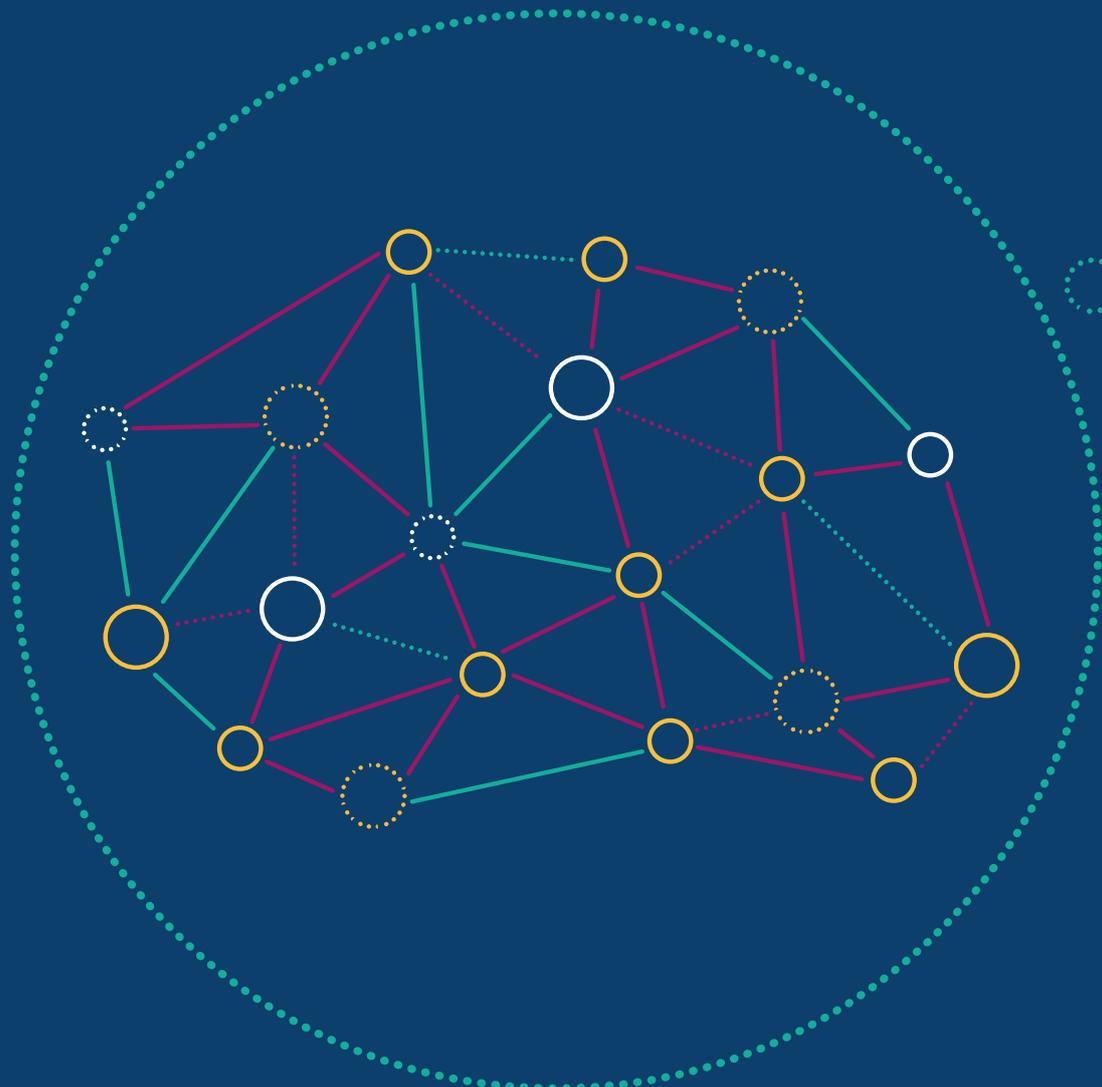




Research for health
in humanitarian crises

| elrha

REVIEW AND ASSESSMENT OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT INTERVENTION RESEARCH IN HUMANITARIAN SETTINGS



ABOUT ELRHA

We are a global charity that finds solutions to complex humanitarian problems through research and innovation. We are an established actor in the humanitarian community, working in partnership with humanitarian organisations, researchers, innovators, and the private sector. We have supported more than 200 world-class research studies and innovation projects, championing new ideas and different approaches to evidence what works in humanitarian response. But it's not just about pinpointing what works. We transform that evidence-based knowledge into practical tools and guidance for humanitarian responders to apply in some of the most difficult situations affecting people and communities, so that those affected by crises get the right help when they need it most.

RESEARCH FOR HEALTH IN HUMANITARIAN CRISES (R2HC)

R2HC aims to improve health outcomes for people affected by humanitarian crises by strengthening the evidence base for public health interventions. Our globally-recognised research programme focuses on maximising the potential for public health research to bring about positive change and transform the effectiveness of humanitarian response. The work we do through the R2HC helps inform decision-making. Since 2013, we have funded more than 60 research studies across a range of public health fields.

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The HIF aims to improve outcomes for people affected by humanitarian crises by identifying, nurturing and sharing more effective and scalable solutions. The HIF is our globally recognised programme leading on the development and testing of innovation in the humanitarian system. Established in 2011, it was the first of its kind: an independent, grant-making programme open to the entire humanitarian community.

Through the HIF, we fund, support and manage innovation at every stage of the innovation process. Our portfolio of funded projects informs a more detailed understanding of what successful innovation looks like, and what it can achieve for the humanitarian community. This work is leading the global conversation on innovation in humanitarian response.

OUR DONORS

Our Research for Health in Humanitarian Crises programme is funded by the Foreign, Commonwealth & Development Office (FCDO), Wellcome, and the UK National Institute for Health Research (NIHR)



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EXECUTIVE SUMMARY

This study conducted by Anthrologica and the MHPSS Collaborative, commissioned by Elrha, reviews mental health and psychosocial support (MHPSS) research generated since 2010. Its purpose is to assess the extent to which new evidence generated through MHPSS research funded in the last 10 years has addressed the identified need for research that provides tangible benefits for MHPSS programming in humanitarian settings.

The scope and aims of mental health and psychosocial interventions targeting people affected by humanitarian emergencies are wide and a review in 2010 identified a disconnect between MHPSS research and practice¹. It recognised the urgency to research commonly used approaches that target the broader MHPSS needs of those affected by humanitarian crises, particularly those that aim to prevent distress and promote wellbeing, including community-based interventions. Subsequent recommendations identified a clear need to generate useful evidence that could be immediately translated to MHPSS programming². Ten years on, this study assesses the evidence that has been generated since the recommendations were made. Specifically, this study examines how the generated evidence has contributed to the public health evidence base, influenced programming and policy in humanitarian settings, and advanced the research agenda.

Approach

1. A review of published MHPSS research since 2010 was conducted to assess its contribution to advances in knowledge in the last 10 years. Studies meeting the inclusion criteria needed to describe the outcomes of testing interventions in humanitarian settings. The evidence was reviewed against the MHPSS priority research areas and questions developed in 2010 by Tol and colleagues.
2. A consultation process was conducted to assess uptake of research evidence using key informant interviews with stakeholders in the MHPSS field, an online survey and then a validation workshop with MHPSS professionals to discuss the overall findings and agree on ways forward to ensure research informs MHPSS programming.
3. Findings from the review and the consultation process were consolidated to identify new directions for MHPSS research and dissemination.

¹Tol, W.A., C. Barbui, A. Galappatti, et al. (2011a). 'Mental Health and Psychosocial Support in Humanitarian Settings: Linking Practice and Research.' *Lancet*: London, England 378 (9802): 1581–91. [https://doi.org/10.1016/S0140-6736\(11\)61094-5](https://doi.org/10.1016/S0140-6736(11)61094-5).

²Tol, W.A., V. Patel, M. Tomlinson, et al. (2011b). 'Research Priorities for Mental Health and Psychosocial Support in Humanitarian Settings.' *PLoS Medicine* 8 (9): e1001096. <https://doi.org/10.1371/journal.pmed.1001096>.

Findings And Future Directions

Advances in knowledge:

- In the last 10 years, the body of relevant MHPSS research has increased significantly. During that time group interventions were most commonly researched, whilst gaps in the published evidence were identified on outcomes for children, whole family interventions and evidence of the effectiveness of family-based interventions.
- The broadening in scope and range of research involved a general shift from focusing on mental health disorders and 'dysfunction' to using more positive outcome measures of mental health and psychosocial wellbeing and to research that gives greater attention to context.
- There was a common mismatch between study outcomes, and the nature of the intervention being tested, such as measuring symptoms of psychological distress and disorder in programmes intended to be preventive and promotive.
- Few published studies examined long-term impacts of the interventions with follow-up data collection.

Uptake:

- Despite some changes in global policy, instrumental change in policies at the level of national governments in countries affected by humanitarian crises were rarely reported.
- MHPSS practitioners were not highly engaged either with global research or research generated in country settings beyond their own; this was particularly so for those based beyond Europe and North America.
- MHPSS implementation research was largely still found to be top-down rather than responsive to needs on the ground.

To ensure that MHPSS research over the next ten years delivers positive impact for MHPSS programmes and policies for people affected by crisis, the MHPSS research community should:

- Support practitioner-researcher collaborations that integrate programming with intervention research in crisis settings, so as to understand and address the social determinants of mental health and psychosocial wellbeing within context.
- Invest in knowledge brokering competencies for researchers. Ensure adequate time for uptake activities on research projects, and for monitoring and evaluation of these activities against specified outcomes, to ensure demonstrable impacts for people and communities. This could enable research that delivers more tangible changes to policy and practice.
- Build knowledge and skills by strengthening platforms and networks that foster learning and collaboration and provide country-level practitioners better access to 'translated' research.
- Ensure flexible/long-term funding for the above to ensure sufficient time for MHPSS approaches to be co-designed, tested in varied crisis contexts, disseminated and translated for uptake, and to build the evidence base to know what works, in which settings and with whom.

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ACRONYMS AND ABBREVIATIONS

CBO	Community Based Organisation
CBT	Cognitive Behaviour Therapy
CETA	Common Elements Treatment Approach
DFID	Department for International Development – now known as the Foreign, Commonwealth & Development Office (FCDO)
DEGRP	DFID–ESRC Growth Research Programme
EASE	Early Adolescent Skills for Emotions
EEPI	Evidence for Policy and Practice Information and Coordinating Centre
ESRC	Economic and Social Research Council
FUSAM	Follow Up of Severely Malnourished Children
GBV	Gender–Based Violence
HIC	High Income Country
HIV	Human Immunodeficiency Virus
IASC	Inter Agency Standing Committee
IFRC	International Federation of Red Cross and Red Crescent Societies
IPV	Intimate Partner Violence
INGO	International Non Governmental Organisation
IPT–G	Group Interpersonal Therapy
JIF	Journal Impact Factor
LIC	Low Income Country
LMIC	Lower Middle Income Country
M&E	Monitoring and Evaluation
mhGAP	Mental Health Global Action Plan
NGO	Non Governmental Organisation
PFA	Psychological First Aid
PM+	Problem Management Plus
PTSD	Post–Traumatic Stress Disorder
STRENGTHS	Scaling Up Psychological Interventions with Syrian Refugees
R2HC	Research for Health in Humanitarian Crises
RCT	Randomised Controlled Trial
REF	Research Excellence Framework
SH+	Self Help Plus
UMIC	Upper Middle Income Country
WHO	World Health Organisation

INTRODUCTION

The Global Humanitarian Overview anticipates that nearly 168 million people will need humanitarian assistance and protection in 2020 (UN OCHA, 2020). The numbers of forcibly displaced people and refugees have reached unprecedented high levels. Being a refugee, displaced person, or someone affected by conflict or a natural disaster impacts negatively on mental health and psychosocial well-being, with evidence of increased psychological distress, social problems and both common and severe mental disorders. It is estimated that more than one in five people in post-conflict settings have depression, anxiety disorder, post-traumatic stress disorder, bipolar disorder, or schizophrenia, and that almost one in ten people in post-conflict settings have a moderate or severe mental disorder at any point in time (Charlson, Ommeren et al. 2019).

The composite term mental health and psychosocial support (MHPSS) is used to describe any type of local or external support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder (United Nations High Commissioner for Refugees 2013). Addressing the mental health and psychosocial wellbeing of communities affected by humanitarian crises is a critical, cross-sectoral component to effective and responsible programming (Meyer and Morand 2015).

The need to understand the impact of MHPSS research on practice

Historically, mental health research focusing on those affected by humanitarian crises has largely concentrated on identifying rates of post-traumatic stress disorder (PTSD) and other common mental disorders. Mental health problems such as severe mental disorders, non-specific forms of psychological distress, and psychosocial problems have been less researched.

The degree of disconnect between mental health and psychosocial support research and practice has been frequently emphasised. In 2010, an interdisciplinary group identified a clear need to generate useful evidence that could be immediately translated to MHPSS programming, and the following year Tol and colleagues further highlighted that most research focused on interventions that were rarely used in practice (Tol, Barbui et al. 2011). They concluded that there was an urgent need to understand approaches that are commonly used in practice and that target the broad MHPSS needs of those affected by humanitarian crises, particularly around preventing distress, and promoting wellbeing. This would require close collaboration between researchers and practitioners, attention to sociocultural context, and amplifying the voice of those directly affected by humanitarian crises.

Review objectives

The objective of this review is to examine the extent to which MHPSS research generated since 2010 has contributed to the public health evidence base and how this has influenced and impacted programming and policy in humanitarian settings. Specifically, using three areas of inquiry, the review sought to identify whether the evidence since 2010 has:

1. Advanced knowledge

Documenting the range and quality of that evidence; how it corresponds to research priorities; whether it has captured innovations in approaches.

2. Achieved uptake

Identifying the knowledge transfer pathways of the evidence; if 'the right people' know about the evidence; if it informed global MHPSS guidelines and strategy; if it informed programmes; if it influenced the policy debate at organisational levels and through coordination mechanisms.

3. Advanced the MHPSS research agenda

Identifying new dimensions emerging from the recent research or gaps that have yet to be addressed.

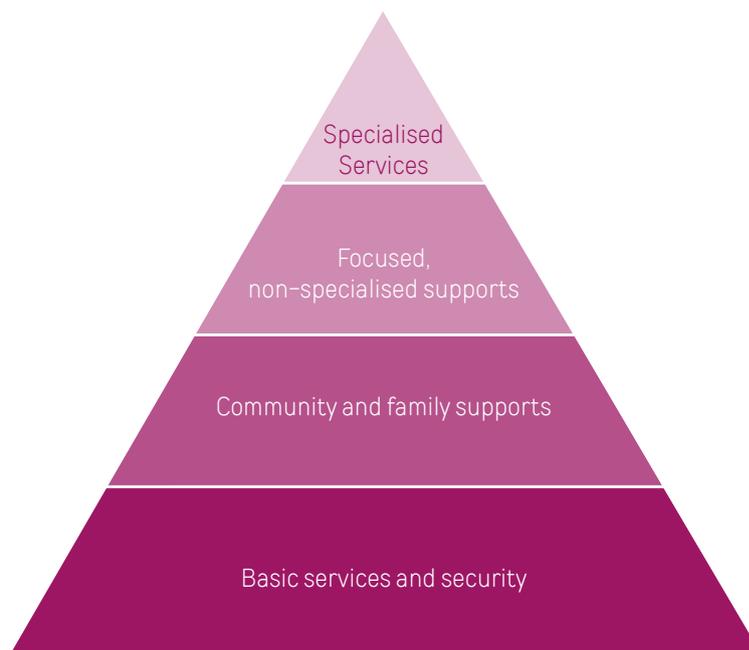
Building on these objectives, the review sought to highlight potential future directions for MHPSS research and recommendations for the MHPSS research community to ensure that research continues to enhance programming and policy that has positive impact on people affected by crisis.

Study framing

The breadth of the scope and aims of MHPSS approaches and interventions targeting communities affected by emergencies can range from embedding social and cultural considerations into basic services at the outset, to providing specialised services for individuals with more complex mental health concerns.

A key to organising MHPSS is to establish a layered system of complementary supports as set out by the Inter-Agency Standing Committee (IASC) as an intervention pyramid (see Figure 1). The IASC pyramid indicates the layers of services and approaches necessary to meet the range of mental health and psychosocial support needs of different groups at every phase of the crisis. The pyramid is referred to throughout this report when determining relevance of the studies included in the review and to map findings and recommendations.

Figure 1: IASC (2007) MHPSS in emergencies intervention pyramid



The consensus-based research agenda and priorities developed by Tol et al. (2011) were also used to frame this review. The areas they identified as priorities for research included: problem analysis, MHPSS interventions and information management, and contextual realities in programme implementation (discussed in more detail in Section 2, see also Table 5). The studies included in this review were assessed in line with those research priorities.

Report structure

Following this introduction, the methodology used for the literature review and primary data collection is described in detail. Sections 1 to 3 present the review's key findings.

Section 1 (published literature) and Section 2 (Elrha studies) describe the evidence generated through MHPSS research focusing on intervention outcomes and the uptake of that research (as per the review's objectives 1 and 2 outlined above).

Section 3 synthesises and consolidates these findings with insight from the consultation (both interviews and an online survey) to shed further light on the extent to which evidence has been taken up in policy, strategy and programming. It also presents the gaps and priorities emerging from the study, as well as potential new directions for MHPSS research (objective 3).

The conclusion of the report presents potential new horizons and recommended ways forward to ensure future research informs MHPSS programming.

METHODOLOGY

The review used mixed methods to identify the facilitating and inhibiting factors for each of the three areas of inquiry, and to understand the broader context in which knowledge is generated and taken up. This was done in three stages:

- i) the review of published literature;
- ii) the review of R2HC-funded MHPSS literature; and
- iii) consultation process.

Ethical approval was granted by the Research Ethics Committee at London School of Economics (Ethics reference: 2090).

i) Literature review

Given the time and resources available, the literature review adopted a structured approach. This approach follows a rigorous process that includes defined study selection and inclusion and exclusion criteria, but does not seek to identify and incorporate every relevant paper or document. Rather, it focuses on the synthesis being thematically comprehensive, with the final synthesis presenting all relevant themes that could have been identified ('conceptual saturation').

The search terms according to study setting, research outcomes and type of intervention are set out in Table 1. The search terms were limited to specific fields: title, abstract and keywords.

Table 1: Search terms

Search concept	Search terms [used alone or in combination]
Setting	Humanitarian; Crisis; War; Conflict; Emergency; Epidemic; Genocide; Earthquake; Flood; Famine; Drought; Tsunami; Terror; Trauma; Violence; Accident; Refugee; Migrant; Displaced; Disaster
Outcomes	Wellbeing; Well-being; Mental health; Stress reduction; Functioning; Hope; Self-efficacy; Resilience; Reconciliation; Social connectedness; Social cohesion; Coping; Distress; Social support
Intervention	Psychosocial support; Psychosocial intervention; Psychological support; Psychological intervention; Mental health support; Mental health intervention; Social support; MHPSS; Psychotherapeutic; Counselling; Socio-therapy; Support groups; Peer support; Community healing dialogues; Communal healing; Psychoeducation; Community support; Family support; Social networks; Self-care; Self care; Self-help; Self help; Safe space; Child friendly space; Psychological First Aid; Psychosocial considerations
Study type	Intervention; trial; programme; pilot

Selection criteria

The review included studies published since 2010 that described the testing, trialling, or evaluation of MHPSS interventions delivered in humanitarian settings, that were not focused on mental health disorders (e.g. PTSD, depression).³ Relevant MHPSS interventions included those integrated into basic humanitarian service provision, activities focused on community and family support, and psychological or social activities considered to be 'interventions', provided in order to achieve MHPSS-related outcomes.

Studies were included of both stand-alone interventions and those integrated into other sectors of a response, such as MHPSS and nutrition; MHPSS and disaster prevention; MHPSS and gender-based violence (GBV) prevention etc. Studies needed to be based in the context of a humanitarian response, where governmental or non-governmental organisations (NGOs) were supporting a country to deal with the immediate impacts, the aftermath, or the consequences of an emergency, including war, conflict, natural disaster, and epidemic. The event had to be referenced in the paper. Studies included those targeting both adults and children.

³Substance use disorder was also not included

With the aim of capturing a broad range of MHPSS intervention evidence generated in this period, studies of both the outcomes of interventions and studies with a focus on participant experiences and perspectives (including from process evaluations⁴) were included. Where a purely quantitative design was used to measure outcomes, including experimental, quasi-experimental and prospective cohort studies, only controlled designs were included. Comparison groups could be those with no intervention, on a waiting list, other active interventions, or usual care. Qualitative and mixed methods studies looking at participant experiences and perspectives (including from process evaluations), were included even where the quantitative component had no pre-test or control group.

Studies that did not meet any of the following criteria were excluded:

- Studies published before 2010
- Non-English language studies
- Studies from non-humanitarian/crisis-affected settings, including HIV and poverty contexts
- Studies from high-income countries (HICs) and upper middle-income countries (UMICs) as defined by www.data.worldbank.org
- Systematic reviews
- Multiple analyses of the same data pool (the most comprehensive study was retained)
- Studies of interventions with no mental health or psychosocial wellbeing target/outcome specified from the outset⁵
- Studies focusing on PTSD and/or other mental health disorders with interventions that stated their primary orientation as being to treat clinical disorders
- Studies in which primary outcome measures were disorder-focused and clinical change was expected through delivery of the intervention

Search and selection process

The following international databases were searched: PsycINFO (peer reviewed), Medline, Web of Science, the Cochrane Library and Google Scholar. The search terms in Table 1 were adapted as appropriate to the syntax of each database (see tables of search terms in [Appendices – available online](#)). When searching academic literature, the bibliographies of relevant studies were reviewed (through ancestor searching and snowballing of sources). The reference lists of recent, relevant systematic reviews that included literature published since 2010 were hand-searched.

The grey literature search included the websites of the 27 organisations and agencies that form the IASC MHPSS in Emergencies Guidelines Taskforce; the Intervention Journal website; and four other specialist research websites (socialprotection.org; MHPSS.net; mhinnovation.net and the Regional Psychosocial Support Initiative). The resource pages of all websites were searched for 'mental health', 'psychological', 'psychosocial'.

Finally, the threads 'humanitarian mental health intervention research' and 'humanitarian psychosocial intervention research' were inputted into a simple Google search, and findings were limited to the first five pages of hits. Sources were imported into a citation management software to facilitate inventory, cross-checking, removal of duplications, and for further screening.

⁴The broad purpose of a process evaluation is to explore aspects of the delivery and implementation process to see how an intervention works. <https://www.gov.uk/government/publications/evaluation-in-health-and-well-being-overview/process-evaluation>.

⁵This included studies focused on staff training / capacity-building / systems strengthening that did not report ultimate outcomes of beneficiary / staff mental health or psychosocial wellbeing.

Quality and risk of bias appraisal

The review aimed to capture a broad landscape of existing evidence, which meant including studies that may be excluded from formal systematic literature reviews. Nevertheless, a quality appraisal process was applied to all pre-selected studies.

The rigour of studies exploring participants experiences and perspectives using qualitative methods was assessed according to the following methodological criterion:

1. sampling;
2. data collection;
3. data analysis;
4. the extent to which the study findings are grounded in the data (reliability criteria 1–4);
5. whether the study privileged the perspectives of participants; and
6. the breadth and depth of findings (usefulness criteria 5–6).

This approach is in line with Bangpan et al. (2017) who re-purposed EEPI-Centre tools (Hurley et al. 2013; Brunton et al. 2016; Hurley et al. 2018) to assess the quality of study designs in a large-scale MHPSS systematic review process.

Risk of bias was assessed in the RCTs and controlled before-and-after studies, using the criteria outlined in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins et al. 2011). According to seven domains, each potential source of bias was judged as either high, low or unclear and the risk of bias judgments were listed across different studies for each of the domains.

For the studies using a cohort design, an adaptation of the Newcastle-Ottawa Scale (Wells, Shea, and O'Connell 2019) was used to review quality according to the following methodological criteria:

1. Selection:
 - a) representativeness of the exposed cohort,
 - b) selection of the non-exposed cohort,
 - c) ascertainment of exposure, and
 - d) demonstration that outcome of interest was not present at start of study.
2. Comparability of cohorts
3. Outcome:
 - a) assessment of outcome,
 - b) follow-up was long enough for outcomes to occur, and
 - c) adequacy of follow-up of cohorts.

Two researchers independently assessed quality and risk of bias for each study, resolving any disagreements by discussion, and consulting with a third researcher when required.

ii) Review of R2HC Elrha-funded MHPSS studies

The extraction and synthesis processes described above were also applied to the subset of MHPSS studies funded directly by Elrha through its R2HC programme, to assess their contribution to the wider literature. Academic articles and final project reports generated from nine completed studies were used to inform the analysis. The inclusion/exclusion criteria for the wider literature review were not applied.

iii) Consultation

The consultation process used mixed methods to capture and document opinions, experiences, priorities and suggestions of researchers, practitioners, policymakers, coordinators, and funders in the MHPSS field. The consultation included key informant interviews, an online survey and a validation meeting.

The consultation aimed to assess uptake of the studies reviewed; contribute to the analysis of the status of current MHPSS intervention research; better understand knowledge transfer, use and impact; analyse new dimensions for research; and, to produce user-centred recommendations for research to better support humanitarian practice.

Research tool design

Based on the literature review and the overall study objectives, the research team drafted a topic guide as a platform for the design of specific interview and survey tools for data collection (see [Appendices – available online](#)). The tools were informed by the four research impact areas that the Elrha R2HC focus on: conceptual impact, instrumental impact, capacity, and enduring connectivity (Tilley et al. 2018). The research tools were designed to be cross-cutting, include key profession-specific questions, and tailored to the context of the research sites and the target groups being engaged.

Data collection

The study participants are summarised in Table 2 below.

Table 2: Consultation data collection method, number of respondents

Method	Respondents	Number
Key informant interviews	MHPSS researchers	5
	MHPSS practitioners	4
	Global MHPSS coordinators	4
	National government MHPSS focal persons	2
	European governments/policymakers who fund MHPSS	4
	Subtotal	19
Online survey	MHPSS researchers	20
	MHPSS practitioners	32
	Subtotal	52
	Total	71

Key informant interviews were held with the range of stakeholders (see Table 2) in May and June 2020. Interviews followed the pre-prepared semi-structured interview guide (see [Appendices – available online](#)). Questions were reviewed and refined during data collection in response to themes arising during the course of interviews conducted. Consent was given by all participants (see [Appendices – available online](#)) and confidentiality assured. Interviews were undertaken and recorded through an online platform, and each lasted for approximately 75 minutes.

An online survey was disseminated to MHPSS researchers and practitioners working in humanitarian settings using Google Forms. The survey used check boxes to record the majority of answers, but certain questions allowed for more detailed qualitative responses.

Participants and sampling

Given the time and resources limitations of the review, the sampling of interview participants was purposive and designed to reflect various professional, geographical and gender configurations that well represent this group of informants. The online survey was shared widely through platforms and resource hubs with MHPSS researchers and practitioners (e.g. through MHPSS.net and minnovation.net) with the aim of capturing a cross-section of these two participant groups.

The final sample included 19 key informant interview participants (two key informants requested to be interviewed together), and 52 survey respondents. Further demographic details of participants can be found in [Appendices – available online](#).

Data analysis

One researcher led each key informant interview, whilst a second researcher took detailed notes. The notes were fully transcribed, cross-referenced with the sound recording of the interview, and annotated with comments and analysis.

Thematic analysis was used for the qualitative data. A coding scheme was developed based on the broad themes of the topic guide, and from the initial hand coding of the interview data. This involved systematically sorting through the data, labelling ideas and phenomena as they appeared and reappeared. The lead researcher worked with a second researcher to trial the coding scheme and isolate discrepancies, and the scheme was revised accordingly. All interview data were coded and analysed, with the coded transcripts being reviewed by a second researcher. The trends that emerged were critically analysed according to the review's central aims.

Validation meeting

In August 2020, a validation meeting with MPHSS professionals was held to review and receive input on the key findings and recommendations set forth in the draft report. The process provided the opportunity for critical reflection and engagement on the report findings. Participants included colleagues from WHO, the Africa Mental Health Research and Training Foundation, Copenhagen University, War Child Holland, the MHPSS Collaborative, global coordinators from MHPSS IASC reference group, IFRC PS Centre, MHPSS.net, and International Medical Corps.

Methodological limitations

Although the process was rigorous, the literature review adopted a structured rather than systematic review methodology, and in its balance of rigour and realism it is possible that some relevant studies were not captured. One prevailing issue is that in order to be found, literature largely needed to self-identify as MHPSS orientated. Thus, some intervention studies, particularly those integrated into basic humanitarian service provision, may not have been identified. For example, food provision or camp management approaches designed to promote a sense of safety and be socially and culturally appropriate may not explicitly identify as MHPSS interventions and may not measure the potential MHPSS impact of their programmes. Also, the review only included English language studies, so relevant studies from non-Anglophone settings may have been omitted.

The review did not include studies that focus on mental health disorders. Defining when research is 'disorder-focused' or not is complex, and despite the robust rationale and systematic selection process, another research team may have yielded different results. Nevertheless, the approach facilitated a strong analysis of the 'grey area' that exists for interventions that are not clinical, but that use clinical outcome measures. Aiming to capture a range of studies which may not be included in a more traditional systematic literature review posed a challenge for quality assessment. Three separate tools were used to cover the range of designs in the study, each measuring different aspects of 'quality' and/or risk of bias. Together, they provided a good indication of the overall quality of the body of evidence collected. Finally, if this had been a full systematic review, it would have been preferable to use the recent ROBINS-I Cochrane tool (Sterne et al. 2016) for the non-randomised studies.

The consultation process was constrained by the COVID-19 pandemic. Although the interviews were conducted remotely, many potential interviewees were engaged in their emergency response capacity and therefore not able to participate. As such, only two government representatives participated. Fortunately, other key informants provided data on their interactions with national government actors, particularly senior practitioners and coordinators who work closely with this cohort.

The same problem may have limited the number of respondents to the survey. The response to the survey was positive considering these circumstances, however it was too small to disaggregate findings to a very granular level, e.g. comparing answers of community-based organisation (CBO) staff with those working for international non-governmental organisations (INGOs). The sample size was not large enough to provide statistically significant findings, but was adequate for its intended purpose of triangulation with the qualitative interview data and considering the depth and detail of the form, the number of responses was judged to be satisfactory.

SECTION 1: REVIEW OF THE PUBLISHED LITERATURE

This section describes evidence generated through MHPSS research published since 2010 that focuses on intervention outcomes, and assesses how it has contributed to advancing knowledge in the last 10 years (review objective 1): the range and quality of the evidence, whether it has captured innovations in approaches, and the extent to which it corresponds to the priorities reported by Tol et al. (2011). It then describes the extent to which that evidence has been taken up in policy, strategy and programming, insofar as can be observed from published materials (review objective 2).

Search results

A total of 11,062 references were generated from the searches (see Figure 2 below). After excluding duplicates and screening from title and abstract, the full-text reports of 737 remaining citations were retained and screened. A further 687 citations were excluded at this stage of the screening process, including studies conducted in high- or upper-middle income countries (criteria 3) (n=83), and studies with a primary focus on mental health disorders (criteria 8 and 9) (n=56). Many of the studies in the grey literature had a purely quantitative design with no control group and were excluded for this reason.

A total of 50 research studies were included in the review, of which one contributed to two study reports from two different data pools (Betancourt et al. 2014; McBain et al. 2015). Of the studies included, 20 presented data on participant experiences/perspectives (including from process evaluations) using mixed methods and qualitative data, and 30 were focused on outcomes, using primarily quantitative data.

1.1. Advances in knowledge in the last 10 years

Humanitarian context and geographical reach

Figure 3 illustrates the context and region of the studies included in the review. The majority of the selected studies were set in East Africa (n=16), followed by West Africa (n=9), Central Africa (n=7), South Asia (n=6) the Middle East (n=6), South East Asia (n=4), Southern Africa (n=1) and South America (n=1).

The majority evaluated MHPSS interventions delivered in the context of conflict/war (n=25) or post-conflict/war (n=19). Fewer studies evaluated programmes in the context of exposure to natural disasters (n=4), drought/food insecurity (n=1) and epidemics (n=1).

Figure 2: Humanitarian context and region of studies included in the review

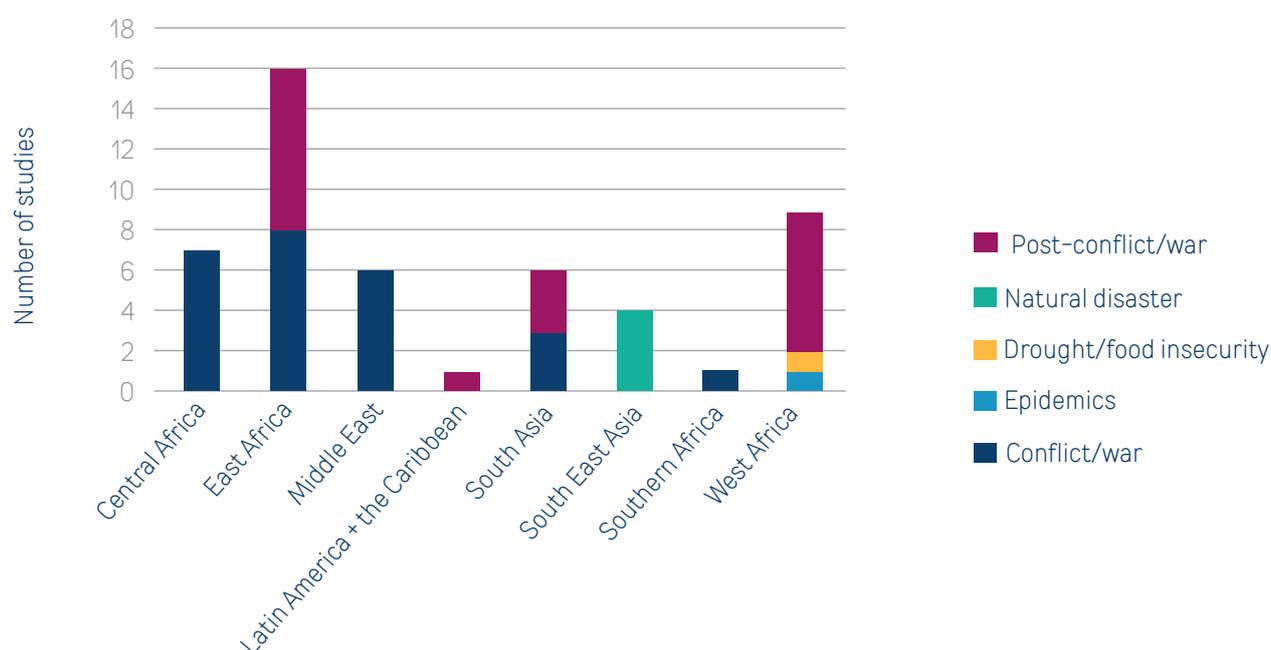
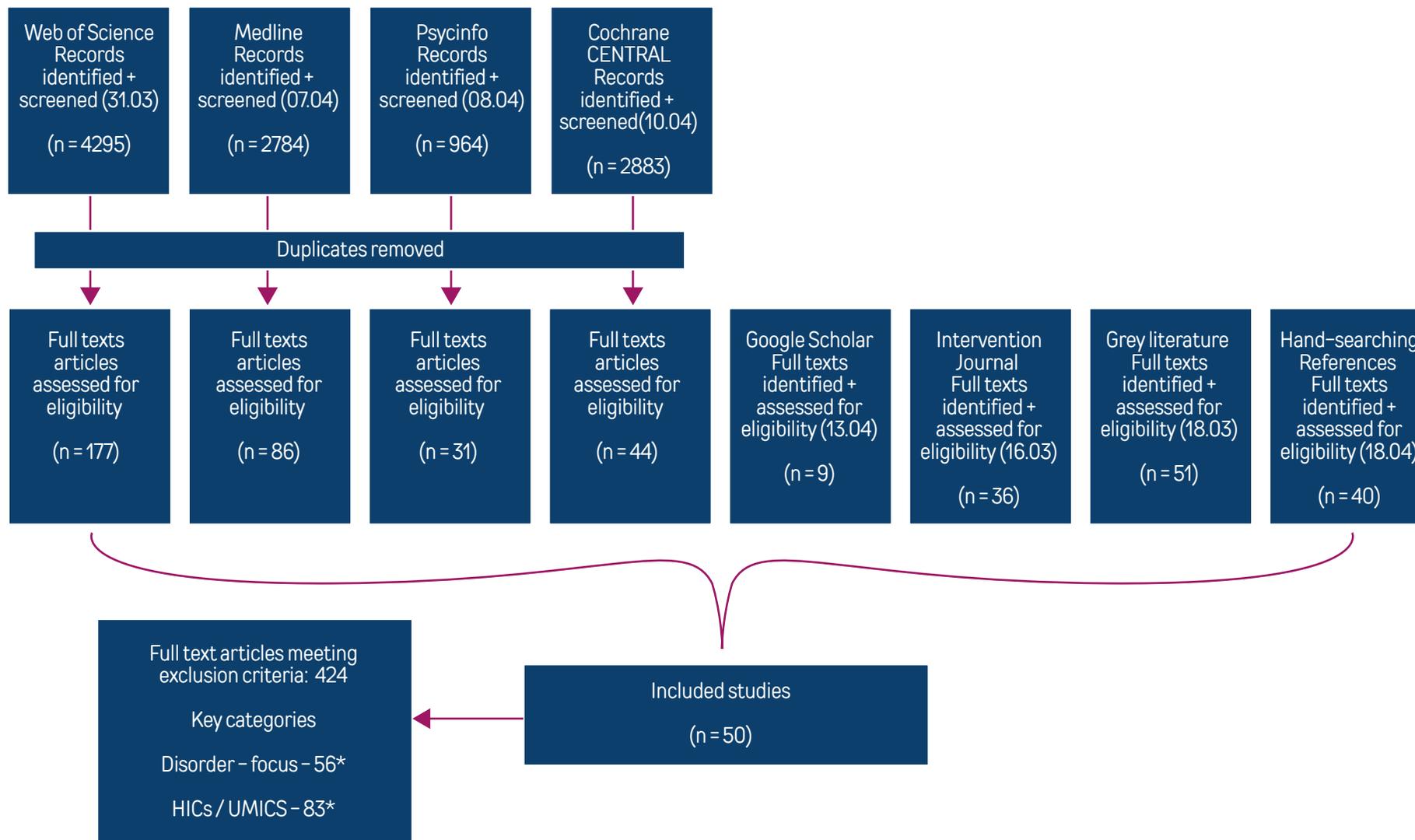


Figure 3: Flow of studies through review

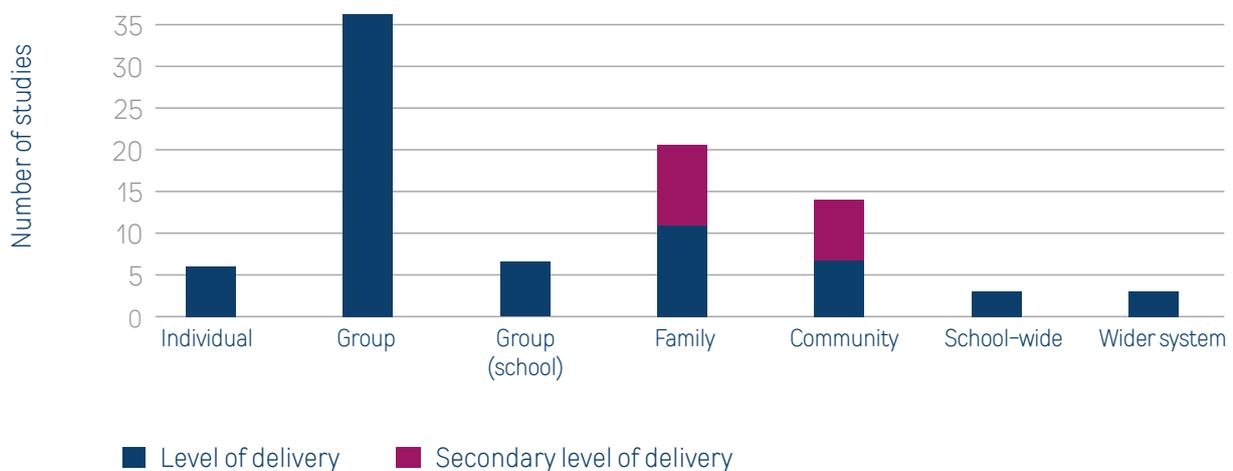


* portion of full-text articles assessed – some from these categories were excluded during earlier screening
Not mutually exclusive, so some papers could be both HIC and UMIC and disorder – focused

Delivery

The most common level of intervention delivery was at the group-level (n=36), followed by the family (n=21) and then the community level (n=14). These are not mutually exclusive, with half (n=25) of the interventions included in the review delivered at multiple levels, with some serving as additional or secondary components to facilitate the main intervention. For example, 10 of the 21 family-level and seven of the 14 community-level activities were caregiver, parent or community meetings, or attendance at ceremonies designed to facilitate the main intervention which was delivered at another level, usually group-level. This means that engagement of the whole family, and of the whole community, was significantly less common than interventions that worked with groups. The majority of the studies delivered at the individual level studied 'psychological interventions' (n=4) (see Figure 4).

Figure 4. Level of intervention delivery*



*not mutually exclusive as some interventions had multiple components

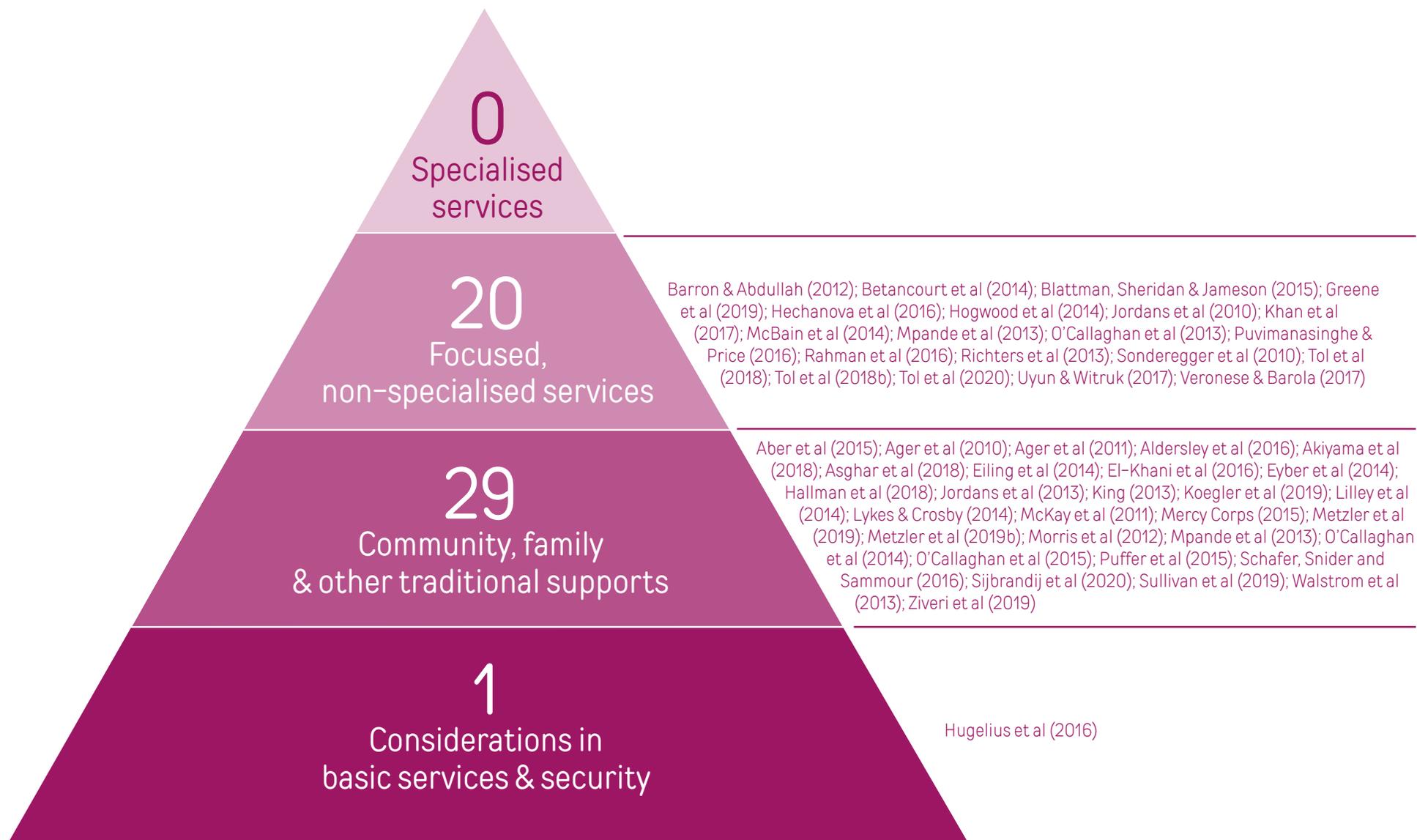
Categorisations

The studies were mapped against the IASC (2007) intervention pyramid according to their intervention goals, characteristics and implementation activities (see Figure 5). A total of 20 studies were judged to evaluate focused, non-specialised services, 29 studies were judged to evaluate MHPSS programmes aiming to strengthen community and family support, and only one study was identified to address basic services and security. No studies examining specialised services were included, due to their primary focus on mental health disorders.

It is important to note that a number of interventions were difficult to classify under one specific tier. For example, a number of studies were focused on strengthening elements of community and family supports, but were delivered by trained, non-specialised staff with the aim of reducing symptoms of mental health concerns. These cases were discussed and resolved through the clinical judgement of two researchers.

It should also be noted that many of the MHPSS approaches were multi-layered, in accordance with best practice guidance (UNICEF, 2019). A range of definitions for 'psychosocial' activities and interventions were observed in the narrative of many articles included in the review. For example: as comprising 'mental and physical health, social relations, religion, culture, and value' (Teresa S. Puvimanasinghe and Price 2016); as including five key principles '(1) a sense of safety, (2) calming, (3) a sense of self and community efficacy, (4) connectedness, and (5) hope' (Mpande et al. 2013); and encompassing: 'many different approaches, from recreational activities to counselling... the core of PSS in this study is active listening and dialogue. We have considered awareness of stress factors and coping opportunities' (Ziveri, Kiani, and Broquet 2019).

Figure 5: Studies included in the review mapped against the IASC (2007) intervention pyramid



Studies of MHPSS integrated within other technical areas

A number of studies integrated MHPSS with other technical areas (see Figure 6). Of these, the most common was MHPSS–child protection (n=8), which included studies of child- and youth-friendly space and safe space interventions. Some interventions were integrated with more than one other technical area. The nature of what counted as ‘integration’ varied across these studies and included those that incorporated programmatic components usually seen in another sector into their intervention design (e.g. the MHPSS–economic support studies integrated cash, economic support and group fund-shares into the interventions); those in which the intervention had shared outcomes relevant to two sectors (e.g. MHPSS–peacebuilding studies included reintegration and reconciliation programmes); and those that worked directly with systematic aspects of another sector (e.g., MHPSS–Education studies included curriculum change and changing the learning environment). As per the inclusion criteria, all of these interventions set out to measure MHPSS outcomes.

Figure 6: Studies of integrated interventions



Studies focused on mental health disorders

Excluding ‘disorder-focused’ studies from the literature included in the review was not always straightforward. The included studies ultimately fell into three categories related to how the study framed what it was trying to understand:

- studies in which the primary focus/primary outcomes were broad, non-specific psychological distress and wellbeing;
- studies in which the primary focus/outcomes were other non-disorder related psychosocial and psychological constructs; and
- studies in which the primary focus/outcomes were symptoms of mental health disorders, but the intervention was explicit in not targeting a population with mental disorder in need of treatment and did not aim to see clinical change (see Table 4).

As many studies had multiple primary outcomes, these are not mutually exclusive categories. Outcome measures of the quantitative designs frequently included components of symptom checklists associated with particular disorders, even when the interventions were not geared towards clinical populations (i.e. populations with mental disorder in need of clinical mental health intervention) or towards treating mental health disorders.

Table 4: Primary stated outcome or focus of the included studies

Non-specific psychological distress and wellbeing (Total 24 studies)	Other non-disorder related psychosocial and psychological outcomes (Total 38 studies)	Specific disorders but intervention was explicitly non-clinical (Total 5 studies)
Aber et al. (2015) Ager et al. (2010) Ager et al. (2011) Betancourt et al. (2014)* Blattman et al. (2015) Eiling et al. (2014) Greene et al. (2019)** Hallman et al. (2018)** Khan et al. (2017)*** Koegler et al. (2019) Lilley et al. (2014) McBain et al. (2015)* Metzler et al. (2019) Metzler et al. (2019b) Morris et al. (2012)** Mpande et al. (2013)*** Puffer et al. (2015)*** Rahman et al. (2016)** Sonderegger et al. (2010) Tol et al. (2018) Tol et al. (2018b) Tol et al. (2020)** Uyun & Witruk (2017)*** Walstrom et al. (2013) Ziveri, Kiani and Broquet (2019)	Aber et al. (2015) Ager et al. (2010) Ager et al. (2011) Akiyama et al. (2018) Aldersey et al. (2016) Asghar et al. (2018) Barron and Abdullah (2012) Betancourt et al. (2014)* Blattman et al. (2015) Eiling et al. (2014) El-Khani et al. (2016) Eyber et al. (2014) Hallman et al. (2018) Hechanova et al. (2016) Hogwood et al. (2014) Hugelius et al. (2016) Jordans et al. (2010)** Jordans et al. (2013)** Khan et al. (2017)*** King (2019) Lykes and Crosby (2014) Mercy Corps (2015) McBain et al. (2015)* McKay et al. (2011) Morris et al. (2012)** Mpande et al. (2013)** O'Callaghan et al. (2013)** O'Callaghan et al. (2015)** O'Callaghan (2014)** Ordóñez-Carabaño et al. (2019) Puffer et al. (2015)** Puvimanasinghe and Price (2016) Richters et al. (2013) Schafer et al. (2016) Sijbrandij et al. (2020) Sonderegger et al. (2010) Sullivan et al. (2019) Veronese and Barola (2018)	Jordans et al. (2010)** Jordans et al. (2013)** O'Callaghan et al. (2013)** O'Callaghan (2014)** O'Callaghan et al. (2015)**

*Symptoms of disorders integrated into their measurement tools
 ** Stand-alone disorder-specific scales used
 *** General scale associated with disorders used

There was significant diversity across the specific constructs measured under these three groups of studies.

Non-specific psychological distress/wellbeing constructs included: mental/emotional/psychosocial wellbeing, psychological/emotional distress, mood, 'steady head' (a local term for mental stability in study area).

Other psychosocial and psychological constructs included: psychosocial wellbeing, resilience, self-efficacy, self-esteem, confidence, quality of life, hope, coping skills, social support/social networks, victimisation, burnout, motivation, prosocial attitudes and behaviour, emotional regulation, identity and values, self-regard, warm and supportive parenting, caregiver-child interactions, role, aggression, reconciliation, forgiveness, mutual healing, social reintegration, social transformation, social participation, community connectedness.

Specific mental health disorder constructs included: post traumatic stress disorder (PTSD), depression, anxiety.

There was also a fourth category of studies whose interventions were not focused on a clinical population (as determined through the clinical judgement of the reviewers) but which measured specific disorders as primary outcomes or dependent variables. As the authors of those studies did not explicitly state that the interventions were not geared towards clinical change these studies were excluded (including Bass et al. 2012; Bass et al. 2016; Dhital et al. 2019; James et al. 2020; Jani et al. 2016; Kohrt et al. 2015; Welton-Mitchell et al. 2018; Tol et al. 2010).

Positive aspects of wellbeing verses mental health disorders

MHPSS interventions can be aimed at enhancing wellbeing from a 'positive psychology' perspective versus being focused on reducing symptoms of disorder and psychological suffering. For each study reviewed, both the aims of the interventions, and the focus of the research design (including selected outcomes measured) were categorised according to these two dimensions.

A total of 23 of the interventions studied were described as purely focused on promoting wellbeing, using outcome measures that expressed mental health; 18 of the interventions were described as focusing on both promoting wellbeing/resilience and reducing suffering/dysfunction; and nine were focused on only reducing suffering/dysfunction.

A total of 15 of the research designs were focused purely on wellbeing/resilience in a 'positive psychology' framework; 30 of the research designs considered aspects of both wellbeing/resilience and reductions in suffering/dysfunction; and only five were purely focused on reductions in suffering/dysfunction.

The tendency towards a 'positive psychology' framework within the selected studies supports the sector's move towards adopting a more positive approach to both MHPSS interventions and MHPSS research designs.

In several cases, there was a mismatch between the stated aims of interventions and the chosen focus of the research (including selected outcome measures). In 12 studies, the intervention was described as purely focused on promoting wellbeing/resilience, and yet the research design included a focus on suffering/dysfunction. In seven studies, the intervention was described as purely focused on reducing suffering/dysfunction, and yet the research design also covered more positive dimensions of wellbeing/resilience. In three studies, the intervention was described as being focused on promoting wellbeing/resilience yet this was not a focus of the research design, and in three studies, the intervention was described as being focused on reducing suffering/dysfunction, but again this was not a focus of the research design.

Quality of the evidence

The majority of studies looking at participant experiences and perspectives (including process evaluations) using mixed methods and qualitative data were reliable and useful. Specifically, six studies were scored as high reliability, 11 were scored as medium reliability, and three were scored as low reliability. Ten studies were scored as high usefulness, 80 were scored as medium usefulness and two were scored as low usefulness.

As illustrated in Figure 7 below, there was a predominance towards a low risk of bias across the 16 RCTs for each of the domains, except for allocation concealment, blinding of participants and personnel, and allocation concealment, which were more 'unclear'.

There was a much higher risk of bias and greater lack of clarity amongst the 12 controlled before-and-after studies, as shown in Figure 8 below. However, when assessing the extra dimension of comparability (whereby either exposed and non-exposed individuals must be matched in the design and/or confounders must be adjusted for in the analysis), seven of the studies scored the maximum of two stars, three of the studies scored one star and the remaining two studies did not provide enough information for scoring.

Aside from risk of bias, a number of the RCTs and controlled before-and-after designs had an additional qualitative component (Blattman, Jamison, and Sheridan 2015; Jordans et al. 2013; Khan et al. 2017; Puvimanasinghe and Price 2016; Rahman, Riaz, et al. 2016; Veronese and Barola 2018) which increased their usefulness.

Amongst the two cohort studies, one received an overall fair quality score, and another received a poor-quality score. See [Appendices \(available online\)](#) for a full scoring of the quality measures.

Figure 7: Risk of bias scores for RCTs included in the review

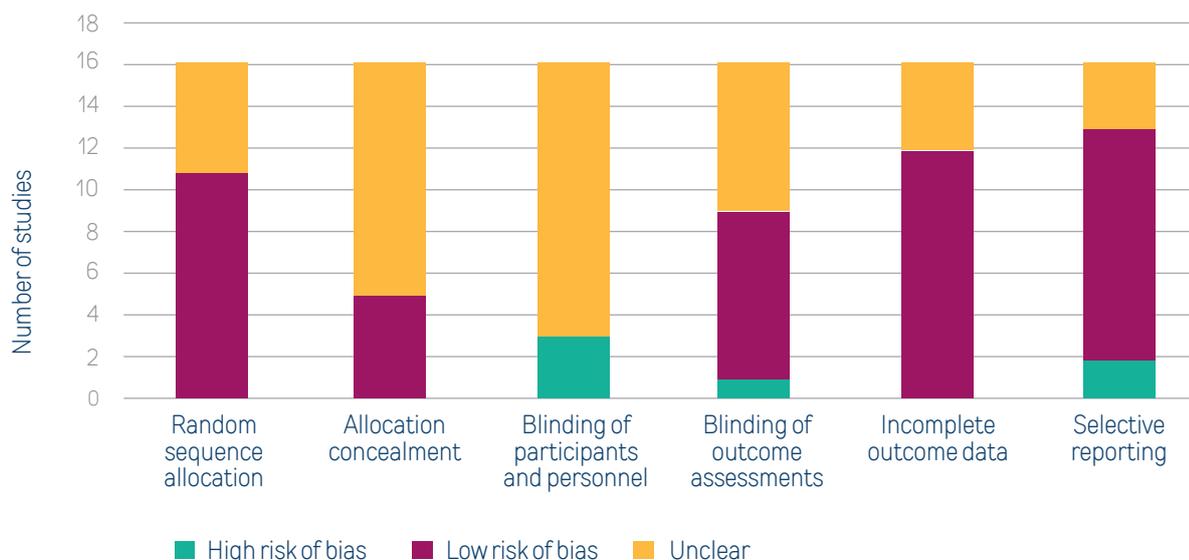
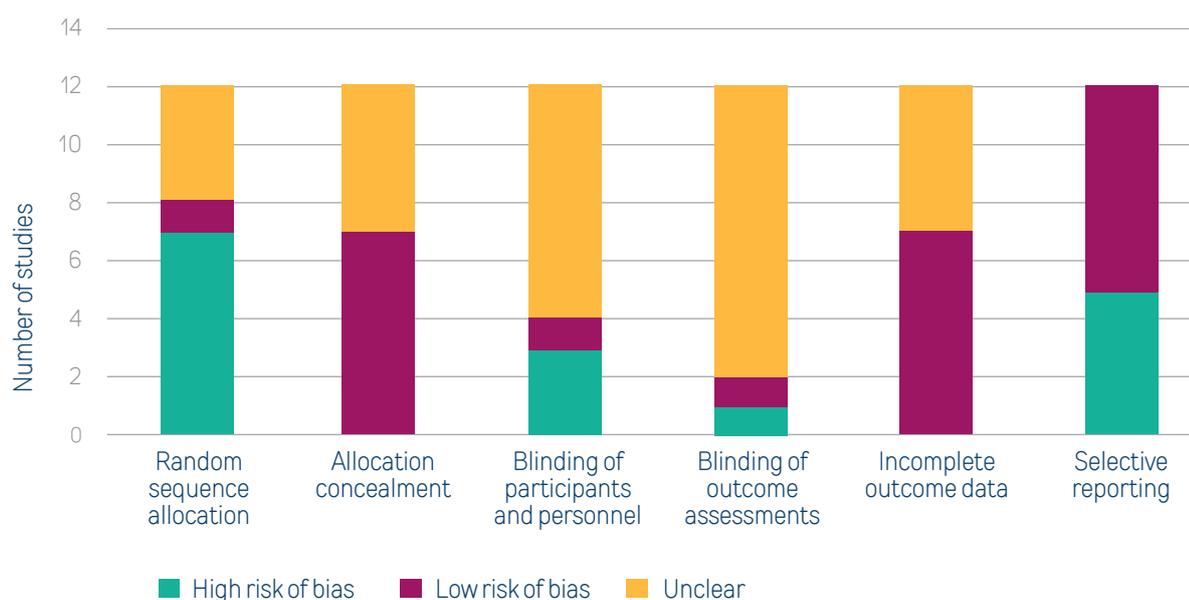


Figure 8: Risk of bias scores for the controlled before-and-after studies included in the review



How does the evidence correspond to the research priorities?

The consensus-based research agenda developed by Tol et al. (2011) identified a need for useful evidence that could be immediately translated to MHPSS programming. The priorities for research developed by that team are set out in Table 5. The review assessed how the selected studies matched those research priorities.

Within the scope of this review, priorities 5 and 8 were deemed observable in the evidence, and priorities 2, 6, 7, and 10 to be partially observable. The other research priorities (1,3,4,9) were not expected to be observable in a review of this scope.

Research priority 5: Adapting MHPSS interventions to different sociocultural contexts

Amongst the selected studies, 21 gave a rich description of the sociocultural context and humanitarian conditions in which participants lived, 20 gave a sparse description and nine studies gave no extended description.⁷ A total of 23 studies researched previously socio-culturally adapted interventions, 22 studies actively adapted the intervention to the sociocultural context for the purpose of the study, two studies gave extensive detail on the adaptation process (including formative research, pilot testing and process evaluation, and the process of translation, adaptation, and pilot testing with a process evaluation component) and three studies examined already-running locally developed interventions.

Table 5: Research priorities

Priority research area	Priority Question
Problem analysis	1. What are the stressors faced by populations in humanitarian settings?
	2. How do affected populations themselves describe and perceive mental health and psychosocial problems in humanitarian settings?
	3. What are the major protective (including individual factors such as coping and hope) and contextual factors (e.g. justice mechanisms, religious practices) for mental health and psychosocial problems in humanitarian settings?
	4. Which are the most common mental health and psychosocial problems in the general population in humanitarian settings?
Mental health and psychosocial support interventions	5. How can we best adapt existing MHPSS interventions to different sociocultural contexts?
	6. What is the effectiveness of family-based interventions to prevent mental disorders and protect and promote psychosocial wellbeing and mental health amongst children and adults living in humanitarian settings?
	7. What is the effectiveness of school-based psychosocial and mental health interventions to prevent mental disorders and to protect and promote psychosocial wellbeing and mental health among children and adults in humanitarian settings?
Research and information management	8. What are appropriate methods to assess mental health and psychosocial needs of populations in humanitarian settings?
	9. What are appropriate indicators to use when monitoring and evaluating the results of mental health and psychosocial support in humanitarian settings?
Mental health and psychosocial support context	10. To what extent do current MHPSS interventions address locally perceived needs?

Research priority 8: Appropriate methods to assess mental health and psychosocial needs of populations in humanitarian settings

Amongst the selected studies, 42 used adapted assessment tools, actively adapted assessment tools, or created new assessment tools to fit the setting and context. A number of the studies described the development of locally-relevant tools, and incorporated these into their assessment processes (for example, Ager et al. 2011; McKay et al. 2011; Mpande et al. 2013). As already noted, however, there were several studies in which there was a mismatch wherein the study focused on measuring suffering/dysfunction but the intervention itself was based on promoting wellbeing/resilience.

⁷Studies with 'rich description' included those that detailed cultural norms, values and beliefs, including the population's daily stressors or local idioms of distress. They included specific local needs related to socio-cultural aspects of life, emphasised the role of cultural, social and religious factors that may influence physical or mental wellbeing and/or mentioned inherent contextual challenges for the provision of MHPSS related to the humanitarian context. Studies that gave a 'sparse description' included a description of the specific humanitarian setting in which the intervention was implemented and general aspects of the population's cultural beliefs or social norms. Studies that gave 'no extended description' provided only a general overview of the humanitarian context, for instance the historical (conflict) context of the region and general aspects of the effects on the population, including displacement, poverty, and sexual abuse.

Research priority 2: How populations themselves describe and perceive mental health and psychosocial problems in humanitarian settings

Although only partially observable within the scope of this review, it was noted that 13 studies asked populations how they describe and perceive mental health and psychosocial problems versus using pre-existing constructs. Of these 13 studies, eight were of qualitative design or included a qualitative component.

Research priority 6: Effectiveness of family-based interventions

A total of 21 studies were delivered to some degree at the family level. However, 10 of these involved caregiver/parent meetings or attendance at ceremonies, which were geared to facilitate the main intervention delivered at another level. Amongst the other 11 studies were mother-infant psychosocial stimulation activities, parent psychoeducation intervention and parenting classes, which may be better described as having a 'family-focus' rather than being family-based. Few of the interventions engaged the whole family or had a focus on family-based outcomes.

Research priority 7: Effectiveness of school-based interventions

A total of five studies were group-based interventions delivered in the school environment. An additional three were 'school-wide' as they engaged the wider school environment, trained teachers and/or made curriculum change. Other studies targeting children were based outside of the school environment, including in Child/Youth Friendly Spaces and in other community-based 'Safe Spaces'.

Research priority 10: To what extent do current MHPSS interventions address locally perceived needs

Although only partially observable from the scope of this review, it was noted that 19 studies actively assessed locally perceived needs, 20 studies described their intervention designs as being informed by assessments of locally perceived needs, and 31 studies described their interventions as being designed to address locally perceived needs.

The other research priorities (numbers 1,3,4 and 9) may be more observable in reviews of other types of literature such as prevalence studies and descriptive epidemiology and therefore were not included in this review. Based on the selected studies for this literature review, however, it can be concluded that a gap remains in understanding the mechanisms of change for priority questions, long-term effects of the interventions, and how these interventions can be scaled in real-world non-controlled settings.

Innovations

The body of studies included two of the WHO scalable psychological interventions, including Self Help Plus and Problem Management Plus (PM+) (n=1). Scalable psychological interventions are defined as brief, basic, non-specialist-delivered versions of existing evidence-based psychological treatments (e.g., basic versions of cognitive behavioural therapy, interpersonal therapy). A second PM+ article was excluded due to its focus on a more clinical population, but is included in the Elrha review below (Rahman, Riaz et al. 2016) and a third was excluded due to its setting (as per the review's inclusion criteria). Studies conducted on mhGAP were excluded for their focus on treating mental health disorders.

Several Common Elements Treatment Approach (CETA) studies also did not meet the inclusion criteria of the review (either due to setting or due to a focus on mental health disorders). Other promising, emerging interventions such as Early Adolescent Skills for Emotions (EASE), Sustainable Technology for Adolescents to Reduce Stress (STARS), and telephone-Common Elements Treatment Approach (CETA) (remotely delivered) were yet to publish findings at the time of the review.

1.2 Uptake of evidence

To begin to understand the knowledge transfer pathways of the published evidence, and to assess the degree to which this evidence has informed global MHPSS guidelines and strategy, the review included an examination of the citation analysis and journal impact factor for each of the selected studies. (Note that more detailed discussion about evidence uptake is included in Section 3 of this report).

Citation analyses calculated through Google Scholar (https://scholar.google.com/schhp?hl=en&as_sdt=0,5) ranged from 0 (for example, Aber et al. 2015; Eyber et al. 2014; Hallman et al. 2018; Mercy Corps 2015; Metzler et al. 2014; Sijbrandij et al. 2020; Sullivan et al. 2019; Ziveri, Kiani, and Broquet 2019) to over 50 (for example, 100 citations of Ager et al. 2011 were registered; Betancourt et al. 2014 had been cited 70 times; Blattman, Jamison and Sheridan 2015 had been cited 183 times; Morris et al. 2012 had been cited 53 times; Jordans et al. 2010 had been cited 210 times; O'Callaghan et al. 2013 had been cited 188 times). The citation analysis for each study is included in [Appendices \(available online\)](#). The most-cited articles had been published in academic journals at least five years previously and were either RCTs or controlled before-and-after studies. They were all focused on children, adolescents, or youth populations, except for one adult-targeted intervention. The least-cited articles were all classified as grey literature or were published in the *Intervention Journal*.

Journal Impact Factor (JIF) scores ranged from 0 and 1 (for example, Aldersey, Turnbull and Turnbull 2016; Barron and Abdullah 2012; Hechanova, Waelde and Ramos 2016; Walstrom et al. 2013) to 10 and over (Rahman, Riaz et al. 2016; Tol, Augustinavicius et al. 2018; Tol et al. 2020). Those with the highest JIFs were RCTs of WHO scalable interventions. Those with the lowest JIFs were qualitative studies, except for one non-controlled mixed methods design. JIFs could not be located for some journals including *Intervention Journal*, *Global Mental Health*, *Journal of Peace Psychology*, *Disaster Health*, *Trends and Issues in Interdisciplinary Behaviour and Social Science*, and obviously none existed for the grey literature. (JIFs for all the studies included in the review are presented in [Appendices – available online](#)).

To what extent has this evidence informed global MHPSS guidelines and strategy?

Amongst the body of 24 global MHPSS guidelines and strategy documents reviewed (see [Appendices – available online](#)), seven of the selected studies were cited once (Ager et al. 2011; Eiling et al. 2014; Jordans et al. 2010; Morris et al. 2012; O'Callaghan et al. 2013; Puffer et al. 2015) or twice (Ager et al. 2010). In addition, 11 studies were cited indirectly through their inclusion in systematic reviews which were referenced in the MHPSS guidelines and strategy documents. Five of these studies were included in one cited systematic review (Betancourt et al. 2014; Blattman, Jamison, and Sheridan 2015; Eiling et al. 2014; McKay et al. 2011; O'Callaghan et al. 2015); four were cited in two systematic reviews (Ager et al. 2010; Jordans et al. 2013; O'Callaghan et al. 2013; O'Callaghan et al. 2014); and two were cited four systematic reviews (Ager et al. 2011; Jordans et al. 2010). These two studies were mostly focused on children, adolescents or parents, and were cited in either UNICEF and War Child documents (UNICEF 2011; 2018; War Child (N.D.)).

SECTION 2: REVIEW OF R2HC MHPSS STUDIES

Between 2014 and 2019, Elrha funded 16 MHPSS studies through its R2HC programme. Nine studies focused on specific MHPSS interventions and were completed at the time of this review and seven studies were still underway. This section presents findings specific to the R2HC MHPSS portfolio, in terms of the range (of all 16 studies), and the types of intervention of the nine complete intervention studies, their contribution to the wider evidence base and their reach. It follows the same structure as the previous section for ease of reference.

Thirteen academic articles generated from the nine completed MHPSS intervention studies also informed this analysis (Greene et al. 2019; Hermosilla et al. 2019; Horn et al. 2019; James et al. 2020; Metzler et al. 2019; Panter-Brick et al. 2017; Rahman, Riaz et al. 2016; Rahman, Hamdani et al. 2016; Sijbrandij et al. 2020; Tol, Augustinavicius et al. 2018; Tol, Augustinavicius et al. 2018; Tol et al. 2020; Welton-Mitchell et al. 2018). Five of the nine completed studies generated multiple articles, and one study had yet to be published but had two articles under review at the time of writing. Only articles that detailed the testing, trialling or evaluation of interventions were included. In addition, the nine final project reports were also used to inform this analysis.

Academic articles generated from five of the nine completed studies were also included in the main literature analysis (Greene et al. 2019; Metzler et al. 2019; Rahman, Riaz et al. 2016; Sijbrandij et al. 2020; Tol, Augustinavicius et al. 2018; Tol, Augustinavicius et al. 2018; Tol et al. 2020).⁸

Table 6: R2HC studies included

Authors/publication date of academic articles for 9 completed studies		Studies included in the main analysis of evidence (section 2)
1	Greene et al. 2019	●
2	Hermosilla et al. 2019	
3	Horn et al. 2019	
4	L.E. James et al. 2020	
5	Metzler et al. 2019	●
6	Panter-Brick et al. 2017	
7	Rahman, Riaz, et al. 2016	●
8	Hamdani et al. 2016	
9	Sijbrandij et al. 2020	●
10	Tol, Augustinavicius, Carswell, Leku, et al. 2018	●
11	Tol, Augustinavicius, Carswell, Brown et al. 2018	●
12	Tol et al. 2020	●
13	Welton-Mitchell et al. 2018	

⁸Of those that did not meet inclusion criteria for the wider literature review, one study did not generate an intervention research article; one was from an upper-middle income country setting (Panter-brick et al. (2017), and two studies measured disorders as their primary outcomes (Welton-Mitchell et al. (2018), James et al. (2020)).

2.1. Advances in knowledge in the last 10 years

Humanitarian context and geographical reach

Several of the R2HC-funded studies covered multiple sites, providing 19 study sites across the portfolio of 16 complete and ongoing studies. As with the broader literature, the majority of study sites were in East Africa (n=7), followed by the Middle East (n=5), South Asia (n=5), West Africa (n=1) and Latin American and the Caribbean (n=1). The majority of the study sites were in the context of war/conflict (n=12) and natural disaster (n=4). Fewer studies evaluated programmes in the context of post-conflict/war (n=1) and epidemics (n=1). One of the portfolio studies that was still being conducted at the time of the review aims to convert the Humanitarian Emergency Perceived Needs scale (HESPER) to a web-based format, and therefore looks more generally across the humanitarian context (n=1).

Age groups

The majority of the portfolio is focused on interventions targeting adults (n=10), followed by children (n=4) adults-and-infants (n=1) and adolescents/youth (n=1). The age range of target groups of the entire body of evidence spans 6 months to 78 years.

Long-term follow-up

Seven of the R2HC-funded studies examined the impacts of their interventions over the longer term with follow-up data collection. One did so by a longer term second measure (T2) and six did so by a third time measure (T3).

Intervention delivery

The nine complete MHPSS interventions studied were arranged by the same coding categories used in the wider literature review. The most common intervention type was group-based psychosocial interventions (n=3) followed by psychological interventions (n=2), Child/Youth Friendly Spaces (n=1), skills training (n=1), family strengthening (n=1) and Psychological First Aid (PFA) (n=1).

The most common level of intervention delivery for the complete MHPSS intervention was at the group-level (n=6), followed by the individual level (n=3) and then the family and community level (n=2). Levels of delivery are not mutually exclusive, and four of the nine interventions were delivered at multiple levels. As in the main literature review, engagement of the wider family and engagement of the whole community were more likely to be additional components to an intervention delivered at another level and were therefore significantly less common than interventions that were delivered at the group or individual levels. Two studies had a community-focus as they discussed matters of community resilience, but the intervention itself was delivered at a group level.

Categorisations

The nine Elrha-funded studies were mapped against the IASC (2007) intervention pyramid according to their intervention goals, characteristics, and implementation activities. Four studies evaluated focused, non-specialised services and five studies evaluated programmes aiming to strengthen community and family support. No studies were identified as addressing basic services and security. As in the wider literature review, it was difficult to classify some of the interventions, especially PFA, which may be defined as a set of skills for frontline responders designed to foster supportive, practical help rather than as an intervention.

Studies of MHPSS integrated within other technical areas

Six of the nine completed studies looked at MHPSS interventions integrated to varying degrees with other technical areas. The most common was MHPSS–disaster preparedness (n=2), followed by MHPSS–child protection (n=2), MHPSS–nutrition (n=1), MHPSS–GBV/IPV (n=1) and MHPSS–livelihoods (n=1). One study was integrated with both livelihoods and child protection.

Positive aspects of wellbeing versus mental health disorders

The primary stated outcome and/or focus of eight of the 13 articles generated from the Elrha portfolio was non-specific psychological distress and wellbeing (Greene et al. 2019; Hermosilla et al. 2019; Metzler et al. 2019; Panter–Brick et al. 2017; Rahman, Riaz et al. 2016; Tol, Augustinavicius, et al. 2018; Tol, Augustinavicius et al. 2018; Tol et al. 2020). Outcome measures in this group still commonly included components of symptoms checklists associated with particular disorders. The primary stated outcome and/or focus of two of the 13 articles was other psychosocial and psychological outcomes (Horn et al. 2019; Sijbrandij et al. 2020). These constructs included safety, hope, calm, efficacy, connectedness, professional attitude, quality of life.

One of the 13 articles stated its primary outcome as specific mental health disorders and included people screened for common mental health disorders (Rahman, Hamdani et al. 2016). Two of the 13 articles measured symptoms of specific disorders as primary outcomes, but did not explicitly state whether they expected clinical change (James et al. 2020; Welton–Mitchell et al. 2018).

How does the evidence match the research priorities?

The review analysed how the nine completed R2HC–funded MHPSS studies aligned with the MHPSS research priorities set in 2010 (see Table 5). Within the scope of this review, priorities 5 and 8 were deemed observable, priorities 2 and 10 were partially observable, and priorities 6 and 7 were not observable. As with the wider literature, the other research priorities (1,3,4,9) were not be expected to be observable in a review of this scope.

Research priority 5: Adapting MHPSS interventions to different sociocultural contexts

Amongst the 13 academic articles generated from the nine completed MHPSS studies, three articles included a rich description of the sociocultural context and humanitarian conditions in which participants lived, four articles gave a sparse description, and six articles gave no or limited description.⁹

According to their final reports, however, the nine completed projects either contextually adapted the intervention before, during or after the research. The Self–Help Plus research in Uganda led by the WHO used cognitive interviewing, a pilot intervention and a concurrent process evaluation to inform the subsequent RCT, whilst the Problem Management Plus research in Pakistan conducted an initial qualitative assessment to learn about local population priority concerns. The integrated approach to Intimate Partner Violence (IPV) research led by Johns Hopkins Bloomberg School of Public Health included formative research and a formal adaptation phase.

⁹Studies with a 'rich description' included details of cultural norms, values and beliefs, including the populations daily stressors or local idioms of distress. They addressed specific local needs related to socio-cultural issues, emphasised the role of cultural, social and religious factors that may influence physical or mental wellbeing and/or described inherent contextual challenges for the provision of MHPSS. Studies that provided a 'sparse description' included general aspects of the population's cultural beliefs or social norms alongside characteristics of the specific humanitarian setting in which the intervention was implemented. Studies that gave no or limited description only included an overview of the humanitarian context, for instance the historical (conflict) context of the region (community dynamics, local conflicts and politics), general aspects of the affects on the population (displacement, poverty, sexual abuse), and/or a general mention of the types of trauma.

The integrated disaster preparedness research in Nepal led by Colorado University ran a concurrent qualitative component looking at both stressors and reactions to the intervention to help explain the context of the intervention setting. The ‘child friendly spaces’ study led by World Vision ran a concurrent qualitative component to understand the context of implementation, including to identify key resources and institutions available to protect children, and to understand and validate key constructs related to child wellbeing. The PFA research led by War Trauma Foundation was both qualitative and quantitative and focused on the effectiveness of short training programmes for incorporating the key principles of PFA into practice.

The research led by Yale University measuring health and wellbeing of refugee youth also developed and validated a culturally grounded measure and, following the research, the overall findings informed the adaptation of the ongoing programme (see case study 2 presented in Section 3 below). Both integrated disaster intervention studies led by Colorado University used service-user feedback to adapt the intervention package following the study (James et al. 2020; Welton-Mitchell et al. 2018). The integrated nutrition intervention led by ACF used learnings from the supervision processes to inform context-specific adaptations of the intervention and the process itself informed a psychosocial protocol manual.

Research priority 8: Appropriate methods to assess mental health and psychosocial needs of populations in humanitarian settings

Of the 13 academic articles generated from the completed projects, 11 used adapted assessment tools, actively adapted assessment tools, or created new assessment tools to fit the setting and context. Panter-Brick et al. (2018) is an additional study generated from the R2HC-funded portfolio which specifically describes the development and testing of a locally-relevant Child and Youth Resilience Measure.

Research priority 2: How populations themselves describe and perceive mental health and psychosocial problems in humanitarian settings

Although only partially observable from the scope of this review, it was noted that two of the 13 articles reported asking populations exactly how they describe and perceive mental health and psychosocial problems versus using pre-existing constructs. An additional article by Panter-Brick et al. (2018) specifically described the development and testing of a locally-relevant Child and Youth Resilience Measure.

Research priority 10: To what extent do current MHPSS supports address locally perceived needs

Six of the published academic articles actively assessed locally perceived needs, six of the studies described their intervention designs as being informed by assessments of locally perceived needs, and eight of studies described their interventions as being designed to address locally perceived needs (this was not mutually exclusive). Also relevant to this research priority, was the adaptation of the HESPER into a web-based tool led by Orebro University. The HESPER aims to provide a quick, scientifically robust assessment of perceived needs of people affected by humanitarian emergencies or disasters.

Research priority 6: (family-based interventions) was not observable.

Two of the nine complete MHPSS studies were delivered at the family-level, however one was as a secondary component to the main intervention delivered at another level (family education sessions alongside a child friendly space intervention). The other example was mother-infant psychosocial stimulation. None of the interventions engaged the whole family or had a focus on family-based outcomes. Similarly, research priority 7 (school-based interventions) was not observable as none of the completed R2HC MHPSS studies were school-based.

Innovations

Three of the nine completed MHPSS studies looked at scalable interventions, including the WHO models Problem Management Plus and Self Help Plus. The R2HC-funded MHPSS studies that were still underway at the time of this review included two more studies of these scalable interventions in addition to phone delivered CETA (t-Ceta) and guided e-mental health care.

2.2 Uptake of evidence

The 13 academic articles that had been published from the nine completed Elrha-funded MHPSS intervention studies were used to analyse the uptake, use and impact of evidence generated.

Citation analyses calculated through Google Scholar ranged from 0 (James et al. 2020; Welton-Mitchell et al. 2018) to 114 (Rahman, Hamdani et al. 2016). The highest scoring articles of 30 and over were all RCTs of scalable interventions published in 2018 or earlier. The lowest scoring articles were all more recently published, three were RCTs and one was a mixed methods formative research and pilot study.

The articles published in journals with the highest journal impact factors (JIFs) of 15 and above (Rahman, Riaz et al. 2016; Rahman, Hamdani et al. 2016; Tol, Augustinavicius et al. 2018; Tol et al. 2020) were all RCTs of WHO scalable interventions (Self Help Plus and Problem Management Plus). The articles published in journals with the lowest JIFs (scoring two and below) covered a range of interventions and designs.

According to the final project reports, the most common dissemination strategies of the completed studies included journal publications and presentations at international conferences. Two research teams conducted webinars reporting research progress and findings. Many strategies included meetings at district and national levels with presentations to key stakeholders, and workshops and training to local service providers with the aim of disseminating the intervention model. Some researchers published programme manuals on their organisations' and/or their funders' websites whilst others published online blogs. A small number of research teams developed and shared policy-oriented syntheses through relevant interest group mailing lists and newsletters. Only two teams used social media channels like Twitter and Facebook to share blogs or promote events. Targeting a broader audience, two authors included video documentaries and clips explaining the research topic or visualising the research process.

To what extent has this evidence informed global MHPSS guidelines and strategy?

None of the published academic articles were cited amongst the body of 24 global MHPSS guidelines and strategy documents reviewed (see [Appendices – available online](#)).

Open access manuals and guidelines have been produced that are directly informed by these R2HC-funded studies, these include for Problem Management Plus; IPT-G; Thinking Healthy; Doing What Matters in Times of Stress: An Illustrated Guide; and general MHPSS programming such as the IASC MHPSS guidelines and MHPSS-disaster preparedness interventions. At the time of the review, an open access guideline was also being developed for Follow-Up of Severely Malnourished Children (FUSAM). All of these have been directly informed by the R2HC-funded studies (WHO 2018; WHO 2020; James, Welton-Mitchell and Moun 2016; James, Welton-Mitchell and TPO Nepal 2016).

SECTION 3: SYNTHESIS AND FUTURE DIRECTIONS

This section synthesises findings from the literature review, complementing them with insight from the consultation process to focus on how evidence has been used to influence policy and practice (objectives 1 and 2). It then describes how the research agenda has been advanced, highlighting successful approaches that have been adopted and a discussion of potential new horizons for MHPSS research (objective 3) to ensure uptake and impact of research for learning within the humanitarian community.

3.1 Advances in knowledge in the last 10 years

Since the research priorities were set in 2010, the body of relevant MHPSS research has increased significantly, including the 16 MHPSS research studies funded by Elrha through its R2HC programme. Recent systematic reviews of MHPSS interventions in humanitarian settings showed a remaining evidence gap in broad-based community interventions (Bangpan et al. 2017; Bangpan, Felix and Dickson 2019; Dickson and Bangpan 2018; Haroz et al. 2020). There was some recognition that the study of community interventions had been poorly replicated (Haroz et al. 2020), and that routine impact evaluation which forms part of standard programme monitoring and evaluation was not commonly done (Lee et al. 2019). The analysis of studies covered in this review are in line with these findings and supported by the consultation.

The quality of the research published since 2010 and included in this review was deemed reasonably high and unbiased. Quantitative research designs when complemented with qualitative data were particularly noted as having increased usefulness. There was a geographic emphasis in the literature towards East and West Africa where about two thirds of the studies reported were located. Despite considerable humanitarian work occurring in the Middle East and in Asia (the latter generally characterised by natural disasters), these settings had relatively limited representation in the literature. Evidence relating to Latin American and other non-English speaking contexts was potentially limited by conducting this review with English language sources only.

Intervention type and delivery

The literature review identified a growing evidence base that evaluated a range of MHPSS interventions. Group interventions were the most common type of delivery researched, with community-focused interventions the least researched. The age range in the research studies included in the wider review spans throughout the life course starting at age six (younger in the R2HC studies), and the majority of the studies evaluated MHPSS programmes aiming to strengthen community and family support.

However, MHPSS interventions identified in this review predominantly targeted adults with limited direct evidence on outcomes for children and adolescents, nor specific attention to whole family approaches. Where family focused interventions have been used, the interventions are primarily directed at parents and caregivers, for example, parenting skills. This was also noted by two key informants who emphasised the need for studies to focus on family-based interventions that measure family-oriented outcomes. In addition, there remains a need for targeted research that looks at the effectiveness of family-based interventions as identified in the 2010 research priorities.

A lack of clarity of definitions and categorisations has been highlighted in recent reviews, including around what is meant by the term 'psychosocial' (Lee et al. 2019), and where different interventions might fit in the levels of the IASC (2007) MHPSS intervention pyramid (see Figure 1; and Purgato, Gross et al. 2018). A pattern has been observed in the mismatch between study outcomes, and the nature of the intervention being tested, e.g., measuring symptoms of psychological distress and disorder in programmes intended to be preventive and promotive (Haroz et al. 2020; Purgato et al. 2019). Apart from a number of interventions for Child/Youth Friendly Spaces there were minimal replications of the same approach in different settings. Researching the replication of preventive and promotive interventions across settings and population groups would contribute to better understanding of their effectiveness and generalizability. However, as a first step towards achieving this, it is important to note that a significant proportion of interventions have been adapted to different sociocultural contexts before being tested, in line with the research priority for sociocultural adaptation.

Long-term follow-up

A relatively low proportion of the academic studies in the broader literature review examined long-term impacts of the interventions with follow-up data collection, or, if the follow-up did occur, this was not reflected in the literature. In contrast, the final Elrha project reports show that follow-up may be more common than is obvious from the published literature. The importance of follow-up is further articulated below regarding researcher and practitioner collaboration.

Studies of MHPSS integrated within other technical areas

Of the limited studies which integrated MHPSS within other technical areas, the most common were MHPSS–child protection and MHPSS–disaster preparedness. Key informants noted the importance of integrating MHPSS with humanitarian programming activities that address the most pressing and urgent humanitarian issues (e.g., cash, shelter, food distribution, livelihoods, other social determinants) to achieve greater impact of other sectoral outcomes and to synergise effects and outcomes across humanitarian priorities. Combining longer-term integrated programming with implementation research in crisis settings was reported to both meet priority humanitarian needs and improve how to understand and address the social determinants of mental health and psychosocial wellbeing such as poverty, interpersonal relationships, family dynamics, and access to education.

Methods for measurement

Using appropriate methods to assess the mental health and psychosocial needs of populations has been identified as a research priority. Most studies reviewed used adapted assessment tools, actively adapted assessment tools, or created new assessment tools to fit the setting and context, while a number of the studies described the development of locally-relevant tools and incorporated these into their assessment processes. Most of the MHPSS systematic literature reviews conducted have focused on a small number of RCTs as the more robust measure of effectiveness (Lee et al. 2019). However, RCTs tend to focus more on person-centred interventions and individual mental health outcomes, and exclude the more positive outcome measures of psychosocial wellbeing (Patel et al. 2007; Tol, Barbui et al. 2011). Bangpan et al. (2019) noted the need to look beyond mental health outcomes to identify impact on less frequently reported measures of psychosocial well-being such as resilience, hopefulness, social support and coping strategies.

The value of a range of research designs within the MHPSS intervention evidence base was highlighted by key informants. Having RCTs that demonstrate the effectiveness of MHPSS interventions was seen as advancing the field: *'everyone loves an RCT, it adds an extra level of credibility to interventions.'* (Pr 1)* However, the limitations of this research design were also acknowledged, for example being more readily applied to person-focused interventions with validated scales, and less to community-focused interventions that address difficult-to-measure changes and complex social dynamics. A risk associated with this was noted by one global coordinator: *'RCTs are good for studying certain sorts of problems and interventions. This creates a bias around what studies are included in systematic reviews, which skews your view of what works, and skews what is included in what WHO recommends and is going to be scaled up.'* (Co 2)*

Although stakeholders generally agreed that RCTs are important to demonstrate effectiveness, given the controlled conditions required for an RCT, many felt that other types of research design are required to understand how an intervention works in real life. MHPSS evidence generated more recently was acknowledged to include 'a greater range of methods' with biological and behavioural measures having been incorporated into recent studies for example. Key informants also concluded that the global MHPSS community was increasingly placing greater 'legitimacy' and value on qualitative research. A combination of methods, particularly mixing quantitative and qualitative approaches, was felt to be the most helpful approach by the country-level MHPSS practitioners interviewed. These mixed designs were common within both the broader literature and the R2HC literature reviewed.

*Key to referencing in appendix – available online.

Measuring positive aspects of wellbeing versus mental health disorders

Published evidence and the conclusions of key informants both point to the clear broadening in scope and range of research over the last 10 years, moving from a focus mostly on mental health disorders and ‘dysfunction’ to using more positive outcome measures of mental health and psychosocial wellbeing and giving greater attention to context. Some key informants also noted an increased interest in research on the determinants of mental health and psychosocial wellbeing (e.g., poverty, gender-based violence, marginalisation). However, there is still an overall predominance of MHPSS research focusing on clinical outcome measures rather than wider social outcomes related to mental health and wellbeing.

The studies reviewed frequently had more than one primary outcome and there remained a disconnect in many studies, whereby the interventions were broad, community-based and geared towards positive outcomes, but the outcome measures used still focused on changes in symptoms of mental health disorders. Sometimes this may be appropriate, but more often it fails to capture the breadth of outcomes that could be generated by these types of interventions (e.g., social cohesion, social connectedness, functioning, agency) and thus restricts potential learning.

It is well recognised that these constructs may be more difficult to measure given the paucity of available validated scales, however progress is being made in this regard. For example, the IASC MHPSS Common Monitoring and Evaluation Framework (forthcoming second version) includes qualitative and quantitative means of verification for each impact indicator. It is important to note this broadening in scope and range has been significant in research conducted in high-income countries and there is potential to take lessons learned and apply them, where applicable, to research conducted in humanitarian settings.

There is a notable group of studies whose interventions were focused on a clinical population and so did not meet inclusion criteria for this review, but they remain an important group of studies. A number of these published studies reflected that they had delivered lower-level interventions (on the intervention pyramid), measured mental health disorder symptoms, and found minimal or no change on these outcomes (e.g. Bass et al. 2012; Dhital et al. 2019; Jani et al. 2016; Kohrt et al. 2015). Other authors of such studies identified the mismatch between the intervention being delivered and the outcome being measured. The study by Kohrt et al. (2015) noted the need to look more broadly than disorder-specific symptoms: “An important issue to consider is that our outcomes for this analysis were limited to depression, PTSD, and function impairment. The benefits of different reintegration programmes on other life domains such as employment, economic security, physical health and social status were not evaluated.”

*“ I anticipate a big shift...[to continue] over the next 10 years. The Lancet Commission on Global Mental Health was clear on that. Taking a full spectrum approach, moving away from the dichotomy of disorder versus non-disorder, but I think we are at the beginning of that. I think the research domain, if you are aware of looking at MHPSS as a continuum, has been dominated by the ‘MH’ part ... In fact, we are now putting a number of proposals together that are looking at issues of social connectedness, much more mechanistic outcomes, for example understanding the interplay between social determinants and mental health. That is part of the shift we are all in. ” (Re 5)**

Interviewees further explained the previous focus on symptoms and disorders also related to the historical roots of MHPSS from medicine and psychiatry; the existing, validated measurement tools being mostly disorder-focused; and the primary biomedical paradigm of certain high impact academic journals.

*Key to referencing in appendix – available online.

3.2 Uptake of evidence

The impact of research when applied to humanitarian interventions may be immediate or long range, intended and unintended, positive and negative (Beck 2003), with pathways to change that are indirect and difficult to track (Department for International Development 2014). To operationalise research findings and examine change resulting from R2HC-funded research initiatives, Elrha defines four domains of impact (Elrha, 2019, adapted from the Economic and Social Research Council (ESRC) and DFID-ESRC Growth Research Programme):

1. Conceptual knowledge and attitude of key stakeholders
2. Instrumental programme and/or policy change
3. Capacity building and increased awareness of study team/partners/other stakeholders to understand, use, apply the knowledge or research, and conduct similar work in the future
4. Enduring connectivity through the existence and strengthening of networks and communities of practice.

This review looked specifically at the second domain, although the consultation process revealed some insights into the other domains when participants discussed how evidence responds to the 2010 research priorities.

Decision-making and locally perceived needs

The priorities set in 2010 identified a need to understand the extent to which current MHPSS research addresses locally perceived needs. In terms of MHPSS implementation research, a theme emerged around it remaining top-down rather than being responsive to needs on the ground. Even though a shift was partially observable from the literature reviewed, it was recognised in the consultation that topics of MHPSS intervention research still need to be better ‘driven by needs in the field’ and not just ‘*a good idea from a researcher behind the table.*’ (Co 2)*

Academic researchers reported being under pressure from university requirements to secure publications in highly rated academic journals ‘*that does change my focus quite a bit*’ (Researcher 1)*, and from funders who can act as ‘*arbiters*’ over the final topic of research. In addition to responding to priorities of local government and practitioners, the importance of responding to the ‘*lived experience*’ (Co 1)* of people living in affected by crises was raised. Furthermore, a geographic divide due to the hierarchy of ideas of the global north over the global south and supported by structural inequalities in research funding was noted by one national government focal person who described ‘*ideas coming from the North and [being] sold to professionals in the South.*’ (NaGov 2)* The online survey conducted as part of the review’s consultation asked researchers (n=20) for the single most important reason behind their choice of current / most recent MHPSS intervention research topic, and found, from the five options presented, that personal interest/ continuation of previous research was the most important influence (n=8).

Has evidence informed practice?

A review of the 24 global or regional MHPSS guidelines and strategy documents showed that only seven of the selected studies were cited in the resources, suggesting that published research evidence is not well taken-up in these global or regional resources. The scope of published academic research may be limited for this purpose. Some of the R2HC research reports reviewed (see Section 2) revealed a greater level of useful detail for programming than the academic literature reviewed. The need for MHPSS programming to be more based on evidence than it is currently was also identified in the interviews. That practitioners felt that research has positively impacted programmes, implying that research has affected them, but the translation into programming seems to happen by staff at higher levels. The more important question may therefore be “who should be connected with research findings for change to occur?”.

*Key to referencing in appendix – available online.

Examples from Elrha project reports included detailed descriptions of how interventions were adapted to sociocultural contexts, and the adaptation of tools (both of which are identified research priorities). In contrast, the impact of the published academic literature may be more limited for practitioners. Practitioners rely on a wide range of evidence for their work, and only rarely draw on academic research to inform programming, preferring instead an in-person transfer of knowledge and through online resources. The literature review was able to identify how publications were cited (RCTs were most impactful by far in this respect) but not the extent to which that evidence informed practice; that is, impact on programming may have been achieved, but may not have been considered relevant to document in these papers.

When asked what they defined as ‘the sort of evidence that should inform programming’ the MHPSS country-level practitioners interviewed during the review placed emphasis on the routine data they collect, for example from needs assessments, monitoring and evaluation activities, and from health information systems. The policymakers and national government focal persons reported relying on ‘expert opinions’ from advisors (that may itself be informed by formal research) and also ‘stories’ sent to them from country-level programming: ‘*[we] don’t need more research – we need more story-telling – bring real-life experience to the table.*’ (DoG 2)* What type of evidence is used, when, and for what purpose were important considerations for this group of stakeholders. As one respondent concluded,

“Evidence doesn’t always need to come from big research projects... It would depend on the purpose. If we take a hypothetical scenario that we need to understand the right or wrong direction – if the scenario is if we were to engage in a new area of work, or shift priority in a bigger area of work where more global or regional evidence is needed then that would be relevant. The context-specific admin data could be very relevant if we already have a presence in a country.” (DoG 1)*

As one global MHPSS coordinator (headquarter-based) noted: ‘*there is an urgency and desire to say we are evidence-based*’ (Co 1)*. A researcher described it as ‘inappropriate’ to implement programming without an evidence base: ‘*we wouldn’t release a drug before going through trials*’ (Re 4)*. This comment, however, could speak more to clinical mental health interventions rather than broad based community interventions. Yet, despite progress, programmes not being based on evidence was described as the reality in many contexts: ‘*a lot of NGOs run MHPSS programming that has no evidence-base*’ (Re 1)*. Alongside a shared value placed on cultivating the evidence base was a caution to think beyond this, to ensure that evidence informs action:

“I think the MHPSS community is so much concerned with being evidence-based that the step to operationalisation is sometimes forgotten.” (DoG 2)*

How has evidence influenced practice?

MHPSS implementation research over the last 10 years has influenced programmatic changes and uptake for several interventions, particularly scalable, psychological-based interventions. Studies implementing these interventions were identified in the review. Although not all implementation research (research with the specific aim to study a particular approach in a particular context or with certain target groups) leads to continued change, or new programming, the following examples have been instrumental:

- Contextual refinement and implementation of newly developed interventions (e.g., SH+, Common Elements Treatment Approach (CETA), PM+, the PRIME programme in Nepal).
- Further developing existing interventions (e.g., Advancing Adolescents in Jordan and Syria).
- Influencing uptake and scaling of various interventions because of the evidence base supporting them (e.g., mhGAP, PM+, tele/remote-psychology approaches, IPT-G – group interpersonal therapy). Informants reported that the fact that Psychological First Aid (PFA) is an ‘evidence-informed’ approach encouraged its wide uptake.
- Re-evaluating and improving existing approaches. For example, multi-country evaluation of child friendly spaces led to a critical re-evaluation of the approach and greater attention to quality safeguards in its implementation.

*Key to referencing in appendix – available online.

Practitioners are documented as using a range of evidence to inform their work (Lee et al. 2019), yet most systematic literature reviews to date have focused on a small number of RCTs as the more robust measure of effectiveness. Practitioners surveyed and interviewed provided specific examples of how MHPSS intervention research had informed their programming. Frequently, participants confirmed that research had influenced their choice of overall intervention, and referred to both scalable interventions PM+ and IPT-G. Survey respondents also reported that MHPSS intervention research influenced their choice of specific components of MHPSS approaches, e.g., the use of lay workers, a focus on coping strategies, and engagement with families, even when a component was not delivered in the context of the overall intervention in which it was originally studied. A small number (n=3) of survey respondents mentioned being able to advocate for extra funding to expand their programming through the use of research findings.

Informants in the review described a range of information, products and channels through which MHPSS evidence is taken up. A comprehensive study of how evidence is translated into practice should take these into account. Differences emerged amongst practitioners, researchers, and donors as to which information, products and channels are most useful to them:

- Information: practitioners and donors confirmed their use of a range of sources of evidence to inform their work, and reported a preference for locally derived evidence. Practitioners placed greater value on locally produced information, including the routine data they collected from needs assessments, lessons learned reports, and routine monitoring and evaluation activities. These were perceived as being more useful and relevant to inform practice. ‘Stories’ from country programmes were described as being particularly helpful for donor government officials in lobbying for funds.
- Products: practitioners appeared to most commonly use manuals and guidelines, with practitioners based outside Europe and North America also using more online blogs and articles. Academic researchers generally prioritised the publication of academic articles (even though they themselves reported such articles to be less effective at sparking programme and/or policy change), and were less invested in lessons learned/evaluation documents and online blogs/articles.
- Channels: different knowledge transfer channels were perceived as being useful for researchers and practitioners. For researchers, in-person means of transferring knowledge were central. The majority of researchers sampled used presentations at conferences or other events as the most common channel to engage stakeholders. The second most commonly used channel was in-person meetings or briefings with key stakeholders. In-person channels were also perceived by researchers as the most effective, with in-person meetings rated as ‘highly effective’ among those who use them. Similarly, in-person trainings and communities of practice were also deemed effective, although these were only used by a smaller proportion of researchers. The channels used by practitioners were more varied, although one channel clearly stood out: online resource collections (such as MHPSS.net and MHIInnovation.net). All practitioners reporting using these, with public online resource collections like MHPSS.net perceived as the most effective channel (75% of practitioners sampled rated them as ‘highly effective’). Other highly used channels include conferences, mailing lists, working groups/clusters, communities of practice, and webinars. Country-level MHPSS practitioners felt there were fewer products and channels open or accessible to them.

Interestingly, one key informant described the WHO as being the most effective, long-running and overarching resource hub, *‘that has been one mechanism to ensure uptake’* (Re 5)*. This was reportedly through supporting research and developing guidance and tools on mhGAP and other scalable interventions, and the work on the EQUIP (Ensuring Quality in Psychological Support) platform.

*Key to referencing in appendix - available online.

Challenges to achieving uptake

During the interview process, the country-level based MHPSS practitioners described feeling ‘*not very familiar*’ (Pr 3)* with global research and research generated in country settings beyond their own, and none had heard of the 2010 MHPSS research priorities. This extended into a wider theme of ‘fragile knowledge’ and the disconnection of country-level based MHPSS practitioners from formal MHPSS intervention research findings.

Country-level based MHPSS practitioners were prone to be particularly disconnected from certain types of research, for example, research published primarily in academic journals: ‘*Another thing – who has access to journals? Field-based practitioners don’t have access.*’ (Co 1)* Although this lack of access to journals may be true for many field-based practitioners, practitioner interviewees still reported that practice has been impacted by research – and this was further supported by survey findings.

80% of practitioners surveyed who were based in Europe and North America rated their familiarity with MHPSS intervention research from the past 10 years as either four or five out of five, but only 36% of practitioners based outside of Europe and North America did so. When asked how easy it is to access MHPSS research, 60% of practitioners in Europe and North America reported a four or five out of five, whereas only 27% of those based outside Europe and North America did so. 94% of all practitioners agreed somewhat or very much that information is expensive or in difficult-to-access closed communities or portals. These findings give a sense of the pathway that research travels through organisations and into practice. The pathway appears to be multi-layered involving several different actors at different levels, each likely engaged in their own preferred channels. The more channels practitioners can access, the more likely it is that research findings will be taken up in ways that more effectively influence policy change and programming.

Country-level practitioners raised concerns regarding interpreting and thinking critically about MHPSS intervention research. Not having the skills and knowledge to do this was thought to risk under-appreciating the significance of research generated; misreading and/or over-stating the significance of research generated; and/or mis-applying findings and recommendations.

A further limit to the knowledge brokering process was that practitioners and policymakers lacked the time to access and become familiar with research. Ninety-four percent of the practitioners surveyed (n=30/32) agreed somewhat or very much that they lacked time to search for and engage in research learnings. As noted by one policymaker who was interviewed, this can present a ‘Catch-22’:

“Maybe we are also at fault as policymakers in the sense that we don’t read much. We are bogged down with issues of administration, planning, but with planning we need to plan with evidence” (NaGo 2).*

The step of actively transforming and translating evidence from knowledge to practice was raised across all the stakeholder groups as being critical to the knowledge brokering process. The majority suggested that evidence products should be digestible, practical and focused on the end user, without losing the nuance of the findings. The following quotes are representative.

“How research findings can be digested in a way that is easy to understand and see how it related... How evidence can lead to higher quality, more effective programming.” (Co 3)*

“Key challenges with research projects and findings is the communication of them and that often they are not targeted to who needs to receive them.” (DoG 1)*

“We need to simplify the information. One-page policy brief, giving infographics if there is a need for that.” (NaGo 2)*

*Key to referencing in appendix - available online.

Programmatic and policy change attributable to research

At the level of global MHPSS policy, research was thought to have influenced the shift from ‘critical incident stress debriefing’ to broad endorsement of PFA, and the shift from a single focus on trauma counselling and PTSD-focused interventions to transdiagnostic and community interventions. Furthermore, there has been an increased focus on and allocation of resources for adapting interventions based on rigorous needs assessments, consultations with end users and engagement with community-based stakeholders (see Box 1). Despite this, however, debate continues around the role or influence of socio-cultural context and locally developed/sourced interventions versus adapted MHPSS interventions.

Box 1: How MHPSS research has translated to change

When researchers who participated in the survey as part of the review’s consultation were asked how MHPSS research has translated to ‘change’, the primary change that they reported from their own research was improved knowledge among policymakers and practitioners, with 70% claiming this change (n=14/20).

The other commonly identified changes reported included influencing the design or implementation of direct humanitarian programming (45%, n=9/20), improving the capacity of actors to understand or use knowledge or research (40%, n=8/20) and strengthening connectivity through networks/communities of practice (35%, n=7/20). Instrumental change seemed limited to the programme space however, as global and/or national policy change was only reported by 15% (n=3/20) of researchers.

Notably, 45% (n=9/20) of researchers noted that they do not systematically gather information on the changes that result from their research. Some impacts of research on MHPSS practices or policy may therefore not be well documented or captured by researchers.

Still, these figures correlate quite closely with the change practitioners felt that MHPSS intervention research has had on their work. Encouragingly, 81% (n=26/32) of practitioners reported that MHPSS research resulted in changes in the design or implementation of their programmes. In addition, 94% (n=30/32) of practitioners reported that research had improved their knowledge; 50% (n=16/32) believed that they had improved their capacity to access, understand, or use research through their engagement with research; and 44% (n=14/32) reported strengthened connections through networks/communities of practice.

Change at the global policy level was reported by more practitioners than researchers (44%, n=14/32) as were changes at the national government level (25%, n=8/32). This could reflect the closer engagement of practitioners – especially those based in the field where programmes are delivered – with local and regional advocacy and policy efforts at local and regional levels.

Strategies to track the uptake of interventions were also described, for example by War Child through the development of indicators that partners must adhere to if they use one of their interventions: *‘We are developing those four standards for attendance, fidelity, competence and cost. Validating them. Here is the minimum threshold. Organisations, including ourselves, are using them, are free to use our interventions, the only thing they need to commit to is reporting on those, for us to track the uptake of those interventions. That gets collected in a central database. That is my thinking at the moment to try to bridge that gap.’* (Re 5)*

Despite some changes in global policy, such as the place of child friendly spaces in global Child Protection policy as a result of a multi-country study (see case study 1) and Advancing Adolescents in Jordan (see case study 2), instrumental change in policies at the level of national governments in countries affected by humanitarian crises were rarely reported.

Case study 1: Child-friendly spaces

The series of impact evaluations of the widely-adopted child-friendly space intervention concluded that outcomes of this intervention may be small, and primarily related to quality and fit with the local context. A major recommendation was that providing a 'safe space' on its own is not enough.

Results were presented as an easy-to-read two-page summary that provided the necessary evidence contributed to the uptake of the research. This was widely shared with and discussed by child protection agencies through the Child Protection Alliance which directly led to the removal of a specific standard on child-friendly spaces in the original Minimum Standards for Child Protection in Humanitarian Action. This was replaced by a standard on group activities for child wellbeing and to a more socio-ecological approach being taken to child protection interventions in general.

In turn this led to a deliberate shift away from focusing on establishing 'spaces' to thinking about what children need, and tailoring interventions to meet that need within a safe environment.

Case study 2: Advancing Adolescents in Jordan

Mercy Corps' 'Advancing Adolescents' (Nubader) programme brings together at-risk Syrian and Jordanian youth living in urban communities. Through a Profound Stress and Attunement approach, the programme aims to alleviate stress and enhance social cohesion among youth affected by the Syrian crisis by providing them with psychosocial support through socialising activities and informal education.

In 2015–2016, Mercy Corps partnered with Yale University and Taghyeer (a local Jordanian NGO) to conduct a quantitative, randomised control trial to evaluate the programme impact of the Advancing Adolescents.

Family-level activities included for caregivers focused on strengthening dialogue and knowledge of adolescent development and a parallel Wellness Centre was established to offer a form of contextualised counselling. New livelihood activities were included in the package and the length of the intervention was extended. An extra 'personal development' stream was developed for the most vulnerable, and a number of culturally relevant tools that were developed through the research programme were adopted to measure intervention outcomes.

At the global level the Advancing Adolescents research reinforced Mercy Corps' commitment to young people feeling safe and was a foundational piece for their broader youth development programming. The Profound Stress and Attunement work, also known regionally as 'Hearts and Heads', has yet to be replicated outside the Advancing Adolescents programmes in Lebanon, Jordan and Iraq.

3.3 Advances in the research agenda

Researcher and practitioner collaboration

Researcher–practitioner collaborations were reported by participants as the most effective way of shaping research and sharing findings that can lead to achieving uptake. The researchers interviewed as part of the review’s consultation reported that translating research findings to changes in programme practices is an ongoing process that should start at the inception of the research, rather than a set of discrete activities and/or dissemination outputs. That this takes a significant amount of time was emphasised.

Useful collaborations can include a range of stakeholders such as researchers, global- and country-level MHPSS practitioners, local and national governments, and community stakeholders. Strong collaborations were seen to result in:

1. mutual learning for all parties involved;
2. improved quality of research through the insights of partners;
3. buy-in for the intervention from key stakeholders; and
4. more direct avenues for programme and policy change.

However, 97% of practitioners (n=31/32) and 95% of researchers (n=19/20) who responded to the review’s survey agreed or somewhat agreed that researchers do not actively connect with practitioners. Furthermore, although only 25% (n=5/20) of researchers saw this as a significant barrier to change, 50% of practitioners (n=17/32) reported it as a barrier.

Effective collaborations were described as achieving four things:

- Building capacity:
Strong collaborations provide opportunities for mutual learning for all involved. *‘Researchers have the tools and the lens of looking at things in an ideal way of how research should be organised and how it should move forward in a systematic way. To anticipate and mitigate any risks. There is so much detailed level planning, especially for many humanitarian workers who maybe don’t have the same time for the granular planning can really learn from. Also, simultaneously the researchers can hear the field realities, you can plan for so many things, but field realities arise, how to be flexible with things that cannot be anticipated.’* (Co 3)*
- Better quality research:
Research quality can be improved by combining technical research expertise with more grounded expertise and relevant lived experience. This was seen as especially critical for cultural adaptation of interventions being studied.
- Buy-in for the intervention:
Both practitioner and policymaker interviewees who had been directly and meaningfully engaged in a research partnership reported that they understood, saw the value, and were even enthused by the intervention: *‘We realised that actually CETA works in Zambia here and in other places.’* (NaGo 2)*
As another survey respondent noted: *‘If buy-in is created around priority recommendations by practitioners, policymakers and funders it is more likely these will be supported during implementation.’*
- More direct avenues for programme and policy change:
The collaborations described in the STRENGTHS project (see case study 3) and SH+ projects were described as enabling policy and programming opportunities to be identified from the outset. *‘The STRENGTHS project is the best effort I have seen of the five-year grant being about the uptake and dissemination. The whole point is that, presuming there is evidence, how to scale up at a national level.’* (Co 3)*

*Key to referencing in appendix - available online.

The features of a strong collaboration included: being mutually beneficial and seen as an intentional joint learning opportunity; engaging partners early in the process; participatory decision-making; regular communication; on-going and sustained contact with an emphasis on personal relationships; and being fostered in the context of encouraging systems, for example when research funders require a certain degree of investment in a partnership.

There was a clear preference for engaging local or international researchers who have extensive country-level/programming experience, as this was thought to lead to more contextually and culturally relevant research design. As highlighted above, however, there continues to be a disconnect between country-level practitioners and academic research findings. Country-level practitioners reported less familiarity with and accessibility to academic research. It was noted that local stakeholders may lack the time, capacity and/or incentives to evaluate and apply evidence appropriately to their work, and may lack access to the context of a wider pool of academic knowledge that would help them contextualise evidence. It is the responsibility of 'knowledge brokers' to understand practice needs and translate those, so that practitioners can interpret context and recommendations and apply the evidence accordingly. Greater investment is required to broker this knowledge and actively transform and translate research findings for country-level practitioners.

A number of networks and resource hubs, platforms and communities of practice focused on ensuring uptake of research linked to recent MHPSS intervention research initiatives were described by participants, and examples were given at the international, regional and national levels. At a global level, examples included the STRENGTHS project; building an uptake network for PM+; Mercy Corps' sharing of the Advancing Adolescents findings as part of the CIES and USAID ECCN; and USAID Youth Power's efforts to build the Social Emotional Learning (SEL) evidence base and communities of practice. National level examples included the GROW project in Zambia and PRIME in Nepal. However, the limited connections between country-level MHPSS practitioners and global MHPSS intervention research outcomes imply that such hubs, platforms and communities of practice are not inclusive to all. Indeed, there were few examples of networks that engaged country-level MHPSS practitioners on an on-going basis.

Case study 3: STRENGTHS project

The STRENGTHS project trains Syrian refugees to provide PM+ to fellow Syrian refugees in eight different countries in Europe and the Middle East and North Africa. Through the project, psychological interventions (individual and group PM+, Early Adolescent Skills for Emotions (EASE) and an internet delivered version) are translated, adapted, tested and implemented. The STRENGTHS project seeks to go beyond answering the question 'does the intervention work or not' to understanding how it can be implemented in a specific context, and whether or not it is cost effective.

The STRENGTHS project aims to disseminate and promote 'buy-in' of a validated framework and strategy for large-scale implementation to providers of health and social services, as well as policymakers, and funding agencies by:

- a) validating and disseminating the culturally and contextually adapted PM+ training manuals developed for implementation for large scale dissemination through the UN agencies (WHO, UNHCR), the Red Cross Movement and other partners;
- b) the cultural and contextual adaptation manual both developed for large scale implementation through the WHO, UNHCR, the Red Cross Movement and other partners; and
- c) establishing a sustainable STRENGTHS training network for delivering training in PM+ programmes beyond the duration of the project hosted by existing MHPSS networks.

CONCLUSION AND RECOMMENDATIONS

We have presented a review and assessment of MHPSS intervention research evidence in humanitarian settings since 2010, describing its contribution to advancing knowledge, and the uptake of that evidence. This section outlines potential new horizons for MHPSS research based on the available evidence published in literature since 2010, and the insights generated by participants in the review's consultation process. It then proposes recommendations for how to better translate knowledge into practice.

Potential new horizons for MHPSS research

The potential horizons in MHPSS intervention research were identified through the four streams of analysis: research gaps were extracted from the discussion sections of the literature review studies and the R2HC-supported MHPSS publications, and key informants and survey respondents were asked to identify the 'priority research gaps' that would best support their work. Themes identified in these data were synthesised, with the most reported areas for research highlighted.

Improving research design and measures:

Potential new horizons for research and measurement emerged including:

1. a focus on the inclusion of the lived experience, perspectives and opinions of participants in studies, instead of quantitative studies that integrate a qualitative component;
2. longitudinal follow-up to track long-term impact and implications, including tracking the role of the intervention and contextual factors in sustaining any change; and
3. measuring outcomes beyond individual mental health disorders (especially for broad, community-based interventions), such as positive aspects of wellbeing, collective aspects of healing, other psychosocial impacts and other life areas.

Investment in specific interventions:

Specific interventions that require further investment include:

1. the integration of MHPSS with humanitarian programming activities that address the most pressing and urgent humanitarian issues (e.g., cash, shelter, food distribution, livelihoods, other social determinants) and community-based support;
2. family-based and family-focused interventions that measure family-oriented outcomes.

Furthering research with specific intervention groups for whom there is a limited evidence base:

Furthering the evidence base with specific intervention groups includes:

1. interventions that address the needs of neglected populations, including those with severe mental health disorders and substance use problems, and for the prevention of suicide; and resources and services (e.g., women who cannot attend health centres, people without internet access).

Furthering advancements in programme delivery:

Aspects of programme delivery in humanitarian settings that could be strengthened through intervention research include:

1. how interventions work in real-world, low-resource settings through the analysis of the implementation and delivery of evidence-based interventions and including longer-term observational approaches;
2. how to best apply a socio-cultural lens to adapt interventions and gain a systematic understanding of acceptability and appropriateness, including the development of tools and guidelines to support this process through participatory community engagement and co-design; and
3. how to establish stronger, more resilient preparedness systems for MHPSS service delivery in emergency settings that build on existing processes.

Ways forward to ensure research informs MHPSS programming

Practice-based research and strong collaboration as the foundation

The literature reviewed identified a rapidly growing evidence base that evaluated a range of MHPSS interventions. One key finding concluded that the ways in which interventions are studied also need to highlight real world implementation realities more effectively. Implementation research is one way to achieve this as it provides a way to understand the realities of day-to-day roll out, the cost-effectiveness of interventions, and the various approaches to measuring and maintaining quality and fidelity. Conducting RCTs on MHPSS interventions continues to be a high priority but key stakeholders reported the need for other types of research design to understand how an intervention actually works in complex humanitarian settings with the myriad of challenges and complexities that arise and cannot always be predicted.

The review identified a disconnect between country-level practitioners and MHPSS intervention research. There may be significant returns on efforts by researchers and MHPSS coordinators/programme implementers to make it easier, more cost effective, and more rapid for country-level practitioners to engage with research findings through diverse products and channels for knowledge dissemination. Engaging with practitioners working in areas affected by humanitarian crises from the inception of the research onwards will better inform the research agenda, empower practitioners to be active participants throughout the life of the process, and can in turn support the advancement of programming. It would also help facilitate the identification and design of research needed to meet real demand, ensuring that studies conducted are contextually and culturally relevant and cross-sectoral. Overall, this would strengthen the evidence base for commonly delivered Layer 1 and 2 MHPSS interventions.¹⁰

Greater investment in collaborative research by funders, researchers, practitioners and organisations, policy makers and people with lived experience might be the most effective way of shaping and implementing research that can also lead to increased uptake. Not only would this build the capacity and competencies of those involved (including the researchers), but would increase the likelihood of higher quality research, sustained buy-in from key stakeholders, and more direct avenues for programme and policy change.

Strong and inclusive collaboration processes can facilitate both higher quality and more relevant implementation research design, as well as supporting the interpretation and contextualisation of findings in ways that are most useful to the lived realities of practitioners and people affected by crises. In addition, funder-driven initiatives such as Elrha's Research Impact Workshops are valuable in bringing together diverse stakeholders to engage from the outset of the project through to analysis, the validation of findings, development of recommendations and dissemination.

¹⁰Layers 1 and 2 of the IASC MHPSS intervention pyramid relate to social considerations in basic services and security (layer 1) and family and community supports (layer 2). For further details, see the IASC Guidelines for MHPSS in Emergencies (2007).

To further the ability of practitioners to make best use of research findings for programme and policy change, more investment is needed in knowledge brokers (e.g., knowledge managers, technical specialists) who can effectively translate between practitioners and researchers and help to bridge the gap. Furthermore, webinars by MHPSS.net, MHInnovation.net and other platforms are important vehicles for knowledge dissemination to country-level practitioners. Investment in these channels would be welcome and would strengthen their ability to reach country-level practitioners. Multiple languages and a variety of platforms should be used to facilitate the participation of those with less internet access, for example, through regional hubs and through the use of both technological and traditional dissemination methods.

Integration and measurement

For interventions to achieve greater impact requires longer-term funding for MHPSS programming, as well as the effective integration of MHPSS approaches within other sectors (e.g., education, cash, shelter, food distribution, livelihood activities) to synergise effects and outcomes across humanitarian priorities. Combining longer-term, integrated programming with intervention research in crisis settings would both meet priority humanitarian needs and improve how to understand and address the social determinants of mental health and psychosocial wellbeing such as poverty, interpersonal relationships, family dynamics, access to education, etc. One specific example is how to effectively deliver family-based interventions and not just family-focused interventions, providing renewed attention to the mental health and wellbeing of the child and the larger support system surrounding the child.

One clear shift identified in the review was the measurement of positive aspects of wellbeing. Global MHPSS coordinators and researchers should continue to work alongside practitioners to inform funders about the range of relevant MHPSS outcomes, and to identify which are most appropriate when assessing individual and community wellbeing. The following publications provide useful information on advances to measurement selection: Monitoring and evaluation of MHPSS programmes in humanitarian settings: A scoping review of terminology and focus (Augustinavicius, Greene et al. 2018), the standards for monitoring and evaluation outlined in the IASC Common MHPSS Monitoring and Evaluation Framework (IASC, 2017), and its forthcoming second version which will include means of verification for the six outcome indicators outlined in the IASC framework.

Improving access and uptake

Manuals and guidelines (e.g. Problem Management Plus, Psychological First Aid, IASC Guidelines on Mental Health and Psychosocial Support in Emergencies) are most utilised by practitioners and should continue to be developed and made accessible for newly developed interventions as highlighted in the potential new horizons for MHPSS research. Accessibility and uptake are enhanced through use of dynamic platforms that facilitate practitioners in learning and applying the content, through translation into appropriate languages, and by training workshops to engage in the content beyond just email dissemination. Whereas most manuals and tools now exist to guide and evaluate several targeted interventions, there is a need to prioritise the development of clear guidelines for Layer 1 and 2 interventions (social considerations in basic services and security, and community and family-approaches, respectively) as these are the most widely implemented. As few community and family-focused intervention studies have been replicated (see Haroz et al. 2020), new research is required to underpin the development of these tools.

Findings show that researchers invest heavily in the publication of academic articles. This is understandable given current academic incentives and requirements, but these publications have limited reach and influence for country-level practitioners. In addition to the publication of academic articles, country-level practitioners may be better served if researchers also committed to developing and disseminating lessons learned/evaluation documents, short summaries and white papers, webinars, and online blogs/articles that are digestible to a broader audience including those without an academic background. Funders should be encouraged to stipulate this as a grant requirement. As an example of this, the R2HC programme now requires researchers to produce open access summaries ('research snapshots') to ensure their work is made accessible to a wide range of key stakeholders.

The review also concluded that researchers often find it challenging to isolate the changes that result from their research projects in emergency environments, and monitoring the results of knowledge uptake is not a routine part of many research project or funding cycles. Tracking this should be the responsibility of all those involved in generating and using evidence-based interventions. A shared mindset should be fostered so that all stakeholders appreciate the need to learn whether interventions actually help people in real-world settings (how and why / why not). This is particularly important for interventions intended to be scalable. Models and mechanisms for the centralised collection of data of this type exist; for example, War Child obliges partners who implement one of their interventions to submit data on attendance, fidelity, competence, and cost indicators.

Humanitarian organisations and global coordination bodies could consider investing in a central database to track who is using scalable psychological interventions and how, although this would likely require significant resources.

At a more foundational level, it is important that there is consensus on what constitutes evidence, impact, 'evidence of impact' and what these terms mean for MHPSS delivery in humanitarian setting. Global MHPSS coordinators can and do play a key role in aligning understanding of these key definitions and related approaches.

Building knowledge and skills

One way for research to lead to positive and meaningful change is to create a more equitable, mutual process of co-producing research evidence, where capacity building is bi-directional. This is enshrined in Elrha's principles of partnership (equity, transparency, mutual benefit and responsibility) as cited in the Partnership Review: Research for Health in Humanitarian Crisis (2019). This can be achieved by engaging practitioners in the research process from start to finish, by ensuring research findings are fed back to interlocutors, and by increased efforts to translate and disseminate research findings to improve accessibility, as discussed above. In addition, investment in more formal bi-directional capacity building for researchers, practitioners, and local advisory committees might be fruitful, particularly for key implementing organisations.

Our review highlighted seven determinants to ensure that MHPSS intervention research and its corresponding findings and recommendations, are translated into change. MHPSS intervention research must be:

1. Appropriate, acceptable and relevant to the setting and the needs of people affected by humanitarian crises
2. Matched with the capacity of stakeholders to understand and use the outcomes, feasible, practical and linked to tools and manuals that guide implementation
3. Relevant and linked to existing institutional and humanitarian architecture
4. Responding to political agendas and changing governments and supported by champions and advocates at the decision-making level
5. Matched with funds to continue, operationalise or introduce new programming
6. Given enough time to introduce, implement and see change
7. Long term, with active follow up by research teams to encourage knowledge transfer and to continue to evaluate impact

Learning institutions and hubs can help to collate relevant research and evidence to better meet the immediate, priority needs of programmers, and to improve efficiency in applying evidence to improving systems and programming and effecting policy change. Further support should be provided for institutions (including INGOs, NGOs and other implementing bodies) to enable them to produce rapid research and learning that meets their immediate operational priorities, alongside the generation and operation of a longer-term, rigorous research agenda. Where research and learning capacity exists in multi-sectoral organisations, this could be strengthened to promote the use and translation of MHPSS evidence. Learning hubs might include national research groups associated with key institutions that act as 'translators' of knowledge. These hubs could be regionally or globally connected, whilst working to ensure that their focus remains relevant to the local level.

The role of funders in ensuring that research informs programming

Funders can play a major role in influencing the direction that the MHPSS research agenda takes and the following recommendations are specifically directed at organisations and governments that fund MHPSS research.

Pre-application guidance and funding application processes should encourage organisations, researchers and practitioners to think together critically about how their objectives, design and projected process will result in uptake and impact. Research logs and project reports can help monitor how this plays out in real-time.

Funders can promote researcher-practitioner collaborations in activities that mutually build their capacities to strengthen the applicability and relevance of evidence to programming and policy changes. Achieving uptake and impact in MHPSS programming requires sufficient time and a degree of flexibility to make space and funds available. Longer-term flexible funding for programme co-design and implementation, monitoring and evaluation, and intervention research will greatly help to build the evidence base.

It was notable that the majority of colleagues who participated in the review's consultation, both through the interviews and online survey, were unable to articulate any ultimate impacts resulting from the last decade of MHPSS research on affected populations. This suggests a need to improve engagement of communities before, during and after research, in a way that is supported by funding bodies. Community engagement in research should have both 'instrumental' value to ensure accountability and help facilitate the research, but also 'intrinsic' value, whereby people benefit in relevant and meaningful ways from engaging in the process. Thus, this finding also reflects a wider challenge across the humanitarian/development/academic nexus in monitoring and evaluating the impact of research projects – and the need to ensure monitoring and evaluation of research are budgeted for and undertaken.

Stand-alone research divorced from programming has several limitations, including presenting challenges for later uptake, as well as ethical challenges particularly in humanitarian settings. Where possible, funders should align funding structures to facilitate the integration of rigorously researched interventions into existing and future programming.

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APPENDICES

All appendices for this report are available on the [Elrha website](#).

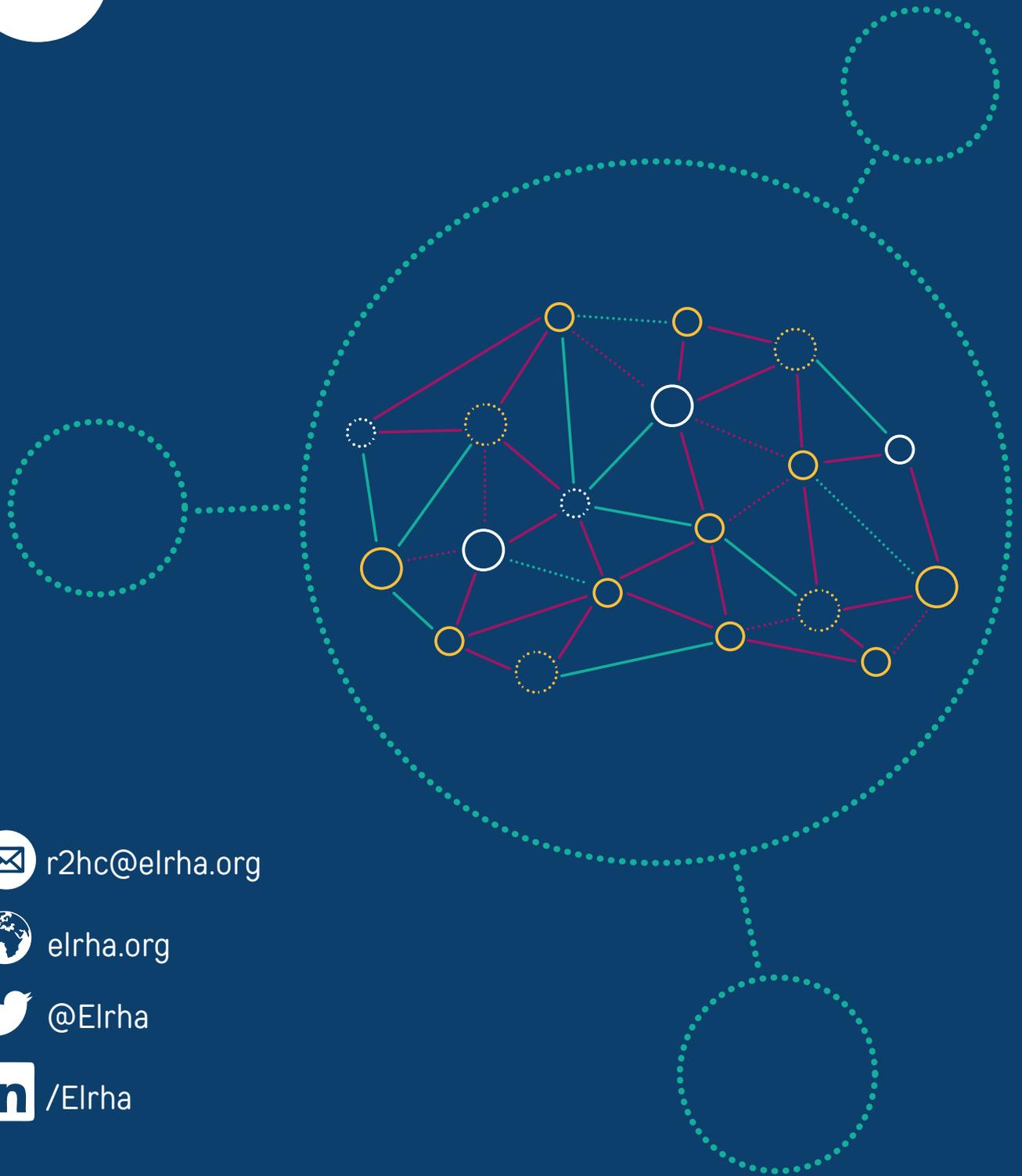
Appendices list:

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