Integrated Framework

DELIVERABLE 7.5

SCALING UP PSYCHOLOGICAL INTERVENTIONS WITH SYRIAN REFUGEES

STRENGTHS

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1. Executive summary

Worldwide by mid-2022 there were more than 103 million forcibly displaced people. This includes 6.8 million refugees from Syria, more than any other country. Protecting and strengthening the mental health of refugees fleeing conflict is a pressing global mental health issue, further exacerbated by 5.8 million Ukrainians now seeking refuge. Refugees and internally displaced people are at heightened risk of developing many common mental health conditions including depression, anxiety and post-traumatic stress disorder. Poor mental health, if untreated in refugees, can have long term mental and physical health consequences that may persist even, as for instance seen in conflict-affected people in the former Yugoslavia, many years after that conflict ended. Early intervention to meet needs may help to avoid some of these initial and longer-term impacts, but access to mental health supports for many refugees remains difficult in high, middle and low income countries.

Having a better understanding of the case for action is important when making the case to national governments, as well international donors and relief agencies/non-governmental organisations, for more investment in measures to support the psychosocial health of refugees and other displaced people. This is more than simply strengthening what we know about the effectiveness of any intervention, it is also about improving what is known about the best ways to implement and sustain implementation of interventions that have be shown as effective.

This can be particularly challenging when looking at interventions for refugees. Refugees may not be a high priority for investment by host countries particularly when health system resources are limited. The vast majority of funding for refugee health services comes from donor aid in low and middle-income countries. Politically, in all countries, it may also not be a popular issue. Effective implementation needs to look not only at how to appeal to and reach the intended target refugee population, but it must look at ways to encourage all potential funders (international relief agencies, national governments, NGOs) that better mental health of refugees and other displaced people is a sound investment. These stakeholders, in making these investment decisions, will want to know as much as possible about the mid to longer term benefits of intervention, alongside the costs of development, and the budgetary and human resource consequences of any scale up of access to and coverage for effective interventions to support the mental health needs of refugees. Local health systems and other local actors may also be more likely to support services if they can see benefits for the local population, for instance a reduction in demands to make use of health services, or perhaps an expansion of access to psychological support services for local populations.

This deliverable brings together learnings and insights on the implementation of the WHO Problem Management Plus intervention, individual or group formats (iPM+ and gPM+), as well as the Step by Step (SbS) brief psychological intervention and EASE in the different country settings. It draws on information from all Work Packages 2-7 and also has implications for dissemination in WP8. As well as learning from, existing implementation efforts, it looks at the implications for effective scale up and replication.

Our integration framework provides insights and recommendations on actions across four phases of implementation: Formative / Planning Phase; Intervention Delivery Phase; Maturation and Sustainability Phase; and the Scale-up and Replication Phase. The framework emphasises the importance of adapting and tailoring intervention packages to the specific contexts in which they are being delivered and the importance of engaging early with local stakeholders to help facilitate implementation. There are also important insights on how to reach Syrian refugees; with various mechanisms having to be used in different country settings reflecting the differing circumstances that refuges find themselves in.

The findings of the definitive implementation trials, as well as their economic analysis, can provide arguments for continued investment, and we also look at how the case for scale-up and replication can be influenced by taking advantage of the human and other capacities that have been gained through initial intervention implementation. While the economic case for intervention at 3 month follow up varies considerably across settings, modelling analyses indicated that if costs of implementation could be reduced, for instance through lower training costs or any quality of life gains being sustained beyond 3 month follow up, then the economic case for investment may be strengthened considerably in many settings. This can help reduced costs of implementation and potentially also help expand access.

Further analyses, not yet in the public domain, as well as additional data that has been collected by STRENGTHS over the longer 12-month follow-up time frame will further inform the integration framework. This includes pooling of data from the results of both the five pilot randomised controlled trials (RCTs) and seven definitive RCTs conducted within STRENGTHS within a meta-analytic dataset. Therefore, an updated version of this integration framework report will become available from the authors once the results of all the individual studies and the meta-analyses have been accepted for publication.

2. Background / context

The Syrian conflict has been major cause of population displacement, with some neighbouring countries having become safe havens for millions of conflict-affected refugees. Almost 7 million refugees have sought refuge, primarily in neighbouring countries, as well as in Europe. For example, Türkiye, the country that hosts the highest number of refugees worldwide (3.7 million refugees), had given “under temporary protection” status to 3.5 million Syrians, nearly all of whom live in the community, while Jordan now hosts more than 676,000 Syrian refugees, of which more than 133,000 live in refugee camps (United Nations High Commission for Refugees 2022c). This can present great logistical and financial challenges for host countries; in Lebanon, relative to the national population, refugees and displaced people make up 1 in 6 of the population (United Nations High Commission for Refugees 2022b).

The conflict in Syria is just one reason why protecting and strengthening the mental health of refugees fleeing conflict is a pressing global mental health issue (Patanè et al. 2022).These challenges internationally have been exacerbated further in 2022 by the conflict in Ukraine; by mid-2022 5.4 million Ukrainians had to seek refuge in other countries, mainly in Europe(United Nations High Commission for Refugees 2022b). Globally, by mid 2022, 103 million people had been forcibly displaced from their homes (United Nations High Commission for Refugees 2022b), more than doubling the number a decade earlier (United Nations High Commission for Refugees 2022a), including 40% who have fled to other countries. 74% of refugees are hosted in low and middle-income countries (LMIC)s.

Refugees and internally displaced people are at heightened risk of developing many common mental health conditions including depression, anxiety and post-traumatic stress disorder. Poor mental health, if untreated in refugees, can have long term mental and physical health consequences that may persist even many years. Meta-analytic evidence shows rates of common mental disorders (CMDs) as high as 32% for depression and 31% for posttraumatic stress disorder (PTSD) among refugees and asylum seekers (Blackmore et al. 2020; Hoell et al. 2021). Prevalence rates among Syrian refugees in Türkiye were 34.7% and 19.6%, respectively. (Acarturk et al. 2021).

Early intervention to address mental health conditions, if effective, may help to avoid some long-term health and wider impacts such as exclusion from work, all of which have avoidable economic costs. One potential way to expand access to services is to move away from a reliance on specialist mental health service providers to services that can be provided through primary care and other community health services, including delivery by lay practitioners.

This approach has been used to implement the use of brief psychological interventions to address multiple mental health conditions. One such intervention is Problem Management Plus (PM+), a five-session programme developed by the World Health Organization (WHO) to address poor mental health in individuals affected by adversity, such as conflict (Dawson et al. 2015). It is a transdiagnostic intervention, intended to reduce many different common mental disorders, through a common approach and can be delivered in individual or group formats in five weekly sessions. It can be delivered under supervision by peer lay facilitators after 8-days of training. Studies on PM+ in non-refugee samples in Pakistan and Kenya previously have shown its effectiveness in reducing depression, anxiety, PTSD, functional impairment, and self-identified problems (Bryant et al. 2017; Rahman et al. 2019). Another potential intervention is an online delivered brief programme, Step by Step (SbS), focused on addressing depression(Carswell et al. 2018). Online interventions, if effective, potentially may be easier to scale up than face to face interventions. Brief psychological interventions targeted at adolescents are also being developed. The Early Adolescent Skills for Emotions (EASE) brief intervention is another face to face intervention intended to address depression and anxiety, as well as other internalising disorders.(Dawson et al. 2019)

Having a better understanding of the case for action is important when making the case to national governments, as well as international donors and relief agencies/non-governmental organisations, for more investment in measures to support the psychosocial health of refugees and other displaced people. This is more than simply strengthening what we know about the effectiveness of any intervention, it is also about improving what is known about the best ways to implement and sustain implementation of interventions that have be shown as effective. In response to the challenges of refuge mental health the STRENGTHS consortium has been assessing the effectiveness, cost-effectiveness, and implementation of brief psychological interventions for Syrian refugees in countries in Europe and the Middle East, including group and individual versions of PM+, SbS and EASE (Sijbrandij et al. 2017).

This report D7.5 brings together learning and insights from STRENGTHS on implementation and synthesises this in an integration framework that can potentially be used by future funders and service providers to facilitate implementation.

3. Aims and methods

Our overarching aim here is to highlight issues to consider in the implementation and scale up of brief psychological interventions delivered within the STRENGTHS project: iPM+, gPM+, SbS and EASE. To do this, we have drawn on information collected in WPs 2 to 6 which have looked at the context in which STRENGTHS interventions have been implemented, including the development of the culturally adapted interventions, and the way in which interventions have then been rolled out in the implementation trials in the different STRENGTHS countries. We also draw on material from Deliverables 7.1 to 7.2 which have looked at different economic aspects of development and implementation observed in the implementation trials, as well as the return on investment and modelling of scale-up of interventions described in Deliverable 7.3.

It should be stressed that any detailed consideration of implementation must be preceded by evidence that interventions are effective (Jordans and Kohrt 2020). This is an underlying assumption of STRENGTHS. Interventions have already been shown to be effective for similar population groups but in differing contexts. STRENGTHS is focused on implementation, looking at how well these interventions can be adapted and tailored to new specific country contexts and how effective interventions are within the context of implementation trials. Our integration framework therefore focuses on implementation rather research requirements. It assumes that there are four phases of implementation as we previously set out in Deliverable 7.1. These are:

1. **Formative / Planning Phase**
2. **Intervention Delivery Phase**
3. **Maturation and Sustainability Phase**
4. **Scale-up and Replication Phase**

We highlight key issues and learnings for each of these phases, for example looking at key actions to facilitate development in the formative stage, and issues around reach and uptake in the intervention delivery stage. For the latter two stages we look at actions that could help embed and sustain interventions, and for example draw on our modelling analyses to look at the potential economic case for scale up and /or replication of STRENGTHS interventions, where shown to be effective.

Further analyses, not yet in the public domain, as well as additional data that has been collected by STRENGTHS over the longer 12 month follow-up time frame will further inform the integration framework. In addition, report D7.4 sets out the approach being taken to pool the results of both the five pilot randomised

controlled trials (RCTs) and seven definitive RCTs conducted within STRENGTHS within a meta-analytic dataset. Therefore, an updated version of this integration framework report will become available from the authors once the results of all the individual studies and the meta-analyses have been accepted for publication.

4. Formative/planning phase for implementation

Forward planning is critical for effective implementation. A key and unavoidable element of the formative implementation phase is adaptation to any mechanism, in this case psychological intervention, to the local context. Even in situations where arguably there is relatively modest differences in language and culture between settings, e.g. between the UK and Ireland this process of adaptation is still required. Indeed, it may also be necessary to consider within the same country, particularly where administration for health and social care are devolved, or where there is significant linguistic and other cultural diversity between regions.

Previous research has pointed to specific cultural and other challenges in the implementation of mental health interventions within a Middle Eastern context. One review on this issue (Gearing et al. 2013) reported that barriers can include issues around the acceptability of interventions within the cultural context, including issues around stigma, community and system factors, notably availability and access to services, as well as the clinical engagement processes, where issues such as treatment expectation and therapeutic alliance were important. Thus, it is important to invest sufficient time and resource in a process of ensuring that planned interventions and approaches will be acceptable to and meet the needs of the intended target population, in this case Syrian refugees. Constant iterative engagement with (and ideally buy in) from multiple stakeholders is also vital to any implementation process (Boaz et al. 2018; Boaz, Baeza, and Fraser 2011).

4.1. Co-design and engagement with stakeholders

The importance of testing adaptations of interventions and meticulously documenting the way in which this is done not only helps with the immediate task of implementing the intervention in question, but it can be used in future to inform the adaptation of that or other interventions to be delivered in different contexts and settings (Bernal, Jiménez-Chafey, and Domenech Rodríguez 2009).

One key learning from STRENGTHs is the importance of co-design and engagement with stakeholders, in this case Syrian refugees and organisations working to support these refugees. A good level of co-design and ongoing iterative engagement will help strengthen the likelihood of successful implementation and ensure

that interventions are delivered in an appropriate format that meets local needs. Considerable time and effort was expended at the start of STRENGTHS on cultural, contextual and e-health adaptation of existing brief psychological interventions. Deliverable 3.1 led by the Danish Red Cross describes the process followed in detail.

D 3.1 describes how intervention protocols for iPM+, gPM+ and EASE were systematically modified following a cultural and contextual adaptation process adapted from a draft WHO adaptation protocol to consider language, culture and context in such a way that it is compatible with the cultural patterns, meanings and values of Syrian refugees' living in the five of the project sites. For the eHealth adaptation of SbS an established eHealth adaptation framework was also used within the STRENGTHS project and focused specifically on optimising reach, user engagement and the dissemination potential of the intervention for Syrian refugees living in three project sites was employed.

In doing this, the STRENGTHS team was able to draw on already established links with stakeholder organisations in each partner country. (See Table 9 in D3.1 for more detailed information on stakeholder engagement). These partners in turn were also able to reach further Syrian refugees to participate in the adaptation process, although the mechanisms used for this are specific to project sites. For example, in Lebanon, where the target population was broader than refugees, relationships established through an existing War Child Holland project facilitated engagement with and recruit of participants for rapid qualitative assessments and cognitive interviews that were used to inform cultural adaptation of interventions. In the Netherland a snowball recruitment process was used to reach refugees, where key individuals and organisations, social media and VUA Syrian interviewers were able to identify Syrian refugees Policy makers and (mental) health professionals involved in refugee mental health care were identified through professional websites and networks of the researchers within VUA and local partner i-Psy.

Rapid qualitative assessment can be a very useful mechanism to engage with refugees and other stakeholders and help in the co-design of adapted versions of interventions. In STRENGTHS this process looked at issues including local health and social system contexts, the perceived relevance of interventions to mitigate psychological distress, understand how people in the different settings experience psychological distress and help-seeking strategies. Refugees in some country settings were also engaged through subsequent cognitive interviews and/or focus groups to help improve the translation of intervention materials. These engagement processes provided important insights into the acceptability and feasibility of the proposed intervention. In the case of the implementation of PM+ in the Netherlands, the proposed intervention was switched from gPM+ to iPM+ partly as a result of views in qualitative assessments and focus group discussions, where participants indicated a preference for individual rather group sessions. There were concerns about sharing experiences and problems in a group format, perhaps reflecting the

multiple perspectives on the Syrian conflict of Syrian refugees. Issues of distrust between Syrians were noted; differences in politics and religious views were noted as potential barriers to participation. In contrast there were no negative factors flagged up about using an individual delivery format for PM+. Adaptation workshops, involving all relevant partners, were also held to come up with a final set of recommendations on cultural adaptation.

4.2. Digital interventions: put an emphasis on user-centred design

Stakeholder engagement is also essential to the development of online interventions such as SbS. It is important to involve end-users iteratively in designing and testing the usability of apps and other online interventions. The development of the apps used for SbS in STRENGTHS emphasised the importance of assessing the country specific conditions faced by service users. Notwithstanding, issues already highlighted on the appropriateness of interventions in Section 4.1, for online interventions additional key issues concern the ability of Syrian refugees and any other end users to be able to firstly access digital technologies (such as the availability of smart phones) and also determine whether there may be any barriers to uptake, such as a lack of familiarity with mobile-phone delivered apps. Other practical issues may be the cost of connectivity and a potential lack of privacy if phones are shared between several people.

Any e-mental health intervention needs to be accessible and attractive to as many potential users as possible, hence time and effort need to be focused on human-interface interaction, as well as literacy and technical capacities of the target population. Investing in professional design input is likely to increase use of any app or website. Some of this may be specified in procurement offers where the design of software programmes is subcontracted to specialist teams, but where third parties are involved in design these contracts should also stipulate that need to engage with end users and promote co-design.

Even when online interventions have been developed there are other potential barriers and facilitators to implementation that still need to be considered. Previous studies of e-mental health interventions have identified barriers such as limited awareness among the target population, resistance from local medical professionals who may feel that the apps might lead to a loss of status and/or income, insufficient funding, and a lack of an independent accreditation process (Batterham et al. 2015; Goss et al. 2017). Facilitators can include support / endorsement and accreditation from governmental and clinical organisations, effective media campaigns to raise awareness and secure streams of funding (Batterham et al. 2019; Schreiweis et al. 2019). All of these issues have resource implications.

One key learning from STRENGTHS for further digital interventions is the importance of early prototyping which allows immediate user and stakeholder participation and therefore iterative improvement throughout the development process. This can be done practically at modest cost by mocking-up smartphone screens or websites. This can then be used as an initial element in a process of usability testing with potential service users, which places considerable emphasis on obtaining qualitative insights into strengths and weakness of the digital interventions (Walsh and Richards 2017). There are many different apps available that look at mental health and wellbeing. Any new digital apps need to appeal to potential service users; and in the case of SbS where multiple sessions of support are provided, they also must also be stimulating enough to encourage repeat use and to sustain user interest for the time needed to complete the therapeutic session. Ease of use is critically important, as well as ability to use the app offline. Technical problems in using any app will also act as a barrier to repeat use.

Important issues that were taken into the final design of the app were revealed through engagement with refugees in the STRENGTHS usability assessment process. These included limits on technological literacy, especially for older people, and also concerns about the trustworthiness and credibility of the app. Participants in the usability assessment process also expressed reservations about data security and how all the information collected would be used. This process also revealed other concerns, not specifically linked to the apps themselves, but to wider issues such as low levels of mental health literacy, and a reluctance to seek help for mental health issues. Some participants felt that other day-to-day living concerns, such as financial difficulties or worries over their residency status in their host countries, were of more importance than mental health and that they would not have motivation to seek out information from a mental health app. Although challenges were highlighted, the good degree of engagement with Syrian refugees also indicated that they were generally positive to the availability of an app and agreed that the app's objective to support Syrian refugees with mental distress and problems was "important" and "highly needed". The self-help character of the SbS intervention was emphasised as positive by most respondents.

4.3. Invest time and resource in high quality translation

Translation is at the core of cultural adaptation work. Past studies, e.g. in Denmark, have shown that interventions which require real-time use of translators can be less effective than interventions delivered/facilitated by individuals who speak the same language as those individuals making use of the service (Sander et al. 2019). Restrictions on funded translation services in the Netherlands, for example may also act as an effective barrier to use of some services; poor communication skills have in the past acted as a barrier to mental health service use in other migrant groups in the Netherlands (Liu et al. 2015).

For effective implementation therefore it is important to have access to skilled translators. Ideally these translators should also be familiar with mental health terminology, but for Arabic-English translators this knowledge was limited. One key learning from STENGTHS is to establish early on, not only the competence and skills of translators, but also their knowledge of the topic for intervention. Implementors should have contingency funds to cover additional translation related costs where such knowledge is limited. In STRENGTHS, additional resources were therefore invested in quality assurance measures to ensure that translators had appropriate skills and cultural understanding. The full costs of adaptation, translation and quality assurance of any materials need to be considered as part of any implementation process.

Practical recommendations coming out of WP3 for the engagement activities necessary for cultural and contextual adaptation and subsequent implementation include the importance of translating all materials to classic or colloquial Arabic and ensuring there are Arabic speaking (male and female) interviewers at all sites. It is also prudent, where feasible, to hold any training sessions for interviews as close as possible to the engagement events, such as rapid qualitative assessments, free-flowing interviews and focus group discussions that they may be facilitating. Arabic-English translators could help ensure fidelity to qualitative engagement protocols and consistency in translation by checking each other's work. Cultural and contextual adaptation teams will benefit from having some fully bilingual team members, who also understand the purpose and content of interventions. This will also help avoid time delays and costs associated with the need to employ interpreters.

One final learning point is that while translation and the need for other cultural adaptations may involve substantial sunk-costs, it is important to recognise that once translated, there may be longer term economies of scale gained when considering scaling up interventions to other settings where language and culture are similar (Blignault et al. 2019). There is scope for such economies of scale for Arabic-language interventions, although some adaptation may still be needed given different dialects and differences in interpretation in Arabic.

4.4. Undertake expert consultation for development of online/mobile interventions

In addition to the issues of engagement with stakeholders and investment in approaches to ensure high quality translation of intervention materials, STRENGTHS has highlighted the specific implementation challenges that have to be met when developing online e-mental health interventions. Interventions need to be developed to work on both Android and iOS (Apple) operating phones and tablets, as well as for desktop personal computers. There are specific issues to be considered when developing and implementing any online intervention. These range from technical, but practical issues, such as the approach used for software

development: a hybrid approach to software development or separate app development for different phone operating systems, as well as web-based versions of software. Separate app development for each of the interfaces may have technical advantages and make updating/future proofing easier to achieve but it can also lead to significantly higher development and maintenance costs, which may be an issue for long term sustainability.

In the case of STRENGTHS, a consultation took place with technical experts. Using this input and noting budgetary limitations the hybrid software approach had to be adopted. In this approach, web-development tools are used to create a shared code basis that can be used as an app on iOS and Android but also as a standard website.

4.5. Maintaining a site-specific focus to intervention adaptation

Information on specific country context was also taken into account in the cultural and contextual adaptation process, for instance housing and accommodation arrangements, as well as access to routine health care services and having the right to work and obtain welfare services. STRENGTHS benefited from having undertaken situation appraisals in all countries as part of WP2 that could inform this process. The entitlement of refugees to make use of the health services within a country, as well as any out of pocket costs in addition to access parallel refugee specific services, will also have a bearing on potential uptake. For instance, cost has been highlighted as a key barrier to service access in both refugee camps and urban settings in Jordan (Al-Rousan et al. 2018; Doocy et al. 2016; Dator, Abunab, and Dao-Ayen 2018). There is also evidence from multiple contexts that non-health system factors can have a substantial bearing on mental health (Juárez et al. 2019), and may also have an impact on the willingness to engage with the interventions offered by STRENGTHS.

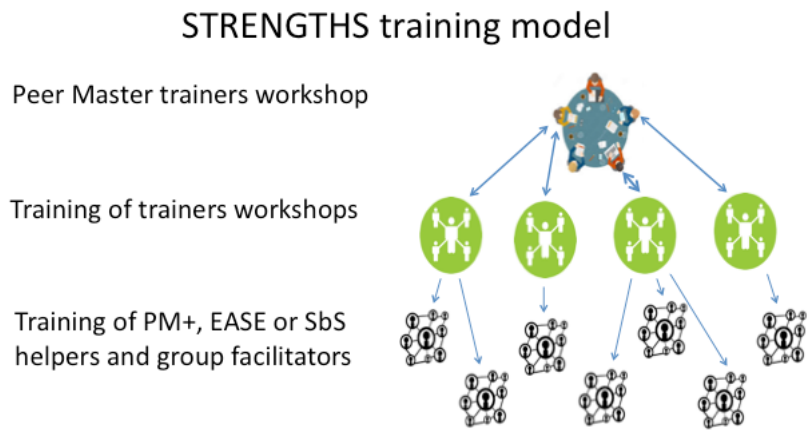
While it might be tempting to bypass some of the specific steps in adapting interventions when looking at multi-country, multi-site interventions, and thus avoid some of the costs associated with intervention development, this may be a false economy. Another key learning from STRENGTHS, as highlighted by WP3, is the importance of maintaining a site-specific focus to end user engagement and co-design when undertaking cultural and contextual adaptation. As report D3.1 noted "*site level data collection will help reduce researcher bias and form the evidence base for assessing the feasibility of developing a single cultural adaptation of the intervention materials for all sites. If this is deemed feasible, a cross-site or cross-cultural*

analysis should be carried out to inform the eventual adaptation. The data collected as site level becomes key once more for implementation, and to some extent training, as it can be used to inform the final site-level tailoring of the intervention that will inevitable be necessary."

4.6. Training: Using a training the trainers approach to help facilitate implementation and future scale up

STRENGTHS has trained Syrian refugees without specific mental health qualifications or experience to implement brief psychological interventions as helpers (individual interventions) or facilitators (group interventions). There will also be 'on-the-job' learning after training, aided by regular supervisory support. Using peer-delivered mechanisms to implement interventions is often seen as fundamental to a task-shifting approach moving the provision of mental health care away from a reliance on (what are often limited) specialist mental health services. It is also intended to increase access to services within the community. Figure 1 shows the approach taken to build capacity to deliver interventions. A training-of-trainers model was at the heart of the approach used to facilitate the implementation. Two Peer Master trainers workshops were held, one for iPM+ and gPM+ and one for EASE. This was followed by two training-of-trainers workshops, again one for one for iPM+ and gPM+ and one for EASE. These trainers then went on to train helpers and group facilitators at the different implementation sites.

Figure 1: Training-of-trainers concept used for STRENGTHS training package.



The decision to adopt this model was in part pragmatic as very few trainers had prior knowledge on how to provide training for the specific interventions used in STRENGTHS. This could have long term advantages as designing a training-the-trainers model potentially can be helpful in sustaining and potentially scaling up access to any intervention, particularly when existing training capacity is limited in a specific setting. In low and middle-income countries increasing training capacity may also reduce the need to make use of what are likely to be more costly external training resources.

Local trainers, if they remain linked to the different intervention programmes could go on to train more lay people to facilitate these brief psychological interventions. However, while this in principle may work, a review of training-the-trainer models in global health initiatives highlights other factors that need to be taken into account in the mid to long-term (Mormina and Pinder 2018). These factors are likely to include workload challenges, as trainers are likely to be performing this function on a part-time basis in addition to other activities, as well as long term financial support. This is also something going forward that needs to be considered as part of any scale-up process.

In STRENGTHS the extent to which helpers and facilitators were remunerated for their work varied across contexts; in some countries rules around employment for refugees who do not have official residency status may prevent payments being made. In Türkiye and the Netherlands payment (other than a small honorarium) is not feasible while in Switzerland there have been considerable legal and bureaucratic barriers to paying Syrian trainers and helpers, and these rules are administered at an individual canton level. In the longer term, as refugees gain the right to work in their host country, payments are likely to be necessary to help with helper/facilitator retention. Otherwise, understandably, helpers and facilitators may prefer to spend their time on paid employment activities. Another key learning message from STRENGTHS is also the

need to incorporate additional training on supervision as well as self-help measures that facilitators and helpers can take to protect their own mental health.

4.7. Co-design and piloting training packages

As with the design of the interventions themselves it is also important to engage with trainers, as well as lay helpers and facilitators, to co-design training programmes. During a pilot phase further feedback can be used to modify programmes as necessary. This involvement in development can help create a sense of ownership over the training process and may help with the retention of trainers, helpers and facilitators.

In STRENGTHS co-design was at heart of the approach to training. This is set out in detail in Deliverable D3.2. As part of piloting training the trainer workshops were evaluated by participants. This led to revision of description of training activities, additional scripts to support more challenging topics, information to support the research activities and a clearer layout to support easy use. There was further feedback post training workshops via Skype and e-mail from the different STRENGTHS sites. The Danish Red Cross as the lead partner responsible for training co-created revised materials with this end user input, such as reformulate phrases and definitions of key concepts. Further feedback and revision was also obtained from the pilot trials conducted in STRENGTHS.

5. Intervention delivery phase of implementation

5.1. Monitoring and reacting to real-time intervention uptake rates

Understanding factors that influence levels of uptake with interventions and investing resources in mechanisms to promote uptake are critical to successful implementation. Regardless of the effectiveness of any intervention, if there is insufficient uptake it will not have much impact on target population health. In our STRENGTHS trials, recruitment of participants turned to be an important challenge in both in Europe and in Middle Eastern settings, even before the onset of the COVID-19 pandemic. There is much that can be learnt from various approaches to implementation trial recruitment in STRENGTHS that also apply to everyday delivery of these interventions, although some of the challenges faced on recruitment and sustained uptake were undoubtedly affected by the COVID-19 pandemic.

Nonetheless, one key message is the important of routinely monitoring and reacting to any indications of low uptake rates. STRENGTHS survey work in Türkiye highlighted the issue of self-exclusion for multiple factors, including stigma (Fuhr et al. 2019). The pilot trials also provided an opportunity to examine this issue. In Switzerland, for example, less than 15% of the expected number of participants for the pilot study had been recruited after four months. The STRENGTHS team reacted to this by engaging in a focus group exercise with Syrian refugees and relevant organisations which identified a number of barriers to participation. These included lack of awareness about the interventions being offered, a lack of trust in the research team and others delivering the intervention, communication barriers, such as using "too academic" language in dissemination materials, and anticipated stigma associated with receiving mental health support. There were also practical barriers such as the cost of transportation to receive intervention, and also because they prioritised other immediate practical issues, such as finding work or housing. The lower than anticipated number of Syrian refugees seeking shelter in Switzerland was a further challenge.

This engagement process with refugees and other stakeholders led to modifications in the approach to recruitment in both the pilot and main study, including asking key informants in the Syrian community to promote the study, as well as redesigning study information to make it more accessible and less stigmatising to potential participants. This led to an increase in the number of screening interviews for the pilot RCT. A pragmatic decision for the main trial, given the low number of Syrians in the country, and in order to have more chance of reaching enough people to say something definitive about effectiveness, was to open up the intervention to other non-Syrian Arabic speakers also experiencing psychological distress. This could also help with future scale up as there would already be evidence that the intervention had been successfully used by other population groups.

In Lebanon it was not possible to reach the intended number of participants, but the circumstances here might also be considered very unusual with a combination of extreme adverse events, including the COVID-19 pandemic, economic collapse, political instability and the Beirut port explosion. That said, a detailed qualitative analysis of barriers to participation did reveal some issues in Lebanon that do need be considered in promoting intervention uptake more generally. These include the high rates of children (the main target population group in the EASE study) who were in employment; this made it difficult for them to participate in EASE, as this could mean a loss of family income. Transportation to intervention settings was also problematic and the EASE team had sought to address this issue by providing bus transport from the rural agricultural areas where children often lived. The unusual circumstances in Jordan where the trial took place in a closed camp where all participants were Syrian refugees meant that there were no significant barriers to participation and retention rates were also very high. Interventions had also been administered before the COVID-pandemic.

Uptake of online interventions such as SbS presents different challenges, as engagement with refugee populations and opportunities to provide feedback are more limited. One key learning here from the experience of STRENGTHS is that very different strategies may be required to reach Syrians in different countries, even though, ultimately, they are all accessing the same intervention. However, at the heart of all these mechanisms was the issue of trust in online apps.

We noted earlier in this deliverable that mock-ups of app design were discussed with end-users, and these consultations can also provide an opportunity to discuss issues of how to reach target populations. Experience from the SbS definitive trial in Egypt indicates the potential value of working in partnership with a local non-governmental organisation to raise awareness amongst its contacts of the app, directly contacting refugees by phone. This can also provide an additional level of trust in the app; something that had been noted as being important to potential app users.

Constant monitoring of app engagement rates indicated that the simple social media awareness campaign used in the pilot trial in Germany was insufficient to promote uptake in both Sweden and Germany in the definitive trial. Engaging with a number of non-governmental organisations supporting Syrian refugees in the definitive trial also did not have a major impact, although COVID may have acted as a further barrier. The STRENGTHS team also worked with an advertising agency to produce videos targeted at the Syrian community, as well as front a specific Facebook advertising campaign. Perhaps the most effective mechanism however was collaboration with Syrian social media influencers; these influencers were seen as a trusted source of information and their endorsement of the app meant that it was also a more trusted intervention.

In summary, lessons learned from our trials, in part through active consultation and feedback from Syrian refugees indicate that different barriers, often varying with country and setting context, need to be identified and addressed to promote intervention uptake. Implementers should include contingency budgets to adopt enabling measures to respond to issues raised through active and ongoing monitoring of uptake. These may include the need to further build trust, tailor communication to specific communities, be even more mindful of the risk of stigmatisation and if feasible provide financial and other support to overcome some structural barriers, such as need for transportation. Childcare can also be an issue, and in Türkiye some gPM+ groups were able to provide some limited childcare support in the same location while sessions were underway. Perhaps it is also feasible for intervention implementers to act as ‘signposters’ to other social supports, such as help finding job opportunities and affordable housing. There are also specific issues around engaging with men, which we highlight in Section 5.3.

5.2. Transportation issues must be considered as part of implementation

Insights from STRENGTHS have highlighted transportation as a barrier in both Europe and the Middle East. It is clear from experience seen so far in STRENGTHS that the time, logistics and expense of travel can be a barrier to participation. Some refugees in some settings have even more fundamental fears of travelling anywhere because of issues including insecurity. As noted in one report, "fears surrounding the commute from home to a program or service stymies participation in recreational, educational, and psychosocial programs for eligible young people" (Salemi, Bowman, and Compton 2018).

Financial incentives covering the costs of transportation have been used to encourage participation in some settings, e.g. in Switzerland and Türkiye. It is important to identify resources and costs associated with transportation, even if these are budgeted for within a research project budget. For long term sustainability it may be necessary to continue to budget to cover transportation costs.

One way round this would be to hold the intervention within a local community setting thus reducing the need for transportation. This may be more practical where the target population is heavily concentrated in specific locations, e.g. within a refugee camp in Jordan (but even in this example the refugee camp covers a large geographical area requiring transportation), but may not be feasible where refugees are widely dispersed across the community as in the Netherlands and Switzerland.

In Türkiye, where the target population are located mainly in a relatively small geographical area of Istanbul, the transportation system may not function well, meaning that it can still take considerable time to travel to an intervention venue. In Türkiye originally buses were being used to pick up participants for PM+ sessions, logistically this approach proved unwieldy and also did not provide the same level of incentive for participation compared to retrospective receipt of travel expenses after attendance at a therapy session. Participants in Türkiye, for instance, also worried about being stigmatised as having mental health problems if the intervention is delivered in a local setting where they can be recognised on a bus associated with a mental health service.

5.3. Increasing the appeal and uptake of psychological interventions to men

One issue concerning the delivery of psychological (and many other mental health) interventions is to have greater levels of appeal and engagement with men. In the STRENGTHS trial men made up 60% of study participants in the Netherlands, but only around 30% of participants in Türkiye and Jordan. Further analyses may be able to explore whether any of the circumstances around the higher rates of participation for men in the Netherlands can in anyway provide valuable learnings in other high, middle or low income country contexts. Greater access to welfare support, as well as longer term residency in the Netherlands may have reduced the financial consequences of attending iPM+. In Türkiye data collected on the recruitment process indicated that it was difficult for men to attend because many were working six days a week and wanted to spend the limited free time that they did have with their families. Implementers might be able to overcome some of these financial and time barriers by exploring the possibilities of organising interventions in locations close to where people work, and also explore whether it might be possible to deliver interventions at more flexible times, such as in the evening.

5.4. Importance of ongoing supervision and support during the implementation phase

In section 4 we noted the importance of training specifically for supervisors. The lack of effective supervision post training has previously been identified as a barrier to effective implementation of mental health interventions in low and middle-income country settings (Faregh et al. 2019; Kohrt et al. 2018). A key insight from STRENGTHS is the value of ongoing supervision that has been provided either by one of the master-trainers trained by STRENGTHS or other mental health professionals to the Syrian refugees who are acting as individual helpers or group facilitators.

6. Maturation and sustainability phase

In this section we provide some preliminary insights for the framework on the maturation and sustainability of implemented. It is still early to make a full assessment on the maturation and sustainability of services; this has to take account of the results of the effectiveness analyses. However, the majority of the analyses

discussed in deliverables from WP 4 to 6 focus on outcomes at 3 months, and the economic analyses in WP7, as reported in D7.2, also focus on the economic case at 3 month follow up. Longer term data will also be considered to fully inform arguments for sustaining the services delivered through STRENGTHS. Indeed, in some settings, e.g. Switzerland, there is insufficient evidence from 3 month follow up to make a judgement on the effectiveness of the intervention and longer term data are needed, while EASE does not appear to be effective at 3 months. The meta-analysis pooling data across pilot and definitive trials in D7.4 will also provide additional information on effectiveness that may not visible in single trials, as well as allowing us to explore whether sociodemographic, clinical and migration variables moderate the effects of psychological interventions among Syrian refugees (de Graaff et al. 2022). With this caveat we highlight some initial important learnings from STRENGTHS, as well as drawing on broader implementation literature.

6.1. Engaging early with stakeholders to explore ways to integrate service into existing primary and community mental health supports

On key issue, which is fundamental to all implementation, is to consider whether any implemented service can be integrated into existing service structures as part of a maturation process. Early engagement with people making use of a service, as well as organisations/structures that might fund or support intervention, is prudent. This may help with securing future sources of funding and may also help facilitate greater access to and awareness of the service.

One mechanism for doing this is to hold Theory of Change workshops. These bring together a range of stakeholders and service users to try and reach a common consensus on why and how it may be possible to implement and scale up services within the country specific health system and wider policy context. Not only do these workshops generate outputs in the form of Theory of Change maps showing potential pathways to impact, as well as intermediate and longer term outcomes that may be achieved, but they also provide another opportunity to build a sense of partnership and dialogue between different stakeholders. More dialogue and a better sense of partnership can also help build relationships that facilitate implementation in the longer term. STRENGTHS undertook these workshops in Lebanon, the Netherlands and Türkiye (See Deliverable 2.4 for detailed information on workshop outputs).

In the Netherlands, for example, the Theory of Change Workshop and other consultations with stakeholders highlighted three possible ways to sustain the iPM+ service. These options included bidding for a service tender to continue to offer iPM+ within the initial refugee /asylum seeker reception centres that support new refugees arriving in the country. The consultation highlighted the benefits of potential early access to

refugees with mental health needs, and a reduction in the challenges around service uptake, given that the service would be offered to many individuals supported in a single location. Potential risks such as a lack of focus on mental health within these refugee centres and risks of a lack of continuity of care when individuals move to the community were also highlighted and can therefore be considered.

Other options raised included mainstreaming iPM+ within the mental health system, potentially covered by the social health insurance system, but there may be regulatory barriers on which professionals may be reimbursed, as well as high initial out of pocket payments prior to receiving insurance coverage. Similar issues can incidentally be seen in other settings, such as restrictions on who can be reimbursed for providing psychological therapies, as well as the level of reimbursement, as in Switzerland (European Association for Psychotherapy 2016). This may mean that in some settings health system professionals may be resistant to increased available of psychological therapies delivered by lay psychological counsellors, as they potentially might be competitors.

In the Netherlands consultation and theory of change workshop refugees also raised concerns about the stigma associated with going to a formal mental health service. Partnerships with local municipalities was a third option, felt to be very feasible, but limited because municipalities have limited geographical reach and secure long-term funding may be limited. This is just one country specific example of how different forms of deliberative discussions, whether they take the form of focus groups or theory of change workshops can help with planning. It can also help identify whether there is specific interest in some stakeholder groups for future partnership work; discussions generally help strengthen engagement and building relationships with stakeholders.

6.2. Planning early to secure longer term funding

A highly related issue to 6.1 is the need to develop a strategy early in the implementation cycle for securing longer term funding. The discussions in 6.1 may help identify potential funding routes, but a wider range of options can also be explored. Ensuring information is being collected on service outcomes and throughput, as well as testimonials from past service users can also aid in this task. Collating information on the economic case for investment can also be helpful; for instance, highlighting some of the consequences of not taking early action that have previously been reported, such as an increased risk of longer term health service utilisation. For example, researchers using data covering nearly 20 years in Germany have shown that short term restrictions in access to services for refugees may actually lead to higher long term costs to health systems (Bozorgmehr and Razum 2015).

6.3. Consider funding the time of helpers and facilitators

STRENGTHS has in part relied on unpaid or nominally paid helpers and facilitators. Going forward, one key issue that has been highlighted is the need to move towards a system where there is appropriate remuneration for helper and facilitator time. This was also noted in section 4 of the report where funding may impact on retention rates. Syrian peers may be unwilling to deliver interventions for a long period of time if they are not paid to deliver the services. We have seen in STRENGTHS that some helpers / facilitators have left their roles in STRENGTHS to understandingly take on paid roles. Indeed, some have said that the experience that they have gained through STRENGTHS has helped them obtain new skills and also employment. This is quite a common outcome of projects that rely on skilled volunteer input, and it is appropriate in the longer term that roles are funded wherever possible. Maximising flexibility in working hours so that it is possible to combine external paid work with additional work as a helper/facilitator is another issue raised in STRENGTHS.

7. Scale-up and replication

We have noted that evidence at 3 months on the effectiveness and cost effectiveness of interventions is mixed, and in some cases inconclusive. The case for scale up and replication will be further informed and become more definitive when 12 month follow up data, as well as data pooled across all trials, are taken into account. Here we briefly note some of the learnings that already can be seen from STRENGTHS at 3 month follow up that may influence scale-up and replication.

7.1. Make use of return on investment modelling to estimate benefits and costs of intervention replication and scale up.

Information on the cost-effectiveness of interventions is likely to be very influential in decisions on the scale-up and replication of services. If interventions do not appear to be cost effective compared to existing or alternative interventions, then they are unlikely to appeal to decision makers. Even if cost effective they can also be costly, eating up what can often be a very limited budget. Information on the budgetary impact of interventions is therefore also a key factor in decision making, alongside any cost offsets that might be achieved over time as a result of effective intervention.

Return on investment modelling can be used to present information on both cost effectiveness and budgetary impact. It can also look at how these variables change over time and present information on the short, mid and long term returns on investment. It is increasingly used as tool to help policymakers and other potential service funders in any decision on whether to maintain investment in services, as well as in their potential expansion through replication in different settings or scale-up to increase the level of population coverage. It has been used in high, middle and low-income settings, and specifically in the context of mental health policy making (Chisholm et al. 2016; McDaid, Park, and Knapp 2017).

Return on investment can be thought of as the net monetary value of resource use consumed and other economic impacts such as time out of role compared to the costs of two or more policy choices. Returns greater than one for any intervention generate net positive returns to the economy. Monetary values can also be attached to impacts on quality of life years gained (or disability adjusted life years averted), the primary outcome measure used in health economic analysis. It is therefore prudent to invest resource in estimating potential return on investment as information on the effectiveness and costs of interventions becomes available. To do this information on resources used, including the time of volunteers and other in-kind supports, as well as process indicators such as number of people making use of the service, and finally information on outcomes is needed. Some of this information will need to be collected as part of routine implementation monitoring data, but some data in some country settings, may also be available from other sources, such as hospital records and other databases. Information is also needed on one or more counterfactuals, i.e. what would happen in the absence of investment in the intervention; again, some of this may be available from databases or published literature, or collected within trials (as in STRENGTHS).

As part of STRENGTHS a return on investment modelling tool in Excel was developed to look specifically at the potential economic case for investment in iPM+, gPM+, and SbS, as well as the costs of implementing EASE. The tool draws on effectiveness and cost information collected during the implementation trials. In the absence of longer-term evidence, our modelling tool allows policy makers and other end users, such as international agencies and advocacy organisations, to look at the potential longer-term impacts of intervention beyond the end of any evaluation, by making assumptions on whether longer-term impacts on service utilisation and quality of life (or other outcomes) will be seen.

Policymakers can also see what magnitude of benefit or resource use averted is needed in order for the intervention to have a positive return on investment. They are then better informed to make judgements on how plausible it is to realise these benefits of intervention. They can also adjust key elements of the model to reflect their own implementation circumstances. Full details on the model and its operation are described in Deliverable D7.3. At present, the modelling tool mainly uses cost-effectiveness data from 3-month follow

up analyses shown in Deliverable D7.2, as well as information collected on the implementation costs of the different psychological interventions. The modelling tool is dynamic, allowing the end user to change many modelling assumptions including 1) impacts on the costs of implementation, 2) health service costs and productivity losses 3) assumptions on effectiveness, levels of uptake, coverage and impacts on resource utilisation.

In report D7.3 we described one illustrative example of how changes in parameters can impact on overall return on investment, using the example of iPM+ in the Netherlands. Using default values from the definitive trial in the Netherlands at 3 month follow up, and on the assumption that these impacts will persist beyond 3 months, our tool indicates that if the very modest improvements in quality of life are maintained then there will be a positive return on investment within 12 months. It also illustrates how this economic case for investment is strengthened considerably if costs of training can be reduced; something that should be feasible given the use of a train-the-trainers model, even allowing for some regular turnover (and therefore additional training) for some helpers and facilitators. The models can also potentially look at the economic impacts of providing interventions in combination with other interventions, rather than just being delivered in isolation.

7.2. Identify additional benefits of interest to host communities and external funders

Information on the effectiveness of psychosocial interventions alone, as well as the level of return on investment are just two types of information that may influence decision making. Country level policy makers may be concerned that any support for refugees, especially in settings where resources are limited, might divert resources away from their own populations. Domestic politics might also play a role, with a reluctance of some politicians to be seen to be funding services for refugees (Biddle, Wahedi, and Bozorgmehr 2022).

As part of the process of securing local political support and potentially funding for replication and scale up of services it can therefore also be helpful for implementers to engage with local policy makers and other stakeholders to identify wider benefits to the local population that may come, either indirectly from better refugee mental health, or directly through expanding coverage of services to support local populations with psychological distress. An example of the former, might be an association between better refugee mental health and greater rates of participation in employment in countries where this is permitted. For example, Afghan refugees in Iran who are in work have been able to make salary related contributions to the national

health insurance system (Spiegel, Chanis, and Trujillo 2018). In Lebanon the EASE programme had already been available to children in need regardless of nationality; in the same way an expansion of PM+ services could benefit the local population, many of whom may be at high risk of psychological distress because political and economic situation in the country (Farran 2021).

Given that the majority of funding for health services for refugees in low and middle income countries is provided by external donor aid, as well as direct financial support from the United Nations High Commissioner for Refugees (UNHCR) and other international agencies (Spiegel, Chanis, and Trujillo 2018; United Nations High Commission for Refugees 2022b), it can also be helpful to look at further benefits that may be of interest to these stakeholders. This could, for example, include making interventions available to military veterans and aid workers who have also been exposed to conflict-related trauma. This may also help to sustain the capacity and maintain skills for delivering interventions, as there will be fluctuations over time in the need to support refugees. There are already examples of psychological and other interventions, including PM+ that are now being adapted to support the mental health of high-risk population groups during the COVID-19 and future pandemics, for example health and social care workers (Hooper et al. 2021; Ottisova et al. 2022; Mediavilla et al. 2022).

8. Conclusions

This integration framework draws on all elements of STRENGTHS to look at challenges to the implementation process and how they have been addressed. A series of key insights are described, covering the four phases of implementation: Formative / Planning Phase; Intervention Delivery Phase; Maturation and Sustainability Phase; and the Scale-up and Replication Phase.

Further analyses, not yet in the public domain, as well as additional data that has been collected by STRENGTHS over the longer 12 month follow-up time frame will further inform our findings. These include pooled data from the five pilot randomised controlled trials (RCTs) and seven definitive RCTs in STRENGTHS within a meta-analytic dataset. Therefore, it is important to stress that an updated version of this integration framework report will become available from the authors once the results of all the individual studies and the meta-analyses have been accepted for publication.

The framework emphasises the importance of adapting and tailoring intervention packages to the specific contexts in which they are being delivered and the importance of engaging early with local stakeholders to help facilitate implementation. There are also important insights on how to reach Syrian refugees; including the importance of ongoing monitoring and opportunities for feedback. This has led to various mechanisms having to be used in different country settings reflecting the differing circumstances that refugees find themselves in.

The need to build trust is at the heart of all of these engagement activities. Results from various feedback processes with Syrian refugees and other stakeholders show that, overall, the interventions were positively evaluated with high levels of acceptability. These activities at the formative stage, where there was a focus on cultural adaptation and development of training packages, crucially helped to ensure that revisions were made to materials and processes to increase levels of trust and acceptability. Services can also be communicated in a way that addresses limited levels of mental health literacy and also reduce any sense of stigmatisation associated with engagement with mental health support services.

With interventions such as those offered by STRENGTHS, which make use of a task-shifting approach to expand access to mental health supports, appropriate training, supervision and support to the helpers and facilitators is vital. Trainers will also need support, and recognition that they have limited time. Any training activities they provide will have to be built around their main activities. If services are mainstreamed and sustained, it may also not be feasible to rely on volunteers to deliver interventions, and there may regulatory barriers to remunerating some refugees. Within STRENGTHS a key motivation for turnover in helpers/ facilitators has been the need to obtain paid employment. In the longer term, budgeting for resource to

compensate helpers and facilitators may be critical to sustainability. Services may also potentially be impacted by any regulatory restrictions related to certification and accreditation and who is permitted to deliver psychological supports. Good dialogue with professional bodies and regulators may help address these issues.

We cannot stress enough the importance of ongoing dialogue with different stakeholders needs to continue during the intervention delivery and maturity/sustainability phases. One benefit of this can be to identify potential pathways towards long-term sustainability, as well as building relationships with potential partners who may be able to help integrate STRENGTHS interventions with other services and supports. It is also important to have monitoring mechanisms in place to document the implementation process, including level of uptake, fidelity to therapy completion, as well as data on outcomes, as this can add to evidence that the intervention can work in this specific setting in which it is being delivered. This can include collection of some formal outcome measurements related to mental health and quality of life, as well as health care and other service use, but it can also include testimonials from service users. Benefits to volunteers working as helpers and facilitators may also be documented.

STRENGTHS has started from the premise that there is an existing evidence base around brief psychological interventions for people experiencing psychological distress related to conflict and displacement. It has undertaken definitive implementation trials to examine effectiveness and cost effectiveness of iPM+, gPM+, SbS and EASE in different settings. The findings of theses definitive implementation trials, as well as their economic analysis, can also inform deliberations on continued investment, and the case for scale-up and replication. Obtaining funding to sustain services is clearly one critical challenge. Building an economic case for investment can help in leveraging funds.

While our analysis indicates that the short-term economic case for intervention varies considerably across settings, our integration framework also highlights the value of using modelling approaches to consider how the economic case for investment will change over the longer term, depending on whether or not there are further changes in outcomes such as quality of life and use of health services. Modelling tools can also look at how the budgetary impact and economic case for action changes if the costs of implementation can be reduced, something this likely to be feasibility as interventions mature. For example, we noted that if costs of implementation could be reduced, for instance through lower training costs or any quality of life gains being sustained beyond 3 month follow up, then the economic case for investment may be strengthened considerably in many settings.

Efforts to scale up and sustain STRENGTHS interventions in settings where they have been shown to be both effective and have a positive return on investment will also need to consider wider considerations that funders, policymakers and other stakeholders will take into account. A key barrier may be concerns within

countries that spending resource on refugee mental health has little benefit to the population of the host country. It is imperative that implementers also look at potential benefits to local populations through different forms of expansion and scale up, including direct provision of these services to local, as well as refugee, populations. It is equally important to look at whether there may be additional co-benefits to external donors and other international actors that are likely to provide the bulk of funding for refugee mental health interventions in low and middle income countries.

Some of these issues may also be picked up through investment in deliberative dialogues, such as theory of change workshops that were run in some STRENGTHS countries. Structural issues need to be addressed to facilitate sustained implementation. For instance, one consideration about scaling up highlighted by stakeholders both Europe and in the STRENGTHS countries neighbouring Syria is that the brief psychological interventions should not be implemented as "stand-alone" interventions, but be fully embedded with other services and supports. Routes for integration will vary between countries, and will be influenced by regulatory and organisational structures around refugee health, as well as differences in the 'welcome', social welfare and asylum procedures between countries. Integration may be with health services, but it might be with broader welfare supports such as services dealing with housing, job-seeking and other urgent practical problems that may be prioritised by refugees.

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10. Research outputs

In preparation

Paper summarising the key messages of the integration framework to inform implementation processes (Lead: LSE)