A Policy Brief on WHO's Problem Management Plus, EASE, and Step-by-Step Interventions in Addressing Mental Health Concerns Among Syrian Refugees

Fostering Responsive Mental Health Systems in the Syrian Refugee Crises: Scaling up Psychological Interventions with Syrian Refugees (STRENGTHS)

STRENGTHS

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Executive Summary

By mid-2022, an estimated 103 million people had been forcibly displaced worldwide due to conflicts, violence, human rights violations, and fear of persecution[1]. While many displaced persons demonstrate great resilience, the mental well-being of refugees is often under pressure, and compared to non-refugee populations a higher proportion of them show common mental health problems such as anxiety and depression, and posttraumatic stress. At the same time, health systems within and outside Europe may struggle to provide sufficient mental health care to large groups of incoming refugees. The World Health Organization (WHO) has developed several scalable psychological interventions, which may be useful in increasing displaced people's access to mental health care.

This policy brief provides information about the findings of a European Commission funded study called STRENGTHS (Scaling Up Psychological Interventions with Syrian refugees)[2]. The STRENGTHS research consortium examined the mental health needs of Syrian refugees and the health system responsiveness to those needs in eight countries. Furthermore, the consortium studied the effectiveness, cost-effectiveness, and scale-up potential of three scalable psychological interventions that were developed by the WHO: Problem Management Plus (PM+), Early Adolescent Skills for Emotions (EASE), and a digital intervention called Step-by-Step (SbS). The studies included over 2600 Syrian refugees and asylum seekers in Europe, the Middle East and North Africa.

PM+ trials took place in two high-income countries (The Netherlands & Switzerland), as well as an urban lower-income setting (Türkiye) and a refugee camp setting (Jordan). EASE was studied in Lebanon, and SbS was examined in Sweden, Germany, and Egypt.

PM+

Problem Management Plus (PM+)

- Five-sessions evidence-based, trans-diagnostic scalable psychological intervention which can be delivered by trained and supervised non-specialist facilitators in person to individuals or groups of 8-10 people
- Aimed at adults with increased psychological distress and reduced functioning
- Addresses common mental health symptoms through four evidence-based strategies: stress management, problem solving, behavioural activation, and skills for strengthening social support

Early Adolescent Skills for Emotions (EASE)

- Trans-diagnostic scalable intervention for children and young adolescents with increased psychological distress which can be delivered by trained and supervised non-specialist facilitators
- Consists of seven group sessions with young adolescents (ages 10-14 years) and three sessions with their caregivers delivered in groups of 6-10 people
- Addresses common mental health symptoms through evidence-based strategies for understanding emotions, stress management, behavioural activation, and problem solving

Step-by-Step (SbS)

- Is a 5-session transdiagnostic mobile application-based intervention, targeting common mental health symptoms in adults
- Included psychoeducation, behavioural activation training and teaching of basic cognitive behavioural techniques through an illustrated narrative with audio recordings
- Can be used with additional guidance from trained non-professionals, for example, in the form of weekly phone calls; within STRENGTHS the completely self-guided version of the app was investigated

The STRENGTHS Project

- Evaluated the implementation, effectiveness and cost-effectiveness of several psychological interventions among Syrian refugees in eight countries in Europe, and the Middle East and North Africa
- Examined the responsiveness of health systems across Europe and the Middle East to address mental health concerns of Syrian refugees and the potential for scaling up the WHO transdiagnostic interventions across these health systems
- Funded by the European Union's Horizon 2020 Research and Innovation programme Societal Challenges (2017-2022)

Background

Syrian refugee crisis

The number of people forcibly displaced has more than doubled in the last decade, reaching over 103 million by mid-2022[1]. This includes 53.2 million internally displaced people, 32.5 million refugees and 4.9 million asylum-seekers. More than 4 in 5 of the world's refugees are hosted in low and middle-income countries.

People from Syria form the largest group of refugees, with 6.8 million Syrian refugees hosted worldwide, mostly in the Middle East, North Africa and Europe. Many Syrian refugees have fled violence and destruction in their home country facing poverty, loss of loved ones and fear of harm[3]. These pre-flight hardships are typically followed by more difficulties during the flight, while they may also face a multitude of stressors in the hosting countries.

Psychosocial well-being and mental health of Syrians

For refugees displaced to countries near Syria, challenges related to language and culture may be relatively small, but they often face major socio-economic challenges and lack of access to essential services. Syrians displaced to European countries, on the other hand, may face more challenges to integration because of language and culture, even if certain basic services and provisions like housing may be more easily available.

As a result of increased risk factors before, during, and after displacement, Syrian refugees have an elevated risk of developing mental health conditions[4]. These symptoms can further impede integration in the host country, with negative impacts for individuals, their family, and with economic and social consequences due to, for example, not being able to work or study.

Health care systems: responsiveness and influencing factors

The arrival of high numbers of refugees presents challenges to the health systems of receiving countries. These challenges may look different in different refugee hosting countries, depending on the structure of the health system, the specific refugee population, as well as the socioeconomic situation of a country. Some of these challenges include:

- Limited number of mental health providers and appropriate services within the health system in general; long waiting times for specialist services
- Few mental health specialists who can provide appropriate culturally competent mental health services in the target language

- Limited mental health awareness among the target population, and/or among the host population, potentially leading to stigmatization and discrimination related to mental health issues
- Access to healthcare limited by financial issues such as high out-of-pocket costs, lack of transport, or inability to attend services within their opening hours

What are scalable psychological interventions?

Scalable psychological interventions (sometimes called “low-intensity interventions”) have been developed to improve access to mental health services. They are brief (5-8 sessions) evidence-based psychological treatments that have been modified for use by non-specialist providers. This is called *task-shifting* or *task-sharing*: some work that is usually done by specialized mental health workers is carried out by trained non-professionals under supervision of specialized mental health workers. This requires fewer resources compared to conventional psychological treatments by specialists and therefore has the potential to create more accessible mental health care that reaches a larger number of people who would otherwise remain unserved. The STRENGTHS project studied three types of scalable psychological interventions developed by the World Health Organization (WHO).

Problem Management Plus

Who is it for?

Problem Management Plus (PM+) was developed for adults affected by adversity experiencing psychological distress.

What is it?

PM+ is a scalable psychological intervention delivered in person for adults with psychological distress. It can be delivered by paraprofessionals, or non-specialists after eight days of training. It is a transdiagnostic intervention in that it does not target a single disorder, but a set of symptoms of common mental health conditions related to anxiety, depression, and posttraumatic stress disorder. It is based on well-tested cognitive behavioural and problem-solving techniques. There are two variants of PM+: an individual intervention and a group intervention.

Intervention overview

Individual version

- Five 90-minute sessions
- Clients learn four strategies:
  1) Stress management,
  2) Problem solving,
  3) Behavioural activation,
  4) Skills to strengthen social support
- The sessions focus on the difficulties the client is facing in their daily life

Group version

- Five 2-hour group sessions with 8-10 people per group
- Groups can be mixed-gender or gender-specific
- Covers the same four strategies as in the individual variant of PM+:
- The sessions are structured around case examples brought in by the helper, rather than each individual's own daily difficulties. The clients are asked to reflect on how the strategies discussed during the session may apply to their own lives.

Early Adolescent Skills for Emotions

Who is it for?

Early Adolescent Skills for Emotions (EASE) was developed for young adolescents (boys and girls between 10 and 14 years old) experiencing psychological distress.

What is it?

EASE is an intervention that is carried out in a group setting by a non-specialist provider. It incorporates evidence-based strategies for dealing with common mental health symptoms, such as depression, anxiety, and distress. It focuses on young adolescents, but also includes caregiver sessions.

Intervention overview

- Seven group sessions for the young adolescents
- Three sessions for the caregivers
- The sessions include understanding emotions, stress management, behavioural activation, and problem solving

Step-by-Step

Who is it for?

Step-by-Step (SbS) is a digital intervention developed for adults experiencing psychological distress. It is suitable for individuals who have access to a mobile device and an internet connection.

What is it?

Step-by-Step can be accessed through a smartphone and targets symptoms of depression and related conditions by providing psychoeducation and self-help techniques through an illustrative narrative that the client follows throughout the sessions on their internet- connected device. The intervention covers techniques such as behavioural activation, stress management, gratitude, social support strengthening and relapse prevention.

For users who require additional support, a contact-on-demand system with trained Syrian e-helpers was developed. These e-helpers provided technical assistance, helped with referral information, and supported with SbS content and STRENGTHS study procedures through an in-app messaging system. Users of SbS could choose to reach out if they wished.

Intervention overview

- Five self-paced sessions, each of which includes an illustrated story with audio recordings of the text
- Each session consists of up to three subparts, each of which take approximately 20 minutes to complete. The user can access their next session only four days after the completion of the previous one, to allow time for practicing the previous session's content
- Can be either completely self-guided or with weekly support from trained non-specialist providers; in STRENGTHS, the self-guided version was tested

The research at a glance

Where?

WHO Scalable Interventions

PM+ **Individual**

SbS

PM+ **Group**

EASE

Who?

Syrian refugees, both adults (PM+, Sbs) as well as children and adolescents (EASE)

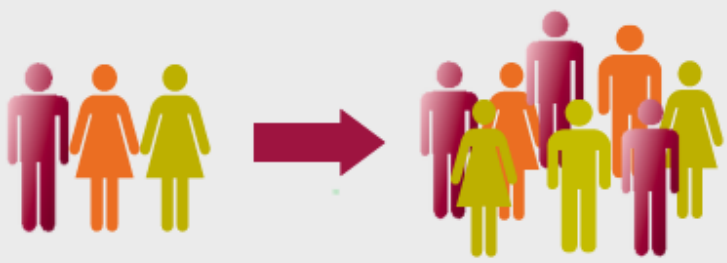
Experiencing increased psychological distress and decreased functioning

Altogether 2600+ participants across all pilots and trials

Improving Health System Responsiveness

Compared the effectiveness and cost-effectiveness of the WHO scalable psychological interventions.

Investigated barriers and facilitators for scaling up across the different settings.



How?

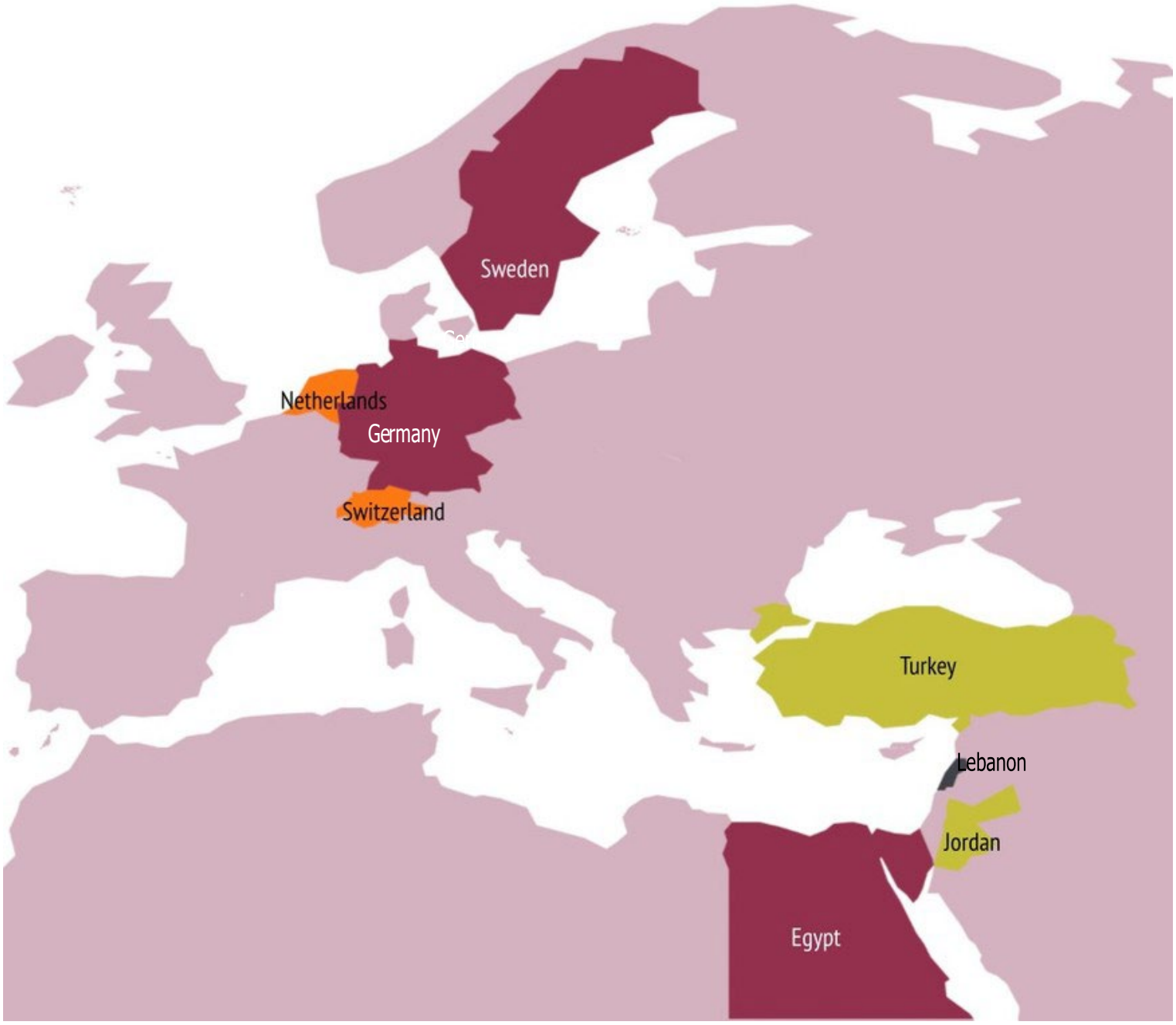
Symptoms of anxiety, depression, post-traumatic stress disorder, and general functioning were assessed before treatment and at 3 and 12 months after treatment. The treatment and care-as-usual groups were compared to see if there were any differences in the symptom changes between the two groups.

Qualitative interviews were carried out with a variety of stakeholders across project countries to examine the potential for further scaling up the WHO interventions.

Outcomes

The WHO scalable psychological interventions are effective in reducing symptoms of anxiety and depression, and improving general functioning among Syrian refugees. They may improve the responsiveness of health systems to address mental health concerns among refugees.

Main results of the STRENGTHS project



Effectiveness of the WHO scalable interventions

PM+ individual

In the Netherlands and in Switzerland, PM+ individual was implemented in community settings. A pilot study among 60 Syrians in a non-governmental organization in Rotterdam and a larger study among 206 people with a Syrian refugee background across the Netherlands showed that at one week and at three months after the intervention, Syrians who received PM+ had significantly lower levels of depression, anxiety, symptoms of posttraumatic stress disorder and personal problems than care-as usual controls[5]. The twelve-month follow-up data are being analyzed. These positive results in terms of reducing symptoms of psychological distress were confirmed by a smaller trial among 54 people with a Syrian refugee background in Switzerland.

PM+ group

The study among 402 Syrian refugees in the Azraq refugee camp in Jordan showed that three months after the study, participants in group PM+ had greater reductions in depression symptoms, personal problems, and inconsistent disciplinary parenting[6]. The differences were not maintained after one year[7]. In Türkiye (368 participants), group PM+ was implemented in a community setting in Istanbul. Symptom declines were seen in both the group PM+ group and the care-as-usual group, without significant differences in the symptom changes between the two groups[8].

EASE

EASE was implemented among 198 young adolescents in Lebanon. The trial had to be stopped prematurely due to the COVID-19 pandemic and the worsening socio-economic and political situation in the country. Only 44% of the required number of children could be included in the trial. This sample size was too small to make firm conclusions about effectiveness. Both EASE and the one-session psychoeducation home visits (control) showed similar improvements. However, in a parallel study funded by ELRHA R2HC, among 471 young Syrian adolescents in Jordan, EASE led to reduced psychological distress among adolescents and reduced distress and less inconsistent disciplinary parenting behaviour among their caregivers[9].

SbS

Studies on the digital unguided version of SbS among people with a Syrian refugee background in Germany (559 participants), Egypt (538 participants) and Sweden (184 participants), showed that SbS was usable, acceptable and accessible, and has the potential to reduce psychological distress and improve daily functioning. Participants who completed at least four out of the five SbS sessions showed more benefits. SbS worked best for participants in Egypt, where fewer treatment alternatives were present and where the life circumstances of Syrians resembled the humanitarian settings for which SbS was originally developed.

Many participants wished for additional personal contact with a mental health professional through the app, and some found that the narrative content did not always sufficiently match their current life circumstances.

A parallel trial in Lebanon among 680 people with depression and impaired functioning investigated the guided version of SbS, where non-professional helpers provided support to participants. This trial showed positive effects on depression, functioning, posttraumatic stress, anxiety, subjective well-being and personal problems 3 months after the end of the programme[10].

Cost-effectiveness

Despite the existing knowledge about the increased mental health risks for displaced people, and the evidence that there are long-term adverse economic consequences of delayed access to appropriate care services, there have been very few studies that have evaluated the economic case for investing in measures to protect the mental health of refugees and displaced people. STRENGTHS is one of the first studies that has fully embedded economic evaluation into analysis of the implementation of brief psychological interventions to protect the mental health of refugees. Our analyses indicated that:

- PM+ has the potential to be cost-effective in both European and Middle Eastern contexts
- Overall, at 3-month follow-up, there was little change in the use of health care services, but some improvements in quality of life were observed. This indicates that the scalable interventions studied in STRENGTHS are likely to have better outcomes but at higher costs than usual care, 3 months after completing the programmes
- Upcoming longer-term 12-month follow-up analysis will provide information on whether or not changes in health service utilization are observed, and whether positive outcomes seen at 3 months can be sustained over a longer time period

While STRENGTHS has demonstrated the potential for brief psychological interventions to be cost-effective, it is heavily dependent on the costs of implementation. It is important to consider the context in which interventions are delivered, when interpreting the results of the economic analysis. Factors such as ease of access to health services, level of out-of-pocket costs for services, as well as the right to employment and education, may also have impacts on the mental health of study participants.

Example: The Netherlands

- In the Netherlands, the cost per Quality Adjusted Life Year (QALY) gained is just above the threshold often used to indicate cost-effectiveness of an intervention. However, modelling analysis suggests that if the costs of training can be reduced, the intervention has a high probability of being cost-effective
- The scalable interventions will also become more cost-effective if some QALY gains are sustained beyond three months and also if any long-term increased need for health care services is avoided through early intervention

- In the Netherlands, where most study participants had the legal right to work, the case is further strengthened by reductions in time spent out of work or other activities in the PM+ group

Example: Jordan

- There were some improvements in quality of life at the 3-month follow-up, although health service use remained very low
- The intervention can be considered potentially cost-effective in a Jordanian context if the costs of training can be reduced
- The intervention was delivered in a remote refugee camp by Jordanian helpers who lived elsewhere. This led to additional logistics costs for transport and security measures. Such costs may not occur when helpers live in the place where the intervention is delivered.

Mental health needs, health system responsiveness, and scaling up psychological interventions

Mental health needs

We identified high levels of mental health needs among Syrian refugees:

- Through a cross-sectional survey conducted in 2018 with 1678 Syrian refugees in Istanbul, Türkiye, the prevalence of symptoms of posttraumatic stress disorder, depression and anxiety was found to be 19.6%, 34.7% and 36.1% respectively[11].
- Only around 10% of the respondents with these disorders had sought services for them (i.e., a treatment gap of around 90%).
- Key barriers to seeking care included cost, availability, and quality of care; awareness of symptoms and stigma around mental health; and preferring to self-treat or feeling symptoms would reduce by themselves.

Health system responsiveness

We also assessed health system responsiveness to the mental health needs of Syrian refugees in the STRENGTHS study countries, using secondary analysis of literature and other data sources. Constraints to health system responsiveness included[12]:

- Limited appropriate mental health providers and services
- Cultural, language, and knowledge-related barriers caused by insufficient numbers of culturally sensitive providers and interpreters
- High out-of-pocket costs for psychological treatment and transport to services (especially in Lebanon, Jordan, Türkiye)
- Long waiting times for specialist mental health services
- Low mental health awareness and stigma around mental illness among Syrian refugees

Scaling up psychological interventions

Lastly, we explored strategies to scale up PM+ (and similar interventions) to help meet the mental health needs of Syrian refugees in the study countries. Common themes included[13,14]:

- Formalizing the roles of new non-specialist workers (including from affected communities, particularly refugees themselves), including developing structures for their accreditation, support, and supervision
- Dedicated financing of scalable mental health services such as PM+ at primary care and community levels (including for training and supervision)
- Health policy reforms to support the integration of scalable interventions into primary care and community services

Learning more about implementation?

When considering to implement the described scalable interventions please consult the STRENGHTHS Implementation and Advocacy Support Package that documents lessons learned within the STRENGHTS project and contains details about:

- How to culturally and contextually adapt PM+[15]
- The resources need to train and supervise people in PM+
- Strategies to overcome implementation challenges in PM+

Key recommendations

The STRENGTHS project research results have led to the following key recommendations for implementing PM+ and other scalable psychological interventions for Syrian refugees, or other refugee groups:

1. **Consider evidence-based scalable psychological interventions like PM+ individual, PM+ group, EASE and SbS** for populations with limited access to mental health care, such as refugees, asylum seekers and migrants. By using trained and supervised peer-facilitators to provide psychosocial support in the target group's own language, pressure on the health system can be reduced and more people can access culturally relevant mental health care.

2. **Involve the target community in the implementation** by working with key stakeholders trusted by the target community. Engaging already trusted parties can be helpful in increasing mental health awareness, reducing the stigma of accessing psychosocial services, and engaging the people who could benefit from the intervention. Furthermore, members of the target community can be involved as providers of the intervention which can have empowering effects.[16, 17]

3. **Work together with local health service providers** who can help embed the scalable interventions into the existing systems of care and can support setting up appropriate structures for implementation. For example, existing mental health providers can be involved in supervision of facilitators and can facilitate referral of people with complex of severe conditions that cannot be addressed by the scalable psychological interventions.

4. **Identify potential implementation barriers in your setting, and where possible develop actions to address these.** The success of scaled up implementation will depend on many aspects ranging from sustainability of funding to acceptability of the intervention by the target community and current health care system. These barriers may be vastly different in low and middle-income countries, compared to high-income countries.

5. **Ensure quality control in implementation** by providing adequate training and supervision by mental health professionals such as clinical psychologists and professional counsellors, and by monitoring and evaluating the intervention's effects. Facilitators may need extra support in specific dimensions (e.g., addressing their own stigma around mental health, facilitating group interactions).

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The STRENGTHS project

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