

Mental Health among displaced Syrians: findings from the Syria Public Health Network

Aula Abbara¹, Adam Coutts², Fouad M Fouad³, Sharif A Ismail⁴, Miriam Orcutt⁵; the Syria Public Health Network

¹National Heart and Lung Institute, Imperial College London, London, UK

²Department of Politics and International Studies, University of Cambridge, Cambridge, UK

³Faculty of Health Sciences, American University of Beirut, Beirut, Lebanon

⁴Department of Primary Care and Public Health, Imperial College London, London, UK

⁵Conflict and Health Research Group, King's College London, London, UK

Corresponding author: Sharif A Ismail. Email: sharif.ismail15@imperial.ac.uk

The scale of displacement caused by the conflict in Syria is the largest since World War II. Rates of internal displacement are difficult to quantify accurately, but it is thought that at least 7.6 m Syrians have been forced to move, many on multiple occasions.¹ It is estimated that there are now over 4.3 m registered refugees in neighbouring frontline countries.² Turkey hosts the largest number, but there are also over a million in Lebanon and hundreds of thousands in Jordan, Iraq and Egypt. Some 150,000 have received asylum in European Union (EU) member states to date.³ Around 51% of all refugees from Syria are under the age of 18 years.²

In late 2015, a group of Syrian medical professionals, humanitarian aid workers, public health specialists and academic researchers met at the Royal Society of Medicine to examine the current mental health situation both inside Syria and across the region, and review the humanitarian response to it – highlighting gaps and possible policy options. The meeting was convened by the Syria Public Health Network, and discussions focused on mental health needs among displaced populations and addressed epidemiological and service delivery questions in addition to research priorities. Key findings are outlined below.

Many Syrians have experienced prolonged exposure to high levels of psychological stress.⁴ While clinic-reported prevalence rates for mental disorder from camps in Turkey and Lebanon indicate high levels of psychosocial distress (42%),⁵ anxiety and depression among refugees, Post-traumatic stress disorder (PTSD) diagnoses have been generally lower than expected, despite reported rates of up to 33% in some refugee camp-based studies.⁶ We know little about mental health problems among displaced

Syrians outside refugee camps despite the fact that, for example, in Jordan up to 80% of Syrian refugees live outside these settings.⁷ The provision of culturally appropriate mental health and psychosocial support will be critical to improving service access in this context and comprehensive cultural and linguistic guidance for those working with Syrians is now available.⁸

Mental Health and Psychosocial Support (MHPSS) service delivery has been hampered by a shortage of trained mental health professionals in Syria and neighbouring countries, weak service coordination and an absence of sustained interventions. There were less than 100 psychiatrists across Syria and no psychiatric nurses before the conflict began; the number of psychiatrists has fallen to less than 60 after four years of conflict. MHPSS service provision in surrounding countries remains limited outside major urban centres and tends to be focused on short-term or one-off psychosocial interventions that are poorly integrated with other sectors such as education and livelihoods to address the wider social determinants of mental health. The shortage of healthcare professionals has been further exacerbated by the restrictions on Syrian doctors working in surrounding countries, some of which are preventing Syrian doctors from practising. From a coordination perspective international non-governmental organisations have been found to be duplicating work with refugee groups, often delivering multiple interventions of varying quality. Innovative service delivery models are emerging (e.g. in Lebanon), but success has been contingent on broader political commitment to mental health exemplified by Lebanon's National Mental Health Strategy.⁹

Three clear research needs were identified at the workshop. First, research efforts should focus on

strengthening routine mental health programme monitoring and evaluation, rather than resource-intensive, primary epidemiological work on prevalence of mental disorder – especially given the volume of primary evidence now available from other conflict settings.^{10,11}

Second, implementation research focused on testing interventions should be prioritised. Policymakers and donors need to know what works, why and for whom – questions to which answers are currently lacking in the health response more broadly.¹² Very few humanitarian interventions and policies have been properly evaluated for their impacts and effectiveness within the Syria response. This has significant implications for assessing the cost-effectiveness of response funds. Given the difficulties in raising money for the response, this is an issue which is likely to dominate the agenda over the coming year. Evidence from telemental health pilots with Syrian refugees in Turkey presented at the workshop suggests that scalable interventions for supporting mental health professionals exist, but acceptability of telemental health to patients may be reduced by concerns over security and stigma.⁵ Adequate testing of interventions that have shown promise elsewhere (e.g. ‘Teaching recovery techniques’, an intervention designed to give children affected by war better coping strategies for psychological stress)¹³ will be crucial.

Finally, the potential role of self-efficacy in managing psychological stress has received little attention within response interventions. Promotion of family support and direction of people to appropriate services is needed.

As donors and humanitarian agencies prepare for the Syria humanitarian response conference on 4 February 2016, a coherent policy approach to refugee health needs and challenges in the Middle East and Europe is required. This should include detailed and real-time assessment of the health situation, impact evaluations of humanitarian interventions and greater emphasis on cross-sector interventions incorporating health, education and livelihoods. Without these, the response will continue to be less than effective at a time when displaced Syrians need it the most.

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