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Psychosocial Support Interventions in the Context of Forced Displacement

Process and Findings from a Systematic Review of the Global Literature



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STUDY BRIEF

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February 2021

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5 KEY TAKE AWAYS

1.

The meta-analysis showed strongest effects for psychosocial wellbeing, reinforcing narrative findings that people subjectively feel better after receiving psychosocial support. However, the most commonly measured outcomes were indicators of distress, for instance a reduction in symptoms of post-traumatic stress disorder or depression, not positive outcomes such as wellbeing. A reduction in clinical symptoms of distress falls often outside what can be expected from a psychosocial intervention. There is a need to more carefully choose the outcomes to be measured.

2.

Qualitative feedback was almost entirely positive. However, when quantitatively comparing two groups of people there were often no longer meaningful differences between those who did and did not receive the intervention, suggesting subjectively perceived impacts may not always be due to the intervention. There seems to be a tendency to focus only on the positive outcomes in qualitative studies. Worsening outcomes were rarely reported but did show up – particularly in quantitative studies.

3.

Whether by gender, age, psychosocial needs, or other characteristics, studies that looked at subgroups did often find differences in impact by these features.

Trying to offer interventions that serve too broad a group may not end up being helpful for everyone and could even make problems worse. There is a need for more careful matching of participants to interventions.

4.

Lack of standardization in reporting made it difficult to collect information on all the population, intervention, implementation, and context characteristics we were hoping to explore.

5.

Due to poor follow up of participants, as well as missing implementation information (such as participant attendance rates or whether the intervention was delivered as intended) **differences in effectiveness can not only be attributed to intervention design.**

OVERVIEW

Psychosocial Wellbeing in Forced Displacement

Forced displacement refers to involuntary movement of people due to events that threaten their health and safety such as armed conflict, persecution, disaster, or a breakdown in social order. This can include people who are displaced within their home country, known as internally displaced people (IDPs), as well as people who cross international borders, such as refugees and asylum seekers. Over the past decade, at least 100 million people have been forcibly displaced. Of these, only a minority have been able to safely return home or be permanently and legally resettled in a new community; as a result, there are currently nearly 80 million people living in insecurity.¹

Traditionally, most global humanitarian support for these populations has focused on meeting basic needs such as shelter, food assistance, water and sanitation, etc. However, in the past decade it has been increasingly recognized that people who have been displaced experience a wide range of stressors, such as exposure to traumatic experiences and the breakdown of social support. These stressors can contribute to mental distress or disorder, poorer interpersonal relationships, and difficulty coping – in other words, poor psychosocial wellbeing. This recognition has led to a growing effort by the international community to address mental health and psychosocial support (MHPSS) needs in situations of displacement.

MHPSS is defined as “any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder.”² This includes psychotherapeutic or medical treatments of mental disorders as well as psychosocial support activities such as cultural or recreational activities, peer groups, and positive youth development programs aiming to improve social and psychological aspects of wellbeing (such as interpersonal relationships, support and connection, community life, emotions, behaviors, skills and coping strategies, etc.) and reduce the likelihood of developing mental health problems.

While there is growing evidence for the effectiveness of a relatively narrow set of mental health treatments³, there are still major gaps in knowledge on understanding what comprises the most effective psychosocial interventions. This gap is especially glaring as it is these psychosocial interventions that comprise the bulk of MHPSS programming. Specifically, there is much less consensus around psychosocial programming best practices and the extent to which these interventions work, how they work, and where, when, and for whom they work best.⁴

1 / UNHCR. Global trends: Forced displacement in 2019. Available at <https://www.unhcr.org/globaltrends2019/>

2 / Inter-Agency Standing Committee (2007). IASC Guidelines for mental health and psychosocial support in emergency settings. Available at https://www.who.int/mental_health/emergencies/9781424334445/en/

3 / Purgato et al. (2019). Psychological therapies for the treatment of mental disorders in low- and middle-income countries affected by humanitarian crises. Cochrane Database of Systematic Reviews, Issue 7. Art. No.: CD011849. Available at <https://pubmed.ncbi.nlm.nih.gov/29975811/>

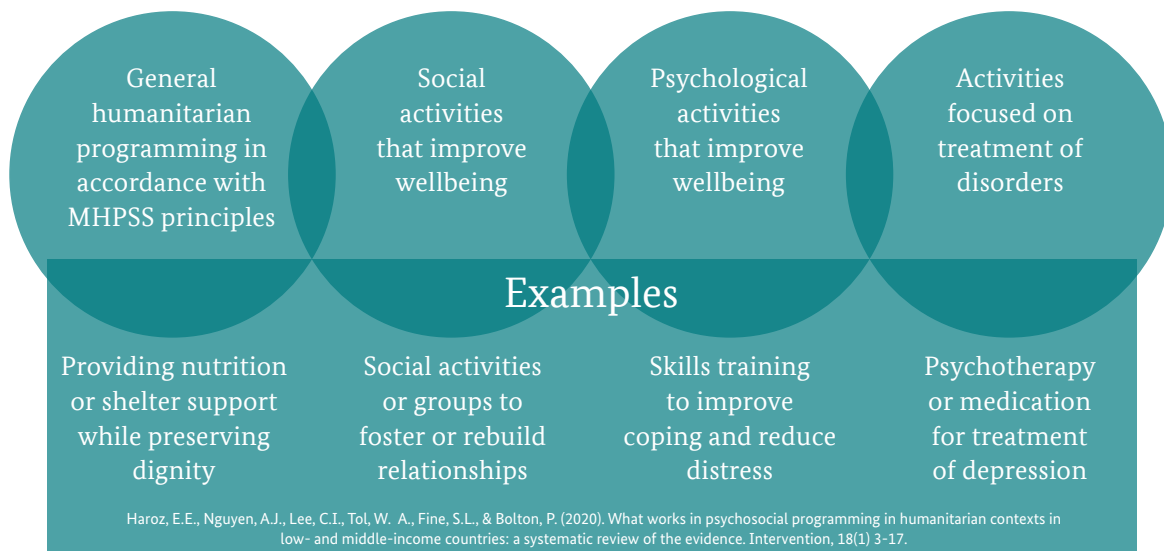
4 / Tol et al. (2011). Mental health and psychosocial support in humanitarian settings: linking practice and research. *Lancet*, 378(9802), 1581–1591. Available at <https://pubmed.ncbi.nlm.nih.gov/22008428/>

To address these questions, in 2020, GIZ, on behalf of the German Federal Ministry for Economic Cooperation and Development BMZ, **launched a study led by the University of Virginia to review and synthesize the global evidence regarding the effectiveness of psychosocial interventions for populations affected by displacement.** The goal of the study was to gain the best possible understanding of: 1) what types of interventions have been evaluated, where, and for whom; and 2) what the evidence suggests on what they do and how well they work. For a complete and thorough report on this project please email alena.mehlau@giz.de.

Continuum of Mental Health and Psychosocial Support Programming

As portrayed in Figure 1 below, the different types of activities that make up MHPSS programming exist on a continuum ranging from integrating MHPSS considerations into the delivery of basic services to psychotherapeutic and psychiatric treatment. Importantly, basic services, social activities, psychological activities and the treatment of disorders should not be understood as discrete sets of activities. Many psychosocial interventions include both social and psychological components, such as both engaging participants in recreational activities to promote social interaction and providing training to improve coping skills. Likewise, psychosocial interventions may incorporate elements typically found in treatment approaches, such as processing traumatic experiences or teaching different ways of managing problematic thoughts or feelings, even when used in a preventative approach not targeting people experiencing disorder.

Figure 1:
The MHPSS
Continuum



This complexity reflects the challenge the field faces between providing a breadth of supports for a wide range of people and needs, while at the same time trying to create meaningful groupings of interventions to help make sense of evidence and improve practice. **For the purposes of this review, efforts were focused on investigating general humanitarian programming, as well as social and psychological activities that specifically sought to promote mental health and wellbeing.** This excluded the investigation of treatment of mental disorders, and also excluded general humanitarian programming for which psychosocial outcomes were not assessed.

PROJECT APPROACH

Collecting Information

- The review **included 162 evaluation reports**, covering interventions from anywhere in the world and interventions focused on people who had experienced any type of involuntary displacement. It also included a wide range of study designs to gain a fuller picture of what types of interventions have been evaluated, important information about participant perspectives, and how or why interventions might or might not have worked. Evaluation reports were sourced from academic databases and organizational people working within the MHPSS field as practitioners and policy makers, and through a number of working groups and platforms. To be included, **reports had to have evaluated a psychosocial intervention provided to people affected by displacement which intended to impact any of a wide range of psychosocial outcomes, and that assesses these outcomes** (e.g., indicators of distress, functioning, subjective wellbeing, coping, social behavior, social connectedness).

Synthesizing Evidence

The resulting information was used in the following ways:

- To describe **key features of the included reports** related to design, population, displacement, intervention, implementation, and impact.
- To explore, using a more **narrative approach**, how often reported outcomes suggested positive impact, both overall and for specific populations, interventions, and contextual factors. It also took a deeper exploration into studies that examined findings by subgroup (e.g., age, gender, level of support needed, etc.) and other questions of interest.
- To conduct a statistical approach called **meta-analysis** for a subset of reports. This approach **averages findings across multiple studies** while taking into account information about each study (for example, giving a larger study more weight than a smaller one). Inclusion in meta-analyses requires meeting certain study design features, such as having a quantitative measure of a common outcome of interest that was taken before and after the intervention in both a group of people receiving the intervention and a comparison group that was not offered the intervention. **Unlike the narrative synthesis, which is more descriptive, this approach allows for standardization and quantification of intervention effectiveness.** For each outcome the analysis looked at *overall effects* (i.e. all studies that measured that outcome), and then also looked at differential effects across various *subgroups* (e.g., looking separately at adult vs. child outcomes, different intervention approaches, displacement context, etc.).

Consulting with Stakeholders

To ensure that this review was aligned with needs and priorities in the field, an 8-member steering committee comprised of expert MHPSS practitioners, researchers, and policy makers was established. Committee involvement was sought during each stage of the process. A larger pool of stakeholders was also engaged through both an interim workshop focused on addressing challenges to studying contextual influences of MHPSS programming in the Middle East, and again through a final dissemination meeting, after which further feedback was incorporated into findings and recommendations.

DESCRIPTION OF INCLUDED REPORTS



Displacement Experiences and Population Characteristics

- Regions in which the evaluations were **most often conducted included North America (30%), the Middle East and North Africa (23%),** and Europe and Central Asia (15%). The origin of participants was most commonly the Middle East and North Africa (41%), Sub-Saharan Africa (36%) and South Asia (21%). This distinction between study location and population origin reflects the large number of studies **conducted in resettlement contexts (45%)** relative to externally (32%) or internally (20%) displaced contexts. It is likely that the high proportion of studies in resettlement contexts reflects the challenges associated with conducting research in settings of displacement and ongoing instability.
- In the majority of reports the population had been **displaced due to armed conflict (64%)** and held formal recognition of their displacement status (62%), although these categories were based on the information available in the papers, and in many cases, it was not clearly reported. It is possible that this information was not reported because it was sensitive to ask.
- Nearly **40% of interventions focused on general adult populations,** 14% on youth and young adults, 21% on children, and 7% on young children. About 11% focused specifically on supports for parents or families and only about 2% on the elderly. Although this review focused on evaluation reports rather than a mapping of practices, it is likely that the lack of evaluations reflects a similar lack of programming specifically focused on supporting older adults.
- Most interventions **(80%) were not gender-specific,** while 18% targeted women or girls and only 2% targeted men and boys. No interventions offered targeted supports for LGBTQI+ persons.

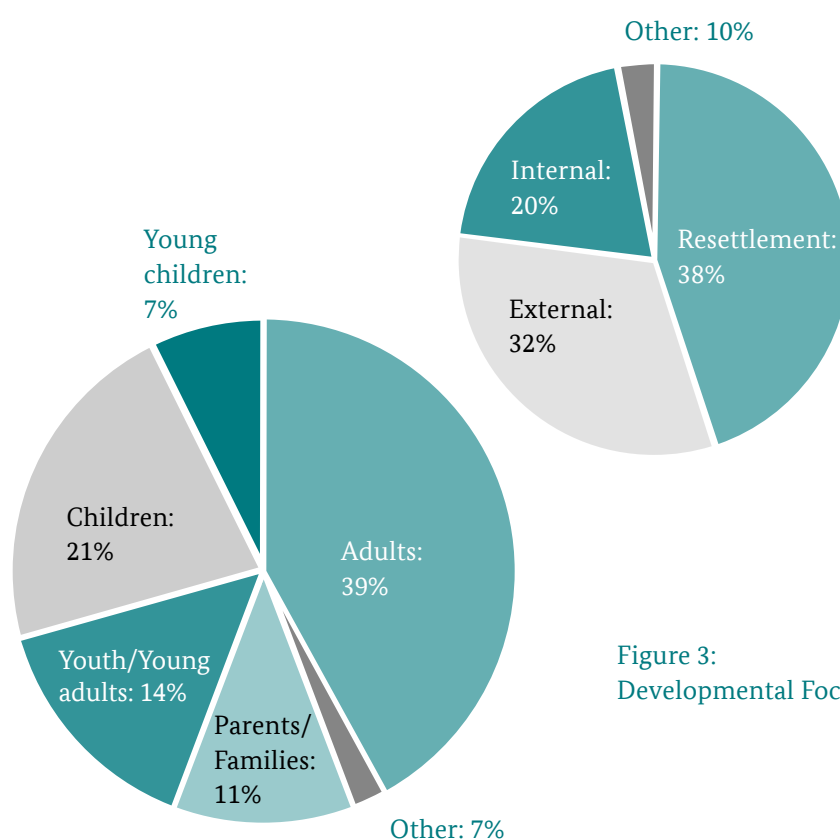


Figure 2:
Displacement Setting

Figure 3:
Developmental Focus

Categorizing Intervention Approaches

Most interventions involved multiple programming approaches, such as a combination of social and psychological activities. However, to provide broad (but rough) categories, each intervention was classified according to the predominant approach. For example, an intervention that primarily involved social interaction or relationship building but also provided some information about mental health and trauma would be categorized as predominantly social, whereas an intervention that included social or recreational activities but largely emphasized coping skills and processing trauma would be categorized as predominantly psychological. Taking this strategy:

- Interventions predominantly featured **social approaches to improving wellbeing (64%)**, such as facilitating peer connections or support, engagement in recreation or creative expression activities, or the connecting to resources.
- Fewer featured a primarily **psychological approach (25%)**, e.g., changing patterns of thinking, processing experiences and memories, building coping skills).
- Interventions within **basic services were very limited (8%)**, e.g., mainstreaming of MHPSS considerations in nutrition or financial support, health services, or shelter management, such as by grouping shelter tents according to community of origin to facilitate social participation).

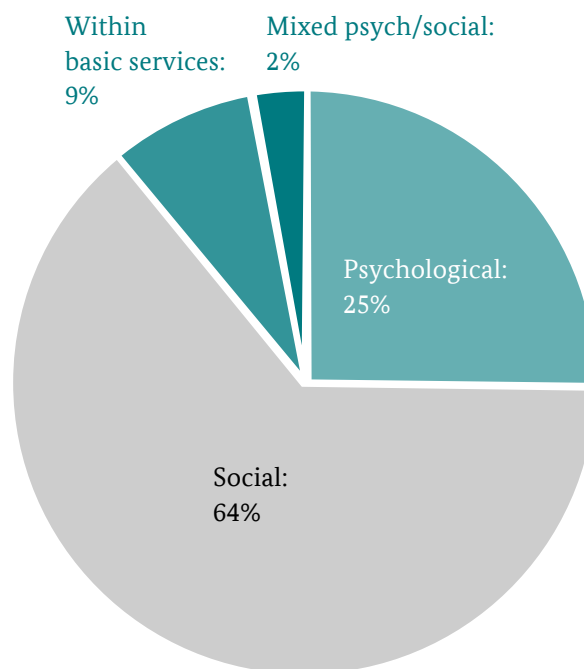


Figure 4:
Primary Approach

The vast majority (90%) of interventions were offered broadly to the target group and did not select participants based on their level of distress. Most were also offered in a group or other collective format (family, classroom); only 20% were offered individually. These types of delivery approaches reflect the nature of PSS programming that seeks to provide generally supportive services to a wide range of people.

Because the broad MHPSS classifications result in over-simplification, interventions were also categorized according to their primary activities as described in the evaluations, although there is a certain level of overlap in activities across approaches (Table 1).

Approach	Description	n	%
1. Financial Capacity	Integration of PSS considerations into social enterprise or financial literacy/support interventions (e.g., training refugees to navigate financial stressors in resettlement)	11	6.47
2. Coping/ Resiliency	Involving a range of “treatment-like” elements with a focus on addressing trauma, decreasing distress, improving coping	20	11.76
3. Creative Expression	More specifically focused on processing experiences through expression (e.g., sand play, theater)	26	15.29
4. Health Promotion	Programs focused on health literacy, health service delivery, nutrition	13	7.65
5. Integrated MHPSS	Focus on integrating tiered MHPSS services into community resources (such as by integrating a range of MHPSS activities into primary healthcare and evaluating impacts on stigma)	7	4.12
6. Parent/ Family	Improvement of parent wellbeing or skills to impact family processes, or provision of direct family-level supports	25	14.71
7. Psychoed & Referral	Psychoeducation, assessment, and referral (e.g., psychological first aid)	5	2.94
8. Relaxation	Mind-body focused approaches (e.g., listening to music, yoga)	6	3.53
9. Social Integration	Increasing social supports or community integration (e.g., reconciliation workshops, buddy/mentor programs)	30	17.65
10. Child Protection, Social Integration	Safe spaces, community-focused child protection services	11	6.47
11. Positive Development	Education, life skills, recreation, etc. (e.g., activities that promote healthy development rather than focusing on trauma recovery)	16	9.41

Study Features

- **Less than half the studies included a comparative study design** (e.g., comparing people who received an intervention to people who did not). This is important because without a comparison group that gives some understanding of how people would fare without the intervention, it is difficult to say whether observed changes were due to the intervention itself or due to other factors that could change with time, such as living conditions.
- Over half of the studies collected data before and after the intervention, while **about a quarter did so at a single point in time**; these were often studies that gathered qualitative data only, such as through post-intervention interviews and focus groups, whereas a majority of studies collected quantitative (49%) or both quantitative and qualitative (26%) data.



Study Limitations

Less than half the studies compared outcomes between people receiving an intervention and people who did not, and about a quarter collected information only at a single point in time. These types of studies provide a lot of very important information (such as participant perceptions), but cannot provide quantitative indicators for effectiveness.

- Studies typically evaluate impacts on **many psychosocial outcomes** (e.g., symptoms of distress, perceptions of wellbeing, social support, etc.); across all the included studies, there were 909 reported outcomes – an average of nearly 6 outcomes per study. This suggests a lack of focused expectations on/of what the intervention should achieve for the participants.
- The **most commonly evaluated outcome indicators were related to distress, such as symptoms of post-traumatic stress**, depression, anxiety and somatic complaints (25%). These outcomes were also **the most uniformly measured using standardized, well-validated instruments**. Indicators of subjective wellbeing (21%; e.g., mental wellness, happiness, hope, positive self-concept, etc.) and social connectedness (19%; e.g., connectedness, cohesion, social support, acculturation, etc.) were also commonly measured, but with much less consistency around how these were conceptualized and what tools were used.

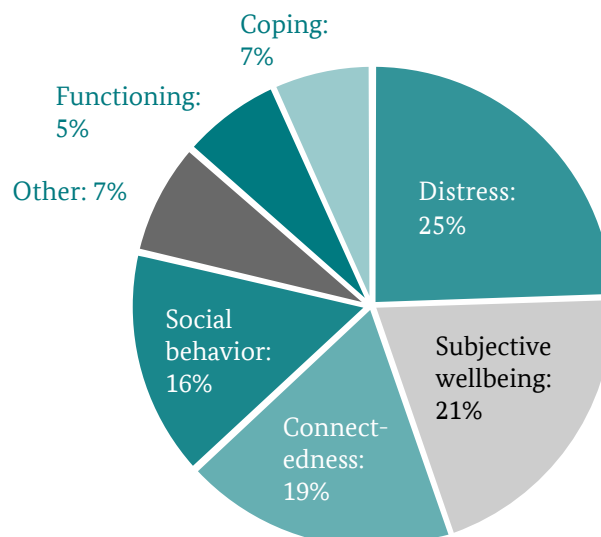


Figure 5:
Outcome Categories

Studies from the Middle East and North Africa

This region has experienced a number of long-running conflicts resulting in long-term and complex displacement circumstances. Some interesting findings include that for example, a number of very carefully conducted, rigorous studies have been carried out in the Occupied Palestinian Territories (OPT). Because of their recognized status as refugees all studies from OPT were included, even though many people living in the OPT have been there now for generations and may not share similar displacement experiences as more recently displaced groups. For example, multiple school-based studies in OPT appear to have been carried out in relatively stable school settings, which may make findings from these studies less likely to apply to displaced student populations elsewhere. Because of this, studies in OPT were categorized as a distinct displacement context, separate from either internal or external displacement. And whereas one might expect that having formal refugee status increases access to support services, for Palestinian refugees in neighboring countries who are formally registered, their receipt of formal supports may in some ways serve to restrict their rights in host communities. As it related to the Syrian refugee crisis, multiple studies discussed context factors related to increased tensions between the host and refugee communities due to a strain on local resources; the impact of this type of contextual factor may be particularly meaningful to explore in future MENA-focused research.

Regional Focus: MENA



- 37 MENA reports studied 30 unique interventions; 24 were evaluated a single time, whereas 6 interventions were reported on multiple times either through progressively more complex studies (e.g., single group study followed by a study using a comparison condition) or through replication studies in different settings
- MENA reports had higher proportion of war/armed conflict as the motivating driver of displacement, and also higher proportions of protracted displacement experiences (greater than 10 years)
- There were no studies specifically focused on men or boys in MENA, nor any studies focused on the elderly
- MENA studies appeared to have more focus on children and family needs. For example, fewer studies focused on adult populations (18%) whereas more focused on children (39%). There was also a higher proportion of parent/family strengthening interventions in MENA (26%), and fewer group-delivered interventions (56%) with slightly more interventions delivered to whole families (13%) or classrooms/schools (18%)
- There were trends toward a slightly higher rate of positive reporting for some intervention types, including positive youth development, and parent/family strengthening

SUMMARY OF KEY FINDINGS



Are Psychosocial Interventions Effective?

Approximately 60% of findings were reported to be positive; this includes both findings that had been statistically evaluated and shown to be meaningful, as well as positive reports that were not statistically tested, such as positive stakeholder perceptions. If also including findings that showed positive trends but were not statistically strong, positive findings increased to 85%. **Positive findings were relatively more common for subjective wellbeing and social connectedness** compared to distress, suggesting the interventions might have stronger or more immediate impact on these outcomes even though measures of distress are more commonly measured.



Positive Findings

Qualitative feedback was almost entirely positive, whereas findings from quantitative measurements taken before and after intervention were more mixed. When quantitatively comparing two groups of people, there were often no longer meaningful differences between those who did and did not receive the intervention.

The meta-analysis to statistically examine effectiveness generally showed **small changes across outcomes that were in the positive direction but mostly not statistically significant**, meaning the change could be due to chance and we cannot draw strong conclusions about effectiveness. We ultimately included 33 studies, looking at seven outcomes that were chosen both because they were of priority interest and because they were reported often and consistently enough to allow for averaging across studies. A description of the outcomes and findings is included in Table 2. Some of the outcomes, such as wellbeing (e.g., feeling happy, mentally well) and internalizing problems (e.g., depression, anxiety, or general distress, such as sadness, social withdrawal, worry), were measured among both adults and children; others, such as externalizing problems (e.g., anger, disruptive behavior) and total difficulties (a combined measure of internalizing and externalizing), were only consistently measured among children.



Psychosocial Wellbeing

The largest impact across studies was found for psychosocial wellbeing, illustrating that people subjectively feel better after participating in psychosocial interventions.

Across these outcomes, a moderately strong overall effect – measured without regard to intervention type, population subgroups, etc. – was found for psychosocial wellbeing, reinforcing the narrative findings that **people subjectively feel better after participating in psychosocial interventions**. A trend toward a small impact on both internalizing and externalizing problems was also observed, although these observations were less robust, suggesting that more research would be needed to confirm and reinforce these findings.

Table 2. Description of Overall Meta-Analysis			
Outcome Category	Description	No. of Estimates	Effect Size
Internalizing	Combined symptoms of depression, anxiety, or general distress, such as sadness, social withdrawal, worry	39	-.152 [†]
Externalizing	Behavior/conduct problems such as anger, fighting, being disruptive (specific to children)	14	-.249 [†]
Total Difficulties	Combined internalizing and externalizing (specific to children)	16	-.062
Psychosocial Wellbeing	Positive subjective feelings of mental health, feeling well	13	-.534 [*]
Functional Impairment	Loss of ability to fully engage in tasks of daily living	12	-.034
Prosocial Behavior	Positive social behavior such as being kind, helpful, considerate (specific to children)	10	-.011
Social Support	Perceptions of having access to tangible or emotional support from others, people one can turn to for help	9	-.113
<p>Note: Standardized effect sizes range from -1 (large improvement) to 1 (large worsening); findings near 0 indicate no meaningful impact, while findings near .2, .5, and .7 suggest small, medium, and large impacts, respectively</p> <p>*Statistically significant at $p < .05$; [†]Marginally significant at $p < .07$</p>			

What do we know about differences in effectiveness by features of interest?

1) Comparing across studies (meta-analysis): Comparing adult-focused vs. child-focused impacts in the meta-analysis, **we found a small but significant improvement for adult internalizing problems** (e.g., symptoms of depression and anxiety) **and a small but significant worsening for children.**⁵ One possible explanation for this difference is that the child-focused interventions were often delivered in schools and classrooms where children received the intervention regardless of their level of psychosocial support needs, whereas adults had more choice about whether to participate in interventions. So, for adults there may be a better fit between actual needs and interventions. We also know that symptoms of depression and anxiety increase

5 / Adult ES: -0.289, calculated from 19 outcome measures; Child ES: 0.129, calculated from 20 outcome measures; Women/Girl ES: -0.313 calculated from 8 outcome measures

in adolescence,⁶ so interventions addressing these types of problems may just be more appropriate for older youth and adults than they are for children.



Opposite Effects?

Adults with symptoms of depression and anxiety experienced improvement after interventions, whereas children experienced a small worsening of symptoms.

Another interesting trend suggested that **when interventions were specifically designed for and delivered to women and girls instead of mixed groups, they worked better in reducing symptoms of anxiety and depression.** Again, this could be because women and girls are more likely to experience these types of problems,⁷ so the interventions are a better fit to their needs. However, with so few gender-specific studies included, it could also just be that the effect was pulled up by one or two particularly strong interventions (e.g., Self Help Plus) that just happened to be studied among women.

2) Group comparisons within singly studies: Beyond these comparisons across studies in the meta-analysis, some studies also compared groups within a single study and found interesting differences between groups that suggest trends of differential impacts according to key characteristics. These include:

Trauma exposure or symptom level: Most studies reporting this focused on children, finding across multiple studies that **children responded differently to interventions based on how severely they had been impacted by their experiences.** The patterns themselves varied; in some cases, children with fewer symptoms benefited, while children with more symptoms did not; in other cases, the opposite was true. These findings suggest **a need for more careful consideration of the level of support the intervention provides and how that matches identified needs;** for example, a program focused on skill building and positive development may be more appropriate for children who aren't showing distress, whereas children with substantial distress may need a program focused on addressing trauma.



Subgroups Differences

Whether by gender, age, psychosocial needs, or other characteristics, studies that looked at subgroups did often find differences in impact by these features. Trying to offer interventions that serve too broad a group may not end up being helpful for everyone and could even make problems worse.

Gender: Child-focused interventions in some cases showed **more impact for girls than for boys on the same outcomes,** and in other cases significant impacts on different outcomes for girls and boys. This suggests that the same intervention might be a better fit for, or be working differently for, girls vs. boys. There were also adult-focused studies that showed either impacts for women but not men on some outcomes, or lower perceived intervention fit for men compared to women.

6 / <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>

7 / https://www.who.int/gender/other_health/genderMH.pdf

Age: Some studies focusing on classroom-based and child-friendly spaces programs reported **stronger impacts for younger children compared to older children/youth**, again suggesting a need for more refinement of activities or targets to match developmental needs.

Other displacement experiences: A few studies reported differences across factors such as ethnicity, level of acculturation (e.g. first vs. second generation immigrant), or motivation for displacement (e.g. economic vs. persecution). These sparse reports provide rationale for more careful study in the future.

What do we know about the negative or unintended impacts of psychosocial interventions?

We found it was very rare for study authors to explore or report negative or unexpected outcomes. Studies that did report these findings tended to be based on quantitative measures in which change or movement in a negative direction could be observed, but potentially without rich qualitative information to help make sense of what might have happened. In contrast, most qualitative studies overwhelmingly reported positive impacts and did not seek to explore unanticipated or harmful impacts. While this is not unique to MHPSS evaluations, this bias and exclusion of exploring negative outcomes needs to be addressed by donors, practitioners, and researchers alike.



Negative Findings

Worsening outcomes were rarely reported but did show up – particularly in quantitative studies. There is a tendency to focus only on the positives in qualitative studies.

How feasible was it to collect and synthesize information related to key factors of interest?

We encountered inconsistent reporting on key details and characteristics across reports that made it difficult to record and analyze the information we hoped to collect from many of the evaluations.

Population and displacement experiences: One challenge was differences in reporting of key variables between humanitarian settings compared to resettlement contexts. For example, **studies in current displacement settings were more likely to focus on a distinct, describable population or displacement experience, whereas studies in resettlement contexts tended to focus on a diverse group of resettled participants.** At times the commonly used terms were also not informative. For example, people in both resettlement and current displacement settings are often described as refugees, while some descriptions of internally “conflict-affected” populations lack clarity on whether the participants had experienced displacement. Studies also often either did not ask or did not report sensitive information such as legal status or formal recognition, although in general, it appeared that informal or undocumented populations were under-represented in these evaluations. This is important, as undocumented populations may face additional psychosocial stressors and be less able to access support services.

Intervention activity descriptions: Most reports provided some level of description about the contents or activities of an intervention (e.g. skills training, play groups, sewing). However, reports did not include the level of detail that would be needed to accurately compare the extent to which specific practices or activities were consistent across interventions, or to fully understand why each activity was included. This made it difficult to make clear distinctions between interventions themselves, or to clearly understand what the intervention intended to do.

Implementation factors that potentially influenced intervention effectiveness were also not commonly reported. For example, information about participant attendance at interventions was often lacking, and only about a quarter of reports included any information about whether the intervention was delivered as intended. Half of reports that included pre- and post-intervention data collection indicated loss of more than 1 in 5 study participants, and typically findings were based on those for whom complete data was available. These information gaps make it difficult to disentangle differences in effectiveness due to intervention design vs. implementation challenges. For example, if an intervention did not produce great change, is this because the activities were not (and would not be) helpful, or because they weren't carried out as intended? If many people dropped out, is this because they did not like the intervention, or because other issues (for instance lack of transportation) made it difficult to attend? If a report was highly positive, does this reflect a majority experience or only those who chose to stay and complete it?



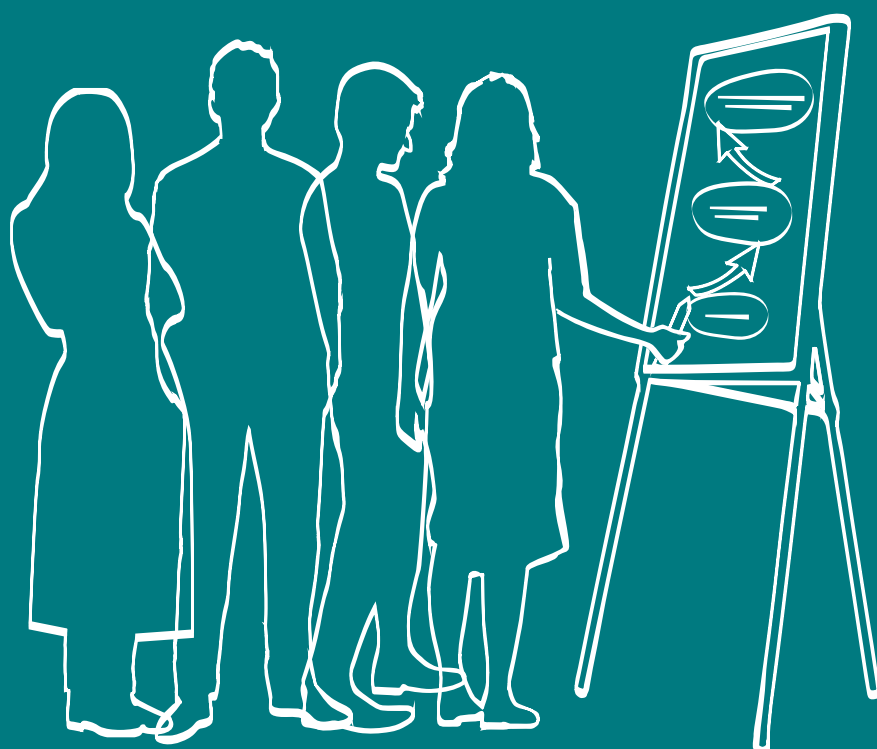
Implementations

Poor follow up of participants, as well as missing implementation information (such as participant attendance rates or whether the intervention was delivered as intended) made it difficult to attribute differences in effectiveness only to intervention design.

Broader contextual influences: Contextual factors, such as the political and legal environment of the host community, level of discrimination experienced by refugees, etc., can influence the effectiveness of MHPSS interventions. While some reports included interesting information about the local situation, details were often specific to the focus of the study rather than information that could be categorized or compared across studies. There is a tension between standardizing reporting to enable learning across interventions and settings or maintaining flexibility to better reflect specific local conditions. Unresolved questions as to how best to integrate contextual factors in assessing program effectiveness that require further discussion are:⁸ Is context reporting something that can – or should – be standardized, and to what extent? To what extent are context-level indicators meaningful representations of lived experiences?

⁸ / To better understand which contextual factors are most important and generate ideas about how to best incorporate them, the research team hosted a workshop, engaging researchers, practitioners, and policy makers who had worked in the Middle East and North African region to gather further insights on this issue. The workshop report is available from alena.mehlau@giz.de

RECOMMENDATIONS & FUTURE DIRECTIONS



In summary, findings from this review indicate positive perceptions and observations of psychosocial programs, accompanied by promising but more limited quantitative evidence for their effectiveness. Positive findings for outcomes such as psychosocial wellbeing are particularly encouraging, while different trends across subgroups suggest a need for more careful study of what works best, when, and for whom. Results of this project lay a rich groundwork for next steps, recommendations, and future directions in practice, research, and policy to improve the impact of psychosocial interventions for populations affected by forced displacement. Below is a brief summary of these recommendations. A longer Recommendation Brief is available from alena.mehlau@giz.de.

Develop clear theories of change

A clear rationale (i.e., “theory of change”) of how an intervention is thought to work is critical to:

- Guide intervention design
- Link intervention activities to assumptions of potential impact
- Inform subsequent decisions related to both practice and research, such as: who the intervention should be offered to; how the intervention should be delivered; what types of outcomes should be evaluated; what unexpected outcomes could happen; and what components of the intervention can or should be adapted.

Making the theory of change more explicit can help improve consistency across similar types of psychosocial interventions, for example by including similar activities and outcomes, which will in turn make it easier to draw conclusions across interventions. This includes building-in detailed assumptions about timing and order of activities (e.g., if trying to improve both social connectedness and distress, how do these relate to each other? Does the program aim to decrease distress first in order to increase social interaction or increase social interaction in order to decrease distress?).

Theories of Change



1. Connect intervention activities to expected outputs and outcomes
2. Map-out relationships between different pieces of the model
3. Identify critical assumptions that need to be met
(e.g., assuming that living conditions are safe and stable)
5. Can be tested and iteratively refined

Increase focus on the impact of each component or activity of an intervention

Interventions that involve multiple activities or components are in general described and evaluated as a package, even when participants may opt into only a subset of activities. **Identifying the value add of each activity in an intervention could help to make psychosocial interventions shorter, more useful, and potentially less resource intensive. Ultimately, instead of delivering complex psychosocial programs, programs could be reduced to the subset of activities that work best for specific target groups.** Research, then, must be designed to examine and test the theories driving selection of

intervention components, to help improve the intervention and theories of change. When reporting, clearer descriptions of these different components and their rationale will also be helpful for future attempts to compare findings across interventions. For example, by looking at impact by activity rather than by the intervention as a whole, we may find that even in interventions that have many differences, it is the same few activities that are really making the impact.

Link psychosocial outcomes to the theory of change, and improve their measurement

Whereas the most commonly measured outcomes were those focused on indicators of distress, these often fall outside what could reasonably be expected to be impacted by a psychosocial intervention, at least in the short term. More clarity is needed for many studies around issues of **which outcomes are chosen, and why** (e.g., why does it make sense to assess post-traumatic stress symptoms for a particular intervention? How is the intervention meant to improve these symptoms?), **priority outcomes** (studies often evaluate many different outcomes; where do we definitely want to or expect to see change and what outcomes are being measured more on an exploratory basis?), and timing (which outcomes are thought to be impacted first and which later?).



Selecting Outcomes

More clarity is needed around issues of: which outcomes are chosen, and why; which are primary or priority outcomes vs. exploratory outcomes; and anticipated timing of expected outcomes.

Moreover, the predominant use of distress measures is likely reinforced by their longer history of use in the field, resulting in better tested, more extensively validated measures, with less consensus about how best to conceptualize and consistently measure indicators of outcomes such as coping, subjective wellbeing, social connectedness, family processes, etc. **A clear priority for future research is to address measurement challenges and produce valid, consensus-based, user-friendly tools and approaches to measuring a more diverse range of outcomes.**

Increase practice and research focus on subgroup needs and experiences

In practice, more attention is needed to develop and tailor interventions to meet the specific needs of subgroups, such as boys and men who are less often the targeted focus of interventions and for whom existing interventions may work less well, older vs. younger children who may have different problems and needs, and other under-represented groups such as the elderly and those with disabilities. Likewise, more work is needed to understand how to better tailor interventions for those experiencing higher levels of distress or unique support needs, as there seems to be a risk that by trying to offer an intervention to too broad a range of people without considering subgroup needs could reduce impact or even cause harm. Tailoring, however, should be balanced against being overly specific, requiring a novel intervention for each specific group in a way that may drain resources and increase

identification. For example, one of the benefits of a more broadly applicable approach that does not require screening for distress is that it can be offered to a large group while avoiding the potential for stigma; might there be ways to maintain a combined group with differing levels of need while still tailoring to the individual needs of participants? As discussed above, increased use of measures that assess other psychosocial indicators beyond distress may also assist with screening while minimizing stigma. To support practical progress in this area, **more research is needed that explicitly explores differences in these subgroup needs and experiences from both a quantitative and qualitative approach.**



Subgroups

It is important to understand and explore not only where differences in impacts by subgroups are found, but why, in order to improve intervention design and implementation.

Balance the momentum toward a minimum service package with locally/contextually rooted interventions

There is substantial interest and momentum toward the development of a minimum MHPSS service package for humanitarian settings. This could be of great value in terms of standardizing activities, methods, and tools to deliver and evaluate interventions. Coming to consensus on a minimum set of activities would enable progress toward the development of standard theories of change and evaluation frameworks to begin comparing “like” approaches across different target groups, contexts, and implementation strategies, which would help to address many of the knowledge and practice gaps highlighted in the review. However, even with a standard package, substantial adaptations will always be needed to ensure appropriate fit to a specific context and/or target group. This is especially true given the challenges and complexities associated with operating in crisis contexts such as: access and feasibility, protection and safety and security; cultural needs, etc. Accordingly, the development of a minimum service package must be carried out with extensive stakeholder consultation and be accompanied by clear guidance on what and how to adapt programs to local circumstances. There is also the risk that “ownership” of the minimum service package, and thus influence on what is included, is dominated by large international organizations or donors without sufficient representation from local communities. A robust psychosocial support response must recognize that such a package really is the minimum; to be enriched and complemented by locally developed, community-based interventions.

Integrate psychosocial interventions into basic humanitarian programming, and measure psychosocial impacts of basic programming

Even though basic PSS are certainly thought to have an impact on wellbeing, psychosocial aspects of these programs are often not clearly described, nor were psychosocial outcomes commonly measured in the included programs. In addition, most humanitar-

ian aid practitioners still lack basic understanding on what MHPSS is and how it should be integrated and prioritized. Support for better attention to integration of psychosocial considerations in general humanitarian programming and the various clusters is needed.

Whenever possible, include a comparison condition in research and evaluation – even if that means getting creative!

Discrepancies between largely positive subjective perceptions of psychosocial interventions and weaker quantitative/numeric findings for their effectiveness suggest that identified changes may not always be a result of the intervention itself. For example, changes could be due to typical recovery/improvement over time, or changes in other aspects of life, such as increased support or improved circumstances outside of the intervention. To know for sure, it is necessary to have comparison conditions (e.g., comparing a group of people receiving the intervention to a similar group not receiving it) whenever possible. This is especially important in complex or rapidly changing situations such as humanitarian settings because changes in crisis context can also have an impact on mental health and wellbeing (making it hard to isolate results of interventions). Some interventions lend themselves more readily to the traditional comparison designs, whereas particularly with regard to the less clinical, “low threshold” interventions (e.g., integrated MHPSS, psychological first aid, etc.), it can be very difficult or even unethical to assign people to comparison conditions. For example, assigning people to a condition that withholds supports otherwise available and thought to be helpful is not ethical. **These challenges highlight the need not only to increase use of comparison conditions when feasible, but also to think creatively about alternative ways to evaluate interventions when randomly assigning participants to different groups is not an option.** Where comparisons are not feasible, it may be even more critical to ensure very high participant follow-up including follow-up of people who drop out of the intervention, and to pursue rich qualitative exploration of quantitative study findings from a range of perspectives.

Getting Creative with Comparisons



- Offer more vs. less intensive supports
- Compare groups across areas where an intervention is and is not [yet] available, with purposeful selection or matching to make the groups look similar in other key characteristics
- Giving different groups of people different parts of an intervention, or in a different order
- Comparing groups in which everyone receives the intervention, but other aspects are changed such as how it is delivered, or by whom, or with different session frequency
- Deliver the intervention in sections with break periods in between, and look at changes during active participation vs during break periods

Intentionally explore unanticipated and negative intervention impacts

It is critical that future reports and evaluations improve on the exploration and reporting of all unanticipated and potentially negative impacts, both to avoid doing harm and to help improve interventions and iteratively revise theories of change. To address this gap, both qualitative and quantitative research is needed. At the intervention design phase qualitative research that specifically seeks to explore, through clear questioning, all positive and negative changes experienced during the intervention period and the extent to which participants attribute these to the intervention itself would be useful. At the testing phase, plausible intervention impacts must be clearly specified in advance and measured accordingly, with additional hypothetical or exploratory impacts separately noted and measured. Post-intervention debriefing that presents unanticipated findings back to stakeholders to help understand the potential causes is also critical.



Negative Impacts

It is critical that future evaluations improve on the exploration and reporting of all unanticipated and potentially negative impacts, both to avoid doing harm and also to help improve interventions and iteratively revise theories of change.

Standardize reporting of key study features

While there will remain tension in the field about what and how much intervention delivery, research, and reporting can or should be standardized, a substantial contribution would be the generation of consensus-based guidance around these questions. Great progress has been made toward a common framework to monitoring and evaluation.⁹ Additional consensus guidance is needed for factors such as what and how to report population characteristics, displacement experiences, intervention and delivery characteristics, implementation factors, and broader contextual influences. Such standardized reporting for even a small collection of shared features across studies would make it more feasible in the future to combine data from multiple studies to learn more about individual differences in experiences. It would also be useful for creating databases that focus on specific intervention activities. Where standard approaches to reporting key study features cannot be identified or agreed upon, guidance



Standard Reporting

Great progress has been made toward a common framework to monitoring and evaluation. Additional consensus guidance is needed for factors such as what and how to report population characteristics, displacement experiences, intervention and delivery characteristics, implementation factors, and broader contextual influences.

⁹ / Inter-Agency Standing Committee. (2017). *Mental Health and Psychosocial Support in Emergency Settings: A common monitoring and evaluation framework*.

on what and how to report features unique to a particular intervention, study, or region would also be helpful; for example, that all interventions delivered through the health system include a description of how the health system operates, whereas this would not be relevant for other interventions. Standardization in reporting need not undermine context-specific reporting but would help to better understand differences.

Increase focus and reporting of implementation factors

There is a strong need for greater focus on implementation strategies and factors, and the extent to which impacts (or lack thereof) may be attributed to intervention components themselves (i.e., the activities just were not helpful) vs implementation factors that influence intervention impact (e.g., the activities *could* be helpful, but were not delivered well). As described above, in the future, implementation features should be included in reporting standards.

Pursue replication of interventions and studies

Many of the included studies were descriptive, feasibility, or pilot studies reporting on early intervention development and initial evaluation. The large number of unique interventions also suggests that organizations are inclined to develop their own interventions, rather than sharing interventions and lessons learned across organizations, which strains already limited resources. With a few exceptions of well-tested interventions, there was a lack of repeat studies across contexts, as well as in most cases a lack of large evaluations of promising interventions. Given the preventive nature of psychosocial programs, one would anticipate many of the effects to be relatively small, which means studies often need to be quite large to be able to measure the change. In many of the included studies, having too few participants may have contributed to lack of clear answers about effectiveness. To address many of the outstanding questions highlighted above, **there is a strong need to advance pilot studies with promising findings to full scale evaluations, and then to replicate these evaluations in different settings and across different types of implementing organizations.**

Coordinate and align funding for psychosocial programming and research

Funding should be used to incentivize programming that reinforces many of the above recommendations to develop better theories, refine and repeat interventions, and improve fit for different groups, with investment for rigorous evaluation of funded programs to further develop the evidence base. This includes:

- Setting more specific and detailed evaluation and reporting requirements tied to programmatic funding, including stating and testing intervention theories, building in comparison conditions and means of exploring unintended outcomes, and requiring standard reporting elements. It should also be ensured that adequate support and capacity is provided to be able to do this.

- Providing funding and support for intervention development, measurement, and methods research.
- Supporting research and intervention delivery capacity in community organizations through authentic, long-term community-academic partnerships.
- Enacting funding cycles that reflect the long-term, iterative nature of intervention development and testing that allow time and flexibility for learning.



Funding Drives Progress

Funding should be used to incentivize programming that reinforces many of the above recommendations to develop better theories, refine and streamline interventions, and improve fit for different groups to optimize impact, with investment for rigorous evaluation of funded programs to further develop the evidence base.

Terms and definitions:

Mental health and psychosocial support (MHPSS): The composite term MHPSS describes all measures designed to preserve and improve psychosocial wellbeing. It emphasises that mental health and psychosocial wellbeing are inter-linked and that psychological dispositions and social circumstances go hand in hand. Psychosocial support refers to all measures, actions and processes that promote the holistic psychosocial wellbeing of individuals in their social world and help people deal with psychological problems and related social conflicts and stresses. It includes support provided by various support systems, for example social workers, teachers, psychosocial counsellors, family and community. Mental health care is a highly specialised form of psychosocial support for people with clinically relevant mental health conditions (such as depression, schizophrenia, anxiety disorder etc.), which is delivered by psychotherapists or psychiatrists.

Psychosocial distress broadly refers to a (short or prolonged) unpleasant experience of an emotional, psychological, social, or spiritual nature that gets in the way of daily life, personal growth and constructive relations with others and that interferes with the ability to cope with the events causing the distress. It encompasses a continuum, from common feelings of vulnerability, sadness, and fears to severe distress, traumatisation and mental health conditions like anxiety disorder or major depression.

Empowerment in MHPSS refers to all activities and approaches that encourage and support individuals to (re-)discover their own strength and to regain their autonomy, feeling of control, and dignity. Empowerment also looks at (re-) building interpersonal relationships that enable mutual support and at creating new goals and life plans by activating existing resources (personal skills, positive world-views, social networks etc.).

Stabilisation in MHPSS refers to all measures taken to support individuals in shock or acute severe psychosocial distress in calming down and moving past the prevailing emergency mind-set. This includes making them feel safe, giving them orientation and helping them to regulate their physiological reaction.

List of abbreviations and acronyms:

BMZ	German Federal Ministry for Economic Cooperation and Development
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
IASC	Inter-Agency Standing Committee
IDPs	Internally Displaced Persons
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex +
MENA	Middle East and North Africa
MHPSS	Mental Health and Psychosocial Support
OPT	Occupied Palestinian Territories
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

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