Ethically Augmenting Access to Appropriate Mental Health and Psychosocial Services (MHPS) for Adolescent Syrian Refugees in Jordan

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I. Project Rationale, Goal and Specific Objectives

As articulated by the UN in its *Universal Declaration of Human Rights*, every human being has a right to "a standard of living adequate for the health of himself and his family, including medical care and necessary social services" (1). If healthcare either cannot be provided or utilized, is inaccessible, or is of poor quality or inappropriate for a given condition, is inadequate, it is an ethical issue because its limitation or inappropriateness infringes upon the human right to individual health as defined above. One aspect of health rights that is woefully ignored is the right to mental health. The rights to "human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, and access to information" are further enumerated as aspects of an individual's right to health (1). Lack of or inadequate mental health care can have psychological or emotional ramifications for those in need of care. This deficiency therefore encroaches on one's individual right to "human dignity [and] life" (1). Adolescent access to mental health and psychosocial (MHPS) services is especially important as this population comprises the next generation of leaders and thinkers – the future rests in their hands.

The issue of limited access to appropriate mental health services is exacerbated in the developing world. According to the WHO, "75% of those suffering from mental disorders in developing countries receive no medical attention at all" (13). This issue is apparent in areas of the world affected by rampant violence, such as the Middle East, with Syria as a poignant example (4). Since 2011, Syrian citizens have fled to the neighboring countries of Iraq, Lebanon, Turkey, and Jordan (4). More than a quarter of externally displaced Syrians have fled to Jordan (2). This flight represents a unique challenge for the mental health assessment, monitoring, and treatment of adolescent Syrian refugees in Jordan.

This proposal will draw upon Alex London's Human Development Approach to humanitarian intervention in the developing world to augment access to appropriate mental health care for adolescent Syrian refugees in Jordan. London emphasizes equitable, directed, and "thoughtful distribution of scarce resources" and investment in "community social programs" (5). Given this ethical framework, the overall goal of this project is: to strengthen access to appropriate mental health services for adolescent Syrian refugees in Jordan. The specific objective is:

1. To build on existing mobile health services by integrating general and psychological healthcare, through mobile healthcare units called Mobile Integrative Medical and Health Clinics (MIMHCs), in order to expand access to MHPS services, thereby:
    a. Increase communication between and engagement of all stakeholders
    b. Coordinate care
    c. Equitably allocate scare resources (Minimization of healthcare and medical personnel resource waste)
    d. Strengthen capacity community support programs
    e. Decrease stigmatization pressures felt by those who seek MHPS services
    f. Decrease tensions between adolescent Jordanians and Syrian refugees
    g. Improve early detection screening and diagnostics for MHPS and general conditions

The services integration pilot project will be carried out in Mrajeeb Al-Fhood, Jordan's smallest refugee camp, and Ar Ramtha, a smaller northern Jordanian city (4).

II. Background and Significance

II. 1 Recent History

The Arab Spring began in December 2010 with a Tunisian uprising. Similar revolts occurred in Egypt, Libya, Yemen, Syria, Bahrain, and other Arab nations, stemming from dissatisfaction with local governments, significant socioeconomic disparities, and very high unemployment among youth (10). In June 2011, youth unemployment rates in Syria reached 48%, "six times higher than the unemployment rate among Syrian adults" (12). Uprisings and turmoil ensued. By September 2013, reported death rolls reached 100,000. Two million people had fled their homes for safer conditions in neighboring countries and another four million Syrians had been internally displaced (8).

II. 2 Syrian Displacement

In May 2014, the United Nations High Commissioner for Refugees (UNHCR) declared the situation in Syria to be "the largest forcible displacement in the world" (2). The refugee number and political instability continue to climb. Just two years later on July 9th 2015, UNHCR announced the latest figures, reporting the total number of Syrian refugees at just over 4,013,000 people (5). Given the current rate of growth, UNHCR expects the figure to reach around 4.27 million by the end of 2015 (4). An additional 7.6 million people are displaced inside Syria (4).

II. 3 Adolescent Syrian Refugees in Jordan

Nearly one-fifth (17%, or 629,128 individuals) of these Syrian refugees currently reside in camp and community (non-camp) settings in Jordan, now approximately 10% of the Jordanian population (3). Overall, 52% (319,000) of the Syrian population in Jordan is between the ages of 0-17 years old. Consequently, adolescents constitute a major population within the greater Syrian refugee population in Jordan (3).

II. 4 Adolescent Syrian Refugees in Camps in Jordan

Since 2011, the exodus from Syria has led to the formation of four major refugee camps: Za'atari, Marjeeb al-Fahood, Cyber City, and Al-Azraq camps (11). Established in July 2012, Za'atari is currently the second largest refugee center in the world, home to 79,150 Syrians and occupying 6.8 square miles (4). Of its total population, 56.5% (44,720) of its residents are 17 years of age or younger (4). Similar adolescent demographics exist in the other three refugee camps, but the majority of research has been conducted in Za'atari, as it is the largest of the four (4).

II. 5 Adolescent Syrian Refugees in Non-Camp Settings in Jordan

Over the past few years, the camp population has decreased as refugees have been forced to seek employment and resources more readily available in Jordan's non-camp settings (3). For example, Za'atari's population peaked at 202,993 in April 2013, but has since more than halved (3). According to UNHCR, currently 88% of Syrian refugees in Jordan live in the local cities of Mafraq, Irib Zarqa, and Amman, Jordan's capital, and of them, 54% are between the ages of 0 and 17 (3). Ar Ramtha is a town in Irib Zarqa, both of which are within the Irbid Governorate (11). The number of Syrian refugee adolescents in camp and non-camp settings is shocking. Thus, it is crucial to consider their MHPS needs in planning for and augmenting health and other services in Jordan.

II. 6 MHPS Problems of Adolescent Syrian Refugees in Jordan

As a result of the violence and displacement, MHPS problems of adolescent Syrian refugees are characterized by specific emotional vulnerabilities (see Figure 1 in the Appendix). A 2013 study conducted by the Eastern Mediterranean Public Health Network noted, "adolescents affected by situations of unrest, violence, loss, separation, and drastic changes in social and living conditions, are likely to experience a number of distressing psychological reactions such as hopelessness, helplessness, anxiety, as well as behavioral and social problems" (3). These responses are normal reactions to abnormal events (3). It is worth

noting that in a minority of cases, violence and displacement do not entirely precipitate MHPS conditions, but rather trigger a predisposition for a condition or exacerbate a pre-existing condition (3). A successful mental healthcare system accounts for the needs of both the majority and minority populations.

II. 7 Existing MHPS Services Available to Adolescent Syrian Refugees in Jordan

According to a 2008 article from *The National*, Abu Dhabi's first English-language publication, the National Center for Mental Health (NCMH) in Jordan estimated that "20% of the population numbering 5.8 million [was] in need of psychiatric care" (13). At this point, before the influx of Syrian refugees in 2011, an estimated 60 psychiatrists were operating in 33 psychiatric consultancy clinics in Jordan (13).

The organizations that currently provide mental health services to adolescent Syrian refugees in Jordan are enumerated in Figures 2 (camp) and 3 (non-camp) in the Appendix (3). The increase in population, reported at 6.6 million in 2013, with the arrival of Syrians exacerbates the aforementioned "critical understaffing" and scarcity of MHPS services in Jordan (13, 12). In its 2013 report, the Eastern Mediterranean Public Health Network reported that 71.7% of Syrian refugee adolescents "expressed additional need for services and support to help them with their problems" (3).

II.8 Cultural Barriers to Providing Accessible and Appropriate Mental Healthcare for Adolescent Syrian Refugees in Jordan

In the face of undeniable need and waxing demand for healthcare service, there are cultural considerations that impact the capacity of Jordan to manage the MHPS conditions of adolescent Syrian refugees. First, the cultural environment of many Middle Eastern countries, like Syria, is rife with stigma surrounding MHPS issues. *The National* quoted Mohammed Asfour, the head of the NCMH, "there is a stigma attached to seeing a psychiatrist in Arab societies and people feel embarrassed by how society perceives them" (13). Cultural norms equate mental illness with shame and weakness, deterring those who experience symptoms from seeking help (13). A larger issue still is the lack of self-recognition of symptomology. The stigmatization of mental illness is so pervasive that Syrian adolescents are rarely exposed to mental health as a concept (2). Consequently, adolescents may not recognize an acute MHPS issue or a chronic MHPS condition. As a result, concerns go unaddressed, conditions go untreated, and adolescent mental health deteriorates.

Another cultural barrier to mental health services is people's fundamental mistrust of institutions and medicine (3). Syrians will frequently seek advice and assistance about their health concerns from community healers, self-proclaimed providers, or as Dr. Asfour, the head of Jordan's NCMH, calls them "imposters," rather than traveling to an accredited clinic (13). This phenomenon can perpetuate illness as these "imposters associate psychological troubles with magic and the presence of *jinnis*, or spirits" (13).

Of crucial importance, community support groups (CSGs) are also tasked with providing MHPS services because a great majority of adolescent refugees both in camps and communities flock to the locations of these groups, as the source of their social interactions outside of school (2). Out of location convenience and community trust, CSGs have been entrusted to provide MHPS relief if alternative MHPS services are unavailable or inaccessible, detracting from their intended function as "creative, interactive outlets for adolescents," strengtheners of family interpersonal relationships, and promoters of general health through therapeutic activities, including journaling, crafting, painting, drawing, etc. (2). CSGs allow for community members to take personal ownership in their psychological health through therapeutic outlets. When the responsibility to manage MHPS conditions falls on CSGs, their capacity to promote general wellbeing and health is diminished. This is a direct violation of London's recommendation that community social structure, which in this case includes CSGs, should provide individuals with the "opportunity to cultivate their basic intellectual, affective, and social capabilities to pursue a meaningful life" (5).

Additionally, CSGs are unprepared and ill equipped to manage mental health problems generally, never mind those of Syrian adolescent refugees affected by violence and displacement. Moreover, each community support group's approach to manage MHPS concerns is different. There is not an organized treatment protocol or pre-determined healthcare authority responsible for coordinating mental healthcare needs (2). This lack of systematization and disorganization discourages healthcare providers from communicating, leading to fragmentation of the healthcare "system," and leaving fewer people served.

II.9 Socioeconomic Barriers to Providing Accessible and Appropriate Mental Healthcare for Adolescent Syrian Refugees in Jordan

Socioeconomic factors also impact the capacity of Jordan to provide MHPS services for adolescent Syrian refugees. Oftentimes the practice of turning to a healer or community support group for MHPS

concerns is compounded for Syrians that live far away from mental health clinics. The community infrastructure is simply not there (2). Therefore, while certainty rooted in their trust of familiar healers and community-based groups, Syrians sometimes cannot feasibly or physically access mental care clinics. This proximity impediment is a crucial socioeconomic barrier.

The huge refugee explosion in Jordan has strained an already limited healthcare resources and insubstantial mental healthcare system, as described in sections II.7 and II.8. Scarcity of medical resources, medical personnel, pharmaceuticals, etc. is an obvious socioeconomic concern.

II.10 Ethical Framework for the Proposal

An ethical means of instituting a new approach to MHPS care that accounts for these cultural and socioeconomic barriers to healthcare access is crucial. London's Human Development Approach is the most apt ethical framework through which a project should be devised to address the specific MHPS needs of adolescent Syrian refugees in Jordan (5). He suggests that "any frank and straightforward account of the health needs in the developing world reveals that they are staggeringly pervasive, profound, and urgent" (5). This is a call for appropriate, thoughtful action. London goes on to say, "people in the developing world who live in poverty and toil under some of the world's poorest social conditions also bear some of the heaviest burdens of sickness and disease" (5). The project proposal was fashioned with these facts at the forefront.

Two of London's points about humanitarian intervention hugely impacted the formulation of the specific aim and long-term goal of this project. First, London states, "the duty to aid must target more than financial transfers" (4). He refutes the idea that aid requires a significant transfer of wealth from developed to developing countries. He expands by saying that it is a gross misconception that "this redistribution of wealth would supposedly alleviate the conditions of poverty that provide the ecological niche in which sickness and disease flourish" (4). Great wealth in and of itself would not provide the world's poorest countries with a magic bullet solution to ameliorate problems with their mental healthcare systems. The critical piece of London's argument is his emphasis on the allocation of donated resources. He says that the potential benefit of financial donation or transfer of resources "depends crucially on the ends to which such resources are employed" (4). In order for these resources to reach people who need them, their incorporation into a developing country must be thoughtful and directed.

London's second point offers a target for these financial contributions and resource transfers. If these resources are to successfully benefit intended recipients, their allocation must focus on "improving those elements of the host community's basic social structure that affect individual agency and social opportunity, while taking interim stages to mitigate the adverse effects of existing social structures on the health and welfare of those who are subject to them" (5). In order to intervene in a developing nation and implement significant, helpful change, the donated resources or financial package must be targeted at augmenting individual agency by: 1) improving social opportunities; and 2) minimizing harmful fallout from existing social structures. These two points provide an excellent ethical framework through which to fashion a successful project that ethically improves the psychological and emotional capacities, and therefore the lives of countless people, by increasing health access and equity and encouraging health and wellbeing.

III. Project Design and Methods

The project design, including the overall goal and specific objective and the implementation plan, align with London's ethical framework. The project will facilitate the transition from the currently fractured Jordanian healthcare system and the paucity of mental healthcare services for refugees (provided for example, through UNHCR and NGOs), to a mobile healthcare system that prioritizes integration of mental and general healthcare, communication between stakeholders, and coordination of care. Mobile Integrative Medical and Health Clinics (MIMHCs) will strengthen existing mobile health clinics and expand access to MHPS services in a culturally and socioeconomically appropriate way.

III. 1 Stakeholders for Piloting Capacity

Logistically, integration of general and mental health services through MIMHCs will require coordinated efforts from donor agencies (e.g. USAID, United States Agency for International Development), an implementation team, and the mental health offices within Jordan's Ministry of Health (MOH).

III. 2 Stakeholder Responsibilities

The donor agencies will be responsible for the financial and/or resource contribution, specifically targeted at augmenting the agency of existing mental health clinics, and therefore improving the individual agency of adolescent Syrian refugees. The mental health services offices within the MOH will provide a

healthcare perspective dedicated to the improvement of health and protection of the well-being of Jordan's inhabitants. The implementation team will be comprised of groups active on the ground, including the International Medical Corps (IMC), various youth organizations, and healthcare-focused non-government organizations (NGOs). The youth organizations will assess the MHPS needs of adolescent Syrian refugees. The NGOs and IMC will work together to deliver appropriate physical, psychological and social therapies. A project team comprised of dedicated and educated Syrian and Jordanian communication experts will facilitate this coordination.

III.2 Components of Project

→*Selection of Locations*

Two separate locations, Mrajeeb Al-Fhood refugee camp and the town of Ar Ramtha, were chosen for this pilot project. Mrajeeb Al-Fhood was chosen because it is the smallest refugee camp in Jordan (4). The success of this project needs to be evaluated in a smaller location before expanding it to the larger refugee camps in Jordan. This provides an ethical safeguard; fewer people will be exposed to any potential unforeseen drawbacks of this project. The town of Ar Ramtha is in northern Jordan. It too is relatively small, but was chosen chiefly for its high proportion of adolescent Jordanian inhabitants (2). The hope is that by providing mobile healthcare services to both adolescent Syrian refugees and Jordanians, this project could minimize the existing tensions between Syrians and Jordanians. These tensions are currently the source of huge MHPS issues, especially in school-aged adolescents. This point is extrapolated below in section III.3.

→ *Identification of Need*

The youth advocacy organizations will be responsible for identifying the needs of adolescent Syrian refugees in Jordan and determining the adolescent Syrian refugees within the chosen locations that demonstrate the highest level of need. Youth advocacy organizations will be chosen based on: 1) amount of time they have been active, 2) level of establishment and renown in-country, 3) effectiveness of past initiatives/ work with adolescents, and 4) external evaluations. These criteria are adapted from criteria suggested by UNICEF in their 2014 exploration of adolescent Syrian refugees in Jordan (2). Utilization of Jordan-based youth advocacy groups to assess need will allow for thoughtful and targeted resource allocation, as recommended by London in his Human Development Approach to humanitarian invention (5).

→ *Assembling of Medical Personnel*

The NGOs and IMC in accordance with MOH mental health statues will organize a team needed to functionalize MIMHCs: care-providers, native nurses and physicians, medical administrators, and public health professionals. Jordanian nurses and psychiatrists will be recruited from Jordanian universities and Syrian nurses and psychiatrists will be located and mobilized. In accordance with London's ethical framework, there is no better way to improve individuals' capacity to participate in their own health than to capitalize on the health services they may be able to provide to fellow community members (5). Medical administrators and public health professionals may temporarily be outsourced from the donor country/countries, but the majority of these individuals will either be Jordanian or Syrian, ensuring sustainability of the project. They will create a logistically feasible plan for maximal effectiveness based on the need assessment provided by the youth advocacy organizations.

→*Training of Clinicians*

Nurses will receive detailed training from psychiatrists in preparation for delivering care to adolescent Syrian refugees and Jordanians. Critically, psychiatrists will explain key signs of MHPS problems in order to facilitate early recognition and diagnosis of conditions. Public health professionals will guide psychiatrists about what to emphasize in their training sessions with nurses in order to provide the greatest number of adolescent Syrian refugees with appropriate and quality healthcare.

→*Delivery of Care*

Trained nurses will travel daily aboard MIMHCs to provide healthcare services. Because of the integral involvement of CSGs in the lives of both adolescents, MIMHCs will set up shop at the physical location of these groups at a specified time each day. This designated time will not be during school hours. There are proportionally more Jordanian nurses than psychiatrists (2, 13). Therefore, simply based on availability and human resources, nurses, will be trained by psychiatrists to administer MHPS care. This method will allow for maximal use of available resources.

Nurse awareness of MHPS conditions will be heightened when conducting general check-ups, allowing them to dually assess the mental wellbeing of patients. On regular visits, nurses will be especially attentive to possible discrimination of Syrian adolescents by their Jordanian counterparts. Identified targets

of this discrimination will be immediately screened for common MHPS symptoms. They will be asked questions about their current emotional status (i.e. whether they have experienced pervasive and frequent feelings of sadness, anxiety, anger, insomnia, bed-wetting, within the last few months.) Nurses will decide the appropriate course of action on a case-by-case basis based on severity of signs and symptoms. Incredibly serious cases will warrant the presence of a highly trained psychiatrist.

This mobile healthcare delivery system is currently ongoing in Jordan. According to their website, the IMC provides comprehensive response programs in Syria and Jordan (14). In Jordan specifically, the primary healthcare aspect of these programs involves the deployment of "mobile medical units" (MMUs) to Palestinian and Syrian refugees as well as internally displaced Jordanians (14).

III. 3 Proposal Benefits: Ethics in Action

The hope of this project is that MIMHCs will augment the capacity of Jordan to provide *both* general and psychological care to refugees, especially adolescent Syrians, and internally displaced Jordanians. This approach will decrease stigmatization pressures felt by those with MHPS issues, decrease tensions between adolescent Jordanians and Syrians, improve early general and mental health diagnostic procedures and rates, strengthen the capacity of community support groups, ensure more equitable distribution of scarce resources, and increase stakeholder communication and engagement. This specific objective and the consequences of successful expansion will contribute to the broader aim of strengthening access to appropriate mental healthcare for adolescent Syrian refugees in Jordan.

→*Early Detection Screening and Diagnostics for MHPS and general conditions*

Successful integration of primary and mental healthcare will give providers' the ability to assess the mental health status of adolescent Syrian refugee patients while treating general health conditions. Because mental health issues do not initially present as physical ailments, laymen may not recognize the presentation of MHPS symptoms. This unfortunately can lead to neglect of MHPS problems, especially if an individual has not been culturally exposed to the idea of mental health, and therefore mental illness. Consequently, mental or emotional problems are likely to fester longer than for example, an open wound, which outwardly appears to require more emergent care. A lengthy incubation period for mental illness can further imbed existing issues, making them even more difficult to treat once they are finally noticed and addressed.

Additional problems can also crop up and require costly treatments as a result of an untreated mental illness, ultimately worsening Jordan's crippling socioeconomic status. With the creation of MIMHCs, this cycle is no longer allowed to persist. Adolescents will receive the care needed to ethically uphold their right to health.

Integrative services will facilitate early detection of mental and general health conditions in adolescent Syrian refugees. Early detection of mental illness is critically important and currently underemphasized aspect of proper mental health treatment of adolescent Syrian refugees in Jordan. In fact, in the 2013 analysis produced by the Eastern Mediterranean Public Health Network highly recommended implementing an early detection initiative (3).

→ *Decrease Tensions Between Adolescent Jordanian and Syrian Refugees*

Second, integrative primary and mental healthcare through mobile health clinics will minimize the cultural stigma associated with seeking MHPS support. Stigmatization as a deterrent from seeking MHPS assistance will be rendered obsolete. If it does not outwardly appear as if those individuals in need are seeking MHPS treatment, their behavior cannot be stigmatized. In addition to providing care to ameliorate MHPS conductions, mobile health clinics diminish the stress associated with seeking out and then receiving MHPS care. As such, the deterrent pressures of mental illness stigmatization would be significantly reduced.

According to a 2014 UNICEF report, the majority of Jordanian parents reported that their children felt as if Syrian adolescents were "taking ownership of a cultural experience and physical land that was not theirs" (2). Jordanian adolescents grew to resent their Syrian counterparts for receiving attention in a country that was not theirs. This resent fostered psychosocial feelings of anger (2). Conversely, Syrian adolescents felt as if Jordanians were discriminating against them, specifically at school (2). This discrimination was cited as the source of psychosocial anxiety and fear (2). Consequently, Syrian adolescent refugees became conditioned to avoid seeking medical treatment, a subconscious attempt to minimize these feelings (2). An informed determination of the most appropriate method for intercalating adolescent Syrian refugees into the Jordanian mental healthcare system is crucial. Because these clinics will be piloted in both camp and non-camp settings, adolescent Syrian refugees as well as adolescent Jordanians will be eligible to receive care. This facet of the program will decrease Jordanian adolescent frustration about perceived Syrian adolescent

privilege. It will also allow for the native Jordanian population to provide feedback about and interact with the program, thereby engaging the recipient population in shaping these services.

→ *Strengthen Capacity of CSGs*

Coordination of care is characterized by universal diagnostic and treatment protocols, outlined by medical administrators and public health professionals. The coordinated care provided by mobile health clinics will bolster the capacity of CSGs to cater to the social, interactive, and creative needs of Syrian refugee adolescents. With the purpose of diagnosing and treating mental health conditions localized to a few trained mobile health teams, this initiative will allow for the development and strengthening of community social support programs. As it exists now, CSGs are frequently tasked with providing MHPS support to adolescent Syrian refugees (2). When CSGs are no longer responsible for handling unfamiliar symptomology, they will be able to turn all attention to fostering key family and interpersonal relationships through community social programs, and promoting a sense of community, involvement and belonging. Redirecting responsibility will generate a healthy growth trajectory for adolescents.

This focus on the importance of community support is key and demonstrated by continuous, worldwide support. In a 2013 study with adolescent Syrian refugees in Turkey, researchers found that the majority of those afflicted with MHPS conditions "exhibit resiliency" and recover over time using "natural coping mechanisms fostered by supportive environments" within their communities (3). This importance of community is found all over the world, not just in the Middle East.

→ *Increased Stakeholder Communication and Engagement*

The process of implementing mobile health clinics will increase communication between all stakeholders: the project team of communication experts, the donor agency, the MOH, and the implementation team composed of the IMC, various NGOs, and youth organizations. This communication will foster an organization and arrangement previously unattained.

Beyond simply increasing organization, a communicative structure for the administration of mental and general health services as fostered by this mobile health clinic program will allow for the amelioration of the aforementioned socioeconomic factors. Given the limited healthcare resources, human and healthcare resource waste must be reduced through streamlining protocols. Healthcare resources will not be allocated

and medical supplies will not be approved for purchase unless two of the three stakeholders noted above demonstrate support. This safeguard will provide a check for ethically appropriate allocation of resources.

III. 4 Lessons from Other Countries

Lessons can be gleaned from observing how other developing nations have provided MHPS support to vulnerable populations. One example is the Presbyterian Community Based Rehabilitation (PCBR) program located in Sandema, Sierra Leone responds to people's MHPS needs by bolstering community social groups. The group's mental health delivery protocol reflects this mission. PCBR's mental health delivery protocol has four specific components: task sharing, community self-help, raising awareness, and job training (7). This protocol is consistent with London's emphasis on intervention that provides individuals with tools to succeed in their environments and within their social structures.

Another lesson can be gleaned from the following study. Psychiatric researchers in a 2014 study in *The Lancet* followed 253 patients in India separated into two groups: those receiving standard clinical care and those receiving standard care plus community support, including regular home visits from lay healthcare workers and links to local groups (7). Both groups improved on measures of symptoms severity over 12 months, but those who experienced the community-based component did slightly better than those who did not. This phenomenon was especially apparent in the very rural site, Tamil Nadu. These patients were more likely to show "sustained relief of symptoms like suspiciousness, withdrawal, and delusions; to become more social and engaged at home; and to be working" (7). Evidence in favor of a treatment protocol that fosters a community-based support structure is thin, but a foundation is currently being laid.

III. 5 Proposal Limitations

→ *Project Planning and Development Limitations*

As with every project, there are expected challenges and potential limitations. There are two limitations with respect to project planning and development. They are: 1) need for assent and consent for participation in services, and 2) the published reports on which the project planning is based. In order to legally and ethically assess the mental health status of and treat adolescents, the children need to assent to the treatment and their parents will have to consent to the treatment of their children. The published reports on which the study design is based indicate an urgent need for MHPS services among Syrian adolescent

refugees residing in Jordan and perceptions of adolescents and their guardians regarding access to care and other factors that impact on receipt of services (2, 3). If these data are inaccurate or disintegrated, the proposal intervention is compromised.

→ *Limitations of Project's Components*

The next category of limitations deals with specific aspects of the proposal. First, there may be a negative reaction to the coordination efforts (i.e. establishment of basic universal diagnostic and treatment protocols for certain symptoms) on the grounds that each village has unique, village-specific, culturally diverse beliefs about treatment of MHPS conditions. The role of a community is particularly important for mental health interventions, as mentioned above, especially in remote areas. In the same way that a village can expel a disruptive person with mental illness, it can reject a program that offends its traditional conception of mental issues (7). However, if a community takes to the program after observing its respectful approach and medical success, this same self-protective instinct can work to support the program.

Another proposal limitation could be lack of access to appropriate medications to address the mental health conditions. This limitation would largely apply to preexisting mental illnesses requiring medications such as schizophrenia, depression, anxiety, etc., and less so to psychosocial mental health issues stemming from the trauma of violence and displacement. Although the majority of reported MHPS concerns experienced by adolescent Syrian refugees stem from the trauma of viewing violence and/or being displaced as outlined in Figure 1 (see Appendix), statistically speaking there is likely to be a subpopulation of adolescent Syrian refugees with pre-existing mental illnesses that require medication. Because MIMHCs will treat this subpopulation as well, this is an important limitation to consider.

The proposed program operates under the assumption that there are adequate medications for treatment if needed. In her New York Times article, "In West Africa, A Mission to Save Lives," Carey Benedict states that "drug supply is perhaps the largest obstacle to success," noting that there are shortages in places like Ghana frequently (7). If drug shortages continue, this could lead to discouragement and facilitate reliance on traditional healers. Of course this is ethically problematic because it introduces the idea of rationing. Given two people with similar symptomologies and severity of illness, the first is equally as

entitled as the second to receive the available pharmaceuticals. This potential outcome may beg answers from certain unanswerable ethical questions, thereby limiting the program.

III. 6 Alternative Avenues for Strengthening Mental Health Services in Jordan

If any of these limitations prevail, alternative approaches to addressing the MHPS needs of adolescent Syrian refugees include improving conditions generally and expanding education efforts. In their study, the Eastern Mediterranean Public Health Network suggested that "securing additional services that are not purely MHPS in nature" could improve the mental health of adolescent Syrian refugees (3). These improvements could include improving living conditions, sanitation, and general hygiene, augmenting food provisions, and building simple recreation centers for creative and cooperative learning (2). This alternative measure would integrate MHPS considerations in cross-sectorial initiatives, emphasizing a holistic approach to human health.

A second alterative to the above proposal would be to increase educational outreach. This education effort could take the form of production and distribution of flyers and pamphlets that explain common MHPS condition symptomology to adolescent Syrian refugees. Obvious challenges arise, including the reading level and language in which these educational materials will be printed. Educational outreach could also take the form of increasingly emphasizing positive coping strategies, such as socialization and engagement in religious practices, rather than mal-adaptive coping strategies, like violence and smoking (2). These interventions have the potential to promote resilience and self-efficacy.

IV. Project Evaluation

The success of this project will be qualitatively and quantitatively assessed for both short and long term goal accomplishment. This assessment is displayed in Table 1.

Table 1: Evaluation of Overall Goal and Specific Aim Using Specific Measurements

Goal/Aim	**Measures**	**Source of Data**	**Data Collection Methods**
Overall: To strength access to appropriate mental health services for adolescent Syrian refugees in Jordan	- Improvement in community support programs determined by event attendance -Number of existing community support initiative and programs	- Interview transcripts - Clinical records - Monthly visits to physical location of community support groups within specified areas by public health	- Quantitative: Review clinical records - Qualitative: Conduct interviews with children and parents living in designated areas about community support groups and

	- Number of adolescents who received healthcare annually	professionals	availability of health services
Specific Aim: To build on existing mobile health services in order to expand access to MHPS services	- Satisfaction with services - Self-reported improvement in mental health/emotional status - Number of adolescents who received services from mobile health clinics annually	- Interview transcripts - Clinical records	- Quantitative: Review clinical records - Qualitative: Conduct interviews with children and parents who have been treated by mobile health clinics about their experience with them

For the purpose of evaluation, an external advisory board will be created to facilitate the interactions and discussion among the stakeholders (described in section III.1) with respect to the following:

1. Final design evaluation
2. Final selection of measures of goal and objective achievement
3. Final selection of data collection instruments and statistical approaches
4. Review of quantitative and qualitative data
5. Interpretation of data

These are just a few ideas. The discourse should be no means limited to this list. This discursive and communicative method of evaluation is most ethical because it allows all stakeholders to influence the direction of the project and the management of mental health care for adolescent Syrian refugees in Jordan.

Appendix

Section II.6 MHPS Problems of Adolescent Syrian Refugees in Jordan

In a 2014 study conducted in Jordan by UNCEF, Syrian adolescent refugees were asked: "What kinds of problems do adolescents have because of the war or living in Jordan?" Figure 1 lists the most common responses.

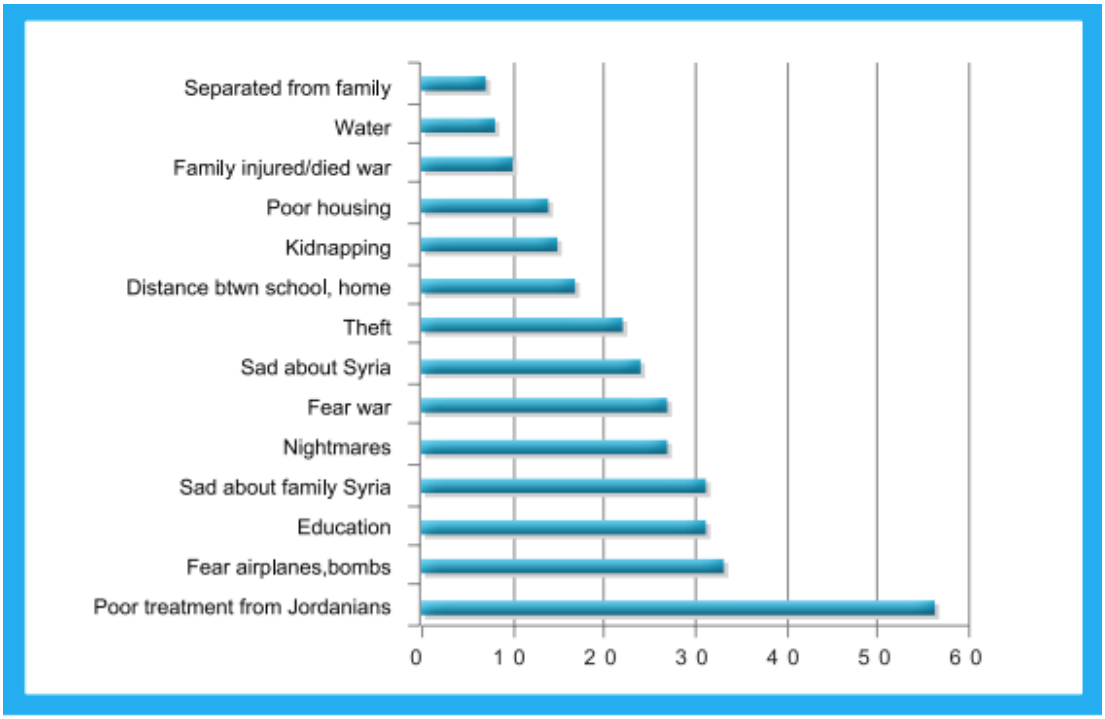

Figure 1. General Problems for displaced Syrian adolescents (2)

Section II.7 Existing MHPS Services Available to Adolescent Syrian Refugees in Jordan

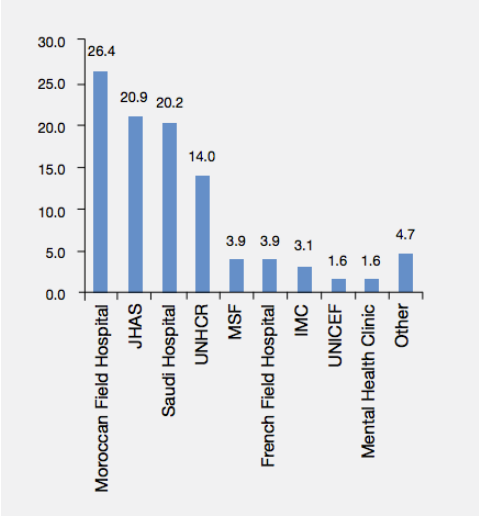

Figure 2: Percent Distribution of Organizations Identified to Provide Mental Health Services to Syrian Refugees Living in Za'atari Camp in Jordan. *Other Category includes: Italian Hospital, Save the Children, Mafraq HC, Legal Ground Society, Human Rights, and UNRWA (3).

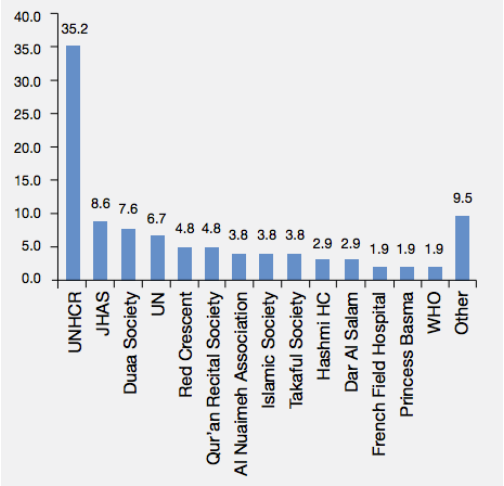

Figure 3: Percent Distribution of Organizations Identified to Provide Mental Health Services to Syrian Refugees Living Outside Za'atari Camp in Jordan. *Other Category includes: Moroccan Field Hospital, IMC, Italian Hospital, Save the Children, Mafraq HC, Aman HC, Noor Al-Hussein Foundation, Akle Hospital, and Orphan Society (3).

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