SYSTEMATIC REVIEW
Humanitarian Evidence Programme

MARCH 2017

EXECUTIVE SUMMARY

THE IMPACT OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT PROGRAMMES FOR POPULATIONS AFFECTED BY HUMANITARIAN EMERGENCIES

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About this executive summary

This is the executive summary of an independent systematic review commissioned by the Humanitarian Evidence Programme – a partnership between Oxfam GB and the Feinstein International Center at the Friedman School of Nutrition Science and Policy, Tufts University. It was funded by the UK government through the Humanitarian Innovation and Evidence Programme at the Department for International Development. The views and opinions expressed herein are those of the authors and do not necessarily represent those of Oxfam, Feinstein or the UK government.

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The initial database search was conducted in October–November 2015 as part of the protocol/scoping exercise, and website searches, hand searching and citation checking were completed by June 2016.

The full version of the systematic review, which forms part of a series covering child protection, market support, mental health, nutrition, pastoralist livelihoods, shelter, urban contexts, and water, sanitation and hygiene, can be accessed from:

- https://www.gov.uk/dfid-research-outputs
- http://fic.tufts.edu/research-item/the-humanitarian-evidence-program/
- http://policy-practice.oxfam.org.uk/our-work/humanitarian/humanitarian-evidence-programme.

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Photo credit

Rebuilding lives and hope in Pakistan, a year on from the floods. Vicki Francis/DFID.

0 EXECUTIVE SUMMARY

The systematic review *The impact of mental health and psychosocial support interventions on people affected by humanitarian emergencies* draws together primary research on mental health and psychosocial support (MHPSS) programmes for people affected by humanitarian crises in low- and middle-income countries (LMICs). It investigates both the process of implementing MHPSS programmes and their receipt by affected populations, as well as assessing their intended and unintended effects. The review was commissioned by the Humanitarian Evidence Programme and carried out by a team from the EPPI-Centre, University College London (UCL).[a]

What are 'mental health and psychosocial support programmes'?

Humanitarian emergencies can impact the mental health and psychosocial well-being of local populations. MHPSS programmes are one way of seeking to reduce negative impacts and provide assistance to affected populations. MHPSS interventions may vary regarding the extent to which they develop contextually unique programmes. We broadly define MHPSS in this review as interventions 'to protect or promote psychosocial well-being and/or prevent or treat mental disorder' (IASC, 2007: 11)

We asked the following research questions:

1. What are the barriers to, and facilitators of, implementing and receiving MHPSS interventions delivered to populations affected by humanitarian emergencies?
2. What are the effects of MHPSS interventions delivered to populations affected by humanitarian emergencies?
3. What are the key features of effective MHPSS interventions and how can they be successfully developed and implemented?
4. What are the gaps in research evidence for supporting delivery and achieving the intended outcomes of MHPSS interventions?

To address the research questions, we:

- conducted comprehensive searches of electronic databases and websites, and contacted experts in the field (the initial database search was conducted in October–November 2015 and website searches, hand searching and citation checking were completed by June 2016)
- included studies reporting on the implementation or receipt of MHPSS programmes and outcome evaluations of MHPSS interventions carried out in LMICs, published in English from 1980 onwards
- coded and described key characteristics of process and outcome evaluations
- synthesized the evidence to answer the review questions (questions 1–3)
- identified gaps in the existing research base (question 4).

0.1 WHAT ARE THE BARRIERS TO, AND FACILITATORS OF, IMPLEMENTING AND RECEIVING MHPSS INTERVENTIONS DELIVERED TO POPULATIONS AFFECTED BY HUMANITARIAN EMERGENCIES?

Studies evaluating the delivery and receipt of MHPSS programmes were highly contextual. Mapping programmes against the Inter-Agency Standing Committee's layered system of complementary MHPSS supports (the 'intervention pyramid' – IASC, 2007: 11-12[b]), the evidence base included tier four specialized services in post-conflict settings and immediately after an earthquake and tier three programmes focused on the psychological and social impact of the Rwandan genocide. Meanwhile, programmes primarily targeting

[a] The Humanitarian Evidence Programme is a partnership between Oxfam GB and the Feinstein International Center at the Friedman School of Nutrition Science and Policy, Tufts University. It is funded by the United Kingdom (UK) government's Department for International Development (DFID) through the Humanitarian Innovation and Evidence Programme.

[b] IASC (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC.

children were more likely to be delivered at tier two. See Figure 0.1 for more details of all of the different types of programme included in the qualitative synthesis of process evaluations.

Figure 0.1: Characteristics of studies included in the qualitative synthesis of process evaluations

IASC tier	Disaster setting	Intervention
Tier 4: Specialized services	Post-conflict: Civil war	**Primary mental health** and community outreach service for adults and children in Northern Uganda
		Primary mental healthcare: psychiatric hospitals and community mental health services for former child soldiers in Sierra Leone
	Immediate response: Natural disaster	Various models of **specialized MHPSS programmes** for adults affected by the 2010 earthquake in Haiti
Tier 3: Focused, non-specialized support	Post-conflict: Genocide	**Psychosocial trauma recovery programme** for children and care-givers in Rwanda
		Community counselling groups for adult women in Rwanda
		The Healing of Life Wounds programme for adults in Rwanda
Tier 2: Community and family supports	Ongoing conflict	Qaderoon' (We Are Capable) **social skills building programme** for refugee children (11–14 years old) in Palestine
	Post-conflict: Civil war	**Children and war rehabilitation psychological and social programme** for former male child soldiers in Mozambique
		Creative arts project with Mayan women in Guatemala
	Post-natural disaster: Tsunami Earthquakes	**Sri Lanka:** post-tsunami **after-school programme** for students
		Sport and play programme for traumatized children and youth (6–18 years old) after the 2003 earthquake in Iran
		School-based psycho-educational programme for children and parents after the 1999 earthquake in Turkey
Tier 1: Basic services and security	Post-conflict: Civil war	**Village health worker clinic** integrating health delivery with other community development initiatives for the community in Burundi

Key findings from the thematic synthesis of MHPSS programmes

We included 13 process evaluations in the review. Ten studies were judged to be of either high or medium reliability or usefulness,[c] providing an overall sound evidence base. Three studies were of low reliability, two provided medium useful findings, and one was low on both criteria. The summary of key findings from the thematic synthesis is presented in Figure 0.2.

Figure 0.2: Summary of key findings

Themes		No. of studies	Quality	
			Reliability	Usefulness
Theme 1: Engagement with local communities and government agencies	Enable community mobilization and sensitization	n=3	1 high 1 medium 1 low	2 high 1 medium
	Develop effective local community and government partnerships	n=2	1 high 1 medium	1 high 1 medium
	Establish good relationships with parents to support uptake of MHPSS programmes	n=4	1 high 2 low	2 medium 1 low
Theme 2: Sufficient number of trained MHPSS programme providers	Address challenge of recruiting and retaining providers	n=3	1 high 2 low	2 medium 1 low
	Ensure providers are trained to deliver MHPSS programmes	n=4	1 high 3 low	3 medium 1 low
Theme 3: Experience of programme activities	Increase meaningful and enjoyable engagement of programme activities	n=3	2 high 1 medium	2 high 1 medium
	Ensure cultural relevance of activities	n=2	2 medium	2 high
Theme 4: Benefits of group-based programmes	Provide a group-based resource and source of support	n=4	2 high 2 medium	3 high 1 medium
	Provide a safe space to tell stories	n=2	2 medium	2 high
Theme 5: Quality and nature of relationships with programme providers	Build trusting and supportive relationships	n=2	2 medium	2 high
	Develop personal qualities so providers can act as role models	n=3	3 medium	3 high

[c] Reliability was judged according to whether steps had been taken to increase rigour in methods of sampling and data collection/analysis and the extent to which the study findings were grounded in the data. Usefulness was judged according to whether the study privileged the perspectives of participants and on the breadth and depth of findings to answer the review question.

Theme 1: Community engagement was a key mechanism to support the successful implementation and uptake of MHPSS programmes in humanitarian settings. For example, mental health sensitization and mobilization strategies and the need to develop effective partnerships with local communities, government and non-governmental organizations (NGOs) were seen as pivotal in increasing programme accessibility and reach. Establishing good relationships with parents may also be important when there is a need to communicate the value of children and young people (CYP) participating in MHPSS programmes.

Theme 2: Sufficient numbers of trained MHPSS providers were essential in ensuring that a range of MHPSS programmes were delivered as planned; however, this could be challenging in resource-limited settings where there can be a lack of incentives to work in the mental health sector.

Theme 3: Experience of programme activities from the perspectives of recipients suggests that MHPSS programmes need to be socially and culturally meaningful to local populations to ensure that they are appealing and to enhance their ability to achieve their intended aims.

Theme 4: Benefits of group-based programmes included providing an opportunity to connect with people from similar circumstances and backgrounds and to share stories, helping to promote greater social cohesion and reducing social isolation.

Theme 5: Building trusting and supporting relationships was important to recipients and helped to maximize their engagement and increase the impact of programmes. Providers who could relate by bridging differences, being nurturing and acting as role models were highly valued.

0.2 WHAT ARE THE EFFECTS OF MHPSS INTERVENTIONS DELIVERED TO POPULATIONS AFFECTED BY HUMANITARIAN EMERGENCIES?

0.2a Overview of MHPSS programmes for children and young people (CYP)

Trial evaluations for CYP were likely to use cognitive behavioural techniques or to employ other psychotherapy modalities such as narrative exposure or interpersonal grief-focused therapy. Interventions were delivered primarily in whole-classroom or other school-based settings, for a maximum duration of three months.

Figure 0.3: Overview of MHPSS programmes delivered to children and young people

Type of programme: • Psychotherapy: cognitive behavioural therapy (CBT, n=13) • Narrative Exposure Therapy (NET, n=5) • Other psychotherapy modalities (n=5) • Psychosocial programmes (n=6)
Population: Mostly mixed. Three studies also evaluated gender-specific MHPSS programmes.
Format: Delivered in group formats and implemented in school/classroom settings.
Length/intensity: Between four and 15 sessions, for one or two hours, for a period of 1–3 months.

Key findings on the effectiveness of MHPSS programmes for CYP

We included 26 randomized controlled trial (RCT) studies (eight low, 13 medium and five high risk of bias studies) in the in-depth review and quantitative analysis. The findings from the synthesis were as follows:

Strong evidence

- **MHPSS** programmes are effective in reducing functional impairment but have little or no impact on anxiety.

Moderate evidence

- **MHPSS** programmes probably slightly reduce symptoms of post-traumatic stress disorder (PTSD), psychological distress and conduct problems.
- **MHPSS** programmes may have no impact on depression or prosocial behaviours.
- **Trauma-focused cognitive behavioural therapy** (TF-CBT) programmes are effective in reducing PTSD symptoms, conduct problems and emotional problems.
- **Classroom/school-based intervention** (CBI-CBT) programmes may have little or no impact on anxiety.
- **Narrative Exposure Therapy (NET)** can improve symptoms of functional impairment.
- **NET** probably has little impact on PTSD symptoms.
- **Psychosocial interventions** may lead to an increased level of depression symptoms and may slightly decrease prosocial behaviours.
- **Psychosocial interventions** probably make no improvement to functional impairment.

Limited evidence

- **MHPSS** programmes may reduce emotional problems, slightly reduce somatic complaints and marginally increase hope.
- **MHPSS** programmes may slightly decrease social support perceived by CYP.
- **TF-CBT** programmes may improve prosocial behaviours.
- **CBI-CBT** programmes appear to be effective in reducing depression, functional impairment and psychological distress and in slightly improving hope, but might have little or no impact on PTSD symptoms, conduct problems or prosocial behaviours.
- **NET** may have a negative impact on depression, or may slightly increase anxiety and somatic complaints, and probably has little impact on school performance.
- **Psychosocial interventions** may reduce PTSD symptoms, emotional problems and conduct problems.

Narrative synthesis suggests that:

- **CBT** may have no impact on social support (two medium risk of bias studies).
- **NET** (one low risk of bias study) may have a negative trend on anxiety and somatic complaints, and no impact on school performance.
- **Psychotherapy programmes show a** positive trend (from four studies, one medium and three high risk of bias: mind and body skills group, counselling and a school-based trauma-grief intervention) in reducing PTSD symptoms.
- **Psychosocial interventions** may improve social support (low risk of bias study) and have no impact on psychological distress (low risk of bias study).
- **Psychosocial interventions** may increase anxiety symptoms (low risk of bias study).

Figure 0.4: Summary of findings of the impact of MHPSS programmes on CYP

Impact of MHPSS	Pooled effect size; or stated otherwise	Size and quality of evidence and consistency (n = number of participants)	Overall strength of evidence
1. Impact of all MHPSS programmes			
1. PTSD	-0.46 (-0.69, -0.24)	21 studies; n=3,615; 16 high- or medium-quality studies; inconsistent	**Moderate**
2. Depression	-0.06 (-0.27, 0.14)	14 studies; n=3,516; 10 high- or medium-quality studies; inconsistent	**Moderate**
3. Conduct problems	-0.45 (-0.81, -0.09)	8 studies; n=1,918; 7 high- or medium-quality studies; inconsistent	**Moderate**
4. Functional impairment	-0.24 (-0.39, -0.09)	8 studies; n=1,574; 7 high- or medium-quality studies; consistent	**Strong**
5. Prosocial behaviours	0.09 (-0.16, 0.34)	8 studies; n=1,997; 7 high- or medium-quality studies; inconsistent	**Moderate**
6. Psychological distress	-0.24 (-0.52, 0.03)	8 studies; n=1,908; 6 high- or medium-quality studies; inconsistent	**Moderate**
7. Anxiety	0.02 (-0.11, 0.14)	6 studies; n=1,886; 5 high- or medium-quality studies; consistent	**Strong**
8. Emotional problems	-1.02 (-1.5, -0.53)	5 studies; n=955; 4 high- or medium-quality studies; inconsistent	**Limited**
9. Hope	0.45 (0.19, 0.71)	5 studies; n=1,703; 3 high- or medium-quality studies; inconsistent	**Limited**
10. Social support	-0.41 (-0.88, 0.07)	2 studies n=416; 2 high- or medium-quality studies; inconsistent	**Limited**
11. Somatic complaints	-0.36 (-1.27, 0.55)	2 studies; n=197; 1 high-quality study	**Limited**
Coping, grief, suicide, guilt, stigmatization, resilience	**Insufficient**		
2. Impact of cognitive behavioural therapy (CBT)			
2.1 Impact of trauma-focused CBT (TF-CBT)			
1. PTSD	-2.21 (-2.7, -1.72)	3 studies; n=152; 3 high- or medium-quality studies; consistent	**Moderate**
2. Conduct problems	-1.2 (-1.58, -0.81)	3 studies; n=152; 3 high- or medium-quality studies; consistent	**Moderate**
3. Prosocial behaviours	0.63 (-0.55, 1.82)	3 studies; n=152; 3 high- or medium-quality studies; inconsistent	**Limited**
4. Emotional problems	-1.76 (-2.3, -1.22)	3 studies; n=152; 3 high- or medium-quality studies; consistent	**Moderate**
Psychological distress	**Insufficient**		
2.2 Impact of classroom/school-based intervention CBT (CBI-CBT)			
1. PTSD	-0.198 (-0.50, 0.11)	6 studies; n=2,102; 4 high- or medium-quality studies; inconsistent	**Limited**
2. Depression	-0.26 (-0.45, -0.07)	6 studies; n=2,102; 4 high- or medium-quality studies; inconsistent	**Limited**
3. Functional impairment	-0.27 (-0.47, -0.08)	5 studies; n=1,458; 4 medium-quality studies; inconsistent	**Limited**
4. Hope	0.45 (0.19, 0.71)	5 studies; n=1,703; 3 medium-quality studies; inconsistent	**Limited**
5. Conduct problems	-0.17 (-0.61, 0.28)	4 studies; n=1,607; 3 medium-quality studies; inconsistent	**Limited**
6. Anxiety	-0.04 (-0.15, 0.07)	4 studies; n=1,607; 3 medium-quality studies; consistent	**Moderate**
7. Prosocial behaviours	0.08 (-0.16, 0.31)	3 studies; n=1,204; 2 medium-quality studies; inconsistent	**Limited**
8. Psychological distress	-0.24 (-0.51, 0.04)	3 studies; n=1,204; 2 medium-quality studies; inconsistent	**Limited**

Impact of MHPSS	Pooled effect size; or stated otherwise	Size and quality of evidence and consistency (n = number of participants)	Overall strength of evidence
Coping, social support, somatic complaints, emotional problems	Insufficient		
2.3 Impact of Teaching Recovery Techniques CBT (TRT-CBT)			
1. PTSD	-0.35 (-0.74, 0.04)	3 studies; n=558; 2 high- or medium-quality studies; consistent	**Moderate**
Depression, psychological distress, prosocial behaviours, resilience	Insufficient		
3. Impact of Narrative Exposure Therapy (NET)			
1. PTSD	-0.11 (-0.37, 0.15)	4 studies; n=287; 4 high- or medium-quality studies; consistent	**Moderate**
2. Depression	0.66 (-0.54, 1.86)	2 studies; n=209; 2 high- or medium-quality studies; inconsistent	**Limited**
3. Functional impairment	-0.52 (-1.02, -0.03)	2 studies; n=116; 2 high- or medium-quality studies; consistent	**Moderate**
4. Anxiety	Not pooled effect size: 0.20 (-0.15, 0.56)	1 study; n=124; 1 high-quality study	**Limited**
5. Somatic complaints	Not pooled effect size: 0.16 (-0.55, 0.87)	1 study; n=31; 1 high-quality study	**Limited**
6. School performance	No impact on school grade (p<0.19)	1 study; n=47; 1 high-quality study	**Limited**
Grief, guilt, suicide, stigmatization	Insufficient		
4. Impact of psychosocial interventions			
1. PTSD	-0.67 (-1.39, 0.04)	4 studies; n=381; 4 high- and medium-quality studies; Inconsistent	**Limited**
2. Depression	0.27 (0.07, 0.46)	4 studies; n=631; 4 high- and medium-quality studies; consistent	**Moderate**
3. Emotional problems	-0.98 (-2.82, 0.86)	2 studies; n=209; 2 high-quality studies; inconsistent	**Limited**
4. Conduct problems	-0.45 (-1.76, 0.86)	2 studies; n=209; 2 high-quality studies; inconsistent	**Limited**
5. Functional impairment	-0.01 (-0.31, 0.29)	2 studies; n=399; 2 medium-quality studies; consistent	**Moderate**
6. Prosocial behaviours	-0.27 (-0.55, 0.02)	2 studies; n=209; 2 low risk of bias studies; consistent	**Moderate**
7. Anxiety	Trend in favour of the control group	1 study; n=145; 1 high-quality study	**Limited**
8. Psychological distress	No impact	1 study; n=87; 1 high-quality study	**Limited**
9. Physical health	Mixed	2 studies; n=232; 2 high-quality studies	**Limited**
10. Social support	Positive trend in favour of the intervention group compared with the control group	1 study; n=87; 1 high-quality study	**Limited**
Suicide, guilt and stigmatization	Insufficient		

- There is evidence to suggest that programme intensity is associated with the effect of MHPSS programmes for CYP on PTSD. Also, there is evidence that the follow-up period is associated with the effect of MHPSS programmes on depression for CYP.
- We observed no clear pattern from a small number of studies to confirm that characteristics of participants, exposure to traumatic events or family and social supports are factors influencing the impact of MHPSS programmes on CYP.

0.2b Overview of MHPSS programmes for adults

Studies evaluating MHPSS programmes for adults using randomized controlled methods were most likely to involve brief, focused psychotherapies delivered in 1:1 sessions in both clinical and non-clinical settings, for a maximum period of three months.

Figure 0.5: Overview of MHPSS programmes for adults

Type of programme: • Psychotherapy: (CBT, n=6) • Narrative Exposure Therapy: (NET, n=7) • Other psychotherapy modalities: (n=9)
Population: Mostly mixed, with fewer than one-fifth of the studies evaluating MHPSS designed for women; one included men only.
Format: Delivered in individual formats in clinics, refugee camps and community/home settings.
Length/intensity: On average programmes lasted 4–13 sessions, for one or two hours in each session, and delivered over a period of two weeks to three months.

Results on the effectiveness of MHPSS programmes for adults

The findings from 20 RCTs (eight low, two medium and 10 high risk of bias studies) were included in the quantitative synthesis. The findings from the synthesis were as follows:

Moderate evidence

- **MHPSS programmes** probably reduce PTSD, depression, anger and self-reported sexual violence.
- **MHPSS programmes** may have no impact on social support.
- **NET** is effective in reducing depression and anxiety symptoms.
- **NET** may have little or no impact on social support.

Limited evidence

- **MHPSS** programmes may lead to improvements in symptoms of anxiety, common mental health problems and fear/avoidance. In addition, MHPSS programmes may slightly reduce grief and emotional problems.
- **CBT** is effective in reducing PTSD and depression, and may slightly reduce grief.
- **NET** may also reduce PTSD and common mental health problems, and may slightly improve coping.
- **NET** may slightly increase emotional problems.

Findings for the narrative synthesis suggest:

- a positive trend in favour of **other psychotherapy interventions** in reducing PTSD symptoms (eye movement desensitization and reprocessing (EMDR) and interpersonal psychotherapy (IPT)); depression (EMDR, counselling, IPT, Thought Field Therapy (TFT)); anger (TFT and IPT); anxiety symptoms (TFT and IPT); fear and avoidance (TFT); partner violence (IPT); and common mental health problems (counselling).

Figure 0.6: Summary of findings on MHPSS programmes for adults

Impact of MHPSS	Pooled effect size; (95% CI); or stated otherwise	Size and quality of evidence and consistency (n = number of participants)	Overall strength of evidence
1. Impact of all MHPSS programmes			
1. PTSD	-0.75 (-0.997, -0.5)	7 studies; n=1,924; 8 medium- or high-quality studies; inconsistent	**Moderate**
2. Depression	-1.18 (-1.65, -0.71)	12 studies; n=841; 6 medium- or high-quality studies; inconsistent	**Moderate**
3. Anxiety	-1.41 (-2.21, -0.61)	6 studies; n=630; 3 high-quality studies; inconsistent	**Limited**
5. Emotional problems	-0.25 (-0.796, 0.29)	5 studies; n=653; 3 high-quality studies; inconsistent	**Limited**
6. Common mental health problems	-0.88 (-1.45, -0.30)	5 studies; n=420; 3 high-quality studies; inconsistent	**Limited**
7. Fear and avoidance	-0.73 (-1.01, -0.45)	4 studies n=254; 1 high-quality study	**Limited**
8. Anger	-0.80 (-1.13, -0.47)	3 studies; n=197; 2 medium-quality studies; consistent	**Moderate**
9. Social support	0.08 (-0.49, 0.64)	2 studies; n=52; 2 high-quality studies; consistent	**Moderate**
10. Partner violence	0.44 (-0.97, 0.09)	2 studies; n=71; 2 medium-quality studies; consistent	**Moderate**
11. Grief	-0.23 (-0.63, 0.16)	2 studies; n=147; 1 high-quality study	**Limited**
Functional impairment, conduct problems and somatic complaints	**Insufficient**		
2. Impact of CBT			
1. PTSD	-0.74 (-1.04, -0.43)	6 studies; n=989; 1 high-quality study; inconsistent	**Limited**
2. Depression	-0.54 (-1.07, -0.01)	4 studies; n=465; 1 high-quality study; inconsistent	**Limited**
3. Grief	-0.23 (-0.63, 0.16);	2 studies; n=147; 1 high-quality study; consistent	**Limited**
Functional impairment, fear and avoidance, emotional problems, anxiety, conduct problems, common mental health problems	**Insufficient**		
3. Impact of NET			
1. PTSD	-1.24 (-1.99, -0.489)	7 studies; n=596; 4 high-quality studies; inconsistent	**Limited**
2. Depression	-1.19 (-1.72, -0.66)	3 studies; n=70; 2 high-quality studies; consistent	**Moderate**
3. Common mental health problems	-1.27 (-2.31, -0.23)	4 studies; n=301; 3 high-quality studies; inconsistent	**Moderate**
4. Anxiety	-1.31 (-1.94, -0.68)	2 studies; n=52; two high-quality studies; consistent	**Moderate**
5. Social support	0.08 (-0.49, 0.64)	2 studies; n=52; two high-quality studies; consistent	**Moderate**
6. Coping	0.31 (-0.53, 1.16)	1 study; n=22; 1 high-quality study	**Limited**
7. Emotional problems	0.48 (-0.32, 1.28)	1 study; n=4; 1 high-quality study	**Limited**
Somatic complaints	**Insufficient**		

0.3 WHAT ARE THE KEY FEATURES OF EFFECTIVE MHPSS INTERVENTIONS AND HOW CAN THEY BE SUCCESSFULLY DEVELOPED AND IMPLEMENTED?

To address the review question, we brought together the six hypotheses generated from the synthesis of process evaluations (Question 1) and outcome evaluations (Question 2). We ran a meta-regression for two key outcomes (PTSD and depression) and subsequently we explored any gaps in the analysis. Each hypothesis thus showed that programmes may be more effective if they address the following implementation issues.

Hypothesis 1: Community engagement – steps are taken to engage with the community and/or family members

- Thirteen programmes for CYP and three for adults engaged with the community as part of programme delivery.
- Findings from the meta-regression found no significant association for PTSD or depression for either population group.

Hypothesis 2: Government partnership – programmes are delivered in partnership with governments and/or local agencies

- The MHPSS programmes in nine RCTs cited brief examples of informal government involvement; four of these programmes were delivered to children and five to adults.
- As with Hypothesis 1, no significant association for PTSD or depression was found for either CYP or adults.

Hypothesis 3: Trained providers – the challenge of recruiting and retaining trained providers is overcome

- MHPSS programmes were delivered by trained providers in 26 cases for children and 19 for adults.
- No significant association in reducing PTSD or depression was found for adults. However, a significant association was found between having trained providers and the effect of PTSD in programmes for CYP ($p=0.026$).
- Further explorative examination of statistically successful MHPSS programmes in reducing PTSD in CYP supported this association, revealing that (with the exception of one) all MHPSS programmes effective in reducing PTSD were delivered by trained providers.
- For depression, all successful MHPSS programmes that reported a significant impact of MHPSS in reducing depression were delivered by trained providers.

Hypothesis 4: Socially and culturally meaningful MHPSS – programme activities are socially and/or culturally meaningful

- Seventeen MHPSS programmes for CYP and 11 for adults aimed to be socially and culturally meaningful.
- We found a significant association with this aspect of programming for MHPSS programmes for CYP in depression only ($p=0.031$). This finding was supported by explorative analysis of successful MHPSS programmes for CYP, finding that all MHPSS programmes that reported a significant impact in reducing depression were adapted to be sensitive to local cultures and social contexts.
- Two studies that did not clearly report if MHPSS programmes for children had been adapted to local contexts showed a significant unintended effect of MHPSS on depression.
- No further statistical associations were found for PTSD in CYP or for either outcome in adults.

Hypothesis 5: Group-based programmes – opportunities are provided for people to interact as a group

- Twenty-six programmes delivered to CYP were group-based, while only three programmes were delivered in a group format to adults.
- Despite positive appraisal of the group experience in process evaluations, no significant association for PTSD or depression was found.

Hypothesis 6: Establish good relationships – programme providers build trusting and supportive relationships with programme recipients

- Establishing trusting and supportive relationships between programme providers and recipients was addressed in 11 programmes delivered to children compared with two for adults.
- For adults, no significant association was found for PTSD or depression.
- For children, a significant association was found for PTSD (p=0.003), but not for depression. Exploration of MHPSS programmes successful in reducing PTSD and depression in CYP also revealed a non-statistical negative trend across four studies that did not emphasize the importance of establishing relationships between programmes providers and recipients.

0.4 WHAT ARE THE GAPS IN RESEARCH EVIDENCE FOR SUPPORTING DELIVERY AND ACHIEVING THE INTENDED OUTCOMES OF MHPSS INTERVENTIONS?

Overall, there is a rapidly growing evidence base evaluating a broad range of MHPSS programmes for children and adults in LMICs. By comparing the hypotheses emerging from the process evaluation synthesis of providers' and participants' views against the trials evaluating MHPSS programmes (Question 3), and exploring the extent to which the trials addressed these hypotheses, a number of gaps become apparent.

For example:

- Very few of the trials evaluating adult MHPSS programmes sought to mobilize or sensitize local communities about the impact of humanitarian crises on MHPSS.
- The need to work in collaboration with government and local NGOs was either met (and not reported) or did not appear to be a barrier to implementation.
- Many programmes targeting children decided to extend their reach by delivering to groups and providing opportunities for peer support, but this was not apparent in programmes for adults.
- Although providing a significant association in the meta-regression, another gap was the extent to which programmes took steps to build supportive relationships with recipients – a phenomenon that was present, but thinly reported, across all trials.

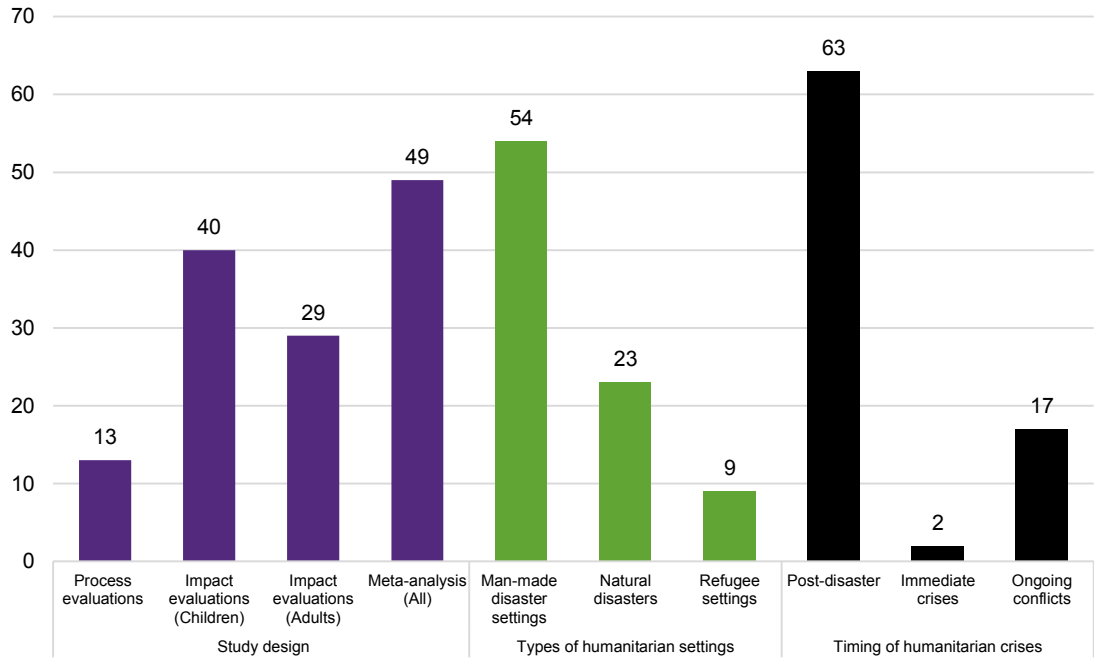
In addition, within this evidence base there are some notable gaps. Firstly, there is a tendency to focus on post-conflict settings, with far fewer studies conducted in the context of natural disasters. Secondly, there remains a lack of studies evaluating the impact of MHPSS programmes designed to provide basic services and security (tier one in the IASC pyramid). Thirdly, there also remains a gap in research on cost-effectiveness and long-term follow-up studies exploring the possibilities and implications of implementing MHPSS programmes in resource-constrained settings. In addition, although trials provided some evidence on characteristics of participants that might moderate programme effects, similar insights from people's views were lacking in process evaluations. There is also a lack of evidence on younger (≤10 years old) or ageing populations (≥55), a common finding across social evaluations. Further, despite the relatively high volume of trials, there was limited crossover with the process evaluations. For example, we did not identify any mixed-methods evaluations and very few process evaluations investigating similar types of MHPSS programmes.

Overview of evidence included in the review

Included studies

A total of 82 distinct research studies were included in the review, and 18 additional kin reports of the same study.[d] Of the 82 studies, 13 evaluated the process of implementation or receipt of MHPSS programmes and 69 evaluated the impact of MHPSS programmes either with children (n=40) or with adults (n=29). We included 29 RCTs in the impact synthesis on children and 20 RCTs on adults. The majority of studies were conducted in man-made disaster settings (n=54), such as civil wars, including refugee settings with children and adults. Twenty-three studies were delivered in natural disaster settings. Evaluations were overwhelmingly conducted in post-disaster settings (n=63). Two studies evaluating MHPSS programmes responding to immediate crises were conducted in the context of natural disasters. Programmes delivered during humanitarian emergencies were in ongoing conflict settings (n=17), many of which were in the Middle East (e.g. Egypt, Syria, Palestine).

Figure 0.7: Overview of studies included in the review



Further considerations for developing the evidence base on MHPSS programmes

- Could include generating evidence on: basic services and security programmes, cost-effectiveness, MHPSS programmes in ongoing conflict and natural disaster settings, and gender- and age-specific evaluations.
- Could consider adopting consistent approaches to measuring mental health and psychosocial outcomes across settings. Long-term follow-ups for impact and process evaluations could also be considered and incorporated into study design to inform the sustainability and maintenance of benefits, or to detect harmful consequences.
- Could consider measuring other psychosocial outcomes such as resilience, coping and social support and other mental health presentations such as substance misuse or suicidal ideation.

[d] 'Kin studies' are additional publications of the same study which may report only part or certain aspects of the main study (e.g. a pilot study, preliminary findings and so on).

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