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Abstract

This article offers recommendations for coordinating mental health and psychosocial support (MHPSS) programs for Syrian refugees and internally displaced persons in the Middle East with those available to Syrian asylum seekers in Europe.

It examines the Netherlands' progressive policies toward MHPSS programs in conflict crises that can provide examples of good practice in policy and advocacy. It calls on host governments to address their support for the enhanced provision of MHPSS not just in humanitarian responses overseas but also for refugee populations in their own countries. It seeks to identify challenges and obstacles in existing programming and proposes the creation of a coordination mechanism at the national level in countries bridging national and international programs, as well as the formation of a knowledge hub to address the urgent and crucial needs of global peace and humanitarian development work. Key topics for learning collaboration are identified to foster the intersection of MHPSS and peacebuilding work.

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The psychological aspects of peacemaking require robust and innovative policies in the design and provision of mental health and psychosocial support (MHPSS) programs for conflict-affected populations. Emergencies, disasters, and war put psychological and social stress on individuals, families, and their communities. Not only do people experience significant trauma and atrocities before or during flight but once they have reached safety, the living conditions in their new reality continue to impose significant stress and hardship.[1] Once the most immediate concerns are addressed, such as providing food, housing, and medical attention to ensure physical survival, secondary concerns, such as documentation and livelihood, begin to take priority over the longer-term psychological needs that may be more difficult to detect and address and that may surface after years or decades. Some people, such as survivors of violence or those who have lost family members or become separated from them, are more vulnerable to distress. People who have endured these hardships can overcome them with time, access to the right resources, and the presence of a supportive family or community environment.

Peacebuilding can include a wide range of formal and informal activities led by civil society or private-sector actors who seek to address the root causes of violent conflicts and establish conditions in which peace management and conflict resolution are more likely to increase capacity for constructive change.[2] Healthy, sound, and mentally resilient populations are better prepared to participate in this change to rebuild their societies and communities. The healing of communities at the individual and group levels would complement longer-term peacebuilding work in postconflict recovery, stabilization, and rebuilding. As Jan Kizilhan has noted, "In a cycle of war, hatred and violence, psychological aid is crucial. Without spiritual and mental recovery, there is no room for forgiveness and peace."[3]

In response to calls to more effectively support the mental health and psychosocial well-being of people affected by the Syria crisis, this article looks at how MHPSS activities can be made broad and inclusive and functionally linked within a system with reference mechanisms.[4] The Netherlands is used as a case study because of recent efforts by the Ministry of Foreign Affairs to put MHPSS on the global conflict response agenda.[5] Research for this article involved qualitative interviews with academics, representatives from the Netherlands Ministry of Foreign Affairs and Ministry of Justice and Security, and Dutch nongovernmental organizations (NGOs) working at the national and international levels, as well as international nongovernmental organizations (INGOs), such as the International Medical Corps (IMC) and the International Committee of the Red Cross (ICRC).

Mental Health and Psychosocial Support in Peacemaking

Researchers and peace actors have reiterated calls for further development of policies and integration of MHPSS into peacebuilding so that it is no longer a stand-alone support isolated from others services but is integrated and streamlined into the public health, education, and protection systems.[6] Mental health care should be integrated into the general health system rather than run in parallel as a series of separate services.[7] Investing in MHPSS also has a positive effect on other humanitarian programming because the psychological well-being of individuals and communities has a direct impact on their capacity to participate in education, livelihood, and other programs, as well as peacebuilding initiatives such as openness and willingness to attend community events.

National politics and debate around the issue of refugees affect the quality and reach of such programs, which bear a cost on peaceful coexistence between communities. Thus, the learning potential of a knowledge exchange between national and international MHPSS programs on topics such as overcoming obstacles and stigma or best ways to work with the target population could increase the efficient use of their resources. This exchange would leverage what is already being implemented at the national level within countries.

As migrants from war-torn Syria, Iraq, and Afghanistan continue to risk their lives crossing the Mediterranean to seek asylum in Europe, governments have been struggling to different degrees since 2015 to cope with the surge of refugees. As MHPSS programs expanded in humanitarian and relief operations in these conflict-affected countries, European host countries also saw a growth in MHPSS initiatives for refugees in their own communities.

The quality and reach of these programs, however, differs greatly between countries, and one way these differences are being addressed is by the European Union–funded Strengths Project, which is nearing the end of its five-year plan to evaluate the Problem Management Plus (PM+) program as an effective MHPSS intervention in the Syrian refugee community in eight European countries. PM+ is a World Health Organization–designed transdiagnostic psychological intervention that is a brief, five-session program targeting common mental health problems in adults that is designed for use by nonspecialist health workers. A key characteristic is its scalability and relative low cost compared to targeted clinical interventions that are heavy on resources, such as time and money, and that do not address the stressful daily experiences that conflict-affected populations experience.[8] Research from Purgato and colleagues has shown that further research into focused MHPSS as a distinct approach that benefits a larger population compared with clinical services is vital for global health because of the negative impact on education, livelihood, and vulnerability to and perpetration of violence that mental health problems place on humanitarian settings.[9] Though approaches such as PM+ should not be framed as a substitute for clinical services, they can protect against negative psychosocial outcomes, promote functioning, hope, coping, and well-being, and provide social support.

These valuable nonclinical benefits support the United Nations High Commissioner for Refugees (UNHCR) recommendations on MHPSS, which emphasize that the main psychosocial interventions in a crisis should aim to "revive and strengthen family and community support systems and promote positive coping mechanisms of affected individuals and their families." UNHCR also recommends the integration of MHPSS approaches in all humanitarian programs, while ensuring that any interventions uphold the dignity of and foster resilience in the target populations. More important, along with several actors, it has called for coordination between different sectors, such as health, education, nutrition, child protection, community-based protection, and sexual- and gender-based violence, through a technical working group.[10]

Resilient communities are at the heart of stable, peaceful societies. In fractured societies, psychological and emotional healing at the community and individual levels need to be prioritized to allow people to participate in rebuilding and, eventually, in reconciliation efforts. Researchers have called for coherence and greater clarity in the design, implementation, and evaluation of psychosocial interventions to address the health and well-being of children and adolescents in humanitarian settings. The suggestion calls for further research into the unique contribution of focused psychosocial support over different functions beyond the psychiatric clinical paradigm that is usually used in such contexts.[11]

Migration Consequences of the Syrian Civil War

The civil war in Syria, ongoing since 2011, has led to the internal displacement of approximately 6.1 million people, and more than 5.5 million people have fled for safety in Lebanon, Turkey, Jordan, and beyond. While a staggering 11 million people remain in need of humanitarian assistance in Syria,[12] Europe has experienced a migrant crisis since 2015, when nearly a million people escaping conflict mainly in Syria, Afghanistan, and Iraq made it to European shores, with thousands losing their lives in the Mediterranean Sea. Though by 2019 that initial wave of asylum seekers had begun to abate, Europe now grapples with large numbers of refugees whose countries of origin, such as Syria, remain in a state of conflict.[13]

The presence of these refugees has fueled national debates in host countries on the longer-term integration and status of Syrian refugees, many of whom have experienced conflict-related violence and traumatic stress not just in Syria but also on their journeys seeking safety. Some members of the community have expressed fear of double traumatization: enduring the effects of waiting in uncertainty while their applications are being processed and dealing with the possibility of rejection and forced return. This situation is compounded by the daily stressors of ongoing displacement. These stressors include poverty, lack of basic needs and services such as access to livelihood, risks of violence and exploitation, including sexual and gender-based violence, and the absence of family and community support. Unfortunately, one way of coping with uncertainty has been early marriage, which has become more and more prevalent and has only increased distress for young girls and their families. Reaching physical safety may leave refugees still struggling with feelings of isolation, desire for homeland, and discrimination and social tensions in host countries.[14]

The immense exposure to traumatic stresses may show up as different symptoms in different people. But experts are careful to point out that the presence of these symptoms does not necessarily indicate a mental disorder, which is a clinical diagnosis; or post-traumatic stress disorder as it is strictly defined. Mental health professionals are advised to refrain from overdiagnosing mental disorders among displaced Syrians, many of whom are facing insecurity due to daily stressors and who instead may benefit more from nonclinical interventions related to improving their living conditions than from psychological or psychiatric intervention.[15] This approach can be taken into account when devising policy strategies around MHPSS issues in conflict-affected populations.

What may be overlooked by governments and communities feeling pressure on their economies and infrastructure is the significant positive human and social capital that Syrian refugees can contribute to their host countries.[16] For this potential to be fully realized, these populations could benefit from MHPSS support that can raise awareness and address and target (when necessary) psychological adjustment issues to help these populations regain their capacities as fully functioning individuals with self-agency.

As the protracted crisis in Syria continues into its tenth year, international humanitarian aid agencies have expanded their MHPSS programs in Syria and refugee camps in the surrounding countries. Different local programs have been developed in places where psychological support largely did not exist before the conflict. Specialized psychiatric care was available to treat clinical mental disorders, but the Syrian public health system was lacking in formal psychological or psychosocial support through therapy or counseling. A mental-health working group has since been established in the protection sector, and MHPSS support is included in child protection and gender-based violence interventions.

A pervasive sense of superficiality, however, and a lack of seriousness in addressing MHPSS has emerged when there are more pressing life-threatening issues at stake, such as people's physical safety. A resulting outcome is a misunderstood or misappropriated approach to MHPSS as an umbrella term for a range of vague initiatives such as children's activities.[17] The guidelines for activities can be better clarified and defined to ensure that MHPSS is well understood and used in humanitarian settings, so that resources such as funding and personnel can also be properly allocated. This clarification would be timely because the shifting political and security landscape requires MHPSS in Syria to frequently expand or pivot its focus. Some of the current needs include reintegration of returnees who are mostly internally displaced persons (IDPs) from Lebanon and Jordan into homes, schools, and health centers as security improves in certain parts of the country. Sanctions are also causing Syrians to consider leaving the country again, prompting questions of a possible second wave of refugees. The uncertainties around the evolving situation in Syria mean that MHPSS will grow increasingly

relevant to humanitarian and peacemaking policy not just for Syria but for host countries of asylum seekers.

In this regard, governments and organizations can leverage existing resources and best practices, such as the mapping exercises that have been conducted on MHPSS activities in Jordan and Lebanon, including how MHPSS has been incorporated into public healthcare systems in these countries through partnerships with UN agencies. In Jordan, for example, local and international NGOs have implemented child-friendly spaces as investments into the national MHPSS capacity.[18] These success stories can be presented to European host countries as examples of good practice for their refugee communities and of how their own healthcare systems for citizens could be enhanced by incorporating MHPSS design. Who may be best placed to lead such efforts, what form such a knowledge sharing or coordinating hub might take, what outcomes can reasonably be expected, and other such questions are addressed in the following sections.

Mental Health and Psychosocial Support Programs in Syria and Beyond

A host of actors and agencies are working at the local and international levels on MHPSS in Syria, its surrounding countries, and Europe. These include large international agencies, such as UNHCR, the International Organization for Migration (IOM), IMC, WHO, and the ICRC, and NGOs working regionally or locally. These activities may take the form of psychoeducation, community workshops, or mobile clinics, or they may target children, youth, or adults who are subject to gender-based violence.

A certain level of collaboration already exists among several humanitarian aid agencies. For example, the Syrian Arab Red Crescent works with UNHCR and the ICRC in public health centers to set up MHPSS teams and clinics. In-depth knowledge of local context and parameters is key to effective design and implementation. Because only psychiatry or psychosocial counseling was offered in universities in Syria before the civil war, locally trained psychologists were in short supply and the very concepts around psychological issues were largely beyond social discourse and shrouded in stigma. These counselors are now being retrained as psychologists so they can be integrated into the system, which has also been redesigned to reduce stigma by having psychologists work in teams with doctors at clinics or health centers. These changes have reduced anxiety around mental health issues by framing them in the context of medical health. A referral process that was established between doctors and mental health professionals has also normalized access to such services, demonstrating how crucial local knowledge is in adapting program needs to the contextual demands.

Host countries usually have their own MHPSS programs housed in reception centers or as part of healthcare systems after asylum has been granted. Local NGOs may continue to provide MHPSS outreach and services thereafter. The Strengths Project would conclude with PM+ being approved for middle-to-high income countries, enabling evidence-based low-intensity psychological intervention to be made available to Syrian refugee communities across Europe. This approach will include two PM+ programs targeting the group and the individual, as well as EASE, an internet-delivered version that targets youth, and an app called STEP by STEP that is being trialed by fifteen partners in eight countries.

Such programs are viable, and they fill a gap in existing work because they involve the community directly while providing culturally relevant assistance designed to reach the widest group of people for whom formal diagnosis is not required. This cognitive and behavior therapy approach uses problem-solving techniques and targets symptoms that adults impaired by distress from exposure to adversity may have, not single disorders. It involves relaxation and engagement in activities, breaking problems down into manageable pieces and activating social networks, and it can help with trauma, anxiety, stress, and depression. Research taking place

at the time of this writing is investigating how this therapy approach can be implemented in specific contexts and whether it can be a cost-effective measure within healthcare systems.

While many MHPSS programs are used in refugee populations, PM+ is an example of an evidence-based program that potentially could reach the largest number of people in need. A common goal for any such program would be to help IDPs and refugees from Syria construct meaning from suffering and find ways to cope with their situation by providing culturally safe environments for dialogue and collaborative opportunity.[19]

A Shared Responsibility

Various large organizations or working groups involved in MHPSS for migrant populations operate at the national, regional, and international levels; but how do their approaches differ, and does coordination exist between them? Who might take stock of MHPSS programs for Syrian refugees and displaced persons so that the psychological dimensions of peacemaking policies could be better addressed across sectors and countries?

At the regional, EU level, the European Asylum Support Office at the European Commission, the European Council on Refugees and Exiles, Refugees' Ideas and Solutions for Europe, and the European Migration Forum are just some of the agencies that could coordinate MHPSS strategies between states and NGOs. For example, in Greece, the Syn-Eirmos NGO operates a center for migrants' mental health called Babel, which coordinates responses between government and local actors and works to have MHPSS included in humanitarian response. Babel also coordinates with the UNHCR Working Group on MHPSS to effectively manage issues related to the mental health of refugees and migrants. Policy makers may consider whether there could or should be room for involvement at the regional level with an EU agency as well.

At the international level, the World Health Organization (WHO) has a mental health– gap action program aimed at low-to-middle-income countries.[20] The International Federation of Red Cross and Red Crescent Societies' (IFRC) regional Red Cross Red Crescent Psychosocial Support Programme networks exist in several zones,[21] while IOM provides direct MHPSS to migrants and host communities by implementing capacity-building initiatives in various sectors, such as emergency response and humanitarian activities throughout its programs and services. IOM is part of an interagency collaboration with WHO, UNHCR, United Nations Children's Fund (UNICEF), and IFRC on MHPSS and coordinates with the Inter-Agency Standing Committee's (IASC) MHPSS Reference Group. This group supports country-level MHPSS working groups, one of which focuses on MHPSS and peacebuilding and on developing a common monitoring and evaluation framework.

Thus, while collaboration exists between agencies at an international level, the question remains, Who could oversee input from, for example, best practices in MHPSS programs or public health systems dealing with Syrian refugees feeding into knowledge exchange between the national, regional, and international domains? Such exchanges on coordination could be housed in a global repository, such as the Migration Health Research Portal,[22] *Intervention Journal*,[23] or the MHPSS Collaborative,[24] for policy makers and practitioners alike and could be expanded beyond the Syrian context to address other migrant groups.

It is important to note that these MHPSS actors and specialists in this exclusive domain should not alone be supporting refugees and conflict-affected persons but, instead, a broader and more inclusive MHPSS concept should be made relevant for and include everyone involved in providing support for such populations, such as language teachers and social workers. Global MHPSS programming has shifted emphasis from vulnerability-based approaches to increasing agency among refugees and conflict-affected persons to be active decision-makers in the face of challenges.[25] This shift would benefit from oversight and

coordination of policies at all levels. The decision to create an interlevel body to coordinate the various actors will depend on need, resources, and political will.

Obstacles to Programming and Implementation in the Syrian Context: Areas for Learning and Collaboration

Greater collaboration and learning could be beneficial to improving the access and quality of MHPSS services for Syrian refugees and displaced persons. But first, the common obstacles and challenges involved in implementing these services should be more closely examined.

Political will around these issues is a recurring challenge, affecting the funding and development of programs and the impact on national public policies. For example, some European countries face issues regarding access to mental health for their own citizens and therefore are less likely to devote resources to investing in programs for refugees or displaced persons. Public opinion in many European countries is divided over the issue of national involvement in the Syrian crisis, as well as the reception, acceptance, and length of stay of refugees and consequently these countries' peacemaking policies. An emphasis on socioeconomic concerns in humanitarian crises should be addressed first, with psychological aid further down the list of priorities. The prospect of refugees holding temporary status in these countries may also impact the quality and reach of MHPSS services. Simultaneously, the fear of asylum rejection and forced returns and a general uncertainty about future outcomes for their safety keep many asylum seekers in a state of trauma and anxiety, generating a further need for MHPSS. If they do receive asylum, many refugees may not know how to continue or access such services for refugees.

Thus, awareness of and knowledge about access to MHPSS services remain challenging for programs aimed at Syrian refugees and displaced persons. Whereas flying in psychological specialists to Syria and the surrounding countries' refugee camps or providing resource-intensive psychological treatment to asylum seekers in Europe make little sense because of the long-term therapeutic relationship and stretch on resources, solutions involving lay outreach within the community and low-cost wide-ranging interventions could help address the burden on resources while targeting the relevant mental health needs of the community.

At the same time, care should be taken that such self-help psychosocial interventions do not stand as mere band-aids[26] but include long-term solutions in the psychological dimensions of peacemaking in Syria and other conflict-affected countries. One creative solution to maximize the reach of resources has been the Syrian Tele-Mental Health Network, a form of telemedicine linked with nineteen health centers in Syria that provides mental health consultation and treatment at a distance. This initiative, too, has faced many obstacles, not least being the Syrian military forces' targeting of health clinics.[27]

For several reasons, MHPSS remains a severely underfunded area in humanitarian aid and peacemaking. A challenge for donors is the use of monitoring and evaluation methods to assess MHPSS programs because subjective experiences of and improvements to mental health and well-being are difficult to qualify or quantify, making easily digestible assessment indicators challenging to formulate. This is an area for which the IASC has published common frameworks[28] and that Swiss NGO Interpeace has addressed in their intercommunal collective trauma healing project in Rwanda.[29]

Exchanging lessons learned throws the spotlight on where exchanging lessons learned can hold tangible benefits for the advancement of MHPSS programs in peacemaking. Early detection mechanisms such as the one Dutch NGO Pharos has developed could be shared with other practitioners and implementors to observe where and when psychosocial intervention is needed. In some instances, disappointment that the international community is not helping them may be prevalent among Syrian refugees and displaced persons, affecting their interaction

with humanitarian staff.[30] This is another area of potential exchange between humanitarian workers in MHPSS that could generate ideas for addressing relations between the target group and MHPSS actors.

The key to the success and effectiveness of any MHPSS program is the eventual empowerment and involvement of the target group in their own self-agency and healing journey. The involvement of the Syrian community is necessary in such programs to help implement logistical improvements, such as having translators for the right dialect of Syrian Arabic—a common challenge for Arabic translators in host countries. But community involvement is equally important for the target group's dignity and to ensure that the programs are relevant and accessible. Community involvement creates ownership and sustainability of programs in an area that is heavily stigmatized.

Culturally different concepts of trauma and mental health mean there are spiritual elements in the Syrian understanding of mental health issues. Psychological help is perceived within the community as a service relevant only for the mentally unsound rather than as part of a person's overall health and well-being. This stigma is one of the biggest barriers to MHPSS access. Beyond using the right dialect, understanding Arabic and Syrian idioms of distress is important for communication with refugees because certain expressions may be used to convey empathy, to support and convey interventions, and to clarifying concepts around stigma.[31]

In addition, the Syrian community has particular notions to explain illness, and expectations of treatment often involve the "white doctor's coat and prescribed pills" combination. Because of the preoccupations of daily life, there may be expectations for services to be brief, directive, and immediately effective, making longer-term approaches less appealing. Ethnic, religious, and tribal identities attached to traditional leaders can also be obstacles to seeking mental health support. These shifting identities have been used in the past by the Syrian government. They are obstacles that impact displaced people,[32] reinforcing the need for community involvement to help drive, design, and implement MHPSS programs with detailed local knowledge.

Aware of the importance of community involvement, the European Commission has called for the creation of an expert group made up of people with immigrant backgrounds to participate in the development and implementation of policies on migration, asylum, and integration.[33] The participation of migrants, asylum seekers, and refugees in all aspects ranging from needs assessment to decision making is essential to make policies more effective and better adapted to long-lasting peacemaking efforts in conflict-affected states and between communities in host countries. Participation by right-holders in decisions affecting them is also a key human rights principle, because it provides them with opportunities to make decisions for their own lives and to feel hope for the future.

Access to livelihood and opportunities are closely linked with mental health. Having little or no access to work can cause stress, anxiety, and depression, especially for Syrian men, that can impair a person's ability to seek employment or perform tasks once work is found. This important linkage presents another area of potential cross-country and cross-sector learning to improve the situation. Accessing and navigating MHPSS services in an effort to get the right help can be a daunting process that is often aggravated by linguistic barriers. In some instances, these challenges can be addressed as part of a referral process from a local general practitioner. Health insurance systems would also require reviews in different countries.

The Dutch Approach

The Dutch approach to MHPSS nationally and in conflict responses, such as in Syria, provides insights into what national and international-level coordination strategies could look like. One of the strongest defining elements of the Dutch approach has been long-term, sustained

advocacy at the academic and governmental levels to support MHPSS inclusion in policy making.

Since 2020 Dutch humanitarian aid strategy has placed special focus on psychosocial factors in peacebuilding,[34] which has been boosted by advocacy efforts within the UN international fora to push for systematic attention on MHPSS in peacebuilding issues.[35] Policy recommendations in this area have also been made in the UN *Peace Building Architecture Review* for 2020, helpfully raising the profile of the oft-overlooked psychological components of sustainable peacemaking efforts.[36] The Netherlands is an example of a country that truly "walks the talk" and values the importance of supporting mental health across their humanitarian and development projects, policies, and actions. These were largely enacted under the leadership of minister for foreign trade and development cooperation Sigrid Kaag, who has been a champion for these issues since her tenure in this position began in October 2017.[37] Having a passionate and outspoken leader has been understood to be instrumental in getting MHPSS to the forefront of public awareness and discussion in the Netherlands. Just as gender champions made their way to helping mainstream gender equality and inclusion in peacemaking and other realms, MHPSS champions can inspire similar effects.

Building on this leadership drive, the Netherlands hosted the first International Conference on Mental Health and Psychosocial Support in Crisis Situations in October 2019. At the conclusion of the conference, twenty-five countries endorsed the Amsterdam Declaration, a set of basic principles for MHPSS integration in crisis responses. The Netherlands, represented by Minister Sigrid Kaag, then hosted a side event focused on the crucial role of young people in MHPSS at the IV Brussels Conference on the Future of Syria in June 2020. The Netherlands also works with UNICEF in Jordan to support the MHPSS needs of Syrian refugee children.[38] These are some of the recent milestones the Netherlands has established in setting the global agenda for MHPSS in humanitarian responses.

Several insights have emerged from written and oral interviews about the Dutch approach, the first of which is that a coordination mechanism would be useful for sharing knowledge that can inform policies around MHPSS programs for Syrian refugees in the Netherlands and in Syria and the Middle East.

This mechanism could consist of more formalized exchanges between national coordinating networks, such as Pharos, a center of expertise on health disparities, particularly for people with limited health literacy, including non-Western migrants and refugees, and organizations with global links, such as the Netherlands Red Cross or Cordaid, an NGO working to end poverty and exclusion in conflict-affected areas such as Syria, as well as the Netherlands. While Pharos develops resources, including a list of all MHPSS programs offered locally in the Netherlands, and acts in an advisory role to other local NGOs working in MHPSS,[39] Cordaid works through a consortium of five INGOs in the Netherlands known as the Dutch Relief Alliance's Syria Joint Response, which coordinates internal referrals and services in health facilities within Syria.[40] The Netherlands also hosts networks of established experts in the field of MHPSS, such as ARQ International (formerly the War Trauma Foundation), that are valuable resources for international exchange on best practices in MHPSS policies and programs.

Asylum centers coordinate their efforts in other ways at the national level and through an informal network overseen by the government's Asylum, Reception and Return Unit.[41] Learning lessons and best practices in overcoming common obstacles to implementing MHPSS in the Netherlands and in programs they support in Syria and the Middle East could be valuable areas of exchange between such organizations, units, and consortiums and could also inform policy considerations in peacemaking and humanitarian responses to strengthen social cohesion and rebuild societies well. Advancing this process is a study commissioned by the Ministry of Foreign Affairs currently being undertaken by the Verwey-Jonker Instituut, which

forms an external stocktaking and evaluation of the lessons learned and best practices of initiatives and structures in an effort to facilitate access to work and MHPSS for asylum seekers and refugees in the Netherlands.[42]

A second observation emerging from the interviews is the need to align MHPSS initiatives more closely with peacebuilding. MHPSS efforts tend to be a stand-alone issue, often subsumed under healthcare with minimal interaction with other sectors that play a vital role in strengthening the MHPSS response. Potential areas of overlap include advocacy and awareness, fostering community resilience, resource sharing, and access to livelihood in the national and the international context. This cooperation could also help to replicate positive outcomes in both settings, improving the cost effectiveness of such programs and potentially influencing future funding prospects for the sector.

Interviews also revealed that the Netherlands had introduced self-empowering policies in communities, given power to municipalities over decisions related to refugees' livelihood, education, and healthcare by January 2021. Integration programs for Arabic-speakers, such as Radboud Universiteit's Mosaic training program, aimed at the municipality level, use positive psychology approaches to increase community participation.[43] Local NGOs, such as Vlutelingenwerk, the largest organization working with refugees, also help with practical integration processes, including navigating procedures to see a doctor within the healthcare system. These new policies and ongoing practices aim to encourage refugees to increase participation in society and take ownership of their futures, contributing to more inclusive, stable, and resilient communities.

Recommendations for an Opportunity to Intersect: Formation of a Mental Health and Psychosocial Support Coordination Mechanism

With several global MHPSS working groups and resource networks already in existence, any additional coordinating mechanism or learning hub dealing with Syrian refugees and IDPs would be tailored to the exchange of policy practice between national networks in Europe and national and international organizations in Syria and the neighboring countries hosting large numbers of Syrian refugees.

These efforts might involve the creation of a coordinating structure between a national-level advisory body on MHPSS—such as an agency or institute with links to academia, government, and practitioners that connect international policies and programs on MHPSS in peacemaking and humanitarian responses at the government level—and other networks focused on national refugee programs. Such a national-level network could then be integrated into an international or globally operational organization such as the UNHCR, IASC, ICRC, or other INGOs to share lessons learned between MHPSS implementation in different refugee contexts, forming a cyclical exchange at national and global levels on policy and practice. At each stage of the process, migrant community involvement, leadership, and participation is critical because it underlines the very meaning and purpose of the work. Responsibility for such an initiative could be discussed by a relevant government ministry in each country.

This exchange of expertise could help develop MHPSS approaches in the peacemaking community and increase the efficacy of programs when common challenges are addressed from multiple stakeholder perspectives and examples are shared of how public healthcare systems have adapted to refugee MHPSS needs or how a particular community program has found ways to overcome stigma associated with mental health support.

Without anchoring host country MHPSS policies in sustainable development with the resources such programs require, countries in Europe will continue to be challenged with the psychological aspect of integration issues. Peaceful communities cannot be forged across Europe without bringing peace to the minds and hearts of individuals within them. In other

words, MHPSS efforts in peacebuilding in any society should be addressed first at the intrapersonal level, then the interpersonal, and finally the intercommunal. Peacemaking efforts in conflict-affected crises will also flounder under ongoing psychological strain that remains unaddressed, and returnees such as those going back to Syria as the security situation stabilizes in select parts of the country will be able to reintegrate and rebuild stronger societies and economies when they return as resilient, psychosocially supported individuals.

Locally acceptable ways to integrate MHPSS in Syria also may include approaching it as a humanitarian response rather than as a peacebuilding measure, since the term "peacebuilding" is viewed from some angles as a political maneuver. Just as mainstreaming of protection issues has become commonplace in humanitarian programs in Syria, the intersection of MHPSS with such programs could also feasibly become the norm across sectors when peacemaking policies are carefully designed and implemented within a culturally appropriate context.

Recommended Issues for Exchange

Coordination and learning in the Syrian context could entail the following topics:

Community-related

- Raising awareness of and access to MHPSS services and resources
- Finding ways to reduce stigma around mental health issues
- Providing psychoeducation through, for example, psychosocial workshops not just for refugee populations but also for local populations in host countries to better understand the complex issues around conflict, asylum, and their own country's involvement in the politics of the country of origin
- Increasing Syrian community involvement from needs assessment to decision making
- Engaging and training community therapists within the Syrian community for applications
- Finding ways to meet MHPSS needs for children and adolescents, in and out of school
- Providing livelihood coaching

Program Design

- Offering substantive program content: scope and reach, training, monitoring, and evaluation and indicators of success
- Working with evidence-based programs, such as PM+
- Funding streams and resource allocation
- Offering brief rather than long-term interventions
- Identifying and sharing of high-risk cases, including gender-based violence, or sharing of medical records for special cases, such as individuals who are transitioning between genders
- Integrating MHPSS into healthcare systems and national or private insurance, if applicable

Political and Security Considerations

- Government advocacy, including recommendations for policies in humanitarian and peacemaking programming
- Ways to engage the peacemaking community
- Strategies for operating safely within Syria
- Strategies for streamlining MHPSS into peacebuilding and humanitarian responses

- Ways to overcome resistance from peacebuilding actors to MHPSS integration

Conclusion

MHPSS lies at the heart of psychological dimensions in peacemaking. Trust-building, dialogue, and reconciliation can occur in their fullest potential when a safe space has been created to raise and address mental health issues in conflict-affected populations. Healing from trauma, grief, and loss at the intrapersonal level and receiving psychosocial support for daily life stressors empowers the individual and strengthens interpersonal relationships, creating stronger more resilient societies that can move toward peaceful rebuilding. As the Syrian crisis continues in its tenth year, the large numbers of IDPs in Syria and Syrian refugees in Europe, Turkey, Jordan, Lebanon, and beyond require sustainable coordinated efforts to integrate MHPSS in humanitarian response and peacebuilding work.

The Netherlands has taken the global lead in supporting the advancement and implementation of MHPSS in conflict crises, including hosting the first International Conference on MHPSS in Crisis Situations in 2019, where twenty-five countries endorsed the Amsterdam Declaration. Dutch coordination efforts on MHPSS within the country involve an informal network of national stakeholders in asylum and protection issues within the Netherlands, as well as the Syrian Joint Response as part of the Dutch Relief Alliance for NGOs working internationally. These streams of work share common obstacles to MHPSS design and implementation in conflict-affected communities that could benefit from cooperation. While several MHPSS networks, working groups, or repositories already exist at the global level, a coordination mechanism focusing on the acute needs of Syrian communities would be useful to exchange lessons learned and best practices between a national-level network in countries that can plug into the international peacemaking community working on MHPSS. A cyclical ongoing exchange can then take place between successful practice and policy in three main categories: community-related issues, MHPSS program design, and political and security considerations.

MHPSS in conflict crises as a whole requires more awareness to be driven by governments and the global peacemaking community. Severe underfunding in this area needs to be urgently addressed and further policy and practitioner research would enrich the expanding pool of MHPSS resources. As this field develops and continues to gain momentum, a growing number of MHPSS champions are needed to join the effort and help drive the agenda across peacebuilding sectors.

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