

Towards the Successful Implementation of Low-Intensity Psychological Interventions: Implementing 'Problem Management Plus' for Venezuelan Migrants and Refugees

Camila Perera Aladro

Supervised by: Dr. Frédérique Vallières

2020

This dissertation is submitted to the University of Dublin in fulfilment of the requirements for the award of a Doctorate in Philosophy, School of Psychology

CONTEXT has received funding from the European Union's Horizon 2020 research and innovation programme, under the Marie Skłodowska-Curie grant agreement No 722523.

Declaration

March 17th, 2020

I, Camila Perera Aladro, declare that the enclosed dissertation has not been submitted as an exercise for a degree at this or any other University and is entirely a product of my own work. I agree that the Library may lend or copy this dissertation upon request. This permission however, covers only single copies made for study purposes, subject to normal conditions and acknowledgement of my contribution. I consent to the examiner retaining a copy of the thesis beyond the examining period, should they so wish (EU GDPR May 2018).

A handwritten signature in black ink, appearing to read 'C Perera', with a stylized, cursive script.

Camila Perera Aladro

Executive Summary

Background: Despite available evidence on effective psychological interventions, in low and middle-income countries most forcibly displaced persons with mental health problems do not receive any type of mental health care. The last decade has seen growing interest in the use of simple and cost-effective, low-intensity psychological interventions that can be delivered by lay providers. Developed by the World Health Organization, Problem Management Plus (PM+) is a low-intensity psychological intervention for adults suffering from symptoms of common mental health problems (e.g., depression, anxiety, stress or grief), as well as self-identified practical problems (e.g., unemployment, interpersonal conflict). Individual PM+ has been found to be effective in reducing symptoms of psychological distress and PTSD three months post-intervention among non-refugee adult populations, in two randomised control trials conducted in Kenya and Pakistan. Despite these important findings, whether PM+ can be associated with improved psychological outcomes outside of controlled settings is yet to be determined. Similarly, research on the process of adapting these interventions before implementation is needed. Lastly, little is understood about the factors that may contribute or hinder the implementation of these programmes in real-world settings.

Methods: These evidence gaps were addressed in three research phases. In *phase one*, I conducted a systematic review to examine the evidence on low-intensity psychological interventions among forcibly displaced persons, as well as the factors known to influence the implementation of such interventions. The findings of this review informed the subsequent parts of this study and lead to *phase two*, the cultural adaptation of the intervention under study (i.e. PM+). *Phase two* sought to determine what contextual and cultural adaptations needed to be made to the PM+ manuals to make the them relevant and meaningful to the implementation context. Within this phase, I developed and applied a four-step process (i.e. information gathering, adaptation hypotheses, local consultation and external evaluations) to culturally adapt PM+. Lastly, the outcomes of the *phase two* were used in the implementation of PM+ for Venezuelan migrants and refugees living in Saravena, Colombia. Accordingly, *phase three* of this study involved of the evaluation of the implementation of PM+ through an operational phased-in quasi-experimental study to ascertain the association of PM+ with improved outcomes in subjective wellbeing (the WHO-5 Wellbeing Index), anxiety (Generalised Anxiety Disorder 7) and quality of life (World Health Organization Quality of Life – BREF) among the study population. Semi-structured interviews and focus group discussions with intervention participants, PM+ supervisors and lay providers were used to explore the factors influencing the implementation of PM+ in this setting.

Results: In *phase one*, 3,847 relevant references screened, 18 met the inclusion criteria, 15 of which aimed to address child and/or adolescent mental health. Despite the available evidence supporting the use of high and low-intensity versions of CBT interventions, the evidence on low-intensity CBT interventions for forcibly displaced persons identified through this review was scarce and inconclusive. Evidence on the effectiveness and acceptability of parenting skills interventions, narrative exposure therapy, interpersonal psychotherapy and problem-solving counselling was identified. Cultural and contextual adaptations contributed to increasing interventions' relevance and participant retention. Distrust among participants of group interventions, lack of reliable protection of participants and the negative impact of interventions on lay providers' mental health may hinder implementation. Time, resource constraints and weak coordination can also affect the sustainability of these interventions.

In *phase two*, the information gathering step yielded key information on the socioeconomic aspects of the study population, the availability and need for mental health and psychosocial support, and existing barriers to accessing care. The adaptation hypotheses step further identified the need for clearer explanations of key concepts, the need for sensitive topics to match local attitudes (e.g., domestic violence, thoughts of

suicide), and the identification of culturally appropriate social supports. Building on these first two steps, local consultation subsequently resulted in revised PM+ protocols. The adapted protocols differed from the original format in their focus on the problems unique to these population groups, the way that psychological distress is expressed in this context, and the inclusion of locally available supports. The results of the external evaluation supported the adaptations made to the PM+ manuals.

In *phase three*, a univariate ANCOVA of the PM+ group's (n=38) post-intervention scores and the control groups' scores at waitlist (n=25), controlling for baseline scores, and demographic variables (i.e. sex, age, level of education), indicated significant effect for the PM+ group across all outcome measures: WHO-5 ($\eta^2 = .75$, $p = <.001$); GAD-7 ($\eta^2 = .92$, $p = <.001$), WHOQOL-BREF Physical ($\eta^2 = .6$, $p = <.001$); WHOQOL-BREF Psychological ($\eta^2 = .78$, $p = <.001$); WHOQOL-BREF Social Relationships ($\eta^2 = .64$, $p = <.001$); WHOQOL-BREF Environment ($\eta^2 = .48$, $p = <.001$). In addition to baseline scores, sex had a significant effect on the WHO-5 scores ($\eta^2 = .06$, $p = .05$). Cohen's d and Hedge's g were above 2.5 across all study outcomes. The following factors influenced the implementation of PM+ in this setting: trust, engagement, integrated approach, teamwork, autonomy, supervision, acceptability and inclusion.

Conclusions: The results of this study support the use of PM+ as an acceptable approach for decreasing psychological distress among forcibly displaced persons. Although the findings of this study support the implementation of PM+, various factors should be considered and put in place before implementing it. This study contributed to existing knowledge in this topic through a review and analysis of the available evidence on this topic, a new process for culturally adapting low-intensity psychological interventions and a better understanding of the implementation of PM+ by lay providers. The implications of these finding for theory, policy and practice are discussed.

Acknowledgements

I have been privileged to have Dr. Frédérique Vallières as my supervisor. I would like to thank her for her continuous encouragement, wisdom and help in navigating the field of global mental health research. The passion she has for research has motivated me even during the tough times of the Ph.D. journey. I am grateful for having had such an exceptional professor and person as my mentor. I would also like to thank my non-academic supervisors Cecilie Dinesen and Nana Wiedemann, from the IFRC Reference Centre for Psychosocial Support, for their advice and support throughout this three years (and a bit more). Had I not met you, I would probably have never entered the MHPSS field. I am also grateful to my co-supervisor Dr. Maj Hansen from the University of Southern Denmark, for her valuable feedback and sense of humour.

I would also like to thank my fellow CONTEXT fellows, especially my great friends Kinan Aldamman and Ida Haarh-Pedersen who have been an essential source of support, knowledge, collaboration and excellent advice. Kinan and Ida, thank you for celebrating good news and supporting me when there were difficulties, for you I would go to the Statistics evening classes all over again. Also thanks to the staff and fellow PhD students from the Trinity Centre for Global Health whose input was so important during my first year. Thanks specially to Helen Farrelly for being so caring and helping me solve all types of administrative problems. And of course, I would like to thank my colleagues at the IFRC Reference Centre for Psychosocial Support for their friendship, laughs and sharing their knowledge and experience. I would specially like to thank Sarah Harrison for her invaluable feedback, the snacks and allowing me to constantly interrupt her during the last two years. Thanks also to Ahlem Cheffi and Pernille Hansen for allowing me to learn from their exceptional training skills. The systematic review included in this study would not have been possible without the help of Greg Sheaf. Thank you for your support with the systematic review's strings and data extraction. Thanks also to Mary Harasym and Tiziano Scott for supporting me with the systematic review screening and quality assessments. I would also like to acknowledge the feedback from Alicia Salamanca-Sanabria, Pernille Hansen and Lya Feldman in the cultural adaptation process.

This work would have not been possible without the support from my friends and family. Thanks to my beautiful sister Susana, my cousins Carlos and Nikie and their partners for their support. I thank my grandmother, aunt and uncle who I miss every day. I would also like to thank my friends Sayana and Nicole for their friendship all these years. Thanks to my parents, who support me in all my pursuits and even revised translations of interview guides. Without doubt, I would not have been able to complete this thesis without your love and support. I am grateful to my wonderful partner Guillermo who is always so proud of me and made sure my thesis and documents were safe. Thank you for your patience and love.

Last, but certainly not least, I would like to extend my immense gratitude to the study participants, who shared their experiences for this study. Thanks to the Colombian Red Cross, and specially to the lead supervisor, for believing in this work. Mostly, I would like to acknowledge the work of the Colombian Red Cross staff and volunteers of the Psychosocial Support Unit in Saravena, who I cannot unfortunately mention, your work and dedication have inspired me to write this thesis. Thank you for letting me into your world and helping me understand what you do day by day to make this world a better place.

Thank you!

This thesis is dedicated to each of you, since without your help it would not have been completed.

Table of Contents

CHAPTER 1:INTRODUCTION TO THE STUDY	1
1.1 BACKGROUND TO THE PROBLEM	1
1.1.1 <i>Definitions of Forced Displacement</i>	<i>2</i>
1.1.2 <i>Displacement and Mental Health in the Context of Colombia</i>	<i>4</i>
1.2 RESEARCH AIM, OBJECTIVES AND RESEARCH QUESTIONS	6
1.3 SIGNIFICANCE OF THE STUDY.....	7
1.4 READING GUIDE.....	8
CHAPTER 2:LITERATURE REVIEW	11
2.1 CHAPTER OVERVIEW	11
2.2 MENTAL HEALTH IN HUMANITARIAN SETTINGS	11
2.3 FORCED DISPLACEMENT AND ITS IMPACT ON MENTAL HEALTH.....	13
2.3.1 <i>Theoretical Models of Forced Displacement and Mental Health</i>	<i>14</i>
2.3.2 <i>Forced Displacement and Mental Health: Contextual factors.....</i>	<i>20</i>
2.3.3 <i>Forced Displacement and Mental Health: the Venezuela-Colombia Displacement Crisis.....</i>	<i>22</i>
2.4 ORIGINS OF THE FIELD OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT.....	27
2.4.1 <i>Mental Health and Psychosocial Support Programming</i>	<i>30</i>
2.4.2 <i>Low-Intensity Psychological Interventions: Increasing Access to Evidence-Based Therapies.....</i>	<i>39</i>
2.5 COGNITIVE BEHAVIOURAL THERAPY: AN OVERVIEW OF THEORY AND EVIDENCE... 49	
2.5.1 <i>Trans-diagnostic Approaches to Cognitive Behaviour Therapy: A New Paradigm Shift 52</i>	
2.5.2 <i>Low-Intensity Psychological Interventions: An Innovative Way to Deliver CBT... 54</i>	
2.5.3 <i>Low-Intensity CBT Interventions in Humanitarian and Low and Middle-Income Settings.....</i>	<i>56</i>
2.6 THE ROLE OF CULTURE IN PSYCHOTHERAPY	61
2.6.1 <i>Significance of Culturally Adapting Interventions</i>	<i>62</i>
2.6.2 <i>Theoretical Foundations of Cultural Adaptations of Mental Health Interventions .</i>	<i>65</i>
2.6.3 <i>Considering Culture and Context in Humanitarian Settings.....</i>	<i>69</i>
2.7 SUMMARY OF CURRENT RESEARCH GAPS	70
CHAPTER 3:METHODOLOGICAL AND THEORETICAL APPROACHES.....	72
3.1 CHAPTER OVERVIEW	72
3.2 GENERAL DESIGN OF THE STUDY	72
3.3 PHILOSOPHICAL AND THEORETICAL FOUNDATIONS.....	73
3.3.1 <i>Positionality Statement</i>	<i>75</i>
3.4 STUDY STRATEGY OF INQUIRY: IMPLEMENTATION RESEARCH	76
3.4.1 <i>Key Characteristics of Implementation Research</i>	<i>77</i>
3.4.2 <i>Challenges and Limitations of Implementation Research</i>	<i>79</i>
3.4.3 <i>Theoretical Approaches in Implementation Research</i>	<i>80</i>
3.5 CONCEPTUAL MODEL FOR PROCESS EVALUATION.....	84
3.6 CO-DESIGN OF IMPLEMENTATION RESEARCH PROJECT	87
3.7 INTERVENTION UNDER STUDY: PROBLEM MANAGEMENT PLUS (PM+).....	89
3.8 STUDY SETTING	91
3.9 ETHICAL CONSIDERATIONS.....	93
3.9.1 <i>Data Protection</i>	<i>97</i>
CHAPTER 4:SYSTEMATIC REVIEW.....	98
4.1 CHAPTER OVERVIEW	98
4.2 METHODS	98
4.2.1 <i>Identification and Selection of Studies</i>	<i>98</i>
4.2.2 <i>Data Extraction and Quality Assessment</i>	<i>101</i>
4.2.3 <i>Data Synthesis.....</i>	<i>102</i>
4.2.4 <i>Study Characteristics</i>	<i>103</i>
4.2.5 <i>Implementation Factors.....</i>	<i>111</i>

4.3 DISCUSSION	114
CHAPTER 5: CULTURAL ADAPTATION	120
5.1 CHAPTER OVERVIEW	120
5.2 METHODS	120
5.2.1 Step 1: Information Gathering	121
5.2.2 Step 2: Adaptation Hypotheses	122
5.2.3 Step 3: Local Consultation	123
5.2.4 Step 4: External Evaluations	124
5.3 RESULTS AND DISCUSSION	124
5.3.1 Step 1: Information Gathering	124
5.3.2 Step 2: Adaptation Hypotheses	127
5.3.3 Step 3: Local Consultation	129
5.3.4 Step 4: External Evaluations	135
CHAPTER 6: PROCESS EVALUATION	138
6.1 METHODS	138
6.1.1 Participants and Procedures	139
6.1.2 Data Analysis	149
6.2 RESULTS	153
6.3 STEP 1: OPERATIONAL PHASED-IN QUASI-EXPERIMENTAL STUDY	153
6.3.1 Intention-to-Treat analysis	162
6.4 STEP 2: QUALITATIVE PROCESS EVALUATION	162
6.5 DISCUSSION	182
CHAPTER 7: LIMITATIONS AND RESEARCH RECOMMENDATIONS	189
7.1 CHAPTER OVERVIEW	189
7.2 PHASE 1: SYSTEMATIC REVIEW	189
7.3 PHASE 2: CULTURAL ADAPTATION	191
7.4 PHASE 3: PROCESS EVALUATION	193
7.5 AREAS FOR FUTURE RESEARCH	198
CHAPTER 8: CONCLUSION	201
8.1 MAIN EMPIRICAL FINDINGS	202
8.1.1 No Implementation without Cultural Adaptation	202
8.1.2 Effectiveness of LIPIs for Forcibly Displaced Persons	202
8.1.3 Implementation Factors	203
8.2 IMPLICATIONS FOR THEORY, POLICY AND PRACTICE	205
REFERENCES..	208
APPENDIX A TO I	238

Tables and Figures

Table 2.1. Dimensions and definitions of the Ecological Validity Model (Bernal et al., 1995).....	66
Table 3.1. Summary of the study's research phases	73
Table 3.2. Implementation concepts and definitions (Proctor et al., 2011).....	85
Table 3.3. Structure of Problem Management Plus	91
Table 4.1. Operational definitions of the study	99
Table 4.2. Phases of thematic analysis (Braun & Clarke, 2012).....	103
Table 4.3. Studies meeting inclusion criteria	107
Table 5.1. A four-step process to culturally adapt low-intensity psychological interventions in humanitarian contexts	121
Table 5.2. Adaptation hypotheses across the eight dimensions of the EVM	128
Table 5.3. Original and adapted versions of a PM+ case example	130
Table 6.1. Participant demographic characteristics by group	154
Table 6.2. Group differences at baseline.....	156
Table 6.3. Means (SDs) and effect sizes for group comparisons.....	160
Table 6.4. Factors determining the implementation of PM+	181
Figure 2.1. Possible pathways in response to humanitarian emergencies (Bangpan et al., 2016; Johns Hopkins Bloomberg School of Public Health & International Federation of Red Cross and Red Crescent Societies, 2008)	12
Figure 2.2. Daily stressors as partially mediating the relationship between humanitarian crisis and mental health and psychosocial status (Miller & Rasmussen, 2010).....	18
Figure 2.3. Intervention pyramid for mental health and psychosocial support in emergencies. Adapted from IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Inter-Agency Standing Committee, 2007) and Ventevogel, Jordans, Eggerman, van Mierlo, and Panter-Brick (2013)	31
Figure 3.1. Aims and categories of theoretical approaches in implementation science.....	82
Figure 3.2. Key milestones of the study.....	89
Figure 3.3. Map of Colombia, Arauca Department marked in blue	92
Figure 4.1. PRISMA flow-chart diagram.....	104
Figure 5.1. Original version of inactivity cycle of the PM+ behavioural activation strategy on the left and adapted version on the right	132
Figure 6.1. Phased-in process for quasi-experimental study of Problem Management Plus	140
Figure 6.2. Likert scale and visual cues used for the WHO-5	147
Figure 6.3. Participant Flow Chart	153
Figure 6.4. Means of primary and secondary outcomes of group one at post-intervention and group two at waitlist.	161
Figure 6.5. Domains and factors influencing the implementation of low-intensity psychological interventions for forcibly displaced persons.....	188

List of Acronyms

ADAPT: Adaptation and Development After Persecution and Trauma
ANCOVA: Analysis of Co-Variance
BA: Behavioural Activation
CBT: Cognitive Behavioural Therapy
CONTEXT: COLlaborative Network for Training and EXcellence in psychoTraumatology
CRC: Colombian Red Cross
CETA: Common Elements Treatment Approach
CC: Completed Cases
COR: Conservation of Resources Theory
CRQ: Cultural Relevance Questionnaire
CSF: Cultural Sensitivity Framework
DIME: Design, Implementation, Monitoring and Evaluation
EMDR: Eye Movement Desensitisation and Reprocessing
EVM: Ecological Validity Model
EU: European Union
FGD: Focus Group Discussion
GAD-7: Generalised Anxiety Disorder-7 Questionnaire
HF: Heuristic Framework
IR: Implementation Research
IAPT: Improving Access to Psychological Therapies
ITT: Intention-to-Treat
IASC: Inter-Agency Standing Committee
IDP: Internally Displaced Person
IFRC: International Federation of Red Cross and Red Crescent Societies
INGO: International Non-Governmental Organisation
IOM: International Organization for Migration
IPT-G: Interpersonal Group Psychotherapy
IPT: Interpersonal Psychotherapy
IR: Implementation Research
JAC: Community Action Assembly (Spanish acronym)
LMIC: Low and Middle-Income Country
LI-CBT: Low-Intensity Cognitive Behavioural Therapy
LIPI: Low-Intensity Psychological Intervention
MHPSS: Mental Health and Psychosocial Support
mhGAP: Mental Health Gap Action Programme
mhGAP-HIG: mhGAP Humanitarian Intervention Guide
mhGAP-IG: mhGAP Intervention Guide
NET: Narrative Exposure Therapy
NGO: Non-Governmental Organisation
PTS: Post-traumatic Stress
PTSD: Post-traumatic Stress Disorder

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PM+: Problem Management Plus
PST: Problem-Solving Therapy
PRIME: Programme for Improving Mental Health Care
PSYCHLOPS: Psychological Outcome Profiles
RCT: Randomised Controlled Trial
SGBV: Sexual and Gender-Based Violence
PEP: Special Stay Permit (Spanish acronym)
SDGs: Sustainable Development Goals
T-CaST: Theory Comparison and Selection Tool
TD-CBT: Trans-diagnostic Cognitive Behavioural Therapy
UNHCR: UN High Commissioner for Refugees
UN: United Nations
WEIRD: Western, Educated, Industrialised, Rich, and Democratic
WHOQOL-BREF: WHO Quality of Life
WHO-5: World Health Organization Five Wellbeing Index
WHO: World Health Organization

Chapter 1: Introduction to the Study

1.1 Background to the Problem

Displacement is a direct consequence of humanitarian crises that impacts individuals' mental health. Most forcibly displaced persons reside in low and middle-income countries (LMICs), where mental health services often fall short (United Nations High Commissioner for Refugees, 2018a). During and after large-scale population movements, local health care systems are overwhelmed and unable to meet the increased demand for services (Ventevogel, van Ommeren, Schilperoord, & Saxena, 2015). Human resources become overstretched and access to mental health specialists is limited (Ventevogel et al., 2015). Even prior to displacement, workforce shortages and inequity in the distribution of resources are major contributors to psychiatric morbidity in LMICs (Demyttenaere et al., 2004). As a result, mental health and psychosocial support programmes in low-resource and humanitarian settings increasingly rely on task-shifting or task-sharing approaches to deliver mental health interventions to displaced populations.

Within task-sharing or task-shifting, less complex cases are transferred to trained and supervised lay providers (e.g., community health workers, nurses, teachers, volunteers), thus ensuring that those without access to a specialist, receive some level of support (Patel et al., 2007). Aligned with task-shifting approaches, recent evidence points to the effectiveness a Low-Intensity Psychological Interventions (LPIs) as an effective method of delivering Mental Health and Psychosocial Support (MHPSS) (Bangpan, Felix, & Dickson, 2019; van Ginneken et al., 2013). Low-intensity psychological interventions contribute to mitigating the shortage of specialists and increase access to mental health care in humanitarian settings. Broadly speaking, LPIs are structured and brief interventions that aim to reduce symptoms of highly prevalent mental health disorders. They are often simplified forms of evidence-based therapies, such as Cognitive Behavioural Therapy (CBT), that focus on teaching skills for self-

management of practical problems (e.g., unemployment, interpersonal conflict). Their level of brevity and simplicity enables lay providers to learn and deliver them in a short period of time, possibly indicating higher cost-effectiveness in comparison to conventional therapies (Rodgers et al., 2012). As a result, LIPIs are increasingly being recommended as an effective approach for improving access to mental health in low, middle and high-income settings (National Institute for Health and Excellence, 2011; World Health Organization, 2017).

Developed and tested by the World Health Organization (WHO), Problem Management Plus (PM+) is a type of LIPI that is part of the WHO's Mental Health Gap Action Programme (mhGAP). PM+ was developed for adults suffering from symptoms of common mental health problems (e.g., depression, anxiety, stress or grief), as well as self-identified practical problems (e.g., unemployment, interpersonal conflict). To date, two Randomised Controlled Trials (RCTs) have found individual PM+ to be effective in comparison to enhanced treatment as usual among non-refugee adult populations in Kenya and Pakistan (Bryant et al., 2017; Rahman et al., 2016). Though this evidence points to the effectiveness of the delivery of low-intensity psychological interventions by lay providers (Bryant et al., 2017; Rahman et al., 2016; van Ginneken et al., 2013), the effectiveness PM+ for use among migrants and refugees has yet to be explored. In addition, while there has been focus on whether PM+ ameliorates negative mental health outcomes (e.g., depression, anxiety, PTSD), there is limited evidence on whether it is associated with improvements in positive outcomes such as wellbeing and quality of life. Before delving into the context and aim of this study, it is necessary to discuss how the term 'forced displacement' is understood.

1.1.1 Definitions of Forced Displacement

An estimated 70.8 million people globally, or 1 in every 108, were forcibly displaced from their communities by the end of 2018 (United Nations High Commissioner for Refugees, 2019b). This includes 13.6 million people who were newly displaced in 2018 alone, at a rate of 37,000 per day (United Nations High Commissioner for Refugees,

2019b). Most displaced persons come from Syria and other parts of the Middle East such as Iraq or Yemen, parts of sub-Saharan Africa such as the Democratic Republic of the Congo and South Sudan, and Myanmar (United Nations High Commissioner for Refugees, 2019b). In 2018 alone, Ethiopians made up the largest group of newly internally displaced persons, while Venezuelans made up the largest newly internationally displaced population (United Nations High Commissioner for Refugees, 2019b).

Displacement takes many forms. The technical definitions relating to migration and displacement vary across legal, political and social spectra (Hadfield et al., 2018; United Nations High Commissioner for Refugees, 2018b). However, the terms ‘forced displacement’ and ‘forcibly displaced person’ are used by social scientists and by the UN High Commissioner for Refugees (UNHCR) to refer to forms of involuntary or coerced movement, which include: refugees, asylum seekers and internally displaced persons (United Nations High Commissioner for Refugees, 2018a).

A refugee is someone who has been forced to flee his or her country because of persecution, war or violence and has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group (United Nations High Commissioner for Refugees, 2018b). These persons are recognised by the 1951 Convention relating to the Status of Refugees, its 1967 Protocol, the 1969 Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa, the 1984 Cartagena Declaration on Refugees as well as by national laws and by the UNHCR statute (United Nations High Commissioner for Refugees, 2019b).

Asylum-seekers, on the other hand, are individuals who have sought international protection and whose claims for refugee status have not yet been determined (United Nations High Commissioner for Refugees, 2019b). These individuals have specific needs and rights which are protected by a series of legal frameworks (United Nations High Commissioner for Refugees, 2019b).

Internally displaced persons are individuals who have been forced to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights, or natural or man-made disasters, and who have not crossed an international border (United Nations High Commissioner for Refugees, 2019b). Whilst refugees and asylum seekers are protected by international law, IDPs need to seek protection within their own governments, which in many cases are not capable or unwilling to provide protection (United Nations High Commissioner for Refugees, 2019e).

Lastly, some populations are made up of groups of people on the move with diverse and unknown migratory status. This may include forcibly displaced persons but also migrants, former refugees who have returned to their countries of origin and former IDPs. The preferred practice is to refer to groups of people travelling in mixed movements as ‘refugees and migrants’ (United Nations High Commissioner for Refugees, 2018b).

1.1.2 Displacement and Mental Health in the Context of Colombia

The ongoing socio-economic, political and human rights crisis in the Bolivarian Republic of Venezuela (hereinafter Venezuela) drives thousands of people out of the country daily. Between 2015 and 2019, 4.7 million Venezuelans left their country at a rate of 5,500 persons per day, making this population movement the largest in the modern history of Latin America and the Caribbean (Response for Venezuelans, 2019, 2020). By the end of 2020, the number of Venezuelan migrants and refugees is expected to rise to 6.5 million people (United Nations High Commissioner for Refugees, 2019c).

Colombia is the primary destination of Venezuelan migrants and refugees (Response for Venezuelans, 2020). At the time of writing, more than one million Venezuelans are estimated to be living in Colombia, a figure that rose exponentially from less than 39,000 people who arrived in 2015 (Ministry of Foreign Affairs of Colombia, 2018; Response for Venezuelans, 2020). With seven formal and hundreds of informal crossing points, Colombia has also acted as the main transit route to other host countries in the region (e.g. Ecuador and Peru). In addition, many Venezuelans (known

as *pendular* migrants) cross the border daily to receive medical attention, seek temporary employment or eat at soup kitchens (Page et al., 2019). Colombia is also receiving an unknown number of Colombian returnees, or Colombians who fled to Venezuela during the Colombian internal armed conflict and who are now returning to Colombia, following the recent peace agreement (Page et al., 2019).

The numerous social and environmental stressors that migrants and refugees experience throughout the migration process, as well as greater exposure to traumatic events, makes these populations more susceptible to psychological distress (Gareth, Steve, & Alice, 2017). Stressors of migration are associated with Post-Traumatic Stress Disorder (PTSD), depression and anxiety symptoms and a higher prevalence of psychological distress is found among migrants and refugees compared to settled populations (Close et al., 2016; Fazel, Wheeler, & Danesh; Gerritsen et al., 2006). The World Health Organization estimates that after humanitarian emergencies, 15% to 20% of those affected might experience mild or moderate mental disorders (e.g., mild and moderate forms of depression and anxiety disorders) and 3% to 4% could experience severe disorders (e.g., severe depression, psychosis) (World Health Organization & United Nations High Commissioner for Refugees, 2012). In addition, the estimated prevalence of mental disorders (i.e. depression, anxiety, post-traumatic stress disorder, bipolar disorder and schizophrenia) among conflict-affected humanitarian populations is 22.1% (CI 95%, 18.8-25.7) (Charlson et al., 2019).

Venezuelan migrants and refugees face many barriers to accessing mental health care. Undocumented, unemployed Venezuelan migrants and refugees do not have access to the contributory system and therefore cannot access health insurance under the subsidised system (Fernandez-Nino & Bojorquez-Chapela, 2018). Moreover, Venezuelan migrants and refugees with regular status in Colombia have difficulties accessing health services due to the scale of the population movement and the challenges it poses to the Colombian public institutions (International Rescue Committee, 2018; Response for Venezuelans, 2019). As a result, Venezuelan migrants and refugees' access to health services is often limited to emergency services and public health interventions

(Fernandez-Nino & Bojorquez-Chapela, 2018) and to the interventions provided by non-governmental humanitarian organizations and government auxiliaries, such as the Colombian Red Cross (CRC).

1.2 Research Aim, Objectives and Research Questions

The scale of the population movement from Venezuela into Colombia has created considerable challenges to Colombia's health and social welfare systems (Fernandez-Nino & Bojorquez-Chapela, 2018). In response, the Red Cross and Red Crescent Movement as well as a series of United Nations (UN) agencies and Non-Governmental Organisations (NGOs) working in Colombia have scaled-up operations to respond to the MHPSS needs of Venezuelan migrants, refugees and Colombian returnees (Response for Venezuelans, 2019). These operations include the implementation of MHPSS interventions (e.g., family tracing, support groups, counselling), often delivered by lay providers. Among these, the Colombian Red Cross is currently implementing PM+ for Venezuelan migrants and refugees through its volunteer workforce.

While the field of MHPSS is increasingly investing in implementing LIPIs, including PM+, little is known about whether this intervention is associated with improved psychological outcomes among forcibly displaced populations. Similarly, research on the process of adapting PM+, such that it is more acceptable to affected populations is also needed. Lastly, little is understood about the factors that may contribute or hinder the implementation of these programmes in real-world settings.

The overall aim of this thesis is to contribute to existing knowledge on the implementation of low-intensity psychological interventions for improving psychological outcomes among forcibly displaced persons. Set in the context of the Venezuelan population movement to Colombia, this aim will be achieved through the following objectives and their associated research questions.

Objective 1: Determine which low-intensity interventions are deemed effective in reducing psychological distress among forcibly displaced persons.

Question 1: Which low-intensity interventions are deemed effective in reducing psychological distress among forcibly displaced persons?

Objective 2: Identify the factors influencing the implementation of low-intensity interventions

Question 2: What factors influence the implementation of low intensity psychological interventions among forcibly displaced persons?

Objective 3: Understand what adaptations to a low-intensity psychological intervention (i.e. PM+) are necessary to ensure its meaningfulness and relevance to a local context.

Question 3: What adaptations to the current version of PM+ need to occur to make it more relevant and meaningful for Venezuelan migrants and refugees in the Colombian context?

Objective 4: Determine whether the implementation of adapted PM+ is associated with improved psychological outcomes among Venezuelan migrants and refugees in the Colombian context.

Question 4: Is the implementation of PM+ in this context associated with improved psychological outcomes?

Objective 5: Identify the context-specific factors influencing the implementation for Problem Management Plus for Venezuelan migrants and refugees in Colombia

Question 5: What are the perceived factors influencing the implementation of PM+ for Venezuelan migrants and refugees?

1.3 Significance of the Study

This research was conducted as part of the Horizon 2020-funded research and training programme CONTEXT: Collaborative Network for Training and EXcellence in psychoTraumatology. CONTEXT is an international, interdisciplinary collaboration between nine European partner organisations spanning the academic, non-governmental, voluntary, and public sectors. CONTEXT seeks to gain a better understanding of the nature of psychological responses across different contexts and

recognises the importance of conducting implementation research to enable a faster uptake of the latest evidence (Vallièrès, Hyland, Murphy, et al., 2018).

This study lies at the intersection of mental health and psychosocial support and implementation research. Its ultimate goal is to bring these two fields together and contribute to our current knowledge of implementation of low-intensity psychological interventions within humanitarian settings. In doing so, this study also contributes methodological advances for how to culturally adapt LIPIs for their implementation in different contexts. At a practical level, the results of this doctoral thesis are directly applicable to the work of the implementing partners and are also valuable to National Societies in the Red Cross and Red Crescent Movement, NGOs or public institutions seeking to implement low-intensity psychological interventions such as PM+. At a policy level, the outcomes of this study inform ongoing efforts by global actors (e.g., the Lancet Commission on Global Mental Health, the United for Global Health Movement, the Red Cross and Red Crescent Movement's MOMENT project) to scale up mental health interventions delivered by lay providers.

1.4 Reading Guide

This thesis is divided into eight chapters that review and synthesise the literature, describe the study methods and outcomes and discuss findings, limitations and contributions of the study to theory and practice. Chapter 1, has provided a background to the problem: during and after large-scale population movements, such as the Venezuelan migration crisis, mental health and psychosocial needs are high and access to specialised, evidence-based mental health care is limited. Low-intensity psychological interventions, and specifically PM+, are put forward as an innovative approach to improve access to mental health care in low-resource and humanitarian settings. The research aim, objectives and questions as well as the significance of the study are put forward.

Chapter 2 provides an in-depth overview on how displacement is theorised and known to impact mental health. It reviews the development of the field of mental health

and psychosocial support into a fundamental component of humanitarian work before delving into the increasingly important role of task shifting mental health interventions to improve access to mental health care. The evidence on low-intensity psychological interventions and more specifically, low-intensity cognitive behavioural therapies, along with the importance of considering culture before implementing low-intensity psychological interventions in humanitarian settings are described. The research gaps to be addressed by the study are identified.

Chapter 3 introduces pragmatism as the philosophical foundation of the study and implementation research as the strategy of inquiry. The characteristics and theoretical models of implementation research are described and compared, and their challenges and limitations are acknowledged. The process of evaluating an implementation research project is presented in relation to the study's research aim and objectives. Finally, the ethical considerations of the study are explained.

Chapter 4 presents the results of a systematic literature review that addresses objectives one and two of this study: (1) determine which low-intensity interventions are deemed effective in reducing psychological distress among forcibly displaced persons and; (2) identify the factors influencing the implementation of low-intensity interventions. Among the most salient factors identified is the cultural adaptation of low-intensity psychological interventions prior to their implementation. Chapter 5 therefore presents a new methodology for cultural adaptation and reports the results of applying this process to the cultural adaptation of PM+ for Venezuelan migrants and refugees and Internally Displaced Persons (IDPs) living in Saravena, Colombia – in fulfilment of objective three of the study.

Objectives four and five are addressed in Chapter 6, which presents an evaluation of the implementation of PM+ for Venezuelan migrants and refugees living in Saravena, Colombia. The findings are presented and discussed in the context of the extant literature. Chapter 7 presents the limitations of this study and proposes directions for future research. Finally, Chapter 8 concludes the thesis by summarising the main

empirical findings of the study and highlighting the theoretical and practical implications of this body of work.

Chapter 2: Literature Review

2.1 Chapter Overview

Chapter 2 presents an overview of how humanitarian emergencies, specifically forced displacement, is theorised and known to impact mental health. It reviews the development of the field of mental health and psychosocial support into a fundamental component of humanitarian work before introducing ‘task-shifting’ mental health as a strategy to increase access to evidence-based care in these settings. This chapter provides important background information on low-intensity psychological interventions, a specific form of task-shifting, and the significance of considering culture before implementing LIPIs in humanitarian settings. A number of research gaps within the existing literature are identified.

2.2 Mental Health in Humanitarian Settings

Humanitarian crises (e.g., armed conflicts, generalised violence, natural disasters) pose a critical threat to the health, safety, security, or wellbeing of affected populations. In 2019 alone, nearly 132 million people were in need of humanitarian assistance and protection (United Nations Office for the Coordination of Humanitarian Affairs, 2019). In addition to the evident physical, economic and environmental consequences, humanitarian emergencies can have a profound impact on mental health (Roberts & Browne, 2011).

Crises often limit individuals’ and families’ ability to function and to cope with everyday life and reduce the capacity of communities to respond to the needs generated by the emergency (Bangpan, Felix, Chiumento, & Dickson, 2016). Humanitarian emergencies increase risk of exposure to stressful or traumatic events and their associated mental health problems (e.g., grief, depression, anxiety disorders) (de Jong, Komproe, & Van Ommeren, 2003; Norris et al., 2002; van Ommeren, Saxena, & Saraceno, 2005a), erode support systems (e.g., *via* disruption of social networks, community and

institutional structures, family separation) (Batniji, Van Ommeren, & Saraceno, 2006), and exacerbate pre-existing problems (e.g., social and income inequality, pre-existing mental health problems) (Inter-Agency Standing Committee, 2007).

While most people affected by emergencies will not develop mental health problems, a large and unknown percentage of the affected population will experience increased psychosocial needs (e.g., distress, debilitated social support, family separation) (World Health Organization & United Nations High Commissioner for Refugees, 2012). Based on previous work published by the Johns Hopkins Bloomberg School of Public Health and International Federation of Red Cross and Red Crescent Societies (2008), Bangpan et al. (2016) theorised that humanitarian emergencies impact individual mental health and psychosocial wellbeing through two possible pathways (Figure 2.1).

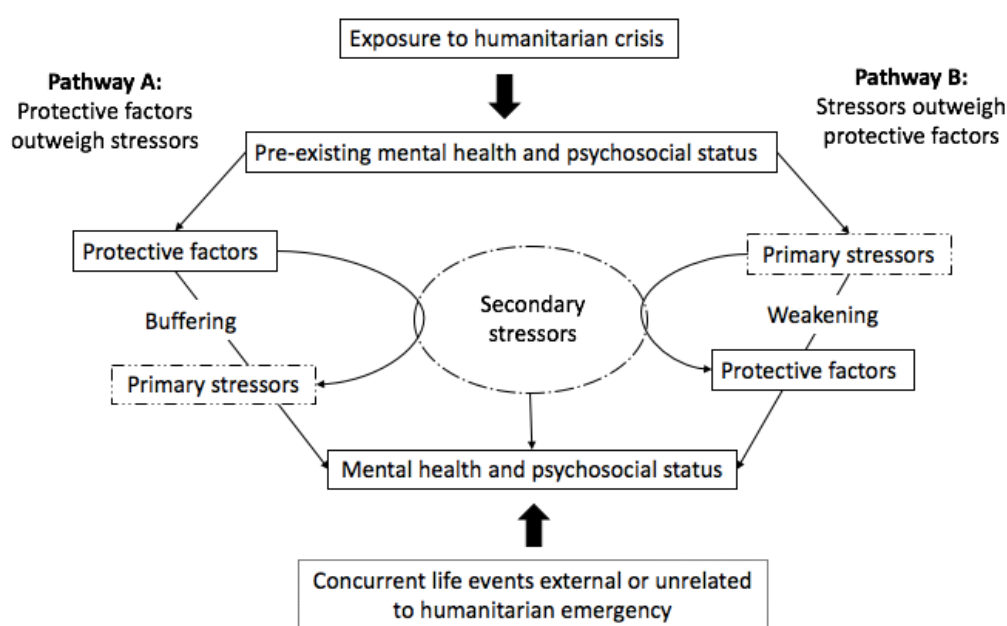


Figure 2.1. Possible pathways in response to humanitarian emergencies (Bangpan et al., 2016; Johns Hopkins Bloomberg School of Public Health & International Federation of Red Cross and Red Crescent Societies, 2008)

According to Bangpan et al. (2016), the first pathway is comprised of protective factors (i.e. contextual and individual factors that mitigate the effects of exposure to humanitarian emergencies), which may act as buffers to alleviate the impact of stressors generated by the emergency (Bangpan et al., 2016). The second pathway is comprised of

stressors from the emergency, which may outweigh protective factors and affect individuals' mental health and psychosocial wellbeing (Bangpan et al., 2016). Bangpan et al. (2016) further differentiate between stressors that are primary outcomes of crises (e.g., witnessing violence, death or human rights abuses), and others that are considered secondary or by-products of the emergency (e.g., inability to access health services, economic, material losses) (Bangpan et al., 2016). They also consider pre-existing mental health and psychosocial conditions and simultaneous life events unrelated to humanitarian emergencies, which can further compound stressors or have a direct impact on the mental health and psychosocial needs of people affected by crises (Bangpan et al., 2016). Finally, the ongoing impact of humanitarian crises (e.g., unresolved issues of protection, insecurity or lack of access to economic resources) may also inhibit individual and collective opportunities for self-reliance and social support, further impacting their mental health and psychosocial wellbeing (Bangpan et al., 2016).

While forced displacement is a direct consequence of the second pathway outlined by Bangpan et al. (2016), from this theoretical perspective, it is also viewed as a humanitarian crisis in and of itself, or as a protraction of the emergency, comprised of specific and shared primary (e.g., human trafficking, interpersonal violence, dangerous border crossings) and secondary stressors (e.g., overcrowded housing, family separation, insecurity).

2.3 Forced Displacement and its Impact on Mental Health

The numerous stressors associated with forced displacement, including greater exposure to traumatic events, suggest that forcibly displaced persons are at increased risk for developing mental health problems (Turrini et al., 2017). One in five individuals in conflict-affected humanitarian settings are living with a mental disorder at any given point in time (Charlson et al., 2019). Although the prevalence of mental disorders varies largely due to differences across groups of forcibly displaced persons, host countries and research methods, the highest prevalence have been found for depression (5% to 44%) and anxiety disorders (4% to 40%), including Post-Traumatic Stress Disorder (PTSD) (9%

to 36%) (Charlson et al., 2019). Notably, increased prevalence of psychological morbidity in comparison to settled populations has been reported among displaced persons from diverse range of backgrounds and cultures (Tribe, Sendt, & Tracy, 2017). While forced displacement is not a new phenomenon, the type of care provided to forcibly displaced persons is influenced by evolving conceptualisations and theories of how forced displacement impacts mental health.

2.3.1 Theoretical Models of Forced Displacement and Mental Health

Our current understanding of the impact of forced displacement on mental health has been traced back to seminal ancient texts such as *The Iliad of Homer* and *The Odyssey* (Weisaeth, 2014). Nonetheless, the period between the 1970s to 2000 is recognised as the formative period of the so-called field of 'refugee mental health' (Silove, Ventevogel, & Rees, 2017). Prior to 1970, testimony therapy, a type of treatment for torture survivors from Chile's military dictatorship, was influential to the forthcoming developments of trauma-focused approaches since it used techniques of prolonged exposure and behavioural therapy to overcome fears and phobias and served as a mechanism for reporting human rights abuses (Silove, Tay, & Rees, 2019).

Between the 1970s and 1980s, highly specialised centres for torture and trauma rehabilitation were established in host countries across Europe, North America, Australia and New Zealand. This period coincides with the development of a number of theoretical frameworks and trauma-focused models of care that continue to be used today (Silove et al., 2019). Most of the epidemiological research on the mental health of refugees during this period focused on investigating PTSD (Nickerson, Bryant, Silove, & Steel, 2011). The trauma-focused approach to treatment was, and continues to be, grounded in cognitive behavioural frameworks developed during this time (Nickerson et al., 2011). Most models of PTSD view fear conditioning as the main causal or etiological agent in the development of PTSD (Nickerson et al., 2011). It was understood that extreme fear at the time of the traumatic event (e.g., experiencing physical or sexual violence, witnessing the death or disappearance of a loved one) was paired with other stimuli associated with the trauma, resulting in a strong conditioned response

(Nickerson et al., 2011; Rauch, Shin, & Phelps, 2006). Rooted in this approach, today most trauma-focused therapies involve gradually learning that the cues initially conditioned with the trauma are no longer a threat, thereby resulting in reduced anxiety (Bryant et al., 2008). In addition, contemporary trauma-focused therapies also aim to alleviate symptoms by processing the traumatic memories and maladaptive cognitions that lead to avoidance behaviours associated with PTSD (Ehlers & Clark, 2000). Trauma-focused therapies, and most of the empirical research conducted during this formative period, therefore focused on addressing the psychological sequelae of past traumas (Ventevogel, 2018). However, this approach presents several limitations.

Firstly, PTSD is not the only mental health problem identified among refugees and migrants. The exclusive focus on PTSD therefore diverts attention away from other highly prevalent problems (e.g., prolonged grief, depression, generalised anxiety) (van Ommeren, Saxena, & Saraceno, 2005b). In addition, trauma-focused approaches are criticised for overlooking the importance of social determinants of psychological distress (e.g., socioeconomic status, social support networks, level of education) and their impact on mental health (Patel & Kleinman, 2003; Summerfield, 1999; van Ommeren et al., 2005b; Ventevogel, 2018).

As a result, the past four decades of the refugee mental health field are largely characterised by debates among advocates of individualised trauma-focused approaches and those arguing in favour of so-called multimodal approaches (Nickerson et al., 2011; Silove et al., 2017). Multimodal approaches have featured heavily in the field of refugee mental health in recent years, with most contemporary theoretical models aiming to provide a comprehensive and ecological conceptualisation of the experience of displacement where psychological morbidity and wellbeing are seen as outcomes of a wide-range of determinants and experiences (Silove et al., 2017). Consistent with trauma-focused models, these models recognise the profound impact of direct exposure to potentially traumatic events, but also go beyond this traditional focus to consider the numerous pathways through which forced displacement impacts on mental health. This approach further addresses psychological morbidity by providing comprehensive

accounts of the experiences of forced displacement through previously established concepts from the social sciences including the ecological theory of human development, which conceptualises individuals as nested within multiple interacting systems (Bronfenbrenner, 1992; Silove et al., 2017).

An example of a regularly used multimodal approach in humanitarian programming is the Conservation of Resources Theory (COR) (Hobfoll et al., 2007). The COR was the result of a meeting of a global panel of experienced researchers and practitioners from the fields of humanitarian and refugee mental health to reach a consensus on a series of intervention principles (Hobfoll et al., 2007). According to Conservation of Resources Theory, objective losses, and the meaning attributed to these losses, are what determine mental health and resilience. For Stevan Hobfoll, the main proponent of this theory, “resources are those entities that either are centrally valued in their own right (e.g., self-esteem, close attachments, health, and inner peace) or act as a means to obtain centrally valued ends (e.g., money, social support, and credit)” (Hobfoll, 2002, p. 307). According to COR, the loss of resources and their impact on individuals’ mental health is theorised to be addressed by promoting a sense of safety, calming, sense of self and collective efficacy, connectedness, and hope (Hobfoll, Dunahoo, & Monnier, 1995; Hobfoll et al., 2007).

Ultimately, the utility of these models lies in their capacity to inform the development of interventions (Miller & Rasmussen, 2010). In practice, the so-called ‘Hobfoll principles’ have guided the development of many psychosocial interventions as well as preventive efforts, policy development, and international practice guidelines (Inter-Agency Standing Committee, 2007). As a result, many psychosocial programmes for forcibly displaced persons include support in family reunion, support in resettlement processes, referral to social and medical services as well as problem-solving interventions and general psychosocial support (Nickerson et al., 2011). In fact, providing favourable psychosocial conditions (e.g., permanent residency, access to resettlement services and psychosocial support) is associated with low rates of PTSD and related symptoms of anxiety and depression (Steel et al., 2005). Similarly, research

within the same population sample has shown that denying these benefit is associated with high levels of PTSD and associated disorders (Steel et al., 2011; Steel et al., 2006).

Despite aiming to provide a comprehensive conceptualisation of forced displacement and its impact on mental health, multimodal approaches place greater emphasis on certain pathways over others. For example, while the COR places an emphasis on the role of loss of resources valued by individuals, the Adaptation and Development After Persecution and Trauma (ADAPT) –another known multimodal approach— considers how specific foundations of society are disturbed or eroded during emergencies, and how these disturbances, in turn, impact on mental health. More specifically, the ADAPT model identifies five core psychosocial pillars thought to be disrupted during humanitarian crisis and displacement: systems of safety and security, interpersonal bonds and networks, justice, roles and identities, and existential meaning and coherence (Silove, 1999). Individuals’ mental health and psychosocial wellbeing is theorised to depend on these pillars, which constitute “the bedrock on which stable societies are grounded” (Silove et al., 2017, p. 134). Similar to the COR theory, the ADAPT model acknowledges the significant impact of resource loss on mental health and psychosocial wellbeing. While the COR theory provides a wide-ranging definition of what resources are however, the ADAPT model narrows resources down to a specific set of interdependent systems.

According to Miller and Rasmussen (2010) neither the direct effect model, nor the fully mediated model proposed by psychosocial advocates are consistent with key findings: (1) unexplained variance in mental health outcomes when exposure to armed conflicts is used as the sole predictor of psychological distress; (2) research on the mental health of refugees settled in high-income countries indicating that post-migration stressors (e.g., social isolation, unemployment, discrimination) consistently predict levels of distress as well, or better than, pre-migrations stressors; (3) data from non-conflict affected populations showing that daily stressors are more often highly associated with mental health symptoms severity than major life events (Bogic, Njoku, & Priebe, 2015; Kanner, Coyne, Schaefer, & Lazarus, 1981; Miller & Rasmussen, 2010;

Porter & Haslam, 2005). Based on this evidence, Miller and Rasmussen (2010) aimed to reconcile the longstanding divide between advocates for trauma-focused and psychosocial approaches by presenting the Daily Stressors Model depicted in Figure 2.2.

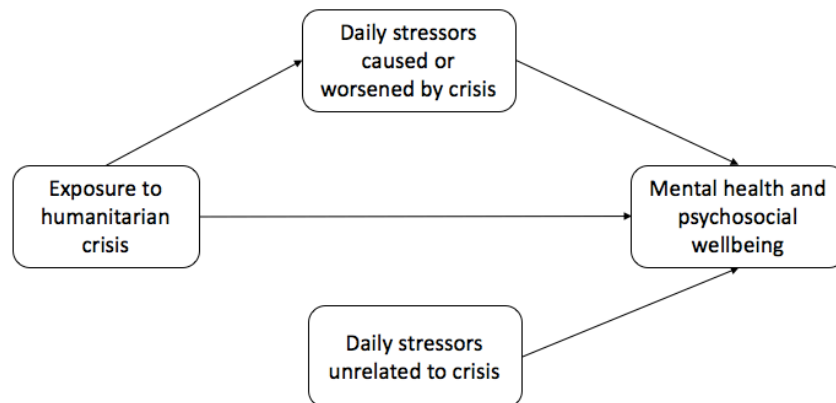


Figure 2.2. Daily stressors as partially mediating the relationship between humanitarian crisis and mental health and psychosocial status (Miller & Rasmussen, 2010)

According to the Daily Stressors Model, humanitarian crises, and more specifically armed conflicts, increase exposure to loss and violence, which directly affect mental health and psychosocial functioning (Miller & Rasmussen, 2010). In addition, Miller and Rasmussen (2010) argue that this exposure gives rise to a series of daily stressors that partially mediate the relationship between exposure to crises and mental health. This model further recognises the influence of other daily stressors considered unrelated to the emergency on the mental health of the affected population (Miller & Rasmussen, 2010).

Notably, although the authors use the term daily stressors, these do not necessarily occur on a daily basis and include a wide range of stressors such as lower intensity stressors (e.g., overcrowded housing, unemployment, social isolation) as well as difficult and potentially traumatic experiences that occur episodically (e.g., child physical and sexual abuse, intimate partner violence). The main contribution of this integrated approach is its emphasis and focus on tackling daily stressors, as well as its consideration of the specialised clinical needs of highly distressed persons.

Miller and Rasmussen (2010) present a set of four general guidelines for the development of interventions and the allocation of mental health disorders that are

consistent with suggestions by other authors [e.g., Betancourt and Williams (2008), Barenbaum, Ruchkin, and Schwab-Stone (2004)]. According to Miller and Rasmussen (2010), before developing mental health and psychosocial interventions, it is important to first undertake a rapid and contextually grounded assessment of locally salient daily stressors. Secondly, before providing specialised trauma-focused interventions, it is important to address those daily stressors that are particularly salient and that can increase the effect of more specialised interventions. Third, Miller and Rasmussen (2010) suggest that where specialised clinical interventions are needed, interventions should go beyond PTSD to also address other forms of distress that result from exposure to adversity, violence and loss. Lastly, the authors argue that it is essential to consider that not all symptoms of trauma are necessarily related to conflict exposure but could instead be related to other sources of trauma (Miller & Rasmussen, 2010).

In a more recent publication, Miller and Rasmussen (2017) adapted the original Daily Stressor Model to illustrate the impact of armed conflict and displacement on refugee mental health. In this new model, the authors argue that displacement-related stressors are a specific constellation of daily stressors that arise from the combined experiences of armed conflict and forced migration. Based on a robust body of evidence, Miller and Rasmussen (2017) show that displacement-related stressors exert a distinctly strong influence on mental health because they are pervasive, immediate and ongoing sources of stress over which refugees have limited or no control. These strong effects are also hypothesised to be related to the fact that displacement-related stressors include a wide array of stressors and events from limited coping resources to potentially traumatic experiences. The adapted model demonstrates the importance of simultaneously responding to the direct effects of armed conflicts and displacement-related sources of distress.

The introduction of these integrated models resulted in a shift in research and practice, whereby the experience of forced displacement is now understood to be characterised by multiple events occurring in multiple contexts that persist over time (Zimmerman, Kiss, & Hossain, 2011). This new direction therefore advocates for

interventions that consider the enduring contextual factors that occur before departure, during travel and transit, and after arrival, whether traumatic or not, and their association with negative mental health outcomes and decreased psychosocial functioning. The following section illustrates these contextual factors.

2.3.2 Forced Displacement and Mental Health: Contextual factors

2.3.2.1 Pre-Departure Phase

The pre-departure phase comprises the time before individuals leave from their place of origin or usual residence (Zimmerman et al., 2011). Factors that might affect the mental health of individuals during this phase include human rights violations, interpersonal violence and the disappearance or death of family members (Priebe, Giacco, & El-Nagib, 2016; Zimmerman et al., 2011). These experiences are often prolonged, repeated, interpersonal in nature and potentially traumatic, and may thus have a profound impact on the individual's mental health and psychosocial wellbeing (Nickerson et al., 2017). Moreover, the impact of these events on mental health is partially exacerbated by social and environmental consequences, such as poor and unsafe living conditions, inability to meet basic needs such as food, water and shelter, and destruction of social networks (Miller & Rasmussen, 2010). Individual factors such as gender, age, indigeneity, sexual orientation, area of origin may also increase exposure to adversity before departure and across all phases of migration (Nickerson et al., 2017). Indeed, a systematic review concluded that in LMICs, where most displaced persons reside, risk factors for the development of mental disorders include: higher level of exposure to serious disruptions of community functioning (e.g., natural disasters, armed conflict, violence), a history of mental illness, being female, unmarried, being of younger or older age, of lower socioeconomic status, lower educational attainment, of minority group status, unemployed, insecure living conditions (Lund et al., 2018).

2.3.2.2 Travel and Transit Phase

Risk factors present during the travel and transit phase vary according to the mode of transportation used (e.g., by foot, boats, closed containers), and have been associated

with disease outbreaks, limited access to safe drinking water, food, medical assistance and adverse weather conditions (Nickerson et al., 2017; Zimmerman et al., 2011). In cases of human trafficking, the journey may also involve interpersonal violence as well as illegal and dangerous border crossings (Zimmerman et al., 2011). In addition, the travel phase can involve stopovers at camps, detention or reception centres, where safety, hygiene and access to medical attention may be compromised (Zimmerman et al., 2011). Prolonged lengths of stays in interception points have been found to be a risk factor for poor mental health (Hallas, Hansen, Staehr, Munk-Andersen, & Jorgensen, 2007; Steel et al., 2006).

2.3.2.3 Destination Phase

Most displaced persons remain close to home, with four out of five displaced persons living in countries contiguous with their country of origin (United Nations High Commissioner for Refugees, 2019b). Arrival to their destination can also involve physical harm, including sexual violence, infectious diseases, and a high risk of extortion and human trafficking (Priebe et al., 2016). The resettlement or post-migration phase may be characterised by uncertainty due to changing policies and limited access to information (Inter-Agency Standing Committee, 2015). Lastly, lack of social support (e.g., isolation, family separation), insecurity regarding migration status as well as reduced housing and employment prospects have been associated with long-term poorer mental health outcomes after reaching destination (Gareth et al., 2017).

Some studies have identified post-migration stressors as more detrimental to mental health than past traumas (Chu, Keller, & Rasmussen, 2013; Li, Liddell, & Nickerson, 2016; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011). Indeed, meta-analytic evidence found high prevalence of depression among long-settled refugees and strong associations between rates of depression and post-migratory stressors (e.g., unemployment, low-income, poor language proficiency and lack of social support) (Bogic et al., 2015). Research has also showed that the stressors of displacement are associated with additional psychosocial and mental health consequences, such as anger,

harsh parenting (Rees, Thorpe, Tol, Fonseca, & Silove, 2015), and intimate partner violence (Zakar, Zakar, Faist, & Kraemer, 2012).

2.3.3 Forced Displacement and Mental Health: the Venezuela-Colombia Displacement Crisis

Of the four million that have fled the country since the end of 2015, 1.3 million Venezuelans are now living in neighbouring Colombia, which currently hosts the largest number of Venezuelan refugees and migrants (United Nations High Commissioner for Refugees, 2019d). In addition to those residing in Colombia, many Venezuelans also cross to Colombia daily in order to eat at communal kitchens or buy food and medicines, before returning to Venezuela. Others stay in Colombia temporarily before transiting to other countries in the region (e.g., Ecuador, Peru, Brazil). Among refugees and migrants from Venezuela are also Colombians, many of who fled to Venezuela as a result of the Colombian internal armed conflict, and who are now returning to Colombia following the recent peace agreement and as a result of the humanitarian situation in Venezuela (Page et al., 2019).

2.3.3.1 Pre-Departure Phase

Various interconnected factors are forcing Venezuelans to leave. The current complex humanitarian crisis in the country started in 2008, and is marked by hyperinflation, a widespread shortages of food staples, medicines and medical equipment, increased insecurity, violence and reports of human rights abuses, and the continuous deterioration of the national health and social welfare systems (Daniels, 2019).

Hyperinflation, which is estimated to reach 10 million percent by the end of 2019, as well as the collapse of the food infrastructure, puts the costs of food out of reach for nine in ten Venezuelans (The Lancet, 2019). In 2018, 82% of Venezuelans or 28.5 million people and 75% of health centres around the country did not have access to potable water (Daniels, 2019). Blackouts were also continuously reported, including a five-day widespread blackout in March 2019 (Daniels, 2019). Results from the National Hospital

Survey 2019 suggest that 1,557 died in 2019 because of insufficient hospital supplies, although counts are likely underreported (Daniels, 2019).

According to local non-governmental organisations, the depleting health system has also led to an increase in morbidity and mortality due to infectious and parasitic diseases (e.g., malaria, measles, diphtheria), many of which had been previously controlled or eradicated (García, Correa, & Rousset, 2019). This increase in communicable diseases has been associated with inadequate access to basic sanitation, malnutrition and lack of vaccination campaigns (García et al., 2019). The deterioration of the Venezuelan health system has also severely impacted on infant mortality rates (21.1 deaths per 1000 livebirths), which in 2016 was almost 40% higher than in 2008 (García et al., 2019). Another report noted that by September 2019, 53% of operating theatres in Venezuela were closed, 71% of emergency rooms could not provide regular services and 79% of hospitals lacked a reliable water supply (Centre for Justice and Peace, 2018). According to Venezuela's leading pharmaceutical group, 85% of psychiatric medicines were unavailable and thousands of mental health patients had interrupted therapy because of a lack of medications in 2016 (Casey, 2016). Mental health institutions released patients due to food and medicine shortages (Casey, 2016). In 2013, and according to a report from the Ministry of Health, there were 23,630 long-term psychiatric patients in public hospitals, compared to only 5,558 in 2015 (Casey, 2016).

A recent report by the United Nations High Commissioner for Human Rights (2019) documents clear and serious violations to the highest attainable standard of health and food in Venezuela. This situation is further exacerbated by systematic reports of human rights abuses committed by state authorities, including excessive use of force against protestors, use of excessive force in non-protest related security operations, arbitrary detentions, torture and restrictions on democratic space (United Nations High Commissioner for Human Rights, 2018, 2019). Consequently, international protection considerations, according to the refugee criteria in the 1951 Convention/1967 Protocol and the 1984 Cartagena Declaration on Refugees are applicable to most Venezuelans (United Nations High Commissioner for Refugees, 2019b). Taken together, the most

common reasons for leaving Venezuela among refugees and migrants include: violence, insecurity, fear of being targeted for their political opinions (whether real or perceived), shortages of food and medicine, lack of access to social services, and being unable to support themselves and their families (United Nations High Commissioner for Refugees, 2019b).

2.3.3.2 Travel and Transit Phase

While some enter Colombia by air, many are traveling on foot. Known as “caminantes” or “walkers”, most lack financial means to travel to Colombia through any other means (International Rescue Committee, 2018). According to a needs assessment survey conducted by the International Rescue Committee in various cities across Colombia in September 2017, risks faced by refugees and migrants in transit included theft, extortion, physical violence and accidents (International Rescue Committee, 2018). Similarly, Venezuelan migrants and refugees in transit to Colombia have reported adverse travel conditions such as lack of shelter and food, and health conditions such as pneumonia and skin infections (International Rescue Committee, 2018). Moreover, Venezuelan refugees and migrants without the required documentation to enter Colombia legally are increasingly relying on irregular and dangerous routes to cross borders (known as “trochas”), which increases their risks of being sexually exploited, abused and kidnapped, especially in areas where illegal armed groups and guerrillas are still in operation (United Nations High Commissioner for Refugees, 2019b).

2.3.3.3 Destination Phase

The Government of Colombia has put in place two special permits for Venezuelan refugees and migrants. In 2017, it introduced a Special Stay Permit (‘Permiso Especial de Permanencia’ or PEP, in its Spanish acronym) which allows Venezuelans who enter through formal border points to gain access to public services and request work permits (Response for Venezuelans, 2019). In addition, the government put in place a registration process for Venezuelan refugees and migrants who entered illegally, which allows them to later apply to receive the PEP (Response for Venezuelans, 2019). The government has

also intermittently offered Border Mobility Cards which allow Venezuelans to enter Colombia frequently, for up to seven days (Response for Venezuelans, 2019). More recently, the Colombian government instated a temporary two-year measure to combat statelessness, whereby children born to Venezuelan parents in Colombia can receive Colombian citizenship, a legal exception that is supposed to immediately benefit around 24,000 children and which has received international praise and support (United Nations High Commissioner for Refugees, 2019a). These legal efforts have been accompanied by a series of expansions of basic rights and provision of basic services to Venezuelans, such as emergency healthcare and basic schooling in 2018 (Response for Venezuelans, 2019).

Though these are largely commendable initiatives, the resulting influx of forcibly displaced Venezuelans into Colombia has put considerable strain on the health care system, which is struggling to respond to the increased demand for health services (Daniels, 2019). In 2015, there were 1,475 emergency health-care treatments given to Venezuelans. In 2019, this number reached 131,958 (Daniels, 2019). As a result, various organizations including the UNHCR, International Organization for Migration (IOM), other UN agencies, NGOs and the Red Cross and Red Crescent Movement and other International Non-Governmental Organizations (INGOs), have stepped up operations to support the State's response to the growing needs of refugees and migrants from Venezuela, Colombian returnees and host communities (Response for Venezuelans, 2019).

A recent survey of service providers from UN organizations, INGOs, local NGOs, church-affiliated organizations and Venezuelan networks identified undocumented refugees and migrants as a highly vulnerable group, given their lack of access to ongoing government health, employment, housing, and education services (International Rescue Committee, 2018). Reported security threats to Venezuelans include violence, sex work, theft, extortion, xenophobia, sleeping on the street, working dangerous jobs, and risk of recruitment into armed groups or into the drug trade (International Rescue Committee, 2018), with undocumented refugees and migrants

more likely to take on hazardous jobs under difficult conditions and circumstances. A survey administered to newly registered Venezuelans showed that 46.3% of interviewees worked informally (Bahar, Dooley, & Huang, 2018). In addition, Venezuelan migrants and refugees are settling in different areas of Colombia, including areas affected by the Colombian armed conflict. This group is especially vulnerable as their settlement poses additional protection risks such as forced recruitment, secondary displacement, violence, human trafficking, abuse and Sexual and Gender-Based Violence (SGBV), and utilization in the narcotic production chain (Response for Venezuelans, 2019).

Women report additional threats compared to men, including sexual violence, sexual exploitation and slavery, transactional sex, sexual abuse, intimate partner violence, emotional and verbal abuse (e.g. receiving threats of being deported by their partners) as well as forced and early marriages (i.e. Venezuelans marrying Colombians to access documentation) (International Rescue Committee, 2018). Pregnant women as well as adolescent girls are identified as a particularly vulnerable group. The local public hospital in Cucuta, the Colombian border town through which most Venezuelan migrants and refugees enter Colombia, attended to 488 Venezuelan mothers in April 2019 alone, or 86% of the mothers treated that month (Daniels, 2019). A third of patients treated at the hospital are women, with pregnant women making up 20% of total patients treated (Daniels, 2019). No reports or studies have rigorously assessed the mental health needs of Venezuelan migrants in Colombia, resulting in information to date being largely anecdotal. Lastly, though no figures or needs assessments are currently available, a number of INGOs report incidences of Colombian returnees in need of international protection (Response for Venezuelans, 2019). Specifically, this subpopulation is in need of support to prevent re-victimization and to access institutional attention routes for victims of the armed conflict, with the aim of ensuring humanitarian assistance, compensation, and/or reparations for victims of human rights violations (Response for Venezuelans, 2019).

There is a growing recognition of the greater need for health services for Venezuelans, including mental health and psychosocial support services, to address the increased risk for developing mental health problems due the 'triple threat', or the range of risk factors often experienced before, during and after migration. The above demonstrates the importance of delivering mental health interventions alongside other basic services within a humanitarian context.

2.4 Origins of the Field of Mental Health and Psychosocial Support

Recognition of the mental health and psychosocial impacts of conflict, disaster and displacement within the humanitarian and development assistance sphere and has only emerged in the last 25 years (Meyer & Morand, 2015). Until the 1990s, leading manuals on post-disaster and armed conflict humanitarian assistance focused almost exclusively on addressing biological and material needs. In other words, guidelines prioritised food, shelter and physical medical attention, but offered no guidance on how to alleviate psychological distress and address the social and psychological impact of emergencies (Jordans, Tol, & Ventevogel, 2014). Mental health was considered a negligible problem in comparison to health conditions causing high mortality, such as diarrhoeal diseases and acute respiratory infections (Jordans et al., 2014).

Several humanitarian crises occurring in the 1990s triggered a concern for mental health and psychosocial wellbeing within humanitarian settings (Meyer & Morand, 2015; United Nations High Commissioner for Refugees, 2013). Specifically, the emergencies taking place in Cambodia, the crises in Bosnia-Herzegovina and the Rwandan genocide, as well as the documented impact of these events on the individual and on their communities, contributed to an increased attention towards mental health in humanitarian contexts (United Nations High Commissioner for Refugees, 2013; Williamson & Robinson, 2006). In 2004, experiences from the tsunami in Sri Lanka led to the development the UN-led Inter-Agency Standing Committee (IASC) Mental Health and Psychosocial Support (MHPSS) Task Force, drawing increased attention to this field. The 2007 Inter-Agency Guidelines on Mental Health and Psychosocial Support in

Emergency Settings offered an inter-agency consensus on what –and equally as important, what does not– constitute an adequate and coordinated MHPSS response. The consensus was based on the following six guiding principles: human rights and equality; participation; do no harm; building on available resources and capacities; integrated support systems and; multi-layered supports (Inter-Agency Standing Committee, 2007).

The international recognition of fields such as psychology, psychiatry, anthropology and social work also contributed to bringing mental health issues in humanitarian settings to the fore (White, Jain, Orr, & Read, 2017; Williamson & Robinson, 2006). The consolidation of evidence on the impact of conflict, disaster and displacement on the mental health and psychosocial wellbeing of affected populations (Meyer & Morand, 2015; Steel et al., 2009; United Nations High Commissioner for Refugees, 2013), including landmark studies such as the Global Burden of Disease Studies and the World Mental Health Surveys, provided epidemiological evidence on the burden of mental, neurological and substance abuse disorders and the number of years lost to life or in disability due to these disorders (Ventevogel, 2016). In the first Global Burden of Disease study, known as the GBD 1990, mental health and substance abuse disorders, which were not prominent in mortality tables, emerged as the leading cause of disability, with depression as the single leading cause of disability worldwide (Murray & Lopez, 1996). Later, the first World Mental Health Survey concluded that mental disorders were: highly prevalent globally, frequently associated with impairment and often untreated (Demyttenaere et al., 2004). In 2007, a series of publications in the *Lancet*, synthesised decades of interdisciplinary research in global mental health and strongly advocated for collaborative research partnerships (e.g., between researchers, practitioners and policy makers) to address mental health in humanitarian and low-income settings (Patel et al., 2007; Saraceno et al., 2007; Saxena, Thornicroft, Knapp, & Whiteford, 2007b; Ventevogel, 2016).

What followed this consolidation of evidence on the burden of mental disorders was several different tools and policies, designed to address mental health in

humanitarian crises, and recognising mental health as an important component of service delivery in emergencies. A clear example of this is the WHO's 'mental health Gap Action Programme'. First published in 2008 (World Health Organization, 2008), mhGAP contains evidence-based guidance and tools for the assessment and management of mental, neurological and substance abuse disorders within primary care in humanitarian emergencies (mhGAP Humanitarian Intervention Guide or mhGAP-HIG), in non-specialised health care settings (mhGAP Intervention Guide 2.0 or mhGAP-IG 2.0) and most recently in community settings (World Health Organization, 2016b; World Health Organization & United Nations High Commissioner for Refugees, 2015). The first version of mhGAP-IG has been used in over 100 countries and is widely accepted by a range of stakeholders, including ministries of health, academic institutions and INGOs (Keynejad, Dua, Barbui, & Thornicroft, 2018). More recently, a key milestone has been the recognition of the importance of promoting mental health and wellbeing in the United Nations Sustainable Development Goals (SDGs) (Patel et al., 2018); mental health having been notably absent from the preceding Millennium Development Goals. Specifically, Target 3.4 requests that countries to reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing by 2030 (UN General Assembly, 2015).

Today, the composite term Mental Health and Psychosocial Support is commonly used in humanitarian settings to describe "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorders" (Inter-Agency Standing Committee, 2007, p. 1). The *psychosocial* element of the term acknowledges the close interconnection between social and psychosocial needs. This approach has roots in community psychology, peace psychology and the human rights movement that flourished in Latin America and Southern Africa in the 1970s and 1980s, and follows a trend in the field of psychology to recognise the impact that social factors have on psychological factors and *vice versa* (Agger, 2002; Williamson & Robinson, 2006).

The field of MHPSS has developed substantially in recent years and is currently an integral and required component of all major recent humanitarian emergencies, from the ongoing conflicts in Yemen and Syria to natural disasters and crises such as the 2010 Haiti earthquake, the 2018 earthquake and tsunami in Indonesia and the recent COVID-19 pandemic (Meyer & Morand, 2015). Today, MHPSS, as well as its integration within other humanitarian sectors (e.g., water and sanitation, food distribution, education and shelter), is recognised as an important component of effective humanitarian work (Ventevogel, 2018). Given its relatively new status as a pillar of humanitarian assistance however, research within the field of MHPSS, including documentation of programme outcomes and MHPSS pathways of change, is still limited.

2.4.1 Mental Health and Psychosocial Support Programming

Consistent with the increased recognition of integrated models reconciling trauma-focused and multimodal approaches described in section 2.3, the current scope of MHPSS programming varies widely, ranging from individualised clinical approaches (e.g., counselling, psychotherapy), community and school-level programmes, to interventions to increase social participation or empowerment (Bangpan et al., 2016). Within the model commonly referred to as the IASC MHPSS pyramid, all interventions are conceptualised into a multi-layered approach (Figure 2.3). The overarching structure of the pyramid encompasses interventions that take place within the health sector but also in other relevant areas, such as the education and social sectors (Wessells & Van Ommeren, 2008).

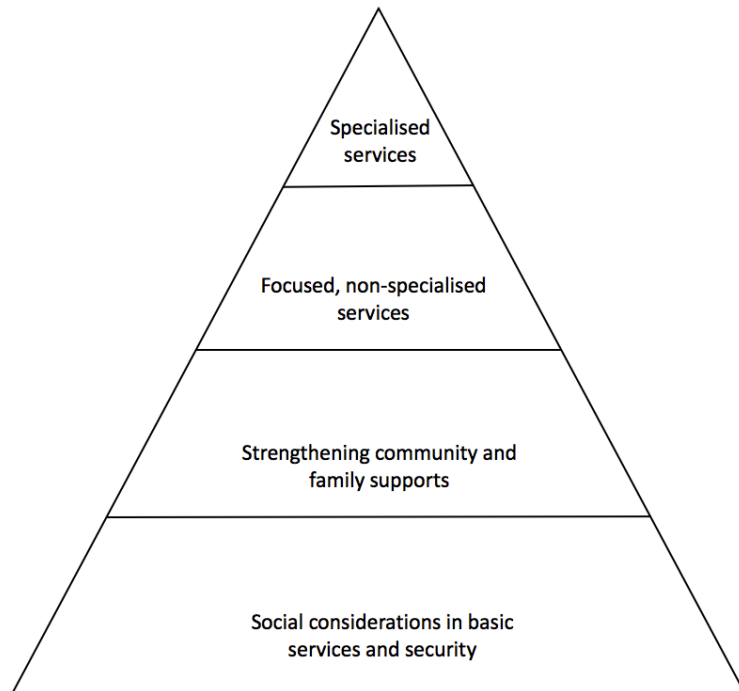


Figure 2.3. Intervention pyramid for mental health and psychosocial support in emergencies. Adapted from IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Inter-Agency Standing Committee, 2007) and Ventevogel, Jordans, Eggerman, van Mierlo, and Panter-Brick (2013)

According to this framework, the types of MHPSS support required in a humanitarian response are interrelated and categorised into four levels. The first level, or bottom layer, acknowledges that most persons affected by the emergency will cope with the difficulties of the emergency, but will need access to basic services as well as security. Organisations supporting the MHPSS needs of affected populations at this level would typically advocate for basic services (e.g., shelter, water and sanitation, food) that are safe, participatory, socially appropriate and that protect dignity. This is achieved by: advocating that these basic services are put in place with responsible actors; documenting their impact on mental health and psychosocial wellbeing; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial wellbeing (Inter-Agency Standing Committee, 2007).

The second layer addresses the needs of people affected by disruptions in key family and support networks. Here, affected populations are thought to benefit from supports that activate social networks and communal traditions (e.g., family tracing and

reunification, communal healing ceremonies, child-friendly spaces and livelihood activities) (Ventevogel et al., 2013). The third layer consists of individual or group interventions provided by trained and supervised health workers (e.g., case worker systems, simplified interventions) as well as by members of the affected communities (i.e. lay providers) who are not necessarily mental health specialists (Ventevogel, 2016). Finally, the fourth layer consists of specialised supports provided by mental health specialists (e.g., psychiatrist, psychologist, psychiatrist nurse) thought to be required by persons with severe mental disorders whenever their needs exceed the capacities of existing primary health services (Inter-Agency Standing Committee, 2007). Notably, this layered system has been designed to emphasise complementarity between the layers. Ideally all layers of the pyramid should be in place concurrently and the same person should be able to access the interventions at each layer, if needed (Inter-Agency Standing Committee, 2007).

2.4.1.1 Task-Shifting: An Approach for Bridging the Mental Health Treatment Gap

Despite this important advancement in MHPSS programming, including the greater recognition of MHPSS needs, the field confronts a critical challenge: the mental health treatment gap, or the persistent, large gap between the number of people in need of care and support and the number of people who receive it. In high-resource settings, between 35.5% to 50.3% of those living with psychiatric disorders do not have access to treatments or support services (Demyttenaere et al., 2004; Patel, Maj, et al., 2010; Saxena et al., 2007b). By contrast, this gap reaches rates of 76.3% to 85.4% in low-resource contexts, including humanitarian settings.

There are various obstacles to bridging the mental health treatment gap. A key challenge is the limited availability of mental health resources, which takes many forms. Notably, the small budget allocations to mental health, estimated to be less than US\$2 per capita in LMICs, geographic barriers, and limited infrastructure (Joshi et al., 2014). Another well-established resource limitation is the inadequate number of people trained to provide mental health care (Saraceno et al., 2007). The rate of mental health workers, including psychiatrists, psychologists, psychiatric nurses, occupational and speech

therapists, can be as low as 2 per 100,000 persons in low-income countries, 6.2 per 100,000 persons in LMICs and 20.6 in upper-middle income countries (World Health Organization, 2018). This is in stark contrast with the more than 70 mental health workers per 100,000 persons in high-income countries (World Health Organization, 2018). Indeed, it is estimated that there is a current shortage of 1.18 million specialist mental health personnel in LMICs (World Health Organization, 2011). This urgency has stimulated research on interventions and models for increasing access to mental health services (Kakuma et al., 2011; Murray, Tol, et al., 2014; Patel et al., 2007; Patel et al., 2018; Saxena, Thornicroft, Knapp, & Whiteford, 2007a). The redistribution of care is one such innovation.

Task-sharing or task-shifting, as defined by the World Health Organization, is “a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications” (World Health Organization, 2008, p. 7). In other words, less complex cases are transferred to lay providers (e.g., nurses, community health workers, teachers, paramedics, volunteers), thus ensuring that those who would not be able to access a specialist, receive some level of support (Patel et al., 2007). There are many examples of task delegation for delivering a range of health services across various health disciplines, notably HIV, primary care and maternal and child care (Bolton, 2019). Indeed, evidence suggests that task shifting can produce equivalent or superior outcomes for many diseases and health interventions including: screening and prescription for non-communicable diseases (e.g., hypertension, diabetes, cardiovascular disease) (Anand, Joseph, Geetha, Prabhakaran, & Jeemon, 2019; Joshi et al., 2014); HIV/AIDS therapy (Kredo, Adeniyi, Bateganya, & Pienaar, 2014); and maternal and reproductive health (Dawson, Buchan, Duffield, Homer, & Wijewardena, 2014).

Originating from the field of physical healthcare, the concept of task-shifting traces back to the 1920s, to a programme known as the ‘barefoot doctors’. Initially implemented in the Ding Xian County in rural China (1926-1937), village health workers were trained to provide basic medical treatments, and refer cases outside their expertise

(Bolton, 2019). Although at first implemented as part of an experiment, the barefoot doctors programme was ultimately adopted by the Chinese government in 1965, and subsequently scaled up across rural China (Bolton, 2019). The 'barefoot doctors' programme served as an inspiration to the Alma-Ata Conference on Primary Health Care in 1978, which called for the training of community health workers in the treatment and prevention of physical illness as the most important strategy for increasing access to physical health care (Bolton, 2019). The Global Strategy on Human Resources for Health: Workforce 2030, a more recent international commitment, aims to ensure universal availability of the health force and acknowledges the important role and specific needs of community health workers in achieving this goal (World Health Organization, 2016a).

Within high-income countries, the process of task-shifting is best represented by the three-tiered health care system (i.e. primary, secondary and tertiary care), whereby primary care physicians act as gatekeepers to more specialised secondary and tertiary levels. To tackle the high treatment gap in LMICs, however, some health systems in these settings have resulted to embedding an additional gatekeeper level, before primary care physicians, in the form of lay providers, or close-to-community providers (Bolton, 2019). Lay providers, also known as community health workers or village health workers, lack professional health care certifications and may be volunteers working without salaries but receiving other types of compensations (e.g., stipends, trainings, preferential access to health care or microcredit), or employed by NGOs or public services (Pallas et al., 2013). Some examples of the activities provided by lay health workers include health education, health promotion and linking community members to formal services (Pallas et al., 2013). Increasing attention has focused on the potential of lay health workers to expand access to essential health services, particularly in LMICs due to their ability to overcome geographic, cultural, and financial access barriers (Javadi, Feldhaus, Mancuso, & Ghaffar, 2017). Their proximity to communities means that they can reach community members faster, at a lower cost and alleviate the heavy workload of more specialised cadres (Javadi et al., 2017; Pallas et al., 2013). These programmes are also considered

sustainable schemes as lay providers are from the communities they serve, which enhances their accountability and credibility (Pallas et al., 2013).

While policies, programmes, and research on task-shifting within the physical health arena have advanced considerably since Alma-Ata, the importance of task-shifting for mental health has only recently started to gain global attention, and this largely due to the publication and the aforementioned guidelines (i.e. mhGAP) (Bolton, 2019). Correspondingly, lay providers in low and middle-income settings are increasingly engaged to help detect, diagnose, prevent and treat mental health problems (Kakuma et al., 2011). While limited, the available evidence on task shifting interventions for the treatment of mental disorders to date is promising. Specifically, in their seminal meta-analysis van Ginneken et al. (2013), found that, in comparison to usual care, mental health care delivered by providers with no mental health background increases the number of adults in LMICs who recover from depression or anxiety, two to six months after treatment (prevalence of depression: risk ratio (RR) 0.30, 95% confidence interval (CI) 0.14 to 0.64; low-quality evidence), provided that they receive appropriate training and continued supervision.

There is also some evidence that interventions delivered by non-specialised health workers reduce symptoms for mothers with perinatal depression (severity of depressive symptoms: standardised mean difference (SMD) -0.42, 95% CI -0.58 to -0.26; low-quality evidence) (van Ginneken et al., 2013). Task shifting interventions can also reduce the symptoms of adults with PTSD (severity of PTSD symptoms: SMD -0.36, 95% CI -0.67 to -0.05; low-quality evidence) and slightly improve the symptoms of people with dementia (severity of behavioural symptoms: SMD -0.26, 95% CI -0.60 to 0.08; moderate-quality evidence) (van Ginneken et al., 2013). In addition, interventions delivered by non-specialised health workers have been found to improve the mental wellbeing, burden and distress of carers of people with dementia (carer burden: SMD -0.50, 95% CI -0.84 to -0.15; moderate-quality evidence) and may decrease the amount of alcohol consumed by people with alcohol-use disorders (drinks/drinking day in last 7

to 30 days: mean difference -1.68, 95% CI -2.79 to -0.57); low-quality evidence) (van Ginneken et al., 2013).

Although valuable, these results should be interpreted with caution. In the interventions analysed by van Ginneken et al. (2013), non-specialists had diverse roles such as follow-up or rehabilitation of people with chronic severe mental health disorders, treatment of disorders as well as detecting and dealing with relapse/reoccurrence, compliance issues, side effects of treatment or psychosocial problems. Due to the low availability of evidence, the authors were not able to conclude which specific interventions were most effective. In addition, as van Ginneken et al. (2013) highlight, the quality of the evidence is low and many pooled results were statistically and clinically heterogeneous due to various factors such as the small number of studies, varying geographical, health worker and participant characteristics, which hindered their ability to reach more definite conclusions (van Ginneken et al., 2013).

In addition to the evidence suggesting that task-shifting for mental health offers some promise in terms of alleviating adverse mental health outcomes, there is evidence to suggest that task-sharing for mental health intervention is also cost-effective (Spedding & Chibanda, 2019). Data from implementation of task-sharing mental health interventions across five districts estimated the cost of task-shifting at US\$0.21-\$0.56 per capita per year in Ethiopia, Uganda, Nepal, India and South Africa (Chisholm et al., 2016). In other words, an estimated US\$100,000 to 300,000 would be required to bridge the treatment gap (based on Global Burden of Disease data) within a district with a population of half a million people (Chisholm et al., 2016). Another estimate, based on an evaluation of a trial in Goa, India in which lay providers collaborated with specialist and primary health care physicians in delivering mental health care, suggests that the mean total cost of the human resources for mental health associated with this intervention was US\$2 per participant, per year (Buttorff et al., 2012). By contrast, and although comparison to other cost-effectiveness analyses poses limitations, specialised treatment of depression per person, per year in India alone has been estimated at \$107 (Chisholm & Saxena, 2012).

Despite the limited but mounting research on effectiveness and cost-effectiveness of task-sharing mental health interventions, even less is known about the task-sharing workforce's perceptions of these interventions. The uptake and success of these interventions depends on the acceptability and well as a series of contextual factors (Proctor et al., 2011). A systematic review of 21 studies conducted by Padmanathan & De Silva (2013) investigating the acceptability and feasibility of task sharing mental health interventions in LMICs found favourable results in terms of participants' satisfaction with services, and in particular with the task-sharing workforce. The review also found varying levels of satisfaction in the way the interventions provided met participants' needs (Padmanathan & De Silva, 2013). This could be attributed to an inadequate consideration of culture and a lack of cultural adaptation or development (Balaji et al., 2012; Patel, Chowdhary, Rahman, & Verdeli, 2011). Less conclusive is the evidence available on the acceptability of using a task-sharing workforce, with available studies identifying workforce distress (e.g., burnout, vicarious trauma) as a key limitation of the task-sharing model (Padmanathan & De Silva, 2013). Padmanathan and De Silva (2013) argue that adequate training and continuous monitoring and evaluation could possibly contribute to preventing distress among close-to-community mental health providers (Padmanathan & De Silva, 2013). In addition, they suggest that initial assessments of workforce motivation, managing workers' expectations in terms of the workload that the intervention entails, as well as incentives could contribute to bridging this limitation (Padmanathan & De Silva, 2013). In contrast, failure to provide insufficient training and supervision could lead to 'task-dumping' or overloading lay providers with tasks they cannot perform (Eaton et al., 2011).

In addition to provider and beneficiaries' acceptability of task-shifting programmes, in a systematic review Dickson and Bangpan (2018) identified 15 studies reporting on a series of factors that contribute to the implementation of MHPSS programmes in emergency settings including: community engagement, sufficient numbers of trained providers, socially and culturally meaningful MHPSS interventions, trusting and supportive relationships with providers and engagement with peers in

group-based programmes and families. Even when these factors are taken into account however, additional challenges may hinder the implementation of these interventions including: lack of security, lack of health care facilities, long distances and lack of transportation, stigma associated with mental illness, lack of trust in formal health systems, difficulties integrating evidence-based MHPSS interventions into government health plans and lack of funding to implement and sustain services (Murray, Tol, et al., 2014).

Building on findings previous evidence, the Programme for Improving Mental Health Care (PRIME) examined the implementation of task-sharing mental health interventions in Ethiopia, India, Nepal, South Africa, and Uganda (Mendenhall et al., 2014). After analysing the results of 36 focus group discussions and 164 in-depth interviews with primary care service providers (physicians, nurses, and community health workers), community members, and service users, Mendenhall et al. (2014) found task-sharing was commonly seen as an innovative way to increase access to mental health care, linking community needs with health workers' capabilities (Mendenhall et al., 2014). However, in order to be feasible and acceptable the following key conditions were identified: increased numbers of human resources and improved access to medications, adequate training, support, and compensation for health workers who take on new mental health tasks, and ongoing structured supportive supervision at community and primary health care levels. Consistent with Padmanathan and De Silva (2013) and Murray, Tol, et al. (2014), evidence from the PRIME study showed that fundamental barriers to task-sharing were: overburdening health workers, inadequate training and supervision, insufficient remuneration, and inadequate integration of mental health care tasks into existing health systems (Mendenhall et al., 2014).

As shown by van Ginneken et al. (2013), there is a dearth of empirical evidence demonstrating the effectiveness of lay health workers' delivery of specific psychological interventions on their own, or as part of a collaborative care model. Additional research is further needed to understand how participants and lay health workers experience task-sharing mental health interventions, preferably through mixed-methods designs

(Padmanathan & De Silva, 2013). With research at the intersection of task-shifting and mental health still in its early phases, important gaps remain as to the context-specific factors that might enable or inhibit the implementation of task-shifting programmes (Mendenhall et al., 2014; Murray, Tol, et al., 2014; Padmanathan & De Silva, 2013).

2.4.2 Low-Intensity Psychological Interventions: Increasing Access to Evidence-Based Therapies

Recently, low-intensity psychological interventions, a specific subset or form of task-shifting for mental health has gained substantial attention from researchers and practitioners working in humanitarian settings. Here, lower *intensity* means that the intervention requires less time from a practitioner compared to conventional treatments, but it also refers to lower intensity across other dimensions including: time required from patients, cost, and practitioners' level of expertise (Van Straten, Hill, Richards, & Cuijpers, 2015). Used in the United Kingdom at the beginning of this century, the term low-intensity psychological intervention refers to the stepped model of care in which low-intensity or simplified psychological therapies are recommended in conjunction with high-intensity or conventional therapies (Bower & Gilbody, 2005; Haaga, 2000; Lovell & Richards, 2000). In this model, and as in case of the three-tiered health care system and the multi-layered approach of MHPSS, treatment is planned in a sequential manner, whereby participants first receive less intense or low-intensity interventions with those failing to improve being subsequently referred for more intensive interventions (National Institute for Health and Excellence, 2011).

A central tenet of low-intensity psychological interventions, common to all task-sharing interventions, is that in the face of scarce resources, including highly qualified mental health specialists, the implementation of LIPIs has the capacity to increase access to care, improve efficiency and cost-effectiveness (Bennett-Levy, Richards, & Farrand, 2010).

Although there is no agreed upon, comprehensive definition of low-intensity psychological interventions, LIPIs are characterised by several broad features that

differentiate them from traditional, high intensity interventions. First, and in comparison, to high-intensity interventions, LIPIs are usually less complex, involve a reduced level of contact with the person receiving the intervention (five sessions on average), are often trans-diagnostic, and often use novel forms of delivery (e.g., in group settings, via telephone, audio-guided or computerised interventions) (Bennett-Levy et al., 2010; Rodgers et al., 2012). In addition, the nature of the treatment itself differs from high-intensity interventions in terms of who delivers and receives the intervention (Ali et al., 2014). LIPIs are intended for persons with mild to moderate symptoms and less complex presentations and are designed to be delivered by professionals or para-professionals with less extensive level of training on mental health (Bennett-Levy et al., 2010). Another distinguishing characteristic of low-intensity psychological interventions is that they tend to be simplified forms of ‘evidence-based’ high-intensity psychotherapies, and are often manualised to ensure fidelity (Bennett-Levy et al., 2010). In this way, LIPIs follow the same principles as full or high-intensity treatments, thereby enabling the dissemination of knowledge and building upon decades of evidence of psychological therapies.

2.4.2.1 Low-intensity Formats of Evidence-Based Psychotherapies

The term ‘evidence-based’ was first documented in 1987 in workshops for designing clinical practice guidelines for medicine in the United Kingdom and began to be used for clinical decision making in the 1990s (Cook, Schwartz, & Kaslow, 2017). In 1996, evidence-based was defined as the “conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 72). Sackett et al. (1996) also noted that the practice of evidence-based medicine involved integrating individual clinical expertise with the best available clinical evidence from systematic research. Later, the concept expanded to include patients’ preferences and actions as determinants of treatment continuation (Cook et al., 2017). Today, the best clinical evidence considered in evidence-based medicine comes from a combination of meta-analyses, randomised

controlled trials, effectiveness studies, single case reports, systematic case studies, qualitative and ethnographic research, and clinical observation (Cook et al., 2017).

In determining which psychotherapies to recognise as evidence-based, the World Health Organization follows a rigorous process involving regular monitoring of new evidence and feedback from numerous mental health specialists, researchers and practitioners. These are then integrated into their leading guidelines for mental health in non-specialised or primary health care settings (mhGAP-IG 2.0) and mental health in humanitarian emergencies (mhGAP-HIG) (World Health Organization, 2015). The latest versions of both guidelines list Interpersonal Psychotherapy (IPT), Problem-Solving Therapy (PST), parenting skills training, Eye Movement Desensitisation and Reprocessing (EMDR), Behavioural Activation (BA), and Cognitive Behavioural Therapy (CBT) as evidence-based therapies for depression, child and adolescent mental and behavioural disorders and anxiety (World Health Organization, 2016b; World Health Organization & United Nations High Commissioner for Refugees, 2015). The evidence for low-intensity versions of these therapies is summarised below. The arrangement of the evidence does not indicate priority.

Interpersonal Psychotherapy

Interpersonal Psychotherapy is a structured, time-limited intervention originally developed for the treatment of depression. IPT focuses on the four types of interpersonal difficulties that are most central to the development of depression: grief, interpersonal disputes, role transitions (e.g., parenthood, retirement) and interpersonal deficits (e.g., social isolation, loneliness) while also helping individuals to enhance the quality of their social relations (Markowitz & Weissman, 2012). IPT has also been applied to other disorders linked with interpersonal stressors (e.g., binge eating, social anxiety) (Cuijpers, Donker, Weissman, Ravitz, & Cristea, 2016).

Meta-analytic evidence has shown moderate to large effects of high-intensity IPT on depression compared to control groups, with smaller effects among older adults, in clinical samples, and in samples meeting diagnostic criteria for depressive disorder (Cuijpers et al., 2016). IPT was not more or less effective than other therapies for

depression and is possibly effective in the treatment of eating and anxiety disorders (Cuijpers et al., 2016). In subthreshold depression, IPT significantly prevented the onset of major depression and significantly reduced relapse (Cuijpers et al., 2016). Despite its advantages, Cuijpers et al. (2016) also found that the effectiveness of IPT for the treatment of depression was associated with the number of sessions, with ten or more sessions resulting in an increase in the effect size and 16-session IPT possibly being more effective than shorter versions.

In a 16-session lay delivered, low-intensity group version of IPT tested among depressed adults in rural Uganda, participants who received IPT showed significant reductions in their depression symptoms and improvements in functioning (Bolton et al., 2003). At 6-month follow-up, only 12% of individuals in the IPT group met the diagnostic criteria for major depressive disorder, compared with 55% of those receiving usual care (Bass et al., 2006). In this study, facilitators had at least finished high school education, did not have any previous mental health or counselling experience, and received two weeks training in IPT (Bolton et al., 2003).

Also in Uganda, a more recent nonrandomised trial of a 12-session, group-based IPT intervention with 142 caregivers of children affected by nodding syndrome found greater reductions in risk of depression among caregivers and children in the IPT group, from baseline to 1-month and 6-month post-intervention, compared with usual care (Mutamba et al., 2018). Psychological distress, stigma, and social support among caregivers in the IPT group were also significantly improved (Mutamba et al., 2018; Spedding & Chibanda, 2019).

Based on the evidence of the first trial in Uganda documented by Bolton et al. (2003) and Bass et al. (2006), Patel, Weiss, et al. (2010) conducted a cluster randomised trial whereby lay health workers in primary care facilities in Goa, India provided psychoeducation to adult patients who screened positive for common mental health disorders, as per the 10th revision of the WHO's International Statistical Classification of Diseases and Related Health Problems (ICD-10), and IPT to moderately to severely depressed patients as an alternative to pharmacological treatment or in addition to

antidepressant drugs for those who did not respond to antidepressant treatment. Locally recruited lay health providers underwent a structured 2-month training course. A minimum of six IPT sessions, with an optimum of eight and a maximum of 12, were offered through this trial (Patel, Weiss, et al., 2010). Findings from this study showed modest evidence for a beneficial effect of the stepped care approach on recovery from common mental disorders at 6 months, but no effect of the IPT intervention on the subgroup of patients with depression.

Despite these mixed findings, there are indications that low-intensity IPT may be a feasible option for reducing symptoms of depression in South Africa (Spedding & Chibanda, 2019). A smaller study conducted in South Africa piloted a 12-week, group-based IPT intervention delivered by community health workers to treat 60 adult women from similar educational and socioeconomic levels, who were primary healthcare patients with moderate-to-severe depression (Petersen, Bhana, & Baillie, 2012). The intervention group showed a significant reduction in depressive symptoms at both 12 and 24-week after the baseline assessment, compared with the control group.

Problem-Solving Therapy

Problem Solving Therapy is a brief, structured psychological intervention in which the client or patient creates a problem list, identifies possible solutions, lists and develops a plan to implement the best solution, and evaluates outcomes in relation to the problem (Mynors-Wallis & Lau, 2010). Although often presented as a distinct form of therapy, PST is increasingly used as a component of cognitive behavioural interventions in both low and high intensity formats (Bell & D'Zurilla, 2009). Originally developed by D'Zurilla and Goldfried (1971), PST is based on a model of stress and wellbeing (i.e. psychological, social, and health functioning) in which social problem solving is assumed to play an important role as a mediator and a moderator of the relationship between stressful life events (major negative events as well as daily problems) and wellbeing (Bell & D'Zurilla, 2009).

The results of two meta-analyses support the use of PST as strongest for depressive disorders. Cuijpers, van Straten, and Warmerdam (2007) found moderate to

large effect sizes in favour of PST for the treatment of depression among adults. However, the meta-analysis was limited by the low number of studies and high heterogeneity across them. In an effort to address these limitations, Bell and D'Zurilla (2009) conducted a second meta-analysis and confirmed PST to be as equally effective as other psychosocial therapies and medication treatments and significantly more effective than no treatment and support/attention control groups, although details on the comparison groups were not specified by the authors. Bell and D'Zurilla (2009) also identified PST to be more effective when the programme included (a) training in a positive problem orientation (vs. problem-solving skills only), (b) training in all four major problem-solving skills (i.e. problem definition and formulation, generation of alternatives, decision making, and solution implementation and verification), and (c) training in the complete PST package (problem orientation plus the four problem-solving skills).

Another problem-solving therapy task-shifting intervention, delivered by grandmothers outside local polyclinics, known as the 'Friendship Bench', has been thoroughly researched in Zimbabwe (Abas et al., 2016; Chibanda et al., 2017; Chibanda et al., 2011; Chibanda, Verhey, Munetsi, Cowan, & Lund, 2016; Chibanda, Weiss, et al., 2016; Munetsi et al., 2018). The intervention consists of six sessions of 30–45 min of structured PST, delivered in a discrete area outside of the clinic building on a bench (The Friendship Bench). The PST components consist of problem listing and identification, problem exploration, developing an action plan, implementation, and follow up (Chibanda et al., 2015). In a RCT, Chibanda, Weiss, et al. (2016) found that participants taking part in the 'Friendship Bench' had significantly lower symptoms of depression and other symptoms of common mental health disorders, as measured by a locally validated tool, in comparison to enhanced usual care at 6-months follow-up. Similar findings were also observed among a sub-sample of participants on the Friendship Bench programme who had reported suicidal ideation (Munetsi et al., 2018). Abas et al. (2016) demonstrated that the Friendship Bench is positively received by clients, rewarding for female lay health workers to deliver, and can be sustained over time at

low cost. Another qualitative evaluation of the same programme found that some male clients may however, prefer to see a male lay community health worker (Chibanda et al., 2017).

Parenting Skills Training

Parenting skills training is defined as a family of treatment programmes that aims to change parenting behaviours and strengthen confidence in adoption of effective parenting strategies (World Health Organization, 2016b). Parenting skills training involves teaching parents emotional communication and positive parent-child interaction skills, and positive reinforcement methods to improve children/adolescent's behaviour and functioning (World Health Organization, 2016b). The mhGAP guidelines also provide advice on child and adolescent mental and behavioural problems and acknowledges the essential role of parents in child development. Effective parenting behaviour and responsiveness to child signals and behaviours facilitate prosocial behaviours (Mingebach, Kamp-Becker, Christiansen, & Weber, 2018). On the contrary, inconsistent discipline or negative emotional expressiveness affect a child's emotion regulation, which, in turn, can lead to and maintain disruptive behaviour problems (Duncombe, Havighurst, Holland, & Frankling, 2012; Grusec, 2011). Parenting skills interventions therefore aim to address parental behaviour and have been shown to impact positively not only on parenting and child behaviour, but also on parental perceptions and parental mental health (Mingebach et al., 2018).

A meta-meta-analysis of 26 meta-analyses showed significant and moderate effects of parenting skills interventions on externalising behaviour problems among children, with possible long-term effects (Mingebach et al., 2018). Although the evidence on the effects of parenting skills training on internalising behaviour is not as strong, the results from this meta-meta-analysis confirm the categorisation of parenting skills training as an evidence-based intervention for the treatment of children with externalising behaviour problems and disorders (Mingebach et al., 2018).

Despite the supporting evidence however, parenting skills programmes tend to have low participation and high attrition rates, limiting the potential impact of these

interventions (Heinrichs, Bertram, Kuschel, & Hahlweg, 2005). According to Tully and Hunt (2016) review, this could be due to the lengths of most parenting skills interventions, 8-24 sessions, presenting a number of opportunity costs for parents. Lengthy parenting skills programmes are also resource-intensive in terms of practitioners' training and supervision. Tully and Hunt (2016) synthesised the evidence on low-intensity parenting skills interventions, including a brief lay-delivered individual or group interventions as well as self-directed interventions. The authors reported inconclusive findings for parental mental health and partner relationship functioning. Although heterogeneity prevented a meta-analysis of the data, the authors retrieved nine studies which found significant improvements in parent-reported child externalising behaviours, parenting skills and parenting self-efficacy, relative to control or treatment as usual, with findings maintained at follow-up (Tully & Hunt, 2016).

Eye Movement Desensitisation and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapeutic approach developed in the late 1980s by Francine Shapiro that aims to treat traumatic memories and their associated stress symptoms (Shapiro, 1989). This trauma-focused approach consists of a standard protocol which includes eight phases (i.e. history taking, client preparation, assessment, desensitisation, installation, body scan, closure and re-evaluation of treatment effect) and bilateral stimulation (usually horizontal saccadic eye movements) to desensitise the discomfort caused by traumatic memories. The aim of the therapy is to achieve the reprocessing and integration of the traumatic event(s) within the patient's standard biographical memories (Valiente-Gómez et al., 2017). The effectiveness of EMDR therapy has been the subject of various meta-analyses [e.g., Bradley, Greene, Russ, Dutra, and Westen (2005); Davidson and C. H. Parker (2001); Chen et al. (2014); Chen, Zhang, Hu, and Liang (2015); Seidler and Wagner (2006)], culminating in the final recognition by the World Health Organization as a potential psychotherapy of choice in the treatment of PTSD in adults (World Health Organization & United Nations High Commissioner for Refugees, 2015).

However, the evidence of low-intensity EMDR is quite limited. One small study conducted in Bolivia trained and supervised two paraprofessionals to provide a low-intensity group version of EMDR to personnel from NGOs who reported work-related PTSD symptoms. Results indicate that a low-intensity version of EMDR had a significant effect on the reduction of PTSD symptoms at follow-up (Jarero, Rake, & Givaudan, 2017). These outcomes were maintained at three months after the end of the intervention, even though participants continued working in the same environment and were continuously vicariously exposed to the same events. The study however has a number of limitations including sample size, the use of only one measure (i.e. PTSD), and the lack of comparison with a control group or treatment (Jarero et al., 2017).

Behavioural Activation

Behavioural Activation (BA) is a behavioural psychotherapy initially developed in the 1970s by Lewinsohn and colleagues (Dimidjian, Barrera, Martell, Munoz, & Lewinsohn, 2011), that uses the principles of operant conditioning through scheduling to encourage depressed people to reconnect with environmental positive reinforcement (Ekers et al., 2014). Although initially popular and empirically supported, with the emerging acceptance of cognitive therapy in the 1980s, BA as a stand-alone treatment started losing momentum among practitioners (Kanter, Puspitasari, Santos, & Nagy, 2012). Although the principle of BA was still valued, cognitive constructs started being viewed as important to depression. Cognitive therapists thus began including the primary behavioural techniques of activity monitoring and activity scheduling in its treatment package such that today BA is largely seen as a component of CBT (Kanter et al., 2012; Soucy Chartier & Provencher, 2013).

A meta-analysis has shown no significant difference between stand-alone BA therapy for depression and other psychotherapies (i.e. CBT, third-wave CBT, psychodynamic, humanistic and integrative therapies) (Shinohara et al., 2013). In addition, low-quality evidence showed better response to CBT than BA, better response to BA over psychodynamic therapies, and no significant differences in response rate or acceptability (Shinohara et al., 2013). In response to the need for higher quality fully

powered evidence on BA, Richards et al. (2017) conducted a non-inferiority trial in the United Kingdom assessing the effects of BA in comparison to CBT for the treatment of depression and found BA to be as effective as CBT in the reduction of symptoms of depression. Similar findings were also reported by Ekers, Richards, McMillan, Bland, and Gilbody (2011). Both studies found that the simplicity of BA renders it more suitable for delivery by junior mental health specialists, which also has implications for costs and increased availability of treatment. The simplicity of BA may therefore prove valuable when transferring it to low-intensity formats. However, a systematic review on the effectiveness of low-intensity BA was inconclusive since the studies identified focused on older samples (50 years and older) and varied in many methodological aspects (Soucy Chartier & Provencher, 2013).

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy refers to a family of time-limited problem-focused psychotherapies under the core premise that maladaptive ways of thinking and behaving generate mental and behavioural problems (Thoma, Pilecki, & McKay, 2015). Most low-intensity psychological interventions are adapted versions of CBT (National Collaborating Centre for Mental Health, 2011). The appeal of low-intensity CBT is four-fold (Kuo, 2019). Firstly, there is a large body of empirical evidence supporting the use of high-intensity CBT (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). In addition, CBT integrates useful techniques from other evidence-based psychotherapies (i.e. problem-solving and behavioural activation). This last characteristic makes CBT more compatible with trans-diagnostic approaches. Indeed, mhGAP endorses the use of CBT in non-specialised settings for a wide range of disorders (e.g., depression, child and adolescent mental and behavioural problems, psychoses, substance abuse). Moreover, CBT can be delivered by a wide-range of providers, including both mental health specialists and non-specialists (Patel et al., 2011), and across different formats or platforms (e.g., individual, group and internet-based formats) (Fann et al., 2015; Farrer, Christensen, Griffiths, & Mackinnon, 2011; Gratzner & Khalid-Khan, 2016; Kuo, 2019). Finally, CBT has been shown to offer a clear model for structured training and support

required for task-shifting (Magidson, Regenauer, Andersen, & Safren, 2019). Despite its appeal, the evidence for CBT is geographically biased. For instance, out of the 115 RCTs on CBT for adult depression analysed by Cuijpers et al. (2013), only eight were conducted in LMICs. Nevertheless, CBT is one of the key therapeutic approaches underpinning MHPSS interventions in humanitarian contexts and could be a feasible and sustainable solution to address the treatment gap in resource-limited settings.

2.5 Cognitive Behavioural Therapy: An Overview of Theory and Evidence

In the 1960s, cognitive and behavioural theories merged to form a combination of therapeutic approaches, known today as Cognitive Behavioural Therapy (CBT). Specifically, CBT emerged from a combination of Aaron Beck's cognitive therapy (Beck, 1967) and Albert Ellis's early work on behavioural therapy (Ellis, 1957; Kuo, 2019). The central tenet of CBT is that helping people think differently about themselves and their difficulties can alleviate distress (Bennett-Levy et al., 2010).

Cognitive behavioural therapies therefore share the following propositions: cognitive activity affects behaviour; cognitive activity may be monitored and altered and desired behaviour change may be affected through cognitive change (Dozois, Dobson, & Rnic, 2019). CBT includes psychological treatments that combine cognitive components aimed at thinking differently, for example, identifying and challenging unrealistic negative thoughts, and behavioural components aimed at doing things differently, such as helping the person to participate in more rewarding activities. CBT assumes that psychopathology, or emotional disturbance, is the result of biased cognitions and unhelpful behaviour. These treatments thus aim to improve symptoms of psychopathology by addressing these unhelpful cognitions and behaviours (Hofmann et al., 2012).

CBT is currently the most widely researched and empirically supported form of psychotherapy, to the point that it has been coined as 'one of the big success stories of contemporary psychology' (David, Cristea, & Hofmann, 2018). The reasons for its

success are many. Firstly, CBT was the first type of psychotherapy to be tested in RCTs (David et al., 2018; Hofmann, Asmundson, & Beck, 2013). Since then, it has been compared to strong comparison conditions and evidence has shown that even when there are systematic differences between psychotherapies, these tend to support the use of CBT (David et al., 2018; Hofmann et al., 2013). CBT was also the first psychotherapy to be described as evidence-based and different forms of CBT are currently present in all major international clinical guidelines (e.g., United Kingdom's National Institute for Health and Excellence guidelines, mhGAP) (David et al., 2018). Third, unlike many of its predecessors, CBT is time-limited, therefore increasing the cost-effectiveness of psychotherapy. Lastly, CBT keeps evolving to reflect new evidence and paradigms, such as what is commonly referred to as 'third-wave CBT', which seeks to integrate the principles of acceptance, mindfulness and non-judgemental awareness with traditional CBT approaches (e.g., Acceptance and Commitment Therapy and Dialectical Behaviour Therapy) (Thoma et al., 2015).

Beck and Beck (2011) described a series of fundamental characteristics of the CBT approach. First, CBT is based on a constantly evolving formulation of the client or patient's problems (e.g., current thinking, problematic behaviours, patterns of interpretation of said problems). In addition, CBT depends on a strong therapeutic relation or alliance through active listening, making empathic statements, accurate summaries of the person's feelings, among others. Thirdly, CBT is goal oriented and problem-focused, the client or patient present their problems and sets specific goals that then guide the sessions (Beck & Beck, 2011). Accordingly, CBT is collaborative, rather than being confrontational towards the patient or client's negative conceptualisation of themselves or negative interpretation of life experiences. Beck proposed a collaborative process in which the therapist guides the patient so as to allow them to explore and examine their thoughts and determine their accuracy or helpfulness (Thoma et al., 2015). CBT focuses on the present problems and specific situations distressing the person. The focus only shifts to the past when the patient or client requests it (Beck & Beck, 2011). CBT is also educational as the therapist instructs the client/patient on how to practice

CBT techniques themselves. CBT teaches the client/patient to identify automatic thoughts and adopt a more realistic or helpful perspective. CBT sessions follow a structure to make the therapy more effective and efficient. In addition to cognitive strategies, CBT relies on behaviour and problem-solving techniques that vary across different diagnosis and according to key characteristics of the client/patient (e.g., intellectual development, cultural background, problems).

CBT is currently used to effectively treat a wide range of mental disorders. Meta-analyses of CBT for depression have shown CBT to be an efficacious therapy for adult depression (Cuijpers et al., 2013; Cuijpers, Noma, Karyotaki, Cipriani, & Furukawa, 2019; Hofmann et al., 2012). CBT for adults with depression was found to be at least as effective as other psychotherapies, including behavioural activation, problem-solving therapy, psychodynamic psychotherapy and interpersonal psychotherapy, although not superior (Barth et al., 2013; Cuijpers et al., 2013). Results from another review however found support for the superior results for CBT over another psychotherapy (i.e. psychodynamic therapy) at follow-up (Tolin, 2010).

A review of meta-analyses on the efficacy of CBT showed that strongest effects of CBT were found for the treatment of anxiety disorders, somatoform disorders, bulimia, anger control problems, and general stress (Hofmann et al., 2012). More recent meta-analyses suggest that the evidence for CBT is growing rapidly and research continues to support its efficacy for various treatment targets (e.g., anxiety disorders such as post-traumatic stress disorder and obsessive-compulsive disorder, bipolar disorders, insomnia) (Chiang et al., 2017; Montero-Marin, Garcia-Campayo, López-Montoyo, Zabaleta-Del-Olmo, & Cuijpers, 2018; Van Straten et al., 2018). Likewise, Hofmann et al. (2012) conclude that the evidence for CBT is strong, although less research has been conducted on specific subgroups such as low-income populations, including refugees and migrants.

Research on the effectiveness of psychotherapies among refugee and migrant samples to date largely focus on addressing symptoms of PTSD. While inconsistent, the literature tends to support the use of trauma-focused CBT interventions (Thompson,

Vidgen, & Roberts, 2018; Tribe et al., 2017; Turrini et al., 2019). A systematic review of research of adult refugee and asylum seeking samples with different backgrounds and trauma types found that Narrative Exposure Therapy (NET), a manualised short-term variant of trauma-focused CBT, and to a less extent, culturally-adapted CBT and EMDR were effective in reducing PTSD, depression and anxiety symptoms (Tribe, Sendt, & Tracy, 2017). In another review, Thompson et al. (2018) found limited evidence supporting the use of both NET and EMDR for decreasing symptoms of PTSD among adult refugees and asylum seekers. Conversely, a more recent meta-analysis found that trauma-focused CBT was effective in decreasing PTSD and anxiety symptoms, but EMDR was not effective in reducing symptoms of PTSD, and NET did not show benefits for PTSD or depression (Turrini et al., 2019).

2.5.1 Trans-diagnostic Approaches to Cognitive Behaviour Therapy: A New Paradigm Shift

As the most researched form of psychotherapy, CBT now offers a wide range of evidence-based disorder-specific protocols and various disorder-specific CBT protocols have been shown to be beneficial for comorbid disorders [e.g., Tsao, Mystkowski, Zucker, and Craske (2005); Borkovec, Abel, and Newman (1995)]. This has resulted in a shift away from the disorder-specific approach that has historically dominated the conceptualisation, treatment, and research of mental health disorders (Newby, McKinnon, Kuyken, Gilbody, & Dalgleish, 2015).

Similarly, a parallel body of research has identified shared symptoms and underlying processes across disorders (Mansell, Harvey, Watkins, & Shafran, 2009). Mansell, Harvey, Watkins, and Shafran (2008) identified 12 specific trans-diagnostic cognitive and behavioural processes across numerous disorders (e.g., avoidance behaviour, emotional reasoning, positive and negative metacognitive beliefs). Some have argued that commonalities across disorders may outweigh the differences (Barlow, Allen, & Choate, 2004), resulting in the increased use of trans-diagnostic or principle-specific approaches as an alternative method to single-diagnosis treatments.

Correspondingly, trans-diagnostic Cognitive Behavioural Therapy (TD-CBT) interventions address the shared cognitive and behavioural mechanisms that underpin mental health problems (e.g., depression, anxiety, stress and grief). TD-CBT responds to cognitive and behavioural domains (i.e. attention, memory, reasoning, thought and behaviour) by targeting various processes (e.g., avoidance, recurrent negative thinking, emotional reasoning) through varying strategies (Mansell et al., 2009). This is operationalised in various ways. Some TD-CBT interventions are developed by bringing together strategies of disorder-specific protocols; whereas others develop conceptual frameworks that delineate common elements of certain disorders and develop strategies to address them. Others again, identify strategies that simultaneously target the commonalities between disorders (Clark, 2009).

Accumulating evidence for the effectiveness of trans-diagnostic CBT treatments shows promising results. Evidence from the Unified Protocol for Trans-Diagnostic Treatment of Emotional Disorders, a thoroughly researched example, has shown that treatment gains for general symptoms of anxiety and depression as well as daily functioning are still maintained 12-months after treatment in a clinical sample (Bullis, Fortune, Farchione, & Barlow, 2014). Results from a meta-analysis of trans-diagnostic treatments has demonstrated their efficiency, with large effect sizes for anxiety and depression (Hedges g_s = .85 and .91 respectively), and moderate increases for quality of life measures (Hedges g = .69). Meta-analytic data indicates that trans-diagnostic CBT provides equally strong effects for the treatment of anxiety compared to diagnostic-specific treatments (Newby et al., 2015; Pearl & Norton, 2017). Preliminary evidence indicates significant differences between trans-diagnostic and diagnostic-specific CBT, with results in favour of trans-diagnostic treatments (Newby et al., 2015).

In addition to their effectiveness, there are various pragmatic reasons for the use of TD-CBT. Trans-diagnostic CBT interventions address the needs of persons that do not fit neatly within specific diagnostic criteria and address the limitations of diagnostic imprecision (Mansell et al., 2009). This approach is useful as most persons present comorbidities (McEvoy, Nathan, & Norton, 2009). Thus, TD-CBT increases flexibility for

clients to address different emotional responses (e.g., depression, anger, grief) simultaneously (McEvoy et al., 2009). In addition, TD-CBT interventions are more accessible, as practitioners administering the interventions do not need to learn multiple diagnostic and treatment manuals (Murray, Dorsey, et al., 2014). Less training and resources translates into shorter waiting periods for accessing mental health care and increased availability of practitioners that can respond to multiple disorders (McEvoy et al., 2009). Thus, and probably the most important benefit of trans-diagnostic CBT protocols, is their potential to increase the number of people gaining access to evidence-based treatments. Low-intensity versions of TD-CBT are therefore a promising approach for use in humanitarian contexts, where both human resources for mental health and finances are scarce.

2.5.2 Low-Intensity Psychological Interventions: An Innovative Way to Deliver CBT

Widespread acceptance of CBT has led to increased demand and to the recognition that the currently limited number of trained practitioners restricts access to CBT (Bennett-Levy et al., 2010). As a result, forerunners such as Isaac Marks, author of *Living with Fear*—one of the first and most read CBT self-help books—, have pioneered ways of making CBT more available to a general population (Bennett-Levy et al., 2010). Consistent with the task-shifting approach, in the 1970s, Marks convinced the government of the United Kingdom to experiment with training nurses to deliver CBT, ultimately demonstrating that nurses could successfully deliver CBT within primary care settings (Bennett-Levy et al., 2010; Marks, 1985). As a result of these early efforts, low-intensity psychological interventions are the primary form of care accessed by 900,000 people each year in the United Kingdom. This is largely done through the Improving Access to Psychological Therapies (IAPT) scheme, which was first introduced in 2008 (Bower et al., 2013).

Indeed, meta-analytic evidence from high-income countries involving 3,962 patients, and mainly from the United Kingdom, suggests that Low-Intensity Cognitive Behavioural Therapy (LI-CBT) interventions delivered in primary care by someone other

than the patient's general practitioner, as well as problem-solving therapy and counselling, are effective for the treatment of highly prevalent disorders such as anxiety and depression (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010). Although the low-intensity interventions analysed by Cape et al. (2010) (i.e. CBT, counselling, IPT, psychodynamic psychotherapy, problem-solving therapy) showed low effect sizes in comparison to specialist-delivered high-intensity interventions, low-intensity CBT for anxiety showed comparable effect sizes to high-intensity treatments. In addition, meta-analytic evidence has showed that computerised CBT (i.e. CBT delivered over the internet or by computer in a clinic) for anxiety and depressive disorders, especially via the internet, leads to effective acceptable outcomes (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010). Another meta-analysis showed guided self-help LI-CBT can be effective in the treatment of anxiety and depression, with medium effect sizes (Gellatly et al., 2007).

Even when initial severity of depression is considered, research on LI-CBT interventions indicates that participants with more severe depression at baseline show at least as much clinical benefit from low-intensity interventions as less severely depressed participants (Bower et al., 2013). In addition, results from two studies in the United Kingdom's IAPT initiative showed that most patients (55%) who had attended at least two sessions of low-intensity interventions, such as guided self-help and computerised CBT, were recovered when they left the service and that the benefits of the intervention were maintained at the 10-month follow-up (Clark et al., 2009). Additional evidence from different IAPT services concluded that in contrast with IPT programmes, where ten or more sessions result in an increase of the effect sizes, the effectiveness of LI-CBT interventions is maximised between four and six sessions and that additional sessions after this point rarely lead to better outcomes (Delgadillo et al., 2014; Firth, Barkham, Kellett, & Saxon, 2015).

Depression and anxiety disorders, however, are relapse-prone conditions and the evidence on whether the effects of LI-CBT are sustained is limited. A recent longitudinal study conducted in the United Kingdom, found that one in two patients

who experienced remission of symptoms after acute-phase treatment experienced a clinically significant deterioration of symptoms within 12 months of completing treatment, and that those reporting residual depression symptoms at the end of treatment had high risk of relapse that could be addressed by incorporating relapse prevention strategies into the interventions (Ali et al., 2017).

2.5.3 Low-Intensity CBT Interventions in Humanitarian and Low and Middle-Income Settings

As evidenced by the above, LI-CBT presents an opportunity to extend mental health care to individuals that would otherwise not have access. In recognition of this, and given existing evidence for the use of low-intensity psychological interventions to increase access to mental health care in high income countries, research is rapidly emerging on the use of these interventions within humanitarian and low-income settings. For instance, Chowdhary et al. (2015) pilot-tested a LI-CBT intervention known as the 'Healthy Activity Program' in India among 62 mostly female patients and found a significantly lower prevalence of depression among depressed participants who joined the programme, in comparison to those receiving enhanced treatment as usual. After assessing the acceptability of the intervention, the authors reported that most interviewed participants found the Healthy Activity Program to be useful and that the lay providers helped them in addressing their problems. Specifically, the lay provider's ability to promote treatment engagement and provide continuous support were seen as important factors contributing to acceptability (Chowdhary et al., 2015). Of the participants who dropped out, some found the treatment to be useful, although others admitted that they had not understood what the treatment was about, and were nervous about meeting the lay counsellor (Chowdhary et al., 2015).

Chowdhary et al. (2015)'s findings were subsequently used to adapt the intervention prior to testing it in a definite RCT. This trial confirmed that the low-intensity psychological intervention delivered to 495 adult patients, used in conjunction with enhanced usual care, was more effective and cost-effective than enhanced usual

care alone for the treatment of severe depression and resulted in almost two-thirds increase in remission at 3-months follow-up after treatment, and results being maintained 12 months after treatment (Patel et al., 2017; Weobong et al., 2017). A separate RCT was also conducted concurrently in the same primary health centres to assess the effectiveness of a harmful drinking intervention through motivational enhancement and behavioural and cognitive elements. Weobong et al. (2017) found that the intervention was associated with strong effects on abstinence and remission three months after enrolment, although the intervention was not found to have any effects on those who chose to continue drinking.

In another study, Rahman, Malik, Sikander, Roberts, and Creed (2008) randomly assigned 463 Pakistani mothers (aged 16-45 years) with post-partum depression to receive 'Thinking Healthy', a lay health worker delivered CBT intervention, or to enhanced routine care, and found significantly lower depression and disability scores and significantly higher functioning and perception of social support among mothers in the intervention group, in comparison to the control group. Following the delivery of a LI-CBT intervention for perinatal depression described by Rahman et al. (2008), Atif et al. (2016) conducted a qualitative study to explore the facilitators and barriers to the acceptability of the programme. Some of the identified factors contributing to the mothers' acceptability towards the intervention were: personal characteristics of the health workers (e.g., being local and having an ability to form a trustworthy and empathetic relationship with the mother and family) and perceiving the intervention as beneficial. For lay health workers, perceptions of personal gain (e.g., altruism, opportunity) as well as the support from their family and community were named as important contributors to their own motivation (Atif et al., 2016). Similarly, barriers to acceptability included: the lay health worker being seen as external to the community they served (e.g., they are perceived as 'foreign' to the community) and the intervention not being perceived as useful or effective. Another key finding was that in absence of an acceptable intervention, families were still willing to receive any type of support. Additional barriers to the implementation of this programme included poor workforce

motivation, which would result in lack of credibility among community members, interventions that did not address mental health stigma and that did not take into account cultural norms (Atif et al., 2016).

In another qualitative study exploring peer-delivered care for maternal depression in two South Asian contexts, Singla et al. (2014) identified practical challenges (e.g., women's housework and childcare) as well as family members' perceived suspicions of the lay health worker as challenging of existing family norms and sociocultural hierarchies, as potential barriers to implementation. Correspondingly, key facilitators included introducing lay health workers to family members and involving family members in appropriate sessions of interventions (Singla et al., 2014).

The Common Elements Treatment Approach (CETA) is another example of a trans-diagnostic LI-CBT intervention which has been shown to offer benefits for symptoms of depression, anxiety and PTSD (Dawson & Rahman, 2018; Murray, Dorsey, et al., 2014). The CETA programme trains lay providers in eight components of CBT (e.g., behavioural activation, exposure techniques, cognitive restructuring) and on how to make decisions about admission to the programme and dosing of the CBT techniques. When studied among Burmese survivors of imprisonment and torture, CETA was found to significantly reduce depression, posttraumatic stress, functional impairment, anxiety symptoms and aggression (Bolton et al., 2014). Similar findings were also reported among Iraqi survivors of violence (e.g., torture, unlawful imprisonment, persecution), whereby those receiving CETA had significant reductions in PTSD, anxiety and depression scores, with large effect size (Cohen's $d = 1.54$) (Weiss et al., 2015).

A study conducted by Bass et al. (2013) in the Democratic Republic of Congo found that cognitive processing therapy—a form of CBT for the treatment of PTSD—administered by lay providers to survivors of sexual violence, led to significant improvements in anxiety, depression, PTSD and functional impairment at the end of treatment. Moreover, significantly less participants in the therapy, compared to the control group, met the criteria for all measured mental health and functioning outcomes after six months (Bass et al., 2013). An RCT based on a stepped-care approach whereby

non-specialist health workers provided a CBT-based intervention and physicians provided medication to female patients with severe or persistent depression was conducted in low-income areas in Chile. Effectiveness comparisons to usual care (i.e. medication or referral for specialised treatment) among 240 adult female primary-care patients with major depression showed substantial differences in favour of the stepped care approach. At six months' follow-up, 70% of the stepped-care programme compared with 30% of the usual-care group had recovered (HDRS score <8) (Araya et al., 2003).

Unfortunately, a systematic review seeking to analyse the effectiveness and efficacy of low-intensity online interventions in LMICs was inconclusive, as only three RCTs were found and none of the online interventions studied were compared with active controlled conditions (Arjadi, Nauta, Chowdhary, & Bockting, 2015). Interest in guided self-help approaches, on the other hand, is increasing. Self-Help Plus is a five session guided self-help intervention currently being researched by the World Health Organization that is based on principles of Acceptance and Commitment Therapy, incorporates acceptance and mindfulness and encourages meaningful living despite adversity (Epping-Jordan et al., 2016). Self-Help Plus does not require diagnostic assessment since it aims to target a broad range of psychological difficulties (e.g., depressive and/or anxious mood, stress reactions and self-identified psychosocial problems) that cause distress, but do not necessarily meet the diagnostic criteria for a mental disorder (Epping-Jordan et al., 2016). The effectiveness of the intervention was tested across 14 villages in refugee settlements in northern Uganda and showed meaningful reductions in psychological distress at three-month follow-up (Brown et al., 2018; Tol et al., 2020). The effectiveness and cost-effectiveness of the intervention is currently being tested in two RCTs across six countries in Europe (Italy, Austria, Germany and the UK) as well as in Turkey (Purgato et al., 2019).

Developed by the World Health Organization and now recommended as part of its mhGAP package, 'Problem Management Plus' is another low-intensity CBT-based intervention. As presented in section 1.1, PM+ has been found to be effective in comparison to enhanced treatment as usual in reducing symptoms of psychological

distress and PTSD three months after the end of the intervention across two randomised control trials conducted in Kenya with 421 women with a history of gender-based violence and in Pakistan 346 adult primary care attendees (Bryant et al., 2017; Rahman et al., 2016). In Kenya, Bryant et al., 2017 found that the difference between PM+ and enhanced usual care in the change from baseline to 3 months on psychological distress (measured the 12-item General Health Questionnaire or GHQ-12) was 3.33 (95% CI 1.86–4.79, $P = 0.001$) in favour of PM+. In terms of secondary outcomes, for impaired functioning (measured by WHO Disability Adjustment Schedule or WHODAS) the difference between PM+ and enhanced usual care in the change from baseline to 3-month follow-up was 1.96 (95% CI 0.21–3.71, $P = 0.03$), for symptoms of post-traumatic stress (measured by the Posttraumatic Stress Disorder Checklist or PCL) it was 3.95 (95% CI 0.06–7.83, $P = 0.05$), and for PSYCHLOPS it was 2.15 (95% CI 0.98–3.32, $P = 0.001$), all in favour of PM+. Overall, the authors found PM+ to be associated with moderate reductions in psychological distress among a community sample of women with a history of gender-based violence at a 3-month follow-up. A qualitative evaluation of PM+ further found that both participants and lay health workers identified positive changes (i.e. mental, behavioural, interpersonal, physical and knowledge changes) that PM+ had made in their lives (Van't Hof et al., 2018). Van't Hof et al. (2018) identified structural, attitudinal and psychological barriers to adherence to the intervention. These included significant opportunity-costs, whereby participants and lay health workers reliant on casual labour found it difficult to plan sessions; participants not being used to self-identifying their problems; a disbelief in the intervention; and challenging living circumstances of participants that could not be improved through the intervention (e.g., financial problems, caring for disabled family members).

In sum, and although scarce, the evidence on the use of LI-CBT interventions in humanitarian and low and middle-income settings to date is promising. Indeed, the growing supply of evidence on this innovative model of care represents an important step towards increasing access to mental health care (Patel et al., 2018). However, caution is needed before applying LI-CBT interventions across culturally and contextually

distinct settings. Although CBT is recognised as a widely used and empirically supported evidence-based therapy, its origins, as well as most of the existing evidence, in both high and low-intensity formats, predominantly comes from high-income settings. Yet, with careful and systematic modifications, LI-CBT has the potential to be culturally appropriate, contextually relevant and useful to a variety of populations in need, and address many of the barriers to implementation identified above.

2.6 The Role of Culture in Psychotherapy

Mental health research has been critiqued for being Western-centred (Berry, 2013; Cole, 2006; Sue, 1999). Specifically, research from the fields of behavioural science and psychology has been criticised for being overly based on samples from what Henrich, Heine, and Norenzayan (2010) call WEIRD samples – or Western, Educated, Industrialized, Rich, and Democratic— which only represent about 12% of the world's population. Despite making up such a small proportion of the world's population, samples from WEIRD countries make up 96% of all studied samples with US samples making up 68% of all the data presented across six of psychology's most influential journals (Arnett, 2008).

While all societies share basic aspects of cognition, motivation and behaviour, there is substantial psychological and behavioural variation among human populations across a variety of domains (e.g., cooperation, moral reasoning, self-concepts) (Henrich et al., 2010). Correspondingly, cultural differences have been identified for prevalence, diagnosis and prognosis of mental illnesses (Kleinman, 1988). Moreover, culture has been found to shape a person's response to psychological interventions and can also play a fundamental role in alleviating distress (Freedheim, 1994). Research has shown that certain signs and symptoms are restricted or more common among specific cultures. For example, *taijin kyofusho* has been identified in the Japanese culture and is described as a phenomenon characterised by excessive nervousness and fear in social situations. While it has been described as subtype of social anxiety it is also characterised by the fear to offend or harm others (Suzuki, Takei, Kawai, Minabe, & Mori, 2003). *Ataque de nervios*

among Puerto Ricans and Dominicans is another example (Keough, Timpano, & Schmidt, 2009) and is characterised by tremors, a feeling of heat that starts in the chest and rises to the head, fainting and epileptic episodes (Nogueira, Mari, & Razzouk, 2015).

In addition, universally recognised mental health disorders such as depression manifest distinctly across different contexts, influenced by ideas about religion, social relationships, morality, stigma, cultural norms among others (Marsella, 2003; White et al., 2017). A large body of literature has identified that cultural variations exist in meaning, perceived causes, onset patterns, epidemiology, symptom expression and course of depression (Kessler & Bromet, 2013; Kleinman & Good, 1985; Marsella, 2003). Indeed, a seminal book based on many cross-cultural reviews on depression reach various important conclusions on the topic. That is, somatic signs and complaints are common in non-Western contexts while guilt and self-deprecation, suicidal ideation and gestures, and existential complaints are rarer in these settings (Kleinman & Good, 1985). In addition, Kleinman and Good (1985) highlight the importance of studying idioms of distress and culture-specific coping mechanisms specific across cultures to provide relevant mental health care.

A cultural mismatch in the care provided cross-culturally can render treatments ineffective and lead to poor uptake of interventions. Overall, lack of attention to cultural differences may have serious implications for the inaccurate use of screening tools; incomplete and potentially inaccurate conclusions; ineffective implementations of interventions that populations and practitioners do not want, or use, or result in harm (Greene et al., 2017). As a result, cultural adaptation of mental health interventions has emerged as a strategy for counter-balancing the ‘one-size-fits-all’ trend in mental health research (Kirmayer, 2012).

2.6.1 Significance of Culturally Adapting Interventions

The process of cultural adaptation has been defined as “the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client’s cultural patterns, meanings, and values” (Bernal, Chafey, & Domenech Rodríguez, 2009, p. 362). Cultural adaptation

is also understood as “the process of altering a program to reduce mismatches between its characteristics and those of the new context in which it is to be implemented or used” (Card, Solomon, & Cunningham, 2011, pp. 25-26). Accordingly, the aim of cultural adaptations is to reconcile two opposing views: (1) evidence-based interventions are applicable to all societies without a need for adaptation or change and (2) interventions need to be culturally grounded and its content should consist of culturally-specific values beliefs and practices (Barrera et al., 2013; Falicov, 2009). The objective of cultural adaptations is thus to balance fit and fidelity, such that mental health interventions are supported by evidence, while also responding to the person’s culture and context. Whereas *fidelity* to an evidence-based intervention ensures that the intervention will be effective, although not necessarily within a specific population sample, flexibility to the population’s culture ensures that the intervention will *fit*, although not necessarily lead to effectiveness, or change in psychological outcomes (Bernal & Domenech-Rodríguez, 2012b).

Advocates of cultural adaptations argue that interventions are composed of three major elements: underlying philosophical assumptions (i.e. ontology, epistemology of assumptive world or worldviews), the propositional model (i.e. theory of change) and the procedural model (i.e. steps, stages, procedures for change to occur) (Bernal & Adames, 2017). Changes to the underlying assumptions and to the propositional model imply that the fundamental principles of the intervention have been changed, which will in turn, result in a different intervention, which may or may not benefit the participants (Bernal & Adames, 2017). Cultural adaptations therefore focus on changes to the steps, sequence of modules or methods of the interventions such that these changes, it has been argued, do not affect the integrity of the intervention (Bernal & Adames, 2017).

While the definition of cultural adaptations proposed by Bernal, Jiménez-Chafey, and Domenech Rodríguez (2009) was presented recently, practitioners have previously adapted psychotherapy to the cultural perceptions of their clients. An early example is Carl Rogers’ person-centred psychotherapy (Rogers, 1946), which empowered clients to lead the discussion thereby being inclusive of their cultural values and norms. The

fundamental differences between this modern definition and previous cultural adaptations are therefore the systematic nature of contemporary cultural adaptation as well as its wide-ranging focus on the client's culture (i.e. language, context, cultural patterns, meanings and values). A systematic review suggests that most recent cultural adaptations of psychological interventions tend to focus on language, context and practitioner allocation (Chowdhary et al., 2014). However, there is no single, unified method of conducting cultural adaptations and different components are adapted across adaptation studies. These might include for example, changing technical terminology with informal expressions, attention to context-specific somatic signs, and embedding non-written or graphic material in the sessions.

Regardless of how interventions are adapted however, cultural adaptations seem to yield positive outcomes. The importance of cultural adaptation has been demonstrated by several meta-analyses, which found that culturally adapted psychological interventions are associated with greater effectiveness than non-culturally adapted psychological interventions. For example, a meta-analysis of 76 studies (25,225 participants) found a moderately strong effect of culturally adapted ($d = .45$) over unadapted interventions (Griner & Smith, 2006). Likewise, another meta-analysis of 65 studies (8,620 participants) showed that culturally adapted interventions were moderately more effective ($d = .46$) and that the most effective treatments were those with the largest number of adaptations (Smith, Rodríguez, & Bernal, 2011). Another meta-analysis of 21 studies comparing unadapted and culturally adapted versions of interventions found that culturally adapted interventions were modestly, but significantly more effective ($d = .32$) (Benish, Quintana, & Wampold, 2011). More recently, a meta-analysis showed a statistically significant benefit in favour of culturally adapted treatments of depressive disorders ($SMD = -0.72$), compared to non-culturally adapted interventions (Chowdhary et al., 2014).

Some have argued that adaptations should be conducted only when there is evidence that the original intervention does not fit the populations' needs (Kumpfer, Pinyuchon, de Melo, & Whiteside, 2008). Others have questioned whether the additional

costs of conducting cultural adaptations are justified by the superior clinical outcomes (Kazdin, 1993). Culturally adapting interventions however, is also an ethical responsibility, as it reduces the risk of experiencing treatments or interventions that intrude or transgress individual cultural values and norms (Bernal & Adames, 2017). The greater effectiveness of culturally adapted interventions may therefore be explained by the increased acceptability, appropriateness, the client's better understanding of the intervention as well as sustained fidelity (Bernal, Bonilla, & Bellido, 1995; Ferrer-Wreder, Sundell, & Mansoor, 2012). Correspondingly, implementing psychological interventions that have not been culturally adapted can have negative consequences on treatment continuation, lead to unintended harmful practices and distrust in mental health care (Cabassa & Baumann, 2013).

2.6.2 Theoretical Foundations of Cultural Adaptations of Mental Health Interventions

In the 1990s, a series of theoretical approaches to cultural adaptation emerged as mental health practitioners, mostly based in the United States and United Kingdom, aimed to respond to the need of clients from different cultural backgrounds (Bernal & Domenech-Rodríguez, 2012c). One early adaptation model, developed by Bernal et al. (1995), has been recurrently applied to the development and adaptation of psychological interventions. Known as the Ecological Validity Model (EVM), it proposes eight dimensions to guide cultural adaptations: language, persons, metaphors, content, concepts, goals, methods and context (Table 2.1). Bernal et al. (1995) propose the explicit adaptation of interventions across these eight dimensions to increase the ecological and external validity of an intervention (Bernal et al., 1995). Here, ecological validity refers to the equivalence between the client's experiences of their cultural context and the cultural adaptations made to an evidence-based intervention or made on an *ad hoc* basis by a practitioner (Bernal & Domenech-Rodríguez, 2012c). The EVM has informed the adaptation of evidence-based interventions such as parenting skills trainings and CBT for various populations in the United States (e.g., Latino/as, Chinese, Native Americans)

(Baumann et al., 2015; Bernal & Domenech-Rodríguez, 2012c; Castro, Barrera, & Steiker, 2010).

DIMENSIONS	DEFINITIONS
Language	Culturally appropriate, culturally syntonetic language
Persons	Role of socio-cultural similarities and differences between the person providing the interventions and the person receiving it
Metaphors	Symbols, concepts and sayings shared within the population
Content	Cultural knowledge, values, costumes and traditions; uniqueness of groups (social, economic, historical, political)
Concepts	Intervention concepts consonant with culture and context
Goals	Transmission of positive and adaptive cultural values; support adaptive values from the culture
Methods	Development and /or cultural adaptation of treatment methods

Table 2.1. Dimensions and definitions of the Ecological Validity Model (Bernal et al., 1995)

Another frequently cited model is the Cultural Sensitivity Framework (CSF). Emerging from the field of substance use prevention, the CSF recommends making changes to two possible structures within an intervention: the surface and deep structures (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000). The surface dimension involves matching the intervention's content and messages to observable social and cultural behaviour while the second dimension is concerned with understanding how the cultural, social and historical environment influence health behaviour, and integrating this knowledge into the structure of the intervention (Resnicow et al., 2000). While the first dimension is concerned with increasing acceptability and receptivity of the intervention, deep structure changes are meant to increase salience (Resnicow et al., 2000). Another distinct

characteristic of the CSF is the primary role it gives to research methodology in the process of cultural adaptation (Bernal & Domenech-Rodríguez, 2012c). Resnicow et al. (2000) support the use of both qualitative and quantitative methodology as well as literature searches in cultural adaptations.

Based on their experiences with cultural adaptation in research and in practice and building on Lau (2006)'s previous findings, Barrera and Castro González (2006) proposed a four stage process for conducting adaptations: (1) information gathering, (2) preliminary adaptation design, (3) preliminary adaptation tests, and (4) adaptation refinement. Known as the Heuristic Framework (HF), this theoretical approach seeks to guide the identification of features of an intervention that should be subjected to cultural adaptation (Bernal & Domenech-Rodríguez, 2012c). The first stage is broad and consist of gathering information from different sources, including qualitative and quantitative research, anecdotal evidence, as well as accounts from relevant stakeholders (e.g., practitioners, community members, implementers) (Barrera & Castro González, 2006). The objective of this stage is thus to identify ideas that could contribute to bridging disparities between the population's cultural context and what is provided in the intervention manual or protocol (Barrera & Castro González, 2006). At this stage, the HF encourages conducting qualitative research with potential participants and experts working with the target population to gather additional information on their cultural background. Barrera and Castro González (2006) also encourage the use of other cultural adaptation frameworks, such as the EVM, within this stage to understand and explore cultural discrepancies in the protocol (Barrera & Castro González, 2006; Castro, Barrera, & Martinez, 2004).

The second stage of the HF consists of making preliminary changes to the intervention protocol based on the gathered ideas from the previous stage. In this second stage, the HF also presents the opportunity of using qualitative research methods to elicit further information (Barrera & Castro González, 2006). The authors emphasise on the possibility of having various iterations of the first and second stages, if needed (Barrera & Castro González, 2006). The adaptations made at the second stage are then tested

during the third stage through pilot or case studies. Finally, the fourth stage consists of refinements to the adaptation which are based on outcomes from the preceding step (Barrera & Castro González, 2006). Despite being initially data driven, the HF values the importance of stakeholder experience via consultations or qualitative interviewees or focus group discussions throughout its four steps (Bernal & Domenech-Rodríguez, 2012c). Another key characteristic of this framework is that it allows the integration of dimensions such as the ones presented by Resnicow et al. (2000) or Bernal et al. (1995). Namely, the HF combines prescriptive and non-prescriptive approaches to cultural adaptations (Ferrer-Wreder et al., 2012).

Despite consensus supporting a culturally informed and sensitive intervention, there is little guidance on *how* to culturally adapt an evidence-based intervention. Moreover, there is a lack of guidance for how to culturally adapt interventions within humanitarian emergencies, where time and human resources are scarce. The Applied Mental Health Research Group, based in Johns Hopkins University, aimed to address this gap by presenting a comprehensive road-map on cultural adaptation for humanitarian organisations (Applied Mental Health Research Group, 2013). This user manual was initially developed to assist researchers and practitioners in the implementation of mental health HIV-related programs, but its guidance can be applied to other mental health interventions. Although not originally meant to focus on cultural adaptation, its first module outlines a series of qualitative techniques and topics that contribute to cultural adaptation. Some of the topics of relevance to MHPSS programming to discuss in the qualitative interviews include co-occurring psychosocial issues, common mental health problems, severe mental disorders, problems that can be addressed through existing/to-be-developed services and local perceptions of what constitute important areas of functioning related to daily living. Like the HF, the Design, Implementation, Monitoring and Evaluation (DIME) methodology incorporates qualitative participatory techniques (e.g., free-listing, key informants interviews, focus group discussion) and suggests involving experts and well as community members in the process of cultural adaptation.

2.6.3 Considering Culture and Context in Humanitarian Settings

Cultural adaptations ensure that evidence-based interventions fit into the populations' broader social context (Chowdhary et al., 2014). Within humanitarian settings, working with vulnerable populations, limited funding, time and human resources, poor security and logistics, compromises the capacity to culturally adapt interventions (Ager et al., 2014). The failure to consider culture in MHPSS humanitarian programming however, can have negative consequences. For example, several researchers noted the problematic disconnect between Western and traditional approaches to treating mental illness in 2004 post-tsunami Sri Lanka (Galapatti, 2005; Wickramage, 2006). In a rush to respond to the psychosocial needs of tsunami affected communities, international NGOs overlooked local strategies of dealing with bereavement, displacement and family separation used in conflict-affected areas, thus implementing culturally inappropriate and conflict insensitive interventions, which confused and, in some cases, exacerbated distress among the affected populations while also compromising the success of previous mental health programs (Galapatti, 2005; Wickramage, 2006).

Taken together, there is evidence to suggest that mental health interventions without cultural and contextual adaptations can at its best, result in ineffective or less effective interventions. At its worst, the failure to culturally adapt interventions may lead to harmful practices and worse outcomes for programme beneficiaries¹. To provide effective support it is therefore important to understand how distress is understood, experienced and expressed. Humanitarian agencies working on the MHPSS field are increasingly aware of the need to learn from previous lessons. The need to bring together local and global expertise in humanitarian settings as well as incorporate expertise on cultural differences by, for example, incorporating anthropologists into the response is now recognised as a principal guidance within this field (Inter-Agency Standing Committee, 2007). Indeed, the development of culturally sensitive prevention and

¹ Beneficiary is a term commonly used by humanitarian organisations to refer to the persons that receive their services.

treatment is considered one of the grand challenges of global mental health (Collins et al., 2011).

2.7 Summary of Current Research Gaps

Most displaced persons live in LMICs, such as Colombia, where access to mental health care is largely limited due to shortages of specialised mental health personnel. Although the evidence on lay-delivered innovative models of care, such as low-intensity versions of traditional therapies, is mounting, several research gaps remain. First, and as the above literature suggests, a range of existing low-intensity psychological interventions have the potential to reduce psychological distress among displaced persons across a different of settings. However, there is currently no general agreement of which low-intensity psychological interventions are effective among forcibly displaced populations. In addition, interventions that are theoretically effective may not necessarily be adopted or utilised and specific factors (e.g., stigma, level of trust on mental health services, funding) may enable or hinder the implementation of LIPs among forcibly displaced persons. However, research into the factors influencing the implementation of low-intensity psychological interventions among displaced persons is scarce and has yet to be systematically examined.

Secondly, a large body of evidence indicates that culturally adapting psychological interventions contributes to effectiveness, acceptability, appropriateness, adherence to the treatment or intervention as well as to the participant's understanding of the intervention (Bernal et al., 1995). Overlooking the social and cultural context can result in ineffective implementations of interventions that populations and practitioners do not want, use, or even result in harm (Greene et al., 2017). Culturally adapting interventions, within and outside of research studies, is an ethical responsibility, as it protects individuals from treatments or interventions that intrude or disrupt cultural norms and values (Bernal & Adames, 2017). Despite this knowledge, however, there is little guidance on *how* to culturally adapt low-intensity psychological interventions for their use in low-resource, humanitarian and emergency settings.

Lastly, several pioneering randomised controlled trials have analysed the effectiveness of low-intensity psychological interventions in humanitarian settings. However, the conditions of an RCT are far removed from the experiences of ‘real-world’ mental health care (De Silva & Ryan, 2016). In addition, as this chapter has shown, refugee mental health research, initiatives, interventions and surveys have largely focused on negative constructs of mental health. Understanding refugee mental health entails the simultaneously investigating mental *illness* and *health* (Keyes, Dhingra, & Simoes, 2010). There is therefore a need to investigate whether the implementation of low-intensity CBT interventions, such as PM+, in natural settings is associated with reduced psychopathology as well as optimal mental health outcomes (e.g., wellbeing and quality of life). This study will contribute to bridging this, and the other current research gaps summarised above.

Chapter 3: Methodological and Theoretical Approaches

3.1 Chapter Overview

Chapter 2 provided a justification for the current study, offering a broad overview of the challenges of providing mental health and psychosocial support in humanitarian settings, specifically in the context of forced displacement. It further put forward an argument for the use of low-intensity psychological interventions in these settings and presented the research gaps addressed throughout the current study. This chapter briefly outlines the general design of the study before introducing pragmatism (Dewey, 1925) as the strategy of inquiry employed to answer the research questions proposed in Chapter 1. This chapter lays out the process of co-designing this implementation research study, describes the intervention under study (i.e. PM+), the study setting, and the study's ethical considerations. Chapter 3 therefore serves as a foundational explanation of the assumptions that underpin the methodological decisions described in the empirical chapters of this dissertation (i.e. Chapters 4, 5 and 6).

3.2 General Design of the Study

The study employed a multi-method approach including expert consultations, questionnaire data, qualitative multi-stakeholder interviews and focus group discussions. The study consists of three consecutive phases (Table 3.1). The first phase of the study consists of a systematic review (Chapter 4) which informed the implementation of PM+ for Venezuelan migrants and refugees by the Colombian Red Cross' volunteer workforce. The findings of the systematic review also revealed the importance of culturally adapting the PM+ manuals before providing the intervention. Phase two was therefore the development and application of a systematic four-step process for the adaptation of PM+ for forcibly displaced Venezuelans and Colombians in Colombia. The results of this cultural adaptation process are presented in Chapter 5. In the third phase of this study, the implementation of PM+ was evaluated via two steps:

an operational phased-in quasi-experimental study and a qualitative process evaluation. The methods used in each phase of the study are described in their respective chapters.

RESEARCH PHASE	METHOD OR STEPS
Phase 1: Systematic Review (Chapter 4)	Narrative synthesis
Phase 2: Cultural Adaptation of Problem Management Plus (Chapter 5)	Step 1: Information gathering Step 2: Adaptation hypotheses Step 3: Local consultations Step 4: External evaluations
Phase 4: Process Evaluation (Chapter 6)	Step 1: Operational phased-in quasi- experimental study Step 2: Qualitative process evaluation

Table 3.1. Summary of the study's research phases

3.3 Philosophical and Theoretical Foundations

This study adopts a pragmatic approach as its core research philosophy. At the centre of pragmatism is a rejection of the 'impossible question' of philosophy, that of the nature of the mind's relationship to reality (Biesta, 2010). Instead, pragmatists determine the value of knowledge by its extrinsic usefulness for addressing practical questions within daily life (Long, McDermott, & Meadows, 2018). Pragmatism differs from more traditional paradigms (e.g., positivism or post-positivism and constructivism or interpretivism) in that it transcends the contentious issues of truth and reality, it accepts, philosophically, that there are singular and multiple realities that are open to empirical inquiry and orients itself toward solving practical problems in the 'real world' (Dewey, 1925; Feilzer, 2010). Accordingly, pragmatism requires the identification of a socially situated problem and adequate action to address it (Kaushik, Walsh, & Lai, 2019).

Pragmatism does not focus on the pursuit of knowledge through inquiries but on the gaining of knowledge in the pursuit of solving specific problems (Morgan, 2014). In the context of this study, this means that the aim is not solely to pursue knowledge about mental health benefits of low-intensity psychological interventions, but to gain

knowledge that contributes to the implementation of these interventions and, therefore, enables optimal conditions for their effects. In other words, through the implementation of Problem Management Plus, the thesis aims to gain knowledge on what factors determine the implementation of PM+ in a specific context, while still aiming to improve mental health outcomes.

Another feature of pragmatism is the contextualisation of knowledge and the premise that as contexts change, so does the criteria of usefulness for knowledge (Long et al., 2018). In this study, this implies that the implementation context (e.g., participants' culture and values, organisation characteristics and team dynamics) influence study findings. This does not mean however, that the knowledge gained through pragmatic research cannot be translated across contexts. Rather, and while knowledge can lead to collective learning, context-free generalisations are considered impossible (Tashakkori & Teddlie, 1998).

Pragmatism is based on the proposition that researchers should use the methodological approach that works best for the specific research problem that is being investigated (Tashakkori & Teddlie, 1998). Therefore, pragmatism focuses on the consequences of research rather than on the methods used. Although it has been associated with mixed-methods, the aim of pragmatism is to address the research question(s), investigate a phenomenon, or test a theory with the most appropriate research method. This characteristic is evidenced by the wide range of methods employed throughout this dissertation, including systematic review, questionnaires, expert consultations, key informant interviews and focus group discussions.

Lastly, pragmatism's problem-solving approach means that research is viewed as social action. The utility of research within pragmatic epistemology is measured by its consequences, whether they be predicted or emergent (Long et al., 2018). In this thesis, this is achieved by co-producing knowledge that is useful to implementers of low-intensity psychological interventions. The research questions of this study are based on

the following pragmatic aim: to contribute to existing knowledge on the implementation of low-intensity psychological interventions for improving psychological outcomes among forcibly displaced persons. Furthermore, the case for the use of low-intensity psychological interventions is pragmatic in nature, as it seeks to resolve the most pressing problem in global mental health: reducing the difference between the number of people with mental health disorders and the number of people who access evidence-based services (section 2.4.1.1).

3.3.1 Positionality Statement

The researcher's experiences, values, beliefs, and social background influence the research process (Manohar, Liangputtong, Bhole, & Arora, 2017). Furthermore, "[a] researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (Malterud, 2001, p. 483–484). Conducting research therefore involves being attentive to how this position shapes interactions and the outcomes of the study (Sultana, 2007). What follows is a reflection of my positionality within this study.

Firstly, I consider my academic background in Development Studies and Public Health as a strength of this study. This academic experience has made aware of the urgency of addressing the social determinants of health in populations affected by adversity in low-resource settings and motivated me to pursue this line of research. In addition, my academic training in qualitative and quantitative methods also shaped the decisions I made regarding the methodology and design of the study. I share the linguistic background of study participants (Spanish), which allowed me to conduct this study in Colombia. I am Cuban and I consider that being from a relatively similar cultural background contributed to my role in the cultural adaptation process by allowing me to understand recommendations for changes to the manuals.

However, it has been suggested that researchers who undertake cross-cultural research should be 'insiders' that share the social, cultural and linguistic characteristics

of study participants (Manohar et al., 2017). Indeed, although my language skills contributed to the feasibility of this study, Spanish is composed of many regional and national varieties and this probably affected my ability to discern some local expressions of distress identified throughout the cultural adaptation process. In contrast, others have argued that cultural outsiders are able to gain a deeper understanding of a phenomenon under investigation by being 'less biased' and curious enough to raise provocative questions (Merriam et al., 2001). In any case, when it comes to cross-cultural research, I coincide with the assumption that "the insider's strengths become the outsider's weaknesses and vice-versa" (Merriam et al., 2001, p. 411).

Lastly, throughout this research project, I was professionally affiliated to the International Federation of the Red Cross and Red Crescent Societies. This affiliation, as well as the knowledge I gained through this professional experience, motivated me to pursue pragmatism as the philosophical approach of this study, was essential for conducting this investigation (e.g., by providing access, professional contacts) and contributed to the overall design of the study, as described later in this chapter. However, within the Colombian Red Cross, my affiliation established a hierarchical relationship between the research team and I, which is a potential limitation of my involvement. In addition, even though being from the Global South addressed some barriers of access and relational aspects (Sultana, 2007), I am also a doctoral candidate from a European university. These class and educational characteristics differentiate between the research team, study participants and I. Overall, I acknowledge that the characteristics and experiences listed above mean that my status as a researcher in this project constantly shifted from 'insider' to 'outsider' and that this represents both a limitation and strength of the study.

3.4 Study Strategy of Inquiry: Implementation Research

It takes 17 years on average for 14% of biomedical research to make its way into health settings (Balas, 1998). Despite this alarming finding, delayed research utilisation is not the only problem at hand. Chalmers and Glasziou (2009) found that 85% of biomedical

research is lost and never reaches patients. This waste and delay in knowledge transfer has been attributed to different reasons, such as low-quality studies or insufficient descriptions of the interventions or practices (Chalmers & Glasziou, 2009). An important reason for the low and slow uptake –and one that has been less explored– is that research findings are not sufficiently meaningful to practitioners and policymakers (Wells, Williams, Treweek, Coyle, & Taylor, 2012). Namely, research often lacks the context-specific characteristics that allow a faster uptake of evidence-based interventions or practices. This means that clients or patients are slow, if at all, to benefit from research investment and from findings relevant to their health (Grant, Treweek, & Wells, 2016).

Over the past 10-15 years, an interest in increasing the return on healthcare and research investment has led to the development of the field of implementation research (Bauer, Damschroder, Hagedorn, Smith, & Kilbourne, 2015). Implementation Research (IR) has been described as “the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services” (Eccles & Mittman, 2006, p. 1). The entire IR field is based on the premise that while understanding the mechanism of illnesses and health conditions is crucial, it does not guarantee improved health outcomes and wellbeing.

3.4.1 Key Characteristics of Implementation Research

Implementation research aims to address the gap between what is known and what is delivered (Meffert, Neylan, Chambers, & Verdelli, 2016). Although IR has only recently been defined, it has been conducted across various health fields in recent decades. For example, research on different modes of delivery of the smallpox vaccine, such as the use of the bifurcated needle and ring vaccination, whereby response teams quickly vaccinated everyone in affected villages to build rings of resistance, was crucial for the success of the eradication of smallpox (Theobald et al., 2018). Similarly, implementation research was used to show that when hospitalisation of patients with sepsis is not possible, regimens of outpatient care management contribute to achieving high rates of reduction in neonatal mortality (Theobald et al., 2018). Together these case studies

illustrate that when treatments are effective, as determined by controlled trials, IR can facilitate the identification of modes of delivery or other areas of important consideration that work to improve service delivery and maximise health outcomes.

Implementation research is context-specific and embedded within the specific health organisations that demand it, thus making research meaningful to practitioners and enabling real-time improvements of health services. IR presents an opportunity to take an under-utilised or new evidence-based practice and study the barriers and facilitators for scaling it up or implementing it within specific health settings, while also acknowledging the importance of de-implementing interventions that do not offer clinical benefit or may be harmful (Bauer et al., 2015; Wilson et al., 2017). Accordingly, IR requires the expertise of different stakeholders, engaging implementers and researchers in a process of co-creation and co-design.

IR is multidisciplinary in nature and draws from a wide range of disciplines (e.g., epidemiology, psychology, management, economics) for strategy development, theoretical approaches and methodological designs. As such, IR tends to include diverse designs (e.g., observational studies for identifying evidence-practice gaps, proof of concept studies, combined implementation and effectiveness trials) (Geng, Peiris, & Kruk, 2017). IR does not usually take place under controlled trial conditions, but rather takes place within the reality of healthcare organisations and within ongoing service delivery. In this way, implementation research tends to focus on evaluating the process and outcomes of the implementation, and while IR may focus on the use of interventions at the client/patient level, it also focuses on practices taking place at organisational, practitioner and health system levels (Bauer et al., 2015).

The commonalities between the philosophical approach (i.e. pragmatism) and the strategy of inquiry of this thesis (i.e. implementation research) are noteworthy. Firstly, both aim to create ‘useful’ knowledge for the stakeholders involved in the delivery of services to clients and patients. Second, both pragmatism and IR prioritise the research problem over theoretical or methodological purity. Third, both emphasise

the importance of contextualisation of knowledge. Finally, both see research as a form of social action or as an approach to solving societal problems (Long et al., 2018).

Implementation strategies, or the specific activities designed to put an evidence-based intervention into practice, are an essential component of IR. They are the 'how to' component of increasing uptake (Proctor, Powell, & McMillen, 2013). Some examples of implementation strategies include methods for training practitioners, practice guidelines, economic strategies, monitoring systems, among others (Proctor et al., 2013). Through the use of strategies, IR seeks to address the barriers for scaling up innovations and effective practices, sustainability challenges, inefficiency, barriers to implementation, among others (Peters, Adam, Alonge, Agyepong, & Tran, 2013).

3.4.2 Challenges and Limitations of Implementation Research

Much of the current literature on the limitations of IR pays close attention to the so-called trade-off between rigorous methodology and perceived utility of the research. Implementation research tends to be embedded within specific health settings which can lead to rapid adoption, but which may also compromise the generalisability of research findings (Theobald et al., 2018). While clinical trials focus on controlling the intervention environment, producing externally valid results under optimal conditions, implementation research limits the researchers' involvement to measuring implementation outcomes within the specific health setting (Bauer et al., 2015). To tackle this limitation, Theobald et al. (2018) suggest detailing the research's theoretical background and making use of standards for reporting implementation studies. Reporting studies in sufficient detail to allow replication, adaptation and knowledge transfer is therefore suggested as a way to overcome this challenge (Pinnock et al., 2017).

Implementation strategies vary considerably in scope, breath and complexity. After reviewing 68 implementation strategies, Powell et al. (2012) systematically grouped all strategies into six key categories that represent larger implementation processes: planning, educating, financing, restructuring, managing, quality and policy context. While more importance is being paid to the description and research of the most effective strategies, some limitations remain, given that many implementation strategies

are idiosyncratic. Commenting on this challenge, Proctor et al. (2013, p. 1) argue that “implementation strategies are often inconsistently labelled and poorly described, are rarely theoretically justified, lack operational definitions or manuals to guide their use, and are part of ‘packaged’ approaches whose specific elements are poorly understood”. Adequate documentation of the implementation strategy or strategies via reporting guidelines has been proposed as an important step towards increasing reproducibility and the value of strategies in IR (Implementation Science, 2019; Proctor et al., 2013). Lastly, a less obvious limitation of IR, as raised by Theobald et al. (2018), is the possible conflicts of interests between the different stakeholders involved in the implementation (e.g., researchers, practitioners, policy makers). These conflicts of interest could relate to differences in work methodology, different budgetary timelines, or researchers needing to give up some control over their research.

3.4.3 Theoretical Approaches in Implementation Research

Theory is an integral part of implementation research as it guides an understanding of which strategies work, why and how (Damschroder & Hagedorn, 2011). Using theoretical approaches in IR leads to a more transparent reporting of the implementation process by making implicit knowledge explicit and allowing for generalisation across implementation efforts (Birken et al., 2018). In addition, using theoretical approaches allows implementers and researchers to identify which components might fail or succeed, to select implementation strategies, share knowledge of past experiences and refine theories to improve future practice. In this way, while theories provide an explanation and prediction of phenomena, models and frameworks are used to describe, clarify and organise phenomena (Bauer et al., 2015; Nilsen, 2015).

Although these theoretical approaches (viz. theories, models and frameworks) represent different concepts, they are often used interchangeable throughout the literature (Bauer et al., 2015). Likewise, IR theoretical approaches vary considerably in scope, breadth and depth. In a survey conducted on the use of theories by implementation researchers, Birken et al. (2017) found that respondents used over 100 different theoretical approaches. The most commonly listed theoretical approaches were

the Consolidated Framework for Implementation Research, Theoretical Domains Frameworks, Promoting Action on Research Implementation in Health Services, Diffusion of Innovations, Reach Effectiveness Adoption Implementation Maintenance, Quality Implementation Framework, and Interactive Systems Framework (Birken et al., 2017).

The interdisciplinary nature of IR enables implementation researchers to adopt theoretical approaches from different fields (e.g., nursing, medicine, sociology, public health). However, this advantage also translates into the challenge of selecting from a large pool of available theoretical approaches (Birken et al., 2017). Some authors argue that the difficulties in this selection lead to the underuse, superficial use or misuse of theories (Birken et al., 2017). Through a concept mapping exercise, Birken et al. (2018) recently presented their Theory Comparison and Selection Tool (T-CaST), a tool to assists scientists and practitioners in selecting the appropriate theoretical approach for implementation projects. The T-CaST checklist consists of 16 specific criteria grouped into four concepts (i.e. usability, testability, applicability and acceptability) which assists researchers in selecting a theoretical approach from a short list of potentially relevant approaches (Birken et al., 2018).

In a taxonomy proposed by Nilsen (2015), IR theoretical approaches respond to three different aims: describing and guiding the process of translating research into practice; understand and explain influences on implementation outcomes and; evaluate implementation (Nilsen, 2015). Nilsen (2015) further separates theoretical approaches into the specific aims they correspond to as well as into the following five categories: process models, determinant frameworks, classic theories, implementation theories and evaluation frameworks (Figure 3.1).

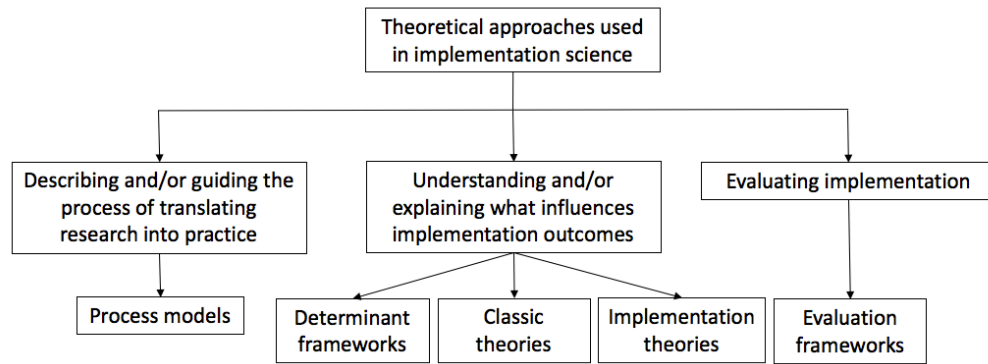


Figure 3.1. Aims and categories of theoretical approaches in implementation science

To describe or guide the process of translating research into practice, *process models* outline the stages of translating research into practice, from the research breakthrough to the routine use in specific settings (Nilsen, 2015). Some process models list actions, stages and steps that need to be followed to secure the uptake of the evidence-based practice and tend to emphasise the importance of planning at the early stages of the implementation (Nilsen, 2015). The Quality Implementation Framework, an example of a process model, consists of sequential phases and 14 distinct steps and approaches for guiding the implementation process in a systematic way (Meyers, Durlak, & Wandersman, 2012). The steps can be applied to different populations, interventions and expected outcomes (Meyers et al., 2012).

Understanding or explaining what influences implementation outcomes, on the other hand, makes use of determinant frameworks, classic theories, or implementation theories. *Determinant frameworks* outline the constructs and factors that influence the implementation process (Nilsen, 2015). Determinant frameworks analyse the implementation from multiple levels (e.g., individual, organisation, health system) but coincide regarding the types of determinants, also referred to as classes or domains, to account for: intervention, practitioners/users (e.g., providers, supervisors), end users (e.g., beneficiaries, or patients), context and strategy or means of facilitating the implementation (Nilsen, 2015). Therefore, implementation researchers agree to a large extent on what are the main determinants of implementation outcomes (Nilsen, 2015).

Each determinant is composed of specific factors that act as independent variables to implementation outcome, or dependent variables.

Classic theories come from fields other than IR and tend to focus on describing how change happens (Nilsen, 2015). Various classic theories (e.g., Theory of Reasoned Action, Theory of Planned Behaviour, the Social Cognitive Theory) focus on the process of behaviour change among health care professionals (Nilsen, 2015; Nilsen, Roback, Broström, & Ellström, 2012). Classic theories also include theories on team relations and social capital, organisational culture, leadership, organisational learning, and economic theories (Nilsen, 2015). The Theory of Diffusion of Innovations is a highly influential classic theory in implementation research that proposes five attributes of an innovation that affect adoption: relative advantage, compatibility, complexity and observability (Rogers, 2003; Scott, Plotnikoff, Karunamuni, Bize, & Rodgers, 2008).

Implementation theories encompass theoretical approaches from other fields adapted for the analysis of specific aspects of implementation (Nilsen, 2015). The Normalization Process Theory, a frequently cited implementation theory, was originally a model stemming from the implementation of new technologies. Normalization Process Theory claims that the understanding implementation requires more than outcome measurements, as implementation depends on the social relations that lead to the outcomes (May et al., 2007). This model was developed into a theory that presents the inter-relations between the constructs of the social interactions that mediate the implementation of a evidence-based practices (Nilsen, 2015).

A large and growing body of the IR literature focuses on evaluating the implementation process. This has led to the development of evidence-based strategies and protocols for successful implementations (Bauer et al., 2015). According to Bauer et al. (2015), these evaluations are divided into three types of evaluation (i.e. process evaluation, formative evaluation and summative evaluation). During a process evaluation, data is collected throughout or at the end of the implementation; it is evaluated but not fed back to implementers. The intent is therefore not to interfere with an ongoing process but to generate evidence for future implementations (Bauer et al.,

2015). Formative evaluations differ from process evaluations in that data is presented to implementers during implementation, with the objective of correcting the course, adapting or improving the process of implementation. Finally, summative evaluations seek to evaluate the impact of an implementation strategy, with a specific focus on determining the economic impact of an IR strategy (Bauer et al., 2015).

3.5 Conceptual Model for Process Evaluation

Conceptualising and evaluating success is a challenge to implementation researchers (Proctor et al., 2011). Proctor et al. (2009) developed a heuristic 'skeleton' model for the study of implementation processes which postulates that any implementation process is composed of an intervention strategy or evidence based-practice (e.g. Problem Management Plus) and an implementation strategy or strategies (e.g. enrolling lay providers). Proctor et al. (2009) further propose a series of outcomes (i.e. acceptability, adoption, appropriateness, feasibility, fidelity, implementation costs, penetration and sustainability) that can be explored in process evaluations (Table 3.2). These are preliminary outcomes that emerged from a narrative review conducted by Proctor et al. (2009), who acknowledge that other concepts may emerge from future empirical work.

CONCEPT	DEFINITION
Acceptability	The perception among stakeholders that a given treatment, service, practice, or innovation is agreeable, palatable, or satisfactory.
Adoption	The intention, initial decision, or action to try or employ an innovation or evidence-based practice. Adoption also may be referred to as uptake.
Appropriateness	The perceived fit, relevance, or compatibility of the innovation or evidence based practice for a given practice setting, provider, or patient; and /or perceived fit of the innovation to address a specific issue or problem.
Cost	Cost impact of an implementation effort.
Feasibility	The extent to which a new treatment, or an innovation, can be successfully used or carried out within a given agency or setting.
Fidelity	The degree to which an intervention was implemented as it was prescribed in the original protocol or as it was intended by the program developers.
Penetration	The integration of a practice within a service setting and its subsystems.
Sustainability	The extent to which a newly implemented treatment is maintained or institutionalised within a service setting's ongoing, stable operations.

Table 3.2. Implementation concepts and definitions (Proctor et al., 2011)

Proctor et al. (2011) propose a formula for determining implementation success: $I = fE + IO's$, whereby implementation success (I) is modelled to reflect the effectiveness (E) of the intervention being implemented, plus the evidence gathered on implementation outcomes (IO's). This formulation is considered of benefit to implementation researchers as it conceptualises the need to generate evidence across both research lines (i.e. intervention effectiveness and implementation evidence) simultaneously (Curran, Bauer, Mittman, Pyne, & Stetler, 2012). The bridging of these two research lines is a growing trend in implementation research, as it speeds knowledge generation and evidence uptake (Landes, McBain, & Curran, 2019). This design is especially pertinent to the field of global mental health due to the limited availability of research of mental health treatments in low-income and humanitarian settings and due to the multiple

challenges around implementation present in these settings, as described in sections 2.4.1 and 2.5.3 (Patel et al., 2011; Saxena et al., 2007b).

Employing the formulation presented by Proctor et al. (2011), an operational phased-in quasi-experimental design (QED) was used in this study to determine the association between PM+ and improved psychological outcomes among the study population. This design was chosen for various reasons. Firstly, in contrast with RCTs, quasi-experimental designs do not require the random allocation of the intervention and the manipulation independent variables, which may pose a series of ethical, social and logistical constraints in real-life settings (e.g., inappropriate control alternatives such as no intervention or treatment as usual, withholding information from participants, inability to provide two different treatment options simultaneously) and may defeat the purpose of conducting implementation research (Allden et al., 2009; Handley, Lyles, McCulloch, & Cattamanchi, 2018). Secondly, this methodology also enables researchers to simultaneously assess the association of an intervention (i.e. PM+) with desired outcomes as well as evaluate the use of an implementation strategy (i.e. enrolling lay providers). Aligned with pragmatism and IR, selecting this methodology therefore places an emphasis on the external validity of the intervention (i.e. the extent to which a research conclusion can be generalised to the population or to other settings) over internal validity (i.e. extent to which a study can establish causality, related to the degree it minimises error or bias). Although not unique to implementation research, these characteristics make QED a particularly useful design within implementation research (Miller, Smith, & Pugatch, 2019).

Qualitative methods were also employed to investigate the implementation outcomes of this study. Qualitative methods give a voice to participants and stakeholders and allow the integration of different perspectives, values and opinions into process evaluations (Palinkas et al., 2011; Sofaer, 1999). Although Proctor et al. (2011) outlined a range of means of verification and data that can be used to measure implementation outcomes (e.g., surveys, checklist, administrative data, observation), they argue that most implementation outcomes can be inferred through expressed

attitudes and opinions, intentions, or reported or observed behaviours of key stakeholders. In the process evaluation conducted as part of this thesis, evidence on implementation outcomes was therefore accessed by exploring the factors influencing the implementation of PM+ as perceived by participants and key stakeholders. Accordingly, interview and FGD guides were informed by the implementation concepts and definitions presented in Table 3.2. It should be noted that evaluation frameworks such as the one proposed by Proctor et al. (2009) do not function as study designs but provide guidance on what to measure when evaluating implementation processes. The methodology of the process evaluation conducted as part of thesis is detailed further in the beginning of Chapter 6.

3.6 Co-Design of Implementation Research Project

As introduced in section 1.3, this study is part of an international and interdisciplinary collaboration (i.e. CONTEXT) conducting implementation research to enable a faster uptake of evidence in the field of psychotraumatology (Vallières, Hyland, Murphy, et al., 2018). As an implementation research project, this work was co-designed in collaboration with the IFRC Reference Centre for Psychosocial Support, a centre of expertise within the International Federation of Red Cross and Red Crescent Societies (IFRC) that provides technical support to a 192 Red Cross and Red Crescent National Societies on mental health and psychosocial support, and the Colombian Red Cross, an auxiliary to the Colombian government and one of the National Societies of the Red Cross and Red Crescent Movement.

The project was first formulated out of a series of requests from Red Cross and Red Crescent National Societies for guidance on how to implement the World Health Organization's low-intensity psychological interventions for displaced populations. Based on this strong desire to advance knowledge on this topic, I first conducted a mapping exercise, based on available documentation from the IFRC Reference Centre for Psychosocial Support, to identify National Societies that could act as implementing partners. The inclusion criteria considered in this mapping exercise were: language

requirements (e.g., need for translators for training, supervision and interviews), the ability to refer to specialised services, the possibility of securing in-country ethical approval, and whether the National Society was already providing MHPSS programmes to displaced populations.

The Colombian Red Cross was ultimately prioritised for having strong psychosocial programmes throughout the country, and a track-record of supporting beneficiaries with different displacement status (e.g., internally displaced persons, refugees, returnees and migrants). In addition, this partnership would not require the use of translators as I could communicate with National Societies staff, volunteers and beneficiaries in Spanish, which was essential due to research funding restrictions and to evade the methodological limitations that have been associated to the use of translators or interpreters (e.g., reduced trustworthiness and conceptual equivalence) (Squires, 2009).

This process led to a series of meetings between staff from the IFRC Reference Centre for Psychosocial Support, the Colombian Red Cross and myself. Throughout this process, I was responsible of establishing and formalising a research collaboration between the IFRC Reference Centre for Psychosocial Support and the Colombian Red Cross, in the form of a Memorandum of Understanding. I also secured ethical approvals, led and developed the process of cultural adaptation of the PM+ manuals (Chapter 5), trained Colombian Red Cross staff and volunteers in PM+, led the data collection process, and disseminated the results of the study within and outside the Red Cross and Red Crescent Movement. Figure 3.2 outlines key milestones of the study.

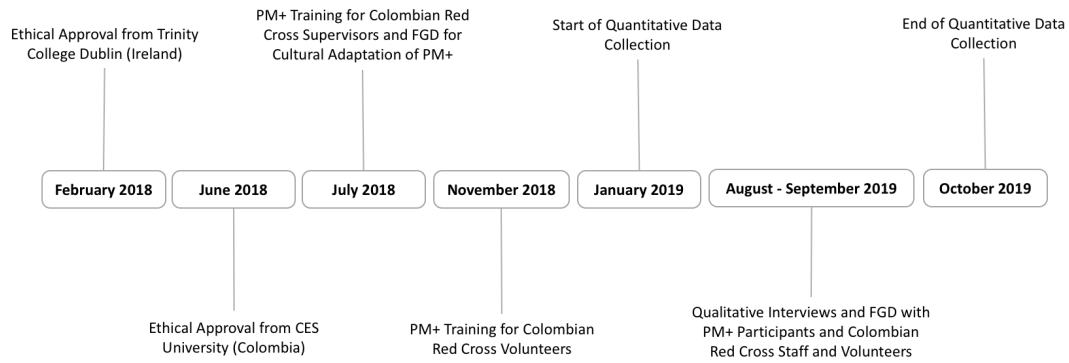


Figure 3.2. Key milestones of the study

3.7 Intervention under Study: Problem Management Plus (PM+)

As introduced in Chapter 1 and described in greater detail in section 2.7, this study aims to contribute to existing knowledge on the implementation of LIPIs for improving psychological outcomes among forcibly displaced persons. The World Health Organization has developed and rigorously tested the effectiveness of several low-intensity psychological interventions (including PM+), largely through RCTs taking place across various LMICs, and making them freely available globally as part of the mhGAP (World Health Organization, 2017). These interventions are specifically designed to be administered by practitioners without a formal mental health background and are grounded in high intensity therapies, including interpersonal therapy, acceptance and commitment therapy and cognitive behavioural therapy, as explained in section 2.4.2. PM+ was therefore selected as the intervention of interest in this study on the basis of having been tested and published in two RCTs, and endorsed by the WHO, and since it responded to the needs identified by the implementing partners.

Specifically, ‘Problem Management Plus (PM+)’ has been designed for adults suffering with symptoms of common mental health problems (e.g., depression, anxiety, stress or grief), as well as self-identified practical problems (e.g., unemployment, interpersonal conflict) living in humanitarian or low-resource settings (Dawson et al., 2015). PM+ includes a psychoeducation component delivered in the first session where

individuals learn about common reactions to adversity. During this session, a brief motivational interviewing exercise helps participants to become actively engaged in PM+. The intervention is composed of four core strategies: stress management ('Managing Stress'), problem solving ('Managing Problems'), behavioural activation ('Get Going, Keep Doing') and strengthening social support. 'Managing Stress' consists of a slow breathing exercise meant to help manage stress and anxiety symptoms and enhance relaxation. 'Managing Problems' consists of a seven-step problem solving strategy (e.g., listing problems, choose a solvable problem, define, brainstorm, decide and choose helpful strategies, action plan and review). In 'Get going, keep doing' individuals are encouraged through a series of self-identified actions to re-engage gradually with pleasant task-oriented activities to improve mood and address inertia, a distinguishing feature of depression (Dawson et al., 2015). Lastly, the strengthening social support strategy is the last strategy introduced on the manual and helps individuals identify sources of support within their communities and how they provide support to others. Lastly, although not a core strategy of PM+, the manual also includes a relapse prevention that involves identifying signs of relapse and testing individuals' knowledge of the strategies of PM+ and how they can continue to apply them in the future. Multiple language versions of PM+ are available in the WHO's website (World Health Organization, 2016c). PM+ is available in individual and group formats, and more recently in versions for children and adolescent, as well as an internet delivered version which are currently being tested (Sijbrandij et al., 2017). Its scalability is also currently being assessed across eight countries (Dawson et al., 2015; Sijbrandij et al., 2017). Table 3.3 presents the structure of PM+ by session.

SESSION	CONTENT
1	Introductions and confidentiality (5 mins) Review from assessment and PSYCHLOPS (10 mins) What is PM+? (20 mins) Understanding Adversity (30 mins) Managing Stress (20 mins) Ending the session (5 mins)
2	General review and PSYCHLOPS (5 mins) Managing Problems (70 mins) Managing Stress (10 mins) Ending the session (5 mins)
3	General review and PSYCHLOPS (5 mins) Managing Problems (20 mins) Get Going, Keep Doing (20 mins) Strengthening Social Support (30 mins) Managing Stress (10 mins) Ending the session (5 mins)
4	General review and PSYCHLOPS (5 mins) Managing Problems (20 mins) Get Going, Keep Doing (20 mins) Strengthening Social Support (30 mins) Managing Stress (10 mins) Ending the session (5 mins)
5	General review (20 mins) Staying Well (30 mins) Imagining How to Help Others (20 mins) Looking to the future (15 mins) Ending the programme (5 mins)

Table 3.3. Structure of Problem Management Plus

3.8 Study Setting

The Colombian Red Cross provides a wide range of programmes, including health (e.g., primary health care, vaccinations, community-based health promotion, first aid, nutrition and water and sanitation), education, social inclusion, peacebuilding, disaster risk reduction and human rights through its 32 branches based in the capital of each of

Colombia's 32 departments or provinces and 250 local units. The Colombian Red Cross has 31,420 registered volunteers and 2,092 paid staff (IFRC, 2019). Out of the 32 branches of the Colombian Red Cross, 18 are implementing mental health and psychosocial support programmes. One of the units of the Colombian Red Cross, Saravena, located in the Arauca Department, was selected as the study setting (Figure 3.3).



Figure 3.3. Map of Colombia, Arauca Department marked in blue

Saravena and the study population was ultimately chosen as the research site by the Colombian Red Cross, based on the needs assessment for migrant and refugees in the area (e.g., lack of access to health care system, psychosocial needs identified by the Colombian Red Cross' Health Department), characteristics of the Psychosocial Support team (e.g., trained supervisor, team members are certified in Psychological First Aid), existing programming and availability to refer to specialised mental health services (i.e. Doctors without Borders or the International Committee of the Red Cross).

Saravena is a city and municipality located six kilometres south of Colombia's border with Venezuela. The area has a population of about 47,203 persons and in recent years has received an unknown but high number of Venezuelan migrants and refugees, Colombians returnees, migrants and refugees transiting through the municipality, or coming in daily to find work or buy goods (Government of Colombia, 2019). Despite a

peace agreement between the Colombian Government and the Revolutionary Armed Forces of Colombia (FARC, by its acronym in Spanish), the National Liberation Army, Colombia's largest leftist guerrilla group, as well as FARC dissidents and the Colombian military are all still active in Saravena. Saravena is therefore one of the areas of Colombia that continues to be directly affected by the armed conflict, increasing the vulnerability of Venezuelan migrants and refugees, as discussed in section 2.3.3.3, requiring a number of additional ethical considerations.

3.9 Ethical Considerations

The findings of a systematic review of ethical consideration of MHPSS research with adults in humanitarian settings were influential in the development of the research design and throughout the research project. In this review, Chiumento, Rahman, Frith, Snider, and Tol (2017) identified five ethical principles of MHPSS research in emergency settings relating to scientific research design, participation, safety, neutrality, and purpose and benefit. More specifically, the authors highlight the importance of considering the contextual realities of the emergency, not impeding relief, minimising risk, conducting research in appropriate time and paying attention to non-pathological processes such as resilience and wellbeing. In addition, researchers should provide a clear rationale as to why the research should be conducted in an emergency setting and should be informed by practitioner expertise and theoretical relevance and not by the interest of researchers (Chiumento et al., 2017). Researchers should also consider safety when gathering groups, take extra measures to ensure strong confidentiality and anonymity procedures, avoid (inadvertent) disclosure, put in place adequate responses to research participants' discomfort or adverse reactions, including functional referral pathways for MHPSS care, and ensure research team self-care. Another important consideration of conducting MHPSS research in humanitarian emergency settings is the cultural and contextual adaptation of instruments and tools, including informed consent procedures, used in research projects. Researchers are advised to consider ways to reach socially marginalised groups through the selection of participants. Closely connected

with this is the principle of neutrality which requires that researchers be aware of social and economic inequalities that are augmented in emergency settings and take them into account when conducting research in these settings by, for example, addressing knowledge asymmetries in research procedures and through 'reverse triage' that empower local community members to take decisions on inclusion criteria or how potential participants are selected (Citraningtyas, Macdonald, & Herrman, 2011). Researchers should recognise that voluntary participation for research conducted within MHPSS services in humanitarian settings could be undermined and additional steps should be taken to prevent coercion. Participants and the research team's safety is also considered essential in humanitarian settings and researchers are required to put mechanisms in place to guarantee safety. Lastly, all research in humanitarian settings should ensure direct benefit to participating communities, build sustainable collaborations that deliver benefit and disseminate findings to the participating communities (Chiumento et al., 2017).

These recommendations were operationalised in this study in various ways. First, ethical approvals were obtained both through the Health Policy & Management/Centre for Global Health Research Ethics Committee, Trinity College Dublin, Ireland on February 28th, 2018, as well as from the Ethics Committee of CES University, Colombia on June 21st, 2018 (Appendix A- Ethical Approval Letters). Participants in all research phases received sufficient information about the nature of their involvement in the study through written participant information leaflets and consent forms. The information leaflets detailed the following: research purpose and procedures (e.g., length and content of interviews and questionnaires), possible risks and discomforts (i.e. some questions could raise discomfort), potential benefits (e.g., improved quality of services provided by the Red Cross), the possibility to conduct sessions or interviews at participant's home, provisions of confidentiality, voluntary participation and the right to discontinue participation without penalty, contacts for additional information, termination of participation by the investigator (e.g., if the study is discontinued or in case of harm to members of the research team), permissions and

access to recordings. The consent forms included the same information plus a declaration from the person requesting consent and space for signatures from both parties (Appendix B – Informed Consent Forms).

Colombian Red Cross volunteers were trained to obtain consent by clearly explaining the above, using lay language and terminology, and were instructed to read the consent form out loud to potential participants, while also giving potential participants time to read the information leaflet and consider their participation for a period of at least seven days. To avoid coercion, the consent form included information on participant's voluntary participation which the volunteers were trained to adhere to. Consent forms also included information on the purpose of the study, permission to use the data provided and the Colombian Red Cross supervisor's and my contact information. The Spanish versions of the consent forms were revised by the ethical board of CES University and by Colombian Red Cross staff to ensure the language used was simple and appropriate.

Participants were reminded that they could still receive the intervention should they decline to participate. During trainings, Colombian Red Cross staff and volunteers were trained on how to discuss participants' difficulties with the intervention with other colleagues, in a way that also maintained participants' confidentiality. Participants were also informed that should they express a will to harm themselves or others, the volunteers would be required to report this to their supervisor, who would then contact the participant before approaching the appropriate services, as outlined in the Code of Ethics of the Colombian Red Cross (Colombian Red Cross, n.d.). Confidentiality was upheld through the following additional measures: data collected electronically was deleted from the data collection online platform, numbers were assigned to participants during transcription and quantitative data was analysed at a group level. Since the study took place in a unit of the Colombian Red Cross, the anonymity of the supervisors could be guaranteed, as respondents could be indirectly identifiable based on their role in the organisation during the interviews. Anonymity was therefore protected through the

following measures: the names of the supervisors were redacted at transcription phase and are not presented in this study, supervisors were ensured that they could withdraw from the study or refuse to answer any questions without repercussions and request to read the transcripts or listen to the recordings at any point, the possibility of being identified through their role was acknowledged in the supervisors' consent forms and they were reminded of this risk during the interviews.

Changes in subjective wellbeing and quality of life were also evaluated as part of this study. To guarantee the safety of the research team and beneficiaries during research activities, Colombian Red Cross volunteers travelled in teams to the migrant settlements, where most of the sessions were conducted. Beneficiaries were also given the option to receive the sessions in the Colombian Red Cross office, if this was more suitable for them. As a second security measure, volunteers attended PM+ sessions with a colleague. If a volunteer was not trained in Psychological First Aid, she/he would be accompanied by a trained volunteer who was trained to respond to a crisis event. In line with *Caring for Volunteers* guidelines from the International Red Cross and Red Crescent Movement, volunteers were provided with Terms of Reference outlining what was expected from them, as well as the type of support they would receive (i.e. supervision, training and per diems) throughout the course of the research project (IFRC Reference Centre for Psychosocial Support, 2015). Lastly, Colombian Red Cross volunteers travelled to Bogota twice. First to receive one of the trainings and the second time to participate in Focus Group Discussions (FGDs) and key informant interventions. The decision to conduct the FGDs in Bogota was made due to security concerns. Interviews with participants were conducted over the phone due to preventive security lockdowns issued by the local government entities in the area at the time the research was conducted. The limitations that these security considerations pose in terms of the study design are further discussed in Chapter 7.

3.9.1 Data Protection

Quantitative data was collected electronically through KoBo Toolbox, an electronic suite for data collection commonly used in humanitarian contexts as data can be collected without the need for internet access. The data collected on this platform was kept in my (non-commercial) password-protected server. Qualitative data was collected using a dictaphone, and audio files were transferred to my server immediately following collection to prevent data loss. Signed consents forms were stored in a locked cabinet with limited access (e.g., researcher and Colombian Red Cross supervisor) and handed over to Trinity College Dublin to be stored for a period of seven years. Data was treated under the European General Data Protection Regulations. As a European Union funded project, the current study is covered by the European Union open data policy, requiring data collected during the project to be made publicly available. To ensure protection of participant confidentiality, a restricted open data policy is employed for the current project, whereby all requests for access to data will be processed by me to ensure that requests for data do not breach confidentiality.

Chapter 4: Systematic Review

4.1 Chapter Overview

The literature reviewed in Chapter 2 evidences a clear gap in our current knowledge of which low-intensity psychological interventions are effective among forcibly displaced populations. In addition, interventions that are theoretically effective may not necessarily be adopted or utilised and there are specific factors that influence the implementation of LIPs among forcibly displaced persons. However, the literature on this topic is scarce and has yet to be systematically examined. The mixed-methods systematic review presented as part of this chapter therefore aims to bridge these two research gaps and meet the first and second objectives of this study.

4.2 Methods

4.2.1 Identification and Selection of Studies

The systematic review followed the Evidence for Policy and Practice Information and Co-ordinating Centre's (EPPI-Centre) Methods for Conducting a Systematic Review, designed for broad research questions and to include a variety of study designs (EPPI-Centre, 2006). Included studies investigated low-intensity psychological interventions for reducing psychological distress among forcibly displaced persons. To be included, studies also had to be published in English, the language interpretable to all review collaborators. No geographical or date limiters were set as part of the exclusion criteria. In line with the definition of low-intensity psychological interventions presented in section 2.4.2, study interventions had to be delivered by lay providers. This meant that intervention provided by a mental health specialist as well as self-help, online or phone interventions that did not require support from trained lay providers were excluded. Authors were contacted when details on the intervention or the cadre of health workers was not clear from the article. As discussed in section 2.4.2.1, interventions were considered 'evidence-based' if they were included in the mhGAP guidelines. As a

reminder of the definitions introduced in Chapters 1 and 2, a list of the operational definitions used in the development of the search strategy and selection criteria is presented in Table 4.1.

CONCEPT	DEFINITION
Low-intensity psychological interventions (Bennett-Levy et al., 2010)	Simplified, brief, versions of evidence-based psychological therapies that can be delivered by trained lay providers regardless of formal training in mental health
Evidence-based therapies (World Health Organization, 2016b; World Health Organization & United Nations High Commissioner for Refugees, 2015)	Behavioural activation, cognitive behavioural therapy, family therapy, interpersonal psychotherapy, problem-solving counselling, parenting skills training, eye movement desensitisation and reprocessing, relaxation training
Forced displacement (United Nations High Commissioner for Refugees, 2019b)	The coerced movement of people arising from natural or man-made causes. Encompasses the concepts of refugee, asylum seeker, stateless person, and internally displaced person
Lay provider	Any type of worker such as lay health worker, teacher, nurse, social worker or volunteer, who does not have any formal training in mental health or psychology, but who had been trained to deliver a mental health intervention

Table 4.1. Operational definitions of the study

Primary quantitative or mixed-methods studies, regardless of whether they included a control/comparison group, so long as they assessed changes in psychological distress from baseline to the last available follow-up were included. This enabled the inclusion of both randomised and quasi-experimental designs which provide valuable evidence on the effects of low-intensity psychological interventions (Rockers, Røttingen, Shemilt, Tugwell, & Bärnighausen, 2014). Psychological distress was defined as a state of emotional suffering characterised by symptoms of depression (e.g., lost interest, sadness, hopelessness) and anxiety (e.g., restlessness, feeling tense) (Drapeau, Marchand, & Beaulieu-Prévost, 2012), which may be tied in with somatic complaints (e.g., insomnia, headaches, lack of energy) that are likely to vary across cultures (Kleinman, 1988). A global definition of the outcome variable, namely psychological distress, was chosen as

it allowed for the inclusion of a greater number of studies while also acknowledging the different forms of clinically relevant distress reported by refugees (e.g., PTSD, depressions and related symptoms of sleep problems and somatic complaints) and conforming with the trans-diagnostic nature of many low-intensity psychological interventions. Accordingly, no restrictions on outcome measures were applied. Interventions aiming solely to preventing mental disorders or promote positive mental health were excluded since the premise behind low-intensity psychological interventions is to help bridge the mental health treatment gap, or the persistent, large gap between the number of people in need of care and support and the number of people who receive it. Quantitative studies with less than ten participants were excluded to decrease the risk of selection bias (Gough, Oliver, & Thomas, 2017). Qualitative studies and research published in peer-reviewed journals, book chapters and grey literature (e.g., PhD theses and research reports) were also included to identify all evidence relevant to the research questions (Paez, 2017). Secondary data such as systematic reviews, meta-analyses, clinical cases, editorials and letters were excluded to obtain data from original research (EPPI-Centre, 2006).

The systematic review was first conducted in between September and October 2017 and was updated in August 2019 to include new literature published during this period. Accordingly, the studies included in this review were retrieved on August 16, 2019 from the following general and specialist databases: Scopus, MedLine, Embase, CINAHL and PsycINFO. These databases were selected based on consultations with an information specialist (i.e. subject librarian) from Trinity College Dublin. During these consultations Scopus, MedLine and Embase were selected as primary tools for systematic searches as they cover a wide range of titles from publishers and peer-reviewed journals from the life, social, physical and health sciences. CINAHL and PsycINFO were also selected as specialist databases including peer-reviewed and grey literature from the field of nursing and psychology. The following terms with relevant synonyms and controlled vocabulary were searched: (refugee OR asylum OR displaced)

AND (simpl* OR low-intensity) AND (mental health OR depression OR PTSD) AND (intervention OR session OR counsel*). The complete search strings for each database is presented in Appendix C – Search Strings. The reference lists of the selected studies were also scanned to identify other relevant articles. Duplicates were removed in EndNote X8 and references were imported into Covidence for title, abstract, and full text screening.

4.2.2 Data Extraction and Quality Assessment

Articles were then independently screened by both Mary Harasym (a Global Health Master student from the University of Copenhagen) and myself between August 16 and November 7, 2019. Full text conflicts were solved by a third person (Kinan Aldamman, a PhD student from Trinity College Dublin) on November 7, 2019. Two reviewers (Tiziano Scott, a Global Health Master student from Trinity College Dublin, and I) independently assessed the quality of each study. I extracted the predetermined study characteristics for each study (i.e. country, country/region of origin, population, provider and training length, study design, intervention, comparison, outcome, findings) and conducted the data synthesis. The selection process was recorded in agreement with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Moher, Liberati, Tetzlaff, Altman, & Group, 2009).

The methodological quality of the evidence was assessed using the Checklist for Assessing the Quality of Quantitative Studies (Standard Quality Assessment Criteria for Evaluating Primary Research Papers – QualSyst) (Kmet, Lee, & Cook, 2004). QualSyst was chosen as it allows for the assessment of quantitative and qualitative studies of different designs and methodology. The checklist is comprised of 10 and 14 fixed-choice questions for qualitative and quantitative studies respectively; yielding scores of 0 (=No), 1 (=Partial), 2 (=Yes), or a 'not applicable' category. A summary score was calculated as a fraction of the total score and the total possible score, which excluded not applicable items. Studies scoring less than 59% were classified as low-quality, scores of 60%-64% were considered medium-low quality evidence, 65%-69% were interpreted as medium quality evidence, 70%-74% were categorised as medium to high quality

evidence, and studies scoring more than 75% were considered as high quality evidence (Kmet et al., 2004). An inter-class correlation coefficient was used to estimate the degree of agreement or consensus among the raters. The intra-class correlation coefficient of the quality assessment was 0.89 (95% CI 0.65 - 0.96), almost perfect agreement according to Fleiss' interpretation (Fleiss, 1971).

4.2.3 Data Synthesis

In a first step, the outcomes of the studies were analysed narratively, following Guidance on the Conduct of Narrative Synthesis in Systematic Reviews (Popay et al., 2006). The main characteristics of the studies were tabulated and studies were grouped according to similarities and differences in intervention characteristics (e.g., study design and outcomes) to explore patterns in the data. Data was explored by looking at the patterns between and within studies and characteristics of the samples and outcomes. In a second step, the results and discussion sections of the identified studies were analysed through thematic analysis using NVivo (Version 11) in order to identify the factors determining the implementation of the interventions. The phases of the thematic analysis are: familiarisation with the data, generating initial codes, searching for themes, revising themes, defining and naming themes and writing the interpretation as presented in Table 4.2 (Braun & Clarke, 2006).

PHASE	DESCRIPTION OF THE PROCESS
1. Familiarising yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking in the themes work in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table 4.2. Phases of thematic analysis (Braun & Clarke, 2012)

4.2.4 Study Characteristics

A total of 4,717 titles were identified from the database search, of which 876 were duplicates. Out of the 3,841 retrieved studies, 68 full texts were assessed and 53 were excluded based on meeting at least one of the exclusion criteria. Upon screening completion, 18 studies met the criteria for inclusion and were taken forward for analysis (Figure 4.1). Included articles were published between 2001 and 2019. A summary of the characteristics of the studies retained is presented in Table 4.3.

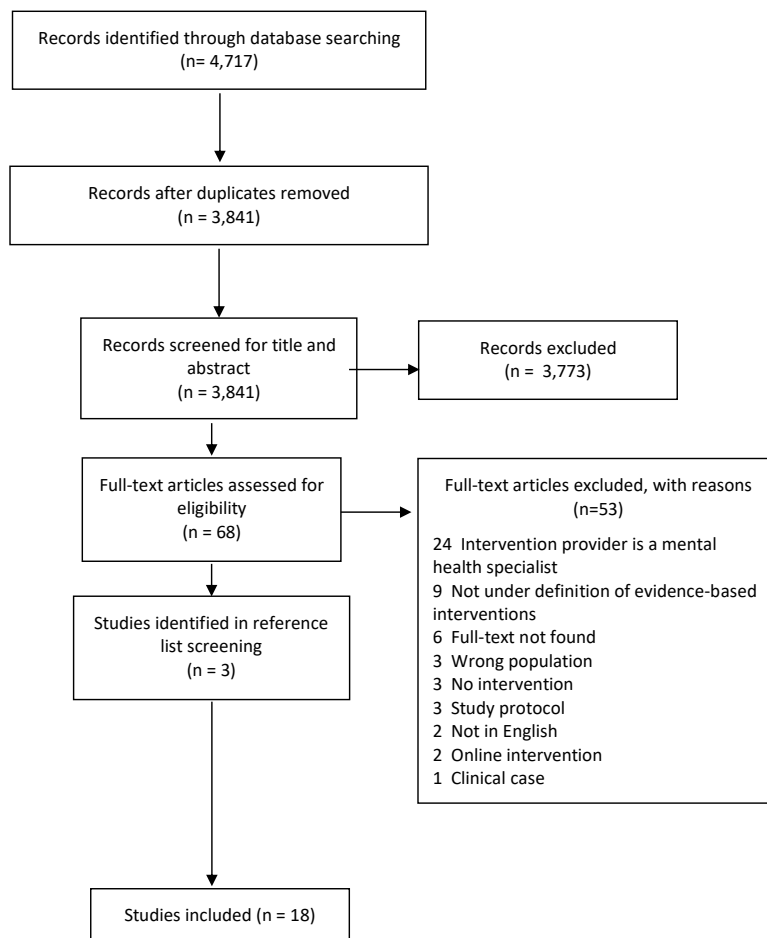


Figure 4.1. PRISMA flow-chart diagram

Study	Country	Country/ Region of origin	Population	Provider and Training Length	Study design	Intervention	Comparison	Outcome	Findings	Qualsyst score
Acosta & Chica (2018)	Jordan	Syria	Refugees and host community adults and children	NGO psychosocial workers	Qualitative study	Parenting Skills Intervention (5-6 group sessions) and Relaxation Training (5-6 group sessions)	None	Participants' satisfaction with the interventions and perceptions of effectiveness	Participants reported reduced isolation and strengthened social support, improvements on their communication with children and on child behaviour, and being able to manage stress, problems and anger. Participants reported improved perception of well-being and self-confidence as well as improved mutual understanding and communication between members of both communities.	Low
Annan, Sim, Puffer, Salhi, & Betancourt, 2016	Thailand	Myanmar	479 Refugee children and parents	NGO community-based facilitators (5-day training)	Randomised Controlled Trial	Parenting Skills Intervention (14 weekly group sessions * 2 hours)	Wait-list control	Internalising problems, externalising problems and protective factors in children and caregivers' acceptability	Significant improvements in externalising problems, child attention problems and prosocial protective factors at 1-month follow-up in intervention group. No significant intervention effect on children's internalising problems. The intervention was acceptable to caregivers who reported having enjoyed learning about family meetings how to teach good behaviours, setting goals and objectives, negative effects of drugs and alcohol and using rewards.	High
Bolton et al., 2007	Uganda	Uganda	314 Internally displaced adolescents	NGO facilitators (2-week training)	Randomised Controlled Trial	Inter-Personal Group Psychotherapy (16 weekly group sessions * 1.5-2 hours)	(1) Creative play (2) Wait-list control	Depression, anxiety, conduct problems symptoms and functionality	Statistically significant reduction in depression symptoms was found among girls in the IPT-G group but not among boys. No statistically significant improvement on anxiety, conduct problems or functionality were found in any intervention groups.	High
Catani et al., 2009	Sri Lanka	Sri Lanka	31 Internally displaced children	School teachers (76-day training)	Randomised Controlled Trial	Narrative Exposure Therapy for children (6 individual sessions * 60-90 min)	Meditation-R relaxation (six sessions)	PTSD severity, functional and physical impairment	Significant reductions in PTSD symptoms and functional impairment after both interventions at 1-month post-test and 6-month follow-up in comparison to wait-list control. No significant differences across groups in any outcome measure.	High
Dybdahl, 2001	Bosnia and Herzegovina	Bosnia and Herzegovina	87 Internally displaced mother-	School teachers	Randomised Controlled Trial	Parenting Skills Intervention (20 group sessions) and basic medical care	Basic medical care	Children's trauma reactions, depression, problems, functioning, concentration problems, well-being, cognitive skills, behavioural problems and physical measures. Mother's trauma reactions, well-being and perceived social support.	Children's behavioural problems reduced significantly. No significant group differences in other mental health outcomes. Significant reduction on mothers' hyperarousal symptoms.	High
El-Khani et al., 2018	Turkey	Syria	14 Refugee mothers and 16 children	School teachers (3-day training)	Quasi-experimental study	Teaching Recovery Techniques and Parenting Skills Training (5 group sessions*2 hours with children and 5 group session*2 hours with parents)	None	Child PTS, depression, anxiety and behavioural and emotional adjustment problems and caregiver' parenting skills, efficacy and confidence, acute stress, depression and anxiety	Significant decline in intrusion scores reported by children, parent-reported child behavioural problems and parent-reported total intensity of problems in children two weeks after the end of the intervention. Significantly improved parenting skills, confidence and perceived self-efficacy rates. No significant effects on parental mental health.	Medium

(Continued)

Study	Country	Country/ Region of origin	Population	Provider and Training Length	Study design	Intervention	Comparison	Outcome	Findings	Qualsyst score
Ertl et al., 2011	Uganda	Uganda	85 Internally displaced children	NGO lay counsellors	Randomised Controlled Trial	Narrative Exposure Therapy (8 individual sessions * 90-120 min)	(1) Academic catch-up with counselling (2) Wait-list control	PTSD severity, depression symptoms, severity of suicidal ideation, feeling of guilt and perceived stigmatisation	Significant reduction in PTSD symptom severity in NET group from pre-treatment to 12 month follow-up in comparison to academic catch-up and to wait-list control. NET was superior to both comparison groups in on analysis of PTSD symptom change over time. Narrative Exposure Therapy was associated with more improvement in functioning with large within and between intervention effect sizes.	High
Fox et al., 2005	United States	Cambodia and Vietnam	58 Refugee children	School teachers and nurses	Quasi-experimental study	Cognitive Behavioural Therapy (8 weekly group sessions * 1 hour)	None	Depression	Significant decrease in child depression scores one month after the intervention.	Low
Gormez et al., 2017	Turkey	Syria	32 Refugee children and adolescents	School teachers (2-day training)	Quasi-experimental study	Group Cognitive Behavioural Therapy (8 group sessions*70-80 min)	None	Child PTS, anxiety and behavioural and emotional problems	Statistically significant reductions in anxiety and PTSD total scores, although PTSD avoidance-related symptoms were not significantly lower at post-test. No significant change on behavioural problems (i.e., conduct, hyperactivity, peer-relationship problems, prosocial behaviour).	High
Kieft et al., 2018	The Netherlands	Various (e.g., Afghanistan, Iraq, Azerbaijan)	74 Adult asylum seekers	NGO psychosocial workers (7-week training)	Qualitative Study	Problem-solving counselling (approx. 3 individual sessions)	None	Clients and counsellors' experiences with the intervention	Most clients expressed some form of positive change as a result of the counseling service. Counsellors' involvement in the project led to an improved sense of well-being, meaning and belonging.	Low
McDonald, Coover, Sandler, Thao, & Shalhoub, 2012	United States	Various (South East Asia)	38 Refugee children	Hmong elders (2-day training)	Pilot Randomised Controlled Trial	Parenting Skills Intervention (8 weekly group sessions * 2.5 hours)	Wait-list control	Anxiety, depression, social skills and family adaptability	Statistically significant improvements in child anxiety, child social skills and family adaptability at post-test and at 6-month follow-up. No changes in family cohesion or child aggressiveness.	Medium-High
Neuner et al., 2008	Uganda	Rwanda and Somalia	277 Adult refugees	NGO lay counsellors (6-week training)	Randomised Controlled Trial	Narrative Exposure Therapy (6 individual sessions * 1-2 hours)	(1) Trauma counseling (6 sessions * 1-2 hours) (2) Wait-list control	PTSD severity and physical health	Both treatment groups were statistically and clinically superior to wait-list control but no difference was found across the two treatment groups. Fewer participants dropped-out of NET and a slightly higher number of NET participants did not fulfill a PTSD diagnosis at 6-month follow-up.	High
Neuner et al., 2008	Uganda	Rwanda and Somalia	277 Adult refugees	NGO lay counsellors (6-week training)	Randomised Controlled Trial	Narrative Exposure Therapy (6 individual sessions * 1-2 hours)	(1) Trauma counseling (6 sessions * 1-2 hours) (2) Wait-list control	PTSD severity and physical health	Both treatment groups were statistically and clinically superior to wait-list control but no difference was found across the two treatment groups. Fewer participants dropped-out of NET and a slightly higher number of NET participants did not fulfill a PTSD diagnosis at 6-month follow-up.	High
Onyut et al., 2004	Uganda	Rwanda and Somalia	50 Adult refugees	NGO lay counsellors (6-8 weeks training)	Quasi-experimental study	Narrative Exposure Therapy (4-6 individual sessions * 1-2 hours)	Problem- solving counselling (4-6 sessions * 1-2 hours)	Symptoms of PTSD and psychological distress	Preliminary symptom reduction and improved functioning across both groups at post-intervention.	Medium-High

Study	Country	Country/ Region of origin	Population	Provider and Training Length	Study design	Intervention	Comparison	Outcome	Findings	Qualsyst score
Osman, Flacking, Schon, & Klingberg- Allvin, 2017	Sweden	Somalia	120 Asylum seeker children	Group leaders	Randomised Controlled Trial	Parenting Skills Intervention (12 weekly group sessions * 1-2 hours)	Wait-list control	Children's emotional and behavioural problems	Significant improvement on behavioural problems in the intervention group at 2-month follow-up. No significant difference on internalising problems between the intervention and comparison groups.	High
Pfeiffer & Goldbeck 2017	Germany	Gambia, Pakistan, Albania, Somalia, Syria, Iraq, Sudan, Nigeria and Ghana	29 Refugee children and adolescents	Social workers (2-day training)	Quasi-experimental study	Cognitive Behavioural Therapy (6 weekly group sessions * 90 min)	None	Symptoms of post-traumatic stress	Significantly fewer symptoms of post-traumatic stress after the intervention, especially in the domains of reexperiencing, avoidance and negative alterations and cognitions. Improvements in symptoms of hyperarousal was not significant.	High
Pfeiffer et al., 2018	Germany	Afghanistan, Syria, Gambia, Somalia, Iran, Eritrea, Senegal, Iraq, Ethiopia, Pakistan, Angola, Ghana, Guinea, Guinea-Bissau and Kurdistan	50 Refugee children and adolescents	Social workers (2-day training)	Randomised Controlled Trial	Cognitive Behavioural Therapy (6 weekly group sessions * 90 min)	Usual care (referred to psychotherap y if needed)	Post-traumatic stress severity, symptoms of depression, dysfunctional post-traumatic conditions and caregiver-reported symptoms of post-traumatic stress	The intervention group had significantly superior improvements in self-reported post-traumatic stress symptoms and depression at post-intervention and this effect was not present in the control group. There were no significant differences in individual clinical improvements across groups. No differences were found in caregiver-reported symptoms and self-reported dysfunctional post-traumatic cognitions across groups.	High
Pfeiffer et al., 2019	Germany	Afghanistan, Syria, Gambia, Somalia, Iran, Eritrea, Senegal, Iraq, Ethiopia, Pakistan, Angola, Ghana, Guinea, Guinea-Bissau and Kurdistan	17 Refugee children and adolescents	Social workers (2-day training)	Quasi-experimental study	Cognitive Behavioural Therapy (6 weekly group sessions * 90 min)	Usual care (referred to psychotherap y if needed)	Post-traumatic stress severity, symptoms of depression, dysfunctional post-traumatic conditions and caregiver-reported symptoms of post-traumatic stress	From post-intervention to 3-month follow-up, no statistically significant mean change was found for symptoms of post-traumatic stress, depression or dysfunctional post-traumatic cognitions. Country of origin (Middle East vs. African countries) was the only significant predictor of post-traumatic stress symptom improvement.	High
Verdeli et al., 2008	Uganda	Uganda	Internally displaced adolescents	NGO facilitators (2-week training)	Qualitative study	Inter-Personal Group Psychotherapy (16 weekly group sessions * 1.5-2 hours)	None	Implementation outcomes (i.e., adaptation, appropriateness and sustainability)	Strategies used in the implementation included pre-group meetings with participants, talking about general topics at the start of sessions, contextual adaptation of the implementation and being flexible to the needs of adolescents.	High

Table 4.3. Studies meeting inclusion criteria

Twelve out of the 18 identified samples consisted of children and adolescents, three focused on children and caregivers with the remaining three samples consisting of adults. In 11 studies, samples were refugees, five study samples were internally displaced persons and two studies sampled asylum seekers. Of these, three studies sampled Syrian refugees, three sampled Ugandan internally displaced children and adolescents, two sampled Rwandan and Somali adults, one sampled Somali asylum seeking children, one sampled Bosnian and Herzegovinian mother and child dyads, one sampled refugee children from Myanmar and five studies sampled forcibly displaced persons from different countries/regions in Africa, the Middle East or Asia. Six studies investigated parenting skills interventions, one of these studies used a combination of trauma-focused CBT and parenting skills training and another simultaneously investigated parenting skills interventions and relaxation training. Five studies analysed simplified interventions of CBT, four studies investigated NET, two studies focused on Interpersonal Group Psychotherapy (IPT-G) and one study researched problem-solving counselling. Interventions consisted on average of 8 sessions, ranging from three and 20 sessions. Eight studies were RCTs, six were quasi-experimental studies and three were qualitative studies. Twelve of the included studies received a high-quality rating with scores ranging from 75-93 (Mean = 74.9, SD = 15.3), three studies received a low-quality rating with scores ranging from 38-57, two studies received medium-high scores and one study received a score of 68, indicating medium quality.

Ten studies recruited lay providers based on their similar demographics to the intervention participants (e.g., level of education, place of residence or origin) (Acosta & Chica, 2018; Annan, Sim, Puffer, Salhi, & Betancourt, 2016; Bolton et al., 2007; Ertl et al., 2011; Kieft, Jordans, de Jong, & Kamperman, 2008; McDonald, Coover, Sandler, Thao, & Shalhoub, 2012; Neuner et al., 2008; Onyut et al., 2003; Osman, Flacking, Schon, & Klingberg-Allvin, 2017; Verdelli et al., 2008). Eight studies enrolled NGO psychosocial workers or lay counsellors as facilitators, four enrolled school teachers, three enrolled social workers, two recruited community leaders and one selected both teachers and

nurses to deliver the intervention. Neuner et al. (2008) enrolled non-specialists that had a previous PTSD diagnosis and trained them on the intervention after they had received treatment. Studies varied in the length of training provided to non-specialists: one study (Annan et al., 2016) reported a training of 72 non-consecutive days, whereas six studies reported trainings of 2-3 days. Three studies reported one to two weeks of training, three additional studies reported six to eight weeks of training and five studies did not provide information on training duration. One study reported having conducted a refresher training and 13 studies indicated that the providers received regular supervision through different formats (i.e. on-site, group, individual and remote).

4.2.4.1 Parenting Skills Interventions

Acosta and Chica (2018); Annan et al. (2016); Dybdahl (2001), El-Khani et al. (2018); Osman et al. (2017) independently showed that parenting skills interventions were associated with reduced behavioural problems in children. More specifically, Annan et al. (2016) found significant improvements in child attention and in prosocial protective factors at one and six-month follow-up. In their study, McDonald et al. (2012) did not find significant improvements on child aggressiveness and family cohesion after the programme was implemented, but found significant improvements in family functioning (measured by reduced child anxiety/depression, social skills and family adaptability) at one and six-month follow-up (McDonald et al., 2012). El-Khani et al. (2018) demonstrated the feasibility of the combination of trauma-focused interventions with parenting skills training to reduce the symptoms of intrusion and total intensity of problems in children. The intervention also significantly improved parents' skills, confidence and perceived self-efficacy rates but did not lead to any differences on caregiver mental health (El-Khani et al., 2018). Dybdahl (2001) identified that mothers' hyperarousal symptoms were reduced significantly in the intervention group. In Acosta and Chica (2018)'s study, parents reported reduced isolation, strengthened social support, improvements on their communication with children after taking part in the sessions.

4.2.4.2 Cognitive Behavioural Therapy

Low-intensity versions of cognitive behavioural therapies were associated with significant reductions in most symptoms of post-traumatic stress (PTS) among refugee children and adolescents, except for symptoms of hyperarousal (Pfeiffer & Goldbeck, 2017), superior improvements in self-reported symptoms of PTS and depression but no significant differences in caregiver-reported symptoms of PTS and self-reported dysfunctional post-traumatic cognitions in children (Pfeiffer, Sachser, Rohlmann, & Goldbeck, 2018). Those results were maintained at three-month follow-up as reported by Pfeiffer, Sachser, Tutus, Fegert, and Plener (2019). Gormez et al. (2017) found that a school-based cognitive behavioural group intervention resulted in significant reductions of anxiety and PTS symptoms among refugee children and adolescents. The authors did not find significant changes in PTSD avoidance symptoms and behavioural problems post-intervention. Fox, Rossetti, Burns, and Popovich (2005) reported a significant decrease in child depression scores one month after the intervention was delivered to Cambodian and Vietnamese refugee children living in the United States.

4.2.4.3 Narrative Exposure Therapy

Ertl et al. (2011) found significant reduction in PTSD symptom severity in groups of former Ugandan child soldiers who received NET in comparison to academic catch-up (i.e. English academic training) and wait-list controls, 12 months after interventions were delivered. Onyut et al. (2003) reported reductions in symptoms of PTSD and improved functioning in Rwandan and Somalian adult refugees in Uganda who received NET and another group from the same community who received problem-solving counselling sessions, but did not provide evidence of these results. Similarly, Neuner et al. (2008) compared the effects of the same manualised NET intervention to more flexible trauma counselling sessions, as well as to a waitlist condition among adult Rwandan and Somalian refugees and did not find any significant differences in PTSD symptoms across the two interventions, although significantly fewer participants dropped out of NET. Catani et al. (2009) studied the effectiveness of NET delivered by school teachers among internally displaced Sri Lankan children and found a significant decrease in symptoms

of PTSD as well as functional impairment among both groups, but no significant differences across the two intervention groups on other outcome measures (i.e. PTSD severity and physical health symptoms).

4.2.4.4 Interpersonal Psychotherapy

Verdeli et al. (2003) documented the adaptation and implementation process of an IPT intervention among internally displaced Ugandan adolescents and identified a series of strategies (i.e. pre-group meetings with participants, talking about general topics at the start of sessions, contextual adaptation of the implementation and being flexible to the needs of adolescents) that contributed to the implementation. An RCT conducted in the same context showed significant reductions in depression symptoms among adolescent girls aged 14-17, but not among boys in the same age group, in comparison to a waitlisted group and a group participating in creative play (Bolton et al., 2007).

4.2.4.5 Problem-Solving Counselling

Kieft et al. (2008) assessed the experiences of adult refugee clients and counsellors participating in a problem-counselling program and found that most clients expressed some form of positive change after the counselling service and that providers' involvement in the project led to an improved sense of wellbeing, meaning and belonging.

4.2.5 Implementation Factors

Cultural adaptation, as described in section 2.6.1, was most frequently cited by authors as a factor contributing to the implementation of low-intensity psychological interventions. Adapting manualised interventions to the context was consistently seen as an important step for increasing interventions' relevance to participants, helping to retain them throughout the course of the intervention and contributing towards the successful implementation of low-intensity psychological interventions (Osman et al., 2017). Specifically, various authors highlighted the importance of conducting more than just 'surface' adaptations, and to additionally adapt the material or mode of delivery to characteristics and customs of the target population (e.g., level of education, culturally

appropriate grief and bereavement traditions, culturally appropriate parenting practices). Some authors further suggest that interventions be adapted to consider additional contextual factors such as participants' time, mobility and availability (Acosta & Chica, 2018; Annan et al., 2016; Kieft et al., 2008); match gender of participants and providers (Kieft et al., 2008); integrate feedback from family members (Acosta & Chica, 2018; Verdeli et al., 2008); and include practical information to access local services through the intervention (Osman et al., 2017). Lastly, McDonald et al. (2012) recommended to involve lay providers in the process of the cultural adaptation of the intervention, as this may empower and motivate them to deliver the intervention.

Linked to the theme of adaptation and as described in section 2.6.1, two studies (Annan et al., 2016; McDonald et al., 2012) emphasised on the importance of striking an appropriate balance between adaptation and intervention fidelity, or the degree to which an intervention is delivered as it was originally planned. They further highlight the need for an intervention to factor in the sociocultural aspects of mental health and wellbeing relevant to the community (e.g., values and beliefs), while also ensuring that the core components of the intervention are maintained. The importance of documenting the adaptation process to monitor changes that may affect fidelity was also underlined (McDonald et al., 2012).

Various studies acknowledged the difficulties of recruiting lay providers from the study population. These difficulties included possible re-traumatisation by triggering previous trauma-related memories and reactions during sessions (Gormez et al., 2017; Kieft et al., 2008; Onyut et al., 2003) as well as the development of subjective views on the clients' problems. Based on their experience, Kieft et al. (2008) advise others to study the principles of the therapeutic alliance during training and supervision. Gormez et al. (2017) highlighted the importance of making care available to teachers providing the interventions. Kieft et al. (2008) also advise against employing asylum seekers as providers, since they may be distressed to learn about others' difficulties with the asylum-seeking process. Despite these challenges, Kieft et al. (2008) and Gormez et al. (2017) found that by being involved in the implementation of the interventions, social

workers and lay counsellors acquired new skills that contribute positively to their work experience and opportunities.

Building trust among participants was found to influence the implementation of low-intensity psychological interventions. For instance, Acosta and Chica (2018) and Verdeli et al. (2008) found that participants were not willing to disclose traumatic or difficult experiences in group settings. In response to this, Verdeli et al. (2008) found it useful to talk in the beginning of the session about general issues that camp adolescents frequently faced (e.g., pregnancy, substance use, suicidality, domestic violence, abductions) without referring to specific individuals, and to discuss which IPT skills might help manage these issues. The authors found that this helped participants disclose more personal information. Pfeiffer et al. (2019) also stressed how having a 'safe space' is a pre-requisite for trauma-focused interventions and is questionable whether participants can benefit from exposure-based treatment if they lack reliable protection. Implementing interventions in challenging and insecure settings was presented as a barrier against intended outcomes.

Some authors reflected on the sustainability of the low-intensity model. Annan et al. (2016) noted that low-intensity psychological interventions require intensive training and supervision as well as monitoring, all of which require human and financial resources. To overcome this, the authors suggest that future implementations explore peer supervision and new technologies as models for increasing support. In addition, the authors suggest training lay providers in general clinical skills so they can respond to a wider range of challenges. Acosta and Chica (2018) also caution against the long-term sustainability of these interventions. The short duration of these programmes, they argue, limits the ability of organisations to raise awareness about mental health. Kieft et al. (2008) identify how having limited cooperation between lay counsellors and mental health professionals providing specialised care hinders this model of care and should be addressed in future implementations. Despite the noted challenges to sustainability, various authors suggested the model of training lay providers remains an efficient way of increasing access to mental health care (Catani et al., 2009; Fox et al., 2005; Kieft et al.,

2008; Pfeiffer & Goldbeck, 2017; Pfeiffer et al., 2018; Pfeiffer et al., 2019; Verdelli et al., 2008).

4.3 Discussion

These results show that implementing low-intensity psychological interventions can yield positive mental health outcomes for forcibly displaced persons. The implementation of LIPIs however, is not without challenges. Modifying parenting skills interventions to be delivered by lay providers in decentralised settings may be associated with improvements in child behavioural outcomes. Most studies found an association with behavioural but not with emotional problems in children. El-Khani et al. (2018) did find an association with emotional improvements among children by combining parenting skills and trauma-focused CBT components. The changes in child behaviour identified in this review may be explained by the parenting skills interventions' focus on behavioural change. Indeed, in their study McKee, Colletti, Rakow, Jones, and Forehand (2008) argue that the impact of parenting interventions on child externalising behaviour is well established in the literature but that little research has focused on whether and how parenting skills interventions address internalising problems in children. This may be due to the challenge of detecting internalising problems in children (Tandon, Cardeli, & Luby, 2009), which might prove especially difficult in humanitarian settings. Two studies showed improvements on parental/caregiver mental health outcomes after parenting skills interventions. This finding is not consistent with the broader parenting skills literature (Knerr, Gardner, & Cluver, 2013; Pedersen et al., 2019), but could be a specific finding within forcibly displaced populations, as parenting skills interventions may contribute to strengthening social support, thereby contributing to caregivers' mental health. Considering the association between caregiver and child mental health, more holistic, family-centred parenting interventions for forcibly displaced populations may offer benefits to these populations (Foka, Hadfield, Pluess, & Mareschal, 2020; Panter-Brick, Grimon, & Eggerman, 2014).

Notably, despite the available evidence supporting the use of high and low-intensity versions of CBT interventions (Cuijpers et al., 2013; Nose et al., 2017; Turrini et al., 2019), the evidence on low-intensity CBT interventions for forcibly displaced persons identified through this review is very limited. Trauma and non-trauma focused CBT interventions for children were associated with improvements in total PTS scores, but results were inconclusive across two symptom clusters (i.e. hyperarousal and avoidance). In addition, three of the studies included interventions developed by the study's authors. This further evidences the need to examine whether low-intensity CBT interventions are associated with improved mental health outcomes, especially among forcibly displaced adults.

Results suggest using low-intensity NET for forcibly displaced persons is at least as beneficial as meditation relaxation sessions or trauma-focused counselling. One study found evidence for the effectiveness of NET among internally displaced children over controls (Ertl et al., 2011) but the remaining three NET intervention studies failed to detect any advantages of NET over other interventions. That said, Neuner et al. (2008) did find significant differences in dropout rates among the treatment groups, possibly indicating higher acceptability of NET among the study population. Nevertheless, the literature on the effectiveness of high-intensity NET in comparison to the other therapies also shows mixed results. On the one hand, two previous systematic reviews identified NET, when delivered by specialists, as the best supported modality for decreasing PTSD prevalence among adult trauma-exposed refugees and asylum seekers (Nose et al., 2017; Tribe et al., 2017). In a recent meta-analysis, however, NET did not show benefits for PTSD or depression at post-test when delivered by specialist or lay providers delivered (Turrini et al., 2019). A plausible explanation for this is that lay-delivered interventions may be more frequently implemented in insecure or humanitarian settings due to the lack of specialised personnel. In these contexts, as argued by Pfeiffer et al. (2019), the effects of trauma-focused interventions may be compromised.

Lastly, and consistent with Tribe et al. (2017)'s findings, further research on IPT is necessary to determine its effectiveness among forcibly displaced persons. The only

study found using this intervention, while robust and detecting significant decreases in depression symptoms, only resulted in positive effects for adolescent girls. Further research is therefore needed to ascertain its effectiveness among adults and boys.

Although most of the studies meeting the inclusion criteria aimed to assess the impact of LIPIs on the mental health of forcibly displaced persons, the thematic analysis added valuable information on LIPIs' implementation processes. Cultural and contextual adaptations may contribute to the relevance of low-intensity interventions as well as participants' retention through the study. Distrust among participants, lack of reliable protection and the negative impact of interventions on providers' mental health may hinder implementation. Time, resource constraints and weak coordination could further affect the sustainability of these interventions.

As low-intensity psychological interventions tend to be based on models designed and tested in Western contexts (Cork, Kaiser, & White, 2019; Silove et al., 2017), cultural and contextual adaptations are necessary for interventions to be meaningful and tailored to the needs of forcibly displaced persons. Cultural adaptations should ensure that interventions are responsive to participants' needs by incorporating local cultural and psychosocial factors that influence health behaviours. This is consistent with the finding of Dickson and Bangpan (2018)'s review of the implementation of MHPSS programmes. Specifically, they also identified the importance of culturally meaningful interventions and how community and stakeholders should be involved in the process of cultural adaptation. The difficulty remains in striking a balance between cultural and contextual adaptations, which can increase programme acceptability, without compromising treatment fidelity, such that adaptations undermine the intervention's core components. To achieve this, while also maximising intervention fidelity, the process of cultural adaptation should be informed by structured adaptation protocols or frameworks (Chowdhary et al., 2014; Wessells, 2009).

Dickson and Bangpan (2018) also recognised the importance of building trusting and supporting relationships between programme providers and recipients to maximise engagement and increase programme impact. Indeed, the strategies for establishing

therapeutic alliance have been widely discussed in the literature (Norcross & Wampold, 2011). However, as shown in this review, distrust may also arise among participants in group interventions. Ways of mitigating distrust among participants in group interventions should be considered in future implementations and may include discussing the general issues that community members frequently face (e.g., pregnancy, substance use, suicidality, domestic violence, abductions) without referring to specific individuals, and discussing how the intervention might help manage those issues (Verdeli et al., 2008). Other strategies may include explaining and reminding group members about confidentiality, praising openness and encouraging respect and active listening among group members (IFRC Reference Centre for Psychosocial Support, 2018).

The importance of a 'safe space' was also identified through the narrative synthesis as a factor contributing to the successful implementation of these interventions. Pfeiffer et al. (2019) questioned the benefit of trauma-focused interventions if recipients lack reliable protection. This challenge highlights the importance of enabling safety through community-based psychosocial programming before providing more specialised interventions as discussed in section 2.4.1 (Inter-Agency Standing Committee, 2007).

The studies identified in this review further advised on the need to explore the psychological impact of becoming a lay facilitator, including measures of vicarious trauma (Thormar et al., 2013). This is especially important in the case of programmes recruiting providers that have also been forcibly displaced or have been exposed to similar experiences as participants. Various factors have been shown to influence humanitarian staff and volunteers' mental health and wellbeing, including perceived social support, supervision, individual factors (e.g., coping style, prior psychopathology, demographics) (Quevillon, Gray, Erickson, Gonzalez, & Jacobs, 2016). Provider wellbeing is a crucial aspect of humanitarian work, self-care strategies (e.g., setting boundaries on workload, encourage healthy habits, peer support schemes) should be practiced individually and promoted by humanitarian agencies (Quevillon et al., 2016).

The sustainability of the low-intensity model was also identified as a factor influencing the implementation of these interventions. In addition to the sustainability challenges identified in this review (i.e. limited human and financial resources, ability to raise awareness about mental health and cooperation between lay providers and specialists), lack of incentives for lay providers, time-bound humanitarian funding, lack of integration of interventions with national and local systems have also been proposed as a threat to sustainability (Organization, 2008; Tol et al., 2011). To improve the sustainability of MHPSS programmes, Tol et al. (2011) recommend that specific funding is allocated to strengthening existing national and local health, education, and social service systems, to address mental health and psychosocial problems. Furthermore, promoting local adaptation and local ownership of programmes has been proposed as a crucial strategy for achieving long-term sustainability (Inter-Agency Standing Committee, 2007).

Lastly, an underlying obstacle to the implementation of low-intensity psychological interventions is the lack of documentation on implementation processes (Annan et al., 2016; Dybdahl, 2001; Kieft et al., 2008; Neuner et al., 2008; Osman et al., 2017). For instance, training and supervision were only briefly discussed in some studies, or not discussed at all. Future studies should include more detailed information on recruitment, training, supervision, coordination, access and security considerations given their recognised importance in the implementation of interventions by lay providers. This recommendation is aligned with calls and ongoing efforts for the development and research of models of training and supervision using cross-culturally validated measures (IFRC Reference Centre for Psychosocial Support, 2019; Murray et al., 2011). Future implementations of low-intensity psychological interventions would benefit from more detailed and rigorous accounts on the factors determining the successful implementation of these interventions and strategies to counter these challenges. Aligned with Padmanathan and De Silva (2013) and Dickson and Bangpan (2018), I argue that more research is needed on the factors determining the implementation of MHPSS interventions. Further research is also needed to determine

which of these low-intensity interventions are *most* effective in reducing psychological distress among forcibly displaced persons (especially among adults) and whether these can be successfully implemented in real-life settings.

Chapter 5: Cultural Adaptation

5.1 Chapter Overview

Chapter 2, and more specifically section 2.6, presented evidence on how culturally adapting mental health interventions contributes to increased effectiveness, acceptability and sustainability of treatments. This chapter further evidenced that little guidance currently exists for how to adapt low-intensity psychological interventions in a systematic and time-efficient way. In the systematic review presented on Chapter 4, cultural adaptation emerged as an important factor contributing to the implementation of low-intensity psychological interventions for forcibly displaced persons. Based on these findings, Chapter 5 proposes a four-step process for cultural adaptation of LIPIs that can be carried out with limited time and resources. The results of applying this process to the cultural adaptation of PM+ for Venezuelan migrants and refugees and internally displaced Colombians living in Saravena, Colombia is also reported. Of note, although the evaluation of PM+ presented in Chapter 6 of this study does not include results from Colombian IDPs as participants, this population was considered in the cultural adaptation process as the Colombian Red Cross also intends to provide PM+ to Colombian IDPs.

5.2 Methods

Notwithstanding the potential of existing models to inform the design of cultural adaptation methodologies described in section 2.6.2, there is a need to describe *how* to culturally adapt interventions. In addition, cultural adaptation has primarily been an area of focus among academics and researchers. To address this gap, I drew on the Heuristic Framework for Cultural Adaptation, while also incorporating useful elements of the DIME methodology and the Ecological Validity Model, to develop a systematic, four-step process to culturally adapt a low-intensity psychological intervention for use in humanitarian settings. This process is in line with the four overarching phases of

cultural adaptation identified across a wide range of fields of implementation science (Movsisyan et al., 2019). In addition, the process outlined in this study was designed for practitioners or implementers without research experience. As with all cultural adaptations, the aim of the present study was to identify what changes were required to the current version of the PM+ protocols in order to make PM+ more meaningful and acceptable to beneficiaries. To this end, four theory-driven steps were applied to determine which change(s), if any, were required to the existing PM+ protocols and delivery for implementation with Venezuelan migrants and refugees and Colombian IDPs living in Saravena, Colombia. These steps are summarised in Table 5.1.

STEPS	DESCRIPTION	TOOLS
Step 1: Information gathering	Conduct a rapid desk review to gather relevant pre-existing information (e.g., demographic, socio-economic, help-seeking patterns, coping mechanisms)	Desk review guidance on MHPSS (World Health Organization & United Nations High Commissioner for Refugees, 2012)
Step 2: Adaptation hypotheses	Revise PM+ protocols to identify components for adaptation based on the Ecological Validity Model.	Eight-dimension matrix of the Ecological Validity Model (Bernal et al., 1995)
Step 3: Local consultations	Develop a focus group discussion guide based on Step 2 and use it to interview local specialists and implementers to elaborate and/or validate previous findings.	Focus Group Discussion guide A step-by-step guide to thematic analysis (Braun & Clarke, 2006)
Step 4: External evaluation	Engage two external reviewers in the evaluation of the PM+ intervention protocol using the Cultural Relevance Questionnaire to determine the protocol's level of functional, conceptual and linguistic equivalence.	Cultural Relevance Questionnaire (CRQ) (Salamanca-Sanabria, Richards, & Timulak, 2019)

Table 5.1. A four-step process to culturally adapt low-intensity psychological interventions in humanitarian contexts

5.2.1 Step 1: Information Gathering

The Heuristic Framework for Cultural Adaptation (section 2.6.2), advises every adaptation process to be guided by a preliminary step of information gathering.

Accordingly, a desk review of both peer-reviewed and grey literature (e.g., news articles, non-governmental organisation and government reports) was conducted over the course of four days. Demographic, socioeconomic, cultural and general health and mental health aspects of the intervention populations were gathered, according to the outline provided in Appendix D – Desk Review Guidance. This outline was chosen as it was developed by the WHO and the UNHCR (World Health Organization & United Nations High Commissioner for Refugees, 2012) and is specifically designed to assist in drafting literature reviews that are immediately useful sources of information for practitioners in humanitarian settings. Moreover, this guidance was chosen as it can be completed in as little or as much time as the nature of the emergency response (i.e. acute response period or protracted emergency) allows for (Greene et al., 2017). The process of designing the desk review guidance, and examples of completed desk reviews, are described elsewhere (Greene et al., 2017). Among other information, this initial gathering stage yielded information on common problems among intervention populations, coping strategies, explanatory models for mental health and psychosocial problems and availability of mental health services. This information was then brought forward for Step 2 of the cultural adaptation process.

5.2.2 Step 2: Adaptation Hypotheses

Next, PM+ intervention and training protocols were read and screened to identify components of the intervention that could be subjected to cultural adaptation, across each of the eight EVM dimensions (Bernal et al., 1995). Based on the information gathered through Step 1, possible sources of cultural non-fit (e.g., common problems, explanatory models of distress, coping strategies) or parts of the intervention that could be incompatible with the population's cultural patterns, meanings, and values were also identified. Finally, and given the recommendation common to available adaptation models (e.g., EVM, DIME methodology, CSF) that process models be informed by the expertise of stakeholders (e.g., practitioners, community members, implementers), possible sources of cultural non-fit identified in Step 2 (e.g., common and culturally appropriate social support and leisure activities) were developed into specific questions

(e.g., What do people from these two populations do to enjoy themselves? What do some activities people from these two populations do to connect with others?) to explore further within focus group discussions. As such, qualitative research methods were applied to further understand the populations needs, risks and resilience factors (Bernal & Domenech-Rodríguez, 2012a; Ferrer-Wreder et al., 2012).

5.2.3 Step 3: Local Consultation

Consistent with recommendations from the Heuristic Framework and the DIME methodology, focus group discussions guides were developed based on the results of the previous steps to be conducted with MHPSS specialists, programme implementers, and community members (Applied Mental Health Research Group, 2013; Barrera & Castro González, 2006). Two FGDs were initially planned with representatives from the two intervention populations (i.e. Venezuelan migrants and refugees and Colombian IDPs) (Bernal et al., 1995; Castro et al., 2010) but unfortunately, security issues lead to the cancellation of these local consultations. Thus, ultimately one FGD was conducted with four employees and volunteers for the Colombian Red Cross (Saravena branch), over 18 years of age, who had roles as MHPSS volunteers and supervisors and who worked closely with the intervention populations for the delivery of MHPSS programming. The FGD guide is presented as part of the Appendix E – Focus Group Discussion Guide (Phase 2 – Step 3).

I conducted the local consultation in Spanish, which lasted approximately three hours and were audio-recorded. The audio was transcribed verbatim and the data was analysed in Spanish. Quotes selected to support the results presented in this chapter were translated into English. Results were analysed using thematic analysis in NVivo (Version 11), following the steps or phases outlined by Braun and Clarke (2006). Thematic analysis was chosen due to its recognition as a flexible and useful method, that provides simplicity while also potentially enabling a rich and detailed analysis of data (Braun & Clarke, 2006), as presented in Table 4.2. The data was subjected to deductive analysis, whereby pre-determined topics and codes from Step 2 were identified within the data. A second round of open-coding also took place to allow for new codes to

emerge. The resulting themes generated were subsequently used to inform the adaptation of the PM+ intervention and training protocols as well as providers' training and supervision, prior to having the culturally adapted version of PM+ verified by external evaluators in Step 4.

5.2.4 Step 4: External Evaluations

The culturally adapted version of the PM+ intervention protocol was assessed by a Colombian and a Venezuelan psychologists, both based in academic institutions, who independently evaluated the protocol using the Cultural Relevance Questionnaire (CRQ) (Salamanca-Sanabria et al., 2019). Grounded in cultural sensitivity and ecological validity theories and principles, the CRQ was specifically developed to evaluate the degree of ecological validity following cultural adaptation (Bernal, Jiménez-Chafey, & Domenech-Rodríguez, 2009; Helms, 2015). A quick, easy to use, five-item questionnaire, the CRQ has demonstrated good reliability (Cronbach's $\alpha = 0.74$). The English-version of the CRQ is presented in Appendix F – Cultural Relevance Questionnaire, with permission from the authors. The CRQ also contains a section dedicated to the evaluation of each intervention module, or session of the intervention. This part of the CRQ was therefore divided into each of the five sessions of PM+ and these were independently evaluated according to content, case examples, and exercises.

5.3 Results and Discussion

What follows are the results of a systematic process for culturally adapting a low-intensity psychological interventions in humanitarian settings, described across four specific steps, and how applying these steps ultimately resulted in the cultural adaptation of PM+ for use among Venezuelans migrants and refugees and Colombian IDPs.

5.3.1 Step 1: Information Gathering

Step 1 yielded practical information on the social and cultural context, including key barriers to access to mental health for Venezuelans and Colombian IDPs. Importantly,

the information gathering stage elucidated how socioeconomic aspects, access to mental health, and psychosocial support differed across these two population groups. Of note, although some of these findings of the information gatherings step were previously introduced in Chapter 2 in greater detail, they are summarised below to illustrate the four-step process of cultural adaptation presented as part of this chapter.

5.3.1.1 Socioeconomic Aspects

Demographic data showed that approximately 33% of Colombian IDPs were children and young adults, with the majority not able to return to school following displacement (IDMC, 2016). Nearly a quarter (23%) of displaced Colombians had not gone to school (González et al., 2016). Many did not have the education and training necessary for accessing the employment sector and unemployment was much higher among IDPs (76%), in comparison to the national rate of 12% (González et al., 2016). Rates of unemployment and employment in the informal sector were also higher among IDPs, which translates into economic instability and insecurity (Hernández-Bello & Gutiérrez-Bonilla, 2008). In contrast, 65% of Venezuelan migrants had reached secondary education and 29% had a technical or university degree (Federación Colombiana de Gestión Humana, 2018). In addition to violence, sex work, theft, extortion, xenophobia, sleeping on the street, and risk of recruitment by armed groups or the drug trade, working dangerous jobs was a commonly reported threat among Venezuelan migrants and refugees (International Rescue Committee, 2018). A survey recently administered to newly registered Venezuelans suggested that 46.3% of interviewees worked informally (Bahar et al., 2018).

5.3.1.2 Mental Health and Psychosocial Support Context

While several studies reported on the prevalence of mental illness among Colombian IDPs (Castañó-Pérez et al., 2018; Chaskel et al., 2015; Lagos-Gallego, Gutierrez-Segura, Lagos-Grisales, & Rodriguez-Morales, 2017; Shultz, Ceballos, et al., 2014; Shultz, García, et al., 2014), information on the mental health of Venezuelan migrants remained largely anecdotal. A 2018 census of Venezuelans without legal residence in Colombia found that

3% of participants self-identified as having a mental health problem (Moreno, 2018). Overall, there was little literature offering explanatory models of mental health and psychosocial problems and help-seeking patterns for both study populations. A study identified domestic violence, unplanned pregnancies and mental health problems as frequently reported problems among displaced Colombians (Hernández-Bello & Gutiérrez-Bonilla, 2008). Drug addiction, domestic violence and mental health problems, including suicide attempts, were perceived as prevalent issues among young displaced women and men (Hernández-Bello & Gutiérrez-Bonilla, 2008). A study of 677 adults exposed to the armed conflict (including IDPs) on coping strategies found religion to be one of the most common used coping strategies among this population, together with “waiting for things to be fixed on their own” (Hewitt-Ramirez et al., 2016). This same study found that adults exposed to the armed conflict were more likely to report religion as a coping strategy compared to other Colombians (Hewitt-Ramirez et al., 2016). Conversely, qualitative research among women affected by the armed conflict (including IDPs) identified religion as an avoidance strategy (Arnosó-Martínez, Cárdenas-Castro, Beristain, & Alfonso, 2017).

5.3.1.3 Barriers to Accessing Mental Health Care

Both Venezuelan migrants and refugees and IDPs reportedly faced many barriers to accessing mental health care. For IDPs, these barriers include inability to pay for consultations, difficulties caused by bureaucratic requirements, discriminatory treatment and lack of transportation to and from health clinics (Mogollón-Pérez & Vázquez, 2008). Undocumented and unemployed Venezuelan migrants do not have access to the contributory system and therefore cannot access health insurance under the subsidised system (Fernandez-Nino & Bojorquez-Chapela, 2018). Even though Colombian authorities have experience with internal displacement, this large transnational movement of people is reported to have led to major health and social challenges (e.g., difficulties in securing health care funding for migrants, registration of migrants) (Fernandez-Nino & Bojorquez-Chapela, 2018). Their access is thus limited to emergency services and public health interventions offered by non-governmental organisations and

government auxiliaries (Fernandez-Nino & Bojorquez-Chapela, 2018). Among the main reasons given by Venezuelans for requesting temporary transit permits to Colombia were buying medicines and receiving medical care (Ministry of Foreign Affairs of Colombia, 2018).

5.3.2 Step 2: Adaptation Hypotheses

Table 5.2 demonstrates how the eight dimensions of the Ecological Validity Model (Bernal et al., 1995) were elaborated across the components of PM+ for cultural adaptation, as informed by Step 1 of this methodology. The hypotheses described in Table 5.2 were subsequently formulated into open-ended questions for the FGD guide presented in Appendix E – Focus Group Discussion Guide (Phase 2 – Step 3). For example, as discussed in Step 1, low education attainment is a common difficulty among Colombian IDPs leading to the identification of technical terms as part of Step 2. Correspondingly, FGD participants were asked to read the original PM+ protocol before the FGD, asking them to pay attention to the language used in the manual and questions on terminology were probed during local consultation (Step 3). As another example, Step 1 identified the lack of access to health and social services among Venezuelan migrants and refugees. In turn, the FGDs were developed to include a discussion on the services available to this population through government and non-governmental agencies.

DIMENSIONS	ADAPTATION HYPOTHESES
Language	- Language should be simplified to match literacy level of providers and study populations
Persons	- Material's graphics should depict individuals from both populations - Case examples should be adapted to reflect common problems and stressors, reactions and coping strategies among the population, as well as institutions and individuals providing support - Consider culturally appropriate interaction between providers and beneficiaries (e.g., physical contact, ways of addressing each other).
Metaphors	- Identify sayings and metaphors to express distress - Identify somatic expressions of psychological distress
Content	- Identify common and culturally appropriate social support and leisure activities - Consider culturally appropriate ways of discussing sensitive topics (e.g., domestic violence, thoughts of suicide, grief) - Intervention activities are understood and are appropriate in the cultural context
Concepts	- Key concepts (e.g., confidentiality, consent, intervention) and titles are correctly interpreted by both populations - Technical terms (e.g., distress, withdrawal, social isolation) match literacy level
Goals	- Intervention goals match social and cultural values
Methods	- Intervention delivered in a format that is acceptable to populations (e.g., including family, appropriate location, time between sessions) - Instruments are validated with target population and revised by volunteers for comprehension
Context	- Address barriers to participation (e.g., child-care, financial situation) - Address barriers for providers (e.g., time of day of sessions, reaching participant's house) - Consider any issues unique to the populations context (e.g., family separation, migratory status) - Conduct sessions in culturally appropriate locations - Identify culturally and context appropriate referral pathways

Table 5.2. Adaptation hypotheses across the eight dimensions of the EVM

5.3.3 Step 3: Local Consultation

Results from the FGDs showed eight prominent themes for cultural adaptation of PM+ in this context.

Theme 1: Promote social activities that support the community throughout the intervention

FGD questions centred on the types of support, resources and activities and yielded information on the importance of adapting the social activities presented in the PM+ intervention protocol to promote social cohesion and healthy habits within the community. For example, participants identified community members' participation in community service days (e.g., cleaning the streets, opening ditches, changing or adding new pipes) as an important value and local resource. They acknowledged that while displaced Colombians are used to taking part in community work activities, Venezuelans have difficulties getting used to this practice. Participants considered contributing to community work an important factor in Venezuelans' integration and acceptance by the community. Other identified social activities included teaching a skill or craft, such as playing the guitar, a new game or sewing, to children in the neighbourhood or settlements. Participants highlighted the importance of including healthy living activities in the intervention manual (e.g., going to the river to swim during the weekends, going to the open-air gyms to exercise or joining an open-air gym class, dancing). These suggestions were subsequently used to adapt case examples of the behavioural activation strategy ('Get going, keep doing') of PM+ as well as to the list of suggestions used for this strategy (World Health Organization, 2016c, pp. 62-63). Section 3.7 described the different strategies of PM+.

Theme 2: Focus on common problems among Venezuelan migrants and refugees

When asked about common problems faced by both populations, participants highlighted common practical problems among Venezuelan migrants and refugees. These included economic needs, debt, lack of water in the settlements, family separation, overcrowding, threats of being expelled from the settlement if they do not contribute to

the community work, recruitment by armed groups. Participants also reported how migrant children are bullied at school and that they have difficulties adapting to their new lives, as shown in the quote below by a CRC Volunteer: *“I know fitting in has been hard for children... if something gets lost [at school] children would say ‘it was the Venezuelan child’, if there is a Venezuelan child he would be the one to blame”*

These problems were used to reformulate case examples to be used during the training of CRC Volunteers. Table 5.3 shows an example of an original and an adapted case. The original case was adapted based on common characteristics of beneficiaries (e.g., age, family structure, reason for migrating, common problems) that were described by the interviewed staff and volunteers during the consultation in Step 3. Specifically, in this case the age was changed to reflect a younger woman, who had migrated alone and encountered difficulties finding employment upon arrival but needs to send remittances to her family.

Original version	37-year-old woman who witnessed her son killed in a motorbike accident 4 months ago. She is very anxious about the safety of her other children- she does not let them play outside anymore for fear they might be killed. She continues to grieve the loss of his son and finds it difficult to be around her other children because this makes her miss her son and she becomes very upset. When her children misbehave, she gets very angry with them and will tell them that the “good son” died. She feels irritable all the time and is now crying uncontrollably. She is embarrassed about this as it can happen when she is around her friends or at work.
Adapted version	Angela is a 32-year-old woman who arrived from Venezuela three months ago to look for work. She left her two children in Venezuela with her mother because she was worried about bringing them without having a place to stay. She must send them food and other products and she should also pay her rent, but she hasn't found a job. She worries about her children and her mother having difficulties and sometimes she can't sleep through the night. There have been a few days when she feels that her situation is so desperate that she does not want to leave the house.

Table 5.3. Original and adapted versions of a PM+ case example

Theme 3: Include common explanatory models of distress

While participants presented some explanatory models of mental health (e.g., family conflicts, professional challenges, challenges in their daily life), economic problems emerged as the most recurrent explanatory model of distress among IDPs and Venezuelan migrants and refugees, together with the situation of displacement. Participants also highlighted how *'being bored'* is commonly used among Venezuelans and Colombians alike to express withdrawal, and as a common expression of depression in this context. This expression along with the explanatory models of distress were therefore integrated into psychoeducation ('Understanding Adversity') and problem-solving strategies ('Managing Problems') case examples.

Theme 4: Map available social support networks

Participants listed the available support networks and services to both intervention populations (e.g., the CRC Listening Centre, other non-governmental organisations providing material support such as food vouchers or prosthetics and psychosocial support to migrants, refugees and IDPs, the local government entity in charge of protection of human rights). Using this information, a mapping exercise was developed for training volunteers involved in the delivery of PM+. Volunteers were also trained on how to regularly map the services available into a whiteboard, as these services are known to change constantly in humanitarian contexts. This would enable volunteers to better refer beneficiaries to appropriate organisations and services.

It was also found that Venezuelans tend to seek support and protection from other Venezuelans, while Colombians resort to neighbours for sharing their problems or distress. Some social networks were discussed as having negative influences (e.g., drinking every day with friends, joining armed groups). These examples were included in the training of CRC Volunteers for how to respond when beneficiaries propose negative coping strategies for managing their problems.

Theme 5: Change images to show a more realistic picture of the person and include different groups

Participants discussed some of the visual changes required to the images in the PM+ intervention protocol. For example, they argued that more images of men were needed. In addition, participants requested more realistic images. Specifically, they requested that images portray clear and genuine expressions: *“It is important to highlight that the supporting images should not be disfigured or distorted, they should reflect the local context, and consider gender so beneficiaries feel represented in the pictures”*.

Participants also stressed the importance of representing different groups within the images (i.e. young and older adults, people with disabilities, indigenous people and Afro-Colombians). Images were therefore adapted to reflect the suggestions in themes 6 and 7, an example of which is provided in Figure 5.1, below.

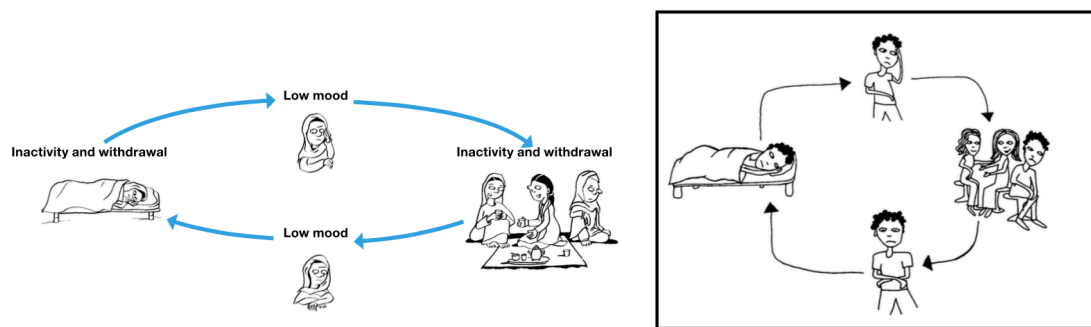


Figure 5.1. Original version of inactivity cycle of the PM+ behavioural activation strategy on the left and adapted version on the right

Theme 6: Consider that community work acts as a source of conflict and distrust

Although no questions directly enquired about the relationship and interactions between Venezuelans and Colombians, participants recurrently talked about difficulties of the integration of Venezuelans and the relations between the two groups. Interviewees, who were all Colombian nationals, described how while Venezuelans were initially met with solidarity, distrust towards Venezuelans had developed, as described by a CRC Volunteer:

There has been a change. At the beginning, Colombians were more sympathetic, they were kinder to the arrival of Venezuelans. However, there were reports of theft and murders of landlords renting to Venezuelans and there's been many examples of these types of situations which have caused distrust and rejection.

Examples of discrimination were also given and it was suggested that Venezuelans must adapt quickly to their new context, as a volunteer said: *"They have had to adapt... and those that cannot, must leave the settlement due to the rules of coexistence of the settlement"*.

Although the Colombian Red Cross branch representative had not received any reports of xenophobia, the interviewees noticed that Venezuelans were now less welcome in the community, and suggested this was due to Venezuelan's lack of familiarity with shared community systems, or what they referred to as 'rules of coexistence'. For example, in most communities, the water bill is shared among the neighbours, which is a system which may be unfamiliar to incoming migrants. Another is that communities hold community work days every 8-15 days.

Despite difficulties, one of the participants talked about how Venezuelans are integrating into the communities. Participants recurrently presented how solidarity is valued by Colombians while Venezuelans were often perceived as rude and lazy, as one volunteer said: *"It also shows that we are from completely different cultures. We come from a culture where, be it good or bad, we have values that have been entrenched through by our families and they are sometimes very rude"*. Based on these findings, I added two exercises on subjectivity and objectivity to the training manual, to ensure that PM+ providers (i.e. CRC Volunteers) put personal values aside when to providing PM+ to Venezuelan migrants and refugee. The exercises consisted of presenting various case examples where the narrator was being subjective or objective. Throughout these exercises the volunteers were asked to differentiate between the cases and discuss how the different ways of presenting the case would affect the interaction between intervention participants and volunteers and the type of care they receive.

Theme 7: Change titles and terminology to match literacy level

Interviewees also proposed a series of changes to the titles of the sessions and strategies in the protocol, with the purpose of facilitating participants', as well as providers' understanding. For example, the word 'adversity' in title of the psychoeducation component 'Understanding adversity' and throughout the PM+ protocol was changed for 'difficulties', to facilitate understanding. Likewise, the title of the intervention (i.e. Problem Management Plus) was changed to 'Managing your problems' ('Manejando tus problemas'). This was done to emphasise on the ownership beneficiaries have of their problems, to make sure volunteers remember that the problems discussed during the session are the beneficiary's own difficulties, and in this way, prevent volunteer burnout. Finally, the language used in the intervention protocol was considered too difficult for some volunteers, many of whom come from diverse professional and educational backgrounds (e.g., economist, farmer, nurse, engineer). Based on their suggestions, the protocol was revised to ensure it matched the literacy level of all volunteers. Some examples of the suggested changes were replacing the words 'session' with 'meeting', 'questionnaire' with 'form', 'strategy' with 'tool'.

Theme 8: Integrate good practices for volunteers' relations with participants

A series of recommendations were made to improve the quality of the delivery of PM+. These recommendations were therefore added as an exercise to the PM+ training manual. Recommendations for improving the quality of service delivery included instructing lay providers on how to maintain a professional relationship (e.g., calling beneficiaries by their names, avoiding nicknames, ways of facing beneficiaries during sessions, not sharing their personal phone number with beneficiaries). In addition, for security reasons, it emerged that PM+ providers should go to the settlements in teams and to the PM+ sessions with a second volunteer. This was seen as a method to also contribute to peer support and supervision within the implementation. This model would also allow for child-care in the instance when a parent was attending a PM+ session, such that the second volunteer could care for the children.

5.3.4 Step 4: External Evaluations

Across the categories, the cultural adaptation was scored as average to good (3.5 out of 5). Similarly, the adaptation across sessions was also considered average to good (3.5 out of 5), with the first session of PM+ scoring the lowest and the third and fourth session scoring the highest. While mean scores are indicative of satisfactory cultural adaptation, the CRQ, more importantly, led to additional recommendations for the cultural adaptation of PM+ for use in this context.

A suggestion was made to include real-life case studies of persons from the study populations containing commonly used cultural expressions when presenting the problem management strategy. Adding real-life case examples was seen as a way to contribute to the cultural sensitivity of the protocol and to the work of providers. It was also suggested to add more examples to the protocol's session 2 to improve providers' understanding of the strategies presented. It was also found that some literal translations of the content from English, the original language of the protocol, were incorrect, and recommendations were made for revisions of specific parts of the protocol. One of the reviewers highlighted the possibility that beneficiaries with lower levels of education might have some difficulties understanding certain concepts. Conversely, another reviewer argued that most concepts would be understood by Venezuelans and Colombians alike but some national and regional cultural idioms might emerge during the sessions. Accordingly, it was suggested to recruit Venezuelan as volunteers so they can discern these cultural concepts.

One reviewer emphasised the importance of referring to women and men throughout all examples. This would be particularly important in the section describing sexual violence which presents the example of a woman, but which should also consider the perspective and circumstances of males. Another suggestion was to include more examples of the problem of discrimination towards migrants. Images were considered too general by one of the reviewers, who thought they did not reflect the specific characteristics of displaced Colombians. A final suggestion was to include additional culturally relevant activities in the description of the behavioural activation strategy

such as cooking and preparing typical food (e.g., *hayacas* and *tamales*) as well as listening or dancing to popular songs (e.g. vallenato) to break the inactivity cycle.

The adaptations to the PM+ manuals made throughout the four-step process presented in this Chapter were used in the implementation of PM+ for Venezuelan migrants and refugees in Saravena. While this process is systematic, it is also meant to be simple. Although a qualitative analysis software was used to analyse the outcomes of the local consultations, the steps for thematic analysis can be followed manually using structured notes instead of transcripts and highlighters or coloured pens. Another positive characteristic of this process is that, although it is presented as a stepped model, it can also be understood as an iterative process, as social and cultural constructs and understanding constantly evolve. Thus, when the emergency recedes it can be reapplied to consider new literature as well as the experience gained by implementers through their work with these populations. In contrast with other models introduced in section 2.6.2 (i.e. HF, CSF and EVM) this process presented in this chapter outlines specific steps that can be taken to adapt low-intensity psychological interventions. In contrast with the DIME methodology, this process was originally developed to be used for cultural adaptation. In addition, the DIME methodology is time and labour intensive, requires multiple people, and can take up to 8-10 months to complete. The process outlined in this chapter is a practical method, that retains a systematic approach and can therefore be used in time-constrained and fast-paced contexts of humanitarian emergencies settings.

Humanitarian practitioners support persons from a wide variety of cultural backgrounds and are often ‘outsiders’ to these social and cultural groups. As such, MHPSS humanitarian programming has been previously criticised for its lack of cultural sensitivity (Tol et al., 2018). Within humanitarian settings, working with vulnerable populations, limited funding and human resources, poor security and logistics, limit the capacity of programmers to culturally adapt interventions (Ager et al., 2014). As a result, and contrary to the agreed upon minimum guidelines on mental health and psychosocial support (MHPSS) in emergency settings, programme implementers often overlook

cultural adaptation as a critical step in the implementation of MHPSS programming (Inter-Agency Standing Committee, 2007). This chapter contributes towards bridging this gap by proposing and applying a four-step process for culturally adapting low-intensity psychological interventions for use in humanitarian contexts.

Chapter 6: Process Evaluation

This chapter is concerned with evaluating the implementation of the culturally-adapted version of Problem Management Plus (PM+), derived from the results of Chapter 5 and subsequently delivered to Venezuelan migrants and refugees in Saravena, Colombia. As presented in Chapter 3, Proctor et al. (2011)'s taxonomy of implementation guided this evaluation whereby, implementation success is gauged as an outcome of: (1) intervention effectiveness and (2) implementation outcomes (e.g., acceptability, adoption, appropriateness, feasibility, fidelity, implementation costs, and sustainability). This chapter employs this taxonomy to evaluate the implementation of the culturally-adapted version of PM+, thereby addressing the fourth and fifth research questions of this study. The content of the intervention under study (i.e. PM+), the rationale for its implementation as well as the study setting are presented in detail in Chapter 3.

6.1 Methods

A mixed-methods design was adopted to address two related objectives of this research study. Firstly, I aimed to determine whether the implementation of the culturally adapted version of PM+ is associated with reduced psychological distress among Venezuelan migrants and refugees in the Colombian context. An operational phased-in quasi-experimental design was employed to address this objective. Primary outcomes were changes in subjective wellbeing and anxiety. Quality of life and changes in problems for which the person sought help (measured by the Psychological Outcomes Profile Instrument) were secondary outcomes. Second, to identify the context-specific factors influencing the implementation of PM+ for Venezuelan migrants and refugees in Colombia. A qualitative process evaluation consisting of semi-structured interviews and focus group discussions with the participants as well as PM+ supervisors and volunteers was conducted. Although these two objectives are closely related and both enabled the evaluation of PM+, the methods and results of the operational phased-in quasi-

experimental study are presented as ‘Step 1’ and the methods and results of the qualitative process evaluation are presented as ‘Step 2’, in order to facilitate the readers’ navigation of this chapter. The findings of both steps are then discussed together in the discussion section of this chapter.

6.1.1 Participants and Procedures

6.1.1.1 Step 1: Operational Phased-in Quasi-Experimental Study

Intervention participants were eligible to participate in the study if they were above the age of 18, were Venezuelan migrants, refugees or Colombian returnees, planned to stay in Saravena for at least six months and scored less than or equal to 74, but more than 28, in the screening tool (i.e. WHO-5). Beneficiaries who scored less than or equal to 28 on the WHO-5 or reported thoughts of suicide were excluded from the study and were instead referred to specialised services provided by two INGOs operating in Saravena (i.e. Doctors without Borders or the International Committee of the Red Cross). Ultimately, no persons were referred to specialised services due to suicidal ideation. Demographic data collected through this study included age, sex, level of education, nationality and reason(s) for migrating.

The decision to provide PM+ specifically to Venezuelan migrants and refugees was made by the Colombian Red Cross’ Health Department, based on this populations’ level of marginalisation from mental health and social services. Intervention participants were recruited by the Psychosocial Support team of the Colombian Red Cross’s unit in Saravena via community meetings and CRC programmes. During the community meetings, the Psychosocial Support team provided information about psychosocial support services provided through the Colombian Red Cross, including PM+. Similarly, beneficiaries were told about the possibility of receiving PM+ when they were taking part in other CRC programmes, such as the Listening Centre –an office within the Colombian Red Cross local unit in Saravena where community members go to find out how to access local services–, family reunification and food distribution services. If participants were interested in receiving PM+ they were screened by the volunteers and

if they met the inclusion criteria, they were invited to participate in the study. To address literacy difficulties identified through the cultural adaptation process, Colombian Red Cross volunteers read out loud the consent forms and requested consent.

Data was collected between January 13th, 2019 and October 10th, 2019 at the offices of the Colombian Red Cross in Saravena and/or at the participants' homes. The PM+ sessions were conducted either at the offices of the Colombian Red Cross in Saravena and/or at the participants' homes to accommodate to participants' schedules and need to care for children at home. Although PM+ is meant to be delivered on a weekly basis, restrictions on the mobility of volunteers due to security concerns meant that several sessions had to be postponed to the following week. The small number of PM+ providers further limited the number of participants that could simultaneously receive PM+. Accordingly, group one underwent the first and final assessments and the waitlisted group (i.e. group two) responded to the initial questionnaire twice and once to the final questionnaire, as presented in Figure 6.1. Intervention participants were randomised into the two groups through a random number generation table.

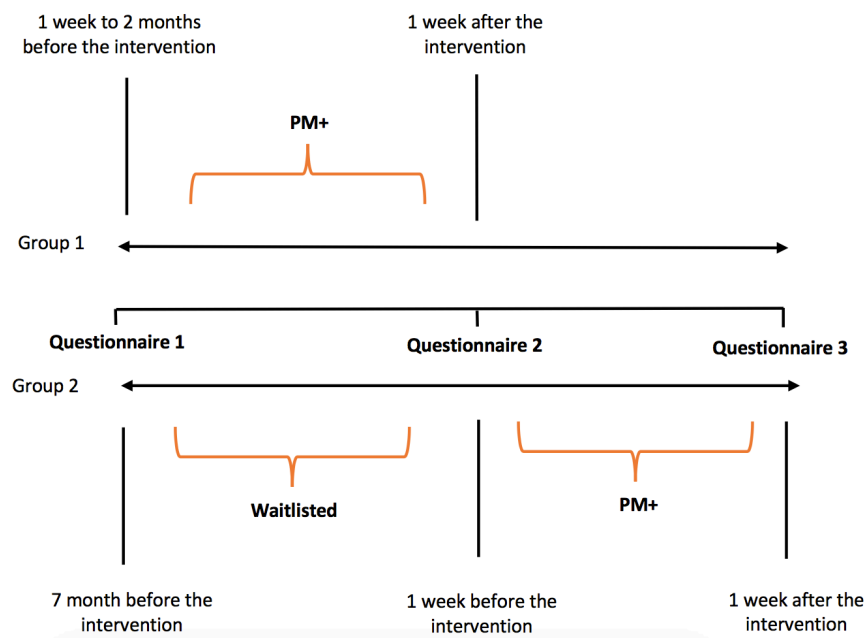


Figure 6.1. Phased-in process for quasi-experimental study of Problem Management Plus

Problem Management Plus Trainings

In July 2018, two Colombian Red Cross volunteers and two supervisors were trained over the course of a four-day training to deliver PM+. Ahlem Cheffi, a specialist technical advisor from the IFRC Reference Centre for Psychosocial Support and I conducted the training. Both Ahlem and I had been previously trained in PM+ and Ahlem had experience implementing PM+ through various INGOs in the Middle East. Due to security concerns, the volunteers flew from Saravena to Bogota to attend the training. Following the adaptation process described in Chapter 5, one of the supervisors and I trained a group of nine Colombian Red Cross volunteers in a second four-day training, held in November 2018 in Saravena. During this training, all CRC volunteers were trained as data collectors. Of the total 11 trained volunteers, only four went on to provide PM+ between May and October 2019. Out of the four volunteers who provided PM+, one volunteer provided supervision to the team and another volunteer supported the coordination. A lead supervisor from the CRC's Health Department, based in Bogota, provided additional technical support. Both the lead supervisor and supervisor are psychologists and could provide additional support if participants became distressed.

Study Tools

The first questionnaire of this study consisted of 48 questions, 10 of which were demographic questions, the second and third questionnaires consisted of 38 questions. As part of PM+, the Psychological Outcome Profiles (PSYCHLOPS), a short measure assessment of self-identified problems and how they are affecting participants is collected at the beginning of every PM+ session. The outcomes and measures used in this study (i.e. WHO-5, GAD-7, WHOQOL-BREF and PSYCHOLOPS) are described below. The included scales were administered in interview format across all study participants by the Colombian Red Cross volunteers, rather than independently completed by participants as originally designed. This decision allowed for the inclusion of respondents with low levels of literacy.

Primary Outcomes

Subjective Wellbeing

The World Health Organization Five Wellbeing Index (WHO-5), a widely used short measure of subjective wellbeing, was used as a primary outcome measure and as screening tool for depression. The scale was selected for its demonstrated adequate cross-cultural validity as a screening tool for depression, one of the common mental health problems PM+ aims to address. In addition, the WHO-5 has shown adequate validity as an outcome measure in clinical trials and has been applied successfully across a wide range of study fields (Topp, Ostergaard, Sondergaard, & Bech, 2015). The WHO-5 was also selected for its straightforward and simple language that does not seem to transgress cultural norms, as well as its availability in Spanish (Topp et al., 2015). A systematic review of the construct validity of the WHO-5 found that the five items constitute a unidimensional scale, whereby each item contributes unique information regarding the respondent's level of wellbeing (Topp et al., 2015). The clinical validity of the WHO-5 was confirmed by Hall, Krahn, Horner-Johnson, and Lamb (2011) to be very high and at the top of 85 reviewed scales. The WHO-5 has been validated in Spanish among older adults (Cronbach's $\alpha = 0.86$) and patients with bipolar disorder (Cronbach's $\alpha = 0.83$, Pearson correlation coefficient $r = 0.83$) and in Colombia among adolescents (Cronbach's $\alpha = 0.67$, Pearson correlation coefficient $r = 0.612$), indicating acceptable internal consistency and test-retest reliability (Bonnin et al., 2018; Campo-Arias, Miranda-Tapia, Cogollo, & Herazo, 2015; Lucas-Carrasco, 2012a). In this study, internal consistency for WHO-5 was acceptable (Cronbach $\alpha = 0.69$).

The WHO-5 items are: (1) 'I have felt cheerful and in good spirits', (2) 'I have felt calm and relaxed', (3) 'I have felt active and vigorous', (4) 'I woke up feeling fresh and rested' and (5) 'My daily life has been filled with things that interest me'. Respondents are asked to rate how well each of the five statements applies to them, when considering the last two weeks (Topp et al., 2015). Each of the five items is scored on a six-point Likert Scale, ranging from None of the Time (= 0) and All of the Time (= 5). The raw score

therefore theoretically ranges from 0 (absence of wellbeing) to 25 (maximal wellbeing), with the final score presented as a percentage scale from 0 (absence) to 100 (maximal) (Topp et al., 2015). The following cut-off points were used, based on the recommendations by Topp et al. (2015): 74-51 is indicative of having some psychosocial problems; 29-50 indicates mild depressive symptoms; and a score of ≤ 28 indicating major depressive symptoms (Topp et al., 2015).

Anxiety

Consistent with the trans-diagnostic nature of PM+, the Generalised Anxiety Disorder-7 Questionnaire (GAD-7) was also included as a primary outcome measure. The GAD-7 was selected given that it is a brief tool with demonstrated validity to identify probable cases of Generalised Anxiety Disorder in a primary care setting (Cronbach $\alpha = 0.92$) (Plummer, Manea, Trepel, & McMillan, 2016; Spitzer, Kroenke, Williams, & Löwe, 2006). The GAD-7 in Spanish has shown good internal consistency (Cronbach $\alpha = 0.93$; 0.83) (Garcia-Campayo et al., 2010; Munoz-Navarro et al., 2017). Garcia-Campayo et al. (2010) found that the Spanish version of GAD-7 showed excellent psychometric properties. That is, all items of the scale measure the same concept and in the same direction, the construct assessed by the GAD-7 is distinguishable from depression-related symptoms and the scale correlates well with other scales assessing anxiety (e.g., HAM-A, HADS) (Garcia-Campayo et al., 2010). In addition, Munoz-Navarro et al. (2017) also found that the GAD-7 in Spanish offered strong ecological validity in primary health centres, indicating that it can be generalised to real-life settings. No studies to date have confirmed the validity of the GAD-7 among Colombian or Venezuelan samples. In this sample, the internal consistency was high (Cronbach $\alpha = 0.83$), indicating reliability among this sample.

The GAD-7 asks respondents, how often, during the last two weeks, were they bothered by the following problems: (1) feeling nervous, anxious, or on edge; (2) not being able to stop or control worrying; (3) worrying too much about different things; (4) trouble relaxing; (5) being so restless that it's hard to sit still; (6) becoming easily annoyed

or irritable; (7) feeling afraid as if something awful might happen (Spitzer et al., 2006). Each of the seven items is scored using a five-point Likert Scale, ranging from Not at All (=0) to Nearly Every Day (= 4). Raw scores therefore range from zero to 21. According to Spitzer et al. (2006), a score of 10 or greater on the GAD-7 represents a reasonable cut-off point for identifying cases of GAD. Cut points of 5, 10, and 15 are interpreted as mild, moderate, and severe levels of anxiety, respectively (Spitzer et al., 2006).

Secondary Outcomes

Impact of Self-Identified Problems

The Psychological Outcome Profiles Questionnaire (PSYCHLOPS) consists of four questions covering three domains: problems (two question), function (one question) and wellbeing (one question). The first question asks: 'Choose the problem that troubles you most. Please write it in the box below'. Having described the problem, the respondent is invited to score it on a six-point score ranging from 'not at all affected' to 'severely affected'. The duration of the problem is also elicited: 'How long ago were you first concern about this problem?'. Next, the questionnaire asks for a description and scoring of another problem that is troubling the respondent, as well as the duration of the problem. This is followed by a description and scoring of any consequent functional impairment: 'Choose one thing that is hard to do because of your problem'. Finally, the respondent is asked to score their wellbeing ('How have you felt this last week?') using a six-point score, ranging from Very Good (=0) to Very Bad (=5) (Ashworth, Robinson, Godfrey, Shepherd, et al., 2005).

The PSYCHLOPS is administered at the beginning of every PM+ session and is used to help providers start a conversation about the problems experienced by participants. When used as an evaluation or study tool, responses to the questionnaires of the first and last session are compared to determine change. Accordingly, the last questionnaire is like the first questionnaire but refers to the problems and functional impairment identified by the participants in the first questionnaire (e.g. This is the problem you said troubled you the most when we first asked, how much has it affected you over the last week?') (Ashworth, Robinson, Godfrey, Shepherd, et al., 2005). A study

on the psychometric properties of PSYCHLOPS in English indicates that the patient-centred measure has strong internal consistency pre-intervention (Cronbach α = 0.79) and at the last session (Cronbach α = 0.87). PSYCHLOPS was also found acceptable to use as a standardised form of measurement by therapists and clients from the United Kingdom (Ashworth, Robinson, Godfrey, Parmentier, et al., 2005). No studies to date have assessed the PSYCHLOPS in Spanish.

As described above, PSYCHLOPS is based on items (issues) selected by patients, rather than on a list of pre-specified items. It therefore gives participants the opportunity to identify problems they wish to address and discuss during the session. PSYCHLOPS' focus on the person's problems means that the questionnaire lends itself to the problem-solving elements of PM+ (Harper Shehadeh et al., 2019). Moreover, the emphasis on the individual's perspective captures concerns of greatest personal salience, deemed particularly important among people affected by adversity, rather than relying solely on an external frame of reference to interpret one's psychological distress and recovery. The free-text responses of PSYCHLOPS act as a starting point to the sessions and provide a source of material for qualitative analysis (Ashworth, 2007). Indeed, the qualitative responses of PSYCHLOPS were also integrated into this study to gain a better understanding of the types of problems participants sought to address during PM+.

Quality of Life

The abbreviated WHO Quality of Life measure (WHOQOL-BREF), was included in the evaluation of PM+ as a secondary outcome measure. It was included to test the hypothesis that interventions, such as PM+, which focus on self-identified practical problems (e.g., unemployment, interpersonal conflict), may impact quality of life as described in the literature (Bakas et al., 2012). This is appropriate considering that most of the evidence on interventions for forcibly displaced populations evaluates the effect of these interventions on depression, anxiety and PTSD and less attention has been paid to whether they improve functioning and mental health (Foka et al., 2020). Developed for use in situations where time is limited, the short version of the WHOQOL, the WHOQOL-BREF, contains 24 questions covering four domains (i.e. physical,

psychological, social relationships and environment) (World Health Organization, 1996). Items under each domain include questions such as: Physical, 'How well are you able to get around?' and 'How satisfied are you with your sleep?'; Psychological, 'To what extent do you feel life to be meaningful?' and 'How well are you able to concentrate?'; Social Relationships, 'How satisfied are you with your personal relationships?' and 'How satisfied are you with the support you get from your friends?'; Environmental, 'How safe do you feel in your daily life?' and 'How healthy is your physical environment?' (World Health Organization, 1996). The WHOQOL-BREF was developed in response to increasing demand for a quality of life assessment that could be applied cross-culturally, while also offering a holistic measure of health and wellbeing (World Health Organization, 1996). Raw scores vary across each domain and are scored on a five-point Likert scale, with a final score presented as a percentage ranging from 0 (absence of quality of life) to 100 (maximal quality of life).

The Spanish version of WHOQOL-BREF has been validated in numerous studies in Spain and Latin America, showing satisfactory psychometric properties in the form of acceptability, internal consistency (i.e. Cronbach α 's ranged from 0.74 for the psychological domain to 0.80 for the physical domain) (Lucas-Carrasco, 2012b), evidence convergence, and discriminant validity (Benitez-Borrego, Guardia-Olmos, & Urzua-Morales, 2014; Espinoza, Osorio, Torrejón, Lucas-Carrasco, & Bunout, 2011). Though moderately positively correlated, the WHO-5 and WHOQOL-BREF have been found to measure different concepts (i.e. subjective wellbeing and multi-dimensional concept of quality of life) (Lucas-Carrasco, 2012a; Lucas-Carrasco, 2012b). An analysis of the factorial validity of the Spanish version of WHOQOL-BREF from several Spanish-speaking countries found that the WHOQOL-BREF is best modelled as the four-factor solution proposed by the classical theoretical model (Benitez-Borrego et al., 2014). In this study, the internal consistency was acceptable for the WHOQOL-BREF Physical (Cronbach $\alpha = 0.88$); WHOQOL-BREF Psychological (Cronbach $\alpha = 0.65$) and WHOQOL-BREF Environmental (Cronbach $\alpha = 0.73$), but not for WHOQOL-BREF

Social Relationships (Cronbach $\alpha = 0.29$), possibly due to this domain consisting of only three items (Bland & Altman, 1997).

Piloting the Questionnaires

Initially, and consistent with the suggestions of the PM+ manual, the General Health Questionnaire-12 and the WHODAS 2.0 were selected as tools for measuring the association of the implementation of PM+ and changes in psychological distress and functioning in this setting (World Health Organization, 2016c). Consistent with cultural adaptation principles, these scales were revised internally by CRC staff and volunteers who suggested substantial changes to the GHQ-12 and WHODAS to enable beneficiaries' understanding. Accordingly, the decision was made to replace these two scales with the WHO-5, GAD-7 and WHOQOL-BREF, for their simple language and robust evidence of their validity and reliability across multiple settings. During internal revisions, the CRC staff and volunteers further recommended including pictures in addition to the written statements, to enable participants' understanding of the scales. Figure 6.2 shows an example of the visual cues used for the WHO-5.

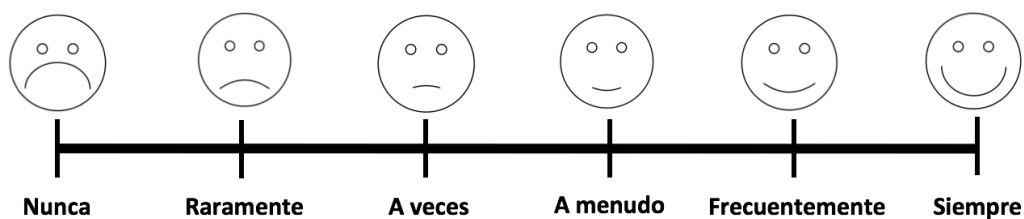


Figure 6.2. Likert scale and visual cues used for the WHO-5

The new scales were revised internally by CRC staff who then pilot tested them with a sample of 10 Venezuelan migrants and refugees attending other services of the Colombian Red Cross in Saravena. CRC volunteers were asked to note the difficulties respondents had when answering the questionnaire and to ask specifically whether there were any questions they did not understand or were confusing or difficult to answer. The results of the pilot were discussed internally in the Psychosocial Support team and shared with me. This pilot test yielded a minor change to item 6 of GAD-7 and

additional changes in eight items of the WHOQOL-BREF, which are presented in Appendix G – Changes to Scales.

6.1.1.2 Step 2: Qualitative Process Evaluation

Five CRC staff and volunteers involved in the implementation of PM+ and five intervention participants who completed PM+ participated in the qualitative process evaluation. I conducted the interviews and focus group discussions, with a view to addressing the fifth objective of the study: Identify the context-specific factors influencing the implementation for Problem Management Plus for Venezuelan migrants and refugees in Colombia. Due to security concerns, the PM+ supervisor and volunteers travelled from Saravena to Bogota to attend the interviews and focus group discussions. The PM+ supervisor and lead supervisor were interviewed individually for their perspectives, without the influence of any other members of the team. Both of the latter interviews lasted approximately 80 minutes. Examples of questions asked of the lead supervisor were: *“How do you think this type of intervention aligns with the plans for the RC’s Psychosocial Support Groups?”* and *“How would it be to implement PM+ in other branches or Psychosocial Groups of the Red Cross?”* Examples of questions asked of supervisor were: *“Can you talk to me about challenges the volunteers faced and how were they managed?”* and *“What should others look for when identifying volunteers for the delivery of PM+?”*. The volunteers were interviewed in a focus group discussion, which allowed volunteers to reflect on the topics being discussed and the researcher to understand the different collective or individual perspectives of the implementation. The focus group discussion lasted two hours and included questions such as *“In your opinion, how did the community perceive the work you were doing with each participant?”* and *“How were you supported throughout the delivery of PM+?”* Lastly, two focus group discussions were conducted with the entire PM+ team to gather their opinion on the implementation process. These discussions lasted approximately 50 minutes, one was conducted before all other interviews and focus group discussions and another one was conducted after to collect any last thoughts and reflections. They included questions such as: *“How does this*

intervention align (or not) with the needs of the population?” and “Is there something we have not discussed that you would like to talk about?”.

Due to security concerns, PM+ participants were interviewed over the phone. The author interviewed five PM+ participants individually, with each interview lasting approximately 30 minutes. Examples of questions included in the individual interview guide were *“How was attending the session (e.g., time, place)? Did you face any inconveniences?”* and *“What are some things that the volunteer did during the sessions that you found useful?”*. The FGDs and semi-structured interviews in English and Spanish are presented in Appendix H – Focus Group Discussion and Interview Guides (Phase 3 – Step 2). Of note, interviews were initially planned with participants who were lost-to-follow and volunteers who participated in the trainings but did not provide PM+. Unfortunately, challenges in reaching them meant that these interviews could not be conducted.

6.1.2 Data Analysis

6.1.2.1 Step 1: Operational Phased-in Quasi-Experimental Study

To index the relative effects of the intervention and waitlisted groups, univariate analyses of co-variance (ANCOVAs) of completed cases (CC) for each of the three sets of continuous measures as dependent variables (WHO-5, GAD-7 and WHOQOL-BREF Domains), including baseline scores as covariates, were performed; group membership (intervention/ control) was the independent variable. Significant differences on scores at baseline and key demographic variables were tested using an independent sample t-test. The main demographic variables of this study (i.e. age, sex and level of education) were also introduced as covariates, in the instance where they were found to have significant effect on the outcome measures. Effect sizes were calculated between both groups post-intervention and between group one at post-intervention and group two at second questionnaire (Figure 6.1). Cohen’s *d* effect sizes were calculated to account for the difference across group sample sizes, computed by calculating the mean difference between the questionnaires of group one post-intervention and questionnaires of group

two at waitlist and at post-intervention and dividing this by the pooled standard deviation (Cohen, 1988). Following Cohen (1988) suggestion, I interpreted d as: small (0.2), medium (0.5) and large (0.8). I also derived Hedges' g effect sizes to correct for variations due to small sample sizes. Sample sizes for this quasi-experimental study was not calculated *a priori* but was contingent on the capacity of CRC volunteers to deliver PM+ within the study period. The achieved sample size was judged to be adequate to answer the fourth research question based on a post-hoc power calculation conducted using G*Power, that is with an alpha of 0.05 and an average effect size of 0.54, the achieved power was 0.98.

Scores of the dependent variables at post-intervention were not normally distributed. With large enough sample sizes (e.g., > 30), Altman and Bland (1995) make the case that the sample distribution of the mean can be assumed to be normal. In the case of scores at waitlist of group two, the sample was below 30, but was normally distributed across all outcome variables. Parametric tests were therefore carried out (Heinzen & Nolan, 2016). ANCOVA was used to answer the research question, by determining whether there was a difference between both groups when removing the effects of the covariates (i.e. sex, age, level of education, baseline scores). In other words, an ANCOVA was used to answer: Are the mean differences in the study outcomes associated with group allocation after adjusting for differences in sex, age, level of education and baseline scores? Data analyses were performed using the IBM SPSS software (Version 25).

Although the percentage of missing data was low (6.4%), in addition to running ANCOVAs for the completed cases, a secondary set of ANCOVAs, based on Intention-to-Treat (ITT) data, were also carried out. Conducting ITT analyses is recommended in the literature as an approach to accounting for treatment non-compliance and/or missing data (Gupta, 2011). Multiple imputation was used for the ITT analysis, as a recognised strategy for handling missing data (Sterne et al., 2009). Multiple imputation runs simulations relative to the data that is available to replace the missing values with those most likely to occur (TheRMUoHP Biostatistics Resource Channel, 2013). The first

step of multiple imputation consists of determining whether there are patterns across variables. Finding that the data is missing at random minimises the chance of bias and implies that no question(s) have systematically been skipped by study participants. This assumption is required for conducting the multiple imputation. The second step consists of inputting the missing values by producing a series of iterations based on patterns within the available data. After producing the iterations, the software programme makes a probability judgement as to what the missing data would likely be. The missing values are then replaced with the imputed values to create a full dataset that is then used for the ITT analysis.

6.1.2.2 Step 2: Qualitative Process Evaluation

Interviews and FGDs were conducted in Spanish, transcribed *verbatim* and analysed thematically in Spanish following a six-phase approach outlined by Braun and Clarke (2006) in NVivo (Version 11). A selection of quotes were translated to support the results presented in this chapter. As outlined in Chapter 5, thematic analysis is a qualitative research method that can be used across a wide range of epistemological and research questions (Nowell, Norris, White, & Moules, 2017). This theoretical freedom makes it a flexible approach that adapts to the characteristics of different studies, while still providing a rich and complex account of the data (Braun & Clarke, 2006; Nowell et al., 2017). In addition, thematic analysis equips the researcher with a set of tools for a well-structured approach to handling data (King, 2004; Nowell et al., 2017). The data was analysed inductively to allow themes to be formed outside a specific framework.

The process of thematic analysis begins with familiarisation with the data, a phase that is common to all forms of qualitative analysis and that involves immersing oneself in the data by listening to the data recordings, transcribing the data, and the rereading of textual data (Braun & Clarke, 2012). This phase also entails note-taking which helps in gaining an analytical and critical view of the data (Braun & Clarke, 2012). Phase two of thematic analysis consists of the systematic analysis of the data through coding. Codes identify and provide a label for a feature of the data that is potentially relevant to the research question (i.e. What are the perceived factors influencing the

implementation of PM+ for Venezuelan migrants and refugees?). Codes can be either descriptive or interpretative and some can illustrate the participants' language or concepts or the researcher's conceptual or theoretical frameworks. Coding is a preliminary analytical step. As Braun and Clarke (2012) argue, "codes are succinct and work as shorthand for something you, the analyst, understands; they do not have to be fully worked-up explanations—those come later" (Braun & Clarke, 2012, p. 61). What matters at this point is therefore that coding is inclusive, systematic and relevant to answering the research question (Braun & Clarke, 2012).

The third phase of thematic analysis is known as 'searching for themes'. A theme "captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). The objective of this phase is to identify any broad topics around which the codes cluster. This phase was used to explore the relationship across themes and explore how the identified themes provide an overall picture or reflection of the data (Braun & Clarke, 2006). The following phase, termed 'reviewing potential themes' is described as a quality check to see if the themes match the collated excerpts of data; discards or relocates codes accordingly; collapses or splits themes if necessary; or relocates themes as sub-themes in case there are two or more overarching patterns within a theme. This fourth phase also involves a last reread of all the data to make sure the identified themes capture the entire data set (Braun & Clarke, 2012).

In the fifth phase of thematic analysis, known as 'defining and naming themes', the analyst makes sure each theme has a clear focus, scope and purpose. During this phase, relevant, vivid and compelling extracts that illustrate the themes are selected. In addition, the fifth phase is characterised by the analyst revising each theme's name to make sure they are concise, informative and appealing (Braun & Clarke, 2012). Lastly, the sixth phase of thematic analysis consists of producing a report that presents the themes in a logical and meaningful way and identifies connections with existing research. Notably, although Braun and Clarke (2006) present the six-phased process of thematic analysis as a linear method, they as well as Nowell et al. (2017), emphasised the

iterative and reflective nature of this method which develops over time and involves moving back and forward between phases.

6.2 Results

6.3 Step 1: Operational Phased-in Quasi-Experimental Study

A total of 110 Colombian Red Cross beneficiaries were screened by the Colombian Red Cross Psychosocial Support team in Saravena (Figure 6.3). Of these, 13 were referred to specialised mental health services and 79 were included in the study and randomised into two groups. Four participants were lost-to-follow up and three were excluded from the analysis due to high WHO-5 scores (i.e. $\text{WHO-5} > 74$).

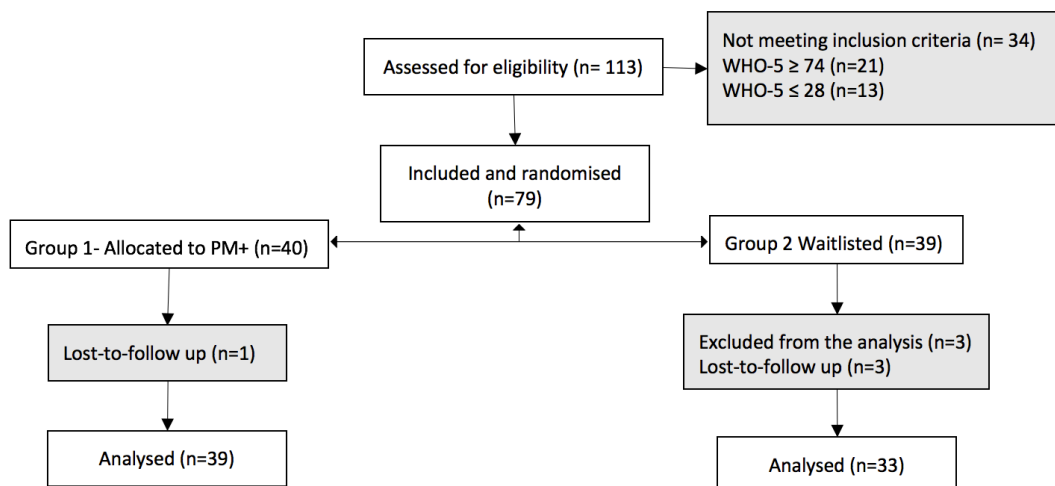


Figure 6.3. Participant Flow Chart

The study had a low participant drop-out rate (5.3%). Table 6.1 summarises the demographic characteristics of participants, including type of self-identified problems identified through PSYCHLOPS, and reason(s) for migrating. Mean age of participants was 34.4 year (SD=9.6), the average number of years of spent in education was 7.5 (SD=3.3), the majority had some primary education, and 63.9% of the sample was male. The most common reason for migrating across both groups were uncertainty and food insecurity. The most frequently reported problems to be addressed in PM+ were economic (e.g., unemployment, debts, food insecurity), followed by psychological or

somatic (e.g., stress, worry, sleep problems), interpersonal (e.g., problems with children or partners, lack of social support), physical (e.g., illness, physical pain) and security-related (e.g., generalised violence, theft).

Characteristic or Problem	Group 1 (<i>n</i> =39)	Group 2 (<i>n</i> =33)	Total (<i>n</i> =72)
Age in years, mean (SD)	30.21 (6.68)	39.30 (10.27)	34.38 (9.61)
Education in years, mean (SD)	8.26 (3.08)	6.52 (3.33)	7.46 (3.29)
Sex, <i>n</i> (%)			
Female	19 (48.7)	7 (21.2)	26 (36.1)
Male	20 (51.3)	26 (78.8)	46 (63.9)
Nationality, <i>n</i> (%)			
Venezuelan	35 (89.7)	26 (78.8)	61 (84.7)
Colombian returnees	4 (10.3)	7 (21.2)	11 (15.3)
Reason for migrating, <i>n</i> (%)			
Uncertainty	20 (51.3)	15 (45.4)	35 (48.6)
Food insecurity	15 (38.5)	14 (42.4)	29 (40.3)
No medical treatment	14 (35.9)	3 (9.1)	17 (23.6)
Insecurity	6 (15.4)	10 (30.3)	16 (22.2)
Stress	4 (10.3)	5 (15.2)	9 (12.5)
Other	2 (5.1)	3 (9.1)	5 (6.9)
Self-identified problems, <i>n</i> (%)			
Economic	28 (71.8)	24 (72.7)	52 (72)
Psychological	20 (51.3)	17 (51.5)	37 (51)
Interpersonal	13 (33.3)	15 (45.5)	28 (39)
Physical	8 (20.5)	9 (27.3)	17 (24)
Security	4 (10.3)	1 (3)	5 (7)

Table 6.1. Participant demographic characteristics by group

Groups differed significantly at baseline in terms of demographic outcomes, WHO-5, GAD-7, WHOQOL-BREF Social Relationships and WHOQOL-BREF Environment and PSYCHLOPS scores (Table 6.2). These differences were therefore adjusted for in the ANCOVAs.

Outcome measure	Group 1 (n=39)	Group 2 (n=33)	<i>t</i>	<i>df</i>	Cohen' <i>d</i>
Demographic characteristics					
Age in years, mean (SD)	30.21 (6.68)	39.30 (10.27)	-4.5***	70	1
Education in years, mean (SD)	8.26 (3.08)	6.52 (3.33)	2.3*	70	.5
Female, n (%)	19 (48.7)	7 (21.2)	-2.5**	70	.6
Baseline scores, mean (SD)					
WHO-5 (max. 100)	55.59 (11.74)	47.27 (9.72)	3.2**	70	.8
GAD-7 (max. 21)	11.18 (4.19)	9.73 (2.24)	1.8	70	-
WHOQOL-BREF Physical (max. 100)	53.19 (9.53)	50.89 (8.60)	1	70	-
WHOQOL-BREF Psychological (max. 100)	53.39 (15.79)	52.99 (12.08)	.4	70	-
WHOQOL-BREF Social Relationships (max. 100)	43.42 (13.44)	35.16 (12.65)	2.8**	69	.6
WHOQOL-BREF Environment (max. 100)	52.46 (15.35)	37.79 (10.27)	4.7***	69	1.1
PSYCHLOPS (max. 20) – Session 1	11.59 (3.53)	16.13 (1.34)	-6.9***	69	1.7

Table 6.2. Group differences at baseline

Note: Statistical significance: * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

A univariate ANCOVA of group one's post-intervention scores and group two's scores at waitlist, controlling for baseline scores, indicated significant effect for the PM+ group across all outcome measures: WHO-5 ($\eta^2 = .75$, $p = <.001$); GAD-7 ($\eta^2 = .92$, $p = <.001$), WHOQOL-BREF Physical ($\eta^2 = .6$, $p = <.001$); WHOQOL-BREF Psychological ($\eta^2 = .78$, $p = <.001$); WHOQOL-BREF Social Relationships ($\eta^2 = .64$, $p = <.001$); WHOQOL-BREF Environment ($\eta^2 = .48$, $p = <.001$). Table 6.3 shows the mean scores and standard deviations for all outcome measures at baseline and post-intervention for both groups, waitlist scores for group two and the results of the ANCOVAs. Figure 6.4 presents mean differences between group one at post-intervention and group two at waitlist graphically.

A multivariate ANCOVA of group one's post-intervention scores and group two's scores at waitlist, again controlling for baseline scores, age, gender and level of education was conducted to determine whether these significant differences could be explained by any of these covariates. In addition to baseline scores, sex had a significant effect on the WHO-5 scores [$F(1, 60) = 4.1$, $p = .05$, $\eta^2 = .06$]. Sex explained 6% of the variance on the dependent variables, suggesting females are moderately more likely to benefit from receiving PM+. Cohen's d and Hedge's g were above 2.5 across all outcomes: WHO-5 (Cohen's $d = 3.9$, Hedges $g = 3.8$), GAD-7 (Cohen's $d = 6.5$, Hedges $g = 7.2$) and WHOQOL-BREF Physical (Cohen's $d = 2.7$, Hedges $g = 2.5$), WHOQOL-BREF Psychological (Cohen's $d = 3.9$, Hedges $g = 3.7$), WHOQOL-BREF Social Relationships (Cohen's $d = 3$, Hedges $g = 2.9$), WHOQOL-BREF Environment (Cohen's $d = 2.5$, Hedges $g = 2.3$). This indicates that at least 99.4% of groups receiving PM+ will be above the mean of a control group, 21.1% of the two groups will overlap, and there is a 96.1% chance that a person picked at random from the PM+ group will have a higher score than a person picked at random from the control group (probability of superiority). Moreover, this means that if 100 people receive PM+, at least 75.1 people will have a favourable outcome compared to if they had received no intervention. Both groups reported an average change of more than 20 points in the WHO-5 from baseline to post-intervention, which is considered clinically meaningful (Bech, Lindberg, & Moeller,

2018). The reliability of WHO-5 at baseline (Cronbach's $\alpha = 0.44$) was low, indicating low internal consistency of the scale. In addition, at post-intervention, groups did not significantly differ in outcome measures, except for the case of WHO-5. WHO-5 scores at post-intervention were significantly different, although effect sizes were small. This could be explained by a decreased reliability of the scales since the last group was assessed three times or by other unmeasured differences across groups.

Lastly, a repeated measure ANOVA of the control group (i.e. Group 2) alone, over the three time points showed large differences in effect sizes for all measures: WHO-5 [Wilks' Lambda = .19, $F(2,23) = 47.2$, $p < .001$, $\eta^2 = .8$]; GAD-7 [Wilks' Lambda = .02, $F(2,23) = 519.2$, $p < .001$, $\eta^2 = .9$]; WHOQOL-BREF Physical [Wilks' Lambda = .09, $F(2,23) = 113.5$, $p < .001$, $\eta^2 = .9$]; WHOQOL-BREF Psychological [Wilks' Lambda = .1, $F(2,23) = 98.3$, $p < .001$, $\eta^2 = .9$]; WHOQOL-BREF Social Relationships [Wilks' Lambda = .1, $F(2,23) = 75.7$, $p < .001$, $\eta^2 = .8$] and WHOQOL-BREF Environmental [Wilks' Lambda = .1, $F(2,23) = 127.2$, $p < .001$, $\eta^2 = .9$]. No significant differences were found between baseline and waitlist scores. Thus, showing no indication of spontaneous remission or increased severity of problems among this group.

Outcome measure	Group 1 (Intervention)		Group 2 (Control)		F	Eta Squared
	<i>n</i>	Mean (SD)	n	Mean (SD)		
WHO-5 (max. 100)						
Baseline	39	55.59 (11.74)	33	47.27 (9.72)		
Post-intervention to Waitlist	39	88 (13.6)	25	42.4 (9)	182.2***	.75
GAD-7 (max. 21)						
Baseline	39	11.18 (4.19)	33	9.73 (2.24)		
Post-intervention to Waitlist	39	.41 (.64)	25	9.9 (1.9)	735.4***	.92
WHOQOL-BREF Physical (max. 100)						
Baseline	39	53.19 (9.53)	33	50.89 (8.60)		
Post-intervention to Waitlist	39	77.29 (13.35)	25	49.57 (5.95)	92.5***	.6
WHOQOL-BREF Psychological (max. 100)						
Baseline	39	53.39 (15.79)	33	52.99 (12.08)		
Post-intervention to Waitlist	39	77.24 (9.74)	25	43.66 (7.43)	213.9***	.78
WHOQOL-BREF Social Relationships (max. 100)						
Baseline	38	43.42 (13.44)	33	35.16 (12.65)		

Post-intervention to Waitlist	38	81.84 (16.43)	25	37.33 (12.53)	105.8***	.64
WHOQOL-BREF Environment (max. 100)						
Baseline	39	52.46 (15.35)	33	37.79 (10.27)		
Post-intervention to Waitlist	39	64.66 (15.21)	24	35.62 (5.85)	56.2***	.48
PSYCHLOPS (max. 20)						
Session 1	39	11.59 (3.53)	32	16.13 (1.34)		
Session 1 to Session 5	39	2.1 (2.6)	32	2.4 (2.4)	.98	-

Table 6.3. Means (SDs) and effect sizes for group comparisons

Note: F = ANCOVA test; Statistical significance: * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$.

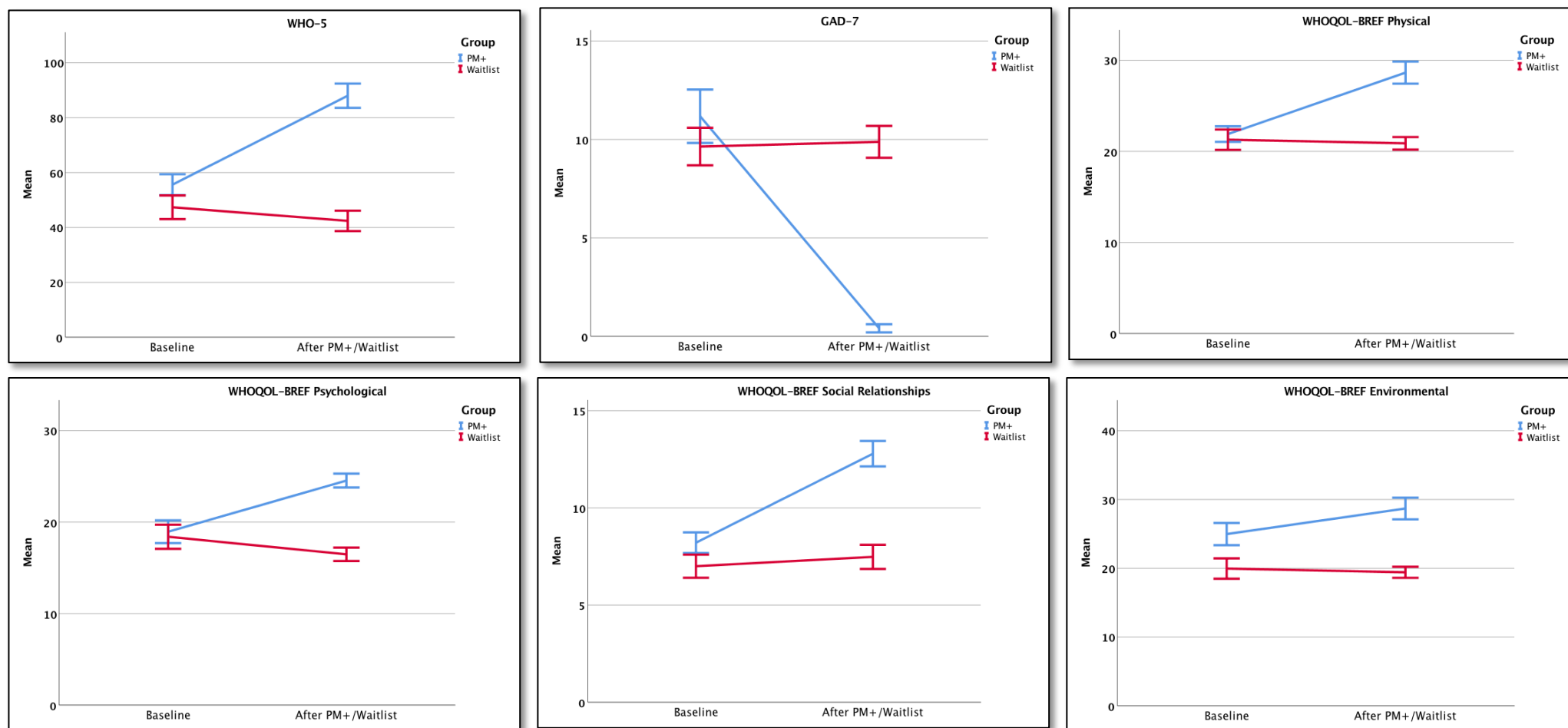


Figure 6.4. Means of primary and secondary outcomes of group one at post-intervention and group two at waitlist.

Note: Error bars indicate 95% confidence intervals

6.3.1 Intention-to-Treat analysis

Effect sizes of the ITT ANCOVAs of Group 1's post-intervention scores and group 2's scores at waitlist, controlling for baseline scores were similar to those reported in the CC ANCOVA: WHO-5 [$F(1, 374) = 1006, p = <.001, \eta^2 = .73$], GAD-7 [$F(1, 61) = 3012, p = <.001, \eta^2 = .89$], WHOQOL-BREF Physical [$F(1, 374) = 534, p = <.001, \eta^2 = .6$], WHOQOL-BREF Psychological [$F(1, 374) = 929, p = <.001, \eta^2 = .71$], WHOQOL-BREF Social Relationships [$F(1, 374) = 685, p = <.001, \eta^2 = .65$], WHOQOL-BREF Environment [$F(1, 374) = 280, p = <.001, \eta^2 = .45$].

Sex had a significant effect on WHO-5 scores [$F(1, 374) = 18.5, p = <.001, \eta^2 = .05$], WHOQOL BREF Physical [$F(1, 374) = 11.5, p = .001, \eta^2 = .03$], WHOQOL BREF Psychological [$F(1, 374) = 4.9, p = .026, \eta^2 = .01$] and WHOQOL BREF Social Relationships [$F(1, 374) = 10.5, p = .001, \eta^2 = .03$], whereby females were slightly more likely to benefit from the intervention. After multiple imputations, age had a small but significant effect on GAD-7 scores [$F(1, 374) = 12.1, p = .001, \eta^2 = .03$] and WHOQOL BREF Physical [$F(1, 374) = 7.9, p = .005, \eta^2 = .02$]. Education had an effect on WHOQOL BREF Psychological [$F(1, 374) = 5.2, p = .02, \eta^2 = .01$] and WHOQOL BREF Social Relationships [$F(1, 374) = 15.3, p = <.001, \eta^2 = .04$].

6.4 Step 2: Qualitative Process Evaluation

The following section presents the themes derived from the thematic analysis. The themes are not listed in order of priority.

Theme 1: “Someone who listens to me, a person I trust”: Trust

PM+ participants described repeatedly how comfortable they felt with the PM+ volunteers, highlighting how meaningful it was that the volunteer remembered their situation and they did not have to retell their difficulties at every session. As expressed by two participants:

It is really great, one feels full confidence with the professionals. I never felt like if I said something they would laugh and make me feel uncomfortable. It is [PM+] dynamic, they would tell me ‘please tell me more’ and give me the opportunity to vent, one feels comfortable.

Intervention participant, male, 19 years old

The other thing I liked was that I always saw the same person and he keeps the threat, he knows how to make it [the session] more personal, more trustful. He remembers what we’ve been talking about, which makes the conversation more pleasant because we work on the same problem. I don’t have to repeat it, he already knows. It creates a more familiar, a friendlier bond.

Intervention participant, female, 47 years old

Beneficiaries felt understood, sensed that they could discuss intimate and distressing problems (e.g., debts, family problems, unemployment), like they could with a professional, without being judged. They also felt able to discuss issues that they would not discuss with others, over fears of worrying them. Despite positive attitudes from PM+ participants, staff and volunteers stressed how difficult it was to build trust with the community. As recounted by the lead supervisor, they felt unprepared in the face of this humanitarian emergency (i.e. displacement from Venezuela) and did not have experience working with this population. The Colombian Red Cross volunteers explained how delivering PM+ was a challenging experience because, while they felt at ease with implementing programmes with their own communities, they underestimated how difficult it would be reach the Venezuelan community. Indeed, as explained by the lead supervisor, this mistrust from the Venezuelan community towards Colombians demotivated the team at the start of the implementation. In addition, while migrants and

refugees were receptive to receive aid in the form of goods or food vouchers, they were cautious or indifferent about psychosocial support programmes.

To build trust the volunteers and supervisors proposed and employed two strategies, which they argued would be useful to others implementing PM+. Firstly, they went to the settlements or communities to conduct mental health promotion activities, described the role and principles of the International Red Cross and Red Crescent Movement, organised recreational activities and informed community members about the mental health and psychosocial services provided by the Red Cross (e.g., the Listening Centre, PM+ and family reunification services). During these community meetings, they dispelled concerns of volunteers reporting Venezuelans to authorities or armed groups. This, they argued, was especially important at a time when there was news of Venezuelans being killed by armed groups in Saravena. Lastly, volunteers and the supervisor took advantage of the delivery of other services to tell potential participants about PM+. More specifically, they highlighted how the Listening Centre – an office within the Colombian Red Cross local unit in Saravena where community members go to find out how to access services– played a central role in gaining the trust of the Venezuelan community. As described by one volunteer:

I can be working for Restoring Family Links and spot that there is an abuse problem, and here I can refer. This is how you start earning trust. Not everyone would talk to you about their problems, you can't reach people just like that. It's important that the minute they see you they know you won't share that with others, you won't disclose it and you must show them that. Later a person would come to me and tell me that their son broke his foot and I would take them to ICRC [International Committee of the Red Cross]. That's a way to build trust.

Theme 2: “We missed, and we should have, involved the branch”: Engagement

This theme revolves around two forms of engagement with (1) community stakeholders and (2) internal stakeholders (with the Red Cross). Firstly, supervisors and volunteers highlighted the importance of identifying and meeting regularly with informal and formal community leaders to explain the value of the intervention to them. Specifically,

they highlighted the role of the presidents of the Community Action Assembly (in Spanish, Junta de Acción Comunal or JAC) which is a traditional and formal community structure in Colombia that safeguards people's needs and, therefore, are key stakeholders in the local area. In this setting, the JAC presidents were able to quickly and efficiently convene community members, which facilitated volunteers' safe access to the communities. As explained by the supervisor:

We've been working in the municipality since 2014 and we've developed programmes both in the rural and urban areas. For the most part, the presidents of the JAC hardly rotate, so they know all about the work we do and thus it is easier for us to access the communities... They know about our work and this provides us with security to enter the area.

However, many leaders discriminated against Venezuelans and were not supportive of the intention of the Colombian Red Cross to support Venezuelan migrants and refugees. In addition, many Venezuelans had their own informal leaders, who the Red Cross volunteers had to take time to identify and meet, before they would be granted access to the community. According to the supervisors and volunteers, these meetings were necessary to conduct the previously described trust building community meetings and the PM+ sessions.

In addition to the community leaders, the volunteers identified two internal management bodies within the Colombian Red Cross (e.g., regional branch and headquarter offices) as key stakeholders in the implementation of PM+. They acknowledged how a failure to involve one of these bodies (i.e. regional branch) impacted the implementation. As one volunteer explained, at the time of the implementation the branch was not prioritising psychosocial support activities and many people within the branch did not perceive psychosocial support as an important component of humanitarian work. Prior to the implementation of PM+, the lead supervisor and I held a series of meetings with high-level management based in Bogota, as well as with the implementing unit based in Saravena, to seek their support for the study. However, a planning oversight, we neglected to visit the branch, based in the capital of the province where Saravena is located. Although they were aware of the

implementation, the fact that they were not involved meant they did not fully understand the process and consequently, did not support the implementation of PM+. As explained by the supervisor:

It would have helped if, the branch would have at least understood the exercise we are doing [PM+], not to receive praise from them but so they understood the process and would not overburden us. Instead they would have taken ownership and, let's say, when the results of the study are out, they could know is something we all did.

This lack of involvement also meant the branch would often request more of the volunteers' time on other projects, which increased stress and frustration among the volunteers. According to the volunteers, involving the branch in the implementation would have meant that they could have discussed strategies on how to gain the trust of Venezuelan migrants and refugees or would have been able to train some of their volunteers and deliver PM+ to more participants. In addition, per diems, or volunteer stipends, are paid from the branch. A lack of involvement of the branch was therefore a contributing factor for why payments of volunteer stipends were delayed for up to five months. This delay in payment represented an important challenge for volunteers, most of which rely on these payments for their livelihood.

Theme 3: “We had to re-design the strategy, because at the beginning we were loose and we realised that it [PM+] had to be linked with something, and we were wondering what to do to make it work and that is when we thought of the food vouchers”: An Integrated Approach

In this theme, supervisors and volunteers explained how PM+ had to be embedded or affiliated with other services (e.g., food voucher programme supported by the World Food Programme, Restoring Family Links programmes or the Listening Centre). This was thought to be necessary for the implementation since, given that there was insufficient awareness on the importance of mental health for PM+ to be the main component of their work. The volunteers argued that while there was a small budget for the implementation of PM+, this did not prevent it from being delivered. There are many NGOs that do not provide any type of psychosocial support. The key is to affiliate PM+

to these projects, so as to more efficiently identify and subsequently assist those who would benefit from the intervention. Specifically, the volunteers advised that PM+ should be embedded within long-term projects that are working with a community for periods of six or eight months. Examples include livelihoods programmes, which could be complemented by psychosocial support in the form of PM+ and community-based PFA. The volunteers and supervisor' suggestion of conducting PM+ alongside livelihood programmes was based on previous experience, but also on the observation that participants that were part of the food distribution programme were prone to using the food vouchers as part of their problem-solving strategy:

I would recommend it [PM+] because it's very practical, very practical. It's not particularly difficult and people have the tools, we just guide them. We have programmes that consist of aid, 'here is a food voucher, you do with it whatever you want', but if they have an economic problem they could find ways to administer this voucher, how it can help them, and how they can use it in the strategy. Some would say 'I have a debt and I will start selling empanadas with what I received from the food voucher'. So, they would integrate it in their [problem-solving] strategy and this for me was fundamental".

The volunteers emphasised how providing non-food items (NFIs), such as a community meal or a PM+ handbook, would encourage the community to join PM+. They further highlighted that having a PM+ handbook for participants would not only be a symbolic gesture of the organisation's support, but also something that would help them remember the strategies learned to better be able to practice them. They highlighted that providing these items would be not be difficult, given that the local Red Cross unit is already providing various NFIs to this population. All in all, they argued this integration would contribute to the sustainability of PM+ and other programmes, as explained by a volunteer: *"the sustainability of this programme depends on how well it has been associated to another [programme]"*.

Theme 4: “Commitment is the starting point, but teamwork is the key to success”: Teamwork

Within the theme of fostering teamwork, various considerations were brought up by the interviewees. Firstly, commitment and motivation to learning and delivering PM+ were fundamental to the implementation of PM+. According to supervisors and volunteers, it is essential for the implementing team to be committed and motivated to the organisation and to the services provided. Related to the theme of engagement, this level of commitment must be reflected within the organisation. Supervisors and volunteers also discussed the importance of clear, continuous and non-hierarchical communication as well as triangulation of information across the entire team, as important practices that encouraged teamwork. Teams implementing PM+, they argued, should be decentralised, its members should not seek to stand out and should respect and learn from each other as well as from the community's difficulties and experiences. Having a small team, the lead supervisor argued, enabled clear communication and coordination. The lead supervisor acknowledged that this 'fluid communication' is a special characteristic of the Saravena Psychosocial Support Team and that this is not always achieved in other Psychosocial Support Teams across the Colombian Red Cross. Another characteristic of the team that contributed to teamwork and to the timely implementation of PM+ was having one of the volunteers support the coordination of the implementation. These coordination activities included organising the community meetings, meetings with local leaders, sessions with participants as well as team supervision and self-care sessions.

There were also individual characteristics of each team member that were important for fostering teamwork. Through the implementation of PM+, the lead supervisor learned that lay providers could become skilled in delivering a psychological intervention, such as PM+. However, to become proficient in PM+, the lead supervisor argued, volunteers should have a strong interest or vocation for psychosocial support. Commitment and motivation were also seen as essential individual characteristics for providing PM+. Indeed, when probed about the reasons for the high volunteer attrition

in the implementation, the lead supervisor highlighted that *“this work is not for everyone”* and stressed commitment to psychosocial support as an important determinant of volunteer attrition. In addition, a PM+ volunteer should have strong communication skills, feel comfortable and inclined to speak in public, should feel at ease approaching different people about psychosocial support, and be able to manage their emotional reactions in the face of difficult circumstances. Various PM+ participants stressed how charisma was a very valuable trait of a PM+ volunteer. Staff and volunteers explained that a PM+ volunteer should be willing to admit their mistakes and value others’ suggestions, interested in learning new skills, and trained in psychological first aid. If a volunteer is not trained in psychological first aid, it was argued, they should always be accompanied by a volunteer who is. Despite these suggestions, not all volunteers who provided PM+ in Saravena initially possessed all the necessary characteristics. As one volunteer concluded *“in some cases, volunteers won’t have the full profile, but what matters the most is their commitment, the rest they will learn it on the way”*. Staff and volunteers agreed that Red Cross team leaders or coordinators are ideally suited to identify those volunteers with the right profile. Notably, they emphasised that it is difficult to find volunteers with the required level of commitment and even if these criteria are met, some volunteers would eventually leave the programme for different reasons. Some of the reasons given for volunteer attrition were finding a full-time job and contributing less hours to the CRC, moving out of the city, not following the principles of the of the International Red Cross and Red Crescent Movement or bearing arms.

Another factor contributing to the implementation of PM+ was that the team practiced self-care, mitigating the risk of vicarious trauma. In this setting, self-care was seen as a team responsibility to be carried out through meeting weekly to speak openly about their difficulties with their work. Difficult topics encountered in their work, such as violence and rape, and how this contributed to their own stress and exhaustion came up often across interviews. As one volunteer explained:

We have our own problems and to this we add that another person tells us about their own problems, and this becomes a double emotional burden which makes the spaces of emotional disclosure between ourselves so important.

According to the lead supervisor, when openness is not achieved within the team, they often send a staff member from other parts of the Colombian Red Cross to meet with the volunteers and provide psychosocial support. The volunteers highlighted how taking care of themselves also included not sharing personal contact details with PM+ participants, including their address or personal phone number. Even though volunteers and staff members highlighted the importance of self-care, a volunteer expressed how sometimes it is difficult not to feel powerless:

There is a part that is not so positive, sometimes one feels powerless, like you want to give more but you know you should not intrude, 'I need to help you help yourself'. [A participant might say] 'I have these children, I am sleeping in the street, I am staying here temporarily, I have to go to that neighbourhood, I haven't paid the rent'. We would like to give more than what we have, but we must learn control that anxiety, 'I can't involve myself, because I wear a uniform, I carry an emblem'

Despite the measures taken to ensure volunteers' wellbeing, this last quote illustrates the challenges of volunteering in this context and how witnessing the economic difficulties of beneficiaries, can be a source of stress for volunteers, putting them at risk of compassion fatigue.

Theme 5: "It depends on your strengths, I've worked with the community for more than ten years, I know how to manage groups": Autonomy

Interviewees discussed the importance of autonomy from various perspectives. This theme revolved around the liberty to provide PM+ through different formats (group or individual PM+) and settings, as well as training providers on the process of referral and signposting participants to other services. For instance, attitudes on whether PM+ should be delivered in group or individual formats varied, but there seemed to be agreement that preferences would vary across participants and volunteers. On the one

hand, the lead supervisor emphasised the added value of having PM+ delivered in a group format over individual sessions:

I think it is much easier, Camila. I am convinced, and this is something that I just highlighted in a meeting about a new project, I am convinced that meeting individually is something for the clinical psychologist, seating somewhere doing a process. For us, humanitarian workers, it's a group action. You see results faster and obtain greater benefit by strengthening the community. For me, it's in groups.

The lead supervisor mentioned how group PM+ would allow them to more efficiently reach populations potentially interested in the programme, such as the different groups of female victims of sexual violence across Colombia who already meet every eight days in the local Colombian Red Cross unit/branch and who are very interested in self-improvement; with groups of young men that already meet to discuss gender issues (positive masculinity); or with any other group that meets regularly to talk about health and sanitation.

On the other hand, the supervisor thought it would be difficult to bring very shy participants into a group setting and acknowledged that there are people who require individual attention. All in all, she explained that there are some participants who would do very well in a group setting and suspected that some volunteers would also enjoy working in this way. This was confirmed by one of the volunteers when they stated:

It depends on your strengths, I've worked with the community for more than ten years, I know how to manage groups of five or ten persons. The groups allow you to do the exercises but also group members can give feedback to each other, commit to the group and form ties of friendship.

The remaining volunteers however, reported that they were not as comfortable working with groups and that they would find this challenging. They mentioned that they would be willing to start out by supporting the other volunteers that did feel comfortable leading a group, until they felt ready to do the same. Working in groups, the volunteers argued, would allow them to reach more people that they identified as needing

psychosocial support, such as Venezuelan school children being bullied and schoolteachers experiencing high levels of burnout.

Interviews with PM+ participants were consistent with the supervisor's point of view. When asked about meeting in groups, some PM+ participants mentioned they would like to learn about other participants' ways of managing their problems since they probably have similar situations. However, other interviewees suggested that there are some issues they would not share with others in the community. Overall, the volunteers and supervisor agreed that they would prefer having both options be available, and give participants and volunteers the autonomy to decide which format to take part in.

PM+ participants also valued the flexibility of the volunteers to conduct the sessions at the participant's home or at the CRC office, and to change the time of the sessions when they could not meet, especially when they had a last-minute job opportunity or had to take care of their children at home. This flexibility came with limitations for the volunteers. For example, sometimes volunteers would go to a community, which in most cases are far from the city, and maybe the person had moved houses without telling them, which was stressful and frustrating for volunteers. Having the sessions at the participants' houses also meant that the volunteers had to stop frequently if children needed something, the neighbour started playing loud music or if the person had to sweep the floor or make lunch. When they were cooking, the volunteers would often follow participants into the kitchen which, in the volunteers' opinion, was inappropriate and unprofessional and meant that the person would get easily distracted. In contrast, when the sessions were in the CRC office, volunteers had participants' undivided attention during the entire session, which took place in a friendly and quiet atmosphere. Despite these limitations, the volunteers highlighted the importance of adapting to the needs of the participants because most were street vendors and do not have regular schedules.

Knowledge of referral and signposting pathways gave confidence to volunteers. Learning the referral and signposting pathways within and outside the CRC unit (e.g., to governmental and non-governmental agencies) is a process that requires continuous

practice. At the start, the supervisor mostly gathered this information. As the implementation progressed however, the volunteers also started learning it. This knowledge and the ability to refer to a wide range of services was rewarding to PM+ volunteers, as explained by the supervisor:

[The referral process] is something I learned by practicing, while I was at the Listening Centre, and I realised I was listening without doing anything else. So, I started talking to personería [the government's human rights office], and they would explain their processes to me. I learned what to do in cases of forced recruitment or when I received cases of extortion, I would meet with them to ask what they did and how they did it ... By the end other institutions would come to me and ask about these pathways. Now, I know all the pathways and so it was very easy to explain it to [the volunteers]. I taught them the pathways in case they found a case, it was easy for me and [the volunteers] felt so supported, this was ideal. I would tell them 'what is going to happen if I am not here'. They started learning and they liked it, because they had the tools, they knew who to talk to, the contacts, everything.

This was confirmed by a volunteer who explained how knowing psychological first aid as well as the referral mechanisms, gave him the confidence to act independently in a difficult situation:

You can imagine, I went to visit a lady and they had killed her daughter to get her necklace, you can imagine this is an extremely complicated situation, so I offered psychological first aid. That is all I can do, I referred because if you don't have the capacity you can make things worse. You cannot compromise yourself and you cannot put the Red Cross in jeopardy. So, I called [a psychologist] and I told her [the participant] 'he will meet you at 3pm' and we made an appointment.

Both supervisors and volunteers repeatedly stressed the importance of being familiar with referral and signposting pathways. As explained in Theme 1, this knowledge played an important role in identifying and gaining the trust of the population. As discussed by the volunteers and supervision, the referral and signposting contribute simultaneously to the implementation of PM+ and to the implementation of other

projects within and outside the Red Cross. Lastly, further emphasising the importance of knowing the referral pathways, the supervisors argued that without the support from other organisations (i.e. MSF and ICRC) the implementation of PM+ would have not been possible, since they were the ones providing mental health care in instances of severe cases.

Theme 6: “Being a supervisor is not an easy job”: Supervision

Throughout her interview, the lead supervisor stressed how supervising was a difficult task for her: *“The fact that I was giving technical support, that I provided guidance on the cases that came in, that was not easy. It’s not easy because my job is not clinical and there were clinical cases. This is not an easy role, I repeat, it was not easy”*. She went on to explain how this was a very different role to the one she was used to. At first, she did not feel confident providing this type of supervision, but as the cases presented, she realised she did have the knowledge and tools to supervise. As the lead supervisor, she often felt under pressure. She was unsure the volunteers would be able to deliver PM+ appropriately, but she eventually realised it was important to trust in them: *“[The implementation of PM+] made me a better supervisor and lifted many biases I had, like [I would think] ‘what is [volunteer’s name] doing, can they do this?’, I then told myself ‘no, I have to trust in them”*.

Later she commented on how rewarding it was to see them learn and deliver the sessions and how proud she was of their work:

For example, look at [volunteer’s name], she is not a psychologist, she is not a doctor, she has nothing to do with health care and still, she does such an interesting work. A lot of the supervision work I did was with her, because while she was working on it, she had many questions and doubts... She now manages the different terminology, it excites me to hear her speak.

She emphasised how empowering and motivating the team, instead of pressuring them, contributed to their strong performance. She explained how with PM+ her strategy for motivating volunteers had to be different because she had to constantly reassure them that even though they did not have a college education that they could do this type of work and that mental health and psychosocial support was a very important

responsibility. In line with the theme of autonomy, she concluded that giving the volunteers agency and independence was fundamental to the implementation of PM+:

At the beginning I lectured them, but then I said to myself 'that is not going to be my role or my strategy'. I told them 'look I trust in you, I rely on you, I chose Saravena because of your work, because of your commitment but this commitment is not with me, it's with the population'.

Looking back, the lead supervisor reflected on how she would have liked to dedicate more time to supervise, coordinate and follow the process closely but the security situation in the region meant she could not travel as much as she expected to Saravena. For the supervisor and volunteers having the support of the lead supervisor was important and they felt that the lead supervisor was following up the process well, even if she was not based in the city, as showed in the quote below by the supervisor:

We always had [Name of the lead supervisor], that's been the advantage, to have her support. She was always ready to listen to us, she didn't complaint about our work. She would not say "why are you guys doing that?". When we had difficulties, she would say to us "let's try to do this [other strategy]"... She was always available to support us either on WhatsApp, over e-mail, she was always there.

For the supervisor based in Saravena, feeling comfortable with the intervention was influential in her role as a supervisor, as she said:

I had the knowledge to tell a volunteer 'remember this basic helping skill, praise openness, congratulate the person, remember how these skills can help you'. If you don't have the knowledge, it is difficult to supervise. A person that doesn't really know [PM+] would just say 'why are you doing it like that, that's not how it's done'. For me it was very important to really understand the programme"

A key challenge for her was to slowly train a shy volunteer on how to address PM+ participants respectfully until he felt comfortable to lead the sessions. This was especially difficult when participants were also shy. Her approach in this case was to accompany and help him during the first sessions, slowly letting him lead. Another

strategy that helped her in her role as supervisor was to always know which cases the volunteers were working on and to briefly chat with them before each session. Volunteers valued having a confident supervisor that was not supervising out of an interest in recognition and authority, but to address the needs of the community. Both staff and volunteers agreed that a PM+ supervisor should have a strong knowledge of referral pathways and should continuously share this knowledge and new information with team members.

Theme 7: “It [PM+] helped me feel a bit calmer, not to worry so quickly about things”: Acceptability

PM+ was well-received by the PM+ participants, who throughout the interviews were grateful for the programme, reflected on how it helped them with their problems and were proud to know the CRC was helping their community. As expressed by three participants:

It [PM+] helped me feel a bit calmer, not to worry so quickly about things, they lift me up a bit and helped lifted my self-esteem a bit, to manage my problems with debts better. To manage things in an easier way, to be calmer and know that everything can be solved somehow.

Intervention participant, female, 47 years old

Look, this is a beautiful thing, because we live in neighbourhoods where is rare to see any public service, be it from a mayor's office, be it the mail, or government. Because they are informal neighbourhoods that have not been legalised. I think the little you are doing, it helps us and guides us, the individual but also the community, it is flatters us that you visit us.

Intervention participant, male, 38 years old

It's rewarding in many ways, it fills my heart with happiness to know that things can go better with the support from professionals who are really committed, who are not here to fulfil a requirement of a volunteer. No, you can see that they put their shirt on and its really to help and to accompany the person when one needs it.

Intervention participant, male, 19 years old

The supervisor stressed that PM+ was a practical and comprehensive intervention because it helps participants identify resources they already have, as she explained:

The programme first gives you the tools but also promotes the persons' abilities, which they have forgotten about... For example, I would tell [the volunteers] 'we should not see the person as a white canvas because they have tools, they've not only had this difficulty in their life, they've had many. The exercise is that they themselves identify which tools they used to get out of other problems... If you see the person as a white canvas, like if they did not know to how to manage, then it gets complicated but you must understand that they already have coping strategies'

In addition, the volunteers discussed how PM+ could potentially act as a suicide prevention intervention given the increased rates of suicides reported in the region and that there are currently no suicide prevention initiatives in the area. Lastly, and as explained by both supervisors and volunteers, PM+ was important for their personal and professional development. For some, delivering PM+ helped them feel more comfortable with public speaking, building trust with beneficiaries, and even motivated them to finish their studies. Volunteers also talked about the rewarding experiences of providing humanitarian assistance and all spoke about how much they learned from each other.

Despite the positive feedback, both PM+ participants and volunteers mentioned that participants had difficulties with some components of the PM+ intervention. For example, many did not take the breathing exercises seriously at the beginning, reporting that they thought it took too long or that it was difficult to concentrate on. The volunteers stressed how during their training, they would have liked to have practiced how to explain the value and importance of the breathing exercises to the participants. Despite initial reluctance, this strategy was ultimately seen as acceptable among volunteers and turned out to be valuable to many participants. As one participant explains:

Breathing, I enjoyed that very much because I am always very stressed about my personal life and that helps me a lot. [The volunteer's name] tells me: this you can apply it at any moment, when you get stressed because your children

don't listen to you, you can apply it and support yourself, it's an exercise so you don't feel stressed.

Intervention participant, female, 25 years old

In addition to indicating the level of acceptability towards this strategy, this quote also illustrates the volunteers' fidelity to the explanations provided in the manual and practiced during the training and the subsequent understanding of the strategy by the participant. In addition, PM+ participants and volunteers agreed it was easy for most participants to identify with both the behavioural activation and problem-solving strategy – identifying these PM+ strategies as the most useful. As explained by a participant:

It's like if your car breaks but you are not a mechanic, to make the comparison, since you are not a mechanic you are alone in the street thinking 'what am I going to do now', and it can be something easy like a spark plug, but since you don't have the tools you do know what to do.

Intervention participant, male, 38 years old

This quote illustrates the participant's understanding of the problem management strategy as a tool or method that can be used during difficult situations, possibly indicating the sustainability of the intervention. Although most participants found the problem-solving strategy useful, the volunteers and supervisor reported that many had difficulties identifying a simple problem to start with. One volunteer explained how one participant had finished the second session still talking about all problems, without still being able to select only one to work with.

Theme 8: "Working only with migrants infringes our principle of neutrality": Inclusion

When providing PM+ for migrants and refugees, it is also important to analyse whether the host population would also benefit from the intervention, and if so, make PM+ available to them as well. Not doing so would affect the reputation of the Colombian Red Cross or other implementing organisations as it would undermine the principle of

impartiality², especially when the host population is also in need. As the supervisor explained it:

Another thing to keep in mind is, depending on the local unit, not to work with a specific group, at least carry out an analysis of the place. Us, in Saravena, we live the conflict and there are stressful factors that people deal with daily, not only because of displacement, but because they are always subjected to and there is always tension regarding whether social cleansing has started again or because they can't leave [their houses] because there's been attacks, these are stressful factors that we should be thinking about. Depending on the place it's important to carry out an analysis, on what factors do people experience and how PM+ could help them. Not only due to migration but also due to the situations people live in the settlements. You know in the settlements people live... there is not only economic problems... but people live in vulnerability.

The volunteers and supervisor described how Saravena is a region affected by the armed conflict and that people experience stressful circumstances daily as a result. This quote also illustrates the challenges of providing psychological interventions such as PM+ in humanitarian settings, where there are multiple populations in needs and limited human resources. Despite these challenges, a volunteer explained that by not offering services to all beneficiaries: *“our reputation could be affected if we are not seen as impartial within the community”*. Table 6.4 summarises the factors that were found to influence the implementation of PM+ in this setting identified through this thematic analysis, as well as the strategies proposed by the interviewees to operationalise each factor.

²The principle of impartiality states that the International Red Cross and Red Crescent Movement makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

FACTOR	STRATEGY
Trust	- Disseminate knowledge about the role and principles of the International Red Cross and Red Crescent Movement, the mental health and psychosocial activities provided by the Colombian Red Cross (including PM+) through community-based awareness and recreational meetings - Disseminate knowledge about PM+ and mental health and psychosocial support through other activities (e.g., family reunification, community-based health programmes)
Engagement	- Identify and meet regularly with formal and informal community (e.g. Community Action Assembly) leaders - Consider involving all levels of management within the organisation (e.g., regional branch and headquarter offices) to increase the support towards this initiative, avoid overloading PM+ providers' and delaying work benefits (e.g., stipends)
Integrated Approach	- Integrate PM+ within established or emerging social, health or humanitarian programmes (e.g., livelihood, non-food items or food vouchers) within or outside the Red Cross - Before implementation, meet other service providers in the area (e.g., governmental and non-governmental agencies) to inform them about the implementation of PM+ and identify synergies - Given the pressing economic needs of this population, PM+ should preferably be integrated to long-term (6-8 months) livelihoods programmes
Teamwork	- When recruiting PM+ providers and supervisor, consider level of commitment and motivation, and ensure PM+ providers have a strong interest or vocation for mental health and psychosocial support - Additional helpful traits in a PM+ provider include being charismatic, willingness to admit mistakes, value others' suggestions, interested in learning new skills, and trained in psychological first aid and strong communication skills. - Encourage clear, continuous and non-hierarchical communication as well as triangulation of information within the team - Establish staff and volunteer care practices and include additional training sessions on self-care to prevent compassion fatigue

	- Nominate/select a team leader to coordinate implementation of the intervention
Autonomy	- Give beneficiaries the option of receiving group or individual PM+ - Consider offering PM+ to groups that already meet on weekly/bi-weekly basis - Match PM+ providers with their preferred format (individual or group PM+) - Offer to change time and setting of PM+ session to accommodate the needs of beneficiaries - During training and supervision sessions conduct service mapping exercises to increase PM+ providers' knowledge and autonomy over referral and signposting of beneficiaries
Supervision	- Strengthen supervision skills of PM+ supervisors (including clinical supervision skills) and knowledge of strategies for motivating and empowering PM+ providers - When recruiting supervisor, consider their level of motivation, interest in the professional development of PM+ providers and knowledge of referral pathways - Ensure PM+ supervisors have time for supervision sessions and coordination - Make sure supervisors feel comfortable with PM+
Acceptability	- Ensure PM+ is acceptable to beneficiaries, providers and supervisors who view PM+ as a useful intervention for their communities - Ensure all intervention strategies (e.g., relaxation exercise, problem management strategy) are applicable to that local context and train providers on how to explain the value of each strategy
Inclusion	- Conduct an in-depth population analysis to identify groups that would benefit the most from PM+ - Provide PM+ impartially while assigning priority based on need

Table 6.4. Factors determining the implementation of PM+

6.5 Discussion

This mixed-methods study provided an evaluation of the implementation of Problem Management Plus, delivered by Colombian Red Cross volunteers to Venezuelan refugees and migrants in Saravena, Colombia. The results show that PM+ is associated with improved outcomes in subjective wellbeing, anxiety and quality of life, with large effects across all outcomes measures. This is consistent with RCTs conducted in Pakistan and Kenya which identified medium to high improvements in anxiety, depression and functioning at post-intervention for individual PM+, in comparison to primary mental health care (Bryant et al., 2017; Rahman et al., 2016). Similarly, a feasibility study and a subsequent RCT of group PM+ delivered by Lady Health Workers in Swat, Pakistan showed significant improvements in depression, anxiety, general psychological profile and functioning on the PM+ group in comparison to enhanced treatment as usual (i.e. psychoeducation and referral to primary health care physician when appropriate) (Khan et al., 2019; Rahman et al., 2019). The findings of the implementation of PM+ in Colombia are consistent with previous evidence indicating that lay providers can deliver simplified psychological intervention to tackle moderate cases of highly prevalent mental health problems (i.e. depression and anxiety) (Singla et al., 2017; van Ginneken et al., 2013). A distinct finding of this study is the strong and significant association between PM+ and quality of life. Although previous studies have identified significant improvements in functioning among participants receiving PM+ (Bryant et al., 2017; Rahman et al., 2016), this study suggests that it is also associated with the broader and multidimensional construct of quality of life, which includes aspects such as physical function, psychological state, social interaction and environmental aspects. This is an important finding considering that PM+ was designed for communities affected by adversity with long-term impacts on quality of life (World Health Organization, 2017).

Despite these consistent findings, two of the three RCTs assessing the effectiveness of PM+ have included women only (Rahman et al., 2016; Rahman et al., 2019). In this study, females were more likely to benefit from PM+. Although the effect

on the dependent variable (WHO-5) was small, the intention-to-treat analysis showed similar effects in other outcome variables. While it is unclear as to why this difference exists in this context, a systematic review of psychological treatments in LMICs identified a participant gender gap, whereby two-thirds of the identified trials exclusively focused on women, and indicating a potential gap on specific treatment needs of men in these settings (Singla et al., 2017).

In addition to the demonstrated association between PM+ and improved psychological outcomes in this sample, eight factors were found to influence the implementation of this intervention. Trust in the Red Cross and MHPSS activities among community members was a determining factor in the implementation of PM+ in Saravena. Fear and distrust of government authorities have been previously identified as barriers to access medical help among migrants, causing delays in preventive care, thus potentially leading to worse and long-term illnesses among this population (Hacker, Anies, Folb, & Zallman, 2015; Jindal, 2020). In addition, trust in health professionals and organisations have been referred to as the foundation of effective treatment and has been associated with beneficial health outcomes, less severe symptoms, higher quality of life and increase satisfaction with treatments (Birkhäuser et al., 2017; Calnan & Rowe, 2006). Moreover, while other studies have also identified distrust during sessions as a barrier to the implementation of low-intensity psychological interventions among forcibly displaced populations (Acosta & Chica, 2018; Verdelli et al., 2008), the current study found that distrust also affected volunteer motivation. Future implementations of PM+ should consider assessing how community members feel about the organisation providing this type of service and plan strategies for building trust before implementing the programme. Failure to use trust-building strategies could discourage both providers and beneficiaries from delivering or receiving PM+, respectively.

Early and ongoing stakeholder engagement was another important factor supporting the implementation of PM+. This finding resonates with the global mental health literature reviewed in section 2.4.1.1, which considers engagement and

collaboration with a wide range of stakeholders (e.g., local governments, NGOs, religious and political organisations, multi-sectorial mental health agencies) a critical factor to maximise resources, reduce duplication of services, increase reach and accessibility to MHPSS programmes and other services (Dickson & Bangpan, 2018; Tol, Rees, & Silove, 2013).

The findings further suggest that integrating livelihoods or economic programmes and PM+ may enable future implementations. Although the integration of livelihoods and MHPSS programmes is recommended in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, this simultaneous implementation is not common practice (Inter-Agency Standing Committee, 2007; Lund et al., 2011; Schinina et al., 2016). This integration is known to contribute to breaking the cycle whereby economic and mental health and psychosocial needs become mutually reinforcing, especially in humanitarian setting (Schinina et al., 2016). In their qualitative evaluation of PM+ Kenya, Van't Hof et al. (2018) discuss the possibility of integrating mental health and economic activities as a way of increasing the feasibility of PM+.

Participants' difficulties with identifying a simple problem to start the problem-solving strategy have been also reported in other PM+ studies in Kenya and Pakistan, evidencing the multitude of complex challenges people experience in humanitarian settings (Khan et al., 2019; Van't Hof et al., 2018). Based on these findings, I argue that the integration of livelihoods/economic and MHPSS programmes may increase the acceptability of PM+ and may also contribute to the sustainability of MHPSS programmes since livelihoods/economic programmes are more likely to receive funding (Financial Tracking Service, 2019). Furthermore, in a series of reports, the UN Special Rapporteur on the Right to Health has called for a substantial change in how mental health problems are conceptualised and responded to. He suggested that "given the deep connections between mental health and the physical, psychosocial, political and economic environment, the right to determinants of health is a precondition for securing the right to mental health" (United Nations High Commissioner for Human Rights, 2017, p. 15). This further evidences the importance of providing programmes,

such as PM+, and livelihood or other socioeconomic programmes in tandem (Burgess, Jain, Petersen, & Lund, 2020). Lastly, as shown in this study, witnessing the economic difficulties of beneficiaries was a source of stress for volunteers and may act as a risk factor for secondary traumatisation (Rizkalla & Segal, 2019). Thus, integrated approaches may also contribute to furthering the wellbeing of lay providers.

Commitment was identified as essential to fostering teamwork in this setting. Indeed, a lack of commitment and motivation partially explained the high provider attrition observed in this study. According to the literature on motivation of community health workers in the areas of maternal and child health and HIV / AIDS programming, motivation is determined by several inter-related factors including: intrinsic factors such as personal motives, values, empathy, altruism and pride desire for self-fulfilment and extrinsic factors such as money, opportunities for employment, non-monetary material rewards (e.g., uniforms, bicycles) and non-material rewards such as increased social status and knowledge (Bhattacharyya, Winch, LeBan, & Tien, 2001). Supportive supervision has also been identified as a key determinant of community health worker's motivation (Hill et al., 2014; Vallières, Hyland, McAuliffe, et al., 2018). Accordingly, although this study showed commitment and motivation as a pre-requisite of becoming a PM+ provider, evidence shows that these qualities can also be promoted through organisational support practices (Aldamman et al., 2019).

Although this study showed that volunteers from a wide range of academic and /or professional backgrounds can be trained to provide PM+, the interviews (Theme 4) indicate that providers should possess various key characteristics (e.g., strong communication skills, emotional self-regulation). In line with previous research (Shahmalak, Blakemore, Waheed, & Waheed, 2019), this study demonstrates that although these models enable a wider range of individuals to deliver psychological interventions, providers are required to have a specific set of skills and traits to deliver interventions such as PM+.

The capacity to refer and signpost beneficiaries to mental health specialists and other social services contributed to lay providers' autonomy and to the implementation

of PM+. Based on the results of 15 systematic reviews commissioned by the WHO, the Guidelines on Health Policy and System Support to Optimise Community Health Worker Programmes identified referral as a core competency of community health workers (Cometto et al., 2018). Despite this recognised importance there is little guidance on how to adequately involve lay providers in the process of referral. While processes such as the 5W (i.e. Who, What, Where, When, for Whom) are used to map MHPSS services and referral mechanisms, more guidance is needed to ensure safe referral by lay providers.

The opportunity to reschedule or change the setting of the PM+ sessions were identified as useful strategies contributing to beneficiaries' autonomy. The concepts of patient autonomy, choice or self-determination are well established within the medical literature (Arrieta Valero, 2019). Autonomy is known to influence participants' acceptability and adherence to treatment, by allowing participants to engage in activities they would otherwise be excluded from (Arrieta Valero, 2019). The concept of autonomy, however, is less explored in task-shifting studies conducted in low-income or humanitarian settings, given that scarcity of resources often impedes beneficiaries' autonomy. Given the findings of this study, future research should explore how autonomy can be better supported in humanitarian and low-resource settings.

Supervision was another factor influencing the implementation of PM+. This was stressed by the lead supervisor, who felt supervision required clinical skills and strong knowledge of different strategies to motivate volunteers. Supervision has been previously identified as a key determinant of successful community-based health programmes for its role in influencing providers' motivation, retention and performance (Kok et al., 2015). The lack of clear guidelines for supervision of lay mental health providers is a recognised gap within the field of humanitarian assistance and research on this topic is underway (IFRC Reference Centre for Psychosocial Support, 2019).

Generally speaking, PM+ was acceptable to participants who viewed the sessions as a safe space to discuss intimate and distressing problems and the volunteers as prepared and professional providers. The low drop-out rate and high retention might

also be indicative of participants' satisfaction. Most participants identified easily with both the behavioural activation and problem-solving strategies, but some reported having difficulties with the breathing exercise. Difficulties with the breathing exercise might be due to the strategy not being commonly used in this setting. While this does not reduce the value of the strategy, as highlighted in the qualitative process evaluation, this difficulty indicates the need to identify which strategies may be acceptable in each context, and where necessary, find ways to train providers to explain these strategies in more culturally relevant ways. The cultural adaptation process described in Chapter 4 may contribute to bridging this gap. As a cyclical or iterative process, the cultural adaptation process can be reapplied to consider new literature as well as the experience gained by implementers through their work with these populations.

Under the theme of inclusion, interviewees identified the importance of conducting a population needs assessments that would enable them to provide PM+ impartially while assigning priority based on need. The *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings* is a frequently used toolkit that can be employed to conduct broad population needs assessments in humanitarian settings (World Health Organization & United Nations High Commissioner for Refugees, 2012). However, it should be noted that the Colombian Red Cross chose to purposefully provide PM+ to Venezuelan migrants and refugees due to the level of marginalisation of this population from mental health and social services. Accordingly, in addition to the population needs assessment, wide community meeting explaining the rationale for providing the intervention to specific population could help address the problem of inclusion.

As presented in section 3.4.3, after revising the eight most commonly used determinant frameworks of implementation research, Nilsen (2015) identified five domains that encompass implementation determinants: intervention, practitioners/users (e.g., providers, supervisors), end users (e.g., beneficiaries, or patients), context and strategy or means of facilitating the implementation. Adapting Nilsen (2015)'s findings, I propose that implementation outcomes (section 3.5) of low-

intensity psychological interventions for forcibly displaced persons are influenced by: (1) intervention; (2) implementation team (e.g., lay providers, supervisors); (3) beneficiaries; (4) context and; (5) implementation strategies or means of facilitating the implementation (Nilsen, 2015). Each of the identified domain is, at the same time, comprised of individual factors or variables (e.g., cultural adaptations, trust, engagement) that determine the implementation of LIPIs. Based on the findings of Chapters 4 and 6, Figure 6.5 illustrates each of these domains and their corresponding determinants.

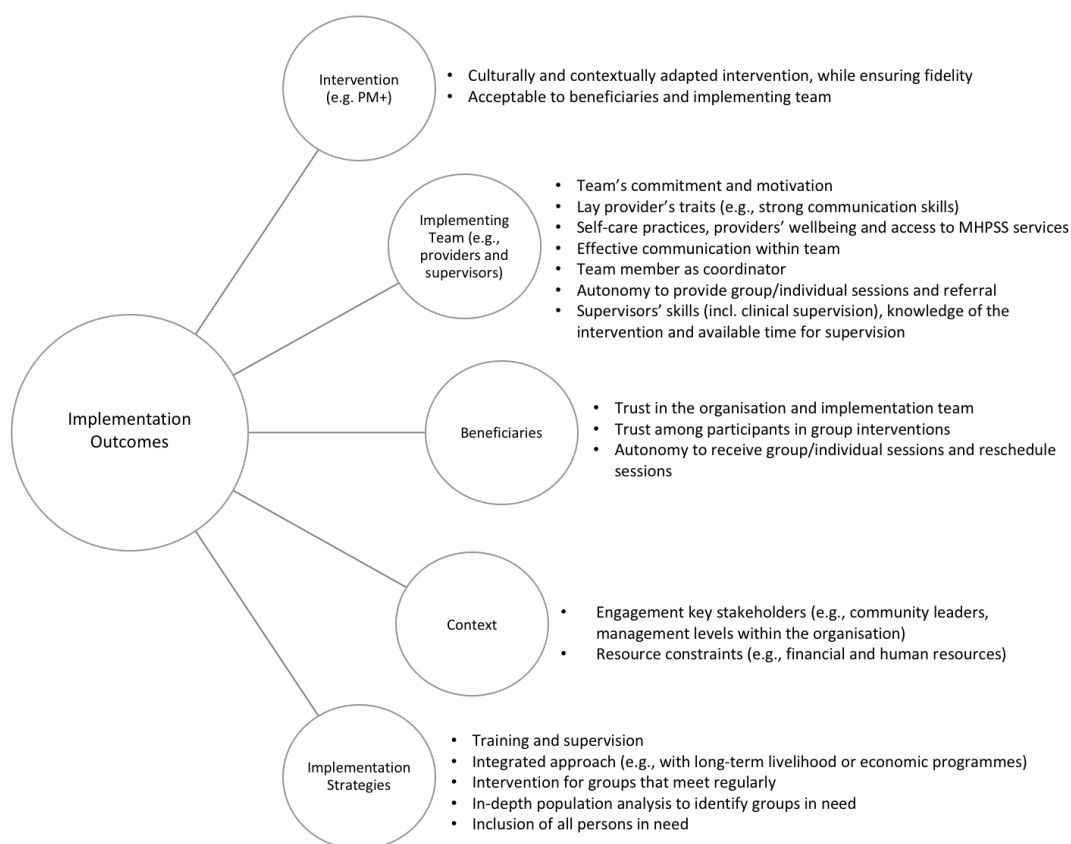


Figure 6.5. Domains and factors influencing the implementation of low-intensity psychological interventions for forcibly displaced persons

Chapter 7: Limitations and Research Recommendations

7.1 Chapter Overview

This study contributes the current knowledge on the implementation of low-intensity psychological interventions (LPIs) for reducing psychological distress among forcibly displaced persons. Conducted in a challenging and fragile setting, this study further provides useful knowledge on the process of implementing LPIs in humanitarian settings using readily available human resources. Despite its value, this study is not without limitations. The following chapter describes the key limitations of each phase of the study and offers some suggestions for future research.

7.2 Phase 1: Systematic Review

There are five limitations to the systematic review presented in Chapter 4. First, the results of the method used to synthesise the evidence (i.e. narrative synthesis) do not provide causal evidence on the relation between the studied interventions and its outcomes. Given inter-study heterogeneity (e.g., types of low-intensity psychological interventions delivered, populations, settings, statistical and methodological variation), a meta-analysis of the data was inappropriate, as it would have largely limited the study of this diverse body of evidence. Instead, the use of narrative synthesis generated a global overview of trends within the study of low-intensity psychological interventions for forcibly displaced populations. Despite this effort, the small number of studies identified through the review limited the ability to conclude which intervention(s) is/are deemed most effective for forcibly displaced persons. Second, psychological distress was used as the outcome measure of the review. However, this construct was understood within the dual continuum of mental illness and health, which is why the results include findings relating to positive mental health (e.g., well-being, meaning, belonging). Future reviews investigating refugee mental health within this continuum should select more appropriate outcome measures, such as mental health (Keyes et al., 2010; Westerhof &

Keyes, 2010). In addition, although thematic analysis was used to synthesize the evidence on implementation, the qualitative evidence identified was scarce. This meant that even though the steps of thematic analysis were followed, the results did not yield rich themes and were presented instead in a narrative form. Although grey literature was not excluded, reports from agencies exploring the use of LIPIs (e.g., UN and governmental agencies, NGOs) may not have been uploaded into the databases used in this review (e.g., Scopus, MedLine, Embase, CINAHL and PsycINFO). Future reviews should consider putting up calls to agencies on the evidence being researched or search non-academic databases that could retain grey literature. In addition, only studies published in English (the language interpretable to all review collaborators) were included, thereby possibly missing relevant evidence published in other languages. Although this exclusion criteria might have led to a language bias, the potential impact of this bias may be small considering the recent shift towards publications of studies in English (Higgins & Green, 2011).

Lastly, this systematic review, and the study as a whole, adopted a broad definition of 'lay provider' to include any individual providing a mental health intervention other than a mental health specialist (e.g., psychiatrist, psychologists, psychiatric nurse, mental health social worker). This includes non-specialist health workers (e.g., nurses and paraprofessionals), workers without a professional degree as well as other professionals with no previous health roles (e.g., teachers and community-level workers) (van Ginneken et al., 2013). This is in contrast to other studies who define a lay provider as "any health worker carrying out functions related to healthcare delivery, trained in some way in the context of the intervention, and having no formal professional or paraprofessional certificate or tertiary education degree" (Lewin et al., 2005, p. 2). The inconsistent use of a definition of lay provider, across this and other studies, thus limits comparisons across studies.

The definition for lay provider used in this study expands the scope of low-intensity psychological interventions by considering any person without a mental health background as a lay provider of this type of support. Restricting this definition to

include only those without a tertiary education would have further limited the number of studies included in the systematic review, therefore limiting my ability to analyse the outcomes of certain interventions. In addition, restricting the definition would have meant that fewer volunteers would have been trained to provide PM+ in this context and in turn, fewer persons would have been able to receive the intervention. Despite these advantages, it could be argued that the positive outcomes of the process evaluation and of some studies included in the systematic review could be partly attributed to providers' previous educational background. This should be considered in systematic reviews studying the effectiveness of PM+, as the outcomes of this study in this setting might be overestimated.

7.3 Phase 2: Cultural Adaptation

Several limitations of the cultural adaptation methodology presented in Chapter 5 and its use in the present study should be acknowledged. As discussed in Chapter 2, a large body of literature has demonstrated the benefits of culturally adapted psychological interventions (e.g., increased effectiveness, acceptability, appropriateness, the client's better understanding of the intervention, sustained fidelity). Despite this evidence, the question remains as to whether the changes made to the PM+ manuals through the cultural adaptation procedures developed as part of this study, offered any increased benefits to the study population, compared to a non-adapted version of PM+. Linked to this, another limitation of the adaptation process was the absence of a baseline measure of the Cultural Relevance Questionnaire. Future adaptations should consider including a baseline assessment of the protocol's cultural sensitivity to further ascertain whether the cultural adaptation process is associated with greater perceived cultural sensitivities. Along with the other possible advantages of cultural adaptations presented in section 2.6.1, the cultural adaptation process increased lay providers' and participants' level of acceptability of the intervention, as indicated by the interviewed staff and volunteers. In addition, this process contributed to the training of lay providers. By learning from the revised manual, providers were able to reflect on relevant case studies and take part in

training activities that were culturally and contextually sensitive. This added value should be considered in future evaluations of cultural adaptation processes.

Secondly, and despite my initial intention to include community consultations in step 3 of this methodology (i.e. local consultation), this was not possible due to the unstable security situation in Saravena. Thus, contrary to available guidance on cultural adaptations, security restrictions meant that the cultural adaptation of PM+ was not informed by the feedback of community members, which may have limited the cultural relevance of the intervention. This limitation was unavoidable since research in humanitarian settings must, first and foremost, respect the ethical principle of safety towards both participants and the research team, which could not be ensured at the time of the study (Chiumento et al., 2017).

Thirdly, due to security restrictions, and despite my initial intention to engage community members in local consultations as the primary beneficiaries of this intervention, the case studies were ultimately adapted based on the outcomes of consultation with employees and volunteers for the Colombian Red Cross (i.e. Step 3). Where time, safety and resources allow, future cultural adaptation efforts should therefore encourage the participation of beneficiaries (i.e. community members) in this process, in order to ensure that adaptations also reflect the perspectives, needs, and input of the very individuals the intervention is intended to serve. Some examples of these methods include: cognitive interviewing for adapting case studies as described in the DIME methodology; presenting a focus group discussion with a blank template of how a case example should be structured so they can collaboratively develop an example based on experience; developing case examples through the use of Forum Theatre or Theatre of The Oppressed, a form of theatre that encourages audience interaction and explores different options for dealing with a problem or issue (Applied Mental Health Research Group, 2013; IFRC Reference Centre for Psychosocial Support, 2018) or employing elicitation techniques of cultural domain analysis which are ethnographic techniques (e.g., freelist, pilesort and triads) that enable researchers to identify and understand shared definitions or cultural terms (Borgatti, 1999).

7.4 Phase 3: Process Evaluation

The limitations of the process evaluation revolve around the following topics: volunteer attrition, limited access, selection, reporting and response bias, single researcher data analysis, selecting cut-off scores and sample size limitations. Firstly, personnel attrition (e.g., due to health issues, maternity leave, migration, organisational factors) has been identified as one of the most important limitations of the task-shifting approach (Murray et al., 2011). The limited number of registered volunteers in the branch as well as volunteer turnover, including voluntary and involuntary departures, were key limitations of this study. The reduced number of volunteers (i.e. nine volunteers) that participated in the PM+ trainings further limited the number of beneficiaries that could receive PM+ (i.e. the sample size of the study) and the range of volunteers' perspectives featured in the interviews and focus group discussions. Voluntary reasons for leaving the CRC or the programme were finding a full-time job, and therefore having less time to contribute to the CRC and moving out of the city. Attrition could also be explained by a lack of commitment and motivation of the trained volunteers to deliver PM+, which were identified as important considerations in section 6.4.

To reduce staff and volunteer attrition, some suggest introducing a combination of non-financial and financial incentives (e.g., managing workloads, increasing supervision, providing formal certificates after trainings, embedding lay providers into the health system, certifying staff as Trainers of Trainers) (Haines et al., 2007; Mundeve, Snyder, Ngilangwa, & Kaida, 2018; Murray et al., 2011). Evidence on new strategies for reducing volunteer turnover specific to MHPSS programming, however, is needed. While there is evidence of the advantages of recruiting a volunteer workforce in humanitarian settings (e.g., improving access to basic health service), some authors have also highlighted the potential disadvantages of this model (e.g., potential for exploitation and disempowerment). It is important to emphasise that the increased vulnerability of unpaid volunteers identified in other studies should be considered in the design and decision to implement low-intensity psychological intervention in humanitarian and

low-income settings (Shahmalak, Blakemore, Waheed, & Waheed, 2019; White et al., 2017). The WHO Human Resources for Mental Health module suggests that retention can be achieved by improving remuneration, developing jobs that meet the needs of workers, providing ongoing training and support, improving social ties and morale among staff, and hiring people who have established ties with the community and in whom the community has confidence (World Health Organization, 2005). Given the important role of remuneration and job development, high attrition can also be considered a limitation of providing mental health interventions through a volunteer workforce.

Secondly, working in conflict and humanitarian settings such as Saravena has been described as working *in extremis* due to safety threats, population movement and the resultant limited access to certain areas and populations (Juntunen, 2011). This study was conducted in a transit city on the migration route from Venezuela to Colombia and Ecuador, which meant that it was difficult to identify migrants and refugees staying for the time required for the intervention. Newly arrived migrants and refugees were often sceptical of services provided by government auxiliaries, such as the Red Cross, which extended the recruitment period, increased volunteers' workload and ultimately limited the access to this population. These challenges possibly meant that highly vulnerable and transient beneficiaries did not have access to PM+. Limited access to certain areas meant that research activities were frequently rescheduled, posing logistical complications and delays for the research team.

In this study, the safety of the research team and participants was prioritised over research activities, as described in Chapter 3. Although essential, safety consideration also limited the scope of this study. For example, key informant interviews with PM+ participants had to be conducted over the phone which has been linked to increased social distance (Drabble, Trocki, Salcedo, Walker, & Korcha, 2016). There is no consensus as to whether face-to-face interviews are superior to phone interviews (Drabble et al., 2016). It has been hypothesised that phone interviews may increase social distance due to the absence of non-verbal cues, but this same social distance may also allow

respondents to disclose sensitive information more freely (Drabble et al., 2016). In this study setting, phone interviews enabled the inclusion of PM+ participants' perspectives without compromising interviewer or participant safety.

There are several ways in which reporting, and response biases could have occurred in this study. Volunteers often assisted PM+ participants to complete the questionnaires by reading the items out loud to them and entering their answers through the mobile application. This was done to compensate for low reading comprehension and low rates of literacy identified through the cultural adaptation process. In this scenario, PM+ participants could have answered questions based on what they believed to be socially acceptable or agreeable to the volunteer, and deny 'undesirable' claims or answer items based on the way questions were worded (Nederhof, 1985). In addition, PM+ participants could have responded inaccurately or falsely to questions regarding their wellbeing to reward the volunteers for the service provided. Indeed, most participants reported almost no anxiety symptoms after treatment. Since the GAD-7 was the only scale consisting entirely of 'undesirable' criteria (e.g., feeling nervous, anxious or on edge; being so restless that is hard to sit still), this positive finding could be explained by therapeutic alliance or the PM+ participants' desire to reward providers for their support. The simultaneous role of CRC volunteers as PM+ providers and data collectors may have influenced participants' responses and overestimated the positive outcomes of the study.

Key informant interviews with PM+ participants could have also been subjected to this bias, whereby participants may have overemphasised their satisfaction with the intervention, if they thought this would benefit volunteers. Indeed, the magnitude of response bias has been found to be stronger among collectivistic societies, such as Colombia (Kim & Kim, 2013). Power dynamics between interviewed staff, volunteers, and myself could have also introduced a response bias. Specifically, and given my involvement in the implementation of PM+ (e.g., training, monitoring, research guidance), staff and volunteers may not have seen me as an external researcher, but as a Red Cross team leader. Moreover, due to limited access, only intervention participants

who completed PM+ were interviewed. The experiences and feedback from participants who dropped out of PM+ or declined participation in the study were therefore not captured, an indication of selection bias.

The small sample size of this study means that the quantitative results need to be interpreted with caution. Most studies on psychosocial intervention with refugee samples also include similar sample sizes (Nose et al., 2017) and this has been recognised as a limitation in the field. Although the results do not indicate any risk of Type I or II errors, the small sample size possibly meant that associations between the outcome variables and demographic indicators could have been overlooked in the Case Completer analysis. This limitation was addressed in the ITT analysis which offers hypotheses of what these associations could be.

In this study, participants were not assessed at follow-up. Thus, it's not possible to draw conclusions as to whether any observed improvements were maintained over time. The wider literature in this area suggests that 'recovery' should only be considered following an extended period (i.e. 6-12 months) of full remission of symptoms (Bockting, Williams, Carswell, & Grech, 2016). Other PM+ studies have found sustained differences between persons receiving PM+ in comparison to those receiving enhanced treatment as usual at three months (Bryant et al., 2017; Rahman et al., 2016; Rahman et al., 2008). However, a lack of evidence at long-term follow-up raises concerns about the sustainability of results and of this model of care.

Another limitation of this phase is that only I conduct the data cleaning, transcription and analysis. Single researcher analyses and data processing could compromise the trustworthiness of the results through validation of hypothesised outcomes, errors in data cleaning, transcription or analysis. In this study, this limitation was mitigated by providing a transparent description of the methods and results of the study, triangulating transcripts and data sets and redoing the quantitative analyses. Future studies can prevent this limitation by employing multiple researchers to independently analyse the data and establishing inter-rater reliability in the case of qualitative research, comparing the outcomes in quantitative research or using mixed-

methods approaches to respond to the same research question (Roberts, Dowell, & Nie, 2019). The qualitative interviews and FGD were transcribed and analysed in Spanish. To promote trustworthiness and credibility in qualitative data analysis, I encourage researchers to collaborate with colleagues who speak the language used in the interviews when transcribing and analysing the results of the study. Alternatively, the interviews and FGDs can be translated to allow other researchers to independently analyse them.

In this study, WHO-5 cut-off scores were applied for two reasons. First, the PM+ protocol advises against providing the intervention to persons with severe representations of psychological distress and recommends referring them to specialised services. Second, the limited number of staff and volunteers trained in PM+ and the limited time each of them had to provide the intervention meant that resources had to be used strategically (e.g. by excluding participants with high WHO-5 scores). The cut-off scores used in this study have been used for screening for depression in a wide range of studies and fields (Topp et al., 2015). However, selecting cut-off scores that identify as many cases as possible while minimising misclassifications is challenging (McEwen et al., 2020). In addition, scores developed for a specific population might not be optimal when applied to others. Future studies can prevent this limitation by testing or selecting cut-off scores that have adequate sensitivity and specificity locally (McEwen et al., 2020).

Lastly, Figure 6.5 presented a hypothesised model of the domains and factors that may influence future implementations of LIPIs for forcibly displaced persons. By presenting this framework I intend to stimulate future debates on the topic of successful implementation of LIPIs, however, as argued by Nilsen (2015), many determinants frameworks ignore the complexity of relations between determinants, assuming a linear relation between the determinant and the outcome. Future discussions on this subject would benefit from studies addressing the nature of the relationships between the factors and domains that determine the outcomes of successful implementations.

7.5 Areas for Future Research

Considering the above limitations and evidence gaps identified throughout this study, several recommendations for future research are put forward. Firstly, as low-intensity psychological interventions, such as PM+, start to be implemented globally it is important to identify and test procedural frameworks for cultural adaptations. Combining aspects of various cultural adaptation frameworks and methodologies, I propose a four-step process for culturally adapting low-intensity psychological interventions for use in humanitarian contexts. However, further reflections and accounts of the utility and effectiveness of this or similar adaptation processes are strongly encouraged and needed.

Results from Chapter 4 showed that participating in parenting skills interventions is, in some cases, associated with improvements in caregiver/parental mental health. Considering that this finding is not consistent with the broader parenting skills literature, and may be a specific result within this population, future research should further explore whether and how family-centred parenting interventions for forcibly displaced populations offer benefits to these populations (Panter-Brick et al., 2014).

Long-term follow-up studies are necessary to provide insight as to whether these interventions continue to be implemented, following the end of projects. Research with large pools of participants on whether the use of these interventions in real-life settings is associated with improved psychological wellbeing over longer time periods, or whether additional sessions should be provided to maintain such effects, is also needed. As argued by Bockting et al. (2016), it is only through improved knowledge of the sustainability of these interventions within organisations and sustained improvements on the mental health of beneficiaries that one could reliably discuss the scalability of low-intensity psychological interventions in humanitarian and low-resource settings.

Studies investigating the scalability of low-intensity psychological interventions in humanitarian and low-income settings could also focus on investigating how to

embed various levels of low-intensity psychological interventions within the same system in a stepped-care approach. Such as, providing a short, preventive low-intensity lay-delivered psychological intervention in the first instance and referring beneficiaries who do not improve to a longer low-intensity psychological intervention (Tol et al., 2014). Making preventive approaches available in advance may contribute to the sustainability of this model of care and reduce the burden on lay providers. Similarly, evidence explaining why and how the implementation of low-intensity psychological interventions, such as PM+, work through theory-driven methodologies, such as realist evaluation or Theory of Change, would also inform future practice. This type of research should also consider the perspectives of participants who drop-out prematurely, including staff, volunteers and beneficiaries, or who do not consent to receive/provide PM+, to better allow us to ascertain the acceptability of low-intensity psychological interventions. These types of exploration would enable more nuanced implementations of these interventions across different contexts (Tareen & Tareen, 2019). To avoid or mitigate reporting and response bias and increase the trustworthiness of such research efforts, data collection should preferably be facilitated by external researchers and data cleaning, transcription and analysis should be conducted by at least two researchers.

Providers have a significant effect on the outcome of psychotherapies. However, there has been little research conducted on why some therapists are more effective than others (Saxon, Firth, & Barkham, 2017). This study did not account for the variability between volunteers providing PM+, or the so-called therapist effect. Underestimating or ignoring such effect may lead to overstating the effect of the PM+ model. Research on this topic is even scarcer when it comes to studying the effect of lay provided mental health interventions and could be investigated by assessing the ability of lay providers to recognise and repair ruptures to the alliance, unilateral termination of the sessions and treatment fidelity (Saxon et al., 2017). In support of the findings from Chapter 4, research on the long-term wellbeing on lay providers (e.g., vicarious trauma, level of motivation, supervisory need and work-related stress, burnout) would also contribute to better programming.

Lastly, advancing current knowledge on the implementation of low-intensity psychological interventions or task sharing mental health interventions entails designing and testing packages or combinations of implementation strategies that can be simultaneously implemented. These packages of strategies could include processes for cultural adaptations, training and supervision methodologies, peer support schemes, strategies for building trust among community members, and reducing lay providers' turnover, while minimising the risks associated with this type of work.

Chapter 8: Conclusion

Providing appropriate mental health care in low-resource and humanitarian settings remains one of the great challenges of our times. Within and outside humanitarian settings, a clear pattern of increased vulnerability has been observed among forcibly displaced persons due to higher exposure to interpersonal violence, family separation, poor and unsafe living conditions, among others. As reviewed in section 2.4.1.1, evidence points to a critically large gap in humanitarian settings between the number of people in need of mental health care and the number of people who receive it.

In face of these circumstances, the last two decades have seen important developments on research and implementation of simplified, evidence-based interventions that can be delivered by lay providers. In line with previous evidence, the outcomes of the implementation of Problem Management Plus in Colombia have shown that, in a very fragile environment, under natural circumstances lay providers can effectively deliver PM+ to tackle moderate cases of highly prevalent mental health problems (i.e. depression and anxiety) (Bryant et al., 2017; Rahman et al., 2016; Singla et al., 2017; van Ginneken et al., 2013). However, as the results of this study suggest a series of important factors may influence the implementation of this intervention.

As presented in sections 2.4.2 and 2.5.3, prior to this study, others had researched the effectiveness of low-intensity psychological interventions, and more specifically PM+, in humanitarian settings under controlled conditions. Few studies aimed to evaluate the implementation of these interventions under real-life conditions. Fewer still, study the process of culturally adapting these interventions to make them more meaningful to those who receive it. Few studies explored the context-specific factors that underpin the implementation of these interventions. The purpose of this study was to contribute to bridging such research gaps. This final chapter summarises the main findings of this thesis and conveys implications for theory, policy and practice.

8.1 Main Empirical Findings

8.1.1 No Implementation without Cultural Adaptation

The value of cultural adaptations of low-intensity psychological interventions was evidenced through all phases of this study. Although there is an increased recognition of the importance of culturally adapting and integrating cultural concepts of distress into MHPSS interventions (Cork et al., 2019), processes that follow a systematic approach and can be used in the context of time-constrained and fast-paced contexts of humanitarian emergencies are needed. Developed based on existing theory, I applied a four-step process (i.e. information gathering, adaptation hypothesis, local consultation and external evaluations) to culturally adapt a low-intensity psychological intervention for use in humanitarian settings. The proposed four-step process offers a guide for *how* to adapt low-intensity psychological intervention within humanitarian settings. Despite its limitations, it shows that even when time and resources are scarce it is possible and necessary to culturally adapt MHPSS interventions.

8.1.2 Effectiveness of LIPIs for Forcibly Displaced Persons

This study further contributes to our growing understanding of which LIPIs can contribute to improving psychological outcomes among forcibly displaced persons. Moreover, this is the first study to test Problem Management Plus among migrants and refugees. Results of the systematic review of the literature or phase 1 of this study, showed that parenting skills interventions are associated with improvements in child behaviour and contributed to caregivers' mental health. Narrative Exposure Therapy was found to be as beneficial as other interventions (relaxation and counselling) in reducing symptoms of post-traumatic stress among children and adults. Evidence was found for Interpersonal Psychotherapy indicating significant reductions in depression symptoms among adolescent girls.

Results on the association between low-intensity Cognitive Behavioural Therapy and improved mental health outcomes among forcibly displaced populations identified through the systematic review were scarce and inconclusive. However, phase 3 of this

study helped bridge this evidence gap by showing that Problem Management Plus is, with high effect sizes, significantly associated with improved subjective wellbeing and anxiety in comparison to waitlist control. This supports previous findings on the effectiveness of PM+ in different cultural contexts (i.e. Kenya and Pakistan), as discussed in section 6.5. In addition, this study also identified strong associations between PM+ and increased quality of life and showed that females are more likely, although slightly, to benefit from PM+. These findings merit further investigation.

8.1.3 Implementation Factors

Given the global magnitude and complexity of forced displacement, the findings of this study indicate that PM+ is a valuable resource to increase the access of migrants and refugees to culturally-appropriate mental health care, provided that a series of implementation factors are considered. The systematic review showed that cultural and contextual adaptations contributed to the implementation of LIPIs. Distrust among participants of group interventions, lack of reliable protection of participants and the negative impact of interventions on lay providers' mental health may hinder implementation. Time, resource constraints (i.e. human and financial) and weak coordination can affect the sustainability of these interventions. In phase 3, the following eight factors were found to influence the implementation of PM+ in this Colombia: trust, engagement, integrated approach, teamwork, autonomy, supervision, acceptability and inclusion.

Consistent with previous literature on health-seeking behaviours among refugees, trust in the organisation providing MHPSS services was a determinant of the implementation of PM+ in Colombia. While other studies found throughout the systematic review identified distrust among participants during group sessions as a barrier to the implementation of low-intensity psychological interventions among forcibly displaced populations, within this study distrust also found to affected volunteer motivation. In addition, in line with the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, early stakeholder support was fundamental to the implementation of PM+ in this setting. This finding ratifies what two

decades of MHPSS practice have already shown: the importance of multi-sectorial coordination and thorough stakeholder mappings and participatory assessments before implementing MHPSS interventions (Inter-Agency Standing Committee, 2007).

Furthermore, and echoing the recommendations of Tol et al. (2014) and Burgess et al. (2020), I found that psychological interventions are only part of the picture. Given the impact of social and economic factors on humanitarian settings, providing PM+ alongside socioeconomic programs (e.g. livelihood programmes) simultaneously addressed the cause of adversity while also providing beneficiaries with the tools to manage psychosocial difficulties. Providing these programmes in tandem could also positively impact the sustainability of this model of care, which has been recently described as a challenge, and may also contribute to the providers' wellbeing (Barbui et al., 2020).

Teamwork was also influential to the implementation of PM+ in this setting. Commitment to the organisation and MHPSS activities influenced teamwork and, conversely, a lack of commitment and motivation partially explained the high provider attrition. In this study, commitment and motivation was identified as a pre-requisite of becoming a PM+ provider. However, evidence shows that these traits can also be promoted through organisational support practices. Providers and beneficiaries' autonomy contributed to the implementation of PM+ in this setting. More specifically, the capacity to refer and signpost beneficiaries to mental health specialists and other social services contributed to lay providers' autonomy and to the implementation of PM+. In addition, the opportunity to reschedule or change the setting of the PM+ contributed to beneficiaries' autonomy. This finding supports previous evidence on autonomy within health settings and indicates that despite resource and security concerns, providers and beneficiaries' autonomy can be pursued in humanitarian context.

Supervision, and more specifically supervisors' skills and knowledge, influenced the implementation of PM+ among Venezuelan migrants and refugees. This finding shows a clear gap on MHPSS programming and reinforce the importance of supervision

guidelines for the MHPSS field. Despite challenges with supervision, PM+ contributed to their personal and professional development of supervisors and providers. For some, delivering PM+ helped them feel more comfortable with public speaking, building trust with beneficiaries, and even motivated them to finish their studies. Volunteers also talked about the rewarding experiences of providing humanitarian assistance and all spoke about how much they learned from each other. PM+ was also acceptable to participants who viewed the sessions as a safe space to discuss intimate and distressing problems and the volunteers as prepared and professional providers. The low drop-out rate and high retention might also be indicative of participants' satisfaction.

Lastly, providing the intervention to all populations, giving priority to the most urgent cases of distress, was important for the implementation of PM+. While this ratifies the importance of conducting thorough assessments of the population's needs, it also indicates that wide community meetings explaining the rationale for providing the intervention to specific subset of the population might be needed.

8.2 Implications for Theory, Policy and Practice

Departing from the RCT model, this study contributed to existing knowledge on the implementation of low-intensity psychological interventions for improving psychological outcomes among forcibly displaced persons in real-life settings. Although additional research is underway [e.g., Graaff et al. (2020); Sijbrandij et al., (2017); University of Liverpool, (2020)], this is the first study supporting the use of Problem Management Plus among migrants and refugees. This study also uncovered the different factors determining implementation and identified culture as an important aspect of implementation and acted on the need to advance implementation research, one of the main challenges of global mental health (Collins et al., 2011). In doing so, this study contributed to the theoretical discourse on implementation research in a low-income or humanitarian setting in two ways: (1) development and application of systematic processes for cultural adaptation and; (2) application of the Five Domains

Framework for implementation of low-intensity psychological interventions for forcibly displaced persons.

Such theoretical outcomes have practical implications. Firstly, the process of cultural adaptation is gaining increased recognition considering the evidence on intercultural differences (e.g., idioms of distress, coping mechanisms) and increased effectiveness of culturally adapted interventions. Systematic processes for cultural adaptation, that make use of existing theory, may ease tensions between the need to maintain fidelity with the original intervention and the need to contextualise interventions to make them locally-relevant. In this study, PM+ was culturally adapted based on a series of cultural adaptation frameworks (i.e. HF, DIME methodology, EVM). Using a combination of validated tools and measures, this cultural adaptation process was thoroughly described to enable its replication and amendments before future implementations. At a practical level, this enables the cultural adaptation of LIPIs in time and resource constrained settings. Secondly, the outcomes of this study informed the development of a theoretical framework on the domains and factors influencing the implementation of low-intensity psychological interventions for forcibly displaced persons. Based on the five types of domains or core determinants identified by Nilsen (2015), this model stimulates the theoretical debate on what general domains and factors influence the implementation of LIPIs and what determines implementation success. Despite the value of the Five Domains Framework, its application to the MHPSS field is new. Indeed, previous research investigating the factors determining the implementation of MHPSS interventions, such as those described in section 2.4.1.1, has not follow any clear theoretical approach. Accordingly, this study expands the applications of determinant frameworks of implementation research discussed in section 3.4. The application of the Five Domains Framework helps practitioners and implementers (e.g., from National Societies in the Red Cross and Red Crescent Movement, NGOs or public institution) working with low-intensity psychological interventions to identify determinants in a structured way and thus influence

implementation outcomes. Thoughtful applications of this model and a consistent use of terminology may contribute to its development.

The outcomes of this study have local and global political implications. Locally, the current crises in the Middle East have led to increased migration into European countries who have not been able to adequately cope with the increased demand for health services. Problem Management Plus could act as valuable strategy for increase access to mental health care for migrants and refugees (Sijbrandij et al., 2017). To enable this implication, I drafted a policy brief for EU policymakers to consider the value of PM+ in supporting the mental health and psychosocial wellbeing of migrants and refugees through a volunteer workforce (Appendix I – Policy Brief). Globally, the recent inclusion of mental health and substance use in the Sustainable Development Goals, represents a unique and historical opportunity to shape the global mental health agenda (Patel et al., 2018). In this agenda, world leaders committed themselves to reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing by 2030. One of the key innovations to be scaled up in the context of the SDGs is task-sharing of psychosocial interventions to non-specialised workers (Patel et al., 2018). By presenting evidence supporting the implementation of Problem Management Plus in humanitarian and low-resource settings, this study informs ongoing efforts by global actors (e.g., the Lancet Commission on Global Mental Health, the Movement for Global Mental Health, the Red Cross and Red Crescent Movement's MOMENT project, United Nations) aiming to meet this global goal.

References

- Abas, M., Bowers, T., Manda, E., Cooper, S., Machando, D., Verhey, R., . . . Chibanda, D. (2016). 'Opening up the mind': problem-solving therapy delivered by female lay health workers to improve access to evidence-based care for depression and other common mental disorders through the Friendship Bench Project in Zimbabwe. *International Journal of Mental Health Systems*, 10(1), 39. doi:10.1186/s13033-016-0071-9
- Acosta, P., & Chica, N. (2018). Psychosocial support to foster social cohesion between refugee and host communities in Jordan. *Intervention*, 16(2), 147-153. doi:10.4103/intv.Intv_40_18
- Ager, A., Burnham, G., Checchi, F., Gayer, M., Grais, R. F., Henkens, M., . . . Spiegel, P. (2014). Strengthening the evidence base for health programming in humanitarian crises. *Science*, 345(6202), 1290-1292. doi:10.1126/science.1254164
- Agger, I. (2002). *Therapeutic approaches to the treatment of refugees: A historical perspective*. Retrieved from <http://www.oasis-rehab.dk/Sider/Bibliotek/Artikler/Inger%20Agger.pdf>
- Aldamman, K., Tamrakar, T., Dinesen, C., Wiedemann, N., Murphy, J., Hansen, M., . . . Vallières, F. (2019). Caring for the mental health of humanitarian volunteers in traumatic contexts: the importance of organisational support. *European Journal of Psychotraumatology*, 10(1), 1694811. doi:10.1080/20008198.2019.1694811
- Ali, S., Littlewood, E., McMillan, D., Delgadillo, J., Miranda, A., Croudace, T., & Gilbody, S. (2014). Heterogeneity in patient-reported outcomes following low-intensity mental health interventions: a multilevel analysis. *PLOS One*, 9(9), e99658. doi:10.1371/journal.pone.0099658
- Ali, S., Rhodes, L., Moreea, O., McMillan, D., Gilbody, S., Leach, C., . . . Delgadillo, J. (2017). How durable is the effect of low intensity CBT for depression and anxiety? Remission and relapse in a longitudinal cohort study. *Behaviour Research and Therapy*, 94, 1-8. doi:10.1016/j.brat.2017.04.006
- Allden, K., Jones, L., Weissbecker, I., Wessells, M., Bolton, P., Betancourt, T. S., . . . Sumathipala, A. (2009). Mental health and psychosocial support in crisis and conflict: report of the Mental Health Working Group. *Prehospital and Disaster Medicine*, 24 Suppl 2, s217-227. doi:10.1017/s1049023x00021622
- Altman, D. G., & Bland, J. M. (1995). Statistics notes: The normal distribution. *BMJ*, 310(6975), 298. doi:10.1136/bmj.310.6975.298
- Anand, T. N., Joseph, L. M., Geetha, A. V., Prabhakaran, D., & Jeemon, P. (2019). Task sharing with non-physician health-care workers for management of blood pressure in low-income and middle-income countries: a systematic review and meta-analysis. *The Lancet Global Health*, 7(6), e761-e771. doi:10.1016/S2214-109X(19)30077-4
- Andrews, G., Cuijpers, P., Craske, M. G., McEvoy, P., & Titov, N. (2010). Computer Therapy for the Anxiety and Depressive Disorders Is Effective, Acceptable and Practical Health Care: A Meta-Analysis. *PLOS One*, 5(10), e13196. doi:10.1371/journal.pone.0013196
- Annan, J., Sim, A., Puffer, E. S., Salhi, C., & Betancourt, T. S. (2016). Improving Mental Health Outcomes of Burmese Migrant and Displaced Children in Thailand: a Community-Based Randomized Controlled Trial of a Parenting and Family Skills Intervention. *Prevention Science*, 18(7), 793-803. doi:10.1007/s11121-016-0728-2.
- Applied Mental Health Research Group. (2013). *Design, Implementation, Monitoring, and Evaluation of Cross-Cultural HIV-Related Mental Health And Psychosocial Assistance Programs: A User's Manual for Researchers and Program Implementers (Adult Version)*. Retrieved from <https://www.jhsph.edu/research/centers-and-institutes/research-to-prevention/dime-manual/DIME-MODULE-1.pdf>

- Araya, R., Rojas, G., Fritsch, R., Gaete, J., Rojas, M., Simon, G., & Peters, T. J. (2003). Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. *The Lancet*, 361(9362), 995-1000. doi:10.1016/s0140-6736(03)12825-5
- Arjadi, R., Nauta, M. H., Chowdhary, N., & Bockting, C. L. H. (2015). A systematic review of online interventions for mental health in low and middle income countries: a neglected field. *Global Mental Health*, 2, e12. doi:10.1017/gmh.2015.10
- Arnett, J. J. (2008). The neglected 95%: why American psychology needs to become less American. *American Psychologist*, 63(7), 602-614. doi:10.1037/0003-066x.63.7.602
- Arnoso-Martínez, M., Cárdenas-Castro, M., Beristain, C. M., & Alfonso, C. (2017). Armed Conflict, Psychosocial Impact and Reparation in Colombia: Women's Voice. *Universitas Psychologica*, 16(3). doi:http://dx.doi.org/10.11144/Javeriana.upsy16-3.acpi
- Arrieta Valero, I. (2019). Autonomies in Interaction: Dimensions of Patient Autonomy and Non-adherence to Treatment. *Frontiers in Psychology*, 10, 1857-1857. doi:10.3389/fpsyg.2019.01857
- Ashworth, M. (2007). PSYCHLOPS – a psychometric outcome measure that is finding a niche. *Counselling and Psychotherapy Research*, 7(4), 201-202. doi:10.1080/14733140701706870
- Ashworth, M., Robinson, S., Godfrey, E., Shepherd, M., Evans, C., Seed, P., . . . Tylee, A. (2005). Measuring mental health outcomes in primary care: The psychometric properties of a new patient-generated outcome measure, 'PSYCHLOPS' ('psychological outcome profiles'). *Primary care mental health*, 3, 261-270.
- Ashworth, M., Robinson, S. I., Godfrey, E., Parmentier, H., Shepherd, M., Christey, J., . . . Matthews, V. (2005). The experiences of therapists using a new client-centred psychometric instrument, PSYCHLOPS (Psychological Outcome Profiles). *Counselling and Psychotherapy Research*, 5(1), 37-42. doi:10.1080/14733140512331343886
- Atif, N., Lovell, K., Husain, N., Sikander, S., Patel, V., & Rahman, A. (2016). Barefoot therapists: barriers and facilitators to delivering maternal mental health care through peer volunteers in Pakistan: a qualitative study. *International Journal of Mental Health Systems*, 10, 24-24. doi:10.1186/s13033-016-0055-9
- Bahar, D., Dooley, M., & Huang, C. (2018). *Integrating Venezuelans into the Colombian labour market: Mitigating costs and maximizing benefits*. Retrieved from <https://www.brookings.edu/research/integrating-venezuelans-into-the-colombian-labor-market/>
- Bakas, T., McLennon, S. M., Carpenter, J. S., Buelow, J. M., Otte, J. L., Hanna, K. M., . . . Welch, J. L. (2012). Systematic review of health-related quality of life models. *Health and Quality of Life Outcomes*, 10(1), 134. doi:10.1186/1477-7525-10-134
- Balaji, M., Chatterjee, S., Koschorke, M., Rangaswamy, T., Chavan, A., Dabholkar, H., . . . Thornicroft, G. (2012). The development of a lay health worker delivered collaborative community based intervention for people with schizophrenia in India. *BMC Health Services Research*, 12(1), 42.
- Balas, E. A. (1998). From appropriate care to evidence-based medicine. *Pediatric Annals*, 27(9), 581-584.
- Bangpan, M., Felix, L., Chiumento, A., & Dickson, K. (2016). *The impact of mental health and psychosocial support programmes for populations affected by humanitarian emergencies: A systematic review protocol*. Retrieved from <https://policy-practice.oxfam.org.uk/publications/the-impact-of-mental-health-and-psychosocial-support-programmes-for-populations-605150>
- Bangpan, M., Felix, L., & Dickson, K. (2019). Mental health and psychosocial support programmes for adults in humanitarian emergencies: a systematic review and meta-analysis in low and middle-income countries. *BMJ Global Health*, 4, e001484. doi:10.1136/bmjgh-2019-001484
- Barbui, C., Purgato, M., Abdulmalik, J. O., Acarturk, C., Eaton, J., Gastaldon, C., . . . Thornicroft, G. (2020). Efficacy of psychosocial interventions for mental health

- outcomes in low-income and middle-income countries: an umbrella review. *The Lancet Psychiatry*. doi:10.1016/S2215-0366(19)30511-5
- Barenbaum, J., Ruchkin, V., & Schwab-Stone, M. (2004). The psychosocial aspects of children exposed to war: practice and policy initiatives. *Journal of Child Psychology and Psychiatry*, 45(1), 41-62. doi:10.1046/j.0021-9630.2003.00304.x
- Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy*, 35(2), 205-230. doi:https://doi.org/10.1016/S0005-7894(04)80036-4
- Barrera, M., & Castro González, F. (2006). A Heuristic Framework for the Cultural Adaptation of Interventions. *Clinical Psychology: Science and Practice*, 13(4), 311-316. doi:doi:10.1111/j.1468-2850.2006.00043.x
- Barth, J., Munder, T., Gerger, H., Nüesch, E., Trelle, S., Znoj, H., . . . Cuijpers, P. (2013). Comparative Efficacy of Seven Psychotherapeutic Interventions for Patients with Depression: A Network Meta-Analysis. *PLoS Medicine*, 10(5), e1001454. doi:10.1371/journal.pmed.1001454
- Bass, J., Neugebauer, R., Clougherty, K. F., Verdelli, H., Wickramaratne, P., Ndogoni, L., . . . Bolton, P. (2006). Group interpersonal psychotherapy for depression in rural Uganda: 6-month outcomes: randomised controlled trial. *British Journal of Psychiatry*, 188, 567-573. doi:10.1192/bjp.188.6.567
- Bass, J. K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., . . . Bolton, P. A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *The New England Journal of Medicine*, 368(23), 2182-2191. doi:10.1056/NEJMoa1211853
- Batniji, R., Van Ommeren, M., & Saraceno, B. (2006). Mental and social health in disasters: Relating qualitative social science research and the Sphere standard. *Social Science and Medicine*, 62(8), 1853-1864. doi:10.1016/j.socscimed.2005.08.050
- Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC Psychology*, 3, 32. doi:10.1186/s40359-015-0089-9
- Baumann, A. A., Powell, B. J., Kohl, P. L., Tabak, R. G., Penalba, V., Proctor, E. E., . . . Cabassa, L. J. (2015). Cultural Adaptation and Implementation of Evidence-Based Parent-Training: A Systematic Review and Critique of Guiding Evidence. *Children and youth services review*, 53, 113-120. doi:10.1016/j.childyouth.2015.03.025
- Bech, P., Lindberg, L., & Moeller, S. B. (2018). The Reliable Change Index (RCI) of the WHO-5 in primary prevention of mental disorders. A measurement-based pilot study in positive psychiatry. *Nord J Psychiatry*, 72(6), 404-408. doi:10.1080/08039488.2018.1463393
- Beck, A. T. (1967). *Depression: Causes and Treatment*. Philadelphia: University of Pennsylvania Press.
- Beck, J. S., & Beck, A. (2011). *Cognitive behavior therapy. New York: Basics and beyond. Guilford Publication.*
- Bell, A. C., & D'Zurilla, T. J. (2009). Problem-solving therapy for depression: A meta-analysis. *Clinical Psychology Review*, 29(4), 348-353. doi:10.1016/j.cpr.2009.02.003
- Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. *Journal of Counseling Psychology*, 58(3), 279-289. doi:10.1037/a0023626
- Benitez-Borrego, S., Guardia-Olmos, J., & Urzua-Morales, A. (2014). Factorial structural analysis of the Spanish version of WHOQOL-BREF: an exploratory structural equation model study. *Quality of Life Research*, 23(8), 2205-2212. doi:10.1007/s11136-014-0663-2
- Bennett-Levy, J., Richards, D. A., & Farrand, P. (2010). Low intensity CBT interventions: a revolution in mental health care. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B. Klein, M. A. Lau, J. Proudfoot, L. Ritterband, J. White, & C. Williams (Eds.), *Oxford Guide to Low Intensity CBT Interventions*. New York: Oxford University Press.

- Bernal, G., & Adames, C. (2017). Cultural Adaptations: Conceptual, Ethical, Contextual, and Methodological Issues for Working with Ethnocultural and Majority-World Populations. *Prevention Science*, 18(6), 681-688. doi:10.1007/s11121-017-0806-0
- Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Psychology*, 23(1), 67-82.
- Bernal, G., Chafey, M., & Domenech Rodríguez, M. (2009). *Cultural Adaptation of Treatments: A Resource for Considering Culture in Evidence-Based Practice* (Vol. 40).
- Bernal, G., & Domenech-Rodríguez, M. M. (2012a). Bridging the Gap between Research and Practice in a Multicultural World *Cultural adaptations: Tools for evidence-based practice with diverse populations*. (pp. xix, 307-xix, 307). Washington, DC, US: American Psychological Association.
- Bernal, G., & Domenech-Rodríguez, M. M. (2012b). *Cultural adaptations: Tools for evidence-based practice with diverse populations*: American Psychological Association.
- Bernal, G., & Domenech-Rodríguez, M. M. (Eds.). (2012c). *Cultural adaptations: Tools for evidence-based practice with diverse populations*. Washington, DC, US: American Psychological Association.
- Bernal, G., Jiménez-Chafey, M. I., & Domenech-Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, 40(4), 361-368. doi:10.1037/a0016401
- Berry, J. W. (2013). Global psychology. *South African Journal of Psychology*, 43(4), 391-401. doi:10.1177/0081246313504517
- Betancourt, T. S., & Williams, T. (2008). Building an evidence base on mental health interventions for children affected by armed conflict. *Intervention*, 6(1), 39-56. doi:10.1097/WTF.0b013e3282f761ff
- Bhattacharyya, K., Winch, P., LeBan, K., & Tien, M. (2001). *Community health worker incentives and disincentives: how they affect motivation, retention, and sustainability*: BASICS II Arlington.
- Biesta, G. (2010). Pragmatism and the philosophical foundations of mixed methods research.
- Birken, S. A., Powell, B. J., Shea, C. M., Haines, E. R., Alexis Kirk, M., Leeman, J., . . . Presseau, J. (2017). Criteria for selecting implementation science theories and frameworks: results from an international survey. *Implementation Science*, 12(1), 124. doi:10.1186/s13012-017-0656-y
- Birken, S. A., Rohweder, C. L., Powell, B. J., Shea, C. M., Scott, J., Leeman, J., . . . Presseau, J. (2018). T-CaST: an implementation theory comparison and selection tool. *Implementation Science*, 13(1), 143. doi:10.1186/s13012-018-0836-4
- Birkhäuser, J., Gaab, J., Kossowsky, J., Hasler, S., Krummenacher, P., Werner, C., & Gerger, H. (2017). Trust in the health care professional and health outcome: A meta-analysis. *PLOS One*, 12(2), e0170988-e0170988. doi:10.1371/journal.pone.0170988
- Bland, J. M., & Altman, D. G. (1997). Statistics notes: Cronbach's alpha. *BMJ*, 314(7080), 572. doi:10.1136/bmj.314.7080.572
- Bockting, C. L. H., Williams, A. D., Carswell, K., & Grech, A. E. (2016). The potential of low-intensity and online interventions for depression in low- and middle-income countries. *Global Mental Health*, 3. doi:ARTN e2510.1017/gmh.2016.21
- Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: a systematic literature review. *BMC International Health and Human Rights*, 15(1). doi:10.1186/s12914-015-0064-9
- Bolton, P. (2019). 1 - Global mental health and psychotherapy: Importance of task-shifting and a systematic approach to adaptation. In D. J. Stein, J. K. Bass, & S. G. Hofmann (Eds.), *Global Mental Health and Psychotherapy* (pp. 11-24): Academic Press.

- Bolton, P., Bass, J., Betancourt, T., Speelman, L., Onyango, G., Clougherty, K. F., . . . Verdeli, H. (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda - A randomized controlled trial. *Jama-Journal of the American Medical Association*, 298(5), 519-527. doi:DOI 10.1001/jama.298.5.519
- Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., . . . Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda: a randomized controlled trial. *JAMA*, 289(23), 3117-3124. doi:10.1001/jama.289.23.3117
- Bolton, P., Lee, C., Haroz, E. E., Murray, L., Dorsey, S., Robinson, C., . . . Bass, J. (2014). A Transdiagnostic Community-Based Mental Health Treatment for Comorbid Disorders: Development and Outcomes of a Randomized Controlled Trial among Burmese Refugees in Thailand. *PLoS Medicine*, 11(11). doi:ARTN e100175710.1371/journal.pmed.1001757
- Bonnin, C. M., Yatham, L. N., Michalak, E. E., Martinez-Aran, A., Dhanoa, T., Torres, I., . . . Reinares, M. (2018). Psychometric properties of the well-being index (WHO-5) spanish version in a sample of euthymic patients with bipolar disorder. *Journal of Affective Disorders*, 228, 153-159. doi:10.1016/j.jad.2017.12.006
- Borgatti, S. P. (1999). Elicitation techniques for cultural domain analysis. *The ethnographer's toolkit*, 3, 115-151.
- Borkovec, T. D., Abel, J. L., & Newman, H. (1995). Effects of psychotherapy on comorbid conditions in generalized anxiety disorder. *Journal of Consulting and Clinical Psychology*, 63(3), 479-483.
- Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency. Narrative literature review. *British Journal of Psychiatry*, 186, 11-17. doi:10.1192/bjp.186.1.11
- Bower, P., Kontopantelis, E., Sutton, A., Kendrick, T., Richards, D. A., Gilbody, S., . . . Christensen, H. (2013). Influence of initial severity of depression on effectiveness of low intensity interventions: meta-analysis of individual patient data. *BMJ*, 346, f540.
- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, 162(2), 214-227. doi:10.1176/appi.ajp.162.2.214
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi:10.1191/1478088706qp063oa
- Braun, V., & Clarke, V. (2012). Thematic analysis *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological*. (pp. 57-71). Washington, DC, US: American Psychological Association.
- Bronfenbrenner, U. (1992). Ecological systems theory *Six theories of child development: Revised formulations and current issues*. (pp. 187-249). London, England: Jessica Kingsley Publishers.
- Brown, F. L., Carswell, K., Augustinavicius, J., Adaku, A., Leku, M. R., White, R. G., . . . Tol, W. A. (2018). Self Help Plus: study protocol for a cluster-randomised controlled trial of guided self-help with South Sudanese refugee women in Uganda. *Global Mental Health*, 5, e27. doi:10.1017/gmh.2018.17
- Bryant, R. A., Felmingham, K., Whitford, T. J., Kemp, A., Hughes, G., Peduto, A., & Williams, L. M. (2008). Rostral anterior cingulate volume predicts treatment response to cognitive-behavioural therapy for posttraumatic stress disorder. *Journal of Psychiatry and Neuroscience*, 33(2), 142-146.
- Bryant, R. A., Schafer, A., Dawson, K. S., Anjuri, D., Mulili, C., Ndogoni, L., . . . van Ommeren, M. (2017). Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: A randomised clinical trial. *PLoS Medicine*, 14(8), e1002371. doi:10.1371/journal.pmed.1002371
- Bullis, J. R., Fortune, M. R., Farchione, T. J., & Barlow, D. H. (2014). A preliminary investigation of the long-term outcome of the Unified Protocol for

- Transdiagnostic Treatment of Emotional Disorders. *Comprehensive Psychiatry*, 55(8), 1920-1927. doi:10.1016/j.comppsy.2014.07.016
- Burgess, R. A., Jain, S., Petersen, I., & Lund, C. (2020). Social interventions: a new era for global mental health? *Lancet Psychiatry*, 7(2), 118-119. doi:10.1016/s2215-0366(19)30397-9
- Buttorff, C., Hock, R. S., Weiss, H. A., Naik, S., Araya, R., Kirkwood, B. R., . . . Patel, V. (2012). Economic evaluation of a task-shifting intervention for common mental disorders in India. *Bulletin of the World Health Organization*, 90(11), 813-821. doi:10.2471/blt.12.104133
- Cabassa, L. J., & Baumann, A. A. (2013). A two-way street: bridging implementation science and cultural adaptations of mental health treatments. *Implementation Science*, 8(1), 90. doi:10.1186/1748-5908-8-90
- Calnan, M., & Rowe, R. (2006). Researching trust relations in health care: conceptual and methodological challenges--introduction. *J Health Organ Manag*, 20(5), 349-358. doi:10.1108/14777260610701759
- Campo-Arias, A., Miranda-Tapia, G. A., Cogollo, Z., & Herazo, E. (2015). Reproducibilidad del Índice de Bienestar General (WHO-5 WBI) en estudiantes adolescentes. *Revista Salud Uninorte*, 31, 18-24.
- Cape, J., Whittington, C., Buszewicz, M., Wallace, P., & Underwood, L. (2010). Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression. *BMC Medicine*, 8(1), 38. doi:10.1186/1741-7015-8-38
- Card, J. J., Solomon, J., & Cunningham, S. D. (2011). How to Adapt Effective Programs for Use in New Contexts. *Health Promotion Practice*, 12(1), 25-35. doi:10.1177/1524839909348592
- Casey, N. (2016). At a Loss for Meds, Venezuela's Mentally Ill Spiral Downward. *The New York Times*. Retrieved from <https://www.nytimes.com/2016/10/02/world/americas/venezuela-mental-health-medicine-shortages.html>
- Castañó-Pérez, G. A., Sierra-Hincapié, G. M., Sánchez-Acosta, D., Semenova-Moratto, N., Salas-Zapata, C., Buitrago-Salazar, C., & Agudelo-Martínez, M. A. (2018). *Salud mental en víctimas de desplazamiento forzado por la violencia en Colombia. El caso de Bogotá, Medellín y Buenaventura*. Medellín: Editorial CES.
- Castro, F. G., Barrera, M., & Martinez, C. R. (2004). The Cultural Adaptation of Prevention Interventions: Resolving Tensions Between Fidelity and Fit. *Prevention Science*, 5(1), 41-45. doi:10.1023/B:PREV.0000013980.12412.cd
- Castro, F. G., Barrera, M., & Steiker, L. K. H. (2010). Issues and Challenges in the Design of Culturally Adapted Evidence-Based Interventions. *Annual Review of Clinical Psychology*, 6, 213-239. doi:10.1146/annurev-clinpsy-033109-132032
- Catani, C., Kohiladevy, M., Ruf, M., Schauer, E., Elbert, T., & Neuner, F. (2009). Treating children traumatized by war and Tsunami: a comparison between exposure therapy and meditation-relaxation in North-East Sri Lanka. *BMC Psychiatry*, 9, 22. doi:10.1186/1471-244X-9-22
- Centre for Justice and Peace. (2018). *Complex Humanitarian Emergency in Venezuela: Right to Health*. Retrieved from https://cepaz.org/documentos_informes/complex-humanitarian-emergency-in-venezuela/
- Chalmers, I., & Glasziou, P. (2009). Avoidable waste in the production and reporting of research evidence. *Obstetrics and Gynecology*, 114(6), 1341-1345. doi:10.1097/AOG.0b013e3181c3020d
- Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *The Lancet*. doi:10.1016/S0140-6736(19)30934-1
- Chaskel, R., Gaviria, S. L., Espinel, Z., Taborda, E., Venegas, R., & Shultz, J. M. (2015). Mental health in Colombia. *BJPsych International*, 12(4), 95-97.
- Chen, L., Zhang, G., Hu, M., & Liang, X. (2015). Eye movement desensitization and reprocessing versus cognitive-behavioral therapy for adult posttraumatic stress

- disorder: systematic review and meta-analysis. *The Journal of Nervous and Mental Disease*, 203(6), 443-451. doi:10.1097/nmd.0000000000000306
- Chen, Y. R., Hung, K. W., Tsai, J. C., Chu, H., Chung, M. H., Chen, S. R., . . . Chou, K. R. (2014). Efficacy of eye-movement desensitization and reprocessing for patients with posttraumatic-stress disorder: a meta-analysis of randomized controlled trials. *PLOS One*, 9(8), e103676. doi:10.1371/journal.pone.0103676
- Chiang, K.-J., Tsai, J.-C., Liu, D., Lin, C.-H., Chiu, H.-L., & Chou, K.-R. (2017). Efficacy of cognitive-behavioral therapy in patients with bipolar disorder: A meta-analysis of randomized controlled trials. *PLOS One*, 12(5), e0176849. doi:10.1371/journal.pone.0176849
- Chibanda, D., Bowers, T., Verhey, R., Rusakaniko, S., Abas, M., Weiss, H. A., & Araya, R. (2015). The Friendship Bench programme: a cluster randomised controlled trial of a brief psychological intervention for common mental disorders delivered by lay health workers in Zimbabwe. *International Journal of Mental Health Systems*, 9(1), 21. doi:10.1186/s13033-015-0013-y
- Chibanda, D., Cowan, F., Verhey, R., Machando, D., Abas, M., & Lund, C. (2017). Lay Health Workers' Experience of Delivering a Problem Solving Therapy Intervention for Common Mental Disorders Among People Living with HIV: A Qualitative Study from Zimbabwe. *Community Mental Health Journal*, 53(2), 143-153. doi:10.1007/s10597-016-0018-2
- Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R., & Abas, M. A. (2011). Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BMC Public Health*, 11(1), 828. doi:10.1186/1471-2458-11-828
- Chibanda, D., Verhey, R., Munetsi, E., Cowan, F. M., & Lund, C. (2016). Using a theory driven approach to develop and evaluate a complex mental health intervention: the friendship bench project in Zimbabwe. *International Journal of Mental Health Systems*, 10, 16-16. doi:10.1186/s13033-016-0050-1
- Chibanda, D., Weiss, H. A., Verhey, R., Simms, V., Munjoma, R., Rusakaniko, S., . . . Araya, R. (2016). Effect of a Primary Care-Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe: A Randomized Clinical Trial Primary Care Intervention for Mental Disorders in Zimbabwe Primary Care Intervention for Mental Disorders in Zimbabwe. *JAMA*, 316(24), 2618-2626. doi:10.1001/jama.2016.19102
- Chisholm, D., Burman-Roy, S., Fekadu, A., Kathree, T., Kizza, D., Luitel, N. P., . . . Lund, C. (2016). Estimating the cost of implementing district mental healthcare plans in five low- and middle-income countries: The PRIME study. *British Journal of Psychiatry*, 208(s56), s71-s78. doi:10.1192/bjp.bp.114.153866
- Chisholm, D., & Saxena, S. (2012). Cost effectiveness of strategies to combat neuropsychiatric conditions in sub-Saharan Africa and South East Asia: mathematical modelling study. *BMJ*, 344, e609. doi:10.1136/bmj.e609
- Chiumento, A., Rahman, A., Frith, L., Snider, L., & Tol, W. (2017). Ethical standards for mental health and psychosocial support research in emergencies: Review of literature and current debates. *Globalization and Health*, 13. doi:10.1186/s12992-017-0231-y
- Chowdhary, N., Anand, A., Dimidjian, S., Shinde, S., Weobong, B., Balaji, M., . . . Patel, V. (2015). The Healthy Activity Program lay counsellor delivered treatment for severe depression in India: systematic development and randomised evaluation. doi:10.1192/bjp.bp.114.161075
- Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J., . . . Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. *Psychological Medicine*, 44(6), 1131-1146. doi:10.1017/S0033291713001785
- Chu, T., Keller, A. S., & Rasmussen, A. (2013). Effects of post-migration factors on PTSD outcomes among immigrant survivors of political violence. *J Immigr Minor Health*, 15(5), 890-897. doi:10.1007/s10903-012-9696-1

- Citraningtyas, T., Macdonald, E., & Herrman, H. (2011). A Second Tsunami?: The Ethics of Coming into Communities following Disaster. *Asian Bioethics Review*, 2, 108-123. doi:10.1353/asb.2010.0015
- Clark, D. A. (2009). Cognitive behavioral therapy for anxiety and depression: possibilities and limitations of a transdiagnostic perspective. *Cognitive Behaviour Therapy*, 38 Suppl 1, 29-34.
- Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, 47(11), 910-920. doi:10.1016/j.brat.2009.07.010
- Close, C., Kouvonen, A., Bosqui, T., Patel, K., O'Reilly, D., & Donnelly, M. (2016). The mental health and wellbeing of first generation migrants: a systematic-narrative review of reviews. *Globalization and Health*, 12. doi:ARTN 4710.1186/s12992-016-0187-3
- Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences*. New York: Routledge.
- Cole, M. (2006). Internationalism in psychology: we need it now more than ever. *American Psychologist*, 61(8), 904-917. doi:10.1037/0003-066X.61.8.904
- Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., Daar, A. S., . . . Walport, M. (2011). Grand challenges in global mental health. *Nature*, 475(7354), 27-30. doi:10.1038/475027a
- Colombian Red Cross. (n.d.). *Code of Ethics*. Retrieved from http://intranet.cruzrojavaile.org.co/crc/cruzroja/PDF/CODIGO_DE_ETICA.pdf
- Cometto, G., Ford, N., Pfaffman-Zambruni, J., Akl, E. A., Lehmann, U., McPake, B., . . . Taylor, D. (2018). Health policy and system support to optimise community health worker programmes: an abridged WHO guideline. *The Lancet Global Health*, 6(12), e1397-e1404. doi:10.1016/s2214-109x(18)30482-0
- Cook, S. C., Schwartz, A. C., & Kaslow, N. J. (2017). Evidence-Based Psychotherapy: Advantages and Challenges. *Neurotherapeutics*, 14(3), 537-545. doi:10.1007/s13311-017-0549-4
- Cork, C., Kaiser, B. N., & White, R. G. (2019). The integration of idioms of distress into mental health assessments and interventions: a systematic review. *Global Mental Health*, 6, e7-e7. doi:10.1017/gmh.2019.5
- Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A Meta-Analysis of Cognitive-Behavioural Therapy for Adult Depression, Alone and in Comparison with other Treatments. *The Canadian Journal of Psychiatry*, 58(7), 376-385. doi:10.1177/070674371305800702
- Cuijpers, P., Donker, T., Weissman, M. M., Ravitz, P., & Cristea, I. A. (2016). Interpersonal Psychotherapy for Mental Health Problems: A Comprehensive Meta-Analysis. *American Journal of Psychiatry*, 173(7), 680-687. doi:10.1176/appi.ajp.2015.15091141
- Cuijpers, P., Noma, H., Karyotaki, E., Cipriani, A., & Furukawa, T. A. (2019). Effectiveness and Acceptability of Cognitive Behavior Therapy Delivery Formats in Adults With Depression: A Network Meta-analysis. *JAMA Psychiatry*. doi:10.1001/jamapsychiatry.2019.0268
- Cuijpers, P., van Straten, A., & Warmerdam, L. (2007). Problem solving therapies for depression: a meta-analysis. *European Psychiatry*, 22(1), 9-15.
- Curran, G. M., Bauer, M., Mittman, B., Pyne, J. M., & Stetler, C. (2012). Effectiveness-implementation Hybrid Designs: Combining Elements of Clinical Effectiveness and Implementation Research to Enhance Public Health Impact. *Medical Care*, 50(3), 217-226. doi:10.1097/MLR.0b013e3182408812
- D'Zurilla, T. J., & Goldfried, M. R. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology*, 78(1), 107-126. doi:10.1037/h0031360
- Damschroder, L. J., & Hagedorn, H. J. (2011). A guiding framework and approach for implementation research in substance use disorders treatment. *Psychology of Addictive Behaviors*, 25(2), 194-205. doi:10.1037/a0022284

- Daniels, J. P. (2019). Colombia struggles to cope with care in Venezuelan influx. *The Lancet*, 393(10187), 2185-2186. doi:10.1016/S0140-6736(19)31229-2
- David, D., Cristea, I., & Hofmann, S. G. (2018). Why cognitive behavioral therapy is the current gold standard of psychotherapy. *Frontiers in psychiatry*, 9, 4.
- Davidson, P., & C. H. Parker, K. (2001). *Eye movement desensitization and reprocessing (EMDR): A meta-analysis* (Vol. 69).
- Dawson, A. J., Buchan, J., Duffield, C., Homer, C. S., & Wijewardena, K. (2014). Task shifting and sharing in maternal and reproductive health in low-income countries: a narrative synthesis of current evidence. *Health Policy and Planning*, 29(3), 396-408. doi:10.1093/heapol/czt026
- Dawson, K. S., Bryant, R. A., Harper, M., Kuowei Tay, A., Rahman, A., Schafer, A., & van Ommeren, M. (2015). Problem Management Plus (PM+): a WHO transdiagnostic psychological intervention for common mental health problems. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, 14(3), 354-357. doi:10.1002/wps.20255
- Dawson, K. S., & Rahman, A. (2018). Low Intensity Interventions for Psychological Symptoms Following Mass Trauma. In N. Morina & A. Nickerson (Eds.), *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (pp. 341-356). Cham: Springer International Publishing.
- de Jong, J. T., Komproe, I. H., & Van Ommeren, M. (2003). Common mental disorders in postconflict settings. *The Lancet*, 361(9375), 2128-2130. doi:10.1016/s0140-6736(03)13692-6
- De Silva, M. J., & Ryan, G. (2016). Global mental health in 2015: 95% implementation. *The Lancet Psychiatry*, 3(1), 15-17.
- Delgadillo, J., McMillan, D., Lucock, M., Leach, C., Ali, S., & Gilbody, S. (2014). Early changes, attrition, and dose-response in low intensity psychological interventions. *British Journal of Clinical Psychology*, 53(1), 114-130. doi:10.1111/bjc.12031
- Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P., . . . Chatterji, S. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA*, 291(21), 2581-2590. doi:10.1001/jama.291.21.2581
- Dewey, J. (1925). The Later Works of John Dewey, 1925-1953: 1925, Experience and Nature. In J. A. Boydston & S. Hook (Eds.): Southern Illinois University Press.
- Dickson, K., & Bangpan, M. (2018). What are the barriers to, and facilitators of, implementing and receiving MHPSS programmes delivered to populations affected by humanitarian emergencies? A qualitative evidence synthesis. *Global Mental Health*, 5, e21. doi:10.1017/gmh.2018.12
- Dimidjian, S., Barrera, M., Jr., Martell, C., Munoz, R. F., & Lewinsohn, P. M. (2011). The origins and current status of behavioral activation treatments for depression. *Annual Review of Clinical Psychology*, 7, 1-38. doi:10.1146/annurev-clinpsy-032210-104535
- Dozois, D. J. A., Dobson, K. S., & Rnic, K. (2019). Historical and Philosophical Bases of Cognitive-Behavioral Therapies. In D. J. A. Dozois & K. S. Dobson (Eds.), *Handbook of Cognitive-Behavioural Therapies* (Fourth Edition ed.). New York The Guilford Press.
- Drabble, L., Trocki, K. F., Salcedo, B., Walker, P. C., & Korcha, R. A. (2016). Conducting qualitative interviews by telephone: Lessons learned from a study of alcohol use among sexual minority and heterosexual women. *Qualitative Social Work: Research and Practice*, 15(1), 118-133. doi:10.1177/1473325015585613
- Drapeau, A., Marchand, A., & Beaulieu-Prévost, D. (2012). Epidemiology of Psychological Distress.
- Duncombe, M. E., Havighurst, S. S., Holland, K. A., & Frankling, E. J. (2012). The contribution of parenting practices and parent emotion factors in children at risk for disruptive behavior disorders. *Child Psychiatry and Human Development*, 43(5), 715-733. doi:10.1007/s10578-012-0290-5

- Dybdahl, R. (2001). Children and mothers in war: an outcome study of a psychosocial intervention program. *Child Development*, 72(4), 1214-1230.
- Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R., . . . Saxena, S. (2011). Scale up of services for mental health in low-income and middle-income countries. *The Lancet*, 378(9802), 1592-1603. doi:10.1016/S0140-6736(11)60891-X
- Eccles, M. P., & Mittman, B. S. (2006). Welcome to Implementation Science. *Implementation Science*, 1, 1-1. doi:10.1186/1748-5908-1-1
- Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38(4), 319-345. doi:10.1016/S0005-7967(99)00123-0
- Ekers, D., Richards, D., McMillan, D., Bland, J. M., & Gilbody, S. (2011). Behavioural activation delivered by the non-specialist: phase II randomised controlled trial. *British Journal of Psychiatry*, 198(1), 66-72. doi:10.1192/bjp.bp.110.079111
- Ekers, D., Webster, L., Van Straten, A., Cuijpers, P., Richards, D., & Gilbody, S. (2014). Behavioural Activation for Depression; An Update of Meta-Analysis of Effectiveness and Sub Group Analysis. *PLOS One*, 9(6), e100100. doi:10.1371/journal.pone.0100100
- El-Khani, A., Cartwright, K., Ang, C., Henshaw, E., Tanveer, M., & Calam, R. (2018). Testing the feasibility of delivering and evaluating a child mental health recovery program enhanced with additional parenting sessions for families displaced by the Syrian conflict: A pilot study. *Peace and Conflict: Journal of Peace Psychology*, 24(2), 188-200. doi:10.1037/pac0000287
- Ellis, A. (1957). Outcome of employing three techniques of psychotherapy. *Journal of Clinical Psychology*, 13(4), 344-350. doi:10.1002/1097-4679(195710)13:4<344::AID-JCLP2270130407>3.0.CO;2-9
- EPPI-Centre. (2006). EPPI-Centre Methods for Conducting Systematic Reviews Retrieved from <https://eppi.ioe.ac.uk/cms/>
- Epping-Jordan, J. E., Harris, R., Brown, F. L., Carswell, K., Foley, C., Garcia-Moreno, C., . . . van Ommeren, M. (2016). Self-Help Plus (SH+): a new WHO stress management package. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, 15(3), 295-296. doi:10.1002/wps.20355
- Ertl, V., Pfeiffer, A., Schauer, E., Elbert, T., Neuner, F., Ertl, V., . . . Neuner, F. (2011). Community-implemented trauma therapy for former child soldiers in Northern Uganda: a randomized controlled trial. *JAMA*, 306(5), 503-512. doi:10.1001/jama.2011.1060
- Espinoza, I., Osorio, P., Torrejón, M. J., Lucas-Carrasco, R., & Bunout, D. (2011). Validación del cuestionario de calidad de vida (WHOQOL-BREF) en adultos mayores chilenos. *Revista Medica de Chile*, 139, 579-586.
- Fann, J. R., Bombardier, C. H., Vannoy, S., Dyer, J., Ludman, E., Dikmen, S., . . . Temkin, N. (2015). Telephone and in-person cognitive behavioral therapy for major depression after traumatic brain injury: a randomized controlled trial. *Journal of Neurotrauma*, 32(1), 45-57. doi:10.1089/neu.2014.3423
- Farrer, L., Christensen, H., Griffiths, K. M., & Mackinnon, A. (2011). Internet-based CBT for depression with and without telephone tracking in a national helpline: randomised controlled trial. *PLOS One*, 6(11), e28099. doi:10.1371/journal.pone.0028099
- Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*, 365(9467), 1309-1314. doi:http://doi.org/10.1016/S0140-6736(05)61027-6
- Federación Colombiana de Gestión Humana. (2018). *Informe mensual del mercado laboral* Retrieved from Bogota: https://www.repository.fedesarrollo.org.co/bitstream/handle/11445/3792/1/ML_Junio_2019.pdf?sequence=1&isAllowed=y
- Feilzer, M. (2010). Doing Mixed Methods Research Pragmatically: Implications for the Rediscovery of Pragmatism as a Research Paradigm. *Journal of Mixed Methods Research*, 4, 6-16. doi:10.1177/1558689809349691

- Fernandez-Nino, J. A., & Bojorquez-Chapela, I. (2018). Migration of Venezuelans to Colombia. *The Lancet*, 392(10152), 1013-1014. doi:10.1016/S0140-6736(18)31828-2
- Ferrer-Wreder, L., Sundell, K., & Mansoor, S. (2012). Tinkering with Perfection: Theory Development in the Intervention Cultural Adaptation Field. *Child & Youth Care Forum*, 41(2), 149-171. doi:10.1007/s10566-011-9162-6
- Financial Tracking Service. (2019). Total reported funding for 2019. Retrieved from <https://fts.unocha.org/global-funding/overview/2019>
- Firth, N., Barkham, M., Kellett, S., & Saxon, D. (2015). Therapist effects and moderators of effectiveness and efficiency in psychological wellbeing practitioners: A multilevel modelling analysis. *Behaviour Research and Therapy*, 69, 54-62. doi:https://doi.org/10.1016/j.brat.2015.04.001
- Fleiss, J. L. (1971). Measuring Nominal Scale Agreement among Many Raters. *Psychological Bulletin*, 76(5), 378-382. doi:DOI 10.1037/h0031619
- Foka, S., Hadfield, K., Pluess, M., & Mareschal, I. (2020). Promoting well-being in refugee children: An exploratory controlled trial of a positive psychology intervention delivered in Greek refugee camps. *Development and Psychopathology*, 1-9. doi:10.1017/S0954579419001585
- Fox, P. G., Rossetti, J., Burns, K. R., & Popovich, J. (2005). Southeast Asian refugee children: a school-based mental health intervention. *International Journal of Psychiatric Nursing Research*, 11(1), 1227-1236.
- Freedheim, D. K. (1994). Historical perspectives on psychotherapy. *Annals of the New York Academy of Sciences*, 727, 123-132.
- Galapatti, A. (2005). Psychosocial work in the aftermath of the tsunami: challenges for service provision in Batticaloa, Eastern Sri Lanka. *Intervention*, 3, 65-69.
- García, J., Correa, G., & Rousset, B. (2019). Trends in infant mortality in Venezuela between 1985 and 2016: a systematic analysis of demographic data. *The Lancet Global Health*, 7(3), e331-e336. doi:10.1016/S2214-109X(18)30479-0
- García-Campayo, J., Zamorano, E., Ruiz, M. A., Pardo, A., Perez-Paramo, M., Lopez-Gomez, V., . . . Rejas, J. (2010). Cultural adaptation into Spanish of the generalized anxiety disorder-7 (GAD-7) scale as a screening tool. *Health Qual Life Outcomes*, 8, 8. doi:10.1186/1477-7525-8-8
- Gareth, M., Steve, M., & Alice, W. (2017). Exploring the relationship between postmigratory stressors and mental health for asylum seekers and refused asylum seekers in the UK. *Transcultural Psychiatry*, 54(5-6), 653-674. doi:10.1177/1363461517737188
- Gellatly, J., Bower, P., Hennessy, S., Richards, D., Gilbody, S., & Lovell, K. (2007). What makes self-help interventions effective in the management of depressive symptoms? Meta-analysis and meta-regression. 37(09), 1217. doi:10.1017/s0033291707000062
- Geng, E. H., Peiris, D., & Kruk, M. E. (2017). Implementation science: Relevance in the real world without sacrificing rigor. *PLoS Medicine*, 14(4), e1002288-e1002288. doi:10.1371/journal.pmed.1002288
- Gerritsen, A. A. M., Bramsen, I., Devillé, W., van Willigen, L. H. M., Hovens, J. E., & van der Ploeg, H. M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, 41(1), 18-26. doi:10.1007/s00127-005-0003-5
- González, M. L., Peñaloza, R. E., Matallana, M. A., Gil, F., Gómez-Restrepo, C., & Landaeta, A. P. (2016). Factores que determinan el acceso a servicios de salud mental de la población adulta en Colombia. *Revista Colombiana de Psiquiatría*, 45(S1), 89-95. doi:http://dx.doi.org/10.1016/j.rcp.2016.10.004
- Gormez, V., Kılıç, H. N., Orengul, A. C., Demir, M. N., Mert, E. B., Makhoulouta, B., . . . Semerci, B. (2017). Evaluation of a school-based, teacher-delivered psychological intervention group program for trauma-affected Syrian refugee children in Istanbul, Turkey. *Psychiatry and Clinical Psychopharmacology*, 27(2), 125-131. doi:10.1080/24750573.2017.1304748

- Gough, D., Oliver, S., & Thomas, J. (2017). *An introduction to systematic reviews*. London: Sage.
- Government of Colombia. (2019). Saravena. Retrieved from <https://www.arauca.gov.co/gobernacion/municipios/municipio-de-saravena>
- Graaff, A., Cuijpers, P., Acarturk, C., Bryant, R., Burchert, S., Fuhr, D., . . . Sijbrandij, M. (2020). Effectiveness of a peer-refugee delivered psychological intervention to reduce psychological distress among adult Syrian refugees in the Netherlands: study protocol. *European Journal of Psychotraumatology*, 11, 1694347. doi:10.1080/20008198.2019.1694347
- Grant, A., Treweek, S., & Wells, M. (2016). Why is so much clinical research ignored and what can we do about it? *British Journal of Hospital Medicine*, 77(10), 554-555. doi:10.12968/hmed.2016.77.10.554
- Gratzer, D., & Khalid-Khan, F. (2016). Internet-delivered cognitive behavioural therapy in the treatment of psychiatric illness. *Canadian Medical Association Journal*, 188(4), 263-272. doi:10.1503/cmaj.150007
- Greene, M. C., Jordans, M. J. D., Kohrt, B. A., Ventevogel, P., Kirmayer, L. J., Hassan, G., . . . Tol, W. A. (2017). Addressing culture and context in humanitarian response: preparing desk reviews to inform mental health and psychosocial support. *Conflict and Health*, 11, 21. doi:10.1186/s13031-017-0123-z
- Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy*, 43(4), 531-548. doi:10.1037/0033-3204.43.4.531
- Grusec, J. E. (2011). Socialization processes in the family: social and emotional development. *Annual Review of Psychology*, 62, 243-269. doi:10.1146/annurev.psych.121208.131650
- Gupta, S. K. (2011). Intention-to-treat concept: A review. *Perspectives in Clinical Research*, 2(3), 109-112. doi:10.4103/2229-3485.83221
- Haaga, D. A. (2000). Introduction to the special section on stepped care models in psychotherapy. *Journal of Consulting and Clinical Psychology*, 68(4), 547-548.
- Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: a literature review. *Risk management and healthcare policy*, 8, 175-183. doi:10.2147/RMHP.S70173
- Hadfield, K., Ungar, M., Emond, A., Foster, K., Gatt, J. M., Mason-Jones, A., . . . Wu, Q. (2018). Challenges of developing and conducting an international study of resilience in migrant adolescents. *International Social Work*, 0020872818796147.
- Haines, A., Sanders, D., Lehmann, U., Rowe, A. K., Lawn, J. E., Jan, S., . . . Bhutta, Z. (2007). Achieving child survival goals: potential contribution of community health workers. *The Lancet*, 369(9579), 2121-2131. doi:10.1016/S0140-6736(07)60325-0
- Hall, T., Krahn, G. L., Horner-Johnson, W., & Lamb, G. (2011). Examining functional content in widely used Health-Related Quality of Life scales. *Rehabilitation Psychology*, 56(2), 94-99. doi:10.1037/a0023054
- Handley, M. A., Lyles, C. R., McCulloch, C., & Cattamanchi, A. (2018). Selecting and Improving Quasi-Experimental Designs in Effectiveness and Implementation Research. *Annual Review of Public Health*, 39, 5-25. doi:10.1146/annurev-publhealth-040617-014128
- Harper Shehadeh, M., Van't Hof, E., Schafer, A., van Ommeren, M., Farooq, S., Hamdani, S. U., . . . Albanese, E. (2019). Using a person-generated mental health outcome measure in large clinical trials in Kenya and Pakistan: Self-perceived problem responses in diverse communities. *Transcultural Psychiatry*, 1363461519854831. doi:10.1177/1363461519854831
- Heinrichs, N., Bertram, H., Kuschel, A., & Hahlweg, K. (2005). Parent recruitment and retention in a universal prevention program for child behavior and emotional problems: barriers to research and program participation. *Prevention Science*, 6(4), 275-286. doi:10.1007/s11121-005-0006-1

- Helms, J. E. (2015). An examination of the evidence in culturally adapted evidence-based or empirically supported interventions. *Transcult Psychiatry*, 52(2), 174-197. doi:10.1177/1363461514563642
- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences*, 33(2-3), 61-83; discussion 83-135. doi:10.1017/S0140525X0999152X
- Hernández-Bello, A., & Gutiérrez-Bonilla, M. L. (2008). Vulnerability and Exclusion: Life Conditions, Health Situation, and Access to Health Services of the Population Displaced by Violence settled in Bogotá - Colombia, 2005. *Revista de Gerencia y Políticas de Salud*, 7(14), 145-176.
- Hewitt-Ramirez, N., Juárez, F., Parada-Baños, A. J., Guerrero-Luzardo, J., Romero-Chávez, Y. M., Salgado-Castilla, A. M., & Vargas-Amaya, M. V. (2016). Afectaciones Psicológicas, Estrategias de Afrontamiento y Niveles de Resiliencia de Adultos Expuestos al Conflicto Armado en Colombia. *Revista Colombiana de Psiquiatría*, 25(1), 125-140. doi:10.15446/rcp.v25n1.49966
- Higgins, J. P., & Green, S. (2011). *Cochrane handbook for systematic reviews of interventions* (Vol. 4): John Wiley & Sons.
- Hill, Z., Dumbaugh, M., Benton, L., Källander, K., Strachan, D., Ten Asbroek, A., . . . Meek, S. (2014). Supervising community health workers in low-income countries—a review of impact and implementation issues. *Global health action*, 7(1), 24085.
- Hobfoll, S. (2002). Social and Psychological Resources and Adaptation. *Review of General Psychology*, 6, 307-324. doi:10.1037/1089-2680.6.4.307
- Hobfoll, S. E., Dunahoo, C. A., & Monnier, J. (1995). Conservation of resources and traumatic stress *Traumatic stress: From theory to practice*. (pp. 29-47). New York, NY, US: Plenum Press.
- Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., . . . Ursano, R. J. (2007). Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. 70(4), 283-315. doi:10.1521/psyc.2007.70.4.283
- Hofmann, S. G., Asmundson, G. J., & Beck, A. T. (2013). The science of cognitive therapy. *Behavior Therapy*, 44(2), 199-212.
- Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. *Cognitive Therapy and Research*, 36(5), 427-440. doi:10.1007/s10608-012-9476-1
- IDMC. (2016). *Global Report on Internal Displacement*. Retrieved from Geneva: <http://www.internal-displacement.org/assets/publications/2016/2016-global-report-internal-displacement-IDMC.pdf>
- IFRC. (2019). *Everyone Counts*. Retrieved from Geneva: <http://data.ifrc.org/fdrs/report>
- IFRC Reference Centre for Psychosocial Support. (2015). *Caring for Volunteers: Training Manual*. Retrieved from Copenhagen: <http://pscentre.org/wp-content/uploads/2018/02/Caring-for-volunteers-a-training-manual.pdf>
- IFRC Reference Centre for Psychosocial Support. (2018). *A Guide to Psychological First Aid for Red Cross and Red Crescent Societies*. Retrieved from <http://pscentre.org/topics/publications/>
- IFRC Reference Centre for Psychosocial Support. (2019). *The Missing Link: Improving MHPSS Service Delivery through Strengthened Supervision*. Retrieved from <https://www.ifrc.org/en/what-we-do/health/psychosocial-support/reference-centre-for-psychosocial-support/>
- Implementation Science. (2019). Announcing new submission requirements. Retrieved from <https://implementationscience.biomedcentral.com/journal-news>
- Inter-Agency Standing Committee. (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Retrieved from Geneva: https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
- International Rescue Committee. (2018). *Venezuelan Migrants in Colombia: Expansion*. Retrieved from

- <https://reliefweb.int/sites/reliefweb.int/files/resources/IRC%20Assessment-%20Venezuelans%20in%20Colombia%20Nov2018.pdf>
- Jarero, I. N., Rake, G., & Givaudan, M. (2017). *EMDR Therapy Program for Advanced Psychosocial Interventions Provided by Paraprofessionals* (Vol. 11).
- Javadi, D., Feldhaus, I., Mancuso, A., & Ghaffar, A. (2017). Applying systems thinking to task shifting for mental health using lay providers: a review of the evidence. *Global Mental Health*, 4, e14. doi:10.1017/gmh.2017.15
- Jindal, R. M. (2020). Refugees, asylum seekers, and immigrants in clinical trials. *The Lancet*, 395(10217), 30-31. doi:10.1016/S0140-6736(19)32529-2
- Johns Hopkins Bloomberg School of Public Health, & International Federation of Red Cross and Red Crescent Societies. (2008). *Public Health in Emergencies*. Retrieved from Geneva: <https://reliefweb.int/sites/reliefweb.int/files/resources/Forward.pdf>
- Jordans, M. J., Tol, W. A., & Ventevogel, P. (2014). New frontiers in mental health and psychosocial wellbeing in low resource and conflict affected settings. *Intervention*, 12, 5-14.
- Joshi, R., Alim, M., Kengne, A. P., Jan, S., Maulik, P. K., Peiris, D., & Patel, A. A. (2014). Task shifting for non-communicable disease management in low and middle income countries--a systematic review. *PLOS One*, 9(8), e103754. doi:10.1371/journal.pone.0103754
- Juntunen, C. (2011). Reflections on the Opportunities and Challenges of Disaster Response. *The Counseling Psychologist*, 39, 1182-1192. doi:10.1177/0011000011417146
- Kakuma, R., Minas, H., van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., . . . Scheffler, R. M. (2011). Human resources for mental health care: current situation and strategies for action. *The Lancet*, 378(9803), 1654-1663. doi:10.1016/S0140-6736(11)61093-3
- Kanner, A. D., Coyne, J. C., Schaefer, C., & Lazarus, R. S. (1981). Comparison of two modes of stress measurement: daily hassles and uplifts versus major life events. *Journal of Behavioral Medicine*, 4(1), 1-39.
- Kanter, J. W., Puspitasari, A. J., Santos, M. M., & Nagy, G. A. (2012). Behavioural activation: history, evidence and promise. *British Journal of Psychiatry*, 200(5), 361-363. doi:10.1192/bjp.bp.111.103390
- Kaushik, V., Walsh, C., & Lai, D. (2019). Pragmatism as a Research Paradigm and Its Implications for Social Work Research. *Social sciences*, 8, 255. doi:10.3390/socsci8090255
- Kazdin, A. E. (1993). Psychotherapy for children and adolescents. Current progress and future research directions. *American Psychologist*, 48(6), 644-657. doi:10.1037//0003-066x.48.6.644
- Keough, M. E., Timpano, K. R., & Schmidt, N. B. (2009). Ataques de nervios: culturally bound and distinct from panic attacks? *Depression and Anxiety*, 26(1), 16-21. doi:10.1002/da.20498
- Kessler, R. C., & Bromet, E. J. (2013). The epidemiology of depression across cultures. *Annual Review of Public Health*, 34, 119-138. doi:10.1146/annurev-publhealth-031912-114409
- Keyes, C. L. M., Dhingra, S. S., & Simoes, E. J. (2010). Change in level of positive mental health as a predictor of future risk of mental illness. *American Journal of Public Health*, 100(12), 2366-2371. doi:10.2105/AJPH.2010.192245
- Keynejad, R. C., Dua, T., Barbui, C., & Thornicroft, G. (2018). WHO Mental Health Gap Action Programme (mhGAP) Intervention Guide: a systematic review of evidence from low and middle-income countries. *Evidence Based Mental Health*, 21(1), 30. doi:10.1136/eb-2017-102750
- Khan, M. N., Hamdani, S. U., Chiumento, A., Dawson, K., Bryant, R. A., Sijbrandij, M., . . . Rahman, A. (2019). Evaluating feasibility and acceptability of a group WHO trans-diagnostic intervention for women with common mental disorders in rural Pakistan: a cluster randomised controlled feasibility trial. *Epidemiol Psychiatr Sci*, 28(1), 77-87. doi:10.1017/s2045796017000336

- Kieft, B., Jordans, M. J., de Jong, J. T., & Kamperman, A. M. (2008). Paraprofessional counselling within asylum seekers' groups in the Netherlands: transferring an approach for a non-western context to a European setting. *Transcult Psychiatry*, 45(1), 105-120. doi:10.1177/1363461507088000
- Kim, S. H., & Kim, S. (2013). National Culture and Social Desirability Bias in Measuring Public Service Motivation. *Administration & Society*, 48(4), 444-476. doi:10.1177/0095399713498749
- King, N. (2004). Chapter 21: Using Templates in the thematic analysis of text. In C. Cassell & G. Symon (Eds.), *Essential guide to qualitative methods in organizational research*. London: SAGE Publications.
- Kirmayer, L. J. (2012). Rethinking cultural competence. 49(2), 149-164. doi:10.1177/1363461512444673
- Kleinman, A. (1988). *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: Free Press; Collier Macmillan.
- Kleinman, A., & Good, B. (1985). *Culture and depression : studies in the anthropology and cross-cultural psychiatry of affect and disorder*. Berkeley: University of California Press.
- Kmet, L. M., Lee, R. C., & Cook, L. S. (2004). *Standard quality assessment criteria for evaluating primary research papers from a variety of fields*. Retrieved from Alberta: <http://www.biomedcentral.com/content/supplementary/1471-2393-14-52-s2.pdf>
- Knerr, W., Gardner, F., & Cluver, L. (2013). Improving positive parenting skills and reducing harsh and abusive parenting in low- and middle-income countries: a systematic review. *Prevention Science*, 14(4), 352-363. doi:10.1007/s11121-012-0314-1
- Kok, M. C., Dieleman, M., Taegtmeyer, M., Broerse, J. E., Kane, S. S., Ormel, H., . . . de Koning, K. A. (2015). Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review. *Health Policy and Planning*, 30(9), 1207-1227. doi:10.1093/heapol/czu126
- Kredo, T., Adeniyi, F. B., Bateganya, M., & Pienaar, E. D. (2014). Task shifting from doctors to non-doctors for initiation and maintenance of antiretroviral therapy. *Cochrane Database of Systematic Reviews*(7), Cd007331. doi:10.1002/14651858.CD007331.pub3
- Kreutzer, T., Vinck, P., Pham, P., An, A., Appel, L., DeLuca, E., . . . Orbinski, J. (2019). Improving Humanitarian Needs Assessments through Natural Language Processing. *IBM Journal of Research and Development*, 1-1. doi:10.1147/JRD.2019.2947014
- Kumpfer, K. L., Pinyuchon, M., de Melo, A. T., & Whiteside, H. O. (2008). Cultural Adaptation Process for International Dissemination of the Strengthening Families Program. *Evaluation and the Health Professions*, 31(2), 226-239. doi:10.1177/0163278708315926
- Kuo, C. (2019). Cognitive behavioural therapy around the globe. In D. J. Stein, J. K. Bass, & S. G. Hofmann (Eds.), *Global Mental Health and Psychotherapy* (pp. 87-126): Academic Press.
- Lagos-Gallego, M., Gutierrez-Segura, J. C., Lagos-Grisales, G. J., & Rodriguez-Morales, A. J. (2017). Post-traumatic stress disorder in internally displaced people of Colombia: An ecological study. *Travel Medicine and Infectious Disease*, 16, 41-45. doi:10.1016/j.tmaid.2017.02.008
- Landes, S. J., McBain, S. A., & Curran, G. M. (2019). An introduction to effectiveness-implementation hybrid designs. *Psychiatry Research*, 280, 112513. doi:https://doi.org/10.1016/j.psychres.2019.112513
- Lau, A. S. (2006). Making the Case for Selective and Directed Cultural Adaptations of Evidence-Based Treatments: Examples From Parent Training. *Clinical Psychology: Science and Practice*, 13(4), 295-310. doi:doi:10.1111/j.1468-2850.2006.00042.x

- Lewin, S., Dick, J., Pond, P., Zwarenstein, M., Aja, G. N., van Wyk, B. E., . . . Patrick, M. (2005). Lay health workers in primary and community health care. *Cochrane Database of Systematic Reviews*(1). doi:10.1002/14651858.CD004015.pub2
- Li, S. S., Liddell, B. J., & Nickerson, A. (2016). The Relationship Between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers. *Curr Psychiatry Rep*, 18(9), 82. doi:10.1007/s11920-016-0723-0
- Long, K. M., McDermott, F., & Meadows, G. N. (2018). Being pragmatic about healthcare complexity: our experiences applying complexity theory and pragmatism to health services research. *BMC Medicine*, 16(1), 94. doi:10.1186/s12916-018-1087-6
- Lovell, K., & Richards, D. (2000). Multiple access points and levels of entry (MAPLE): ensuring choice, accessibility and equity for CBT services. *Behavioural and Cognitive Psychotherapy*, 28, 379–391.
- Lucas-Carrasco, R. (2012a). Reliability and validity of the Spanish version of the World Health Organization-Five Well-Being Index in elderly. *Psychiatry and Clinical Neurosciences*, 66(6), 508-513. doi:10.1111/j.1440-1819.2012.02387.x
- Lucas-Carrasco, R. (2012b). The WHO quality of life (WHOQOL) questionnaire: Spanish development and validation studies. *Quality of Life Research*, 21(1), 161-165. doi:10.1007/s11136-011-9926-3
- Lund, C., Brooke-Sumner, C., Baingana, F., Garman, E., Breuer, E., Chandra, P. S., . . . Saxena, S. (2018). Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *The Lancet Psychiatry*, 5, 357-369. doi:10.1016/S2215-0366(18)30060-9
- Lund, C., De Silva, M., Plagerson, S., Cooper, S., Chisholm, D., Das, J., . . . Patel, V. (2011). Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. *The Lancet*, 378(9801), 1502-1514. doi:10.1016/S0140-6736(11)60754-X
- Lynch, E., Mudge, A., Knowles, S., Kitson, A., Hunter, S., & Harvey, G. (2018). *“There is nothing so practical as a good theory”: a pragmatic guide for selecting theoretical approaches for implementation projects* (Vol. 18).
- Magidson, J. F., Regenauer, K. S., Andersen, L. S., & Safren, S. A. (2019). 12 - Chronic physical diseases. In D. J. Stein, J. K. Bass, & S. G. Hofmann (Eds.), *Global Mental Health and Psychotherapy* (pp. 259-277): Academic Press.
- Manohar, N., Liamputtong, P., Bhole, S., & Arora, A. (2017). Researcher Positionality in Cross-Cultural and Sensitive Research. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 1-15). Singapore: Springer Singapore.
- Mansell, W., Harvey, A., Watkins, E., & Shafran, R. (2008). *Cognitive Behavioral Processes Across Psychological Disorders: A Review of the Utility and Validity of the Transdiagnostic Approach* (Vol. 1).
- Mansell, W., Harvey, A., Watkins, E., & Shafran, R. (2009). Conceptual foundations of the transdiagnostic approach to CBT. *Journal of Cognitive Psychotherapy*, 23(1), 6-19.
- Markowitz, J. C., & Weissman, M. M. (2012). Interpersonal Psychotherapy: Past, Present and Future. *Clinical Psychology & Psychotherapy*, 19(2), 99-105. doi:10.1002/cpp.1774
- Marks, I. (1985). Controlled trial of psychiatric nurse therapists in primary care. *BMJ*, 290(6476), 1181-1184. doi:10.1136/bmj.290.6476.1181
- Marsella, A. (2003). Cultural Aspects of Depressive Experience and Disorders. *Online Readings in Psychology and Culture*, 10. doi:10.9707/2307-0919.1081
- May, C., Finch, T., Mair, F., Ballini, L., Dowrick, C., Eccles, M., . . . Heaven, B. (2007). Understanding the implementation of complex interventions in health care: the normalization process model. *BMC Health Services Research*, 7(1), 148. doi:10.1186/1472-6963-7-148
- McDonald, L., Coover, G., Sandler, J., Thao, T., & Shalhoub, H. (2012). Cultural adaptation of an evidence-based parenting programme with elders from South

- East Asia in the US: Co-producing Families and Schools Together-FAST. *Journal of Children's Services*, 7(2), 113-127. doi:10.1108/17466661211238673
- McEvoy, P. M., Nathan, P., & Norton, P. J. (2009). Efficacy of transdiagnostic treatments: A review of published outcome studies and future research directions. *Journal of Cognitive Psychotherapy*, 23(1), 20.
- McKee, L., Colletti, C., Rakow, A., Jones, D. J., & Forehand, R. (2008). Parenting and Child Externalizing Behaviors: Are the Associations Specific or Diffuse? *Aggress Violent Behav*, 13(3), 201-215. doi:10.1016/j.avb.2008.03.005
- Meffert, S. M., Neylan, T. C., Chambers, D. A., & Verdelli, H. (2016). Novel implementation research designs for scaling up global mental health care: overcoming translational challenges to address the world's leading cause of disability. *International Journal of Mental Health Systems*, 10, 19. doi:10.1186/s13033-016-0049-7
- Mendenhall, E., De Silva, M. J., Hanlon, C., Petersen, I., Shidhaye, R., Jordans, M., . . . Lund, C. (2014). Acceptability and feasibility of using non-specialist health workers to deliver mental health care: Stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda. *Social Science and Medicine*, 118(Supplement C), 33-42. doi:https://doi.org/10.1016/j.socscimed.2014.07.057
- Merriam, S. B., Johnson-Bailey, J., Lee, M.-Y., Kee, Y., Ntseane, G., & Muhamad, M. (2001). Power and positionality: negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education*, 20(5), 405-416. doi:10.1080/02601370120490
- Meyer, S., & Morand, M.-B. (2015). Mental health and psychosocial support in humanitarian settings: reflections on a review of UNHCR's approach and activities. *Intervention*, 13(3), 235-247.
- Meyers, D. C., Durlak, J. A., & Wandersman, A. (2012). The quality implementation framework: a synthesis of critical steps in the implementation process. *American Journal of Community Psychology*, 50(3-4), 462-480. doi:10.1007/s10464-012-9522-x
- Miller, C. J., Smith, S. N., & Pugatch, M. (2019). Experimental and quasi-experimental designs in implementation research. *Psychiatry Research*. doi:10.1016/j.psychres.2019.06.027
- Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science and Medicine*, 70(1), 7-16. doi:10.1016/j.socscimed.2009.09.029
- Miller, K. E., & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. *Epidemiol Psychiatr Sci*, 26(2), 129-138. doi:10.1017/s2045796016000172
- Mingebach, T., Kamp-Becker, I., Christiansen, H., & Weber, L. (2018). Meta-meta-analysis on the effectiveness of parent-based interventions for the treatment of child externalizing behavior problems. *PLOS One*, 13(9), e0202855. doi:10.1371/journal.pone.0202855
- Ministry of Foreign Affairs of Colombia. (2018). *Migration Venezuela-Colombia*. Retrieved from Bogota: <http://www.migracioncolombia.gov.co/index.php/es/prensa/multimedia/6308-radiografia-de-venezolanos-en-colombia-31-12-2017>
- Mogollón-Pérez, A. S., & Vázquez, M. L. (2008). Factores que inciden en el acceso de la población desplazada a las instituciones prestadoras de servicios de salud en Colombia. *Cadernos de Saúde Publica*, 24, 745-754.
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Group, P. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Journal of Clinical Epidemiology*, 62(10), 1006-1012. doi:10.1016/j.jclinepi.2009.06.005
- Montero-Marin, J., Garcia-Campayo, J., López-Montoyo, A., Zabaleta-Del-Olmo, E., & Cuijpers, P. (2018). Is cognitive-behavioural therapy more effective than

- relaxation therapy in the treatment of anxiety disorders? A meta-analysis. *Psychological Medicine*, 48(9), 1427-1436. doi:10.1017/s0033291717003099
- Moreno, J. (2018). El 89 % de los venezolanos censados se quieren quedar en Colombia. *El Tiempo*. Retrieved from <https://www.eltiempo.com/colombia/otras-ciudades/resultados-del-censo-de-venezolanos-en-colombia-229716>
- Morgan, D. L. (2014). Pragmatism as a Paradigm for Social Research. *Qualitative Inquiry*, 20(8), 1045-1053. doi:10.1177/1077800413513733
- Movsisyan, A., Arnold, L., Evans, R., Hallingberg, B., Moore, G., O'Cathain, A., . . . Rehfuess, E. (2019). Adapting evidence-informed complex population health interventions for new contexts: a systematic review of guidance. *Implementation Science*, 14(1), 105. doi:10.1186/s13012-019-0956-5
- Mundeva, H., Snyder, J., Ngilangwa, D. P., & Kaida, A. (2018). Ethics of task shifting in the health workforce: exploring the role of community health workers in HIV service delivery in low- and middle-income countries. *BMC Medical Ethics*, 19(1), 71. doi:10.1186/s12910-018-0312-3
- Munetsi, E., Simms, V., Dzapasi, L., Chapoterera, G., Goba, N., Gumunyu, T., . . . Chibanda, D. (2018). Trained lay health workers reduce common mental disorder symptoms of adults with suicidal ideation in Zimbabwe: a cohort study. *BMC Public Health*, 18(1), 227. doi:10.1186/s12889-018-5117-2
- Munoz-Navarro, R., Cano-Vindel, A., Moriana, J. A., Medrano, L. A., Ruiz-Rodriguez, P., Aguero-Gento, L., . . . Ramirez-Manent, J. I. (2017). Screening for generalized anxiety disorder in Spanish primary care centers with the GAD-7. *Psychiatry Research*, 256, 312-317. doi:10.1016/j.psychres.2017.06.023
- Murray, C. J., & Lopez, A. D. (1996). The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020: summary.
- Murray, L. K., Dorsey, S., Bolton, P., Jordans, M. J., Rahman, A., Bass, J., & Verdeli, H. (2011). Building capacity in mental health interventions in low resource countries: an apprenticeship model for training local providers. *International Journal of Mental Health Systems*, 5(1), 30. doi:10.1186/1752-4458-5-30
- Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiahy, M. M., Haydary, A., . . . Bolton, P. (2014). A Common Elements Treatment Approach for Adult Mental Health Problems in Low- and Middle-Income Countries. *Cognitive Behavioral Practice*, 21(2), 111-123. doi:10.1016/j.cbpra.2013.06.005
- Murray, L. K., Tol, W., Jordans, M., Zangana, G. S., Amin, A. M., Bolton, P., . . . Thornicroft, G. (2014). Dissemination and implementation of evidence based, mental health interventions in post conflict, low resource settings. *Intervention*, 12(Suppl 1), 94-112. doi:10.1097/WTF.0000000000000070
- Mutamba, B. B., Kane, J. C., de Jong, J., Okello, J., Musisi, S., & Kohrt, B. A. (2018). Psychological treatments delivered by community health workers in low-resource government health systems: effectiveness of group interpersonal psychotherapy for caregivers of children affected by nodding syndrome in Uganda. *Psychological Medicine*, 48(15), 2573-2583. doi:10.1017/s0033291718000193
- Mynors-Wallis, L., & Lau, M. A. (2010). Problem solving as a low-intensity intervention. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B. Klein, M. A. Lau, J. Proudfoot, L. Ritterband, J. White, & C. Williams (Eds.), *Oxford Guide to Low Intensity CBT Interventions*. New York: Oxford University Press.
- National Collaborating Centre for Mental Health. (2011). *Generalised Anxiety Disorder in Adults: Management in Primary, Secondary and Community Care* Vol. NICE Guidelines, No. 113. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK83459/>
- National Institute for Health and Excellence. (2011). Common mental health disorders: Identification and pathways to care. Retrieved from <https://www.nice.org.uk/guidance/cg123>

- Nederhof, A. J. (1985). Methods of coping with social desirability bias: A review. *European Journal of Social Psychology*, 15(3), 263-280. doi:10.1002/ejsp.2420150303
- Neuner, F., Onyut, P., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: a randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 76(4), 686-694. doi:10.1037/0022-006X.76.4.686
- Newby, J. M., McKinnon, A., Kuyken, W., Gilbody, S., & Dalgleish, T. (2015). Systematic review and meta-analysis of transdiagnostic psychological treatments for anxiety and depressive disorders in adulthood. *Clinical Psychology Review*, 40, 91-110. doi:10.1016/j.cpr.2015.06.002
- Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review*, 31(3), 399-417. doi:10.1016/j.cpr.2010.10.004
- Nickerson, A., Liddell, B., Asnaani, A., Carlsson, J., Fazel, M., Knaevelsrud, C., . . . Rasmussen, A. (2017). *Trauma and Mental Health in Forcibly Displaced Populations: An International Society for Traumatic Stress Studies Briefing Paper*. Retrieved from <https://istss.org/public-resources/istss-briefing-papers/trauma-and-mental-health-in-forcibly-displaced-pop>
- Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science*, 10, 53. doi:10.1186/s13012-015-0242-0
- Nilsen, P., Roback, K., Broström, A., & Ellström, P.-E. (2012). Creatures of habit: accounting for the role of habit in implementation research on clinical behaviour change. *Implementation Science*, 7, 53-53. doi:10.1186/1748-5908-7-53
- Nogueira, B., Mari, J., & Razzouk, D. (2015). Culture-bound syndromes in Spanish speaking Latin America: the case of Nervios, Susto and Ataques de Nervios. *Archives of Clinical Psychiatry (São Paulo)*, 42, 171-178. doi:10.1590/0101-60830000000070
- Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, 48(1), 98.
- Norris, F. H., Friedman, M. J., Watson, P. J., Byrne, C. M., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981-2001. *Psychiatry*, 65(3), 207-239.
- Nose, M., Ballette, F., Bighelli, I., Turrini, G., Purgato, M., Tol, W., . . . Barbui, C. (2017). Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis. *PLOS One*, 12(2), e0171030. doi:10.1371/journal.pone.0171030
- Nowell, L., Norris, J., White, D., & Moules, N. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative*, 16. doi:10.1177/1609406917733847
- Onyut, L., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M., & Elbert, T. (2003). The Nakivale Camp Mental Health Project: Building local competency for psychological assistance to traumatised refugees. *First publ. in: Intervention* 2 (2004), 2, pp. 90-107, 2.
- Organization, W. H. (2008). *Recommendations, Task Shifting Global*. Retrieved from Geneva: https://www.who.int/workforcealliance/knowledge/resources/taskshifting_guidelines/en/
- Osman, F., Flacking, R., Schon, U.-K., & Klingberg-Allvin, M. (2017). A Support Program for Somali-born Parents on Children's Behavioral Problems. *Pediatrics*, 139. doi:10.1542/peds.2016-2764
- Padmanathan, P., & De Silva, M. J. (2013). The acceptability and feasibility of task-sharing for mental healthcare in low and middle income countries: a systematic review. *Social Science and Medicine*, 97, 82-86. doi:10.1016/j.socscimed.2013.08.004
- Paez, A. (2017). Gray literature: An important resource in systematic reviews. *Journal of Evidence-Based Medicine*, 10(3), 233-240. doi:10.1111/jebm.12266

- Page, K. R., Doocy, S., Reyna Ganteaume, F., Castro, J. S., Spiegel, P., & Beyrer, C. (2019). Venezuela's public health crisis: a regional emergency. *The Lancet*, 393(10177), 1254-1260. doi:[https://doi.org/10.1016/S0140-6736\(19\)30344-7](https://doi.org/10.1016/S0140-6736(19)30344-7)
- Palinkas, L. A., Aarons, G. A., Horwitz, S., Chamberlain, P., Hurlburt, M., & Landsverk, J. (2011). Mixed method designs in implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(1), 44-53.
- Pallas, S. W., Minhas, D., Pérez-Escamilla, R., Taylor, L., Curry, L., & Bradley, E. H. (2013). Community health workers in low- and middle-income countries: what do we know about scaling up and sustainability? *American Journal of Public Health*, 103(7), e74-e82. doi:10.2105/AJPH.2012.301102
- Panter-Brick, C., Grimon, M.-P., & Eggerman, M. (2014). Caregiver—child mental health: a prospective study in conflict and refugee settings. *Journal of Child Psychology and Psychiatry*, 55(4), 313-327. doi:10.1111/jcpp.12167
- Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., . . . van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet*, 370(9591), 991-1005. doi:10.1016/S0140-6736(07)61240-9
- Patel, V., Chowdhary, N., Rahman, A., & Verdeli, H. (2011). Improving access to psychological treatments: Lessons from developing countries. *Behaviour Research and Therapy*, 49(9), 523-528. doi:<https://doi.org/10.1016/j.brat.2011.06.012>
- Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries / Vikram Patel and Arthur Kleinman. *Bulletin of the World Health Organization*.
- Patel, V., Maj, M., Flisher, A. J., De Silva, M. J., Koschorke, M., & Prince, M. (2010). Reducing the treatment gap for mental disorders: a WPA survey. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, 9(3), 169-176.
- Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., . . . Unutzer, J. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392(10157), 1553-1598. doi:10.1016/S0140-6736(18)31612-X
- Patel, V., Weiss, H. A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S., . . . Kirkwood, B. R. (2010). Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. *The Lancet*, 376(9758), 2086-2095. doi:10.1016/S0140-6736(10)61508-5
- Patel, V., Weobong, B., Weiss, H. A., Anand, A., Bhat, B., Katti, B., . . . Fairburn, C. G. (2017). The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: a randomised controlled trial. *The Lancet*, 389(10065), 176-185. doi:10.1016/s0140-6736(16)31589-6
- Pearl, S. B., & Norton, P. J. (2017). Transdiagnostic versus diagnosis specific cognitive behavioural therapies for anxiety: A meta-analysis. *Journal of Anxiety Disorders*, 46, 11-24. doi:10.1016/j.janxdis.2016.07.004
- Pedersen, G. A., Smallegange, E., Coetzee, A., Hartog, K., Turner, J., Jordans, M. J. D., & Brown, F. L. (2019). A Systematic Review of the Evidence for Family and Parenting Interventions in Low- and Middle-Income Countries: Child and Youth Mental Health Outcomes. *Journal of Child and Family Studies*, 28(8), 2036-2055. doi:10.1007/s10826-019-01399-4
- Peters, D. H., Adam, T., Alonge, O., Agyepong, I. A., & Tran, N. (2013). Implementation research: what it is and how to do it. *BMJ*, 347. doi:10.1136/bmj.f6753
- Petersen, I., Bhana, A., & Baillie, K. (2012). The Feasibility of Adapted Group-Based Interpersonal Therapy (IPT) for the Treatment of Depression by Community Health Workers Within the Context of Task Shifting in South Africa. 48(3), 336-341. doi:10.1007/s10597-011-9429-2

- Pfeiffer, E., & Goldbeck, L. (2017). Evaluation of a Trauma-Focused Group Intervention for Unaccompanied Young Refugees: A Pilot Study. *Journal of Traumatic Stress*, 30(5), 531-536. doi:10.1002/jts.22218
- Pfeiffer, E., Sachser, C., Rohlmann, F., & Goldbeck, L. (2018). Effectiveness of a trauma-focused group intervention for young refugees: a randomized controlled trial. *Journal of Child Psychology and Psychiatry*, 59(11), 1171-1179. doi:10.1111/jcpp.12908
- Pfeiffer, E., Sachser, C., Tutus, D., Fegert, J. M., & Plener, P. L. (2019). Trauma-focused group intervention for unaccompanied young refugees: "Mein Weg"—predictors of treatment outcomes and sustainability of treatment effects. *Child and Adolescent Psychiatry and Mental Health*, 13(1), 18. doi:10.1186/s13034-019-0277-0
- Pinnock, H., Barwick, M., Carpenter, C. R., Eldridge, S., Grandes, G., Griffiths, C. J., . . . Taylor, S. J. C. (2017). Standards for Reporting Implementation Studies (StaRI) Statement. *BMJ*, 356. doi:10.1136/bmj.i6795
- Plummer, F., Manea, L., Trepel, D., & McMillan, D. (2016). Screening for anxiety disorders with the GAD-7 and GAD-2: a systematic review and diagnostic metaanalysis. *General Hospital Psychiatry*, 39, 24-31. doi:https://doi.org/10.1016/j.genhosppsych.2015.11.005
- Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., . . . Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews: a product from the ESRC Methods Programme*. Retrieved from Lancaster: http://www.lancs.ac.uk/shm/research/nssr/research/dissemination/publications/NS_Synthesis_Guidance_v1.pdf
- Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *JAMA*, 294(5), 602-612. doi:10.1001/jama.294.5.602
- Powell, B. J., McMillen, J. C., Proctor, E. K., Carpenter, C. R., Griffey, R. T., Bunger, A. C., . . . York, J. L. (2012). A compilation of strategies for implementing clinical innovations in health and mental health. *Medical Care Research and Review*, 69(2), 123-157. doi:10.1177/1077558711430690
- Priebe, S., Giacco, D., & El-Nagib, R. (2016). WHO Health Evidence Network Synthesis Reports *Public Health Aspects of Mental Health Among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers and Irregular Migrants in the WHO European Region*. Copenhagen: WHO Regional Office for Europe
- Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., . . . Hensley, M. (2011). Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(2), 65-76. doi:10.1007/s10488-010-0319-7
- Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, 36(1), 24-34. doi:10.1007/s10488-008-0197-4
- Proctor, E. K., Powell, B. J., & McMillen, J. C. (2013). Implementation strategies: recommendations for specifying and reporting. *Implementation Science*, 8, 139. doi:10.1186/1748-5908-8-139
- Purgato, M., Carswell, K., Acarturk, C., Au, T., Akbai, S., Anttila, M., . . . Van Ommeren, M. (2019). Effectiveness and cost-effectiveness of Self-Help Plus (SH+) for preventing mental disorders in refugees and asylum seekers in Europe and Turkey: study protocols for two randomised controlled trials. *BMJ Open*, 9(5), e030259. doi:10.1136/bmjopen-2019-030259
- Quevillon, R. P., Gray, B. L., Erickson, S. E., Gonzalez, E. D., & Jacobs, G. A. (2016). Helping the Helpers: Assisting Staff and Volunteer Workers Before, During,

- and After Disaster Relief Operations. *Journal of Clinical Psychology*, 72(12), 1348-1363. doi:10.1002/jclp.22336
- Rahman, A., Hamdani, S. U., Awan, N. R., Bryant, R. A., Dawson, K. S., Khan, M. F., . . . van Ommeren, M. (2016). Effect of a Multicomponent Behavioral Intervention in Adults Impaired by Psychological Distress in a Conflict-Affected Area of Pakistan: A Randomized Clinical Trial. *JAMA*, 316(24), 2609-2617. doi:10.1001/jama.2016.17165
- Rahman, A., Khan, M. N., Hamdani, S. U., Chiumento, A., Akhtar, P., Nazir, H., . . . van Ommeren, M. (2019). Effectiveness of a brief group psychological intervention for women in a post-conflict setting in Pakistan: a single-blind, cluster, randomised controlled trial. *The Lancet*, 393(10182), 1733-1744. doi:10.1016/S0140-6736(18)32343-2
- Rahman, A., Malik, A., Sikander, S., Roberts, C., & Creed, F. (2008). Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised controlled trial. *The Lancet*, 372(9642), 902-909. doi:10.1016/S0140-6736(08)61400-2
- Rauch, S., Shin, L., & Phelps, E. (2006). Neurocircuitry Models of Posttraumatic Stress Disorder and Extinction: Human Neuroimaging Research-Past, Present, and Future. *Biological Psychiatry*, 60, 376-382. doi:10.1016/j.biopsych.2006.06.004
- Rees, S., Thorpe, R., Tol, W., Fonseca, M., & Silove, D. (2015). Testing a cycle of family violence model in conflict-affected, low-income countries: A qualitative study from Timor-Leste. 130, 284-291. doi:10.1016/j.socscimed.2015.02.013
- Resnicow, K., Soler, R., Braithwaite, R. L., Ahluwalia, J. S., & Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of Community Psychology*, 28(3), 271-290. doi:10.1002/(SICI)1520-6629(200005)28:3<271::AID-JCOP4>3.0.CO;2-I
- Response for Venezuelans. (2019). *Regional Refugee and Migration Response Plan* Retrieved from Geneva: <https://reliefweb.int/report/colombia/regional-refugee-and-migrant-response-plan-refugees-and-migrants-venezuela-january>
- Response for Venezuelans. (2020). Refugees and migrants from Venezuela. Retrieved from <https://r4v.info/en/situations/platform>
- Richards, D. A., Rhodes, S., Ekers, D., McMillan, D., Taylor, R. S., Byford, S., . . . Woodhouse, R. (2017). Cost and Outcome of Behavioural Activation (COBRA): a randomised controlled trial of behavioural activation versus cognitive-behavioural therapy for depression. *Health Technology Assessment*, 21(46), 1-366. doi:10.3310/hta21460
- Rizkalla, N., & Segal, S. P. (2019). Trauma during humanitarian work: the effects on intimacy, wellbeing and PTSD-symptoms. *European Journal of Psychotraumatology*, 10(1), 1679065-1679065. doi:10.1080/20008198.2019.1679065
- Roberts, B., & Browne, J. (2011). A systematic review of factors influencing the psychological health of conflict-affected populations in low- and middle-income countries. *Global Public Health*, 6(8), 814-829. doi:10.1080/17441692.2010.511625
- Roberts, K., Dowell, A., & Nie, J.-B. (2019). Attempting rigour and replicability in thematic analysis of qualitative research data; a case study of codebook development. *BMC Medical Research Methodology*, 19(1), 66. doi:10.1186/s12874-019-0707-y
- Rockers, P., Röttingen, J.-A., Shemilt, I., Tugwell, P., & Bärnighausen, T. (2014). Inclusion of quasi-experimental studies in systematic reviews of health systems research. *Health policy (Amsterdam, Netherlands)*, 119. doi:10.1016/j.healthpol.2014.10.006
- Rodgers, M., Asaria, M., Walker, S., McMillan, D., Lucock, M., Harden, M., . . . Eastwood, A. (2012). The clinical effectiveness and cost-effectiveness of low-intensity psychological interventions for the secondary prevention of relapse after depression: a systematic review. *Health Technology Assessment*, 16(28), 1-130. doi:10.3310/hta16280
- Rogers, C. R. (1946). Significant aspects of client-centered therapy. *American Psychologist*, 1(10), 415-422.

- Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: Free Press.
- Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn't. *BMJ*, 312(7023), 71-72. doi:10.1136/bmj.312.7023.71
- Salamanca-Sanabria, A., Richards, D., & Timulak, L. (2019). Adapting an internet-delivered intervention for depression for Colombian college student population: An illustration of an integrative approach. *Internet Interventions*. doi:https://doi.org/10.1016/j.invent.2018.11.005
- Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., . . . Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, 370(9593), 1164-1174. doi:10.1016/S0140-6736(07)61263-X
- Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007a). Global Mental Health 2 - Resources for mental health: scarcity, inequity, and inefficiency. *The Lancet*, 370(9590), 878-889. doi:10.1016/S0140-6736(07)61239-2
- Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007b). Resources for mental health: scarcity, inequity, and inefficiency. *The Lancet*, 370(9590), 878-889. doi:10.1016/S0140-6736(07)61239-2
- Saxon, D., Firth, N., & Barkham, M. (2017). The Relationship Between Therapist Effects and Therapy Delivery Factors: Therapy Modality, Dosage, and Non-completion. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5), 705-715. doi:10.1007/s10488-016-0750-5
- Schinina, G., Babcock, E., Nadelman, R., Walsh, J. S., Willhoite, A., & Willman, A. (2016). The integration of livelihood support and mental health and psychosocial wellbeing for populations who have been subject to severe stressors. *Intervention*, 14(3), 211-222.
- Schweitzer, R. D., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post-migration experience. *Australian and New Zealand Journal of Psychiatry*, 45(4), 299-307. doi:10.3109/00048674.2010.543412
- Scott, S. D., Plotnikoff, R. C., Karunamuni, N., Bize, R., & Rodgers, W. (2008). Factors influencing the adoption of an innovation: an examination of the uptake of the Canadian Heart Health Kit (HHK). *Implementation Science*, 3, 41-41. doi:10.1186/1748-5908-3-41
- Seidler, G. H., & Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study. *Psychological Medicine*, 36(11), 1515-1522. doi:10.1017/S0033291706007963
- Shahmalak, U., Blakemore, A., Waheed, M. W., & Waheed, W. (2019). The experiences of lay health workers trained in task-shifting psychological interventions: a qualitative systematic review. *International Journal of Mental Health Systems*, 13, 64. doi:10.1186/s13033-019-0320-9
- Shapiro, F. (1989). Eye movement desensitization: a new treatment for post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 20(3), 211-217.
- Shinohara, K., Honyashiki, M., Imai, H., Hunot, V., Caldwell, D. M., Davies, P., . . . Churchill, R. (2013). Behavioural therapies versus other psychological therapies for depression. *Cochrane Database of Systematic Reviews*(10). doi:10.1002/14651858.CD008696.pub2
- Shultz, J. M., Ceballos, Á. M. G., Espinel, Z., Oliveros, S. R., Fonseca, M. F., & Florez, L. J. H. (2014). Internal displacement in Colombia: Fifteen distinguishing features. *Disaster Health*, 2(1), 13-24. doi:10.4161/dish.27885
- Shultz, J. M., García, N. M., Ceballos, Á. M. G., Florez, L. J. H., Araya, R., Verdelli, H., . . . the, O. O. T. (2014). Outreach to internally displaced persons in Bogotá, Colombia: challenges and potential solutions. *Disaster Health*, 2(2), 75-81. doi:10.4161/21665044.2014.954500
- Sijbrandij, M., Acarturk, C., Bird, M., Bryant, R. A., Burchert, S., Carswell, K., . . . Cuijpers, P. (2017). Strengthening mental health care systems for Syrian

- refugees in Europe and the Middle East: integrating scalable psychological interventions in eight countries. *European Journal of Psychotraumatology*, 8(sup2), 1388102. doi:10.1080/20008198.2017.1388102
- Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. *The Journal of Nervous and Mental Disease*, 187(4), 200-207.
- Silove, D., Tay, A., & Rees, S. (2019). Psychotherapy for refugees and other populations exposed to conflict (pp. 341-362).
- Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: an overview of mental health challenges. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, 16(2), 130-139. doi:10.1002/wps.20438
- Singla, D., Lazarus, A., Atif, N., Sikander, S., Bhatia, U., Ahmad, I., . . . Rahman, A. (2014). "Someone like us": delivering maternal mental health through peers in two South Asian contexts. *Journal of Affective Disorders*, 168, 452-458. doi:10.1016/j.jad.2014.07.017
- Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological Treatments for the World: Lessons from Low- and Middle-Income Countries. *Annual Review of Clinical Psychology*, 13(1), 149-181. doi:10.1146/annurev-clinpsy-032816-045217
- Smith, T. B., Rodríguez, M. D., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, 67(2), 166-175. doi:doi:10.1002/jclp.20757
- Sofaer, S. (1999). Qualitative methods: what are they and why use them? *Health Services Research*, 34(5 Pt 2), 1101-1118.
- Soucy Chartier, I., & Provencher, M. D. (2013). Behavioural activation for depression: efficacy, effectiveness and dissemination. *Journal of Affective Disorders*, 145(3), 292-299. doi:10.1016/j.jad.2012.07.023
- Spedding, M. F., & Chibanda, D. (2019). 6 - Emerging models of psychotherapy. In D. J. Stein, J. K. Bass, & S. G. Hofmann (Eds.), *Global Mental Health and Psychotherapy* (pp. 127-152): Academic Press.
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166(10), 1092-1097.
- Squires, A. (2009). Methodological Challenges in Cross-Language Qualitative Research: A Research Review. *International Journal of Nursing Studies*, 46, 277-287. doi:10.1016/j.ijnurstu.2008.08.006
- Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA*, 302(5), 537-549. doi:10.1001/jama.2009.1132
- Steel, Z., Momartin, S., Silove, D., Coello, M., Aroche, J., & Tay, K. W. (2011). Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. *Social Science and Medicine*, 72(7), 1149-1156. doi:10.1016/j.socscimed.2011.02.007
- Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *British Journal of Psychiatry*, 188, 58-64. doi:10.1192/bjp.bp.104.007864
- Steel, Z., Silove, D., Chey, T., Bauman, A., Phan, T., & Phan, T. (2005). Mental disorders, disability and health service use amongst Vietnamese refugees and the host Australian population. *Acta Psychiatrica Scandinavica*, 111(4), 300-309. doi:10.1111/j.1600-0447.2004.00458.x
- Sterne, J. A. C., White, I. R., Carlin, J. B., Spratt, M., Royston, P., Kenward, M. G., . . . Carpenter, J. R. (2009). Multiple imputation for missing data in epidemiological and clinical research: potential and pitfalls. *BMJ*, 338, b2393. doi:10.1136/bmj.b2393
- Sue, S. (1999). Science, ethnicity, and bias: where have we gone wrong? *American Psychologist*, 54(12), 1070-1077.

- Sultana, F. (2007). Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research. *ACME*, 6, 374-385.
- Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, 48(10), 1449-1462.
- Suzuki, K., Takei, N., Kawai, M., Minabe, Y., & Mori, N. (2003). Is taijin kyofusho a culture-bound syndrome? *American Journal of Psychiatry*, 160(7), 1358. doi:10.1176/appi.ajp.160.7.1358
- Tandon, M., Cardeli, E., & Luby, J. (2009). Internalizing disorders in early childhood: a review of depressive and anxiety disorders. *Child and Adolescent Psychiatric Clinics of North America*, 18(3), 593-610. doi:10.1016/j.chc.2009.03.004
- Tareen, A., & Tareen, K. I. (2019). Management of psychological distress by non-specialists in conflict-affected areas. *The Lancet*, 393(10182), 1676-1677. doi:10.1016/S0140-6736(18)32614-x
- Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Thousand Oaks, CA, US: Sage Publications, Inc.
- The Lancet. (2019). Venezuelans' right to health crumbles amid political crisis. *The Lancet*, 393(10177), 1177. doi:10.1016/S0140-6736(19)30729-9
- Theobald, S., Brandes, N., Gyapong, M., El-Saharty, S., Proctor, E., Diaz, T., . . . Peters, D. H. (2018). Implementation research: new imperatives and opportunities in global health. *The Lancet*, 392(10160), 2214-2228. doi:10.1016/S0140-6736(18)32205-0
- TheRMUoHP Biostatistics Resource Channel. (2013). How to Use SPSS-Replacing Missing Data Using Multiple Imputation (Regression Method). Retrieved from <https://www.youtube.com/watch?v=ytQedMywOjQ>
- Thoma, N., Pilecki, B., & McKay, D. (2015). Contemporary cognitive behavior therapy: A review of theory, history, and evidence. *Psychodynamic Psychiatry*, 43(3), 423-461.
- Thompson, C. T., Vidgen, A., & Roberts, N. P. (2018). Psychological interventions for post-traumatic stress disorder in refugees and asylum seekers: A systematic review and meta-analysis. *Clinical Psychology Review*, 63, 66-79. doi:10.1016/j.cpr.2018.06.006
- Thormar, S. B., Gersons, B. P., Juen, B., Djakababa, M. N., Karlsson, T., & Olff, M. (2013). Organizational factors and mental health in community volunteers. The role of exposure, preparation, training, tasks assigned, and support. *Anxiety Stress Coping*, 26(6), 624-642. doi:10.1080/10615806.2012.743021
- Tol, W. A., Barbui, C., Bisson, J., Cohen, J., Hijazi, Z., Jones, L., . . . van Ommeren, M. (2014). World Health organization guidelines for management of acute stress, PTSD, and bereavement: key challenges on the road ahead. *PLoS Medicine*, 11(12), e1001769. doi:10.1371/journal.pmed.1001769
- Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., . . . van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: linking practice and research. *The Lancet*, 378(9802), 1581-1591. doi:10.1016/S0140-6736(11)61094-5
- Tol, W. A., Ebrecht, B., Aiyo, R., Murray, S. M., Nguyen, A. J., Kohrt, B. A., . . . Nakku, J. (2018). Maternal mental health priorities, help-seeking behaviors, and resources in post-conflict settings: a qualitative study in eastern Uganda. *BMC Psychiatry*, 18(1), 39-39. doi:10.1186/s12888-018-1626-x
- Tol, W. A., Leku, M. R., Lakin, D. P., Carswell, K., Augustinavicius, J., Adaku, A., . . . van Ommeren, M. (2020). Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: a cluster randomised trial. *The Lancet Global Health*, 8(2), e254-e263. doi:10.1016/S2214-109X(19)30504-2
- Tol, W. A., Rees, S. J., & Silove, D. M. (2013). Broadening the scope of epidemiology in conflict-affected settings: opportunities for mental health prevention and promotion. *Epidemiol Psychiatr Sci*, 22(3), 197-203. doi:10.1017/S2045796013000188

- Tolin, D. F. (2010). Is cognitive-behavioral therapy more effective than other therapies?: A meta-analytic review. *Clinical Psychology Review*, 30(6), 710-720.
- Topp, C. W., Ostergaard, S. D., Sondergaard, S., & Bech, P. (2015). The WHO-5 Well-Being Index: a systematic review of the literature. *Psychotherapy and Psychosomatics*, 84(3), 167-176. doi:10.1159/000376585
- Tribe, R. H., Sendt, K. V., & Tracy, D. K. (2017). A systematic review of psychosocial interventions for adult refugees and asylum seekers. *Journal of Mental Health*, 1-15. doi:10.1080/09638237.2017.1322182
- Tsao, J. C., Mystkowski, J. L., Zucker, B. G., & Craske, M. G. (2005). Impact of cognitive-behavioral therapy for panic disorder on comorbidity: a controlled investigation. *Behaviour Research and Therapy*, 43(7), 959-970. doi:10.1016/j.brat.2004.11.013
- Tully, L. A., & Hunt, C. (2016). Brief Parenting Interventions for Children at Risk of Externalizing Behavior Problems: A Systematic Review. *Journal of Child and Family Studies*, 25(3), 705-719. doi:10.1007/s10826-015-0284-6
- Turrini, G., Purgato, M., Acarturk, C., Anttila, M., Au, T., Ballette, F., . . . Barbui, C. (2019). Efficacy and acceptability of psychosocial interventions in asylum seekers and refugees: systematic review and meta-analysis. *Epidemiol Psychiatr Sci*, 1-13. doi:10.1017/s2045796019000027
- Turrini, G., Purgato, M., Ballette, F., Nosè, M., Ostuzzi, G., & Barbui, C. (2017). Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. *International Journal of Mental Health Systems*, 11, 51-51. doi:10.1186/s13033-017-0156-0
- UN General Assembly. (2015). *Transforming our world: the 2030 Agenda for Sustainable Development* Retrieved from New York:
- United Nations High Commissioner for Human Rights. (2017). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Retrieved from <https://reliefweb.int/sites/reliefweb.int/files/resources/G1707604.pdf>
- United Nations High Commissioner for Human Rights. (2018). *Human Rights Violations in the Bolivarian Republic of Venezuela: a downward spiral with no end in sight*. Retrieved from https://www.ohchr.org/Documents/Countries/VE/VenezuelaReport2018_EN.pdf
- United Nations High Commissioner for Human Rights. (2019). *Human rights in the Bolivarian Republic of Venezuela*. Retrieved from Geneva: <https://reliefweb.int/report/venezuela-bolivarian-republic/report-united-nations-high-commissioner-human-rights-situation>
- United Nations High Commissioner for Refugees. (2013). *UNHCR's Mental Health and Psychosocial Support for Persons of Concern*. Retrieved from Geneva, Switzerland: <https://www.unhcr.org/research/evalreports/51bec3359/unhcrs-mental-health-psychosocial-support-persons-concern.html>
- United Nations High Commissioner for Refugees. (2018a). *Global Trends: Forced Displacement in 2017*. Retrieved from Geneva: <https://www.unhcr.org/5b27be547.pdf>
- United Nations High Commissioner for Refugees. (2018b). 'Refugees' and 'Migrants' - Frequently Asked Questions (FAQs) Retrieved from <https://www.unhcr.org/news/latest/2016/3/56e95c676/refugees-migrants-frequently-asked-questions-faqs.html>
- United Nations High Commissioner for Refugees. (2019a). Colombia acts to ensure children born to Venezuelan parents are not left stateless.
- United Nations High Commissioner for Refugees. (2019b). *Global Trends: Forced Displacement in 2018*. Retrieved from Geneva: <https://www.unhcr.org/5b27be547.pdf>
- United Nations High Commissioner for Refugees. (2019c). The Refugee Brief - 29 October 2019. Retrieved from <https://www.unhcr.org/refugeebrief/the-refugee-brief-29-october-2019/>

- United Nations High Commissioner for Refugees. (2019d). Refugees and migrants from Venezuela top 4 million: UNHCR and IOM. Retrieved from <https://www.unhcr.org/news/press/2019/6/5cfa2a4a4/refugees-migrants-venezuela-top-4-million-unhcr-iom.html#>
- United Nations High Commissioner for Refugees. (2019e). What is a Refugee? Retrieved from <https://www.unrefugees.org/refugee-facts/what-is-a-refugee/>
- United Nations Office for the Coordination of Humanitarian Affairs. (2019). *Global Humanitarian Overview 2019*. Retrieved from <https://www.unocha.org/sites/unocha/files/GHO2019.pdf>
- University of Liverpool. (2020). Feasibility study and pilot trial of an evidence-based low intensity psychosocial intervention delivered by lay therapists for asylum seekers and refugees (PROSPER). Retrieved from <https://www.liverpool.ac.uk/population-health-sciences/departments/health-services-research/research/prosper/>
- Valiente-Gómez, A., Moreno-Alcázar, A., Treen, D., Cedrón, C., Colom, F., Pérez, V., & Amann, B. L. (2017). EMDR beyond PTSD: A Systematic Literature Review. *Frontiers in Psychology, 8*, 1668-1668. doi:10.3389/fpsyg.2017.01668
- Vallièrès, F., Hyland, P., McAuliffe, E., Mahmud, I., Tulloch, O., Walker, P., & Taegtmeier, M. (2018). A new tool to measure approaches to supervision from the perspective of community health workers: a prospective, longitudinal, validation study in seven countries. *BMC Health Services Research, 18*(1), 806. doi:10.1186/s12913-018-3595-7
- Vallièrès, F., Hyland, P., Murphy, J., Hansen, M., Shevlin, M., Elklit, A., . . . Bramsen, R. H. (2018). Training the next generation of psychotraumatologists: COLlaborative Network for Training and EXcellence in psychoTraumatology (CONTEXT). *European Journal of Psychotraumatology, 9*(1), 1421001. doi:10.1080/20008198.2017.1421001
- van Ginneken, N., Tharyan, P., Lewin, S., Rao, G. N., Meera, S. M., Pian, J., . . . Patel, V. (2013). Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries. *Cochrane Database of Systematic Reviews*(11), CD009149. doi:10.1002/14651858.CD009149.pub2
- van Ommeren, M., Saxena, S., & Saraceno, B. (2005a). Aid after disasters. *BMJ, 330*(7501), 1160-1161. doi:10.1136/bmj.330.7501.1160
- van Ommeren, M., Saxena, S., & Saraceno, B. (2005b). Mental and social health during and after acute emergencies: emerging consensus? *Bulletin of the World Health Organization, 83*(1), 71-76.
- Van Straten, A., Hill, J., Richards, D. A., & Cuijpers, P. (2015). Stepped care treatment delivery for depression: a systematic review and meta-analysis. *Psychological Medicine, 45*(2), 231-246. doi:10.1017/s0033291714000701
- Van Straten, A., Van Der Zweerde, T., Kleiboer, A., Cuijpers, P., Morin, C. M., & Lancee, J. (2018). Cognitive and behavioral therapies in the treatment of insomnia: A meta-analysis. *Sleep Medicine Reviews, 38*, 3-16. doi:10.1016/j.smrv.2017.02.001
- Van't Hof, E., Dawson, K. S., Schafer, A., Chiumento, A., Harper Shehadeh, M., Sijbrandij, M., . . . van Ommeren, M. (2018). A qualitative evaluation of a brief multicomponent intervention provided by lay health workers for women affected by adversity in urban Kenya. *Global Mental Health, 5*, e6. doi:10.1017/gmh.2017.26
- Ventevogel, P. (2016). *Borderlands of Mental Health: Explorations in Medical Anthropology, Psychiatric Epidemiology and Health Systems Research in Afghanistan and Burundi*: Peter Ventevogel.
- Ventevogel, P. (2018). Interventions for Mental Health and Psychosocial Support in Complex Humanitarian Emergencies: Moving Towards Consensus in Policy and Action?: Theory, Research and Clinical Practice (pp. 155-180).
- Ventevogel, P., Jordans, M. J., Eggerman, M., van Mierlo, B., & Panter-Brick, C. (2013). Child mental health, psychosocial well-being and resilience in Afghanistan: a

- review and future directions *Handbook of resilience in children of war* (pp. 51-79): Springer.
- Ventevogel, P., van Ommeren, M., Schilperoord, M., & Saxena, S. (2015). Improving mental health care in humanitarian emergencies. *Bulletin of the World Health Organization*, 93(10), 666-666a. doi:10.2471/blt.15.156919
- Verdeli, H., Clougherty, K., Bolton, P., Speelman, L., Lincoln, N., Bass, J., . . . Weissman, M. M. (2003). Adapting group interpersonal psychotherapy for a developing country: experience in rural Uganda. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, 2(2), 114-120.
- Verdeli, H., Clougherty, K., Onyango, G., Lewandowski, E., Speelman, L., Betancourt, T. S., . . . Bolton, P. (2008). Group Interpersonal Psychotherapy for depressed youth in IDP camps in Northern Uganda: adaptation and training. *Child and Adolescent Psychiatric Clinics of North America*, 17(3), 605-624, ix. doi:10.1016/j.chc.2008.03.002
- Weisaeth, L. (2014). The History of Psychic Trauma In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice*, 2nd ed. (pp. xvii, 718-xvii, 718). New York, NY, US: Guilford Press.
- Weiss, W. M., Murray, L. K., Zangana, G. A. S., Mahmooth, Z., Kaysen, D., Dorsey, S., . . . Bolton, P. (2015). Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: a randomized control trial. *BMC Psychiatry*, 15(1), 249. doi:10.1186/s12888-015-0622-7
- Wells, M., Williams, B., Treweek, S., Coyle, J., & Taylor, J. (2012). Intervention description is not enough: evidence from an in-depth multiple case study on the untold role and impact of context in randomised controlled trials of seven complex interventions. *Trials*, 13(1), 95. doi:10.1186/1745-6215-13-95
- Weobong, B., Weiss, H. A., McDaid, D., Singla, D. R., Hollon, S. D., Nadkarni, A., . . . Patel, V. (2017). Sustained effectiveness and cost-effectiveness of the Healthy Activity Programme, a brief psychological treatment for depression delivered by lay counsellors in primary care: 12-month follow-up of a randomised controlled trial. *PLoS Medicine*, 14(9), e1002385. doi:10.1371/journal.pmed.1002385
- Wessells, M. (2009). Do no harm: toward contextually appropriate psychosocial support in international emergencies. *American Psychologist*, 64(8), 842-854. doi:10.1037/0003-066x.64.8.842
- Wessells, M., & Van Ommeren, M. (2008). *Developing inter-agency guidelines on mental health and psychosocial support in emergency settings* (Vol. 6).
- Westerhof, G. J., & Keyes, C. L. M. (2010). Mental Illness and Mental Health: The Two Continua Model Across the Lifespan. *Journal of adult development*, 17(2), 110-119. doi:10.1007/s10804-009-9082-y
- White, R., Jain, S., Orr, D., & Read, U. (2017). Situating Global Mental Health: Sociocultural Perspectives.
- Wickramage, K. (2006). *Sri Lanka's post-Tsunami psychosocial playground: lessons for future psychosocial programming and interventions following disasters* (Vol. 4).
- Williamson, J., & Robinson, M. (2006). Psychosocial interventions, or integrated programming for well-being? *Intervention*, 4(1), 4-25.
- Wilson, P. M., Sales, A., Wensing, M., Aarons, G. A., Flottorp, S., Glidewell, L., . . . Straus, S. (2017). Enhancing the reporting of implementation research. *Implementation Science*, 12(1), 13. doi:10.1186/s13012-017-0546-3
- World Health Organization. (1996). *WHOQOL BREF: Introduction, Administration, Scoring and Generic Version of the Assessment*. Retrieved from Geneva: https://www.who.int/mental_health/media/en/76.pdf
- World Health Organization. (2005). *Human Resources and Training in Mental Health Policy and Service Guidance Package*. Geneva: World Health Organization.
- World Health Organization. (2008). *mhGAP : Mental Health Gap Action Programme: scaling up care for mental, neurological and substance use disorders*. Geneva: World Health Organization.

- World Health Organization. (2011). *Human resources for mental health: workforce shortages in low- and middle-income countries*. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/44508/9789241501019_eng.pdf?sequence=1
- World Health Organization. (2015). *WHO mhGAP Guideline Update*. Retrieved from Geneva: https://www.who.int/mental_health/mhgap/guideline_2015/en/
- World Health Organization. (2016a). *Global Strategy on Human Resources for Health: Workforce 2030*. Retrieved from Geneva: <https://www.who.int/hrh/resources/globstrathrh-2030/en/>
- World Health Organization. (2016b). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) – version 2.0*. Retrieved from Geneva: <http://www.who.int>
- World Health Organization. (2016c). *Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity (WHO Generic field-trial version 1.0)*. Retrieved from Geneva: https://www.who.int/mental_health/emergencies/problem_management_plus/en/
- World Health Organization. (2017). *Scalable psychological interventions for people in communities affected by adversity*. Retrieved from Geneva: <http://apps.who.int/iris/bitstream/10665/254581/1/WHO-MSD-MER-17.1-eng.pdf>
- World Health Organization. (2018). *Mental Health Atlas 2017*. Retrieved from Geneva: https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/
- World Health Organization, & United Nations High Commissioner for Refugees. (2012). *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings*. Retrieved from Geneva: http://apps.who.int/iris/bitstream/handle/10665/76796/9789241548533_eng.pdf?sequence=1
- World Health Organization, & United Nations High Commissioner for Refugees. (2015). *mhGAP Humanitarian Intervention Guide (mhGAP-HIG) Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies*. Retrieved from Geneva: http://apps.who.int/iris/bitstream/10665/162960/1/9789241548922_eng.pdf?ua=1
- Zakar, R., Zakar, M. Z., Faist, T., & Kraemer, A. (2012). Intimate partner violence against women and its related immigration stressors in Pakistani immigrant families in Germany. *SpringerPlus*, 1, 5-5. doi:10.1186/2193-1801-1-5
- Zimmerman, C., Kiss, L., & Hossain, M. (2011). Migration and health: a framework for 21st century policy-making. *PLoS Medicine*, 8(5), e1001034. doi:10.1371/journal.pmed.1001034

Appendix A to I

Appendix A - Ethical Approval Letters



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Camila Perera Aladro
Centre for Global Health
7-9 Leinster Street South
Trinity College Dublin
Dublin 2

28 February 2018

Re: Towards the Successful Implementation of Low-Intensity Psychological Interventions for Internally Displaced Persons (IDPs): Implementing Problem Management Plus for IDPs in Colombia

Application 02/2018/02

Dear Camila,

Thank you for your submission of the above proposal to the HPM/CGH REC.

The REC has given ethical approval to the proposed study.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Charles Normand'.

Prof Charles Normand
Chair of the HPM/CGH REC

Bainistíocht agus Beartas Sláinte

3-4 Plás Foster,
Coláiste na Tríonóide,
Baile Átha Cliath,
Ollscoil Átha Cliath,
Baile Átha Cliath 2, Éire.

Health Policy and Management

3-4 Foster Place,
Trinity College Dublin,
The University of Dublin,
Dublin 2, Ireland.

+353 1 896 2201

hsmsec@tcd.ie

www.medicine.tcd.ie/health_policy_management

Acta N° 121
Proyecto: "EVALUACIÓN DE UNA INTERVENCIÓN PSICOLÓGICA DE
BAJA INTENSIDAD (ENFRENTANDO PROBLEMAS PLUS) PARA
PERSONAS DESPLAZADAS EN ARAUCA, COLOMBIA"
Código del proyecto: 760
Segunda revisión



UNIVERSIDAD CES
Un compromiso con la excelencia
Resolución del Ministerio de Educación Nacional No. 1371 del 22 de marzo de 2007

1977

40 AÑOS

2017

Medellín, 05 de junio de 2018

Doctora
CAMILA PERERA ALADRO
Investigadora

El Comité Institucional de Ética de Investigación en Humanos Universidad CES en su sesión número 121 del 07 de mayo de 2018, sometió a consideración el proyecto **"EVALUACIÓN DE UNA INTERVENCIÓN PSICOLÓGICA DE BAJA INTENSIDAD (ENFRENTANDO PROBLEMAS PLUS) PARA PERSONAS DESPLAZADAS EN ARAUCA, COLOMBIA"**, cuyos investigadores son los doctores Camila Perera Aladro, Frédérique Vallières, Maj Hansen, Rikke Holm Bramsen, Nana Wiedemann, Joyce Caballero Bernal y Juvenal Francisco Moreno Carrillo.

El objetivo general del estudio es: Contribuir a la evidencia sobre la implementación de intervenciones psicológicas de baja intensidad para reducir malestar psicológico de personas desplazadas en Colombia.

En la evaluación del proyecto, participaron los siguientes miembros del El Comité Institucional de Ética de Investigación en Humanos Universidad CES: Doctor Jorge Julián Osorio Gómez, Doctor Rubén Darío Manrique Hernández, Doctor Julián Emilio Vélez Ríos, Doctora Andrea Echavarría Arboleda, Doctor John Wilson Osorio, Doctora Mónica María Massaro Ceballos, Doctora Nadia Semenova Moratto, Doctor David Andrés Galvis Pareja y el Doctor Arlex Uriel Palacios Barahona.

De acuerdo con los conceptos y opiniones de los miembros del Comité Institucional de Ética de Investigación en Humanos Universidad CES, expuestos y sometidos a consideración durante la sesión descrita cuyo contenido explícito aparece en el acta correspondiente y luego de revisar el cumplimiento de los ajustes sugeridos a los investigadores, se desprenden las siguientes consideraciones principales:

CONSIDERACIONES:

- ✓ Una vez revisadas la correcciones, el comité aprueba el poroyecto para dar inicio.

MINISTERIO DE EDUCACIÓN NACIONAL
N° 1371

www.ces.edu.co

Calle 10 A N° 22-04

A.A. 054 591

Conmutador 444 05 55

Fax 266 60 46

NIT 890.984.002-6

Medellín / Colombia

VIGILADA MINEDUCACIÓN

Acta N° 121

Proyecto: "EVALUACIÓN DE UNA INTERVENCIÓN PSICOLÓGICA DE BAJA INTENSIDAD (ENFRENTANDO PROBLEMAS PLUS) PARA PERSONAS DESPLAZADAS EN ARAUCA, COLOMBIA"

Código del proyecto: 760

Segunda revisión



UNIVERSIDAD CES

Un compromiso con la excelencia
Resolución del Ministerio de Educación Nacional No. 1371 del 22 de marzo de 2007

1977

40 AÑOS 2017

CONCLUSIÓN:

Una vez revisada la documentación, el Comité Institucional de Ética de Investigación en Humanos Universidad CES concluye que el proyecto está ceñido a los principios éticos que regulan la investigación en seres humanos y que el equipo de investigación es idóneo para desarrollar el proyecto de acuerdo con los principios de validez y confiabilidad, por consiguiente, el Comité Institucional de Ética de Investigación en Humanos Universidad CES APRUEBA el proyecto por el tiempo que dure su ejecución.

Es responsabilidad del Comité Institucional de Ética de Investigación en Humanos Universidad CES, garantizar el cumplimiento de los compromisos éticos establecidos en el protocolo del proyecto aprobado. En virtud de lo anterior, el investigador principal se compromete a:

- ✓ Informar por escrito a los investigadores sobre la obligación que tienen de notificar oportunamente al Comité Institucional de Ética de Investigación en Humanos Universidad CES: los eventos adversos serios que ocurran, las desviaciones mayores al protocolo, las fallas en la aplicación de las buenas prácticas clínicas, las violaciones a las normas que regulan el ejercicio de la actividad científica, las denuncias que hagan personas, participantes o no en el estudio, sobre fallas en la protección de los derechos o el bienestar de las personas, alertas sobre posibles fraudes o mala conducta científica en el estudio.
- ✓ Entregar a cada participante una copia del documento de consentimiento que haya firmado.
- ✓ Enviar al Comité Institucional de Ética de Investigación en Humanos Universidad CES, con la frecuencia que éste determine, entregar el formato de copia del consentimiento.
- ✓ Garantizar que no haya entre ellos y los testigos que firman el consentimiento informado, relaciones de primer grado de afinidad, segundo civil o cuarto de consanguinidad. De ello dejarán constancia en el mismo documento.

Además:

- ✓ El Comité Institucional de Ética de Investigación en Humanos Universidad CES podrá realizar, con el apoyo de sus miembros o de personas con experiencia e idoneidad, visitas de supervisión a los estudios en proceso de realización con el fin de verificar el cumplimiento de los compromisos éticos.
- ✓ El Comité Institucional de Ética de Investigación en Humanos Universidad CES podrá solicitar la suspensión temporal o definitiva del estudio cuando concluya que los investigadores o los patrocinadores han incurrido en una falta grave a los principios y compromisos éticos durante la realización del estudio. Cuando sea necesario el comité notificará a la autoridad que le corresponda conocer la situación.

MINISTERIO DE EDUCACIÓN NACIONAL
NÚMERO 1371

www.ces.edu.co

Calle 10 A N° 22-04

A.A. 054 591

Conmutador 444 05 55

Fax 266 60 46

NIT 890.984.002-6

Medellín / Colombia

VIGILADA MINEDUCACIÓN

Acta N° 121

Proyecto: "EVALUACIÓN DE UNA INTERVENCIÓN PSICOLÓGICA DE BAJA INTENSIDAD (ENFRENTANDO PROBLEMAS PLUS) PARA PERSONAS DESPLAZADAS EN ARAUCA, COLOMBIA"

Código del proyecto: 760

Segunda revisión



UNIVERSIDAD CES

Un compromiso con la excelencia
Resolución del Ministerio de Educación Nacional No. 1371 del 22 de marzo de 2007

1977

40 AÑOS

2017

Se adjunta a esta comunicación, la versión final aprobada del consentimiento informado, esta es la versión que deberá utilizarse en el desarrollo de la investigación. Cualquier modificación que se haga deberá ser avalada por el Comité Institucional de Ética de Investigación en Humanos Universidad CES antes de su aplicación. De no ser así, será considerada una violación ética grave en el desarrollo de la investigación.

Con la firma de recibido de este documento, los investigadores se comprometen a desarrollar el proyecto bajo las condiciones aprobadas en el Comité Institucional de Ética de Investigación en Humanos Universidad CES.


JORGE JULIAN OSORIO GÓMEZ, MD

Presidente

Comité de Ética en Investigación en Humanos Universidad CES.

comiteeticahumanos@ces.edu.co



Appendix B – Informed Consent Forms

Informed Consent Form - Phase 2

CONSENTIMIENTO INFORMADO

Título del estudio: Evaluación de una intervención psicológica de baja intensidad (Enfrentando Problemas Plus) para personas desplazadas en Arauca, Colombia

Investigadora principal:

Camila Perera Aladro
Investigadora doctoral
Afiliación: Universidad de Dublín

Co-investigadores: Frédérique Vallières, Nana Wiedemann, Rikke Holm Bramsen y Maj Hansen

Entidad donde se desarrolla la investigación:

Cruz Roja Colombiana

Naturaleza y Objetivo del estudio: Cuando se viven circunstancias o eventos difíciles, la mayoría generalmente sentirá diferentes emociones como un temor intenso, pesar, tristeza o desesperanza. Algunas personas hasta describen no sentir ninguna emoción en lo absoluto o que se sienten como si estuvieran emocionalmente adormecidos.

La Organización Mundial de la Salud ha desarrollado una intervención o terapia simplificada para ayudar a las personas a sobreponer esas dificultades. Esta intervención (Enfrentando Problemas Plus – EP+) será administrada por primera vez por voluntarios de la Cruz Roja, por lo que la Cruz Roja junto con la Universidad de Dublín están investigando este nuevo servicio. Esta investigación tiene el objetivo de determinar si la intervención es exitosa, si ayuda a las personas a manejar los problemas emocionales que están experimentando y si es viable en el contexto de la Cruz Roja.

Propósito: Usted está leyendo este documento ya que ha mostrado interés en contribuir a la adaptación de EP+ al contexto colombiano. El manual está escrito en un español simple y no incluye expresiones y palabras comúnmente usadas en Colombia para describir la angustia o el estrés. La adaptación del manual nos permitirá adecuarlo al contexto y que este sea más pertinente y relevante para las personas que reciben la intervención. Mediante este consentimiento informado, queremos describir los detalles del proceso de adaptación para que tome una decisión informada sobre si quiere participar o no.

Procedimiento: La adaptación consistirá en una reunión en grupo (grupo focal) guiada por la investigadora (Camila Perera), en la que usted y otros especialistas en salud mental y voluntarios de la Cruz Roja Colombiana reflexionarán sobre algunas frases, metáforas y expresiones del manual. Asimismo, el grupo conversará y enumerará algunos de los problemas psicosociales que los beneficiarios de EP+ podrían estar experimentando. Esta reunión debe durar aproximadamente una hora y media.

Riesgos asociados a su participación en el estudio: El objetivo de la reunión en grupo no es hablar sobre problemas que usted esté experimentando en ese momento, sino que platicar sobre los problemas que los beneficiarios pueden estar experimentando y sobre los que puede ser adaptado del manual. Si algo le molesta durante cualquiera de las dos actividades, usted podrá solicitar una pausa. Usted también podrá salir del grupo en cualquier momento y dejar de participar en la investigación.

Beneficios de su participación en el estudio: Participar en las actividades de adaptación no genera

un beneficio para usted, pero los resultados obtenidos del estudio podrán generar beneficio futuro para las personas que recibirán este tipo de intervención.

Voluntariedad: Su participación es voluntaria. Si usted decide no participar o retirarse puede hacerlo sin explicar por qué y sin que esto ocasione una sanción para usted. Aceptar o rechazar la participación en el estudio no impactará en el trabajo que usted lleva a cabo en la Cruz Roja.

Confidencialidad: Si usted decide participar, garantizamos que toda la información suministrada será manejada con absoluta confidencialidad, sus datos personales no serán publicados ni revelados, la investigadora principal se hace responsable de la custodia y privacidad de los mismos.

Si algo que usted dice es escrito en algún documento de investigación, se le asignará un seudónimo para que nadie pueda identificarlo. Estas precauciones se toman para proteger su identidad y para que usted pueda darnos su opinión libremente. La reunión será grabada en audio y usted podrá solicitar una copia escrita para corregir algo que usted piensa puede identificarlo o para cambiar algo.

Compartir los resultados: Los resultados del estudio puede que sean reportados en revistas de investigación o en documentos externos e internos de la Cruz Roja pero su información personal (su nombre) permanecerá confidencial.

Conflicto de interés del investigador: La investigadora principal y los co-investigadores no tienen conflicto de intereses con los participantes ni con la fuente de financiación.

Contactos: Usted puede contactar a la investigadora si tiene alguna pregunta sobre la investigación.

[Introducir nombres y teléfonos o dirección de correo]

☐ *Acepto participar en la reunión de grupo (grupo focal)*

☐ *Acepto que la investigadora acceda a mis respuestas y que las uses para fines académicos sin tener que contactarme, siempre y cuando no utilice mi nombre*

Nombre y firma del participante:

Fecha:

Declaración

Yo certifico que le he explicado a esta persona la naturaleza y el objetivo de la investigación, y que esta persona entiende en qué consiste su participación, los posibles riesgos y beneficios implicados. Todas las preguntas que esta persona ha hecho le han sido contestadas en forma adecuada. Así mismo, he leído y explicado adecuadamente las partes del consentimiento informado. Hago constar con mi firma.

Nombre y firma:

Fecha:

Informed Consent Forms - Phase 3 (PM+ Participants)

CONSENTIMIENTO INFORMADO

Título del estudio: Estudio de una intervención psicológica de baja intensidad (Manejando tus Problemas) para personas desplazadas en Arauca, Colombia

Entidad donde se desarrolla el ejercicio académico: Cruz Roja Colombiana - Seccional Arauca Grupo de Apoyo Saravena

Naturaleza y Objetivo del estudio: Cuando se viven circunstancias o eventos difíciles, la mayoría de personas generalmente sentirá diferentes emociones como un temor intenso, pesar, tristeza o desesperanza. Algunas personas hasta describen no sentir ninguna emoción en lo absoluto o que se sienten como si estuvieran emocionalmente adormecidos.

La Organización Mundial de la Salud ha desarrollado una intervención o terapia simplificada para ayudar a las personas a sobreponer esas dificultades. Esta intervención (Manejando tus Problemas) será administrada por primera vez por voluntarios de la Cruz Roja Colombiana, por lo que la Cruz Roja Colombiana junto con el apoyo de una investigadora están estudiando este nuevo servicio. Este ejercicio académico tiene el objetivo de determinar si la intervención es exitosa, si ayuda a las personas a manejar los problemas emocionales que están experimentando y a reducir el estrés y la angustia.

Propósito: Usted está leyendo este documento porque puede beneficiarse de esta intervención y queremos describir los detalles del estudio para que tome una decisión informada sobre si quiere participar o no.

Procedimiento: Un voluntario de la Cruz Roja Colombiana - Seccional Arauca Grupo de Apoyo Saravena, le ha hecho algunas preguntas sobre su bienestar para determinar si puedes beneficiarse de Manejando tus problemas. Su participación en el ejercicio académico consistirá en permitir que obtengamos acceso a sus respuestas a esas preguntas. Asimismo, como parte del estudio usted responderá a las mismas preguntas dos veces más durante el curso de la intervención. Al firmar este consentimiento informado usted le daría acceso a la investigadora a sus respuestas a estas preguntas también. Como usted ya respondió el cuestionario sabe que esto le tomará poco tiempo. Al tener acceso a las respuestas que usted proporcionó, la investigadora podrá determinar el impacto que tuvo la intervención en su bienestar y salud mental. Al final de Manejando tus problemas, la investigadora invitará a algunas personas que recibieron la intervención a participar en una entrevista de una hora y media durante la cual se conversará sobre sus experiencias con este servicio, lo que le gustó, o incomodó o no obtuvo al recibir la intervención.

Riesgos asociados a su participación en el estudio: Como usted respondió el cuestionario sabe que está compuesto de preguntas sobre su bienestar y sobre su salud. Aunque puede que responder algunas de estas preguntas le resulte incomodo, el objetivo de Manejando tus problemas es que usted aprenda estrategias para manejar dificultades y problemas que usted este experimentando. Durante la entrevista, usted y la investigadora conversarán sobre su experiencia con la intervención. El objetivo de la entrevista no es hablar sobre problemas que usted esté experimentando en ese momento, sino que platicar sobre lo que a usted le gustó, incomodó o no obtuvo al recibir la intervención. Si algo le molesta durante esta entrevista, usted podrá solicitar una pausa, parar la entrevista y planificar otra fecha u hora para continuar. Usted también podrá dar por terminada la entrevista en cualquier momento y dejar de participar en la investigación.

Beneficios de su participación en el estudio: Recibir este servicio generará un beneficio a su salud y a su bienestar y participar en el estudio genera un beneficio social ya que los resultados obtenidos del estudio podrán generar beneficio futuro para otras personas que reciban este tipo de intervención en el futuro y para el trabajo de la Cruz Roja Colombiana - Seccional Arauca Grupo de Apoyo Saravena.

Voluntariedad: Su participación es voluntaria. Si usted decide no participar o retirarse del estudio en cualquier momento, aun cuando haya iniciado su participación, puede hacerlo sin explicar por qué y sin que esto ocasione una sanción para usted. Aceptar o rechazar la participación en el estudio no afectará los servicios que recibe en la Cruz Roja Colombiana ni cualquier servicio que reciba en el futuro.

Confidencialidad: Si usted decide participar, garantizamos que toda la información suministrada será manejada con absoluta confidencialidad, sus datos personales no serán publicados ni revelados. Si algo que usted dice en la entrevista es escrito en algún documento de sobre el estudio, se le asignará un número (su información personal permanecerá confidencial) para que nadie pueda identificarlo. Estas precauciones se toman para proteger su identidad y para que usted pueda darnos su opinión libremente. Las entrevistas serán grabadas y usted podrá solicitar una copia escrita para corregir algo que usted piensa puede identificarlo o si desea para cambiar algo que dijo.

Compartir los resultados: Los resultados del estudio puede que sean reportados en revistas de investigación o documentos externos e internos de la Cruz Roja Colombiana pero su información personal (su nombre) permanecerá confidencial.

Contactos: Usted puede contactar a la referente del GAPS y/o coordinación de la Cruz Roja Colombiana - Seccional Arauca Grupo de Apoyo Saravena si tiene alguna pregunta sobre este ejercicio académico.

- ☐ Acepto participar en el presente estudio
- ☐ Acepto ser entrevistado/a por la investigadora después de recibir Manejando tus problemas
- ☐ Acepto que la investigadora acceda a mis respuestas a los cuestionarios y que las use para fines académicos sin tener que contactarme, siempre y cuando no utilice mi nombre

Nombre y firma del participante:

Fecha:

Declaración:

Yo certifico que le he explicado a esta persona la naturaleza y el objetivo del ejercicio académico, y que esta persona entiende en qué consiste su participación, los posibles riesgos y beneficios implicados. Todas las preguntas que esta persona ha hecho le han sido contestadas en forma adecuada. Así mismo, he leído y explicado adecuadamente las partes del consentimiento informado. Hago constar con mi firma.

Nombre y firma de voluntario:

Fecha:

Informed Consent Forms - Phase 3 (PM+ Supervisors)

CONSENTIMIENTO INFORMADO

Título del estudio: Evaluación de una intervención psicológica de baja intensidad (Manejando tus Problemas) en Saravena, Colombia

Investigadora principal:

Camila Perera Aladro
Universidad de Dublín y Cruz Roja Danesa

Co-investigadores: Nana Wiedemann, Cecilie Dinesen, Maj Hansen y Frédérique Vallières

Entidad donde se desarrolla la investigación:

Cruz Roja Colombiana

Naturaleza y Objetivo del estudio: La Organización Mundial de la Salud ha desarrollado una intervención o terapia simplificada para ayudar a las personas a sobreponer esas dificultades. Esta intervención (Manejando tus Problemas) será administrada por primera vez por voluntarios de la Cruz Roja, por lo que la Cruz Roja junto con la Universidad de Dublín están investigando este nuevo servicio. Esta investigación tiene el objetivo de determinar si la intervención ayuda a las personas a manejar los problemas emocionales que están experimentando y si es viable en el contexto de la Cruz Roja.

Propósito: Usted está leyendo este documento porque ha participado en la implementación o supervisión de Manejando tus Problemas y queremos pedirle que participe en una entrevista individual con la investigadora para conversar sobre su experiencia. Mediante este consentimiento informado, queremos describir los detalles de esta entrevista para que tome una decisión informada sobre si quiere participar o no. Su opinión sobre la intervención nos permitirá determinar cuáles son las lecciones aprendidas de esta implementación.

Procedimiento: Durante esta entrevista que durará aproximadamente una hora y treinta minutos, usted conversará con la investigadora sobre su experiencia con la intervención, lo que fue fácil o difícil, lo que usted cree que debe cambiar y su opinión en general sobre esta intervención.

Riesgos asociados a su participación en el estudio: El objetivo de esta entrevista no es hablar sobre problemas que usted esté experimentando en ese momento. Si algo le molesta durante la reunión, usted podrá solicitar una pausa. Usted también podrá salir del grupo en cualquier momento y dejar de participar en la investigación.

Beneficios de su participación en el estudio: Participar en esta entrevista no genera un beneficio directo para usted, pero los resultados obtenidos del estudio podrán generar beneficio futuro para las personas que reciban, faciliten o implementen este tipo de intervención en el futuro.

Voluntariedad: Su participación es voluntaria. Si usted decide no participar o retirarse puede hacerlo sin explicar por qué y sin que esto ocasione una sanción para usted. Aceptar o rechazar la participación en el estudio no impactará en el trabajo que usted lleva a cabo en la Cruz Roja.

Confidencialidad: Si usted decide participar, garantizamos que toda la información suministrada será

manejada con absoluta confidencialidad, sus datos personales no serán publicados ni revelados, la investigadora principal se hace responsable de la custodia y privacidad de los mismos.

Si algo que usted dice es escrito en algún documento de investigación, se le asignará un seudónimo para que nadie pueda identificarlo. Estas precauciones se toman para proteger su identidad y para que usted pueda darnos su opinión libremente. La entrevista será grabada en audio y usted podrá solicitar una copia escrita para corregir algo que usted piensa puede identificarlo o para cambiar algo.

Compartir los resultados: Los resultados del estudio puede que sean reportados en revistas de investigación o documentos externos e internos de la Cruz Roja pero su información personal (su nombre) no será revelada.

Conflicto de interés del investigador: La investigadora principal y los co-investigadoras no tienen conflicto de intereses con los participantes ni con la fuente de financiación.

Contactos: Usted puede contactar a la investigadora si tiene alguna pregunta sobre la investigación.

[Introducir nombres y teléfonos o dirección de correo]

☐ *Acepto participar en la entrevista*

☐ *Acepto que la investigadora acceda a mis respuestas y que las uses para fines académicos sin tener que contactarme, siempre y cuando no utilice mi nombre*

Nombre y firma del participante:

Fecha:

Declaración

Yo certifico que le he explicado a esta persona la naturaleza y el objetivo de la investigación, y que esta persona entiende en qué consiste su participación, los posibles riesgos y beneficios implicados. Todas las preguntas que esta persona ha hecho le han sido contestadas en forma adecuada. Así mismo, he leído y explicado adecuadamente las partes del consentimiento informado. Hago constar con mi firma.

Nombre y firma:

Fecha:

Informed Consent Forms - Phase 3 (PM+ Providers)

CONSENTIMIENTO INFORMADO

Título del estudio: Evaluación de una intervención psicológica de baja intensidad (Manejando tus Problemas) en Saravena, Colombia

Investigadora principal:

Camila Perera Aladro
Universidad de Dublín y Cruz Roja Danesa

Co-investigadoras: Nana Wiedemann, Cecilie Dinesen, Maj Hansen y Frédérique Vallières

Entidad donde se desarrolla la investigación:

Cruz Roja Colombiana

Naturaleza y Objetivo del estudio: Cuando se viven circunstancias o eventos difíciles, la mayoría de las personas generalmente siente diferentes emociones como un temor intenso, pesar, tristeza o desesperanza. Algunas personas hasta describen no sentir ninguna emoción en lo absoluto o que se sienten como si estuvieran emocionalmente adormecidos.

La Organización Mundial de la Salud ha desarrollado una intervención o terapia simplificada para ayudar a las personas a sobreponer esas dificultades. Esta intervención (Manejando tus Problemas) será administrada por primera vez por voluntarios de la Cruz Roja, por lo que la Cruz Roja junto con la Universidad de Dublín están investigando este nuevo servicio. Esta investigación tiene el objetivo de determinar si la intervención ayuda a las personas a manejar los problemas emocionales que están experimentando y si es viable en el contexto de la Cruz Roja.

Propósito: Usted está leyendo este documento porque ha facilitado Manejando tus Problemas recientemente y queremos pedirle que participe en una reunión de grupo con otros facilitadores para conversar sobre su experiencia. Mediante este consentimiento informado, queremos describir los detalles de esta reunión para que tome una decisión informada sobre si quiere participar o no. Su opinión sobre la intervención nos permitirá determinar cuáles son las lecciones aprendidas de esta implementación.

Procedimiento: Durante esta reunión grupal que durará aproximadamente dos horas, usted y otros facilitadores conversaran con la investigadora sobre su experiencia con Manejando tus Problemas, lo que fue fácil o difícil, lo que no usted cree que debe cambiar y su opinión en general sobre esta intervención y su papel como facilitador o facilitadora.

Riesgos asociados a su participación en el estudio: El objetivo de la reunión en grupo no es hablar sobre problemas personales que usted esté experimentando en ese momento. Si algo le molesta durante la reunión, usted podrá solicitar una pausa. Usted también podrá salir del grupo en cualquier momento y dejar de participar en la investigación.

Beneficios de su participación en el estudio: Participar en esta reunión no genera un beneficio directo para usted, pero los resultados obtenidos del estudio podrán generar beneficio para las personas que reciban o faciliten este tipo de intervención en el futuro.

Voluntariedad: Su participación es voluntaria. Si usted decide no participar o retirarse puede hacerlo sin explicar por qué. Aceptar o rechazar la participación en el estudio no impactará en el trabajo que usted lleva a cabo en la Cruz Roja.

Confidencialidad: Si usted decide participar, garantizamos que toda la información suministrada será manejada con absoluta confidencialidad, sus datos personales no serán publicados ni revelados, la investigadora principal se hace responsable de la custodia y privacidad de los mismos.

Si algo que usted dice se escribe en algún documento de investigación, se le asignará un seudónimo para que nadie pueda identificarlo. Estas precauciones se toman para proteger su identidad y para que usted pueda darnos su opinión libremente. La reunión será grabada en audio y usted podrá solicitar una copia escrita para corregir algo que usted piensa puede identificarlo o para cambiar algo.

Compartir los resultados: Los resultados del estudio puede que sean reportados en revistas de investigación o en documentos externos e internos de la Cruz Roja pero su información personal (su nombre) no será revelada.

Conflicto de interés del investigador: La investigadora principal y los co-investigadoras no tienen conflicto de intereses con los participantes ni con la fuente de financiación.

Contactos: Usted puede contactar a la investigadora si tiene alguna pregunta sobre la investigación.

[Introducir nombres y teléfonos o dirección de correo]

☐ Acepto participar en la reunión de grupo

☐ Acepto que la investigadora acceda a mis respuestas y que las uses para fines académicos sin tener que contactarme, siempre y cuando no utilice mi nombre

Nombre y firma del participante:

Fecha:

Declaración

Yo certifico que le he explicado a esta persona la naturaleza y el objetivo de la investigación, y que esta persona entiende en qué consiste su participación, los posibles riesgos y beneficios implicados. Todas las preguntas que esta persona ha hecho le han sido contestadas en forma adecuada. Así mismo, he leído y explicado adecuadamente las partes del consentimiento informado. Hago constar con mi firma.

Nombre y firma:

Fecha:

Informed Consent Forms - Phase 3 (PM+ Supervisors and Providers)

CONSENTIMIENTO INFORMADO

Título del estudio: Evaluación de una intervención psicológica de baja intensidad (Manejando tus Problemas) en Saravena, Colombia

Investigadora principal:

Camila Perera Aladro
Universidad de Dublín y Cruz Roja Danesa

Co-investigadoras: Nana Wiedemann, Cecilie Dinesen, Maj Hansen y Frédérique Vallières

Entidad donde se desarrolla la investigación:

Cruz Roja Colombiana

Naturaleza y Objetivo del estudio: Cuando se viven circunstancias o eventos difíciles, la mayoría de las personas generalmente siente diferentes emociones como un temor intenso, pesar, tristeza o desesperanza. Algunas personas hasta describen no sentir ninguna emoción en lo absoluto o que se sienten como si estuvieran emocionalmente adormecidos.

La Organización Mundial de la Salud ha desarrollado una intervención o terapia simplificada para ayudar a las personas a sobreponer esas dificultades. Esta intervención (Manejando tus Problemas) será administrada por primera vez por voluntarios de la Cruz Roja, por lo que la Cruz Roja junto con la Universidad de Dublín están investigando este nuevo servicio. Esta investigación tiene el objetivo de determinar si la intervención ayuda a las personas a manejar los problemas emocionales que están experimentando y si es viable en el contexto de la Cruz Roja.

Propósito: Usted está leyendo este documento porque ha participado en la implementación de Manejando tus Problemas recientemente y queremos pedirle que participe en una reunión de grupo para conversar sobre su experiencia. Mediante este consentimiento informado, queremos describir los detalles de esta reunión para que tome una decisión informada sobre si quiere participar o no. Su opinión sobre la intervención nos permitirá determinar cuáles son las lecciones aprendidas de esta implementación.

Procedimiento: Durante esta reunión grupal que durará aproximadamente dos horas, usted y otros facilitadores conversaran con la investigadora sobre su experiencia con Manejando tus Problemas, lo que fue fácil o difícil, lo que no usted cree que debe cambiar y su opinión en general sobre esta intervención y su papel como facilitador o facilitadora.

Riesgos asociados a su participación en el estudio: El objetivo de la reunión en grupo no es hablar sobre problemas personales que usted esté experimentando en ese momento. Si algo le molesta durante la reunión, usted podrá solicitar una pausa. Usted también podrá salir del grupo en cualquier momento y dejar de participar en la investigación.

Beneficios de su participación en el estudio: Participar en esta reunión no genera un beneficio directo para usted, pero los resultados obtenidos del estudio podrán generar beneficio para las personas que reciban o faciliten este tipo de intervención en el futuro.

Voluntariedad: Su participación es voluntaria. Si usted decide no participar o retirarse puede hacerlo sin explicar por qué. Aceptar o rechazar la participación en el estudio no impactará en el trabajo que usted lleva a cabo en la Cruz Roja.

Confidencialidad: Si usted decide participar, garantizamos que toda la información suministrada será manejada con absoluta confidencialidad, sus datos personales no serán publicados ni revelados, la investigadora principal se hace responsable de la custodia y privacidad de los mismos.

Si algo que usted dice se escribe en algún documento de investigación, se le asignará un seudónimo para que nadie pueda identificarlo. Estas precauciones se toman para proteger su identidad y para que usted pueda darnos su opinión libremente. La reunión será grabada en audio y usted podrá solicitar una copia escrita para corregir algo que usted piensa puede identificarlo o para cambiar algo.

Compartir los resultados: Los resultados del estudio puede que sean reportados en revistas de investigación o en documentos externos e internos de la Cruz Roja pero su información personal (su nombre) no será revelada.

Conflicto de interés del investigador: La investigadora principal y los co-investigadoras no tienen conflicto de intereses con los participantes ni con la fuente de financiación.

Contactos: Usted puede contactar a la investigadora si tiene alguna pregunta sobre la investigación.

[Introducir nombres y teléfonos o dirección de correo]

☐ Acepto participar en la reunión de grupo

☐ Acepto que la investigadora acceda a mis respuestas y que las uses para fines académicos sin tener que contactarme, siempre y cuando no utilice mi nombre

Nombre y firma del participante:

Fecha:

Declaración

Yo certifico que le he explicado a esta persona la naturaleza y el objetivo de la investigación, y que esta persona entiende en qué consiste su participación, los posibles riesgos y beneficios implicados. Todas las preguntas que esta persona ha hecho le han sido contestadas en forma adecuada. Así mismo, he leído y explicado adecuadamente las partes del consentimiento informado. Hago constar con mi firma.

Nombre y firma:

Fecha:

Appendix C – Search Strings

Search #	Concept	Keywords	Search string for Scopus
S1	Population	(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*)	TITLE-ABS-KEY(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*)
S2	Intervention	(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable) AND (psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD) AND (intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions)	TITLE-ABS-KEY((brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable) AND (psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD) AND (intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions))

Search #	Concept	Keywords	Controlled vocabulary	Search string for EMBASE
S1	Population	(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*)	'migrant'/exp OR 'refugee'/exp OR 'migration'/exp OR 'undocumented OR immigrant'/exp	migrant/exp OR refugee/exp OR migration/exp OR 'undocumented immigrant'/exp OR (Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*):ab,ti AND [embase]/lim NOT [medline]/lim
S2	Intervention	(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable)		(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simpl* OR modified OR 'low-intensity' OR 'low intensity' OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable):ab,ti AND [embase]/lim NOT [medline]/lim
		(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD)	('mental health'/exp OR 'mental disease'/exp OR 'anxiety'/exp OR 'depression'/exp OR 'posttraumatic stress disorder'/exp)	'mental health'/exp OR 'mental disease'/exp OR 'anxiety'/exp OR 'depression'/exp OR 'posttraumatic stress disorder'/exp OR (psychological OR psychosocial OR 'psycho-social' OR 'psycho social' OR 'mental health' OR 'mental disorder' OR 'mental illness' OR 'mental illnesses' OR anxiety OR depression OR stress OR trauma OR traumatic OR posttraumatic OR PTSD):ab,ti AND [embase]/lim NOT [medline]/lim
		(intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions)	('counseling'/exp OR 'psychotherapy'/exp)	'counseling'/exp OR 'psychotherapy'/exp OR (intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions):ab,ti AND [embase]/lim NOT [medline]/lim

Search #	Concept	Keywords	Controlled vocabulary	Search string for PsycINFO
S1	Population	(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*)	DE "Human Migration" OR DE "Geographical Mobility" OR DE "Refugees" OR DE "Immigration"	AB(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*) OR TI(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*) OR DE "Human Migration" OR DE "Geographical Mobility" OR DE "Refugees" OR DE "Immigration"
S2	Intervention	(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable)		(AB(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable) OR TI(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable)) AND (AB(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD) OR TI(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD) OR DE "Mental Disorders" OR DE "Anxiety" OR DE "Anxiety Disorders" OR DE "Depression (Emotion)" OR DE "Post-Traumatic Stress" OR DE "Posttraumatic Growth" OR DE "Posttraumatic Stress Disorder")
		(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD)	DE "Mental Disorders" OR DE "Anxiety" OR DE "Anxiety Disorders" OR DE "Depression (Emotion)" OR DE "Post-Traumatic Stress" OR DE "Posttraumatic Growth" OR DE "Posttraumatic Stress Disorder"	
		(intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions)	DE "Intervention" OR DE "Counseling" OR DE "Psychotherapy"	

Search #	Concept	Keywords	Controlled vocabulary	Search string for CINAHL
S1	Population	(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*)	(MH"Immigrants, Illegal") OR (MH"Refugees") OR (MH"Emigration and Immigration") OR (MH"Immigrants")	AB(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*) OR TI(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*) OR (MH"Immigrants, Illegal") OR (MH"Refugees") OR (MH"Emigration and Immigration") OR (MH"Immigrants")
S2	Intervention	(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable)		(AB(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable) OR TI(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable)) AND
		(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD)	(MH "Behavioral and Mental Disorders+")	(AB(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD) OR TI(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD) OR (MH "Behavioral and Mental Disorders+")) AND (AB(intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions) OR TI(intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions) OR (MH "Psychotherapy+"))
		(intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions)	(MH "Psychotherapy+")	

Search #	Concept	Keywords	Controlled vocabulary	Search string for MEDLINE
S1	Population	(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*)	(MH"Refugee") OR (MH"Emigration and Immigration") OR (MH"Undocumented Migrants") OR (MH"Transients and Migrants")	AB(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*) OR TI(Refugee* OR asylum OR migrant* OR immigrant* OR migration OR displaced OR exile*) OR (MH"Refugee") OR (MH"Emigration and Immigration") OR (MH"Undocumented Migrants") OR (MH"Transients and Migrants")
S2	Intervention	(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable)		(AB(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable) OR TI(brief OR basic OR short OR limited OR quick OR quickly OR reduced OR simplified OR simple OR modified OR "low-intensity" OR "low intensity" OR uncomplicated OR plain OR abridged OR concise OR condensed OR scalable)) AND (AB(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD) OR TI(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD) OR ((MH"Mental Disorders"+) OR (MH"Post-traumatic Growth")) AND (AB(intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions) OR TI(intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions) OR (MH:"Psychotherapy"+))
		(psychological OR psychosocial OR "psycho-social" OR "psycho social" OR "mental health" OR "mental disorder" OR "mental illness" OR "mental illnesses" OR anxiety OR depression OR stress OR traumatic OR trauma OR posttraumatic OR PTSD)	(MH"Mental Disorders"+) OR (MH"Post-traumatic Growth")	
		(intervention* OR therap* OR psychotherapy OR counseling OR counselling OR sessions)	(MH:"Psychotherapy"+)	

Category	PsycINFO	CINAHL	MEDLINE	Embase	Scopus
Filters: English only, peer-reviewed and human, if available. MEDLINE excluded in CINAHL and EMBASE.	483	155	282	649	3148

Total before duplicates removed	4717
Total after duplicates removed	3841
Conflicts at title and abstract	115
Conflicts at full-text	11
Screening start date	16/08/2019
Screening end date	07/11/2019

Appendix D – Desk Review Guidance

Desk Review Guidance on Mental Health and Psychosocial Support
1. Introduction 1.1. Rationale for the desk review (description of current/recent emergency) 1.2. Description of methodology used to collect existing information (including any database search terms used) 2. General Context 2.1. Geographical aspects (e.g., climate, neighbouring countries) 2.2. Demographic aspects (e.g., population size, age distribution, languages, education/literacy, religious groups, ethnic groups, migration patterns, groups especially at risk to suffer in humanitarian crises) 2.3. Historical aspects (e.g., early history, colonization, recent political history) 2.4. Political aspects (e.g., organization of state/government, distribution of power, contesting sub-groups or parties) 2.5. Religious aspects (e.g., religious groups, important religious beliefs and practices, relationships between different groups) 2.6. Economic aspects (e.g., Human Development Index, main livelihoods and sources of income, unemployment rate, poverty, resources) 2.7. Gender and family aspects (e.g., organization of family life, traditional gender roles) 2.8. Cultural aspects (traditions, taboo, rituals and practices related to health and well-being) 2.9. General health aspects 2.9.1. Mortality, threats to mortality, and common diseases 2.9.2. Overview of structure of formal, general health system 3. Mental Health and Psychosocial Context 3.1. Mental health and psychosocial problems and resources 3.1.1. Epidemiological studies of mental disorders and risk/ protective factors conducted in the country, suicide rates 3.1.2. Local expressions (idioms) for distress and folk diagnoses, local concepts of trauma and loss 3.1.3. Explanatory models for mental and psychosocial problems 3.1.4. Concepts of the self/person (e.g., relations between body, soul, spirit) 3.1.5. Major sources of distress (e.g., poverty, child abuse, infertility) 3.1.6. Role of the formal and informal educational sector in psychosocial support 3.1.7. Role of the formal social sector (e.g., social services) in psychosocial support 3.1.8. Role of the informal social sector (e.g., community protection systems, neighbourhood systems, other community resources) in psychosocial support 3.1.9. Role of the non-allopathic health system (including traditional or indigenous health system) in mental health and psychosocial support 3.1.10. Help-seeking patterns (where people go for help and for what problems; who accompanies them; potential barriers to access) 3.2. The Mental Health System 3.2.1. Mental health policy and legislative framework and leadership 3.2.2. Description of the formal mental health services (primary, secondary and tertiary care). Consider the relevant Mental Health Atlas and WHO-AIMS reports among other sources to find out availability of mental health services, mental health human resources, how mental health services are used, how accessible mental health services are (for example distance, fee for service), and the quality of mental health services

3.2.3. Relative roles of government, private sector, NGOs, and traditional healers in providing mental health care
4. Humanitarian Context
4.1. History of humanitarian emergencies in the country
4.2. Experiences with past humanitarian aid in general
4.3. Experiences with past humanitarian aid involving mental health and psychosocial support
5. Conclusion
5.1. Expected challenges and gaps in mental health and psychosocial support
5.2. Expected opportunities in mental health and psychosocial support
6. References

Appendix E – Focus Group Discussion Guide (Phase 2 – Step 3)

Questions and Probes
PM+ will be administered to migrants and displaced persons, what are the best ways to let these populations know about the intervention? Where should we disseminate information about PM+? In your opinion, should information on PM+ be presented in any community meetings? If yes, to whom would be these presentations directed? What in your experience are ways in which these populations express distress? Would you note any difference among certain sub-groups? What type of behaviour would you observe among members of these populations when they are feeling distressed? Would you note any difference among certain sub-groups? What are some expressions used to express sadness or stress? Would you note any difference among certain sub-groups? In general, to what would people in this two populations attribute these feelings of sadness or anxiety? Would you note any difference among certain sub-groups? What do people from these populations do to take care of their wellbeing? Would you note any difference among certain sub-groups? What do people in these populations do to take care of their relatives and friends? Would you note any difference among certain sub-groups?

What do people from these two populations do to enjoy themselves?

What do some activities people from these two populations do to connect with others?

What do some activities people from these two populations do to take care of how they look and for self-care?

What do some activities people from these two populations do to be active?

What would be some activities people from these two populations do daily (e.g., cook, child-care)?

What are some activities people from these two populations do to support or help others (e.g., family, friends, neighbours)?

What types of support do people from these two populations have access to?

Which specific services are available to these two populations?

Which social services do Venezuelan migrants and refugees have access to?

Which organisations, community groups or community members are known for providing psychosocial support to members of these two populations?

What is the role of religious organisations in providing support (e.g., psychosocial, financial) to members of these two populations?

Can you list problems displaced persons have mentioned to you?

Can you list problems Venezuelan migrants and refugees have mentioned to you?

The PM+ manual provides some advice on how to manage sensitive topics (e.g., grief and loss, sexual abuse, ongoing threat). When revising these parts did you note down possible adaptations?

What social and cultural norms do volunteers need to consider when working with members of these two populations?

How should volunteers address the persons receiving the interventions?

Considering the cultural and social background of this communities, when and where should sessions take place?

How is physical contact viewed in these communities?

Considering the cultural and social background of these two groups, how should the concept of confidentiality be introduced?

Considering the cultural and social background of these two groups, how should the concept of consent be introduced?

Now let's revise the titles of the manual and of the PM+ strategies, do you suggest any adaptations, so they are more acceptable to members of these populations?

When revising the intervention, did you identify any terms or concepts that could be misunderstood or difficult to understand in this context?

Now I want you to think of a moment, when you provided words (incl. phrases and sayings) of support or encouragement to someone, what did you say?

What words (incl. phrases and sayings) of support or encouragement would someone from Venezuela use?

Now let's revise the images in the manual.

Questions for each image:

Is this image acceptable (not offensive) among these two communities?

Does this image portray members of these populations?

What changes are necessary to make this image more relevant to the person receiving the intervention?

Appendix F – Cultural Relevance Questionnaire

Cultural Relevance Questionnaire (CRQ) English version

Salamanca-Sanabria, A., Richards, D., Timulak, L (2016)

The Cultural Relevance Questionnaire is an instrument that evaluates a culturally adapted psychotherapy protocol. This questionnaire is based on cultural sensitivity and ecological validity theory by Bernal (2009), and Helms' (2015) proposals for culturally evidence-based practices.

This questionnaire assesses a culturally adapted psychotherapy (CAP). CAP is defined as a systematic change of intervention protocols through which consideration of culture and context modifies treatment in accordance with clients' values and contexts, relevant to the culture of the target population (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009).

CRQ is divided into three categories:

Functional equivalence: It is defined as the extent to which the same ostensible behaviours (e.g., crying) are interpreted similarly in different cultural or racial groups, occur with equal frequency within these groups, and elicit similar reactions from other members of the groups. [Components of the internet-delivered programme could be interpreted similarly by the target cultural group (e.g., personal stories, examples)].

Conceptual equivalence: refers to the extent to which different concepts are analogous for the cultural group that is targeted for the treatment. [Cultural expressions of depression, ideas or analogies about mental illness are included in the internet-delivered programme (e.g., symbols, metaphors and concepts)].

Linguistic equivalence: indicates the language or dialect used during the process and in evaluations of the process and outcome have been adjusted so that it has meaning to the person(s) being assessed. [Level of oral and written language adjustments are made for the internet-delivered programme (e.g. regionalism, slang)].

Likewise, cultural relevance is based on eight (8) areas described by Bernal (2009) for making culturally adapted psychotherapy, which are:

Language: Includes oral and written language, which must be culturally appropriate and syntonic, taking into consideration differences in inner city, regional or subcultural groups.

Person(s): Refers to the client–therapist relationship during the intervention.

Metaphors: Meaning to the symbols and concepts that are shared by a particular cultural group.

Contents: Refers to cultural knowledge about values, customs, and traditions shared by ethnic and minority groups.

Concepts: Indicate the constructs of the theoretical model to be used in treatment.

Goals: Implies the establishment of an agreement between the therapist and client as to the goals of treatment.

Methods: Refers to the procedures to follow for the achievement of the treatment goals.

Contexts: Indicates the consideration of the client's broader social, economic, and political context.

Cultural Relevance Questionnaire (CRQ)

The general evaluation of cultural relevance treatment consists of three categories, which are explained below. Please assess these from 1 to 5 and explain your score.

Categories:

Section 1. Functional equivalence

The Functional Relevance of a questionnaire item refers to whether the item describes behaviour (example: depression) in a way that is interpreted similarly by your culture (example: is a crying person viewed and interpreted the same way in your culture?)

Please use this legend to answer the questions:

1	2	3	4	5
The components are not reflected within the programme.	Most of the components are not reflected within the programme; however, some of them are.	Some components are reflected within the programme and others are not.	Most of the components are reflected within the programme; however, others are not.	All of the components are reflected within the programme.

For each question, please choose the response which best characterises the treatment assessed.

1.1 The programme involves **behavioural** or **emotional expressions** familiar to the cultural group being targeted.

1	2	3	4	5
---	---	---	---	---

Please explain your choice

1.2 **The people** and **cultural context** are reflected in the treatment (e.g. social, political, economic, ethnic, historical).

1.3

1	2	3	4	5
---	---	---	---	---

Please explain your choice

1.3. The **treatment goals** are tailored to work with the user from this cultural context (e.g. examples, personal stories).

1	2	3	4	5
---	---	---	---	---

Please explain your choice

Section 2. Conceptual equivalence

The Conceptual Relevance of a questionnaire item refers to whether the item measures the same concept in your culture. It is the analogy grade is shared by a cultural group, such as: behaviours, symbols, metaphors and concepts. Assess this category on the programme in: psychoeducation sections, personal stories, examples, activities, imagens and quotes.

2.1 The treatment includes **symbols** and **concepts** shared by the cultural group, for instance cultural expressions of depression, ideas or analogies about mental illness are included in the program.

1	2	3	4	5
---	---	---	---	---

Please explain your choice

Section 3. Linguistic equivalence:

Involves oral and written language on the programme. Assess language on the programme, content, examples and activities

3.1 The treatment includes **written** and **oral communication** that can be considered dialects and jargon relevant in this cultural context (e.g. regionalism, slang).

1	2	3	4	5
---	---	---	---	---

Please explain your choice

Culturally adapted treatment per module

Please assess from 1 to 5 the functional relevance, conceptual relevance and linguistic relevance of each module on the programme:

Functional equivalence: The Functional relevance of a questionnaire item refers to whether the item describes behaviour (example: depression) in a way that is interpreted similarly by your culture (example: is a crying person viewed and interpreted the same way in your culture?). Assess this category on the personal stories, examples.

Conceptual equivalence: refers the analogy grade is shared by a cultural group, such as: behaviours, symbols, metaphors and concepts. Assess this category on the programme in: psychoeducation sections, activities, imagens and quotes.

Linguistic equivalence: Involves oral and written language on the programme. (Example: regionalism, slangs).

Please use this legend to answer the questions:

1 The components are not reflected within the module.	2 Most of the components are not reflected within the module; however, some of them are.	3 Some components are reflected within the module and others are not.	4 Most of the components are reflected within the module; however, others are not.	5 All of the components are reflected within the module.
--	---	--	---	---

For each question, please choose the response which best characterises the treatment assessed.

Module 1:

Components	Functional equivalence (1-5)	Conceptual equivalence (1-5)	Linguistic equivalence (1-5)	Observations
Content				
Personal Stories				
Examples				
Activities				
General comments of the module				

Module:

Components	Functional equivalence (1-5)	Conceptual equivalence (1-5)	Linguistic equivalence (1-5)	Observations
Content				
Personal Stories				
Examples				
Activities				
General comments of the module				

Module:

Components	Functional equivalence (1-5)	Conceptual equivalence (1-5)	Linguistic equivalence (1-5)	Observations
Content				
Personal Stories				
Examples				
Activities				
General comments of the module				

Module:

Components	Functional equivalence (1- 5)	Conceptual equivalence (1- 5)	Linguistic equivalence (1- 5)	Observations
Content				
Personal Stories				
Examples				
Activities				
General comments of the module				

Module:

Components	Functional equivalence (1- 5)	Conceptual equivalence (1- 5)	Linguistic equivalence (1- 5)	Observations
Content				
Personal Stories				
Examples				
Activities				
General comments of the module				

Module:

Components	Functional equivalence (1- 5)	Conceptual equivalence (1- 5)	Linguistic equivalence (1-5)	Observations
Content				
Personal Stories				
Examples				
Activities				
General comments of the module				

--

Module: Bringing It All Together

Components	Functional equivalence (1-5)	Conceptual equivalence (1-5)	Linguistic equivalence (1-5)	Observations
Content				
Personal Stories				
Examples				
Activities				
General comments of the module				

Note: The interaction on the platform and modules will be reviewed as part of the validity of this evaluation.

Appendix G – Changes to Scales

SCALE AND ITEM	ORIGINAL ITEM IN SPANISH	ADAPTED ITEM IN SPANISH
GAD-7 (Item 6)	<i>¿Se ha irritado o enfadado con facilidad?</i>	<i>¿Se ha molestado o enfadado con facilidad?</i>
WHOQOL-BREF (Item 1)	<i>¿Cómo calificaría su calidad de vida?</i>	<i>¿Cómo puntuaría su calidad de vida?</i>
WHOQOL-BREF (Item 3)	<i>¿Hasta qué punto piensa que el dolor (físico) le impide hacer lo que necesita?</i>	<i>¿Hasta qué medida piensa que el dolor (físico) le impide hacer lo que necesita?</i>
WHOQOL-BREF (Item 4)	<i>¿En qué grado necesita tratamientos médicos para funcionar en su vida diaria?</i>	<i>¿Cuánto o hasta qué medida necesita tratamientos médicos o medicamentos para funcionar en su vida diaria?</i>
WHOQOL-BREF (Item 6)	<i>¿Hasta qué punto siente que su vida tiene sentido?</i>	<i>¿En qué medida siente que su vida tiene sentido?</i>
WHOQOL-BREF (Item 13)	<i>¿Dispone de la información que necesita para su vida diaria?</i>	<i>¿Qué disponible tiene la información que necesita para su vida diaria?</i>
WHOQOL-BREF (Item 14)	<i>¿Hasta qué punto tiene la oportunidad de realizar actividades de ocio?</i>	<i>¿Hasta qué punto tiene la oportunidad de realizar pasatiempos o actividades de ocio?</i>
WHOQOL-BREF (Item 15)	<i>¿Es capaz de desplazarse de un lugar a otro?</i>	<i>¿Es capaz de desplazarse (físicamente) de un lugar a otro?</i>
WHOQOL-BREF (Item 16)	<i>¿Cuán satisfecho/a está con su sueño?</i>	<i>¿Cuán satisfecho/a está con su sueño? (Se refiere al acto de dormir no a soñar)</i>

Appendix H – Focus Group Discussion and Interview Guides (Phase 3 – Step 2)

Focus Group Discussion Guide Participants: CRC Volunteers

Ice Breaker: To start, I would like to hear broadly about your experience delivering PM+

Romper el hielo: Para empezar, me gustaría que me contaran sobre su experiencia con la intervención

Topic 1: Training

Thank you for this discussion, I will ask you more about this later in the interview, but now I would like to take you back to the training, how was it?

What was difficult about what you learned during the training?

What would have helped you to know more about?

How confident/prepared did you feel about the intervention after completing the training?

You may have noticed that it is only three of you here today from the training, why do you think the rest did not start delivering PM+?

Tema 1: Taller

Gracias por toda esta información, hablaremos sobre esto un poco más adelante, pero ahora, me gustaría hablar sobre el taller que hicimos en noviembre, ¿cómo fue?

¿Qué temas de los que aprendieron durante el taller fueron difíciles?

¿En qué temas les hubiera gustado profundizar más?

¿Hasta qué punto se sintieron seguros y preparados para facilitar MTP después del taller?

Como habrán notado solo son tres aquí en esta reunión, ¿por qué creen que el resto no comenzó a facilitar Manejando tus Problemas?

Topic 2: Data collection

Now, as you were also collecting information for a research project, I want to ask you how was this?

How would you first approach a beneficiary? What did you do to make the participant feel comfortable with asking the questions?

Probing questions:

How did you feel about asking questions to the participants?

How do you think the participant felt?

Would the participant reply individually or would you read the questions to them?

Were there any differences on how you approached or talked to certain persons?

Tema 2: Recopilación de datos

Ahora, como también estuvieron recopilando información para este ejercicio académico, quiero preguntarles ¿cómo fue esa parte?

¿Cómo se acercaban ustedes a los beneficiarios? ¿Qué hacían para lograr que ellos se sintieran cómodos mientras les hacían preguntas?

¿Recuerdan algunas diferencias en cómo interactuaban con ciertas personas?

Preguntas de sondeo:

¿Cómo fue el proceso de administrarle las preguntas a los participantes?

¿Cómo reaccionaba el participante/la participante?

¿Los participantes respondían individualmente o ustedes les administraban las preguntas?

Topic 3: Delivery

Thank you for all this valuable information, now I would like to hear more about the process of delivering PM+.

I would like to start by asking you about how you prepared before going to a session with a participant?

How would you arrange sessions with the participant? How was it to attend these sessions?

In your opinion, how did the community perceive this work you were doing with the participant? What did others (e.g. family members, friends, neighbours of the participants) think you were doing during these sessions?

When you were in the sessions, which strategies or parts of the intervention did you find most difficult to follow/adhere to? Were there parts of the intervention that you had to skip because participants found them difficult? Were there cases in which you had to add another strategy because the participant was not understanding?

Were there sessions when you had to spend longer time working on a strategy because the participant was not understanding?

Which strategies or parts of the intervention did you find easiest to follow/adhere to?

Were there differences in how you worked with different participants?

Tema 3: Facilitación

Muy bien, ahora me gustaría saber más sobre cómo fue facilitar la intervención.

Me gustaría comenzar preguntándoles ¿cómo se preparan para ir a una sesión con un participante?

¿Cómo organizaban las sesiones con los participantes? ¿Qué tal era para ustedes asistir a estas sesiones?

En su opinión, ¿cómo percibe la comunidad este trabajo que hacen con los beneficiarios? ¿Qué piensan los vecinos o familiares que pasa durante estas reuniones?

Durante las reuniones, ¿qué estrategias o partes de la intervención les parecieron difíciles de facilitar o de ceñirse a lo que indicaba el manual? ¿Cuáles fueron las resultaron más fáciles? ¿Hubo partes de la intervención que tuvieron que omitir porque los participantes las encontraron difíciles? ¿Hubo casos en los que tuvo que agregar otra estrategia porque el participante no entendía? ¿Hubo sesiones en las que tuvieron que pasar más tiempo porque el participante no entendía?

¿Me podrían hablar de cómo trabajaban con diferentes personas? ¿Hay diferencias?

Topic 4: Support and supervision

How were you supported throughout the delivery of PM+?

What did you do when you had questions/doubts about your work with a beneficiary? Do you feel these doubts and questions were answered?

How did you manage difficult cases or participants who had very complex problems?

Usually, in these type of intervention, participants stop attending the sessions regularly. But this was not the case with your work. Why do you think this is?

Finally, how do you think we can avoid double actions?

Tema 4: Apoyo y supervisión

¿Qué tipo de apoyo o supervisión han recibido ustedes como parte de este ejercicio académico?

¿Qué hacen cuando tienen preguntas o dudas sobre su trabajo con un beneficiario? ¿Creen que estas dudas y preguntas fueron respondidas?

¿Cómo manejan los casos difíciles o los participantes que tienen problemas muy complejos?

Por lo general, en este tipo de intervención, los participantes dejan de asistir a las sesiones regularmente. Pero este no fue el caso con el trabajo de ustedes ¿Por qué creen que es esto es así?

Finalmente, ¿cómo creen que podemos evitar las dobles acciones?

Topic 5: Participants' opinions of PM+

How do you think the participants saw the intervention?

How do you think the interventions help participants?

What do you think the participants liked or disliked about PM+?

Tema 5: Opiniones de los beneficiarios

En su opinión, ¿qué les parece la intervención a los beneficiarios?

¿Cómo cree que Manejando tus Problemas ayuda a los participantes?

¿Qué crees que les gustó o disgustó a los beneficiarios sobre MTP?

Topic 6: General opinion of PM+

How do you feel about this intervention in general?

How does PM+ compare to other activities you carry out at the Red Cross?

What are some changes we can make to the intervention or to the process of delivering the intervention?

What would you recommend other persons starting to facilitate PM+?

Tema 6: Opinión general sobre Manejando tus Problemas

¿Qué les parece a ustedes este tipo de trabajo?

¿Cómo se compara este programa con otros trabajos que hacen ustedes con la Cruz Roja?

¿Qué les recomendaría a otras personas que estén facilitando MTP?

¿Cuáles son algunos cambios que harían a la intervención o al proceso de facilitarla?

Preguntas de sondeo: Si pudieras volver a cuando comenzaron a trabajar con esta intervención, ¿qué harían de otra forma?

Semi-Structured Interview Guide

Participant: Lead Supervision

Ice Breaker: To start, I would like to hear broadly about your experience managing and coordinating PM+

Romper el hielo: Para empezar, me gustaría que me contaras sobre tu experiencia coordinando e implementado este programa.

Topic 1: Planning PM+

What was your role in implementing PM+?

Thank you for these comments, I would like to know about how was it to coordinate and manage PM+?

What have you liked about managing and coordinating this programme?

What have you disliked about managing and coordinating this programme?

In your opinion, how does your own manager/colleagues perceive this type of work?

Tema 1: Planificación

¿Cuál ha sido tu papel en la implementación de la intervención?

Muy bien, me gustaría también saber cómo fue coordinar este programa. ¿Qué te ha gustado de trabajar este programa? ¿Qué no te ha gustado tanto de trabajar este programa?

¿Qué crees que le parece a tu jefe y a tus compañeros este trabajo que estás haciendo?

Topic 2: Scaling up

How do you think this type of intervention aligns with the plans for the RC's Psychosocial Support Groups?

How would PM+ work with other populations or groups of beneficiaries?

How would it be to implement PM+ in other branches or Psychosocial Groups of the Red Cross?

Probing questions:

What are the characteristics of a type of branch where PM+ could be successfully implemented and why?

What are the characteristics of branches where you think PM+ could not be successfully implemented and why?

Can you tell me a bit about the resources needed to implement PM+?

Would the CRC have the capacity/be interested in running this type of intervention in other branches with your own resources?

I would also like to hear about your interpretation of the difficulties faced during the implementation of PM+, what would you recommend to another coordinator/manager implementing PM+ in another Red Cross National Society?

Is this the first time you have worked with this type of structured intervention in the CRC? Would this intervention be something you would want to use again? Why?

Tema 2: Expansión

Ahora me gustaría escuchar tu opinión sobre ¿cómo este programa se ajusta al plan del Grupo de Apoyo Psicosocial de la SNRCR?

¿Cómo sería llevar esta intervención a otras poblaciones o grupos de beneficiarios con las que trabaja la SNRCR?

¿Cómo sería implementar MTP en otros Grupos de Apoyo Psicosocial de la Cruz Roja?

Preguntas de sondeo:

¿Cuáles son las características que debe tener una filial para implementar MTP con éxito y por qué?

¿Cuáles son las características de una filial donde cree que MTP no se podría implementar exitosamente y por qué?

¿Me puedes contar un poco sobre los recursos necesarios para implementar MTP? ¿Crees que la SNRCR, podría y estaría interesada en implementar esta intervención de nuevo con sus propios recursos?

También me gustaría saber algunas de las dificultades que has tenido durante la implementación de MTP ¿Qué le recomendaría a otra persona que quiera empezar a trabajar con esta intervención en otra SN?

¿Es la primera vez que has trabajado con una intervención como esta en la Cruz Roja? ¿Sería esta intervención algo que querrías usar de nuevo? ¿Por qué?

Topic 3: Supporting the volunteers and supervisors

Excellent, now I would like to talk about any considerations on the work of the team.

Why did you choose this team for working on this project?

I would like to hear about how do you think the supervisor manage with the implementation of PM+? What do you think was difficult for her? What do you think was easy or enjoyable for her?

How would the supervisor report to you?

How do you think the volunteers manage with the implementation of PM+?

Overall, what do you think about this programme?

Tema 3: Apoyo a la supervisora

Excelente, ahora me gustaría hablar sobre el Grupo de Apoyo. En primer lugar, me gustaría saber ¿por qué seleccionaron esta filial para hacer este trabajo?

También me gustaría saber, ¿cómo crees que le ha ido a la supervisora con este trabajo? ¿Cómo se comunicaba ella con ustedes acerca de este programa? ¿Qué crees que le fue difícil a ella? ¿Qué crees que fue fácil o agradable para ella?

¿Cómo cree que les ha ido a los voluntarios? En general, ¿qué crees de este programa?

Semi-Structured Interview Guide

Participant: Supervisor

Ice Breaker: To start, I would like to hear broadly about your experience as a supervisor for PM+

Romper el hielo: Para empezar, me gustaría que me contaras un poco sobre tu experiencia supervisando MTP

Topic 1: Experience as supervisor

Thank you for these comments, I would like to hear more about them through the interview.

I would also like to know about what have you learned from your work as a supervisor of PM+? What was difficult or challenging about supervising the volunteers? What was easy or enjoyable about supervising the volunteers?

I will now take you back to your first training, how confident/prepared did you feel about the intervention and supervision after completing the first training?

You were also in charge of the process of data collection, how was this?

How did you manage complex/difficult cases? What was the process of referral?

How were you supported (e.g., supervision, training) throughout the implementation of PM+?

Tema 1: Experiencia como supervisora

Muchas gracias, te preguntaré más adelante sobre alguna de las cosas que has mencionado.

También me gustaría saber qué ahora sobre que has aprendido de tu trabajo como supervisora ¿Qué fue difícil o desafiante en la supervisión de los voluntarios? ¿En la supervisión de los voluntarios, qué partes fueron fáciles o entretenidas?

Ahora quiero que recordemos un poco el primer taller en el que participaste, ¿qué tan segura/preparada te sentiste para supervisar y facilitar MTP después de completar este primer taller?

También estás a cargo del proceso de recopilación de datos, ¿cómo ha transcurrido esto?

¿Cómo han manejado los casos complejos/difíciles? ¿Cuál ha sido el proceso enrutar?

¿Cómo has recibido apoyo (ej. supervisión, capacitación) durante la implementación de MTP?

Topic 2: Volunteer's experiences

I would like to hear your thoughts about the volunteers' delivery of PM+, what do you think it was like for them to deliver PM+?

Can you talk to me about challenges they faced and how were they managed?

How would you support them with these challenges?

Overall, how would you supervise their work?

What aspects/steps of PM+ do you think are easiest for volunteers to follow? Which ones do you think are less easy to follow/take more creative license?

Probing questions:

How did the work of volunteers differentiate, and why?

Tema 2: Las experiencias de los voluntarios

Me gustaría escuchar su opinión sobre el trabajo de los voluntarios con MTP, ¿cómo crees que ha sido para ellos facilitar esta intervención?

*¿Puedes hablarme un poco sobre los desafíos que ellos enfrentaron y cómo los manejaron?
¿Cómo los apoyas tú con estos desafíos?*

En general, ¿cómo supervisas su trabajo?

¿Qué aspectos/partes de MTP crees que son más fáciles de seguir para ellos? ¿Cuáles crees que son menos fáciles de seguir y han tomado alguna licencia creativa?

Preguntas de sondeo:

¿Cómo se diferencia el trabajo de los voluntarios y por qué?

¿Cómo decidían si hacer la reunión de forma individual o incluir a más participantes?

Topic 3: Delivery

You were supervising the volunteers' work but you were also delivering the intervention so now I would like to hear more about the process of delivering PM+.

I would like to start by asking you about how you prepared before going to a session with a participant?

How would you arrange sessions with the participant? How was it to attend these sessions?

In your opinion, how did the community perceive this work you were doing with the participant?

What did others (e.g. family members, friends, neighbours of the participants) think you were doing during these sessions?

When you were in the sessions, which strategies or parts of the intervention did you find most difficult to follow/adhere to? Were there parts of the intervention that you had to skip because participants found them difficult? Were there cases in which you had to add another strategy because the participant was not understanding?

Were there times when you had to spend longer time working on a strategy because the participant was not understanding?

Which strategies or parts of the intervention did you find easiest to follow/adhere to?

Were there differences in how you worked with different participants?

Usually, in these type of intervention, participants stop attending the sessions regularly. But this was not the case with your work. Why do you think this is?

How do you think the participants saw the intervention?

Finally, how do you think we can avoid double actions?

Tema 3: Facilitación

Muy bien, además de supervisar tú también has facilitado MTP. Me gustaría preguntarte ¿cómo te preparabas para ir a una sesión con un participante?

¿Cómo organizabas las sesiones con los participantes? ¿Qué tal era para ti asistir a estas sesiones?

En tu opinión, ¿cómo percibe la comunidad este trabajo que haces con los beneficiarios? ¿Qué piensan los vecinos o familiares que pasa durante estas reuniones?

Durante las reuniones, ¿qué estrategias o partes de la intervención te parecen difíciles de facilitar o de ceñirse a lo indicado en el manual? ¿Cuáles fueron las resultaron más fáciles? ¿Hubo partes de la intervención que tuviste que omitir porque los participantes las encontraron difíciles? ¿Hubo casos en los que tuviste que agregar otra estrategia porque el participante no entendía? ¿Hubo sesiones en las que pasaste más tiempo porque el participante no entendía?

¿Me podrían hablar de cómo trabajas con diferentes personas? ¿Hay diferencias?

Topic 4: Scaling up

Overall, what is your opinion about this intervention?

If you were to start this process all over again, what would you do differently?

What should others look for when identifying volunteers for the delivery of PM+? Are there any specific characteristics that a volunteer doing this work would have?

Also, we conducted a PM+ training together, what would you recommend to other supervisors in the RC that are in the process of training volunteers in PM+?

You might also remember that there were nine trainees in the training we conducted, why do you think five of them did not start delivering PM+?

There are other versions of PM+. More specifically, there is one version that brings beneficiaries together in a group, and the session is guided by one facilitator. What are your thoughts about using this version in this setting in comparison with the individual version that you used?

What would you recommend to a supervisor working with PM+ in another Red Cross National Society?

Tema 4: Expansión

En general, ¿cuál es tu opinión sobre esta intervención?

Si volvieras a comenzar este proceso desde el principio, ¿qué harías de otra manera?

¿Qué considerarías al seleccionar voluntarios para trabajar con esta intervención? ¿Hay alguna característica específica que debe tener un voluntario que realiza este trabajo?

¿Qué le recomendarías a otros supervisores de la CR que están en el proceso de capacitar a voluntarios en MTP?

También recordarás que en el taller que hicimos juntas había nueve voluntarios, ¿por qué crees que cinco de ellos no comenzaron a facilitar MTP?

Hay otras versiones de MTP. Por ejemplo, hay una versión que reúne a los beneficiarios en un grupo, y la sesión es guiada por un solo facilitador. ¿Qué piensas sobre el uso de esta versión en comparación con la versión individual que utilizamos?

¿Qué le recomendarías a un supervisor que trabaja con MTP en otra Sociedad Nacional de la Cruz Roja?

Semi-Structured Interview Guide

Participant: PM+ Participant

Ice Breaker: First, I would like to thank you again for meeting me and start asking you broadly about your experience with the sessions with the Red Cross volunteer.

Romper el hielo: Ante todo quiero agradecerle por hablar conmigo y empezar por preguntarle sobre su experiencia con las reuniones que tuvo con el voluntario o voluntaria de la Cruz Roja.

Topic 1: General opinion of PM+

Can you describe some of the things that were relevant or beneficial about these sessions?
Could you give me an example of how this help you?

What about something you disliked about it? Was there anything *else* you disliked about it?

What aspects of the sessions did you find easiest to follow? Which ones were not as clear/you found yourself having to come up with your own steps?

Do you see yourself applying what you learned in the future? If so, why/how? If not, why not?

If you had to do the sessions again, what would you change? In your opinion, what can be improved about this experience?

How do you think a friend or family member might respond to these sessions? Do you think they would find them useful?

What would you think of attending group sessions, with other members of your community?

Tema 1: Opinión general

¿Me podría hablar sobre algo que le pareció relevante o le gustó de estas reuniones? ¿Algo más?

¿Me podría hablar de algo que no le gustó tanto de estas reuniones? ¿Algo más?

*¿De las cosas que aprendió con la voluntaria o voluntario que le pareció más fácil y útil?
¿Cuáles fueron menos claras e inclusive tuvo usted que improvisar?*

¿Cree que usará lo que aprendió con el voluntario o la voluntaria en el futuro? ¿Por qué sí o no?

Si usted fuera a comenzar las reuniones de nuevo, ¿qué cambiaría? ¿Qué se puede hacer para mejorarlas?

En su opinión, ¿qué le parecerían estas reuniones a un amigo, amiga o familiar suyo? ¿Cree que les parecerían útiles?

¿Qué le parecería atender a estas reuniones en grupo, junto otros miembros de su comunidad?

Topic 2: Context and relation with facilitator

How was attending the session (e.g. time, place)? Did you face any inconveniences?

What are some things that the volunteer did during the sessions that you found useful?

What are some things that the volunteer did that you found unhelpful? Was there anything that you think the volunteer should have done to make the sessions better?

Topic 2: Contexto y relación con la/el voluntario

¿Qué tal fue asistir estas sesiones (ej. tiempo, lugar, duración)? ¿Tuvo algún inconveniente?

¿Qué cosa hizo el voluntario o la voluntaria durante los encuentros que les resultaron útiles?

¿Qué cosas hizo el voluntario o la voluntario/a durante las sesiones que no resultaron útiles?

¿Hay algo que el voluntario y la voluntaria pudo haber hecho para que las reuniones fueran mejor?

Focus Group Discussion Guide
Participant: Supervisors and Volunteers

How does this intervention align (or not) with the needs of the population?

In general, with this types of interventions, participants stop attending sessions regularly. This was not the case with this work, why do you think that was?

Is there something we have not discussed that you would like to talk about?

Now that we have talked about the process of implementing this intervention, I would like to know what are your general conclusions from your work with it.

¿Cómo se alinea, o no se alinea, esta intervención a las necesidades de esta población?

Por lo general, en este tipo de intervención, los participantes dejan de asistir a las sesiones regularmente. Pero este no fue el caso con el trabajo de ustedes ¿Por qué creen que es esto es así?

¿Hay algo sobre lo que no hemos conversado que les gustaría resaltar?

Ahora que hemos hablado de cómo ha sido el trabajo con la intervención, quiero saber un poco de sus conclusiones generales sobre su trabajo con el programa.

Appendix I – Policy Brief



SCALABLE PSYCHOLOGICAL INTERVENTIONS AS WAY TO ADDRESS STAGGERING MENTAL HEALTH NEEDS OF REFUGEES AND MIGRANTS

This policy brief is based on the results of EU-funded research that has adapted and **tested a simplified psychological intervention** (Problem Management Plus – PM+) among Venezuelan migrants and refugees in Colombia. Developed by the World Health Organization in recent years, PM+ is a **short intervention** and does not target a single disorder, but a set of symptoms of **common mental disorders** such as anxiety, depression, and posttraumatic stress disorder. It is based on **well-tested** cognitive behavioural and problem solving techniques.

PM+ helps people with practical problems such as unemployment or interpersonal conflict and can be provided by trained persons who are **not mental health professionals**, which makes it a **cost-effective strategy** for increasing access to mental health care.

RELEVANCE TO THE EUROPEAN COMMISSION AGENDA

- Refugees and migrants make **4% of the European Union's population** but tend to fare worse than EU citizens in terms of employment, education and social outcomes
- They are **disproportionally affected** by loss of family and community support and are at **higher risk** of developing mental health problems.
- Higher prevalence rates of mental disorders in refugees and migrants are associated with **lack of social integration**, and particularly with **unemployment**.
- The health of migrants and refugee is a **priority of the European Agenda on Migration**
- However, **EU countries are struggling** to provide mental health care on the scale that it is needed.
- Mentoring and peer support programmes led by **municipalities and civil society** organisations across Europe are one of the most commonly implemented practices for the integration of third-country nationals².

RESEARCH FINDINGS

- Our research shows that Problem Management Plus can be **successfully delivered by volunteers** from a government auxiliary (the Red Cross), if they receive the appropriate training and supervision.
- What is more, this intervention is **well-received** by volunteers and migrants and refugees alike



- We thoroughly documented this process and have identified a series of possible factors that can **facilitate the use of PM+**
- These factors include volunteers' interpersonal skills, motivation, strong supervision, knowledge of referral pathways and the involvement of the host community.

BOTTOM LINE

- **Peer support and mentoring programmes** are commonly used across Europe to increase migrants and refugees access to services, community support and integration
- But **they can go further** than that
- Through scalable psychological interventions, peer support and mentoring volunteers can be equipped with the tools to **address and prevent** common symptoms of mental health problems
- This would enable a cost-effective **integration of social and mental health** services
- PM+ helpers receive **a training of 8 days** and frequent supervision by specialists
- PM+ is available in **multiple languages** and can be culturally adapted to fit the needs of different populations

ABOUT THE RESEARCH PROGRAMME

CONTEXT is an international, interdisciplinary collaboration between nine European partner organisations spanning the academic, non-governmental, voluntary, and public sectors. The goal of CONTEXT is to conduct high quality, innovative research, build capacity and expertise, and foster innovative practice in global psychotraumatology¹

Contact Information: CONTEXT Fellow Camila Perera (pererac@tcd.ie)

REFERENCES

1. Vallières F, Hyland P, Murphy J, et al. Training the next generation of psychotraumatologists: COLlaborative Network for Training and EXcellence in psychoTraumatology (CONTEXT). *European Journal of Psychotraumatology* 2018; **9**(1): 1421001.
2. European Commission. Migrant Integration Information and Good Practices. 2019. <https://ec.europa.eu/migrant-integration/search?search=&advanced=1&advtype=intpract> (accessed December 12 2019).
3. WHO. Scalable psychological interventions for people in communities affected by adversity 2017.