CAPACITY NEEDS AND RESOURCES OF MENTAL HEALTH PRACTITIONERS IN SYRIA

RAPID PARTICIPATORY ASSESSMENT

April 2016

أبعاد
abaad

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بالسلامة

BelSalameh

strengthening resilience and peace in syria

تعزيـز السلام وإرادة الحيـاة في سوريـا

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EXECUTIVE SUMMARY

The "Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment" has been undertaken within ABAAD's EU-funded "BelSalameh" project and aims to identify the needs of MH Practitioners working with the war-affected population, in addition to the population's access to and knowledge of available mental health services.

The study was launched in October 2015. Data collection and field work began in November 2015 and ended in January 2016.

The overall objectives of this assessment can be described as follows:

- Assessing whether targeted practitioners within the programme are well-enabled to manage the provision of mental health services and respond to various mental health needs.
- Informing the development of training processes, materials, and tools, as well as related capacity development programmes around specialised mental health needs and emergency-related needs.

The assessment was conducted to identify the capacity needs and available resources for MH practitioners in Syria, explore perceptions about MHPSS problems and coping strategies, and explore perceptions about the availability, accessibility, and expressed need for MHPSS services.

This report aims to present findings of the study undertaken. It includes an overview of the most common psychosocial needs of the war-affected population in Syria (women, men, adolescent girls and boys) and highlights the challenges hindering access to mental health services.

Research Methodology

The Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment combined the qualitative and quantitative methodology to complement data collection and to enrich the study findings. The study adopted the Rapid Appraisal Procedures (RAP) approach, which included:

- Review and analysis of relevant and existing information from multiple sources
- Survey targeting MH practitioners. Through "snowball sampling," a total number of 64 surveys were filled by MH practitioners working in Syria.
- In-depth one-on-one key informant Skype interviews with MH practitioners: a total of 18 interviews were conducted with 18 MH practitioners in Syria.
- FGD sessions with war-affected individuals – a total of 22 focus group discussions with a total of 285 individuals (women, men, caregivers of individuals with disabilities, and adolescent girls and boys) in different geographical locations in Syria.

The research tools used during the assessment consist of:

- Assessment Tool developed for this rapid participatory assessment
- Focus Group Discussion Guide to be used during the sessions, catered to the different target groups

Mental Healthcare in Syria

Even prior to the ongoing humanitarian crisis in Syria, mental healthcare was considerably neglected, with a shortage of MHPSS professionals, especially psychiatrists. It is estimated that not more than 70 psychiatrists (some new statistics refer to a number of 73) are currently available in the country, most of whom mainly work in Damascus. The available psychologists, psychotherapists, and counsellors have also stated that they generally lack both, proper training in their fields as well as sufficient experience in clinical work. This is due to the few opportunities to train as clinical psychologists, psychiatric social workers, or psychiatric nurses. There is no legal framework for psychologists to become registered as psychotherapists or clinical psychologists. Procedures for accreditation, licensing, or advanced studies in clinical psychology do not exist.

The escalating crisis in Syria has brought with it significant deterioration of all aspects of life for people. The historical shortage of mental health professionals in the country, the increase in stress factors, and the dwindling of many protective and supportive factors have made the psychosocial consequences more prominent, and the need for mental health interventions greater.

General needs of MHPSS Practitioners

The rapid participatory assessment revealed substantial and diverse needs and challenges facing mental health practitioners currently working in Syria, which negatively influence their ability to work and respond effectively to the growing mental health and psychosocial needs.

Most MH practitioners who responded to the study (66%) have had some previous experience in humanitarian work prior to the current crisis. Around 50% of the respondents reported a duration of 1-3 years in humanitarian work in Syria, approximately 30% reported duration of 4-6 years, and 10% reported a duration of less than a year in humanitarian work.

The most common and pressing needs of MHPSS practitioners are related to knowledge and skills, capacity building, resources, technical support and ongoing supervision, coordination, referral and case follow up, in addition to self-care and community awareness on mental health.

Needs at the Level of Knowledge and Skills

On the levels of knowledge and skills, MHPSS practitioners currently working in Syria have diverse needs, especially due to the fact that university curricula focus on theoretical knowledge in psychology and neglect field training. MHPSS practitioners demonstrated a gap in knowledge in areas related to mental disorders, their diagnosis, and their management, including: classification of mental disorders, psychosis, epilepsy (including psychogenic seizures), suicide and self-harm, and psychopharmacology. Additionally, further support related to knowledge and skills related to the current situation include: mental health and cases suffering/survivors of rape or sexual abuse, suicide and self-harm, mental health issues and amputations resulting from war, risk assessment, and management. The need to improve knowledge on legislation related to mental health was also highlighted by study respondents. MHPSS professionals need to build their capacities on updated and emergency-related modalities for therapy and work with emergency-affected individuals and families.

The study revealed that training opportunities are rarely offered to MHPSS practitioners, especially to social workers and counsellors, who are only seldom provided with some training from within their organisations. 50% of MHPSS respondents who have been working for 1-3 years in the humanitarian field in Syria reported never having participated in any capacity building workshops, while 50% of those with 4-6 years of experience reported having rarely participated in trainings and capacity building workshops.

Some practitioners have participated in capacity building workshops and reported their need for follow-up training and coaching. Most respondents, especially psychiatrists and psychologists, emphasised the importance and the value of the WHO mhGAP Training using the mhGAP Intervention Guide and CBT, in addition to some training workshops on basic principles of MHPSS in emergencies, PFA, and basic communication skills conducted by IMC, IOM, SARC, and some others INGOs operating in Syria in collaboration with official Syrian authorities and ministries.

The majority of respondents reported a need for further capacity building on family therapy (64%), identification and diagnosis of MH disorders (58%), counselling (47%) assessment of needs and risks (45%), and referral and case follow-up (31%).

Need for Resources on Mental Health and Psychosocial Support

MHPSS practitioners (73%) demonstrated a need for contextualised resources on mental health and psychosocial support in Arabic. Respondents pointed out the need for updated tools, manuals on Cognitive Behavioural therapy (CBT), manuals and step-by-step guides on case management, manuals on assessing needs, resources on working with children and people with disabilities and special needs, resources for bridging the gap in mental health (referring to mhGAP guides), and facilitator guides on effective communication skills.

Need for Technical Supervision and Coaching

Due to the lack or inadequacy of field training, the relatively short duration and insufficient experience in humanitarian work, and the complexity of the current protracted emergency and its considerable needs, MHPSS practitioners have significant needs for ongoing technical support, coaching, and supervision. The majority (70%) reported receiving some form of technical support (mostly social workers, psychologists, and counsellors who reported receiving technical support from within the organisation at which they work). However, the majority of respondents reported that the technical support they receive is not sufficient. Moreover, many MHPSS practitioners highlighted the challenges related to receiving technical support from international mental health experts due to language barriers and issues related to cultural sensitivity.

Need for Self-Care and Staff-Care

In addition to the interventions required to support MHPSS practitioners professionally, special attention needs to be given to their personal psychosocial wellbeing. Most of them reported need for self-care, describing the stress they undergo in their work and their inability to relax sometimes. In spite of their willingness and ability to work in the current humanitarian setting, the MHPSS practitioners have self-care needs that should not be ignored. The escalating security situation in Syria and the difficult living circumstances affect the mental and psychosocial wellbeing of humanitarian actors, who are also affected by the crisis, by their work, and by their losses (many have lost friends and/or relatives during the crisis).

Challenges Faced by MHPSS Practitioners

In addition to the diverse needs, there are enormous challenges faced by MHPSS practitioners currently working in Syria that negatively impact and hinder their work. Most of those barriers overlap with the issues that hinder people from seeking and accessing MHPSS services. The study, in its qualitative and quantitative components (survey, in-depth key informant interviews and FGDs), pointed out the fear of social stigma, lack or insufficiency of awareness and knowledge on existing MHPSS services, the deteriorating security situation affecting movement and access to MHPSS services, in addition to the lack of proper identification and the lack of a referral system. Many MHPSS practitioners who were also active in clinical work prior to the crisis reported some change among people in regards to fear of social stigma in seeking mental healthcare. They reported that with the emergency affecting large numbers of people, the number of persons ready to seek help from MHPSS service providers has grown significantly.

The complexity of the current situation in Syria, the war-related violence, the underdeveloped mental health system, the negative attitudes towards mental health disorders, and the general prevailing atmosphere of mistrust and suspicion influence people's help-seeking behaviour and their readiness to open up and speak about their thoughts and feelings. Traditional beliefs and fear of stigma also keep people from seeking psychological support and lead them to traditional healers or sheikhs. They may also refer to general practitioners at primary healthcare centres to address their psychosocial or mental health needs.

The diverse needs of MHPSS practitioners currently working in Syria and the challenges they face in their work necessitate coordinated and well-planned interventions and a strategy on capacity development. There is a need to strengthen the MH system in the long term and to work on building better-quality and more sustainable mental health systems despite the challenging circumstances. Emergency situations, in spite of the adversity and challenges they create, can be openings to transform mental healthcare. Strategic efforts should be made to convert short-term interest in responding to mental health problems into momentum for mental health reform.

General Needs of the Population and Perceptions on MHPSS Services

The effects of conflict in Syria on the mental health and psychosocial wellbeing of people are profound. The assessment revealed various mental health and psychosocial problems reported by respondents, affecting all aspects of their psychosocial wellbeing (cognitive, emotional, physical, behavioural, and social), and manifesting on the personal, family, and community level.

Levels of psychological stress are high among women, men, girls, and boys. The majority of respondents among women, men, caregivers of individuals with disabilities, and adolescent girls and boys reported being distressed. Most people interviewed are still suffering from the impacts of displacement.

On the personal level, feelings of excessive fear, anxiety, tension, hopelessness, excessive thinking, despair, pessimism, irritability, intense sadness, worries and fears over family and over the future, sense of insecurity and instability, self-neglect, feelings of helplessness and weakness, sleep disturbances, tiredness, forgetfulness, and psychosomatic complaints are common. The aforementioned emotional and psychosocial problems, along with the difficult living conditions and increasing stressors, lead to increased family problems and family conflicts. Most of the respondents reported severe family conflicts, increased domestic violence, and familial problems. Changes in the gender roles contribute to an increase in family conflicts; women reported increased burdens and responsibilities while men reported feeling helpless and weak.

On the social level, distress due to discrimination, an increased sense of alienation, increased sectarianism, and distrust among people were common problems voiced by respondents.

The most common stress factors are linked to war-related violence, difficult circumstances and living conditions, loss, difficulties in accessing services, loss of support networks and change in social fabric, increasing sense of hostility towards IDPs, and a prevailing atmosphere of mistrust and suspicion.

Women experience immense stress mainly due to the increased responsibilities and the changing roles. Women providing care to offspring with disabilities reported extremely high levels of stress and some signs of burn-out, mainly due to the responsibilities growing with the absence of their husbands, lack of MHPSS services and rehabilitation services for their children with disabilities, and their growing self-care needs. Women in particular show a tendency not to share emotional suffering with family members due to cultural and gender-related issues. Many mothers revealed that this is causing them to adopt unnecessary aggressive behaviours with their children.

Men struggle daily as a result of their limited movement, loss of work, and the prevailing sense of sectarianism and tension. They mainly face difficulties in managing their growing stress and anger and usually experience anger spurts and practice violence and aggression with their families.

Adolescents have immense psychosocial needs. In addition to the emotional problems and feelings of sadness, fear, worry, and hopelessness, they struggle daily with parents' over-protectiveness and extreme worry over their safety and security, tension, restricted movement, lack of privacy, loss of friends, and significant changes in their daily lives and activities.

Responses related to social life demonstrate loss of friends (displacement, travel, death) and difficulties in forming new friendships. Adolescents generally reported inability to concentrate, frequent forgetfulness, and confusion, all of which negatively influence the academic performance of those who are still pursuing their education. The conflict in Syria has resulted in the interruption of education among adolescents, many of whom were displaced and had to drop out from school or university. Many adolescent boys had to stop their education to work and provide for their families. Some adolescent girls had to quit school due to parental pressure and preference to marry them at an early age.

Family, faith, and the supportive social network (relatives and friends) are among the primary protective factors identified by respondents.

Another issue of major concern is the lack of opportunities for socialising due to fears over security and safety, and the reported sense of social discrimination, forcing IDPs to socially withdraw. This situation limits, to a great extent, people's capacity to form relationships and their overall sense of wellness and ability to cope with stress and to rebuild some lost protective factors. The circumstances of displacement lead to the modification, re-adaptation, and painful loss of family and social roles. This is particularly evident in families that are separated.

Some people participating in this study revealed responses to trauma that fall under the category of Adversity-Activated Development (AAD). These include satisfaction with personal development and positive changes including increased ambition, feelings of adequacy, building new relationships, and acquiring new skills experienced and reported by some women, all of which have been brought along with the change in gender roles and the difficult circumstances that forced them to go out and work. Additionally, some men's reported satisfaction with the stronger family ties and the new strengthened relationships with their children.

Perspectives on MHPSS Services

Regarding the perspectives on MHPSS services, the study revealed absence (or insufficiency) of awareness and knowledge on existing services. Besides, there is poor knowledge on mental health issues and a negative outlook on mental health disorders. Fear of social stigma, poor knowledge on mental health disorders, a sense of mistrust and suspicion, and difficulties in movement and access to MHPSS services, are all barriers that hinder people from seeking mental healthcare. Thereby, people are unlikely to refer to MHPSS services, and some, as mentioned, visit traditional healers or sheikhs, or refer to general practitioners in PHC centres to seek help. However, women, men, and adolescents all highlighted the need for MHPSS activities that are "safe and confidential," and that would help them vent and speak about their problems.

General Recommendations

According to many MHPSS practitioners, with the crisis affecting such a large proportion of the Syrian population, the number of persons ready to seek help from MHPSS service providers has also grown significantly. A timely intervention is necessary to avoid sedimentation of emotional problems, and to alleviate the suffering of the war-affected Syrians. Community and family-focused psychosocial interventions (including vocational, counselling, supportive trauma-focused help, etc.) in addition to culturally sensitive psycho-education should be provided.

MHPSS professionals should be careful not to over-diagnose clinical mental disorders among displaced Syrians, especially amid those facing insecurity and who thus have many ongoing daily stressors.

There is a need to establish or enhance outreach capacity in providing assistance, establish or enhance coordination and dissemination of information about available services, improve the dissemination of information about available services among the beneficiary community, and to increase the capacity of MHPSS service providers. Age and gender specific activities for women, men, and youth, including social and school counselling, discussion groups, and livelihood activities need to be carried out.

Mental healthcare and psychosocial support should be integrated into non-stigmatising care settings, and should be respectful of local cultural and gender norms.

There is a need to train psychologists and psychotherapists on brief psychological interventions. There is also a need to train unlicensed psychologists and provide them with the necessary regular supervision. Moreover, there is a need to advocate for establishing a legal licensing system for psychologists, psychiatric nurses, and social workers, as well as for monitoring structures for psychological services, social work, school counselling, and psychiatric nursing.

Efforts should aim at improving coordination between organisations and service providers, establishing a clear referral system, and ensuring proper case management and follow up. Moreover, efforts need to be made to secure ongoing, sufficient, and culturally sensitive technical support and supervision of MHPSS practitioners.

There is a need to work on resource development to address MHPSS practitioners' needs for resources. There is also a need to map existing Arabic and contextualised resources on MH and PSS (including those developed in Lebanon during and post the July 2006 war) and modify existing resources. Special focus needs to be given to the capacity building of MHPSS practitioners on the identified areas that require improvement. Opportunities for continuing education, training, and professional development should be provided. Efforts to integrate MH into primary healthcare should be supported further and those efforts should be expanded into both urban and rural settings in Syria.

A specific budget within organisations providing MHPSS services should be allocated to self-care and staff-care activities to alleviate the stress experienced by staff.

INTRODUCTION

Well into the fifth year of unyielding conflict, the humanitarian situation in Syria is consistently deteriorating with intensified fighting, high levels of violence, widespread human rights abuses and complete disregard for the rules of international law and the obligation to protect civilians. Humanitarian needs continue to rise; massive population displacements are increasing, and an entire generation of children is being exposed to war and violence, increasingly deprived of basic services, education, and protection. Syria is currently in the midst of a crisis-level complex emergency which started in 2011 [1], and which is now considered the world's largest humanitarian crisis since World War II.

Syrian refugees now form the biggest population of displaced persons resulting from a single conflict with over 4.6 million Syrian refugees in neighbouring countries and the wider region. Countries bordering Syria are reaching an alarming saturation point, particularly Lebanon, which hosts almost 1.1 million Syria refugees and has, along with Jordan, the largest per capita refugee population in the world. Turkey is currently hosting more than 2.5 million Syrian refugees, the largest number of Syrian refugees in one country globally. More than half of those displaced are children. Space for those considering leaving the country and seeking refuge outside is gradually shrinking due to new border policies introduced by all of Syria's neighbours.

1 Mental health of refugees and displaced persons in Syria and surrounding countries: a systematic review Intervention 2013, Volume 11, Number 3, Page 276 - 294

Facts and Figures (ECHO Factsheet, Syria Crisis - February 2016)

OCHA

Estimated number of people in need (PiN) of humanitarian assistance inside Syria: 13.5 million

In hard to reach/besieged areas: 4.5 million

Estimated number of internally displaced: 6.5 million

UNHCR
The UN Refugee Agency

Number of refugees - registered and awaiting registration: 4,598,594

Lebanon: 1,069,111 *Iraq: 245,022*

Turkey: 2,503,549 *Egypt and North Africa: 117,658*

Jordan: 636,482

Since 2011, an average of 50 Syrian families has been displaced every hour of every day . The humanitarian community now estimates that 13.5 million people in Syria need protection and some form of humanitarian assistance, including 6 million children. 8.7 million people are unable to meet their basic food needs, and 70 percent of the population lacks access to safe drinking water. Health facilities, schools, and other essential services across the country are either operating at reduced capacity or have completely closed.

Most internally displaced persons (IDPs) live in host communities rather than camps, shelters, or sites, and thousands of communities across Syria are hosting displaced persons. As a result of this prolonged displacement and the growing needs, the host communities are bearing a significant burden and are thus in need of assistance. The increasing needs among both the IDPs and the host communities has led to increased protection risks manifesting as family separation and child labour, including the worst forms of the latter; recruitment of children into armed groups, and child marriage.

Currently, IDPs make up an estimated 35 percent of the urban population (4 million people). The most vulnerable urban populations are people with mobility constraints, people with no access to income or who are dependent on relief, and host communities experiencing conflicts between host populations and IDPs.

As the violence in Syria persists, populations are dealing with ongoing risks in their daily lives, facing the immediate and indirect realities of conflict. Indiscriminate attacks, besiegement, and armed clashes continue. As the crisis drags on, violence at the level of households and communities increases. Harmful coping strategies are evident throughout the country. Fear and acceptance of sexual and domestic violence impairs the ability of women and girls to access work, education, and services.

In many cases, mobility is limited to the home. Almost one in five sub-districts reports severe problems with GBV [2]. GBV cases are often very difficult to identify due to a code of silence and fear of social stigma.

The lingering crisis, its consequences and the increasing number of affected population continue to challenge the humanitarian response. The growing number of refugees is placing an increased burden on existing governmental and non-governmental service providers, and is outpacing their ability to respond. Thus, the role of national and international non-governmental organisations is increasingly important in addressing the needs of the Syrian population [3]. The active conflict is increasingly hindering the delivery of humanitarian aid, especially in Northern Syria: supply roads are often disrupted or closed, and humanitarian organisations have been forced to downscale or suspend operations in several areas due to the instability.

The entire healthcare system in Syria, including healthcare facilities, water and sanitation networks, waste management systems, and electricity supplies continue to be severely disrupted[4].

There is general evidence that exposure to continuous, distressing, and potentially traumatic events, depletion of resources, forced displacement, loss of or separation from family members and friends, deterioration in living conditions, absence of security, and lack of basic needs and services can all negatively impact mental health and psychosocial wellbeing and increase the risk of maladjustment. All the latter have both immediate and long-term consequences on the balance and fulfilment of individuals, families, and communities.

Since the beginning of the crisis, there has not been any comprehensive assessment on the mental health and psychosocial needs of the war-affected population, only some small scale assessments providing snapshots of the current situation and highlighting priority areas[5]. Existing studies and reports highlight the profound effects of conflict on the mental health and psychosocial wellbeing of people in Syria. Experiences of conflict-related violence and concerns about the situation in Syria are compounded by the daily stressors of displacement including poverty, lack of basic needs and services, ongoing risks of violence and exploitation, isolation and discrimination, loss of family and community supports, and uncertainty about the future. The escalating crisis has brought with it significant worsening of all aspects of life for its citizens. The historical shortage of mental health professionals in the country, the increase in stress factors, and the dwindling of many protective and supportive factors have made the psychosocial consequences more prominent, and the need for mental health interventions greater.

Conflict-affected Syrians may experience a wide range of mental disorders, and these could be 1) manifestations or exacerbations of pre-existing mental disorders, 2) prompted by the conflict-related violence and displacement, and/or 3) related to the post-emergency context, for example, the living conditions in the areas or countries of refuge.

2 Humanitarian Needs Overview 2016
www.reliefweb.int/sites/reliefweb.int/files/resources/2016_HNO_English_ FINAL.pdf
3 "Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis," IMC http://internationalmedicalcorps.org/document.doc?id=526
4 Regional Situation Report, January 2015 WHO response to the Syrian crisis
5 Mental health of refugees and displaced persons in Syria and surrounding countries: a systematic review Intervention 2013,Volume 11, Number 3, Page 276 - 294

Study Definitions

Specific definitions of the terms "mental health" and "psychosocial support" differ between and within aid organisations, disciplines, and countries. The following definitions detail the underlying conceptual principles guiding this study.

Mental Health - The WHO defines mental health as "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" [6].

Mental Health and Psychosocial Support - The IASC Guidelines define mental health and psychosocial support as two complementary approaches which include "any type of local or outside support that aims to protect or promote psychosocial wellbeing, and prevent or treat mental disorder". The term "psychosocial" is used to indicate the close connection between psychological characteristics of experiences in life (our thoughts, emotions, and behaviours), and broader social experience with the environment (our relationships, traditions, spirituality, interpersonal relationships in the family or community, culture, and life tasks such as school or work) [7]. The use of the term 'psychosocial' incorporates the family and community in assessing problems and needs.

Mental Health System in Syria Prior to the Crisis

Prior to the onslaught of the current crisis, Syria's existing underdeveloped mental healthcare system had been highly oriented towards medical treatment and the use of psycho-pharmaceuticals; mental healthcare was considerably neglected, even in comparison to neighbouring countries such as Iraq, Jordan, and Lebanon. In 2010, Syria had 89 registered psychiatrists for a population of 21.8 million (ratio was 25 times below the desirable ratio set by the WHO of one psychiatrist to every 10,000 people) [8]. There are no psychiatric nurses but rather general nurses with some psychiatric experience. The country had two public psychiatric hospitals: Ibn Sina Hospital in Damascus (800 beds, of which 600 were reserved for male patients and 200 for female patients) and Ibn Khaldoun Hospital in Aleppo (400 beds, of which 250 were for male patients and 150 for female patients). Following partial destruction as a result of violence, both hospitals shut down. The Ministry of Health runs community psychiatry out-patient clinics in big cities in Syria (four of which are in Damascus) that offer psychiatric consultations and medical interventions, but no psychological input. The Ministry of Defence has services including two military general hospitals that have mental health departments. The biggest is Tishreen Hospital (40 beds).

6 http://www.who.int/features/factfiles/mental_health/en
7 The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007
8 Quosh C., Takamol: multi-professional capacity building in order to strengthen the psychosocial and mental health sector in response to refugee crises. Intervention 2011, Volume 9, Number 3, Page 249 – 264; http://www.ourmediaourselves.com/archives/93pdf/Quosh_2011_INT_Takamol_Syria.pdf

There is no formal clinical psychology education or therapy training, as programmes are conducted through university faculties and concentrate on counselling, without formalised or supervised field experience. Graduates in clinical psychology have very limited experience in clinical work with people in need of mental healthcare.

There has been little opportunity to train as a clinical psychologist, psychiatric social worker, and even less opportunity to train as a psychiatric nurse. Psychology, as a field of study, is part of the Faculty of Education in Syria. As a result, the only options are to become a school counsellor and, therefore, part of the Ministry of Education, or to work with a non-governmental organisation (NGO), as a social worker working with children with learning difficulties, developmental problems, or physical disabilities. No job opportunities existed for specialised clinical psychologists who were willing to provide more specialised clinical services. There are very few ways to receive a structured and well-supervised education in clinical interventions. Additionally, there is no legal framework for psychologists to become registered as psychotherapists or clinical psychologists. Procedures for accreditation, licensing, or advanced studies in clinical psychology do not exist. Some motivated students sought out informal training in clinical psychology offered by a handful of professors who studied abroad and went on to provide such trainings at their private clinics. However, the mainstream psychotherapeutic method remains client-centred therapy.

With respect to the legal aspect, mental health legislation exists in Syria but dates back to the year 1953, and as such is quite outdated. In 2010, new legislation in relation to mental health was drafted by the Ministry of Health in collaboration with the World Health Organisation but has yet to be ratified. Moreover, a mental health strategy in Syria was revised in 2007 and officially approved in 2011 [9]. The mental health policy aims to integrate mental health into the primary and secondary healthcare systems, including involving mental health professionals in primary healthcare centres, adding psychiatric units in public hospitals and organising awareness-raising campaigns to reduce stigma. In 2001, the Psychiatric Directorate was also established within the Ministry of Health to improve and develop mental health services.

Psychiatrists, trained general practitioners, neurologists, and psychiatric residents can legally provide psychiatric services in Syria and the licensing of psychiatrists is for life. Although there was an initiative for a yearly review of licenses in order to ensure higher standards of service provision, at present there is neither a legal licensing system for psychologists, psychiatric nurses, and social workers, nor governing legislation or monitoring structures for psychological services, social work, school counselling, and psychiatric nursing. A resolution by the Syrian Ministry of Health for the establishment of an MHPSS Council was issued in 2012 as a governing body with all stakeholders, but has yet to be implemented.

It is also uncommon for distressed people to have access to social workers, case-managers, counsellors, or psychologists.

In Syria, prior to the crisis, there were many obstacles hindering people from accessing psychological support, not only due to the lack of service providers, but also due to the stigma attached to having psychological problems and the lack or insufficiency of knowledge on mental health, in addition to some held traditional beliefs that kept people from seeking psychological support, sometimes leading them to traditional healers instead.

9 WHO 2011 Mental Health Atlas

BelSalameh Project

ABAAD, founded in June 2011, is a non-profit, non-politically affiliated, non-religious civil association that aims to promote sustainable social and economic development in the MENA region through equality, protection, direct service provision, and empowerment of refugee and host community groups who may be vulnerable, especially women.

In April 2015, ABAAD, with the support of the European Union, launched a project for Syria entitled "BelSalameh," (Syrian dialect, term used either to wish someone a safe return or to get well soon), which addresses the multiple psychological dimensions of the crisis and enables individuals and communities to improve their capacity to transform their negative experiences. The strength and resilience-centred approach used within this project will support the capacities of affected communities inside Syria to cope with immediate needs emanating from the crisis, recover from its impacts, and sustain this recovery over the long-term. The project aims at:

- Enhancing the capacities of professionals working in different sectors to respond to the MHPSS and GBV needs of residents of Syria, building upon learning from interventions that have taken place in Lebanon
- Enhancing coping strategies (at the individual and community levels) of the affected population through targeted psychosocial support and art techniques
- Contributing towards peace-building through community and cultural identity development as well as via social cohesion
- Bridging the gap in resources and skills related to GBV case management in emergency settings through creating a pioneer, widely-accessible online resource

The Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment is part of the "BelSalameh" project and aims at identifying the needs of MH Practitioners working with the war-affected population. Mental Health Practitioners in this study refers to the mental health and psychosocial support (MHPSS) staff, such as: psychologists, psychosocial counsellors, social workers, psychiatrists, psychiatric nurses, and others who are involved in providing mental healthcare, including individual or group counselling, psychotherapy, and/or psychiatric treatment for residents of Syria.

Data collection and field work began in November 2015 and ended in January 2016.

This report aims to present the findings of the rapid participatory assessment undertaken to assess the capacity needs of mental health practitioners in Syria. It includes an overview of the most common psychosocial needs of the war-affected population in Syria (women, men, adolescent girls and boys) and highlights the challenges hindering access to mental health services.

THE STUDY

STUDY OBJECTIVES

This comprehensive assessment was conducted to provide ABAAD, other organisations, and public health and humanitarian actors with information necessary for setting strategic plans and delivering MHPSS services to war-affected people in Syria.

The Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment aimed to study the training and capacity needs of mental health practitioners to identify the existing gaps, needs, and resources affecting the work of mental health practitioners. The overall objectives of this assessment can be described as follows:

- Exploring whether targeted practitioners within the programme are well-enabled to manage the provision of mental health services and to respond to various mental health needs.
- Informing the development of training processes, material, and tools, as well as related capacity development programmes around specialised mental health needs and emergency-related needs.

The assessment was conducted to meet the following specific objectives:

- Identify the capacity needs and available resources for MH practitioners in Syria
- Explore perceptions about MHPSS problems and coping strategies
- Explore perceptions about the availability, accessibility, and expressed need for MHPSS services

Study Methodology

The Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment combined the qualitative and quantitative methodology to complement data collection and to enrich the study findings. Results from qualitative and quantitative components were compared, and this process helped in increasing data confidence, highlighting specific findings and providing a clearer understanding of the results. Conclusions were drawn by analysing results from both, the quantitative and qualitative components.

Assessment Tools

The first phase of the assessment consisted of an extensive literature review. Following the literature review and exploration of existing assessment tools on MH Practitioners' capacity needs, an assessment tool was designed by the project consultant and reviewed by a core team of MHPSS specialists. The Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment tool (see Annex III) consists of different complementary sections that aim at identifying the capacity needs and resources of MH Practitioners. A "guidance note" (see Annex I) was developed to provide practical information and necessary advice and guidance that ensure the proper and effective use of the assessment tool.

The primary focus of the assessment was the identification of the capacity needs of MH practitioners in Syria. For this purpose, data collection was done through the use of a comprehensive survey (quantitative component), in addition to in-depth key informant Skype interviews with MH practitioners in Syria (qualitative component).

The secondary focus of the study was the exploration of the Syrian people's perceptions about MHPSS problems and coping strategies, as well as their perceptions about the availability, accessibility, and expressed need for MHPSS services. For this purpose, Focus Group Discussion sessions, which use group dynamics to generate qualitative data, were conducted with different target groups in different areas in Syria. The FGDs were conducted using a set of 10 questions to structure and guide the sessions (see Annex IV). People's perceptions from the MH Practitioners' perspectives were also explored through the assessment tool and the key informant interviews.

Thereby, the study combined three main data collection methods:

1) Survey targeting MH Practitioners
2) In-depth key informant interviews with MH Practitioners
3) FGD sessions with war-affected individuals

Data Collection

ABAAD circulated online surveys to a number of MH practitioners/humanitarian actors working in the field of mental health, who responded to the surveys, and who supported the circulation of the surveys to their respective networks. The surveys were also circulated through national and international NGOs and networks working inside Syria. Through this "snowball sampling," a total number of 64 surveys were filled by MH practitioners working in Syria.

Through ABAAD and its consultants' networks, 18 MH practitioners, psychologists, and counsellors were consulted through one-on-one key informant Skype interviews to get further and more elaborate information. The interviews used the semi-structured technique and helped to collect qualitative data on MH practitioners' needs, existing resources, and common MHPSS needs among people. This technique allows comparison of findings across the sample as participants respond to the same questions, while still allowing them to express their viewpoints and experiences. Probing was used to stimulate responses whenever deemed necessary. A total of 18 Skype interviews were conducted with MH practitioners in Syria. Those were distributed as follows: 12 females and 6 males; 2 psychiatrists, 5 psychotherapists, 6 psychologists and 5 counsellors.

A number of findings present in this report were also the product of a two-day symposium conducted in Beirut with four psychiatrists from Syria (World Health Organisation, Syrian Arab Association of Psychiatrists, international NGOs, and United Nations agencies), where numerous training needs were discussed, in addition to recommendations regarding the development of a standardised MHPSS curriculum that the Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment will be informing.

Additionally, a total of 22 focus group discussions were conducted in different geographical locations in Syria with groups of women, men, and adolescent girls and boys. In some areas, mixed gender focus group sessions were conducted with adolescents while in other areas, there were separate sessions for adolescent boys and girls.

The table below presents the number of sessions conducted in each geographical area in addition to the number of participants in each focus group session.
See Table 1 / FGD participants

Ethical Considerations

All participants joined this assessment voluntarily. The scope and objectives of the assessment study were explained to the study participants. They were told that they could withdraw from the assessment at any time, and were requested to acknowledge the informed consent process. They were reassured that the assessment is anonymous and does not require providing personal information, particularly name and phone number. Respondents were also reassured that their detailed responses would not be discussed outside of the assessment team. (See Annex III for the Informed Consent Form)

Data Processing and Analysis

Data collection and data extraction processes were done electronically using "KoBo Toolbox." Respondents accessed the survey using a web link. Data cleaning and data analysis were performed using Stata MP V13.0. Univariate statistical analysis was performed for all main Axes: the Axis on knowledge, the Axis on skills, the Axis on training, the Axis on resources, the Axis on supervision, the Axis on referral, the Axis on self-care, and the Axis on other issues.

Bivariate analysis was used to stratify the initial analysis by gender, profession, and geographical area. Data tabulation and graphical representation of the main indicators was done using Microsoft Excel.

FGD participants

LOCATION	# sessions	Women	# sessions	Men	# sessions	Adolescents	# sessions	Caregivers of Disabled Individuals	Geographical Location
Damascus	1	7 displaced 8 local residents	1	10 displaced	1	10 girls / 4 boys (All displaced)			39
Jaramana Rural Damascus	1	5 displaced	1	10 local residents	2	28 Both displaced and local residents			43
Sweida	1	20 Both displaced and local residents	1	13 Both displaced and local residents	1	10 girls / 4 boys (Both displaced and local resident)	1	8 local resident (5 mothers of children with disability; 2 women with war-related disability; 1 teacher working with children with disability)	55
Qamishli					2	17 girls / 14 boys (31 local residents) (two separate sessions)			31
Homs	2	14 displaced 10 local residents	1	6 displaced / 7 local residents	3	26 boys / 13 girls (3 Separate sessions)	1	6 displaced / 7 local residents	89
Tartous	1	14 displaced			1	9 girls / 5 boys (14 displaced)			28
Total Individuals	**78**		**46**		**140**		**21**		**285**
Total Sessions	**6**		**4**		**10**		**2**		**22**

Table 1:FGD sessions – participants and geographical locations

Study Limitations

For the purpose of identifying unintended influences on information acquisition and analysis of the assessment data, the prominent limitations to this assessment are presented below:

- The use of structured and semi-structured questionnaires (such as the Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment tool) allows for less flexibility during data collection. The in-depth Skype interviews helped in reducing this specific limitation by exploring the different axes of the study further.

- Group-based qualitative research used in the FGD often produces an abundance of extremely rich data as it captures ideas exchanged between respondents and the diversity of their opinions. However, any analysis must be careful not to discuss opinions expressed in a focus group as an exclusive consensus of the entire group, or of a specific individual. It is also important to take into consideration the influence of any personal bias from the session's facilitator in emphasising and highlighting some points during the discussion or documentation.

- There is a possibility that some responses may have been exaggerated intentionally based on a belief that this may lead to obtaining increased assistance.

- Some variables related to the type, severity, and perception of the FGD respondents' past and current circumstances made it difficult to disaggregate data according to these variables. For example; time elapsing since displacement, past experience related to the conflict and displacement, and extent of family support.

- A part of this assessment targeted perceptions of IDPs. Subjective bias resulting from the respondents' personal or cultural views, prejudices, individual experiences, and expectations is notable.

- The prevailing insecurity and instability, explosions and shelling, as well as besiegement and armed conflict limited mobility and communications, and thereby hindered and delayed several activities including the interviews, online responses, and FGD sessions.

- There is a complete lack of representation about a large population located in the hard to reach areas, including their MHPSS needs and the assistance that might have been locally developed by NGOs and communities, as well as the initiatives that MH professionals working in those areas have been able to take to overcome their limited mobility.

- Poor knowledge among people on mental health may have influenced their identification of the severity of their MHPSS needs.

- The volatile situation in Syria is causing changing and increasing needs, displacement, and an ongoing brain-drain associated to the protracted trend of the population leaving the country (especially the most qualified).

• The method used to collect data from MH practitioners through “snowball sampling” using a pool of initial key informants to nominate, through their social networks, other participants who could potentially contribute to the study has some limitations. ABAAD and the study team tried to ensure that the initial informants are as diverse as possible (professions, geographical locations, years of experience) to guarantee better representativeness.

RESULTS

Quantitative Assessment

Socio-Demographic Profile

The majority of study respondents were females (percentage of 61% females and 39% males). 90% of the respondents were Syrian and 10% Palestinian-Syrian.

Most of the study respondents (61%) belong to the age group of 25-34 years.

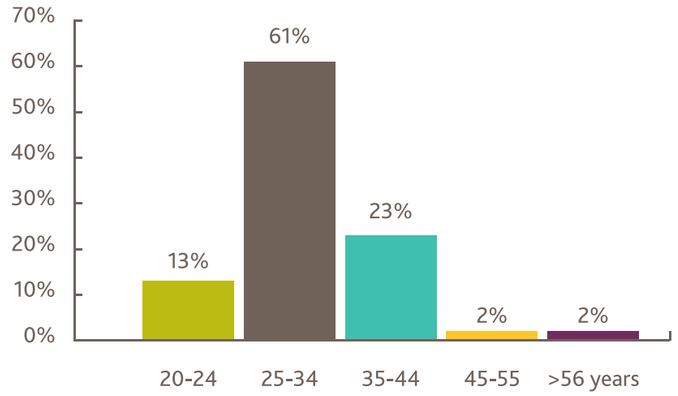

Figure 1: Percent distribution of survey respondents by age

Regarding the distribution of survey respondents by geographical location, the majority were from Damascus and Latakia (31.25%).

- The total number of respondents from Damascus was 20. 20% of those respondents were counsellors, 25% were psychotherapists, 20% were psychologists, 15% were social workers, and 20% were "other."
- The total number of respondents from Rural Damascus was 4. These consisted of 1 psychologist, 1 psychotherapist, 1 social worker and 1 "other" (including psychosocial animators and mental health programme coordinators).
- The total number of participants from Aleppo was 4; these consisted of 3 psychologists and 1 social worker.
- The total number of participants from Latakia was 20. 90% of those were social workers, 5% psychologists, and 5% "other" (including psychosocial animators and mental health programme coordinators).
- The total number of respondents from Homs was 7. Those include 1 psychiatrist, 1 psychotherapist, 1 social worker and 4 "other" (including psychosocial animators and mental health programme coordinators.).
- The total number of respondents from Al Hasakeh was 5; these were all social workers.
- The total number of respondents from Daraa was 2. Those included 1 psychologist and 1 "other" (psychosocial animators and mental health programme coordinators).
- The total number of respondents from Tartous was 1 psychologist.

The majority of survey respondents were social workers (44%) while a minority were psychiatrists (2%). The remainder of the respondents were psychologists (16%), psychotherapists (11%), counsellors (10%), and some others including psychosocial animators and mental health programme coordinators.

Concerning current work and previous experience in the humanitarian field, 66% of the survey respondents reported having experience in humanitarian work prior to the current crisis in Syria. Around 50% of the respondents reported a duration of 1-3 years of work in the humanitarian field in Syria, approximately 30% reported a duration of 4-6 years, and 10% reported a duration of less than 1 year in the humanitarian field.

Axis I – Knowledge

Responses under this axis indicated the need for the development of knowledge mainly on the following topics:

Mental disorders, their diagnosis, and their management: Classification of mental disorders, psychosis, epilepsy (including psychogenic seizures), suicide and self-harm, and psychopharmacology.

Current circumstances and mental health: Mental health and cases suffering/survivors of rape or sexual abuse, suicide and self-harm, mental health and amputations resulting from war, risk assessment, and management.

Ethical considerations and special cases: Respondents indicated a need to improve their knowledge of mental health legislations. 35% of survey respondents pointed out to poor knowledge on legislations in mental health, and 20% of survey respondents reported a need for training to improve their knowledge on mental health legislations.

Responses related to knowledge on confidentiality and ethical issues and principles of psychosocial and mental health work indicated a perceived good knowledge among survey respondents.

Axis II – Practice and Skills

Responses related to practice and skills were consistent with responses related to knowledge in regards to the need for capacity building on specific topics.

Mental disorders, their diagnosis, and their management: Classification of mental disorders, psychosis, epilepsy (including psychogenic seizures), suicide and self-harm, and psychopharmacology.

Current circumstances and mental health: Mental health and cases suffering/survivors of rape or sexual abuse, suicide and self-harm, mental health and amputations resulting from war, risk assessment, and management.

Ethical considerations and special cases: Respondents indicated a need to improve their knowledge

in regards to mental health legislations. 35% of survey respondents pointed out to poor knowledge on Legislations in mental health; 20% of survey respondents reported a need for training to improve knowledge on mental health legislations.

Responses related to skills in practicing confidentiality and handling ethical issues indicated a perceived good knowledge among survey respondents.

Axis III – Training

The majority of respondents among MH practitioners reported a need for further capacity building on family therapy (64%), identification and diagnosis of MH disorders (58%), counselling (47%) assessment of needs and risks (45%) and referral and case follow-up (31%).

53% of survey respondents reported never having participated in capacity building workshops. 50% of respondents with 1-3 years of experience in humanitarian work in Syria reported never having participated in capacity building workshops. 50% of those with 4-6 years of experience reported having rarely participated in trainings and capacity building workshops.

The majority of respondents (78%) attend trainings carried out by the organisations at which they work (those were mostly social workers, 93%). 47% of respondents attend trainings carried out by other organisations (mostly MH professionals).

Axis IV - Resources

The majority of survey respondents (73%) reported a need for Arabic contextualised resources on mental health. (See Figure 2)

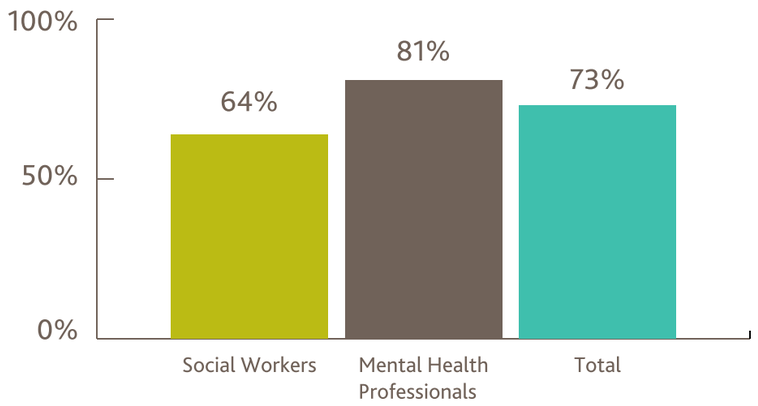

Figure 2: Percent distribution of respondents who need Arabic contextualised resources on MH

Responses on the type of needed resources were as follows: manuals (72%), diagnostic tools (48%), reporting and documentation forms (48%), and assessment tools (45%). Regarding the type of needed resources, there was no significant difference between the responses of social workers and the responses of mental health professionals.

Respondents pointed out the need for updated tools, manuals on Cognitive Behavioural Therapy (CBT), manuals and step-by-step guides on case management, manuals on assessing needs, resources on working with children and people with disabilities and special needs, resources for bridging the gap in mental health (referring to mhGAP guides), and facilitator guides on effective communication skills.

Axis V - Supervision, Coaching, and Technical Support

50% of survey respondents reported that in order to be able to work more effectively, they would require technical support. The majority of respondents (70%) reported receiving some kind of technical support, with most of them receiving it from the organisations at which they work (90%).

30% of respondents who receive technical support also have access to additional and more specialised support from other sources (those are mainly mental health professionals). 10% of respondents receive remote technical support through professional networks or MH experts abroad.

58% of respondents reported that the technical support they receive is useful but not sufficient, highlighting the fact that they need additional ongoing technical support and supervision in their work.

Axis VI – Referral, Follow-Up, and Coordination

Survey respondents pointed out challenges related to referral and follow-up of cases. They highlighted the poor coordination between organisations and the challenges related to the lack of a clear referral system. 25% of respondents reported the absence of referral mechanisms and a referral system within their organisations, while 25% of respondents described the existing referral system within their organisations as unclear to staff.

Axis VII – Self-Care and Support

MH practitioners demonstrated a need for self-care activities. 50% of survey respondents reported sometimes not being able to relax and sometimes becoming easily irritable. 45% of respondents reported having a supportive social network and sometimes asking others for help.

Other Issues

Regarding the challenges that MH practitioners face in their work, respondents' responses were as follows: challenges related to insufficient mental health awareness among beneficiaries (73%); challenges related to stigma correlated with mental health problems and disorders (52%); challenges related to access to mental health services (transportation, security situation…) (50%); challenges related to security situation (48%); challenges related to humanitarian workers' (frontline workers') capacity to identify and refer cases/lack of proper identification and referral (30%).

Regarding the barriers that hinder the people who need specialised MH services from seeking help, responses pointed out the poor and insufficient knowledge among people on mental health and available MHPSS services, stigma correlated with mental health problems and disorders, the unstable security situation, and difficulties related to accessibility of services – all factors obstructing people's seeking out MHPSS services. In addition to the above, numerous concerns were expressed regarding confidentiality and privacy of mental health services, difficulties in movement and transportation, prevailing negative attitudes towards mental health services, and a general belief that seeking MH care is a sign of weakness or "insanity."

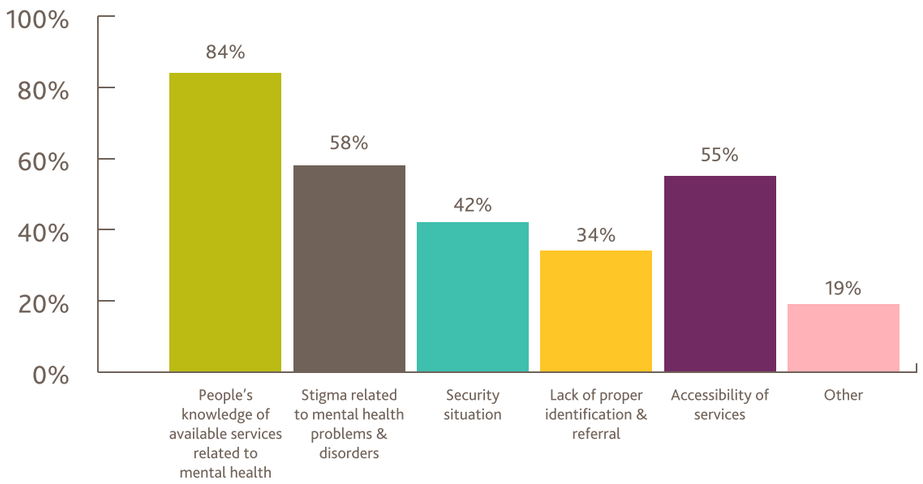

Figure 3: Percent distribution of barriers that hinder people from seeking and accessing MH services

Qualitative Assessment

Results of Focus Group Discussions

The primary purpose of the FGDs was to explore the Syrian people's perceptions about mental health and psychosocial issues and coping strategies, as well as their perceptions about the availability, accessibility, and expressed need for MHPSS services. For this purpose, Focus Group Discussion sessions were conducted with groups of women, men, caregivers of children or individuals with disabilities, and adolescent boys and girls in different areas in Syria.

The structure of the sessions (see Focus Group Discussion Guide in Annex IV) was designed to gather information related to the following main axes:

I. The Syrian people's perceptions of the effects of the current crisis on their mental health at the individual, family, and community levels, including the manifestations of stress and the most common needs

II. Syrian men's and women's perceptions of their experiences related to possible changes in roles, especially changes in gender roles

III. The most common coping strategies being adopted by the Syrian people

IV. The most common terms and phrases used by the Syrian people to refer to their feelings of distress or unease

V. Perceptions of stress factors and protective factors that influence the Syrian people's resilience and stress-coping mechanisms

VI. The Syrian people's perceptions about the availability, accessibility, as well as the expressed needs, suggestions, and attitudes towards MHPSS services

Focus Group Sessions with Women

DAMASCUS

Effects of the Crisis on Mental Health:

On the individual level: the majority of respondents reported being distressed. The most common mental health and psychosocial issues reported included feelings of excessive fear, anxiety and tension, hopelessness, excessive thinking, feelings of despair and pessimism, irritability, intense sadness, worries and fears concerning the future, a sense of insecurity and instability, self-neglect, feelings of helplessness and weakness, isolation, and social withdrawal. In addition to that, respondents who have experienced displacement reported challenges related to loss of homes and possessions, and difficulties in coping with their new environments.

On the family level: family disruption, family tension and problems, difficulties in dealing with children, and aggressive tendencies among men were common responses.

On the community level: increased feelings of alienation, a sense of distrust, a sense of disappointment in others ("the masks have fallen"), increased social tensions, intolerance, and sectarianism were reported by most of the respondents and all of the displaced women. Few among those who have been displaced described some new opportunities such as getting to know new environments.

Change in Gender Roles:

Most women referred to an increase in marital problems and regular conflicts with husbands, increased responsibilities, and changing gender roles where they currently play both the role of mother and father. Absence of marital harmony, intimacy, and sexual life were common responses.

Stress and Protective Factors:

Women referred to the difficult living conditions, fear related to the future and the unknown, stress resulting from having relatives who are detained and/or abducted, and absence of supportive factors except for limited aid received from some organisations. Most of the respondents mentioned coping difficulties, difficult living conditions, poverty, and complicated grief as stress factors.

Coping Strategies:

Most of the respondents reported that the following activities help them cope with their stress: going out, walking, praying, expressing feelings by crying or talking to family members/friends, reading, working, and engaging in embroidery or other available vocational training sessions. Many respondents reported shouting at their children and going through phases of social withdrawal when they are extremely stressed.

MHPSS Services:

Few reported that they refer to a psychiatrist or general practitioner when in need; some reported visiting a nearby SARC centre where mental health services are provided.

Concerning the barriers that hinder seeking MHPSS services, most women reported that there is no proper follow-up on mental healthcare, difficulties in accessibility due to the security situation that limits their movement; and services available mostly target refugees and IDPs rather than host communities (expressed by many local residents).

RURAL DAMASCUS

Effects of the Crisis on Mental Health:

The majority of respondents reported being distressed.

On the individual level: most responses pointed out feelings of excessive fear, anxiety and tension hopelessness, over-thinking and confusion, a sense of insecurity and instability, worry over the situation and over family, feelings of despair and pessimism, irritability, intense sadness, self-neglect, feelings of helplessness and weakness, isolation and social withdrawal, sleep disturbances, tiredness, forgetfulness, abdominal pains, and loss of sexual desire.

On the family level: most responses were family disruption, worries and fears over the future of the family, family tension and problems, regular fights with children, difficulty in dealing with children, aggressive tendencies among men, and partners' psychological distress affecting family dynamics.

On the community level: most respondents reported feelings of alienation, a sense of distrust, limited movement and fear of going out, considerably different cultural norms and dressing norms (displaced), increased social tensions, intolerance, and sectarianism. Few described some new opportunities like getting acquainted with previously unknown environments.

Change in Gender Roles:

Many respondents (displaced) reported stress related to carrying out tasks that should be, culturally, carried out by men (working in factories, bringing in humanitarian aid); men not going out much due to fear of being caught or due to their psychological distress; marital problems and neglect from the part of their husbands, increased responsibilities and changing gender roles, in addition to absence of intimacy with their husbands and no sexual life.

Coping Strategies:

Most of the respondents reported that the following activities help them cope with their stress: going out, walking, praying, expressing feelings by crying or talking to someone close, shouting at their kids, social withdrawal, working, sometimes reading, or sometimes engaging in embroidery or other available vocational training sessions.

MHPSS Services:

Most respondents reported very poor knowledge about existing mental health services. Few respondents reported visiting traditional healers.

They suggested awareness campaigns and home visits to increase awareness and reduce stigma related to seeking mental health.

SWEIDA

Effects of the Crisis on Mental Health:

The majority of respondents reported being distressed.

On the individual level: most responses pointed out feelings of excessive fear, tension, hopelessness, excessive thinking, worries, feelings of despair and pessimism, irritability, intense sadness, and ambivalent feelings concerning the travel of children.

On the family level: most respondents reported concern over their children and the need to maintain and protect the family, and some experienced the loss of their husbands (joined military activities or passed away). There was no mention of family tensions.

Change in Gender Roles:

Many respondents pointed out continuous fear over their husbands who are in danger and currently "hide" at home. They reported stress related to having to play the role of both the mother and father. Many women referred to the changes they have undergone in terms of their roles and responsibilities. According to many women, the absence of their partners forced them to go out and find work in order to support their families. They reported excessive workloads and responsibilities. However, some respondents reported feelings of adequacy, an increased sense of ambition and personal development, along with working to support their families in spite of the emotional distress resulting from the crisis.

Coping Strategies:

Most of the respondents reported that the following activities help them cope with their stress: Some try to think positively of going back home, others drink 'mate' [traditional drink made of yerba mate leaves] and smoke, while some spend time with their children, watch television, or play "Candy Crush".

MHPSS Services:

Most respondents reported weak knowledge on existing MHPSS services. Few reported knowing of small number of psychiatrists but most respondents would not think of visiting one due to fear of stigma. Few visit a nearby church offering medical services.

Suggestions from most of the respondents on MHPSS services were as follows: establishing centres for mental health services, mobile mental health consultation services, and services for women experiencing violence.

HOMS

Effects of the Crisis on Mental Health:

On the individual level: anxiety and tension, hopelessness, over-thinking, feelings of despair and pessimism, irritability, intense sadness, worries and fears concerning the future, a sense of insecurity and instability, self-neglect, and feelings of helplessness and weakness.

On the family level: most respondents referred to excessive attachment to their children, especially following the loss of a husband. Many respondents reported ongoing stress related to the loss of husbands and the struggle to take care of their children, and sometimes their parents too. Most of them mentioned excessive fear over their children, causing increased over-protectiveness that creates regular conflicts with children at home. Many respondents reported stronger family ties and closer relationships between family members since the beginning of the crisis.

On the community level: many respondents referred to the prevailing sectarianism and discrimination and the disruption of social networks.

Change in Gender Roles:

Many respondents referred to the changes in the gender roles where many reported extreme stress due to having to play the role of both the mother and father, including taking care of the household and going out to work. Many respondents reported feeling stronger and more responsible after they began working.

Stress and Protective Factors:

Most common responses related to stress factors are financial constraints, family members' needs, difficult living conditions, electricity cuts, insecurity, and loneliness. Few mentioned they suffer from the nervousness and withdrawal of husbands.

Most common responses on protective factors described by the women in Homs were children, feeling responsible, work, good relationships with neighbours, and faith.

Coping Strategies:

The common responses on coping strategies were as follows: spending time with children. Some respondents reported their use of Lexotanil without referring to a psychiatrist or medical worker (Lexotanil, a benzodiazepine derivative drug used to treat anxiety or panic states, shares with other benzodiazepines the risk of abuse, misuse, psychological dependence, or physical dependence).

MHPSS Services:

Few respondents referred to traditional healers to receive help with their mental health and psychosocial issues. Most respondents do not seek help from mental health specialists mainly because of fear of social stigma – a main fear is that if people from the community found out about an individual visiting a therapist, no one would marry any girl from that family.

Suggestions on MHPSS services were as follows: organising regular "speaking out" group sessions to help individuals express their thoughts and feelings.

Focus Group Sessions with Men

DAMASCUS

Effects of the Crisis on Mental Health:

On the individual level: most respondents reported excessive feelings of anger and tension, feelings of helplessness, a sense of failure, and constraints on movement (especially affecting men) causing them additional stress. This is in addition to anxiety, hopelessness, excessive thinking, feelings of despair and pessimism, irritability, intense sadness, inability to comprehend the current situation, and the constantly changing circumstances.

On the family level: most respondents pointed out regular conflicts with their wives and children, in addition to increased family problems. Most of them reported severe family conflicts that can lead to serious fights, violence, and/or divorce.

On the community level: some respondents reported their distress due to discrimination, an increased sense of alienation coupled with the negative outlook towards them as refugees, increased sectarianism, and distrust among people. Few respondents pointed out some positive changes including forming new relationships and getting to know new settings, while many respondents reported sadness at the loss of many friends.

Change in Gender Roles:

Many respondents pointed out to the difficulties they are facing with the changing gender roles as women are going out of the house and becoming the family providers.

Stress Factors:

Most of the respondents talked about the stress related to the difficult circumstances and living conditions, loss of belonging and work, and difficulty starting their lives all over again.

Coping Strategies:

Most of the respondents reported that the following activities help them cope with their stress: going out, walking, praying, watching television, or joining educational sessions when available (men living in Damascus). Many respondents reported using violence against their wives and children when they are stressed.

MHPSS Services:

There were significant differences regarding the respondents' outlook on seeking mental healthcare, especially when comparing responses from different governorates. Respondents from Damascus reported more awareness of available mental health services in their area and a higher level of acceptance towards the idea of seeking mental healthcare. A few respondents from Damascus have visited psychiatrists or an organisation providing mental healthcare nearby despite the social stigma correlated with mental disorders. Respondents from Tartous, however, revealed a lack of knowledge on mental health, on available mental healthcare services, and negative perspectives towards mental healthcare.

RURAL DAMASCUS

Effects of the Crisis on Mental Health:

On the individual level: the most common responses were mood swings, a sense of fear over family and self, anxiety and tension, hopelessness, over-thinking, feelings of despair and pessimism, irritability, intense sadness, as well as the inability to comprehend the current situation and the deteriorating circumstances. Many respondents reported muscle pains, migraines, intestinal pains, and other physical manifestations of stress (referring to psychosomatic symptoms).

On the family level: most respondents pointed out negative impacts (such as family tensions and violence) of their psychological distress on their relationship with family members. Many respondents reported their dissatisfaction with the way they are dealing with their children and their difficulty in managing their anger.

On the community level: many respondents pointed out their disturbance regarding their restricted mobility, sectarianism, discrimination, and a sense of distrust in their new environment.

Change in Gender Roles:

Most respondents reported severe changes in their roles as family providers.

Coping Strategies:

Respondents reported practicing their hobbies (drawing, playing lute) to cope with feelings of distress. Others pointed out difficulties in anger and stress management, and an increase in conflicts with their wives and family members, often leading to violence.

MHPSS Services:

Regarding their perspectives on seeking help and mental healthcare, most of the respondents pointed out the fact that their stress is normal and related to the current circumstances. Many of them reported feeling no need to seek professional help. One man mentioned having previously visited a psychiatrist who described anti-depressant medication, but no follow-up was made as the psychiatrist left the country. However, respondents in Jaramana highlighted the need for awareness-raising on mental health issues, suggesting psycho-educational campaigns in shelters, schools, and different settings to improve knowledge on mental health and mental healthcare. They demonstrated an interest in activities that provide them with the space to express their thoughts and feelings, and to receive support.

SWEIDA

Effects of the Crisis on Mental Health:

On the individual level: Respondents in Sweida, many of whom were displaced from Qusair, Daraa and other areas, and some of whom had gone through multiple displacements (5 times), reported high levels of stress. Most of the respondents pointed out the difficult living conditions, loss of homes and personal belongings, worry about their families and children, fear of expressing thoughts or feelings, and persistent anxiety and tension.

On the family level: No responses were provided regarding the impacts of the current situation on their family life and family dynamics. However, many respondents referred to excessive worry over their children who were away from them.

On the community level: most of the respondents reported stress resulting from their inability to integrate into their new environments. Most reported widespread discrimination, a prevailing sense of distrust, and sectarianism. According to many, this atmosphere of hostility and social tension contributes to their sense of social withdrawal and their feelings of alienation.

No responses tackled changes in gender roles. There were no responses reported on coping behaviours. The results from the FGD with men in Sweida reveal the extremely stressful situation that the men are experiencing and their need to speak out and express themselves.

MHPSS Services:

No responses were reported on this axis. Most respondents correlated the improvement in their psychosocial wellbeing to the improvement in the security situation and the end of the crisis.

Suggestions mainly included opening centres for mental healthcare and creating opportunities for expression.

HOMS

Effects of the Crisis on Mental Health:

The majority of respondents reported high levels of stress.

On the individual level: most responses pointed out feelings of an excessive and increased sense of insecurity and instability, a reduced sense of self-esteem, and feeling defeated. Physical pains and disturbances due to the crisis (muscle pains, asthma) were also somewhat common. Many respondents pointed out having lost their work and thus experiencing feelings of inadequacy and helplessness.

On the family level: most respondents referred to a positive change in their relationships with their children. As per their responses, the crisis has brought them closer, both on the emotional and physical levels. They reported their satisfaction with engaging in long conversations with their children and generally feeling closer to them. However, few responses indicated difficulties in managing anger, stress, and regular conflicts with wives and children. Most respondents referred to avoidance of sharing their thoughts and feelings with others as, according to them, "all people are distressed."

Stress Factors:

Loss of work, displacement, and difficult living conditions were among the most common responses that were identified during the session. On the other hand, the only response related to protective factors was "family."

Coping Strategies:

The common responses on coping strategies were as follows: use of alcohol, and excessive smoking of both tobacco and cannabis to help reduce stress.

MHPSS Services:

Most of the respondents in Homs stated they would not consider visiting a mental health professional. Responses on seeking MHPSS services indicated that most respondents believe that they are well-aware of the stressors in their lives, and feel that mental health professionals would only give them "theoretical" solutions. Some respondents reported perceptions that seeking mental healthcare is a sign of weakness. Despite their outlook on mental healthcare, most respondents in Homs suggested organising mental health awareness activities in schools, communities, and on the internet, including mental healthcare coverage in health insurance policies, and group speak-up sessions instead of individual sessions at a clinic.

Focus Group Sessions with Caregivers of Individuals with Disabilities

SWEIDA

Session participants included mothers of children with special needs (cerebral palsy, developmental disorders/autism), women and children with trauma-induced disability and amputations, and a teacher of children with disabilities. The respondents reported high levels of stress. All responses pointed out immense responsibilities related to taking care of the family, and their children with disabilities added to the growing needs resulting from displacement, loss of homes, loss of husbands, and loss of support networks and personal belongings. All respondents reported daily stress and feelings of insecurity and instability, and they all emphasised their need for assistance, relaxation, and psychological support.

MHPSS Services:

Some respondents mentioned seeking help from traditional healers. Most reported extreme stress related to the daily struggle with social stigma towards them or their children, and pointed out their inability to access any specialised centres to provide rehabilitation and care for their children. Most respondents reported a need for entertainment activities for their children with special needs, in addition to support in order to improve their knowledge on how to deal with their children/children's needs. The respondent who teaches and works with children with disabilities referred to the absence of specialised services and the need for multidisciplinary teams; she described the immense stress resulting from working with groups of children who have higher levels of needs.

HOMS

Session participants were mothers of children with special needs in Homs. They reported increased levels of stress within the current emergency setting. Most responses pointed out feelings of anxiety, fear, instability, and loss of control, compounded with feelings of worry over the future of their children with disabilities, exhaustion, and burnout resulting from the growing responsibilities. Many respondents reported an increase in conflicts with other family members (including husbands) following the onset of the crisis and the increase in responsibilities. Some reported having lost their husbands in the war, and pointed out feeling immense stress due to being the sole providers of the family. Most of the respondents reported social withdrawal due to their psychological distress and the added responsibilities of caring for children with disabilities.

Coping Strategies:

No in-depth responses on self-care and coping behaviours were reported, but a few respondents mentioned attending a club for mothers of children with disabilities available in Homs.

MHPSS Services:

Many responses indicated that many of the rehabilitation centres respondents used to visit have either closed or have become hard to reach due to security constraints.

Suggestions related to MHPSS services were opening inpatient rehabilitation centres for children with disabilities (indicating exhaustion due to the related responsibilities). No responses about the respondents' own psychological wellbeing and the MHPSS services directed at them were reported.

Focus Group Sessions with Adolescents

DAMASCUS

During mixed group sessions, adolescent respondents in Damascus pointed out the stressful situation they are experiencing.

Effects of the Crisis on Mental Health:

The majority of respondents reported being distressed.

On the individual level: common responses pointed out by displaced adolescents interviewed in Damascus were feelings of tiredness, inability to concentrate, unpleasant thoughts concerning the future, anxiety, fear, tension, feelings of disgust, a sense of isolation, crying at night, missing their homes and friends, and feelings of nostalgia. A few respondents referred to traumatic experiences they have gone through and reported immense emotional distress caused by those experiences. The majority of respondents reported feelings of hopelessness and pessimism.

On the family level: most responses pointed out a loss of privacy, and crowded living places. Many respondents mentioned increasing conflicts at home, where they all feel they are "suffocating." Two respondents reported previous suicide attempts. Most of reported deteriorating academic performance due to psychological distress, crowded rooms at their new living places, crowded classrooms, and a perceived sense of discrimination at their new schools and environments.

On the community level: responses indicated difficulty in making new friends and integrating into their new environments.

Coping Strategies:

Common responses on coping strategies were as follows: visiting nearby community centres to join educational and psychosocial activities, watching television, and listening to music.

MHPSS Services:

Respondents were knowledgeable of some entertainment activities and psychosocial sessions carried out for parents.

Suggestions on MHPSS services were to conduct more group psychosocial and educational activities targeting adolescents.

RURAL DAMASCUS

During mixed group sessions, most adolescent respondents in Jaramana reported feelings of anxiety, tension, a sense of insecurity and instability, overwhelming unpleasant thoughts and memories, tiredness, headaches, inability to concentrate, increased alertness, in addition to feelings of despair. With respect to the impact of the crisis on families, most responses referred to an increase in conflicts at home. Respondents reported feeling imprisoned at home and having to go through to continuous quarrels with their parents regarding their movement. Adolescent girl respondents pointed out financial constraints being experienced by their families.

Coping Strategies:

Concerning their responses on coping strategies, most adolescent boy respondents reported spending time on the street, walking, fighting with their siblings, and crying. Some adolescent boys pointed out the fact that working and helping the family makes them feel better. Most adolescent girl respondents referred to crying or talking to parents as coping strategies.

MHPSS Services:

Most of the respondents indicated no awareness or knowledge on available mental health services. Only a few respondents (including one who suffers from war-related epilepsy) reported visiting a centre that provides psychosocial support.

Suggestions related to MHPSS services were: awareness-raising campaigns on mental health in schools and on the internet, home visits for psychosocial support, and regular speak-up groups and psychosocial activities for adolescents.

SWEIDA

During a mixed group session, most adolescent respondents in Sweida reported growing feelings of anxiety, instability, insecurity, pessimism and loss of ambition, in addition to an increased sense of isolation and distrust.

Stress and Protective Factors:

The most common responses reported by adolescent respondents were the difficult living conditions, the lack of privacy, conflicts with family, loss of friends, and personal distress. Family and friends were the most common responses reported on protective factors.

Coping Strategies:

Concerning their responses on coping strategies, most adolescent respondents reported reading or listening to music, dancing, drawing, or talking to their friends. A few girl adolescents referred to talking to their mothers when they are stressed. Most boy adolescents reported isolating themselves from their surroundings and smoking to cope with stress.

MHPSS Services:

Two adolescent respondents reported visiting a psychiatrist to receive mental healthcare. Most respondents reported absence of awareness on available mental health services. Most responses on MHPSS services indicated negative perceptions; "such services not useful" as they "cannot change current circumstances." Many respondents referred to the need for psychosocial and mental health services.

Most suggested MHPSS services that would provide them with optimism, hope, understanding, and allow them to talk about their problems.

HASAKEH (Qamishli)

Focus group sessions in Qamishli were separate for boys and girls.

BOYS
Effects of the Crisis on Mental Health:

Most adolescent boy respondents reported feelings of tension, a sense of insecurity and fear of being forced to join armed groups, worries about the future, increased tension at home, disruption of the family, and dispersion of family members. One respondent reported extreme stress due to being forced to stop his university studies in Damascus due to the crisis. Some respondents also mentioned dropping out from school in order to work and support their families

MHPSS Services:

Responses of adolescent boys indicated poor knowledge of existing mental health services. Only a few respondents reported knowing about a centre that provides MHPSS services in the area. Most respondents demonstrated negative perspectives on MHPSS and seeking mental health services. Responses related to MHPSS services reported social stigma and poor knowledge on mental health.

GIRLS
Effects of the Crisis on Mental Health:

The majority of adolescent girls reported feelings of anxiety, tension, instability, despair, and worries about the future as well as over family members. Many respondents pointed out to experiences of displacement following extremely difficult conditions. Some respondents reported living in ISIS-controlled areas before displacement. One respondent among the adolescent girls referred to extreme distress related to experiences of kidnapping and torture. Many reported loss of family members or relatives and stress related to having their fathers or brothers forced into military service. Most of the displaced adolescents reported difficulties forming new friendships.

Most respondents referred to financial difficulties faced by their families and the changes in family conditions (loss, travel, and/or dispersion of family members). They highlighted changes in their academic performance due to their forced displacement, current living conditions, and interruption of their education. A few respondents also mentioned facing difficulties at school due to the Democratic Union Party's changing some schools' curricula into the Kurdish curricula. Many respondents reported a lack of motivation to study or pursue an education as a result of pessimism concerning the future.

Coping Strategies:

Most respondents stated they turn to mothers or older sisters for support.

MHPSS Services:

Responses indicated poor knowledge of available mental health services (except for the girl respondent who had experienced kidnapping and who reported visiting a psychiatrist). They also demonstrated negative perspectives and attitudes towards MHPSS services and seeking mental healthcare. Respondents reported fear of social stigma, misconceptions related to mental health, and distrust in the capacities of school counsellors. Most respondents reported an interest in mental health services that would be offered free of charge and carried out by well-trained professionals. They also stressed the need for awareness-raising on mental health within their communities.

HOMS

Focus group sessions in Homs were separate for boys and girls.

GIRLS
Effects of the Crisis on Mental Health:

The majority of adolescent girl respondents reported feelings of irritability, nervousness, and severe mood swings. Responses indicate growing tensions within households and regular fights with mothers who are increasingly tense and overprotective, while fathers have become passive, withdrawn, or away. The majority reported an inability to concentrate, frequent forgetfulness, and confusion, all negatively influencing their academic performance. Responses also demonstrated the loss of friends (displacement, travel, death) and difficulties in forming new friendships.

Coping Strategies:

The most common responses among adolescent girl respondents were: smoking hookah (shisha), eating (emotional eating), talking to a friend, or sleeping for long hours.

MHPSS Services:

Respondents reported poor awareness of existing MHPSS services in their area, as well as negative attitudes towards seeking mental healthcare. Many respondents were open to receiving mental healthcare if it were confidential and free of charge.

BOYS
Effects of the Crisis on Mental Health:

Most adolescent boy respondents reported feelings of nervousness, a continuous fear of explosions, abduction/detainment, and being forced into military service, anger, tension, and psychological distress. Many respondents reported tension and conflicts in the household, where parents have grown extremely over-protective. A few reported an improvement in family dynamics since the beginning of the crisis; family members have become closer to each other and more frequently express their feelings towards each other. Many respondents' education has been interrupted due to displacement, working after school to help their families, demotivation, and fear of going to school. Most of the respondents reported not practicing hobbies due to feelings of disinterest or due to other pressing priorities. One reported having stopped playing the lute after the loss of his music teacher during the war. Most reported changes in their social life and their relationships with friends due to increased senses of distrust, suspicion, sectarianism.

Coping Strategies:

The most common responses were: talking to siblings or close friends and going for walks despite the security situation.

MHPSS Services:

Respondents indicated poor awareness of available MHPSS services. Many responses indicated some knowledge of existent school counselling, towards which they have a negative perspectives based on previous experiences (according to the respondents, school counsellors in the area do not listen and need training).

Suggestions for MHPSS services were: conducting trainings targeting parents on stress management sessions, parenting skills, and healthy ways of dealing with children and adolescents.

TARTOUS

During a mixed focus group session with adolescents currently living in Tartous, respondents described the impacts of the crisis on their lives.

On the personal level, most respondents reported feelings of intense fatigue, worries about the future, instability, mixed feelings, a sense of isolation, and negative thinking. Responses indicated difficulties in adapting or integrating into the new environment.

Most of the adolescents reported dropping out of school either to help support their families (boy respondents) or because their parents do not want them to pursue their education (girl respondents).

GIRLS
Effects of the Crisis on Mental Health:

Most girl respondents pointed out the immense stress resulting from displacement on one hand, and from their parents' desire to marry them at an early age and prevent them from leaving their homes or going to school on the other. They reported feeling isolated from their new environments, especially given the significant differences in terms of customs, values, and way of life. A few respondents pointed out some positive changes resulting from their displacement due to the more "open" environment. Some girl respondents reported violence at home.

BOYS
Effects of the Crisis on Mental Health:

Adolescent boy respondents reported school dropping out of school in order to work and support their families. They pointed out feelings of hopelessness and pessimism, especially after displacement and the interruption of their education. Many respondents reported excessive worry over their families in their new environments, which are greatly differ from their original environments. Many adolescent boys reported difficulties in managing their feelings of stress, and thus practicing violence against siblings at home. Many also reported experiencing violence and abuse at the hands of their fathers or uncles.

Coping Strategies:

Most responses on coping strategies referred to sleeping for long hours (girl respondents), or smoking, leaving their homes, and/or engaging in conflicts (boy respondents).

MHPSS Services:

Most of the adolescent boy respondents reported no interest in participating in psychosocial and entertainment activities conducted by mobile teams in their areas as they feel they are men and they do not need psychological help.

Adolescent girl respondents reported a desire to take part in psychosocial support activities. All girl adolescents stressed the importance of having mental health services in the area.

DISCUSSION

The rapid participatory assessment revealed substantial and diverse needs and challenges faced by mental health practitioners currently working in Syria, which negatively influence their ability to respond effectively to the growing mental health and psychosocial needs.

Mental Health and Psychosocial Support (MHPSS) service delivery has been hampered by a shortage of trained mental health professionals in Syria. There is a shortage of MHPSS professionals, especially psychiatrists. It is estimated that not more than 70 psychiatrists are currently available in the country and are mainly working in Damascus [1]. There are psychologists, psychotherapists, and counselors, but they generally lack the proper training and experience in clinical work. This is due to the little opportunity to train as a clinical psychologist, psychiatric social worker, or psychiatric nurse.

1 http://www.syrianobserver.com/EN/Features/27029/Drastic+Shortage+of+Psychiatrists+Amid+Substantial+Surge+in+Number+of+Patients

Using statistics from the WHO to make the following calculations, the Syrian Arab Association of Psychiatrists found that:

4% is the current percentage of severe MH disorders among Syrians (1.2 million out of 24 million) [1].

1 UNHCR report, Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians. 2015; http://mhinnovation.net/resources/culture-context-and-mental-health-and-psychosocial-well-being-syrians#.Vg5NZOztmko

Currently in Syria, there are only **70 registered psychiatrists.**

If it could actually be assumed that each psychiatrist can follow up on 15 cases every single day, five days a week, 52 weeks per year, and they provide no more than three follow ups per patient per year, then (70x15x5x52)/3

91,000 cases can receive follow up.

This results in only

7.6% of the individuals who have severe MH disorders **receiving treatment**;

in other words, more than

92% of severe cases **cannot reach any MH support or follow up.**

Capacity Needs and Resources of MH Practitioners

The assessment revealed that many MHPSS practitioners have previous experience in humanitarian work. Many of those professionals have worked with Iraqi families displaced in Syria prior to the Syrian crisis, and have thus gained some field experience on MHPSS work in humanitarian settings.

It was also revealed that many MHPSS practitioners need to develop and improve their knowledge on the identification, classification, and management of mental disorders (especially social workers and counsellors) as reported by the study respondents. Special focus, highlighted by all MHPSS respondents, needs to be given to building knowledge on suicide and self-harm, epilepsy (including psychogenic seizures), mental health of survivors of abuse, torture, sexual abuse or rape, mental health and disabilities resulting from war, assessment of needs and risks, and mental health legislations.

Although theoretical knowledge is crucial, it is not enough to work effectively, and skill development is therefore needed to translate knowledge into practice.

MHPSS practitioners demonstrated a need to build and develop their skills in many areas related to MH. The special focus areas for skill development, as reported by MHPSS practitioners, were consistent with the above identified areas for knowledge development. MHPSS practitioners highlighted their need for capacity building on different modes of therapy, mainly CBT, family and systemic therapy, and new schools in psychotherapy that are culturally-specific and can help them work with the emergency-related cases of complicated grief, PTSD, and survivors of torture and abuse.

Some MHPSS professionals who are engaged in conducting training workshops highlighted the need for capacity-building targeting social workers and counsellors, focusing on basic communication and counselling principles and skills, including active listening skills, rephrasing, and reflection.

There is a need to integrate MHPSS services within community-based and multidisciplinary programmes. Many Syrian families, especially those internally displaced in Syria, live in very difficult circumstances. Within such contexts, MHPSS practitioners are usually expected to help clients address issues beyond the scope of their own service.

The study revealed a significant need for training and capacity-building among MHPSS practitioners. The majority of MHPSS practitioners with few years of experience and a short duration of work in humanitarian settings reported a complete insufficiency in or absence of training opportunities. Other MHPSS practitioners, during the key informant interviews, highlighted the value of some training and capacity-building opportunities offered to MHPSS practitioners (described below).

A few recommendations were made regarding capacity-building and training workshops. One recommendation highlighted the need to organise regular workshops and follow ups to guarantee an ongoing learning process on specific topics.

Another recommendation was to organise separate training workshops for different groups with specific profiles of MHPSS practitioners, since, as per some MHPSS key informant interviews, combining diverse backgrounds and levels of experience would reduce the effectiveness of the training.

Examples of existing capacity building workshops in Syria are:

- Training on basic principles of MHPSS in emergencies, PFA and basic communication skills, and structured PSS activities. These training workshops are organised by registered INGOs (IMC, IOM, SARC and some others) operating in Syria in collaboration with official Syrian authorities and ministries.
- A "Master's Programme in Psychosocial Support and Dialogue," a comprehensive training programme held in Beirut and organised by IOM in collaboration with the Lebanese University. The curriculum included psychosocial support, conflict and dialogue, and art based interventions. Conducted over week-ends as an in-service training, the programme facilitated the participation of working professionals and the immediate implementation of skills and knowledge acquired.
- mhGAP training using the WHO mhGAP Intervention Guide for treating people with mental, neurological, and substance use disorders in non-specialised health settings. More than 500 non-specialist health-care professionals have been trained in the Syrian Arab Republic, since 2013, to provide support for mental disorders. 250 primary healthcare physicians in seven governorates received training on the Mental Health Gap Action Programme, as part of MHPSS services integration in primary healthcare. 36 psychologists have been trained through a psychotherapy diploma programme. The programme equips the trainees with skills for basic and advanced counselling, family therapy, and cognitive behavioural therapy.
- Training on implementing MHPSS projects and activities. These training workshops are organised by INGOs operating in Syria and providing in-house trainings for their staff/partner staff.
- Takamol Project: a multi-professional capacity-building jointly held by an interagency working group and the Syrian MoH [2] co-chaired by UNHCR and the Ministry of Health. Master trainers trained 12 psychiatrists, 28 psychologists and 4 social workers; most of whom work in the urban centre of Damascus.
- Case discussions within closed groups on Facebook pages; access to tools and documents of reference on websites in Arabic; peer support; coaching and mentoring. These professional development opportunities are provided by some online international resources centres and).

The majority of respondents emphasised the need for contextualised mental health resources developed in Arabic. Among the respondents, psychotherapists and psychiatrists reported referring to existing English or French textbooks to improve their knowledge in some areas. However, there was a general need for culturally-specific resources, mainly guides and manuals, which would shed light on topics such as mental healthcare for people with war-related disabilities, the mental health of survivors of abuse, and dealing with suicide and self-harm.

Respondents pointed out the need for updated tools, manuals on Cognitive Behavioural therapy,

2 Quosh C., Takamol: multi-professional capacity building in order to strengthen the psychosocial and mental health sector in response to refugee crises. Intervention 2011, Volume 9, Number 3, Page 249 – 264; http://www.ourmediaourselves.com/archives/93pdf/Quosh_2011_INT_Takamol_Syria.pdf

manuals and step-by-step guides on case management, manuals on assessing needs, resources on working with children and people with disabilities/special needs, resources for bridging the gap in mental health (referring to mhGAP guides), and facilitator guides on effective communication skills.

Examples of some existing resources on MHPSS:

- WHO mhGAP Humanitarian Intervention Guide (2010) [3] [4] and mhGAP-HIG (2015) and IMC-WHO mhGAP Training Videos [5] that aim at scaling up services for mental, neurological and substance use disorders in non-specialised healthcare settings. Primarily targets general healthcare providers as well as MH practitioners.
- WHO Psychological First Aid Guide [6] for Field Workers and the Facilitators' Manual for Orienting Field Workers; targets first-line field and aid workers as well as MH practitioners engaged in emergency responses (critical incidents).
- War Child Holland, Psychosocial Modules for Children, Youth, and Parents. [7] Primarily targets animators and psychosocial workers. I DEAL programmes combine creative activities with games and group discussions to build resilience and improve children and young people's coping skills to better 'deal' with their daily lives.

- IASC MHPSS Reference Group – UNICEF, Webinar on MHPSS [8] related issues. Free access, but only available in English. Provides general guidance on international standards. Targets MH practitioners and PSS staff.
- ABAAD/Promundo - A Manual for Engaging Men in Fatherhood, Care-giving and Maternal and Child Health. [9] Provides concrete strategies and activities to engage men in active positive fatherhood within the family, preventing violence against women and children on basis of equality and non-violence. Targets MHPSS Programme Managers, medical staff, and PSS staff, among others.
- IOM's Self-help Booklet for Men Facing Crisis and Displacement. [10] Provides psycho-education/guidance to men and families on issues of emotional consequences of the crisis and changes in traditional roles. Targets affected populations directly, as well as MH practitioners and PSS staff.

3 WHO, mhGAP Humanitarian Intervention Guide, 2010; http://mhinnovation.net/sites/default/files/downloads/resource/WHO%20MHGap%20Guide%20English.pdf
Arabic version: http://mhinnovation.net/sites/default/files/downloads/resource/WHO%20MHGap%20Guide_Arabic.pdf

4 WHO, mhGAP Humanitarian Intervention Guide (mhGAP-HIG), 2015; http://reliefweb.int/sites/reliefweb.int/files/resources/9789241548922_eng.pdf
5 IMC-WHO, mhGAP IG Training Videos; https://www.youtube.com/playlist?list=PL8EFD1932C0CF4C96
6 WHO, Psychological First Aid: Facilitators' Manual for Orienting Field Workers. 2013; http://apps.who.int/iris/bitstream/10665/102380/1/9789241548618_eng.pdf for a (non-official) Arabic version see: MHPPS.net Website, Arabic translation of PFA Facilitator's Manual (2013) slides, for use when training on the PFA Guide for Fieldworkers (2011), http://mhpss.net/?get=242/1392630443-20131020DRAFTLSPFAFGuideSlides17Oct2013Arabic.ppt
7 War Child Holland, I DEAL site Modules, information and training for life skills facilitators; http://www.warchildlearning.org/downloadmodules/arabic
8 IASC MHPSS Reference Group-UNICEF, Webinar on Psychosocial support for staff, Nov. 2013: http://mhpss.net/webinar-psycho-social-support-for-staff-and-volunteers-26-november-2013-13-00-14-30-gmt/
9 ABAAD-Save the Children, Programme P: A Manual for Engaging Men in Fatherhood, Care giving and Maternal and Child Health. 2015; http://men-care.org/what-we-do/programming/program-p/
10 IOM, Self-Help Booklet for Men facing crisis and displacement, 2015; http://publications.iom.int/bookstore/free/Self_help_booklet_EN.pdf

Respondents also pointed out to a need for technical support, supervision, and coaching. Some reported receiving some form of technical support (mostly social workers, psychologists, and counsellors who reported receiving technical support from within the organisations at which they work). However, the majority of respondents reported that the technical support they receive is not sufficient. Moreover, many MHPSS practitioners highlighted challenges related to receiving technical support from international mental health experts, namely the language barrier, and the lack both of regular support, and of culturally-specific technical support.

Many MHPSS practitioners refer to the supervision, coaching, and technical support that they receive with the term "control." This indicates a need for operationally redefining what "technical support" entails, as well as what to expect from it.

Coordination among organisations working in the MHPSS field, and between the latter and other existing service providers in Syria is generally weak, as reported by most study respondents. There is no established referral system, and usually, MHPSS practitioners need to rely on their personal networks to make referrals. Consequently, case follow-up is usually inexistent.

Currently, IMC and UNHCR co-chair an MHPSS working group in Damascus, but only a limited number of organisations participate in the meetings (registered international NGOs; very few are local NGOs). This limitation is due to security constraints, mainly related to the local NGOs' limited mobility on the roads if based outside of Damascus. IMC specifies in its report that the current MHPSS working group "is not officially a coordination platform, though it includes coordination and mapping as one of its core functions." There is no mention that it plays a role in facilitating referrals within the sector.

Some MHPSS practitioners pointed out the need for self-care, describing the stress they face within their work, and their inability to relax sometimes. In spite of their express willingness and ability to work in the current humanitarian setting, they have self-care needs that should not be overlooked. The escalating security situation in Syria and the difficult living circumstances affect the mental and psychosocial wellbeing of humanitarian actors, who are also affected by the numerous consequences of the crisis, and who also may have experienced losses of friends or relatives.

In addition to the diverse needs, there are enormous challenges faced by MHPSS practitioners currently working in Syria that negatively impact and hinder their work. Most of these challenges overlap with the barriers that hinder people from seeking and accessing MHPSS services. The assessment, in its qualitative and quantitative components (survey, in-depth key informant interviews and FGDs), pointed out the fear of social stigma, lack or insufficiency of mental health awareness and knowledge on existing MHPSS services, the deteriorating security situation affecting mobility and access to MHPSS services, in addition to the lack of proper identification and the lack of a referral system. Many MHPSS practitioners who were active in clinical work prior to the crisis reported that with the crisis affecting such a large proportion of the Syrian population, the number of persons ready to seek help from MHPSS services has also grown significantly.

This has had a direct effect on reducing the stigma associated with MH needs, which are now perceived as more and more "normal" as per the UNHCR report "Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians." [11]

11 UNHCR report, Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians. 2015; http://mhinnovation.net/resources/culture-context-and-mental-health-and-psychosocial-wellbeing-syrians#.Vg5NZOztmko

Prior to the crisis, many obstacles hindered people in Syria from accessing psychological support: the lack of service providers, the stigma attached to having psychological problems, the lack or insufficiency of knowledge on mental health, and some traditional beliefs.

The complexity of the current situation in Syria, the war-related violence, the underdeveloped mental health system, and the negative attitudes towards mental health disorders and the general prevailing atmosphere of mistrust and suspicion have also influenced people's help-seeking behaviour and their readiness to open up and speak about their thoughts and feelings.

Thus, a number of people have avoided specialised MH services and have instead sought out traditional healers or sheikhs, religious or supernatural healing practices, or general practitioners at primary healthcare centres to address their psychosocial or mental health needs.

The diverse needs and challenges faced by MHPSS practitioners currently working in Syria necessitate coordinated and well-planned interventions, in addition to a strategy on capacity-development. There is a need to strengthen the MH system in the long-term and to work on building higher quality and more sustainable mental health systems despite the challenging circumstances. Emergency situations, in spite of the adversity and challenges they create, can be openings to transform mental healthcare. Strategic efforts should be made to convert short-term interest in responding to mental health problems into a more stable momentum for mental health reform.

Mental Health and Psychosocial Needs of the Crisis-Affected Population

The effects of conflict in Syria on the mental health and psychosocial wellbeing of people are profound. Given the increasing levels of poverty, losses, deterioration in living conditions, uncertainty about the future, imitations on refugees' rights to seek international protection and to access services in neighbouring countries, there is a pervasive sense of hopelessness setting in for many Syrians. The ongoing hardships and violence they experience are compounded by the daily stressors of displacement, including: financial pressures, lack of resources and services to meet basic needs, risks of violence and exploitation, discrimination, and social isolation. This leads to unhealthy coping strategies in dealing with stress and a rise in mental health and psychosocial problems and disorders.

The assessment revealed that psychological and social distress among people in Syria manifests in a wide range of psychosocial issues (emotional, cognitive, physical, behavioural, and social) manifesting on the personal, family and community levels. Feelings of tension, distress, fear, hopelessness, anger, nervousness, stress, loss of control, helplessness, worry, despair, grief, frustration, anxiety, anger, and despair are common. Similarly common are behaviours of withdrawal, aggression, and interpersonal conflicts.

Levels of psychological stress are high among women, men, girls, and boys. The majority of respondents among women, men, caregivers of children with disabilities, and adolescent girls and boys reported being distressed. Most people interviewed are still suffering from the impacts of displacement.

On the personal level, feelings of excessive fear, anxiety, tension, hopelessness, excessive thinking, despair, pessimism, irritability, intense sadness, worries and fears over family and the future, a sense of insecurity and instability, self-neglect, feelings of helplessness and weakness, sleep disturbances, tiredness, forgetfulness, and psychosomatic complaints are common. All these emotional and psychosocial problems, along with the difficult living conditions and increasing stressors, lead to increased family problems, conflicts, and domestic violence. An additional contributing factor is the change in gender roles, as women reported increased burdens and responsibilities, while men reported feeling helpless and weak.

On the social level, distress due to discrimination, an increased sense of alienation, sectarianism, and distrust among people were common among respondents.

The most common stress factors are directly linked to war-related violence, difficult circumstances and living conditions, losses, difficulties in accessing services, loss of support networks, changes in the social fabric, an increasing sense of hostility towards IDPs, and a prevailing atmosphere of mistrust and suspicion.

Women (especially according to respondents displaced in Homs and Sweida) experience immense stress mainly due to the increased duties and changing roles. Women caring for children with disabilities reported extremely high levels of stress and some signs of burnout, mainly due to the responsibilities growing with the absence of their husbands, the lack of MHPSS and rehabilitation services for their children, and their growing self-care needs. Women in particular showed a tendency not to share emotional suffering with family members due to cultural and gender-related issues. Many mothers revealed that this causes them to adopt unnecessary aggressive behaviours with their children.

Men struggle daily as a result of their limited mobility, loss of work, and the prevailing sense of sectarianism and tension. They mainly face difficulties in managing their growing stress and anger; they usually experience fits of rage and adopt violent and aggressive behaviours with their families.

Adolescents have high levels of psychosocial needs. In addition to the emotional problems and feelings of sadness, fear, worries, and hopelessness, they struggle daily with parents' over-protectiveness and extreme worry over their safety and security, tension, restricted mobility, a lack of privacy, the loss of friends (displacement, travel, death) and difficulties in forming new friendships, and significant changes in their daily lives and activities.

Adolescents generally reported the inability to concentrate, frequent forgetfulness, and confusion. This has especially negatively influenced the academic performance of those who are still pursuing their education. The conflict in Syria has caused an interruption of education among adolescents, many of whom had to drop out of school or university, due to displacement, pursuing work to provide for their families (mainly boys), or parental pressure to marry at an early age (mainly girls, especially those displaced in Tartous).

Family, faith, and the supportive social network (relatives and friends) are among the primary protective factors identified by respondents.

Another major issue of concern is the lack of opportunities for socialising due to fears over security and safety, as well as the reported sense of discrimination, which has largely affected IDPs,

forcing them to socially withdraw. This situation has limited, to a great extent, people's capacity to form relationships, their overall sense of wellness, as well as their ability to cope with stress and to rebuild some lost protective factors. The circumstances of displacement have led to the modification, transformation, re-adaptation, and painful loss of family and social roles (especially evident among families that are separated).

Some people participating in this study revealed responses to trauma that fall under the category of Adversity-Activated Development (AAD). In addition to their negative reactions to the crisis, some people often experience fundamental reviewing and hence renewal of their lives. Examples are the satisfaction with the personal development experienced and reported by some women who have been forced to work to support their families as a result of the change in gender roles. Some of those women highlighted positive changes such as increased ambition, feelings of adequacy, building new relationships, and acquiring new skills. Another example is related to family dynamics. Some respondents, including men in Homs, pointed out their satisfaction with the stronger family ties, especially in terms of their relationships with their children.

The reported common expressions used to refer to the feelings of distress and uneasiness are as follows:

May God make things easier	الله يفرّج
May God save us	الله يخلّصنا
I cannot tolerate myself	مو طايقة حالي
Why, God?	ليش يا ربي
May God put an end to my life	الله يقرب آخرتي
Enough, enough	بكفي بكفي
God do not forget us	يا الله لا تنسانا
There is no power but in God the Almighty	لا حول ولا قوة إلا بالله العلي العظيم
God, we are bored and fed up	ملينا يا لله
I'm going to break	رح طق
Our soul is suffocating	روحنا ضايقة
May God make things easier	الله يهونها
I feel I will explode	رح افقع

The above phrases indicate people's turning to God for support, or convey their high levels of distress and inability to tolerate their situations.

According to MHPSS practitioners, with the crisis affecting such a large proportion of the Syrian population, the number of persons ready to seek help for MHPSS services has also grown significantly. This was corroborated by responses given during the FGDs, where women, men and adolescents all highlighted the need for MHPSS activities that are "safe and confidential" and that would help them vent and speak about their problems.

Building on the population's progressively increasing willingness to seek MHPSS services, a timely intervention is necessary to avoid sedimentation of emotional problems, and to alleviate the suffering of the war-affected Syrians. Nevertheless, the resilience showed, and the suggestions made by those interviewed should not be overlooked. In fact, they should be the basis of any intervention aiming to help them.

The mental health and psychosocial needs indicate feelings of distress and what can be referred to as Ordinary Human Suffering (OHS) [12]. These phenomena may occur in people who feel distressed but do not have a mental disorder. However, when distress significantly impacts daily functioning or includes specific constellations of characteristic symptoms, the person may have a mental disorder. The rates of mental disorders among Syrians have likely gone up significantly, but there are no reliable estimates of prevalence [13].

The current study shows consistency with the existing studies and reports on the MHPSS needs of Syrians. According to a study by IMC [14], Syrians face limited access to basic health, education, food, shelter, mental health, and other services. The most common psychosocial and mental health problems are severe emotional disorders (54 percent) most commonly including depression and anxiety, followed by epilepsy (17 percent) and psychotic disorders (11 percent).

Among children, epilepsy (26.6 percent), intellectual and developmental disorders (26.6 percent), and severe emotional disorders (3.6 percent) are the most common. The availability of quality services is low due to overstretched capacity and a shortage of trained mental health professionals working in local governmental, non-governmental, and community-based mental health systems.

The study reported high numbers of psychotic illnesses and non-PTSD presentations [15].

According to WHO statistics, it is estimated that more than 350,000 individuals suffer from a severe form of mental disorders, over 2,000,000 suffer from mild to moderate mental problems such as anxiety and depression disorders, and a large percentage have moderate to severe psychological/social distress (WHO).

Moreover, 10-15% of pregnant women in Syria are estimated to be exposed to pre-postpartum depression (UNFPA). These impacts negatively on them, hindering them from completing daily tasks, maintaining good social and family relationships, as well as taking care of their physical

12 Refugees, Trauma, and Adversity-Activated Development. Renos Papadopoulos. European Journal of Psychotherapy and Counseling, September 2007; 9(3): 301–312
13 Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial support staff working with Syrians Affected by Armed conflict 2015
14 "Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis," http://internationalmedicalcorps.org/document.doc?id=526.

15 IMC. Ongoing war creates invisible mental health crisis for Syrian people. International Medical Corps, March 16, 2015. https://internationalmedicalcorps.org/press-release/2015_03_16-syria-mental-health-report-release

health [16]. Difficult life circumstances may result in mental disorders or exacerbate them, but also contribute to non-clinical phenomena, such as demoralisation and hopelessness, and may be related to profound and persistent existential concerns of safety, trust, coherence of identity, social role, and society. Moreover, non-clinical interventions, relating to improvement of living conditions of refugees and IDPs, may contribute significantly to improving mental health, in many cases more so than any psychological or psychiatric intervention.[17]

Hence, there is a need to establish or enhance outreach capacity in providing assistance, to establish or enhance coordination and dissemination of information about available services, to establish or enhance comprehensive dissemination of information about available services among the beneficiary community, and to increase the capacities of MHPSS service providers.

Age and gender-specific activities for women, men and youth, including social and school counselling, discussion groups, and livelihood activities need to be carried out.

Mental healthcare and psychosocial support should be integrated into non-stigmatising care settings, and should be respectful of cultural and gender local norms.

16 Bou Khalil R. Where all and nothing is about mental health: Beyond post-traumatic stress disorder for Displaced Syrians. American Journal of Psychiatry 2013; 170(12): 1396-7
17 Bou Khalil R. Where all and nothing is about mental health: Beyond posttraumatic stress disorder for Displaced Syrians. American Journal of Psychiatry 2013; 170(12): 1396-7

CONCLUSION AND RECOMMENDATIONS

Mental healthcare has had a long-standing unpopularity in Syria dating back even prior to the current setting. However, with the onset of the crisis that began in March 2011 and which continues to multi-laterally challenge the lives of Syria's population, this assessment has shown that people are slowly becoming more accepting towards learning about and receiving mental health and psychosocial support.

In addition to being a critical time to mobilise and enhance mental healthcare systems, the current emergency situation can be capitalised upon as an important opportunity to transform mental healthcare and build long-term, sustainable, high-quality mental health systems. Strategic efforts should be made to convert short-term interest in responding to mental health problems into momentum for large-scale mental health reform. In order to do so, as well as to mainstream well-planned, coordinated interventions and a standardised strategy on capacity development, the diverse needs of MHPSS practitioners currently working in Syria and the challenges they face in their work must be taken into consideration.

Coordination and Capacity Building

There is a need to activate a Mental Health and Psychosocial Support taskforce to establish a long-term MH strategy and coordinated activities that aim at responding to the various needs.

Efforts should focus not only on training of staff and community members to recognise acute mental health symptoms, use PFA, and establish referral systems into specialist care, but also on expanding to include community-based and culturally sensitive programmes that enhance functionality and coping strategies of affected populations and protect future generations.

For MHPSS practitioners, opportunities for continuing education, training, and professional development, especially on the identified areas that require improvement, are crucial to professional advancement and the provision of necessary specialised support should be provided. Moreover, MHPSS practitioners also require continuous, sufficient, and culturally-sensitive technical support and supervision.

Referral Systems and Follow-Up

Efforts should aim at improving coordination between organisations and service providers and consequently establishing a clear referral system. This will also serve to ensure proper case management and follow up.

Contextualised Arabic Resource Development

According to study respondents, there is an immense need for contextualised resources in the Arabic language that address MHPSS practitioners' needs. Some participants were also unaware of available resources, and thus, there is a need to map existing Arabic and contextualised resources on MH and PSS (including those developed in Lebanon during and post the July 2006 war). Following the mapping, existing resources need to be modified to fit the emergency situation.

Community-Based PSS Interventions

Since the majority of people display signs of distress, community and family-focused psychosocial interventions (including vocational, counselling, supportive trauma-focused help, and similar), in addition to culturally sensitive psycho-education, should be provided. This would aim to promote and built on people's resilience, increase understanding of symptoms and treatability of trauma effects and complicated grief, and reduce stigma. Such an approach is especially important because it supports the objectives of the WHO Mental Health Action Plan 2013–2030 in the creation of "comprehensive, integrated, and responsive mental health and social care services in community-based settings." [1]

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.

1 WHO, Mental Health Atlas 2014. World Health Organisation, 2015

Improving MHPSS Service Geographical Coverage

The current centralisation of services in certain urban areas restricts people's access to important MHPSS services. Efforts need to be made to ensure better geographical coverage of MHPSS services nationwide, which requires advocacy and effective utilisation and involvement of existing infrastructures.

Avoiding Over-Diagnosis of Clinical Mental Disorders

MHPSS professionals should be aware and take precautions not to over-diagnose clinical mental disorders among displaced Syrians, especially among those facing high insecurity and instability, and who have many ongoing and/or extreme daily stressors.

Integrating MH Care into Primary Healthcare

Efforts to integrate MH into primary healthcare should be supported, and those efforts should be expanded into urban and rural settings in Syria. In many countries, the WHO, the International Medical Corps, and several other agencies are already training general healthcare providers on mental healthcare and its provision.

Specific percentages of national health budgets must be dedicated to community mental health services as part of general healthcare (which is provided free of charge).

Encouraging and Promoting Self-Care and Staff-Care

Organisations with employees providing MHPSS services and case management should allocate a specific budget for self-care and staff-care activities to alleviate the stress experienced by staff, reduce possibilities of burnout, and avoid other negative effects of being constantly exposed to high-stress accounts and environments (compassion fatigue).

ANNEXES

Annex I - Guidance Note on the Use of the Assessment Tool

Objectives and Structure of the Guidance Note

This document aims at providing practical information, necessary advice, and guidance to ensure the proper and effective use of the "Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment" tool. It sheds light on the basic principles that govern the assessment process. It also provides information related to each section of the assessment tool, describing its objectives and relevance. The guidance note serves to explain the objectives and value of the assessment exercise and guarantee informed consent from those participating in the assessment.

Objectives of the "Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment"

This rapid participatory assessment is part of the "BelSalameh" project being implemented by ABAAD and supported by the European Union. It is a rapid assessment of the training and capacity needs of mental health practitioners, and aims at identifying the existing gaps, needs, and resources influencing the work of mental health practitioners. The overall objectives of this assessment can be described as follows:

- Exploring whether targeted practitioners within the programme are well-enabled to manage the provision of mental health services and respond to various mental health needs.
- Informing the development of training processes, materials, and tools, as well as related capacity development programmes around specialised mental health needs and emergency-related needs.

"BelSalameh" aims at supporting individuals (women and men) by enabling them to play an effective and active role in promoting resilience and healthy coping on the individual and societal levels, and to contribute effectively in promoting opportunities for peace building in their communities.

This assessment is based upon the profound belief, acknowledgement, and appreciation of the fundamental role played by mental health professionals. It is also based upon the realisation of the arising and increasing mental health-related needs in the emergency context.

The assessment shall inform different consequent activities such as resource development and trainings, to help support mental health practitioners and improve their work.

Professional and Ethical Considerations Governing the Assessment Process

The assessment of needs and resources is considered a fundamental activity for the proper planning, implementation, monitoring, and evaluation of interventions. It is necessary for identifying existing gaps and needs that require response as well as existing resources and opportunities that can be used and built upon. In emergencies, findings from needs assessments make good decision-making possible. They help put information together to build a full picture of the needs of the disaster-affected community.

There is a set of ethical principles that the assessment team should abide by to ensure a proper assessment process that respects and protects the research team as well as the research participants, causing No Harm [2]. Consideration should be given to the ethical issues regarding ownership and use of information, confidentiality, raised expectations versus unmet needs, and the dangers of stigmatising groups and communities. We present here some main principles:

Objectivity: including reliability of information and avoidance of bias or modifying information as per the researcher's subjective interpretation of results.

Confidentiality and Privacy: including the protection of all information provided by the study participants, dealing with the information in a professional manner and limiting the use of the collected information to the study. It also includes avoiding sharing of information with others outside the assessment study context and thereby respecting the privacy of participants.

Informed Consent: the participation in the study should be voluntary. It is necessary to properly explain the purpose of the study, the topic it tackles, its importance and the different steps it includes and getting the participant's consent at the beginning of the assessment.

Trust: an essential element of any assessment process. It is necessary to build trust with the assessment study participants and ensure its respect in all the assessment phases.

Truthfulness and Accuracy: trustworthiness of information, trust that the results reported by others are valid and that no bias influences the results.

Safety: includes protecting the study participants from any potential physical, psychological, emotional, social or economic harm, or even causing any suffering as a result of the assessment.

2 ACAPS (2014) Humanitarian Needs Assessment: The Good Enough Guide, The Assessment Capacities Project (ACAPS), Emergency Capacity Building Project (ECB) and Practical Action Publishing, Rugby, UK.

Notes on the Different Sections of the Assessment Tool

The assessment tool is composed of different complementary and related sections.

Section One: General Information

This section includes a variety of questions about the study participants regarding age, sex, nationality, geographical location, educational level, and the nature and type of work. It also includes questions about the different activities implemented by the mental health professional and questions assessing the participants' workload.

The following sections are divided into different axes that assess participants' needs and capacities. These axes are as follows:

- Knowledge on mental health-related topics
- Skills needed to work with different cases
- Training, continuing education, and capacity development
- Resources (available and needed resources)
- Technical support and supervision
- Referral, follow up, and coordination
- Self-care
- Other Issues (questions related to the mental health and psychosocial needs of beneficiaries and the challenges they face, from the mental health professionals' perspective)

This assessment shall be accompanied by focus group discussion sessions with women, men, and adolescents (girls and boys) to identify their mental health and psychosocial needs, their knowledge and use of existing mental health services, and the main factors influencing their uptake of available services.

Section on Knowledge

This section aims at assessing the mental health professionals' needs that are related to knowledge of different topics related to their work.

Topics

A. Mental disorders, their diagnosis and management

1. Classification of mental disorders
2. Depression
3. Anxiety, panic attacks, phobia
4. Psychosis
5. Epilepsy (including psychogenic seizures)
6. Mental disorders in children
7. Developmental disorders
8. Disorders related to substance abuse
9. Post- traumatic stress disorders
10. Suicide and self-harm
11. Mood disorders
12. Dementia and elderly mental health problems
13. Psychopharmacology

B. Current circumstances and mental health

1. Trauma and mental health
2. Psychosocial support
3. Mental health and amputations resulting from war
4. Mental health and survivors of torture
5. Mental health and cases suffering /survivors of rape or sexual abuse
6. Psychosocial and MH assessment
7. Mental health and child survivors of abuse
8. Mental health and separated or unaccompanied children
9. Psychological First Aid
10. Risk assessment and management
14. Self-care

C. Ethical considerations and special cases

1. Legislations in mental health
2. Confidentiality and ethical issues in mental health

Section on Skills

This section aims at assessing the mental health professionals' skills on different issues specific to their work. It is designed as a self-assessment where participants would evaluate their skills and abilities to work with different cases and under different conditions. The topics listed in this section are similar to those in the previous section on knowledge. This was based on the belief that knowledge in itself is not enough and that skills are needed to translate knowledge into action, therefore properly addressing each case.

Section on Training and Capacity Development

This section includes questions on training workshops and existing (as well as needed) opportunities for improving knowledge, skills, and continuing education. It explores the availability of capacity-building opportunities and sources while also assessing the effectiveness of these opportunities from the participants' perspectives. The section aims at identifying the main topics and domains that the mental health workers require further training on (in addition to what was identified in the previous sections of the assessment study).

Section on Resources

This section aims at assessing mental health workers' need for Arabic, contextualised resources that are culturally-specific (ex: books, manuals, brochures, reports, and documentation forms…). It also aims at identifying the topics on which there is a lack of resources. The section also aims at identifying existing resources that MH workers currently utilise and find useful in their work.

Section on Supervision and Technical Support

This section includes different questions that aim at identifying the following: availability of technical support opportunities; source of technical support (internal within the organisations, external from other organisations, or remote technical support). The section also assesses the available technical support, the need for it, and the areas on which technical supervision and coaching are required (continuous supervision, consultation on specific topics, support in terms of knowledge on different topics…).

Section on Referral, Follow-up and Coordination

The difficulties related to the referral and follow-up of cases among people who need specialised care are common and hinder the work of MHPSS workers. This section thus aims at exploring and assessing the referral mechanisms (both, internal within the organisations and external between the different service providers). This helps shed light on the extent of knowledge on existing service providers.

Section on Self-care and Support

This section aims at shedding light on forms and dynamics of self-care amongst mental health professionals. The section does not aim at profoundly assessing the different self-care needs (as this is the objective of another concurrent study on self-care needs also being conducted under "BelSalameh"). The different questions in this section help explore some main self-care-related needs.

Section on Other Issues

This section tackles some other issues related to the most common challenges currently faced by MHPSS workers. It also aims at identifying the most common needs and challenges faced by beneficiaries from the perspective of mental health professionals. The section includes questions on the common terms or phrases (sayings, proverbs…) used by beneficiaries to describe their psychological distress as well as on the most common barriers that usually hinder people from getting specialised help when needed.

Annex II - Informed Consent Form

Capacity Needs and Resources of MH Practitioners in Syria Rapid Participatory Assessment

This rapid participatory assessment is part of the "BelSalameh" project being implemented by ABAAD and supported by the European Union. It is a rapid assessment of the training and capacity needs of mental health practitioners, and aims at identifying the existing gaps, needs, and resources influencing the work of mental health practitioners. The overall objectives of this assessment can be described as follows:

- Assessing whether targeted practitioners within the programme are well-enabled to manage the provision of mental health services and respond to various mental health needs.
- Informing the development of training processes, materials, and tools, as well as related capacity development programmes around specialised mental health needs and emergency-related needs.

The assessment shall inform different consequent activities such as resource development and trainings, to help support humanitarian workers and improve their work.

This assessment tool is anonymous and does not require specifying the name of the person filling it or any information pertaining to his/her identity. The project team respects the privacy and confidentiality of all study participants. The project team is only seeking information that can be useful to understand the capacity needs of mental health practitioners.

I have the right to stop filling the survey when I feel the need to. I also have the right to review the results of the study when it is ready.

I have read this consent form and have been given the opportunity to ask questions. I give my consent to participate in this study.

Date _____

Participant's Signature _____

Thank you for your cooperation,

The assessment team

Annex III - Assessment Tool

Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment

This rapid participatory assessment is part of the "BelSalameh" project being implemented by ABAAD and supported by the European Union. It is a rapid assessment of the training and capacity needs of mental health practitioners, and aims at identifying the existing gaps, needs, and resources influencing the work of mental health practitioners. The overall objectives of this assessment can be described as follows:

- Assessing whether targeted practitioners within the programme are well-enabled to manage the provision of mental health services and respond to various mental health needs.
- Informing the development of training processes, materials, and tools, as well as related capacity development programmes around specialised mental health needs and emergency-related needs.

The assessment shall inform different consequent activities such as resource development and trainings, to help support humanitarian workers and improve their work.

This assessment tool is anonymous and does not require specifying the name of the person filling it or any information pertaining to his/her identity. The project team respects the privacy and confidentiality of all study participants. The project team is only seeking information that can be useful to understand the capacity needs of mental health practitioners.

Thanks for your cooperation,

The project team

General Information

1- Nationality ◯ Syrian ◯ Palestinian-Syrian ◯ Others (please specify, if possible)

2- Age ◯ 20-24years ◯ 25-34years ◯ 35-44years ◯ 45-55 years ◯ above 55years

3- Sex ◯ Male ◯ Female

4- Region ◯ Syria (Please specify governorate) _____

◯ Lebanon (Please specify governorate) _____

5- Profession ◯ Psychiatrist ◯ Psychologist ◯ Psychotherapist ◯ Counsellor ◯ Psychiatric nurse ◯ Social worker ◯ Others, please specify _____

6- Type of work/activities(you can tick more than one option)

◯ Individual sessions ◯ Group support sessions ◯ Trainings and awareness

◯ Self-care and staff care activities for other staff ◯ Supervision
◯ Other, please specify _____

7- Number of working hours per day(approximately) _____

8- Average number of patients seen per week (approximately) _____

9- Do you have previous experience in humanitarian and emergency work before your current work?

◯ Yes ◯ No

If your answer is yes, please specify type of work _____

10- Duration of work in the humanitarian field in Syria (and other emergency settings)

◯ Less than a year ◯ 1-3years ◯ 4-6years

◯ More than 6 years ◯ Other, please specify _____

Axis I - Knowledge

1- Kindly assess your knowledge on the following topics and mark the topics which you think you need to know more about

Evaluation Of knowledge	Excellent	Satisfactory	Fair	Poor	Require further training to improve my knowledge on
A. Mental disorders, their diagnosis and management					
15.Classification of mental disorders					
16.Depression					
17.Anxiety, panic attacks, phobia					
18. Psychosis					
19. Epilepsy (including psychogenic seizures)					
20. Mental disorders in children					
21. Developmental disorders					
22. Disorders related to substance abuse					
23. Post- traumatic stress disorders					
24. Suicide and self-harm					
25. Mood disorders					
26. Dementia and elderly mental health problems					
27. Psychopharmacology					

Evaluation Of knowledge	Excellent	Satisfactory	Fair	Poor	Require further training to improve my knowledge on
B. Current circumstances and mental health					
11. Trauma and mental health					
12. Psychosocial support					
13. Mental health and amputations resulting from war					
14. Mental health and survivors of torture					
15. Mental health and cases suffering /survivors of rape or sexual abuse					
16. Psychosocial and MH assessment					
17. Mental health and children survivors of abuse					
18. Mental health and separated or unaccompanied children					
19. Psychological First Aid					
20. Risk assessment and management					
21. Self-care					
C. Ethical considerations and special cases					
3. Legislations in mental health					
4. Confidentiality and ethical issues in mental health					

2- Kindly specify additional topics that you need to improve your knowledge on

_____

_____

_____

Axis II - Practices and Skills

1- Kindly assess your skills on the following topics and mark the areas you think you need to improve your skills in

Evaluation Of skills related to…	Excellent	Satisfactory	Fair	Poor	Require further training to improve my skills in
D. Mental disorders, their diagnosis and management					
1. Classification of mental disorders					
2. Depression					
3. Anxiety, panic attacks, phobia					
4. Psychosis					
5. Epilepsy (including psychogenic seizures)					
6. Mental disorders in children					
7. Developmental disorders					
8. Disorders related to substance abuse					
9. Post- traumatic stress disorders					
10.Suicide and self-harm					
11. Mood disorders					
12. Dementia and elderly mental health problems					
13. Psychopharmacology					

Evaluation Of skills related to…	Excellent	Satisfactory	Fair	Poor	Require further training to improve my skills in
E. Current circumstances and mental health					
1. Trauma and mental health					
2. Psychosocial support					
3. Mental health and amputations resulting from war					
4. Mental health and survivors of torture					
5. Mental health and cases suffering /survivors of rape or sexual abuse					
6. Psychosocial and MH assessment					
7. Mental health and children survivors of abuse					
8. Mental health and separated or unaccompanied children					
9. Psychological First Aid					
10. Risk assessment and management					
11. Self-care					
F. Ethical considerations and special cases					
1. Legislations in mental health					
2. Confidentiality and ethical issues in mental health					

2- Please mark the areas that require further skill and capacity building:

- ◌ Identification and diagnosis
- ◌ Assessment of needs and risks
- ◌ Case management
- ◌ Counselling
- ◌ Family therapy
- ◌ Prescribing medications (if applicable)
- ◌ Referral and case follow up
- ◌ Handling difficult situation (security and ethical challenges); please specify if possible _____
- ◌ Other needed skills, please specify _____

Axis III - Resources

Training

1- How frequently do you participate in training and professional development workshops:

◯ Frequently ◯ Sometimes ◯ Rarely ◯ Never

2- The trainings you participate in are:

◯ Organised by the organisation you work in

◯ Organised by other organisations

◯ Other, specify_____

Title of the training (or topic)	Organiser/ Location/ Date (if possible)	Impact of the training		Comments
		Was effective	**Was not effective**	

3- With respect to trainings you have attended over the past 5 years, please specify:

4- Kindly specify top training topics of interest

_____

_____

_____

Resources

1- What are some available resources (books, manuals, reports…) that you find useful in your work?

Title	Topic	Organisation or publisher

2- Do you need additional Arabic contextualised resources in your work? ◯ Yes ◯ No

If yes, kindly specify the type of resource and the topics (you can tick more than one option)

Topic

Mental disorders, their diagnosis and management

◯ Classification of mental disorders

◯ Depression

◯ Anxiety, panic attacks, phobia

◯ Psychosis

◯ Epilepsy (including psychogenic seizures)

◯ Mental disorders in children

◯ Developmental disorders

◯ Disorders related to substance abuse

◯ Post- traumatic stress disorders

◯ Suicide and self-harm

◯ Mood disorders

◯ Dementia and elderly mental health problems

◯ Psychopharmacology

Current circumstances and mental health

- ◯ Trauma and mental health
- ◯ Psychosocial support
- ◯ Mental health and amputations resulting from war
- ◯ Mental health and survivors of torture
- ◯ Mental health and cases suffering /survivors of rape or sexual abuse
- ◯ Psychosocial and MH assessment
- ◯ Mental health and children survivors of abuse
- ◯ Mental health and separated or unaccompanied children
- ◯ Psychological First Aid
- ◯ Risk assessment and management
- ◯ Self-care

Ethical considerations and special cases

- ◯ Legislations in mental health
- ◯ Confidentiality and ethical issues in mental health

Resources Needed

◯ Diagnostic tools ◯ Manuals ◯ Reporting/documentation forms ◯ Assessment tools

◯ Other, please specify _____

Supervision, coaching and technical support

Statement	Never	Rarely	Sometimes	Frequently	Always	Other Comments and explanation
1- I can easily access technical support and supervision when I need it umstances and mental health						
2- I need technical support to work more effectively (please specify)						

3- Do you receive any form of technical support in your work? ◯ Yes ◯ No

a) If yes, do you receive the technical support ◯ From within the organisation

◯ From other institutions ◯ Remote (website, professional network…)

Please specify _____

b) If yes, how do you assess the support you receive?

◯ Sufficient and useful ◯ Insufficient and useful ◯ Ineffective

◯ Other, specify _____

4- Please specify areas in which you need technical support

_____

_____

_____

Referral, follow up and Coordination

Statement	Never	Rarely	Sometimes	Frequently	Always	Other Comments and explanation
1. I have clear roles and responsibilities						
2. I find it easy to refer cases with specific needs whom I work with to appropriate service providers						
3. I think that coordination and cooperation among organisations working in my area are not enough (please explain)						

4. Is there a referral mechanism within your organisation? (you can tick more than one option)

- ◯ Yes
- ◯ Yes, but procedures not clear to all staff
- ◯ Yes, but not used effectively
- ◯ No

Statement	Never	Rarely	Sometimes	Frequently	Always	Other Comments and explanation
1. I can set appropriate boundaries at work with the cases I work with (ex: no phone calls after work hours…)						
2. I set realistic goals, work plans and timelines						
3. I talk to my colleagues at appropriate times about my feelings and my reactions to professional issues						
4. I work as part of a team (in cooperation with a team)						
5. I meet my colleagues and we talk about issues, share problems and solutions						
6. I feel that the organisation I work at appreciates my work						
7. I am aware of my feelings and I can sense when I am not feeling well						
8. I get satisfaction from my ability to help others						
9. I feel stressed because of the workload						
10. I feel exhausted because of my work in the humanitarian and support fields						
11. I feel that I am easily irritable						
12. I feel unable to relax						
13. I ask others for help (friends, family members, others) when I am feeling stressed						
14. I have a supportive social network						

Other Issues

1- Please specify other challenges you face in your current work (you can tick more than one option):

- ◌ Challenges related to insufficient awareness in mental health among beneficiaries
- ◌ Challenges related to stigma correlated with mental health problems and disorders
- ◌ Challenges related to referral
- ◌ Challenges related to access to mental health services (transportation, security situation…)
- ◌ Challenges related to security concerns and trust in confidentiality of mental healthcare
- ◌ Challenges related to humanitarian workers (frontline workers') capacity to identify and refer cases
- ◌ Challenges related to compliance of beneficiaries with therapy
- ◌ Challenges related to poor collaboration of family
- ◌ Other, please specify _____

2- What are the most common mental health problems and disorders among beneficiaries/people you work with?

- ◌ Depression
- ◌ Anxiety
- ◌ Psychosis
- ◌ Epilepsy (including psychogenic epilepsy)
- ◌ Developmental disorders (children and adolescents)
- ◌ Problems related to abuse
- ◌ Disorders related to substance abuse (alcohol and/or drugs)
- ◌ Post-traumatic stress disorders
- ◌ Trauma, rape and/or torture
- ◌ GBV
- ◌ Problems related to disabilities/amputations resulting from war
- ◌ Suicide and self-harm
- ◌ Other, please specify _____

In order to better understand how beneficiaries perceive mental health services:

3- What are the common terms used by beneficiaries to describe psychological distress?

_____

_____

_____

4- What are some barriers that usually hinder people (who need specialised mental healthcare) from getting specialised help when needed?

- ◌ People's knowledge of available services related to mental health
- ◌ Stigma related to mental health problems and disorders
- ◌ Security situation
- ◌ Lack of proper identification and referral
- ◌ Accessibility of services
- ◌ Other, please specify _____

5- Other comments _____

Annex IV - Focus Group Discussion Guides

Focus Group Discussion Sessions with Women, Men, Girls, and Boys

Structure of the Focus Group Session

Preparatory phase: Sample selection taking into consideration variables of age, sex, geographical location, educational level.

First Phase: Opening

- Welcoming participants, introducing ourselves and facilitating some ice breaker exercises
- Informing participants about the duration of the session
- Collectively establishing a set of ground rules (including respecting privacy and confidentiality of information, never sharing information and restricting their use to the study, respecting different viewpoints…).
- Introducing the topic and purpose of the meeting.

The following ideas can be useful to explain the purpose and value of the meeting:

Our psychological wellbeing is influenced by multiple factors and circumstances surrounding us. The current emergency situation and the problems resulting from it influence people and groups differently.

The purpose of this session is to collectively identify the most common mental health needs, mental health problems, and the sources of strength and support. The session aims at helping the study team understand the effects of the current emergency situation on individuals, families and communities. It also aims at identifying people's coping strategies and use of existing mental healthcare services.

The information revealed by participants shall help in planning and designing activities that aim at responding to the identified needs, benefiting from the available resources.

Second Phase: Discussion

The facilitator reminds participants of the agreed-upon ground rules and asks the questions specific to each group. Upon discussing each question, the facilitator asks additional probing questions that help better understand the participants' responses around each topic.

Third Phase: Closure

The facilitator summarises the main ideas and asks for further explanation or clarification if needed. The facilitator reminds participants of the purpose of the study and thanks them for their input and cooperation.

Sample Questions for FGD Sessions with Women

1. In your opinion, how does the current situation in Syria affect mental health…?
   - On the individual level
   - On the family level
   - On the community and societal levels

   What are the most common manifestations of uneasiness on the different levels? What are the most important and most common mental health needs?

2. According to you, how do the emergency circumstances influence your different roles (as a woman, as a wife, as a mother, as a partner/friend…)? (We explore how the prevailing circumstances affect, if in fact they do, their daily self-care, their interaction with others including their children and partners, and their social interactions).

3. How do you usually manage your feelings of uneasiness and stress resulting from the current emergency situation? What do you usually do to cope and to get rid of the unpleasant feelings?

4. What are the terms and phrases you usually use to refer to feelings of uneasiness and/or distress?

5. What are the most prevalent stress factors in your life currently? What are the most important protective and supportive factors that help you handle difficulties and cope with stress?

6. When do you feel that your psychological and emotional wellbeing (or that of a family member or a person close to you) require specialised professional care? Has that happened before? What did you do?

7. Who do you turn to if you (or a family member or close person) requires specialised mental healthcare? (We try to find out if they turn to traditional healers)

8. Are there any mental health services in your area? Do you know about available mental health services? What do you know about them?

9. What are the main barriers that hinder your access to mental health services? (We try to learn about existing barriers, difficulty in access and distance to services, fear of social stigma, lack or insufficiency of knowledge about existing services, gender as a barrier that hinders service seeking…).

10. What are your suggestions to facilitate access to mental healthcare services and improve its use by people who need such services?

Sample Questions for FGD Sessions with Men

1. In your opinion, how does the current situation in Syria affect mental health…?
   - On the individual level
   - On the family level
   - On the community and societal levels

   What are the most common manifestations of uneasiness on the different levels? What are the most important and most common mental health needs?

2. According to you, how do the emergency circumstances influence your different roles (as a man, as a husband, as a father, as a partner/friend…)? (We explore how the prevailing circumstances affect, if in fact they do, their daily self-care, their interaction with others including their children and partners (here, we can ask about possible use of violence), and their social interactions).

3. How do you usually manage your feelings of uneasiness and stress resulting from the current emergency situation? What do you usually do to cope and to get rid of the unpleasant feelings?

4. What are the terms and phrases you usually use to refer to feelings of uneasiness and/or distress?

5. What are the most prevalent stress factors in your life currently? What are the most important protective and supportive factors that help you handle difficulties and cope with stress?

6. When do you feel that your psychological and emotional wellbeing (or that of a family member or a person close to you) require specialised professional care? Has that happened before? What did you do?

7. Who do you turn to if you (or a family member or close person) requires specialised mental healthcare? (We try to find out if they turn to traditional healers)

8. Are there any mental health services in your area? Do you know about available mental health services? What do you know about them?

9. What are the main barriers that hinder your access to mental health services? (We try to learn about existing barriers, difficulty in access and distance to services, fear of social stigma, lack or insufficiency of knowledge about existing services, gender as a barrier that hinders service seeking…).

10. What are your suggestions to facilitate access to mental healthcare services and improve its use by people who need such services?

Sample Questions for FGD Sessions with Adolescent Girls

1- How do the current prevailing circumstances affect your psychological wellbeing? (We ask specific questions about influences on the physical, cognitive, behavioural, emotional, and social levels).

2- Do the current prevailing circumstances affect your ability to practice your daily activities (school, meeting friends, practicing hobbies…)?

3- Do the current prevailing circumstances influence your family? How? (We try to understand how the prevailing circumstances affect family members and the family dynamics, interactions with each other and with the surrounding).

4- How do you usually manage your feelings of uneasiness and stress resulting from the current emergency situation? What do you usually do to cope and to get rid of the unpleasant feelings?

5- What are the terms and phrases you usually use to refer to feelings of uneasiness and/or distress?

6- What are the most prevalent stress factors in your life currently? What are the most important protective and supportive factors that help you handle difficulties and cope with stress?

7- When do you feel that your psychological and emotional wellbeing (or that of a family member or a person close to you) require specialised professional care? Has that happened before? What did you do?

8- Who do you turn to if you (or a family member or close person) requires specialised mental healthcare? (We try to find out if they turn to traditional healers)

9- Are there any mental health services in your area? Do you know about available mental health services? What do you know about them?

10- What are the main barriers that hinder your access to mental health services? (We try to learn about existing barriers, difficulty in access and distance to services, fear of social stigma, lack or insufficiency of knowledge about existing services, gender as a barrier that hinders service seeking…).

11- What are your suggestions to facilitate access to mental healthcare services and improve its use by people who need such services?

Sample Questions for FGD Sessions with Adolescent Boys

1- How do the current prevailing circumstances affect your psychological wellbeing? (We ask specific questions about influences on the physical, cognitive, behavioural, emotional, and social levels).

2- Do the current prevailing circumstances affect your ability to practice your daily activities (school, meeting friends, practicing hobbies…)?

3- Do the current prevailing circumstances influence your family? How? (We try to understand how the prevailing circumstances affect family members and the family dynamics, interactions with each other and with the surrounding).

4- How do you usually manage your feelings of uneasiness and stress resulting from the current emergency situation? What do you usually do to cope and to get rid of the unpleasant feelings?

5- What are the terms and phrases you usually use to refer to feelings of uneasiness and/or distress?

6- What are the most prevalent stress factors in your life currently? What are the most important protective and supportive factors that help you handle difficulties and cope with stress?

7- When do you feel that your psychological and emotional wellbeing (or that of a family member or a person close to you) require specialised professional care? Has that happened before? What did you do?

8- Who do you turn to if you (or a family member or close person) requires specialised mental healthcare? (We try to find out if they turn to traditional healers)

9- Are there any mental health services in your area? Do you know about available mental health services? What do you know about them?

10- What are the main barriers that hinder your access to mental health services? (We try to learn about existing barriers, difficulty in access and distance to services, fear of social stigma, lack or insufficiency of knowledge about existing services, gender as a barrier that hinders service seeking…).

11- What are your suggestions to facilitate access to mental healthcare services and improve its use by people who need such services?

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LIST OF ACRONYMS

AAD	Adversity Activated Development
ABAAD	"Dimensions"
CBO	Community-based organisation
CBT	Cognitive Behavioural Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
FGD	Focus Group Discussion
GAD	Generalised anxiety disorders
HIS	Health Information System
IASC	Inter-Agency Standing Committee
IDP	Internally displaced persons
INGO	International non-governmental organisation
IOM	International Organisation for Migration
MH	Mental health
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
mhGAP	Mental Health Gap Action Programme
mhGAP-IG	Mental Health Gap Action Programme Intervention Guide for management of mental, neurological and substance use disorders in non-specialised health settings
NGO	Non-governmental organisation
PHC	Primary healthcare
PFA	Psychological First Aid
PiN	People in need
PTSD	Post-Traumatic Stress Disorder
SHARP	Syrian humanitarian assistance response plan
SARC	Syrian Arab Red Crescent
SGBV	Sexual and gender based violence
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WG	Working Group
WHO	World Health Organisation
WHO-AIMS	WHO-Assessment Instrument for Mental Health Systems

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