treat symptoms of depression, insomnia and stress in Arabic-speaking immigrant populations indicated promising treatment results [234]. Interviewed MHPSS providers added that psychotherapy, Eye Movement Desensitization & Reprocessing (EMDR), and narrative exposure therapy were being offered to Syrian refugees (KI).

The Swedish Red Cross runs six treatment centres, for survivors of war and torture, in Skellefteå, Uppsala, Stockholm, Skövde, Gothenburg and Malmö and are a well-established part of the healthcare delivery landscape, treating 1,700 patients, predominantly asylum seekers and refugees, in 2019 [225]. 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) [235-237]. Health communicators are active in selected municipalities, who inform newly arrived asylum seekers and refugees about the health system. These communicators speak the same language and have a similar cultural background to the refugees. In response, refugees have received health communicators well and have identified them as helpful in navigating the healthcare system [238].

By law, all asylum seekers in Sweden should be offered a free, voluntary health assessment to identify their physical and mental health needs, although participation is low (around 50%). Qualitative research by Delilovic and colleagues (2018) amongst authorities and health providers involved in the

delivery of health examinations found that some of their study respondents felt examinations focused too heavily on screening for infectious disease rather than addressing psychological needs. Furthermore, some providers in their study described ethical concerns around delivering these assessments when there is no guarantee that follow-up care could be provided [239]. In interviews for our study, MHPSS service providers shared the challenge that they have to cover many tests during the 'health assessment' and that the allowed 1 hour window is often insufficient time to cover mental health as well, or to cover it to any depth (PR). Given the scale of asylum seeker / refugee influx in 2015, services were overwhelmed and many child and adolescent psychiatry units around the country refused to treat children and youth while in the asylum process, claiming that the necessary stability for successful PTSD treatment was lacking [240].

4.5.3.6 Psychotherapeutic medicines

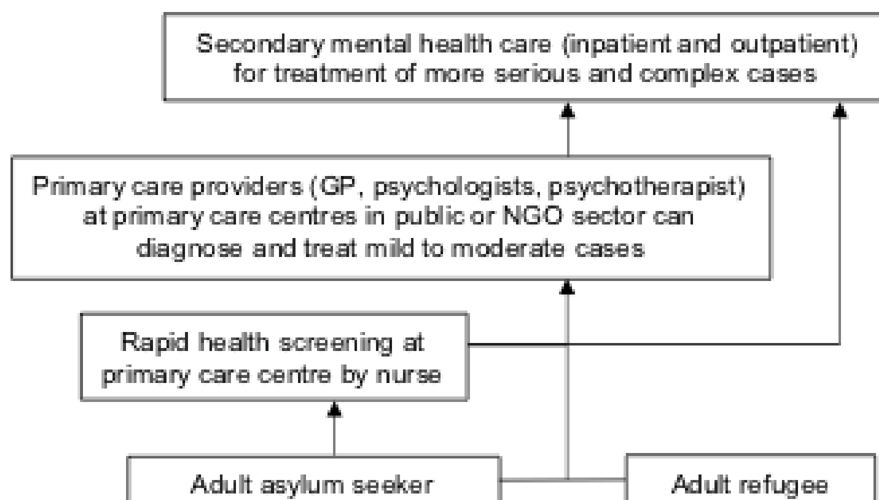
Essential drugs lists are determined at county level in Sweden, meaning the availability and content of such lists may differ. The drug list for Stockholm County Council includes psychotropic medicines for anxiety and depression [241]. A recent study established a statistically significant difference between the time for unaccompanied refugee minors when compared to the longer time periods for accompanied refugee minors, to access inpatient and outpatient psychiatric care and being prescribed for psychotropic drugs. The differences corresponded to 1.58 years (unaccompanied minors - UMs), compared to 3.86 years (accompanied minors - AMs) for impatient care, 1.37 (UMs) years vs 3.10 years (AMs) for outpatient care, and 1.58 years (UMs) vs 4.47 years (AMs) to first prescription of psychotropic drugs [242].

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 4.5.1.

Figure 4.5.1: 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 [222] (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 (PR). However, county councils are only obliged to provide asylum seekers and undocumented migrants “care that cannot be deferred”. The interpretation of this term differs regionally and some NGOs report needing to advocate for individuals in order to guarantee access to MHPSS [243]. The facility completing the health check can often be different from the local GP/PHC facility, indicating a further hand-off or disconnection for asylum seekers, prior to them achieving standard public care once residency is achieved (PR).

Primary care providers (e.g. psychologists, psychotherapists) at these units can offer treatment to Syrian refugees with minor to moderate mental health issues. While residents in Sweden can freely choose their primary care provider, either public or private [231], asylum seekers and refugees are generally directed to a specific health provider specialised in treating these groups, often personnel are located in the asylum centre accommodation, or are part of the parallel refugee healthcare system (PR:KI). These specialist providers 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 [231] (PR:KI). Prescriptive medicines can be bought at the pharmacy and are often 50 krona (5 Euros) for adult asylum seekers and are free for those under 18 years of age [223].

Severe cases who do not benefit from treatment in primary health care are referred to secondary care (PR), which can be inpatient or outpatient. Patients can also access secondary care directly via self-referral [231], although MHPSS providers mention that refugees can struggle to achieve a specialist appointment directly and can require the support and follow-up from the GP to do so (PR).

The Swedish public employment service, ‘Arbetsförmedlingen’ is identified by MHPSS providers as an important source of referral for adult refugees (PR). Teachers in some cases also act as a valuable point of mental health referral for refugee children [244].

4.5.4.2 Access and coverage

Access and coverage encompass the availability, accessibility, accommodation, affordability, and acceptability [245] of MHPSS. Healthcare utilisation due to common mental disorders, has been found to be lower in refugees living in Sweden, than in Swedish-born peers, with the association being consistent over time [246], whilst a recent study of adult asylum seekers found that 28% self-reported a need for healthcare [247].

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.

Mental Health intervention programmes for refugees have been offered over preceding years, including ‘Teaching Recover Techniques’, a community -based group intervention addressing PTSD for refugee youth, and ‘AMIN’ a psycho-social group intervention offered in asylum accommodation. Studies report that the ability to offer these interventions had been based on external funding, which is now less possible due to changes in resource allocation to refugee care, which is now at a lower level to the 2015 refugee crisis [248, 249].

(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. According to healthcare providers, low participation in voluntary health assessments for refugees could be attributed to a lack of information and difficulties getting to appointments [239]. This is supported by interviews with asylum seekers who reported mobile clinics and transportation organised by refugee accommodation centre staff as facilitators of service use [250].

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 (PR). In a study of predominantly Syrian refugees in Sweden, the most commonly reported reason for refraining from seeking healthcare was language barriers (40%) [251]. In addition (to language barriers), lack of information and inadequate knowledge of how the healthcare system works in Sweden, were also highlighted as barriers for refugees [252]. Furthermore, low mental health literacy and limited exposure to Western concepts of mental health add cultural access barriers for newly arrived asylum seekers [253].

Similarly, asylum seekers and refugees in another study described not understanding the voluntary nature of health assessments, since invitation letters were delivered in Swedish [250]. Integrating cultural mediators into healthcare settings has shown promising results [243]. Since April 2020, prompted by Corona and the urgent need to increase accessibility to non-Swedish speaking residents, health centres in Stockholm, Gothenburg, Norrkoping, and other main cities in Sweden have implemented telemedicine platforms with a broader language reach than has previously offered, where healthcare professionals fluent in different languages (Arabic, Somali, Tigrinya/ Amharic and Persian/Dari) are available via telehealth to provide information, triage symptoms, and guide on home care. The current scope only relates to Corona, although this highlights the potential for healthcare language accommodation in Sweden [254].

Affordability:
Affordability issues need to be explored in future qualitative work, since they did not arise yet in existing studies and interviews.

Acceptability:
All PRs and KIs perceived a need for an additional intervention such as Step-by-Step (SbS), a digital mental health intervention for Syrian refugees, that would have lower barriers of use and therefore be more accessible to greater numbers of Syrian refugees and asylum seekers. Design considerations that increase access and acceptability include the online digital and app format, relevant language (Levantine Arabic dialect), and the e-helpers to offer support. “For younger people, that's a trend (digitisation of society) that works to the advantage if they work, they may have working hours they are not compatible with going at certain hours to a healthcare facility.. so if you can go anytime you want and then at your own pace, that's advantageous.”(PR). PRs and KIs also confirmed recent research that Syrians refugees are “…the most tech-savvy population of migrants in history”[255]. Furthermore, a PR commented that, “You see that interventions that are entirely self-guided are often effective but maybe people don't do them as much, So I think Step-by-Step has found a good balance between being.. about scalability, but also that there's someone that you [SbS user] can at least contact if you want to”.

Mental health interventions do however need to address the cultural barrier of mental health stigma in Syrian society. “The idea of you having a psychotherapist or psychologist out in the community that people booked an appointment to see as a family, is just a completely foreign unheard-of concept,

and for people also to speak about things outside of the family or to talk about difficult emotions on an individual level, it's not something that's common in that society, it's a very kind of western concept from their perspective" (KI). A recent ICBT intervention addressing CMD for Arabic-speaking immigrant populations struggled to achieve one third of the targeted recruitment for the intervention, despite the intervention being free and various relevant channels being leveraged for recruitment [234]. This low level of interest may be due to different cultural framing and understanding of migration-related stress [253]. Low interest could also be connected to asylum-seeker priorities, where livelihood (58.8%), separation from loved ones (48.8%), displacement from home (45.9%), distress (34.1%) and too much free time (30.1%) were self-identified by refugees as more significant priorities than healthcare needs (28.2%) [247]. There are established cultural differences between Sweden and Syria regarding mental health. According to refugee study participants, mental health problems or seeing a psychologist was embarrassing, stigmatising, and in Syria could cause trouble such as a girl not being able to marry. This is compared to the cultural view in Sweden that it is perceived as 'normal' to see a psychologist [244].

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).

Recently arrived refugees find concrete written health-related explanations valuable, but often not accessible or adapted to their requirements. Experiences are that language and prior knowledge is sometimes not considered in meetings with health care professionals. The concluding desire is for concrete explanations and contextual Swedish knowledge to be made available in a variety of sources, through a variety of formal and informal channels, and specifically for recorded messages of healthcare facilities and voicemail messages to be accessible to non-Swedish speakers [256]. 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).

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 others (12.4%) did not undergo the assessment [257]. A policy maker in our study explained that the percentage of asylum seekers attending these health assessments has increased over the years (currently about 50%). Additionally, this interviewee commented that assessments focus on physical issues and that "questions linked to mental health rarely come up". This is in line with other studies showing that while health assessments were generally positively received by asylum seekers, their psychological needs were overlooked [250, 257]. Screening for mental health problems among asylum-seeking minors was similarly reported to be inadequate [258, 259]. Some asylum seekers described disappointment that the health professionals delivering assessments had not provided them with more information about how the Swedish healthcare system works, how much services cost, what they were being tested for, and not having received the results of these tests [250].

Whilst Sweden has specific targets for healthcare wait times, there is no disaggregated data for either refugees, or for mental healthcare. The targets set by the Swedish government are no more than 90 days for first consultation and no more than 90 days for a subsequent specialist appointment

Generally, 77% of (general population) patients have waited 90 days or less for a first visit to specialised care in the public or private sector, although this varied from 69% to 90% between districts [260, 261]. Wait times for specialised psychiatric care were considered to be long (6-12 months) by a policy maker interviewed in our study in 2018, although an MHPSS service provider interviewed for our study in 2021 explained that due to covid, less patients were coming forward, and that they had essentially no wait lists in 2021, however due to administration it can take one month to set an appointment. Based on anecdotal evidence, we understand that most refugees and asylum seekers would experience wait times greater than 90 days to access primary or secondary care.

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 [61], including one on "Internet-Based Psychological Treatment" which focuses on common mental disorders [262].

The asylum process is also highlighted as negatively contributing to mental wellbeing, with mental health interventions being insufficient for the median level of severe distress and moderate severity clinical insomnia being experienced in asylum centre accommodation. In addition, the government strategy of 'distributing' asylum seekers around the country, impacts the asylum seeker's location and affects treatment continuity, this being the major reason for intervention non-completion [249]. A recent ICBT study addressing CMD for Arabic-speaking immigrant populations also highlights the unstable living conditions and location as the major likely reason for intervention drop-out, where 30% of agreed participants were not even able to commence the intervention [234]. In another similar intervention study, 'Hälsostöd', 36% drop-out was experienced due to re-location to another asylum-seeker accommodation, or a decision on the asylum application [263].

4.5.5 Mental health outcomes

A cross-sectional study of Syrian refugees, recently resettled in Sweden, found high levels of CMDs, including depression (40.2%), low subjective well-being (SWB) (37.7%), anxiety (31.8%), and PTSD (29.9%) [264]. Longitudinal population studies conclude that compared to Swedish-born youth, refugee youth have a slightly lower risk of treated major depressive and anxiety disorders (0.73 vs 0.74, but a 3-to-8-fold higher risk of post-traumatic stress disorder (PTSD), of 2.78 and 8.40 for accompanied refugees and unaccompanied refugees respectively [265].

4.5.6 Discussion

In this section we have analysed the responsiveness of the Swedish health system to the MHPSS needs of Syrian refugees in the country. Our appraisal was based on available statistics and literature, as well as qualitative interviews collected as part of the STRENGTHS project.

This rapid analysis suggests that Syrian asylum seekers and refugees do not actively seek mental health care, and mental health is often not enquired about by healthcare providers. Post-migratory stressors such as (lack of) income, asylum-accommodation and geographical movements within Sweden, result in asylum seekers and refugees not being able to prioritise mental wellness.

Furthermore, western concepts of mental health are unfamiliar and culturally different to the heavily stigmatised view of mental health common in Syria, and mental health literacy is commonly low. Language creates a barrier in knowledge to navigate the Swedish healthcare system, and in organising appointments. Translators are often available for appointments in primary healthcare, yet a lack of patient trust in the education level and confidentiality of translators can cause resistance to discussing stigmatised topics like mental health. Health screenings for asylum seekers are too short to adequately inquire about mental health, hampering early detection of psychological issues.

Initial findings also indicate that there are a lack of health centres and providers specialising 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 surprising as the literature indicates that refugees are required to make out-of-pocket payments for their health visits and medications. While rates are heavily capped, this might be an additional barrier to access (face-to-face) mental health care. Further exploration is required on this issue.

PRs and KIs were in agreement that a digital mental health intervention such as SbS could be an additional and complimentary offering to address common mental health concerns for Syrian refugees. Potential integration scenarios of SbS include scaling up both inside the health system and outside of the health system. Integration of SbS within the health system could imply offering SbS as a first step in a stepped care provision within primary health care, offered by nurses, GPs and psychologists. Scaling up outside of the health system has additional benefits of a wider potential reach, where refugees who may not engage with the health system could still access the SbS intervention. In this scenario, offering the app-based intervention could be integrated through organisations commonly in contact with refugees such as asylum accommodations, language schools (mandatory for refugees), NGOs, and refugee community groups.

When considering the potential for scaling up SbS preliminary findings (though interviews with PRs and KIs) indicate six key influencing factors, including quality and accountability; concept acceptability and accessibility; stigma; peers and influencers; key touch points; and evidence and impact. Quality and accountability were confirmed as critical to health professionals and the ability to scale up within the Swedish health system, where clarity on roles and a quality system would be required to ensure effectiveness and non-maleficence. The concept acceptability was considered to be broadly positive from both a user and health professional perspective, whilst also improving accessibility for target users given the digital format and possibility to scale outside of the health system. Stigma is a general barrier to people seeking support for mental health concerns, although appears heightened in Syrian society and culture. Promotional language on SbS uses non-technical and medical language to minimise this potential barrier. The Syrian community is a relatively closed community where word of mouth is highly influential, hence the planned use of peers and influencers to promote the SbS intervention. Bringing awareness and offering the intervention through existing key touch points and trusted organisations already working with refugees was considered by PRs and KIs to be highly important to increasing the reach or number of Syrian refugees who hear about and have the opportunity to access the intervention. Finally, the evidence-base on the positive impact of the intervention in achieving an improvement in mental well-being of the target population is a key influencing factor of the scaling. This aspect is particularly critical for scaling within the Swedish healthcare system. These preliminary findings on the scalability of SbS are currently being complemented with additional interviews and compared with findings on the scalability of SbS in Germany and Egypt. Final analyses will provide more detailed knowledge about ways to integrate SbS in Sweden and factors influencing integration.

4.6 **Switzerland**

Data presented in this section are based on a desk-based review of existing literature, data and policies (updated in September 2021), and secondary data analysis of qualitative interviews. These interviews included key informants (n=5; KI) such as two policy makers; healthcare providers (n=5; PR) including two working in MHPSS care and three in primary health care; and individual interviews (n=4) and two focus groups (1 male; 1 female; 20 individuals total) with Syrian refugees not using MHPSS (SR non-user). These interviews conducted for the STRENGTHS study have also been published as journal papers.[266, 267]

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. The findings have also been published elsewhere from these interviews.[266]

An annex is available with the key collated data from the rapid appraisal method for Switzerland, along with a spreadsheet of key published literature identified on Syrian refugees mental health in Switzerland. These will also be available on the STRENGTHS website.

4.6.1 Wider environment and policies

From April 2011 to December 2020, 21,105 Syrians refugees and asylum-seekers sought refuge in Switzerland [268]. Asylum seekers arriving at the Swiss border are referred to reception and procedure centres across different cantons or the 'test centre' in Zurich that offers an accelerated asylum procedure [269] (PR). In 2016, 37% of all Syrian nationals in Switzerland (56% male; 44% female) were aged 17 or under [270]. 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) [270].

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 4.9% [111]. Figures for the Syrian refugee workforce in the country are unknown; however, unemployment amongst foreign-born workers is higher than the national average (8.2% vs. 4.7%) [271]. 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 82 and 86 years for men and women respectively [111]. Adult mortality rate was 49 per 1,000 population and maternal mortality 5 per 100,000 live births in 2015

[112]. Both mortality rates are lower compared to their European regional averages of 124 and 16 respectively [112].

Estimated prevalence rates of depression and anxiety disorders are 5% among the general population [32]. These figures are similar to average predicted rates (4.8% depressive; 5.6% anxiety) for high-income countries [32]. 1.99% of the Swiss population was estimated to have died by self-harm in 2015 and 0.87% of deaths were predicted to have been caused by mental and substance use disorders [32].

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 [272]. However, mental health is covered in other laws and mentioned in the general health policy [273]. A mental health plan does exist and includes the integration of mental health into PHC [273]. As for migration integration policies, the country's overall score was 'halfway favourable' and for health 'favourable' [58].

Various NGOs, like the Red Cross and Caritas, provide MHPSS services for refugees. It remains unclear to what extent these services are regulated by the Swiss government.

4.6.3.2 Financing and expenditure

In 2018, the Swiss Government spent 11.9% of its GDP on health [111]. The Swiss health system is funded via social security (71.5%) but also through patient fees (26.8%) [112].

Health insurance is mandatory in the country since 1996 [274]. Cantonal authorities and social welfare institutes arrange and pay for the health insurance of asylum-seekers and refugees [275] (KI). Counselling by a psychologist is however not covered except if it is carried out under a doctor's or psychiatrist's approval [276]. 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 and so did not capture data on Syrian refugees. [277].

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 [272, 273]. Primary care providers (public and private) are predominantly paid by fees for service (90%) but also via capitation (10%) [274]. 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 [278].

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 [279]. Psychotherapy is the main service offered in psychiatric care and can be supplemented by drug

treatment [279]. Study participants (PR) highlighted the availability of outpatient clinics for the victims of torture and war.[2]

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[3], although 'mental health' is not listed as a separate disease group; anti-depressive drugs are covered under neurological diseases [281]. 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 Care pathway

The care pathway of Syrian asylum seekers and refugees showing their first contact with the Swiss health system to accessing MHPSS care is shown in Figure 4.6.1. Asylum centres do not regularly offer health screening according to a provider interviewed in our study. Nursing staff and social workers are those to whom refugees most commonly report any health complaints (PR; KI; SR non-user). These professionals can refer adult asylum seekers and refugees to the responsible GP (for adults) or paediatrician (for minors) (PR; KI; SR non-user). The GP is the gatekeeper in the Swiss health system for refugees (PR; KI). GPs can diagnose, prescribe psychotherapeutic drugs, and refer Syrian patients to either MHPSS providers at: i) general socio-psychiatric facilities (for less acute cases) [279]; ii) outpatient clinics specialised for victims of war and torture (for traumatised migrants) (PR); or iii) inpatient psychiatric hospitals (for severe cases) [282].

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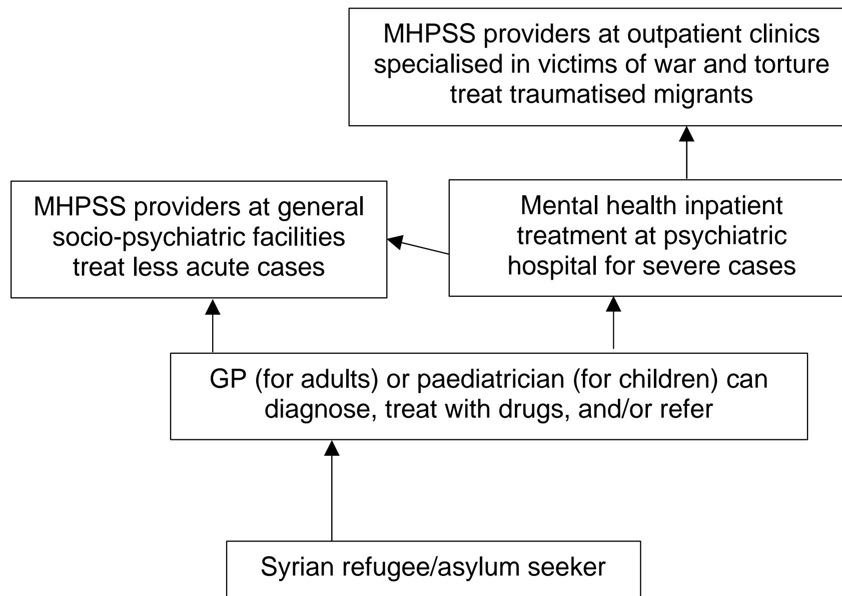
[2] These outpatient facilities provide survivors of war and displacement with medical psychotherapeutic and psychosocial counselling, treatment and advice. Clinics are based in five cities/areas across Switzerland (i.e. Bern, Zurich, Geneva, St Gallen, and Canton Vaud) 280. Ambulatorium für Folter- und Kriegsopfer SRK. *The association: Support for Torture Victims*. 2018 [cited 2018 2 May]; Available from: http://www.torturevictims.ch/en/support-for-torture-victims..

[3] 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

Figure 4.6.1: Typical routes followed by Syrian asylum seekers and refugees with mental health needs in the health system in Switzerland



Recent research reported on utilisation patterns. A study conducted at an outpatient clinic in Geneva found that asylum seekers used outpatient crisis interventions more frequently than permanent residents (26.9% vs. 5.8%) and less frequently inpatient care (25.2% vs. 44.2%); although the reasons were not given [283]. Another study amongst asylum seeking patients at the University Emergency Department in Bern showed most patients were 'walk-ins' (43.7%), followed by referral from police (29.4%), GP (13.4%), ambulance (10.9%), or reception centre (2.5%), and the majority had prior contact to psychiatric services [284]. Dominant reason for referral was suicidal ideation and over half of asylum seekers were admitted as inpatients [284].

4.6.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability [16] 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) who can attend to Arabic speaking refugees. Published research highlights the need for greater Arabic-speakers interpreters.[266, 267, 285, 286] 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. This has also resulted in long waiting times for such services,[266, 267] and reliance on referral from social workers or doctors which may act as a bottleneck for such referrals.[266] Research has indicated that provision of MHPSS services at primary care could be increased to improve availability of services, and reduce the burden of n more specialized treatment centres.[285] Services may also need to be tailored to suit the specific experiences and psychological sequalae felt by refugees.[266] The interviews and related papers highlight a number of other access barriers including uncertainty how the health system works and bureaucracy and complex procedures.[266]

(Geographic) Accessibility:
A key informant 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 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 not working in outpatient clinics do not. Even at primary care level, according to a GP, there was the question of "who is paying" after using an interpreter.

Acceptability:
The most commonly mentioned barriers among participants interviewed for this study concerned acceptability.[266] 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).[266] 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. The gendered nature of healthcare-seeking behaviour was also highlighted, with Syrian men perceiving psychological support as a threat to their concept of masculinity.[266]

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.[266]

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.[266] 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" [287].

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. A recent study amongst treatment-seeking traumatised refugees found that somatic

symptoms were of concern to these refugees and that different patterns of somatic symptoms were associated with clusters of PTSD symptoms [288].

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 religious 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.[266]

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.[266]

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"). This finding was also highlighted in a survey of MHPSS care providers working with refugees and asylum seekers (not only Syrian refugees) which noted the biggest hurdle for care was availability of qualified interpreters and that funding was inadequate for them.[285] A key informant noted 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 but that this is 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 upon 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.

4.6.4.3 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). A recent study amongst asylum seekers (including from Syria) admitted to the University Emergency Department in Bern, Switzerland, reported that 24.4% of consultations used professional interpreting services and 7.6% interpretation through family or colleagues of the patient [284].

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. However, 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 seekers 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 [289].

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, and 84-40% for anxiety disorders [283, 290-294].

Recent studies amongst adult asylum seekers (including several from Syria) admitted to the University Emergency Department in Bern found that many patients suffered from severe psychiatric symptoms such as suicidal ideation and high levels of stress [284, 295]. Those with rejected asylum applications showed more acute symptoms than those with pending status, although not statistically significant [295]. A study at an outpatient clinic in Geneva found similar rates of suicidal thoughts amongst asylum seekers compared to permanent residents [283].

Over a third (35%) of unaccompanied adolescent asylum seekers attending an outpatient clinic in Geneva (89.4% male; 5.3% Syrian) were diagnosed with mental health disorders, including psychological distress (e.g. panic attacks and suicide attempts) and post-traumatic stress disorder [296].

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 has been conducted to further investigate the perceived barriers and facilitators of accessing mental health care among Syrian refugees who are using MHPSS care in Switzerland and the analyses of the data currently being finalised (to be published as separate outputs).

The findings highlight that Syrian refugees appear to have adequate treatment options in Switzerland, but may face structural systemic barriers (e..g lack of Arabic-speaking health personnel) which deter treatment seeking. Acceptability of care was 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 also emerged as key themes and this calls for the need to improve how health authorities interact and communicate with Syrian refugees in order to reduce mistrust or lack of awareness towards the mental health care system and authorities. In addition to strengthening efforts to engage with Syrian communities, it should also include cultural awareness training for Swiss health care providers. 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.

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 (including 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 supplemented with a demand seeking intervention once effectiveness has been proven in the RCTs.

4.7 **The Netherlands**

Data presented in this section is based on a desk-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. The methodology and findings of the first version of the Rapid Appraisal of the Netherlands has been published [1].

In addition, secondary data were complemented by analysis of semi-structured interviews with key informants (*KI*, n=36), MHPSS providers (*PR*, n=17) and Syrian participants in explorative and definitive RCTs on PM+ individual (*SR PM+*, n=12). These interviews were conducted between May 2017 and August 2021. Additionally, summaries of individual interviews (n=10) and four FGDs (1 all male; 3 mixed; 14 individuals) with Syrian refugees *not* using MHPSS (*SR non-user*) were included (conducted May-August 2017) as well as findings from a ToC workshop (held in July 2019). Research was approved by the VU Medical Center Medical Ethics Committee in the Netherlands (submitted in the Netherlands by VUA, Protocol ID: NL61361.029.17, 7 September 2017) and the observational committee of LSHTM (14330-1) in the UK.

4.7.1 Wider environment and policies

From 2010 to 2020, 27,284 Syrian nationals were given a residence permit (59.5% male; 40.5% female; 37.4% below 18 years of age) [297]. 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 [298].

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

2.55% of the general population were estimated to have a depressive and 2.42% an anxiety disorder in 2019 [299]. The anxiety figure is below the average rate for high-income countries (i.e. 4.8% depressive; 5.6% anxiety) [32]. 1.28% of deaths within the Dutch population were attributed to self-harm in 2019 and 0.42% of all deaths were estimated to have been caused by mental and substance use disorders [299].

4.7.3 Mental health system inputs

4.7.3.1 Leadership and governance

The Netherlands has a mental health policy and plan [300] which was considered fully implemented by the WHO Atlas in 2014 [301]. Dedicated mental health legislation exists and legal provisions for mental health are covered by other laws such as the Health Insurance Act [300, 302]. As for migration integration policies, the country scored just ‘halfway favourable’ overall and ‘slightly favourable’ for health [303].

Governance of health services for refugees is organised at municipality level and for asylum seekers 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 provider. By law the provider changes every four years, which is Arts & Zorg [Doctor & Care] from 1 January 2018. Arts & Zorg is responsible for all curative health of asylum seekers, with primary care organised through 'GZA Healthcare' and insurance organised through 'RMA healthcare' [304]. 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 Gemeentelijke Gezondheids Dienst (GGD)- Geneeskundige Hulpverleningsorganisatie in de Regio (GHOR) [Community Health Services – Regional Medical Emergency Preparedness and Planning] and the Centrum Jeugd en Gezin [Centre for Youth and Family] (CJZ). The latter is responsible for preventative health of minors across the country.

For status holders (i.e., refugees with a residence permit), the Dutch government, health insurer, municipalities and GGD are responsible. For those under-age also Youth Care [305]. Municipalities perform roles in managing, financing and initiating with regards to mental healthcare for status holders in their areas [306]. Previous research suggests differences in small/rural and large/urban municipalities; and because municipalities are still exploring their "directive role" this may result in "lack of oversight and coordination" [306, p29]. A recent study in municipalities of Nijmegen, Arnhem and Tiel suggests that local policy efforts (at least for that area) are more focused on the integration of refugees rather than promotion of their mental health. Also, efforts that are available on mental health, focus on migrants in general as opposed to refugees in particular [307].

4.7.3.2 Financing and expenditure

In 2018, the Dutch Government spent 9.97% of its GDP on health [59]. Of the total expenditure on health, 10.7% was used for mental health in 2011, of which 59.2% went towards mental hospitals [300]. 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) [308].

Basic health insurance is mandatory for all citizens, including mental healthcare [302]. Asylum seekers are insured collectively under the 'RMA Healthcare' [Regeling Medische Zorg Asielzoekers] and are entitled to nearly all the care, including mental health, provided under the standard package and the Wlz [304, 309]. Once asylum seekers 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) [302, 310]. 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.

Telephone interpreters are covered by COA for asylum seekers. Dutch Health Authority (NZa) is responsible for payment of care for status holders with health insurance. However, due to a policy change in 2012 there is currently no national policy available for the reimbursement of interpreter services in care for status holders (except those with an auditory impairment). The Dutch government enforced this policy change to reduce costs and because of the believe that status holders are responsible for acquiring Dutch language skills themselves, which is seen as an imperative part of their integration [311]. From May 2017 to May 2019, GPs could temporarily claim interpreter costs for care provided to status holders, although this was only for a duration of six months after their settlement

in the municipality and considered insufficient by interviewees in our study (PR; KI; SR non user) (as it usually takes longer than six months for refugees to sufficiently master the Dutch language). Interpreter costs are integrated as part of 'generieke opslag' [general storage] of the DBCs ('diagnose-behandelcombinatie' [diagnosis and treatment combination]) for mental health care, however, this is likely not sufficient for institutions that treat an above average amount of patients speaking other languages [311].

Several participants (KI; PR) commented on the financial unsustainability of the Dutch mental health system. Participants explained this has led to severe cost cuttings measures, which started about 10 years ago. A provider commented that "Almost all mental health facilities are dealing with financial problems or with severe financial problems." A new financing mechanism called 'Zorgprestatiemodel' [Care prestation model] is proposed by the Dutch Health Authority (NZa) for general 'GGZ' [Mental Health Care], specialist GGZ and forensic GGZ, including the ways in which translators are being reimbursed [311].

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 [300]. Mild to moderate mental disorders are usually treated in basic ambulatory care settings, such as GP offices [279]. 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 [279, 312]. Specialised institutions mentioned in interviews with MHPSS providers are: Centre'45[4] and i-Psy [5].

A variety of psychosocial services are provided in the publicly funded sector, including cognitive and behavioural services, counselling, family and trauma therapy. Additionally, three user organisations for mental health are present at the national level [315] and a selection of social support and prevention programmes are available to refugees in asylum seeker centres and the social domain [316-320]. Mind-Spring[6] (psycho-education) and Mind Fit[7] (integration) are peer-guided group programmes commonly mentioned by study participants as well as voluntary support services by

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[4] 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 313. Centrum'45. *Voor complexe psychotraumaklachten [For complex psychotraumatic complaints]*. 2018 [cited 2018 1 March]; Available from: https://www.centrum45.nl..

[5] Specialist in intercultural psychiatry. Treats and supports people of all ages, socio-cultural backgrounds, and psychological issues 314. i-Psy. *Wie we zijn [Who we are]*. 2018 [cited 2018 1 March]; Available from: https://www.i-psy.nl/over-i-psy..

[6] Psychoeducation for groups of adult and junior refugees and asylum seekers by trained peers 321. Mind-Spring. *Mind-Spring: psychoeducation for asylumseekers & refugees*. 2018 [cited 2018 28 February]; Available from: http://www.mind-spring.org . 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.

[7] 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 322. Vluchtelingenwerk Nederland. *Mind Fit: Aan de slag met integratie en participatie [Mind Fit: Working on integration and participation]*. 2016 [cited 2018 28 February]; Available from: https://www.vluchtelingenwerk.nl/noordnederland/nieuws/mind-fit-aan-de-slag-met-integratie-en-participatie .

VluchtelingenWerk [RefugeeWork][8], and culturally appropriate care by Sensacare[9] (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 [325].

4.7.3.4 Mental health workforce

The Netherlands has a high number of psychiatrists working in the country (24.23 per 100,000 population vs. 7 per 100,000 population for the regional average) [65] 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) [129, 301]. An estimated 11% of all doctors work in mental healthcare [326]. Larger GP practices are generally supported by a mental health care worker (POH-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 to healthcare workers.

Interviewees outlined social workers play a role in the detection and referral of clients with possible psychological problems. Municipalities receive a budget from the government for the organization of social assistance for refugees [327]. This concerns familiarising refugees with the municipality and offering practical support (e.g. completing forms, applying for insurance, other financial and judicial support). Commonly organisations like Refugee Work or local well-being organisations are contracted by municipalities to provide this assistance [327]. Participants in our study mentioned for example client managers from Service Work and Income (DWI) in the council of Amsterdam, or peer coaches from the NGO Stichting Nieuw Thuis Rotterdam [Foundation New Home Rotterdam] in the council of Rotterdam, and that other councils often appoint volunteers from RefugeeWork – a network of 13,500 trained volunteers working in all asylum centres and 300 councils across the country [323]. A cross-sectional study showed most Syrian refugees receive or have received social assistance (91%) and are satisfied with its services (80%) [327].

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 [328]. A recent study reported shortfalls in health information system capacity in the Netherlands and Germany, including limited coverage of specific indicators like mental health [63]. 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.

[8] 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.) 323. Vluchtelingenwerk Nederland. *Wat wij doen voor vluchtelingen [What we do for refugees]*. 2018 [cited 2018 1 March]; Available from: https://www.vluchtelingenwerk.nl/wat-wij-doen/wat-wij-doen-beeld..

[9] Specialist in provision of care, including mental health, to clients that are not from the Netherlands 324. zorg, S. *Over Sensa Zorg [About Sensa Care]*. 2018 [cited 2018 1 March]; Available from: http://www.sensazorg.nl/index.php/over-sensa-zorg..

4.7.3.6 Psychotherapeutic medicines

The country does not have an essential drug list [329]. However, the Netherlands has an extensive list of registered drugs available and measures in place to keep drugs affordable [330, 331]. Primary care providers prescribe drugs to treat CMDs [332].

4.7.4 Process outcomes and responsiveness

4.7.4.1 Care pathway

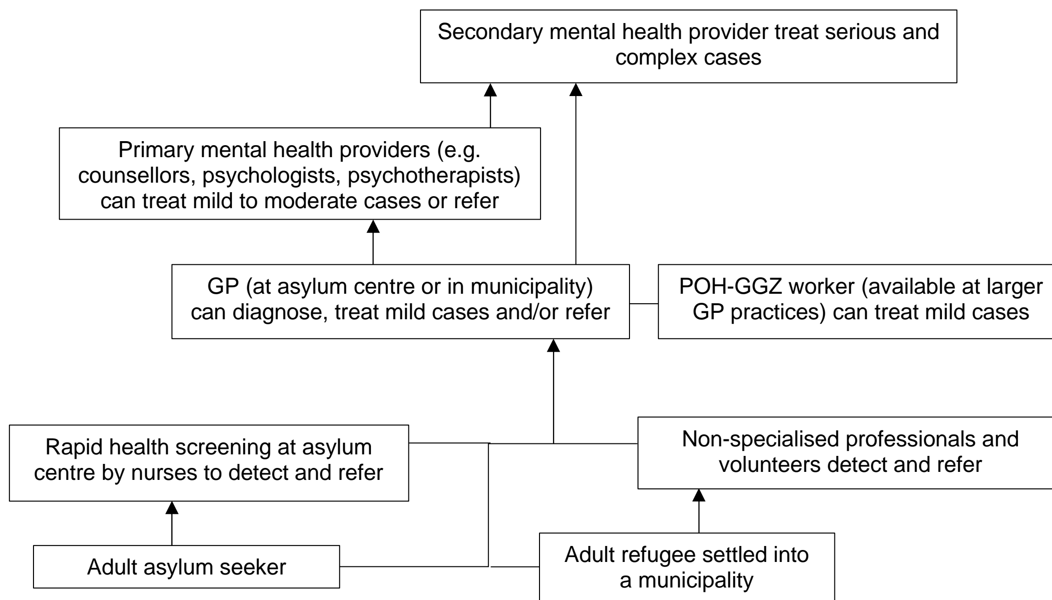
The routes followed by adult Syrian patients from their first contact with the Dutch health system until they receive professional MHPSS care is shown in Figure 4.7.1 below.

Adult asylum seekers typically receive a medical screening at the GP practice that is linked to the asylum centre they are residing at. Several interviewees (PR; KI) in our study commented these screenings were ineffective in identifying psychological needs. Primary findings indicate that early detection and referral also happens through workers of preventative programmes (previously MindSpring, currently Bamboo), 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 (i.e. status holders) can choose their own GP.

Adult Syrian status holders follow a similar route as Dutch nationals through the health system. The GP diagnoses a patient and, if needed, treats or refers [333]. GPs are responsible for treating those with milder forms of mental illness [334]. A mental health worker (POH-GGZ or SPV, often available at larger GP practices) may also support a patient, but the GP retains ultimate responsibility [333, 334]. Those with mild to moderate mental illness can be referred to other providers (e.g. counsellors, psychologists) and those with more serious problems to mental health services at secondary and tertiary levels. People suffering from severe and complex mental disorders are generally admitted to a mental health care institution [334, 335]. Interviews with participants in our study highlight various barriers in this route for Syrians. On the demand-side, stigma and limited mental health awareness create barriers in seeking support. On the supply-side, GPs struggle to recognise mental health symptoms in patients of other cultures, partly due to language barriers, which affects appropriate treatment and referral. And as the regular GGZ institutions (secondary level) are generally not as culturally sensitive as some specialist institutions in intercultural psychiatry (tertiary level) this has led to some tertiary institutions being overburdened with referrals of status holders, leading to long waiting lists. In addition, tertairy institutions (such as ARQ) are also highly focused on specialized treatment for PTSD only and so refugees may be sent back and forth if they have comorbidities.

Findings from another study on the mental well-being of status holders in Nijmegen suggests that while status holders may visit the GP themselves, they are generally directed by actors involved in early signalling or prevention [306]. These actors were grouped in four clusters: 1) naturalisation and participation; 2) societal support; 3) municipal services; and 4) everyday life (e.g. family, religious leaders, teachers) [306]. Status holders with psychosocial or family-related issues were generally directed to the social district team, while those with mental-health related problems were recommended attending the GP [306]. Similarly, interviewees in our study highlighted the early signalling and referral at community level, mentioning MindSpring, case managers, and RefugeeWork (PR; SR PM+). 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 4.7.1: 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) [335].

4.7.4.2 Access and coverage

Access and coverage encompasses the availability, accessibility, accommodation, affordability and acceptability [16] of MHPSS.

Availability:
Several providers interviewed for this study believed ample resources were available to provide care for refugees. For asylum seekers more activities are available in the reception period as before, which are positively related to mental health and host country language proficiency [320]. Many culturally sensitive preventative interventions to strengthen psychological health and resilience of child and adult refugees are available for local implementation [319]. Selected key informants were of the opinion that mental health of 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.

Despite this, a number of study participants (KI; PR; SR PM+) raised availability concerns. A provider felt that a downside of so many MHPSS services at different levels of care was that this makes it difficult for refugees to find and choose the right service. A key informant explained MHPSS support was unequally distributed across the country, with more support available in the Western side than the Eastern side of the country; this while there are many Syrian status holders also living in the Eastern side. Various study participants spoke about an insufficient number of mental health professionals who speak the language of the patients, including those Arabic-speaking. This

insufficiency combined with the financial challenges of professional interpreter services in the Dutch health system results in difficulties in patient-provider communication in both primary and specialist care and long waiting times for specialist mental healthcare (see also *Acceptability* and *Quality & Safety*). A previous study on mental wellbeing of refugees reported a lack of POH-GGZ utilisation [306]. Another provider in our study explained that it is sometimes difficult to have the right amount of care available due to fluctuating numbers of asylum seekers.

Study participants (KI; PR; SR PM+) also highlighted concerns in the availability of culturally appropriate MHPSS care and workforce at primary and secondary care level. This was particularly problematic in regular GGZ (secondary; 'tweede lijn'), which leads to overburdening of the culturally sensitive providers such as in transcultural psychiatry (tertiary; 'derde lijn'). A psychiatrist spoke about a lack of culturally validated questionnaires in mental health care, which could aid in evaluating patterns in health complaints. With regards to primary care, study participants (KI; PR; SR PM+) explained this lack of available culturally appropriate care was expressed in many GPs struggling to recognise mental health issues in patients from other cultures like the Syrian. A provider commented: "Because they [refugees] maybe tend to explain their symptoms in a different way or not problematise what they are experiencing as a mental health difficulty for which treatments are available."

(Geographic) Accessibility:
Some providers and key informants commented that travel costs, time, and logistics may be a barrier for Syrian refugees to access MHPSS services.

Several providers in our study were concerned about the accessibility of mental health services for Syrians residing in rural areas, where less (culturally appropriate) services are available. Similar concerns were raised in an interview study about the mental well-being of status holders in Nijmegen; smaller municipalities have less experience with refugees and cultural sensitive care, although may benefit from "short lines of communication" [306, p29]

Particularly care that is culturally and linguistically sensitive may require extra travel time and costs, which may limit access for refugees: a provider in our study explained that refugees generally receive social benefits and have limited financial means. Similar results were found amongst health professionals in the literature [336]. A key informant in our study felt there was a need to strengthen mental health care locally (i.e. making it more culturally sensitive) in order to increase its acceptability and accessibility.

In a focus group, Syrian refugees (SR non-user) 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. That said, a few other key informants commented about the fact that asylum seekers are frequently moved to another asylum centre, which may disrupt any ongoing treatment and trusted patient-provider relationship.

Accommodation:
The concept of accommodation needs to be explored further in future research. There is some learning about accommodation from the pilot study on PM+ conducted amongst Syrian refugees in Rotterdam, the second largest city in the Netherlands.[337] Flexibility in the appoint time of PM+ sessions was appreciated by both client ('PM+ participant') and peer-provider ('PM+ helper') (SR PM+; KI). Appointments were done at a time convenient to both client and provider and could be postponed and rearranged where needed. Nor the duration of the sessions (1,5 hours each week for 5 weeks)

neither its location was considered an obstacle. Sessions usually took place at a location close to the client and travel costs were reimbursed (from research funds). Whether it is feasible to accommodate these features if PM+ will implemented on a larger scale remains to be seen, but reflections from PM+ users support its feasibility and perceived valud.[338]

Affordability:

Male Syrian refugees reported cost as a barrier to receiving MHPSS support [339]. Several barriers to affordability of MHPSS were raised by participants in our study. Key informants believed that Syrian refugees may experience barriers in seeking MHPSS due to the need to pay for excess services (i.e. the Euro 385,- 'own risk'), which is in line with views from health professionals (reported in other studies) [336]. 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 is not. 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 raised concerning professional interpreter services. While these services are financially covered for asylum seekers (Asylum Seekers Healthcare Scheme (RMA)), it is not for status holders. Lack of compensation for interpreters was a commonly mentioned barrier in another study [306]. Health professionals in this study also mentioned that status holders generally need longer consults to build trust and cope with communication difficulties but that this was challenged "by the fact that a GP consult covered by basic health insurance normally lasts only ten minutes" [306, p32]. This affordability barrier in interpreter services is closely related to acceptability.

Acceptability:

The most commonly mentioned barrier in this study was acceptability. Participants (PR; KI; SR PM+; SR non-user) 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' and some 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 is in line with a previous cohort study amongst Syrian status holders, which reported that for women who did not receive support, this was often the case because they found it difficult to talk about grief and stress, or they did notexpect support would help [339]. This issue of shame and taboo surrounding mental health amongst Syrian refugees in the Netherlands is in line with previous research [306, 336].

Positively, participants (KI; PR; SR non-user) in our study shared that seeking professional support for mental health issues is becoming more socially accepted amongst migrants and Syrian refugees. Particularly amongst the young and more highly educated. Despite this positive trend, interviewees (PR; SR non-user) expressed that most Syrian refugees still prefer to keep such issues to themselves. While some Syrian refugees may share their problems within their networks, participants (PR; SR PM+) explained fear of gossip and mental health related stigma are obstacles.

Participants (PR; KI; SR non-user) explained that Syrians regularly delay seeking psychological support as they prioritise other life issues like gaining citizenship and learning Dutch. When these "basics" are more "stabilised" (KI) there is space to address other problems, like those of psychological nature. Along the same lines, another study proposed this delay in help seeking may be because mental health

problems become noticeable “when the status holder’s survival instinct subsides and practical issues such as housing, education and work are addressed” [306, p32]. Interviewees in this same study thought knowledge of and information about mental health problems was particularly lacking in early stages of integration [306].

Findings in our study also suggest that Syrians who *do* seek support may not always receive appropriate treatment. Similar to another study [306], interviewees (PR; KI; SR PM+) 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 barrier for Syrians to communicate with their GP [340] and to receive MHPSS support [339](PR; KI; SR PM+; SR non user). Both Syrian refugees and health providers which were interviewed experienced communication problems in primary care and specialist mental health care. Refugees found it difficult to clearly express their mental health complaints to professionals in another language or through an interpreter (either professional or non-professional). Likewise, providers perceived it challenging to fully comprehend their patients’ psychological complaints, even if interpreter services were used. Several participants (KI; PR) highlighted privacy concerns in working with non-professional translators (often family or friend of the patient) during health consultations. Many participants in our study (PR; KI; SR PM+) were of the opinion that there are currently insufficient Arabic-speaking mental health specialists in the Dutch health system to meet the demand, resulting in long waiting lists (see *Quality & Safety*).

While not specific to mental health issues, it is worth noting previous research about language barriers. GPs in a study in Gelderland expressed concerns about language and interpreters in their interactions with status holders [306]. Another study in the same area showed asylum seekers struggled most with linguistic and cultural barriers when accessing primary health care [341]. Similarly, Mulders and Tuk [342] found language challenges communication between Syrians and health professionals. And a large survey showed that many Syrian refugees were: dissatisfied with Dutch language courses; commonly struggled speaking and reading in Dutch; perceived language as an issue during consultations at the GP (40% amongst those who arrived in 2015/16 and 35% amongst those in 2014) [327, 343]. Despite this, the same research indicated most Syrians thought the GP listened well (90%), gave good advice (78%), and gave sufficient information about their disease (72%) [343]. Moreover it showed Dutch language was not associated with care utilisation [333].

Besides language, our findings and previous research suggests knowledge and expectations of the health system may be barriers. Several participants (PR; KI; SR PM+) in our study highlighted Syrian refugees are used to another health system and therefore need psychoeducation. For example, a Syrian KI explained that many Syrians are dissatisfied with their GP as its common for health professionals in Syria to tell them what their issues are and how to solve them while the GP in the Netherlands asks them “How can I help you?”. This suggests different cultural expectations of health professionals. Similarly, Beekman [306] argues that refugees may have different expectations of the health system, with Syrians being used to directly going to the hospital [306]. Mulders and Tuk [342] found that Syrian families who were insufficiently informed about the health system struggled to seek and access care, that Syrians lacked understanding of the Dutch health insurance, and that education about the Dutch health system for Syrians varied between municipalities [342].

Trust is another topic highlighted in recent studies that may influence acceptability and therefore access to care. A survey revealed the majority of Syrians trusted the Dutch health system, albeit slightly less than the general population [343]. Those with more trust in the system were more likely in contact with the GP and specialist, while those with less trust more commonly visited the psychologist/psychiatrist [333].

Several initiatives are available to overcome some of these acceptability issues, as explained by key informants and providers. For example, Mind-Spring offers psychoeducation 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 key informant in our study spoke about 'sleutelpersonen' (key persons) being used for (cultural) translation in some municipalities. These key persons are often from the refugee community and knowledgeable about the Dutch health system, however, these often work on a freelance basis and are not embedded in the system (KI). 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 [344].

Participants described areas for further improvement of MHPSS care. Providers suggested increasing the use and quality of professional interpreters in healthcare. To achieve this they believed policy changes were needed to allow reimbursement of such services by (primary) care providers, more well-trained interpreters have to be made available, and providers had to be educated about, and gain more experience with working through interpreters. Increasing cultural sensitivity was opted a solution to improve mental health care for refugees in another study. Interviewees in this study, however, remarked this is difficult to achieve because: GPs are generalists and therefore may lack feeling for diversity; the Western view on PTSD and trauma is dominant in the Dutch health system; and most information and public services are in Dutch [306].

Having more healthcare providers who speak Syrian Arabic and/or are sensitive to the Syrian culture was another suggested improvement by interviewees (PR; KI). Comparing transcultural with regular GGZ institutions, a provider felt the "ambiance" and "treatment" in the former is more accepting of migrants and that hiring a transcultural professional in the latter institution will be insufficient to improve its culture. Employing Syrian mental health providers was considered a good option, however, since their qualifications are not recognised in the Netherlands this means additional training and qualification, including registration in the quality register (i.e. 'Big') (KI; PR). Additionally, interviewed Syrians (KI; SR PM+; SR non-user) commented 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.

4.7.4.3 Quality and safety

The access barriers mentioned above, particularly those related to availability and acceptability, challenge appropriate and timely MHPSS for Syrians in the Netherlands; thereby influencing quality of care.

Long waiting times in mental health care was a frequently mentioned quality concern in our study. While interviewees (PR; KI; SR PM+) were unaware how long a Syrian with psychological needs exactly had to wait in order to start specialist treatment, estimates ranged from zero to twelve months. Many participants (PR; KI; SR PM+) found current waiting times problematic. Waiting times were regarded

particularly long for larger specialist intercultural services like i-Psy (PR; KI; SR PM+) and for youth care (KI). According to a provider, smaller culturally sensitive centres have shorter waiting times but are less well-known than the larger ones. Participants (KI; PR) 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 (KI; PR) highlighted that regular GGZ-institutions are less willing to accept patients with refugee status due to language barriers and the related challenge of getting 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.

National figures show total waiting period (including application and treatment waiting times) was 10,8 weeks for general GGZ, 15,2 for depression, 16,0 for anxiety and 19,4 for trauma treatment in June 2021 [345]. There are large regional differences in waiting times and for treatment of different mental health disorders [345].

Waiting lists and inability to cope with the number of registrations were also highlighted in a study on the mental well-being of status holders in Gelderland [306]. This study additionally highlighted that relying on volunteers for early signalling of mental health problems amongst refugees may be a cause for delay, and that monitoring of mental health treatment was lacking [306]. A provider interviewed in our study also criticised monitoring by saying the Routine Outcome Monitoring (required within GGZ by insurers) was not validated for use amongst those from other cultures.

As described in previous sections, participants in our study raised quality concerns with regards to interpreter services in the health system. The financial barrier of using professional interpreter services result in limited use of these services in GP consultations and refusal of treatment by specialist mental healthcare providers. In GP consultations, alternatively no interpreters are used or non-professional interpreters. Both limit quality of primary care as they challenge effective patient-provider communication. Effective communication is regarded essential for GPs to be able to recognise “idioms of distress” (PR) in patients from other cultures, which affects treatment and referral advise. An additional concern with non-professional interpreters, as raised by some key informants, is that they are not qualified, meaning the quality of their translation skills as well as their privacy and confidentiality cannot be guaranteed.

Language barriers (also describe under *Acceptability* as part of *Access and coverage*) affect service quality and acceptability of care for Syrian refugees as shown by the largest cohort study amongst Syrians in the Netherlands. This cohort study follows Syrians who received asylum between 2014 and mid-2016 in the Netherlands. This study found a slight increase in use of GP 12 months previously (particularly amongst men): 67% in 2017 compared to 71% in 2019 [340, 343]. This study showed that GP contact coverage is similar for Syrians and the general population, but that contact coverage for psychologist or psychiatrist is lower amongst Syrians while psychological health of Syrians is relatively high [339, 340]. Language was regarded still an issue for Syrians in contact with their GP (31% in 2019; 37% in 2017). Reported language issues increased with age, later year of arrival, lower education [340]. Findings from this same cohort show that 8% of Syrian status holders received support for dealing with stress, grief and anxiety (no stats available for 2017; 10% women, 7% men) [339]. Nearly 5% of Syrians have received support in the past, but not currently. Small group (2%) tried to seek support but did not succeed. Of Syrians who receive support a third (31%) receives solely support from family or friends, others receive support from a professional such as psychologist, psychiatrist, GP or POH-GGZ. More Syrian women solely receive support from family and friends (38%) compared to men (27%). Amongst Syrian status holders who do not receive support, 8% did express a need for support. A third gave as reasons for not receiving support language barriers. Women often found it difficult to

talk about grief and stress or expected support would not help them. Men also mentioned costs as a barrier [339].

Research amongst unaccompanied minor asylum seekers (mostly from Syria and Eritrea) reported waiting times for doctor's appointment and mental well-being as sources of dissatisfaction in their lives in the Netherlands [346]. While this research did not focus on mental healthcare, it says something about the responsiveness of the health system' gatekeeper from the perspective of a vulnerable group of asylum seekers.

While long waiting times were perceived to be a major concern, participants in our study felt that emergency cases can be immediately referred and treated. This is confirmed by regional statistics on waiting times in mental healthcare. 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 [347]. Currently, efforts are made to reduce waiting times in mental health care across the country [348].

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.

4.7.5 Mental health outcomes

A cohort study amongst Syrians who received asylum between 2014 and mid-2016 in the Netherlands reported a decrease in proportion of Syrians part of the 'psychological unhealthy' category: 42% of in 2017 compared to 38% in 2019 [339, 343]. 'Psychological unhealthiness' concerned self-reported emotional well-being measured by five questions from the RAND Mental Health Inventory-5.Compared to the same measurement in 2019 in the general population, this is much higher (11.5% for those 12 years and above) [349]. Main decrease in self-reported psychological unhealthiness in the cohort study was amongst those aged 15-24 years. Increase in psychological health amongst status holders who arrived in 2014, decrease in psychological health amongst those who arrived in 2016. Those who arrived earlier were more likely to have paid employment, and are predominantly male (who experienced increase in psychological health). There was no significant difference in loneliness between men and women, but some difference in age and education [339]. Slight reduction in psychological distress in this cohort study was reported from 2019 (30%) compared to 2017 (26%) of Syrians who experience their general health as poor, with elderly and those lower educated perceiving their health as poorer [340].

With regards to the prevalence of mental disorders in the Syrian refugee community in the Netherlands, very limited data are available. 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 the mental health condition of the current larger groups of refugees from Syria and Eritrea" [350, p40]. However, a very recent study with a random population sample of 407 Syrian refugees observed a prevalence for depression of 37.6%, for any anxiety disorder of 33.2% and for PTSD of 18.4% (Patanè, de Graaff, Cuijpers & Sijbrandij, in preparation).

A study amongst asylum permit holders in Rotterdam (n=701; 66% Syrian) found that the duration of the asylum period had negative consequences for mental health due to the associated amount of relocations not the living conditions in the asylum centres [351]. A larger study amongst Syrian permit holder holders in the Netherlands (n=3209) did not find a negative relationship between length of stay and mental health, although did between the number of relocations and mental health [320].

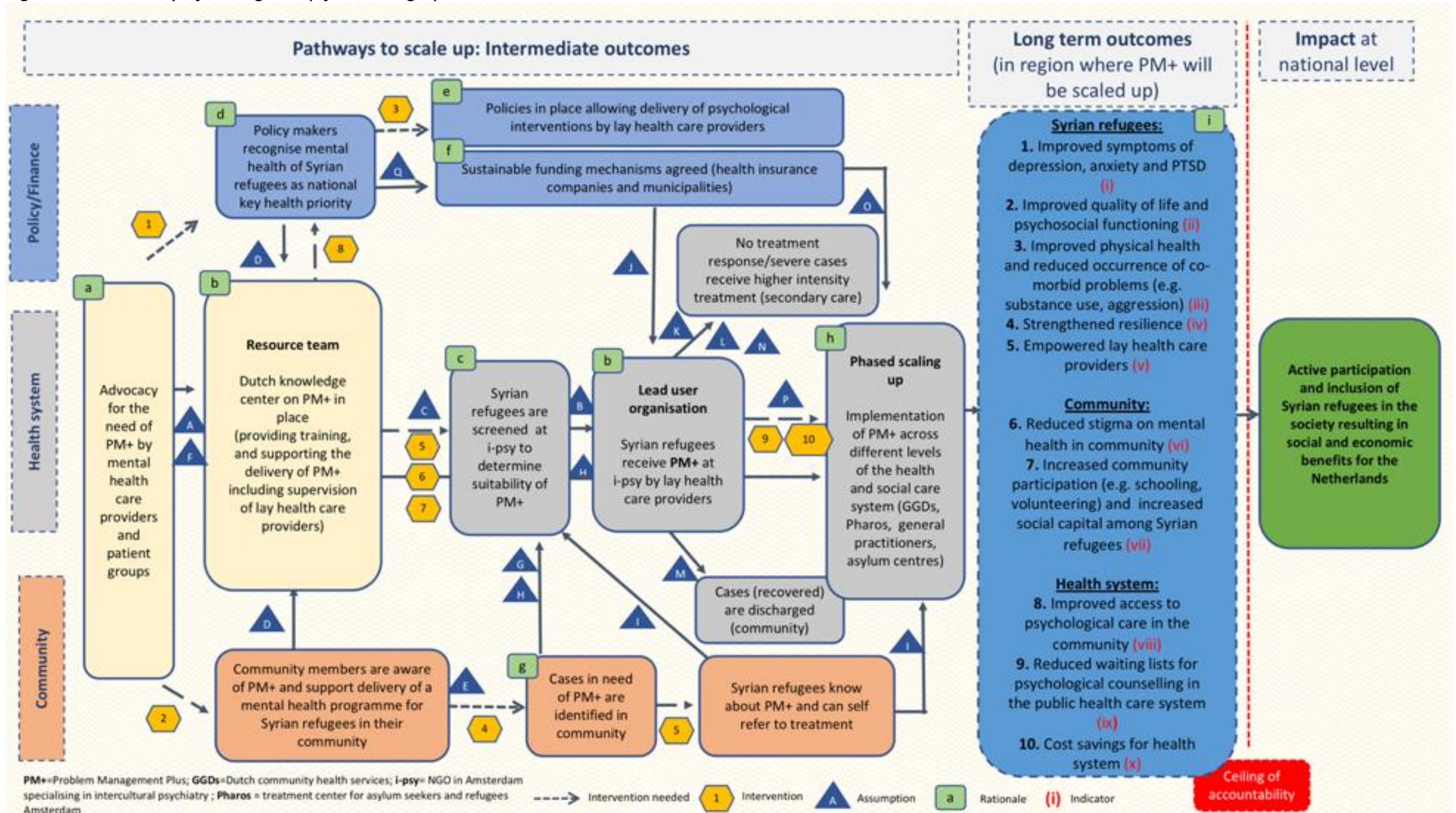
4.7.6 Theory of Change map

A ToC workshop was conducted on Friday 5 July 2019 in Amsterdam to prepare for the scaling up phase of PM+ in the Netherlands, and to explore barriers and facilitators of scaling up PM+. 22 stakeholders participated in this one-day workshop: 8 national and international academics and mental health/conflict researchers from universities and institutions in the Netherlands and the United Kingdom; 6 staff from national non-governmental organisations such as i-psy, Pharos, Veldzicht (Center for Transcultural Psychiatry), and War Trauma Foundation (currently called ARQ International); three providers working in community health services with Syrian refugees; four mental health service providers such as psychiatrists and psychologists (including one Syrian psychiatrist); and three research assistants from Syria (who settled in the Netherlands a few years ago).

Main components of the ToC map are impact, long-term outcomes, intermediate outcomes, assumptions, interventions, rationale and indicators. In ToC, impact refers to the change or real-world impact which we want to achieve by scaling up PM+. Specifically, it refers to the change at the national level that the scale up of PM+ cannot achieve on its own. The impact is behind the ceiling of accountability: the level at which we stop measuring whether outcomes of the scale up of PM+ have been achieved, and therefore stop accepting responsibility. Long-term outcomes are the final outcomes that the scale up of PM+ can achieve on its own. Long-term outcomes apply to the population and the health system in the district/region in which PM+ is being scaled up. Intermediate outcomes are pre-conditions of long-term outcomes. Intermediate outcomes inform and interact with each other, and there are interventions and assumptions associated with intermediate outcomes. Assumptions are external conditions that must exist for each intermediate outcome (or precondition) to be achieved. Interventions are strategies or activities that bring about intermediate outcomes. Intermediate outcomes are usually based on rationales (i.e., evidence) supporting their choice.

Rationales (rationales a-i), assumptions (assumptions a-r), and interventions (interventions 1-9) are outlined and described in the ToC map (Figure 4.7.2).

Figure 4.7.2: Theory of Change map for scaling up PM+ in the Netherlands



1 Interventions

1. Health professionals engage in policy dialogue and seek opportunities to network with policy makers.
2. Syrian refugees and NGO providers campaign on mental health and PM+, and disseminate information (on mental health and PM+) through different communication channels (social media, leaflets distributed in language schools and asylum centers)
3. Dutch health care policies are changed to allow delivery of psychological counselling by lay health care providers
4. Case manager identifies Syrian refugees in need of PM+ in the community (e.g. languages centers, primary health care practices)
5. Digital resource on PM+ is set up serving as main resource for health professionals, lay health care providers and Syrian refugees
6. Knowledge center provides training on PM+ to main user organization (ipsy), and trains the trainers
7. Knowledge center (master trainers) also train supervisors of lay health care providers at i-psy, and provide support to supervisors in times of need
8. Knowledge center reaches out to policy makers, and invites Ministry of Justice, Security and Defense/Ministry of Health, Welfare and Sport to be part of knowledge center
9. PM+ is being incorporated in national mental health and psycho-social support guidelines so that it can be used by all professionals and non-professionals delivering psycho-social interventions to refugees and asylum seekers (including general practitioners, community health workers/POH GGZ and local organisations)
10. Knowledge center supports implementation of PM+ in other centres and organisations though training of PM+ (training the trainers, and training of supervisors)

A Assumptions

A. Stakeholders organise themselves and one organisation takes the lead in setting up Dutch knowledge center (= resource team)
B. There are enough Syrian refugees with the required characteristics who can be trained to deliver PM+
C. There are a sufficient number of (Arabic-speaking) psychologists/psychiatrists who can serve as supervisors to lay health care providers
D. Community representatives such as the COA (Centraal Orgaan Asielzoekersopvang who are responsible for all asylum centers), and municipalities (responsible for organising mental health care for people with a refugee status) form part of the knowledge center
E. Community members (such as language teachers in language centers) are briefed on mental health needs of Syrian refugees (and know of possible mental health symptoms), thereby supporting the case manager to identify cases
F. PM+ has been proven to be effective and cost-effective in the Netherlands through a randomised controlled trial
G. Syrian refugees know about Dutch mental health service structure and are willing to be screened, and to attend PM+
H. Syrian refugees perceive PM+ and referral process not to be stigmatising
I. Syrian refugees know about PM+ (through social media, community campaigns and digital resource), and know how to self-refer to mental health treatment. There are no language barriers hindering the self-referral process.
J. Health insurance companies and/or municipality pays lay health care providers for PM+ delivery and PM+ supervisors for their supervisory time
K. Syrian refugees are referred to more specialised treatment (in case of clinical worsening or no treatment response)
L. There is a sufficient number of psychologists/psychiatrists available (secondary care) who are culturally trained and who can deliver more specialised psychological interventions in Arabic
M. Case manager/client manger supports discharge process and monitors patient after discharge for a few weeks/months
N. Case manager/client manger oversees referral to secondary care
O. Government supports phased scale up and ensures that funding is extended to other health care delivery platforms and social services in the Netherlands
P. Scaling up through i-psy is successful and there is knowledge on the size of the population in need to project future demand of PM+
Q. Government seeks new funding for PM+, and /or shifts funding from different health care budget lines to mental health

a Rationale

a) There is a need to mobilize the community, health professionals and policy makers in the Netherlands, and to create awareness about mental health of conflict-affected populations and PM+ (view of ToC workshop participants)
b) The resource team, the user organisation and the innovation (PM+) are key elements of scaling up (WHO/Expandnet framework of scaling up; WHO, Expandnet, 2010).
c) I-psy is involved in the evaluation of PM+ in the Netherlands, and could serve as first user organisation responsible for implementing PM+ at a larger scale in Amsterdam (view of ToC workshop participant)
d) Interventions have the best chance of being scaled up when they are aligned with policy priorities (Centre for Epidemiology and Evidence, 2014).
e) There needs to be a change in Dutch health care policy to allow lay health care providers to deliver a psychological intervention, and to get paid for it. Currently, insurance companies only pay interventions in specialised mental health care for patients with a clinical diagnosis. Formally diagnosing before delivering PM+ would be necessary (view of NGO provider, ToC workshop)
f) Potential funding sources need to be identified and funding secured before scale up can proceed (Centre for Epidemiology and Evidence, 2014).
g) Syrian refugees in need of mental health treatment may not seek treatment on their own, and may need to be identified in the community (view of psychologist, ToC workshop)
h) Phased scaling up is recommended for several reasons: It allows learning and modification to the innovation before expanding the innovation in several areas/regions; and it allows time for new funding mechanisms to be sought. Phased scaling up is a requirement for horizontal scaling up. (WHO, Expandnet, 2010).
i) Long-term outcomes: **i & ii:** Reduced symptom severity (PTSD and psychological distress) and improvement in psychosocial functioning are primary and secondary outcomes of the PM+ trial in the Netherlands (Graaff, et al, 2019). **iii:** Refugees with mental disorders often present with somatoform disorders, and common mental disorders tend to cluster (Satinsky et al, 2019; and view of psychologist participating in ToC workshop). **iv:** Refugees may learn techniques from PM+ which they can employ themselves in times of (future) psychological distress. This may strengthen their resilience (view of provider, ToC workshop). **v:** Lay health care providers feel empowered after delivery of successful PM+ sessions. The training equips them with new skills and provides them with a new "outlook" in life (results of qualitative research on PM+ in the Netherlands). **vi:** A psychological intervention such as PM+ may improve attitudes on mental health among participants in the community and may reduce stigma if provided alongside (mental health) community awareness activities (Thornicroft et al, 2016). **vii:** An improvement in mental health symptoms may lead to Syrian refugees being more active in the community (view of NGO provider, ToC workshop). **viii:** Scaling up an evidence-based intervention will increase effectiveness coverage (DeSilva et al, 2014). **ix:** PM+ will provide opportunities for Syrian refugees to see a counselor/psychological provider more quickly thereby reducing the waiting time for psychological treatment (view of provider, ToC workshop)

(i) Indicators

(i) Significant improvement in psychological distress and post-traumatic stress symptoms (measured with the PTSD Checklist for DSM-5 (PCL-5) and the Hopkins Symptoms Checklist,HSCL-25)
(ii) Significant improvement in psychosocial functioning (measured with WHO Disability Score Schedule, WHO-DAS) and quality of life (e.g. Quality of Life Scale, QOLS)
(iii) Reduced somatoform symptoms and significant improvement of co-morbid symptoms (e.g. harmful use of alcohol)
(iv) Improved resilience of Syrian refugees (e.g. measured with the Connor-Davidson Resilience Scale (CD-RISC))
(v) Lay providers who feel empowered show significant increase in self-efficacy (e.g. measured with the General Self-Efficacy Scale) and quality of life (e.g. measured with the ProQol tool, professional quality of life)
(vi) Reduced stigma on mental health and improved attitudes on mental health among members of the community (e.g. measured with a survey questionnaire incorporating stigma questions and attitudes towards people with mental health problems)
(vii) Significant increase in community participation (e.g. measured through the number of days off work or off school, and/or social capital among Syrian refugees)
(viii) Significant increase in effectiveness coverage in region where PM+ is scaled up
(ix) Reduced waiting list: Number of days one has to wait to start psychological treatment
(x) Cost-saving for health system (e.g. measured with the Client Service Receipt Inventory)

References:

- World Health Organization, ExpandNet. Nine steps for developing a scaling-up strategy. Geneva: WHO; 2010.
- Centre for Epidemiology and Evidence. Milat AJ, Newson R, and King L. *Increasing the scale of population health interventions: A guide*. Evidence and Evaluation Guidance Series, Population and Public Health Division. Sydney: NSW Ministry of Health, 2014.
- Graaff et al, 2019. Effectiveness of a peer-refugee delivered psychological intervention to reduce psychological distress among adult Syrian refugees in the Netherlands: study protocol. European Journal of Psychotraumatology, in press.
- Satinsky et al, 2019. Mental healh care utlisation and access among refugees and asylum seekers in Europe: A systematic review. Health Policy, 22 Feb 2019, ahead of print. doi: 10.1016/j.healthpol.2019.02.007
- Thornicroft et al, 2016.Evidence for effective interventions to reduce mental health related stigma and discrimination. Lancet. 2016 Mar 12;387(10023):1123-113
- De Silva MJ, Lee L, Fuhr DC, Rathod S, Chisholm D, Schellenberg J, Patel V. Estimating the coverage of mental health programmes: a systematic review. _Int J Epidemiol. 2014 Apr;43(2):341-53.

Impact
Stakeholders identified "Active participation and inclusion of Syrian refugees in the society resulting in social and economic benefits for the Netherlands" as impact to which the scale up of PM+ may be able to contribute towards.

Long-term outcomes
Stakeholders identified nine long-term outcomes (five long-term outcomes related to Syrian refugees; two long-term outcomes related to the community, and two long-term outcomes related to the health system). The following long-term outcomes were anticipated for Syrian refugees: Improved symptoms of depression, anxiety and post-traumatic stress disorder; improved quality of life and psychosocial functioning; improved physical health and reduced occurrence of co-morbid problems (e.g. substance use, aggression); strengthened resilience; and empowered lay health care providers. Community long-term outcomes were the following: Reduced stigma on mental health in the community; increased community participation (e.g. schooling, volunteering) and social capital. Health system long term outcomes were: Improved access to psychological care in the community and reduced waiting lists for psychological counselling in the Dutch public health care system. Initial indicators have been developed for these long-term outcomes which can be used to measure success of the scale up strategy (see indicators i-ix on the ToC map figures).

Intermediate outcomes and pathways to scale up
ToC workshop participants identified three separate pathways to scale up (policy/finance; health system; and community) which are required to achieve the long-term outcomes outlined above.

The earliest intermediate outcome to achieve the long-term outcomes outlined above is advocacy for the need of PM+. Advocacy by mental health care providers and Syrian refugees is an intermediate outcome which spans across all pathways to scale up. This was thought to be necessary for several reasons. Firstly, advocacy efforts would inform government on the need for PM+, thereby also trying to positively influence political decision-making processes. Secondly, campaigns on PM+ would also prepare the community on the delivery and implementation of PM+ in their neighbourhood, thereby increasing awareness and acceptance of PM+ by community members.

Policy/Finance pathway
Advocacy was intended to shift political processes at the government, helping to make mental health of conflict-affected populations a national priority area. It was thought that this would initiate discussions to make changes in health care policies, allowing the delivery of psychological interventions by lay health care providers. A need was raised by participants to integrate PM+ into existing guidelines like those on effective interventions by 'Centrum Gezond Leven', which are checked by the GGD (public health service) and municipalities when buying in services. Integration into practitioner guidelines, developed by the GGZ, was found more challenging due to its lengthy process.

At the same time, sustainable funding mechanisms would have to be sought and agreed upon (such as funding though health insurance companies and/or funding through municipalities). There was discussion on the need for financial incentives for PM+ helpers and the high costs of hiring mental health professionals to serve as trainers and supervisors. The DBC-system ('diagnose-behandelcombinatie') – agreements between insurance companies and hospitals or the GGZ (general mental health care) about costs and quality of care and treatment – was raised in the discussion of funding mechanisms, as well as the 'eigen risico' as possible financial barrier for accessing GGZ care. How PM+ will be framed (treatment and/or prevention) was regarded important for its funding and lobbying options.

Health system pathway
The earliest intermediate outcome on the health system's pathway (also spanning across the community and policy pathway) is the initiation of a Dutch knowledge network (or resource team) on PM+. The task of the Dutch knowledge network would be to provide training of PM+, and to support the delivery of PM+ in the user organisation.

A phased scaling up approach was discussed at the ToC workshop. This may include implementation first at the asylum centres, where there is one insurance system and all refugees are in one place, followed by implementation amongst refugees in the community. Phased scaling up may also involve embedding PM+ into existing mental health organisations like i-psy (currently involved in the trial), Arkin Mental Health Care, or ARQ. Syrian refugees would be screened at these organisations and receive PM+ by a non-specialist helper (a trained Syrian refugee). It was noted that severe cases of clinical worsening would have to be referred to tertiary care for further treatment. Cases who recover and show remission would be discharged in the community. Once scaling up of PM+ via these organisations is proven successful, new areas of expansion could be sought (depending on financing and demand of PM+). Pharos was opted as recommended partner when pursuing the 'municipality route'. And for the 'primary care route' to be successful, participants suggested that PM+ needed to be included in the basic health insurance package, if feasible.

Community pathway
An essential intermediate outcome of the community pathway is acceptance of the delivery of PM+ by community members. Cases in need of PM+ would be identified in the community (with the help of case managers but also community members working with Syrian refugees such as teachers in language schools). The employment of community awareness strategies (via advocacy efforts and a digital resource on PM+ (see also intervention 5)) was also thought to reduce mental health stigma in the community thereby facilitating self-referral of Syrian refugees towards PM+.

The findings from the ToC workshop for The Netherlands were also compared and synthesised with ToC workshops also led by WP2 for STRENGTHS and these have been written up as a journal publication.[21]

4.7.7 Discussion

Findings from our desk study and interviews indicate there are separate mental health systems for asylum seekers and status holders. Results show that there sufficient MHPSS support is available to Syrian refugees, although support, including in primary and secondary care, often lacks cultural and linguistic sensitivity. Findings suggest there are insufficient mental health professionals who speak the language of the patients, including those Arabic-speaking. This insufficiency combined with the financial challenges of professional interpreter services in the Dutch health system – related to its financial unsustainability and austerity measures - challenges patient-provider communication. Mental health stigma limited mental health awareness, and different expectations of the mental health system limit and delay access to the Dutch health system for Syrians. While improvements have been made in relation to psychoeducation amongst refugees, our results indicate more needs to be done; recognition of psychological issues in Syrian patients remains often inadequate and/or delayed, affecting responsiveness of appropriate treatment and referral.

Our findings also show there are regional and institutional differences in culturally sensitive care, which have resulted in long waiting times in selected specialist intercultural psychiatric institutions. Physical access to services may be particularly constrained for Syrian women and those living in rural areas (due to fewer culturally sensitive providers and institutions). While mandatory health insurance covers mental health care some Syrians may still face financial barriers: due to unfamiliarity with the Dutch health system (including its insurance), the required out-of-pocket amount of €385 combined with the complexity of possible reimbursement for this amount for those with low-income poses.

We can conclude that in the Netherlands the current mental health system for Syrian refugees lacks responsiveness. This means there is a window of opportunity for the introduction and integration of novel psychological interventions for this target group such as PM+.

Findings from this rapid appraisal as well as initial results from semi-structured interviews on the scalability of PM+ suggest that PM+ may have several advantages over existing services. Since PM+ (as tested in RCTs in the Netherlands) is peer-provided. This may therefore help address prevailing language and cultural barriers. That said, PM+ as a psychological intervention may be subject to stigma. Moreover, results indicate that some Syrians may distrust providers from their own country, which could be an obstacle for them accepting PM+. This could be solved by having a wider variety of PM+ helpers on staff, although this might mean working through professional interpreters.

Another implication of our findings concerns the affordability of scaling up PM+. Integration of PM+ into the formal health system, including primary and specialist care, would require for treatment to be covered by health insurers to be financially sustainable. Insurance companies, however, do not commonly cover services provided by those who are not professionally registered. These legal barriers may be overcome by formalisation of the PM+ helper role, including accreditation of PM+ training. Another option is for PM+ to be offered outside the formal health system, in the social domain. This domain includes a wider variety of actors such as community, non-governmental and local authorities. If the social domain route is pursued, this would mean collaboration with this wide variety of actors – with their varying (political) interests – and seeking alternative funding streams (e.g. (inter)national donors, local municipalities). The cost-effectiveness and financial sustainability of scaling up PM+ will therefore be critical as also outlined in the ToC map. Both routes require quality assurance through the establishment of training and supervision structures for PM+ helpers, either nationally or internationally.

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; thereby requiring (phased) scaling up

of PM+ to community and/or primary care levels. Hybrid or online versions of PM+ may overcome geographic access barriers, which have shown to be feasible during PM+ trials in the Netherlands: sessions and supervisions had to shift from face-to-face to online due to Covid-19 measures. Final analyses on the scalability of PM+ will go more in-depth into how PM+ can be integrated into local systems and the barriers and facilitators for this integration.

4.8 **Turkey**

Data presented in this section are based on a desk-based review (existing literature) which was updated again for this deliverable. The final Annex for Turkey is available upon request and will be made available on the STRENGTHS website.

In addition, secondary data were 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), the Immigration Authority of Turkey (dd. March 29, 2017), and Koc University (ref 2021.025.IRB3.006). Data collection took place in May and June 2017.

This chapter also includes a Theory of Change map for scaling up PM+ in Turkey which was developed together with stakeholders in November 2018. It also presents new results from the cross-sectional survey in Istanbul conducted as part of the STRENGTHS study on the prevalence of mental disorders, the mental health treatment gap and access to care among a sample of Syrian refugees in the Sultanbeyli district of Istanbul (with other results presented in previous WP2 Deliverables just summarised in this Deliverable).

4.8.1 Wider environment and policies

There are currently 3,574,800 Syrian refugees registered in Turkey (54% male, 46% female, and 46% below 18 years of age).[352] Syrian asylum seekers entering from the Turkish-Syrian border usually receive temporary protection status within two months of arrival. There were around 300,000 Syrian refugees live in camps located in Syrian border cities (Sanliurfa, Gaziantep, Kilis, Hatay, Kahramanmaras, Adiyaman, Adana, and Osmaniye) (KI interview), but this has reduced to around 50,000 Syrian refugees living in temporary refugee centres.[338] The majority of Syrian refugees are living outside camps, and spread throughout Turkey from the south through central and western cities including Istanbul, Ankara, and Izmir.[353]

Tempory protection status gives Syrian refugees the same rights as Turkish citizens, including access to healthcare, education, and work (but need to apply for a work permit). A Temporary Protection Identification is necessary for receiving services, otherwise refugees can only access health care in emergency situations. The Migration Integration Policy Index suggests that for Turkey the country's overall score is 'comprehensive' (having previously been 'slightly unfavourable') and for health it ranks as 'favourable'.[58]

Interviewees highlighted difficulties faced by Syrian refugees with regards to lack of employment and high poverty levels, exploitative employment practices such as unfair wage, long hours, and child labour which in turns impedes children's school attendance. Most Syrians do not speak Turkish which challenges their ability to obtain work and hampers integration into Turkish society. In 2018, 34,573 work permits were issued to Syrian refugees; therefore, most Syrian refugees are believed to be working informally which magnified the risk of labour exploitation.[354]

4.8.2 Health statistics in host population

Life expectancy in 2020 in Turkey is 75 and 81 years for men and women respectively.[111] The adult mortality rate was 117 per 1,000 population for men and 61 per 1,000 population for women. Maternal mortality 16 per 100,000 live births in 2015.[111]

Estimates from 2017 show that around 4% of the general population suffer from depression and 4% from anxiety disorders.[355] The suicide rate is estimated at between 2.4 and 2.7 per 1000,000.[356, 357] The total number of suicides was 3,069 in 2017; with 73.3% male and 26.7% female.[357]

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). 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. A national mental health policy is in place which was implemented in 2006.[358] 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.[359] However, 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.[360] One of our interviewees also raised concerns regarding the cooperation between different public institutions (MoH, Ministry of Education, etc) and highlighted the need for further policy alignment with regards to mental health.

4.8.3.2 Financing and expenditure

In 2018, the Turkish Government spent 4.12% of its GDP on health.[111] There is no information how much of the total expenditure is spent on mental health. 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 Turkish citizens.[361]

4.8.3.3 Mental health workforce

The ratio of psychiatrists is 1.64 psychiatrists and 2.54 psychologists per 100,000 population in Turkey in 2016,[356] and there are 0.76 social workers per 100'000 population respectively.[359] Mental health service providers are usually paid by a fixed salary.[360] The majority of primary health care doctors and nurses have not received official in-service training on mental health within the last five years.[359] 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 cannot treat patients themselves. To date, the Turkish MoH has hired over 400 trained Syrian health workers, physicians and nurses to serve in more than 80 refugee clinics throughout Turkey.[362]

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 insufficient financial resources to support this endeavour.[360] According to the National Mental Health Plan, in 2011 the MoH was largely responsible for mental health service provision in Turkey. Over half (53.5%) of psychiatric beds were within a MoH mental health disorders hospital, 27.2% within one of the MoH's general hospitals, 13.1% in university and general hospitals, and the private sector covered 6.2%.[361] 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%).[358] 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".[361] The rate of admission into psychiatric hospitals was 70.59 per 100,000 population.[359]

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 Turkish MoH, WHO, UNHCR Union of Medical Care and Relief Organizations, International Medical Corps and other national and international NGOs. The Turkish government has made several regulations for Syrian refugees which allow them to benefit from emergency care units and primary, secondary and tertiary healthcare centres in Turkey's 81 provinces free of charge; the financial costs of these benefits are covered by the Disaster and Emergency Management Authority. Effectiveness of healthcare services for refugees is limited by language barriers, mobility of the refugees and some legal restrictions. Mental health and rehabilitation services are relatively weak because of the inadequate number of qualified practitioners.[363]

4.8.3.5 Psychotherapeutic medicines

There is no essential list of drugs in the country.[359] Prescription regulations authorize primary health care doctors to prescribe and/or continue prescription of psychotherapeutic medicines with restrictions.[362]

4.8.4 Process outcomes and responsiveness

4.8.4.1 Care pathway

Providers who 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 (KI). A key informant noted this route may be problematic because there is no medication follow-up or monitoring. As a result, it is preferable for health purposes for a Syrian to get their temporary protection status.

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 encompass the availability, accessibility, accommodation, affordability and acceptability 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.[83]

Accommodation:
The concept of accommodation needs to be explored further (in subsequent qualitative work to be conducted 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 how 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.

Doğan et al (2019) conducted a qualitative study among Syrian refugees and interviewed them about barriers to accessing mental health care.[364] Seven themes were identified which correspond to barriers identified though our literature review. Key issues identified by Doğan et al were (a) difficulties making appointments, (b) difficulties obtaining medicine, (c) personal rights, (d) lack of information, (e) language barriers, (f) discrimination and stigma.[364] Similar barriers were identified in another study investigating barriers to treatment for chronic diseases among Syrian refugees in Turkey through a systematic review and stakeholder analyses (Alawa, 2019). The authors concluded that although access to treatment for displaced Syrians has improved throughout the past five years, five primary barriers persist: registration procedure regulations, navigation problems in a new health system, language barriers, fear of adverse treatment, and cost.[365]

4.8.4.3 Quality and Safety

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

4.8.5

4.8.6 Mental health outcomes

There are no nation-wide population-level estimates on the prevalence of mental disorders among refugees in Turkey. However, there are a number of geographic-specific cross-sectional surveys on mental health outcomes among Syrian refugees (these were discussed in previous deliverables and so not repeated in detail here). In summary, these report widely varying levels for symptoms of common mental disorders such as depression and anxiety and also PTSD, ranging from 20% to 80%.[19, 366-370] While the range of prevalence levels from these multiple studies are extremely wide (reflecting different methodologies and also population groups and settings and associated stressors), the estimates are broadly in line with those from other conflict-affected and forcibly displaced populations globally, and are considerably higher than the Turkish population and non-conflict-affected populations elsewhere globally.[30, 369, 371, 372] The studies also widely report the strong association with mental disorder symptoms of exposure to traumatic events and ongoing daily stressors such as impoverishment, unemployment, isolation and discrimination.[19, 366, 368, 369] A number of studies also highlight a high treatment gap for MHPSS care (~80%), with barriers to MHPSS care support and these include costs of care, stigma around mental health care, limited awareness of mental health symptoms and also services, limited physical access, and concerns around quality of

care.[20, 364] However, other evidence indicates high levels of satisfaction with mental health services by Syrian refugees in Turkey.[373]

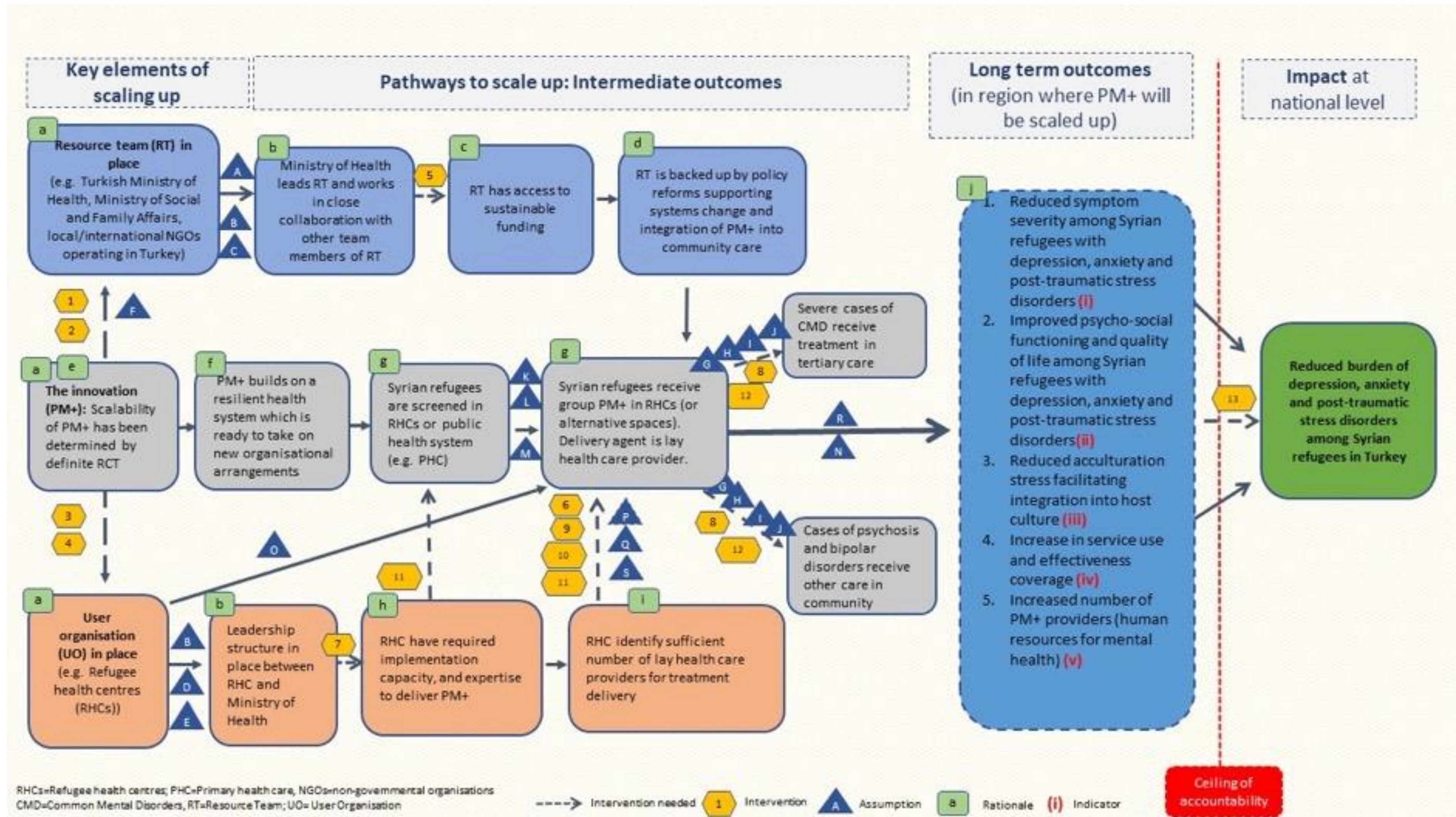
4.8.7 Theory of Change map

To support our understanding of the health system and potential scaling-up of PM+, we conducted a one-day Theory of Change (ToC) workshop on 8 November 2018 in Istanbul, Turkey for WP2 in the STRENGTHS study. The aim was to examine the pathways to support the potential scale-up of PM+ for Syrian refugees in Turkey. Twenty-four stakeholders participated in the workshop (10 national and international academics and mental health/conflict researchers from universities in Turkey, the United Kingdom and the Netherlands; 10 staff from national and international NGOs such as UNHCR, Relief International Turkey, War Trauma Foundation, International Blue Crescent; three psychiatrists and psychologists from local hospitals and community centres, and one government official from the MoH in Ankara). At the beginning of the workshop, PM+ was introduced to external stakeholders who were not involved in developing and adapting PM+ in Turkey. This was followed by a presentation of results from formative research and the PM+ pilot trial in Turkey. A short introduction to scaling up innovations and the concept of ToC was provided to participants.

In ToC, impact refers to the change or real-world impact which we want to achieve by scaling up PM+. Specifically, it refers to the change at the national level that the scale up of PM+ cannot achieve on its own. The impact is behind the ceiling of accountability: the level at which we stop measuring whether outcomes of the scale up of PM+ have been achieved, and therefore stop accepting responsibility. Long-term outcomes are the final outcomes that the scale up of PM+ can achieve on its own. Long-term outcomes apply to the population and the health system in the district/region in which PM+ is being scaled up. Intermediate outcomes are pre-conditions of long-term outcomes. Intermediate outcomes inform and interact with each other, and there are interventions and assumptions associated with intermediate outcomes. Assumptions are external conditions that must exist for each intermediate outcome (or precondition) to be achieved. Interventions are strategies or activities that bring about intermediate outcomes. Intermediate outcomes are usually based on rationales (=evidence) supporting their choice.

The findings from the ToC workshop are summarised in Figure 4.8.1 and described below.

Figure 4.8.1: ToC map for scaling up PM+ in Turkey



1 Interventions

1) Resource team (RT) nominates user organisation (UO) (=refugee health centers, RHCs). RT works with selected RHCs (who implement PM+ in a specific region/site) in a collaborative manner which creates a sense of ownership in RHCs.
2) RT strengthens implementation capacity of RHCs/UO (provision of skills training; personnel, logistics, supplies) to deliver innovation, and trains the trainers of PM+. Government supplies RHCs/UO with continued funding or seeks additional funding for RHCs.
3) RT and RHCs/UO disseminate information about PM+ and nominate a champion who advocates for change before and during scaling up.
4) RT and RHCs/UO monitor quality and accountability, and follow thorough monitoring and evaluation plan over duration of scale up and beyond.
5) Government to initiate changes at legal, institutional and political levels to ensure necessary/additional financial resources are leveraged, and scale up supported through systems change.
6) Refugee health centres work through community leaders and other NGOs to identify sufficient number of lay health care providers for treatment delivery
7) Expert trainers from RT train lay health care providers in PM+ according to manual.
8) Lay health care providers follow treatment protocol which indicates when patient needs to be referred to higher intensity treatment and other social care in case of clinical worsening or occurrence of other clinical conditions.
9) Mental health specialists provide supervision to lay health care providers according to manual.
10) RHCs/UO seek to create positive attitudes and trust towards non-specialized health care among Syrian refugees in the community. This is to increase help-seeking and treatment demand.
11) Community awareness strategy: RHCs/UO disseminate information about PM+ and raise awareness about mental disorders to reduce stigma.
12) RHCs/UO work closely with staff from the public health care system such as PHC staff and tertiary care providers, and refer patients if needed.
13) Gradual scale up: PM+ is scaled up to other refugee sites in Turkey once scale-up in vanguard site has been successful. Gradual scale up builds on lasting institutional capacities in vanguard site, and close collaboration between RT and RHCs/UO.

A Assumptions

A. Innovation is supported by highest government officials, and there is a champion within the government which advocates for change.
B. There are no bureaucratic structures in RT and RHCs/UO so that changes that can be quickly implemented.
C. Researchers who led study in Turkey form part of the RT.
D. One lead member of RHC has been appointed that will take overall responsibility for managing scaling up in site, and reports regularly to RT.
E. RHCs/UO understand the need of innovation, and consider it a health care priority.
F. There is a good working relationship in place between RT and RHCs/UO which is characterised by mutual respect and trust.
G. Structured referral mechanism in place.
H. Sufficient beds are available in tertiary care/community for treating severe cases and other mental disorders such as bipolar disorders/psychosis.
I. Health professionals in primary care, community care and tertiary care work together with RHCs in a collaborative care model.
J. Translators are available at tertiary care level/ other care institutions in community to help Syrians follow treatment.
K. There are no further modifications needed to implement PM+ (adapted for refugees) in RHCs or other community settings (e.g. faith-based organisations).
L. PM+ is delivered to Syrian refugees in RHCs according to manual.
M. After screening, Syrian refugees are referred in a timely manner to group PM+ in RHCs or other alternative spaces (e.g. other community settings or faith-based organisations). PHC staff know about PM+ in RHCs and refer Syrian patients to intervention.
N. RHCs/UO base scale up on published policy document which supports shift towards community-based care and understands PM+ as first step in a collaborative care model.
O. RHCs/UO has sufficient capacity to deliver innovation so that delivery of existing services are not diminished.
P. Lay health care providers deliver intervention as intended, and receive supervision from mental health experts.
Q. Sufficient number of supervisors are available to provide supervision to lay health care workers in RHCs/UO.
R. Syrian refugees find a service which is free of charge useful and commit to PM+ for duration of treatment.
S. Lay Syrian refugee providers are legally allowed to work and get some form of reimbursement for their work (i.e to deliver PM+ in RHCs/UO).

a | **Rationale**

a) RT, UOs and the innovation are key elements of scaling up according to the WHO/Expandnet framework of scaling up (WHO, Expandnet, 2010).
b) Lack of leadership has been reported as one of the barriers to scaling up public health interventions (Yamey, 2012).
c) Potential funding sources need to be identified and funding secured before scale up can proceed (Centre for Epidemiology and Evidence, 2014).
d) Interventions have the best chance of being scaled up when they are aligned with policy priorities (Centre for Epidemiology and Evidence, 2014).
e) Scalability of an intervention (effectiveness, reach and adoption) needs to be assessed before scaling it up (Milat et al, 2014).
f) Health systems in resource constraint settings are often fragmented, and need to be strengthened (supply of funding, staff, training) to take on new organisational arrangements like collaborative care models (view of provider, ToC workshop).
g) PM+ was developed for implementation in the community in Turkey. Syrian refugees can be screened in RHCs or in the public health system (e.g. PHC), and can then receive PM+ in RHCs by trained Syrian provider (views of mental health professionals and key stakeholders in Turkey, ToC workshop).
h) Implementation capacity of UOs is understood as pre-requisite for scaling up (WHO, Expandnet, 2010).
i) Community leaders are most knowledgeable about people living in their communities, and can easily identify potential community members (Syrians) who can deliver and be trained in PM+. Diversification of delivery agents (other than peer-Syrian refugees themselves may increase the number of delivery agents who can be trained facilitating horizontal scale up) (view of lead researcher in Turkey, ToC workshop).
j) Long-term outcome 1 and 2: Reduced symptom severity (PTSD and psychological distress) and improvement in psychosocial functioning have been primary and secondary outcomes of the PM+ trial (Sijbrandij M et al). Long-term outcome 3: People without mental health problems may find it easier to take part in livelihood interventions and take up employment which facilitates integration (view of provider, ToC workshop). Long-term outcome 4: Scaling up an evidence-based intervention will increase effectiveness coverage (DeSilva et al, 2014). Long-term outcome 5: Scaling up PM+ will strengthen the mental health system by providing training and capacity building thereby increasing the number of trained lay health care providers (view of government official, ToC workshop).

(i) Indicators

(i) Significant improvement in post-traumatic stress symptoms (measured with the PTSD Checklist for DSM-5 (PCL-5)) and psychological distress (Hopkins Symptoms Checklist, HSCL-25) among Syrian refugees after intervention delivery.
(ii) Significant improvement in psychosocial functioning (measured with WHO Disability Score Schedule, WHO-DAS) among Syrian refugees after intervention delivery.
(iii) Significantly reduced acculturation stress (using the Acculturative Stress scale) among Syrian refugees after intervention delivery
(iv) Significant increase in health service use and effectiveness coverage by the end of scaling up phase.
(v) Significant increase in number of lay health care providers in region in which PM+ is being scaled up.

References:

- World Health Organization, ExpandNet. Nine steps for developing a scaling-up strategy. Geneva: WHO; 2010.
- Yamey, 2012. What are the barriers to scaling up public health interventions in low and middle income countries. A qualitative study of academic leaders in implementation science. Globalization and Health, 8:11.
- Centre for Epidemiology and Evidence. Milat AJ, Newson R, and King L. *Increasing the scale of population health interventions: A guide*. Evidence and Evaluation Guidance Series, Population and Public Health Division. Sydney: NSW Ministry of Health, 2014.
- Milat AJ, Newson R, Wolfenden L, Rissel C, Bauman A, Redman S. Increasing the scale and adoption of population health interventions: experiences and perspectives of policy-makers, practitioners and researchers. Health Research Policy and Systems. 2014;12:18.
- De Silva MJ, Lee L, Fuhr DC, Rathod S, Chisholm D, Schellenberg J, Patel V. Estimating the coverage of mental health programmes: a systematic review. Int J Epidemiol. 2014 Apr;43(2):341-53.
- Sijbrandij M et al. Problem Management Plus (PM+) in the treatment of common mental disorders in women affected by gender-based violence and urban adversity in Kenya; study protocol for a randomized controlled trial. *International Journal of Mental Health Systems*, 2016, 10:44.

Pathways to scale up:
Three pathways to scaling up PM+ in Turkey were identified. The three pathways to scale up led to five long-term outcomes and an envisaged impact (shown on the right-hand side of the ToC map; see figure 8.1.1 above). Stakeholders identified "Reduced burden of psychological distress and reduced symptoms of depression, anxiety and PTSD among Syrian refugees in Turkey" as the vision or impact that the scaling up of group PM+ may be able to contribute towards. Long term outcomes apply to the population and the health system in the district/region in which PM+ is being scaled up. Five long term outcomes were identified: Reduced symptom severity among Syrian refugees; improved psychosocial functioning and quality of life among Syrian refugees; reduced acculturation stress of Syrian refugees facilitating integration into host communities; increase in service use and effectiveness coverage; and increased number of human resources for mental health. Indicators have been developed for these long-term outcomes which can be used to measure success of the scale up strategy in the region where it will be scaled up. These indicators are outlined in box "indicators".

Resource team pathway
The resource team was perceived as an important pillar of the scaling up strategy. ToC workshop participants argued that the resource team should comprise of the MoH, Ministry of Social and Family Affairs, key NGOs and the Turkish researchers (see assumption C) who developed and adapted PM+ in Turkey. An early intermediate outcome to the resource team's pathway is leadership within the resource team. Leadership was thought to be provided by the MoH or other governmental bodies that have the necessary political power to bring about sustainable funding. It was further argued that sustainable funding should be based upon policy documents outlining reforms for system's change. A key assumption on this pathway was that the innovation must be supported by senior government officials, and that there is a champion within the government who advocates for change (assumption A). For scale up to happen stakeholders perceived a need for the government to initiate changes at the legal, institutional and political levels to ensure additional financial resources are leveraged (intervention 5).

Innovation pathway
The second pathway to scale up is the innovation pathway and focuses on the PM+ intervention itself. It understands scalability of PM+ (i.e., effectiveness of PM+, its wider population reach, and adoption) as an essential pre-requisite before PM+ can be rolled out. Stakeholders noted that PM+ should build on a resilient health system. For successful integration, PM+ should be nested in a health service structure which is functioning well and able to assimilate new organisational arrangements like collaborative stepped care. In a collaborative stepped care model, PM+ would be understood as first treatment step for mild or moderate mental disorders. Due to the health service structure in Turkey, and the need to deliver interventions to Syrian refugees in a cultural relevant way, refugee health centres were identified as preferred delivery platform for scale up. Screening was suggested to take place in either refugee health centres or primary health care while PM+ itself would be offered by Syrian lay health providers in refugee health centres only. Individuals displaying clinical worsening or serious mental disorders such as psychosis would not receive group PM+ but would be referred to tertiary care or other community health care centres for appropriate treatment. A few assumptions around the health system were underlying this pathway; for example, it was assumed that the health system and its staff are responsive to the needs of Syrian refugees and support change (assumption M); that a structured referral mechanism would be in place (assumption G); that an increase in referrals to tertiary care would be absorbed by the public health system (assumption H), and that translators would be available in secondary or tertiary care to guide Syrians through treatment (assumption J).

User organisation(s) pathway

The third pathway refers to the user organisation. Participants of the ToC workshop suggested refugee health centres as user organisation which should offer and implement PM+. A leadership structure between the MoH and the refugee health centres was considered essential for success. Another key requirement was for refugee health centres to have both the capacity and expertise to implement PM+. Refugee health centres were suggested to work through community leaders and NGOs to recruit Syrian lay health care providers for treatment delivery. ToC workshop participants assumed that one refugee health centre would be appointed to take overall responsibility for managing scaling up of PM+ in the site where it will be scaled up, and that this lead organisation would also report and update the resource team on progress being made (assumption D).

Finding enough Syrian lay PM+ providers was an issue discussed extensively. It was suggested that refugee health centres work with community leaders and NGOs to identify a sufficient number of lay health care providers to meet treatment demand (intervention 6). Another key assumption was the availability of mental health specialists to supervise lay providers (assumption Q), and that those delivering PM+ would get some form of reimbursement (in form of a stipend or salary) for their work (assumption S). To support the uptake of PM+, refugee health centres would need to raise community awareness about the intervention and mental disorders (assumption 11) and foster positive attitudes and trust in non-specialised health care among Syrian refugees (assumption 10).

A key intervention was suggested between the resource team and the user organisation: the resource team was thought to be responsible to strengthen implementation capacity of refugee health centers though provision of skills training, personnel and logistics to deliver PM+, and was thought to be in the best position to train the trainers of PM+ (intervention 2). Both the resource team, and the refugee health centres would be required to monitor quality and accountability of the scale up, and follow a thorough monitoring and evaluation plan (intervention 4).

The findings from the ToC workshop in Istanbul have been published.[22] We also conducted ToC workshops in the Netherlands and Lebanon and we have published a comparative paper on the ToC workshops in Turkey, Netherlands and was published a journal publication.[21]

4.8.8 Survey results

As part of the STRENGTHS WP2 work, a cross-sectional survey was conducted between February and April 2018 in Sultanbeyli municipal registry in Istanbul, an area with a very high number of Syrian refugees. A random sampling design was used, with potential respondents randomly selected from from the database of Refugees and Asylum Seekers Assistance and Solidarity Association (RASASA) which is an NGO that is located in Sultanbeyli and the main provider of health and social care to refugees in Sultanbeyli. There were 1,678 participants in the survey (a 59% response rate). The remaining 1,187 participants either refused, missed appointments, were ineligible, could not be contacted or had died. Further information on the study design, survey questionnaire, data analyses and results were provided in previous Deliverables and publications stemming from the survey.[19, 20, 23] To avoid undue repetition, we therefore include here only key summary data from the previous reported results.

Half of the sample were women (51.6%), and the median age of respondents was 34 years. In terms of employment status, 44% of men were in regular paid work and another 23% in irregular employment or self-employed, while 92% of women described themselves as housewives. The economic situation of the household was described as bad for almost half of respondents (43.6%). On average, respondents were

in Turkey for around 3 years since being displaced from Syria. The estimated prevalence of symptoms of PTSD, depression and anxiety was 19.6%, 34.7% and 36.1% respectively.

Of all respondents, 249 respondents (15%) screened positive for either PTSD, depression or anxiety in our survey **and** also self-reported emotional/behavioural problems since arriving in Sultanbeyli. Among these 249, the treatment gap (i.e. proportion of them that that did not seek care) was 89% for PTSD, 90% for anxiety and 88% for depression. Out of those 249 respondents, 22 respondents (9%) sought care, and 219 respondents did not (88%). Over half of respondents wanted to handle the behavioural problem they were facing on their own, were concerned about the cost of health care, and believed that time would improve symptoms. A large proportion of respondents (n=102, 47%) were also unsure which service they should attend and did not know where and how to get help. Around one quarter of participants (n=60, 27%) did not believe that the treatment would improve symptoms and were concerned about opportunity costs and the time spent on treatment. Embarrassment to seek treatment (n=51, 23%) and the concern about what other people would think were also named as reasons for not seeking care. A small proportion of participants (n=22, 10%) mentioned unavailability of appointments, lack of medication and the fear of being put into hospital against their own will as reasons for not seeking care. Out of the 22 respondents who sought care, 12 (55%) did not complete the full course of treatment. Respondents tended to discontinue treatment due to a desire to handle the problem on their own, and mentioned structural barriers hindering them to continuing treatment like lack of time, transportation and problems with the treatment schedule.

We also asked all respondents (N=1678) where Syrian refugees with mental health problems usually seek help. Over 50% of respondents (n=907) reported government hospitals and refugee health centres in the public health system as the most common places to go for mental health treatment. Family and friends (n=890, 53%) and religious leaders (n=735, 44%) were also commonly cited. Private hospitals (n=710) and local government clinics (n=700) were mentioned by around 40% of participants. Around one third of respondents reported NGOs (n=526, 31%) as places to seek treatment. Eight percent (n=138) of respondents indicated that care would not be available at all.

Since the last deliverable, we have also conducted data analysis from the Istanbul survey on post-traumatic growth (PTG) and this is summarised here, and further details can be found in the full published paper.[24] In summary, there was a moderate level of PTG in the study sample, with a mean score of 55.94 (SD=22.91, range 0-105). Factors associated with PTG are shown in Table 4.8.1. Older age was associated with reduced levels of PTG (i.e. a negative effect), while higher education was associated with higher levels of PTG. There was no association with gender. A curvilinear PTG-PTSD relationship was observed, with the highest level of PTG was experienced by those with moderate levels of PTSD, while lower levels of PTG were observed with either low or high levels of PTSD (Figure 4.8.2). These findings reflect those observed in other studies on PTG, including in Turkey.[374-376]

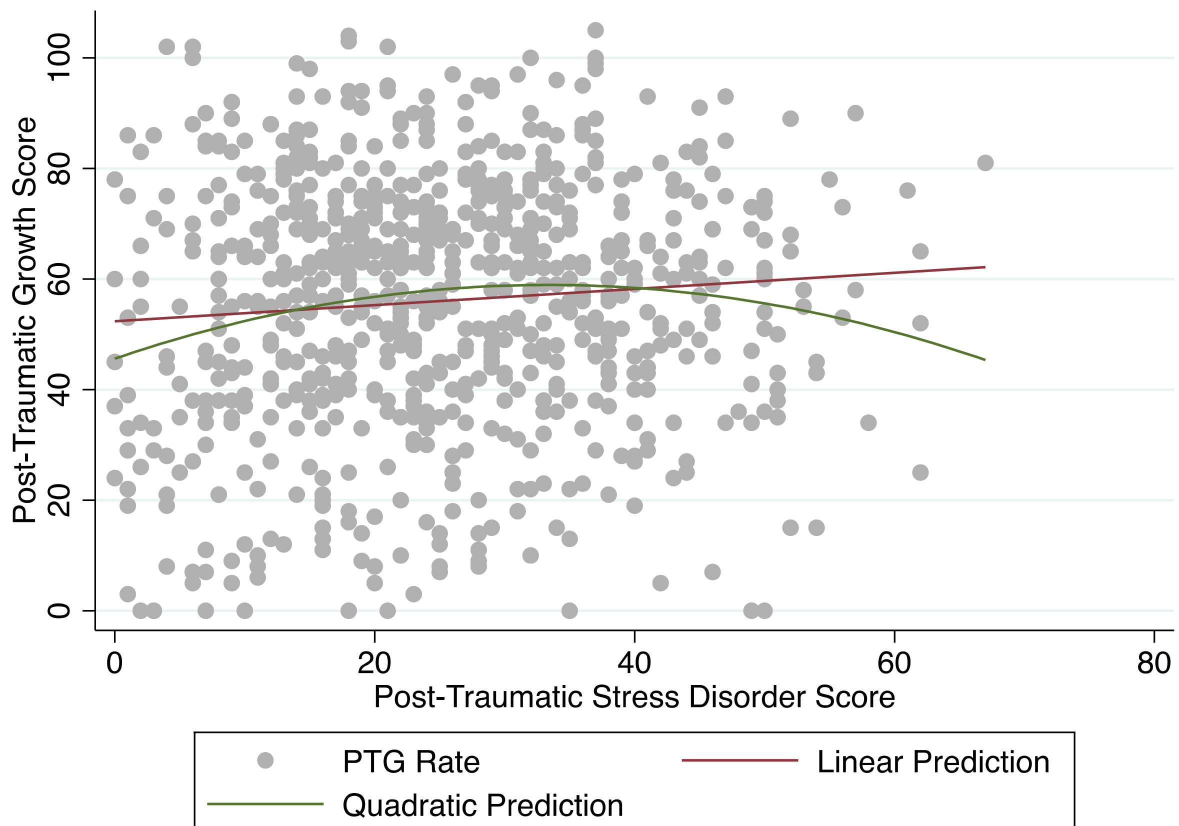
Further details on the STRENGTHS WP2 survey can be found in the academic papers published from the survey.[19, 20, 23, 24]

Table 4.8.1: Factors associated with PTG in multivariate regression analysis

	Step 1			Step 2			Step 3*			Step 4		
Variable	B (SE)	β	p	B (SE)	β	p	B (SE)	β	p	B (SE)	β	p
Sex												
Female	0.42 (1.67)	0.01	0.08	-	-	-	-	-	-	-	-	-
Age group												
25-34 years	2.55 (2.26)	0.05	0.26	2.29 (2.25)	0.05	0.31	1.45 (2.20)	0.03	0.51	0.68 (2.29)	0.01	0.77
35-44 years	0.64 (2.45)	0.01	0.79	0.84 (2.43)	0.02	0.73	1.42 (2.39)	0.03	0.55	0.28 (2.49)	0.01	0.91
45-54 years	-7.71 (2.83)	-0.12	0.007	-6.93 (2.85)	-0.10	0.02	-7.17 (3.74)	-0.11	0.01	-8.43 (2.85)	-0.13	0.003
55+ years	-10.13 (3.24)	-0.13	0.002	-8.58 (3.28)	-0.11	<0.001	-7.85 (3.16)	-0.10	0.01	-8.38 (3.37)	-0.10	0.01
Education (in years)	-	-	-	0.82 (0.22)	0.13	<0.001	0.69 (0.22)	0.11	0.002	0.63 (0.22)	0.11	0.004
Employment												
Irregular employment	-	-	-	-0.1 (2.6)	0.002	0.96	-	-	-	-	-	-
Unemployed	-	-	-	-2.3 (3.3)	-0.03	0.49	-	-	-	-	-	-
Not in employment	-	-	-	-1.6 (2.0)	-0.03	0.43	-	-	-	-	-	-
PTSD score	-	-	-	-	-	-	0.91 (0.22)	0.53	<0.001	0.75 (0.23)	0.45	0.001
Squared PTSD score**	-	-	-	-	-	-	-0.01 (0.004)	-0.40	0.001	-0.01 (0.004)	-0.32	0.02
Somatic distress score	-	-	-	-	-	-	-0.52 (0.15)	-0.14	0.001	-0.44 (0.16)	-0.13	0.007
Overnight stay												
Yes	-	-	-	-	-	-	-7.38 (2.71)	-0.10	0.007	-8.63 (2.80)	-0.11	0.002
Medication***		-	-	-	-	-	-	-	-			
Agree slightly	-	-	-	-	-	-	-	-	-	-4.39 (2.07)	-0.09	0.03
Neither	-	-	-	-	-	-	-	-	-	2.82 (3.57)	0.03	0.43
Disagree slightly	-	-	-	-	-	-	-	-	-	-8.15 (2.79)	-0.11	0.004
Disagree strongly	-	-	-	-	-	-	-	-	-	-4.62 (2.33)	-0.08	0.05
Willing to live****												
Agree slightly	-	-	-	-	-	-	-	-	-	1.53 (2.40)	0.03	0.52
Neither	-	-	-	-	-	-	-	-	-	-0.05 (3.41)	-0.001	0.99
Disagree slightly	-	-	-	-	-	-	-	-	-	4.48 (3.34)	0.05	0.18
Disagree strongly	-	-	-	-	-	-	-	-	-	-4.17 (2.06)	-0.09	0.04
Observations (n)	762			762			756			668		
R^2	0.04			0.06			0.10			0.13		
Adjusted R^2	0.03			0.05			0.08			0.10		
F	5.69			5.56			8.71			5.51		
Prob>F	<0.001			<0.001			<0.001			<0.001		
Δ Adjusted R^2	-			0.02			0.03			0.03		

Note: B=unstandardized regression coefficient; SE=standard error; β=standardized regression coefficient; p=p-value; R^2=variance; adjusted R^2=adjusted variance; *F*=F statistic; Prob>F=probability that the null hypothesis (all regression coefficients in model are zero) is true; Δ Adjusted R^2=difference in the variance between steps. *This is the final adjusted model. **This is the squared continuous PTSD score. ***The full statement is, "Medication can be an effective treatment for people with mental health problems." ****The full statement is, "I would be willing to live with someone with a mental health problem."

Figure 4.8.2: Two-way scatterplot of PTG and PTSD, overlaid with linear and quadratic prediction plots



4.8.9 Discussion

Findings of the rapid appraisal have been based on the literature, policy and data review, primary research conducted in Turkey through the STRENGTHS project including a limited number of qualitative interviews, a ToC workshop, and a cross-sectional survey. Additional interviews have been completed to explore in more depth the responsiveness of the health care system in Turkey to the mental health needs of Syrian refugees and the scalability of PM+ there, and the data analysis for this will be completed by January 2022.

The findings from the rapid appraisal reveal a situation in which health services are made available for refugees, but that MHPSS 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 accommodation and acceptability are considered and addressed during the implementation of PM+. Another key point was the lack of treatment demand among the Syrian population. Raising awareness and provision of information about PM+, its components 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 also seems to be inequity in access to health care when it comes to the difference in temporary protection status of refugees.

The ToC workshop was conducted, and map produced outlining the essential political, operational and institutional components of scaling up PM+ in Turkey via three distinct causal pathways. Context-specific barriers to scale up have been identified, and possible strategies for overcoming these challenges were suggested. These barriers and facilitators were further explored and tested through the in-depth qualitative interviews noted above. We found ToC a particularly useful exercise to discuss the potential scale up of PM+ for refugees in Turkey and will test its use for planning the scale up of PM+ in other sites in the future. Early planning and engagement of key stakeholders is essential to pave the way for scaling up an evidence-based intervention. With the help of ToC, we were able to provide a framework of scaling up PM+ which can be further adapted by stakeholders once the (cost)effectiveness and reach of the PM+ trial in Turkey is known.

Our survey among Syrian refugees was one of the first epidemiological study on the prevalence of mental disorders and access to MHPSS care among Syrian refugees in Istanbul. It highlighted a high burden of PTSD, anxiety, depression and somatic distress among Syrian refugees and this has been confirmed in subsequent studies. It also examined levels and associated factors of PTG. Our survey demonstrated a large mental health treatment gap. Only a small minority of Syrian refugees in need of mental health treatment sought care. Our study makes evident that granting refugees access to the national mental health system for refugees is only a first step that will remain insufficient if barriers of seeking care and negative attitudes towards mental ill health are not tackled. Culturally relevant and contextually appropriate psychological interventions need to be made accessible in community settings. This should be accompanied by community awareness interventions providing information about the functioning of the health system, mental disorders and mental health more generally to overcome the mental health treatment gap among Syrian refugees in Turkey.

5. Next Steps

This report represents the final Deliverable for WP2. All four Deliverables for WP2 focused on the RA methodology. This has now been completed. RA annexes for each country (containing key data and literature extracted by country) are available upon request and will be also made available on the STRENGHTS website. We are also planning to write a journal paper synthesising the key findings from the RA methodology across the study countries.

The next main steps WP2 relate to the other methods/activities in WP2. These next steps include completing: the data collection, analysis and write-up of survey results from Leipzig Germany; the analysis and write-up of results for the in-depth qualitative interviews on scaling-up of PM+ (to be completed by May 2022); secondary data analysis of the health access data recorded by study partners in their STRENGTHS trials.

We will also explore the role of gender in our research. This will include dissagregating the quantative data (e.g. the Leipzig cross-sectional survey and the health access data) by gender and reporting any significant differences by gender. For the in-depth qualitative research we will conduct additional analysis to explore the role of gender in our findings and this will be reported either within the planned papers or as a separate in-depth paper (depending on the findings from this analysis).

6. WP2 Publications and outputs to date

Acarturk, C., et al. (2021). "Prevalence and predictors of common mental disorders among Syrian refugees in Istanbul, Turkey: a cross-sectional study." Social Psychiatry & Psychiatric Epidemiology 56(3): 475-484.

Fuhr, D. C., et al. (2019). "Treatment gap and mental health service use among Syrian refugees in Sultanbeyli, Istanbul: a cross-sectional survey." Epidemiology & Psychiatric Science 29: e70.

Fuhr, DC., et al. (2020) Health systems responsiveness to the mental health needs of forcibly displaced persons. In, Bozorgmehr K, Roberts B, Razum O, Biddle L (Eds), Health Policy and Systems Responses to Forced Migration. Springer International.

Fuhr, D. C., et al. (2020). "Planning the scale up of brief psychological interventions using theory of change." BMC Health Services Research 20(801).

Fuhr, D.C., Acarturk, C., Uygun, E. et al. (2020) Pathways towards scaling up Problem Management Plus in Turkey: a theory of change workshop. Confl Health 14, 22.

McGrath et al (2020). Somatic distress among Syrian refugees in Istanbul, Turkey. A cross-sectional survey. J Psychosom Res 2020 May;132:109993. Epub 2020 Mar 9.

STRENGTHS WP2 team. Rapid Appraisal Country Annexes (to be published on the STRENGTHS website).

STRENGTHS WP2 team. Rapid Appraisal Database of published literature, by study country (to be published on STRENGTHS website).

Wen, K., et al. (2020). "Post-traumatic growth and its predictors among Syrian refugees in Istanbul: A mental health population survey." Journal of Migration and Health 1-2: 100010.

Woodward, A., et al. (2021). A system innovation perspective on the potential for scaling up new psychological interventions for refugees. Intervention, the Journal of Mental Health & Psychosocial Support in Conflict Affected Areas, 19(1), 26-36.

7. References

1. Fuhr, D., et al., *Health systems responsiveness to the mental health needs of forcibly displaced persons*, in *Health Policy and Systems Responses to Forced Migration*, K. Bozorgmehr, et al., Editors. 2020, Springer International: Switzerland. p. 213-234.
2. IASC, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* 2007, IASC: Geneva.
3. UNHCR, *UNHCR's mental health and psychosocial support for Persons of Concern*. 2013, UNHCR: Geneva.
4. UNHCR. *UNHCR. Operational Guidance: Mental Health & Psychosocial Support Programming for Refugee Operations*. 2013 20/10/20121]; Available from: http://www.refworld.org/docid/53a3ebfb4.html.
5. Risso-Gill, I., et al., *Understanding the modifiable health systems barriers to hypertension management in Malaysia: a multi-method health systems appraisal approach.* BMC Health Serv Res, 2015. **15**: p. 254.
6. Balabanova, D., et al., *Navigating the health system: diabetes care in Georgia.* Health Policy Plan, 2009. **24**(1): p. 46-54.
7. Kumar, K., *Rapid Appraisal Methods*. 1993, World Bank: Washington DC.
8. WHO/UNHCR, *Assessing mental health and psychosocial needs resources. Toolkit for humanitarian settings*. 2012, WHO/UNHCR: Geneva.
9. UNHCR/WHO, *Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide*. 2008, UNHCR/WHO: Geneva.
10. Petevi M, Revel J, and J. G., *Rapid assessment of mental health needs of refugees, displaced and other populations affected by conflict and post-conflict situations. A community-oriented assessment*. 2001, WHO: Geneva.
11. WHO, *Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action.* . 2007, WHO: Geneva.
12. Papanicolas, I. and P. Smith, *Health system performance comparison. An agenda for policy, information and research.* 2013, Maidenhead: Open University Press.
13. WHO, *World Health Report 2000. Health systems: improving performance.* 2000, WHO: Geneva.
14. Valentine, N., *Patient experiences with health services: population surveys from 16 OECD countries, In: Murray, Evans DB, editors. Health Systems Performance Assessment: Debates, methods and empiricism*. 2003, WHO: Geneva.
15. Kelley E, H.J., *Health Care Quality Indicators project: Conceptual framework paper*. 2006, OECD: Paris.
16. Penchansky, R. and J.W. Thomas, *The Concept of Access: Definition and Relationship to Consumer Satisfaction.* Medical Care, 1981. **19**(2): p. 127-140.
17. WHO, *Problem Management Plus (PM+). Individual psychological help for adults impaired by distress in communities exposed to adversity*. 2016, WHO: Geneva.
18. Hirschfeld, R.M., et al., *Social functioning in depression: a review.* J Clin Psychiatry, 2000. **61**(4): p. 268-75.
19. Acarturk, C., et al., *Prevalence and predictors of common mental disorders among Syrian refugees in Istanbul, Turkey: a cross-sectional study.* Soc Psychiatry Psychiatr Epidemiol, 2021. **56**(3): p. 475-484.
20. Fuhr, D.C., et al., *Treatment gap and mental health service use among Syrian refugees in Sultanbeyli, Istanbul: a cross-sectional survey.* Epidemiol Psychiatr Sci, 2019. **29**: p. e70.
21. Fuhr, D.C., et al., *Planning the scale up of brief psychological interventions using theory of*

change. BMC Health Serv Res, 2020. **20**(1): p. 801.
22. Fuhr, D.C., et al., *Pathways towards scaling up Problem Management Plus in Turkey: a theory of change workshop.* Confl Health, 2020. **14**: p. 22.
23. McGrath, M., et al., *Somatic distress among Syrian refugees in Istanbul, Turkey: A cross-sectional study.* J Psychosom Res, 2020. **132**: p. 109993.
24. Wen, K., et al., *Post-traumatic growth and its predictors among Syrian refugees in Istanbul: A mental health population survey.* J Migr Health, 2020. **1-2**: p. 100010.
25. UNHCR. *Syria Regional Refugee Response: Egypt*. 2019 [cited 2019 30 October]; Available from: https://data2.unhcr.org/en/situations/syria/location/1.
26. UNHCR. *Syria Regional Refugee Response: Egypt*. 2021 [cited 2021 31 May]; Available from: https://data2.unhcr.org/en/situations/syria/location/1.
27. 3RP. *3RP Regional Refugee & Resilience Plan 2016-2016. In response to the Syria crisis: Egypt.* 2016 [cited 2021 28 May]; Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/Egypt-%E2%80%93-Regional-Refugee-Resilience-Plan-2016-2017.pdf
28. The World Bank. *World Bank Open Data*. 2020 [cited 2021 28 May]; Available from: https://data.worldbank.org.
29. The World Bank. *World Bank Open Data*. 2019 [cited 2021 28 May]; Available from: https://data.worldbank.org.
30. WHO. *Global Health Observatory data repository*. 2017 [cited 2018 4 April]; Available from: http://apps.who.int/gho/data/.
31. Institute for Health Metrics and Evaluation. *Global Burden of Disease (GBD) Results Tool*. 2016 [cited 2018 9 April]; Available from: http://ghdx.healthdata.org/gbd-results-tool.
32. Institute for Health Metrics and Evaluation. *Global Burden of Disease (GBD) Results Tool*. 2016 [cited 2017 19 September]; Available from: http://ghdx.healthdata.org/gbd-results-tool.
33. Ghanem, M., et al., *National Survey of Prevalence of Mental Disorders in Egypt: preliminary survey.* Eastern Mediterranean Health Journal, 2009. **15**(1): p. 65-75.
34. WHO, *Mental health Atlas country profile 2014: Egypt*. 2014, World Health Organization: Geneva.
35. WHO, *Mental Health Atlas 2011: Egypt*. 2011, World Health Organization: Geneva.
36. Deif, I. *Health ministry and UNICEF in Egypt reach out to Syrian refugees*. 2016 [cited 2018 9 April]; Available from: http://english.ahram.org.eg/NewsContent/7/48/251458/Life--Style/Health/Health-ministry-and-UNICEF-in-Egypt-reach-out-to-S.aspx.
37. The World Bank. *World Bank Open Data*. 2018 [cited 2018 4 April]; Available from: https://data.worldbank.org.
38. WHO, *Mental Health Atlas Member State Profile: Egypt*. 2017: Geneva.
39. OECD. *Creditor Reporting System (All Donors Total, Health Total)*. 2018 [cited 2018 9 April]; Available from: https://stats.oecd.org/Index.aspx?DataSetCode=CRS1#.
40. Pande, A., A. El Shalakani, and A. Hamed, *How Can We Measure Progress on Social Justice in Health Care? The Case of Egypt.* Health Systems & Reform, 2017. **3**(1).
41. Jenkins, R., et al., *Mental health policy and development in Egypt - integrating mental health into health sector reforms 2001-9.* International Journal of Mental Health Systems, 2010. **4**(17).
42. Mahmoud, M. *What you need to know about Egypt's universal health insurance law?* 2017 [cited 2018 10 April]; Available from: https://www.egypttoday.com/Article/2/37507/What-you-need-to-know-about-Egypt%E2%80%99s-universal-health-insurance
43. WHO and Ministry of Health Egypt, *WHO-AIMS Report on Mental Health System in Egypt*. 2006: Cairo, Egypt.
44. Bahgat, M., *Survival Strategies and Coping Mechanisms of Syrian Female Head of Household in Egypt*. 2016, American University in Cairo.
45. 3RP. *3RP Country Chapter 2019/2020: Egypt*. 2019 [cited 2021 28 May]; Available from:

https://reliefweb.int/sites/reliefweb.int/files/resources/69672.pdf.
46. WHO, *Mental Health Atlas*. 2017: Geneva.
47. Refuge Egypt. *Programs*. 2017 [cited 2018 10 April]; Available from: http://www.refuge-egypt.org/programs/.
48. Caritas. *Egypt*. 2018 [cited 2018 10 April]; Available from: https://www.caritas.org/where-caritas-work/middle-east-and-north-africa/egypt/
49. CARE. *Syrian Refugees in Egypt: "See the Sun Rising?"*. 2017 [cited 2018 10 April]; Available from: http://www.care.org/impact/our-stories/syrian-refugees-egypt-%E2%80%9Csee-sun-rising%E2%80%9D.
50. WHO. *Egyptian Essential Drug List 2012-2013*. 2012 [cited 2018 10 April]; Available from: http://apps.who.int/medicinedocs/en/d/Js21736en/.
51. Kira, I.A., et al., *A Threatened Identity: The Mental Health Status of Syrian Refugees in Egypt and Its Etiology.* An International Journal of Theory and Research 2017. **17**(3): p. 176-190.
52. BpB. *Zahlen zu Asyl in Deutschland*. 2018; Available from: https://www.bpb.de/gesellschaft/migration/flucht/218788/zahlen-zu-asyl-in-deutschland
53. BpB. *Zahlen zu Asyl in Deutschland*. 2019; Available from: https://www.bpb.de/gesellschaft/migration/flucht/218788/zahlen-zu-asyl-in-deutschland
54. WHO, *Adult Mortality Data by WHO Region*, G.H.O.D. Repository, Editor. 2018: WHO.
55. Jacobi, F., et al., *Twelve-month prevalence, comorbidity and correlates of mental disorders in Germany: the Mental Health Module of the German Health Interview and Examination Survey for Adults (DEGS1-MH).* Int J Methods Psychiatr Res, 2014. **23**(3): p. 304-19.
56. WHO. *ATLAS 2017 Germany country profile mental health* 2017 [cited 2021 12.10]; Available from: https://www.who.int/publications/m/item/mental-health-atlas-2017-country-profile-germany.
57. Cohen AA, Magnezi R, and W. O., *Review and Analysis of mental health reforms in several countries: Implementation, comparison and future challenges.* Ann Psychiatry Treatm 2020. **4**(1): p. 013-024.
58. MIPEX. *Migrant Integration Policy Index 2020*. 2021 [cited 2017 20 September]; Available from: http://www.mipex.eu/.
59. The World Bank. *Current Health Expenditure (% of GDP)*. 2021 [cited 2021 23 August]; Available from: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS.
60. IQWIG:, *Health care in Germany: Health insurance in Germany*. 2015, Institute for Quality and Efficiency in Health Care.
61. Glenngård, A., *International Profiles and Health Care Systems*. 2020. p. p181-189.
62. J., G.-H., *Erstattung von Health-Apps durch die gesetzliche Krankenversicherung.* Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz, 2018. **61**(3): p. 328-33.
63. Bozorgmehr, K., et al., *How Do Countries' Health Information Systems Perform in Assessing Asylum Seekers' Health Situation? Developing a Health Information Assessment Tool on Asylum Seekers (HIATUS) and Piloting It in Two European Countries.* International Journal of Environmental Research and Public Health, 2017. **14**: p. 894.
64. Bozorgmehr, K. and O. Razum, *Effect of Restricting Access to Health Care on Health Expenditures among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994-2013.* PLoS One, 2015. **10**(7): p. e0131483.
65. Eurostat, *'Physicians by medical specialty – Psychiatrists'*. 2021.
66. Bluemel. and Busse. *The German Health Care System*. 2018; Available from: http://international.commonwealthfund.org/countries/germany/.
67. Statistica. *Versorgungsdichte niedergelassener Psychotherapeuten in Deutschland im Jahr 2011 nach Kreistypen (je 100.000 Einwohner)*. 2018; Available from: https://de.statista.com/statistik/daten/studie/198196/umfrage/anzahl-der-niedergelassenen-psychotherapeuten-in-deutschland/.
68. Chenot, J.F., *Undergraduate medical education in Germany.* Ger Med Sci, 2009. **7**: p. Doc02.

69. WHO, *Mental Health Atlas 2011*. 2011, World Health Organization Geneva.
70. Nijman, R.G., et al., *Emergency care provided to refugee children in Europe: RefuNET: a cross-sectional survey study.* Emerg Med J, 2021. **38**(1): p. 5-13.
71. IQWIG:, *Health care in Germany: A guide to psychotherapy in Germany: Where can I find help?* 2016, Institute for Quality and Efficiency in Health Care.
72. Levin, J.N. *Meet the People Helping Refugees in Germany Battle Mental Health Issues*. 2017; Available from: Retrieved from https://medium.com/thrive-global/meet-the-people-helping-refugees-in-germany-battle-mental-health-issues-8b17aa5d9be2.
73. Patel, N., & Bittenbinder, E. , *Refugee survivors of tortue in Europe. Towards positive public policy and health outcomes*. 2018.
74. Federal Office for Public Health. *Medicines: List of specialities 2017*. 2017; Available from: https://www.bag.admin.ch/bag/fr/home/themen/versicherungen/krankenversicherung/krankenversicherung-leistungen-tarife/Arzneimittel.html.
75. Gottlieb, N. and M. Schulle, *An overview of health policies for asylum-seekers in Germany.* Health Policy, 2021. **125**(1): p. 115-121.
76. Bauhoff, S. and D. Gopffarth, *Asylum-seekers in Germany differ from regularly insured in their morbidity, utilizations and costs of care.* PLoS One, 2018. **13**(5): p. e0197881.
77. Hyde, R., *Refugees need health cards, say German doctors.* Lancet, 2016. **388**(10045): p. 646-8.
78. Bajbouj, M., et al., *A Central Clearing Clinic to Provide Mental Health Services for Refugees in Germany.* Front Public Health, 2021. **9**: p. 635474.
79. Bozorgmehr, K. and O. Razum, *Refugees in Germany-untenable restrictions to health care.* Lancet, 2016. **388**(10058): p. 2351-2352.
80. Kalkmann, M., & Kamiab, H. , *AIDA Country Report: Germany.* 2019.
81. Bottche, M., N. Stammel, and C. Knaevelsrud, *[Psychotherapeutic treatment of traumatized refugees in Germany].* Nervenarzt, 2016. **87**(11): p. 1136-1143.
82. Biddle, L., et al., *Health monitoring among asylum seekers and refugees: a state-wide, cross-sectional, population-based study in Germany.* Emerg Themes Epidemiol, 2019. **16**: p. 3.
83. Hassan, G. and et al., *Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflict*. 2015, UNHCR: Geneva.
84. Nikendei, C., et al., *Asylum seekers' mental health and treatment utilization in a three months follow-up study after transfer from a state registration-and reception-center in Germany.* Health Policy, 2019. **123**(9): p. 864-872.
85. Mewes, R., et al., *[Obstacles and Opportunities for the Psychotherapeutic Treatment of Asylum Seekers].* Psychother Psychosom Med Psychol, 2016. **66**(9-10): p. 361-368.
86. Asfaw, B.B., et al., *Experiences of psychotherapists working with refugees in Germany: a qualitative study.* BMC Psychiatry, 2020. **20**(1): p. 588.
87. Ullmann, E., et al., *Emotional and psychological trauma in refugees arriving in Germany in 2015.* Mol Psychiatry, 2015. **20**(12): p. 1483-4.
88. Fuhrer, A., F. Eichner, and A. Stang, *Morbidity of asylum seekers in a medium-sized German city.* Eur J Epidemiol, 2016. **31**(7): p. 703-6.
89. Borho, A., et al., *Somatic distress among Syrian refugees with residence permission in Germany: analysis of a cross-sectional register-based study.* BMC Public Health, 2021. **21**(1): p. 896.
90. Nesterko, Y., et al., *Prevalence of post-traumatic stress disorder, depression and somatisation in recently arrived refugees in Germany: an epidemiological study.* Epidemiol Psychiatr Sci, 2019. **29**: p. e40.
91. Nesterko, Y., et al., *Factors predicting symptoms of somatization, depression, anxiety, post-traumatic stress disorder, self-rated mental and physical health among recently arrived refugees in Germany.* Confl Health, 2020. **14**: p. 44.

92. Georgiadou, E., et al., *Prevalence of Mental Distress Among Syrian Refugees With Residence Permission in Germany: A Registry-Based Study.* Front Psychiatry, 2018. **9**: p. 393.
93. Walther, L., et al., *Psychological distress among refugees in Germany: a cross-sectional analysis of individual and contextual risk factors and potential consequences for integration using a nationally representative survey.* BMJ Open, 2020. **10**(8): p. e033658.
94. Muller, L.R.F., et al., *1-year follow-up of the mental health and stress factors in asylum-seeking children and adolescents resettled in Germany.* BMC Public Health, 2019. **19**(1): p. 908.
95. Muller, L.R.F., et al., *Mental health and associated stress factors in accompanied and unaccompanied refugee minors resettled in Germany: a cross-sectional study.* Child Adolesc Psychiatry Ment Health, 2019. **13**: p. 8.
96. Pfeiffer, E., et al., *The symptom representation of posttraumatic stress disorder in a sample of unaccompanied and accompanied refugee minors in Germany: a network analysis.* Eur J Psychotraumatol, 2019. **10**(1): p. 1675990.
97. Winkler, J.G., et al., *[The Influence of Residence Status on Psychiatric Symptom Load of Asylum Seekers in Germany].* Psychiatr Prax, 2019. **46**(4): p. 191-199.
98. Kleinert, E., et al., *Does refugee status matter? Medical needs of newly arrived asylum seekers and resettlement refugees - a retrospective observational study of diagnoses in a primary care setting.* Confl Health, 2019. **13**: p. 39.
99. Borho, A., et al., *The prevalence and risk factors for mental distress among Syrian refugees in Germany: a register-based follow-up study.* BMC Psychiatry, 2020. **20**(1): p. 362.
100. Apolinario-Hagen, J., V. Vehreschild, and R.M. Alkoudmani, *Current Views and Perspectives on E-Mental Health: An Exploratory Survey Study for Understanding Public Attitudes Toward Internet-Based Psychotherapy in Germany.* JMIR Ment Health, 2017. **4**(1): p. e8.
101. Gaebel, W., et al., *Upscaling e-mental health in Europe: a six-country qualitative analysis and policy recommendations from the eMEN project.* Eur Arch Psychiatry Clin Neurosci, 2021. **271**(6): p. 1005-1016.
102. Hennemann, S., M.E. Beutel, and R. Zwerenz, *Ready for eHealth? Health Professionals' Acceptance and Adoption of eHealth Interventions in Inpatient Routine Care.* J Health Commun, 2017. **22**(3): p. 274-284.
103. Topooco, N., et al., *Attitudes towards digital treatment for depression: A European stakeholder survey.* Internet Interv, 2017. **8**: p. 1-9.
104. UNHCR. *Syria Regional Refugee Response: Jordan*. 2019 [cited 2019 30 October]; Available from: https://data2.unhcr.org/en/situations/syria/location/36.
105. ReliefWeb, *Jordan: UNHCR Factsheet, February 2021.* 2021.
106. UNHCR, *Total Registered Syrian Refugees in Jordan.* 2021.
107. The World Bank, *Unemployment, total (% of total labor force)*. 2021, The World Bank: The World Bank.
108. Washington, K. and J. Rowell, *Syrian Refugees in Urban Jordan: Baseline assessment of community-identified vulnerabilities among Syrian refugees living in Irbid, Madaba, Mufraq and Zarqa*. 2013, CARE Jordan: Amman.
109. Nashwan, J. and Z. Mencutek. *The Employment of Syrians in Jordan: Main Trends and Challenges*. 2020; Available from: https://www.menasp.com/en/opinion/the-employment-of-syrians-in-jordan-main-trends-and-challenges/.
110. 3RP, *Regional Refugee & Resilience Plan 2016-2017 in Response to the Syria Crisis*. 2016, 3RP.
111. The World Bank. *World Bank Open Data*. 2021 [cited 2017 19 September]; Available from: https://data.worldbank.org.
112. WHO. *Global Health Observatory data repository*. 2017 [cited 2017 19 September]; Available from: http://apps.who.int/gho/data/.
113. WHO, *Maternal Mortality Estimates by WHO Region*, G.H.O.D. Repository, Editor. 2019: WHO.
114. Our World In Data. *Suicide Rate*. 2016; Available from: https://ourworldindata.org/grapher/suicide-rate?country=~JOR.

115. Our World in Data. *Death Rates from Mental Health and Substance Use Disorders*. 2017; Available from: https://ourworldindata.org/grapher/death-rates-from-mental-and-substance-disorders-by-age?country=~OWID_WRL.
116. WHO, *Mental health Atlas country profile 2014: Jordan*. 2014, World Health Organization: Geneva.
117. WHO, *Mental Health Atlas 2011: Jordan*. 2011, World Health Organization: Geneva.
118. Ministry of Health, *National Mental Health Policy*. 2011, Ministry of Health of the Hashemite Kingdom of Jordan: Amman.
119. Hijiawi, B., et al., *WHO Profile on mental health in development (WHO proMIND): Hashemite Kingdom of Jordan*. 2013, World Health Organization: Geneva.
120. Ministry of Planning and International Cooperation, *The Jordan Response Plan for the Syrian Crisis, 2017-2019*. 2017, Ministry of Planning and International Cooperation of the Hashemite Kingdom of Jordan: Amman, .
121. Wells, R., et al., *Community Readiness in the Syrian Refugee Community in Jordan: A Rapid Ecological Assessment Tool to Build Psychosocial Service Capacity.* American Journal of Orthopsychiatry., 2019.
122. WHO, *Current Health Expenditure (% of GDP)*, WHO, Editor. 2018.
123. WHO, *Health Expenditure, Out-of-pocket*, WHO, Editor. 2016.
124. UNHCR. *Jordan Factsheet: July 2019*. 2019 [cited 2019 30 October]; Available from: https://data2.unhcr.org/en/documents/download/70665.
125. IMC, *Who is Doing What, Where and When (4Ws) in Mental Health Psychosocial Support in Jordan: 2015/2016 Interventions Mapping Excercise*. 2016, International Medical Corps.
126. Parmar, P.K., et al., *Integrating community health volunteers into non-communicable disease management among Syrian refugees in Jordan: A causal loop analysis.* BMJ Open, 2021. **11**(4): p. e045455.
127. Röth, H., Z. Nimeh, and J. Hagen-Zanker, *A mapping of social protection and humanitarian assistance programmes in Jordan:What support are refugees eligible for?*, in *Working paper 501*. 2017, Overseas Development Institute: London.
128. WHO, *Human Resources Data by Country*, WHO, Editor. 2016.
129. WHO, *Mental Health Atlas 2014*. 2014, World Health Organization: Geneva.
130. WHO and Ministry of Health, *WHO-AIMS Report on Mental Health System in Jordan*. 2011: Amman, Jordan.
131. IMC, *Who is Doing What, Where and When (4Ws) in Mental Health & Psychosocial Support in Jordan? 2017 Interventions Mapping Exercise*. 2017a, International Medical Corps.
132. Rizkalla, N. and S.P. Segal, *Refugee trauma work: Effects on intimate relationships and vicarious posttraumatic growth.* Journal of Affective Disorders, 2020. **276**: p. 839-847.
133. Turki, Y., et al., *Assessment of the knowledge, attitudes, and practices (KAP) among UNRWA* health staff in Jordan concerning mental health programme pre-implementation: a cross-sectional study.* International journal of mental health systems, 2020. **14**: p. 54.
134. Abo-Hilal, M. and M. Hoogstad, *Syrian mental health professionals as refugees in Jordan: establishing mental health services for fellow refugees.* Intervention, 2013. **11**(1): p. 89-93.
135. WHO, *Facilities Data by Country*, WHO, Editor. 2019.
136. Hijazi, Z. and I. Weissbecker, *SYRIA CRISIS: Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis*. 2014, International Medical Corps: Washington DC, USA.
137. WHO and IMC, *Assessment of Mental Health and Psychosocial Needs of Displaced Syrians in Jordan*. 2013, Eastern Mediterranean Public Health Network, Ministry of Health, World Health Organization, and International Medical Corps.
138. IRC, *Public Health Access and Health Seeking Behaviors of Syrian Refugees in Jordan*. 2019, International Rescue Committee: Jordan.
139. Nuseirat, A. and L. Qusous, *Jordan National Drug Formulary: Version 2* 2011, Drug Directorate, Rational Durg Use Department: Amman.

140. UNHCR. *Health: Refugees from all nationalities*. 2021.
141. Mittal and Bashier. 2020; Available from: https://academic.oup.com/eurpub/article-abstract/30/Supplement_5/ckaa165.624/5915512.
142. IMC and SIGI-JO, *Mental Health and Psychosocial Support (MHPSS) Needs Assessment of Displaced Syrians and Host Communities in Jordan* 2015, International Medical Corps & Sisterhood Is Global Institute.
143. IMC, *Understanding the Mental Health and Psychosocial Needs, and Service Utilization of Syrian Refugees and Jordanian Nationals: A Qualitative & Quantitative Analysis in the Kingdom of Jordan (2017)*. 2017b, International Medical Corps: Amman.
144. Basheti, I.A., E.A. Qunaibi, and R. Malas, *Psychological impact of life as refugees: A pilot study on a Syrian Camp in Jordan.* Tropical Journal of Pharmaceutical Research, 2015. **14**(9): p. 1695-1701.
145. Akhtar, A., et al., *Cultural adaptation of a low-intensity group psychological intervention for Syrian refugees.* Intervention, the Journal of Mental Health & Psychosocial Support in Conflict Affected Areas, 2021. **19**(1): p. 48-57.
146. Ansbro, E., et al., *MSF experiences of providing multidisciplinary primary level NCD care for Syrian refugees and the host population in Jordan: an implementation study guided by the RE-AIM framework.* BMC health services research, 2021. **21**(1): p. 381.
147. Rizkalla, N., et al., *Women in refuge: Syrian women voicing health sequelae due to war traumatic experiences and displacement challenges.* Journal of Psychosomatic Research, 2020. **129**: p. 109909.
148. Salemi, C., Bowman, J.A. & Compton, J., *Services for Syrian Refugee Children and Youth in Jordan: Forced Displacement, Foreign Aid, and Vulnerability.* 2018.
149. McNatt, Z.Z., et al., *"What's happening in Syria even affects the rocks": a qualitative study of the Syrian refugee experience accessing noncommunicable disease services in Jordan.* Confl Health, 2019. **13**: p. 26.
150. JRPSC, *Jordan Response Plan for the Syria Crisis 2020-2022*. The Hashemite Kingdom of Jordan ministry of International Planning and Cooperation.
151. Al-Rousan, T., et al., *Health needs and priorities of Syrian refugees in camps and urban settings in Jordan: perspectives of refugees and health care providers.* Eastern Mediterranean Health Journal, 2018. **24**(3): p. 243-253.
152. Ansbro, E., et al., *"To die is better for me", social suffering among Syrian refugees at a noncommnicable disease clinic in Jordan: a qualitative study.* 2019.
153. Alfadhli, K. and J. Drury, *The role of shared social identity in mutual support among refugees of conflict: An ethnographic study of Syrian refugees in Jordan.* Journal of Community & Applied Social Psychology, 2018. **28**(3): p. 142-155.
154. Karnouk, C., et al., *Psychotherapy in Jordan: An Investigation of the Host and Syrian Refugee Community's Perspectives.* Front Psychiatry, 2019. **10**: p. 556.
155. Al-Fahoum, A., et al., *The Provision of Health Services in Jordan to Syrian Refugees.* Health Science Journal, 2015. **9**(22): p. 1-7.
156. Alduraidi, H., Z. Saleh, and A. Hamdan-Mansour, *Socio-demographic predictors of perceived health among syrian refugees in jordan.* Medico-Legal Update, 2021. **21**(1): p. 287-291.
157. Bryant, R., et al., *A lay provider delivered behavioral intervention for Syrian refugees and their children in Jordan.* 2020.
158. UNHCR, *Zaatri Health Information System: Fourth Quarter Report 2016*. 2016, UN High Commissioner for Refugees.
159. Wells, R., et al., *Psychosocial concerns reported by Syrian refugees living in Jordan: systematic review of unpublished needs assessments.* Br J Psychiatry, 2016. **209**(2): p. 99-106.
160. Aburoomi, R.J. and M.Z. Malak, *Evaluation of Social Phobia among Syrian Refugees' Youth in Jordan.* Psychiatric Quarterly, 2021. **92**(3): p. 1175-1185.
161. Halasa, S., et al., *Post-traumatic stress and social anxiety among children of syrian refugees in*

jordan. International Journal of Mental Health and Addiction, 2020: p. No-Specified.

162. Dehnel, R., et al., *Resilience and Mental Health Among Syrian Refugee Children in Jordan.* Journal of immigrant and minority health, 2021.
163. Khader, Y., et al., *Depression and Anxiety and Their Associated Factors Among Jordanian Adolescents and Syrian Adolescent Refugees.* Journal of Psychosocial Nursing and Mental Health Services, 2021. **59**(6).
164. Beni Yonis, O., et al., *Post-traumatic stress disorder among Syrian adolescent refugees in Jordan.* Journal of public health (Oxford, England), 2020. **42**(2): p. 319-324.
165. Sellouti, M., et al., *Risk Factors for Post-Traumatic Stress Disorder among Young Syrian Refugee Children in Jordan.* HSOA Journal of Neonatology & Clinical Pediatrics, 2020.
166. Basheti, I.A., et al., *The Syrian refugee crisis in Jordan: A cross sectional pharmacist-led study assessing post-traumatic stress disorder.* Pharmacy Practice, 2019. **17**(3): p. 1475.
167. Khamis, V., *Posttraumatic stress disorder and emotion dysregulation among Syrian refugee children and adolescents resettled in Lebanon and Jordan.* Child Abuse and Neglect, 2019. **89**: p. 29-39.
168. Bryant, R.A., et al., *A prevalence assessment of prolonged grief disorder in Syrian refugees.* World Psychiatry, 2021. **20**(2): p. 302-303.
169. 3RP. *Regional Refugee and Resilience Plan* 2021 [cited 2021 12.10.]; Available from: https://data2.unhcr.org/en/situations/syria.
170. UNHCR. *UNHCR country fact sheet Lebanon* 2020 [cited 2021 12.10.]; Available from: https://reporting.unhcr.org/lebanon.
171. Government of Lebanon and United Nations, *Lebanon Crisis Response Plan 2017-2020*. 2017, Government of Lebanon: Beirut.
172. The World Bank. *World Bank Open Data* 2021 [cited 2021 12.10]; Available from: https://data.worldbank.org.
173. UNHCR, UNICEF, and WFP, *Vulnerability Assessement of Syrian Refugees in Lebanon*. 2016, UN High Commissioner for Refugees, UN Children's Fund, World Food Programme.
174. Data, W.B. *Life expectancy at birth* 2020 [cited 2021 12.10.]; Available from: http://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN
175. WHO. *Mental health Atlas country profile 2014: Lebanon*. 2014 [cited 2017 19 September]; Available from: http://www.who.int/mental_health/evidence/atlas/profiles-2014/LBN.pdf?ua=1.
176. WHO and Ministry of Public Health, *WHO-AIMS Report on Mental Health System in Lebanon*. 2015, World Health Organization and Ministry of Health: Beirut, Lebanon.
177. Ministry of Public Health. *The National Mental Health Programme*. 2017 [cited 2017 19 September]; Available from: http://www.moph.gov.lb/en/Pages/6/553/nmhp.
178. Karam, E., et al., *Lebanon: mental health system reform and the Syrian crisis.* BJPsych Int, 2016. **13**(4): p. 87-89.
179. Ammar, W., et al., *Health system resilience: Lebanon and the Syrian refugee crisis.* J Glob Health, 2016. **6**(2): p. 020704.
180. WHO, *WHO Support ot the humanitarian response in Lebanon: 2 years in review (2014-2015)*. 2016, World Health Organization: Geneva.
181. UNHCR, *HEALTH SERVICES FOR SYRIAN REFUGEES IN BEKAA: What to do if you need to see a doctor or go to hospital and what you have to pay*, UN High Commissioner for Refugees, Editor. 2016.
182. 3RP. *LCRP 2017 Health sector indicator tracking sheet*. 2017 [cited 2017 19 September]; Available from: http://data.unhcr.org/syrianrefugees/working_group.php?Page=Country&LocationId=122&Id=20
183. WHO. *ATLAS 2017 Lebanon country profile mental health* 2017 [cited 2021 12.10]; Available from: https://www.who.int/publications/m/item/mental-health-atlas-2017-country-profile-

lebanon
184. El Chammay, R. and W. Kheir, *ASSESSMENT OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES FOR SYRIAN REFUGEES IN LEBANON*. 2013, UN High Commissioner for Refugees: Beirut, Lebanon.
185. Akoury-Dirani, L., et al., *Psychological first aid training for Lebanese field workers in the emergency context of the Syrian refugees in Lebanon.* Psychol Trauma, 2015. **7**(6): p. 533-8.
186. Lebanese Psychological Association. *LPA Members*. 2017 [cited 2017 19 September]; Available from: http://www.lpalebanon.org/lpa-members/#.
187. Kronfol, N.M., *Rebuilding of the Lebanese health care system: health sector reforms.* Eastern Mediterranean Health Journal, 2006. **12**(3/4): p. 459-473.
188. Ministry of Public Health, *List of Essential Medicines Lebanon - 2014*. 2014, Republic of Lebanon, Ministry of Public Health: Beirut, Lebanon.
189. Lyles, E. and S. Doocy, *Syrian refugee and Affected Host Population Health Access Survey in Lebanon*. 2015, John Hopkins University and Medicines du Monde.
190. Fleck, F., *Reforming mental health in Lebanon amid refugee crises.* Bull World Health Organ, 2016. **94**(8): p. 564-5.
191. IMC, *Psychosocial Assessment of Displaced Syrians at the Lebanese-Syrian Northern Border: Analysis of Findings*. 2011, International Medical Corps: Beirut, Lebanon.
192. Pérez-Sales, P., *Assessment of Trauma Experiences, Mental Health and Individual and Community Coping Resources of Refugee Syrian Population Displaced in North Bekaa (Lebanon).* 2013, Medicins du Monde.
193. Chahda, N., et al., *Forgotten voices: an insight into older persons among refugees from Syria in Lebanon*. 2013, Caritas Lebanon Migrants Centre: Beirut.
194. Strong, J., et al., *Health status and health needs of older refugees from Syria in Lebanon.* Confl Health, 2015. **9**: p. 12.
195. UNFPA, *Situation analysis of youth in Lebanon affected by the Syrian Crisis*. 2014, UN Fund for Population Activities,.
196. Naal, H., et al., *Prevalence of depression symptoms and associated sociodemographic and clinical correlates among Syrian refugees in Lebanon.* BMC Public Health, 2021. **21**(1): p. 217.
197. Escot, R., et al., *Insights into Syrian Refugee Children's Mental Health Status*. 2016, Caritas Lebanon Migrants Center: Beirut, Lebanon.
198. Khamis, V., *Posttraumatic stress disorder and emotion dysregulation among Syrian refugee children and adolescents resettled in Lebanon and Jordan.* Child Abuse Negl, 2019. **89**: p. 29-39.
199. Hendaus, M., et al., *The psychological impact of the Syrian crisis on refugees living in Lebanon.* Perspect Psychiatr Care, 2021. **57**(3): p. 1376-1381.
200. Chemali, Z., et al., *Needs assessment with elder Syrian refugees in Lebanon: Implications for services and interventions.* Glob Public Health, 2018. **13**(9): p. 1216-1228.
201. Migrationsverket. *Asylum*. 2021 [cited 2021 Jun]; Available from: https://www.migrationsverket.se/English/About-the-Migration-Agency/Statistics/Asylum.html.
202. Eurostat, *Asylum and first time asylum applicants by citizenship, age and sex - annual aggregated data (rounded).* 2021.
203. Government of Sweden, *Sustainable Migration Policy for the long-term*. 2020.
204. The World Bank, *Unemployment, total (% of total labour force).* 2020.
205. Statistics Sweden, *Sharp deterioration in the labour market for young people and foreign born persons*, in *Labour Force Surveys, 3rd Quarter 2020*. 2020.
206. Regeringskansliet. *Snabbspår för hälso- och sjukvårdsyrken lanseras [Fast tracks are being launched for the health care sector]*. 2015 [cited 2017 20 September]; Available from: http://www.regeringen.se/pressmeddelanden/2015/12/snabbspar-for-halso--och-sjukvardsyrken-lanseras/

207. Regeringskansliet, *An improved system of labor immigration*. 2021.
208. Amin, R.R., S; Tinghög, P; Helgesson, M; Runeson, B; Björkenstam, E; Qin, P; Mehlum, L; Holmes, EA; Mittendorfer-Rutz, E, *Healthcare use before and after suicide attempt in refugees and Swedish-born individuals.* Soc Psychiatry Psychiatr Epidemiol., 2021. **56(2):325-338**.
209. The World Bank. *Life expectancy at birth, male (years) - Sweden*. 2019 Jul 2021]; Available from: https://data.worldbank.org/indicator/SP.DYN.LE00.MA.IN?locations=SE.
210. The World Bank. *Life expectancy at birth, female (years) - Sweden*. 2019 Jul 2021]; Available from: https://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN?locations=SE.
211. WHO. *Adult mortality, Data by country.* 2018; Available from: https://apps.who.int/gho/data/view.main.1360?lang=en.
212. The World Bank. *Mortality rate, adult, male (per 1,000 male adults) - Sweden*. 2019 Jul, 2021]; Available from: https://data.worldbank.org/indicator/SP.DYN.AMRT.MA?locations=SE.
213. The World Bank. *Mortality rate, adult, female (per 1,000 female adults) - Sweden*. 2019 Jul 2021]; Available from: https://data.worldbank.org/indicator/SP.DYN.AMRT.FE?locations=SE.
214. The World Bank. *Maternal mortality ratio (modeled estimate, per 100,000 live births) - Sweden*. 2017 Jul, 2021]; Available from: https://data.worldbank.org/indicator/SH.STA.MMRT?locations=SE.
215. IHME. *Global Health Data Exchange*. 2019 Jul, 2021]; Available from: http://ghdx.healthdata.org/gbd-results-tool
216. WHO. *Mental Health Atlas 2017: Sweden*. 2017; Available from: https://www.ecoi.net/en/file/local/2002846/SWE.pdf.
217. MIPEX. *Migrant Integration Policy Index 2020*. 2019 Jul 2021]; Available from: https://www.mipex.eu/sweden.
218. The World Bank. *Current health expenditure (% of GDP) - Sweden*. 2018; Available from: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=SE.
219. The World Bank. *Out-of-pocket expenditure (% of current health expenditure) - Sweden*. 2018 Jul, 2021]; Available from: https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=SE.
220. OECD, *Expenditure by disease, age and gender.* Health Spending, 2016(April 2016).
221. Fjellfeldt, M.M., Urban, *Development of a Swedish community mental health service market.* . Nordic Social Work Research, 2019. **9:1**: p. 72-84.
222. Migrationsverket. *Health care for asylum seekers*. 2021 14/01/2021 Jul 2021]; Available from: https://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/While-you-are-waiting-for-a-decision/Health-care.html.
223. Migrationsverket. *Fees for health care*. 2021 24/05/2021 Jul 2021]; Available from: https://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/While-you-are-waiting-for-a-decision/Health-care/Fees-for-health-care.html.
224. Sveriges Kommuner och Landsting, *Health in Sweden for asylum seekers and newly-arrived immigrants: Final report for the national distribution of interventions from the feasibility study of positive health development for asylum seekers and newly- arrived immigrants*. 2017.
225. Swedish Red Cross. *Annual Report 2019*. 2019; Available from: https://www.rodakorset.se/globalassets/rodakorset.se/dokument/om-oss/ekonomi/arsredovisningar-och-arsberattelser/swedish-red-cross-annual-report-2019.pdf.
226. Eurostat. *Mental health: how many psychiatrists in the EU?* . 2015 10/10/2017 Jul 2021].
227. WHO. *Human resources, Data by country*. 2016 25/04/2019 Jul 2021]; Available from: https://apps.who.int/gho/data/node.main.MHHR?lang=en.
228. Bjorkman, A.A., Kajsa; Bergström, Jenny; Salzmann-Erikson, Martin, *Increased Mental Illness and the Challenges This Brings for District Nurses in Primary Care Settings.* Issues in Mental Health Nursing, 2018. **39:12**: p. 1023-1030.
229. Transkulturellt Centrum. *About us*. 2021 Jul 2021]; Available from:

https://www.transkulturelltcentrum.se/om-oss/.

230. Bäärnhielm, S.E., A S; Ioannou, M; Dahlin, M, *Evaluation of Cross-cultural Psychiatric Training of Staff in Mental Health Care and Refugee Reception in Sweden.* European Psychiatry, 2015. **30**.

231. Patana, P., *Mental Health Analysis Profiles (MhAPs): Sweden*, in *OECD Health Working Papers No 82*. 2015, OECD: Paris.

232. NSPH. *Member Organisations*. 2021; Available from: https://nsph.se/om-oss/var-organisation/medlemsorganisationer/.

233. Swedish Association for Family Therapy. *Mission*. 2012 [cited 2017 20 September]; Available from: http://www.sfft.se/eng/mission.htm

234. Lindegaard, T., *Internet-based cognitive behavioural therapy for depression and anxiety among Arabic-speaking individuals in Sweden: A pilot randomized controlled trial. .* Cognitive Behaviour Therapy, 2021. **47**.

235. Flyktinggruppernas Riksrad (FARR). *About Us*. 2021 Jul 2021]; Available from: https://farr.se/en/.

236. MSF. *Sweden: MSF begins working with asylum seekers*. 2016 [cited 2017 20 September]; Available from: http://www.msf.org/en/article/sweden-msf-begins-working-asylum-seekers

237. OECD, *Working Together: Skills and Labour Market Integration of Immigrants and their Children in Sweden* 2016, OECD Publlishing: Paris.

238. Mangrio, E.Z., S.; Carlson, E., *Refugee women's experience of the resettlement process: a qualitative study. .* BMC Women's Health, 2019. **19, 147**.

239. Delilovic, S.K., A; Åsbring, N. et al., *What value for whom? – provider perspectives on health examinations for asylum seekers in Stockholm.* BMC Health Serv Res, 2018. **18**(601).

240. Warner, G.K., B.; Sarkadi, A. , *Mapping trauma support onto the shifting landscape of seeking refuge in Sweden: insights from an ongoing programme of research on refugee minors' mental health* Eur Child Adolesc Psychiatry, 2020. **1-2**.

241. Stockholm County Council, *The Wise List 2015*. 2015, Stockholm County Council: Stockholm, Sweden.

242. Axelsson, L.B., S.; Dalman, C.; Hollander, A. C. , *Differences in psychiatric care utilisation among unaccompanied refugee minors, accompanied migrant minors, and Swedish-born minors.* Social psychiatry and psychiatric epidemiology, 2020. **55,11**: p. 1449–1456.

243. MSF, *Life in Limbo.* 2018.

244. Pérez-Aronsson, A., et al., *"I'm a Mother Who Always Tries to Give My Children Hope"—Refugee Women's Experiences of Their Children's Mental Health.* Frontiers in Psychiatry, 2019. **10**(789).

245. Pechansky, R. and J.W. Thomas, *The concept of access: Definition and relatinship to consumer satisfaction.* Medical Care, 1981. **19**(2): p. 127-40.

246. Amin, R.R., Syed; Dorner, Thomas E; Björkenstam, Emma; Helgesson, Magnus; Norredam, Marie L; Sijbrandij, Marit; Sever, Cansu Alozkan; Mittendorfer-Rutz, Ellenor, *Country of birth, time period of resettlement and subsequent treated common mental disorders in young refugees in Sweden.* European Journal of Public Health, 2020. **30**(6): p. 1169-1175.

247. Hugelius, K.S., M; Holmefur, M, *Perceived Needs Among Asylum Seekers in Sweden: A Mixed Methods Study. .* International Journal of Environmental Research and Public Health., 2020. **17(14):4983**.

248. Lampa, E.S., A.; Warner, G. , *Implementation and Maintenance of a Community-Based Intervention for Refugee Youth Reporting Symptoms of Post-Traumatic Stress: Lessons from Successful Sites.* Int J Environ Res Public Health, 2020. **18(1):43**.

249. Leiler, A.W., E.; Holmberg, J.; Bjärtå, A., *A Pilot Study of a Psychoeducational Group Intervention Delivered at Asylum Accommodation Centers-A Mixed Methods Approach.* Int J Environ Res Public Health, 2020. **1;17(23):8953**.

250. Shedrawy, J., K. Lönnroth, and A. Kulane, *'Valuable but incomplete!' A qualitative study about*

migrants' perspective on health examinations in Stockholm. International Health, 2018. **10**(3): p. 191-196.
251. Wångdahl, J.L., P; Mårtensson, L.; Westerling. R, *Poor health and refraining from seeking healthcare are associated with comprehensive health literacy among refugees: a Swedish cross-sectional study.* Int J Public Health., 2018. **63(3):409-419**.
252. Amin, R.H., M; Runeson, B; Tinghög, P; Mehlum, L; Qin, P; Mittendorfer-Rutz, E A, *Suicide attempt and suicide in refugees in Sweden – a nationwide population-based cohort study.* Psychological Medicine, 2021. **51(2)**: p. 254-263.
253. Ekblad, S., *To Increase Mental Health Literacy and Human Rights Among New-Coming, Low-Educated Mothers With Experience of War: A Culturally, Tailor-Made Group Health Promotion Intervention With Participatory Methodology Addressing Indirectly the Children.* Front Psychiatry, 2020. **11:611**.
254. Valeriani, G.S.V., I.; Lindegaard, T.; Felizia, R.; Mollica, R.; Andersson, G. , *Addressing Healthcare Gaps in Sweden during the COVID-19 Outbreak: On Community Outreach and Empowering Ethnic Minority Groups in a Digitalized Context.* Healthcare (Basel) 2020, 2020. **1;8(4):445.**
255. Rutkin, A., *Phoning in refugee aid.* New Scientist, 2016. **230**: p. 22-23.
256. Mårtensson, L.L., P.; Westerling, R. et al. , *Experiences and needs concerning health related information for newly arrived refugees in Sweden.* BMC Public Health, 2020. **1044**.
257. Pacheco, L.L., R. Jonzon, and A.K. Hurtig, *Health Assessment and the Right to Health in Sweden: Asylum Seekers' Perspectives.* PLoS One, 2016. **11**(9): p. e0161842.
258. Human Rights Watch, *Seeking Refuge: Unaccompanied Children in Sweden*. 2016, Human Rights Watch: New York, USA.
259. Sandahl, H., et al., *Policies of access to healthcare services for accompanied asylum-seeking children in the Nordic countries.* Scand J Public Health, 2013. **41**(6): p. 630-6.
260. Väntetider. *Väntetider i vården [Waiting times in care]*. 2021 [cited 2017 Jul 2021]; Available from: http://www.vantetider.se
261. OECD, *Waiting Times for Health Services, Next in line.* 2020.
262. Nationella Kvalitetsregister. *All Swedish Quality Registries*. 2021; Available from: https://skr.se/kvalitetsregister.32864.html.
263. Wrede, O., et al., *Promoting mental health in migrants: a GHQ12-evaluation of a community health program in Sweden.* BMC Public Health, 2021. **21**(1): p. 262.
264. Malm, A., *Post-migration stress and mental health among refugees : a population-based survey among refugees from Syria recently resettled in Sweden*, in *Inst för klinisk neurovetenskap / Dept of Clinical Neuroscience*. 2021, Karolinska Institutet.
265. Bjorkensta, E., *Common mental disorders among young refugees in Sweden: The role of education and duration of residency.* Journal of Affective Disorders, 2020. **189**.
266. Kiselev, N., et al., *Structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland.* European Journal of Psychotraumatology, 2020. **11**(1): p. 1717825.
267. Nikolai, K., et al., *Problems faced by Syrian refugees and asylum seekers in Switzerland.* Swiss Medical Weekly, 2020. **150**(43-44).
268. UNHCR. *Syria Regional Refugee Response: Inter-agency Information Sharing Portal. Europe: Syrian Aslylum Applications*. 2021 [cited 2017 19 September]; Available from: http://data.unhcr.org/syrianrefugees/asylum.php#
269. Asylum Information Database. *Accelerated procedure: Switzerland*. 2018 [cited 2018 2 May]; Available from: http://www.asylumineurope.org/reports/country/switzerland/asylum-procedure/procedures/accelerated-procedure.
270. Swiss Federal Statistical Office. *STAT-TAB: Permanent and non permanent resident population by canton, sex, residence permit, age and citizenship, 2016*. 2017; Available from: https://www.pxweb.bfs.admin.ch/default.aspx?px_language=en

271. OECD. *OECD data*. 2021 [cited 2017 20 September]; Available from: https://data.oecd.org.
272. WHO. *Mental health Atlas country profile 2014: Switzerland*. 2014 [cited 2017 21 September]; Available from: http://www.who.int/mental_health/evidence/atlas/profiles-2014/che.pdf?ua=1.
273. WHO. *Mental Health Atlas 2011: Switzerland*. 2011 [cited 2017 21 September]; Available from: http://www.who.int/mental_health/evidence/atlas/profiles/che_mh_profile.pdf.
274. De Pietro, C., et al., *Switzerland: Health system review*, in *Health Systems in Transition*. 2015, European Observatory on Health Systems and Policies.
275. Navarra, K., *Health Guide to Switzerland: The Swiss healthcare system in brief - a guide for immigrants to Switzerland*. 2011, Swiss Red Cross and Federal Office of Public Health: Wabern.
276. Migraweb. *Mental health*. 2021 [cited 2017 21 September]; Available from: http://www.migraweb.ch/en/themen/gesundheit/psyche/
277. Federal Office of Public Health. *Gesundheitsmonitoring der Migrationsbevölkerung: Zweites Gesundheitsmonitoring 2010 (GMM II) [Health monitoring of migrant population: Second health monitoring 2010 (GMM II)]*. 2010 [cited 2017 21 September]; Available from: https://www.bag.admin.ch/bag/de/home/themen/strategien-politik/nationale-gesundheitsstrategien/nationales-programm-migration-gesundheit/forschung-migration-und-gesundheit/gesundheitsmonitoring-der-migrationsbevoelkerung.html.
278. Weiss, R., *Confronting Cultural Challenges for Migrant Healthcare in Switzerland*. 2015, Independent Study Project (ISP) Collection: Paper 2104.
279. Mossialos, E., et al., *2015 International Profiles of Health Care Systems*. 2016, The Commonwealth Fund: New York, USA.
280. Ambulatorium für Folter- und Kriegsopfer SRK. *The association: Support for Torture Victims*. 2018 [cited 2018 2 May]; Available from: http://www.torturevictims.ch/en/support-for-torture-victims.
281. Federal Office for Public Health. *Médicaments: Liste des spécialités 2017 [Medicines: List of specialities 2017]*. 2017 [cited 2017 26 September]; Available from: https://www.bag.admin.ch/bag/fr/home/themen/versicherungen/krankenversicherung/krankenversicherung-leistungen-tarife/Arzneimittel.html
282. Schneeberger, A.R. and B.J. Schwartz, *The Swiss Mental Health Care System.* Psychiatric Services, 2018. **69**(2): p. 126-128.
283. Premand, N., et al., *Determinants of Suicidality and of Treatment Modalities in a Community Psychiatry Sample of Asylum Seekers.* Nervous and Mental Disease, 2018. **206**(1): p. 27-32.
284. Schoretsanitis, G., et al., *Psychiatric Emergencies of Asylum Seekers; Descriptive Analysis and Comparison with Immigrants of Warranted Residence.* International Journal of Environmental Research and Public Health, 2018. **15**: p. 1300.
285. Kiselev, N., et al., *Barriers to access to outpatient mental health care for refugees and asylum seekers in Switzerland: The therapist's view.* BMC Psychiatry, 2020. **20**: p. 378.
286. Müller, F., Roose, Z., Landis, F., & Gianola, G., *Psychische Gesundheit von Traumatisierten Asylsuchenden: Situationsanalyse und Empfehlungen. Bericht zuhanden des Bundesamtes für Gesundheit, Sektion Gesundheitliche Chancengleichheit*. 2018, Interface: Luzern:.
287. Bartolomei, J., et al., *What are the barriers to access to mental healthcare and the primary needs of asylum seekers? A survey of mental health caregivers and primary care workers.* BMC Psychiatry, 2016. **16**(1): p. 336.
288. Morina, N., et al., *The Association of Post-traumatic and Postmigration Stress with Pain and Other Somatic Symptoms: An Explorative Analysis in Traumatized Refugees and Asylum Seekers.* Pain Medicine, 2018. **19**: p. 50-59.
289. Pfortmueller, C.A., et al., *Adult Asylum Seekers from the Middle East Including Syria in Central Europe: What Are Their Health Care Problems?* PLoS One, 2016. **11**(2): p. e0148196.
290. Heeren, M., et al., *Mental health of asylum seekers: A cross-sectional study of psychiatric disorders.* BMC Psychiatry, 2012. **12**: p. 114.

291. Heeren, M., et al., *Psychopathology and resident status - comparing asylum seekers, refugees, illegal migrants, labor migrants, and residents.* Compr Psychiatry, 2014. **55**(4): p. 818-25.
292. Premand, N., et al., *Soins psychiatriques pour les requérants d'asile à Genève: Une approche multidisciplinaire pour préserver la singularité des soins [Psychiatric care for asylum seekers in Geneva: A multidisciplinary approach for individualized care].* Revue Médicale Suisse, 2013: p. 1664-1668.
293. Saraga, M., et al., *Durcissement des lois sociales et santé des migrants forcés: trois ans après la Loi sur l'asile (LAsi) [Social policy changes and the health of asylum seekers: 3 years after the introduction of the Asylum Law].* Revue Médicale Suisse 2012: p. 1786-1790.
294. Hecker, T., et al., *Differential Associations Among PTSD and Complex PTSD Symptoms and Traumatic Experiences and Postmigration Difficulties in a Culturally Diverse Refugee Sample.* Journal of traumatic stress, 2018. **31**(6): p. 795-804.
295. Schoretsanitis, G., et al., *Upon Rejection: Psychiatric Emergencies of Failed Asylum Seekers.* International Journal of Educational and Psychological Assessment, 2018. **15**: p. 1498.
296. Magdalini, P., F. Narring, and C. Chamay-Weber, *Health Care Needs for Unaccompanied Asylum-Seeking Adolescents: A Retrospective Study from An Adolescent Health Unit in Switzerland.* Journal of Adolescent Health, 2018. **62**(2): p. S108-S109.
297. CBS, *Immi- en emigratie; leeftijd (31 dec.), burgerlijke staat, geboorteland*. 2021.
298. Government of the Netherlands. *Hoe verloopt het aanvragen van asiel? [What is the asylum procedure?]*. 2017 [cited 2017 10 October]; Available from: https://www.rijksoverheid.nl/onderwerpen/asielbeleid/vraag-en-antwoord/procedure-asielzoeker.
299. IHME, *Institute for Health Metrics and Evaluation*. 2019.
300. WHO. *Mental Health Atlas 2011: Netherlands*. 2011 [cited 2017 10 October]; Available from: http://www.who.int/mental_health/evidence/atlas/profiles/nld_mh_profile.pdf?ua=1
301. WHO. *Mental health Atlas country profile 2014: Netherlands*. 2014 [cited 2017 10 October]; Available from: http://www.who.int/mental_health/evidence/atlas/profiles-2014/nld.pdf?ua=1
302. Kroneman, M., et al., *Netherlands: Health system review*, in *Health Systems in Transition*. 2016. p. 1-239.
303. MIPEX. *MIPEX*. Migrant Integration Policy Index 2019; Available from: https://www.mipex.eu/netherlands.
304. Arts en Zorg. *Over Arts en Zorg Groep [About 'Arts en Zorg' Group]*. 2021 [cited 2021 15 November]; Available from: https://www.artsenzorg.nl/overartsenzorg.
305. Kenniscentrum KJP. *Jeugd-GGZ voor vluchtelingenkinderen [Youth-Mental Health Care for refugee children]*. 2021 [cited 2021 23 August]; Available from: https://www.kenniscentrum-kjp.nl/professionals/dossiers/vluchtelingenkinderen/.
306. Beekman, J., *Dealing with the mental wellbeing of refugees in a Dutch context: A study about prevention and mental health care to refugees in the region Gelderland-Zuid*, in *Nijmegen School of Management*. 2017, Radboud Universiteit: Nijmegen, the Netherlands.
307. Fahham, L., P.J. Beckers, and J. Muller-Dugic, *Mental health and labour market participation of refugees. Local policies in the Netherlands and their relation to the Mosaic intervention: The cases of Nijmegen, Arnhem and Tiel*. 2020, Radboud University, Institute for Management Research: Nijmegen.
308. GGZ Nederland. *Bekostiging [Financing]*. 2018 [cited 2018 28 February]; Available from: http://www.ggznederland.nl/themas/financiering.
309. Government of the Netherlands. *Health insurance and residence permit*. 2017 [cited 2017 10 October]; Available from: https://www.government.nl/topics/health-insurance/health-insurance-and-residence-permit
310. Gezondverzekerd. *Hoe werkt de Gemeentepolis?* 2021; Available from: https://www.gezondverzekerd.nl/over-de-gemeentepolis/hoe-werkt-de-gemeentepolis/.

311. Zorginstituut Nederland, *Tolkvoorziening voor anderstaligen in de geneeskundige geestelijke gezondheidszorg [Interpreter provision for other languages in medical mental healthcare]*. 2020.
312. GGZ Nederland. *GGZ-Sector [Mental healthcare sector]*. 2018 [cited 2018 1 March]; Available from: http://www.ggznederland.nl/pagina/ggz-sector.
313. Centrum'45. *Voor complexe psychotraumaklachten [For complex psychotraumatic complaints]*. 2018 [cited 2018 1 March]; Available from: https://www.centrum45.nl.
314. i-Psy. *Wie we zijn [Who we are]*. 2018 [cited 2018 1 March]; Available from: https://www.i-psy.nl/over-i-psy.
315. Ministerie VWS. *Patiënten- en belangenorganisaties [Patient- and interest groups]*. 2021 [cited 2021 23 August]; Available from: https://www.regelhulp.nl/onderwerpen/patientenorganisaties.
316. Van Schayk, M. and E. Vloeberghs, *Podium voor preventie: Een overzicht van psychosociale preventie voor asielzoekers [Platform for prevention: An overview of psychosocial prevention for asylumseekers]* 2011, Pharos: Utrecht.
317. Vluchtelingenwerk Nederland. *Vluchtelingenorganisaties in Nederland [Refugee organisations in the Netherlands]*. 2017 [cited 2010 10 October]; Available from: https://www.vluchtelingenwerk.nl/feiten-cijfers/weblinks/organisaties-nederland
318. Rode Kruis. *Hulp aan vluchtelingen in Nederland [Support to refugees in the Netherlands]*. 2017 [cited 2017 10 October]; Available from: https://www.rodekruis.nl/hulp-in-nederland/hulp-aan-vluchtelingen/
319. de Haan, A., et al., *Overzicht: Preventieve interventies voor het versterken van de psychische gezondheid en veerkracht van statushouders. Wat kunt u inzetten in de gemeente?* 2018.
320. Damen, R.E., J. Dagevos, and W. Huijnk, *Refugee Reception Re-examined: a Quantitative Study on the Impact of the Reception Period for Mental Health and Host Country Language Proficiency Among Syrian Refugees in the Netherlands.* Journal of International Migration and Integration, 2021.
321. Mind-Spring. *Mind-Spring: psychoeducation for asylumseekers & refugees*. 2018 [cited 2018 28 February]; Available from: http://www.mind-spring.org
322. Vluchtelingenwerk Nederland. *Mind Fit: Aan de slag met integratie en participatie [Mind Fit: Working on integration and participation]*. 2016 [cited 2018 28 February]; Available from: https://www.vluchtelingenwerk.nl/noordnederland/nieuws/mind-fit-aan-de-slag-met-integratie-en-participatie
323. Vluchtelingenwerk Nederland. *Wat wij doen voor vluchtelingen [What we do for refugees]*. 2018 [cited 2018 1 March]; Available from: https://www.vluchtelingenwerk.nl/wat-wij-doen/wat-wij-doen-beeld.
324. zorg, S. *Over Sensa Zorg [About Sensa Care]*. 2018 [cited 2018 1 March]; Available from: http://www.sensazorg.nl/index.php/over-sensa-zorg.
325. CBS. *Gemeentelijke indeling op 1 januari 2018 [Council division on 1 January 2018]*. 2018 [cited 2018 28 February]; Available from: https://www.cbs.nl/nl-nl/onze-diensten/methoden/classificaties/overig/gemeentelijke-indelingen-per-jaar/indeling%20per%20jaar/gemeentelijke-indeling-op-1-januari-2018.
326. Van der Velden, L. and R. Batenburg, *Hoeveel EVC's in de GGZ? Een overzicht en analyse van kwantitatieve gegevens om het potentiële gebruik van het erkennen van Elders Verworven Competenties (EVC's) in de Geestelijke Gezondheidszorg (GGZ) te schatten [How many EVC's in mental healthcare? An overview and analysis of quantitative data to estimate the potential use of Other Attrieved Compentencies (EVC's) in Mental Healthcare (GGZ)]*. 2014, Nivel: Utrecht. p. 14.
327. Dagevos, J. and E. Miltenburg, *Inburgering, maatschappelijke begeleiding en taal [Integration, social assistance and language]*, in *Syriërs in Nederland: Een studie over de eerste jaren van hun leven in Nederland [Syrians in the Netherlands: a study about the first years of their lives*

in the Netherlands], J. Dagevos, et al., Editors. 2018, Sociaal en Cultureel Planbureau: The Hague. p. 80-94.

328. Government of the Netherlands. *Zorggegevens: zoek in actuele bronnen. Geestelijke gezondheidszorg [Care data: search in current sources. Mental health care]*. 2017 [cited 2017 10 October]; Available from: https://bronnen.zorggegevens.nl/Bron/Zoek
329. WHO. *Essential medicines selection: National Medicines LIst/Formulary/Standard Treatment Guidelines*. 2017 [cited 2017 10 October]; Available from: http://www.who.int/selection_medicines/country_lists/en/#N
330. Government of the Netherlands. *What medicines are covered by insurance?* 2021 [cited 2021 23 August]; Available from: https://www.government.nl/topics/medicines/question-and-answer/what-medicines-are-covered-by-insurance.
331. Government of the Netherlands. *Keeping medicines affordable*. 2021 [cited 2021 23 August]; Available from: https://www.government.nl/topics/medicines/keeping-medicines-affordable
332. RMA. *RMA Healthcare*. Geneesmiddelen 2021; Available from: https://www.rmasielzoekers.nl/home/vergoeding/geneesmiddelen.
333. Huijnk, W., E. Uiters, and A. Wijga, *Zorggebruik in beeld [Insight into care utilisation]*, in *Opnieuw beginnen: Achtergronden van positieverschillen tussen Syrische statushouders [Starting anew: Background on position differences between Syrian status holders]*, E. Miltenburg, J. Dagevos, and W. Huijnk, Editors. 2019, Sociaal en Cultureel Planbureau: The Hague. p. 101-118.
334. Rijksoverheid. *Primary and secondary mental health care*. 2018 [cited 2018 5 April]; Available from: https://www.government.nl/topics/mental-health-services/primary-and-secondary-mental-health-care.
335. Rijksoverheid. *Where can I get help for mental health problems?* 2018 [cited 2018 5 April]; Available from: https://www.government.nl/topics/mental-health-services/question-and-answer/help-for-mental-health-problems.
336. Van Berkum, M., et al., *Zorg, ondersteuning en preventie voor nieuwkomende vluchtelingen: Wat is er nodig? [Care, support and prevention for newly arrived refugees: What is needed?]*. 2016, Pharos: Utrecht.
337. De Graaff, A., Cuijpers, P., McDaid, D., Park, A., Woodward, A., Bryant, R., . . . Sijbrandij, M. , *Peer-provided Problem Management Plus (PM) for adult Syrian refugees: A pilot randomised controlled trial on effectiveness and cost-effectiveness.* Epidemiology and Psychiatric Sciences, 2020. **29**(E162).
338. Basil, M., et al., *Personal Reflections on Problem Management Plus: Written by Syrian Helpers at Stichting Nieuw Thuis, Rotterdam, The Netherlands.* Intervention, 2021. **19**(1): p. 118-120.
339. Spijkerman, A. and E. Uiters. *Syrische Statushouders op Weg naar Nederland - Psychische gezondheidl [Syrian Statusholders on the Road to the Netherlands - Psychological health]*. 2021 [cited 2021 23 August]; Available from: https://digitaal.scp.nl/syrische-statushouders-op-weg-in-nederland/psychische-gezondheid/.
340. Uiters, E. and A. Wijga. *Syrische Statushouders op Weg naar Nederland - Gezondheid en zorggebruik [Syrian Statusholders on the Road to the Netherlands - Health and care utilisation]*. 2021 [cited 2021 23 August]; Available from: https://digitaal.scp.nl/syrische-statushouders-op-weg-in-nederland/gezondheid-en-zorggebruik/.
341. van Loenen, T., et al., *Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes.* European Journal of Public Health, 2017. **28**(1): p. 82-87.
342. Mulders, J. and B. Tuk, *Syrische nieuwkomers in de gemeente: Ervaringen van gezinnen met opvang, zorg en opvoeding [Newly arrived Syrians in the municipality: Experiences of families with reception, care and education]* 2016, Pharos: Utrecht.
343. Uiters, E. and A. Wijga, *Gezondheid, leefstijl en zorggebruik [Health, lifestyle and care utilisation]*, in *Syriërs in Nederland: Een studie over de eerste jaren van hun leven in Nederland*

[Syrians in the Netherlands: a study about the first years of their lives in the Netherlands], J. Dagevos, et al., Editors. 2018, Sociaal en Cultureel Planbureau: The Hague. p. 174-192.
344. GGD and Pharos. *Welkom op de website gezond in Nederland*. 2018 [cited 2018 21 March]; Available from: https://www.gezondinnederland.info.
345. Vektis. *Data bij factsheet GGZ wachttijden [data by factsheet mental healthcare waiting times]* 2021 [cited 2021 23 Augustus]; Available from: https://www.vektis.nl/intelligence/publicaties/factsheet-wachttijdinformatie-ggz.
346. Kulu-Glasgow, I., S.M. Noyon, and M. Smit, *Unaccompanied minor asylum seekers in the Netherlands: choice or chance?* 2018, Wetenschappelijk Onderzoek- en Documentatiecentrum, Ministerie van Justitie en Veiligheid: The Hague.
347. GGZ Westelijk Noord Brabant. *Wachttijden nieuwe cliënten [Waiting times new clients]*. 2017 [cited 2017 10 October]; Available from: https://www.ggzwnb.nl/informatie-wachttijden.html
348. GGZ Nederland. *GGZ-PARTIJEN PRESENTEREN GEZAMENLIJKE AANPAK OM WACHTTIJDEN IN DE GEESTELIJKE GEZONDHEIDSZORG AAN TE PAKKEN*. 2017 [cited 2017 10 October]; Available from: http://www.ggznederland.nl/actueel/persbericht--ggz-partijen-presenteren-gezamenlijke-aanpak-om-wachttijden-in-de-geestelijke-gezondheidszorg-aan-te-pakken
349. CBS. *Statline. Gezondheid en zorggebruik; persoonskenmerken [Health and care utilisation; demographics]*. 2021 [cited 2021 18 August]; Available from: https://opendata.cbs.nl/statline/#/CBS/nl/dataset/83005NED/table?ts=1571292951621.
350. Haker, F., et al., *Kennissynthese gezondheid van nieuwkomende vluchtelingen en indicaties voor zorg, preventie en ondersteuning [Knowledge synthesis health of newly arrived refugees and care indications, prevention and support]*. 2016, Pharos: Utrecht.
351. Weeda, L., M. van der Linden, and J. Dagevos, *Breekt de zon door in het AZC? De rol van de AZC-periode voor de mentale gezondheid en sociale integratie van statushouders in Rotterdam.* Mens & Maatschappij, 2019. **93**(4): p. 313-342.
352. UNHCR. *UNHCR Turkey Statistics*. 2021; Available from: https://www.unhcr.org/tr/en/unhcr-turkey-stats.
353. Doganay, M. and H. Demiraslan, *Refugees of the Syrian Civil War: Impact on Reemerging Infections, Health Services, and Biosecurity in Turkey.* Health Secur, 2016. **14**(4): p. 220-5.
354. Refugees Assocation. *Number of Syrians with Work Permits in Turkey*. 2021; Available from: https://multeciler.org.tr/turkiyede-calisma-izni-verilen-suriyeli-sayisi/.
355. WHO, *Depression and Other Common Mental Disorders: Global Health Estimates*. 2017, WHO: Geneva.
356. WHO. *WHO Global health Observatory*. 2021; Available from: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/suicide-mortality-rate-(per-100-000-population).
357. Inanc, B.B., *Suicide Cause and Method from 2009-2017 in Turkey.* Iran J Public Health, 2021. **50**(7): p. 1389-1397.
358. al, M.K.e., *National Mental Health Policy*. 2006: Ankara, Turkey.
359. WHO. *Mental Health Atlas 2011: Turkey*. 2011; Available from: http://www.who.int/mental_health/evidence/atlas/profiles/tur_mh_profile.pdf.
360. Soygür, H. and *Community Mental Health Services: Quo Vadis?* Noro Psikiyatr Ars. 2016;53(1):1-3., 2016. **53**(1): p. 1-3.
361. IMC, *Mental Health and Psychosocial Support Considerations for Syrian Refugees in Turkey: Sources of Distress, Coping Mechanisms, & Access to Support*. 2017, IMC: LA/Washington.
362. WHO. *Health services for refugees in Turkey*. 2017; Available from: https://www.euro.who.int/__data/assets/pdf_file/0006/343905/b7b00138-6c59-11e7-84a9-e89a8f74124e.pdf.
363. Assi, R., S. Ozger-Ilhan, and M.N. Ilhan, *Health needs and access to health care: the case of Syrian refugees in Turkey.* Public Health, 2019. **172**: p. 146-152.

364. Dogan, N., G. Dikec, and E. Uygun, *Syrian refugees' experiences with mental health services in Turkey: "I felt lonely because I wasn't able to speak to anyone".* Perspect Psychiatr Care, 2019. **55**(4): p. 673-680.
365. Alawa, J., P. Zarei, and K. Khoshnood, *Evaluating the Provision of Health Services and Barriers to Treatment for Chronic Diseases among Syrian Refugees in Turkey: A Review of Literature and Stakeholder Interviews.* Int J Environ Res Public Health, 2019. **16**(15).
366. Al-Nuaimi, S., et al., *Psychiatric morbidity among physically injured Syrian refugees in Turkey.* Compr Psychiatry, 2018. **80**: p. 34-38.
367. Kaya, E., et al., *Posttraumatic Stress and Depression Among Syrian Refugees Living in Turkey: Findings From an Urban Sample.* J Nerv Ment Dis, 2019. **207**(12): p. 995-1000.
368. Scherer, N., et al., *Prevalence of common mental disorders among Syrian refugee children and adolescents in Sultanbeyli district, Istanbul: results of a population-based survey.* Epidemiol Psychiatr Sci, 2020. **29**: p. e192.
369. Tekeli-Yesil, S., et al., *Determinants of Mental Disorders in Syrian Refugees in Turkey Versus Internally Displaced Persons in Syria.* Am J Public Health, 2018. **108**(7): p. 938-945.
370. Acarturk, C., et al., *Prevalence and Predictors of Posttraumatic Stress and Depression Symptoms Among Syrian Refugees in a Refugee Camp.* J Nerv Ment Dis, 2018. **206**(1): p. 40-45.
371. Karadag, M. and H. Ogutlu, *Prevalence of psychiatric symptoms among refugee adolescents in Turkey: a controlled study.* Braz J Psychiatry, 2020. **43**(1): p. 55-60.
372. Charlson, F., et al., *New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis.* Lancet, 2019. **394**(10194): p. 240-248.
373. Kahilogullari, A.K., et al., *Satisfaction with mental health and psycho-social support services provided to Syrians under temporary protection in Turkey, evidence from refugee health training centers.* J Migr Health, 2020. **1-2**: p. 100022.
374. Acar, B., et al., *The Role of Coping Strategies in Post-Traumatic Growth among Syrian Refugees: A Structural Equation Model.* Int J Environ Res Public Health, 2021. **18**(16).
375. Cengiz, I., D. Ergun, and E. Cakici, *Posttraumatic stress disorder, posttraumatic growth and psychological resilience in syrian refugees: Hatay, Turkey.* Anadolu Psikiyatri Dergisi, 2019. **20**(3): p. 269-276.
376. Ersahin, Z., *Post-traumatic growth among syrian refugees in turkey: The role of coping strategies and religiosity.* Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues, 2020(Pagination).

8. Annexes

Annex 1: STRENGHTS Rapid Appraisal Tool For Health System Inputs

This Annex presents the Rapid Appraisal (RA) Tool for mental health systems. It was 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 collected (add year 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 collected (add year 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 collected (add year 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 collected (add year 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 collected (add year 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 collected (add year 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-governmental 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* - *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*	Information 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	- *Primary health care facility in place*	Human workforce

	performs a general physical assessment (to screen for any concurrent medical conditions)	- *Doctor in place who can see patients without much waiting time* - *Doctor has training on mental health* - *Co-morbidities identified and recorded*	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)* - *Counsellor has the capacity to take on additional patients*	Human workforce Facilities and Services Medication Information
	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* - *There are guidelines, standards, or regulations for advanced psychosocial interventions/mental health and*	Facilities and Services

		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 no barriers in accessing the service e.g. through lack of transportation)*	Financing
	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*	Information Facilities and Services Medication

		- *Patient has sufficient financial means to pay for medication, i.e. either through insurance or out of pocket*	
	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 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.	Medication Leadership and Governance
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