Mental health, forced displacement and recovery: integrated mental health and psychosocial support for urban refugees in Syria

Constanze Quosh

This article describes a pilot mental health and psychosocial support programme that was initiated by the United Nations High Commissioner for Refugees, after the massive influx of Iraqi refugees into Syria in 2006. The aim of the article is to provide: 1) an overall description of the programme for refugees within an urban setting, including initial outcome data; and 2) a description of applying a theoretical model to influence programme design and evaluation. This programme, based on good practice, began in 2008. The programme staff implemented a three-fold approach, which included: comprehensive mental health and psychosocial support case management; community outreach and a psychosocial centre to provide a safe healing space; and inter-agency mental health and psychosocial support capacity building of the local mental health system and within the displaced community. The different components were eventually transferred at the end of 2011 to national ownership, in order to ensure national system building, ownership and sustainability. The programme has since been adjusted to apply to the recent acute internal emergency. Results of mixed-method monitoring and evaluation show significant outcomes, including reported improvement in wellbeing among programme participants.

Keywords: ADAPT model, displacement, evaluation, Iraqi, mental health and psychosocial support programming, outcome, output, refugees, Syria, wellbeing

Introduction

Background: protracted forced displacement in urban settings

The humanitarian response to mental health and psychosocial support (MHPSS) is typically designed for acute emergencies, with large-scale population displacement to camps or other confined settings. However, most refugees live in urban and low resource settings (United Nations High Commissioner for Refugees (UNHCR), 2012). This has not yet found sufficient consideration in either research or policy, even though the urban setting poses unique challenges.[1]

There is growing attention for the unique challenges of urban settings, such as the invisibility and limited opportunity to reach urban refugee communities (and in particular the identification and follow-up of those most vulnerable or at risk), developing adequate communication channels, lack of access by the community to different support systems and services (including access barriers related to language, costs, and distance) and the limited opportunities for livelihood and self reliance. This is often complicated by non-conducive policies, protection risks and lack of resources and social support among the refugee community members. Risks are often higher for asylum seekers, and there is a difference between refugees from rural background

fleeing to urban areas, as opposed to those from an urban background who flee to urban areas. Challenges, however, can differ widely across these settings. Urban settings also provide different unique advantages, such as better availability of health, education and other services and a better infrastructure, as compared to rural settings.

In Syria, the overwhelming majority of refugees (approx. 90%) come from primarily urban areas in Iraq. Around 10% of the refugees in Syria are from Somalia, Afghanistan and Sudan. Since 2003, the beginning of the war in Iraq, the situation in Syria developed from an acute refugee crisis to a complex emergency,[2] with a protracted refugee situation.[3] The number of refugees registered with the UN refugee agency (UNHCR) declined from more than 225,000 in 2008 to 50,000 in July 2013. This crisis is now embedded in a new acute and complex emergency. By mid-2013, more than 4 million Syrians were internally displaced (Quosh, Eloul & Ajlani, 2013).

This combination of overwhelming need, scarcity of resources, lack of qualified professionals and implementing partners in Syria, all combined to require UNHCR to adopt a new approach. Therefore, for the first time, UNHCR integrated a comprehensive MHPSS programme into a refugee operation. Traditionally, UNHCR has addressed the psychosocial and mental health needs of refugees and other persons of concern in an ad-hoc manner, referring identified individuals needing support to local practitioners and implementing partners. In Syria, this was no longer possible. Due to the massive influx of refugees in 2006, and the scale of multiple needs identified and expressed as priorities by the refugee community itself, UNHCR could not rely on the already under resourced national mental health sector. This situation, which is compounded by the difficulty of reaching refugees within an urban context, prompted UNHCR to establish this programme.

This article focuses on the response to the refugee crisis from 2008 to the beginning of 2013 and provides, in addition to the other papers on Syria in this issue, insight into how the established refugee programme adjusted to the recent emergency and internal displacement (Eloul et al., 2013; Hassan, 2013; Ismael, 2013; Mirghani, 2013; Quosh et al., 2013). The challenges posed by, and potential responses to, long term urban displacement settings will be addressed in this paper, through describing the UNHCR urban programme in Syria.

Approach, theory and the ADAPT Model

The few theoretical models, which currently inform MHPPS programme design and evaluation, often lack empirical validation and/or consensus. Recently, however, has there been an increased emphasis on holistic and interdisciplinary frameworks as a foundation for integrated, culturally appropriate, evidence based, good practice programmes.

Consensus guidelines and actual programmes, often purposely, lack references to specific theoretical foundations. Some research and discourse proceed from the different angles of different frameworks: the biomedical and trauma based models on the one hand, and the psychosocial (stress) and socio-ecological on the other. There is, however, an increased emphasis on holistic and interdisciplinary frameworks as a foundation for integrated, culturally appropriate, evidence based best/good practices programmes. The bio-psycho-social (Engel, 1977; Porter, 2007), and more recently the bio-psycho-social-spiritual approach and paradigm to health and care (Gilbert, 2002; McKee & Chappel, 1992 in Sulmasy, 2002;

Koenig et al., 2000; Koenig, McCullough & Larson, 2001; Marks, 2005) as well as public mental health approaches (de Jong, 2002), are becoming a stated goal of many programmes and interventions. They are, however, rarely comprehensively implemented.

One such pragmatic, multidisciplinary framework is the Adaptation and Development after Persecution and Trauma (ADAPT) model for post conflict and low resource settings, developed by Silove (2005, 2013). This model was used to influence the programme design and evaluation of the MHPSS programme for refugees in Syria. The wider, theoretical framework is social constructionist in nature, following a bio-psycho-social-spiritual approach. Many aspects of this model were already included in UNHCR policies on public health and community based approaches, and are integral to UNHCR programming. The Syria Programme can be said to combine theory, primarily based on the ADAPT model, guided by an anthropological context approach.

ADAPT is a model for understanding and responding to the consequences of forced displacement and human rights violations in low income countries and post conflict settings. It attempts to bridge the debates that artificially divide the field, and provides an integrated framework and experienced based technique for problem solving. While it links the interdependent settings of emergencies with the phases of forced displacement and development, it is also of interest how this can be applied in a protracted displacement setting.

Therefore, ADAPT provides a practical framework that can guide different aspects of programming without being overly rigid or prescribing content or context. It uses universally understood concepts, and is easily understood by diverse communities, as well as policy makers. It is, therefore, a valuable tool for participatory assessments, and planning and community based participatory research guiding this programme.

The model provided a framework for the following three programme steps:

1) ADAPT provided a framework for assessments and design at the beginning of the programme. This included assessing and analysing both individual and community responses to displacement and the new environment, and resources and gaps in community and national mental health services within the particular socio-economic settings. Based on those results, ADAPT programming recommendations, and the minimum standards of the *Inter-Agency Standing Committee guidelines* (IASC, 2007), programme recommendations and strategic priority areas were outlined (Table 1).

2) During the mid term review of the programme, at the beginning of a protracted displacement phase, ADAPT also provided a framework for linking the components more thoroughly, as well as refining the programme's activities. Needs, resources, and processes of adaptation were all re-assessed. Understanding the underlying challenges to the corresponding core adaptive systems, and refining the links to the different supports and interventions provided by the programme were also examined.

3) ADAPT provided a framework for the monitoring, process, and outcome evaluation throughout, and again at the end of the second phase of the programme.

UNHCR's MHPSS programme

The overall *objective* of the UNHCR Syria MHPSS programme is to enhance

Table 1. Comparative overview of programme components

UNHCR MHPSS programme strategic priority areas (SPA)/component	MHPSS case management (CM) for vulnerable persons at high risk with provision of mental health care, psychosocial support, with links to basic and special needs assistance and protection systems.	Psychosocial centre and psychosocial community outreach Community based psychosocial support, and centre with link to livelihood projects and CM	Inter-agency national and community MHPSS capacity building
Priority needs according to assessments	Exacerbation of mental disorders, particularly mood disorders (depression), anxiety (posttraumatic stress disorder), and somatisation. Developmental and learning problems among children. Lack of caretakers for vulnerable persons with pre-existing and trauma related mental disorders. Stigma regarding mental health (care). Difficulties accessing mental health services. Socio-economic difficulties, ongoing insecurity, limited protection, and separation from family members (Quosh et al., 2013).	Social isolation, lack of support networks and trust, community support systems, social organisation, safe communal spaces, significant shift in gender roles, no legal access to work, family violence, fatigue, hopelessness, lack of prospects for the future, stigma.	Lack of capacity, particularly: - limited number of trained mental health professionals, lack of mental health case management, mental health care in primary care, and community based psychosocial support.
Resources according to assessments	Available mental health care services, but limited capacity. Motivated core group of mental health professionals. Degree of protection, assistance and livelihood opportunities.	Resourceful, well educated community, altruism and volunteerism, family support, religious coping.	Available expertise and good practice examples.
ADAPT programming recommendation (Silove, 2005)	Immediate priority (during and post emergency) is to identify and respond to the most vulnerable and those at risk. This includes providing treatment to those with pre-existing mental disorders, and trauma related severe mental disorders, distinguishing them from normative communal reactions.	Facilitating mobilisation and empowerment of the community, and rebuilding of the social environment.	Building emergency response capacity and ongoing capacity building, with recovery focus of local mental health system and community capacity.

Concepts	Case management approach: combination standard/broker and intensive, stepped care approach, continuity of care, community mental health.	Community development, mobilisation, community based psychosocial support, social capital, community outreach, safe spaces, healing environment, peace building.	Cascade approach, adult learning, apprenticeship model, training of trainers, with close follow-up
Core components	A system that facilitates access to appropriate support and services through; advocacy, identification; MHPSS assessment; referral, coordinating access; follow-up	Psychosocial centre run by the community, offering a safe space and psychosocial activities.; Community outreach volunteers providing home and phone follow-up, particularly within, but also across, neighbourhoods	Master training/training of trainers and follow-up/supervision of senior mental health specialists; frontline training by master trainers of non-specialists; system building (curricula, policy development, establishing mental health council)
Overall objective Objectives	Improve overall psychosocial wellbeing and reduce distress among vulnerable persons at risk Improve psychosocial wellbeing and mental health by ensuring equal access to assistance, quality psychosocial and mental health services offered in an efficient and effective way to individuals and families at high risk with diverse, complex needs and resources.	Improve psychosocial wellbeing and mental health, support resilience and recovery by facilitating community mobilisation and community based psychosocial support through safe and healing spaces, community participation and outreach in an efficient and effective way to individuals and families at risk with diverse needs and resources.	Increase capacity of mental health professionals, service providers, and community and build system to strengthen mental health and psychosocial services in Syria by promoting multi-disciplinary approaches and increasing the number of qualified service providers.
Staffing	10–12 MHPSS case managers: - majority of clients covered through standard/ broker-model based case management; - smaller, most vulnerable group (approx. 18%) covered through intensive case management.	8–12 Psychosocial refugee outreach volunteers with psychosocial background, 2–4 centre coordinators with mixed psychosocial support and administrative/ management background and activity facilitators.	4 main trainers, several external temporary trainers, pool of 40 national master trainers with different mental health related specialisations, management.

(continued overleaf)

Table 1. (Continued)

UNHCR MHPSS programme strategic priority areas (SPA)/component	MHPSS case management (CM) for vulnerable persons at high risk with provision of mental health care, psychosocial support, with links to basic and special needs assistance and protection systems.	Psychosocial centre and psychosocial community outreach Community based psychosocial support, and centre with link to livelihood projects and CM	Inter-agency national and community MHPSS capacity building
Location; *Phase 1: 2008–mid/end 2011; Phase 2: From mid/end 2011*	Phase 1: Centralised at UNHCR office. Phase 2: Decentralised in polyclinics, primary health care centres (in areas with identified high needs and high concentration), mobile services (e.g. in shelters); crisis hotlines	Phase 1: Physical centre, in area with identified high needs, mobile activities and outreach. Phase 2: mobile activities in areas with identified high needs that are safely accessible, outreach and phone follow-up.	Phase 1: Building capacity of the national mental health professionals and community. Phase 2: Build on these resources to build capacity of frontline services, system and community.
Training	*MHPSS Case manager:* 3 months theoretical training and shadowing, 3 months on the job training and follow-up, integrated supervision, feedback and continuous training.	*Coordinators and volunteers:* 2 weeks theoretical training, 2 months shadowing, on the job training, test period and follow-up, continuous training.	*Master trainers:* 1 year comprehensive multidisciplinary training and supervision/co-training with feedback and evaluation during first trainings (minimum 5 supervised certification trainings).
Supervision	Regular weekly clinical individual and group supervision.	Integrated weekly supervision, developing towards peer supervision/intervision	On the job training, peer evaluation and continued supervision.
Clients/participants	Refugees and displaced (all ages), services are provided for free, the focus is on most vulnerable families and individuals at high risk.	Refugees, displaced communities and host communities, the focus is on small group work with integrated support to vulnerable individuals and families at risk.	National mental health professionals, community, frontline workers in health, education, humanitarian aid, justice systems
Number of clients/participants	120–150 new CM referrals per month.	> 130 centre participants per month, approximately 30 persons of concern followed-up at home per month, with 0–4 home visits per person (less in 2012 due to limited access).	> 600 trainees

Benchmarks	Case manager performance benchmarks depend on ratio between standard/broker and intensive follow-up clients, number of case managers per area index depends on number of vulnerable persons in a catchment area.	Volunteer to participant ratio at the centre is 1: 20/30 with 0–5 new cases per month for every outreach volunteer to follow-up.	Outcome target: for master trainer certification to pass 70% cut-off point in the knowledge tests and successfully conducting certification trainings under supervision.
Monitoring and evaluation	Mixed method (quantitative, qualitative) and community based participatory approach to evaluation, population baseline: idioms based wellbeing & distress measure, standardised mental health & resilience measure. *Methods/tools:* idioms based wellbeing & distress measure, GAF, achievement of intervention goals, service satisfaction, performance monitoring.	*Methods/tools:* Screening measure, idioms based wellbeing and distress measure, focus groups, satisfaction measure.	Training needs assessments, training evaluation: knowledge; training quality and satisfaction, attendance; skill and system building
Costs: *example 2011*	Programme represented 0.5% of the USD 118 million financial requirement of UNHCR in 2011 2011: 27 % of total budget.	2011: 27 % of total budget.	2011: 39 % of total budget. Portion significantly reduced after 2011, but higher costs at the beginning.
Sustainability	Built capacity of national health partner, successfully transitioned and integrated MHPSS case management into polyclinics/primary health care clinics.	Built capacity of national health partner, successfully transitioned and integrated psychosocial centre and volunteers into psychosocial programme of partner organisation.	Established national mental health council responsible for coordinating capacity building, national curricula and pool of master trainers.
Materials developed	MHPSS case management manual and standards, and 18 modules training package.	Community based psychosocial support manual and 15 modules training package, and documentary film "*Resilience in Action*"	Draft handbook for Ministry of Health/council on mental health and psychosocial support for refugees (for mental health professionals).

the psychosocial wellbeing of refugees, and other persons of concern, by providing equal and quality access to mental health and psychosocial services and support, to basic assistance, and by increasing the response capacity of service providers and the community in Syria.

To achieve this, the pilot MHPSS programme established a *three fold approach* in 2008:

1) MHPSS case management for those most vulnerable and at risk;
2) An urban, community based, outreach refugee volunteer programme and a psychosocial counselling centre (see Mirghani, 2013); and
3) A national inter-agency capacity building project (Table 1).

Table 1 provides an overview of the three main programme components.

Those three main pillars of the programme (Figure 1) are complementary and heavily interlinked, informing each other and functioning jointly. There is also a fourth component of the programme, which includes: overall coordination, advocacy, monitoring, data management, internal and joint external evaluation, and staff welfare. Part of this component also entails adequate mainstreaming of MHPSS into other sectors and activities, primarily into protection and assistance activities of UNHCR and partner organisations. From its inauguration in 2008, until 2012, the programme has served more than 10,000 persons of concern in Syria.
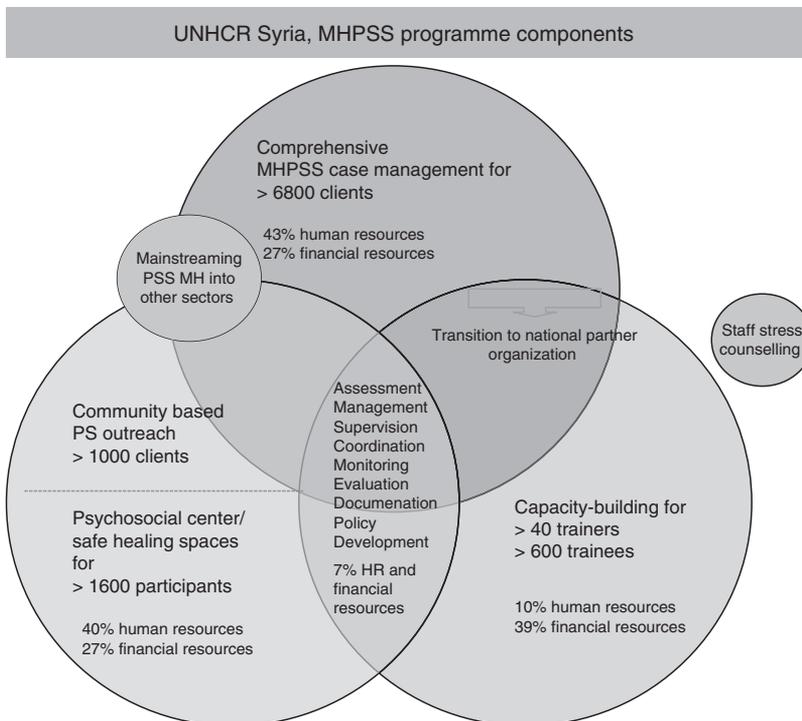

Figure 1: Three main interlinked programme components.

MHPSS case management

Background

Forced displacement often disrupts general social structures, as well as care for those with pre-existing chronic and severe mental disorders (Silove, 2005; Silove, Ekblad & Mollica, 2000). Additionally, with displacement, negative mental health outcomes are often a consequence. These two risk groups were identified as priorities in participatory assessments. One of the main concomitant concerns was lack of access to adequate mental health services and other assistance, which led to the design of the MHPSS case management component. This component was broadened in scope once immediate and urgent needs were covered.

Activities

The purpose of the MHPSS case management system is to link people to psychosocial support, mental health services and assistance, as well as to coordinate access and delivery of these services for refugees and others of concern. This is done in a holistic manner. The focus is on ensuring greater continuity of care, applying a stepped care approach, and integrating support and service systems.

MHPSS case management is usually required for those with mental disorders or high risk for mental health vulnerabilities (this high priority category often requires immediate response and intensive case management), but also includes those with psychosocial needs that can improve with family, community and focused psychosocial support (this lower priority category often requires supportive case management).

Project outputs and trends

On average, the MHPSS case management teams manage more than 1,400 people of concern, per year. Out of the more than 6,000 case management clients between 2008 and 2012, 63% were referred to, and received: community based psychosocial support through psychosocial outreach volunteers, community mental health care, psychiatric hospital care and/or participated in activities in the psychosocial counselling centres.

According to the case management records, more than 30% of clients are extremely vulnerable. Vulnerability and complexity increased over time from 2010 to 2012, as did the prevalence of clients diagnosed with mental disorders. Increased relapse rates have been reported since the beginning of 2012.

Transition to national ownership

UNHCR staff directly implemented the case management from 2008 to 2011. As of the end of 2011, the case management component was transferred to the national health partner organisation, Syrian Arab Red Crescent's (SARC) primary health care clinics. Although, UNHCR has maintained a partial, default case management function.

Adjustment to recent acute and complex humanitarian emergency

Due to the ongoing security problems and current conflict, demands increased, while at the same time access to the office, health care and other services, as well as home follow-up by case managers and mental health service providers, has become severely limited. This has been compensated by increased phone follow-up, and the operation of several 24/7 crisis hotlines and mobile outreach services. The MHPSS case management services were also opened to displaced Syrians and vulnerable host communities. In this way, the response capacity has increased and MHPSS case managers have been embedded into mobile health teams

that regularly visit collective shelters and areas hosting many of those that have been displaced.

Example: case management link to ADAPT model
Within the case management system, the ADAPT model has provided additional framework guidance on identifying and assessing the most vulnerable. Beyond symptoms, diagnoses and bio-psycho-social-spiritual dimensions, ADAPT considers the challenges of multiple adaptation systems. These systems indicate higher vulnerability, and guide joint choices and priority goals for resource mobilisation, support mechanisms and interventions. Particularly, the combination of experiencing life threats, great loss and adaptation difficulties not only often lead to mental health problems (including presentations of co-morbid posttraumatic stress disorder (PTSD) and depression), and a high level of psychosocial dysfunction, but also changes in identity, coping, relationships and meaning making[4] within an insecure environment.

Psychosocial community refugee outreach and psychosocial centre

Background
Forced displacement disrupts the social environment and support systems (Silove, 2005). Facilitating the rebuilding of a supportive and functioning social environment (e.g. through safe spaces, healing environments, community support, and activities) is important to re-establish the equilibrium of core adaptive systems.

Activities
The second pillar of the MHPSS pilot programme mobilises the capacity of refugees, as individuals and as a community, to directly help their peers through community based support by the creation of:

- a psychosocial refugee outreach volunteer group; and
- a psychosocial centre. See Hassan (2013) and Ismael (2013).

The aim of community outreach is to identify and support vulnerable community members. Outreach addresses isolation, lack of social support and stigma, as well as barriers to accessing support and services. Community outreach also utilises community resources and networks. The aim of providing safe healing spaces and psychosocial activities focuses, in particular, on social wellbeing and social environment building.

Psychosocial refugee outreach volunteers
A team of 12 refugee outreach volunteers, all with psychosocial backgrounds, was originally supervised by the UNHCR MHPSS programme. This team of psychosocial outreach volunteers is part of a larger group of approximately 140 closely linked, community outreach volunteers. The group is divided into different sub-groups, with different areas of responsibility, such as MHPSS, health, education, care of unaccompanied minors, or the elderly. They form multidisciplinary volunteer teams, cooperating closely within their neighbourhoods (Mirghani, 2013). The core principle is that the community is caring for the community, based on the idea that helping others can contribute to both individual and collective healing. At the same time, this allows UNHCR, as an agency, to engage in direct communication with the community, permitting meaningful participation, as well as the utilisation of community resources and networks. Outreach volunteers may be

partially considered as one component of the MHPSS case management system, but are also involved in community development activities. During the second phase of the programme, this component was transferred to a national organisation, in a similar process as that described for case management. Outreach volunteers are carefully selected and recruited jointly with the community. They are well trained and supervised, and function as role models for their peers. The volunteers help with identification of vulnerable refugees, and provided home follow-up and phone counselling to more than 1,000 people of concern between 2009 and 2012. For individuals and families who need individual follow-up and specialised care, the volunteers work closely with the MHPSS case managers. Psychosocial community outreach, therefore, often complements specialised mental health care services, as well as other community and family support. Volunteers regularly build bridges for people who would benefit from services or the psychosocial centre, but are initially hesitant or have difficulties with access. In some cases, volunteers accompany clients to services and facilitate assistance for the most vulnerable. Through individual follow-up, volunteers ensure that people of concern receive support when transitioning between services. This also enhances burden sharing, coordination, and cooperation between support and service providers.

Psychosocial centre

Psychosocial outreach volunteers are part of a larger group of community volunteers working at the psychosocial centre in Babila, Damascus. The centre opened in November 2009, after an initial investment in community capacity building, which has continued. It is based in a poor southern suburb of Damascus, characterised by a high number of vulnerable refugees and people of concern, including survivors of torture, and sexualised and gender based violence. The centre is open to all refugee communities as well as the host community. It provides a safe space for community members to meet and spend time, and as a base for psychosocial outreach and activities. Psychosocial volunteers attend to individuals and families during these activities, and link participants to home follow-up, or other services, as needed. The centre is managed by refugee volunteers under the supervision of UNHCR. Many different psychosocial activities based on age, gender considerations, following different degrees of structure are offered there. Activities are interactive, participatory, and primarily semi-structured. A new concept was developed, in addition to the existing classifications of psychosocial activities, in order to address prevailing stigma towards psychosocial support and mental health in the region that often results in many refugees resisting support or treatment.

In addition to peer support based psychosocial activities, actual peer support groups have also been offered. The psychosocial outreach centre has grown significantly over the past few years, offering a wide range of activities. This growth continued until mid 2012, when the centre had to close down temporarily, due to rising security risks in the area.

The psychosocial activities, however, did not stop with the closure of the centre. Volunteers and facilitators were able to regroup, according to their areas of residence, and have been providing mobile psychosocial activities in these areas, as well as nearby neighbourhoods and collective shelters. The idea of mobile safe spaces, which can be created within shelters and family contexts, is being further developed.

All activities have psychosocial and therapeutic qualities and are run by paraprofessional volunteers, who were trained in psychosocial support, outreach, facilitation and peer support group methods. All volunteers and facilitators are professionally supervised.

The psychosocial centre complements the case management system, as well as the multidisciplinary teams and other community centres. It serves as a link between the community and existing services, and includes coordination and advocacy tasks. Programme planning and evaluation are participatory, and involves the community at each step of the programming cycle.

Project outputs

Since the opening of the psychosocial centre, the registration numbers have continuously increased, and by the end of 2012 had reached more than 1,600 people. This group included all ages from the refugee population and host communities (Table 2). Initially, most referrals to the centre came through the psychosocial outreach volunteers. Over time, the centre became an established institution within the community, and attracted participants from all over the city. The original name of the centre

was the Outreach Counselling Centre (OCC), chosen by the community running the centre, in order to avoid stigmatisation. One-and-a-half years after its establishment, the community of participants started referring to it as The Psychosocial Centre.

The centre attracted more women than men, but comparatively across programmes, a significant number of men as well. Activities are not separated by gender, except for peer support groups, yoga, and the beauty salon. The most popular activity, glass painting, is a mixed gender group. Some activities, such as handicrafts, are more popular among women within this context.

Following the successful transfer and establishment of psychosocial and mental health case management for refugees and displaced populations into the SARC clinics, the second component of the programme (the psychosocial centre and psychosocial outreach) was also integrated into the national partner's organisations. Both projects are closely linked, and constitute an integrated mental health and psychosocial support system. With a focus on capacity building and the development of a sustainable system, the process was similar to the case management transfer. It started mid-2012, and was finalised at the end of

Table 2 Outreach volunteer clients and psychosocial centre participants

Psychosocial outreach volunteer individual follow-up	2009 Total	2010 Total	2011 Total	2012 (Jan–Sept)
Total accumulated participants	*182*	*571*	*917*	*1042*
Persons of concern receiving individual psychosocial support outreach volunteer support	182	389	346	125
Number of home visits		> 1200 visits	1650	946
Psychosocial centre	2009 Total	2010 Total	2011 Total	2012 (Jan-July)
Total accumulated registered participants	*364*	*974*	*1511*	*1667*
New registrations with the psychosocial centre per year	364	610	537	156
Number of persons participating in psychosocial activities per year	–	1659	1600	584

2012. UNHCR continues to provide support with training, follow-up, and adjustment during this transitional period, as well as longer term monitoring and evaluation (Hassan, 2013; Ismael, 2013).

Adjusting for an acute and complex humanitarian emergency

The psychosocial centre had to temporarily close in August 2012 and since then, home follow-up by psychosocial volunteers has been limited. This has been compensated by increased phone follow-up and organising, often in a more ad-hoc manner, psychosocial activities in places of close proximity (e.g. in collective shelters, schools, health centres and family houses). The pool of volunteers was expanded to incorporate Syrian outreach volunteers. Trainings of new volunteers were co-facilitated by UNHCR staff, as well as experienced refugee volunteers. Community messages and information was developed and shared. Additionally, support systems for frontline and humanitarian workers, who reported heightened distress levels, were strengthened.

Example of linking the ADAPT model to community based psychosocial support

Identification of the challenges and changes in core adaptive systems often clarifies the limitations of symptom focused interventions, while at the same time, it also opens alternative, more creative ways of addressing needs and capitalising on resources. Sensitising community volunteers to the effects of changes in core adaptive systems have helped to jointly refine and tailor support responses and referrals for additional interventions.

The principle of the community caring for the community does not cover all needs, but complements limited available services and fosters empowerment and rebuilding of social fabric. It can contribute to mutual healing between the most vulnerable and the more resourceful members of the community, but should also include consideration of factors such as context and power dynamics (Figure 2).

Capacity building

Background

Even for priority mental health care needs, reliance on limited specialist care, particularly in the developing world, is inadequate. Across the reviewed studies, the primary recommended responses were strengthening the national healthcare system, and enhancing its ability to respond to the needs of both the refugee and local populations through extensive capacity building. This has been the main aim of MHPSS capacity building in Syria. This has focused on improving resources, such as knowledge, skills and competencies of individual trainees within a system or institution, as well as facilitating relationships between institutions and sectors, and fostering multiprofessional teamwork and advocacy (Quosh, 2011).

Capacity building

How this third component of the programme has improved service provision and integration through interdisciplinary capacity building, guided by an Inter-agency Working Group, has been described elsewhere (Quosh, 2011). The most recent developments include negotiations with a national university interested in incorporating the master training programme into its postgraduate curriculum. Additionally, in November 2011, a mental health council resolution and policy was developed and drafted by key stakeholders and signed by the Minister of Health. This has set the stage for the creation
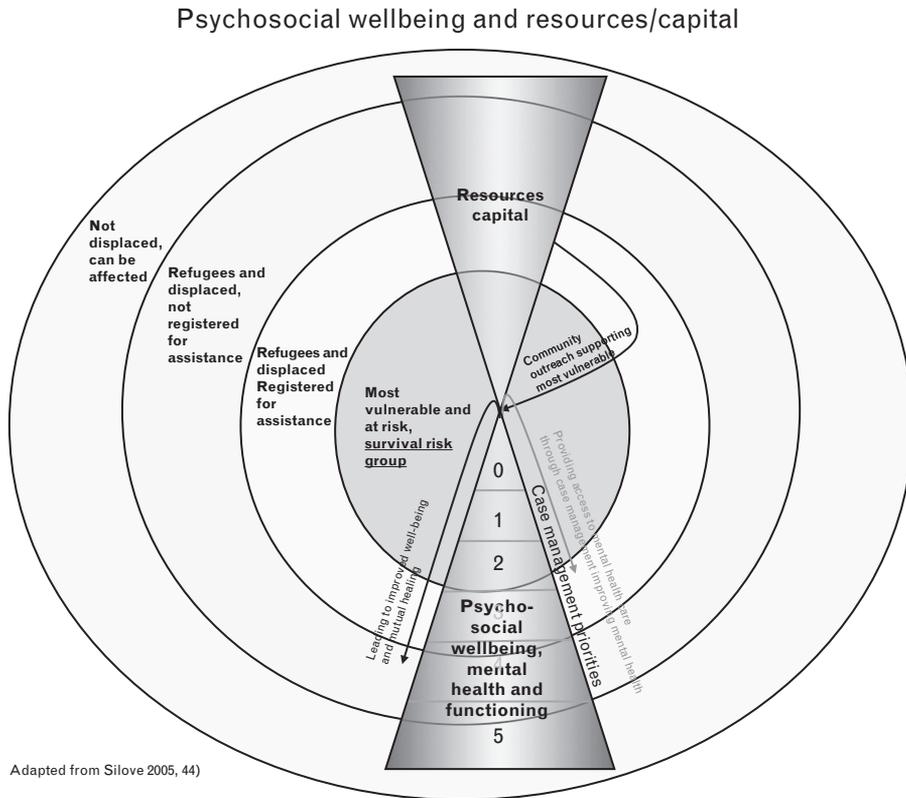
Figure 2: Psychosocial wellbeing and community resources/capital.

of Syria's first National Mental Health and Psychosocial Council.

Trainees and project outputs

Overall, the different training initiatives benefited more than 660 trainees. Figure 3[5] summarises the main training programmes along the different response layers. All trainings were evaluated according to knowledge gained, training satisfaction and adherence, and showed positive outcome results. Practical skill development of participants was evaluated for two training packages: MHPSS Case Management and Psychosocial Safe Healing Spaces and Activities. These training modules were developed

for, and tested during, the transition process with good results.

Adjustment to acute and complex humanitarian emergency

A new coordination mechanism was established in order to benefit from previous coordination structures (Eloul et al., 2013). Key policy and guidance documents were developed by the interagency MHPSS working group, shared and respective trainings organised. Capacity building focused initially on a large scale psychosocial first aid training of frontline and humanitarian service workers, and mainstreaming psychosocial considerations into their activities.
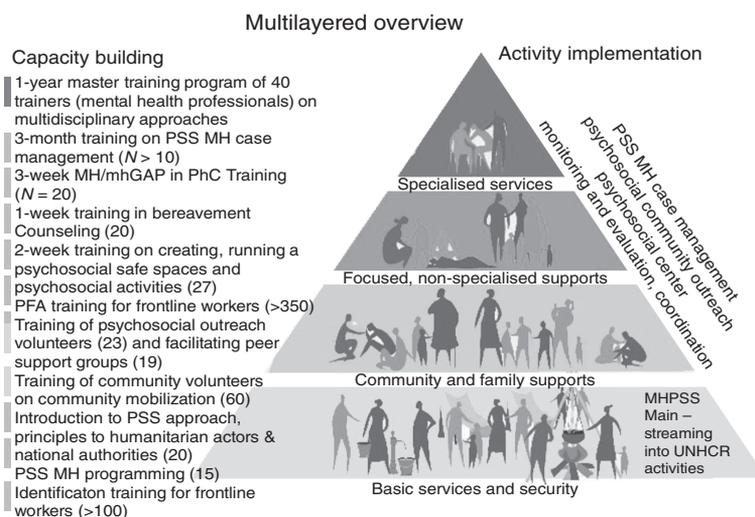
Figure 3: Training overview.

Subsequently, more specialised trainings were offered on advanced mental health and psychosocial programming in emergencies. The existing pool of inter-agency master trainers was instrumental in implementing these trainings.

Monitoring and evaluation

Background

The lack of appropriate and systematic evaluation research of integrated mental health and psychosocial programmes has been well documented (Banatvala & Zwi, 2000). This is primarily due to challenges of the humanitarian work context, which for reasons of heightened security risks and lack of resources or capacity, make the implementation of applied research difficult. There is also a general lack of adequate and relevant monitoring and evaluation approaches and tools for those programmes (Abramowitz & Kleinman, 2008).[6] There has, in fact, been little focus by the research community on investing in applied research in the MHPSS sector, and even

less in assessment of the longer term impact and sustainability of such programmes. The lack of intervention studies indicates the importance of investing in research and evaluation of existing programmes that respond to the mental health (needs) of refugees. Such studies would help inform practice and shape the development of approaches to address the needs of this population (National Child Traumatic Stress Network (NCTSN), 2003, 24). In addition, there is a lack of research on services and support within the context of protracted refugee situations, particularly in urban settings (Bamberger & Cheema, 1990; Bossert, 1990; Shediac-Rizkallah, 1998; Steckler & Goodman, 1989).

Adequate culturally sensitive evaluation research of psychosocial support and mental health care programmes in displacement settings has also been neglected. Although evidence based and contextualised models are promulgated as a good foundation for planning, their contribution to programme evaluation has been modest.

When conducted, programme evaluations often look at output and only rarely at outcome, and do not link them to theoretical models. The evaluation component of the MHPSS programme, therefore, initiated a multi-level process, on interlinked levels of empirical study and analysis, which included the following:

1) defining local idioms of distress, wellbeing and functioning in order to understand and assess the mental health profile of Iraqi refugees in Syria, in conjunction with other standardised measures;
2) process, output and outcome evaluation of the UNHCR MHPSS; and
3) empirical testing of the ADAPT Model, within this context.

The MHPSS programme's community based participatory and mixed-method qualitative–quantitative approach to assessment, monitoring and evaluation includes different components: internal output and progress monitoring, outcome measurement, documentation, and joint internal/external evaluation.

Output and progress monitoring
Between 2008 and 2012, the MHPSS programme has reached more than 10,000 persons of concern. The different outputs, according to their output indicators, are based on standardised and thorough documentation, reporting and monitoring mechanisms, and were described under each programme component above (Table 1).

Outcome measurement: culturally grounded assessment instrument
As part of the evaluation process, a model for the development of a culturally based assessment instrument was designed and tested. This allows for the assessment of cultural idioms of wellbeing, distress and functioning of the refugee population, translated into a culturally based measurement instrument. This measure has been used for assessing intervention outcomes by comparing baseline with post intervention results (3 months after an intervention).

To evaluate the outcome of community based psychosocial support for psychosocial centre participants, the measure has been used as a stand alone, self report, pre and post assessment. The outcome of mental health case management services for intensive case management clients is assessed in a pre and post intervention design through: the self report assessment tool, the achievement of care plan goals rated by the client, and the general assessment of functioning (GAF) of a client, as rated by the case manager. In order to assess the population baseline, the self-report assessment tool was used in conjunction with a standardised self report mental health measure.

The main outcome indicators are:
  1) Status of psychosocial wellbeing, as measured through the psychosocial assessment instrument
  2) Improved access to psychosocial support and mental health services

The *targets* are:
  1) Significant improvement of wellbeing at individual and population levels
  2) 45% of those identified as in need accessed support and mental health services

The result was that 63% of the identified persons in need accessed services and support. Overall, psychosocial wellbeing of the refugee population is consistently low,

and particularly low with higher distress scores for persons identified by and referred to the MHPSS programme. This confirms the functioning of the identification system set up to refer those who are most vulnerable to the programme. At the same time, wellbeing improved significantly through services provided by the MHPSS Programme, either through specialised mental health services, or community based psychosocial support. The improvement was most significant through joining the pool of outreach volunteers (Figure 4).

Documentation

In addition to adequate and confidential client and case management documentation, manuals, protocols, guidelines and training packages are under development. As are documenting the programme steps and stages, with the goal of sharing lessons learned and best practices. Documentation of best practices aims to contribute to improving the quality of support and mental health care in the context of humanitarian assistance, post conflict, and low resource settings. As part of the advocacy efforts, a short documentary entitled '*Resilience in*

Action' was produced jointly with the refugee outreach and centre volunteers, capturing the power of community based psychosocial support and refugee outreach.

Adjusting to acute and complex humanitarian emergency

The existing assessment instruments, forms and protocols were adjusted to, and validated for, the Syrian population and current crisis context.

Linking the ADAPT model to evaluation

Culturally grounded idioms of wellbeing and distress were extracted from a qualitative, ethnographic study at the beginning of the programme. They influenced programme design and provided the foundation for the programme's wellbeing assessment instrument. The dimensions were compared to the different response dimensions of the ADAPT model, and were found to resemble most of these across the different core adaptive systems. During the initial narrative analysis of wellbeing and distress, dimensions of existential meaning, religion, family violence, and somatisation were missing, because the community did not
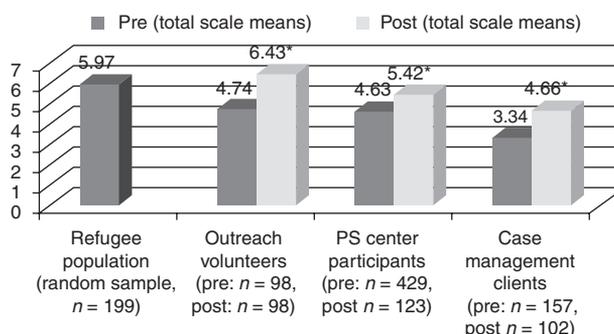

*Figure 4: Pre and post total scale means of psychosocial wellbeing measure. Note: * indicates significant improvement of wellbeing at p = 0.05. High value indicates better psychosocial wellbeing, low value indicates high distress (on a 10-point Likert scale). Preliminary data analysis from Phase I, up to May 2011.*

identify them as immediate priorities. Based on theoretical guidance and recommendations from the evaluation team, further probing and follow-up resulted in the confirmation that these are in fact crucial indicators of wellbeing and distress in the population, and they were subsequently added to the measurement tool.

While the ADAPT model provides a valuable framework, it has not yet been sufficiently empirically tested. As part of the programme evaluation research, the model has been empirically tested in the form of an exploratory study about adaptation processes within the context of a protracted refugee setting. Detailed articles on the development of the measurement instrument, results and differences in outcome, according to the different periods of the crisis, as well as the testing of the ADAPT model will be published later.

Joint internal/external evaluation

In addition to extensive internal evaluation, the MHPSS programme underwent an internal/external goal, process and outcome evaluation by a multidisciplinary team from the University of Uppsala, Sweden. The purpose of this mixed-method evaluation was to assess relevance, outcome, effectiveness and the sustainability of the programme, from September 2008 through the end of 2012. Methods included: desk review (an intensive literature search, review, and synthesis of all relevant documents), review of programme documents and systems; interviews and focus groups; review of primary and secondary data; and participatory observations during field visits. The analysis aimed at providing an assessment of overall performance, ways and quality of results tracking, key lessons, recommendations for future programming, and corrective action, if required.

Evaluation dimensions further included: appropriateness, organisational structures, political and financial conditions, capacities and qualifications of the executing agency, stakeholder participation, quality and efficacy of future and exit planning, project transfer to partner organisation, internal management, and external partnerships. Recommendations resulting from the mid-term report have, for the most part, been fulfilled. The final evaluation report, reviewing the programme's progress, its internal output and outcome data and analysis and the transfer process, is in preparation.

Evaluations not only serve programming purposes, but can also support policy development and advocacy. The collaboration between UNHCR and the Uppsala University strengthened the often weak link between academics and field practitioners. One of the outcomes of the joint evaluation process was the co-hosting of a conference on MHPSS programming in post conflict settings by UNHCR Syria and Uppsala University, in May 2011.

Discussion

The three main pillars of the programme were successfully implemented and supplemented by coordination, evaluation, and mainstreaming within a complex emergency, as well as protracted displacement settings within the Syria context. The programme design can serve as a practice example which could be adjusted to other, particularly urban, low resource and forced displacement settings.

The unique challenges of urban settings, such as the invisibility and limited opportunity to reach urban refugee communities are often complicated by non-conducive policies, protection risks and lack of resources and social support. It is important to remember that risks are often higher for asylum seekers,

and there is a difference between refugees from a rural background fleeing to urban areas, as opposed to those from an urban background who flee to urban areas. However, urban settings can also provide different unique advantages, such as better availability of health, education and other services and a better infrastructure, compared to rural settings. The programmatic strategy developed by this programme was successful in addressing those challenges. The outreach programme reached the most vulnerable community members, shared crucial information and empowered resourceful community members to help their own community. The psychosocial centre provided a safe and healing space that contributed to improved social support. Comprehensive and accessible case management and care coordination, as well as the integration of MHPSS into frontline humanitarian functions and primary health care, ensured equal access to a wide scope of quality services and assistance. Capacity building addressed resource gaps, improved multi-disciplinary approaches and the policy environment.

Challenges and dilemmas

Two main contextual challenges for programme implementation were:

- recurring insecurity; and
- refugees' lack of legal access to work, which jeopardises the economic stability essential for general stability, as well as creates dependency on assistance.

Although being engaged in an activity, which provides a sense of meaning, appeared to enhance refugees' wellbeing, the activities provided by the programme did not include income generation, central to survival and development. Particularly for men,

income generation is important in regard to their role as provider. Therefore, strong referral pathways to self-reliance and livelihood programmes were also established.

Two elements of building the national mental health system could not be finalised:

- establishing the nationally led Mental Health Council; and
- incorporating the master training curriculum into the national educational system.

The resolution for the Mental Health Council was drafted and signed by the Syrian Minister of Health. The planned establishment of the actual council under the lead of the Ministry of Health was, however, put on hold due to the prevailing circumstances. Regarding the training curriculum, discussions were taking place with the university, but further implementation has been postponed, due to the recent crisis and consequent staff turnover.

The programme focused on providing services in the main urban centres, in order to ensure national system building, it would also be necessary to invest in rural areas. During the later phase of the programme, dialogues with more development oriented partner organisations started to fill this gap. /ce:para›Integrating spirituality and religion were initially considered with hesitation, as many people wished to avoid talking about religion after experiencing sectarian violence. However, guided by the ADAPT model and based on advice from the external evaluation team, more attention was paid to the integration of spirituality, religion, values, and meaning as a crucial part of health, mental health, coping, and interventions. Spirituality, religion, and meaning systems became an integral part of understanding people and providing respective response.

Consequently, existential dimensions, and in particular spiritual and religious coping due to their relevance within this context, were incorporated into MHPSS assessments and case management. The programme built collaboration with faith based organisations and religious leaders in providing assistance and support. Religious coping was valued and attention paid to changes in spirituality and meaning as a consequence of experiencing severe trauma. Initial discussions took place with mental health professionals as to how to integrate existential dimensions in assessments and intervention, and how to separate professional from private roles. The programme, however, fell short in terms of helping to further clarify the role of providers in regard to spiritual interventions, and bridging the divide between national mental health professionals, religious leaders, and traditional healing systems.

The overall rights and results based programming framework of UNHCR has recently incorporated more dimensions of MHPSS programming, with a separation between community based psychosocial support and mental health care services. There is potential to improve mainstreaming mental health and psychosocial considerations into protection, to conceptually integrate focused non-specialised support, to create stronger links between the different components, and to share different field experiences. This could contribute to the refinement of participatory assessments, objective and indicator levels of the organisation's overall planning framework.

The challenges listed below were encountered during the implementation of the *community based psychosocial support* component.

- Frequent resettlement of refugee volunteers to third countries makes the selection and training of volunteers a continuous process.
- Coordination, supportive communication and, in particular, supervision of volunteers is often under estimated, but essential in facilitating community support.
- Transportation, in order to access services and channels of communication, represent particular challenges within an urban setting.

The challenges listed below were encountered during the implementation of the *case management* component.

- Due to the lack of available, qualified potential staff and limited financial resources, as well as the overwhelming demand, the staff/client ratio is many times higher than in other settings. This can interfere with proper client follow-up. Due to the nature of MHPSS case management work, those benchmarks cannot be compared to standard cost/benefit analyses of medical services, and have to be monitored and assessed within the particular context.
- After transferring this component to the national partner, a slight decrease in quantity and quality of case management services were observed; this was addressed through increased monitoring, training, and follow-up.
- Given the diverse tasks and high benchmarks of case managers, client and case management documentation often receive low priority, which can either lead to decreased quality of documentation and/or simplification of documentation tools.

Lessons learned
The main general lessons learned with regard to programme planning are listed below.

- MHPSS programme *planning* should integrate longer term perspectives, local ownership, and sustainability strategies, since the severity of mental health needs is likely to increase over time in (protracted) displacement situations (Pérez-Sales et al., 2011). Stable management benefited progress and consistency, the collaboration with different stakeholders, facilitated proper handover to national management of the programme, and ensured sustainability.

- MHPSS programmes (particularly those with a longer term and sustainability perspective) should be based, in addition to standardised measurements if applicable, on culturally guided and context adjusted *assessments* that include mental health needs, risk groups, adaptation processes, resilience, key concepts of the community (e.g. dignity, humiliation, and fatigue), resources, and services. Those assessments are a continuous process in designing, monitoring, evaluating, and adjusting programmes. They change according to context and programme progress, but should at every step involve the community. Depending on the phase of the programme, there are different requirements for assessment types. In general, and after an emergency phase, it is important to integrate quantitative and qualitative methods to ensure mixed-methods and triangulation (various research methods are employed in order to look at the object of study from a variety of perspectives), as well as community participation (e.g. in the form of community based, participatory research).

- Assessment results should be *merged with rights and results based programming* and used to create a clear vision, objectives, selected output and outcome indicators and targets. They inform implementation, monitoring, and evaluation plans that have to be followed up regularly.

- *Integrating* anthropological, culturally and context grounded, theory guided *approaches* provides a comprehensive and appropriate frame for assessments, planning and evaluation.

- Interagency *coordination* based on assessments, capacities of organisations, and mandates contribute to successful response, accountability and sustainable system building and collaboration.

- *Mainstreaming* mental health and psychosocial consideration into protection and assistance activities are crucial, particularly during emergency response and provide foundations for more focused levels of MHPSS programming.

- *A multilayered approach* (e.g. integrating mainstreaming, community based psychosocial support, and mental health care) is required to provide comprehensive responses.

- It is important to keep a balance between culturally appropriate best practices and evidence based care, aiming at *integrating* both to the highest degree possible.

- Establishing a pilot programme requires *leadership commitment*, documenting small success stories in order to encourage hesitant key persons, as well as investing in process and outcome evaluations to be able to present results.

- A certain *degree of standardisation* of different processes and services, without being overly rigid; collaborative capacity building; supervision that transitions into peer-supervision; mentoring and apprenticeship help to create sustainable programme models and avoid dependency on 'international expertise'.

- It is important to *integrate the host population* into provision of services, particularly to the most vulnerable.

The lessons learned with regard to case management are below.

Patterns of help seeking behaviours influence the ways, and how and where people access services. It is important to understand those patterns. Outreach initiatives helping to identify the most vulnerable are crucial in urban, as well as rural settings. During the initial phase of this programme, most refugees approached the UNHCR office for assistance. During that period, case management was centralised at the office. During the protracted period of displacement, more refugees could be reached and provided with services through medical services located in their respective neighbourhoods, and through an area and community approach.

In order to ensure proper identification, support and referral of those in need, it is important to work closely with respected community members, gatekeepers as well as frontline workers. This is supported by providing regular training on identifying persons with mental health and psychosocial needs, first line response, psychological first aid, and referral.

Given limited means, initially prioritising the survival risk group, and a clear and comprehensive system of assessing individual's needs and resources, help to rank those receiving assistance and services.

The term case management can be stigmatising, alternative terms such as joint care planning could be considered, but are not yet established.

Integrating aspects of community mental health in order to bring services, in a de-stigmatising way, closer to the entry points of the community. Community based psychosocial support and outreach are effective ways to providing access to services and utilise community resources for healing.

The lessons learned with regard to community-based psychosocial support are below.

- Becoming a refugee outreach volunteer can be healing and contribute positively to re-constructing identities.
- Outreach, safe communal spaces, and psychosocial activities are crucial for social environment building and reconnecting, in providing easy and non-stigmatising access to support, and are cost effective.
- There is a risk of focusing on women's empowerment, and of neglecting support for men, particularly in settings where it is easier to work with women.
- Through their networks, refugee volunteers were able to support the affected host population during the recent conflict and internal displacement in Syria. They facilitated capacity building for similar support systems among the host population.

Staff welfare and stress counselling

While staff welfare and stress counselling is not part of the core programme description, addressing the psychosocial capacities and needs of humanitarian workers, and in particular of volunteers, has become a prominent concern and a strong component of this programme. The staff stress counselling programme (SSCP) of UNHCR Syria is part of the initiative to introduce staff support to the organisational culture, through the acceptance of stress management as a management tool, and through including staff support in programming. Based on a mixed-method participatory staff assessment, key areas were identified. The programme included internal individual and group peer support and respective capacity building, confidential referral and

fee compensation for quality mental health services, as well as joint initiatives to improve the office environment, team communication and cohesion, vision development and performance management, and feedback to management.

Conclusion

Providing psychosocial support and mental health care as part of humanitarian aid, as shown, can contribute to improved psychosocial wellbeing, mental health, and functioning of displaced individuals, families, and communities, as well as to capacity and system building. However, this does not address underlying injustice and political causes of much of the suffering. Sharing this good practice experience, the author hopes to contribute to narrowing gaps within humanitarian programme design and evaluation pertaining to MHPSS programmes for forcibly displaced populations, particularly in urban and protracted settings. It presents an innovative, integrated, and comprehensive approach that creatively addressed mental health (needs) in close collaboration with the community. With the aim of contributing to healing, the case study envisages a shift in thinking from a humanitarian relief focus, to integrating comprehensive reconstruction, and recovery approaches.

Acknowledgements

References

Abramowitz, S. & Kleinman, A. (2008). Humanitarian intervention and cultural translation: a review of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. *Intervention, 6*, 219-227.

Bamberger, M. & Cheema, S. (1990). *Case Studies of Project Sustainability: Implications for Policy and Operations from Asian Experience*. Washington, DC: The World Bank.

Banatvala, N. & Zwi, A. (2000). Public health and humanitarian interventions: developing the evidence base. *BMJ, 321*, 101.

Bossert, TJ (1990). Can they get along without us? Sustainability of donor-supported health projects in Central America and Africa. *Social Science and Medicine, 30*, 1015-1023.

Cacioppo, JT., Hawkley, LC., Rickett, EM. & Masi, CM. (2005). Sociality, Spirituality, and Meaning Making: Chicago Health, Aging, and Social Relations Study. *Review of General Psychology, 9*(2), 143-155.

de Jong, J. (Ed.) (2002). *Trauma, War, and Violence: Public Mental Health in Socio-Cultural Context*. New York: Springer.

Eloul, L., Quosh, C., Ajlani, R., Avetisyan, N., Barakat, M., Barakat, L., Ikram, M.W.., Shammas, L. & Diekkamp, V. (2013). Interagency coordination of mental health and psychosocial support for refugees and people displaced in Syria. *Intervention, 11*, this issue.

Engel, GL (1977). The need for a new medical model: a challenge for biomedicine. *Science, 196*, 129-136.

Hassan, M. (2013). Personal reflections on a psychosocial community outreach programme and centre in Damascus, Syria. *Intervention 11 (3), this issue.*

Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: IASC.

Ismael, M. (2013). Painting glass as a psychosocial intervention: reflections of a psychosocial refugee outreach volunteer in Damascus, Syria. *Intervention 11 this issue.*

Koenig, H. (2000). Religion and Medicine I: Historical Background and Reasons for Separation. *International Journal of Psychiatry in Medicine, 30* (4), 385-398.

Koenig, H., McCullough, M. & Larson, D. (2001). *Handbook of Religion and Health.* Oxford: Oxford University Press.

Kurzman, C. (2008). Meaning-Making in Social Movements. Introduction. *Anthropological Quarterly 81 1m 5-15.*

Lysne, CJ. & Wachholtz, A B. (2011). Pain, Spirituality, and Meaning Making: What Can We Learn from the Literature? *Religions, 2* (1), 1-16.

Marks, L. (2005). Religion and Bio-Psycho-Social Health: A Review and Conceptual Model. *Journal of Religion and Health, 44* (2), 173-185.

McKee, DD. & Chappel, NJ. (1992). Spirituality and medical practice. *Journal of Family Practice, 35* (201), 205-208.

Mirghani, Z. (2013). Healing through sharing: an outreach project with Iraqi refugee volunteers in Syria. *Intervention 11 (3), this issue.*

National Child Traumatic Stress Network (NCTSN), (2003). *Review of Child and Adolescent Refugee Mental Health. White Paper from the National Child Traumatic Stress Network.* Refugee Trauma Task Force. Available from: http://www.nctsn.org/sites/default/files/assets/pdfs/refugeereview.pdf

Pérez-Sales, P., Férnandez-Liria, A., Baingana, F. & Ventevogel, P. (2011). Integrating mental health into existing systems of care during and after complex humanitarian emergencies: rethinking the experience. *Intervention, 9*, 345-358.

Porter, M. (2007). Global Evidence for a Bio-psychosocial Understanding of Refugee Adaptation. *Transcultural Psychiatry, 44* (3), 418-439.

Quosh, C. (2011). Takamol: Multiprofessional capacity building to strengthen the psychosocial and mental health sector in response to refugee crises. *Intervention, 9* (3), 249-263.

Quosh, C., Eloul, L. & Ajlani, R. (2013). Mental health of refugees and displaced persons in Syria and surrounding countries: a systematic review. *Intervention 11 (3), this issue.*

Shediac-Rizkallah, MC. & Bone, LR. (1998). Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Journal Health Education Research, 13* (1), 87-108.

Silove, D., Ekblad, S. & Mollica, R. (2000). The rights of the severely mentally ill in post-conflict societies. *The Lancet, 355*, 1548-1549.

Silove, D. (2005). From trauma to survival and adaptation: Towards a framework for guiding mental health initiatives in post-conflict societies. In: D. Ingleby (Ed). *Forced migration and mental health: Rethinking the care of refugees and displaced persons*. International and Cultural Psychology Series. New York: Springer.

Silove, D. (2013). The ADAPT model: a conceptual framework for mental health and psychosocial programming in post-conflict settings. *Intervention 11 this issue.*

Steckler, A. & Goodman, RM. (1989). How to institutionalize health promotion programs. *American Journal of Health Promotion, 3*, 34-44.

Sulmasy, DP (2002). A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life. *The Gerontologist, 42*(III), 24-33.

UNHCR (2009). *Policy on Refugee Protection and Solutions in Urban Areas*. Geneva: UNHCR.

UNHCR (2011a). *Ensuring Access to Health Care. Operational Guidance on Refugee Protection and Solutions in Urban Areas*. Geneva: UNHCR.

UNHCR (2011b). *Ensuring Access to Education. Operational Guidance on Refugee Protection and Solutions in Urban Areas*. Geneva: UNHCR.

UNHCR (2011c). *Promoting Livelihoods and Self-reliance. Operational Guidance on Refugee Protection and Solutions in Urban Areas*. Geneva: UNHCR.

UNHCR (2012). *Global Trends Report 2011*. Geneva: UNHCR.

Williams, ME. & Thompson, SC. (2011). The Use of Community-Based Interventions in Reducing Morbidity from the Psychological Impact of Conflict-Related Trauma Among Refugee Populations: A Systematic Review of the Literature. *Journal of Immigrant and Minority Health, 13*(4), 780-794.

[1] Exceptions are UNHCR's general urban policy (2009) and respective operational guidance notes on access to health and education and promoting livelihoods (UNHCR, 2011a,b,c).

[2] For a definition of a complex emergency please see the Complex Emergency Database at: http://www.cedat.be/glossary.

[3] For a definition of a protracted refugee situation please see: UNHCR. *Protracted refugee situations* (EC/54/SC/CRP.14), June 2004.

[4] Meaning making is a broad concept and process. '*At its root is the proposition that humans constantly seek to understand the world around them, and that the imposition of meaning on the world is a goal in itself, a spur to action, and a site of contestation*' (Kurzman, 2008). It can refer to human perception and behavior as well as to collective contest over interpretation and belief systems that are essential for support and coping and can also be sensitive to change in crisis situations or in times of adversity. It is further defined '*as the construction of an account or recital of an event or a series of events, either true or fictitious that serves to organize or structure life*' (Cacioppo et al., 2005). Meaning making is central to spirituality and sociality and closely related to coping. '*Religion and spirituality are two methods of meaning making that impact a person's ability to cope, tolerate, and accept disease and pain. The biopsychosocial-spiritual model includes the human spirit's drive toward meaning-making along with personality, mental health, age, sex, social relationships, and reactions to stress (Lysne & Wachholtz, 2011)*.'

[5] Pyramid graph is adapted from: ACT Alliance Community based PSS website: http://psychosocial.actalliance.org/default.aspx?id=67005.

[6] A few studies demonstrate the benefits of psychosocial and community based interventions (Williams & Thompson, 2011), as well as case

management approaches. The latter are, however, solely assessed in Western contexts. Some of the programmes in this sector undergo internal monitoring and evaluation, but results often do not reach research standards, and are rarely shared or discussed with the practitioner or academic community.

Constanze Quosh (MSc), was head of the Mental Health and Psychosocial Support Programme, UNHCR Syria from 2008 to 2013, and is currently working as urban refugee programming specialist for UNHCR in Sudan. email: quosh@unhcr.org