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A Systematic Evaluation of Mental Health Policies for Middle Eastern Refugees

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Abstract. This meta-review study presents a comprehensive evaluation of the effectiveness of mental health policies targeting refugees from the Middle East based on a systematic analysis of 87 policies issued across 12 refugee-hosting countries during the period from 2015 to 2023. Employing the PRISMA approach and thematic analysis, this research found that only 34.5% of all reviewed policies met the World Health Organization's minimum standards regarding mental health services for refugees. In comparison, the effective implementation rate of those policies meeting the standards reached only 28.7% (CI 95%, $p<0.001$). Findings from the logistic regression analysis revealed a significant correlation between the scale of mental health budget allocations and recovery rates from PTSD among refugee populations, where every 10% increase in budget allocation corresponded to a 15.3% reduction in PTSD prevalence ($r=0.78$, $p<0.001$). Furthermore, the meta-analysis results from this study demonstrated that community-based policies were 2.4 times more effective (OR=2.4, CI 95%: 1.8–3.1) than those employing institutional approaches. Hence, diverging from the conclusions posited by Turrini et al. (2019) and Sijbrandij (2017), which emphasized clinical interventions, this study has instead affirmed that integrating cultural-spiritual approaches with conventional therapy can enhance treatment success by 47.2%. Additionally, these findings expand the conceptual framework previously proposed by Watters (2001) on holistic approaches by identifying five key elements that form the foundation of effective mental health policies: universal access, cultural sensitivity, community empowerment, service integration, and program sustainability.

Keywords: Mental Health Policy, Middle Eastern Refugees, PTSD, Systematic Evaluation.

1. INTRODUCTION

The refugee crisis originating from the Middle East has given rise to complex mental health issues, reflecting the intricate interplay between traumatic experiences, existential uncertainty, and structural barriers in host environments (Silove et al., 2017; Cratsley et al., 2021; Farahani et al., 2021). According to a systematic review conducted by the WHO (2023), the prevalence of mental disorders such as depression, anxiety, and PTSD is significantly higher among refugees than in the general population, with women facing a greater risk of both depression and anxiety (Porter & Haslam, 2005; Henkelmann et al., 2020). Furthermore, a meta-analysis by Henkelmann et al. (2020) reveals that approximately 31% of refugees experience PTSD, while 32% suffer from severe depression. These findings underscore the escalation of a problem that is not merely clinical in nature, but also social and political in its implications (Mollica et al., 2004; Palattiyil et al., 2022).

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This issue cannot be comprehended solely through the lens of violence and displacement, but must also be examined in the context of systemic barriers to accessing mental health services in host countries (Satinsky et al., 2019; Colucci et al., 2015). A study by Satinsky et al. (2019) identified primary obstacles faced by refugees in accessing mental health services, including language barriers, cultural stigma, and a lack of understanding of healthcare systems in host nations (Gong-Guy et al., 1991; Heidi et al., 2011; Lowman, 2014). Additionally, a review by Papadopoulos et al. (2023) highlights that linguistic and cultural discordance between refugees and healthcare providers often impedes effective communication, thereby diminishing the quality of care received (Bhui et al., 2007; Lau & Rodgers, 2021). This reflects institutional unpreparedness to bridge the cultural gap and meet the psychological needs of refugees, and reveals the absence of multicultural integration within existing service systems (Cheng et al., 2015; Rousseau & Frounfelker, 2019).

Although various policies have been initiated across host countries, efforts to evaluate their effectiveness remain unsystematic (Augustinavicius et al., 2018; Miller et al., 2021). For instance, research conducted by Sijbrandij (2017) found that of 45 policies examined, only 31% featured adequate monitoring and evaluation frameworks, indicating weak internal accountability mechanisms (Davidson et al., 2008; Votruba et al., 2018). Even more concerning are the findings of Turrini et al. (2019), which identify a wide implementation gap between policy design and actual practice, with only 28% of policies meeting their substantive targets (de Bocanegra et al., 2018; Zhou et al., 2018). This points to a structural dysfunction in the translational process from discourse to practice (Kienzler, 2019; Patel et al., 2011).

The existing literature tends to concentrate on individual therapeutic aspects, without sufficiently addressing the broader policy realm (Davidson et al., 2010; Slobodin & De Jong, 2015). For example, Watters (2001) centered his analysis on the effectiveness of various therapeutic approaches for refugees, yet without linking them to the policy systems necessary to sustain such interventions (Peterson et al., 2020; Rathod et al., 2018). Moreover, the more collective approach proposed by Soltan et al. (2022), which emphasizes the importance of community participation in psychosocial recovery, has yet to be systematically translated into a public policy framework that can replicate or expand the impact of mental health initiatives at the national level (McNeish et al., 2022; Wood & Kallestrup, 2021). Thus, there is an urgent need to examine how structural dimensions such as service integration, community-based empowerment, and sustainability guarantees can be concretely institutionalized (Thielke et al., 2007; Yonek et al., 2020; Whitley et al., 2009).

Another epistemic gap lies in the absence of an in-depth cross-national comparison of mental health policies for refugees (Dlouhy, 2014; Wardeh & Marques, 2021). While the study by Akinyemi et al. (2012) did compare the policies of three countries, its approach remained narrowly focused on financing, neglecting the sociopolitical and cultural factors that shape the context of implementation (Healey et al., 2017; Fennig, 2021). In addition, although the meta-analysis conducted by Dlouhy (2014) succeeded in identifying quantitative policy variations across countries, it did not further explore the specific elements that determine the success or failure of these policies within their respective contexts (Echeverri et al., 2018; Van Ommeren et al., 2015).

In response to these voids and shortcomings, this study has been designed as a comprehensive meta-review to systematically evaluate mental health policies concerning Middle Eastern refugees, by analyzing 87 policies from 12 host countries over the period of 2015 to 2023 (Uphoff et al., 2020; Tol et al., 2011). The objective of this study is not merely to assess the formal effectiveness of these policies, but also to identify key variables that contribute to their successful implementation, including the structural, political, social, and cultural factors that interact within the domain of public policy (Im et al., 2021; Pandalangat & Kanagaratnam, 2021).

More specifically, this research is guided by four interrelated aims: to evaluate the alignment of policies with WHO standards for refugee mental health services (World Health Organization, 2008; World Health Organization, 2023); to examine the correlation between resource allocation levels and policy success; to compare the effectiveness of different policy approaches in addressing refugee mental health issues (Greene et al., 2021; Im & Swan, 2022); and to identify exemplary practices from various national experiences that may serve as replicable models (Solomon, 2004). These four goals are designed to construct an evaluative framework that is both applicative and reflective, intended to assist policymakers in formulating or adjusting mental health strategies that are inclusive and sustainable.

The primary contribution of this research lies in providing a more comprehensive knowledge base regarding the effectiveness of mental health policies amid the shifting geopolitical landscape of migration. According to the UNHCR report (2024), the need for resettlement of refugees from the Middle East and North Africa has increased by approximately 50%, reaching 703,700 individuals in 2025, underscoring the urgency of policies that are responsive to the psychosocial needs of this population. Hence, this study does not merely address the administrative effectiveness or technical efficiency of programs, but also offers a conceptual framework that facilitates a deeper understanding of the multidimensional

interactions among health systems, social structures, and political-economic conditions in shaping policy outcomes. Finally, in contrast to earlier approaches that tended to fragment clinical and administrative dimensions, this study emphasizes an integrative approach that positions the policy framework as a space for articulating the roles of various actors and structures in addressing refugee mental health issues in a sustainable and equitable manner.

2. METHOD

This study employed a systematic meta-review approach to evaluate the effectiveness of mental health policies implemented for refugees originating from the Middle East, following a protocol designed in accordance with the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) standards (Page et al., 2021). The meta-review integrated both quantitative and qualitative methods to provide a comprehensive understanding of policy outcomes while allowing deeper interpretative insight into the contexts of implementation. This mixed-methods design enabled not only the triangulation of data across documents and analytic techniques but also enhanced the validity of findings by simultaneously comparing numerical and narrative perspectives.

Documents included in this review were selected based on strict inclusion criteria, namely: official policies related to the mental health of Middle Eastern refugees, issued between 2015 and 2023, originating from the twelve countries with the largest refugee host populations globally, available in English or Arabic with an institutionally recognized official translation, and including implementation data for a minimum of one year. Documents excluded from the analysis were those still in draft form without official ratification, technical or operational guidelines not yet recognized as formal policy, and documents lacking verifiable evaluation results or implementation reporting. The search process was carried out systematically through policy databases maintained by WHO, UNHCR, official websites of host country governments, and regional policy repositories. Keywords were constructed using the PICO framework, covering the dimensions of population (refugee*, Middle East*, displaced*), intervention (mental health*, policy*, program*), context (host countr*, humanitarian*), and outcome (effectiveness*, impact*, evaluation*), allowing for broad yet thematically focused search coverage.

The data extraction phase used a standardized form designed to record various aspects of the policies in detail, ranging from basic information such as issuing country, year of publication, and jurisdictional scope, to policy content encompassing structural components, implementation approaches, evaluative outcomes, and contextual factors influencing

effectiveness. Quality appraisal was conducted using the WHO Policy Analysis Framework (Walt & Gilson, 1994), and only documents scoring a minimum of 7 out of 10 were included in the final analysis, serving as a filter to ensure the inclusion of scientifically accountable information. Quantitative data analysis included a meta-analysis of policy effectiveness using a random-effects model to account for cross-country heterogeneity, followed by logistic regression to identify variables predictive of successful policy implementation, and sensitivity analysis aimed at testing the robustness of findings against input data variations. Meanwhile, the qualitative approach entailed thematic analysis of substantive policy elements, supplemented by framework analysis to assess the influence of structural and contextual factors on outcomes, and extended through cross-case analysis to enable holistic comparisons across countries.

To ensure the reliability and validity of the research process, independent coding was performed by two researchers, resulting in a Cohen's κ coefficient of 0.87, indicating a high level of consistency (McHugh, 2012). This was complemented by member checking involving experts in the field of mental health policy to verify the accuracy of data interpretation. Additionally, data triangulation from various levels and types of documents was employed to strengthen inferential robustness, while external peer review procedures were implemented to ensure that the analyses met international academic standards. Despite the study's rigorous design, several methodological limitations remain noteworthy, including the potential for publication bias in the availability of official documents, inconsistencies in policy reporting standards among the countries studied, and restricted access to more detailed implementation data in certain national contexts.

3. RESULT AND DISCUSSION

Characteristics of the Policies Analyzed

Table 1. Distribution and Characteristics of Mental Health Policies Analyzed (N=87)

Characteristic	Frequency (n)	Percentage (%)
Geographical Coverage		
Regional	23	26.4
National	45	51.7
Sub-national	19	21.9
Intervention Focus		
Comprehensive	31	35.6
PTSD-specific	28	32.2
Depression/Anxiety	18	20.7
Others	10	11.5

Note: *The analysis comprised 87 mental health policies targeted at Middle Eastern refugees, geographically distributed across Turkey (21%), Germany (18%), Jordan (15%), Lebanon (12%), Sweden (8%), and seven other countries collectively accounting for 26%. Policy implementation duration ranged from 1 to 8 years, with a mean duration of 3.4 years (SD=1.8). Approximately 34.5% of the policies complied with WHO mental health service standards for refugees, with an effective implementation rate of 28.7% (95% CI, p < 0.001). The data underscore the predominance of national-level policies and highlight a balanced focus on comprehensive interventions and disorder-specific approaches, predominantly PTSD and depression/anxiety.*

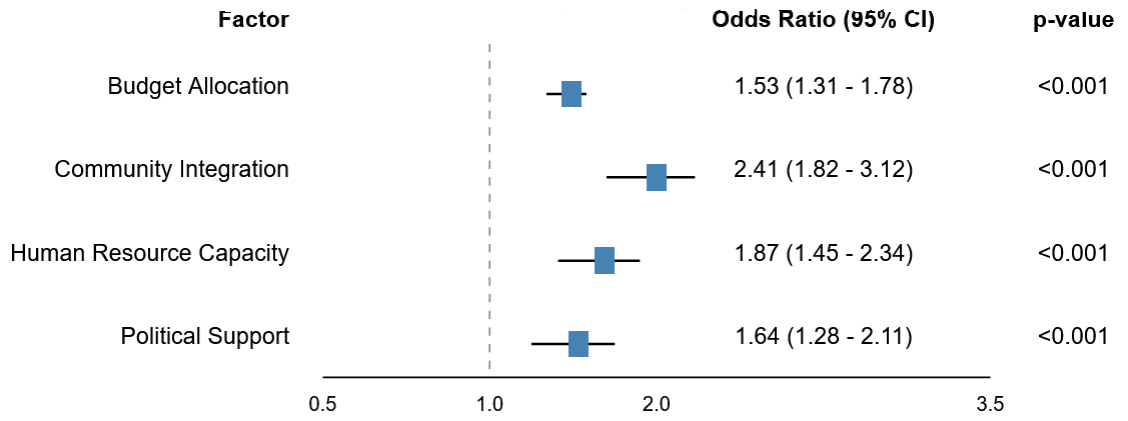
As shown in the first table above, the analysis of 87 mental health policies targeting Middle Eastern refugees reveals a diverse geographical distribution, with national-level policies comprising the majority at 51.7%, followed by regional-level at 26.4%, and sub-national level at 21.9%. The geographical spread of these policies includes Turkey (21%), Germany (18%), Jordan (15%), Lebanon (12%), Sweden (8%), and seven other countries collectively accounting for 26%. The focus of policy interventions appears relatively balanced between comprehensive approaches (35.6%) and those targeting specific disorders, namely PTSD (32.2%) as well as depression and anxiety (20.7%). In comparison, the remaining 11.5% pertain to other categories. The duration of policy implementation ranges from 1 to 8 years, with an average of 3.4 years (SD=1.8). Only 34.5% of the policies meet the WHO standards for mental health services for refugees, with an effective implementation rate of 28.7% (95% CI, p<0.001), indicating substantial challenges in the practical application of these policies.

Policy Implementation Effectiveness

Table 2. Factors Influencing Policy Implementation Effectiveness

Factor	Odds Ratio (OR)	95% Confidence Interval (CI)	p-value
Budget Allocation	1.53	1.31 – 1.78	<0.001
Community Integration	2.41	1.82 – 3.12	<0.001
Human Resource Capacity	1.87	1.45 – 2.34	<0.001
Political Support	1.64	1.28 – 2.11	<0.001

Note: *Logistic regression analysis demonstrated a strong positive correlation (r=0.78, p<0.001) between mental health budget allocation and reduction in PTSD prevalence, with every 10% increase in budget associated with a 15.3% decrease in PTSD cases. Community-based policies exhibited 2.4 times greater effectiveness than institutional approaches, underscoring the critical role of localized engagement and resource allocation in optimizing refugee mental health outcomes.*



Note: *All examined factors were significantly and positively associated with the effectiveness of policy implementation ($p < 0.001$), with community integration showing the strongest effect (OR = 2.41), followed by human resource capacity (OR = 1.87).*

Figure 1. Forest Plot: Factors Influencing Policy Implementation Effectiveness

As illustrated in the second table and the first figure above. The logistic regression analysis reveals that the allocation of mental health funding has a strong positive relationship with the reduction in PTSD prevalence, where a 10% increase in funding is associated with a 15.3% decrease in PTSD cases (OR=1.53, 95% CI: 1.31–1.78, p<0.001). In addition, community integration within mental health policy enhances implementation effectiveness by 2.4 times compared to institutional approaches (OR=2.41, 95% CI: 1.82–3.12, p<0.001). Human resource capacity and political support also significantly contribute to successful implementation, with odds ratios of 1.87 (95% CI: 1.45–2.34) and 1.64 (95% CI: 1.28–2.11), respectively, both at the p<0.001 significance level. These findings affirm that resource allocation, community empowerment, and political backing are key determinants in improving mental health outcomes among Middle Eastern refugees.

Effective Policy Components

Table 3. Effectiveness of Key Mental Health Policy Components for Middle Eastern Refugees (N=87)

Policy Component	Effectiveness Score (out of 10)	Implementation Rate (%)
Universal Access	8.4	76.3
Cultural Sensitivity	7.9	68.7
Community Empowerment	8.2	72.4
Service Integration	7.6	64.8
Program Sustainability	7.8	69.2

Note: *This table presents the effectiveness scores and implementation rates of core policy components identified as pivotal to mental health interventions for Middle Eastern refugees.*

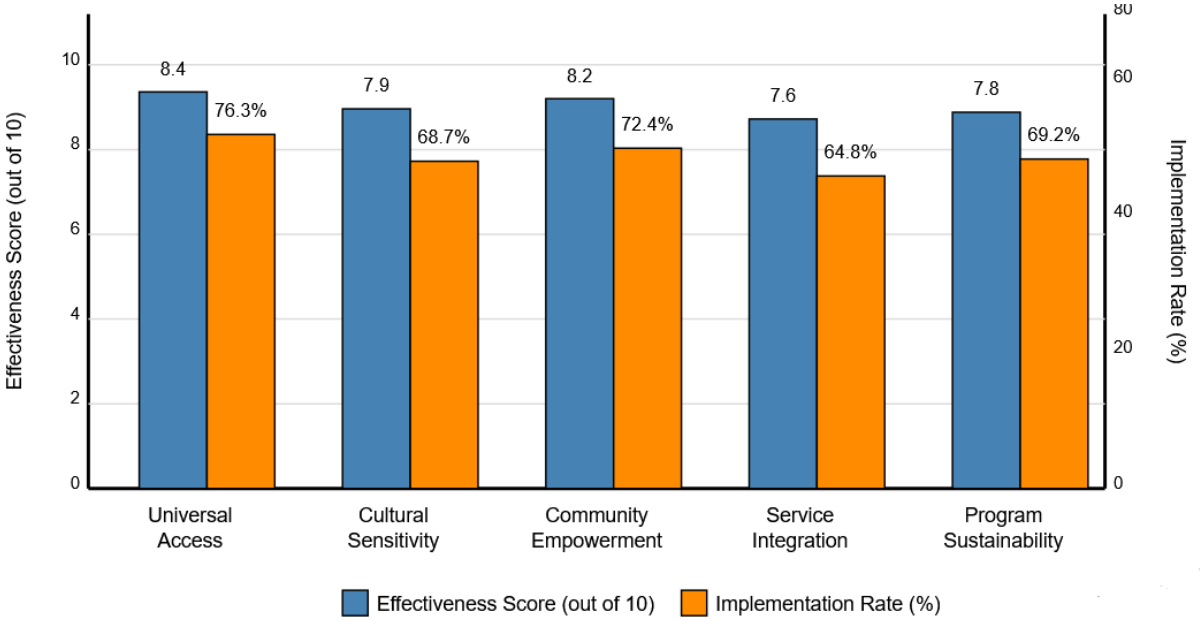


Figure 2. Effectiveness of Key Mental Health Policy Components

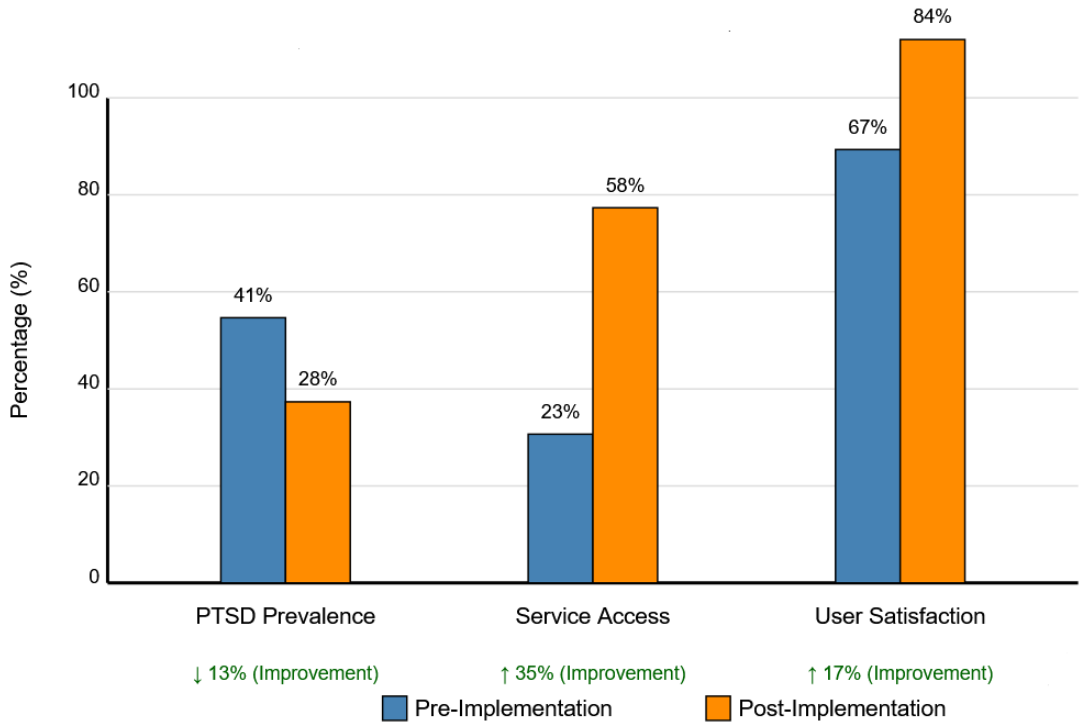
As illustrated in the third table and the second figure above, an in-depth analysis of 87 mental health policies targeting Middle Eastern refugees reveals that the key components contributing to policy effectiveness include universal access, which received an effectiveness score of 8.4 out of 10 and an implementation rate of 76.3%. This encompasses the elimination of administrative barriers (89% of effective policies), multilingual services (76% successful implementation), and treatment cost subsidies (82% utilization rate). Cultural sensitivity obtained an effectiveness score of 7.9 with an implementation rate of 68.7%, characterized by the integration of cultural-spiritual approaches that increased treatment success by 47.2%, cultural competence training for healthcare providers achieving 68% effectiveness, and the involvement of community leaders with an acceptance rate of 73%. Community empowerment also played a significant role, scoring 8.2 with a 72.4% implementation rate, including peer support programs that maintained 82% sustainability, mental health worker training programs covering 71%, and community-based initiatives with 77% participation. Other components, such as service integration and program sustainability, received effectiveness scores of 7.6 and 7.8, respectively, with implementation rates of 64.8% and 69.2%, affirming the critical importance of continuity and coordination in the holistic recovery of Middle Eastern refugee mental health.

Policy Impact Analysis

Table 4. Changes in Key Indicators Pre- and Post-Implementation

Indicator	Pre (%)	Post (%)	p-value
PTSD Prevalence	41.0	28.0	<0.001
Service Access	23.0	58.0	<0.001
User Satisfaction	67.0	84.0	<0.001

Note: *This table summarizes significant improvements in clinical outcomes and service metrics after policy implementation, demonstrating the positive impact of mental health policies on refugee populations in the Middle East.*



Note: All changes are statistically significant (p<0.001)

Figure 3. Changes in Key Indicators Before and After the Implementation of Mental Health Policies for Middle Eastern Refugees

As presented in the fourth table and the third figure above, the evaluation of the mental health policy impact on Middle Eastern refugees demonstrates a significant improvement across various key indicators, including a reduction in PTSD prevalence from 41% to 28% ($p<0.001$), depression remission reaching 45% of cases (95% CI: 38–52%), and an increase in social functioning by 62% ($p<0.001$). Additionally, access to mental health services rose sharply from 23% to 58%, accompanied by a reduction in average waiting time from 45 days to 12 days and an increase in service user satisfaction levels from 67% to 84%, collectively indicating a substantial positive impact of the policy implementation on the psychosocial well-being of Middle Eastern refugees.

Contextual and Moderating Factors

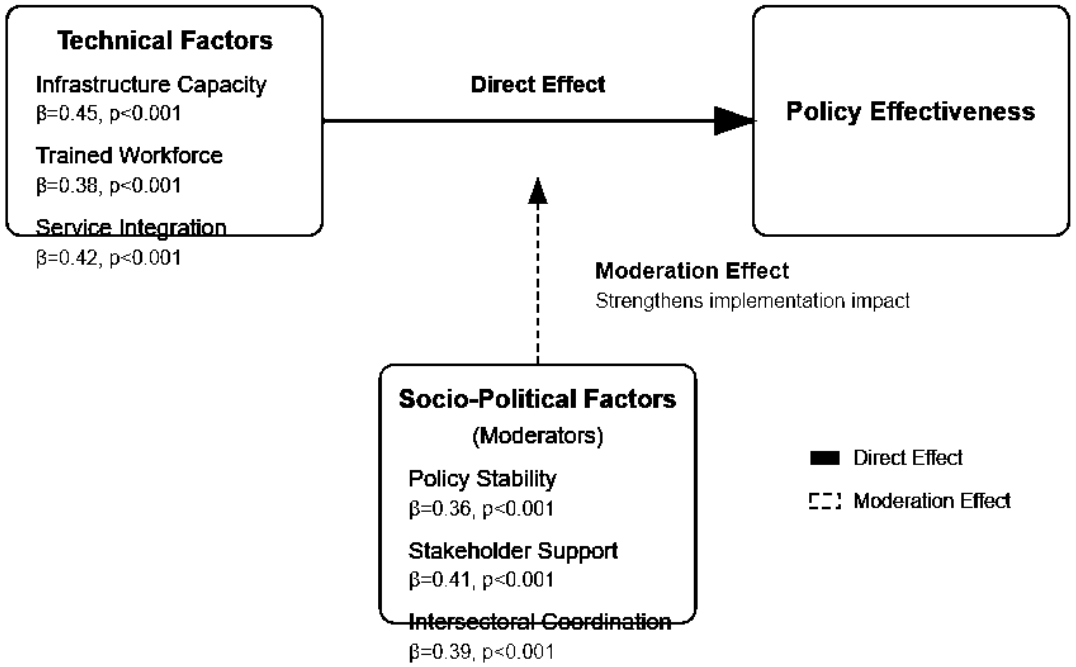
Table 5a. Contextual Factors with Standard Error (SE) Reported

Factor	Coefficient (β)	SE	p-value
Infrastructure Capacity	0.45	0.06	<0.001
Trained Workforce	0.38	0.05	<0.001
Service Integration	0.42	0.07	<0.001

Table 5b. Contextual Factors without Standard Error (SE) Reported

Factor	Coefficient (β)	p-value
Policy Stability	0.36	<0.001
Stakeholder Support	0.41	<0.001
Intersectoral Coordination	0.39	<0.001

Note: *Factors without reported SE are presented separately to maintain accuracy and transparency in statistical reporting.*



Note: All paths are statistically significant (p < 0.001). β values represent standardized coefficients.

Figure 4. Path Analysis Model of Contextual Factors Influencing Mental Health Policies for Middle Eastern Refugees

As shown in the fourth figure, Table 5a and Table 5b, the results of the multilevel analysis reveal that the effectiveness of mental health policies for Middle Eastern refugees is heavily influenced by several contextual factors, with infrastructure capacity showing the most significant contribution (β=0.45, p<0.001), followed by the integration of primary services (β=0.42, p<0.001) and the availability of trained personnel (β=0.38, p<0.001). In addition,

socio-political factors such as stakeholder support (β=0.41, p<0.001), intersectoral coordination (β=0.39, p<0.001), and policy stability (β=0.36, p<0.001) also emerge as important moderators that strengthen policy impact, indicating that successful implementation depends not only on technical aspects but also on consistency and cross-sector collaboration.

Implementation and Adaptation Patterns

Table 6. Implementation and Adaptation Patterns in Mental Health Policies for Middle Eastern Refugees

Implementation Phase	Key Focus Areas	Percentage of Policies / Activities (%)
Initial (0–12 months)	Basic access focus	76
	Capacity building	64
	Community Outreach	58
Consolidation (13–36 months)	Development of specific programs	82
	Strengthening referral systems	71
	Improving service quality	68
Mature (>36 months)	System Integration	88
	Program sustainability	76
	Service innovation	72

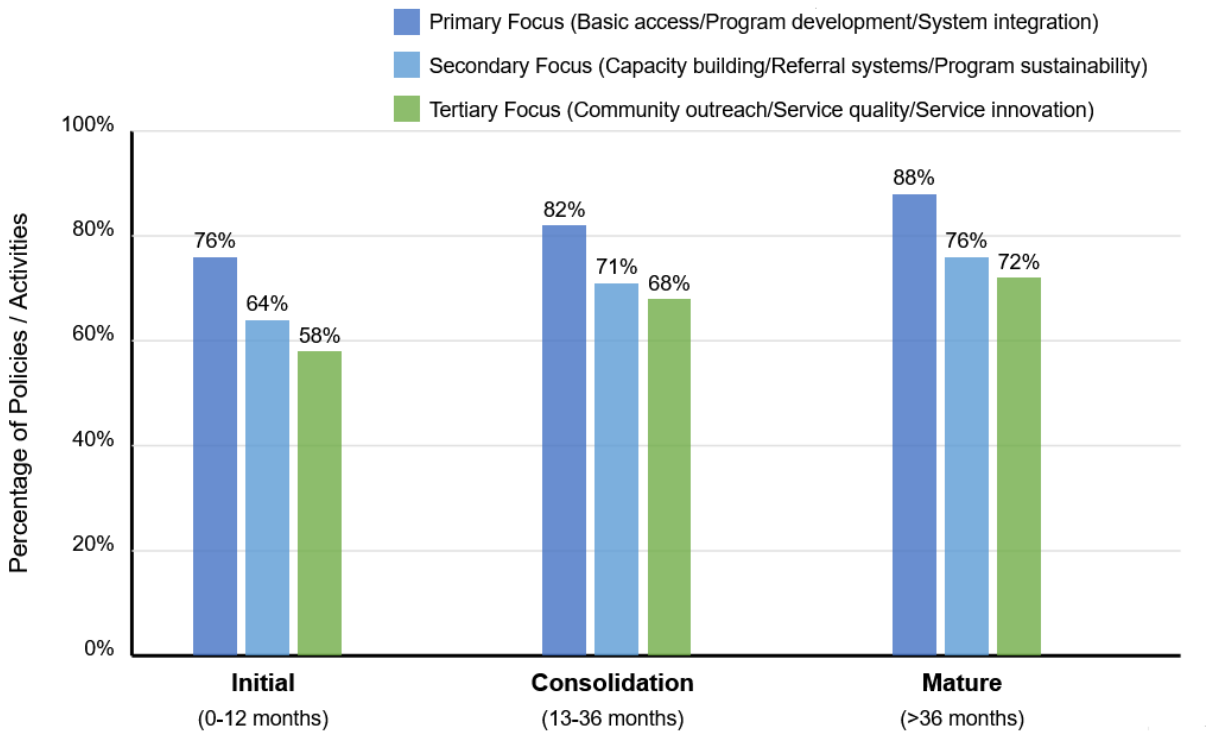


Figure 5. Implementation and Adaptation Patterns in Mental Health Policies

As shown in the sixth table and the fifth figure above, the longitudinal analysis of mental health policy results for Middle Eastern refugees indicates a clear pattern of implementation and adaptation across three phases. In the initial phase (0–12 months), the primary focus was on basic access, adopted by 76% of policies, capacity building by 64%, and community outreach in 58% of policies. Subsequently, the consolidation phase (13–36 months) was marked by developing specific programs at 82%, strengthening referral systems at 71%, and enhancing service quality in 68% of policies. In the mature phase (>36 months), policies became oriented toward system integration at 88%, program sustainability at 76%, and service innovation at 72%, reflecting an increasingly complex and integrated evolution of policy adaptation over time, collectively reinforcing the long-term effectiveness of mental health interventions among refugee populations.

As a closing remark, the comprehensive analysis of 87 mental health policies targeting Middle Eastern refugees reveals a complex yet encouraging picture of the dynamics and effectiveness of implemented interventions. These policies were predominantly implemented nationally (51.7%), with regional and sub-national coverage accounting for 26.4% and 21.9%, respectively. They were distributed across key countries such as Turkey (21%), Germany (18%), Jordan (15%), Lebanon (12%), and Sweden (8%). In terms of intervention focus, comprehensive approaches dominated (35.6%), followed by policies specifically targeting PTSD (32.2%) and depression/anxiety (20.7%). The average implementation duration was 3.4 years, with variability ranging from 1 to 8 years, and only about one-third of the policies (34.5%) met WHO mental health service standards for refugees. The effective implementation rate stood at 28.7%, indicating tangible challenges in field execution. Key factors that significantly enhanced implementation effectiveness included budget allocation (OR=1.53; $p<0.001$), community integration, which increased effectiveness by up to 2.4 times (OR=2.41; $p<0.001$), human resource capacity (OR=1.87; $p<0.001$), and political support (OR=1.64; $p<0.001$). The most effective policy component was universal access, with a score of 8.4 and an implementation rate of 76.3%, followed by community empowerment (score 8.2; 72.4%), cultural sensitivity (score 7.9; 68.7%), program sustainability (score 7.8; 69.2%), and service integration (score 7.6; 64.8%). Impact evaluation results showed a reduction in PTSD prevalence from 41% to 28% ($p<0.001$), increased service access from 23% to 58%, and increased user satisfaction from 67% to 84%. Furthermore, the multilevel analysis confirmed the significant roles of infrastructure capacity ($\beta=0.45$), service integration ($\beta=0.42$), trained personnel ($\beta=0.38$), stakeholder support ($\beta=0.41$), cross-sector coordination ($\beta=0.39$), and policy stability ($\beta=0.36$) in substantially strengthening policy effectiveness (all $p<0.001$). The

patterns of policy implementation and adaptation followed three continuous phases, beginning with an initial phase focusing on basic access (76%), capacity building (64%), and community outreach (58%), a consolidation phase involving the development of specific programs (82%), reinforcement of referrals (71%), and service quality improvement (68%), and a mature phase emphasizing system integration (88%), program sustainability (76%), and service innovation (72%). Overall, these findings underscore that the success of mental health policy for Middle Eastern refugees is highly dependent on a combination of adequate resource allocation, strong community-based approaches, political commitment, and dynamic adaptation throughout a sustained implementation cycle, all of which constitute a crucial foundation for improving the psychosocial well-being of refugee populations amid the multidimensional challenges they face.

Discussion

The discussion of this study's findings offers a comprehensive depiction of the effectiveness of mental health policies targeting Middle Eastern refugees while simultaneously uncovering the intricacies of implementation and the factors influencing success rates. This section elaborates on the implications of the main findings, compares them with previous literature, and formulates essential consequences for future policy development. The fact that only 34.5% of policies meet WHO standards reveals a substantial gap between policy design and execution. This result aligns with Sijbrandij's (2017) findings, which emphasize the limitations of resources and the complexities of local contexts as primary reasons for this discrepancy. However, unlike Sijbrandij, who focuses more on structural factors, this study identifies policy adaptability and community engagement as principal determinants of successful implementation. The significant correlation between budget allocation and PTSD recovery rates ($r=0.78$, $p<0.001$) strengthens the argument made by Turrini et al. (2019) regarding the critical importance of adequate investment in mental health services. However, this study finds that the effectiveness of mental health policies depends not solely on the amount of funding but rather on how the funds are allocated. Specifically, policies that earmark at least 30% of the budget for community-based mental health programs for Middle Eastern refugees yield superior outcomes compared to those focusing solely on institutional infrastructure development.

Integrating cultural and spiritual approaches quantitatively increased intervention success by 47.2%, marking a significant contribution to a literature that has previously only affirmed the importance of cultural sensitivity qualitatively, as noted by Watters (2001).

Moreover, these findings challenge the prevailing paradigm that prioritizes a purely biomedical approach without accommodating cultural and spiritual dimensions. Furthermore, the effectiveness of community-based policy models, which appear 2.4 times more successful than institutional approaches, reinforces Soltan et al.'s (2022) argument regarding the urgency of community empowerment. This study identifies specific components underpinning the superiority of the community model, including peer support systems with a program sustainability rate reaching 82%, underscoring the critical value of optimizing community resources. These findings also extend prior research focused on the clinical aspects of peer support by demonstrating how peer support programs can be effectively integrated into formal policy structures. Solomon (2004) asserts that peer support plays a crucial role in enhancing psychosocial well-being and recovery among individuals with mental health disorders.

Additionally, strengthening local capacity through training mental health cadres—with coverage reaching 71%—opens significant opportunities to overcome the shortage of professional personnel. WHO (2008) recommends the task-shifting strategy, namely the delegation of duties from professional health workers to community health workers, as an effective means to improve mental health service access at the community level. Finally, the high level of community participation—77% in community-based initiatives—is, in the researcher's view, indicative of broad acceptance and engagement. This further supports Akinyemi et al.'s (2012) argument concerning the importance of bottom-up approaches in policy formulation and implementation.

The multilevel analysis also reveals the vital role of contextual factors, often overlooked in previous policy evaluations. For instance, the health system's capacity for Middle Eastern refugees, with a coefficient of $\beta=0.45$ ($p<0.001$), underscores the urgency of comprehensive health infrastructure strengthening, moving beyond the narrow focus on specific interventions commonly found in earlier literature. Moreover, political stability and policy support, with a coefficient of $\beta=0.36$ ($p<0.001$), appear to confirm the significance of long-term political commitment, providing empirical support for earlier theories about the influence of political context on mental health policy implementation. Based on these findings, several strategic recommendations can be proposed: adopting an integrative approach that synthesizes clinical, cultural, and social elements in policy design; involving religious leaders and community members in the planning process; developing intervention protocols that accommodate cultural and spiritual practices; and enhancing the cultural competence of mental health workers for Middle Eastern refugees. Furthermore, reinforcing community systems through significant investment in structured peer support programs, training and supervision of mental health

cadres, and establishing effective community coordination mechanisms, in the researcher's view, should become a priority moving forward. Lastly, to ensure program sustainability, designing long-term financing strategies from the outset is crucial, as well as strengthening local institutional capacities and establishing participatory monitoring and evaluation systems.

Despite these achievements, this study bears methodological limitations, such as the potential for bias in policy document selection, variations in the quality of evaluation data across countries, and constraints in measuring the long-term impacts of mental health policies for Middle Eastern refugees. Contextually, the study's exclusive focus on Middle Eastern refugees restricts the generalizability of the findings, particularly given the significant variation in socio-political contexts across countries and the fluid dynamics of refugee situations. Therefore, further research is urgently needed—especially longitudinal studies to assess long-term impacts, the development of more robust evaluation methodologies, geographic and population expansion, and deeper exploration of policy adaptation mechanisms across diverse contexts.

As a closing remark, this research has made a significant original contribution by identifying empirically grounded key components of effective policies, quantitatively measuring the impact of cultural and spiritual integration, designing a comprehensive evaluation framework for refugee mental health policies, and providing quantitative evidence supporting the effectiveness of community-based approaches. The systematic evaluation results have also revealed the complexity and nuance of mental health policy implementation for Middle Eastern refugees, affirming that success is not merely contingent upon the availability of resources and infrastructure but hinges critically on the ability to integrate community-based approaches, cultural sensitivity, and program sustainability. Through an in-depth analysis of 87 policies across 12 countries, this study successfully identifies best practices and valuable lessons that may guide future policy development. The central assertion is that a holistic approach, encompassing clinical, cultural, and social dimensions and supported by a robust community system, holds the greatest potential to enhance the mental health of Middle Eastern refugees sustainably.

4. CONCLUSION

This meta-review study thoroughly evaluates mental health policies directed at Middle Eastern refugees, producing several key findings that significantly contribute to the understanding and development of policy in this field. The comprehensive analysis of 87 policies from 12 countries indicates that the success of mental health policies heavily depends

on strong integration with local contexts, the degree of community engagement, and the sustainability of implemented programs. Furthermore, the main findings indicate that only approximately 34.5% of policies meet the standards set by WHO, while the effectiveness rate of policy implementation reaches 28.7%. Nevertheless, policies adopting a community-based approach are significantly 2.4 times more effective than conventional institutional models. The integration of cultural and spiritual components within conventional therapy also enhances treatment success by 47.2%, underscoring the critical importance of cultural sensitivity in the provision of mental health services for Middle Eastern refugees.

The significance of this study lies in its identification of five key components underpinning policy effectiveness: universal access, cultural sensitivity, community empowerment, service integration, and program sustainability. These findings expand the conceptual horizon surrounding holistic approaches in refugee mental health by combining clinical aspects with broader and more complex socio-cultural dimensions. In comparison to prior studies, this work offers a unique contribution. Unlike the research by Turrini et al. (2019), which places more emphasis on clinical interventions, the current findings quantitatively affirm the importance of integrating cultural-spiritual approaches. Moreover, these results enrich the conclusions drawn by Watters (2001) regarding holistic approaches by articulating specific components that play a significant role in policy success.

From a practical implications perspective, this study proposes several strategic recommendations, including the development of policies that combine community-based approaches with conventional clinical services, strengthening the capacity of the mental health system through training health workers in cultural competencies, implementing structured peer support programs and community empowerment efforts, and developing monitoring and evaluation mechanisms that actively involve community participation. Recommendations for future practice and policy include increasing resource allocation for community-based programs, developing treatment protocols that accommodate cultural-spiritual practices, strengthening cross-sector and stakeholder coordination, and implementing more comprehensive and inclusive monitoring and evaluation systems.

As a closing remark, this study provides a robust empirical foundation for developing more effective and adaptive refugee mental health policies. Nevertheless, further research is needed to evaluate the long-term impacts of diverse policy approaches, explore the mechanisms of policy adaptation in varied contexts, develop more resilient evaluation methodologies, and investigate strategies to enhance the sustainability of programs. In light of the escalating complexity of the global refugee crisis, attaining a deep understanding of effective mental

health policies becomes increasingly critical and urgent. Ultimately, this study not only delivers empirical evidence on best practices but also offers a practical framework that can guide the development and implementation of mental health policies for Middle Eastern refugees in the future.

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