Mental health and psychosocial support (MHPSS) – row summary

Mental health and psychosocial support (MHPSS) shows large improvements in trauma-related health outcomes and (in one study) social cohesion. But there are little or no effects on violence outcomes and broader social norms.

MHPSS interventions in this evidence base provide structured psychological and social support to people affected by conflict, including survivors of violence, refugees, and current or former combatants.

The included studies cover: (i) individual trauma therapies, especially Narrative Exposure Therapy and forensic adaptations for offenders (NET and FORNET) in DRC; (ii) cognitive and socio-behavioral therapies designed to build self-control and a non-criminal identity (Cognitive Behavioral Therapy and the STYL program in Liberia); (iii) community-based healing and reconciliation approaches that combine psychoeducation with facilitated group dialogue (HCUP in Rwanda); (iv) school-based psychosocial and conflict resolution programming (School Mediation Intervention in Gaza); and (v) survivor support and case management, sometimes bundled with community mobilisation to increase awareness of sexual and gender-based violence services (review evidence from refugee and humanitarian settings in Kenya and Lebanon). In some settings, MHPSS is bundled with economic support (cash grants) or embedded within wider community programming.

These interventions are intended to reduce inter-group violence and strengthen social functioning by addressing conflict-related trauma and its behavioral sequelae. At the individual level, trauma processing and skills-based therapy aim to reduce PTSD symptoms, shame, depression, and appetitive aggression, while improving emotional regulation, impulse control, and future planning. Several programs explicitly target harmful beliefs and social norms, for example rape myth acceptance and stigma toward sexual violence survivors, through facilitated discussion and community engagement. The downstream pathway to violence prevention is typically indirect: improved mental health and self-control are expected to reduce reactive aggression and antisocial behavior, support reintegration into civilian life, and increase participation in prosocial networks and livelihoods. The bundling of MHPSS in some cases makes it difficult to isolate the marginal contribution of psychological components.

Evidence of effects (Hedges g; two decimal places):

- **Intermediate social cohesion outcomes:** Large positive effects in one Rwanda study (HCUP) on trauma reduction and reconciliation (g = 0.58). Effects differed by participant group and program focus (for example secular versus religious and community-focused groups), suggesting sensitivity to local implementation and social context.
- **Food security and nutrition; health security:** Large average improvements in trauma-related health outcomes (g = 0.26) across multiple studies and contexts (DRC, Liberia, Rwanda, Gaza). However, effects were not uniformly positive: the school mediation program in Gaza

stabilised distress and depression but was associated with increased PTSD symptoms for some children, indicating potential adverse effects for highly traumatised participants.

- **Nature and scale of violence or atrocities:** A very small overall reduction in violent behavior and related outcomes (g = 0.03). In Liberia, CBT and STYL were tested both alone and bundled with cash; direct effects on several self-reported criminal and conflict behaviors were not statistically significant, and some intimate partner violence indicators were mixed over time. In Eastern DRC, NETfacts did not show direct effects on victimisation or perpetration, but indirect reductions were observed through decreased rape myth acceptance (a plausible mediating mechanism).
- **Economic security:** A very small improvement in economic reintegration (g = 0.03). In DRC, FORNET was associated with better economic reintegration in later dissemination and longer follow-up periods, suggesting learning and delivery quality may matter. In Liberia, short-term economic gains were largely driven by cash grants; when therapy and cash were bundled, the specific contribution of MHPSS cannot be separated, and gains were not sustained beyond a year in the presence of theft and property insecurity.
- **Social norms regarding violence and atrocities:** No overall effect (g = -0.00). Across CBT and STYL, FORNET, and NETfacts, single-study findings were mixed, including modest improvements in some aggression and weapon-carrying attitudes alongside null findings and at least one adverse direction of effect, resulting in a pooled estimate close to zero.
- **Feelings of trust and acceptance of diversity:** No overall effect (g = -0.00) on shame or broader social disapproval. Some narrower attitudinal changes were reported (for example reduced stigma toward sexual violence survivors in NETfacts, and reduced attachment to military life in FORNET), but these did not translate into consistent improvements in generalized trust or acceptance outcomes, and some effects attenuated over time.
- **Presence and quality of social safety nets:** Narrative review evidence (no effect size reported) suggests improved acceptability and access to services and increased social support in refugee and humanitarian settings, particularly when peer community workers and community mobilisation were used. Because evidence was synthesised narratively and focused on service uptake and support, it is not possible to quantify the size of effect or compare directly with the meta-analytic outcomes above.

Confidence in findings is mixed and often constrained by limited numbers of impact evaluations per outcome, context-specific implementation, and heterogeneity in intervention content and populations. Confidence is low for violence outcomes, economic security, and trust-related outcomes because estimates are based on two studies each and results vary by follow-up period and whether interventions are bundled with cash or other components. Confidence is medium for social norms outcomes and for trauma-related health outcomes because more studies contribute, although effects still vary and some adverse or null findings are present. The large social cohesion effect is based on a single low-confidence study, so it should be treated cautiously. Across outcomes, generalisability beyond the studied settings (predominantly Sub-Saharan Africa, with one study in Gaza and review evidence from refugee settings) is uncertain, and several studies rely on self-reported behaviors or short to medium follow-up.

Effect sizes for MHPSS on conflict and atrocity related outcomes

Outcome	Effect size (g)	Interpretation	Number of studies	Number of effect sizes
Intermediate social cohesion outcomes	0.58	Large effect	1	3
Food security and nutrition; health security	0.26	Large effect	5	25
Economic security	0.03	Little or no effect (small positive)	2	12
Nature and scale of violence or atrocities	0.03	Little or no effect (small positive)	2	8
Feelings of trust and acceptance of diversity	-0.00	No effect	2	8
Social norms regarding violence and atrocities	-0.00	No effect	4	11
Presence and quality of social safety nets	n/a	Positive (narrative synthesis; no effect size)	3	n/a