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# Identifying Barriers to Implementation of Mental Health Policies in Northwest Syria

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## ABSTRACT

This study aims to examine the barriers to the effective implementation of mental health policies in Northwest Syria (NWS). The Delphi technique was employed, and a total of 33 professionals consented to take part in the study. These participants were physicians, policymakers, and administrators involved in healthcare, and shared their insights into the barriers to the implementation of mental health policies. Three rounds of the Delphi technique were conducted to reach consensus among the participants. Within the data collected in the second and third rounds, scores for each barrier were analyzed, and the results indicated that there was a consensus on 16 different barriers with an interquartile width of less than 1.2. These barriers are listed as insufficient societal, cultural, and religious beliefs, policy and coordination, insufficient human resources, funding and financial limitations and other related factors. These results provide a specific understanding of the limitations of mental health services and particular recommendations for reinforcing mental health impacts in NWS.

**Keywords:** Delphi Technique, Mental Health Policies, Northwest Syria

## INTRODUCTION

Mental health policy implementation is a complex process influenced by governance capacity, institutional coordination, and sociocultural context. In conflict settings, health systems are frequently characterized by being in line

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with service structures, dependency, and limited regulatory authority. The healthcare system in Northwest Syria (NWS) has evolved under prolonged conflict since 2011, resulting in a weak and externally dependent health system. This region can be described as a patchwork of disparate healthcare systems that were influenced by different humanitarian and political factors. Numerous regional health systems with distinct capacities and structures have emerged because of the ongoing conflict. However, instead of working together, these systems function independently, which has serious repercussions for the local population's health and well-being. It takes time and effort to rebuild medical facilities, which are essential for delivering basic healthcare services. Recovery efforts are still being delayed by ongoing financial constraints and instability. Previously used as community health centres, hospital buildings are now in ruins and lack staff and necessary equipment. The influx of internally displaced people seeking safety in overcrowded camps and villages has made matters worse. The already precarious health system is further taxed by this dramatic population growth, which deteriorates the situation for patients and healthcare professionals (Enab Baladi, 2024).

Nearly all the funding for the regional health system comes from outside sources. However, the region's urgent needs cannot be met due to the instability and ongoing insufficiency of fund flows. The United Nations has been instrumental in organizing international humanitarian aid and enabling the delivery of aid from neighbouring nations like Türkiye, particularly since 2014. These systems are essential for meeting medical needs in regions that the Syrian government has no authority over. However, it is still unclear how effective these international humanitarian efforts will be overall. The situation is further complicated by accessibility constraints and the politicization of aid since humanitarian operations must take place across several regions under various jurisdictions. Throughout 2024, the health system in NWS is predicted to continue to deteriorate and remain unstable. Prolonged conflict, natural disasters like the 2023 earthquakes, and continuous military escalations have severely disrupted essential services and leaving millions in dire need of aid. While mental health care is frequently deprioritized, basic healthcare services are threatened by inadequate funding. Managing chronic illnesses and injuries sustained during conflicts is still crucial, in addition to providing basic maternity and child healthcare. However, it is predicted that by 2024, about one million people will need mental health and psychosocial support because of the combined effects of natural disasters and conflict (World Health Organization [WHO], 2024).

Both local and foreign actors operate in a disorganized manner because of the region's disjointed and ineffective healthcare governance. Poor policy creation, lax regulation, and insufficient oversight are the results of this lack of unified leadership, which exacerbates unequal access to high-quality care and restricts health outcomes. These challenges are exacerbated by the lack of coordinated management practices, which pose obstacles to hiring and retaining skilled workers.

Although existing studies and reports provide information on general functioning of the healthcare system in NWS, the main gap is the lack of empirical research examining policy implementation, specifically the absence of research explicitly addressing implementation barriers at policy and system levels. Policy-level obstacles to mental health governance, coordination, and sustainability are not sufficiently addressed by current research, which mostly concentrates on emergency response, infrastructure, and general service delivery. Therefore, the purpose of this study is to investigate the obstacles to Northwest Syria (NWS)'s successful implementation of mental health policies.

## **METHODOLOGY**

### **Study Design**

With the objective of comprehensively investigating the barriers to the successful implementation of mental health policy in NWS, this study employed the Delphi technique to incorporate both qualitative and quantitative methods with mixed-methods approach to provide a comprehensive understanding of the subject (Dragostinov et al., 2022). To give a thorough explanation of the current difficulties, this descriptive study collected and analyzed data using a methodical approach. The rigorous and repeated Delphi process was used to gather expert opinions from politicians and medical professionals. This approach is particularly suitable when the questions cover a variety of difficult subjects and viewpoints.

A panel of experts receives questionnaires in several rounds as part of the Delphi technique. Initially, open-ended questions are used, specifically to help collect different perspectives on the obstacles influencing the implementation of mental health policies. The answers provided were then reviewed and condensed as needed, resulting in much needed and organized statements for subsequent rounds. In order to measure consensus, participants evaluated propositions using a Likert scale. Until a consensus is reached or the responses eventually stabilise, the process is repeated. This method can be particularly useful in nations or regions like NWS, where continuous conflict and instability affect data collection and make it difficult.

Additionally, the study aims to validate the results and strengthen the conclusions' robustness by combining statistical methods with quantitative data analysis. Specifically, the quantitative data were analyzed using a statistical consensus methodology, which repeats surveys/data collection phases until consensus is reached. In Delphi research, IQR cut-off values typically range between 1.0 and 1.5, depending on the number of scale points and complexity of the topic (Diamond et al., 2014; Rayens & Hahn, 2000). In this study, for establishing the consensus mentioned, items with an interquartile range of less than 1.2 are utilized as a threshold (Zeliff & Heldenbrand, 1993).

The study's validity is strengthened by the combination of qualitative and quantitative data, which also offers a comprehensive picture of the obstacles to the successful implementation of mental health policies in NWS.

### **Research Question**

According to the study's objectives, the following research question was formulated: What are the main obstacles to the successful implementation of mental health policies?

### **Participants**

The Delphi technique employs non-probability sampling techniques. Purposive sampling is used to identify knowledgeable individuals who possess expertise on a particular subject (Gill et al., 2013). Accordingly, in this study, participants were selected using a purposive sampling method. Purposive sampling is frequently used in policy and health system studies, and it enables the inclusion of basic information (Patton, 2015). Participants' direct knowledge or experience with the implementation of mental health policies in NWS was the main selection criterion. Policymakers and in-service health and mental health professionals made up the participant group.

It is possible to work with a large or small group of experts using the Delphi technique. According to Şahin (2001), there should be a participant group of at least 7 experts. However, according to the phenomenon, the number of participants can be 100 or more. Therefore, the 33 healthcare professionals who agreed to participate in this study were deemed sufficient.

Data collection processes were completed in three iterative rounds. The rounds took place in March 2024 (Round 1), June 2024 (Round 2), and July 2024 (Round 3). The same group of 33 participants took roles in all rounds. All the rounds were conducted with 33 participants.

### **Data Collection**

In the first round, a total of 33 participants were sent the first Delphi survey and were asked to answer the following question: “What are the obstacles encountered in the provision of mental health services in the Northwest Syria Region?” Participants submitted their thoughts anonymously in writing to this question, thus completing the first Delphi round.

Opinions from the first round were listed by grouping them into 35 different categories and enumerated. The second Delphi survey, a structured questionnaire, was created and distributed to participants based on this data. On a 7-point Likert scale, participants were asked to rate how much they agreed with each item. “To what extent do you agree with the barriers listed below?” was one of the questions. Additionally, participants provided written explanations for their agreement or disagreement with each item and whether they thought it was necessary or not. After being given a code, each participant had to send back their coded answers to the researcher by the deadline. The second Delphi round came to an end at this point.

A third round was initiated since there was no agreement in the second round. This is so that a consensus can be reached by repeating the surveys. Items that have an interquartile range of less than 1.2 are deemed to have reached consensus (Zeliff & Heldenbrand, 1993). A third Delphi survey was conducted, showing the average answers from all respondents as well as each participant’s personal assessment of each item. This step employs a controlled feedback mechanism, providing the median and interquartile range of the group’s previous responses. By asking participants to reevaluate, the goal of this round was to reach a consensus. At the end of the process, 16 different items were agreed upon.

### **Ethical Aspects of Study**

Ethical approval for this study was obtained from the İstanbul Medipol University Non-Invasive Clinical Research Ethics Committee (Issue No: E-10840098-202.3.02-1406, Decision No: 184, 20 February 2024).

### **RESULTS**

This study aims to identify and analyze the barriers to the effective implementation of mental health policies. The study included a total of 33 participants with diverse demographic and professional characteristics. The characteristics of participants are detailed in Table 1.

**Table 1:** Characteristics and demographics of participants

| Characteristics          | Sub-Groups                  | N  | Percentage |
|--------------------------|-----------------------------|----|------------|
| Gender                   | Female                      | 5  | 15%        |
|                          | Male                        | 28 | 85%        |
| Age                      | 20–30                       | 2  | 6.1%       |
|                          | 31–40                       | 21 | 64%        |
|                          | 41–50                       | 4  | 12%        |
|                          | 51 and Above                | 6  | 18%        |
| Area of Residence        | Camp/Rural                  | 2  | 6.0%       |
|                          | Urban                       | 31 | 94%        |
| Education Level          | Bachelors                   | 12 | 36%        |
|                          | Certificated                | 3  | 9.1%       |
|                          | Master                      | 16 | 48%        |
|                          | PhD (Doctor of Philosophy)  | 2  | 6.1%       |
| Experience in Total      | 1–5 Years                   | 3  | 9.1%       |
|                          | 6–10 years                  | 8  | 24%        |
|                          | More Than 10 Years          | 22 | 67%        |
| Experience in Management | 0–5 Years                   | 9  | 27%        |
|                          | 6–10 years                  | 15 | 45%        |
|                          | More Than 10 Years          | 9  | 27%        |
| Position/Department      | Health Manager/Director     | 6  | 18%        |
|                          | Health Programs Coordinator | 11 | 33%        |
|                          | Mental Health Supervisor    | 8  | 24%        |
|                          | Psychiatric                 | 6  | 18%        |
|                          | mhGAP Doctor*               | 2  | 6.1%       |

*\*A doctor assigned under the Mental Health Gap Action Programme (mhGAP).*

The majority of participants were male (85%), while females were 15%. Most participants were aged 31–40 years (64%), with smaller percentages in other age groups. Regarding total work experience, 67% had more than 10 years, and 24% had 6–10 years. Management experience was also variable, with 45% having 6–10 years, 27% having more than 10 years, and 24% having 1–5 years. In terms of education, nearly half of the participants held a Master’s

degree (48%), whereas 36% had a Bachelor's degree. Socially, the majority were married (88%) with the remaining participants being either single (6.1%) or divorced (6.1%).

Professionally, the largest group consisted of health programs coordinators (33%), followed by mental health supervisors (24%), health project managers/directors (18%), and those in psychiatric roles (18%), with mhGAP doctors representing the smallest group (6.1%).

At the completion of the first round, a total of 217 different responses were received from participants. These were categorized under 35 different headings using the MaxQDA 2024 program. Table 2 presents the 35 items identified in the analysis, together with the number of participants who mentioned each item. These findings highlight the key systemic and societal obstacles to effective mental health services as reported by participants. The lack of mental health professionals (n=28, 82%) is the most frequently mentioned obstacle that makes it more difficult to provide and accept mental health care, followed by the lack of funding (n=20, 59%), the social stigma associated with mental health (n=19, 56%), shortcomings in leadership and authority (n=15, 44%). The lack of an integrated healthcare system and an efficient coordination mechanism, as well as the lack of unified policies, disjointed service delivery, and inefficient data systems (n=14, 41% each), are other noteworthy obstacles. A lack of mental health support and training (n=11, 32%), low societal awareness, limited knowledge about mental health symptoms and the absence of a work protocol specifically for mental health (n=8, 24% for each), were all mentioned.

Important but less frequently mentioned obstacles include poor economic conditions, insufficient infrastructure, accessibility concerns, and cultural and religious beliefs. Numerous other particular obstacles are also reflected in the data, including the dearth of comprehensive data, policy research, and advocacy, pointing to a complex issue that requires a carefully considered response.

Table 2 also illustrates the results of a Delphi study that was conducted to identify and prioritize the barriers in the mental health system. It exhibits the mean importance scores and the interquartile ranges (IQR) for every barrier throughout the second and third rounds of expert consultation. The findings show trends concerning the consensus and the shifts in priorities during the two rounds. There is consensus on 16 different barriers illustrated in Table 3 highlighted in italics and bold.

**Table 2:** Delphi technique first, second and third round together (identified barriers)

| #  | Barrier                                                                                                                                                                 | Frequency* | %** | 2nd Round   |                    | 3rd Round   |                    |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----|-------------|--------------------|-------------|--------------------|
|    |                                                                                                                                                                         |            |     | Mean        | IQR<br>Mean<br>IQR | Mean        | IQR<br>Mean<br>IQR |
| 1  | <b>Shortage of qualified professionals, inadequate training, brain drain, and low compensation</b>                                                                      | 28         | 82  | <b>6.03</b> | <b>1.00</b>        | <b>6.06</b> | <b>1.00</b>        |
| 2  | <b>Lack of specialized facilities, essential medication, and mental health services in rural areas</b>                                                                  | 20         | 59  | <b>5.56</b> | <b>1.75</b>        | <b>5.53</b> | <b>1.00</b>        |
| 3  | <b>Insufficient resources allocated to mental health, dependence on external funding, and deprioritization compared to other healthcare sectors</b>                     | 19         | 56  | <b>5.94</b> | <b>2.00</b>        | <b>6.03</b> | <b>1.00</b>        |
| 4  | <b>Societal stigma, including among healthcare professionals, and cultural barriers to seeking help</b>                                                                 | 15         | 44  | <b>5.38</b> | <b>1.00</b>        | <b>5.34</b> | <b>1.00</b>        |
| 5  | <b>Lack of leadership and authority</b>                                                                                                                                 | 14         | 41  | <b>5.41</b> | <b>2.00</b>        | <b>5.44</b> | <b>1.00</b>        |
| 6  | <b>Absence of unified policies, fragmented service delivery, and ineffective data systems</b>                                                                           | 14         | 41  | <b>6.09</b> | <b>1.75</b>        | <b>6.09</b> | <b>1.00</b>        |
| 7  | <b>Difficulty accessing services due to various factors such as distance, cost, and security concerns</b>                                                               | 11         | 32  | <b>5.06</b> | <b>2.00</b>        | <b>5.22</b> | <b>1.00</b>        |
| 8  | <b>A fragmented healthcare system with poor coordination and an unstable government, hindering effective implementation</b>                                             | 8          | 24  | <b>5.50</b> | <b>1.75</b>        | <b>5.50</b> | <b>1.00</b>        |
| 9  | <b>Inadequate training opportunities and a lack of standardized job descriptions for mental health professionals</b>                                                    | 8          | 24  | <b>5.22</b> | <b>1.75</b>        | <b>5.16</b> | <b>1.00</b>        |
| 10 | <b>Insufficient data collection and research are hampering evidence-based decision-making</b>                                                                           | 7          | 21  | <b>5.22</b> | <b>1.00</b>        | <b>5.16</b> | <b>1.00</b>        |
| 11 | <b>Limited public awareness and knowledge about mental health</b>                                                                                                       | 7          | 21  | <b>5.31</b> | <b>2.75</b>        | <b>5.53</b> | <b>1.00</b>        |
| 12 | High stress and distress caused by conflict and disasters, security concerns and challenging living conditions for staff, and difficulty reaching displaced populations | 7          | 21  | 4.63        | 3.00               | 4.59        | 3.00               |
| 13 | <b>Absence of a work protocol specifically for mental health</b>                                                                                                        | 6          | 18  | <b>4.66</b> | <b>2.00</b>        | <b>4.56</b> | <b>1.00</b>        |
| 14 | <b>Societal, cultural and religious beliefs and attributing mental disorders</b>                                                                                        | 6          | 18  | <b>6.16</b> | <b>1.00</b>        | <b>6.16</b> | <b>1.00</b>        |
| 15 | Poor economic and social conditions                                                                                                                                     | 6          | 18  | 5.22        | 2.00               | 5.28        | 2.00               |

|           |                                                                                                       |   |    |             |             |             |             |
|-----------|-------------------------------------------------------------------------------------------------------|---|----|-------------|-------------|-------------|-------------|
| 16        | Continuity of hostilities and insecurity in the region                                                | 4 | 12 | 4.66        | 2.00        | 4.63        | 2.00        |
| 17        | Lack of cooperation between health professionals and social leaders                                   | 4 | 12 | 4.88        | 2.75        | 4.84        | 2.00        |
| <b>18</b> | <b>Project support inconsistency and uncertain timeline</b>                                           | 4 | 12 | <b>5.22</b> | <b>2.75</b> | <b>5.25</b> | <b>1.00</b> |
| 19        | The lack of comprehensive data and evidence of a health information management system                 | 4 | 12 | 4.59        | 2.75        | 4.63        | 2.75        |
| 20        | Lack of culturally adapted mental health interventions                                                | 2 | 6  | 4.13        | 3.75        | 4.13        | 2.75        |
| 21        | Increased mental health needs are straining existing resources and hindering policies                 | 2 | 6  | 5.13        | 2.00        | 5.19        | 2.00        |
| 22        | Failure to ensure the continuity of treatment                                                         | 2 | 6  | 4.03        | 3.75        | 4.06        | 3.75        |
| <b>23</b> | <b>Considering mental health services and psychosocial support as a standalone sector</b>             | 2 | 6  | <b>5.34</b> | <b>2.75</b> | <b>5.56</b> | <b>1.00</b> |
| 24        | Lack of key medicines and drug trafficking                                                            | 2 | 6  | 5.06        | 2.00        | 5.06        | 2.00        |
| 25        | Lack of universal healthcare coverage                                                                 | 2 | 6  | 4.69        | 3.75        | 4.66        | 3.75        |
| <b>26</b> | <b>Absence of regional or international conferences and the possibility of publishing articles</b>    | 1 | 3  | <b>4.78</b> | <b>2.00</b> | <b>5.09</b> | <b>1.00</b> |
| 27        | Poor adherence of some patients                                                                       | 1 | 3  | 5.56        | 2.00        | 5.56        | 2.00        |
| 28        | Humanitarian aid dependency                                                                           | 1 | 3  | 4.78        | 2.00        | 4.81        | 2.00        |
| 29        | The detrimental effect of nepotism-based employment policies                                          | 1 | 3  | 4.47        | 3.00        | 4.59        | 2.75        |
| 30        | Corruption within NGO*** and INGO**** organizations                                                   | 1 | 3  | 4.31        | 3.00        | 4.38        | 3.00        |
| 31        | Lack of accountability for violations that occur in the workplace                                     | 1 | 3  | 5.47        | 2.00        | 5.47        | 2.00        |
| 32        | Lack of experience in this field prior to the war                                                     | 1 | 3  | 4.88        | 2.00        | 4.88        | 2.00        |
| 33        | High level of ignorance among the community                                                           | 1 | 3  | 4.31        | 3.00        | 4.31        | 2.75        |
| 34        | High costs organizations have to overcome                                                             | 1 | 3  | 4.53        | 3.00        | 4.53        | 3.00        |
| 35        | Lack of better opportunities for both training and employment for individuals have undergone programs | 1 | 3  | 5.38        | 2.75        | 5.41        | 2.75        |

Below 1.2 IQR value represents consensus.

\* Number of participants mentioned the barrier.

\*\* The proportion of participants was mentioned.

\*\*\* Non-Governmental Organization.

\*\*\*\* International Non-Governmental Organization.

Several barriers emerged as critical issues where there was a high level of consensus. The barrier related to societal, cultural, and religious beliefs, “societal, cultural and religious beliefs and attributing mental disorders”, ranked first, with a stable mean score of 6.16 and an IQR of 1.00 throughout both rounds, thus showing strong agreement on its importance. In the same manner, the barrier related to policy and coordination, “absence of unified policies, fragmented service delivery, and ineffective data systems”, kept a mean score of 6.09 in both rounds. Its IQR decreased from 1.75 in the second round to 1.00 in the third round, suggesting enhanced consensus. Another significant barrier related to human resources, “shortage of qualified professionals, inadequate training, brain drain, and low compensation”, ranked third, with a high mean score of 6.06 in the third round and a narrow IQR of 1.00, suggesting strong agreement among participants.

Several barriers exhibited considerable development in the agreement of the specialists between rounds. The barrier related to funding and financing “insufficient resources allocated to mental health, dependence on external funding, and deprioritization compared to other healthcare sectors” showed an increase in mean score from 5.94 to 6.03 and at the same time the IQR was reduced from 2.00 to 1.00 which indicates that the experts of the field have recognized this issue increasingly.

The barrier placed mental health as separated healthcare services “considering mental health services and psychosocial support as a standalone sector” was increasing about mean score from 5.34 to 5.56 and the IQR was reduced from 2.75 to 1.00, indicating growing recognition of the issue. Also, the barrier related to specialized care setup, “lack of specialized facilities, essential medication, and mental health services in rural areas”, which had a stable mean of around 5.53, noted a decrease in the IQR from 1.75 during the second round to 1.00 in the third, thus demonstrating greater alignment among experts. At the same time, limited public awareness and knowledge, which “limited public awareness and knowledge about mental health” also showed a rise in the average score (5.31 to 5.53) as well as the IQR’s narrowing (2.75 to 1.00), which pointed to its growing perceived importance.

Other barriers showed lower mean scores, thus reflecting low priority or different opinions. Based on their mean values, the following can be listed as follows: The fragmented structure of the healthcare system, poor coordination, and inconsistent management hinder effective implementation. Additional barriers include a lack of leadership and authority, social stigma, prejudice among healthcare professionals, cultural barriers that make it difficult to seek help, unclear timelines, and variable project support. These barriers are listed in Table 3 according to ranking value (mean).

**Table 3:** The barriers participant has reached a consensus

| Rank | Barrier                                                                                                                                      | Mean | Sd.   |
|------|----------------------------------------------------------------------------------------------------------------------------------------------|------|-------|
| 1    | Societal, cultural and religious beliefs and attributing mental disorders                                                                    | 6.16 | 0.846 |
| 2    | Absence of unified policies, fragmented service delivery, and ineffective data systems                                                       | 6.09 | 0.892 |
| 3    | Shortage of qualified professionals, inadequate training, brain drain, and low compensation                                                  | 6.06 | 1.162 |
| 4    | Insufficient resources allocated to mental health, dependence on external funding, and deprioritization compared to other healthcare sectors | 6.03 | 0.782 |
| 5    | Considering mental health services and psychosocial support as a standalone sector                                                           | 5.56 | 0.981 |
| 6    | Lack of specialized facilities, essential medication, and mental health services in rural areas.                                             | 5.53 | 1.163 |
| 7    | Limited public awareness and knowledge about mental health                                                                                   | 5.53 | 1.343 |
| 8    | A fragmented healthcare system with poor coordination and an unstable government, hindering effective implementation                         | 5.50 | 1.391 |
| 9    | Lack of leadership and authority                                                                                                             | 5.44 | 1.366 |
| 10   | Societal stigma, including among healthcare professionals, and cultural barriers to seeking help.                                            | 5.34 | 1.207 |
| 11   | Project support inconsistency and uncertain timeline                                                                                         | 5.25 | 1.646 |
| 12   | Difficulty accessing services due to various factors such as distance, cost, and security concerns.                                          | 5.22 | 1.337 |
| 13   | Inadequate training opportunities and a lack of standardized job descriptions for mental health professionals.                               | 5.16 | 1.221 |
| 14   | Insufficient data collection and research are hampering evidence-based decision-making.                                                      | 5.16 | 1.346 |
| 15   | Absence of regional or international conferences and the possibility of publishing articles                                                  | 5.09 | 1.510 |
| 16   | Absence of a work protocol specifically for mental health                                                                                    | 4.56 | 1.216 |

The results point to a variety of barriers to mental health care, including resource and cultural limitations as well as institutional and legal issues. When taken as a whole, these limitations make it more difficult to provide and receive mental health care.

## DISCUSSION AND CONCLUSION

The research results indicate that multiple barriers exist which prevent mental health initiatives from reaching their goals in the NWS. The results reveal that societal, cultural, and religious beliefs (including stigma) are more significant barriers than financial and infrastructural ones. Systematic deficiencies also emerged as crucial challenges compared to operational issues like working protocols. Therefore, effective intervention requires prioritizing broad cultural and policy actions over the lack of service level improvements. Similar findings have been reported in the literature. For instance, Patel et al. (2018) reported that the main problems with mental health services in violent areas emerge from three key sources: systemic failures, social obstacles and insufficient resource availability. Additionally, the analysis of multiple barriers which block mental health improvement work requires examination of four main elements, including poor governance, staff shortages, cultural stigmas and limited resources (WHO, 2022).

This top barrier shows that cultural standards and social views about mental health create the most significant obstacles to accessing care. Deeply embedded beliefs of this nature serve as the main source of stigma, which keeps numerous individuals from seeking their required mental health care services. In conflict-affected areas, this problem is prevalent across multiple regions because their cultural beliefs and social views about health care access become more influential than in typical circumstances. Existing beliefs along with cultural elements have been assessed in previous research to determine their role in preventing people from seeking assistance and reducing the effectiveness of current policies. In similar cultural contexts, this issue is further complicated by social discrimination against individuals seeking mental health care (Alibrahim et al., 2023). The research from Afghanistan and Nigeria indicates that local cultural and religious traditions create obstacles for people to access and accept mental health services in these countries (United States Institute of Peace, 2024). Therefore, finding solutions that target and tackle these hurdles, which could be through public awareness campaigns and community engagement, is critical for improving mental health outcomes and lowering stigma, especially in NWS (Thornicroft et al., 2016).

Second, systemic obstacles emerged from policy and coordination-related barriers, which represent key challenges for the system. Ambiguous mental health policies, along with scattered service delivery systems, create major obstacles to the implementation of mental health services. The government's insufficient funding for mental health services creates additional challenges,

which worsen these problems. It is well-documented that mental health services receive less funding than physical health services, not only in NWS but in many low- and middle-income countries (Wainberg et al., 2017; Zhou et al., 2018). A shortage of financial resources, combined with an inefficient referral system and political indifference, has created major obstacles for Ethiopia to include mental health treatment within its health extension services. The project's success depends on the combination of better primary healthcare services and active community participation in the area (Yitbarek et al., 2021). The methods show potential for success in NWS since better community engagement and expanded healthcare access may lead to fewer institutional obstacles and higher treatment quality (van Ginneken et al., 2013).

The evaluation process assigned the third-highest importance to staff shortage, indicating it is a critical barrier. The situation consists of two main elements, which involve both the lack of licensed mental health professionals and the low standards of their educational programs. Studies show that task-shifting methods, which train non-specialists to deliver basic mental health care, produce good results in these scenarios. The current mental health professionals working in Syria could alleviate the workload of existing mental health professionals if these recommendations were adapted to the Syrian context (Hamid et al., 2024). The war further depleted the already limited mental health professional population. Multiple studies report that many healthcare professionals left the country, making mental health services inaccessible to large segments of the population (Hamza & Hicks, 2021; Shoib et al., 2022).

The execution of mental health policies depends on the availability of resources, which poses various constraints. The use of digital technologies in mental healthcare shows promise but faces multiple challenges when applied in practice. The current system faces three main barriers, which include complex regulations, insufficient resources, and unwelcoming attitudes. These problems exist throughout the entire world, and they are not unique to Syria. The providers, together with their consumers, express doubts about the authenticity and safety standards and functional aspects of Digital Mental Health Interventions (DMHIs). The adoption of DMHIs faces major obstacles because many people lack digital literacy and cannot access the required equipment in rural and underdeveloped regions (Huang et al., 2024). The adoption of DMHIs needs community engagement, educational programs, and supportive policy reforms, which enable technology access for mental health services (Berardi et al., 2024).

Peer support initiatives have evolved into crucial resources which mental health services depend on to function properly when they operate in resource-constrained environments. The implementation of these initiatives would result in improved clinical results and better social integration and rehabilitation success rates. The success of these programs depends on proper training plus supervision and their integration with existing healthcare delivery systems (Liu et al., 2024). The creation of peer support systems would serve as a valuable resource for NWS patients who face restricted access to formal mental health care services (van Ham, 2018).

A comprehensive strategy needs to be developed to eliminate these obstacles. Systemic problems which affect healthcare delivery can be addressed when organizations shift tasks and develop better primary care systems (Patel et al., 2018). The elimination of social barriers arising from stigma and cultural misunderstandings requires targeted awareness initiatives and active community participation. Resource limitations (Bracke et al., 2019; Mezzina et al., 2022) need legislative and educational funding and resource allocation to address them. To create a more robust and effective mental health system in NWS, research into other war-affected regions and the adaptation of effective tactics to local conditions will be required. The combination of these strategies with efforts to improve policy coordination and reduce stigma will help solve the main problems revealed by the statistics.

Because mental health care is funded primarily by external sources, financial limitations also constitute a significant structural issue in the area. Multiple elements, including social stigma, religious beliefs and cultural perspectives, as well as other factors, lead to insufficient understanding and poor recognition of mental health laws. Healthcare providers and local stakeholders who fail to work together create a major barrier that produces fragmented services and poor resource distribution. The research results highlight the need to understand how these barriers unite to create a complex system which prevents mental health policy development and implementation.

In summary, successful implementation necessitates confronting the larger systemic and cultural dynamics head-on in addition to addressing personal obstacles. The region needs to understand how different mental health problems connect to improve its mental health results. The advancement of mental health requires active participation from service providers, clients, and both national and international institutions. Implementing the recommendations outlined below is essential for addressing these barriers:

- Exchange of best practices and research findings should be promoted because international collaboration must be strengthened.
- The government or authorities at all levels need to increase funding for mental health facilities, professional training programs and service delivery systems.
- The training programs need to expand their reach because this will help society fight stigma while making people more aware of the issue.
- To ensure effective policy implementation, better coordination between government entities, private organizations, and civil society groups should be established.
- The participation of communities ensures that public policies will address the specific requirements of their area.
- Mental health policies require regular evaluation of their effects, which produces data that organizations can use to develop better strategies.

### **Limitations**

This study was conducted in NWS, where a healthcare system, whose resources have been destroyed by a protracted conflict and which relies on external financial and service assistance, is struggling to establish a local authority independent of the central government. Therefore, the findings may not be generalizable beyond this context. Furthermore, although the interviewed participants provide services in the region, they provide services from offices in Türkiye rather than residing permanently in NWS. This may have introduced potential bias into the findings.

**Ethical Approval:** The researcher used encryption techniques and safe data storage techniques to safeguard the information gathered. The records are only accessible to authorized staff members, preventing unauthorized disclosure and promoting wellbeing, engagement, and trust. Also to conduct the research, a decision was received from the İstanbul Medipol University Non-Invasive Research Ethics Committee regarding its scientific and ethical suitability (20.02.2024; Issue No: E-10840098-202.3.02-1406).

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