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The current crisis in Syria has greatly escalated need, while simultaneously damaging infrastructure within the country. In order for humanitarian efforts to be effective, understanding the mental health profile of the population concerned, pre-existing mental health system, resources and gaps, as well as an evaluation of the current service situation is vital. This paper provides an analysis of the shifting resources and infrastructure available to the affected populations in Syria, complementing the systematic review of mental health outcomes elsewhere in this issue. Assessment results from Syria are presented, and capacities and gaps assessed. This article describes how previous, protracted humanitarian and development centred inter-agency efforts to evaluate and improve the mental health and psychosocial system in Syria can be applied as a foundation, and adjusted to address the current internally displaced persons and refugee crises in the country.

Keywords: inter-agency coordination, Iraq, mental health and psychosocial support, Syria

Introduction

Understanding health and illness, explanatory models and help seeking behaviour is impossible without linking them to the local context and service systems. In 2011, Syria (population 21.8 million) had approximately 80 psychiatrists; 25 times less than the minimum ratio recommended by the World Health Organization (WHO). The dramatic influx of Iraqi refugees in 2006 drew into sharp focus the need to develop the mental health system in Syria. Initially, there was no structured approach to mental health and psychosocial support (MHPSS) programming. The refugee emergency had instigated a few scattered initiatives, but without any systemised coordination or standardisation. In addition, there was a lack of prevention efforts and formalised community care. The onset of the current crisis resulted in the flight of many professionals and drained capacity in the field of MHPSS. This paper describes inter-agency efforts to evaluate and reinforce the MHPSS system in Syria, in the face of severe and increasing need.

Mental health resources in Syria

During the initial systematic review of the published and informally published or grey literature on Syria (Quosh, Eloul & Ajlani, 2013), articles and studies were identified, including information about the Syrian mental health system. Only two, partially outdated, grey literature reports (WHO, 2005; Assalman et al., 2008)

included pertinent information. Brief, but current reviews of the crisis and destruction of mental health services can be found in Abou-Saleh & Mobayed (2013) and Amos (2013). There are no reliable estimates of psychiatric morbidity in Syria, due to an insufficient health information system and lack of systematic research (Matar et al., 2009). Additionally, the high level of social stigma associated with mental disorders inhibits reporting (Quosh, 2011). (For more information on mental health legislation in Syria, as well as documentation and information systems, see this article's appendix, http://links.lww.com/INT/A3) Therefore, in order to complement the available published information, structured interviews were conducted with two key stakeholders: a psychology professor from the University of Damascus and a psychiatrist (at that time the Mental Health Director of the Syrian Ministry of Health).

Professionals in mental health include: psychiatrists, psychologists, social workers, primary/secondary health care providers, and traditional healers (training and licensing requirements, as well as existing mental health education and service systems are described in detail in the web appendix, http://links.lww.com/INT/A3). Both public and private mental health care exist in the form of hospitals and office based care, but are limited and highly medicalised. Additionally, they are directed at serious mental illness and disability, and restricted primarily to urban areas. Primary health care (PHC) centres can offer mental health services, either by hosting a rotating psychiatrist, or by having a medical practitioner or resident with training in psychiatry on staff. The primary source of community based support is extended family.

Until recently, there was a clear hierarchy among professionals that often prevented cooperation and coordination. The prejudices held between psychiatrists and psychologists further hindered multiprofessional training and interactive education, perpetuating the lack of communication. Several international agencies and the Ministry of Health have taken an increased interest in mental health in recent years, and implemented a number of trainings to build capacity, which has bolstered cross discipline cooperation (Quosh, 2011). While priorities changed, due to the emergency context, mental health remains high on the agenda and interdisciplinary trainings are increasingly being conducted. This has encouraged practitioners and clinics to adopt a bio-psycho-social-spiritual approach which, in turn, has eased the shift from protracted displacement to emergency mode. There remains, however, limited formal structure for collaboration. Most coordination, particularly outside of humanitarian programming in Damascus and rural Damascus, is based on personal initiatives and the coordination network of 17 remaining master trainers[1] (Quosh, 2011).

Inter-agency coordination

In 2009, several agencies on the ground began taking the initiative to foster improved MHPSS services. Two working groups facilitated coordination of MHPSS for refugees from Iraq:

1) The Response Coordination Working Group (chaired by the Syrian Arab Red Crescent (SARC) and the United Nations High Commissioner for Refugees (UNHCR)), and
2) The Interagency Working Group on Capacity Building (chaired by UNHCR and the Ministry of Health[2]), which transitioned into a National Mental

Health Council at the end of 2011 (chaired by the Ministry of Health, with rotating co-chairs among member organisations).

With the onset of the current Syrian crisis in 2011, a different response structure was required as part of the cluster system approach. A technical MHPSS working and reference group was established, chaired by UNICEF and UNHCR. The purpose of this group was to facilitate sectoral and cross-sectoral coordination, information sharing, contingency planning, mainstreaming of MHPSS across sectors, and provision of technical support and capacity building to other coordination groups (particularly health, education and community services). The working group members from 13 different organisations, including UN agencies, international nongovernmental organisations (INGOs) and national organisations, met regularly. The group prepared and approved: a national MHPSS framework with minimum standards, a guidance document for mainstreaming MHPSS across sectors, a framework for MHPSS assessments during the emergency, and regularly updated 4Ws (who is where, when and doing what) mapping. The working group benefited from the existing close inter-agency cooperation, and referral pathways were strengthened and expanded.

The MHPSS working group was operational until December 2012, when the two staff members from the co-chairing agencies left the country. After that, the group was divided between working groups for Community Services (led by UNHCR) and Health (led by WHO). As a result of this split coordination, MHPSS has become fragmented. A new MHPSS Technical Reference Group (TRG) was established in June 2013[3]. Its members are technical experts, and the group provides advocacy and technical input across sectors, while maintaining basic coordination functions. Lack of access to many geographical areas and of technical MHPSS capacity has re-emphasised the need for capacity building and inter-agency partnerships. In particular, reinvigorating the National Mental Health Council (instituted in 2011), which never functioned due to the onset of the current crisis, became a priority.

Interagency 4W mapping results

Systematic mapping of services

Regular mappings of available mental health services and support structures accessible to the refugee population have been conducted, in order to gain improved understanding of the mental health needs and resources, as well as the overall mental health system. In addition to the 4W mapping [Inter-Agency Standing Committee (IASC), 2012] these mapping exercises have also included: service capacity, quality and training needs, as well as referral structures. Mapping exercises have been conducted with yearly updates. In 2011, facilitated by the inter-agency MHPSS working group and a WHO consultant, the updated information was transferred into the IASC 4Ws mapping format (see O'Connell et al., 2012).

Results and conclusions

The mappings in 2008 and 2009 indicated that, despite the advancements that had been made, there still remained a number of major gaps. These included an increasingly limited capacity of the mental health care system, marked by the complete lack of community mental health services, rehabilitation and integrated day care programmes for those with severe mental

illness. MHPSS had not been sufficiently mainstreamed across sectors when the current crisis began, and lacked multi-disciplinary coordination, including the appropriate integration of basic mental health and case management into PHC. Collaboration between mental health professionals, religious leaders and healers was also extremely limited. Mental health care remained highly centralised, inpatient care based, and available only in urban centres. MHPSS case management was non-existent, as was specialised care for survivors of torture and extreme violence, a steeply increasing need. There was no community based psychosocial support, e.g., community centres, outreach, psycho-education, safe spaces, nor psychosocial activities in schools. Geographically, rural areas remained the most disadvantaged in regard to service structures. These results influenced the design of the previously instituted, inter-agency multi-professional training of master trainers and MHPSS programming in Syria (Quosh, 2011; Quosh, 2013).

The latest 4W mapping exercise, conducted at the end of 2012, in addition to strengthening service delivery and access to monitoring mechanisms, brought up further constraints due to the current crisis. Most significantly, the increasing attrition of mental health professionals since 2012, combined with the burnout of remaining practitioners and the understandable reticence to provide services in insecure areas, is greatly limiting programming. This is further exacerbated by the lack of psychotropic medication available, particularly in areas with high conflict intensity. Interrupted supplies have impacted hospitals. Furthermore, many clients cannot afford to buy medication as prices increased after the collapse of the local pharmaceutical industry, which produced 90% of required medications before the crisis (Kutaini & Davila, 2010). Although the primary psychiatric hospital (Ibn Sina) and addiction centre in Damascus are still functioning, in other major cities psychiatric wards are offline, and emergency patients are treated under general care.[4] There are few monitoring efforts, or contingency plans in place for constrained access to centralised care and medication management. Of particular concern is the closure of the psychiatric hospital in the embattled city of Aleppo.[5] Even where services do exist, physical access by professionals and patients alike is problematic, due to limited mobility caused by increasing insecurity. Many psychiatrists have stopped visiting their local PHC centres because of increased risks. Therefore, services have become even more urban centred, and mainly restricted to Damascus and some parts of rural Damascus. The breakdown of infrastructure has reduced access to safe spaces, resulting in over-crowded collective shelters with insufficient privacy; lack of doors or windows, and in some cases 70 people sharing a single toilet. Community based psychosocial support systems are hindered by separation from family and traditional support systems, as well as an initial capacity building focus on psychological first aid (PFA, more than 1800 trainees), which, while valuable, does not include training on extended support nor more advanced MHPSS skills. There remains little awareness within the general population of mental health and psychosocial support issues, particularly within the context of emergency events. Finally, a lack of joint needs assessments, common assessment and planning tools, as well as field coordination have hampered response efforts.

Based on these results, the MHPSS working group decided to re-emphasise

coordination and capacity building. The response planning was adjusted for the identified gaps. While coordination and response to the new crisis benefited from the established refugee response, more flexible and emergency relevant models have been developed that can respond quickly and effectively to the continuously changing situation. These include:

- Developing and advocating for contingency plans at multiple service levels for various scenarios;
- Strengthening field level coordination, community messaging and information distribution systems, monitoring and assessment systems (particularly in collective shelters);
- Expanding community outreach and community based support;
- Safe spaces, health centres, community and psychosocial centres remaining open depending on security situation and access;
- Expanding individual, family and community support, cash assistance and general assistance distributions, integration of livelihood and income generation strategies for the most vulnerable individuals and families;
- Expanding the number of schools, child friendly spaces, psychosocial support integrated educational and remedial activities;
- Prevention of family separation and enhancement of tracing systems;
- Mobile MHPSS services in order to increase accessibility, hotline services established;
- Area based approaches in service provision:, policies for reimbursement adjusted to allow access to services in close proximity that were not previously part of referral systems;
- Increased emphasis on mainstreaming MHPSS into other sectors;
- Capacity building focus shifted from PFA to more advanced MHPSS training and building capacity for coordination, as well as mental health among medical (in particular PHC) staff;
- Expanding specialised programmes for survivors of sexual and gender based violence, and other forms of extreme violence;
- Scaling up MHPSS and integrated case management and care coordination;
- Intensifying attention paid to developing first responder support systems.

Inter-agency response

The coordinated response by agencies has focused on collaborative national and community capacity building and service provision, according to areas of responsibility and expertise. Key criteria that guide inter-agency coordination are:

- *Urgent response to basic needs gaps*: MHPSS programmes and activities are based on assessments and prioritisations that pay particular attention to timely responses to basic needs gaps and mainstreaming.
- *Multidisciplinary and integrated approaches:* Development, training and implementation of interagency guidelines, mainstreaming guidelines and training; system building for coordination.
- *Integrating independent initiatives into comprehensive programmes and building partnerships:* Activity coordination, joint assessment, planning and fundraising through consolidated appeal and creating referral pathways.
- *Area of mandate, expertise, resources, capacity, and standardised approaches:* Different agencies created different MHPSS case management systems that each filled a

particular gap in the care coordination system; e.g., mental health case management in PHC as well as early childhood development programmes, multidisciplinary units for children and women in polyclinics and MHPSS clinical case management in four polyclinics focusing on identification, outreach, access to services and follow up. The UN agencies engaged in policy development with the Ministries of Health, Education and Social Welfare. Through overall coordination, standardised approaches were applied.

- *Geographic location and population size of most vulnerable populations:* Joint identification of community centre locations and coordination of centre work.
- *Even distribution of limited resources, avoiding duplication and creating effective systems:* Avoiding having already scarce mental health professionals *'recruited away'* between agencies, maintaining an interagency pool, and capacity building network of master trainers, coordination with regard to national consultant fees.
- *Strengthen programmes that facilitate national capacity building and community based support systems:* Inter-agency MHPSS training of master trainers (Quosh, 2011).

Challenges and lessons learned

Challenges

- Locating a technical sub-working/reference group within the cluster, or working group system that balances technical, strategic and political considerations. Integrated coordination (as recommended by the *IASC Guidelines)* is preferred, however, humanitarian response plans commonly separate mental health and psychosocial support into different sectors, based on levels of specialisation. The new MHPSS TRG is an effort to maintain this balance by emphasising mainstreaming as well as coordination.
- Assessment of internally displaced Syrians in the current context is enormously challenging due to the localised and highly fluid nature of the conflict, high levels of insecurity for aid workers and lack of access to community leaders. This is further complicated because many affected Syrians stay in mixed accommodation arrangements (host communities, collective shelters, extended family homes, etc.) making the conventional assessment methodology difficult to apply.
- Burnout among mental health professionals and first line responders.
- Implementing mental health into PHC training during an emergency where the health system has collapsed and other priorities are considered more urgent.
- Internal requirement to work with government institutions in order to be operational versus the implications of association with the government.
- The online coordination forum proved to be difficult to establish, primarily due to a culture that relies heavily on verbal communication, as well as a setting where electronic communication is regularly disrupted.
- An assessment framework, as well as contextualised assessment instruments, were developed and endorsed by the MHPSS working group, yet joint assessment proposals did not gain approval due to differing priorities.

Lessons learned

- Inter-agency coordination is crucial for accountability, transparency, avoiding duplication, information sharing, and efficient use of limited resources. This includes those available locally within

communities, as well as for targeted planning and response.

- The various programmes implemented by different agencies filled particular gaps and became part of the coordinated humanitarian response, avoiding duplication.
- The availability of few Syrian MHPSS professionals requires inter-agency coordination that should include local NGOs and community based organisations. This will avoid shifting national professionals between agencies, while not actually building overall national capacity.
- Availability and continuity of working group coordinators with sufficient technical competence is important for effective and sustainable coordination.
- Efforts are needed for better geographical coverage of MHPSS services nationwide, particularly in under served, rural areas.
- It is important to regularly update mappings. and use these data to continuously inform coordinated MHPSS programming. The current *Excel* based 4W mapping formats are difficult to update regularly and share in real time, especially in dynamic and rapidly changing emergency contexts. An online system with real time updates is recommended, with adequate human resources responsible for this specific task.
- Creating ownership for inter-agency guidance and contextualised standards is vital, for example, through participatory planning and capacity building. Awareness rising on the inclusion of MHPSS into other sectors is essential for an integrated response.

Conclusion

This adaptation of a protracted, humanitarian inter-agency collaborative model of programming may serve as an example for future programming initiatives. However, the escalating need for accessible community based MHPSS services, as well as more specialised mental health systems requires an increasingly efficient use of minimal resources. This is currently primarily provided by humanitarian programmes, which were, as of August 2013, only approximately 40% funded (Office for the Coordination of Humanitarian Affairs (OCHA), 2013). The current centralisation of services in certain urban areas restricts access. Efforts are needed to have a better geographical coverage of MHPSS services nationwide, which requires advocacy and effective involvement of the existing infrastructure. The further development of holistic MHPSS services and effective inter-agency cooperation systems is crucial, and requires a response that is coordinated and inclusive of all stakeholders, including: humanitarian agencies, national NGOs, community based support groups, and traditional and religious healers. Improved coordination will remain a primary need among national partners working in the protection, health, social services, education, and livelihood sectors, in order to maximise the efficacy of limited resources and the sustainability of required MHPSS programming.

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[1] Of the original 40 master trainers, approximately 50% remain in Syria. The authors confirmed 17 personally in July 2013. A coordination network among the master trainers was established in 2012, but discontinued in 2013.

[2] In close cooperation with Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ/EU) and supported by UNICEF.

[3] Co-chaired by the International Organization for Migration, UNHCR and the International Medical Corps.

[4] The general hospitals in Homs and Aleppo are at time of press closed. Supplies to Ibn Sina and other psychiatric care facilities are frequently interrupted during episodes of fighting. Access is thereby limited, and new admissions have been reduced by approximately 70%.

[5] Patients from Ibn Khaldoun psychiatric hospital in Aleppo were relocated to a safer area. UNHCR has provided urgently needed relief items to the 300 patients since April 2013.

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